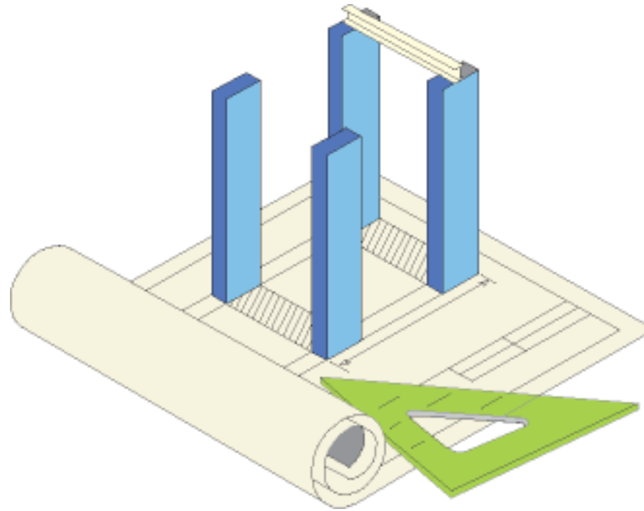

Dimensions of a Recovery-Based System:

NLCMH Blueprint

FY2011-1, current as of 9/15/10

BASED ON 12 ANTHONY SYSTEM DIMENSIONS

1) Design
2) Evaluation
3) Leadership
4) Management
5) Integration
6) Comprehensiveness
7) Consumer Involvement
8) Cultural Relevance
9) Advocacy
10) Training
11) Funding
12) Access
13) Change Management

Source: "A Recovery-Oriented Service System: Setting Some System Level Standards,"
William A. Anthony, Ph.D., Executive Director of the Center for Psychiatric Rehabilitation at Boston University,
Psychiatric Rehabilitation Journal, Vol. 24, No. 2, Fall 2000.

ORIGINAL BLUEPRINT: November 5, 2007

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OVERVIEW:

What started us on the path to changing the system at NLCMH?

We were inspired by

The President's New Freedom Commission on Mental Health report, "Achieving the Promise: Transforming Mental Health Care in America," released on July 22, 2003, which said:

We envision a future when everyone with a mental illness will recover, when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.

We want a future like this.

We were also inspired by

The Michigan Mental Health Commission Report, released the next year, on October 15, 2004. This report said:

A NEW VISION FOR MICHIGAN: For our children and adults, the mental health system needs to be reinvigorated and reinvested in to deliver on Michigan's constitutional promise that "institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported." To that end, the commission has determined that a new vision is essential for the mental health system in Michigan: **Michigan's children and adults enjoy good mental health and are served by a mental health system that responds effectively to the needs of individuals with mental illness and emotional disturbance while promoting resiliency and recovery.**

Making this VISION a reality requires adherence to the following VALUES for the system:

- It must be shaped by the individuals who use mental health services and their families.
- It must be focused on promoting recovery and resiliency and advancing good mental health.
- It must be effective, focusing on clinical quality and system performance.
- It must be equitable, providing accessible, available, and high-quality care to all Michigan citizens.
- It must provide timely and easy access to a full array of services, with "no wrong door" to that care.
- It should be efficient and work in conjunction with the rest of Michigan's human service network.
- It must be accountable, integrated, coordinated, and collaborative. Mental health services must be integrated into the other parts of our system of opportunities and care for state residents.

We want a system like this.

We are also very concerned that people with serious mental illness die, on average, 25 years earlier than the general population.

(Source: Morbidity and Mortality in People with Serious Mental Illness, October 2006.
See Important Reports on our website at http://www.northernlakescmh.org/links.

We want to change this.

OVERVIEW:
What do we believe at NLCMH?

We believe in the Vision and Mission of the Michigan Recovery Council (established 12/05):

VISION Each person who receives public mental health services is supported in their individual recovery journey.

MISSION To lead the transformation of the public mental health system to one based on a recovery foundation.

- Promoting consumer empowerment, self-determination and peer support.
- Creating partnerships and networks of consumers and integrating others who will promote a recovery message throughout the system.
- Providing leadership, education, training and technical assistance on recovery.
- Recommending systems, policies and practices that support recovery.

We actively support the Michigan Recovery Council's vision and mission.

We believe in the Guiding Principles outlined in the MDCH Concept Paper (issued 8/08):

All people in Michigan will have access to a public mental health and substance abuse services system that supports individuals with mental illness, emotional disturbance, developmental disabilities, and substance use disorders. Of highest priority to the system is its obligation to serve individuals who have the greatest and severest needs.

The system will provide adults the supports and services necessary to be healthy and safe and successfully:

- Contribute to their communities,
- Earn an income in a non-segregated, community setting,
- Live in their own homes,
- Have full community inclusion, meaningful participation and membership,
- Have friendships and relationships, and
- Have a self-defined fulfilling life.

The system will provide children and their families the supports, services and advocacy necessary for the child to be healthy and safe and successfully:

- Live with a supportive birth or adoptive family,
- Participate in their neighborhood community school,
- Play an active role in the neighborhood and community activities,
- Enjoy childhood and have friendships and relationships, and
- Develop and prepare for adult life.

We are firmly committed to the 11 principles of the MDCH "Application for Renewal and Recommitment" (June 2009):

- Partnering with Stakeholders in Design, Delivery and Evaluation of Services
- Improving the Culture of Systems of Care
- Assuring Active Engagement
- Supporting Maximum Consumer Choice and Control
- Expanding Opportunity for Integrated Employment
- Assuring Opportunity for Treatment for People in the Criminal Justice System
- Assessing Needs and Managing Demand
- Coordinating and Managing Care
- Improving the Quality of Supports and Services
- Developing and Maintaining a Competent Workforce
- Achieving Administrative Efficiencies

OVERVIEW:
What structures have we put in place at NLCMH?

<u>We feel so strongly about recovery</u>
that we made it a part of our NLCMH Mission Statement.

OUR VISION
Communities of informed, caring people living and working together.

OUR MISSION
To promote the behavioral health of our individuals, families, and communities through programs that promote recovery, build resilience, create opportunity, and improve quality of life.

We have adopted an official NLCMH Recovery Definition.

Recovery is a personal journey of hope, purpose and growth. It is the process of setting our own directions in life. We accept the responsibilities of meeting challenges, using our own abilities, strengths and determination.

We have created an official NLCMH Recovery Policy.

Policy 106.1010: NLCMH Promoting a Recovery-Oriented Service System
Recovery shall be the guiding principle and operational framework for our system of care… This begins with the belief that recovery is achievable and possible. We must project hope, communicate the expectation of recovery, and empower people to exercise choice and control over their lives, including the purchase of supports and services and the choice of providers. This must begin by our being a welcoming environment that begins to build hope from the first contact. (See the entire policy at http://www.northernlakescmh.org/initiatives/?id=394.)

We revised the official NLCMH Self-Determination Policy (106.503) and built a process to implement the Choice Voucher System.

Northern Lakes CMH recognizes that individual budgets are a specific amount of funds developed through a person-centered planning process and under the control and direction of a participant which is the cornerstone of increasing choice, control and self-determination. The Choice Voucher process is one method to transfer control of an individual budget directly to the person served.

Guiding Principles

While Northern Lakes Community Mental Health employs and contracts with many excellent providers and has a sound foundation of recovery oriented services, including peer support services, peer operated services, and clubhouse services, we recognize we must and can do better. Our service delivery model has been developed based on a traditional behavioral health model and not one developed through recovery oriented planning or designed as a recovery oriented system of care. We are committed to making changes to promote consumer outcomes consistent with the Board of Directors recovery based outcomes. (See Board of Directors Ends Policies and Strategic Plan at http://www.northernlakescmh.org/wp-content/uploads/2010/03/819.pdf. To navigate there go to the website at www.northernlakescmh.org. Choose About Us > Organizational Planning > Strategic Plan.) We acknowledge change is difficult and believe that competency in change management will be critical to transformation success. This Recovery Blueprint has been developed based on the work of William A. Anthony, Ph.D., Executive Director of the Center for Psychiatric Rehabilitation at Boston University, and through the excellent contributions from and wisdom of consumers and staff. This group believes that:

- The vision of recovery provides a sense of purpose and meaning to people who work at or contract with NLCMH.
- The organization and employees are energized and mobilized by a shared vision of recovery.
- The power of hope is recognized and valued.
- Person Centered Planning is the foundation of recovery.

Culture

- Recovery is part of our culture.
- Our culture identifies and operates consistent with recovery values.
- Everyone actively champions the cause of building recovery into the culture of NLCMH and promotes the recovery message.
- Organizational culture lives by key recovery values, embracing self-determination/individual choice, full partnership, people first, and growth potential. The system is built around the belief that people will not need our services forever.
- Transparency exists in all aspects of the service delivery system – shared knowledge, free flow of information.
- Recovery is embedded in all aspects of the NLCMH system – quality and strategic plans, policies, finance, etc.
- We are warm and welcoming and have inviting environments.

Partnership

- Providers and consumers are partners in care.
- Consumers play an active role in decision-making and responsibility for their recovery.
- Consumers and family members are full and equal participants.
- Consumers, families and the community are involved in design, administration, delivery, and evaluation of care.
- Consumer integration in all aspects of community membership is encouraged and supported (i.e., churches, clubs, schools, colleges, volunteering in nonprofit organizations such as Habitat for Humanity, etc.).
- Genuine opportunities to construct and maintain meaningful, productive and healing partnerships are available.
- Relationships and partnerships with faith-based communities are built.

Communication

- Recovery-based principles are promoted in the community.
- Communication is planned, continual and comprehensive and speaks to all audiences.

Driving Down the Details

- The system's major operations, be they clinical or managerial, support recovery values; e.g., a clinical process that values self-determination cannot coexist with a management process that values obedience and control.
- The system supports resilience rather than treats deficits.
- Every therapeutic intervention is guided by the ultimate goal of recovery as defined by individuals.
- Everyone (staff and providers, consumers, family members, community members) sees that case management is care coordination rather than "managing cases" and therefore should be available for all who need and want it.
- Stigma, discrimination, and stereotypes are eliminated – (impaired decision-making, dangerousness, belief drug dependence is solely volitional, the wrongful application of coercion, non-therapeutic clinical attitudes).
- Recovery blueprint is part of our ongoing Quality Improvement activity and will be reviewed annually by Recovery Council.
- We are committed to retaining and enhancing consumer directed services across counties in good and bad financial times.
- Recovery applies to children with serious emotional disturbances and their families. Their mental health needs are best met and enhanced through coordinated, community-based systems of care.
- Parents are partners in family-focused care for infants, children and adolescents. They are the experts on their family.

Changing Views of People with Disabilities

This table provides a good summary of the direction in which the public behavioral health system is moving. The principles in the far right column reflect the priorities of the Michigan Department of Community Health and Northern Lakes CMH in supporting individuals' right to live in the world.

