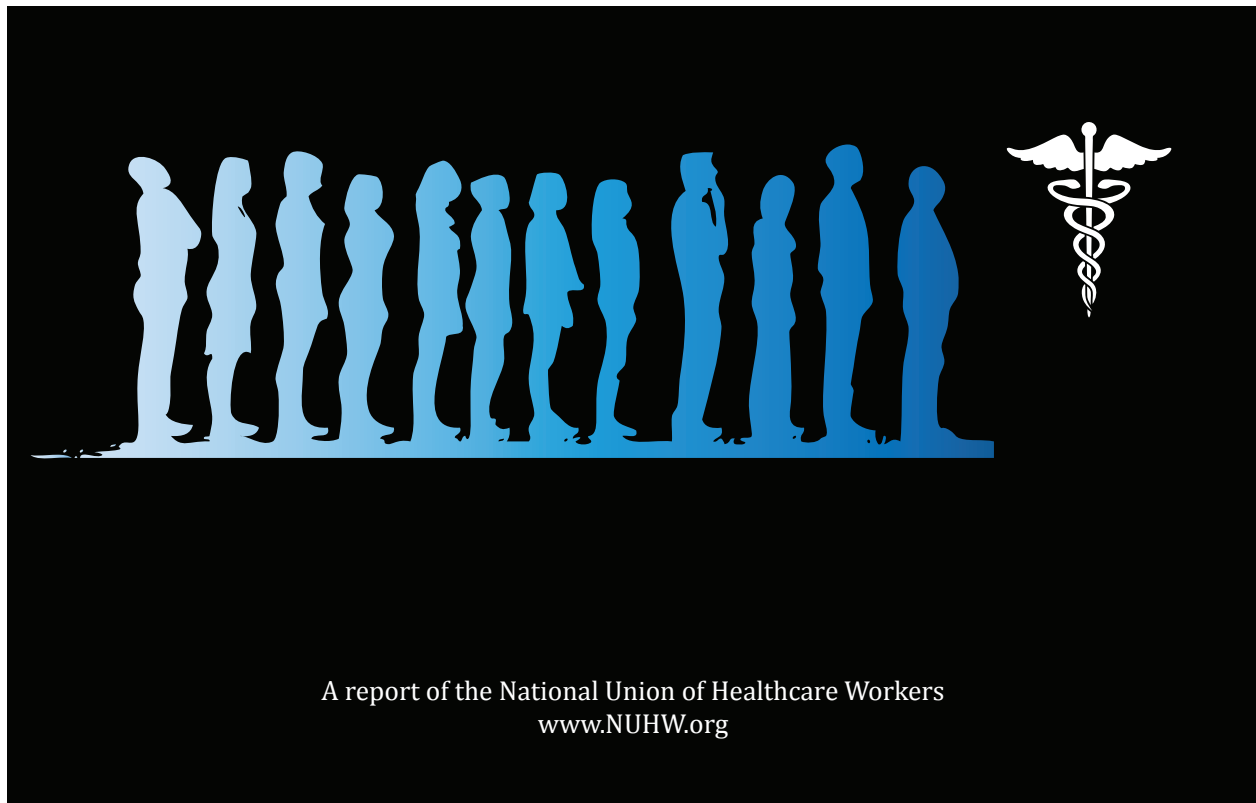


CARE DELAYED, CARE DENIED:

Kaiser Permanente's Failure to Provide
Timely and Appropriate Mental Health Services



A report of the National Union of Healthcare Workers
www.NUHW.org

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Executive Summary

With more than 6.6 million members, Kaiser Permanente is California's largest HMO and plays a massive role in the state's healthcare delivery system by operating more than 35 hospitals and several hundred clinics across the state. Less well known, however, is Kaiser's role in providing mental health services to Californians. Ranking perhaps second only to the State of California, Kaiser is one of the state's largest providers of mental health services. The Oakland-based company guarantees its members a full array of inpatient, outpatient and emergency mental health services provided by several thousand mental health professionals. Each year, thousands of Kaiser's members seek treatment for conditions ranging from autism, anxiety and bi-polar disorder to depression, schizophrenia and suicidal ideation.

Despite Kaiser's pledge to provide comprehensive mental health services to its members, an in-depth analysis suggests that the HMO's mental health services are sorely understaffed and frequently fail to provide timely and appropriate care. Patients often experience lengthy delays in obtaining services, an overreliance on "group therapies," and frustrating obstacles that push many patients to forgo care or seek treatment elsewhere at their own cost.

Drawing on a survey of hundreds of Kaiser's mental health clinicians as well as documentation from regulatory agencies, court filings, patients and frontline caregivers, this study finds that Kaiser frequently fails to comply with California laws aimed at protecting patients' timely access to appropriate services.¹ Furthermore, it finds that Kaiser's failures are systematic and often purposeful. Indeed, the scope and specifics of these failures are sufficiently grave as to merit investigation by state and federal authorities as well as actions

• *"Treatment is "one size fits all" with overemphasis on medications, groups and educational classes in place of effective levels of scientifically-based, best practices care. [Patient] care treatment is too little in frequency, amount and/or duration..."*
 • *-Kaiser Psychologist*

for recovery of funds by public and private payers, including individual Kaiser members. For example, despite receiving more than \$10 billion annually from Medicare to provide a full range of services, including mental health care, Kaiser appears to be miscoding patient evaluation procedures, which may result in fraudulent claims to the Medicare program.

The study's key findings are the following:

- **Kaiser often violates California laws requiring HMOs to provide patients with "timely access" to appropriate mental health services.** Clinicians report that patients frequently endure waits of four weeks or longer for return appointments even though California law mandates a maximum wait time of 10 business days for both initial and return visits unless a licensed health professional has documented that a longer waiting time "will not have a detrimental impact on the health of the enrollee."² Furthermore, many clinicians report that patients' first appointments are often nothing more than group orientation sessions in which initial evaluations do not take place. When such evaluations finally do take place, clinicians report they are often

cursory and insufficient, but nonetheless are coded as if they were thorough and complete. In a survey of 305 Kaiser clinicians, nearly 90 percent of the respondents reported there is insufficient staffing at their clinic to provide patients with timely return visits. More than 75 percent reported that they are either frequently or very frequently “forced to schedule return visits further into the future than you believe is appropriate.”

- **Kaiser reportedly falsifies patient scheduling records in an effort to avoid being cited by state regulators for lengthy appointment delays.** Clinicians report that Kaiser often uses “shadow” scheduling records, deliberately miscategorized appointments, and false appointment cancellations to avoid detection of delays that exceed California’s “timely access” requirements.
- **Kaiser often funnels patients into group therapy even when individual therapy would be more effective.** Kaiser often pressures its clinicians to assign patients to group therapy even when clinicians conclude that individual therapy may be more beneficial. More than 50 percent of Kaiser clinicians report that patients are either frequently or very frequently “assigned to group therapy even though individual therapy may be more appropriate.”
- **Kaiser reportedly performs initial patient evaluations and other mental health services that not only fall short of recommended clinical standards, but are coded incorrectly in possible violation of Kaiser’s contracts with both private and governmental purchasers.** In San Diego, Kaiser has reportedly directed clinicians to spend only half as much time as the clinically recommended minimum for interviewing, assessing and diagnosing patients. This

reported “speed-up” of Kaiser’s assessment procedures can have serious implications. For example, short-cut evaluations lasting only 20 to 30 minutes may result in the misdiagnosis of patients’ conditions. Furthermore, Kaiser appears to be miscoding these procedures in a manner that may result in fraudulent claims to Medicare and other governmental and private purchasers. Interviews with clinicians indicate that Kaiser may be replicating this practice at many sites in California.

- **Kaiser’s current mental health care deficiencies are part of an ongoing pattern of substandard care.** During recent years, government inspectors have cited Kaiser multiple times for failing to provide patients with timely access to mental health services. For example, in 2005 the California Department of Managed Health Care (DMHC) cited Kaiser for failing to provide its patients with timely access to mental health care. In 2010, Kaiser was fined \$75,000 for unreasonably delaying a child’s autism diagnosis for almost 11 months.

In short, Kaiser’s systemic failures recall many of the well-documented abuses of HMOs from an earlier era – one that California believed its revised and expanded regulatory structure had long ago overcome. Kaiser is delivering this substandard care at the same time that the HMO is reporting record profits of \$5.7 billion since 2009.³

The breadth and depth of Kaiser’s failures call for state and federal authorities, as well as private payers, to act with deliberate speed to protect the interests of Kaiser enrollees and ensure they receive the mental health care to which they are entitled, and which they need.

As a first step, the California Department of Managed Health Care (DMHC), which regulates Kaiser’s HMO plans, and the California

Department of Insurance (CDI), which regulates Kaiser’s fee-for-service offerings, should initiate investigations to determine the full extent of Kaiser’s regulatory violations and seek remedies as may be justified for Kaiser’s violation of timely access standards, its failure to provide patients with clinically appropriate care, the insufficiency of its mental health provider network, and its non-compliance with mental health parity requirements, among other potential violations of state statutes and regulations.

As these investigations proceed, other public and private actions that merit consideration include:

- The State Attorney General initiating an investigation to determine whether any of Kaiser’s failures to serve the mental health needs of its patients constitute “unfair business practices” under California Business and Professions Code §17200 or “false advertising” under §17500, and seeking appropriate remedies for any such violations. Additionally, state officials could initiate an investigation by the California Department of Justice’s Medi-Cal Fraud Unit of Kaiser’s potential false claims to Medi-Cal and Healthy Families and the potential breach of its specific contractual obligations or these programs’ general conditions of participation.
- The Office of the Inspector General of the U.S. Department of Health and Human Services initiating an investigation of Kaiser’s apparently false claims to the Medicare program for mental health services provided under the Medicare Advantage program, and its possible violations of its specific contractual obligations or the programs’ general conditions of participation.
- Other public and private payers who purchase health care coverage from Kaiser, most notably large public plans like the Federal Employee Health Benefits Program (FEHB) and the California Public Employees’ Retirement System (CalPERS), pursuing audits of the treatment provided to plan members and seeking appropriate restitution for Kaiser’s failures.
- The California Assembly’s and Senate’s Health Committees scheduling joint subject matter hearings to review the findings raised in this study and deliberate on what additional safeguards might help prevent the development of schemes to violate mental health patients’ rights.

