NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Building a Person-Centered Plan Around a Meaningful Long-Term Goal Statement

yale program for recovery and community health

Janis Tondora, PsyD
North Carolina Person-Centered Planning Initiative

January 29, 2025

Housekeeping

We will **mute audio for ALL** to reduce interference. You can unmute as needed.

For **technical issues** with audio, video, Zoom, **please direct questions in chat to Ingrid Padgett.**

Access your chat box for exercises and to post questions! We want to hear from you.

How to Qualify for Your Certificate of Completion

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Please carefully read: *How to Qualify for Your NBCC Certificate of Completion*.

- Participate in the full duration of the event.
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Failure to meet any of the requirements could result in your not being eligible for certification.

The Certificate will come from a **sender named "Certifier."** Please check junk/spam mail prior to contacting Ingrid Padgett (Ingrid.Padgett@yale.edu) **if your Certificate has not arrived within ONE month after today's event.**

Janis Tondora, PsyD (she/her) is an Associate Professor in the Department of Psychiatry at the Yale Program for Recovery and Community Health. Her work involves supporting the implementation of person-centered practices that help people with behavioral health concerns and other disabilities to get more control over decisions about their services so they can live a good life as they define it. Dr. Tondora has done this work in partnership with over 25 states, and multiple international collaborators, where she both teaches and learns from, stakeholders committed to person-centered systems transformation.

Meet Janis

Fun Fact:
Outside of work, you may find Janis enjoying the great outdoors with her family (human and furry!) on a paddleboard, in the mountains, or at the beach.

How about you? What hat(s) are you wearing today?

Audience Participant Poll (Multiple Hats Allowed)

- Direct support practitioner
- Peer support specialist
- Supervisor/Team Leader
- Family Member/Natural Support
- Guardian/Conservator
- Leadership/Administration
- Managed Care/Funder
- *Service recipient/Person with Lived Experience
- Advocate
- IT/Technical Specialist
- Other: Add to the chat-box

*A note on our use of terms: *Service user/participant, client, person in recovery, patient, person with a disability, psychiatric survivor, person with lived experience, person in distress, consumer.* ***Always honor individual preferences and when in doubt, ASK!***

History of PCP in NC Timeline

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Roots in person-centered approaches to support Thomas S. class members in 1990s

Original NC PCP Manual in 2010

Evolution of "recovery-oriented care" in the behavioral health space

2020 "desk reviews" indicated a need for continued system-wide focus on PCP

Multi-year, multi-stakeholder PCP Workgroup

Creation of the *NC Person-Centered Planning Guidance Document (effective 11-02-2023)*

Widespread introductory training (2022-23)

*Required of all providers working in programs where PCP is included within the service definition

DMHDDSUS recognizes the ongoing need for resources/tools to support PCP

Webinars on PCP "hot topics," an NC PCP Resource Toolkit website, and more!

*The training is housed on the UNC Behavioral Health Springboard website at https://bhs.unc.edu/theory-practice-person-centered-planning-nc for anyone to take free of charge any time.

Audience Poll:

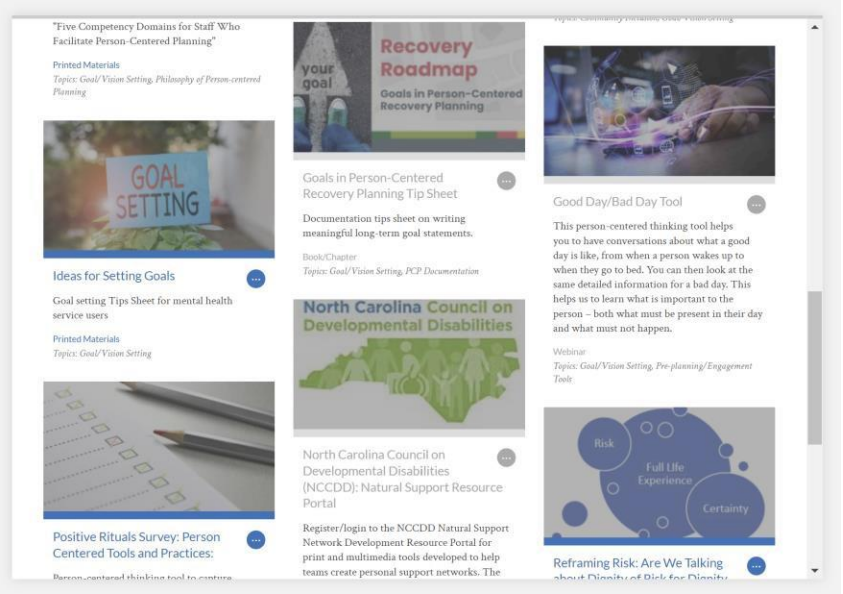
Have you already taken the introductory PCP course, either via a "live" webinar" or online via BHS?

If you have NOT taken this training but you have had OTHER PCP training, let us know in the chat.

YES, I have taken the NC PCP Intro training – live or on-line via BHS

NO, I have not taken the NC PCP intro training

Online PCP Resource Toolkit



- *Completion of the introductory training requirement, gives you access to…
- An extensive online library of articles, guides, webinars, and tools to support PCP implementation
  - Curated resources from both national and local innovators
- Includes an entire section devoted to Goal/Vision Setting

*The training is housed on the UNC Behavioral Health Springboard website at https://bhs.unc.edu/theory-practice-person-centered-planning-nc for anyone to take free of charge any time.

Don’t we already do PCP and prioritize a person’s valued goals?