Focal Questions and Values	Institutional Era	Deinstitutionalization Era	Era of Community Living
Who is Person of Concern?	Patient	Client	Person, Individual, Citizen
What is the Typical Setting?	Segregated Institutions	Group Home, Workshop, Clinics, Day Programs	Own Home, Neighborhood, Work, School, Community
How are Services Organized?	Regimented Facility Programming	Community Care Continuum, Least Restrictive Setting	Supports for Living in the World According to One's Preferences
What is the Model?	Custodial/Medical	Professionally-Driven & Programmatically Oriented	Evidence-based, peer-delivered, Best & Promising Practices, Informal Supports, Self-Determination Arrangements
What are the Services?	Basic Needs & Somatic Treatments	Professional Service & Community-Based Programs	Treatment, Care Coordination & Supports for Living
How are Services Planned?	Professional Plan of Care	Individualized Treatment Plan	Person-Centered Planning
Who Controls the Planning Decisions?	A Professional (usually an M.D.)	An Interdisciplinary Team	Collaboration of Individual, Family, Allies & Professionals
What is the Planning Context?	Standards of Professional Practice	Professional Standards & Team Consensus	Exploration of Preferences & Desired Outcomes, Treatment/Support Needs
What has the Highest Priority?	Protection & Provision of Basic Needs	Symptom Reduction, Illness Remission, Skill Development	Recovery, Supports of Living, Illness Management, Relationships
What is the Objective?	Control, Safety & Amelioration	Arrest Symptoms & Improve Functioning	Community Inclusion & Participation, Independence & Productivity
How are Services Funded?	United States Appropriation	General Funds & Medicaid FFS to Support Programs	Medicaid & General Funds for Individualized Supports & Services
How is Quality Defined?	By Professional Discipline	Structure & Process Measures	Quality of Life & Person-Defined Outcomes

Derived from "Consumer-Centered Social Work Practice: Restoring Client Self-Determination," Kristine D. Tower,
***Social Work,* Volume 39, Number 2, March 1994**

Background Information from Dr. William A. Anthony

9 Essential Services in a Recovery-Oriented System

Used in Dimension 1 - Design

Dr. Anthony says there are 9 "Essential Services" which a good system will be designed around. Good consumer results are the main thing to keep in mind when designing your system, not where the services are provided or in what program the services are provided.

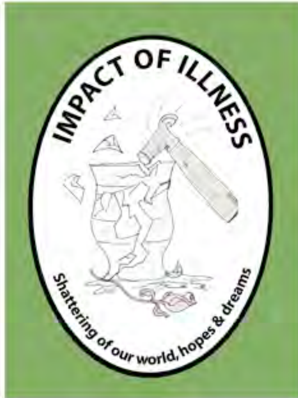
Service Category	Description	Consumer Outcome
1) Treatment	Alleviating symptoms and distress	Symptom relief
2) Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
3) Case Management	Obtaining the services consumer needs and wants	Services accessed
4) Rehabilitation	Developing consumers' skills and supports related to consumers' goals	Role functioning
5) Enrichment	Engaging consumers in fulfilling and satisfying activities	Self-development
6) Rights protection	Advocating to uphold one's rights	Equal opportunity
7) Basic support	Providing the people, places, and things consumers need to survive (e.g., shelter, meals, health care)	Personal survival assured
8) Self-help	Exercising a voice and a choice in one's life	Empowerment
9) Wellness/prevention	Promoting healthy lifestyles	Health status improved

7 Assumptions About Recovery

Factors/Items	Reasons
1. Recovery can occur without professional intervention.	Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system.
2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.	Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need.
3. A recovery vision is not a function of one's theory about the causes of mental illness.	Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.
4. Recovery can occur even though symptoms reoccur.	The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free.
5. Recovery is a unique process.	There is no one path to recovery, nor one outcome. It is a highly personal process.
6. Recovery demands that a person has choices.	The notion that one has options from which to choose is often more important than the particular option one initially selects.
7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.	These consequences include discrimination, poverty, segregation, stigma, and iatrogenic effects of treatment (i.e., illness caused by treatment).

5 Stages of Recovery

Along the way, we also learned about the 5 Stages of Recovery from Larry Fricks and Ike Powell of the Appalachian Consulting Group:



Stage 1 – Impact of Illness

There are times when… the person is ***overwhelmed*** by the disabling power of the illness. The symptoms of the illness are controlling the person's life and the person is often not able to function.

Stage 2 – Life is Limited

There are times when… the person has ***given in*** to the disabling power of the illness. The person doesn't like the way his life is, but believes that it is the best it will ever be. The person is not ready/able to make a commitment to change.

Stage 3 – Change is Possible

There are times when… the person is ***questioning*** the disabling power of the illness. The person believes that there has to be more to life than he or she is currently experiencing and is beginning to believe it can be different.

Stage 4 – Commitment to Change

There are times when… the person is ***challenging*** the disabling power of the illness. The person believes there are possibilities but isn't sure what they are or what to do. The person is willing to explore what it will take to make some changes.

Stage 5 – Actions for Change

There are times when… the person is ***moving beyond*** the disabling power of the illness. The person has decided the direction they want life to go, and is willing to take more responsibility for their decisions and actions.

The bottom line is that
Recovery is The Organizing Principle – The Expectation

Our Overarching Goal:

A consumer and family-driven mental health system based on recovery principles with a recovery environment of excellence, encouragement and hope among consumers, families, staff, providers and community.

How Action Steps Were Developed

Following are the results of efforts to prioritize the recovery system transformation action steps developed by:
1) September 2009 Recovery Conference attendees (consumers and staff);
2) Zoomerang survey results (70 staff);
3) December 18, 2009 Recovery Planning Day (consumers and staff); and
4) Those action steps remaining from the blueprint originally created in November 2007

The NLCMH Strategic Plan and Application for Recommitment and Renewal (ARR) were also included in the action steps developed.

January 2010 Learning Community meeting attendees rating of the action steps within each dimension resulted in **these top 4 priority action steps**:

- Start talking recovery from the very first contact with consumers so that they have the expectation of recovery, including contacts with the access center as well as initial assessments and intakes. Use peers at point of first access (including emergency access).
- Seek out more grants – provide grant writing training and build grant writing expertise of staff and peers.
- Explore the feasibility of increasing the amount of time psychiatrists spend as consultants to primary care providers and the changes needed to support that with other providers. Provide continuing education and/or ongoing communication with primary care physicians and other healthcare providers, sharing information. Family doctor and psychiatrist need to communicate regarding progress/medications – coordination with healthcare providers.
- Improve housing opportunities for consumers.

There are some differences in priorities by office location.

In <u>Traverse City</u>, the highest priorities are:

- Improve housing opportunities for consumers.
- Create strategies to strengthen relationships with partners (jobs, housing, education, social, faith-based, physical health care) and assist them in promoting recovery principles; * Identify and prioritize contractual community partners who are necessary to support recovery within our communities. *Identify and prioritize our community partners with coordination agreements who are necessary to support recovery within our communities. *Identify and prioritize other community partners who are necessary to support recovery within our communities. *Increase community connections and awareness of who in the community does what so we can refer to their services. Identify what works and doesn't work in our community and advocate to fill the gaps (beyond 211). Support relationships with organizations that help our consumers in areas that we don't or can't provide services for within our scope (such as familial relationships).
- Develop an organizational policy and plan to improve housing and employment opportunities with consumers.
- Start talking recovery from the very first contact with consumers so that they have the expectation of recovery, including contacts with the access center as well as initial assessments and intakes. Use peers at point of first access (including emergency access).

In <u>Cadillac</u>, the highest priorities are:

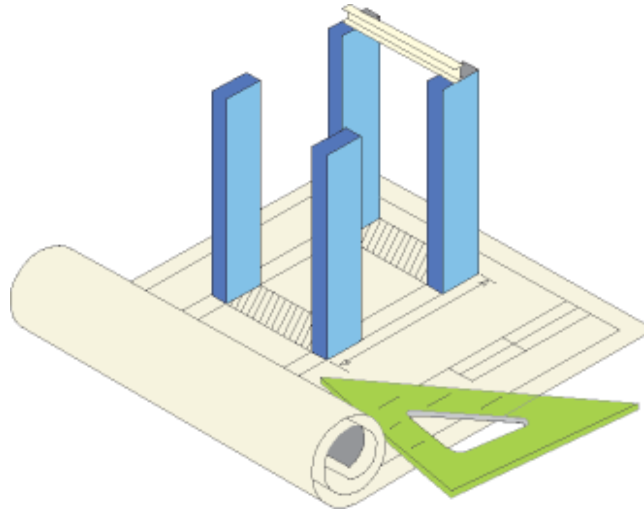
- Explore the feasibility of increasing the amount of time psychiatrists spend as consultants to primary care providers and the changes needed to support that with other providers. Provide continuing

education and/or ongoing communication with primary care physicians and other healthcare providers, sharing information. Family doctor and psychiatrist need to communicate regarding progress/medications – coordination with healthcare providers.
- Include spirituality in service planning, train in spiritual individuality (physicians and other target populations) or link with Dioceses.
- Increase communications on recovery change efforts among all stakeholders, with a goal of having the whole system be more coordinated with everyone with the same idea of what we do and how to get there. (Some examples: Disseminate survey results widespread enough so that all staff and consumers can easily see the results – perhaps newsletters, new computer monitors, posters, lobbies, etc. Provide for greater visibility of our vision/mission statements – read them at meetings, include on documents, etc.)

In Houghton Lake, the highest priorities are these:
- Develop a Fiscal Year (FY) 2010 work plan for the Recovery Council and Learning Communities and annually assess the outcomes of the work of both groups.
- Make a plan for fundraising.
- Need gay, lesbian, bisexual, transgender sensitive/relevant services & hiring practices. (Add sexual orientation on intake materials, list marriage/partner as a choice).
- Educate adolescents into adult systems (schools, physicians, churches).

In Grayling, the highest priorities are these:
- Look for ways to provide clubhouses and drop-in centers in counties where there are none.
- Seek out more grants – provide grant writing training and build grant writing expertise of staff and peers.
- Educate adolescents into adult systems (schools, physicians, churches).

Our work plan, approved by the NLCMH Board of Directors, is on the following pages, based on the 12 "Dimensions" designed by Dr. William Anthony, plus a 13th Dimension we created, called "Change Management."



The Blueprint

Our Blueprint for Recovery System Transformation begins on the next page. This is our work plan, or as some have called it, “Northern Lakes CMH’s Person Centered Plan” for system change.

The Blueprint contains 13 Dimensions. Each Dimension contains a short definition at the top of the page describing in one sentence what that Dimension is about. There are also sections on “Getting the Vision Right,” and “What We Want to Build,” with more detail on what the Dimension is about. Each Dimension also has a Dimension Lead, Action Steps, Action Step Leads, and Timelines.

This Blueprint is intended to be a living, working document which will be revised quarterly to reflect accomplishments and steps yet to be taken. It is intended to be worked over time.

System Dimension 1: Design

Design is where you make a plan to show how something will look and work as it is built.

DIMENSION LEAD: Joanie Blamer

Getting the Vision Right	Consumers, families, providers/staff and community all have a common definition* and understanding of recovery. There is excellent Person Centered Planning, where the individuals' desires drive the support and/or treatment plans. There is a wide range of services which are delivered in a warm, welcoming environment that supports recovery and the individual's plan.
What we want to build is a system where…	• From the top down and the bottom up, everyone "Expects Recovery." • We have the 9 Essential Services (treatment, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, self-help, wellness/prevention). • Care delivery is designed to support the Five Stages of Recovery. • We have great care that is: safe, effective, person-centered, timely, efficient, and fair – delivered in natural or community settings as much as possible. • Consumers clearly feel they have lots of choices for treatment and supports. • Staff feel empowered and excited about their work. They have the support to build their skills so they can be the most effective, the best they can be. There are enough staff so that each can do a good job. • We use evidence-based and promising practices. • There are enough Certified Peer Specialists and other peer-operated services as well as other provider services to meet consumer needs. • More support groups and consumer businesses are available. • Pilot demonstrations serve as places to learn for consumers, families, staff and providers. We share information on what works best so that everyone can benefit and do things the most effective way.

