Complement Document to the Summary of MnCHOICES 2.0
Design Requirements Business Process Review

The MnCHOICES “Business Process Review” focus groups were conducted in the last few months of 2016 with lead agencies across the state. Eighty three counties plus White Earth Nation participated. Those that were unable to participate were given the opportunity to provide feedback via webinar, telephone conference or email survey. Contributors included: intake workers, assessors, case managers, care coordinators, mentors, supervisors, managers and directors. Feedback received is documented below. This information will serve as the basis for development of design recommendations for MnCHOICES 2.0 and where possible, improvements in 1.0.

All sixteen MnCHOICES focus group sites thought these were the most important needs/wishes for the MnCHOICES Redesign

- Upcoming reassessments are not showing up in our queue
- This is my assessment tool, these are CM tools; move those things to the next area for CM
- Putting history of client relationship into CSP, (like ISP); another county does not have that history
- Like to add a check box to designate it to transfer over to the planning summary
- Hover over to get the definition, like structured decision making for AS or SDM tools in SSIS
- Prompts are good for people who haven't done this 120 times
- If they are totally dependent and did not provide the info, it should say that in the CSP
- Think of the practice then develop a tool that supports the practice
- Hovering-type feature that would reveal context, definition or policy-related information in an area
- Need a checkbox with date stamp saying "I updated this item"
- Person information needs to update better
- Entering narratives in one area of the tool or a word document -- unable to renew the tool
- Do not use the tool during the assessment and it gets filled out later -- too much to cover
- Need to have conversational style for Quality of Life -- computer and required fields inhibit my practice
- Difficulties switching screens/domains while having a conversational dialog
- Two hours in the home is the reasonable amount of time for the home visit
- Technical glitches, problems and crashing in the field interfere with running eligibility
- Need an alert that there is a new intake in the queue so you can see it
- MnCHOICES intake is not complementary to the phone call/conversation
- Need a procedure for noting abandoned intakes when no working phone or no answer
• Need a tab in intake that indicates with whom to schedule the assessment. Who wants to be present?
• SSIS intake to interface with MNCHOICES (have just one Intake, not duplicate Intakes)
• Too many questions in Intake, OBRA should not be there
• Not user friendly in the way it’s laid out for Intake
• Type in the person’s address several times during Intake
• Too lengthy; sometimes it takes 45 minutes to complete Intake
• Counties need to be able to prepare and position themselves for any launch into MCO populations
• Managed Care said they aren't doing MnCHOICES
• Nice if domains would flow, aiding the rapport, if not, people won't open up to you
• Many invasive questions are not needed to get the services people need in their home
• Keep questions that establish eligibility, but after that, just a large narrative to describe the needs
• You are doing the summary by redoing all of the info you pull to get the summary
• Multiple guardians is complicating the scheduling process -- co guardians OR ands versus ors
• This assessment is too long and it takes away from our professional practice
• If they truly can't answer, what questions are for them versus a caregiver?
• Join common related questions back together in a natural way
• Domains are not conducive to conversation -- you have to jump around
• Too many redundancies in the medical section like treatment and discussion of areas, etc.
• Need less domains to allow ease of navigation
• Wording of domains/questions creates confusion prior to actually completing the assessment
• Override questions for children on employment, barriers to moving, transportation and some IADLs
• Eliminate some of the IADL questions that don’t pertain to kids
• Navigation that focuses on each area, then those questions come up within the assessment
• Domains should appear based on needs I have identified
• Tailor MnCHOICES assessment for children with age appropriate IADL section
• OBRA is out of order; we are stating they meet the level of care before we do the assessment
• Have to jump around to get all the information
• Built for a person calling for themselves; an outside person doesn’t have all necessary information
• More streamlined; not having to go through several assessments for different services
• Conversation could not be continued in order to hit all the eligibility questions
• Some asterisked questions take away from natural conversation
• Questions are not written open ended, limits them and the responses
• Long tool with duplicative questions -- takes too much time to go to different sections to answer
• Too many questions losing the person centered planning for individuals
• Reduce redundancies in entering information
• Reduce questions that don’t apply, e.g. IADLs for under 10 year olds
• Having more description of questions for more clarity
• Better reports to be able to pull data for what assessor has been assigned, completed date, etc.