What we hope for THEM…

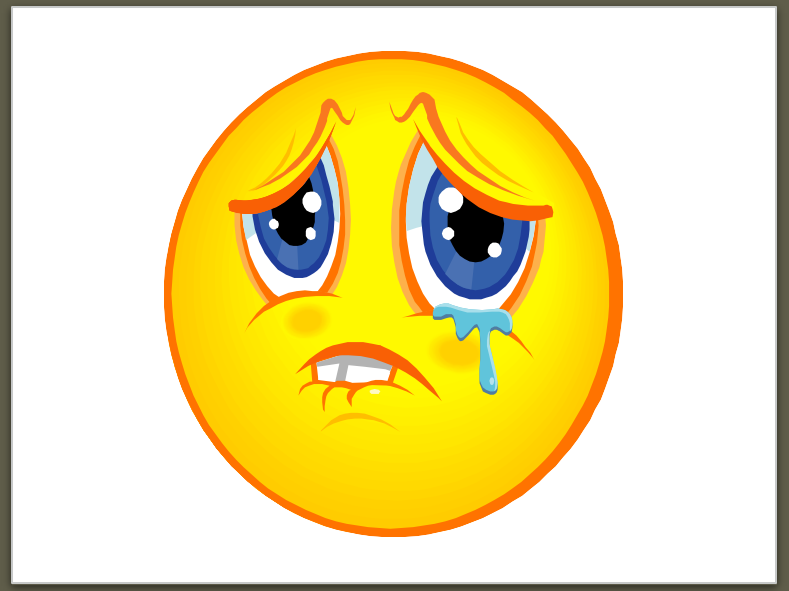
- ✓Compliance with services and meds
- ✓Less disruptive in classroom
- ✓Decreased symptoms/Clinical stability
- ✓Improved ADLs, functional skills
- ✓More time on task
- ✓Attendance at the day program
- ✓Increased Insight…judgement
- ✓Improved communication
- ✓Decreased hospitalization
- ✓Abstinence from substances
- ✓Residential stability
- ✓Healthy boundaries/socialization
- ✓Less outbursts at home
- ✓Improved cognitive functioning
- ✓Expressing emotions appropriately

What we value for US…

- ✓Life worth living
- ✓A spiritual connection to God/others/self
- ✓A real job, financial independence
- ✓Being a good mom…dad…daughter
- ✓Friends
- ✓Fun
- ✓Nature
- ✓Music
- ✓Pets
- ✓**A home to call my own**
- ✓**Love…intimacy…sex**
- ✓Having hope for the future
- ✓Joy
- ✓Giving back…being needed
- ✓Learning

Think About It: Just imagine…

- Beyond US and THEM
  - People with mental health diagnoses, developmental disabilities, and/or substance use concerns generally want the exact same things in life as ALL people.
  - People want to thrive, not just survive…
  - PCP is one tool to help them do just that!
  - And it all starts with a valued, person-centered goal statement.



PCP Plan Elements: Big Picture

GOAL
as defined by person;
what they are moving "toward"…not just eliminating

Strengths/Assets
to Draw Upon

Barriers/Assessed Needs
that Interfere

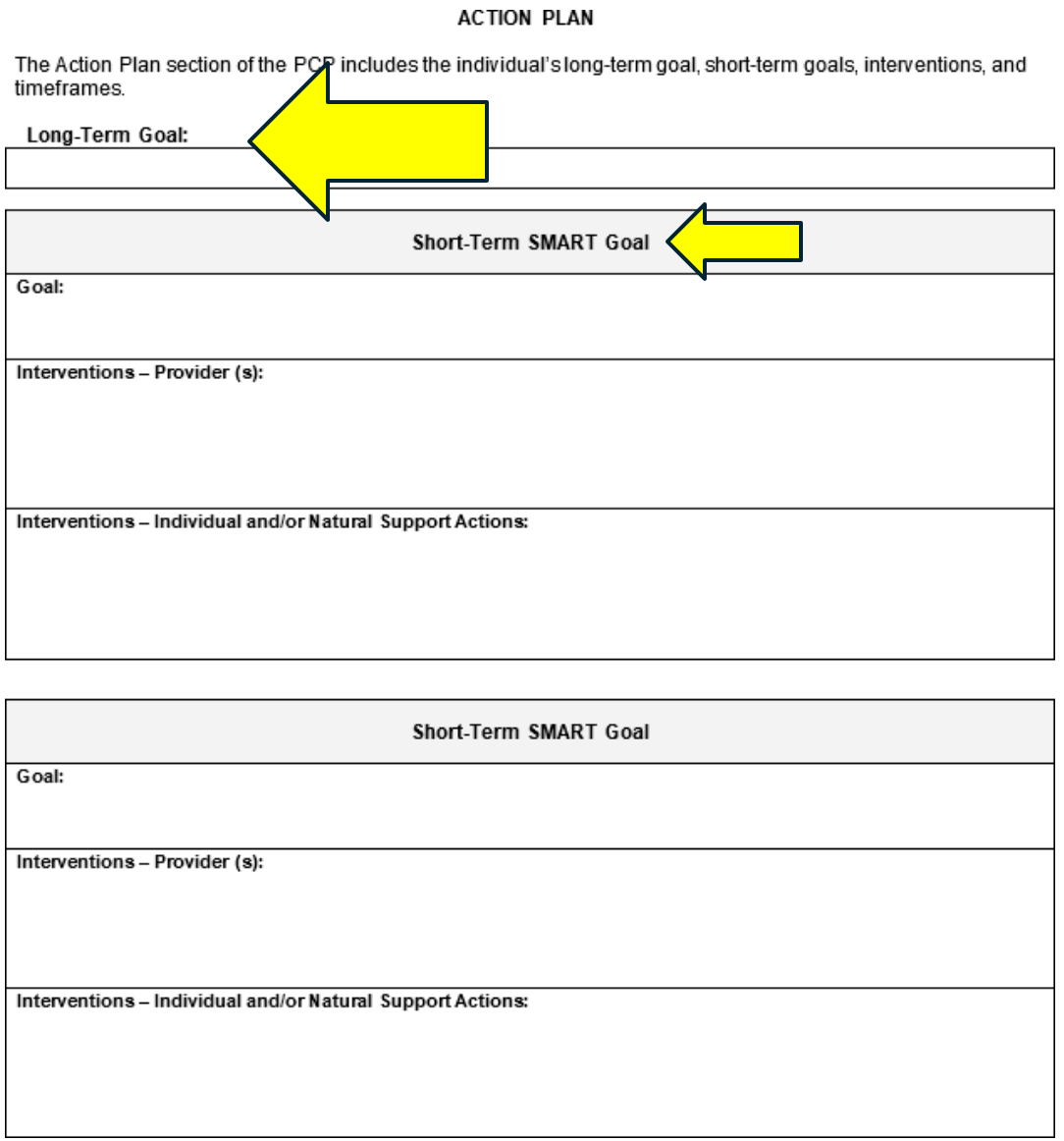
Short-Term Goal/Objective
S-M-A-R-T

Interventions/Methods/Action Steps

- Professional/"billable" services
- Clinical, rehabilitation, personal care services
- Action steps by person
- And roles/actions of family and other natural supporters