Action Steps	Leads	Timelines
A. Develop an organizational policy and plan to improve housing opportunities with consumers.	Becky Gomez	4/11
B. Develop an organizational policy and plan to improve employment opportunities with consumers, and explore the potential of creating a volunteer mentoring/sponsorship program and other volunteer opportunities within the community and NLCMH.	Signe Ruddy, Andy Ulrich, Cindy Petersen	Draft plan 10/30/10 Final plan 3/1/11 Program 7/1/11
C. Review services in light of the "Changing Views of People with Disabilities" grid (above) to keep programs that: expand people's opportunities based on preference, provide support for meaningful activities, and promote movement to full citizenship** to promote a full, productive community life. Decrease reliance and/or eliminate "legacy" programs that contribute to consumers' segregation in the community.	Greg Paffhouse & Executive Team	E. Team agenda 10/10. Consider Blueprint becoming MI-A Improving Outcomes Plan 4/1/11.
D. Support existing workgroups and efforts to create electronic processes to reduce paperwork demands and promote compliance with reporting requirements.	Keith Huggett & COOs	10/1/10
E. Develop a Self-Determination implementation plan.	Dave Branding	11/1/10
F. Consistently seek input and plan for further expansion of NLCMH external website, staff intranet, and Virtual Recovery Center blog.	Deb Freed, Keith Huggett	Ongoing
G. Explore feasibility of after-hours offerings to support recovery.	Joanie Blamer (with Terri Kelty and Mary Hubbard)	1/5/11
H. Revise assessments as necessary to ensure that the life domains (residential, work, educational and social environments) are addressed.	Keith Hugget and COOs	Assessment revised and now being implemented (7/10)

Who should be involved	Consumers, families, providers/staff, NLCMH Board members
Barriers	Potential that some key staff don't support recovery. Make sure that individuals and groups have authority to make things happen.

* **Northern Lakes CMH Definition of Recovery:** Recovery is a personal journey of hope, purpose and growth. It is the process of setting our own directions in life. We accept the responsibilities of meeting challenges, using our own abilities, strengths and determination.

** **Full citizenship** – Having opportunities for full participation in all aspects of society.

System Dimension 2: Evaluation

Evaluation is where you measure something to see its value.

DIMENSION LEAD: Dave Branding (QI Director)

Getting the Vision Right	We have ways of regularly measuring progress in recovery that are simple, reliable, and consumer-driven. We want to measure progress for both individuals and Northern Lakes CMH as an organization. For individuals, we want to measure their progress toward quality of life, including their current hopes and dreams. For the organization, we want to measure progress in achieving the agency Ends.
What we want to build is a system where…	• For each service, results are identified, observable and measured (e.g., number of crises, percentage of people employed). • Input from persons served and their families are included in describing how the organization is doing and how it can continue to be improved. • We look at Recovery for both the system and the individual; we do what the funder and our accreditor ask of us and monitor specific recovery measures. • We achieve high quality data which gives information that is reliable, accurate, valid, complete and drives decision-making. • Personal accounts and recovery successes/challenges are included when we look at an individual's progress toward their own vision of high quality of life. • We measure Hope because hope is a key ingredient to recovery. • We continue to evaluate program comparatively; maintaining what is working and changing or improving what's not working as well. • We avoid using acronyms in evaluation.

Action Steps	Leads	Timelines
A. Use satisfaction survey results in the most meaningful ways possible given available resources (including people's satisfaction with service delivery, their own assessment of their progress toward their recovery goals, and hope) in order to improve person centered planning and treatment success.	Dave Branding & (NLCMH) Quality Improvement Committee (QIC)	10/1/10
B. Develop a recovery evaluation plan and methods which use Recovery Enhancing Environment (REE) survey results to the fullest possible benefit given available resources and link to NLCMH "Ends." *	Dave Branding & Quality Improvement Committee (QIC)	12/1/10
C. Continue to assess and implement strategies to measure outcomes for services which are provided consistent with a person's individually-defined outcomes and organizational Ends*.	Dave Branding & Quality Improvement Committee (QIC)	10/1/10
D. Evaluate the quality of person centered planning is being within all populations.	Dave Branding & Quality Improvement Committee (QIC)	10/1/10

Who should be involved	Dave Branding, Recovery Council, consumer and family participation, Information Systems staff, other providers/staff, MDCH
Barriers	Time and resources

"Ends" are what NLCMH hopes are achieved for each person served. There are 8 "Ends": 1) Enhanced overall quality of life; 2) Children and families have rewarding family relationships; 3) Meaningful relationships (circle of support); 4) A reduction in psychiatric symptoms; 5) Managing mood and substance use; 6) A safe living environment of your choice; 7) Meaningful and satisfying work; and 8) Community membership, inclusion and participation.

System Dimension 3: Leadership

A leader is someone who is followed by a group of people or an organization.
Good leaders ‘light the way’ and inspire people.

DIMENSION LEAD: Greg Paffhouse, Carrie Gray, Aaron Cromar, Kim Silbor

Getting the Vision Right	Our leaders pave the way to recovery. They paint a picture of what our recovery-based system will look like. They constantly guide, advocate, educate and communicate about the vision. They stay committed until recovery becomes a part of who we are. They share leadership with those who “walk the walk” and “talk the talk” of recovery. They demonstrate, through words and action, our new direction towards recovery.
What we want to build is a system where…	• Leaders develop vision, passion, and courage to change the system. • Leaders, through their words and actions, take an active role in changing the system. • Leaders are willing to take risks to change the system for the better. • Leaders constantly energize others to achieve the recovery vision. • Leaders encourage everyone to live by key recovery values, including self-determination and choice, full partnership, people first, and growth potential. • Leaders make sure we keep improvements to our system. • Leaders work to get rid of barriers to care. • We participate in, show leadership on, and learn from state and regional committees (such as the MDCH Recovery Council and Improving Practices Leadership Team). We take what we learn and apply it at NLCMH. • Our recovery blueprint continues to grow over time. • People receiving services control the resources associated with their services. • Leaders constantly energize others to achieve the recovery vision through sharing their own stories.

Action Steps	Leads	Timelines
A. Develop a FY* 2011 work plan for the Recovery Council and Learning Communities and annually assess the outcomes of the work of both groups.	Mary Beth Evans & Joanie Blamer	Develop plan 4/11, Assess 9/11.
B. Continue to promote valuable role of peer support staff.	Carrie Gray & Kim Silbor	Evaluate current capacity and make recommendations for new peer support capacity 12/1/10 (ongoing). Develop draft peer support policy including vision 1/1/11.
C. Seek opportunities to engage consumers in recovery education activities.	Cindy Petersen & CPR**	Define recovery education activities and FY 11 activity plan by 11/1/10. Coordinate with Customer Services regarding integration in Consumer Involvement plan 1/11.
D. Explore offering consumer leadership seminar to teach leadership skills.	Cindy Petersen	Annual ongoing trainings
E. Create a plan and tools to help people understand what services and supports are available to enhance their recovery.	CPR & Mary Beth Evans	1/1/11
F. Prioritize resources to ensure continued system transformation.	Executive Team	Ongoing
G. Implement the NLCMH revised self-determination policy and choice voucher arrangements.	Dave Branding	Implemented and ongoing

Who should be involved	• We would like many leaders and need administration to be responsible and accountable for making decisions that remove barriers, support recovery and ensure resources are available. • Shared leadership as change agents who are persuasive, hopeful and the mouthpiece of change.
Barriers	Stigma—consumer/family/staff/community attitudes

NOTE: Comment made that there is a role for Board responsibility in this dimension.
* FY = Fiscal Year
** CPR = Communications & Public Relations Committee

System Dimension 4: Management

Management is the group of people in charge of running an organization.

DIMENSION LEAD: Tom Denton and Mary Kay Niemisto

Getting the Vision Right	Everyone part of NLCMH, including all providers, shall support, value, promote and expect recovery. Managers stick to the vision of recovery and make sure there are partnerships between providers and people who receive services. NLCMH will only employ and contract with providers who are committed to recovery values.
What we want to build is a system where…	• Policies and procedures are set up to support recovery and the Five Stages of Recovery. • Facilities are welcoming and support recovery and partnerships. • Our programs and procedures are recovery friendly. • Policies and procedures are set up so that each individual service defines itself by the unique process they use. (For example, the basic process of case management might include processes such as setting a goal, planning, linking, and negotiating for access to services.) • Service protocols are set up so that the basic service processes are possible to monitor. • Our computer system collects data on each service and its results to make sure we have the right information for good decisions and consumer success. • Staff are assigned based on competency and preference, to greatest extent possible. • Excellent administrative, business support, and clinical services promote consumer and organizational success. • Our staff and contracted providers have the skills to promote recovery, with performance targets and performance-based job descriptions tailored for each position. • New strategies are developed to promote recovery. • Policies promote sharing of power, risk, and skills and make best use of existing resources.

Action Steps	Leads	Timelines
A. Continue creating a welcoming, recovery-oriented environment by looking for barriers and negative messages to remove and finding improvements in facilities and procedures we can make.	Recovery Council & Facilities Committee	Annual review by 10/1/10 & 10/1/11
B. Make sure staff/providers' jobs are structured to be recovery-oriented.*	Tom Denton & Network Management Team, Operations Managers	4/1/10 & ongoing
C. Design and develop a comprehensive recovery orientation and education program** for consumers, staff and community that emphasizes hope for recovery.	Tom Denton, Cindy Petersen & CPR	1/1/11
D. Create process and forums to use our existing Five Stages and anti-stigma videos for stakeholder groups. Make a short orientation DVD.	Operations Managers, Deb Freed, Cindy Petersen, CPR	1/1/11
E. Review policies, including medication policies, to make sure they contain recovery-oriented language like that found in the "Changing Views of Persons with Disabilities" grid. Eliminate any barriers to recovery found in policies.	Mary Beth Evans reporting to Executive Team	Ongoing
F. Recognize staff's commitment to recovery. Find ways to highlight their good recovery practices, foster a positive CMH culture and morale, and stand behind people and give them encouragement.	Kim Silbor, with support from Executive Team and Operations Managers	12/1/10 & Ongoing
G. Continue to clarify and educate about peer support specialists' roles and responsibilities, tied to state peer certification program and fulfilling continued education requirements.	Carrie Gray & Kim Silbor	Develop consumer brochure that describes peer support services and peer run groups - 12/1/10, ongoing.
H. Improve communication about how the system works as a whole, including how the amount, scope and duration of services are determined. (Toolbox, PCP Dim 3E)	CPR and Operations Managers	7/1/10 PCP accomplished 1/1/11 & ongoing
I. Explore ways to better communicate between programs and how to document this communication process. (Link to QI & Consumer Involvement)	CPR	ongoing

J. Maintain a viable number of MI-PATH and WRAP*** facilitators to ensure classes can be offered in each office.		Joanie Blamer & Terri Kelty	Plan by 1/1/11, ongoing thereafter
Who should be involved	Lead managers, recovery council, facility committee, consumers, family, and providers/staff.		
Barriers	Changing attitudes and “old” non-recovery oriented beliefs.		

* The “structure” of jobs, for example will include: creating recovery-oriented job titles, job descriptions, and annual personnel performance evaluations which define and promote skill development and competencies; making sure that operation managers’ job descriptions include recovery leadership as an essential function; making sure that provider contracts and provider performance evaluations are recovery-oriented; making sure recovery beliefs and practices are woven throughout our Emergency Services training and curriculum.

** Some orientation and education program components will include: orientation and training videos, Chronic Disease Self-Management program (MI-PATH), Pathways to Recovery, WRAP, ethics, rights-recovery issues.

*** WRAP = Wellness Recovery Action Plan

System Dimension 5: Integration

Integration is where you mix things together that used to be kept separate.
In this Blueprint, it means mixing together all the ingredients in the community needed for consumer success.

