LCCCP

LCCCP Overview

- Local Community Care Coordination Program
- Goal of being patient centered and caring for the members utilizing the “whole” person philosophy for the most successful outcome
- Treat and assist member on medical, behavioral, social, and economical needs – a holistic approach
- Closure of gaps of care
- Provide local community resources
- Provide active management of members and facilitate transition of care and tracking of referrals to help ensure a closed loop of information between all entities.

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LCCCP Overview

A LCCCP needs to:

- Provide enhanced access, such as extended office hours outside of 8 AM to 5 PM, open scheduling, and/or alternative communication such as telephonic options or web-based.

- Members enrolled in LCCCP are not eligible for the state's Health Home program **or** HSH CM services. Transition of care should be done between these services/entities. Members can opt out of LCCCP

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LCCCP Overview

A LCCCP needs to:

- Practice evidence based medicine
- Provide patient-centered care
- Coordinate between all the healthcare providers utilized by the patient
- Engage the member and/or family members to participate in decision making process and provided feedback
- Partake in continuous improvement in quality and performance measures
- Utilize health information technology to support care delivery

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Questions or concerns?

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