• Will DHS come up with recs for case load size for counties who aren’t going to split up the roles?
• Working on a better way to break down barriers between assessment and case management
• Training about roles; CMs want the assessor to do it all when some info should come from the CM
• Help desk wants to talk to the mentor and the mentor is the CM and they are out in the field
• The person-centered hat is one thing and our eligibility hat is another thing
• Using a notepad even when working in MnCHOICES
• Use of tablets so documents can be electronically signed in the field
• Nice if there was a centralized DHS training, "Assessor Enhancement" to elaborate on programs
• In informed choice you have to educate that family about all of the services
• We need the definitions sooner, before the roll out of 2.0
• The redundancies limit our capacity/ability to leverage our workforce aligned with the Feds plan
• Being down Fridays and Mondays is not matching up with family’s needs for home visits
• Separate the CSP and CSSP
• Difficult to document details of assessment and click radio buttons at the same time
• Need to process and finalize the assessment before discussing eligibility; not able to complete
• Used to find areas I asked questions wrong

Three Focus Group sites thought these were important needs/wishes for the redesign

• Cannot get the code for the Training Zone until you complete the MnCAT
• For "courtesy referrals", why don’t they do the intake and then send it to the other county?
• Will there be a requirement for annual training hours for assessors?
• Don’t do MnCAT first -- first do shadowing and program training, then do MnCAT
• Next step: finished assessment/CSP goes to Waiver Review for approval process
• More info up front and prompts in MnCHOICES, less time to spend at home with them
• "Please have these things ready for me, that will help expedite", and schedule it in the same call
• An intake questionnaire would best help support assessors so they are prepared when they go out
• Need to guide the next step for the person: who to schedule with, who to notify, who should be there
• Self-scheduling seems to be a challenge in terms of competing priorities
• Many consults happen prior to the weekly meeting for staffing of cases due to seating arrangement
• Centralized checking in MMIS for MA, etc. is so helpful to the Assessor
• I can't toggle through the question groups, so I handwrite
• I need a tool that is about capturing the story
• People need to use SSIS for documenting; we should be able to see notes across counties
• ADLs are marked yes or no on service agreement; when put into MMIS, needs to be "X"
• As a case manager, how do I change anything if they moved if I am not doing my own assessments?
• Not one social worker in this building that has time to help someone look for a job or find housing
• CMs get frustrated with Assessors since CMs have historical info: "why didn't you know that?"
• CM says the plan was for them to go to Assisted Living, they didn't get assessed eligible
• How to get the Case Manager and Assessor to talk upon reassessment
• The frequency of needing to partner and negotiate is increased in MnCHOICES
• What is the difference between the role of the assessor and the case manager
• Need less choices after the questions e.g. needs help with transportation, what do they prefer?
• Behavior needs less categories
• Health section needs less description of what client is doing about each problem and duration
• Processes within counties is a big turmoil
• Current Coordinated Care Plan (CCP) for health plans is better than the support plan we do
• More room to make notes and less clicking
• In Health on Assessment, just have a checkbox for specific disease and comment box for particulars
• Comment boxes that find keywords would be much better than checkboxes
• There are 6-7 questions in the assessment that determine what a person is eligible for
• In region 4 pretty much everyone said they are not running eligibility
• Easier to run eligibility in the field if we didn't have to complete the extra things that do not affect it
• Smaller tool to take out into the field, take your notes, run eligibility and then go back to the office
• Have narrative that pulls over to the CSP for your planning
• How to connect the “my move plan”?
• What feeds over to the CSP, and then how does the CM document the process in the CSSP
• Looking in so many systems to piece together the information about a person
• MnCHOICES contact list for transfers is incomplete and this inhibits smooth transferring
• What's happening is it's not coming down to a DD MMIS screening doc -- the providers don't see it
• In Toileting section, the middle comments do not fit
• Have autofill on the safety and self-preservation info so it can transfer over to the CSP/CSSP
• Need to have conversation in assessment and then pull the info into the CSP
• Pull Person Info to the Eligibility Summary then you don't have to backtrack for info to complete the CSP
• CSSP: have emergency contact person flip over to other lines
• Save OBRA and Screening doc so they don't have to be scanned
• On OBRA, don't want to type in doctor and phone number twice -- should carry over
• Don't want to have to pull all assessments back online that are off
• Can any missed radio buttons in Psycho Social section be highlighted?