DIMENSION LEAD: Terri Kelty

Getting the Vision Right	People have choices and can get the treatment and support services they need to help them make progress toward their individually desired outcomes (recovery).
What we want to build is a system where…	• The function of case management is expected to be performed for each consumer who needs or wants it. • Planning is standardized for all services and is guided by consumer outcomes. • Referrals between services include a description of the consumer results the provider is expected to achieve. • CMH links better with physical health, housing, vocational, substance abuse, education, criminal justice, child welfare, and faith based systems. • Excellent person centered planning leads to a coordinated array of treatments and supports that may involve multiple agencies in a single plan of care. • All people have more opportunities for life in the community. • Consumers have genuine opportunities to build and maintain meaningful, productive and healing partnerships with staff. • All staff are knowledgeable about formal and informal community resources and share this information with consumers.

Action Steps	Leads	Timelines
A. Increase the amount of time psychiatrists spend as consultants to primary care providers and the changes needed to support that. Provide continuing education and/or ongoing communication with primary care physicians and other healthcare providers. Family doctors and psychiatrists need to communicate and be more coordinated regarding progress/medications. Focus some anti-stigma effort towards healthcare providers.	Greg Paffhouse, Dr. Riddle, Terri Kelty, Joanie Blamer, Cindy Petersen	Current and progress update 11/30/10. Pilot and develop initial plan for child psychiatry in one pediatric practice setting 12/10. Agenda topic on 12/10 psychiatrist mtg.
B. Explore developing liaisons, i.e., "go to" persons, for issues of integration (e.g., DHS, primary care, jail/courts).	Executive Team	E. Team agenda 10/10. Possible COO-Op agenda topic 11/10. 12/1/10
C. Maximize the use of the community in promoting wellness and health, physical health, holistic health, spirituality as part of our person centered planning and service delivery model.	System: COOs and Mary Beth Evans Individual Level: Operations Managers	Individual Level 3/1/11, System 4/1/11
D. Develop and implement a plan to capture and share information about community resources with staff and consumers. *	CPR	3/31/11

Who should be involved	All people are care coordinators….everyone is responsible and accountable – staff and providers, community partners, consumers, family members, community members.
Barriers	Lack of clarity on dimension. Time and resources.

* Some strategies mentioned to share info about community resources are: explore how we might use our lobby monitors to share information; explore how to provide access to community resource directories and county web sites beyond our web site links, and 211 when it becomes available; develop staff Wikipedia areas on intranet with decentralized authoring capability to capture and share community resource information.

System Dimension 6: Comprehensiveness

Comprehensiveness means including all or nearly all aspects of something.
In this Blueprint, it means including where you live, learn, work, and socialize.

DIMENSION LEAD: Cindy Petersen

Getting the Vision Right	Consumer goals and opportunities are based on their hopes and dreams to include where they live, learn, work and socialize, and the natural and agency supports they have or need to develop to support those goals, just as the goals and opportunities would be for anyone else in society.
What we want to build is a system where…	• Consumer goals include functioning in living, learning, working, and/or social settings. • Consumer goals include functioning in settings outside of mental health (faith-based organizations, schools, or social clubs, for example). • A well-planned, coordinated array of treatments and supports, involving multiple agencies in a single plan of care, are delivered in natural settings where people are located (jail, housing sites, schools) as much as possible. • More affordable housing, community integration, employment, and natural supports are available. • Technologies such as telepsychiatry, videoconferencing, email, etc. are used to increase access to services, supports, information and education. • We work with the community to improve awareness, education and early intervention for mental health.

Action Steps	Leads	Timelines
A. Create strategies to strengthen relationships with contract providers and other community partners in the areas of jobs, housing, education, social, faith-based, and physical health care and assist them in promoting recovery principles.	Network Management, Greg Paffhouse, Dr. Riddle, Terri Kelty, Joanie Blamer, Cindy Petersen	Review Strategic Plan and Blueprint at Network meetings 1/11. Consider article in next issue of Networker.
B. Create opportunities for community partners to come together to increase our exposure in the community to decrease stigma on a consistent basis (movie nights, community presentations mentioned).	Cindy Petersen	9/27/10, 10/27/10, Houghton Lake and Cadillac by 3/31/11
C. Develop community inclusion plans/strategies centered around our four office locations to include such activities as promoting consumer volunteer opportunities in the community, for example.	Signe Ruddy, Andy Ulrich, Cindy Petersen	Draft plan 10/30/10, Final plan 3/31/11

Who should be involved	Consumers and clinicians, peers, significant others and support people, independent facilitators, community partners (in jobs, housing, education, social, faith-based organizations, etc.)
Barriers	We may have materials, but we don’t make sure people are aware of them and use them. We need to update distribution of materials regularly.

System Dimension 7: Consumer Involvement

Consumer Involvement is where consumers participate.

DIMENSION LEAD: Mary Beth Evans

Getting the Vision Right	Nothing about us without us! Consumers are involved in all areas of operations – design, administration, delivery, training, and measuring care across our service area. Consumers are actively involved in promoting recovery in the community. The NLCMH system is based on consumer strengths, not weaknesses.
What we want to build is a system where…	• We actively seek out consumers for jobs at all levels of the organization with more use of certified peer support specialists. • Consumer controlled, self-help services are available in all geographic areas. • We create and support a network of consumers and families to help change the system. • Staff and consumers partner together in planning for system change. • Consumers are actively involved in anti-stigma activities such as: sharing their recovery stories through personal presentations, print, video, audio; helping with community events and presentations. • Consumers are informed and educated about treatment and supports so they can make informed choices. • There is a focus on self-care, self-management and self-advocacy (consumers and family members need to identify the education, training, orientation, and supports they need to be effective in this role). • Consumers see themselves as "persons first," not "patients."

Action Steps	Leads	Timelines
A. Create and operationalize a plan to ensure consumers are involved in the design, review, planning and evaluation of NLCMH services (identify committees where consumer involvement is needed, identify gaps, and recruit members as needed).	Rosemary Rokita	1/1/11
B. Explore ways to communicate the choices* available to become involved and a clear path to do so.	CPR	1/1/11
C. Provide training to nurture consumer leaders.	Cindy Petersen	6/15/10, 6/18/10, Annual trainings ongoing
D. Identify consumers interested in becoming the leaders for identification, creation and promotion of holistic wellness (i.e.: nutrition, smoking cessation, exercise, self-care).	Mary Beth Evans	6/1/11

Who should be involved	Consumers, peer support specialists, provider staff, family members, administration, key community members.
Barriers	Competing priorities

* Consumer involvement choices include: serving on NLCMH committees throughout the organization including the Board of Directors; planning, reviewing and evaluating their own progress; speaking out in the community to help decrease stigma and participating in other advocacy events and activities; and supporting their own individual recovery through exploration of recovery groups and classes.

Strategies mentioned to communicate these choices: 1) Determine content for video monitors to be used in waiting rooms defining what we do and all the offerings that are happening throughout the day; 2) Review current promotional materials, identifying gaps and consolidating to make simpler, more comprehensive, and easier to understand as coordinated.

System Dimension 8: Cultural Relevance

Taking into account the ideas, customs, and behavior of a group of people.

DIMENSION LEAD: Joanie Blamer

Getting the Vision Right	Consumers can get recovery treatment and supports that fit in with their culture.
What we want to build is a system where…	• Assessment, planning, and services are provided in a way that is sensitive to the person's culture. • Staff have the right knowledge, skills, and attitudes to provide effective care for people from all walks of life. • All people can get services and supports that are right for them – whether they live far out in the country, live in poverty, have a physical disability such as deafness or blindness, or speak a language other than English, for example. • Settings, programs, and services are accessible and responsive to ethnic, cultural, racial, spiritual, linguistic and sexual orientation differences reflective of our communities; e.g., rural population, Native American and Hispanic communities, poverty. • People from all walks of life are involved in helping us change to be recovery-oriented. • Information materials consider the needs of all people (for example, sign language). • People experience a welcoming, gentle environment at CMH.

Action Steps	Leads	Timelines
A. Promote and prioritize culturally relevant and sensitive services; for example, for gay, lesbian, bisexual, transgender (GLBT) and questioning people.	Greg Paffhouse	Review Essential Learning Courses and if available, have Training Committee add as a FY 11 Training Plan priority for professional staff 1/1/11.
B. Review application for services to ensure culturally relevant questions are asked, including that GLBT is reflected in the choices.	Joanie Blamer & Terri Kelty	7/11
C. Provide culturally diverse learning opportunities consistent with community regarding mental health recovery.	Network Management (Cultural Competency Plan), Tom Denton, Cindy Petersen	Adult Mental Health Block Grant: Native American by 4/1/11, Hispanic by 4/1/12
D. Develop an agency strategy on how to honor spirituality as part of the recovery process, including how to best link to the faith-based community.	Greg Paffhouse, Terri Kelty, Joanie Blamer	Seek volunteers (11/10) to develop policy (4/11).
E. Identify and build strategic relationships and coalitions with the various cultures in our area.	Greg Paffhouse, COOs	CPR identify culture groups (11/10) and develop FY 11 outreach plan (4/11)
F. Schedule a meeting with migrant clinic staff to discuss mental health service needs and possible role for NLCMH.	Greg Paffhouse	4/30/11
G. Provide cultural education and training to staff which helps them to promote recovery in ways that are appropriate and sensitive to the needs of the various cultures we serve.	Beth Burke	Develop plan 1/1/11. Adult Mental Health Block Grant: Native American by 4/1/11, Hispanic by 4/1/12.
H. Keep updated on the cultural diversity which exists in our communities to remain up-to-date on the needs.	Network Management (Demand & Capacity Report)	4/1/10 & annually
I. Seek and promote active participation of consumers of all ages and cultural backgrounds with NLCMH activities and initiatives.	Mary Beth Evans	6/1/11
J. Post "Welcome" signs near 4 office site main entrances, and in multiple languages when appropriate.	Greg Paffhouse	Office meeting agenda 1/11. Completed in all offices by 7/11.

Who should be involved	Peer support specialists, Grand Traverse Band, migrant offices, customer services, contractual specialists.
Barriers	Competing priorities

System Dimension 9: Advocacy

Advocacy is where people support a particular cause.

DIMENSION LEAD: Deb Freed

Getting the Vision Right	The voice of consumers and family members is heard, valued and provides a boost for change. We create a community where recovery is expected and everyone is included. It doesn't happen unless it's everyone!
What we want to build is a system where…	• Consumers and potential consumers are seen as people first (not a diagnosis!). • Consumers have the opportunity to participate in the community. • Everyone understands that all people have the potential to recover. • Communities recognize that persons with mental health conditions are valuable and contributing members of society. • Stigma is reduced, and how the public sees people with mental illness improves. • We find ways to keep our anti-stigma and recovery activities going after grant funds run out. • We create and support a network of consumers trained in public speaking and willing to share their stories with the public. • We provide support so that consumers can make decisions, including peer support and advance directives. • Schools and universities work with NLCMH on recovery education.

Action Steps	Leads	Timelines
A. Develop a plan which assists consumers and families to develop skills to be self-advocates and promotes recovery in the community.	Workgroup of representatives from Recovery Council, Mary Beth Evans, Cindy Petersen, Deb Freed	Set workgroup & hold 1st mtg – 12/1/10 Plan by 2/1/11
B. Offer a class on self-stigma and disclosure.	Cindy Petersen, Deb Freed	4/1/11
C. Formalize, expand and sustain an active speakers bureau.	Cindy Petersen, Deb Freed	4/1/11
D. Develop community presentations on recovery.	CPR	1/1/11
E. Develop a strategy for using the Ambassador Training materials.	CPR	1/1/11
F. Keep an up-to-date summary of key issues that people can use to advocate and a plan for regular dissemination.	CPR & Greg Paffhouse	4/1/11 & ongoing
G. Look at building a network of volunteers (Project Volunteer) and communicate volunteer opportunities, where people can choose to volunteer for community projects and assist with individual community members.	Mary Beth Evans	3/1/11 - Ongoing recruiting for Mental Health Block Grant Volunteer Fair by 10/1/11.
H. Approach faculty leads at our colleges and universities about including recovery units in their existing courses.	Cindy Petersen	2/1/11
I. Advocate for those coming out of prison and inpatient facilities and their treatment needs, and provide information on available resources. (Involve Michigan Prisoner Re-entry Initiative staff with Northwest Council of Governments stakeholder's planning group (Kirk Baab).	Joanie Blamer & Becky Vincent	Plan 4/1/11

Who should be involved	Consumers, families, staff, administration, board members and business and other community leaders.
Barriers	

System Dimension 10: Training

Training is about teaching skills so something or someone grows in a particular direction.

