MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

1. Assessments

Completing the Assessment

Q: Can the MCC assessment be saved partway through?

A: No. The assessment cannot be saved until all required fields (marked with a red asterisk) are completed. If staff stop midway, their work will be lost.

Q: How should multiple staff complete the assessment when only one person can enter at a time?

A: Two workarounds are recommended: (1) The first staff member completes all required fields so the assessment can be saved, then other team members can go back in to edit the sections they are responsible for. (2) Staff complete the assessment on paper first, then one person enters all responses into e2LA. Note that workflows that were possible in Casewatch may need to be adjusted.

Q: Can assessments be edited after they are saved?

A: Yes. Completed assessments can be reopened and edited at any time—there is no cutoff period, and every edit is tracked in the system. However, if there has been a significant change in the client's situation (medical, acuity, or life circumstances), staff should consider completing a new assessment rather than editing the existing one, so changes can be tracked over time.

Q: Is there a paper version of the MCC assessment questions?

A: Yes. Appendix A in the MCC Guidelines on the DHSP website contains the full assessment. Note that DHSP recently released an updated version correcting a few questions—agencies should confirm they are using the current version.

Q: Can the assessment be exported or printed?

A: Yes. Once the assessment is completed and the acuity score is available, an “Export to PDF” button will appear above the acuity score. The PDF can then be downloaded, saved, or printed. There is no requirement to print and upload the full assessment to the patient chart; however, agencies should have at minimum a progress note in the chart documenting that the assessment was completed, including the date and acuity result.

Q: Why do exported assessment PDFs not show the client name?

A: This issue has been reported to the e2LA team and is pending review.

Self-Assessment and Division of Labor

Q: Can clients complete the assessment on their own (self-assessment)?

A: Yes. Self-assessment is an option for programs to consider. The assessment does not have to be completed as a staff-led interview. The revised assessment was designed to be brief enough that agencies could consider having clients complete it independently (for

example, on a tablet while in the waiting room). DHSP is available to provide technical assistance to agencies that want to use this approach.

Q: Does the full MCC team (both PCM and MCM) need to be present for every assessment?

A: No. Given current staffing realities, it is allowable for the assessment to be completed by one member of the MCC team individually. Regular team meetings or case conferences are strongly encouraged so that all team members stay informed about shared clients.

Assessment Dates and New Clients

Q: What date should be entered in the "date of last assessment" field of the new assessment?

A: For brand new clients or clients who had their last assessment entered in Casewatch, enter the date of the current assessment being completed. Do not enter a prior assessment date from Casewatch or another system—if the prior date is entered, the system will reflect the assessment as having been completed on that earlier date, resulting in inaccurate records. This issue has been reported to the e2LA team and is pending review.

Q: What should staff do if a client declines to answer certain assessment questions?

A: If the question is not required, staff may skip it. If the question is required (marked with a red asterisk), something must be entered for the assessment to save. Staff should use their clinical judgment to choose the most appropriate response. Staff can later edit the assessment if more information becomes available.

Reassessments and Transition from Casewatch

Q: If we completed an assessment in Casewatch in January 2026, when do we need to complete a new assessment in e2LA?

A: All MCC clients transitioning from Casewatch to e2LA must have a new assessment completed within six months of the March 1, 2026, e2LA launch—by August 31, 2026. This applies even if a recent assessment was completed in Casewatch. Agencies do not need to wait; they are encouraged to begin now so reassessments are not all concentrated at the deadline. Please note, prior to completing the reassessment in e2LA, staff should also re-screen the client as eligibility criteria may have changed.

Q: If a client was lost to follow-up and later returns to care, do they need a new assessment?

A: Not necessarily. A reassessment is not required simply because a client was temporarily lost to follow-up. Staff may resume services where they left off unless their clinical judgment indicates that a new assessment is warranted.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

2. Screening

Q: Is screening optional or required?

A: Screening is required—it is part of the MCC contract. It is not optional. Screener results must be documented in the agency's patient chart.

Q: How often should clients be screened?

A: Clients who are not enrolled in MCC should be screened every six months to identify whether they currently meet eligibility criteria. For clients already enrolled in MCC, rescreening should occur prior to reassessments. If the client no longer meets eligibility criteria, this creates an opportunity to consider whether disenrollment is appropriate. If they still meet criteria, proceed with the reassessment.

Q: Do we need to enter screener results into e2LA for clients who do not complete an assessment?

A: No, it is not required. The expectation is that screener results be entered into e2LA when MCC staff are entering the client's assessment. For clients who do not proceed to an assessment, entering screener results into e2LA is optional but not required. For all clients, screener results should be documented in your agency’s patient chart.