Finally, and most important, Kaiser should:

- Adopt the recommendations of its own mental health providers to increase staffing levels at mental health facilities, limit weekly initial intakes per clinician, and establish a binding system of dispute resolution for staffing problems that is managed by a neutral third party in order to ensure enough capacity to meet state requirements for timely access to appropriate care;
- Cease and desist from the inappropriate management of records, misuse of group therapy, and misrepresentation of orientation sessions and other triage mechanisms to evade its responsibilities to patients with mental health needs; and
- End the practice of 30-minute “intake” evaluations of mental health patients and ensure that patients receive appropriate assessments, properly documented, that conform to the clinical standards set forth by the American Psychological Association (APA) and the American Medical Association (AMA).

About NUHW:

Formed in 2009, the National Union of Healthcare Workers (NUHW) represents 9,000 healthcare workers in hospitals, clinics and long-term care facilities in California and Michigan. NUHW's members include approximately 2,500 mental health clinicians, making it one of the largest unions of such professionals in California. These caregivers play a critical role in ensuring a comprehensive system of health care for California's residents and, together, they represent the occupational categories that make up the majority of the mental health workforce in California.⁴ As these professionals make clear, their desire to help patients drew them into the profession⁵ and their success relies on having sufficient staff and resources to serve their patients. It is in that spirit – of advocating for quality care for our patients – that this report is presented.

Introduction

Each year, approximately 20 percent of the U.S. population experiences a diagnosable mental health condition, according to a study conducted by the U.S. Surgeon General. However, patients often confront multiple barriers that inhibit them from receiving appropriate care. In fact, the Surgeon General's study found that as few as one-third of those with a diagnosable mental health condition actually receive the treatment they need. The implications for patients are often serious, including worsening symptoms, unnecessary hospitalizations, problems at work, and harm to their families as well as themselves. The Surgeon General's report estimated the annual cost to the U.S. economy of untreated mental health conditions at \$79 billion in lost wages, lower productivity and other negative effects.⁶

For decades, California lawmakers and advocacy organizations have sought to ensure timely access to appropriate treatment for patients enrolled in HMOs. Building on principles first introduced by California's landmark Knox-Keene Health Care Service Plan Act of 1975, California legislators approved Assembly Bill 2179 in 2002 and directed the California Department of Managed Health Care (DMHC) to establish clear, enforceable standards to ensure that HMOs provide patients with timely access to care.⁷

Following the enactment of Assembly Bill 2179, the DMHC initiated a multi-year process of stakeholder meetings, research, public input and a review of HMOs' internal guidelines in order to fashion implementing regulations with specific time-standards to ensure that HMOs provide timely access to treatment. The specific regulations, including time-elapsing standards for visits with mental health providers, did not come easy. According to a report authored by Health Access, a nonprofit

organization that was one of AB 2179's sponsors, when the DMHC actually began to write the implementing regulations, the agency encountered "considerable resistance from health plans, doctors, medical groups, and hospitals."⁸

It wasn't until 2010 – eight years after the passage of AB 2179 – that specific regulations regarding timely access were finally approved. For mental health services, the regulations require HMOs to provide appointments for both initial visits and needed follow-up care within 10 business days unless a licensed health professional has documented that a longer waiting time "will not have a detrimental impact on the health of the enrollee."⁹ (See: Table 1) These regulations also require that Kaiser and other HMOs have adequate numbers of doctors and other health care providers in each geographic area to meet the clinical and time-elapsing standards for appointment waiting times. Additionally, the regulations build upon mental health parity legislation that seeks to improve care for those affected by mental health disorders.¹⁰ Specifically, the California Mental Health Parity Act mandates that every health care service plan provide equal coverage for mental health treatment as they do for other physical illnesses and injuries.¹¹ For Kaiser members this is especially salient, as the majority – over 6 million – are covered by mental health parity laws.



Table 1: CALIFORNIA CODE OF REGULATIONS §1300.67.2.2(c)(5)(E)¹²

APPOINTMENT REQUEST	INITIAL	RETURN	TIMELY ACCESS STANDARD
Mental Health Provider	✓		10 business days
Mental Health Provider		✓	10 business days

In late 2010, the DMHC required all HMOs to submit filings demonstrating how they would meet the new standards. In October of that year, Kaiser submitted a 60-page filing to the DMHC containing detailed written policies and procedures that would enable it “to ensure that the requirements of the Timely Access Regulation are consistently met.”¹³ When implementation finally took place on January 17, 2011, the DMHC required HMOs to make sure they “fully implement[ed] the policies, procedures and systems necessary to comply with Rule 1300.67.2.2.”¹⁴

Despite Kaiser’s pledges and its obligations under state law, NUHW’s investigation suggests that Kaiser routinely violates California’s rules for timely access to appropriate mental health services and may be undertaking deliberate efforts to evade accountability to these important requirements.

Methodology

This report presents an analysis of survey results, DMHC records, and interviews with Kaiser clinicians, as well as discussions with Kaiser patients. A review of pertinent literature was also conducted. Literature regarding timely access to care is of particular relevance and is discussed at the end of this section.

Survey Data: In August and September of 2011, NUHW conducted a survey of Kaiser clinicians to assess issues of staffing and patient care at Kaiser facilities providing psychiatric treatment. This 15-item survey was distributed electronically to Kaiser clinicians in California. Responses were received from 305 mental health providers practicing at 57 Kaiser facilities in Northern and Southern California.

Selected measures derived from the survey data included the following; more detailed information regarding the survey results, along with the survey instrument itself, are available in the reference appendices:

- Wait time for appointments. Clinicians were asked to provide the amount of time, in business days, until their next available initial and return appointment. Wait time for third next available initial appointment was also requested.
- Treatment frequency. Clinicians were asked whether they felt routinely forced to schedule appointments further into the future than they believed was appropriate.
- Clinical assessment. Clinicians were asked whether they believed patients were able to receive the appropriate form of therapy and, if not, what outcomes patients experienced as a result.

In addition to this survey, NUHW conducted dozens of interviews with clinicians. In these unstructured conversations, clinicians were asked open-ended questions about their workplace experience with patient access as well as their autonomy to choose appropriate treatment modalities for their patients. Some interviews were guided by “Quality Care Documentation” forms that clinicians used to document problems involving staffing and quality of care. A total of 49 documentation forms were received. Each form listed at least one specific incident or situation directly affecting patient care.

Survey Analysis Procedures: One third of the questions were presented in Likert Scale form. Responses to these questions were sequentially coded from 1 to 5. Binary choice responses in the form of “Yes/No” were coded 2 and 1, respectively. The remaining open-ended questions had no length limitation and responses were reviewed individually.

Communication with Kaiser Patients: Kaiser patients who contacted NUHW were interviewed via telephone regarding their experiences with Kaiser’s mental health services. In these unstructured conversations, patients from Northern and Southern California were asked open-ended questions regarding their experiences. Follow-up communication with patients also occurred by email.

Literature Review: A review of research pertaining to mental health services and access was conducted. This included an analysis of studies that discussed patient outcomes associated with an overreliance on a single treatment modality. According to the Kaiser clinicians surveyed, Kaiser’s treatment approach, with a focus on group therapy,

often leads to substantially higher readmission rates.¹⁵ Journal articles that focused on the ability of HMOs to adequately provide mental health services were also examined. Historically, instances abound of managed care techniques being applied to mental health care with adverse results for quality of care, access and the provider-patient relationship. Although parity legislation now requires that certain mental health conditions receive the same coverage as medical conditions, the literature contains substantial discussion about the traditional treatment model—outpatient service with limited follow-up—and its limited effectiveness.

More information, including the protocol documents used in this report's analysis, are grouped in the appendices.

Findings

NUHW’s investigation yielded five major findings about Kaiser’s mental health services in California.

I. Clinicians report that Kaiser frequently violates California law that requires HMOs to provide patients with timely access to mental health services.

According to Kaiser’s clinicians, patients frequently endure lengthy wait times that are far in excess of California’s requirements. In a survey of 305 clinicians conducted in August and September of 2011, when asked, “In how many business days is your next available initial appointment?,” over 51 percent responded that their next available appointment was in more than 10 business days. When asked about return appointment availability, more than 65 percent stated that their next available return appointment was in more than 10 business days. Additionally, more than 55 percent of the clinicians reported that all of their patients “are routinely required to wait two weeks or more for return appointments.” (See: Chart 1)

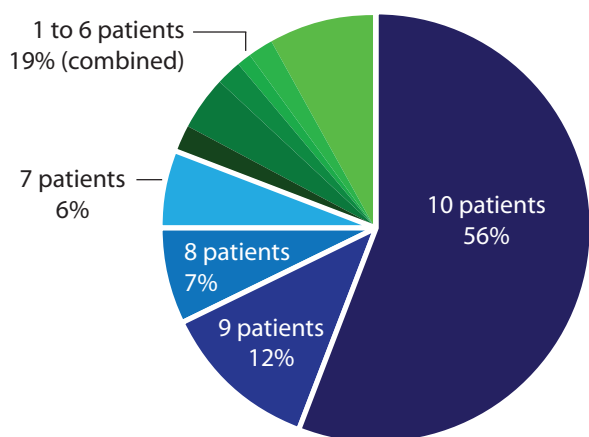


Chart 1: Out of 10 patients, how many are routinely required to wait 2 weeks or more for return appointments?