DIMENSION LEAD: Cindy Petersen and Beth Burke

Getting the Vision Right	All staff have good knowledge about recovery and they believe in recovery. We have a number of recovery classes to choose from which are offered across our six counties for consumers, family members, community members, and staff.
What we want to build is a system where…	• All staff understand the vision of recovery and how they can help in people's recovery. • We have a great training program for staff and other providers to make sure they have the right knowledge, attitudes and skills to help consumers recover. • We have a great training program for consumers to learn about recovery through classes, workshops, forums, learning groups and support groups. • Staff are always improving in screening, diagnosis, assessment, and writing goals. • Peer support specialists have opportunities for continuing education and to learn new skills. • All staff who work with adults with mental illness are knowledgeable about best practices and how to apply them, specifically motivational interviewing, family psychoeducation, physical/mental health/substance abuse integrated treatment, Dialectical Behavior Therapy, Cognitive Behavioral Therapy, smoking cessation skills, ethics, suicide prevention. • We consistently deliver the message of hope (designed by age or target population).

Action Steps	Leads	Timelines
A. Develop a strategy for use of recovery educational materials.	CPR	1/1/11
B. Design process on using the recovery training video for consumers, staff, contractual providers and independent facilitators.	CPR & Mary Beth Evans	1/1/11
C. Create functional talking points and key questions for use with the "5 Stages" video.	Joanie Blamer & Deb Freed	1/1/11

CONSUMERS & FAMILIES

Action Steps	Leads	Timelines
D. Create and distribute a 10-minute recovery presentation and takeaways to instill hope for consumers entering or in services.	Joanie Blamer, Deb Freed, Mary Beth Evans	10-min 5 Stages video by 10/1/10, materials by 1/1/11, IPLT* Evidence Based Practice video by 9/30/11
E. Create process for peers to serve as navigators for new and recent consumers.	Access staff, Kim Silbor and Carrie Gray	9/30/11 (See Mental Health Block Grant)
F. Develop recovery and wellness activities. Create and provide training for consumers in: self-directed services and supports; person-centered planning process and setting life goals which reflect needs, wants and desires; financial management; budgeting; time management; wellness, rights.	Mary Beth Evans, Learning Communities & Recovery Council	Plan by 11/1/10 with CPR Committee. Develop ongoing activities according to Plan.
G. Explore offering different opportunities for learning, open to the public when possible; for example, spirituality, cultural, holistic, wellness, and resources in the community that are available to support learning.	Aaron Cromar, Kim Silbor, Carrie Gray, Mary Kay Niemisto, Deb Freed, Cindy Petersen	Mental Health Block Grant calls for Q1-4, FY2011
H. Educate adolescents into adult systems (schools, physicians, churches).	Mary Hubbard (Mary will identify other work group members as needed)	10/1/11

COMMUNITY & STAKEHOLDERS

Action Steps	Leads	Timelines
I. Provide education to community agencies, other stakeholder groups and the general public regarding whom we serve, what we do, how to access CMH and other behavioral health services.	Cindy Petersen & CPR	7/1/10 & ongoing
J. Provide training and education to community partners in jobs, housing, education, social, faith-based, and physical health care to help them promote recovery principles.	Cindy Petersen	7/1/11 & ongoing
K. Increase awareness and understanding of mental illness to combat stigma and foster hope for recovery.	CPR	7/1/10 and ongoing
L. Broadly communicate the availability of recovery groups and activities that are open to the public.	Mary Beth Evans, Deb Freed & CPR	Ongoing; need system by 11/1/10

PROVIDER TRAINING & COMPETENCY

Action Steps	Leads	Timelines
M. Provide recovery information and training to staff and contracted providers so that they achieve competency in providing recovery-oriented services and supports, in such areas as: the five stages of recovery, the principles and language of recovery, culturally relevant services, and application of recovery-oriented evidence based practices.	Mary Beth Evans, Kim Silbor, Carrie Gray, Dave Branding (CMCO)	Orientation materials & process by 1/1/11, implement training ongoing
N. Review and select Essential Learning modules on recovery for annual training.	Mary Beth Evans	Completed 6/10
O. Develop training for staff who work with adults, using the "5 Stages" video information. (Same as consumer version.)	Joanie Blamer, Deb Freed, Mary Beth Evans	1/1/11
P. Explore development of possible Essential Learning courses on culture, spirituality.	Beth Burke	Review & report findings by 11/1/10
Q. Provide training to all psychiatrists and managers who are in critical leadership roles on the blueprint and recovery.	Executive Team	12/2/10
R. Provide presentations by consumers to staff in all offices on what helps and what hinders recovery.	Cindy Petersen & Speaker's Bureau	7/1/11
S. Provide hands-on mini lessons for staff on Pathways to Recovery (3/11), MI-PATH (5/11), WRAP (7/11).	Mary Beth Evans	Brown bags 3/11, 5/11, 7/11
T. Provide a simulation for staff on accessing care, from calling to going to intake, sitting in waiting room, attending PCP.	Cindy Petersen, Mary Beth Evans, Joanie Blamer, Terri Kelty, Deb Freed	9/30/11
U. Expand co-occurring skills across all services, substance abuse assessment, treatment. (Josh Snyder, Carol Andersen)	Joanie Blamer & Co-Occurring Leadership Team	10/1/11
V. Develop strategies to design and provide comprehensive training to clinical staff on authorizing and communicating individualized guidelines regarding amount, scope and duration of services.	COOs & Ops Managers	Training complete 6/10. Plan to monitor 4/11
W. Train staff on how to document recovery in PCP or notes – more training on writing Recovery-based PCPs which reflect the needs, wants and desires of consumers.	COOs & Ops Managers	Ongoing (see Mental Health Block Grant)
X. Provide training/education to intake personnel to promote a trauma-informed culture of increased gentleness and trust.	Dave Branding (CMCO), COOs	Train 7/11. Monitoring Plan 10/11, ongoing
Y. Identify trainers and arrange training for specific staff on attaining / retaining benefits and benefit management.	Staff Dev. Committee, Joanie Blamer, Mary Beth Evans	10/27/10
Z. Train front line staff to create a positive, welcoming, responsive environment to consumers seeking help.	Joanie Blamer, Terri Kelty, Dave Branding (CMCO), Rob Palmer, Mary Beth Evans, Customer Services	Orientation materials & process 1/1/11, train by 6/11, then ongoing

Who should be involved	Recovery Council members, Recovery Coordinator, consumers, families, board members, staff, providers, community stakeholders (schools, DHS, law enforcement, judicial, faith based, etc.)
Barriers	Involves many people and will need to be well coordinated. Timelines dependent on other action steps.

* IPLT = Improving Practices Leadership Team

System Dimension 11: Funding

Funding is about providing money for a particular purpose.

DIMENSION LEAD: Kevin Hartley

Getting the Vision Right	Treatments and supports that are recovery-oriented get funding.
What we want to build is a system where…	• Dollars are spent based on achieving the recovery goals the consumer has set in his or her individual plan of service. • Funding directly supports the results we want to achieve. • We promote consumer choice and control of individual budgets. • We have some flexibility to pay for effective treatments and services. • We look at quality, results, commitment to recovery and use of evidence-based practices when making decisions about spending money.

Action Steps	Leads	Timelines
A. Seek out more grants – provide grant writing training and build grant writing expertise of staff and peers.	Greg Paffhouse & Executive Team	Explore as possible Recovery Council role specific to recovery grant monitoring (10/10).
B. Make a plan for fundraising and fund development.	Greg Paffhouse & Executive Team	10/11
C. Link to resources for supporting more recreational activities, such as bowling, haircuts, manicures, fitness club, etc.	Mary Beth Evans & Learning Community	3/1/11
D. Develop model or plan on how to recognize and reward recovery-based practices by staff and contract providers. (Link to Quality Improvement Committee. Link to 13C. Annual Recovery Celebration may be one venue.)	Kim Silbor & Beth Burke	Literature review 1/1/11, Draft plan 4/1/11
E. Increase use of self-determination arrangements.	Dave Branding, Joanie Blamer, Terri Kelty	Completed 9/1/10 & ongoing.
F. Investigate providing small consumer recovery mini-grants to reflect local needs. (See Adult Mental Health Block Grant.)	Greg Paffhouse & Executive Team	Recovery Planning Team to develop process and plan by 11/10, notice 12/10, award 2/11

Who should be involved	Through advocacy many have a role in helping to assure continued funding. Key role for staff with board member, community, and consumer input.
Barriers	Continued risk for reduction in base funding.

System Dimension 12: Access

Access means having the right or opportunity to obtain something.

DIMENSION LEAD: Dave Branding (CMCO) and Becky Vincent

Getting the Vision Right	Persons coming to NLCMH for the first time experience a welcoming place where there is an expectation of recovery. Access to services is individualized based on consumers' vision of a meaningful life. Access to services and supports happens through listening and engaging consumers in self-direction.
What we want to build is a system where…	• Access to service environments is by consumer preference rather than professional preference. • Access to service environments does not depend on using a particular mental health service. (For example, access to housing does not depend on taking medication.) • Access to living, learning, working and social environments outside the mental health system is expected. • Access is simple and options are easy to understand. • Persons are well informed of available services and encouraged to choose services that match up with the results they desire.

Action Steps	Leads	Timelines
A. Study and potentially revise access policy/process/ procedures to be more consumer friendly and welcoming. Explore ways to streamline access/intake to make it as easy as possible for people entering services.	Dave Branding (CMCO) & COOs	10/1/11 (New Mental Health Block Grant
B. Start talking recovery from the very first contact with consumers so that they have the expectation of recovery, including contacts with the access center as well as initial assessments and intakes.	Joanie Blamer and Becky Vincent	Orientation materials & process by 1/1/11, implement ongoing
C. Review current capacity and roles of certified peer support staff to see if it is possible to use peers at point of first access (including emergency access) and in PCPs.*	Joanie Blamer, Terri Kelty, Kim Silbor & Carrie Gray	10/1/11
D. Ensure all access staff are trained on stages of recovery/change to make sure interventions match specific stages.	Becky Vincent, Dave Branding (CMCO, Aaron Cromar, Mary Beth Evans	Orientation materials & process by 1/1/11, implement ongoing
E. Communicate at first call that there will be a timeline for services; ask about the person's expectation for timelines.	Dave Branding (CMCO) & Becky Vincent	1/1/11
F. Communicate that there are choices based on eligibility and availability, i.e., "We have recovery, drop-in centers, case managers to speak to, support groups, physicians."	Becky Vincent, Dave Branding (CMCO), Aaron Cromar, Terri Kelty	Orientation materials & process by 1/1/11, implement ongoing
G. Promote a self-determined, person-centered culture by utilizing expectations, skill building and training.	Mary Beth Evans, Terri Kelty, Joanie Blamer, Greg Paffhouse, Mary Hubbard, Dave Branding (CMCO)	Ongoing, track and publicize progress
H. Review current practices and develop strategies to improve process for adolescents to transition into adult systems.	Mary Hubbard (will work with Joanie Blamer [MI] and Terri Kelty [DD] regarding adult services)	4/11
I. Look for ways to provide or improve access to consumer-run and/or consumer-driven programs in counties where there are none (clubhouses, drop-in centers); increase support for consumers interested in establishing microenterprises (including access to support resources, education and skill building).	Mary Beth Evans, Greg Paffhouse, Dave Branding (micro-enterprises), Andy Ulrich & Signe Ruddy (Clubhouses), Ernie Reynolds & Mike Kuhn (Drop In), Recovery Council, consumers	10/1/11. Target Crawford County 7/1/11. Grayling Office agenda 1/11.

