Consultation available for PCMPs and RAEs!

Consultation for clinic operations, billing, and coding - Pam Ballou Nelson

- **Collaborative Care Model (CoCM)**
  - Clearly define the essential principles of the Collaborative Care Model (CoCM) and explain its significance in modern clinical environments.
  - Identify which patient groups are most likely to benefit from the implementation of CoCM.
  - Describe the crucial steps required to establish effective CoCM workflows within a healthcare practice.
  - Review best practices for documentation and billing when using the CoCM
- **LEAN Principles in Healthcare**
  - Conduct a "waste walk" to identify inefficiencies and eliminate unnecessary processes.
  - Utilize A3 Thinking as a structured approach to problem solving.
  - Apply root cause analysis techniques to address underlying issues.
- **Practice Business Assessment and Development**
  - Evaluate and enhance the revenue cycle, focusing on improving relevant skills.
  - Understand the fundamentals of insurance contracting within the practice.
  - Address common issues related to medical billing and coding including denials.

Pediatric Specific Coaching for Family Medicine and Pediatric Clinics - Mindy Craig

- **Understanding recommended best care for kids and supporting implementation of new screening tools**
- **Understanding Colorado's referral landscape for children with developmental delays and disabilities**
- **Supporting practices on strategies to include children of all ages in behavioral health programs**
- **CoCM with pediatric patients**
- **Improving oral health for children living in areas with limited access to pediatric dental care**
- **Colorado specific resources to support best care of kids**

Tactics to address ACC III Opportunities - HealthTeamWorks

- **Targeted Care Management**
  - Guidance on developing the infrastructure, evidence-based protocols, staffing models, and workflows required for a successful transition from fee-for-service (FFS) to value-based care. Coaching emphasizes building sustainable systems that support patient-centered outcomes.
- **Chronic Condition Management**
  - Customized strategies for identifying at-risk patients, using population health data, and implementing risk-based care plans.
- **Specialty Care Collaboration**
  - Strategies for integrating specialty care and primary care for optimal patient outcomes, including data-driven identification of needs, collaborative care agreements, and e-consults. Coaching focuses on building strong specialist relationships and maximizing specialty resources.
- **Behavioral Health Integration**
  - Support for embedding behavioral health into primary care guided by the Building Blocks of Integrated Care. Coaching emphasizes population-based approaches, readiness assessments, and developing long-term behavioral health strategies.
- **Health-Related Social Needs (HRSN) Screening and Referral**
  - Coaching on implementing effective health-related social needs screening processes and workflows and connecting patients to community resources to improve care outcomes.
- **Supporting Whole-Person Care Through Community Supports and Service Navigation**
  - Strategies for connecting patients with community supports and resources to address social, behavioral, and medical needs. Coaching emphasizes building resource libraries, fostering community relationships, incorporating patient voice, and ensuring a prepared workforce capable of delivering culturally relevant, whole-person care.

✉ Questions? Reach out to Allyson at allyson.gottsman@cuanschutz.edu