

# Medical Care Coordination (MCC) All-Staff Meeting

## MCC Guidelines and Assessment Tool

January 28, 2026, 10am to 12pm

### Frequently Asked Questions

1. **Question:** The guidelines say leaving a voicemail is not considered follow-up. How are we expected to handle that?

**Answer:** When trying to reach a patient over the phone and the call goes to voicemail, staff should leave a message with call back information, ideally a direct line to the MCC team, so the patient can get back to you easily. The staff person should then document in the chart that a call was made and a voicemail was left. This process would be considered one attempt at outreach.

MCC staff conduct outreach to patients for various reasons but primarily to offer services or to follow-up once services have been initiated. The MCC guidelines define outreach as “At least three (3) attempts over the course of two (2) weeks with at least 1 attempt in the field when feasible.” When attempting to follow-up with a patient, make sure to make at least 3 attempts over 2 weeks and document them all.

2. **Question:** Please define “fallen out of care” and confirm that we can disenroll a patient that: “have fallen out of care despite multiple attempts by staff to contact the patient and there has been no direct program contact in the past 6 months.”

**Answer:** In the HIV field there are many uses of the concept of being “out of care.” In the MCC program, we have these related uses of the term:

- In the context of MCC eligibility and screening, out of care is defined as having no completed HIV care visit in the past 12 months.
- In the context of outreach, we use the terms “unable to locate” and “lost to follow-up” to describe if someone cannot be reached after at least three (3) attempts over the course of two (2) weeks with at least 1 attempt in the field when feasible.
- In the context of disenrollment, we use the phrase “fallen out of care” to refer to when it has been at least 6 months since the MCC team has last made contact with a client. After 6 months of no contact the team can disenroll a client by documenting this step in the patient chart.

Please note: The MCC programs can determine what their outreach efforts will look like after 2 weeks of outreach attempts, and it is highly encouraged and an HIV services best practice to have protocols in place to continue outreach attempts over time prior to disenrollment at 6 months of no contact.

3. **Question:** Once MCC teams have had time to start implementing these new workflows, what kinds of opportunities will there be for feedback and what types of changes will be considered?

**Answer:** MCC programs can gather and share feedback with their DHSP Program Managers. As well, DHSP will work directly with the MCC Task Force on a formal feedback plan and share details via email and at a future all staff meeting as well.

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**4. Question:** How does this impact the workflow: “The definition of “out of care” for program eligibility purposes has been changed to having no medical appointments in over 12 months.”

**Answer:** The definition of “out of care” for program eligibility purposes has been changed and is now defined as having no HIV care visits in over 12 months. This is in comparison to the prior definition that used a 7-month cut-off. This new definition eliminates the past issue of people with very well-controlled HIV who only see their provider one or two times a year unnecessarily screening into MCC.

For patients who are missing appointments but still coming into clinic sporadically throughout the year, and who also don't meet any of the other MCC eligibility criteria but who would benefit from MCC, then discussion with the provider to consider provider referral is recommended.

**5. Question:** On e2LA, will MCC staff have the ability to input service delivery hours for patients who are lost to follow-up?

**Answer:** Sometimes. MCC staff have the ability to input service units in e2LA for patients who are lost to follow-up only if they have an e2LA record and their Ryan White eligibility is active and up to date. If their Ryan White eligibility has lapsed then no service unit entry will be possible until it is renewed. This is true across all Ryan White programs in e2LA.

DHSP recognizes that loss to follow up is likely to occur frequently for many clients since it is defined as being unable to reach an enrolled client (meaning they have completed an MCC assessment) after at least three (3) attempts over the course of two (2) weeks, which is notably a very short amount of time. Lost to follow up is defined to ensure a minimum outreach effort across programs but should not be considered as a required stopping point in outreach efforts or a cut-off for patients after which they no longer have access to MCC services. We encourage MCC teams to continue outreach and remain open to reconnecting with patients when they eventually call you back or show up at clinic.

