2018 Person Centered Recovery Planning (PCRP) Program Announcement & Implementation Booster

January 24, 2018

Welcome to Via Hope
Person Centered Recovery Planning
2018 Program Announcement & Implementation Booster

- Control Panel on your right
  - Audio - use phone or computer
  - Questions –to send comments or inquiries to the presenters
  - Handouts
- Recording to be posted on Via Hope website
- CEU's – instructions in follow up email later today ($10 fee for clinical professionals)

Welcome to Via Hope
2018 PCRP Program Announcement & Implementation Booster

Presenters

Amanda Bowman, LCSW
Recovery Institute Manager
Via Hope

Betsy Bunt, LMSW
Person Centered Recovery Planning Program Coordinator
Via Hope

Janis Tondora, Psy.D.
Associate Professor
Yale Dept. of Psychiatry
Program for Recovery and Community Health

Agenda

- Welcome & Introduction
- Via Hope & Recovery Institute
- 2018 Person-Centered Recovery Planning (PCRP) Learning Community Introduction
- Dr. Janis Tondora Presents: PCRP – The Practice, Implementation Strategies and Lessons Learned in Texas
  - Featuring Special Guests:
    - Hill Country MHDD: Dawn Brunkenhoefer, Ph.D./LPC Regional Director Hill Country (PCRP Leadership and Change Team – Pilot)
    - Tropical of Texas BH Centers: Leivy Resendiz, Planning and Evaluation Lead (Coordinator Tropical Recovery Workgroup); Stella Bryan, Quality Assurance Director
  - Q&A
- More About 2018 PCRP Program
  - Program Timeline & Activities
  - Participant Teams
  - Application Process
- Q&A

1 hour CEU credit offered

Via Hope

- Introduction and Brief History
  - Working to help make Texas behavioral health system more recovery oriented since 2009
  - Roots go back to President's New Freedom Commission, 2003
  - Recommended transforming system to be individual, family, and youth driven.
  - Recovery (quality life of their choosing) should be expected outcome for anyone with mental health condition.
  - Via Hope created to be part of infrastructure to support new recovery oriented system.
  - Generously supported by grants from HHSC and Hogg Foundation.

Via Hope

- Training, Certification and Professional Development
  - Certified Peer Specialists
  - Certified Family Partners
  - Continuing education opportunities open to Peer Recovery Specialists (Recovery Coaches)
- Peer Voice Program - Leadership Training and Support for Peers (Persons with Lived Experience)
- Peer Run Organizations Program (PROP)
- Organizational Change Initiatives – The Recovery Institute

Via Hope Recovery Institute

- Set of organizational change programs, which promote
  - Implementation of new practices,
  - Elevating the voices of people with lived experience, including professional peer providers,
  - Cultural shifts that reflect the recovery paradigm, and
  - Transformational leadership practices for staff in a variety of roles.
- Program Areas:
  - Recovery Institute Leadership Academy (RILA)
  - Peer Specialist Integration (PSI) – "Peer Services Implementation"
  - Transition Age Youth (TAY) Initiative
  - Person-Centered Recovery Planning (PCRP)
- Stand-alone activities (open registration)
- Learning Community programs (competitive application for longer term support)

Recovery Institute Stand-Alone Activities

Open registration

- **Person Centered: Reimagining Planning and Partnership**, 2-Day Workshop (March 2018)
- **Demystifying the Peer Workforce**, 2-Day Workshop
  - Open to Public, space limited– in Austin, Feb 12-13th
  - On-site by request (and depending on trainer availability)
- **Webinars**
  - *Supporting Your Resilience in Trauma-Exposed Work* – Feb 6th
  - Documentation of Peer Services – Feb 27th (registration opens soon)
- **Online Learning Courses**
  - Recovery-Oriented Practice (2 modules)
  - Partnering: The Person-Centered Approach

*For details, see Events page at ViaHope.org

2018 Recovery Institute Learning Community Offerings

Longer-Term Programs

- **Peer Services Implementation (PSI) Program**
  - Domains: *1) Recovery-Oriented Culture, 2) Funding and Documentation, 3) Role Clarification, 4) Hiring and Recruitment, and 5) Supervision and Career Advancement*
  - 12-Month Program, May 2018 – May 2019
  - Application opens in March, 2018
  - Details of program and application requirements coming soon!

- **Person Centered Recovery Planning (PCRP) Program**
  - Training & Coaching for staff facilitating site-based PCRP training
  - Access to a new library of training tools and resources (trainer's manual, videos, practice exercises, sample plans, and more)
  - Support to develop and implement a PCRP training pro individualized to the needs & priorities of your agency

Details provided later in this webinar!