• Auto filling comments into the goals and referral section
• Spellcheck, and with medical emphasis
• Tablets are great but what if we have to be on a laptop?
• If you want something specific in this box, then you should list that out as a hover over
• Never fill in the last box -- the open box at the end is not useful
• The info that needs to go in that first box is the info that first prints out when you print
• Concerns about my notes passing over to the client on the CSSP; make sure we source the right fields
• Clear direction on expectations for intake versus assessor
• Put it all on one page where you could scroll really quickly and note what the person just mentioned
• Behavior scoring, ADL scoring, tabs, as I am writing my notes -- good to see them side by side
• Narrative that covers a broader sense of a person's life along with measures
• MCO saying if a member prefers to live somewhere else/does not know, CC must do "my move plan"
• Managed care does not think anything is happening in MnCHOICES
• Health plans have told us that it will never launch
• Counties need mentors and need to be training staff on level of care and how to meet it
• How will my staff think the support plan will make the CSP/CSSP a more useful plan for the person?
• Tool is not person-centered, it is just this big doc we use for everyone
• Culturally sensitive tools, if it's an eligibility factor and they don't know the months of the year...
• Mini-cog alternative tool for Alzheimer's -- three words you list out, then draw a clock and the hands
• Narrative box for brain injury, want to explain it, what happened
• Less redundancy or overlapping of behaviors within psychosocial areas; specific categories
• The questions are too lofty, like QoL questions -- more basic needs if they are already in AL
• For response, add "unable to answer" instead of yes, no, choose not to answer
- Other counties have rejected referrals that are not made directly by the person
- Need a policy/procedure for use of transfer function in MnCHOICES for county to county referrals
- How do you handle it when their services now are changed -- need training on that, too
- MA eligibility makes MnCHOICES process confusing and tedious
- How to use the system to know if someone is Rule 185 before sending out the Assessor
- Why don't they use the Minimum Data Set (MDS) that the nursing home use? Use language that we all understand
- If you go to the paper doc for Brain Injury (BI) -- they use the word itself to define -- circular reference
- The Brain Injury (BI) question is worded backwards: can they only get services they need through a BI waiver?
- "Would this person be homeless?" better "Can they live alone?" (did they give up assets for AL)
- We could use more support as a county on the program historic policy info and program staples
- During reassessment they will assess things that are not normal as normal
- Take out ADL equipment category, there are already spots there, we don't need that second section
- Add hospital preference, and plan for emergency/unforeseen health events, unavailable staffing
- In Expo Comma Skills, cannot indicate Alzheimer's that cannot find words for what they want to say
- PCA dependency: add nail cutting, needs help
- Suggestion that the Brain Injury eligibility area only pops up if you need it
- Missing a branch path, there are Developmental Disability people who come in the door who spill over into other worlds
- There are too many options for responses i.e. depression scale, satisfaction with housing
- Some questions are not client-centered, there should be more that they can choose not to answer
- The section on health on perceiving and judgement seems really subjective and people are offended
- If someone lives in their own home and has no desire to move, then no more questions
- Specialized assessments for CADI, EW, PCA, DD
- Housing has bullets but not asterisks; there are too many drop downs
- None of our other DHS stuff works on our tablets -- they are not supported
- Submit our questions to the monthly conference call and then review the answers on that call
- Fix our IT department -- biggest jump out the window moment
- We have a lot of server issues, then I lose connection, have to restart; not state's issue
- Just come over and fix it for me, I am a social worker not an IT person
- It adds 5 hours with 2 IT people being on the phone to fix things for each assessment
• Feels like IT doesn't talk to MnCHOICES systems people
• Are there DHS IT people that counties can talk to? DHS should be offering training to our IT
• Organizing the 3-way call with the help desk is very difficult
• Waiting 3 days for someone to call us back from the help desk is too long
• Some docs on CountyLink are not current; can you label the form as obsolete or non-current
• Some of the info on the grid in CountyLink is out of date
• At DHS you used to know who to contact for program questions including established regional staff
• Using a request sheet and centralized email process is frustrating, you don't know where to go
• Cannot go to my RRS
• Can't call the RRS, have to fill out a form to request to talk to them
• Tablet with handwriting recognition being tested; done in less than 2 hours with a brand new person
• Her surface was calibrated to her and she writes on the bottom continuously
• How to handle the people who have been on the waiver 20 years but now they are not eligible
• MnCHOICES makes us work together in a way that requires more training
• The HCBS experience is just not there out in the counties
• There is too much assumed professional practice
• Each person interprets each question differently, and I don't want web based training
• The MnCAT Step 2 is not good
• Training needs to be more nuts and bolts on interpretation
• Professional practice type of training is needed -- that requires a discussion and conversation
• Some supervisors believe that once you are a CA, then you don't need more training
• Training for families to discuss the continuum of services and what eligibility means
• Training on how to approach the questions
• Define frequency and intensity versus intervention so that we are correct for emotional/behavioral
• Can we have a new document that maps out timelines? Timelines are confusing
• Establish the difference between required or triggers
• Want to be reminded somewhere of what audit wants
• Why asking in intake if they have a healthcare directive?
