Bethesda NEWtrition and Wellness Solutions

An Innovative Care Delivery Practice

&

Care Transformation Organization (CTO)

Bethesda NEWtrition & Wellness Solutions

Our History

Bethesda NEWtrition and Wellness Solutions (BNWS) is a primary care and wellness organization founded in September 2013 to provide nutrition services for diabetes and weight management in Bethesda, Maryland.

In December 2016, primary care services were added to support its mission of coordinated patient care. BNWS is now a comprehensive source for a variety of health care services, both onsite and in the home.

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About BNWS

- Our team of healthcare providers has over 100 cumulative years of experience working in outpatient, small practice settings.
- We focus on partnering with patients as well as creating connections and finding resources in the communities that we serve to provide the most well-rounded, patient-centered care for our patients.

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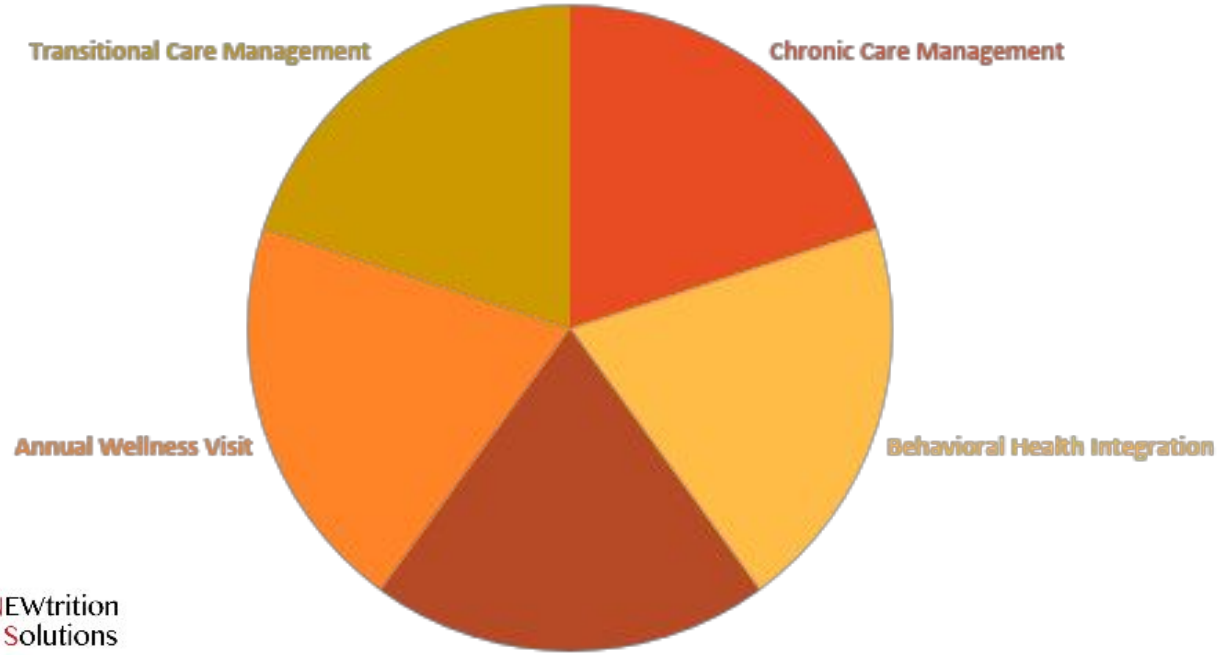
Care Delivery Components



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Chronic Care Management & Care Coordination

We Provide Care Coordination

Our team of care coordinators and healthcare professionals work with patients and providers to:

- Communicate effectively with members of the healthcare team, patients & families
- Manage transitions of care and medications
- Link patients and families to community resources
- Remote monitoring of blood glucose and blood pressure

We Provide Chronic Care Management

Patients who have 2 or more chronic conditions are eligible for these services, including:

- Assess the needs and goals important to the patient
- Create a proactive care plan
- Monitor goal progress and follow up with patients
- Support patient's self-management of their conditions

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Annual Wellness Visit

Annual assessment of the following:

- Cognitive status
- Functional ability and level of safety (falls risk)
- Medication review
- Healthcare team
- Health risk
- Mental health
- Preventative health screening status

- The AWV can direct referrals or additional needs
- Opportunity to look at Social Determinants of Health
- Provides an opportunity for education or counselling
- Looks at the fuller picture of health

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Transitional Care Management

- Patients are monitored by BNWS care coordinators while they are admitted (hospital, ER or nursing home/rehab)
- Coordinators facilitate communication and frequent updates between the primary care provider, the family, and the healthcare team at the inpatient facility
- Once the patient is discharged home, a transitional care visit is set up within 24-48 hours at home
- Patient is monitored for 30 days, and a unique care-plan is established

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Social Determinants of Health

Examples of Referrals		
AWV reveals home safety concerns	☐	Referral for Occupational Therapy and home safety evaluation (in the home)
Malnutrition risk screen is positive	☐	Referrals to social work, registered dietitian, and AAA for food assistance
PHQ-9 depression screen positive	☐	Referrals to LCSW for psychotherapy and behavioral health integration
AWV reveals trouble paying utility bills	☐	Referrals to any or all: chronic care management, social work, AAA, etc.

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MDPCP at a Glance:
Year 1 (2019) Annual Report Snapshot

MDPCP at a Glance

Annual Report Snapshot
Year 1- 2019

During its first year, the MDPCP had three objectives:

- Infrastructure development
- Care transformation
- Quality and utilization improvement.