When asked, “How often are you forced to schedule return visits further into the future than you believe is appropriate?,” more than 75 percent responded either “very frequently” or “frequently.” Only 5 percent responded “very rarely.” (See: Chart 2)

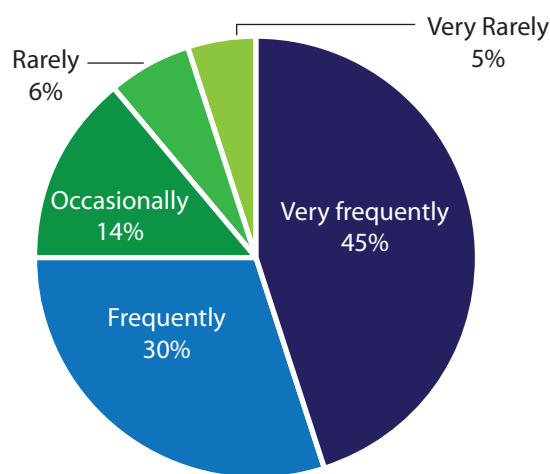


Chart 2: How often are you forced to schedule return appointments further into the future than you believe appropriate?

Furthermore, nearly 85 percent described themselves as either “very dissatisfied” or “dissatisfied” with “your patients’ access to timely mental health appointments.”

The survey responses also indicate the source of patients’ lengthy delays at Kaiser’s mental health facilities: insufficient staffing levels. The vast majority – 90 percent of the respondents – reported that there is insufficient staffing at their clinic to provide patients with timely return visits. (See: Chart 3)

Kaiser’s managers appear to be fully aware of these problems. In an internal email sent on September 9, 2011, Kaiser Adult Service Manager Betty Lynn Moulton acknowledged that at Kaiser’s Oakland facilities, the backlog for psychiatry appointments had reached

28 days. The email, sent to Kaiser’s East Bay administrators, attributed the backlog to three factors: 1) low staffing; 2) increase in demand; and 3) increased patient acuity due to “[t]herapists unable to see severely depressed patients frequently enough to avoid IOP (Intensive Outpatient Program).” The email goes on to outline a plan to address the backlog, with the primary suggestion being to boost the number of intakes performed by already overstretched clinicians.¹⁶

On September 27, 2011, in an internal email, Kaiser Psychiatric Director Marion Lim Yankowitz stated that in San Francisco, “access for new adult appointments continues to be around 21 days.” As a remedy for the appointment buildup, therapists were asked to increase the number of new intakes they performed each month.¹⁷

NUHW’s interviews with clinicians and patients identified additional problems. When patients are scheduled for intake appointments, these appointments can turn out to be nothing more than group orientation sessions designed to introduce new patients to Kaiser’s mental health services. Moreover, when patients are finally evaluated, their assessments are frequently cursory and insufficient, yet are nonetheless coded as if they were thorough and complete.

In July of 2011, one patient described her experience with treatment delays at Kaiser and their subsequent impact on her health:

“I began having horrible chest pains in February of this year. I finally got in to have a stress test done in March which showed everything was fine. But it wasn’t, the chest pains and a variety of other symptoms continued to happen – more frequently. I was petrified and completely debilitated in my life, always riddled with fear of the next “occurrence” hitting. It was absolutely the most horrible experience I’ve had. I FINALLY

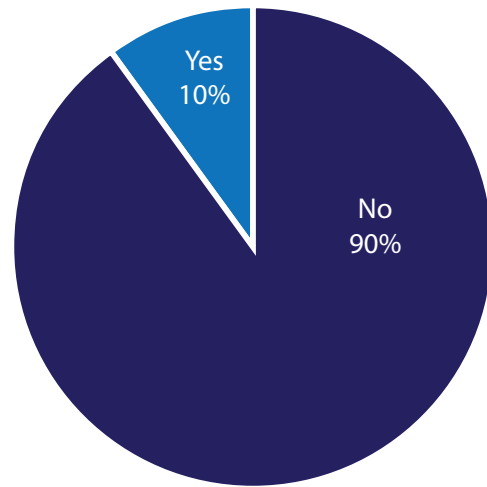


Chart 3: At your clinic is there sufficient staffing to provide patients with timely return visits?

got in to the Kaiser Mental Health group in mid April. I was SO relieved that day – Oh My God, I’m finally going to get help. It was the biggest joke of an appointment I’ve ever had and I left there worse off than I had been, which I didn’t think was possible (basically the lady I met with, who was very nice, just read over the paperwork I had filled out and told me I had to go schedule appointments to see the “real doctors” that could help me).

The appointment to see the “medicine doctor” was scheduled for May 31st. I had to endure 6 additional weeks of this crippling thing I’m learning now is anxiety. Within 2-3 days after seeing the wonderful “medicine doctor”, I started to think I could become human again. The right meds, the right advice and path to walk down, a very empathetic and understanding soul who spent 30 minutes with me saved me. TO realize that I went through MONTHS of agony due to crowded schedules and doctors that are stretched too thin makes me nothing short of disgusted. My husband works for the State of California. We PAY for our healthcare. Yet I was unnecessarily TORTURED for months because I couldn’t get an appointment any earlier. I cannot stress to you enough how horrifying panic attacks are. For them not to be treated in a category of “emergency”

is cruel. But I know it's not the fault of the CSR [Customer Service Representative] who answers the phone to book the appointment. I know it's not the fault of the doctor I FINALLY got hooked up with and help from. It's the fault of people in a position to (sic) high up for me to reach..."

First-time patients are not the only ones reporting lengthy treatment delays. In fact, wait times are reportedly even longer for patients seeking follow-up visits with clinicians.

In September of 2011, another individual recounted his Kaiser experience while caring for his mother:

"My mom is in her 70s and has Parkinson's Disease, chronic depression and severe anxiety disorder. I was incredulous when we were informed that after the doctor who was treating my mother resigned, we would be transferred to another facility much further away and put on a 3-4 month waiting list for an appointment to see a Kaiser psychiatrist.

At present there appears to be NO Kaiser psychiatrist for seniors with psychological needs in all of Ventura County. What little help we have received has been inconsistent and farmed out by Kaiser to sub-contractors who have NO access to patient medical records and therefore no knowledge of whatever medications the patient is currently taking. When I brought up this issue to the Thousand Oaks Geriatrics department I was told by the attending nurse and social worker that they agreed the Psychiatric Department was understaffed but there was nothing they could do and suggested that I contact membership services.

Thus far I feel the response to my mother's psychiatric needs has bordered on negligence and is a disservice to the elderly patients who have signed over their Medicare benefits to Kaiser and are entrusted to their care."

- *"WE are overbooked. I personally use*
- *my 'OD' slots—which are designed to be*
- *available times to attend to crises in the*
- *clinic—to see my return patients, especially*
- *if they have relapsed, or otherwise are in*
- *crisis."*

-Kaiser MFT

According to NUHW's 2011 survey, clinicians' schedules are typically so overbooked with appointments and group therapies that they are unavailable to meet with patients within the 10-day standard. For example, survey results indicate that the average wait time for clinicians' next available return appointment is 13 business days, which exceeds DMHC's 10-day standard. For clinicians in Kaiser's psychiatry departments, the average wait time for return patients is even longer: 17 business days.

At a Kaiser facility in Northern California, one clinician tracked weekly access statistics from February 2011 to August 2011. These figures indicate that, at any given point, the list of new patients for whom the clinic was simply unable to schedule intake appointments contained as many as 45 patients. In order to meet this demand, clinicians at this facility have taken to conducting "intake fairs."

- *"When I was out ill...no one took*
- *over managing my caseload to see*
- *all my individual patients or run my*
- *groups. Only patients who called in and*
- *complained of suicidal thinking or severe*
- *emotional distress were seen by another*
- *therapist, usually only once during the 4*
- *months, but a few were seen twice..."*

-Kaiser LCSW

In July of 2011, a patient's spouse described her family's experience this way:

"...My husband has been a patient of Kaiser Psychiatry for about 7 years now and this fiasco was going on even back then. He is seen by Dr. [NAME WITHHELD] and is on 2-3 anti-depressant medications and when changes had been made with his meds and side effects occurred, we had to battle to get him in to be evaluated. I mean, seriously? This isn't an illness or condition that can be delayed if something is going on, and their usual suggestion is, if it's urgent go to the ER..."

The lengthy waits endured by many of Kaiser's patients are well known to the HMO. Even Kaiser's own in-house medical journal, "The Permanente Journal," has documented this problem. A 2007 article written by a Kaiser psychiatrist noted that:

"...longer intervals between visits have become increasingly common. A recent random search for "next available" return appointments in KP Orange County showed that waits of three to four months were common; access reports from other psychiatric departments at KP in Southern California have shown this as well."¹⁸

NUHW's investigation, conducted during the summer of 2011, indicates that Kaiser's lengthy wait times have persisted since the implementation of California's new "timely access" rules in January of 2011. In September of 2011, a review of clinicians' "next available" return appointments revealed the average wait time for patients to be 17 business days.

According to a behavioral health education clinician at Kaiser's Euclid Medical Offices, many of her colleagues "force book" return appointments into unpaid meal periods or time designated for updating patients' charts because the wait time for an initial child or teen intake is often 4 to 6 weeks.¹⁹ At Kaiser South Bay (Harbor City), a clinician reports that patients

must wait up to four months to see a therapist.