• How to attach a paper med list -- how to attach documentation
• In legacy we attached docs all the time
• Keep fields consistent
• Ensure that user settings are not lost (back to default) when an update occurs
• Need to change the client’s address in the actual intake
• Need button and a plus sign to add another line for additional emergency contact
• The summary is so much better than the check box section -- check boxes are no value added
• Do intake summary and choose what to print so that when you pass it to the case aide it is right
• "This is the format reasoning" in instructions for the assessor for the Olmstead questions
• Child protection tool has hover over
• Housing, employment and getting to know you should all be together
• If PCA service agreement needs to be auto completed, and why can't it calculate the dates?
• Trying to get access to check SMRT is really hard, happy to look it up ourselves if we have access

Two Focus Group sites thought these were important needs/wishes

• You are short dating your service agreement with the 365 rule
• A pertinent history is key to writing a person-centered plan
• Use plans from child and family staff as examples/great model; they expect them to be reviewed in court
• The assessment is too long, especially for people with dementia
• We have "no wrong door policy", we do the intake and pass it off behind the scenes
• We use outlook for the calendar and they schedule the prep and the follow up so they can see it
• Two hours prep, three for assessments, and AM or PM for the rest of it
• Come back to the office and don't open your phone or your outlook so you can complete it
• It is best to have a space that supports the need for lack of interruption
• Schedule a dedicated assessor for those more emergent situations to ensure they can be handled
• How to communicate between assessor and case manager for reassessment process
• CM preps the "CM Recipient Form" and sends a copy of the LTCC and the Plan; give the soft copy back
• Share a copy of the service agreement so assessor knows what services they are getting now
• Assigned to an assessor, assessor tells CM when the assessment will be
• Ask for the referrals in advance so the CM comes to the annual meeting with the assessment results
• Some guardians refuse to meet separately, but most are amenable
• If CM has a question about the assessment, then they have to go back to the assessor directly
• When you choose the client in SSIS or MMIS, MnCHOICES would ideally talk to these systems and pull demographic data, such as marital status, and auto populate the assessment.
• Cannot clear out or update an assessment done before going into residential treatment
• Wing it interview style works better
• If we could just write notes, it would work
• We do a lot of case notes in both SSIS and MnCHOICES, this helps us communicate with Assessors
• Are Assessors reading notes MnCHOICES and SSIS or both? Where are they looking?
