12 HIGH IMPACT PROTOCOL ITEMS

(As identified by 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*

SUPPORT PLAN

General Suggestions for All

- Use person-centered language throughout.
- Use language that is respectful and personable.
- Consider that the support plan is something the person looks to for what was discussed at the assessment, what the agreed plan is, and as a reference (for things such as services, phone numbers, etc.).

General Suggestions for Assessors

- Consider that the Community Support Plan (CSP) is something the person and case manager use for ongoing support planning. For example, it may be used in referrals for various programs and services to support the person with their outcomes and needs.
- The support plan 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!

General Suggestions for Case Managers

- If the assessor did not capture any of the high impact items or important information to the person or for the person's support plan, it is the case manager's responsibility to make sure this information is identified in the Coordinated Services and Support Plan (CSSP). The best place to capture this is the "About Plan" section.
- **Opportunities for choices** can also be outlined in the Long-term Services and Supports (LTSS) evaluation. Summarize these discussions when completing this assessment. If the person says "sometimes" or "rarely", it is the case manager's responsibility to follow up.
- Review the "Referrals Needed" section of the CSP

Washington County

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STAR SERVICES

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Tab in MnSP	CSP	CSSP
About Plan	• Utilize "About Me" Template - Highlights **strengths***, **routines**, **dreams***. Include these highlights, or a statement about why they are not included - Potentially add a statement or summary about the person's **opportunity for choice** (e.g person has **opportunities for choice** throughout their day by having opportunities to choose what they do and go places they want to go) - Include necessary information pertinent to the person (e.g. case mix for AC or EW) - Include date mailed as this is helpful for case managers - Include discussion about supports (formal or informal, programs, services), especially those that related to general preferences, **preferred living situation**, and **preferred work/education/productive activities** • Include information about challenges related to having a person-centered discussion with the person or the person's supports	• Utilize the "About Me" Template if the CSP was completed by another county and does not capture **strengths***, **routines**, **dreams*** • Add additional information not available to the assessor, that the assessor did not include, or changes that occurred since the assessment was completed - E.g**. the person's current physical and/or mental and/or chemical health status***, new diagnoses, changes in supports or needs, etc. • Include discussion about supports and services that occurred after the assessment was completed and closed
Person Information	• Review all sections that print on the CSP for accuracy and update as appropriate • Inquire about and include "preferred name" *("Name" section)* • Include contacts that are **important to the person***, including supports **important to the person***, such as a house manager or job coach *("Provider Information" section)* • Include the person's financial worker and number as sometimes the person does not readily know this information (if in Washington County or known) *(comments in "Health Insurance & Payers" section)*	• Update information that was not included, is not correct, or that has changed since the assessment (e.g. address, phone, insurance, contacts, etc.) • Add additional contacts **important to the person*** that the assessor did not include - E.g. house manager, work or school contacts
Goals	• Include **outcomes*** that the person identified, or would identify if they were able to • If the person or person's supports do not, cannot, or will not identify outcomes, generate outcomes based on what was assessed as **important to the person*** or what the person wants • Consider more general statements in **actions steps to achieve outcomes**, unless a specific action step is known - E.g. assessor knows the job coach is helping the person transition to a new more **preferred job***	• Add additional **outcomes*** discussed after the assessment was completed • Add a provider number if it is known a provider is supporting a person with a specific outcome - This helps to **identify who is responsible for monitoring*** • **Make the action steps** more specific or adjust, as appropriate - E.g. specify that a provider is going to help a person apply for apartments • See Outcomes & Dreams reference material

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	- This is to avoid putting someone in a position to be "responsible" for an outcome that may not be appropriate or part of the plan • See Outcomes & Dreams reference material	
Referrals	• Referrals or supports needing to be explored are identified at the end of each domain in MnCHOICES and only print on the CSP • Include services, equipment, programs, or other supports that were discussed at during the assessment process - It may be helpful to alert the case manager, if any, to these areas in the communication form and/or in an email to help assure they do not get missed	• N/A • (Review the "Recommended Referrals" section of the CSP and consider including information about the status of referrals (e.g. in the "About Plan" section under "supports discussed" or in the "Services" tab and "support instructions")
Caregiver	• Include the person's informal supports, even if it is a paid parent or family member that is providing ongoing support outside of paid time • Consider including information about positive and important pieces of the caregiver's relationship with the person • If the caregiver is having trouble providing support, summarize this discussion here	• N/A • (Review "Informal Caregivers" section of the CSP and consider including information about the status of caregiver needs (e.g. in the "About Plan" section under "supports discussed" or in the "Services" tab and "support instructions")
Services	• N/A	• Highlight if a support (formal or informal) holds responsibility for helping a person achieve an **identified outcome***, including and especially **outcomes related to the person's general preferences***, **preferred living environment**, or **preferred work/education/productive activities** • Include statement in support instructions of the case manager service line that case manager is responsible to coordinate, implement, and monitor the services in the plan - **Identifies who is responsible for monitoring*** • Highlight the person's preferences, including preferences for **social, leisure, and religious activities** in the support instructions - E.g. the person prefers a female to help with showering, prefers to use a specific type of shampoo, prefers to go to a certain type of restaurant, which church the person is a member of (if a formal or informal support is helping them get to church), etc.
Risk	• Always include assessed risk and discussions of risk, but do so in a personable and respectful way	• Always include assessed risk and discussions of risk, but do so in a personable and respectful way

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	• Include all formal and informal supports that are helping the person to stay safe • Complete "How will Health and Safety Issues be Addressed?" section only (the remainder of this tab is completed by the case manager) - E.g. Joe will continue to receive support throughout the day and night to help him stay safe, healthy, and happy. Support will be provided by his mom, the Consumer Support Grant, his dad, and grandma, as well as school supports. • If a discussion occurs about a risk, do complete the "Risk Mitigation Plan" and list name, title of assessor, and date following the summary in the "Summary plan/agreement to address identified risks" - This differentiates that the assessor had this discussion vs. the case manager as this section only prints on the CSSP - Consider the person's **opportunities to make choices** surrounding their risks and their right to take risks - If the person does not have full understanding of a risk, this should be summarized	• Include all formal and informal supports that are helping the person to stay safe • Complete the "Risk Mitigation Plan" and "Emergency & Back Up Plans" sections only (the "Health and Safety" section will be completed by the assessor) • If a discussion occurs about a risk or risks, complete the "Risk Mitigation Plan" - Consider the person's **opportunities to make choices** surrounding their risks and their right to take risks - If the person does not have full understanding of a risk, this should be summarized and include a plan to address the risk
Next Steps	• Always check "you will work with an assessor or case manager to develop a Coordinated Services and Supports Plan for the public program you have chosen" • Select "We are waiting for…" if there was discussion about potential services, programs, equipment, or other requests and list them clearly for the person to see • It is a good idea to always check "For more help locating services and supports options…" as these could be resources for the person or their team throughout the year • If there are unique circumstances surrounding the person's assessment or situation, consider putting those in the "Comments" box - E.g. case transfer circumstances, known delay in accessing something in "we are waiting for", etc.	• N/A

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

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