With return appointments for Kaiser patients difficult to obtain, the overall length of treatment provided to a given patient is often curtailed. Moreover, Kaiser often encourages clinicians to understate the number of appointments needed by patients. At Kaiser Oakland, patients are given an informational sheet which states that "many people improve in a single visit." Such handouts conceal crucial information and prevent patients from making informed decisions about their treatment. Claiming that a single visit leads to improved outcomes for

- *"Having a fixed amount of new*
- *appointments pouring in each week - unless*
- *you are able to discharge the same number,*
- *your caseload just keeps growing and*
- *growing.... If you take any time off, this*
- *pushes back the time a patient can be seen.*
- *I know providers who feel too guilty to take*
- *more than 1 week off at a time, because of*
- *the effect on their caseload."*

-Kaiser MFT

"many people" is at odds with what research shows to be effective for patients' well-being. In 2002, researchers conducted a meta-analysis regarding the amount of therapy needed for patients to improve and found "a general consensus that between 13 and 18 sessions of [individual] therapy are required for 50% of patients to improve."²⁰

According to clinicians, Kaiser's lengthy wait times are principally caused by inadequate staffing levels at Kaiser's clinics. In addition, Kaiser requires clinicians to meet weekly quotas that further limit their ability to provide follow-up visits to patients. According to caregivers, Kaiser typically requires each clinician to perform six to nine intake evaluations per week for first-time patients in addition to

conducting several group therapy sessions. With multiple intake evaluations, group therapy and other clinical responsibilities, mental health professionals are left with limited room to schedule return appointments for their patients.²¹

Kaiser's quota system has long been known publicly. Dr. Gordon Herz reported that Kaiser's intake quotas were the main issue behind a strike conducted by Kaiser's Colorado clinicians in 1998. Herz wrote:

"The Kaiser therapists were not advocating for their own salaries (which had seen no increases in three years) or benefits. They were advocating for ethical care, and against what they perceived to be sub-standard care and serious under treatment of Kaiser mental health patients..."

Data the therapists collected showed that Kaiser members were waiting 2-3 weeks for an initial appointment and 2-6 weeks for return visits. The average wait time for an initial psychiatric medication consultation was 21 days. The therapists had been required to perform 10 initial evaluations per week (up from 4). Consequently, patients were being seen for three visits, at which time there would be room only for new patients on therapists' schedules."²²

At the time of the strike, the American Psychological Association – the organization that sets clinical and professional standards for mental health providers – delivered a letter to Kaiser expressing its concern over treatment delays. A letter authored by Russ Newman, PhD, JD, who then served as the APA's Executive Director for Professional Practice, stated: "APA has serious concerns with any intake procedures that may delay access to treatment and disrupt continuity of services for patients in need of behavioral health-care services."²³

In 2004, Dr. Russell Holstein investigated Kaiser's mental health services and found

similar concerns regarding a system of quotas for intake appointments. Dr. Holstein's study, which he says was "sabotaged" when Kaiser's administrators blocked his access to information, found that Northern California clinicians were required to perform seven intake evaluations per week.

"Kaiser comes off exceptionally badly, even as compared to other managed care plans, in the way they overburden the treating clinicians with new cases. The requirement that therapists have to handle seven or more new intakes per week makes weekly psychotherapy, other than group, a virtual impossibility."²⁴

The effects of untimely care on patients' health is well known. For example, the Agency for Healthcare Research and Quality has linked timely access to significant improvement in morbidity, mortality and cost savings. Furthermore, the legislative sponsors of Assembly Bill 2179 noted that untimely access may be a harbinger of more systemic problems affecting HMOs, such as insufficient resources devoted to providing care.

- *"The requirement to see more patients*
- *than one can adequately treat, thereby*
- *filling a clinician's schedule restricts*
- *the length and frequency of individual*
- *treatment.... At our clinic we are*
- *expected to have 8 new patient slots*
- *available every week in a 40 hour a*
- *week (FTE) schedule. Or 7 new slots if a*
- *clinician runs two weekly group therapy*
- *sessions (2 hours each).... AND, really,*
- *a new slot takes more than an hour on*
- *most occasions -- paperwork to read,*
- *the patient's chart to read, the intake*
- *questions are extensive."*

-Kaiser Psychologist

II. Kaiser reportedly falsifies patient scheduling records in an effort to avoid being cited by regulators for lengthy appointment delays.

Clinicians report that many of Kaiser’s clinics employ techniques to deliberately conceal appointment delays that violate California’s “timely access” requirements.

“Individual treatment is (theoretically) reserved for patients with a diagnosis that meets criteria for mental health parity (e.g., Major Depression, Anxiety Disorder). In reality, only the highest risk (Intensive Outpatient Program) patients (active suicidal ideation, psychotic, risk of psychiatric hospitalization) have access to weekly individual sessions during the time they are designated as “IOP [Intensive Outpatient Program] level”. No other patients in this clinic ever have access to individual treatment....”

-Kaiser LCSW

For example, some clinicians report that Kaiser uses a “shadow” system of paper records to hide lengthy appointment delays from regulators. Ordinarily, patients’ appointments are recorded in Kaiser’s system of electronic medical records. However, clinicians report that some Kaiser clinics use temporary paper records, later discarded, to schedule appointments with lengthy wait times that breach California’s timely access standards.

Another technique involves deliberately miscategorizing patients’ requests for treatment. For example, if a patient requests an individual intake appointment for a mental health condition, Kaiser may describe it inaccurately as a request for a group orientation. When the patient arrives on the appointed day, Kaiser places a new entry in the patient’s medical

record indicating a request for an individual appointment. This system thus allows Kaiser to delay the start of the 10-day timeline.

Still another technique reportedly involves the misuse of appointment cancellations. If Kaiser schedules a patient’s appointment within the prescribed timeline, Kaiser may later cancel and reschedule the patient’s appointment for a later date while falsely attributing the cancellation to the patient. Thus, Kaiser’s records give the appearance that delays were caused by patients rather than Kaiser.

III. Kaiser often funnels patients into group therapy even when individual therapy would be more effective.

Clinicians report that Kaiser often places patients in group therapy sessions rather than providing them with more clinically appropriate and effective individual therapy. Group therapy consists of sessions, ranging from 1 to 2 hours in duration, that are sometimes delivered by one clinician for as many as 20 patients. Many clinicians report that the pressurized circumstances of their oversubscribed and understaffed clinics essentially force them to place patients in group sessions as the only available option to attend to their needs.

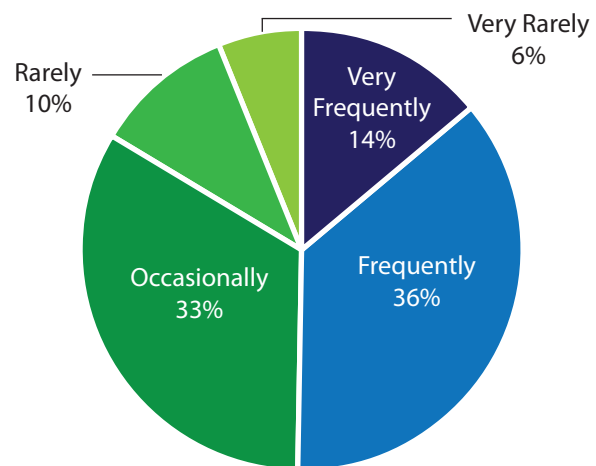


Chart 4: How frequently are patients assigned to group therapy even though individual therapy may be more appropriate?

In 2011, the American Psychological Association’s (APA) Division of Psychotherapy and Division of Clinical Psychology jointly sponsored a task force to identify and disseminate what works in the therapy relationship. Among the recommendations was the following:

“Practitioners are encouraged to adapt or tailor psychotherapy to those specific patient characteristics in ways found to be demonstrably and probably effective.”²⁵

Unfortunately, by prioritizing group therapy as the primary treatment modality, Kaiser severely limits the ability of its mental health providers to “adapt and tailor” therapy to meet the needs of their patients. The task force also identified certain ineffective qualities of therapy:

“By inflexibility [sic] and excessively structuring treatment, the therapist risks emphatic [sic] failures and inattentiveness to clients’ experiences... Dogmatic reliance on particular relational therapy or therapy methods, incompatible with the client, imperils treatment.”

As this recommendation makes clear, reliance on a single treatment modality such as group therapy may not be compatible with patients’ needs. Worse yet, a “one size fits all” approach may ultimately jeopardize treatment.²⁶

According to NUHW’s survey of clinicians, Kaiser’s reliance on group therapy is widespread. More than 50 percent of clinicians report that patients are “frequently” or “very frequently” “assigned to group therapy even though individual therapy may be more appropriate.” (See: Chart 4, prior page)

Many clinicians report that their clinical judgment is significantly curtailed by Kaiser’s unwritten policies. Forty percent of respondents indicate that they “disagree” or “strongly disagree” with the following statement: “I feel supported to choose the treatment modalities

that I want for my patients.” (See: Chart 5)

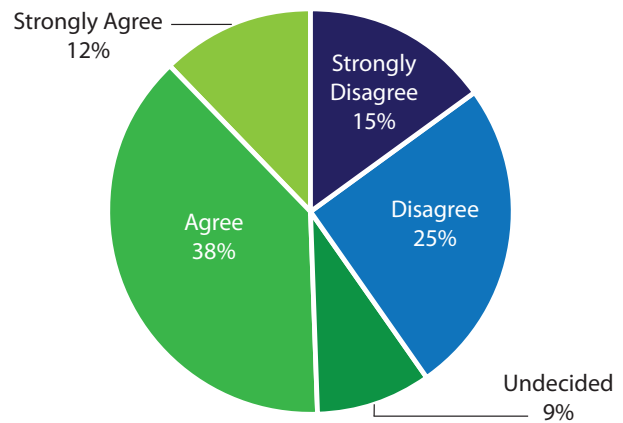


Chart 5: I feel supported to choose the treatment modalities that I want for my patients.