• Notes in MnCHOICES stop once Intake is closed, so we have to take new notes in SSIS
• Made my own word doc and I was able to sit and converse with the daughter of a dementia client
• Get rid of these domains and have one big scroll sheet
• For assessors the most satisfying experience is the talking and typing; come back later to click
• One sheet form so I can fly around the screen, fields big enough to see them
• I would like to click on the left and it hops to that spot -- a long form but navigation shortcuts
• All one sheet, but do command shortcuts so you can navigate to areas
• Most of my assessment is a conversation, need a blank page to capture the highlights
• This is not nursing or social work anymore; case managers spend majority of time behind computers
• Case managers feel like they are not doing CM work anymore, they are doing assessment
• How to parse/route the various pieces of info to the correct docs with correct audience
• CM piece is to set up services, preferences, likes and dislikes
• Route info correctly: assessment/eligibility summary vs info for case manager to use to move forward
• Differences between threshold for program eligibility and threshold for planning
• Case manager can go back to get the medical info and update the real diagnosis
• PCA authorization and codes could be prepopulated for us
• Cumbersome to not be able to edit in the CSP (when it launches)
• Need other dispositions besides abandonment
• Seizure section in DD and in main thing -- duplicative
• Eligibility is looking a little different than when public health did it
• If the goal is to run eligibility, then we have to have a way to keep Olmstead from preventing that
• Can we do a longer eligibility update (expiring when MA is not processed, they are way behind)
• Use a tablet or iPad so you can visit with the person
• Info from initial MnCHOICES stays in the assessment and is never accessible to the next person
• Then the information populates to the care plan
• Move the info to the support plan that is not part of the assessment
• Can't the case manager see the assessment? Most ideal was that it was in the final box
• Need to be able to route info to the correct recipient
• So how to pull the summary in a less redundant manner
• ICD-10 codes transfer to LTC or DD screening doc
• Queue management with statuses and alerts
• When assigning, it would be helpful not to go through all names of the assessors, would like to be able to search
• Would like scroll bar to work in all sections
• Can't cut and paste in all places
• Log back into someone, come back in, and take me to where I left off!
• In MnCHOICES we can't see a good picture of their health status
• Needs more info to put info in like ISP -- losing historically valuable info
• Hyperlinks/hovering to help you know terminology and definitions
• Hovering for definitions
• More specific prompts for the narratives, give people direction on what we are looking for
• General questions re: do they like where they live before you determine if they are looking to move
• Based on motivational interviewing
• Flowing from the yes or no move is not really natural
• Do they have other health insurance -- we have to do that checkbox or else it won't expand the box
• Why do we have that checkbox question about insurance if we have to be filling it in anyway
• Cutting and pasting is a huge issue
• Use a word doc to capture info from the person and then cut and paste it into the SSIS intake
• Eliminate redundancy on intake, entering same info, such as a contact name and address
• Use word doc during intake that contains all info: DOB, address, phone # ins, doctor, emergency contact
• Copy and pasted (c/p) into SSIS and then narrative gets c/p into MnCHOICES intake section with referral date
• We do not directly enter into MnCHOICES Intake because it is too clunky
• Speed and format is an issue for direct entry
• Do it in a word doc and then copy and paste; sometimes we still have more research to do
• Central email to communicate with the financial workers -- no partnership, separate supervisors
• Why do we have to pick a county when we log in? You can see the intakes from other counties, etc.
• Conflict of interest, how does that work with managed care
• What about a historical box, and then an update box that we can add to
• Grey out the history box so you know it is the history
• Is there a different way to capture the satisfaction question about housing for Olmstead
• P-C stuff in intake, take out "client"
• Look at the CSSP also because it needs to be able to be used and the people are throwing them away
• CSP/CSSP needs more specific question areas to meet person centered needs
• By asking that it helps their caretaker remember to do them; but is it the role of the Assessor?
• Kids, parents have legal custody, can only say yes or no, but what if it is one or the other?
• Person centered, asking how to identify gender and it is not only male female; also race
• Way to bring pertinent history in when it is directly connected
• More on social history -- got the getting to know you section but does not feel right
• Social history, saw an assessment for CADI and thought the social history was amazing
• Social history as pertinent history; there are things there that are alive and well in my current life
• Doing an LTCC on a quadriplegic, doesn't show why the person is a quadriplegic, now have to ask
• ICF level of care, NL care needs clarification for DD Waiver, eventually not eligible for those programs
• Can the Screening Docs be put in field order to match the order in MMIS?