PCRP Overview and Implementation Lessons

Janis Tondora, Dawn Brunkenhoefer, Leivy Resendiz, and Stella Bryan

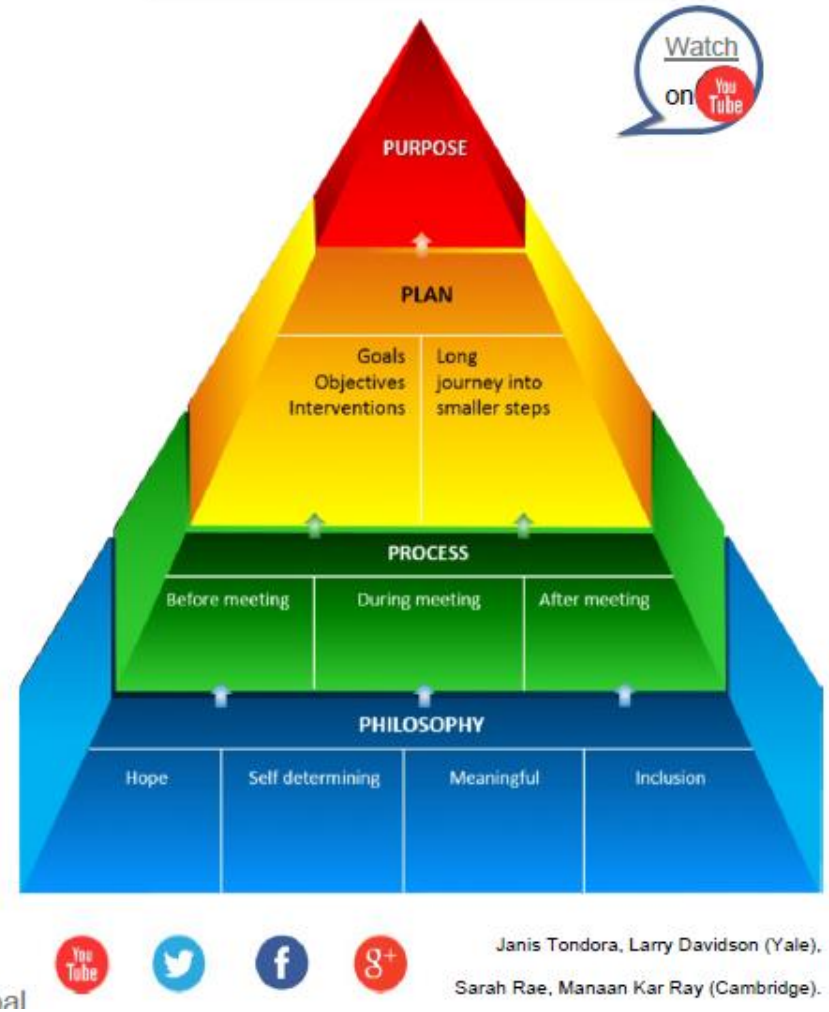
The 4 "Ps" of PCRP

- The ***practice*** of PCRP can only grow out of a ***culture*** that fully appreciates recovery, self-determination, and community inclusion.

- Can change what people "do"… but also need to change the way people feel and think.

- *4 Essential Ps:
  - Philosophy – core values
  - Process – new ways of partnering
  - Plan – concrete roadmap
  - Purpose – meaningful outcomes

Recently Released Web-based Video Overview of PCRP in Behavioral Health See: https://youtu.be/IuNYB9Prnk0 Tondora & Davidson (YALE) and Rae, & Kar Ray (CAMBRIDGE)



Toward Person-Centered Care

Traditional Approaches	Person-Centered Model
Self-determination comes *after* individuals have successfully used treatment and achieved clinical stability	Self-determination is viewed as a fundamental human right of all people
Compliance is valued	Active participation and empowerment is vital
Only professionals have access to information (e.g., plans, assessments, records, etc.)	All parties have full access to the same information – often referred to as “transparency.”
Disabilities and deficits drive treatment; Focus is on illness	Strengths are celebrated; Abilities/choices define supports;
Lower expectations	Higher expectations

Toward Person-Centered Care

Traditional Approaches	Recovery Model
Clinical stability or managing illness	Quality of life/ promotion of recovery
Linear movement through an established continuum of services	Person's chooses from a flexible array of supports and/or creates new support options with team
Professional services only	Diverse supports (professional services, non-traditional services, and natural supports)
Facility-based settings and professional supporters	Integrated settings and natural supporters are also valued
Absence of risk; protection of person and community	Working collaboratively with person to manage risk as they try new activities necessary for growth/recovery; responsible risk-taking

The Person-Centered Train: Who's on Board?

PCRP: Don't we already do it?

Not exactly…

- In the experience of the persons served
- when we "take stock" of current planning practices
- and in the written recovery plan itself…

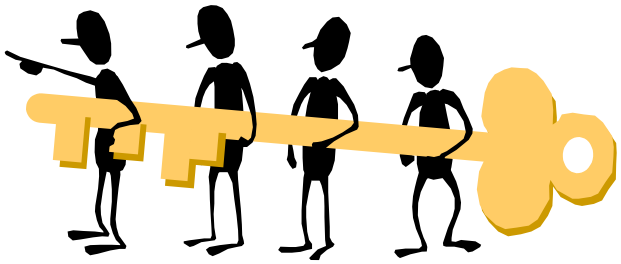
1 Strongly disagree	2 Somewhat disagree	3 Neither agree nor disagree	4 Somewhat agree	5 Strongly agree	DK I don't know

		1	2	3	4	5	DK
1.	I remind each person that she or he can bring family members or friends to treatment planning meetings.						
2.	I offer each person a copy of his or her plan to keep.						
3.	I write treatment goals in each person's own words.						
4.	Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.						
5.	I ask each person to include healing practices in his or her plan that are based on his or her cultural background.						
6.	I encourage each person to include other providers, like vocational or housing specialists, in their meetings.						
7.	I include each person's strengths, interests, and talents in his or her plan.						
8.	I link each person's strengths to objectives in his or her plan.						
9.	I make sure that plans include the next few concrete steps that each person has agreed to work on.						
10.	I include those areas of each person's life that he or she wants to work on (like health, social relationships, getting a job, housing, and spirituality) in his or her plan.						
11.	I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.						
12.	I include in treatment plans the goals that each person tells me are important to them.						
13.	I develop care plans in a collaborative way with each person I serve.						
14.	I encourage each person to set the agenda for his or her treatment planning meetings.						
15.	I use "person-first" language when referring to people in the plan, i.e., "a person with schizophrenia" rather than a "schizophrenic."						