Who should be involved	Consumers, staff (inc. reception, access), community leaders, family members, recovery council, Improving Practices Leadership Team, etc.
Barriers	Competing priorities

* PCP – Person Centered Planning

System Dimension 13: Change Management

Change Management is about planning for change and making sure you get the changes you want.

DIMENSION LEAD: Recovery Planning Team (See list at bottom of page)

Getting the Vision Right	We recognize that change is good, change is always happening whether we want it to or not, and we can manage change. We commit to changing our system and making sure people do what is needed to make the right changes. We keep the quality of services high while the changes are happening. We celebrate successes.
What we want to build is a system where…	• We make system transformation happen! • NLCMH is place where people are optimistic. • Everyone accepts change – individuals, units and Northern Lakes CMH as a whole. • NLCMH is seen as a leader in recovery in the state and nation. • Our skilled and dedicated staff is a valued partner in our change effort. • Our commitment stays strong to change in the right direction so people recover. • We share a picture of the future we are trying to create – that is clear, inspiring and achievable.

Action Steps	Leads	Timelines
A. Provide opportunities for in-depth dialogue with organizational change leaders to ensure they understand the guiding principles and the spirit behind each of the action steps in this blueprint, the reasons why change is needed, how these efforts fit in to the bigger picture of MDCH and NLCMH strategic planning, and gain their buy-in for championing change.	Greg Paffhouse, Joanie Blamer, Terri Kelty, Mary Beth Evans, Recovery Council staff members, Ops Mgrs.	Review updated Blueprint with E. Team 10/10. Provide updated Blueprint to Leads 10/10. Provide ongoing support as needed.
B. Develop a communications strategy to increase communications on recovery change efforts among all stakeholders, with a goal of having the whole system be more coordinated with everyone with the same idea of where we are going and how to get there.	Greg Paffhouse, Dave Branding (CMCO), Network Management Team, Communications & Public Relations (CPR)	Have CPR amend CPR Plan to include recovery communication strategy based on recommendations from Recovery Planning Team 1/11.
C. Develop a multi-level plan to recognize staff for their hard work as well as successes in recovery for individuals and the system. (Link with 11D)	Recovery Council for conference awards. Executive Team for ongoing recognition throughout the year.	7/10 for RC, & ongoing for Exec Team
D. Create a steering committee to broadly oversee overall organization system transformation and support implementation of evidence based practices. Link this committee to the Northwest CMH Affiliation Improving Practices Leadership Team (IPLT).	Greg Paffhouse, Dave Branding (CMCO), Improving Practices Leadership Team	Determine benefit/need to create NLCMH internal IPLT to support Affiliation IPLT 1/11. If yes, seat by 2/11.
E. Designate a subgroup, called Recovery Planning Team*, dedicated to transformation to a recovery-oriented system and improving outcomes for adults with mental illness. Build guiding teams as identified as needed.	Joanie Blamer	Identified leads 6/30/10, monitoring and reporting plan by 12/1/10 & annually
F. Identify leads and timelines for blueprint action steps and a plan for regularly monitoring and reporting on progress. Review blueprint at least annually with large group.	Recovery Planning Team	Identified leads 6/30/10, monitoring and reporting plan by 12/1/10 & annually

Who should be involved	Recovery Planning Team*, Dimension Leads, Action Step Leads (everyone listed in this Blueprint), plus Board of Directors, plus consumer volunteers
Barriers	Change management expertise and competing priorities

* Recovery Planning Team (blueprint and related block grants): Joanie Blamer (lead), Dave Branding, Aaron Cromar, Mary Beth Evans, Deb Freed, Carrie Gray, Terri Kelty, Mary Kay Niemisto, Greg Paffhouse, Cindy Petersen, Kim Silbor.

Leads

DIMENSION LEADS:

Dim. 1 – Design .... Joanie Blamer
Dim. 2 – Evaluation .... QI Director (Dave Branding)
Dim. 3 – Leadership .... Greg Paffhouse, Carrie Gray, Aaron Cromar, Kim Silbor
Dim. 4 – Management .... Tom Denton, Mary Kay Niemisto
Dim. 5 – Integration .... Terri Kelty
Dim. 6 – Comprehensiveness .... Cindy Petersen
Dim. 7 – Consumer Involvement .... Mary Beth Evans
Dim. 8 – Cultural Relevance .... Joanie Blamer
Dim. 9 – Advocacy .... Deb Freed
Dim. 10 – Training .... Beth Burke, Cindy Petersen
Dim. 11 – Funding .... Kevin Hartley
Dim. 12 – Access .... Dave Branding (CMCO), Becky Vincent
Dim. 13 – Change Management .... Joanie Blamer, Dave Branding, Aaron Cromar, Mary Beth Evans, Deb Freed, Carrie Gray, Terri Kelty, Mary Kay Niemisto, Greg Paffhouse, Cindy Petersen, Kim Silbor

Individual Action Step Leads: Joanie Blamer, Dave Branding (QI), Dave Branding (CMCO), Beth Burke, Aaron Cromar, Mary Beth Evans, Deb Freed, Tom Denton, Becky Gomez, Carrie Gray, Mary Hubbard, Keith Huggett, Terri Kelty, Mike Kuhn, Mary Kay Niemisto, Greg Paffhouse, Rob Palmer, Cindy Petersen, Ernie Reynolds, Dr. Riddle, Rosemary Rokita, Signe Ruddy, Kim Silbor, Andy Ulrich, Becky Vincent

Group Action Step Leads: Access Staff, Chief Operating Officers, Co-Occurring Leadership Team, Communications and Public Relations Committee, Customer Services, Executive Team, Facilities Committee, Improving Practices Leadership Team, Learning Communities, Network Management Team, Operations Managers, Quality Improvement Committee, Recovery Council, Recovery Council Staff Members, Recovery Planning Team, Speaker's Bureau, Staff Development Committee

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INDIVIDUAL ACTION STEP LEADS

Joanie Blamer

Dimension 1 – Design Lead
Dimension 8 – Cultural Relevance Lead
Dimension 13 – Change Management Lead

√ Dim 3: Leadership, Row A – Pg. 15, Develop plan 4/11, Assess 9/11
√ Dim 4: Management, Row J – Pg. 17, Plan by 1/1/11, ongoing thereafter
√ Dim 5: Integration, Row A – Pg. 18, Current & progress update 11/30/10; Pilot and develop initial plan for child psychiatry in one pediatric practice setting 12/10; Agenda topic on 12/10 Psychiatrist mtg.
√ Dim 6: Comprehensiveness, Row A – Pg. 19, Review Strategic Plan and Blueprint at Network Meetings 1/11. Consider article in next issue of Networker.
√ Dim 8: Cultural Relevance, Row B – Pg. 21, 7/11
√ Dim 8: Cultural Relevance, Row D – Pg. 21, Seek volunteers (11/10) to write a draft policy (4/11).
√ Dim 9: Advocacy, Row I – Pg. 22, Plan by 4/1/11
√ Dim 10: Training, Row C – Pg. 23, 1/1/11
√ Dim 10: Training, Row D – Pg. 23, 10-min 5 Stages video 10/1/10, materials 1/1/11, IPLT EBP video 9/30/11
√ Dim 10: Training, Row J – Pg. 24, 7/1/11 & ongoing
√ Dim 10: Training, Row O – Pg. 24, 1/1/11
√ Dim 10: Training, Row T – Pg. 24, 9/30/11
√ Dim 10: Training, Row U – Pg. 24, 10/1/11
√ Dim 10: Training, Row Y – Pg. 24, 10/27/10
√ Dim 10: Training, Row Z – Pg. 24, Orientation materials & process by 1/1/11, train by 6/11, then train ongoing
√ Dim 11: Funding, Row E – Pg. 25, Complete & ongoing
√ Dim 12: Access, Row B – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
√ Dim 12: Access, Row C – Pg. 26, 10/1/11
√ Dim 12: Access, Row G – Pg. 26, Ongoing, track and publicize progress
√ Dim 12: Access, Row H – Pg. 26, 4/11
√ Dim 13: Change Management, Row A – Pg. 27, Review updated Blueprint with ETeam 10/10. Provide updated Blueprint to Leads 10/10. Provide ongoing support as needed.
√ Dim 13: Change Management, Row E – Pg. 27, Identified leads 6/30/10, monitoring and reporting plan by 12/1/10 & annually

Dave Branding (CMCO)

Dimension 12 – Access Lead

Dimension 13 – Change Management Lead

- √ Dim 10: Training, Row M – Pg. 24, Orientation materials & process by 1/1/11, implement training ongoing
- √ Dim 10: Training, Row X – Pg. 24, Train 7/11, monitoring plan 10/11, ongoing
- √ Dim 10: Training, Row Z – Pg. 24, Orientation materials & process by 1/1/11, train by 6/11, then train ongoing
- √ Dim 12: Access, Row A – Pg. 26, 10/1/11 (New Mental Health Block Grant)
- √ Dim 12: Access, Row D – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
- √ Dim 12: Access, Row E – Pg. 26, 1/1/11
- √ Dim 12: Access, Row F – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
- √ Dim 12: Access, Row G – Pg. 26, ongoing, track and publicize progress
- √ Dim 13: Change Management, Row B – Pg. 27, Have CPR amend CPR Plan to include recovery communication strategy based on recommendations from Recovery Planning Team 1/11.
- √ Dim 13: Change Management, Row D – Pg. 27, Determine benefit and need to create NLCMH internal IPLT to support Affiliation IPLT 1/11. If yes, seat NLCMH IPLT by 2/11.

Dave Branding (in QI Director Role)

Dimension 2 – Evaluation Lead

- √ Dim 1: Design, Row E – Pg. 13, 11/1/10
- √ Dim 2: Evaluation, Row A – Pg. 14, 10/1/10
- √ Dim 2: Evaluation, Row B – Pg. 14, 12/1/10
- √ Dim 2: Evaluation, Row C – Pg. 14, 10/1/10
- √ Dim 2: Evaluation, Row D – Pg. 14, 10/1/10
- √ Dim 3: Leadership, Row G – Pg. 15, Implemented & ongoing
- √ Dim 11: Funding, Row E – Pg. 25, Complete & ongoing
- √ Dim 12: Access, Row G – Pg. 26, Ongoing, track and publicize progress
- √ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.