These sentiments reflect Kaiser’s 2009 People Pulse findings for the Oakland psychiatric clinic. In that Kaiser-conducted survey, the majority of employees disagreed with the statement that at Kaiser there are “usually enough people in the department to do the job right.” Additionally, only 23 percent of employees agreed that they “can influence decisions affecting work.” In 2010, Kaiser’s People Pulse survey indicated that only 31 percent of Kaiser’s Oakland psychiatric employees felt “satisfaction with KP [Kaiser] as a place to work.”²⁷

Finally, a super-majority of surveyed clinicians report that individual therapy is simply unavailable to patients. More than 86 percent of respondents indicate that they “disagree” or “strongly disagree” with the following statement: “Weekly individual psychotherapy sessions are available to those who need it.” (See: Chart 6)

In 2011, Kaiser psychiatry offices in Orange County introduced a “Model of Care” initiative – different than the Southern California regional effort of the same name. This initiative stressed the importance of promoting group programs. In fact, clinicians even were “reassured” by the local Director of Behavioral Health that with the new changes “patients will have been started in group programs before they even see you for a visit.”²⁸

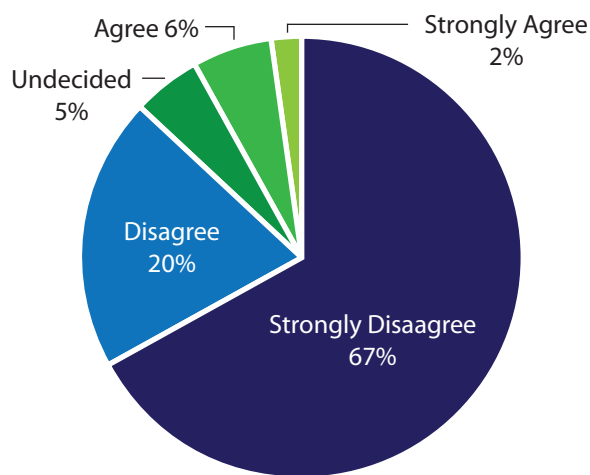


Chart 6: Weekly individual psychotherapy sessions are available to those who need it.

Some clinicians report that Kaiser's overreliance on group therapy borders on the highly irresponsible. For example, clinicians at multiple Northern California clinics report that patients with suicidal ideation and moderate to severe depression are routinely tracked into group therapy and receive only infrequent individual therapy sessions.

In his 2004 investigation of Kaiser's mental health services, Dr. Holstein describes reports of widespread use of group psychotherapy. For example, he reports that "...at a Northern California facility, it was mentioned that the ubiquitous use of group psychotherapy compensated for limited access to individualized treatment."²⁹ Dr. Holstein states:

"The problem with Kaiser's emphasis on group psychotherapy is that there is little evidence that group psychotherapy fits most patients with some evidence clearly against such a primary modality. My experience and the experience of others is that many clients will forgo treatment rather than attend group psychotherapy... At Kaiser, group psychotherapy is the way to pretend that patients are not kept on a waiting list. In sum, at Kaiser, mental health problems are, in my opinion, frequently under-treated, and

I have concluded that attempts at member satisfaction are substituted for appropriate mental health treatment."

Today, many clinicians report that Kaiser's treatment model has shifted towards almost exclusive reliance upon group therapy.

IV. Kaiser reportedly performs initial patient evaluations and other mental health services that not only fall short of recommended clinical standards, but are coded incorrectly in possible violation of Kaiser's contracts with both private and governmental purchasers.

Like for other mental health providers, an essential part of Kaiser's services is to conduct careful initial evaluations of its patients in order to accurately diagnose their conditions and develop effective treatment plans. Kaiser's clinicians – including its licensed psychologists, clinical social workers and marriage and family therapists – are the main front-line caregivers responsible for these assessments. In conducting these evaluations, the caregivers are guided by standards of care, which are the clinical standards established by state licensing boards and independent professional associations that are relatively shielded from the corrupting profit motives of HMOs and hospital companies.

In the case of initial psychiatric evaluations, the American Psychological Association's legislative and judicial advocacy division, the Practice Directorate, worked to develop the psychosocial Current Procedural Technology (CPT) codes, later approved by the American Medical Association.³⁰ According to the APA, these evaluations are comprehensive and usually time intensive. Academic guidelines state that such evaluations should take at least one hour and, according to the APA, these evaluations should be a service in which the clinician "elicits a history (from the patient and/or his family), performs a mental status examination, establishes a tentative diagnosis

of the patient, and evaluates disposition.”³¹

Additionally, the Medicare program – because of its position as the nation’s largest purchaser of healthcare services – performs a key role in defining the standards governing these evaluations, which it has labeled as “Psychiatric Diagnostic Interview Examinations.” Medicare not only describes the procedures that CPT Code 90801 should entail (developed by the APA’s Practice Directorate and recognized by the American Medical Association’s CPT Committee), it also states that documentation is needed of certain examination elements including:

- Identification of a chief complaint
- History of present illness
- Past medical history
- Past psychiatric history
- Family and social history
- Complete mental status examination
- Diagnosis
- Ordering and medical interpretation of laboratory or other diagnostic studies
- Treatment plan and disposition

Despite the clear guidelines governing these critically important evaluations, clinicians report that Kaiser often directs them to conduct evaluations of only 20 or 30 minutes that fall far short of the standards set out by both their professional associations and Medicare. These shortened evaluations are then often coded for billing purposes as “CPT Code 90801,” for which evaluations of at least one hour are the recommended clinical standard. Indeed, it appears that, in multiple regions of California, Kaiser’s system of intake for patients complaining of mental health problems often employs such substandard and miscoded

evaluations.

Some clinicians report that managers often utilize 30-minute assessments in conjunction with so-called “screening clinics” or “assessment fairs.” During these “fairs” or “clinics,” clinicians are required to conduct a succession of “intake” appointments scheduled in back-to-back, thirty-minute time slots over a period of several hours. These pre-scheduled, back-to-back appointments force clinicians to complete each visit in less than 30 minutes so that they can attend to the next patient, who is sitting in a nearby waiting room. During these “short-cut” assessments, Kaiser officials have reportedly instructed clinicians to quickly identify a patient’s primary condition and, in the words of one therapist, to “sell the patient” on one of Kaiser’s many classes or group therapy options. According to clinicians, these shortened assessments typically short-change key elements of an evaluation, such as thoroughly investigating each patient’s family and social history. Furthermore, they reportedly rely heavily on written questionnaires completed by patients as a substitute for more careful direct evaluation by a clinician. Such “short-cut” assessments appear to fall clearly outside the standard of care and may violate professional codes of ethics.

Clinicians report that shortened assessments may produce misdiagnoses of patients’ conditions. According to one clinician, encounters with misdiagnosed patients are not out of the ordinary. In one case, this same clinician reported treating a patient who initially had been diagnosed as suffering from depression, yet after a subsequent and more careful evaluation was determined to be suffering from an anxiety disorder. Such misdiagnoses can have serious implications for patients. For example, they may cause inadequate follow-up treatment and play a role in failures to prescribe appropriate medication. Aside from these obvious impacts on patients’ health, the substandard evaluations may result

in defrauding Medicare and other governmental and private purchasers. In the case of Kaiser's pre-paid Medicare Advantage plans, which account for the vast majority of its Medicare patients, its potential fraud consists of (1) not providing the care that Kaiser has been paid to provide and (2) benefiting from unjustified risk adjustments, as well as potentially increasing the cost basis against which its Medicare Advantage rates are benchmarked in the future. Presumably, to the extent non-Medicare patients are exposed to these same practices, their plans, too, potentially are being defrauded in similar if not identical ways.

In sum, Kaiser's alleged intake practices appear to provide substandard services for patients and may constitute a failure to deliver the quantity and quality of services promised in its contracts. In the case of public programs, Kaiser's apparent false claims might also constitute a violation of their conditions of participation.

V. Kaiser's current mental health care deficiencies are part of an ongoing pattern of substandard care.

Reports of Kaiser's substandard mental health care are not a new phenomenon. In 2005, the Department of Managed Health Care conducted a "focused survey" of Kaiser's mental health services to determine whether it was in compliance with the Knox-Keene Health Care Service Plan Act of 1975. The Act requires HMOs to "provide enrollees timely access and ready referral to mental health services, in a manner consistent with a good professional practice, for the purpose of diagnosis and medically necessary treatment."³² In 2005, investigators issued a 56-page report entitled "Mental Health Parity Focused Survey: Kaiser Foundation Health Plan" that contained the results of its investigation. The report cited Kaiser for multiple deficiencies,³³ including the following:

- In Northern California, the DMHC found

that Kaiser "does not ensure that enrollees have timely access and ready referral to routine mental health services appointments for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code Section 1374.72." According to the DMHC, Kaiser had established "an internal performance standard requiring that at least 90 percent of its routine appointments be seen within two weeks." However, a review of initial visits showed that Kaiser's compliance rate was 61 percent, with some facilities as low as 29 percent. For return visits, the overall compliance rate was even lower, coming in at 47 percent.³⁴

- Kaiser was found to have "incorrectly and inappropriately denied payment for emergency claims" when Kaiser members received emergency treatment for mental health conditions at non-Kaiser hospitals. In some cases Kaiser denied payment even though the patients were diagnosed as requiring emergency "5150" or "5855" treatment. According to the DMHC, such a denial of payment "creates a barrier to future services [by the patient] based on previously denied payments."

In 2009, the DMHC again cited Kaiser for "timely access" deficiencies following a "routine medical survey" to analyze the HMO's compliance with the Knox-Keene Act. The deficiencies, documented in a DMHC report entitled "Routine Medical Survey of Kaiser Foundation Health Plan," consisted of the following:³⁵

- In Northern California, investigators determined that Kaiser's "referral system does not provide patients, suspected of having a diagnosis of autism, timely access and ready referral, in a manner consistent with good professional practice, for the purpose of diagnosis and medically necessary

treatment.” Investigators discovered “a backlog and lengthy appointment wait times for families seeking an evaluation for autism.” Specifically, the DMHC found that, “Current wait times for patient evaluations at Northern California centers were from six to seven months. Wait times over the past several years have fluctuated from four to seven months.” In addition, Kaiser’s internal records “...referenced 405 members who had been referred to an evaluation center, but had not been scheduled for an appointment.”