PLEASE TURN OVER

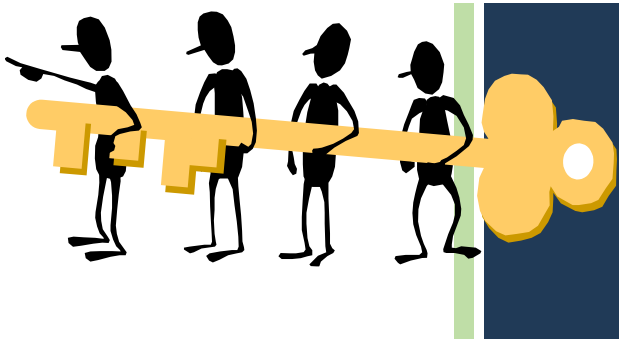
Person-Centered Care Questionnaire: Tondora & Miller 2009
http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQprovider.pdf
http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQperson.pdf

The Process of PCRP: Key Practices



- Person is a partner in all planning activities/meetings; advance notice (person-centeredness)
- Person has reasonable control over logistics (e.g., time, invitees, etc.)
- Person offered a written copy/transparency
- Shift in structure/roles in planning meetings
- Education/preparation regarding the process and what to expect (Toolkit)

The Process of PCRP: Key Practices



- Recognize the range of contributors to the planning process
- Capitalize on role of peers wherever possible
  - –distribution of effort based on unique talents…promotes efficiency AND quality
- Understand/support rights such as self-determination
- Value community inclusion/life - "While," not "after"
- Strengths-based approach in both language and assessment/planning

PCRP Process:
I'm on the Team!!

The Documentation Challenge:

CT Case Manager on trying to be "person-centered" in the context of clinical treatment planning and all the regulatory/fiscal requirements that go with it…

Person-Centered Documentation: Big Picture

GOAL
Life 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 Objective
S-M-A-R-T

Interventions/Methods/Action Steps

- Professional/"billable" services, including purpose
- Clinical & rehabilitation
- Action steps by person in recovery
- Roles/actions by natural supporters

So, what do YOU think? Meet Greg

- Greg reports he is very lonely. 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 group home to do much of anything other than come to the Center. He wonders if this is due to his meds… Although he would like a girlfriend, Greg admits to being "terrified" to get out in community and meet women, and states that its 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 often gets confused or fears others might try to hurt him.

Which of the below is the best goal statement for Greg's PCRP (and WHY?)?

1. I just want to be happy.
2. I don't want to feel like a "zombie."
3. Greg will better manage distressing symptoms of paranoia.
4. I want a girlfriend.
5. Greg will voluntarily attend the Social Skills Group.

Greg's PCRP

- **Goal: I want a girlfriend… someone to share my life with.**
- Strengths:
  - Motivated to reduce social isolation; supportive brother; has identified community interests(e.g., music, Chinese restaurants) well-liked by peers; humorous
- Barriers/Assessed Needs/Problems:
  - Intrusive thoughts/paranoia increase in social situations; possible negative symptoms of schizophrenia and/or med side effects result in severe fatigue/inability to initiate; easily confused/disorganized; need for skill development to: use public transportation/increase community mobility, develop symptoms management strategies, improve communication and social skills, attend to personal appearance
- Objective:
  - Greg will effectively use learned coping skills to manage distressing symptoms to participate in a minimum of 1 preferred social activity per week for the next 90 days

Interventions and Action Steps

- Dr. X to provide Med Management, 2X/mos for 30 min for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning
- Allyson Jackson, Rehab Specialist, will provide in-vivo coping skills training 2X/mos. for 45 min for next 3 mos. to increase Greg's ability to cope with distressing symptoms in social situations (teaching thought stopping, distraction techniques, deep-breathing, visualization, etc.)
- John Smith, Peer Coordinator, will provide travel training 1X/wk. for 60 min 4 weeks to help him become independent with city bus (e.g., identifying most direct bus routes, rehearsing use of coping skills, role playing conversations if confused/lost, etc.)
- Greg's brother, Jim, will accompany Greg to weekly social outings over the next 3 months.
- Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

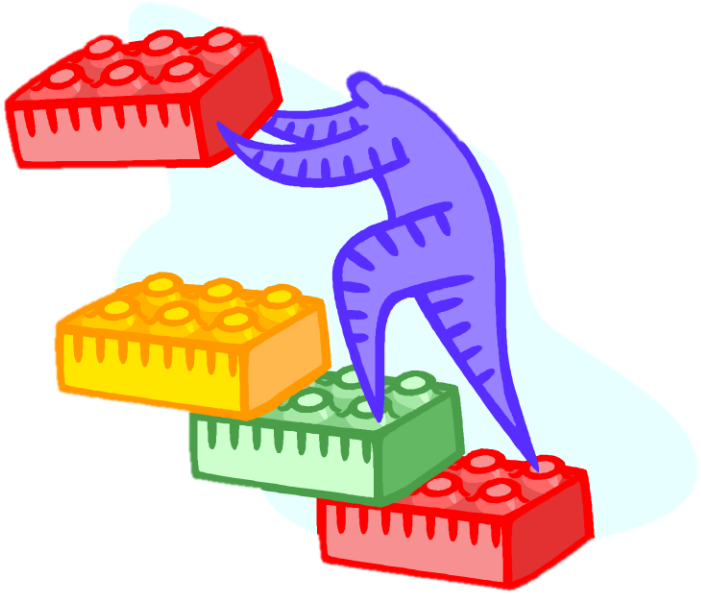
Bottom Line

- We can balance person-centered approaches with medical necessity/regulations in creative ways to move forward in partnership with persons in recovery.

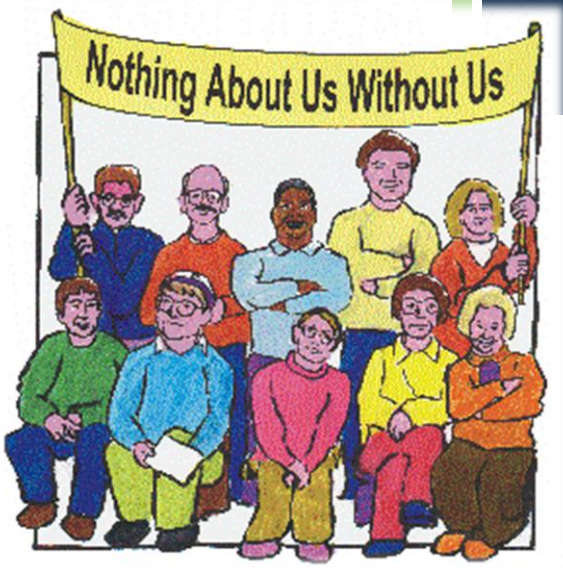
- We can create a plan that honors the person and satisfies the chart!