Official NC Guidance & Action Plan Template

- Critical element of the PCP that maps out what is most important TO a person in their life (the desired long-term goal) and then maps out…
  - What reasonable, concrete step(s) that would make them feel like they are moving in the right direction (short-term goal/s) and…
  - How the whole team will work together to help them get there (interventions: provider, individual, and natural support)



ACTION PLAN

The Action Plan section of the PCP includes the individual's long-term goal, short-term goals, interventions, and timeframes.

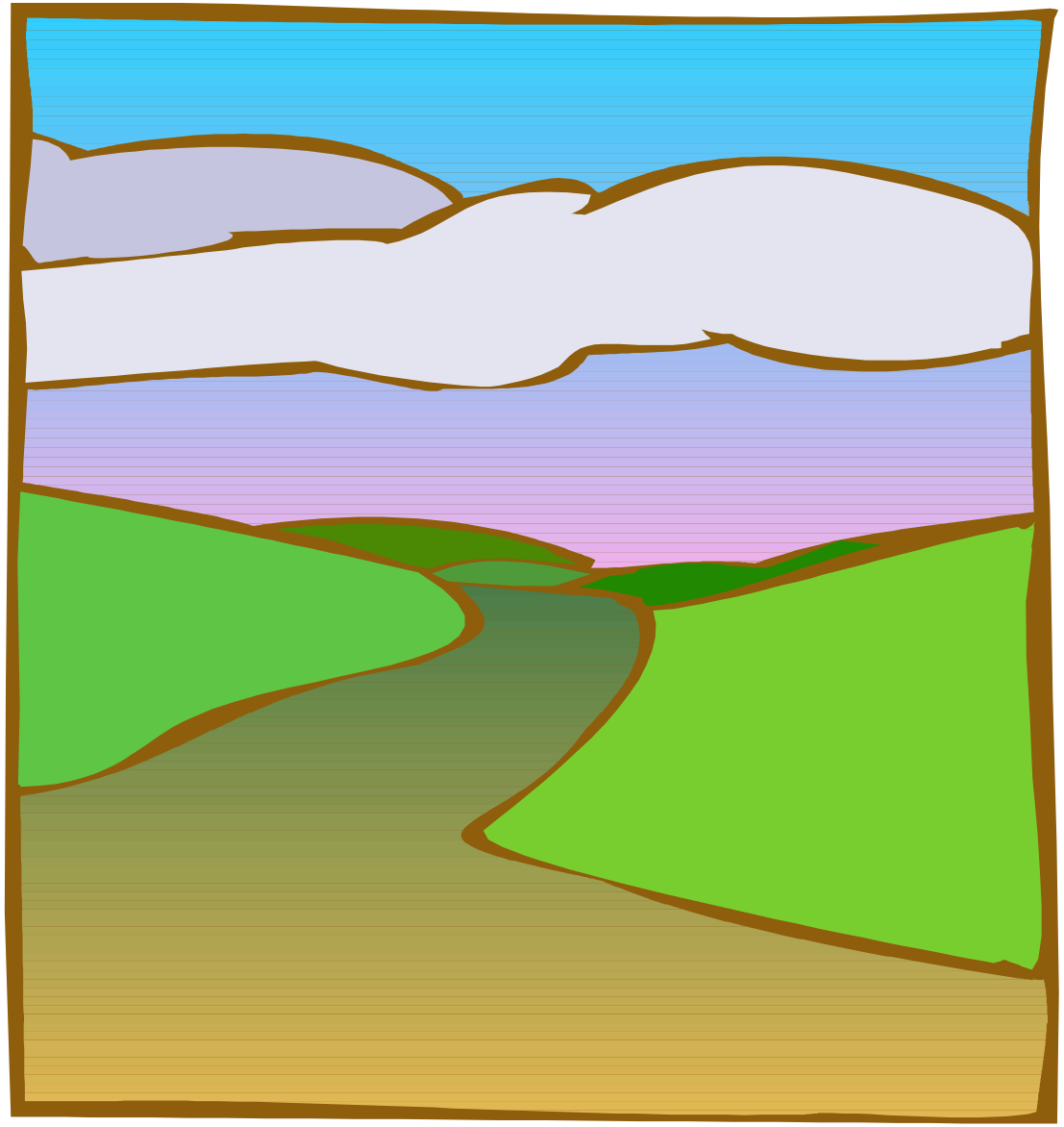
Long-Term Goal:

Short-Term SMART Goal
Goal:
Interventions – Provider (s):
Interventions – Individual and/or Natural Support Actions:

Short-Term SMART Goal
Goal:
Interventions – Provider (s):
Interventions – Individual and/or Natural Support Actions:

Long-term Goals

- Meaningful life changes, longer-term
- Owned by the person/family
  - Ideally expressed in quotes Person's motivation for action; **"Important TO"** them
- Vision of a good life that guides actions by team members
- Written in positive terms, TOWARD something desired
- NOT limited to the management of behavior, problems, or symptoms but about quality of life
- Often reflect wish for greater independence and self-determination; influenced by individual world view



Why is Getting to the “Important To” so Critical in PCP Goal Setting…

“We can’t know what a person needs until we first *understand* what it is that they WANT.”

