LPS Subcommittee Report 10/28/26

The LPS Subcommittee has 46 interested parties who receive our email zoom invitation. This meeting was attended by 27 people including our 5 BHAB members. We heard from Dr Aaron Meyer for 45 minutes on treatment of SMI and SUD sufferers from initial contact, into and through the LPS system, and through post-acute care. He described a number of gaps in the treatment process.

After his presentation we opened up the last 45 minutes for Q&A and comments. There were many comments and questions centered around data and reporting. This resonated throughout the session. One member suggested creating a process map, identifying bottlenecks then requesting reports to track performance and outcomes. One suggested that the county receives many of these reports but that it is difficult for us to access them.

Here are some examples of some potentially helpful reports to ask for:

1 Individualized treatment plans for LPS conservatees

Report the time from conservatorship establishment to confirmed receipt of the individualized treatment plan (pursuant to Welfare and Institutions Code 5352.6) by the Public Conservator, including the median and 90th percentile. Report the number and percentage of active LPS conservatees without a current plan on file, using all active LPS conservatees as the denominator, and days elapsed since establishment for outstanding initial plans. Define what constitutes a current plan.

2 Time to post-acute placement

Report days from documented clinical readiness on an inpatient psychiatric unit for the recommended lower level of care to actual admission, separately for mental health rehabilitation centers (MHRCs), skilled nursing facilities (SNFs), specialized behavioral SNFs, and residential treatment. Include the median and 90th percentile, number placed, and number still waiting over 30, 60, 90, 180, 365 days.

3 Reasons for delayed discharge

Report the number of patients and inpatient administrative days attributable to bed shortages, staffing, admission exclusions, authorization, or legal processes. Define how overlapping barriers are counted. Identify the agency responsible for resolving each barrier, the corrective action, and the expected completion date.

4 Usable post-acute capacity

Report licensed, contracted, staffed, and operational MHRC beds by setting; occupancy; available admission capacity; waiting lists; placement acceptance and denial rates; and denial reasons. Identify capacity for people with standalone or primary severe substance use disorder (per WIC 5675.05), medical needs, or significant mobility impairments.

We agreed that data and reporting will be key to clearly identifying gaps and bottlenecks in care. It would likely take a group of knowledgeable people to create a list of well-focused reports to request in this endeavor.

Robert Alm
LPS SC Chair