Beth Burke

Dimension 10 – Training Lead

- √ Dim 8: Cultural Relevance, Row G – Pg. 21, Develop plan 1/1/11. Adult Mental Health Block Grant: Native American by 4/1/11, Hispanic by 4/1/12.
- √ Dim 10: Training, Row P – Pg. 24, Review & report findings by 11/1/10
- √ Dim 11: Funding, Row D – Pg. 25, Literature review 1/1/11, Draft plan 4/1/11

Aaron Cromar

Dimension 3 – Leadership Lead

Dimension 13 – Change Management Lead

- √ Dim 10: Training, Row G – Pg. 23, Mental Health Block Grant calls for Q1-4, FY2011
- √ Dim 12: Access, Row D – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
- √ Dim 12: Access, Row F – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing

Tom Denton

Dimension 4 – Management Lead

- √ Dim 4: Management, Row B – Pg. 16, 4/1/10 & ongoing
- √ Dim 4: Management, Row C – Pg. 16, 1/1/11
- √ Dim 8: Cultural Relevance, Row C – Pg. 21, Adult Mental Health Block Grant: Native American by 4/1/11, Hispanic by 4/1/12; 10/11

Mary Beth Evans

Dimension 7 – Consumer Involvement Lead

Dimension 13 – Change Management Lead

- √ Dim 3: Leadership, Row A – Pg. 15, Develop plan 4/11, Assess 9/11.
- √ Dim 3: Leadership, Row E – Pg. 15, 1/1/11
- √ Dim 4: Management, Row E – Pg. 16, Ongoing
- √ Dim 5: Integration, Row C – Pg. 18, Individual Level 3/1/11, System 4/1/11
- √ Dim 7: Consumer Involvement, Row D – Pg. 20, 6/1/11
- √ Dim 8: Cultural Relevance, Row I – Pg. 21, 6/1/11
- √ Dim 9: Advocacy, Row A – Pg. 22, Set workgroup & hold 1st mtg 12/1/10. Plan by 2/1/11
- √ Dim 9: Advocacy, Row G – Pg. 22, 3/1/11 - Ongoing recruiting for Mental Health Block Grant Volunteer Fair by 10/1/11
- √ Dim 10: Training, Row B – Pg. 23, 1/1/11
- √ Dim 10: Training, Row D – Pg. 23, 10-min 5 Stages video by 10/1/10, materials by 1/1/11, IPLT* Evidence Based Practice video by 9/30/11
- √ Dim 10: Training, Row F – Pg. 23, Plan by 11/1/10 with CPR Committee. Develop ongoing according to Plan.
- √ Dim 10: Training, Row L – Pg. 24, Ongoing; need system by 11/1/10
- √ Dim 10: Training, Row M – Pg. 24, Orientation materials & process by 1/1/11, implement training ongoing
- √ Dim 10: Training, Row N – Pg. 24, completed 6/10
- √ Dim 10: Training, Row O – Pg. 24, 1/1/11
- √ Dim 10: Training, Row S – Pg. 24, Brown bags 3/11, 5/11, 7/11
- √ Dim 10: Training, Row T – Pg. 24, 9/30/11
- √ Dim 10: Training, Row Y – Pg. 24, 10/27/10
- √ Dim 10: Training, Row Z – Pg. 24, Orientation materials & process 1/1/11, train by 6/11, then ongoing
- √ Dim 11: Funding, Row C – Pg. 25, 3/1/11
- √ Dim 12: Access, Row D – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
- √ Dim 12: Access, Row G – Pg. 26, Ongoing, track and publicize progress
- √ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.
- √ Dim 13: Change Management, Row A – Pg. 27, Review updated Blueprint with ETeam 10/10. Provide updated Blueprint to Leads 10/10. Provide ongoing support as needed.

Deb Freed

Dimension 9 – Advocacy Lead

Dimension 13 – Change Management Lead

√ Dim 1: Design, Row F – Pg. 13, Ongoing
√ Dim 4: Management, Row D – Pg. 16, 7/1/11
√ Dim 9: Advocacy, Row A – Pg. 22, 12/1/10 and 2/1/11
√ Dim 9: Advocacy, Row B – Pg. 22, 4/1/11
√ Dim 9: Advocacy, Row C – Pg. 22, 4/1/11
√ Dim 10: Training, Row C – Pg. 23, 1/1/11
√ Dim 10: Training, Row D – Pg. 23, 10-min 5 Stages video by 10/1/10, materials by 1/1/11, IPLT* Evidence Based Practice video by 9/30/11
√ Dim 10: Training, Row G – Pg. 23, Mental Health Block Grant calls for Q1-4, FY2011
√ Dim 10: Training, Row L – Pg. 24, Ongoing and need system by 11/1/10
√ Dim 10: Training, Row O – Pg. 24, 1/1/11
√ Dim 10: Training, Row T – Pg. 24, 9/30/11

Becky Gomez

√ Dim 1: Design, Row A – Pg. 13, 4/11

Carrie Gray

Dimension 3 – Leadership Lead

Dimension 13 – Change Management Lead

√ Dim 3: Leadership, Row B – Pg. 15, 12/1/10 & Ongoing; Develop draft peer support policy including vision 1/11.
√ Dim 4: Management, Row G – Pg. 16, 12/1/10 & Ongoing
√ Dim 10: Training, Row E – Pg. 23, 9/30/11 (See Mental Health Block Grant)
√ Dim 10: Training, Row G – Pg. 23, Mental Health Block Grant calls for Q1-4, FY2011
√ Dim 10: Training, Row M – Pg. 24, Orientation materials & process by 1/1/11, implement training ongoing
√ Dim 12: Access, Row C – Pg. 26, 10/1/11

Mary Hubbard

√ Dim 10: Training, Row H – Pg. 23, 10/1/11
√ Dim 12: Access, Row G – Pg. 26, Ongoing, track and publicize progress
√ Dim 12: Access, Row H – Pg. 26, 4/11

Kevin Hartley

Dimension 11 – Funding Lead

Keith Huggett

√ Dim 1: Design, Row D – Pg. 13, 10/1/10
√ Dim 1: Design, Row F – Pg. 13, Ongoing
√ Dim 1: Design, Row H – Pg. 13, Assessment revised and now being implemented (7/10)

Terri Kelty

Dimension 5 – Integration Lead

Dimension 13 – Change Management Lead

√ Dim 4: Management, Row J – Pg. 17, Plan by 1/1/11, ongoing thereafter
√ Dim 5: Integration, Row A – Pg. 18, Current & progress update 11/30/10; Pilot and develop initial plan for child psychiatry in one pediatric practice setting 12/10; Agenda topic on 12/10 Psychiatrist mtg.
√ Dim 6: Comprehensiveness, Row A – Pg. 19, Review Strategic Plan and Blueprint at Network Meetings 1/11. Consider article in next issue of Networker.
√ Dim 8: Cultural Relevance, Row B – Pg. 21, 7/11
√ Dim 8: Cultural Relevance, Row D – Pg. 21, Seek volunteers (11/10) to write a draft policy (4/11).
√ Dim 10: Training, Row T – Pg. 24, 9/30/11
√ Dim 10: Training, Row Z – Pg. 24, Orientation materials & process by 1/1/11, train by 6/11, then train ongoing
√ Dim 11: Funding, Row E – Pg. 25, Complete & ongoing
√ Dim 12: Access, Row C – Pg. 26, 10/1/11
√ Dim 12: Access, Row F – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
√ Dim 12: Access, Row G – Pg. 26, Ongoing, track and publicize progress
√ Dim 12: Access, Row H – Pg. 26, 4/11
√ Dim 13: Change Management, Row A – Pg. 27, Review updated Blueprint with ETeam 10/10. Provide updated Blueprint to Leads 10/10. Provide ongoing support as needed.

Mike Kuhn

√ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.

Mary Kay Niemisto

Dimension 4 – Management Lead

Dimension 13 – Change Management Lead

√ Dim 10: Training, Row G – Pg. 23, Mental Health Block Grant calls for Q1-4, FY2011

Greg Paffhouse

Dimension 3 – Leadership Lead

Dimension 13 – Change Management Lead

√ Dim 1: Design, Row C – Pg. 13, ETeam agenda 10/10. Consider Blueprint becoming Mi-A Improving Outcomes Plan 4/1/11

√ Dim 5: Integration, Row A – Pg. 18, Current & progress update 11/30/10; Pilot and develop initial plan for child psychiatry in one pediatric practice setting 12/10; Agenda topic on 12/10 Psychiatrist mtg.

√ Dim 6: Comprehensiveness, Row A – Pg. 19, Review Strategic Plan and Blueprint at Network Meetings 1/11. Consider article in next issue of Networker.

√ Dim 8: Cultural Relevance, Row A – Pg. 21, Review Essential Learning Courses and if available have Training Committee add as a FY 11 Training Plan Priority for professional staff 1/11.

√ Dim 8: Cultural Relevance, Row D – Pg. 21, Seek volunteers (11/10) to write a draft policy (4/11).

√ Dim 8: Cultural Relevance, Row E – Pg. 21, CPR identify culture groups (11/10) and develop FY 11 outreach plan (4/11).

√ Dim 8: Cultural Relevance, Row F – Pg. 21, 4/30/11

√ Dim 8: Cultural Relevance, Row J – Pg. 21, Office mtg agenda 1/11. Completed in all offices by 7/11.

√ Dim 11: Funding, Row A – Pg. 25, Explore as possible Recovery Council role specific to recovery grant monitoring (10/10).

√ Dim 11: Funding, Row B – Pg. 25, 10/11

√ Dim 11: Funding, Row F – Pg. 25, Recovery Planning Team to develop process and plan by 11/10, notice 12/10, award 2/11.

√ Dim 12: Access, Row G – Pg. 26, ongoing, track and publicize progress

√ Dim 12: Access, Row I – Pg. 26, 10/1/11. Target Crawford County 7/1/11. Grayling office agenda 1/11.

√ Dim 13: Change Management, Row A – Pg. 27, Review updated Blueprint with ETeam 10/10. Provide updated Blueprint to Leads 10/10. Provide ongoing support as needed.

√ Dim 13: Change Management, Row B – Pg. 27, Have CPR amend CPR Plan to include recovery communication strategy based on recommendations from Recovery Planning Team 1/11.

√ Dim 13: Change Management, Row D – Pg. 27, Determine benefit and need to create NLCMH internal IPLT to support Affiliation IPLT 1/11. If yes, seat NLCMH IPLT by 2/11.

Rob Palmer

√ Dim 10: Training, Row Z – Pg. 24, Orientation materials & process by 1/1/11, train by 6/11, then train ongoing

Cindy Petersen

Dimension 6 – Comprehensiveness Lead

Dimension 10 – Training Lead

Dimension 13 – Change Management Lead

√ Dim 1: Design, Row B – Pg. 13, Draft plan 10/30/10, Final plan 3/1/11, Program 7/1/11

√ Dim 3: Leadership, Row C – Pg. 15; Define recovery education activities & FY11 activity plan. Coordinate with Customer Service regarding integration in Consumer Involvement Plan 1/11.

√ Dim 3: Leadership, Row D – Pg. 15, Annual ongoing trainings

√ Dim 4: Management, Row C – Pg. 16, 1/1/11

√ Dim 4: Management, Row D – Pg. 16, 1/1/11

√ Dim 5: Integration, Row A – Pg. 18, Current & progress update 11/30/10; Pilot and develop initial plan for child psychiatry in one pediatric practice setting 12/10; Agenda topic on 12/10 Psychiatrist mtg.

√ Dim 6: Comprehensiveness, Row A – Pg. 19, Review Strategic Plan and Blueprint at Network Meetings 1/11. Consider article in next issue of Networker.