And by WANT, we mean what they want out of LIFE, not just what they want out of TREATMENT/SUPPORTS

Need to explore the “bigger picture” at the level of the long-term goal and work to align the rest of the plan accordingly

Long-term Goals: What Do People Want?

Independence:
I want to control my own money.

Work /education:
I want to finish school.

Spiritual connection: *I want to get back to church.*

Health/well-being:
I want to lose weight.

Housing:
I want to move out of the group home.

Social activities:
I want to join the soccer team.

Satisfying relationships:
I want to have friends at school.

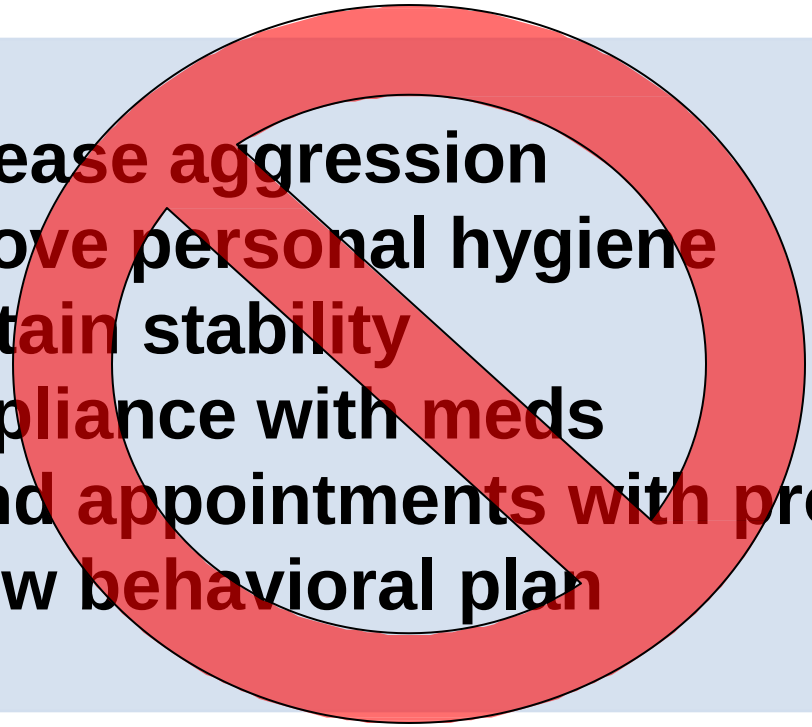
Valued Roles: *I want to volunteer at the Senior Center.*

They want to "live, love, work, learn play, and pursue their dreams in the community…"

And NOT just the territory of traditional treatment plans…

Goal:

- Decrease aggression
- Improve personal hygiene
- Maintain stability
- Compliance with meds
- Attend appointments with providers
- Follow behavioral plan



Sample Long-tem Goal or Vision Statements

- “I want to get my kids back.”
- “I want to be a mechanic.”
- “I want to have friends and get invited to birthday parties.”
- “I want to be able to live in my own apartment.

Goals Serve to Engage and Motivate People

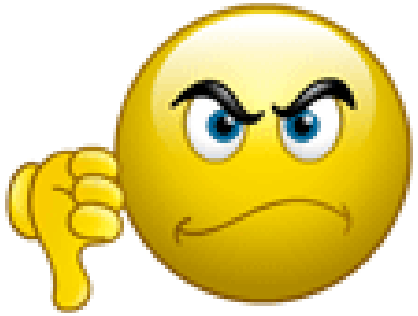
What goal would YOU want to work in your plan?

Recovery Plan Goal

- "I want to have friends and family back in my life."

Treatment Plan Goal

- Patient will experience improvements in interpersonal boundaries and socialization, communication, and relational skills



Traditional vs. PCP Goals

Patient will be med and treatment compliant	I want to go to college.
Joe will have decreased outbursts in class.	I want to go on field trips with my friends.
Client will follow diabetes diet.	I want to be able to live in my own place

Goal Exploration: Digging Deeper

If things were going well, how would life look for you?

Person's Goal	Follow Up Question
"I'll be able to stay out of hospital"	**"If you were able to stay out of the hospital, what would life look like for you?"**
"I just want the voices to be quiet"	**"If they were quiet, what would be different? What could you do that you can't do now?**
"I want to be a professional basketball player."	**"What do you think life as a professional basketball player is like? What part of that lifestyle would you like best?"**
"I want to go to college."	**"Tell me more about why going to college is important to you? When you think about college, what parts are you most looking forward to?**

But the person isn't coming up with anything? They say they want to work on their meds and their hygiene as the focus of their PCP…

- Service recipients and families may have lost the ability to dream and/or become socialized to a narrow model of service planning
- Direct education/capacity building among people with lived experience is essential (often best done by peer and family supporters!)
- Assessments and conversations PRIOR to the PCP development often do not adequately explore/uncover strengths, interests, and valued goals

Reminders in PCP Goal-setting

- Not all people can easily articulate personal goals; The language of goal-setting can be intimidating!
- Different ways of asking the question
- Goal setting takes time and a trusting relationship
- What if the person is focused on goals about symptoms (e.g., *I want to feel less depressed*):
- Who ELSE is in the person's life can help!
- It's OK to use your own observations and make a suggestion to get the ball rolling!

Strengths Inquiry to Support PCP Goal Setting

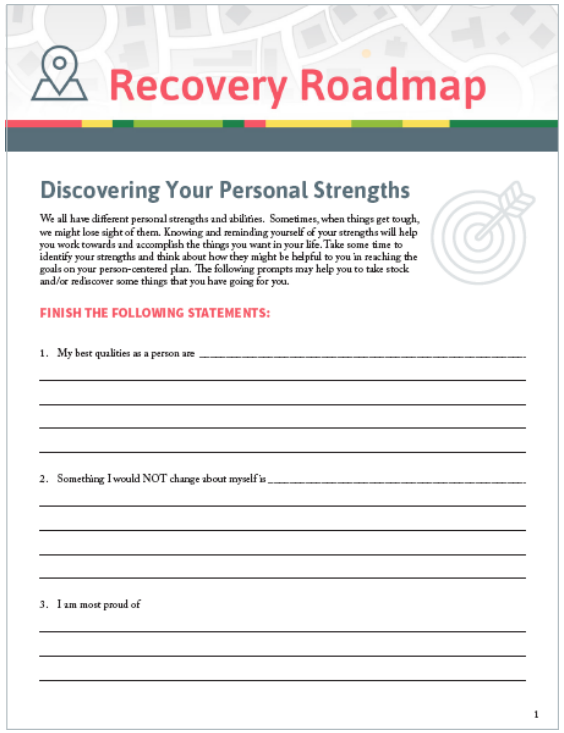
Hopes & Dreams: If you had a magic wand and could do or be anything, what would you wish for? If you could design the "perfect day" what would it look like?

