QUESTION USED TO ELICIT INPUT FROM THE GROUP:

1. What is your immediate reaction to this proposal?
2. What questions do you have?
3. Is anything missing?
4. What are, in your view, the two essential elements that would ensure the success of this proposal?

FEEDBACK - QUESTION #1 (immediate reaction)
- Somewhat overwhelming.
- Community involvement is positive
- Appreciate 51% majority of consumers and family members in the Community Planning Committee
- This proposal makes sense because it responds to the diversity of the County
- Integration is helpful, but it could go wrong. It’s a great theory; the concern is what happens when the theory is operationalized.
- Like the idea because this type of structure fosters more proximity to community needs
- Very positive regarding consumer and family involvement
- For older adults, it makes sense to integrate primary care and behavioral healthcare; when people get older they have more complex needs.
- Concern about segregation and the tyranny of the majority:
  - Concern about groups that don’t fall neatly under a specific category. Example: if a Community Planning Committee has no representatives from a certain community group (i.e., ethnic,) the decisions made by that committee will not represent the true diversity of that community in an equitable way. For example: There are many Filipinos in North County, where they probably constitute the “first minority;” but North County is also home to many Chinese, who may not be equally represented in the Community Planning Committee due to cultural barriers (i.e., language, understated nature).
- Integration of PC/BH will help reduce stigma
- Like the proximity to services (transportation is key to access).
- Good idea
- Danger of concentration of services
- All CSAs should have capacity to hire diverse staff to tend to the needs of each community.

FEEDBACK - QUESTION #2 (questions)
- How will resources be allocated to communities?
- How much will this cost?
- How will this affect the contract monitoring process?
- How will stakeholders be involved in Phase II of this plan?
Do we expect all services to be at all CSAs?
How will equity in access be measured?
How will grievances be handled?
Who will make the final decision?
How will the transition across levels of care work?
Who will be the next group that will be solicited for input? How will they be outreached to?
Will clients be able to choose who they see regardless of CSAs?
Who will decided where the CSAs are? How will this decision be made?
Will the CSA be required to engage in active outreach?
Will we hire more people or will we repurpose existing positions?
How will we pay for this?

FEEDBACK - QUESTION #3 (anything missing?)
- How outreach will be handled.
- Complimentary healing practices
- More visibility of community input
- How the overall structure will be decided
- How cultural humility will be included in this structure
- There is lack of precision regarding transitions across levels of care
- Need to clarify the definition of health

FEEDBACK - QUESTION #4 (essential elements)
- Make sure we offer a place for everybody to get what they need.
- Ensure equity in access for those who are not currently being served in ours and other systems
- Flexible hours should definitely happen (another person seconded this)
- Equity
- Continued funding
- Focus on prevention including complimentary practices
- Service providers should match clients
- Transparency
- Funding and support to staff
- A separate, independent body should ensure accountability
- Holistic conception of healing (bioecological model)
- Make it easy for clients and family members to navigate
- Culturally responsive outreach and engagement
- Ensure broad communication
- Clarity and simplicity in how this is communicated
• Transparency is key, as is ongoing feedback by all
• Internal buy-in (seconded by one other person)
• Managers should be competent, diverse, and passionate
• The essential thing is to serve clients in the best possible way
• Ongoing evaluation
• It’s essential that communities embrace CSAs.