Q: If a client is screened for MCC and does not meet MCC eligibility criteria, but months later a provider refers them to MCC, should we edit the old screener?

A: No. Do not edit the existing screener. Instead, add a new screener.

Q: How is "severe mental illness" defined for screening purposes?

A: Severe mental illness typically refers to a condition that significantly interferes with a person's daily life and ability to function (e.g., schizophrenia, bipolar disorder, major depression). See the SAMHSA definition for reference: https://www.samhsa.gov/mental-health/serious-mental-illness/about. The MCC Guidelines do not establish a single formal definition. Agencies should use clinical judgment and may reference SAMHSA guidance or agency-specific clinical protocols.

Q: Why were repeated STIs removed from the screener?

A: This change reflects the shift to a U=U (Undetectable=Untransmittable) framework. While repeated STIs remain a clinical concern, they are no longer specifically prioritized in the screener in the same way. Providers and staff can still raise the issue and make an MCC referral based on clinical judgment.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

3. Intake, Enrollment, Disenrollment, and Outreach

Intake and Enrollment

Q: What are the required intake forms?

Required MCC Intake and Consent Forms	
Form	**Renewal Timeline**
Limits to Confidentiality	Annual
Release of Information (HIPAA)	Annual
MCC Consent to Receive Services*	Once
Patient & Client Bill of Rights and Responsibilities	Once
Patient grievance procedures	Once

Q: At what point is a client considered enrolled in MCC?

A: A client is considered “enrolled in MCC” once they have completed the MCC assessment. This definition is primarily for evaluation purposes and should not limit MCC staff from providing or documenting services to clients prior to their completion of the assessment as needed.

Q: Can the MCC consent form be completed at intake rather than on the same day as the assessment?

A: Yes. The MCC consent can be completed at intake; it does not have to be on the same day as the assessment. Agencies have up to 30 days from intake to complete the assessment.

Q: If a client has been disenrolled from MCC for any reason and later re-enrolls, is a new consent form required?

A: Completing a new MCC consent form at re-enrollment is considered best practice—it provides an opportunity to review services and confirm the client understands the program. However, this is a best practice, not a strict contractual requirement. At minimum, there must be a signed MCC consent form on file.

Lost to Follow-Up and Disenrollment

Q: What is the minimum outreach requirement for clients who cannot be reached?

A: The minimum requirement is three outreach attempts over two weeks. After completing and documenting these attempts, staff may document the client as Unable to be Located (UTL) if prior to completing an assessment or Lost to Follow-Up (LTFU) if after an assessment has been completed. Continued outreach beyond this two-week minimum is strongly encouraged as best practice, at a frequency that reflects the program's capacity.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

Q: Should a client be disenrolled once they are lost to follow-up?

A: No. Being lost to follow-up is not the same as disenrollment. A client should not be disenrolled until at least six months have passed with no direct contact, despite documented outreach efforts. In the interim, continue outreach as capacity allows.

Q: What is the difference between Lost to Follow-Up (LTFU) and disenrollment?

A: LTFU is a status that can be assigned after the minimum outreach requirement is met (three attempts over two weeks). The client remains enrolled in MCC during this period but the program requirements for follow-up can be paused. Disenrollment is an action that should not occur until at least six months of no contact have passed.

Q: How is disenrollment documented in e2LA?

A: Disenrollment refers to the client's participation in the MCC program and all disenrollment decisions and related actions should be documented in the patient chart with a progress note (e.g., client declined to continue services, no longer meets eligibility criteria, no contact for six months, etc.). There is no existing place within e2LA to document disenrollment from MCC and staff should not remove or delete any client records from e2LA.

Q: If an LRP (Linkage and Re-engagement Program) referral is appropriate, when should it be made?

A: LRP referrals are more appropriate after six months of no contact, not immediately after the two-week outreach window. Teams are encouraged to continue follow-up at some cadence before initiating LRP referrals, as LRP has limited capacity.

Low-Acuity Clients and Graduation

Q: What happens with clients at the time their reassessment is due?

A: When a reassessment is due, staff should first screen the client to review eligibility criteria. For clients where the MCC team's work is complete and the client no longer meets program eligibility criteria, disenrollment can be considered—this is sometimes called “graduation.” If the team or the client thinks continuation in the program is still needed, then discussion with their provider is warranted so that a provider referral can be considered. If the client still meets eligibility criteria at the time that their reassessment is due, then proceed with the reassessment.

Q: Can a low-acuity client be considered for disenrollment before their reassessment is due?

A: Yes. If a low-acuity client clearly no longer meets eligibility criteria, staff may discuss disenrollment, or graduation, with them earlier rather than waiting the full year. DHSP does not support clients being removed inappropriately, but clinical judgment may be used.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

4. Service Units and Time Tracking

Q: Can service units be entered for a client who has not yet completed an assessment?