- In other words: PCRP is not soft!

PCRP Implementation: Lessons learned from the field…



Nothing about us, without us (REALLY!)

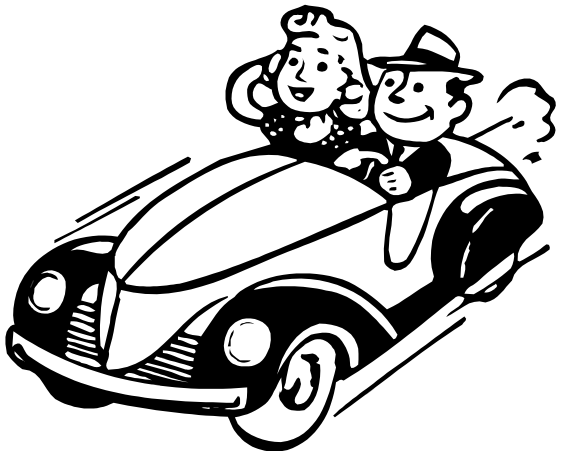


- Primacy of meaningful participation in ALL aspects of system from design to delivery to evaluation
- Research showing we typically UNDERESTIMATE consumers' desire to be involved (Chinman et al, 1999) – NH example
- And… that consumer involvement often has the single-most critical impact on recovery-oriented systems transformation

In other words…

- *"You keep talking about getting me in the 'driver's seat' of my treatment and my life… when half the time I am not even in the damn car!"*

Person in Recovery as Quoted in CT DMHAS *Recovery Practice Guidelines, 2005*



Lesson Learned: Invest In Consumer Involvement!

- Recovery Self Assessment (RSA)
- Programs which score high on Consumer Involvement consistently score higher on overall recovery orientation
- If you get ONE thing right…

RSA Subscales

Nothing about us… without us!

Listen & Respond To Common Concerns

1. People receiving services are usually too impaired or uninterested to partner in the way PCRP requires.
2. PCRP documentation puts us at risk for compliance issues, e.g., it might not meet medical necessity criteria.
3. The forms/templates/EHRs don't have the right fields for PCRP documentation.
4. Lack of time to do PCRP, caseloads are too high
5. If PCRP increases choice, how do we manage risk issues that might emerge in the face of "bad" choices?

Common Concerns/ Barriers

A Word of Caution…

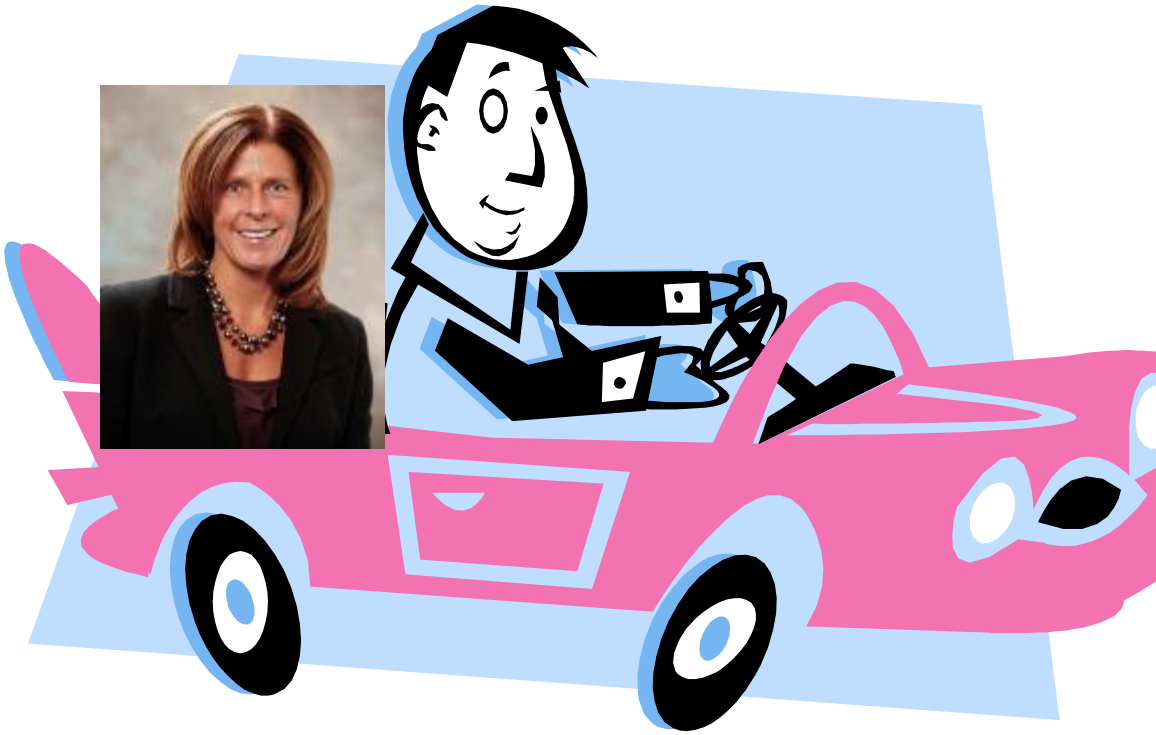
"We want to include you in this decision without letting you affect it."

