



Understanding Outcomes

A Guide to Person-Centered Goals,
Progress, and Documentation



How Boundless@Home Supports Outcomes

At Boundless@Home, we believe services should be about more than completing tasks or meeting requirements. Every service should support something meaningful to the person receiving services.

That's where outcomes come in.

Outcomes help ensure that services are focused on a person's goals, interests, relationships, independence, and overall quality of life. They provide direction for the supports delivered throughout the year and help everyone involved understand what the person wants to achieve. Person-centered outcomes should reflect what is important to the person and what they hope to accomplish.

Boundless@Home partners with individuals, families, employees, and county board teams to help turn those goals into meaningful support. Once outcomes are identified through the person-centered planning process, our team helps ensure services are delivered in ways that support progress toward those outcomes.

This includes:

- Helping families and employees understand the outcomes identified in the ISP
- Supporting activities and experiences that align with those outcomes
- Providing guidance on outcome-based documentation
- Monitoring documentation to ensure progress is being captured appropriately
- Working with families and support teams when questions arise about implementation or documentation requirements

Our goal is not simply to document services. Our goal is to help people work toward the things that matter most to them.





The Person-Centered Planning Process

Person-centered planning is the process used to identify what is important to a person, what supports they need, and what they hope to accomplish in their daily life. The planning process is led by the individual receiving services whenever possible. The person chooses who participates in planning discussions and helps guide decisions about their goals, services, and supports. The focus is on the person's preferences, interests, strengths, relationships, and vision for the future. It is okay if you don't know exactly what outcomes should be included. The planning process is designed to help identify goals and opportunities that are meaningful.

The Role of the County Board and SSA

The Service and Support Administrator (SSA) plays a central role in facilitating the person-centered planning process.

Throughout the year, the SSA works with the individual, family members, guardians, providers, and others who are important in the person's life to gather information and understand:

- What is important to the person
- What is important for the person's health and safety
- The person's strengths, abilities, and interests
- Areas where additional support may be needed
- Goals, dreams, and aspirations for the future

These conversations help shape the Individual Service Plan (ISP) and the outcomes included in that plan. Ohio's person-centered planning process is designed to ensure services and supports reflect the person's individual preferences and desired life goals.

During annual planning meetings, the SSA helps guide conversations that explore:

- What is working well
- What may need to change
- Progress made during the previous plan year
- New opportunities, interests, or goals
- Supports needed to promote success

The SSA works with the team to document these discussions within the ISP and develop outcomes and appropriate frequencies for the upcoming span year.



What to Expect During Your Annual Planning Meeting

Your annual planning meeting is an opportunity to talk about what matters most to you and what you would like to accomplish during the coming year.

Your SSA may ask questions such as:

- What is going well in your life?
- What are you proud of accomplishing?
- What activities do you enjoy?
- Are there new things you would like to try?
- Are there skills you would like to build?
- What would greater independence look like for you?
- How can your support team help you achieve your goals?

There are no right or wrong answers. The purpose of the conversation is to help create a plan that reflects your interests, preferences, strengths, and future goals.

What Are Outcomes?

An outcome is something a person wants to achieve, experience, learn, or work toward during their plan year.

Outcomes help answer questions like:

- What does a good life look like for me?
- What is important to me?
- What do I want to learn, accomplish, or experience?
- What kind of support do I need to reach my goals?

Outcomes are not about paperwork. They exist to ensure services and supports help people make progress toward the life they want to live.

Example Outcome: Learn to prepare simple meals more independently.

Support Activities:

- Creating a grocery list
- Shopping for ingredients
- Following a recipe
- Practicing kitchen safety

Documentation: Staff document progress as the person develops skills and independence.



Why Do Outcomes Matter?

Self-direction is built around the belief that people should have choice and control over their lives.

Outcomes help ensure that services are focused on the person, not just the service being delivered.