- In Southern California, investigators determined that Kaiser “neither performs sufficient monitoring nor ensures medical information is readily exchanged between mental health and medical providers.” According to the DMHC, “...when information is not exchanged between mental health providers and medical providers in a timely fashion, the enrollee risks not receiving timely access and ready referral to mental health services.”

In 2010, the DMHC fined Kaiser \$75,000 for unreasonably delaying a child’s autism diagnosis for almost 11 months.³⁶ The episode began when the child’s father expressed concern about his son’s developmental delays during a visit with a Kaiser physician. According to the DMHC:

“At the time, the Member was 13-months old – an age at which experts agree that autism screening and evaluation are appropriate and can result in an early diagnosis. Therefore, the type of concerns raised by the Member’s father should have been red flags prompting an autism evaluation due to the critical nature and effectiveness of early intervention.”

Yet when the child’s father repeatedly asked for an evaluation, Kaiser deferred and delayed a formal screening. Eventually, “almost 11 months after his father first expressed concerns

about developmental delays,” Kaiser finally diagnosed his child with autism and prepared a treatment plan.

Despite the diagnosis, the father’s difficulties continued. Kaiser failed to provide a treatment plan in which the frequency and duration of services was appropriate, according to the father. The father then filed a grievance with Kaiser, which was dismissed by Kaiser one month later. The father then appealed the grievance to an outside physician, who performed an independent medical review and overturned Kaiser’s denial.

Subsequently, in June of 2010, the DMHC ruled that “Kaiser and SCPMG’s conduct resulted in an unreasonable delay for a formal autism evaluation in violation of Health and Safety Code, sections 1369(d), 1367(e)(1), 1374.72, and California Code of Regulations, title 28, section 1300.74.72(f).” In addition, the agency determined that “Kaiser failed to ensure that services were timely provided or to monitor the follow up of the Member’s care,” among other violations. The agency fined Kaiser \$75,000.

Lawsuits allege similar kinds of systematic problems with Kaiser’s mental health services. In October of 2010, one of Kaiser’s top physicians sued the HMO in Los Angeles Superior Court alleging that Kaiser wrongfully terminated him after he raised concerns about Kaiser’s efforts to withhold care from thousands of patients with physical disabilities and mental health conditions.³⁷ The physician, Dr. Richard Della Penna, served as Kaiser’s national clinical lead charged with developing a model of care for 57,000 Kaiser members enrolled in Special Needs Plans (SNP). SNP, a program funded by Medicare and Medicaid, requires Kaiser to create individualized treatment plans for SNP patients. The treatment plans are developed by an interdisciplinary team comprised of a behavioral health specialist, social worker and physician. In the lawsuit, the physician alleges that Kaiser’s California executives...

“...expressed that they would not invest in meeting the requirements of developing a healthcare plan for each SNP member. They decided to only concentrate on the 5% of the SNP members that were the costliest. Dr. Della Penna objected to this and complained that Kaiser was not compliant with the law. Moreover, they were not providing the appropriate care to a vulnerable population by failing to comply with these laws.”

The lawsuit alleges that, due to Dr. Della Penna’s patient advocacy, Kaiser retaliated against him, harassed him and ultimately “constructively terminated” him from his job. Among other claims, the lawsuit alleges that Kaiser has “a pattern and practice of retaliating against physicians who advocate on behalf of their patients...” and “who refuse to engage in illegal conduct.” Just four months after the lawsuit was filed, the case was apparently settled out of court, according to court records. Terms of the settlement are unknown.

To date, despite repeated concerns by clinicians, including a letter sent in 2010 by IBHS stewards on behalf of Kaiser’s Northern California psychologists, MFTs and LCSWs, unilateral decisions continue to be made, affecting clinical and operational practices and impacting the efficacy of treatment that can be provided.³⁸

In summary, NUHW’s investigation has identified widespread reports of Kaiser’s understaffing of its mental health services, which contributes to lengthy appointment delays for patients and an overreliance on group therapy rather than individualized treatment. According to patients and clinicians, Kaiser’s system of substandard treatment can cause harmful consequences for patients. Furthermore, clinicians and patients report that Kaiser’s substandard care often causes frustrated patients to simply cease seeking mental health services from Kaiser, leaving them to cope with mental health conditions on their own or resort to paying out of their own pockets for mental health services provided by non-Kaiser providers.

“The therapeutic relationship basis for developing and sustaining trust, continuity and time for sufficient exploration and treatment implementation simply does not exist. As a consequence patients break-off treatment, seek non-Kaiser treatment using their own money or most frequently go without treatment that would have helped them....”

-Kaiser Psychologist



Recommendations

The breadth and depth of Kaiser's failures call for state and federal authorities to act with all deliberate speed to protect the interests of Kaiser enrollees and ensure they receive the mental health care to which they are entitled, and which they need. Specifically, NUHW offers the following recommendations:

I. California Department of Managed Health Care and California Department of Insurance:

The California Department of Managed Health Care, which regulates Kaiser's HMO plans, and the California Department of Insurance, which regulates Kaiser's fee-for-service offerings, should initiate immediate investigations to determine the full extent of Kaiser's regulatory violations. The agencies should seek remedies for Kaiser's violation of timely access standards, its failure to provide patients with clinically appropriate care, the insufficiency of its mental health provider network, and its non-compliance with mental health parity requirements, among other potential violations of state statutes and regulations.

II. California Attorney General: The Attorney General should initiate an investigation to determine whether any of Kaiser's failures to serve the mental health needs of its patients constitute "unfair business practices" under California Business and Professions Code §17200 or "false advertising" under §17500, and seek appropriate remedies for any such violations, as well as initiating an investigation by the California Department of Justice Medical Fraud Unit of Kaiser's potential false claims to Medi-Cal and Healthy Families, and its potential breach of its specific contractual obligations or these programs' general conditions of participation.

III. U.S. Department of Health and Human Services: The Office of the Inspector General of the U.S. Department of Health and Human

Services should initiate an investigation of Kaiser's apparently false claims to the Medicare program for mental health treatment provided to patients under the Medicare Advantage program, and its possible violations of its specific contractual obligations or the programs' general conditions of participation.

IV. Public and Private Purchasers: Other public and private payers who purchase health care coverage from Kaiser, most notably large public plans like the Federal Employee Health Benefits Program (FEHB) and the California Public Employees Retirement System (CalPERS), should pursue audits of the treatment provided to plan members with mental health needs and seek appropriate restitution for Kaiser's failures.

V. California Legislators: California's Assembly and Senate Health Committees should schedule joint subject matter hearings to review the findings raised in this study and deliberate on what additional safeguards might help prevent the development of future schemes to violate mental health patients' rights.

VI. Kaiser Permanente: Finally, Kaiser should undertake the following actions:

- Adopt the recommendations of its own mental health providers to increase staffing levels at mental health facilities, limit weekly initial intakes per clinician, and establish a binding system of dispute resolution for staffing problems that is managed by a neutral third party in order to ensure enough capacity to meet state requirements for timely access to appropriate care;
- Cease and desist from the inappropriate management of records, misuse of group therapy, and misrepresentation of orientation sessions and other triage mechanisms to

evade its responsibilities to patients with mental health needs; and

- End the practice of 30-minute “intake” evaluations of mental health patients and ensure that patients receive appropriate assessments, properly documented, that conform to the clinical standards set forth by the American Psychological Association (APA) and the American Medical Association (AMA).

Endnotes

- 1 Throughout this report, “clinician” is the term used to identify licensed mental health professionals of various designations. These clinicians include psychologists (PhDs, PsyDs, and EdDs), marriage and family therapists (MFTs), licensed clinical social workers (LCSWs) and psychiatric social workers.
- 2 California Code of Regulations. Title 28. §1300.67.2.2(c)(5)(G).
- 3 The figure for Kaiser’s “profit” or “net income” was obtained from audited financial statements and press releases issued by Kaiser Foundation Health Plan & Hospitals.
- 4 McRee, T., Dower C., Briggance B., Vance J., Keane D., & O’Neil E. H. (2003). *The Mental Health Workforce: Who’s Meeting California’s Needs?* California Workforce Initiative. California: Center for Health Professions, University of California, San Francisco.
- 5 Blankertz, L.E., & Robinson, S. E. (1997). Turnover Intentions of Community Mental Health Workers in Psychosocial Rehabilitation Services. *Community Mental Health Journal*, 33, 243-257.
- 6 U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville MD: DHHS.
- 7 AB 2179, Chapter 797, Cohn, R. (2002).
- 8 Abbott, E. (2009). About Time: The Story on Winning Timely Access to Health Care. *Health Access*.
- 9 California Code of Regulations. Title 28. §1300.67.2.2(c)(5)(G). For purposes of the regulation, the DMHC defines “appointment” to mean both an initial appointment and a return or “follow-up” appointment. (Personal communication with DMHC)
- 10 California Code of Regulations. Title 28. §1300.67.2.2(c)(5).
- 11 California Health & Safety Code, §1374.72 & California Insurance Code, §10144.5.
- 12 §1300.67.2.2(c)(5)(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H). §1300.67.2.2(c)(5)(G) states that the applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee. §1300.67.2.2(c)(5)(H) states that preventative care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider.
- 13 Kaiser Foundation Health Plan, Inc. (2010). Northern and Southern California Regions, *DMHC Filing - Compliance with Timely Access Regulation*, pp. 6-7.
- 14 California Code of Regulations. Title 28. §1300.67.2.2.
- 15 Stiles, W.B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in Psychotherapy. *Clinical Psychology: Science and Practice*, (5), 439-458.
- 16 Kaiser Permanente, B. Moulton PhD (Adult Service Clinical Manager), internal email communication, September 9, 2011.
- 17 Kaiser Permanente, M. Lim Yankowitz, LCSW (San Francisco Director, Department of Psychiatry), internal email communication, September 27, 2011.
- 18 Moldwasky, Richard (2007). Applying an Open-Access Model to a Psychiatric Practice. *The Permanente Journal*, 11(1), 33-36.
- 19 “Force booking” by clinicians generally entails placing an appointment into a time slot that was designated for non-direct care.
- 20 Hansen, N., Lambert M., & Forman E. (2002). The Psychotherapy Dose-Response Effect and Its Implications for Treatment Delivery Services. *Clinical Psychology: Science and Practice*, 9(3), 329-343.
- 21 At some clinics, intakes have been restructured so that they only take 30 minutes, thereby allowing 2 intakes per hour. Several clinicians report that this shortening of the intake appointment lessens the effectiveness of the initial session.
- 22 Herz, G. I. *Therapists Dodge Bullet - Kaiser Permanente Holds Smoking Gun*. Retrieved August 3, 2011, from <http://drherz.us/for-professionals/kaiser-permanente-holds-smoking-gun>
- 23 McGuire, P.C. (1998, September). Kaiser Therapists Stage One-Day Strike. *American Psychological Association. APA Monitor*, 22.
- 24 Holstein, R. M. (2004), *Triage As Treatment: Phantom Mental Health Services at Kaiser Permanente. Coalition Report*, 4.
- 25 Norcross, J., & Wampold B. (2011). Evidence-based Therapy Relationships: Research Conclusions and Clinical Practices. *Psychotherapy*, 48(1), 98-102.
- 26 Ackerman, S. J., & Hilsenroth, M.J. (2001). A Review of Therapist Characteristics and Techniques Negatively Impacting the Therapeutic Alliance. *Psychotherapy*, (38) 171-185.
- 27 Kaiser Permanente, 2009 People Pulse Survey, Watson Wyatt (HR Consulting).
- 28 Kaiser Permanente, *Orange County Model of Care FAQ*, March 2011. (p. 4)
- 29 Dr. Holstein indicated that once Kaiser found out that he was asking questions around access he was denied direct communication with clinicians and instead was forced to