If or when the patient returns to care with MCC and their chart in e2LA is still active, then the patient and the MCC teams can pick up where they left off. If the patient's Ryan White eligibility has lapsed then that will need to be renewed in order to resume entering service units in e2LA. As always, document all of your efforts and activities in the patient chart at your agency. For services provided that are unable to be documented in e2LA, please include this in the narrative section of your monthly reports.

**6. Question:** What happens if a client refuses to answer assessment questions?

**Answer:** Staff may use their best clinical judgment to answer all of the required questions in the assessment in the case that a patient is unwilling or unable to answer all of the questions themselves. The team can update responses later if the client becomes willing to answer.

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#### 7. **Question:** Are there any differences/changes in how brief interventions work/look?

**Answer:** Brief interventions have not changed conceptually. They are short conversations between patients and providers that utilize motivational interviewing, an evidence-based, goal-oriented counseling style that helps individuals resolve ambivalence and strengthen intrinsic motivation to change habits. The main difference from the prior MCC guidance is that there is no longer a short list of specific brief intervention topics that are required. Brief interventions are based on patient need, whatever that may be about, so if the issue is substance use, smoking cessation, sexual health, physical activity, or something else, if the team can use the brief intervention model to help the patient make healthy behavior changes, then we want you to deploy this technique.

#### 8. **Question:** Does the updated definition of out of care affect retention measures?

**Answer:** In the context of MCC eligibility and screening, out of care is defined as having no HIV care visits in over 12 months. This out of care definition is akin to saying there has been no engagement in care, which is defined as having at least one HIV care visit in a 12-month period. Retention in care is defined as having  $\geq 2$  HIV care visits at least 90 days apart in a 12 month period.

At DHSP, we use HIV labs (viral load, CD4 or genotype test) as a proxy for evidence of HIV care visits since this is what we have access to in our databases. However, for MCC teams, we recommend looking at actual attendance at HIV care visits because they provide more direct, actionable, and specific data regarding a patient's true, active status within the HIV care system.

#### 9. **Question:** When must the integrated care plan be completed? Why did the time frame go from 30 days to two weeks?

**Answer:** The integrated care plan (ICP) must be completed within two weeks of the assessment. This timeline reflects MCC contract requirements.

Please note that because the new assessment provides many opportunities for patients to identify areas of need, the development of an ICP can start as a relatively straightforward process in which the patient and the MCC team set out the action steps needed to address these needs. If a patient requests assistance with many different issues, it is acceptable to recommend they start with only a few, high priority goals in order to stay focused and increase the likelihood for success. As well, developing goals and SMART objectives for more complex needs such as substance use may require more time to build rapport with the patient than this 2-week timeframe allows. MCC teams can update the ICP as needed when patients are ready to add new goals or objectives.

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**10. Question:** What is the difference between “unable to locate” and “lost to follow-up”?

**Answer:** “Unable to locate” refers to when the MCC team makes outreach attempts in order to offer services but the client cannot be reached. This is outreach that occurs prior to completing an MCC assessment.

“Lost to follow-up” refers to clients who completed an assessment but cannot be reached at some point afterward. The MCC has made outreach attempts in order to follow-up with the client but cannot reach them.

**11. Question:** Prior, a patient stating they did not want to be in MCC was an "Opt out" in Casewatch, but the patient still had to be screened every six months which was different than someone being "ineligible" which was someone who for example moved out of LA County/was enrolled in another program such as home health where we then did not have to screen them anymore. So now under these new guidelines, when a patient says they decline MCC, we are supposed to note them as "ineligible" does that mean we will no longer screen them any more as well?

**Answer:** Document in the patient chart that the patient declined MCC and the team will not need to continue to screen them for MCC every 6 months. Let the patient know that they are welcome to change their mind at any time and provide them with information for how to reach your team if they decide they want to enroll in MCC.

It is also best practice to inform the HIV provider about the patient’s decision to decline MCC services. The HIV provider can discuss the program with the patient and refer them at a future date if the patient changes their mind and becomes agreeable to MCC services.