Personal Strengths: What are you most proud of in your life? What was the best compliment you ever received? What do people like best about you?

Interests and Activities: What kinds of hobbies do you have – now or in the past?

- ***Relationships***: Who do you count on when things get tough and who counts on YOU?
- ***Open Ended Statements:***
  - My best qualities as a person are…
  - Something I would not change about myself is…
  - My sense of humor is…
  - The times I am most at peace are when…
  - People like that I am…
  - I feel really good about myself when…
  - The best compliment I ever received was when...
  - When I was little, I wanted to be a ?? When grew up?

Sample Tools To Inspire Hope in Goal Setting



Recovery Roadmap

Discovering Your Personal Strengths

We all have different personal strengths and abilities. Sometimes, when things get tough, we might lose sight of them. Knowing and reminding yourself of your strengths will help you work towards and accomplish the things you want in your life. Take some time to identify your strengths and think about how they might be helpful to you in reaching the goals on your person-centered plan. The following prompts may help you to take stock and/or rediscover some things that you have going for you.

FINISH THE FOLLOWING STATEMENTS:

1. My best qualities as a person are _____

2. Something I would NOT change about myself is _____

3. I am most proud of

1

Setting Goals: The following ideas might help you

State each goal as a positive statement

Express your goals positively—"Have enough energy to take care of my daughter" can be more motivating than a goal of "Be less depressed."

Dream big and break it down

It is important for all of us to allow ourselves to dream. Dreams give us hope, and hope fuels our recovery. But dreams don't happen overnight. It takes hard work, time, planning, and achieving short-term objectives to make it to the end result. Break big goals into smaller ones, and dive in one step at a time.

Stay positive with yourself

Sometimes as we are working toward a goal, unexpected things may happen. We might lose sight of our goal and get off track. We might find that this goal is not what we really wanted after all. We are allowed to make mistakes and change our minds about goals. Running into problems may not always feel good, but it allows you to learn more about what is important to you. Ask yourself: What about that goal wasn't working? What changes can I make? What supports do I need if/when I try again? What is my plan?

Be true to yourself

A goal is based on your hopes and dreams, and not those of others (like parents, society, or even your providers). Sometimes people can have strong opinions and push their ideas of what they think your goals should be onto you. It's ok to listen, but be sure that your goals reflect what you want to achieve.

Set priorities

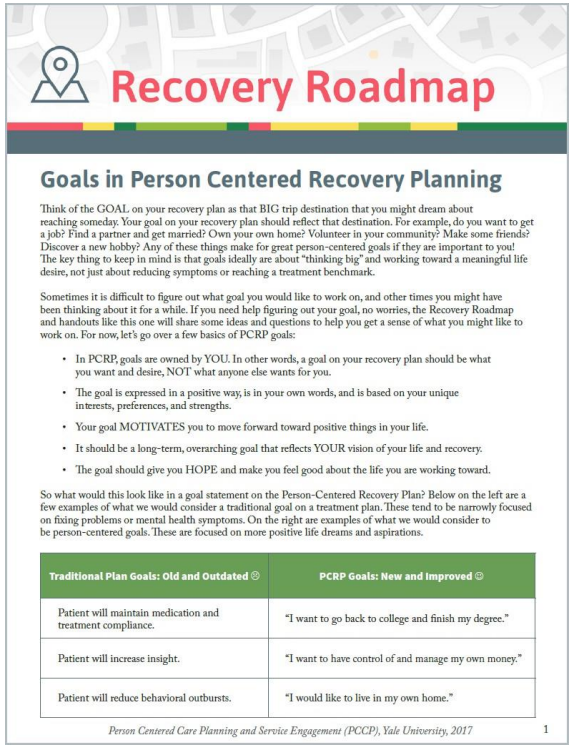
When you have several goals, decide which are the most important ones and which can wait. This helps you focus on the most important things in your life. Don't try to tackle too much at one time!

Believe in yourself

Believing in yourself and having the hope that you will achieve the goals you set is half of the battle. You are the expert in your life and your recovery.

Write goals down

This can make them more real and can give them more weight and meaning. Organize your thoughts ahead of time and be firm with your team about what is most important to you.



Recovery Roadmap

Goals in Person Centered Recovery Planning

Think of the GOAL on your recovery plan as that BIG trip destination that you might dream about reaching someday. Your goal on your recovery plan should reflect that destination. For example, do you want to get a job? Find a partner and get married? Own your own home? Volunteer in your community? Make some friends? Discover a new hobby? Any of these things make for great person-centered goals if they are important to you! The key thing to keep in mind is that goals ideally are about "thinking big" and working toward a meaningful life desire, not just about reducing symptoms or reaching a treatment benchmark.

Sometimes it is difficult to figure out what goal you would like to work on, and other times you might have been thinking about it for a while. If you need help figuring out your goal, no worries, the Recovery Roadmap and handouts like this one will share some ideas and questions to help you get a sense of what you might like to work on. For now, let's go over a few basics of PCRP goals:

- In PCRP, goals are owned by YOU. In other words, a goal on your recovery plan should be what you want and desire, NOT what anyone else wants for you.
- The goal is expressed in a positive way, is in your own words, and is based on your unique interests, preferences, and strengths.
- Your goal MOTIVATES you to move forward toward positive things in your life.
- It should be a long-term, overarching goal that reflects YOUR vision of your life and recovery.
- The goal should give you HOPE and make you feel good about the life you are working toward.