Strong outcomes can help people:

- Increase independence
- Develop new skills
- Build relationships
- Become more involved in their community
- Improve health and wellness
- Explore employment or volunteer opportunities
- Participate in activities that are meaningful to them

Outcomes vs. Services vs. Activities

Outcome = What the person wants to achieve.

Example: Build meaningful friendships in the community.

Service = The support funded through the waiver.

Example: Homemaker Personal Care (HPC).

Activity = The actual experience that happens during service delivery.

Example: Attending a community game night, participating in a fitness class, or joining a hobby group.

Think of it this way:

- **Outcome = Why**
- **Service = Support**
- **Activity = What Happens**

All three work together to help a person make meaningful progress.



How Are Outcomes Chosen?

Outcomes are developed through person-centered planning. The person receiving services leads this process to the greatest extent possible and chooses who they want involved in planning conversations. The planning process focuses on the person's goals, preferences, strengths, interests, and support needs.

The planning team may include:

- The individual
- Family members or guardians
- The SSA
- Providers
- Others who know and support the person

Together, the team discusses:

- What is important to the person
- What is important for the person
- Current strengths and abilities
- Future goals and dreams
- Areas where support may be helpful

Those conversations help identify outcomes for the upcoming plan year.

Examples of Person-Centered Outcomes

Every outcome should be meaningful to the individual. While outcomes look different for everyone, examples may include:

Community Participation

- Increase involvement in local community activities.
- Build new social connections through shared interests.

Independent Living

- Learn to prepare meals more independently.
- Develop routines that support daily living skills.

Health and Wellness

- Participate in regular physical activity.
- Develop healthy lifestyle habits.

Employment and Volunteering

- Explore volunteer opportunities.
- Build skills that support future employment goals.

Relationships

- Strengthen existing relationships.
- Develop meaningful friendships and social networks.





What Is a Span Year?

A span year is the period covered by the Individual Service Plan (ISP). Outcomes are generally developed for that planning period and reviewed throughout the year to determine whether progress is being made. Sometimes an outcome may be achieved quickly. Other times, progress may occur over many months. The goal is not perfection. The goal is meaningful progress.

What Is Outcome Frequency?

Some outcomes include a required documentation frequency. This tells paid staff how often progress toward the outcome must be documented.

Examples might include:

- Daily
- Weekly
- Monthly
- Other frequencies identified in the ISP

Documentation frequency helps ensure the team can track progress and understand whether supports are helping the person move toward their goal. Documentation frequency is determined during the planning process and may vary depending on the person's needs, goals, and the support being provided.

Example:

Outcome frequency identifies how often progress toward a specific outcome must be addressed. Staff must still complete all service documentation required for each service delivered.

The purpose is not simply to meet a requirement. Regular documentation helps the person, family, provider, and SSA understand whether supports are helping the individual make progress toward their goals.

Boundless@Home helps monitor documentation requirements and can answer questions about outcome documentation expectations. Families are not expected to navigate documentation requirements alone.



What Happens After Outcomes Are Created?

Once outcomes are finalized and included in the ISP, they guide service delivery throughout the year.

Paid staff should understand:

- What the outcome is
- How they support the person
- What progress looks like
- What activities relate to the outcome

Outcomes become part of everyday support.

For example:

Outcome: Increase participation in community activities and build meaningful relationships.

Support Activities:

- Attending community events
- Participating in clubs or groups
- Practicing social skills
- Meeting new people with shared interests

Staff support these activities during service delivery.

After the ISP Is Finalized

Once outcomes are approved and included in the ISP, Boundless@Home helps support implementation throughout the year by:

- Educating employees about the outcomes they support
- Assisting families with questions about outcome implementation
- Monitoring required documentation
- Reviewing documentation for accuracy and compliance
- Identifying progress, trends, and opportunities for growth
- Working collaboratively with families and SSAs when updates or adjustments may be needed

This ongoing partnership helps ensure outcomes remain meaningful throughout the span year.

Can Outcomes Change?