• In appeal they will say they didn’t ask me that question versus my observation and judgment
• Toileting -- incontinence answer and a toileting question -- this is incongruent
• Peri-care is under toileting and grooming (PHNs learned this is double dipping in training)
• Are they following minimum data set (MDS) guidelines for homecare area: Centers for Medicare and Medicaid Services (CMS) driven -- versus what our legacy was
• "Do not use this list to set up medications -- get a list from your doctor"
• Cross walking for DD world so we can connect to it
• Assessor is going out there for anything, then we need training for anything
• How to give informed choice to the consumers when focus has been on one area not all areas
• For DD: we need to dissect our world into plain language for everyone, behavioral terminology
• Beef up the behavior piece, use more descriptors; if symptoms boxes, let them be actual symptoms
• Needs to go to the aspect of ADLs; we are not getting consistency on how people are services
• Rely on multi-disciplinary knowledge -- historical in our county, few people
• Core area training area -- maybe DHS can help
• Less jargon in assessment
• More training on PCA, DD qualifications
• A lot of terminology is not intuitive -- no time to look it up -- it's written wrong
• If a * field is missing, make it stand out so we can find it
• When running eligibility, be able to click on the error and jump to the questions you need to fix
• The list of choices is a trigger, especially for new social workers
• ICD 10s get forgotten - is there a way to link them
• Indicators for missing questions - especially psychosocial
• Do not need the caller's address box; need to know what type of caller it is (school, CC, etc.)
• Bathing strengths piece needs to go away
• Preferences strengths and weaknesses needs to go
• Take out OBRA from intake
• Delete middle name field for everyone except the client themselves
• Med management under medications area
• Eating and meal prep should line up
• Better access to reports and statuses, how to measure to the 60 days
• Role of the assessor to determine if this goes forward and gets put on a plan?
• Assessment is more skilled than the support planning
• Eligibility in the field takes too long -- too long to click through everything
• Decouple the non-eligibility stuff from that so you can run eligibility in the home
• DD screening doc with working and accurate numbers in SD
• What we routinely do with non-same person reporters is different than the way MnCHOICES is set up
• Sourcing all of the information and how to display it and when
• Two people getting ready to retire, if we can't shrink the assessment time how to replace them?
• Allow dashes for phone numbers etc. (dashes are not allowed)
• Too many people are putting yes when it is N/A
• How do we know what is pulling into the CSP so we can ensure the language is person-centered
• Demographics, cannot put in dashes for phone numbers like for everyone else
• How to keep notes out of the CSP -- don't want the client to see
• Counters for various statuses in the people's queues
• Send a form to eligibility workers they send back with status or what is missing so we can get it
• Reduce asterisk questions; preference questions do not count towards eligibility
• Built a map in -- what's good for me, what's not good for me, my fears, my goals, my dreams
• Hennepin can share these symptoms lists that impact ADLs
• Based on ages, can the tabs be changed so it isn't doing housing and employment for them
• Age-related tailoring
• Can these be tailored based on a few things like birth date
• For marital statuses: options that make sense for children, etc.
• The excel spreadsheet for tracking is ridiculous
• Time studies training was very confusing, how to handle
• ADLs sections, the nurses receive 3 days of training to do assessments, and we did not
• Structure around who should be a mentor; how all of the TA pieces fit together for the Lead Agencies
• Turnover alone makes the training be too much for any one agency
• Could identify "great" assessments and pull them and list out the characteristics
• More education and training for assessors
• The new quality of life domain questions are not a good way to begin the assessment
• More structured questions in about the person domain to guide conversation and build rapport
• You can pull up MnCHOICES from SSIS tree view and then it is preloaded with info
• No need to click the drill downs on informed choice for someone we indicated is comatose
• Autofill, not entering address three times
• In the second screen, demographics, it is shaded and I can't see it
• Need the "enter" button back -- stop mousing around -- enter and save it (keyboard versus mouse)
• When I switch to a phone call and go back to the MnCHOICES I was in, it does not retain the info
• Get rid of all of the boxes that pop up to congratulate you that the address saved, etc.