So what would this look like in a goal statement on the Person-Centered Recovery Plan? Below on the left are a few examples of what we would consider a traditional goal on a treatment plan. These tend to be narrowly focused on fixing problems or mental health symptoms. On the right are examples of what we would consider to be person-centered goals. These are focused on more positive life dreams and aspirations.

Traditional Plan Goals: Old and Outdated ☹	PCRP Goals: New and Improved ☺
Patient will maintain medication and treatment compliance.	"I want to go back to college and finish my degree."
Patient will increase insight.	"I want to have control of and manage my own money."
Patient will reduce behavioral outbursts.	"I would like to live in my own home."

Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017 1

Reminder, all these goal-setting/vision planning tools are catalogued for you in the new BHS PCP Resource Toolkit ☺

Access and use the tools that work ~~best for YOU and~~ the person/ family you are supporting ☺

CHARTING the LifeCourse

Tool for Developing a Vision - Family

Forming a vision and beginning to plan for the future in each of the life domains he inclusive, quality life in the community. This tool is to help families of all ages – tho an adult or somewhere in between, start to think about a vision for how their famil as an adult.

LIFE DOMAIN		My Vision for My Family Member's Future	priority	C
Daily Life Employment	What do I think my family member will do during the day in his/her adult life?			
Community Living	Where and with whom do I think my family member will live in his/her adult life?			

Life Domains Assessed during Development of Person-Centered Plan:

Daily Life and Employment What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.	**Community Living** Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.
Safety and Security Staying safe and secure – finances, emergencies, relationships, neighborhood, well-being, decision making supports, legal rights, and issues.	**Healthy Living** Managing and accessing health care and staying well – medical, mental health, behavioral, alcohol, tobacco and other drug use, medication management, life span development, exercise, wellness, and nutrition
Social and Spirituality Building/strengthening friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, cultural beliefs, and faith community.	**Citizenship and Advocacy** Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

What do you want to work on? What would you like to accomplish?
Using the assessment of the Life Domains, use this information to determine what is most important to the individual right now? What is their vision of a good life?
What strengths do you currently have?
These are the individualized, personal attributes, gifts, and skills a person possesses. Avoid what makes a "good client". Good examples: good sense of humor, artistic, knowledgeable about gardening, good soccer player, stylish. Avoid: shows up for appointments, takes medications as prescribed, smiles a lot, follows directions.
What are the obstacles to meeting your goals?
Help the individual identify the things that are getting in the way of meeting their goals and the resources they need to meet their goals.

-8-

But I'm afraid their goal is not "realistic" and I don't want to encourage it and set the person up for failure…

- None of us have a crystal ball to predict the future!
- The legacy of low expectations in goal-setting is far more damaging than helping a person to think big
- Achieving the long-term goal may not be the final outcome; but it may still open up new opportunities
- Remember, you can "think big" at the level of the long-term goal, and then later in the PCP break it down into incremental and realistic steps (AKA the SMART short-term goals/objectives)

Vintage Pat Deegan on Goals

Can you engage a person who is actively experiencing psychosis in PCP goal-setting…

- First, are the symptoms actually disrupting a person's life and interfering with goal attainment?
- Even in the case of fixed, unshared beliefs, it can become clear later on, that there are aspects of the person's belief that are, in fact, very much TRUE
- Being willing to explore unshared beliefs with people (rather than immediately moving to extinguish them) often reveals the beliefs have significant MEANING to the person
- … and that can be fruitful ground for exploring goals in PCP

And with all this talk about person-centered long-term goal statements, where/how in the PCP do we tackle the problems and support payment for our services?

- Widely held misperceptions about the rigor of PCP and its documentation
  - You can honor the person AND satisfy the chart!
- Where/how you support “medical necessity” in the record may differ from traditional documentation
- While “problems” may not be the focus of long-term goal, there are MANY other places within the record that medical necessity can, and should, manifest
- Coordination across organizational leadership and funders is necessary to promote consistency in quality expectations and messaging
  - PCP Guidance Document
  - Training being offered directly to TP audiences
    - Details coming soon!

The Documentation Challenge:

Regulations
Required Paperwork
Medical Necessity
Compliance

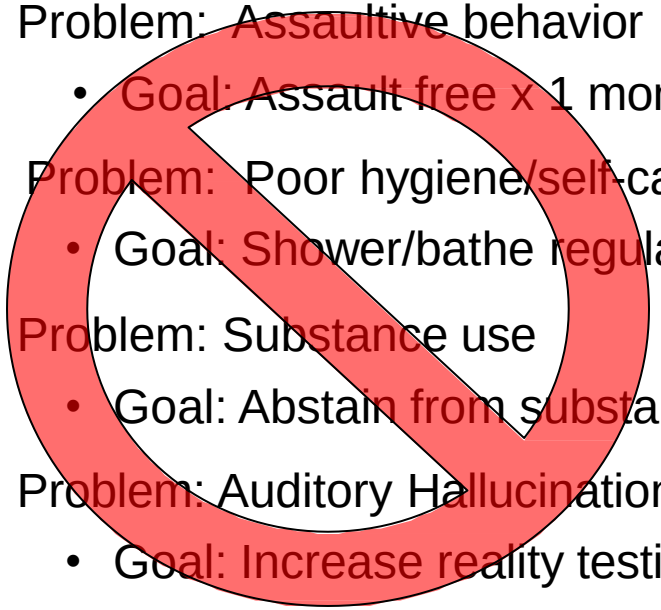
Collaborative
Person-Centered
Strengths-based
Transparent

A Major Shift in The Approach to Plan Documentation

Problem-Centered

One Goal for Every Problem as Identified in the Assessment

- Problem: Assaultive behavior
  - Goal: Assault free x 1 month
- Problem: Poor hygiene/self-care
  - Goal: Shower/bathe regularly
- Problem: Substance use
  - Goal: Abstain from substances
- Problem: Auditory Hallucinations
  - Goal: Increase reality testing