A: Yes, if the client is Ryan White eligible in e2LA with a current e2LA consent then service units can be entered prior to completion of an assessment. A client is considered "enrolled in MCC" only after their assessment is complete, but service units may be entered before that point.

Q: How should service units be handled if a client is in e2LA but is marked ineligible, or their eligibility has expired, or they have no e2LA record at all?

A: The system will not allow service unit entry. Staff should continue outreach and work to obtain updated eligibility documentation and track time locally (e.g., in an Excel log or chart note). This time can be reported to DHSP in the narrative section of your agency's monthly report. Currently, time tracked outside of e2LA does not count toward contract goals. DHSP is pending review of this process and will provide updates if changes are made.

Q: How should time tracking begin and end?

A: Time begins when staff start working on behalf of the client (e.g., opening the chart or EMR) and ends when the work is completed (e.g., documentation is finalized). This includes preparation time, reviewing labs or records, and completing documentation, if it relates to client care and is reflected in progress notes.

Q: Are the time examples shown during training (e.g., 60 minutes for an assessment) required standards?

A: No. The times shown during training are examples only. Staff should use professional judgment to report the actual time spent based on the client's needs and the complexity of the work.

Q: What is the difference between "monitoring" and "follow-up" for service unit entry?

A: Monitoring refers to activities done on behalf of the client without direct client interaction—such as reviewing charts, labs, medication refill history, or speaking with another provider. Follow-up refers to direct interaction with the client, such as a phone call or in-person meeting. A voicemail left for a client after a missed appointment should be documented as Outreach & Engagement, not follow-up, because direct contact did not occur.

Q: How should time be documented for specific scenarios?

A: Below are examples of scenarios and time documentation:

- Reviewing a client chart and labs before their appointment
  → Document as Monitoring.
- 13-minute phone call with client about medication reminders and scheduling
  → Document as follow-up; 1 service unit = time spent up to 15 minutes.
- Leaving a voicemail after a missed appointment
  → Document as Outreach & Engagement (no direct contact occurred).

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

Q: How should hours and goals be tracked for non-enrolled clients?

A: If the client is eligible in e2LA, time for screeners, outreach, or any other activities can be entered as service units. If the client is not in e2LA or their eligibility is not current, document time in an internal log and report it in the monthly narrative.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

5. e2LA System Functionality

Eligibility and Service Entry

Q: What is required to enter service data in e2LA?

A: The following must all be current and valid in e2LA in order for service data to be entered:

1. e2LA consent (aka global consent)
2. Ryan White eligibility with supporting documents (HIV status, residency, income)

If any of these are missing, outdated, or misaligned by date, the system will prevent service entry.

Q: Can eligibility be updated before it expires?

A: Yes. Staff may update eligibility at any time—there is no requirement to wait until the exact expiration date. If updated early, eligibility will be valid for 12 months from the new update date. Avoid creating unnecessary burden on clients.

Q: Can eligibility be updated by other programs in the shared system?

A: Yes. Because e2LA is shared across programs, eligibility may be updated by another program. Staff should always verify the most recent status before requesting new documentation from a client.

Q: How can agencies run caseload and acuity reports like what was available in Casewatch?

A: There is an MCC report in e2LA, but training and roll-out of related modules are still in development. For now, agencies are advised to use internal tracking systems.

Q: How should staff distinguish between e2LA system questions and MCC policy questions?

A: e2LA-related questions (functionality, data entry, reports, technical issues) → Contact e2LA support at e2LASupport@ph.lacounty.gov. Program-related questions (eligibility requirements, documentation standards, program guidelines) → Follow DHSP Program Manager guidance.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

6. Referrals and Care Coordination

Q: Are all referrals required to be entered into e2LA?

A: No, referrals are not required to be entered in e2LA. DHSP recommends using the e2LA referral module for referrals between Ryan White Part A programs within the e2LA system. For referrals to providers or programs outside the Ryan White network, agencies can choose to document these in e2LA by selecting "Provider outside of e2LA" in the referral module—this is optional, not required. Regardless of what is entered in e2LA, all referrals must be documented in the patient chart.

Q: Are all referral categories weighted equally for monitoring and audit purposes?

A: Yes. All referrals count—there is no limitation to specific categories. Referrals should be based on assessed client needs.

Q: Who is responsible for updating referral status (completed, lost to follow-up, canceled)?

A: For a referral placed using e2LA from one Ryan White program in e2LA to another, the receiving program is responsible for updating the referral status. If you submitted the referral, the referring program's role is complete once it shows "Accepted–Pending Action." The receiving team takes next steps. For referrals to outside agencies (non-e2LA), the referring staff should enter the information when they know the outcome.

