12 HIGH IMPACT PROTOCOL ITEMS

(As identified by the Minnesota Department of Human Services (DHS))
*Indicates it must be present in the person's support plan.

1. The Person's Strengths*
2. Opportunities for choices
3. Current Physical and/or Mental and/or Chemical Health status*
4. Rituals and Routines
5. Global Statement about the Person's dreams & aspirations*
6. Preferred Living Setting
7. Preferred work/education/productive activities
8. Social, leisure or religious activities
9. Goals or Skills related to the person's preferences*
10. Action Steps needed to achieve goals or skills
11. Identifies who is responsible for monitoring*
12. Details about what is important to the person*

ASSESSMENT

General Suggestions

- Use person-centered language throughout the assessment
- Use language that is respectful and personable
- Highlight **strengths*** everywhere they are identified!
    - Examples of ways to get at a person's strengths include"
        - "What are your strengths?"
        - "I heard you mention you beat everyone at this game."
        - "What are you good at?"
        - "What are the strong-points about yourself?"
        - "What do other people say you are good at or are your strong points?"
- Identify **preferences*** where able (**outcomes should be linked to the person's preferences***)
- Ensure person-centered components, and components **important to the person*** and/or person's supports, are included in sections of the assessment that print for the person to see. If it is in the body of the MnCHOICES assessment the person and the person's supports do not see it! This could include:
    - Things the **person identifies as important***, **outcomes the person has identified***, and **strengths*** and gains the person has made
    - The person's identified needs and requests
    - Assessed changes that could affect the person's services (i.e. eligibility for programs, Personal Care Assistance (PCA) hours, Consumer Support Grant (CSG) amount, or Consumer Directed Community Supports (CDCS) budget)
        - It helps people and families to see how changes can affect their PCA hours, grant, or budget
- Highlight the person's **opportunities for choices**
    - Examples include meals/times, free time, coming and going, who they live with, where they live, activities, transportation, visitors, who they spend time with, privacy, services and

Washington County

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STAR SERVICES

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providers of services, programs, the way their room looks, appearance, control over personal resources, etc.

- If a person and/or the person's supports are in a situation where they cannot or do not want to provide information related to person-centered or other assessment questions, capture this at the beginning of the summary so it is clear why the assessment may not be as person-centered or why there may not be as much information (e.g. do not want an assessment, the environment where the assessment is happening is chaotic, etc.).
- The assessment is a key tool in the communication between the person/family and assessor and the case manager – be sure to include information that the case manager would need to know to best support the person!
- Update numbers (i.e. ages), remove outdated or incorrect information, and be sure to include new and updated information.

SECTION IN EACH DOMAIN: What the person values and wants for their life/What is important to the person*?

- Identify things that are **important to the person*** as it pertains to the specific domain
  - Things that are **important to the person*** could include their **preferences***
- Consider including **outcomes*** the person has identified as it pertains to the specific domain
  - As appropriate, link **a person's identified preferences to identified outcomes***
- Include any **rituals or routines**, or that **routine** in general, that are **important to the person***
- Do not outline needs in this section, only if it relates to something **the person identifies as important***, as a **preference**, or as an **identified outcome***

Domain in MnCHOICES	**Assessed Needs/Support Plan Implications** ***(Area that prints that the person sees)***
All Domains	• Include any identified **opportunities for choices** • Highlight successes or **strengths*** or the person does well in, perhaps prior to summarizing areas the person needs support with • Include updates, changes, and significant events from the past year
Quality of Life	• Summarize what the person likes to do, where they like to go, who the like to be with, and any preferences in the "Support Plan Implications" (**social, leisure activities)** • Include places, people, things, and activities that are **important to the person*** • Include if the person has identified **religious or spiritual activities** • If the person has identified things they are not doing they would like to be doing, consider including this as an **outcome***
Personal Cares	• Include changes that may affect the person's supports, such as changes to PCA hours or a CDCS budget • Examples of successes or **strengths***: - Person is now able to walk - Person can brush teeth if it is prepared for them
Home Management, Daily Living, Comm. Living Areas	• Examples of successes or **strengths***: - Obtained driver's license - Can now cook a meal
Health	• Include **current physical health status*** • Include major health events or new diagnoses • Include pertinent historical health events or diagnoses • Include summary of any screening tools including assessment of feet, pain, or sleep as it may affect the person's health and health care needs • Examples of successes or **strengths***:

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	- Weight loss - Better control of diabetes
Psychosocial	• If possible, identify why the person may have symptoms, do things that cause challenges, or do things that harm themselves or others (e.g. the person expresses frustrations with communication difficulties by hitting or throwing things) • Include summary of any screening tools including depression screening, suicidal assessment, CAGE questionnaire, etc. • Include **current mental and/or chemical health status*** • Include any new or additional mental health diagnoses • Include pertinent historical symptoms or actions related to the mental health or related diagnoses • If a new diagnostic assessment is obtained during the assessment process, add this information to the assessment, let the case manager know, and place the diagnostic in the person's ECF in Caseworks • Examples of successes or **strengths***: - Completion of a treatment program - Success with new medication or therapy
Memory & Cognition	• Include history of or diagnostic information as it pertains to eligibility for the DD or BI waivers, including potential new diagnoses or diagnostic information • Include the person's cognitive history, history of challenges with memory, and changes over the last year - The memory testing in MnCHOICES is a tool used to help with eligibility for Nursing Facility Level of Care, but it is always helpful to summarize the person's memory or cognitive situation • If a new diagnostic assessment is obtained during the assessment process, add this information to the assessment, let the case manager know, and place the diagnostic in the person's ECF in Caseworks • Examples of successes or **strengths***: - Has developed a system that allows them to be more independent despite memory issues - Has made significant progress in recovery from a brain injury
Safety/Self Preservation	• Summarize if the person feels safe where they live and out of their home and if not, summarize why and how to support the person • Summarize risks and safety concerns in a respectful way • Examples of successes or **strengths***: - Person is now able to go shopping alone
Sensory & Communication	• Include the person's preferred communication method • If the person does not communicate with words, thoughtfully and specifically describe how that person communicates with others and how others communicate with that person • Examples of successes or **strengths***: - Person had successful cataract surgery and can now read again - Person completed speech therapy and now uses an iPad to communicate - Person does best if given time to swing when they get home from school because the transition is difficult
Employment, Volunteering & Training	• Ensure there is summary of discussion of **preferred work, education, or other productive activities** - Summarize this well so the person and case manager are able to clearly see what was discussed and what the person wants • Highlight what they like or don't like • **Include discussion about available employment, school, or volunteer supports to support their preferred work, education or other productive activities** • If the person does not wish to or is not able to work or volunteer, include discussion that they were made aware supports area available should they choose to access them in the future • Summarize questions as • Examples of successes or **strengths***:

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	- Person got a new job they love - Person changed schools and their grades improved - Person has worked at the same job for many years and earned a special recognition award
Housing & Environment	• Ensure there is summary of discussion of **preferred/ideal living situation** - Summarize this well so the person and case manager are able to clearly see what was discussed and what the person wants • Highlight the barriers, if any to the person's **preferred/ideal situation** - Include any action steps toward achieving the person's **preferred/ideal situation** • Highlight what they like or do not like • Include discussion about available supports for the person to live more independently • **If the person wants to move or does not wish to move, highlight why this is important to them*** • If the team has concerns about the person's preferred living situation, outline those concerns in a respectful way keeping the person's preferences in mind • **Include discussion that they were made aware there are supports available to support the person living in their preferred situation** • Examples of successes or **strengths***: - Person moved into their own apartment and is doing well with change in their supports and services - Person has made progress in areas as they work towards moving out to a more independent living situation - Person has not had the same significant challenges as they had in the past since moving to a living situation that provides them with needed support and structure
Self-Direction	• Include any identified **opportunities for choices** • Discuss if the person has someone who assists with supportive decision-making, including if that assistance is keeping the person's preferences in mind • If appropriate, include discussion about services (e.g. PCA Choice or CDCS) that gives the person more flexibility or **opportunity for choices** • Include if the person feels they are not being heard, do not have choices, or their preferences are not being recognized • Examples of successes or **strengths***: - Person does a great job of letting their supports know what their preferences are - Person has a caring and involved guardian who provides supportive decision-making keeping their preferences in mind
Caregiver	• Highlight the person's informal supports, including if it is a paid parent or family member • Include if the person has no informal supports, but identify the positive supports in their life • Identify if the caregiver questionnaire was completed or provided to complete at a later time

If you have additional content or ideas for *Best Practices – Assessment*, please email: molly.henningsgard@co.washington.mn.us or call at 651-430-6500.

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