Yes. Life changes, interests evolve, and new opportunities arise. If an outcome is no longer relevant or a new goal becomes important, families can discuss possible plan updates with their SSA. Outcomes should evolve as people grow. A goal that was meaningful three years ago may no longer reflect what is important today.





A Partnership Focused on Success

Successful outcomes do not happen because of one person or one organization. They happen when individuals, families, support teams, providers, and county board staff work together toward a shared vision.

Each partner brings an important perspective:

- The **individual** shares their goals, preferences, interests, and dreams.
- **Families and guardians** provide valuable insight, encouragement, and support.
- The **SSA and county board** facilitate the planning process and help ensure services align with the person's needs and goals.
- **Boundless@Home and employees** help translate outcomes into meaningful experiences, opportunities, and progress throughout the year.

When communication is strong and everyone stays focused on what matters most to the person, outcomes become more than goals written in a plan.

They become opportunities to:

- Build new skills
- Increase independence
- Develop meaningful relationships
- Become more involved in the community
- Explore new experiences
- Create a life that reflects personal goals and interests

At Boundless@Home, we believe the most meaningful outcomes are often achieved one small step at a time. Every conversation, every experience, and every success along the way contributes to progress.

Together, we can help ensure services are not simply delivered, but that they create opportunities for growth, choice, and meaningful experiences.





How Do Staff Document Outcomes?

Documentation should describe:

What Happened

What support was provided?

How the Person Participated

What did the person do?

Progress Toward the Outcome

How did the activity help move the person toward their goal?

Any Significant Observations

Were there successes, challenges, or new opportunities identified?

Outcome documentation should describe the support provided, the person's participation, and any progress made toward an outcome identified in the ISP.

Example of Outcome Documentation

Less Helpful:

Supported John at the YMCA for two hours.

This tells us where the service occurred but not how it connected to the person's outcome.

More Helpful:

Supported John during a YMCA fitness class. John independently checked in at the front desk and participated in the full class. He introduced himself to another participant and engaged in conversation following the activity. This support promoted progress toward his outcome related to increasing community participation and developing social connections.

This helps demonstrate:

- What support was provided
- What the person accomplished
- How the activity connected to the outcome





More Outcome Documentation Examples

Less Helpful: Completed, Made healthier food choices

More Helpful: Supported Kathy by looking through recipes and meal planning for the week. We made a grocery list together and then went to the store and made a game out of who can find the items on the list first.

Less Helpful: Went to art class

More Helpful: Supported Robert with attending an art class. On the way, we practiced ways to begin conversations with new people, including asking, "Do you prefer colored pencils or markers?" During the class, Robert sat next to someone new, used one of the questions we practiced, and participated in a conversation throughout the class.

Less Helpful: Did laundry.

More Helpful: I asked Anne to help get her dirty clothes in the basket so we could start a load of laundry. Once we gathered the items, I asked Anne to place them in the washer and identify each next step. Anne correctly identified the steps as she completed them.

Remember:

Outcomes are not owned by the County Board, the provider, or the documentation process.

They belong to the person.

The purpose of every outcome is to support a life that reflects what is important to the individual and help them make progress toward the future they envision.





Common Misunderstandings About Outcomes

"The outcome belongs to the provider."

No. Outcomes belong to the person.

"Every activity has to be a major achievement."

No. Small steps count.

"The goal is to complete paperwork."

No. The goal is to support meaningful progress. Documentation simply tells the story of that progress.

"If the person doesn't achieve the outcome, the year was unsuccessful."

Not at all. Many meaningful outcomes take time. Progress and learning are important too.

Remember

Outcomes are more than a requirement in an ISP.

They are a roadmap for the year.

When outcomes are person-centered, they help ensure services focus on what matters most to the individual and support a life filled with choice, relationships, independence, and meaningful experiences.

Key Takeaway

Outcomes are not designed to create more paperwork.

They exist to help people identify what matters most, create a plan for achieving those goals, and measure progress throughout the year.

When services, supports, and documentation are aligned with meaningful outcomes, the focus shifts from simply providing a service to helping a person build the life they want to live.