• SSIS when you tab it goes down, but in MnCHOICES tabs the other way -- sideways
• When you enter the date, why can't you it the space bar like in SSIS
• Need to change the color of the font
• Whatever we print out of 2.0 needs better format and visual
• Readability of the forms is rough
• Prints at 4 or 6 point font size and we cannot read it
• Bring back the right click -- Silverlight never let us have it
• The search feature is challenging before the Intake
• It is cumbersome with the person on the phone to go into MnCHOICES and do state search
• Move doctor info and health insurance and OBRA and Medicare and POA guardian to assessment
• Standardize the phone number entry fields
• Scrolling page would help versus the clicking back and forth
• Drop downs for emergency contact, power of attorney, (to avoid retyping)
• More drop down, less radio buttons
• Medicare could be auto filled versus having to retype
• Medicare has no asterisk and it is often missed
• Create a search function to look up the ICD 10 code
• Take OBRA, healthcare directive, providers, insurance other than MA, emergency contact out of Intake
• Under services and narrative summary, for referral reasons, add nursing facility
• Like how in SSIS I can see a fresh intake with fresh info
• Autofill history with grey, then you have to accept it -- (idea from other applications)
• Nice to designate who is the person who called (guardian, conservator, POA) and it flows from there
• In person tab when updating addresses, should not have to save it two times
• "Reason for call" should be reassessment
• It should tell you the domain and the question number so you can resolve errors
• Under the health question, when was your last colonoscopy, flu shot, can it just be a year
• Conversations are billable even when you don’t complete the form to the point to run eligibility
• We keep notes in SSIS in assessment workgroup -- all work is documented in there
• Create the assessment in MnCHOICES before you go out so it is the right date
• Need to see stats for the case load by assessor and by status
• Want the dashboard about workflow from intake and routing to the assessor
• Don’t like waiting for another county to close it/ having to call and say have your assessor close it
• Half the inquiries that come in are because the assessors didn't close the document
• Need guidance on overall design, how go get into cases, how to see, view, assign
• Staff leaves and assessment needs to be closed, don’t like that I have to assign it to myself
One Focus Group site thought these were important needs/wishes

- If we try to do a robust intake, case aides won’t ask the right questions
- Need system alerts directing you to do follow up steps
- Need triggers in the process to help you manage your workload
- I read what you put in SSIS intake, but then I (assessor) call again and ask questions differently
- Lead workers call back and try to figure out the actual referral info
- Intake requires experienced, critical thinkers about all programs to pull all the people together.
- Idea: intake is some type of electronic portal to send to SLL for review and determination of NH LOC
- Does 2.0 coincide with CFSS roll out?
- Discharge planners are not performing their role and instead are depending on the counties
- What happens when the CM didn’t follow through on the transition plan; now it’s a year later
- CA and CM roles aren’t clearly defined. There is a thin line between the two roles
- How as an assessor can you educate about resources but not determine services?
- Defining the role of CM. Can something be developed prior to rolling out the Support Plan?
- CADI CM goes out to see the person before they have opened the waiver
- Still continue to send PH nurses out (assessor plus nurse); our assessors are educated peer to peer
- Sending out the Assessor and the PHN has gotten great feedback from the recipients
- Capture diagnoses codes when you are printing your screening so no searching for ICD codes
- Remove multiple challenges, strengths, section and do a cross walk to ensure just one remains
- Don’t need to run eligibility to be able to know how to counsel the client on what is happening next
- Condensed more, availability to scroll, likely to run eligibility at home
- Screening docs don’t flow along with MMIS entry, this makes it impossible to train new workers
- Planning summary is not editable. Very hard to read in the format while typing; the box is too small.
- Edit in the planning summary then have the changes carry over to the assessment.
- Good for next assessor to read assessments and CSSP -- it captures the story of the person.
- CM doesn’t have places on CSSP to add info, so we want the assessor to capture more details.
- Feet and the pain should be brought into the health
- MnCHOICES Friday phone calls, people are asking for definitions; hovering would be wonderful
- Juicy notes really do belong in the MnCHOICES intake
- Using function keys to skip around on a single sheet intake doc during the call
- Having the nurse on your team is critical
- How will PCA be handled (PMAP) for MCO launch? PCA work would shift from their contract to ours?
• If it stays in the MCO contract, needs to have one standardized process -- not medical, care, etc.
• You could go insane doing PCAs for the managed care orgs and all of their ways
• When the individual comment boxes go away, where is that info to be kept?
• If you have huge turnover, it will affect the mentor role
• Can’t be online in a non-secure network
• Printable health summary, all diagnoses, conditions medications, etc. to share with HC providers
• MA waiver for housing; housing can be a waiver service that helps people with housing access.
• Forces people to lie on the 365 day mark. The measure should be on the SA not the assessment.
