January 28, 2020

To Whom it May Concern:

In regards to the bill regarding obtaining mental health services when needed.

I am a clinician that is licensed in KS, I have worked inpatient for children (PRTF), addiction treatment for adolescents (ACT), community mental health (Family Guidance Center), inpatient at Osawatomie State Hospital, intensive out patient for adults and adolescents (Research Psychiatric) and currently for a for profit hospital (Cottonwood Springs). I typically work on the severe and persistent mental illness units. I have however, had the privilege recently of working intake/assessment providing assessments to patients who are suicidal, psychotic, depressed, anxious or using substances.

I will list barriers to receiving quality care. This is common among all of the facilities that I have worked regardless if they were community mental health, state facilities or for profit. The barriers are the same.

INSURANCE coverage rules the treatment of all patients. This should NEVER be the case. We have the EMTALA Rule which mandates we must admit and "stabilize" any patient that walks through the doors needing treatment. Stabilization equals, denying suicidal and homicidal statements. It does not always include the patient's ability to make sound decisions due to depression, anxiety or psychosis. This does not include the fact that many patients are homeless or returning to unstable abusive living environments. This does not include assuring to the best of our ability that a patient has wrap around services ie. A therapist, psychiatrist, case manager or the proper level of care.

If you have no insurance you cannot be turned away if you are deemed a danger to yourself or others, however, people with no insurance get less days of treatment.

There are many insurance companies that will only authorize 1 to 3 days for stabilization then the treatment team (Psychiatrist, Therapist, Clinical Director and Nurse) have to word our documentation in order to "justify" treatment. Many doctors do not want to take their limited time to call and do a peer review despite knowing the patient is still depressed, psychotic or unable to function. Insurance companies want the patient out before they are stabilized. Our particular "Acute Care Hospital" is fighting for days the minute the patient is admitted.

We as clinicians in my current facility are required to meet with the patient within 24 hours, despite the patient coming off drugs or ETOH, sleeping because they have not slept for days, paranoid and afraid to talk with us or so depressed they cannot get out of bed. We are required to make contact with family for "collateral" information. Often times collateral is difficult to obtain due to fractured families, homelessness, patients have burned all their bridges, the list goes on and on. We are then required to write treatment plans, and have a "safe" discharge plan within the first three days. Most of the time we have not even been able to meet with the patient to talk with them due to the above-mentioned reasons. The doctors are trying to get them on medications. Many patients have been on so many medications they are leery of taking any more or different medications. Some are not able to shower or take care of their basic needs during this short time. We hear from utilization review every morning who has "days", who doesn't have "days", who is self-pay, who's insurance has refused to pay for more time despite justification for more time. Stabilization rarely takes place in 3-5 days. Medications do not even

start to work until about a week in and they often need to be titrated up or changed because they are not effective. Patients are just starting to feel somewhat normal on day 3 and we are already trying to get them discharged because the insurance rules how long they are covered.

In my opinion no clinician or psychiatrist should be made aware of how many days the patient is "approved" for. It creates a pressure and an ethical dilemma, when that patient is NOT stable but we have to fight for more days. The patient may not meet the criteria for inpatient treatment any longer, but they are still psychotic, they are still depressed, their anxiety is not under control and we have to discharge because inpatient criteria is not met.

We see many readmissions which are costing insurance companies more money. Often the patient was not stable, depression was not cleared up, they are still actively paranoid or psychotic. Safe living arrangements were not able to be made due to the short amount of time to find placement. In our state there are not nearly enough step-down facilities to accommodate these patients. So, they discharge for several days, have no money, it's cold and they readmit. Shelters are full and they are limited.

As a clinician I feel every patient would benefit from at least 14 days of treatment, to make sure medications are working effectively, we have had adequate time to talk with and meet with family members to provide support for patients. Often times there is no time to educate family on issues they may experience with a newly released patient. The treatment team should be given adequate time to complete accurate assessments of patients on a daily basis, however, due to the lack of days provided by insurance companies we are admitting and discharging within 5 days. People are dying because of our inability to manage the red tape we are facing daily.

Often insurance dictates the type of follow up care based on the patient's coverage. We offer a two-level step-down process. The patient must be stable to participate in these programs. Often times the only treatment available to patients are community mental health centers. Which are attempting to care for more patients than they can handle, ever changing staff, long wait times, inability due to funding to meet patient needs especially in regards to long term treatment for trauma patients, lack of case managers. Often patients would benefit from a longer time in the treatment process, after stabilization they are more able to engage in the treatment process, groups, therapy, obtaining support and moving slowly back to their living environments with more appropriate skills. Instead, lack of coverage removes this support for many patients which leads to more readmissions, more suicide attempts, more relapse on drugs and ETOH and more exposure to trauma.

An ideal treatment model would look like:

Inpatient stabilization -true stabilization so the patient can actually function in a step-down program.

Partial Hospital Program- a partial day program that offers, psychiatrist, therapist, group, psychoeducation, etc.

Intensive Out Patient Program-a lower level of care that allows the patient the opportunity to go back to work or school on a part-time basis, assistance with obtaining psychiatrists and therapists in the community that are appropriate for the patient, but still provides education and support. These are often hard to find because people don't have insurance or don't have a particular type of coverage. This is one of the first questions asked when trying to set up appointments for patients.

Transitional living- for some patients that had struggled with SPMI and have burned bridges with families. A place to live that provides support, medication management and therapy as well as basic living skills.

Case management-each patient leaving an inpatient stay should have at least a short amount of time (1 month) with a crisis case manager, who can follow up, assist patients in making appointments, getting them to appointments and provide support. Many patients are truly alone and have no one.

We have had depressed patients turned away because they had suicidal thoughts or a suicide attempt a few days prior to trying to get help. They are turned away because when they walk through the door, they appear stable and don't meet inpatient criteria. It doesn't matter that they are afraid they will attempt suicide or they are unable to stay safe if out of the hospital. We do our best to make sure people get treatment, but it they are not actively suicidal at admission their time in treatment is limited. Even when they are not stable. Medications are prescribed and a lower level of care is recommended. If a patient has a conflict (insurance coverage, work, school, children at home that need care) and is not able to do the PHP or IOP program they are left to navigate a system that is difficult to navigate.

Patients have the right to seek care. The decisions for admission, length of care and type of treatment should not be hindered by insurance or lack thereof. The treatment team should be responsible for making the determination for the need of care for the patient. We are the ones who see these patients daily, interact with them, observe them, talk with them, call their families, call their follow up care providers and navigate the system laid out for us which is sorely lacking already, then insurance further hinders our ability to provide the appropriate amount of treatment for individualized care.

Other barriers to treatment are:

Not meeting inpatient criteria

Cost of medications

Ability to get to appointments and to get prescriptions picked up

Out patient providers are not available for multiple weeks to see patients discharging after a crisis

Inadequate housing for homeless patients

Inadequate support in the form of case management for patients

Lack of psychiatrists and APRNs that are willing to work inpatient/outpatient

Lack of competitive pay for clinicians which keeps people out of the field

Exorbitant student loans with no incentive programs for time in the field keeping people from practicing

Leslie D. Thacker, LPC