Note from Claudia:
The 70+ participants were divided into tables, Notes from each table are below.

**TABLE 1**

OMG – change is hard
Didn’t we do this before?
- Changed to more centralized system for **Consistently**
  Incentive shift
Bring in unit chefs and MDs ASAP
  They’ll be necessary for the success of the operation
Has the decision already been made

1st reactions – Table 1

What does this mean for regions now? Do they get smaller? (sub-divide) more mini regios spent to a community
Now have centralized services, do they “regionalize”
Need space, Money, staff, infrastructure.
Unit chief responsibilities will increase – they become managers
Each clinic has it’s own work culture based on its local community
Mini – MH/SA Board in each region (the 51%)
How to work with various groups

Essential items for success

- Determining how we divide into CSAs
- Having community boards
- Bringing clinic to community
- Identify current locations that work, fit more or less into this model…figure out what is working
- Determine communication between CSAs so we have consistency/no isolated
- Figure out basic operations early (otherwise likely will get stack)
- Figure out human resources needed
- Need to figure out how special needs are met
- Look at outcomes – cost as more or less?
- Need system to evaluate what systems not working

**TABLE 2**

1) Cool – Excited – Sound ambitious (but not in bad way)
   – like diamond (new clarity) n/exposure to ♦
   – access to all 4 dimensions
– makes sense – similar to HMB – community based will allow for more creativity/flexibility at local level.
– Will likely be easier and in smaller clinics
– Reminiscent of ARM approach no more: “that’s not our job”
– Fits in a/healthcare reform
– Where things are moving…

Q’S:
› Impact on programs that are countywide – how to realistically integrate (e.s.: OASIS, Caminar, FSP, YCM, El Centro…)
› Logistic of BHRS existing structure (org chart) Without just adding another layer. How do we get from here to there? “Melting the silo’s” – who will this impact (Primary care clinics structure under hospitals and clinics)

How will managers purchase services needed across regions/contracts/etc.
Locus of control and decision making needs to be at that level (w/in control of CSA manager)
What are we missing?
Disaster Planning
Experienced (community based) stakeholders es. AOD pre. Authoooo??…(NAMI)
Primary care clinician – hospitals a d clinical
Fiscal model; both to support model and to make transitions
Merging leveling melting silos
Good coffee
Support encouragement for all staff to promote flexibility and attitudes
Leave egos at door
Humor
Practical way to measure and celebrate small success
Easily understood milestones/timelines.

**TABLE 3**

Like Idea
› It will take _____.to get used to this way of doing business
Transition will be key for success
› Finally
This structure will ____? Clients need better than current structure

Will finally breakdown silos
Like general idea
Concerns about competencies
Interdisciplinary teams might get at this point
Will have to be really mindful of real state
Location will be key
Questions re: services design:
Around/centered on the clients
Availability of all levels of care
Looking at the EPA experience many positive ideas in team of community empowerment
Pleasingly surprised that SMC is considering this direction
Important to truly involve consumers and clients in service design/delivery
San Mateo has several packets of quite diverse communities
-How do we organize so that we serve all of them according to their specific needs
-It seems “Utopian”
-We need to take all the time we need to get it right!

Questions about role of manager (location of providers right be an issue for contract oversight)
Are there good models in other industries?
Developing and cultivating key partnerships to meet broad clients needs
Clarity regarding county wide services US local
Look at the integrating with other partners in the community (i.e” libraries, others)
Needs social strategy to involve a varied group fo stakeholders

Avoid having the same people show vp aty the same mtgs.
Have a good marketing/communications plan.
Keeping the community at the center of our plan
Include our larger county partners (civil services agencies)
Radical change within the organization
Careful, thoughtful, well planned out service delivery model
Accessible, clear language when communicating plan
Will receive huge flexibility
Take the time to do it right!

**TABLE 4**

How to integrate primary care
How to integrate the system wide services into the various regions
What would each regions entail?
What be our first step?
How to engage the health care system in the conversation
How do we learn from what we’re already done with primary care system?
How to create co-locations for services
How to look at the person as a whole
How do we join the larger health care system-integrated?
What do we do with the noon-publicly insured
Having health administration at the planning table would be needed for success
After policies are completed those providing the services and doing the work need to have
Similar goals and philosophies.

**TABLE 5** == Initial responses

Exciting
What is relationship between youth, adult integrated?
Movement from one age group into next will be easier (ie; youth-adult)
Clinic seen as a community center wholistic all programs under umbrella
Hours could be expanded/more flexible
More outreach – Outreach Team part of the center
Pos. def of family
Web of providers allows for entry at any point, any age, any level of service
More responsible – Meets consumer/family where they are

2 QUESTIONS

- What is criteria for determining “a region” or “community”
- How are people assigned to a CSA?
- What is the capacity in the regions?
- What is the source of funding?
- How to even better integrate with mental health for MH needs.

WHAT IS MISSING

System for moving easily between disciplines – fluidity
Over sight, monitoring, level of supervision, management
More uniform approaches to gaining entry to the services
How are we going to work operationally with each disciplines culture to assure easy access
Good flexible time table for integration

2 Essential elements to assure success

- All stakeholders find value
  o Community involvement
  o Staff involvement crucial
- Effective and uniform and frequent form of communication