√ Dim 6: Comprehensiveness, Row B – Pg. 19 – 9/27/10, 10/27/10, Houghton Lake and Cadillac by 3/31/11

√ Dim 6: Comprehensiveness, Row C – Pg. 19 – Draft plan 10/30/10, Final plan 3/31/11

√ Dim 7: Consumer Involvement, Row C – Pg. 20, 6/15/10, 6/18/10, ongoing Annual Trainings

√ Dim 8: Cultural Relevance, Row C – Pg. 21, Adult Mental Health Block Grant: Native American by 4/1/11, Hispanic by 4/1/12

√ Dim 9: Advocacy, Row A – Pg. 22, set workgroup/hold 1st meeting 12/1/10, plan by 2/1/11

√ Dim 9: Advocacy, Row B – Pg. 22, 4/1/11

√ Dim 9: Advocacy, Row C – Pg. 22, 4/1/11 & ongoing

√ Dim 9: Advocacy, Row H – Pg. 22, 2/1/11

√ Dim 10: Training, Row G – Pg. 23, Mental Health Block Grant calls for Q1-4, FY2011

√ Dim 10: Training, Row I – Pg. 24, 7/1/10 & ongoing

√ Dim 10: Training, Row J – Pg. 24, 7/1/11 & ongoing

√ Dim 10: Training, Row R – Pg. 24, 7/1/11

√ Dim 10: Training, Row T – Pg. 24, 9/30/11

Ernie Reynolds

√ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.

Dr. Riddle

√ Dim 5: Integration, Row A – Pg. 18, Current & progress update 11/30/10; Pilot and develop initial plan for child psychiatry in one pediatric practice setting 12/10; Agenda topic on 12/10 Psychiatrist mtg.

√ Dim 6: Comprehensiveness, Row A – Pg. 19, Review Strategic Plan and Blueprint at Network Meetings 1/11. Consider article in next issue of Networker.

Rosemary Rokita

√ Dim 7: Consumer Involvement, Row A – Pg. 20, 1/1/11

Signe Ruddy
- √ Dim 1: Design, Row B – Pg. 13, Draft plan 10/30/10, Final plan 3/1/11, Program 7/1/11
- √ Dim 6: Comprehensiveness, Row C – Pg. 19, Draft plan 10/30/10, Final plan 3/31/11
- √ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.

Kim Silbor

Dimension 3 – Leadership Lead
Dimension 13 – Change Management Lead
- √ Dim 3: Leadership, Row B – Pg. 15, 12/1/10 & Ongoing; Develop draft peer support policy including vision 1/11.
- √ Dim 4: Management, Row F – Pg. 16, 12/1/10 & Ongoing
- √ Dim 4: Management, Row G – Pg. 16, Develop consumer brochure that describes peer support services and peer run groups 12/1/10, ongoing
- √ Dim 10: Training, Row E – Pg. 23, 9/30/11 (See Mental Health Block Grant)
- √ Dim 10: Training, Row G – Pg. 23, Mental Health Block Grant calls for Q1-4, FY2011
- √ Dim 10: Training, Row M – Pg. 24, Orientation materials & process by 1/1/11, implement training ongoing
- √ Dim 11: Funding, Row D – Pg. 25, Literature review 1/1/11, Draft plan 4/1/11
- √ Dim 12: Access, Row C – Pg. 26, 10/1/11

Andy Ulrich
- √ Dim 1: Design, Row B – Pg. 13, Draft plan 10/30/10, Final plan 3/1/11, Program 7/1/11
- √ Dim 6: Comprehensiveness, Row C – Pg. 19, Draft plan 10/30/10, Final plan 3/31/11
- √ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.

Becky Vincent

Dimension 12 – Access Lead
- √ Dim 9: Advocacy, Row I – Pg. 22, Plan by 4/1/11
- √ Dim 12: Access, Row B – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
- √ Dim 12: Access, Row D – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing
- √ Dim 12: Access, Row E – Pg. 26, 1/1/11
- √ Dim 12: Access, Row F – Pg. 26, Orientation materials & process by 1/1/11, implement ongoing

GROUP ACTION STEP LEADS

Access Staff
- √ Dim 10: Training, Row E – Pg. 23, 9/30/11 (See Mental Health Block Grant)

Chief Operating Officers (COOs)
- √ Dim 1: Design, Row D – Pg. 13, 10/1/10
- √ Dim 1: Design, Row G – Pg. 13, 1/5/11
- √ Dim 1: Design, Row H – Pg. 13, assessment revised and now being implemented (7/10)
- √ Dim 5: Integration, Row C – Pg. 18, Individual Level 3/1/11, System 4/1/11
- √ Dim 8: Cultural Relevance, Row E – Pg. 21, Dim 8: Cultural Relevance, Row E – Pg. 22, CPR identify culture groups (11/10) and develop FY 11 outreach plan (4/11).
- √ Dim 10: Training, Row V – Pg. 24, Training complete 6/10, plan to monitor 4/11
- √ Dim 10: Training, Row W – Pg. 24, Ongoing (see Mental Health Block Grant)
- √ Dim 10: Training, Row X – Pg. 24, Train 7/11, monitoring plan 10/1, ongoing
- √ Dim 12: Access, Row A – Pg. 26, 10/1/11 (New Mental Health Block Grant)

Communications & Public Relations (CPR) Committee
- √ Dim 3: Leadership, Row C – Pg. 15, Calendar established 11/1/10 and ongoing; Define recovery education activities & FY11 activity plan. Coordinate with Customer Service regarding integration in Consumer Involvement Plan 1/11.
- √ Dim 3: Leadership, Row E – Pg. 15, 1/1/11
- √ Dim 4: Management, Row C – Pg. 16, 1/1/11
- √ Dim 4: Management, Row D – Pg. 16, 1/1/11
- √ Dim 4: Management, Row H – Pg. 16, 1/1/11
- √ Dim 4: Management, Row I – Pg. 16, 1/1/11
- √ Dim 5: Integration, Row D – Pg. 18, Ongoing
- √ Dim 7: Consumer Involvement, Row B – Pg. 20, 3/31/11
- √ Dim 8: Cultural Relevance, Row E – Pg. 21, CPR identify culture groups (11/10) and develop FY 11 outreach plan (4/11).
- √ Dim 9: Advocacy, Row D – Pg. 22, 1/1/11
- √ Dim 9: Advocacy, Row E – Pg. 22, 1/1/11
- √ Dim 9: Advocacy, Row F – Pg. 22, 4/1/11 & ongoing
- √ Dim 10: Training, Row A – Pg. 23, 1/1/11
- √ Dim 10: Training, Row B – Pg. 23, 1/1/11
- √ Dim 10: Training, Row I – Pg. 24, 7/1/10 & ongoing
- √ Dim 10: Training, Row K – Pg. 24, 7/1/10 & ongoing
- √ Dim 10: Training, Row L – Pg. 24, System by 11/1/10 & ongoing
- √ Dim 13: Change Management, Row B – Pg. 27 - Have CPR amend CPR Plan to include recovery communication strategy based on recommendations from Recovery Planning Team 1/11.

Co-Occurring Leadership Team
- √ Dim 10: Training, Row U – Pg. 24, 10/1/11

Customer Services
√ Dim 10: Training, Row Z – Pg. 24, Orientation materials & process by 1/1/11, train by 6/1/11, then train ongoing

Executive Team (ETeam)
√ Dim 1: Design, Row C – Pg. 13, ETeam agenda 10/10. Consider Blueprint becoming Mi-A Improving Outcomes Plan 4/1/11
√ Dim 3: Leadership, Row F – Pg. 15, Ongoing
√ Dim 4: Management, Row F – Pg. 16, 12/1/10 & Ongoing
√ Dim 5: Integration, Row B – Pg. 17, 12/1/10, ETeam agenda 10/10. Possible Co-Op agenda topic 11/10.
√ Dim 10: Training, Row Q – Pg. 24, 12/2/10
√ Dim 11: Funding, Row A – Pg. 25, Explore as possible Recovery Council role specific to recovery grant monitoring (10/10).
√ Dim 11: Funding, Row B – Pg. 25, 10/11
√ Dim 11: Funding, Row F – Pg. 25, Recovery Steering Committee to develop process and plan by 11/10, notice 12/10, award 2/11.
√ Dim 13: Change Management, Row C – Pg. 27, 7/10 for Recovery Council with annual review. Ongoing for Executive Team

Facilities Committee
√ Dim 4: Management, Row A – Pg. 16, Annual review by 10/1/10 and 10/1/11

Improving Practices Leadership Team (IPLT)
√ Dim 13: Change Management, Row D – Pg. 27, Determine benefit and need to create NLCMH internal IPLT to support Affiliation IPLT 1/11. If yes, seat NLCMH IPLT by 2/11.

Learning Communities
√ Dim 10: Training, Row F – Pg. 23, Plan by 11/1/1 with CPR. Develop ongoing according to Plan.
√ Dim 11: Funding, Row C – Pg. 25, 3/1/11

Network Management Team
√ Dim 4: Management, Row B – Pg. 16, 4/1/10 & ongoing
√ Dim 6: Comprehensiveness, Row A – Pg. 19, Review Strategic Plan and Blueprint at Network Meetings 1/11. Consider article in next issue of Networker.
√ Dim 8: Cultural Relevance, Row C – Pg. 21, Adult Mental Health Block Grant: Native American by 4/1/11, Hispanic by 4/1/12
√ Dim 8: Cultural Relevance, Row H – Pg. 21, 4/1/10 & annually
√ Dim 13: Change Management, Row B – Pg. 27, Have CPR amend CPR Plan to include recovery communication strategy based on recommendations from Recovery Planning Team 1/11.

Operations Managers (Ops Mgrs)
√ Dim 4: Management, Row B – Pg. 16, 4/1/10 & ongoing
√ Dim 4: Management, Row D – Pg. 16, 1/1/11
√ Dim 4: Management, Row F – Pg. 16, 12/1/10 & Ongoing
√ Dim 4: Management, Row H – Pg. 16, 7/1/10 PCP accomplished. 1/1/11 & ongoing
√ Dim 5: Integration, Row C – Pg. 18, Individual Level 3/1/11, System 4/1/11
√ Dim 10: Training, Row V – Pg. 24, Training complete 6/10. Plan to monitor 4/11
√ Dim 10: Training, Row W – Pg. 24, Ongoing (see Mental Health Block Grant)
√ Dim 13: Change Management, Row A, – Pg. 27, Review updated Blueprint with Exec Team 10/10. Discuss expanding Recovery Steering Team to include adult ops mgrs 10/10.
√ Dim 13: Change Management, Row E – Pg. 27, Identified leads 6/30, monitoring and reporting plan by 12/1/10 & annually

Quality Improvement Committee (QIC)
√ Dim 2: Evaluation, Row A – Pg. 14, 10/1/10
√ Dim 2: Evaluation, Row B – Pg. 14, 12/1/10
√ Dim 2: Evaluation, Row C – Pg. 14, 10/1/10
√ Dim 2: Evaluation, Row D – Pg. 14, 10/1/10

Recovery Council
√ Dim 4: Management, Row A – Pg. 16, Annual review by 10/1/10 and 10/1/11
√ Dim 9: Advocacy, Row A – Pg. 22, Set workgroup & hold 1st meeting 12/1/10. Plan by 2/1/11.
√ Dim 10: Training, Row F – Pg. 23, Plan by 11/1/10 with CPR. Develop ongoing according to Plan.
√ Dim 12: Access, Row I – Pg. 26, 10/1/11, Target Crawford County 7/1/11. Grayling office agenda 1/11.
√ Dim 13: Change Management, Row C – Pg. 28, 7/10 for Recovery Council with annual review. Ongoing for Executive Team

Recovery Council Staff Members
√ Dim 13: Change Management, Row A – Pg. 27, Review updated Blueprint with ETeam 10/10. Provide updated Blueprint to Leads 10/10. Provide ongoing support as needed.

Recovery Planning Team (See Dim 13 for membership)
√ Dim 13: Change Management, Row F – Pg. 27, Identify 6/30/10, Plan 12/1/10 & annually

Speakers Bureau
√ Dim 10: Training, Row R – Pg. 24, 7/1/11

Staff Development Committee
√ Dim 10: Training, Row Y – Pg. 24, 10/27/10