Be clear on what PCRP is **NOT**

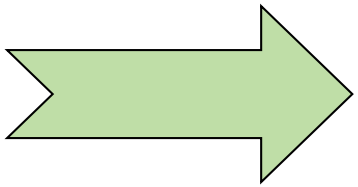
- PCRP is NOT an "add-on" or "special" new program
- PCRP is NOT only for people who are "high-functioning"
- PCRP is NOT "anti-clinical/anti-tx"
- PCRP is NOT something that can be done in a vacuum inside a treatment system

If the person is in the driver's seat of their care, where does that leave me?

- PCRP is based on a model of PARTNERSHIP…
- Respects the person's right to be in the driver's seat but also recognizes the value of professional co-pilot(s) and natural supporters

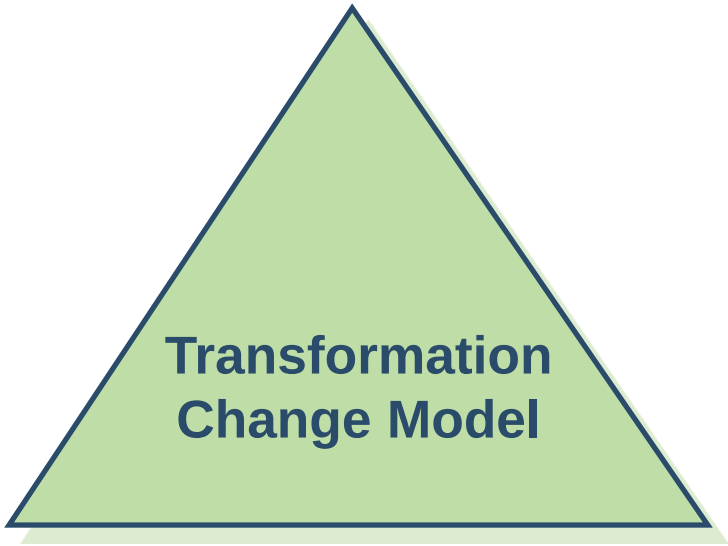


"Training" is necessary, but not sufficient



Competency

knowledge, skills and abilities



Culture Management

behavior and attitude

Project Management

work / business flow

Best Practice Implementation: Beyond "Spray and Pray" ☺

- How we think about training is outdated and inadequate
  - No more "train and run"/"spray and pray"
  - Inefficient use of valuable, LIMITED, resources

- Diverse competency-focused interventions include:
  - **Selection:** Job descriptions, Interviews, Performance evaluations
  - **Training:** 1-day orientation to PCP, 2-day skills training, Train the Trainer; evaluation of training by staff, role-specific training (peers/psychiatrists/service users)
  - **Coaching:** Consultation Calls, Coach Competencies

Roles and Activities to Support PCRP

- There are many ways to support PCRP
  - Culture shaper
  - Trainers (NEO or existing staff/teams)
  - PCRP meeting observer/facilitator
  - QM focus/record review
  - Group and/or individual supervision

Know (and Show) Your Stuff

- Demonstrate knowledge of person-centered culture, planning processes, and documentation
  - Do your homework
  - Role model PCCP at every possible turn
    - Beware "Do as I say…Not as I do."
  - Continually try to learn more yourself
  - Use a "tip sheet" as reference guide (to organize yourself AND your those you are supporting)

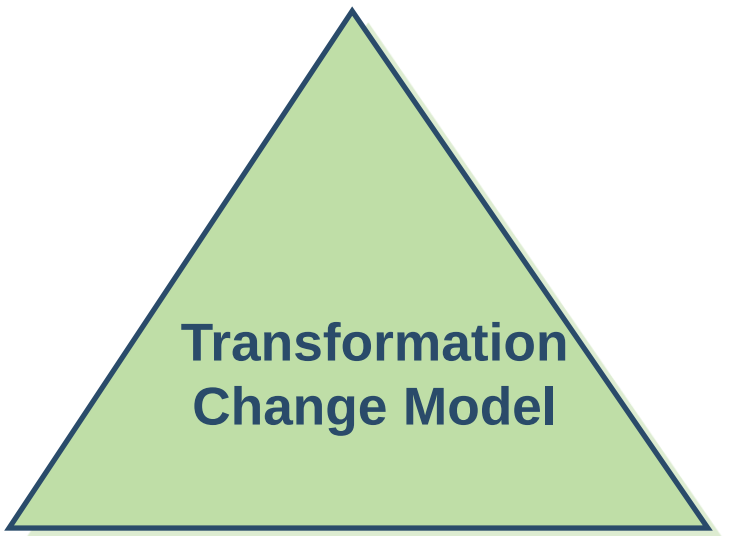
- *As one goes through life one learns that if you don't paddle your own canoe, you don't move.*

  --Katharine Hepburn

BUT…Be Humble

- Be passionate but not "preachy." No one will be able to "hear" you if you are coaching from a pulpit. (implications for trainer/coach selection)
- Being genuinely humble, self-effacing goes a long way
- You will know you have "arrived" when you feel perfectly OK saying, *I just don't know!*
- Seek feedback for yourself (be a good role model); Try to analyze your strengths and areas for improvement and work on them

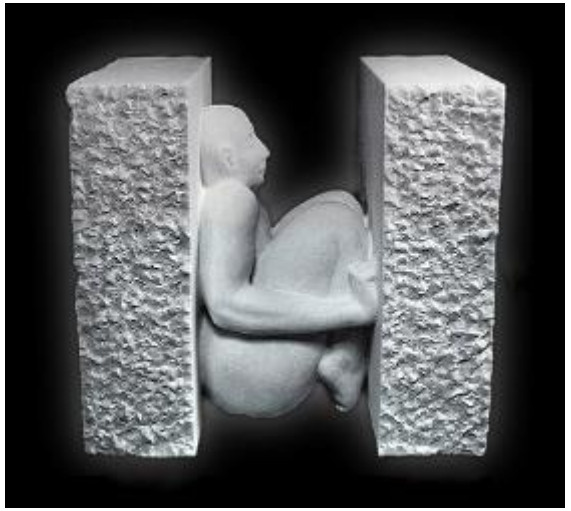
Attend to (real) external barriers



- "When you pit a bad system against a good performer, the system always wins… (Rummler, 2004).

