October 17, 2012

To Whom It May Concern:

My name is Paul Rao, and I am a Yale-trained, board-certified psychiatrist who works with children, adolescents, and adults. I presently work as a child psychiatrist for DCF at Solnit Center, North Campus, a Psychiatric Residential Treatment Facility, and as a staff psychiatrist at Clifford Beers Child Guidance Clinic. I have been chief resident of the Yale-New Haven Psychiatric Hospital's adult treatment unit. I am also on the teaching faculty of the Yale School of Medicine in the Departments of Psychiatry and Yale Child Study Center.

The majority of the people I work with suffer from chronic mental illness and extreme psychosocial stressors that perpetuate the illness. Many are underserved in healthcare in general. Those families who do not meet formal federal criteria for poverty could be accurately described as "the working poor." Many of the families I see do have private insurance but face considerable barriers to obtaining appropriate care.

The major barrier to care that I've encountered is this: Insurance companies routinely denying appropriate coverage for inpatient hospitalization.

Countless times have I worked with children and adults who suffered from severe mental illness and had recently made suicide attempts or injured themselves, requiring stabilization in an inpatient setting. After a few days - sometimes as little as 2-3 days, rarely more than week - the insurer denies coverage of further inpatient treatment. Appealing their decisions requires numerous calls up an administrative phone chain whose sole purpose seems to be to deny any rational or even compassionate argument for keeping a high-risk patient in the hospital. I've spoken to administrators - and sorry to say, physicians representing the insurance companies! - who say that if the patient, after 5 days, has not demonstrated self-harm behaviors or voiced suicidal thinking (to be expected, because they are in a contained setting!), they no longer meet criteria for hospital level of care.

Though these patients may indeed not be voicing suicidal thinking or refraining from self-injury, the family work and care coordination that need to be strongly in place prior to discharge are often still in process. And using absence of active self-injury or suicidal thinking as the primary markers for continuing care means discounting other signs or symptoms that signify continued high risk: high levels of anxiety, insomnia, continued presence of lethal means for suicide or self-harm in the home, or continued environmental turmoil.

Discharging patients prematurely leads to an increase in emergency room visits, which in addition to driving up costs, burdens emergency rooms, which in turn transforms them into brief treatment units, something they are not prepared for. Emergency rooms anyway are not appropriate settings for treating those in severe mental pain.

Inpatient stays now serve the purpose of brief stabilization and coordination of care such that all parties involved are unified in their goals - they set the groundwork for the necessary longer-term processes of alliance-building and treatment of the illness itself. Aftercare options such as intensive in-home child and adolescent psychiatric services (IICAPS), partial hospital programs (PHP) or intensive outpatient programs (IOP) are often required following hospitalization and even periodically between times of stabilization. The paucity of full insurance coverage for these essential treatment modalities that prevent re-hospitalization means frequent cycles of emergency room visits and brief inpatient admissions for many with severe and persistent mental illness.

As long as insurers are not held liable for harm that befalls a patient or family due to premature discharge, I see little motivation for insurers to change their ways.

Thank you for reading, and I hope this is useful information.

Sincerely,

Paul Rao, M.D.
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Department of Children and Families