Newark Beth Israel Medical Center | RWJBarnabas HEALTH

CircleLink Health

Case Study

CircleLink Health Drives Better Chronic Care Management and Profit for a Primary Care Practice

In just a few months, CircleLink Health helped Newark Beth Israel's Beth Prime Care, a hospital- owned clinic, grow its chronic care management (CCM) program over 14X to ~500 participating patients at ~$12,000 of profit each month.

The Challenge

Finding headcount and resources for quality care coaching across hundreds of patients can be challenging, even for hospital-owned primary care practices. Demands on staff continue to increase while reimbursements decline. Many practices lack the resources to focus on the non-face to-face care required for Medicare's new chronic care reimbursement plan. These are missed opportunities that would benefit the patients and the practice.

The Solution

Through a fusion of modern software and high-touch telehealth service, CircleLink Health bridged the gaps in care coordination to support this physician practice in improving health for their patients with chronic conditions. Highly qualified RN Care Coaches engaged patients by phone each month to assess compliance risks/drive preventive appointments, perform medication reconciliation, educate patients and assist with any questions that may have arisen since their last visit. CircleLink Health then provided all the billing data to obtain Medicare reimbursement.

The Results and Benefits

For this urban practice, CircleLink Health grew the program to over 500 patients. The results included improved care, A1C average reduction of 0.7 (for diabetics with starting A1C over 7.0) and a $9,000 monthly boost to the group's bottom line. ER visits and 30-day readmissions rates were also reduced 20% and 25%, respectively.** Anticipated annualized profits are over $150,000, excluding ancillary profit for screenings and services facilitated by CircleLink care coaches.

CircleLink Health completes the missing link in the care continuum, making chronic care management more effective and affordable.

- Grew CCM >14X vs. internal program
- >99% monthly patient retention*
- 28% lower 30-day readmissions rate**
- A1C reduced by 0.7 for patients over 7.0 starting A1C
- 20% ER visits reduction**

*For patients on program >3 months. **For 272 patients on program for a year vs. same patients' prior year.

Call (877) 590-3642 or visit circlelinkhealth.com for more information

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