speak with management officials. (Personal communication)

30 Foxhall, K., (2000). New CPT codes will recognize psychologists' work with physical health problems, *APA Monitor*, 31(10), p. 46.

31 Psychological and Neuropsychological Testing, CPT/HCPAC Advisory Committee: Accessed from: <http://www.ama-assn.org/resources/doc/cpt/psychological-and-neuropsychological-testing.pdf> & Coding Q&A—Medicine: Psychiatry <http://www.ama-assn.org/ama/pub/news/newsletters-journals/ama-ebooknews/ebooknews-29mar2011.page>

32 California Code of Regulations. Title 28, §1300.67.2.2(f).

33 Department of Managed Health Care. (2005). *Mental Health Parity Focused Survey Final Report Kaiser Foundation Health Plan, Inc.* File NO: 933-0055. (pp. 7,12,19)

34 Two years later, in 2007, for return visits, these internal performance standards for Kaiser's Northern California region had not improved, staying at 47 percent. Despite a slight improvement for initial visits, at 71 percent, Kaiser's compliance rate in this area continued to remain below their internal standard.

35 Department of Managed Health Care. (2009). *Routine Medical Survey of Kaiser Foundation Health Plan, Inc. A Full Service Health Plan* File NO: 933-0055. (pp. 7, 9-11)

36 Department of Managed Health Care. (2010). Sturdevant, Patricia - Assistant Chief Counsel, *Enforcement Matter Number 08-331*. California: Department of Managed Health Care. (p. 1)

37 Richard Della Penna vs The Permanente Federation, Kaiser Foundation Health Plan et al., Case No BC447015. Los Angeles Superior Court. October 2010. (pp. 3, 5-8)

38 IBHS (Integrated Behavioral Health Services) Chapter Stewards letter to Robert Pearl CEO & Executive Director of The Permanente Medical Group, March 1, 2010.

Bibliography

- Abbott, E. (2009). About Time: The Story on Winning Timely Access to Health Care. *Health Access*.
- AB 2179, Chapter 797, Stats, 2002, Cohn, R. (2002).
- Ackerman, S. J., & Hilsenroth, M.J. (2001). A Review of Therapist Characteristics and Techniques Negatively Impacting the Therapeutic Alliance. *Psychotherapy*, (38) 171-185.
- Barry, C. L., Venkatesh, M., & Busch S. (2008). Assessing New Patient Access to Mental Health Providers in HMO Networks. *Psychiatric Services*, 59(12), 1413-8.
- Blankertz, L.E., & Robinson, S. E. (1997). Turnover Intentions of Community Mental Health Workers in Psychosocial Rehabilitation Services. *Community Mental Health Journal*, 33, 243-257.
- Boyle, P. J., & Callahan D. (1995). Managed Care in Mental Health: The Ethical Issues. *Health Affairs*, 14(3), 7-22.
- Cummings, N.A. & VandenBos, G.R. (1981). The twenty years Kaiser-Permanente experience with psychotherapy and medical utilization: Implication for national health policy and national health insurance. *Health Policy Quarterly*, (2), 159-175.
- Department of Managed Health Care. (2005). *Mental Health Parity Focused Survey Final Report Kaiser Foundation Health Plan, Inc.* File No: 933-0055.
- Department of Managed Health Care. (2009). *Routine Medical Survey of Kaiser Foundation Health Plan, Inc. A Full Service Health Plan* File No: 933-0055.
- Department of Managed Health Care. (2010). Sturdevant, Patricia - Assistant Chief Counsel, *Enforcement Matter Number 08-331*. California: Department of Managed Health Care.
- Department of Managed Health Care. (2011). *Timely Access*. Retrieved August 3, 2011, from http://www.dmhc.ca.gov/healthplans/gen/gen_timelyacc.aspx
- Foxhall, K., (2000). New CPT codes will recognize psychologists' work with physical health problems, *APA Monitor*, 31(10).
- Hansen, N., Lambert M., & Forman E. (2002). The Psychotherapy Dose-Response Effect and Its Implications for Treatment Delivery Services. *Clinical Psychology: Science and Practice*, 9(3), 329-343.
- Herz, G. I., *Therapists Dodge Bullet - Kaiser Permanente Holds Smoking Gun*. Retrieved August 10, 2011, from <http://drherz.us/for-professionals/kaiser-permanente-holds-smoking-gun/>

- Holstein, R. M. (2004). Triage As Treatment: Phantom Mental Health Services at Kaiser Permanente. *Coalition Report*, 4.
- Kaiser Foundation Health Plan, Inc. (2010). Northern and Southern California Regions, *DMHC Filing - Compliance with Timely Access Regulation*.
- Kaiser Permanente. (2011). RBC Capital Markets L., *Revenue Bonds - \$100,000,000 California Statewide Communities Development Authority*.
- McRee, T., Dower C., Briggance B., Vance J., Keane D., & O'Neil E. H. (2003). *The Mental Health Workforce: Who's Meeting California's Needs?* California Workforce Initiative.
- Moldwasky, Richard (2007). Applying an Open-Access Model to a Psychiatric Practice. *The Permanente Journal*, 11(1), 33-36.
- McGuire, P.C. (1998, September). Kaiser Therapists Stage One-Day Strike. American Psychological Association. *APA Monitor*, 22.
- Norcross, J., & Wampold B. (2011). Evidence-based Therapy Relationships: Research Conclusions and Clinical Practices. *Psychotherapy*, 48(1), 98-102.
- Richard Della Penna vs The Permanente Federation, Kaiser Foundation Health Plan et al. Case No BC447015. Los Angeles Superior Court. October 2010.
- Stiles, W.B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in Psychotherapy. *Clinical Psychology: Science and Practice*, (5), 439-458.
- The Permanente Medical Group. (2005). *Patient Safety Chief's Reference Guide*.
- Timely Access to Non-Emergency Health Care Services, Title 28, Article 7. STANDARDS 1300.67.2.2. (2010).
- U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville MD: DHHS.

Appendix A – NUHW Behavioral Health Survey

Office and Appointment Availability

1. In how many *business days* is your next available initial appointment?
2. In how many *business days* is your third next available initial appointment?
3. In how many *business days* is your next available (in person) return appointment?
4. Out of 10 patients, how many are routinely required to wait 2 weeks or more for return appointments?
5. How satisfied are you with your patients' access to timely mental health care appointments?
 - Very Satisfied
 - Satisfied
 - Undecided
 - Dissatisfied
 - Very Dissatisfied

Treatment

6. I feel supported to choose the treatment modalities that I want for my patients:
 - Strongly Agree
 - Agree
 - Undecided
 - Disagree
 - Strongly Disagree
7. How often are you forced to schedule return visits further into the future than you believe is appropriate?
 - Very frequently
 - Frequently
 - Occasionally
 - Rarely
 - Very rarely
8. How frequently are patients assigned to group therapy even though individual therapy may be more appropriate?
 - Very frequently
 - Frequently
 - Occasionally
 - Rarely
 - Very rarely

9. Weekly individual psychotherapy sessions are available to those who need it:

- Strongly Agree
- Agree
- Undecided
- Disagree
- Strongly Disagree

10. At your clinic is there sufficient staffing to provide patients with timely intake visits?

11. At your clinic is there sufficient staffing to provide patients with timely return visits?

Additional Questions

As you respond below, make sure not to include any patient-identifying information.

12. Are you aware of patients at your clinic who have broken off treatment due to long wait times for appointments? If so, please describe.

13. What situations or circumstances result in restricting the length or frequency of individual treatment? What is the impact on patient care?

14. Are you aware of specific negative patient outcomes due to lack of access to mental health services?

15. I am willing to be contacted by an NUHW representative and share my story.

Appendix B – NUHW Quality Care Documentation Form

NUHW Quality Care Documentation Form

NUHW members are using this form to document concerns around staffing, workload and quality of care issues at Kaiser facilities so that we are better able to address these serious issues.

