MHCC Psychiatric Services Clinical Advisory Group Meeting
Discussion Guide for November 6, 2019

I. Purpose of Psychiatric Services Clinical Advisory Group

- Provide clinical expertise that informs refined analyses by Maryland Health Care Commission (MHCC) staff of trends in the demand for acute inpatient psychiatric services and the volume of emergency department (ED) visits.

- Provide a clinical perspective on specific changes to MHCC's regulations suggested by members of MHCC's Psychiatric Services Work Group and issues raised by this Work Group.

II. Evidence of Access Barriers

1. What is your perception of the root of the problem of access to acute psychiatric services? What factors play a role?

2. Is geographic access an issue? What is a reasonable travel time between location of residence and acute psychiatric services? Should reasonable travel be defined differently for some age groups (children, adolescents, adults)?

3. How can access to acute psychiatric services be optimized while still promoting the cost-effective provision of these services for children and adolescents?

III. Defining the Need for Acute Psychiatric Services

1. How should the need for acute psychiatric services be defined for the purpose of statewide planning?

2. Should there be a projection of the need for inpatient psychiatric services that is used, in conjunction with other information, to determine whether a project to expand or establish new inpatient psychiatric services should be approved?

3. Is capturing more precisely the amount of time that patients board in emergency departments needed? The current data available through the Health Services Cost Review Commission (HSCRC) has beginning and end dates for ED visits and hospital admissions, but it does not include arrival or departure time.

4. Is capturing and considering the intensity of staff resources useful, such as the amount of time that one-to-one staffing is needed? (There is a field in the HSCRC discharge abstract data to capture this information, but it is not used by most hospitals.)

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5. Are there other sources of data that MHCC staff should analyze to provide a better understanding of the demand for acute inpatient psychiatric services in Maryland besides HSCRC data and MHCC capacity data?

6. Is there a maximum number of days that should be considered acceptable to board a psychiatric patient in a hospital's emergency department? Is there a maximum volume of boarded psychiatric patients that should be considered unacceptable for a given day/week/month?

7. Do you think that patient or family preferences contribute to excessive boarding times for some psychiatric patients? If yes, how frequently is this an issue? If applicable, how many excess days are spent in an ED on average, for an individual patient, as a result of this?

8. Is there an outcome measure or are there multiple outcome measures that you think would be useful for evaluating whether the need for acute psychiatric services is being met for the population in a given region in Maryland?

9. Should MHCC's regulations specifically promote the development of specialized beds? Does specifically promoting the development of specialized psychiatric beds create practical problems? Is it feasible?