Attend to (real) external barriers

- Many administrators DO feel stuck between a rock and a hard place… as they struggle to reconcile (seemingly) competing tensions
  - Clinical gate keeping vs. direct access
  - "Eligibility criteria" for voc services
  - Offering copies of plans
  - Compliance and billing issues



But, be prepared for red herrings

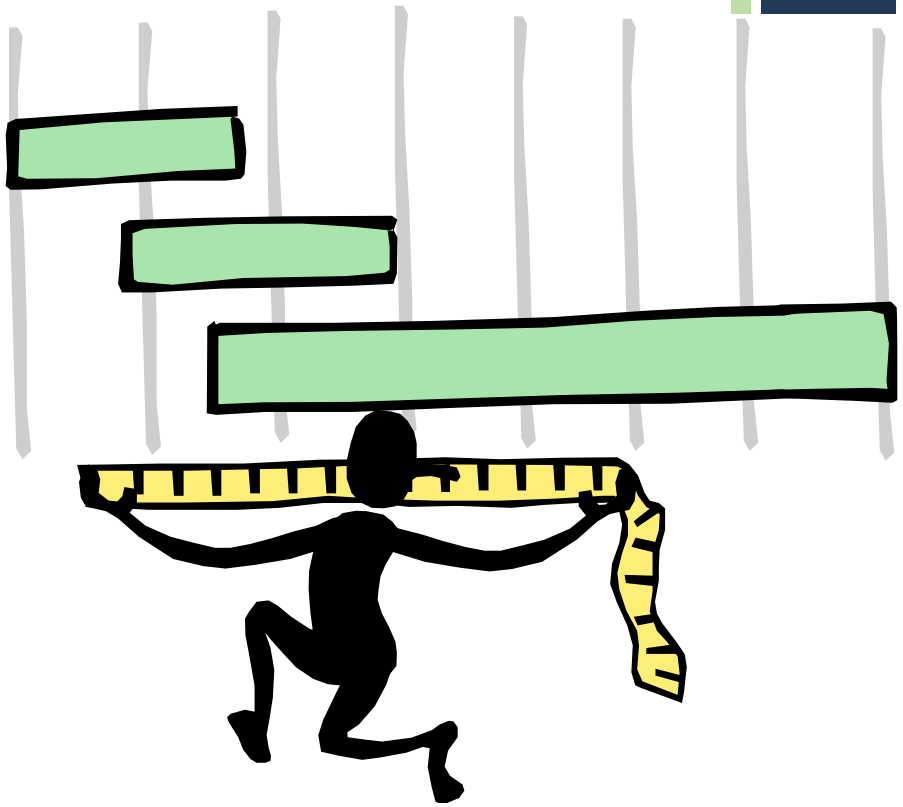
- While attention to organizational factors is important, sometimes this EXTERNAL focus can mask more complex change barriers…

Make Meaningful Use of DATA

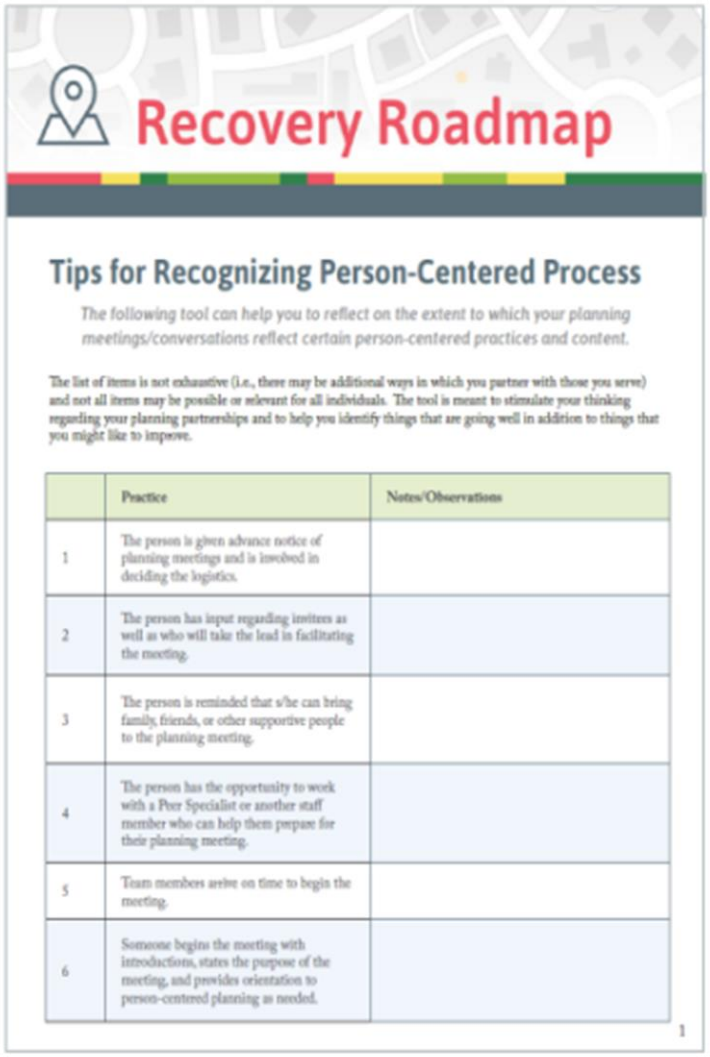
- Data is used for
  - Evaluation of your work
  - Identifies what you need to supervise to
  - Identifies core values at the system level
  - Helps employees understand the "why" of their jobs
- There are measurements of person-centered process and documentation that can assist you in monitoring the impact of your efforts

"What gets measured, gets done."

