OUTCOMES

DEFINITION (from DHS' Person-Centered, Informed Choice and Transition Protocol)

> Person-centered outcomes: *Achievement of what is most important to the person, in ways that work for him or her and build on his or her strengths. These supports help the person connect to opportunities in the community as well as build relationships he or she cares about. Person-centered services and supports make it possible for a person to enhance his or her ability to achieve his or her goals and are measured through the person's quality of life.*

*Washington County supports using the terms *goals* and *outcomes* interchangeably.

DO:

- Include goals that are geared towards what the person wants, the person's preferences, and/or what the person identifies as important.
- Include goals that come directly from the person
- Remember that goals should build on people's strengths
- Remember that goals should help reduce what is not working in someone's life
- If the person is not able to identify outcomes using words, gestures, body language, or other forms of communication, include goals that are developed through conversation with the person's primary supports
    - I.e. "If Joe could tell us what his goal would be, what do you think he would say?"
- Show you had a conversation with the person and/or the person's supports in an effort to really capture what the *person's* goals are.
    - Directly quoting the person is a great way to do this!
    - Other ideas would be:
        - "Joe wants to go to Disneyworld."
        - "Joe would like to go to Disneyworld."
- Help people get to their goal or goals if they or their supports are having a hard time.
    - It can be hard to have conversations with people about their goals when they are feeling hopeless or to influence the goals people identify for themselves.
    - I.e. "I heard you say Disneyworld was important to you. Do you want to work on getting there some day?"
- Use the action steps to specify who is going to help the person with their goal or goals
    - Case managers have the ability to become more specific when doing the CSSP
- Always have at least one goal!

DON'T:

- Get hung up on the tense! It is more important to just show you are capturing what is important to the person and what the person really wants to do with their life.
    - I.e. do not feel you have to have goals such as "Joe goes to Disneyworld."
- Quote the person or identify a goal that says "I will" if the person did not actually say it.
    - Using "Joe will" comes across as a command. It is best to use "Joe wants" or "Joe would like."
- As a case manager, do not feel like you need to be responsible for all goals!

This document was developed by Washington County Community Services and STAR Services. It was made possible through grant funding through the Department of Human Services Disability Services Division.

Developed by Washington County's Person-Centered Best Practices Workgroup: Molly Henningsgard, Angie Hart, Winna Bernard, Judy Schoenecker, Caitlin McNamara, Christina Blake, Txing Vang, Kris Carpenter, Erin Boyle, Chor Her, Thao Le, and Chantelle Heifort-Adams

  - You can specify who is responsible for helping the person in the action steps and the support instructions in the support plan.
  - It is OK for a person to be responsible for their own goal in some circumstances.
- List services as outcomes.
  - When asked what their goal is, especially at intake, a person may say, "I want the Elderly Waiver." Rather that listing this as an outcome, delve a little further (it shouldn't take too long!) about *why* the person wants the Elderly Waiver.
    - Maybe it is to stay in their home (e.g. "Joe wants to stay in his home for as long as possible").
    - Maybe the person wants a clean house (e.g. "Joe would like to have his home be clean and comfortable because this is important to him").
- Use goals that providers list on their plans unless it is what the person tells you they want as an outcome at the time of the development of their support plan.
- Identify outcomes that use numerical values or percentages
  - i.e. "Joe will brush his teeth 75% of the time with 3 or fewer prompts."
- Be influenced by the goal being "attainable." It is the person's goal!
  - If Joe wants to go to the moon, that is Joe's goal.
  - It is up to Joe's team to help him find ways to support Joe with what he wants to do.
    - I.e. Joe's staff in his home could support with his goal in other ways like helping him go to the space museum, research astronauts at the library, or decorate his room like outer space.
- Don't use parent-stated goals or goals stated <u>for</u> the person
  - Rephrase or circle back to get at how the goal that was stated for the person is important to the person.
    - i.e. Parent says, "Joe wants to sit up." After circling back and delving deeper into how this important to Joe: "Joe wants to be able to sit up so he can be closer to and better see the people around him that he loves to be with."
  - If a parent or other person insists on having their goal listed, preface it with "Parent-stated goal: _____." But be sure to include an additional goal or goals that the person wants!

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