• Have more questions that are related to eligibility -- this is such a long tool
• Put the asterisks at the top of the page and get them over with
• Clarify which questions are quality verses eligibility
• Assessed need versus stated need -- critical point
• Shared care in PCA, versus dedicated staff -- coding for direct care
• Clear language choice so you can select the reality of the person, in a phrasing that has descriptors
• Integration of long-term and Home Care and Developmentally Disabled? Is this the time for that?
• More common language
• Program training -- we spend so much time researching: also TOOL training, the definitions
• Give some suggestions in grooming and hygiene so we don’t forget things like shaving or nails
• Prompt questions/drop down up top to give guidance/help button to click to manage own interview
• Under health section, mammogram, colonoscopy, vaccinations, people don’t know that
• Could medication section be moved since you ask about meds in IADLs
• Some questions for PCA services are missing that we should be asking about this
• Put all related questions in one group, not jump back and forth; better explanation on how to answer
• People say things out of order and we are making notes on a separate note pad.
• Flow of the conversation (designed around business structure and not human)
• What questions can be lumped together, but behind the scenes be carried over to the right place.
• Tool talks about behavioral needs but not the social needs
• SNBC navigator or CC does not put in a screening doc, so the county puts in the screening doc
• Someone 65 in a MCO product with resp. for LTC, now you have conflicts between the county/MCO
• CCB waiver, turned 65, in an MCO product, but we retain responsibility, we put in LTC and we can’t
• Go into a nursing home for 60 days, then out, they can’t put them on the waiver, we have to do it
• Neuro section, ICD10, ICD9, you can’t get a J if it is not clicked
• Fear about leaving SSIS -- uncomfortable because we are having our waiver review
• Family support grant for kids under 21, should be in the age tailoring
• People are frustrated about FSG, should be used in an expedited way up front
• One size fits all is really challenging; maybe creating versions (child, mid child, adult then senior)
• More training in Training Zone and more examples to help new assessors
• Think about how much training an eligibility worker goes through -- we need that for this
• Better to search by part name, sex and age range to catch multiple PMI number so you can fix them
• Need some DHS sponsored training for consistency
• We need a save button so we can save our work as we progress
• Intake uses two screens so can look things up and take notes on the intake; wish for three screens
• Build in HTML 5 for multiple browsers: some places have a preference on browsers they support
• When looking at the screen, it is hard to read in the home
• Things need to be combined and related better
• Narrative, click box to give idea of some of the vagaries, clarify what is this pertaining to
• Need shorter assessment, easier, scrolling and pop up boxes to explain what you are answering
• Clean up the lengthy questions that don't get us to where we need to go
• MnCHOICES has to be extremely user friendly to help address the capacity/staffing issues
• They do not want to log out in order to update in another system.
• Default lead agency to option. Can default option be set up? Why not default to intake who signs in?
• New intake should be fresh intake verses information being copied over; what to do with history?
• Having the assessor comments at the front and not three boxes in the end.
• Why is guardian separate section? Should be right away
• Notes page and a page do to all the clicking; maybe have the notes on the side of the questions
• A county will lose 80% of their assessment work when you move to COR
• For reassessments, sometimes they don't get the assessment opened up before the time ran out
• Training for Intake on how to know if it is a new assessment or reassessment
• Functionality such as alerts and statuses
• Management reporting
• Do a phone interview to collect information on paper or in SSIS before using MnCHOICES
• Using SSIS or PH Doc to collect information
• Decrease the number of abandoned assessments by not entering until assessment is scheduled
• Too many update buttons in Intake
• Are there some questions that don’t have to be zeroed out so eligibility can be run faster?
• Run it at the end of the assessment and have a conversation about services once it is complete
• Using the eligibility summary and to verify and find/fix and code errors; not working for new users
• Conversation could not be continued in order to hit all the eligibility questions
• Do not use MnCHOICES in the home because the pages do not load quickly enough
• Because all questions need to be answered
• Comfort with the tool: LTC, DD, barrier of knowledge across programs
• Some workers aren’t comfortable with conversational style
• Lots of dead time where we are typing notes
• Make comment boxes for added information
• DHS MnCHOICES personnel should conduct assessments in the field as a requirement
• Need to answer all the questions and n/a in all comments to be in line for auditor and appeal judge