Unknown Author



PCRP Process Indicators



Recovery Roadmap

Tips for Recognizing Person-Centered Process

The following tool can help you to reflect on the extent to which your planning meetings/conversations reflect certain person-centered practices and content.

The list of items is not exhaustive (i.e., there may be additional ways in which you partner with those you serve) and not all items may be possible or relevant for all individuals. The tool is meant to stimulate your thinking regarding your planning partnerships and to help you identify things that are going well in addition to things that you might like to improve.

	Practice	Notes/Observations
1	The person is given advance notice of planning meetings and is involved in deciding the logistics.	
2	The person has input regarding invitees as well as who will take the lead in facilitating the meeting.	
3	The person is reminded that s/he can bring family, friends, or other supportive people to the planning meeting.	
4	The person has the opportunity to work with a Peer Specialist or another staff member who can help them prepare for their planning meeting.	
5	Team members arrive on time to begin the meeting.	
6	Someone begins the meeting with introductions, states the purpose of the meeting, and provides orientation to person-centered planning as needed.	

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7. COMMUNITY RESOURCES

3	2.5	2	1.5	1	.5	0
STRONG		MODERATE		MINIMAL		ABSENT

- *Providers show an interest in helping the individual locate community resources (outside the mental health system) relevant to his or her goals and desires*
- *If the individual desires, providers offer support in accessing and connecting with those resources (for example: classes, groups, activities, programs, churches).*
- *If the individual desires, effort is put into identifying, locating, and accessing local self-help resources*

- *Providers show little interest in identifying local community resources for the person outside the mental health system , and even appear to actively discourage it*
- *Statements are made that for purposes of safety, the person should just connect with resources and programs within the mental health system*
- *Providers evidence no interest in helping the individual locate and use local self-help resources*

8. WISDOM OF RISK

3	2.5	2	1.5	1	.5	0
STRONG		MODERATE		MINIMAL		ABSENT

- *Providers reinforce efforts and statements by the individual in taking risks in the service of growth and learning, even if they are worried about the outcomes*
- *If concerned about risks the individual is taking, providers try to engage him or her in a balanced dialogue about possible unsafe outcomes and ways to minimize those*
- *If the individual has recently taken risks that led to unsafe or negative consequences, providers highlight the opportunity to learn from the incidents rather than highlighting failure*

- *Providers clearly discourage risk-taking behaviors, equating them with negative outcomes and danger*
- *Providers fail to engage the individual in a balanced dialogue that respects the wisdom of risk and at the same time the potential for unsafe outcomes*
- *In response to recent risk taking by the individual that led to unsafe outcomes, providers highlight failure and the need for compliance in the future, without encouraging a discussion of learning from the incident(s)*

SOME risk IS necessary at individual and systems level

- Is the system organized to perpetuate the "status quo"
- How tolerant of risk/change is the system as a whole?
- How is the burden of risk shared across all stakeholders – including PIR?
- Who is held accountable when things don't work out as planned?
- Just as in individual recovery, taking risks opens door to new opportunities!

“We’ve considered every potential risk except the risks of avoiding all risks.”

How has PCRP been taking shape in Texas? Inquiring minds want to know…

- How did you first get involved in PCRP? Why were you interested in it and how did you start?
- Tell us a little bit about what PCRP has looked like at your agency? How have things unfolded over time?
- Can you tell us about a success /bright moment you have had in your PCRP efforts?

- What has challenged you along the way and how did you address those obstacles? Any surprises?
- What keeps you going when it gets hard?
- Any piece of advice you would give to agencies thinking about deepening their implementation of PCRP?

Hill Country MHDD

Strengths	Barriers
■ Commitment of Leadership	■ Geographic
■ Culture Change	■ Buy-In
■ Peer Support	■ Shortcuts
■ QM & Standards	■ Non-reimbursable Activity
■ Change in Uniform Assessment & Treatment Plan Template	■ Complaints of Time
	■ Availability of Training

Our Story

- PCRP & Anasazi
- Audit & Fidelity
- Performance Standard
- Focused Trainings
- Rising Stars
- Recognition of Progress
- Help!

Person Centered Recovery Plan

The journey so far…

In the beginning…

Why?

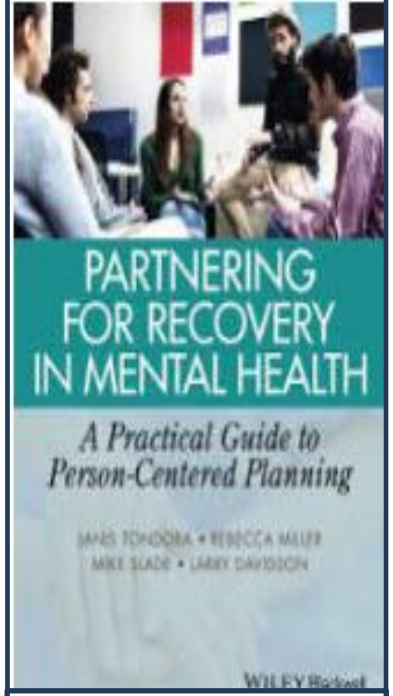
- Used traditional Problem, Goal, Objective, Intervention (PGOI) Set up in electronic Health Record
- Feedback from site visits
- Attending the Via Hope PCRP Training.
- Internal reviews and recognizing needs
  - Improving positive outcomes

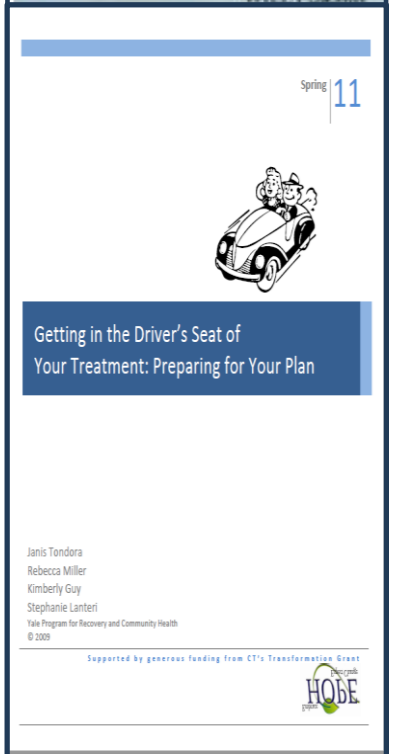
How?