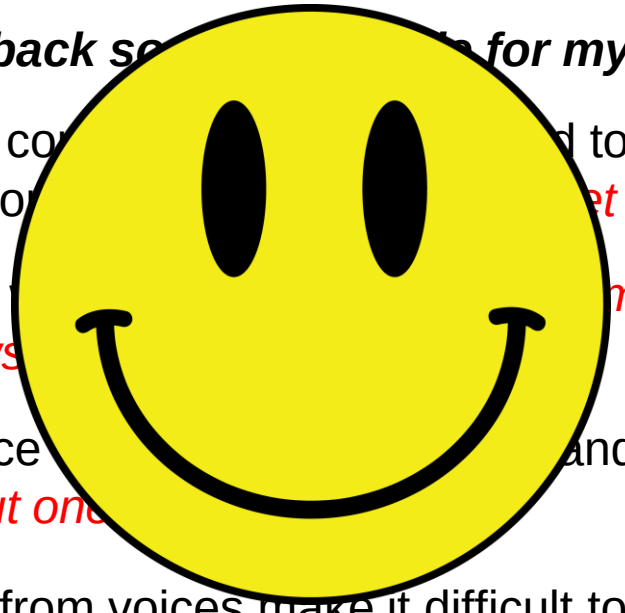


Person and Goal-Centered

Goal of the PERSON and Barriers Interfere

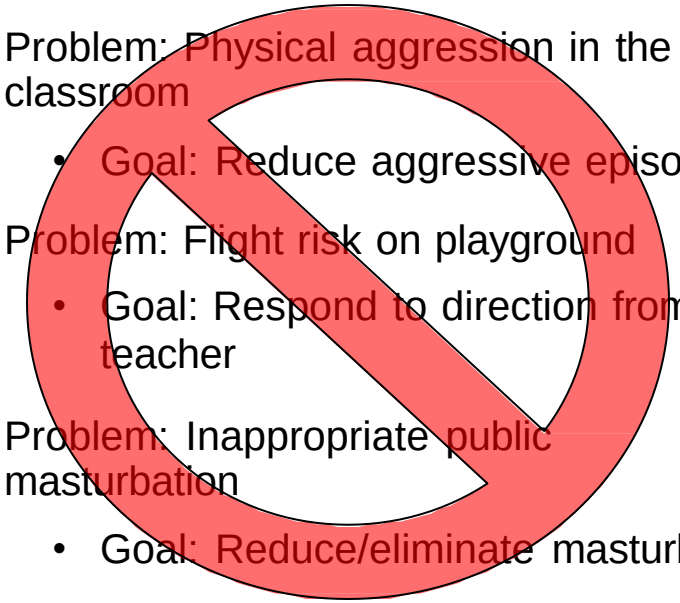
I want my job back so … for my kids.

- Physical co… d to termination… *…et me go.*
- Difficulty … *my best at interviews*
- Substance … and job loss *I called out on…*
- Distress from voices make it difficult to focus at work *I make a lot of mistakes when my symptoms are really bothering me.*



A Major Shift in The Approach to Plan Documentation

Problem-Centered
One Goal for Every Problem as Identified in the Assessment



- Problem: Physical aggression in the classroom
  - Goal: Reduce aggressive episodes
- Problem: Flight risk on playground
  - Goal: Respond to direction from teacher
- Problem: Inappropriate public masturbation
  - Goal: Reduce/eliminate masturbation

This framing often leads to punitive/restrictive interventions

Person and Goal-Centered
Goal of the PERSON and How Barriers Interfere

Long-term PCP Goal: I want to play basketball at recess. But no one wants to play with me.

- Limited verbal comm… …s self with behavior when frustrated; m…
- Tends to run if h… …remarks from peers
- Tends to mast… …eriencing sensory depriva…

This framing leads … approach and more positi… …al support strategies.

The PCP as a Whole Makes Space for Varied Perspectives

IMPORTANT TO the Person

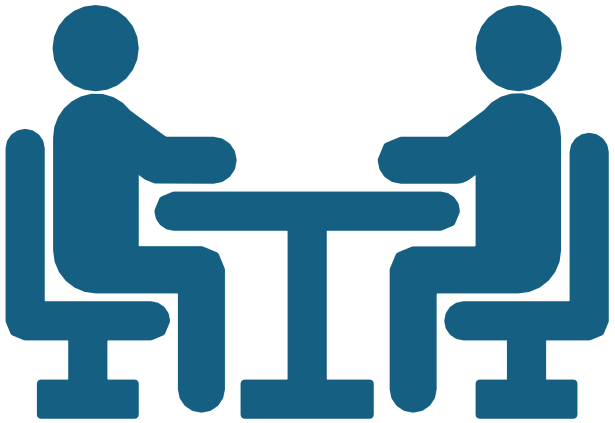
- Meaningful relationships
- A place of my own
- Valued social roles
- Independence/ Freedom of Choice
- Cultural and personal preferences
- Faith and spirituality
- A job, a career
- **Most often reflected at the level of the level of the LONG-TERM PCP goal**

IMPORTANT FOR the Person

- Basic health and safety
- Management of distressing symptoms or behaviors that disrupt life
- Maslow's basic needs
- Harm reduction
- Management of risk
- Legal obligations and mandates
- Daily functioning & life skills
- **Most often, best targeted in the PCP BARRIERS and SHORT-TERM SMART goals**

Short-term Goals: What do they do?

- Concrete, positive CHANGES in behavior/functioning/status
- Divide larger goals into manageable steps of completion
- “Proof” you are getting closer; help to assess progress; is the plan working as intended??
- Send a hopeful message we believe things can, and will, be different for the better!



Transition to the Short-term SMART Goal:

- What barriers are getting in the way of the valued long-term goal?
- What can you tackle first?
- Something that will help a person overcome a barrier and feel like a step in the right direction
- Review your list of assessed needs, and “pick” a barrier(s) from the list and ask what will be the proof this thing is improving in a way that matters to the PERSON?