Q: If a Ryan White agency does not appear in the referral dropdown, what should we do?

A: For a complete list of the Los Angeles County Ryan White Part A programs, please see the Ryan White Fact Sheets here. Programs not listed here will not be able to receive referrals via e2LA and usual referral pathways should be used instead.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

7. Documentation, Charting, and Signatures

Q: When are signatures required for staff and for clients?

A: The below table outlines contract requirements for staff and client signatures.

	Client Signature	MCC Staff Signature
Intake Forms	☑	
Case Conference Authorization	☑	
Integrated Care Plan	☑	☑
Progress Notes		☑
Client Record Review Checklist		☑

Q: Are digital signatures acceptable?

A: Yes, use of digital signatures for both clients and staff is acceptable. This includes the digital signature and timestamp tied to entries in electronic health records.

Q: What must be documented in the patient chart?

A: The chart must tell the full story of the client's care. At a minimum, document: screening results and outcome (eligible/not eligible and why), outreach attempts and client responses, whether the client accepted or declined MCC services, assessment completion date and acuity result, care plan development, brief interventions, referrals and follow-up. e2LA is primarily used for entering the assessment to obtain the acuity scores and for service unit entry.

Q: Do agencies still using paper charts need to print anything from e2LA?

A: No. Printing the MCC assessment from e2LA is not required. A progress note documenting the assessment date and acuity result is sufficient. If printing the assessment is useful for care coordination purposes, then programs are welcome to develop protocols for this purpose.

Q: How should care plan signatures be handled when services are delivered remotely (phone or telehealth)?

A: If a care plan is developed with a client remotely, staff should get verbal confirmation of the client's sign-off and document that the care plan was developed remotely and that the client provided verbal authorization. As best practice, the next time the client is seen in person, they should sign and receive a copy of the care plan. Agencies that have implemented digital signatures may also use that approach.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

Q: Can services be delivered via telehealth or remotely?

A: Yes. The MCC contract outlines multiple communication methods—in-person, phone, video, and other electronic engagement such as text—that MCC teams may use when working with clients. DHSP encourages in-person engagement with clients whenever possible and discourages programs from only offering remote services to clients.

Q: Is there a requirement for face-to-face (in-person) assessments, or are remote/telehealth assessments fully acceptable?

A: There is no requirement that assessments must be conducted face-to-face. The MCC contract allows multiple methods of communication, including in-person, phone, video, and other electronic forms of engagement. MCC teams should use a client-centered approach and determine the most appropriate method based on clinical judgment and the client's needs. The modality used should be documented in the patient chart.

While telehealth is an allowable and important option, MCC staff should not operate exclusively as remote-only. In-person interaction is important for building rapport with clients and may be necessary for certain situations, such as when working with high-acuity clients, during re-engagement efforts, or when clients have limited access to or comfort with technology.

MCC Program

Frequently Asked Questions

Questions compiled from: Program Office Hours (March 19 & 25, 2026) and MCC All-Staff Meeting (April 22, 2026)

8. Forms, Consent, and Annual Renewals

Q: Which forms require annual renewal?

A: The following forms must be renewed annually: (1) Release of Information (ROI) / HIPAA form, and (2) Limits of Confidentiality form. These are kept in the chart and do not need to be uploaded into e2LA. The e2LA consent form must be renewed every three years. All other required intake forms (client rights and responsibilities, grievance procedures, MCC consent form) need to be signed only once.

Q: Is the MCC consent form required to be re-signed regularly?

A: No. The MCC consent form only needs to be completed once. There is no routine requirement to have it re-signed. If a client is formally disenrolled and later re-enrolls, completing a new consent form is considered best practice.

Q: If a client becomes temporarily unreachable and later re-engages, do forms need to be re-signed?

A: No. If a client is temporarily disengaged and later re-engages, staff should resume services where they left off. There is no requirement to re-complete intake forms, including the MCC consent, in this situation.

Q: What is the difference between a contract requirement and a best practice in the MCC guidelines?

A: Contract requirements are mandatory and explicitly stated in the MCC contract. Best practices are recommended approaches that improve care and program quality but are not explicitly required in the MCC contract. For example, the MCC contract states that the MCC team should attempt to contact a client within 24 hours of a missed appointment. In the guidelines, we include this requirement, and we also recommend that the MCC team should make efforts to contact the client *during* the appointment time and convert to a phone appointment if the client is reached and willing to do so. This second piece about attempting to reach the client during the appointment time is considered a best practice.

DHSP is working to more clearly distinguish between these two categories across program guidance.

Q: Is a separate case conference authorization form required?

A: No. Case conference authorization can be described within the MCC consent to receive services. There is no need to have a separate case conference authorization form.