**12. Question:** What is the criteria for “severe untreated mental illness”?

**Answer:** While there is no single, standard definition, the term severe, or serious, mental illness typically refers to a disabling condition which impairs behaviors, thoughts, and emotions. Without treatment and support, severe mental illness may interfere with a person’s ability to manage activities of daily living, function independently, maintain personal or community safety, achieve emotional or cognitive stability, or develop and sustain positive relationships. Severe mental illness includes, but is not limited to, schizophrenia, bipolar disorder, as well as major affective disorders or other severely disabling mental illness and can be tied to substance use as well.

If unsure, the MCC team can consult with the HIV provider or other clinical staff working with a patient to determine their mental health status.

**13. Question:** Why does the bill-paying question appear in more than one domain?

**Answer:** The bill-paying question appears once in the assessment but informs both the housing and financial domains for acuity calculation.

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**14. Question:** It looked like "are you able to pay your bills/utilities" was both under the housing domain questions and the financial domain questions. Or is that single question on the assessment only once but factored into two different domains for acuity calculation purposes?

**Answer:** The "are you able to pay your bills/utilities" question only appears once in the MCC assessment but is used to calculate more than one domain's acuity score.

**15. Question:** In the sexual health questions, are they considered "moderate" if they've had sex with more than one partner?

**Answer:** The sexual health acuity score is designed to help MCC teams ensure they offer sexual health education and resources to people who are sexually active with more than one partner, including in the instance of transactional sex.

**16. Comment:** Typo, in case it's worded on the assessment the same way: gad2 should be "nervous, ANXIOUS (not anxiety), or on edge".

**Answer:** Thank you for pointing out this typo. We have made the necessary correction to Appendix A, the PDF version of the assessment now posted on the DHSP website and are working on making the correction on the e2LA platform.

**17. Question:** Is the Aging Domain only for clients who are 50 years and above?

**Answer:** Yes, the Aging domain questions will only appear on the assessment on the e2LA platform if the client is 50 years or older. If you are using the PDF version of the assessment to guide your interview, please only ask these questions for clients who meet this criteria.

**18. Question:** Just to clarify for the new assessment tool, acuity points are only assigned for diagnoses such as schizophrenia and bipolar disorder. Are other mental health conditions such as ADHD, anxiety disorders, or Major Depressive Disorder not assigned acuity points?

**Answer:** The acuity score for the mental health domain is based on a number of factors including but not limited to results of the GAD2 and PHQ2 screeners and history of schizophrenia or bipolar disorder.

**19. Question:** Do MCC consent forms still have to be dated the same day the assessment was conducted, or can we obtain the signatures beforehand?

**Answer:** No, the MCC consent does not need to be completed the same day as the assessment. All required forms can be completed prior to completing the MCC assessment.

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**20. Question:** After screenings, my understanding assessments are due within 30 days instead of 60. Should we screen patients if their Ryan White is inactive; because the process of enrollment can take longer if we are assisting pt's with getting a benefits appointment prior to assessment scheduling?

**Answer:** There is no timeline requirement between screening and completing an assessment. There is a goal for the assessment to be completed within 30 days of intake. Intake involves offering MCC services, the patient agreeing to MCC services, and completion of required paperwork, if not already done at clinic registration, such as consent forms and Ryan White eligibility. Please document completion of intake in a progress note in the patient's chart.

DHSP is considering a patient "enrolled in MCC" once they have completed the assessment. This is for data and evaluation purposes. We understand that there will be some time spent with clients prior to the assessment including outreach, intake and, in special circumstances, to address acute or urgent needs.

**21. Question:** Will there be a better way to see if a patient is going to different clinics?

**Answer:** If a client is receiving Ryan White services elsewhere in LA County, this will be viewable in e2LA. DHSP is also developing a plan to provide out of care lists to clinics based on information in our surveillance system. You can let your DHSP Program Manager know if your program is interested in participating.

**22. Question:** For patients lost to follow-up, would we have to reassess them if they came back six weeks later?

**Answer:** If a patient is lost to follow up for 6 weeks and then resumes engaging with your MCC team, you do not have to do a reassessment at that time. The new assessment is designed for annual renewal. However, if an MCC team wants to reassess a patient sooner, or update specific sections of the assessment, this is an option in e2LA.