How Barriers Inform Short-term Goals/Objectives & Focus of Support

Barbara knows that getting out into the community and being around people is an important part of her recovery and connected to her long term vision of having a job working with animals. Barbara currently wears tin foil on her head because she believes it's the only thing that can block others from hearing her thoughts. She's embarrassed to leave the house with tin foil on her head, but going outside without it causes considerable distress. As a result, she hasn't seen her friends at the dog park in over 3 weeks and isn't making it to support groups.

How Barriers Inform Short-term Goals/Objectives & Focus of Support

Traditional Approach

Barriers: paranoid delusions, lack of insight, poor compliance with group attendance

Long-term Goal:
Achieve and maintain clinical stability.

Short-term Goal/Objective:
Within the next 2 months, Barbara will attend weekly support groups as the result of increased insight about her illness.

Person-Centered Approach

Barriers: distressing concerns related to feeling exposed and unsafe, difficulty leaving the house, disconnected from outside supports

Long-term Goal:
Someday, I want to be able to work in the community with animals.

Short-term Goal/Objective:
Within the next 2 months, Barbara will feel safe enough to resume her visits to the dog park at least one time per week.

Short-term Goals/Objectives Should be SMART

- **S**imple or Specific
- **M**easurable
- **A**chievable
- **R**elevant
- **T**ime-framed

Will you definitively be able to say, it was achieved, yes or no…?

Technical Formula for Crafting Short-term Goals

Within_____**(amount of time),** _____**(Name)**
will have improved **(documented barrier)** _____, as evidenced by_____
(a meaningful change in functioning or behavior that is related to the life role goal.)

Examples:

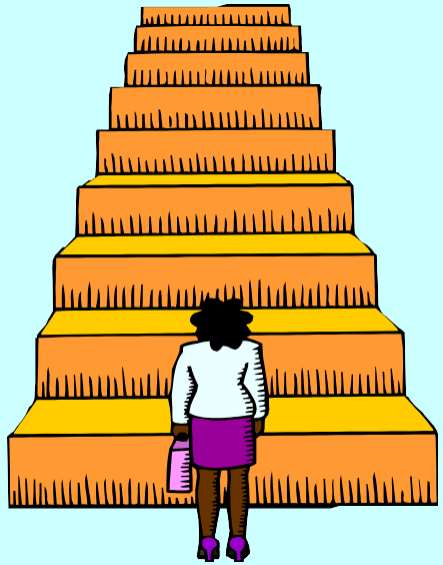
- Within the next 30 days, John will have improved management of panic as evidenced by successfully riding the subway to work without exiting the train before his stop.
- Amy will have improved communication abilities as evidenced by initiating greetings with peers during recess at least 3 times per week.
- Luis will demonstrate improved self-regulation skills by having a full week of home-school communication logs without behavioral incidents.

Short-term Goals/Objectives: NOT about Service Participation!

People can participate in services for years and not achieve the intended benefits!

NO: *Wanda will attend CBT group 2x weekly.*

Reminder: Short-term goals should describe hoped-for **results** of services and actions offered to the person



YES: *Wanda will apply mindfulness techniques to decrease the frequency of self-injury to no more than one instance per week within 90 days.*

Meet Gerry: Closing Exercise

Gerry is a 42-year-old single, white man who is living with a diagnosis of disorganized schizophrenia. He has had numerous lengthy hospitalizations and is currently living in a residential group home with 24-hour supports. Gerry is well-liked by his peers; and has a good sense of humor; a supportive and involved brother; and a wide range of interests (e.g., music, Chinese restaurants) he enjoys participating in and sharing with others when he is feeling well enough to do so. But his experience of feeling confused and fearful of others has been increasingly distressing to him and he is lonely and isolated. He used to go to the downtown jazz fests and meet lots of people, but now he feels like a "zombie." He is not getting out of the house to do much of anything other than come to the Center. He wonders if this is due to his meds or his stress when voices are very active. Although Gerry would really like to start dating and have a girlfriend, he admits to being "terrified" to get out in community and meet women, and states that it's been 10 years since he dated anyone. He wouldn't know where to start…He is currently unable to take the bus and is afraid to go anywhere alone because he gets confused at times and fears others might try to hurt him.

So, what do you think? Which of the below is the best goal statement for Gerry's PCP?

I don't want to feel like a "zombie."

Gerry will better manage distressing symptoms of paranoia.

I want a girlfriend.

Gerry will attend the Social Skills Group.

I just want to be happy.

Assume his goal is:
I want a girlfriend…and social isolation is interfering.

So, what do you think? Which of the below is the best short-term goal for Gerry's PCP?

Case manager will refer Gerry to the local Adult Recreation Department within 1 week.

Gerry's isolation and fear of others will improve as evidenced by his participation in at least one social activity per week outside the group home for the next 90 - days

Gerry will have less distress due to paranoia

Gerry will attend the Social Skills Group weekly

Gerry will pay his cable bill on time each month for the next 3 months

A Parting Thought

- You CAN create a PCP which honors the person and satisfies the chart!
- You CAN, and should, organize the PCP around a personally valued LIFE goal and still meet rigorous documentation standards.
- This is central in your partnership with individuals so they can move forward in their lives and in the community of their choice!

Closing Q&A… Your Thoughts and Ideas

Evaluation & Certificates

You must complete a brief, anonymous training evaluation to receive credit for today's training.

Access the evaluation via the link in chat OR the QR code on your screen.

1. The evaluation will close after TWO weeks. If you do **NOT** complete it within that time frame, you will lose the opportunity for a Certificate of Completion.

2. Follow the prompts at the end of the survey to enter your name (as you would like it to appear on your certificate) and email address.

3. Certificate will be from a sender named “Certifier.” Expect your Certificate by email within approximately 1 month. Please check junk/spam mail prior to contacting Ingrid.Padgett@yale.edu to inquire or to troubleshoot any technical difficulties downloading your Certificate.

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