This MDPCP Annual Report Snapshot summarizes the MDPCP program's accomplishments for each objective during its first year.

Infrastructure Development

Building a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to controlling the growth of Maryland's Medicare part A and B costs.

MDPCP created a robust network of dedicated primary care practices eager to transform care to better serve their patients. 380 practices supported by CTOs, Practice Coaches, and a learning system

MDPCP has developed a broad set of partners including:

CRISP – suite of analytical reports
The Hilltop Institute at UMBC – model predicting avoidable hospital events
Mosaic Group – processes to address substance use
Electronic Medical Record optimization vendor – enhancing practices' use of clinical data
Community-based organizations – linking practices and community partners to address social needs

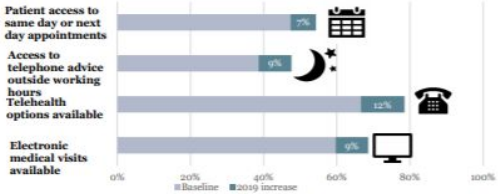
"We have to go upstream to really identify the root cause of why our clients struggle to stay healthy. MDPCP recognizes the importance of focusing on the holistic patient and the CRISP referral system is very helpful. " - Care coordinator at MDPCP practice

Care Transformation

Improving population health through continuous, relationship-based primary care that proactively addresses both medical and behavioral health needs, as well as social determinants of health and provides continuity of care.

MDPCP practices increased patient access to services during 2019.

Increase in Patient Access to Primary Care Providers during 2019



The percentage of patients in longitudinal care management increased by 39%– *from 7.2% to 10.0%.*

Nearly all practices (95%) integrated behavioral health services by the end of quarter 4.

117 practices have implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) for opioid use – *the largest roll-out of this program nationally to date.*

"Why did this program not exist much sooner? It gives me peace of mind that someone cares enough to proactively call me to see how I am doing. My care manager is always patient and nice. I really appreciate that. " – Patient at one MDPCP practice

Quality and Utilization Improvement

Establishing data tools and quality improvement processes that allow practices to monitor performance

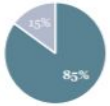
The majority of MDPCP practices had outcomes above median primary care practices on key clinical quality and utilization outcomes.

Clinical Quality Outcomes

Percentage above the 50th percentile in national Merit-Based Incentive Payment System (MIPS) Reporting.

Better Control of High Blood Pressure

Better Control of A1C

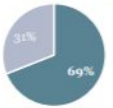


Utilization Outcomes

Percentage above the 50th percentile in all practices with Maryland FFS beneficiaries.

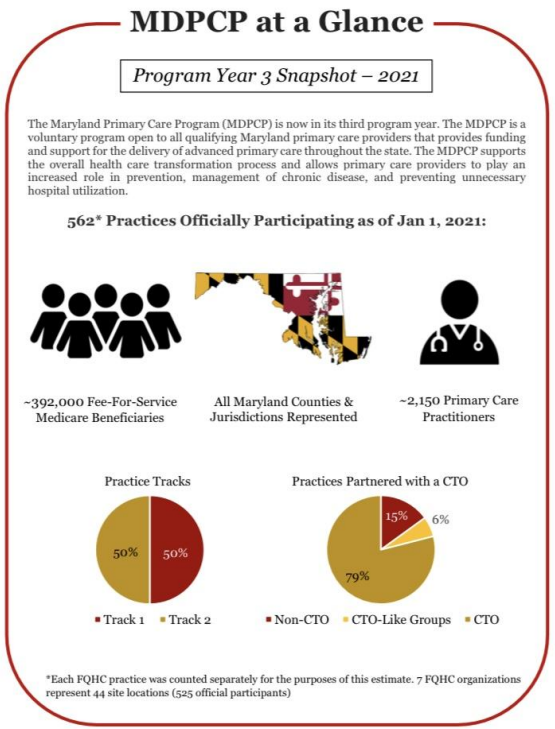
Better Inpatient Utilization

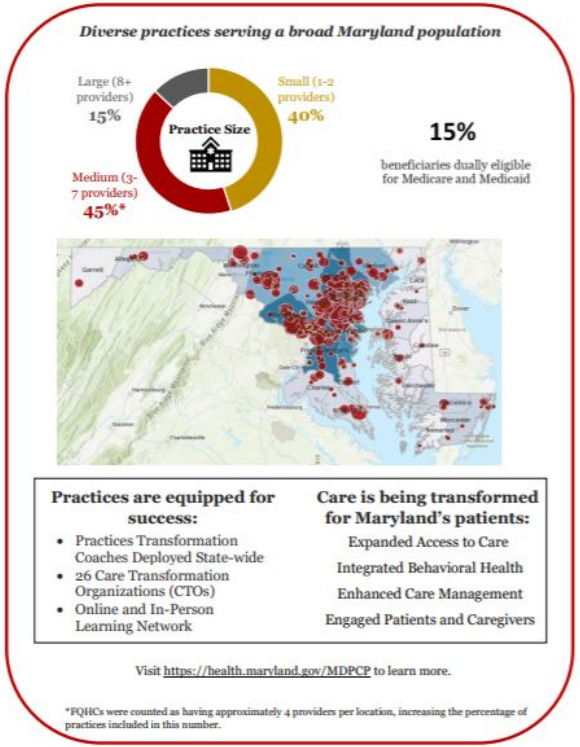
Better Emergency Care Department Utilization



▪ Above 50th percentile ▪ Below 50th percentile

MDPCP at a Glance: Program Year 3 (2021) Snapshot





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Thank you!

Livleen Gill, MBA RDN LDN

240-449-3094
operations@bnws.co

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