**23. Question:** Case Conferences are as needed for moderate and low. What does DHSP consider "as needed"?

**Answer:** DHSP wants your agency and program to decide about case conferencing for low and moderate acuity clients, but it is not required. Case conferencing, even when not required, is a best practice and is very valuable for care coordination purposes. Use your program expertise and clinical judgement to decide when a low or moderate acuity client would benefit from case conferencing with the HIV provider or others involved in the person's care. Please also remember to document these activities even if they are not required.

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**24. Question:** Previously Brief Interventions were done based on acuity and as needed. Has the service delivery based on acuity changed?

**Answer:** Brief interventions are an important tool and modality for supporting clients with making behavior change and should be deployed for this purpose. Acuity is calculated based on identified needs. So, although we do not have a requirement for if, when or how many brief interventions should occur for any given client at any given acuity level, it is likely that brief interventions will play a more significant role in the work you do with higher acuity clients.

**25. Question:** If we are screening patients every 6 months, wouldn't we potentially be re-assessing at that time? How often should MCC screening occur?

**Answer:** All patients at your agency with HIV who are not already enrolled in MCC should be screened for MCC eligibility every six months. Screening results should be documented in their chart in your EMR. Only patients who are eligible for MCC, including those who are referred by their HIV provider, proceed to completing an assessment in e2LA.

For patients already enrolled in MCC, you do not need to screen them every 6 months. Repeat screening prior to completing a reassessment which is due annually.

- If the patient continues to be eligible, proceed with completing a reassessment.
- If the patient no longer meets eligibility criteria for MCC at the time their reassessment, discuss these results with the patient. If they agree to disenrollment, document this step in their chart in your EMR. If they wish to continue MCC services, or the team feels they would benefit from continued participation in MCC, then discuss the case with their HIV provider to see if a provider referral is appropriate.

**26. Question:** Assessments are annual, would there be any reason to complete a reassessment before one year, or are we updating ICP goals, etc.?

**Answer:** It is up to your MCC team if you want to complete reassessments more frequently than once a year. Your team may also choose to deploy other screening and assessment tools not included in the MCC assessment.

MCC efforts should focus on working with patients towards goals established in the Integrated Care Plan and updates to this plan should be made, at a minimum, based on acuity (see Table 1 on page 16 of the 2026 MCC Guidelines). Patients can have new goals or objectives added at any time. As well, goals and objectives that have been addressed or completed can be marked as such.

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**27. Question:** Documentation: the new guidelines say the only MCC -specific documentation in e2LA will be the assessments. Does that mean we will no longer be entering service deliveries (minutes spent) into a county database?

**Answer:** The only MCC-specific section of e2LA is the assessment. All local Ryan White staff enter service units in e2LA.

For MCC, one service unit is equal to fifteen minutes (1 service unit = 15 minutes). For example, if you spent 1 hour (60 minutes) doing an assessment with a client you would enter that as 4 units.

**28. Question:** When you say low acuity are we referring to self-managed patients? if so, can low acuity patients still self-manage out of MCC services?

**Answer:** Low acuity is the new term for what was previously classified as self-managed. If the work between any low acuity client and the MCC team has been completed and the client no longer wants or needs any assistance from the MCC team, they can be disenrolled from the program. Another way a low acuity client may end up graduating from MCC services is if they no longer meet eligibility requirements when their next assessment is due.

**29. Question:** As the new assessment addresses topics like childcare, will DHSP be providing resources/support to MCC Teams around this so we can provide patients with resources that will be helpful to them?

**Answer:** Appendix F, the Assessment Domains Compendium, offers information and key resources about topics covered in the MCC assessment. If your team is having challenges with certain domains or resources and would like support or technical assistance from DHSP, please request this with your DHSP Program Manager.

**30. Question:** As the new assessment addresses topics like childcare, will DHSP be providing resources/support to MCC Teams around this so we can provide patients with resources that will be helpful to them?