- Established the Recovery Workgroup
  - Different voices
  - Breakout workgroups-documentation
- Establishing a template that worked
  - Many drafts!
  - Electronic Health Record
- Consultation (a lot of it, Thank you!☺)
  - Via Hope
  - Dr. Tondora- visited with supervisors, case managers, workgroup, and administration.
- PCRP Training conducted by Via Hope-Supervisors

What we encountered:

- Navigating the conceptual aspects as well as the technical
  - Electronic Health Record
- Buy in from veteran staff
  - Shifting mindsets
- Apprehension vs. Excitement
  - Planning- setting timelines
- Training rollout=massive undertaking





What worked well:

- Having the folks that could assist involved in the process.
- Buy In! (At all levels)
- The book!
  - The kit!
  - Shared resource folders for staff
- Setting timelines
- Planning, prep, accountability
- Break out workgroups
- Consultation visit/training
- "Recovery" everywhere!
  - Trauma Informed Care; Annual CEU Conference; Incorporated into all trainings; Newsletter

Work in progress:

- Peer Provider and Family Partner involvement.
  - Starting groups around the Kit.
  - Continued structured supports.
- Comprehensive Review of outcomes:
  - Staff/client experience
  - Review of TRR scores pre and post PCRP implementation,
  - Formalizing a questionnaire within EHR for reporting.
- Targeted Training to individual programs-opportunity for case staffing as they relate to PCRP.
- Creating tools, e.g. cheat sheets for staff to use as an easy reference

It's an ongoing process!

More About 2018 PCRP Program

2018 PCRP Learning Community

Participants can expect to…

- Develop skill and knowledge of PCRP content
- Expand facilitation skills
- Become equipped to teach PCRP
- Effectively train staff within their organization
- Promote the role of peer support in care planning
- Learn ways to support staff experiencing compassion fatigue and burnout

2018 PCRP Learning Community

Additional Benefits:

- Build a community of trainers
- On-demand tools and resources
- Access to subject matter experts
- Individualized coaching
- On-site consultation
- Professional development

Timeline of Activities

Date	Activity
January 2018	January 24th- Informational Webinar about the PCRP program and application process
February	February 1-Online Application Opens February 6th- Dr. Fisher webinar February 28th- Online Application Closes
March	March 9th- Applicants notified of acceptance
April	Orientation to initiatives Content clarification webinar Teams orient to curriculum and do pre-work
May	Three day Training event- location and exact date TBD
June, July, August	Individual team calls, all-team calls/webinars, teams practice training on site, remote consultation
September - November	Via Hope on-site observation of trainings
December 2018	**Closing Cross-Site Gathering**

2018 PCRP Learning Community

Preview of Curriculum:

- Highly interactive
- Didactic
- Application focused
- **Not** the same as the PCRP public workshop curriculum

2018 PCRP Learning Community

Team Composition:

- 2-4 individuals
- Each person must have attended the PCRP public workshop in the last 2 years
- At least 1 person on the team should have training experience
- At least 1 person on the team should have experience developing PCRP plans

2018 PCRP Learning Community

Participating Team Responsibilities:

- Complete all of the required activities in the timeline
- Deliver PCRP training at least once at your organization during the summer
- Provide peer observation and coaching
- Host Via Hope on-site in fall 2018

The Application Process

The Application Process

- Requirements to Apply
- Application Timeline
- Technology Tips
- Outline/Overview of Steps
- More on the Letter of Commitment
- Final reminders and tips

2018 PCRP Learning Community

Requirements to Apply:

- Organization must be a publicly funded, mental health service provider
- Review program activities to determine the following:
  - Your organization can commit to participating fully
  - Your organization and the 2018 PCRP Learning Community are a good match
- Complete and submit application by February 28th
- Include a letter of commitment from Executive Sponsor
- Compose a team that meets specified criteria

Application Timeline

Date	Activity
January 24th	Informational Webinar about the PCRP program and application process
February 1st	Online application opens
February 28th	Online application will close. Applications must be submitted by 5 pm to be considered
March 9th	Applicants will be notified about their application status
April	Orientation for initiatives will begin
April-December 2018	Program activities will take place

The Application Process

Important Technology Tips

- The "live" application will only allow you to save answers at the end of each page
- Resuming an application at a later date can only be done on the same computer where you started
- We strongly recommend preparing ALL your answers prior to beginning the online application

Application Steps: An Overview-

1. Organizational Background Information
2. 2018 PCRP Learning Community Application Section
3. Letter of Commitment Submission
4. Signature of Executive Sponsor

Letter of Commitment

- Evidence of support from the top leadership
- Superintendent or CEO
- May or may not be your team's executive sponsor

Final Reminders and Tips:

- Look at program details and requirements closely by viewing the **Application Supplement**
- Prepare all application responses before beginning the online application by using the **Application Preview** document
- Both documents will be posted February 1st
- Application opens February 1st and closes February 28th

Questions?

Contact Information:

For questions/information regarding the 2018 PCRP Learning Community, please contact Betsy Bunt, PCRP Program Coordinator at betsy.bunt@viahope.org

For general inquiry regarding the Recovery Institute, please contact Amanda Bowman, Recovery Institute Manager, at amanda.bowman@viahope.org

For More Information

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Watch for:
- Preview of Application
- Application Link
- Questions & Answers
- Recording of this webinar

Thank you for the work you do.