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**31. Question:** Where do resources for utilities, childcare, or financial needs come from?

**Answer:** MCC teams are not expected to pay for services. Their role is to develop expertise in existing resources and refer and support linkage to appropriate community, Ryan White, or other benefits resources, including those listed in Appendix F, the Assessment Domains Compendium.

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#### 32. **Question:** What MCC resources are available to staff and agencies?

**Answer:** Resources include the MCC Program Guidelines and Appendices as well as other materials posted on the DHSP MCC webpage. Agencies are also expected to provide their teams with training and other resources to support the delivery of high-quality care coordination services. If your team is having challenges with certain domains or resources and would like support or technical assistance from DHSP, please request this with your DHSP Program Manager.

#### 33. **Question:** Does lost to follow-up mean immediate disenrollment?

**Answer:** Lost to follow-up occurs after a minimum of 3 outreach attempts over the course of 2 weeks. If a client is unable to be reached after these attempts, it is reasonable for the MCC team to pause activities on behalf of this client until they are able to be contacted. Disenrollment should not be initiated until there has been no MCC program contact for at least six months despite outreach efforts.

#### 34. **Question:** How often must care plans be updated?

**Answer:** Please see Table 1 on page 16 of the 2026 MCC Guidelines. Integrated care plans (ICPs) are to be updated, at a minimum, based on acuity.

- High acuity clients should have their ICP updated at least quarterly.
- Moderate acuity clients should have their ICP updated at least every 6 months.
- Low acuity clients can have their ICP updated as needed.

MCC staff can document patient progress and their work in notes in the patient chart in between these intervals but may also decide to update the ICP more frequently than minimally required.

#### 35. **Question:** If a client declines MCC, are they considered ineligible?

**Answer:** If a client declines MCC, provide them with contact information for the MCC team in case they change their mind in the future and remember to document this in their chart. At this point it is not required to re-screen them for MCC every 6 months.

When a client declines MCC services, it is best practice to inform the HIV provider about the patient's decision. The HIV provider can refer the patient to MCC at a future date if they change their mind and become agreeable to MCC services.

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#### 36. **Question:** What is e2LA and how does it relate to MCC?

**Answer:** e2LA is the new LA County Ryan White Part A data management platform replacing Casewatch starting March 1<sup>st</sup>, 2026. It serves as the system where all Ryan White clients in Los Angeles have their program-related information stored and updated for compliance, reporting, and finance purposes. As such, programs must ensure that Ryan White eligibility information, required Ryan White data, and staff and program service units are documented in e2LA.

For the MCC program, this platform is also where staff must enter their MCC assessments in order to get acuity scoring results. Most other program documentation continues to occur in the patient's chart at your agency.

#### 37. **Question:** When must the MCC assessment be completed?

**Answer:** The MCC assessment should be completed within 30 days of intake. Completion of the assessment in e2LA marks formal enrollment in MCC.

#### 38. **Question:** e2LA: Can assessment responses be edited later?

**Answer:** Assessments can be edited after initial entry in e2LA. The e2LA system tracks all changes made to any data points in the system.

#### 39. **Question:** How is overall acuity calculated?

**Answer:** Overall acuity is calculated as a weighted average across 10 domains. Of these 10 domains, housing, financial, substance use, mental health, and medication adherence are weighted more heavily than other domains.

#### 40. **Question:** Can MCC staff enter service units for clients who were lost to follow-up?

**Answer:** If the client re-engages in MCC services after being lost to follow-up and Ryan White eligibility remains active in e2LA, staff may resume service unit entry for that client. If Ryan White eligibility has lapsed, then no service unit data can be entered in e2LA for that client. In that case the program must work with the client to update the Ryan White eligibility information.

#### 41. **Question:** When does e2LA launch and what support is available?

**Answer:** e2LA launches on March 1, 2026. DHSP is providing online trainings, e2LA manuals, and e2LA office hours. For training beyond these scheduled opportunities, please speak with your DHSP Program Manager to request additional technical assistance.