The information provided in this form will not be made public without your agreement.

*Please be careful not to include any information identifying specific patients.

Name: _____

Facility / Med Center: _____

Department: _____ Job Title: _____

Cell#: _____ Work #: _____

Brief description of incident or situation:

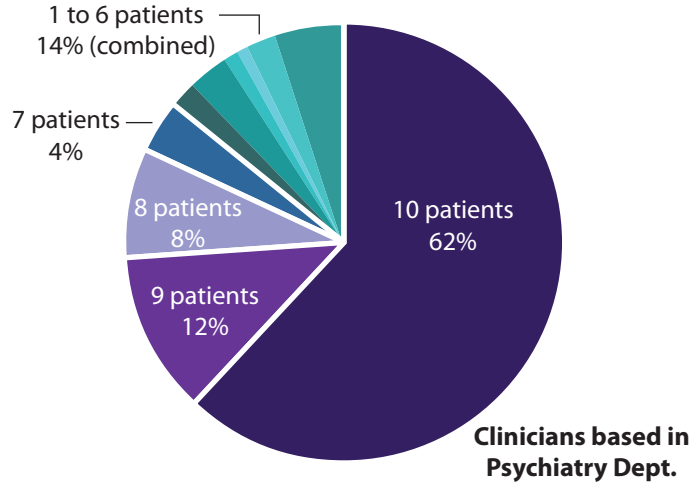
Regulatory issues and/or Kaiser policy that may be relevant:

Possible impact on patient care:

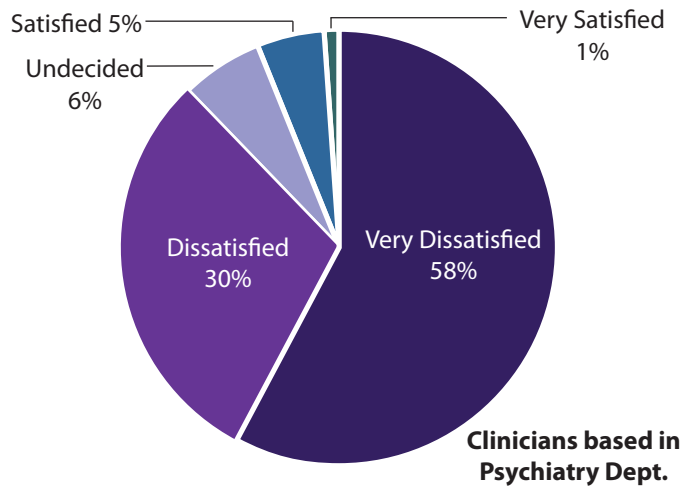
Possible solution or better practice:

Appendix C – Survey Results for Psych. Dept based clinicians

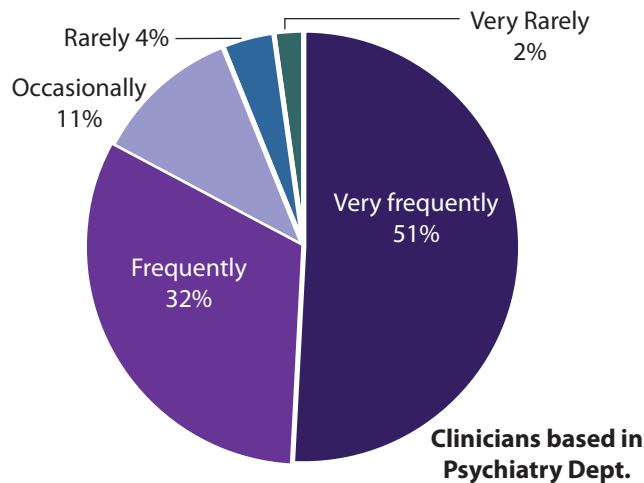
OUT OF 10 PATIENTS, HOW MANY ARE ROUTINELY REQUIRED TO WAIT 2 WEEKS OR MORE FOR RETURN APPOINTMENTS?



HOW SATISFIED ARE YOU WITH YOUR PATIENTS' ACCESS TO TIMELY MENTAL HEALTH APPOINTMENTS?



HOW OFTEN ARE YOU FORCED TO SCHEDULE RETURN APPOINTMENTS FURTHER INTO THE FUTURE THAN YOU BELIEVE APPROPRIATE?



Appendix D – Survey Results, Open-Ended responses

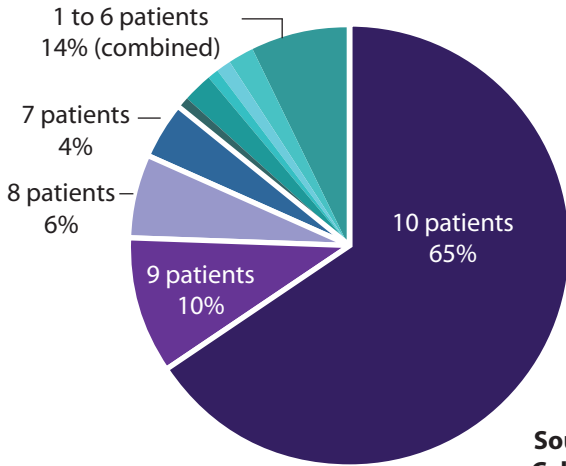
Response	Clinician	Region
“[Patients] have to wait so long that they give up. They often call and utilize crisis services as they are unable to wait for their regularly scheduled appointments 4-6 weeks out.”	LCSW	Northern California
“Many patients are unhappy with our one size fits all combo of group treatment with occasional individual check-ins....We spend a lot of resources trying to lower patients expectations when they come to our clinic. The orientation to our department is specifically about that. Many patients don’t return after the first visit because of this. This is not surprising given the subtext of most treatment encounters, which is ‘how can I get this patient out of my schedule as quickly as possible?’”	Psychologist	Northern California
“Numerous patients will not even schedule an intake [appointment] because they are so far out...They get discouraged and give up on the entire process. Some [patients] have stated to me that they are not getting their “money’s worth with Kaiser”. Most are very disappointed in the long wait times to get in and then return.”	MFT	Northern California
“More often than not, during an intake, I have patients very upset when I tell them my next available appointment, and they often ask for referrals outside of Kaiser. When I tell them this is not a covered Kaiser benefit, I often get asked how it is that they pay for a mental health benefit, yet when they need help, they cannot receive the services unless they pay for it out of pocket. To this, I offer them group therapy once a week, which many of them are not appropriate for...”	Psychologist	Northern California
“[We] need to stay within model of care for offering new intake appointments. If we are not within the model our Department is punished monetarily. To keep within the standard with our low staffing requires offering more intakes then there are return appointments to accommodate with in the required standard. We are constantly juggling limited resources to be able to meet patient needs and not have needed money taken away from our clinic.	LCSW	Northern California
Are you aware of specific negative patient outcomes due to lack of access to mental health services? (Survey Question #15)		
“The negative impact is observed everyday when a patient calls our office and desperately wants an appointment but has to wait 4-8 weeks to get in to see someone. I see Seniors and they often have limited resources in regard to transportation and access.[Many] are struggling with significant medical issues as well as cognitive slowing, dementia, onset of Alzheimer’s. They are significantly impacted by our poor access.”	LCSW	Southern California
“I am aware of a patient on my caseload that was unable to get in quickly to see me. She overdosed and was hospitalized after a family member found her. I don’t know if the appointment would have forestalled the incident but I think patient would have been assessed if she came in.”	MFT	Southern California

CARE DELAYED, CARE DENIED

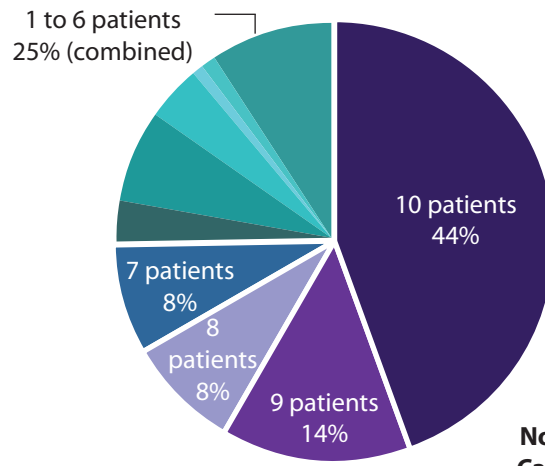
<p>“I have one woman coming in for marital issues but due to not being seen has now started having panic attacks, resulting in a visit to the ER, and depression.”</p>	<p>MFT</p>	<p>Southern California</p>
<p>“One patient I worked with last year could not get in a timely fashion and he became seriously depressed and suicidal again. Today I Spoke w a woman on the phone because I hadn’t seen her in some time and was worried about her. She told me she could not get an appointment with me for 6 weeks when she called in. She was severely depressed and crying today, and was very suicidal yesterday. I made arrangements to add her to my schedule.”</p>	<p>MFT</p>	<p>Southern California</p>
<p>“...some patients that could have been promptly and effectively helped with regular brief weekly sessions that are NOT available may become more distressed. Patients have also complained that unless they INSIST they are suicidal, they may have to wait for weeks to be seen.”</p>	<p>LCSW</p>	<p>Southern California</p>
<p>“Unless these patients are suicidal, or gravely disabled, and eligible for the Intensive Outpatient Program, they have to wait for appointments and are usually put in groups.”</p>	<p>LCSW</p>	<p>Northern California</p>
<p>“Patients with under treatment or aborted treatment for mental health issues often cost more in the long run because of the increase in high cost medical issues when mental health concerns are not adequately addressed. We could save huge dollars across the medical center if we adequately addressed mental health issues in a more proactive, long term fashion...”</p>	<p>Psychologist</p>	<p>Northern California</p>
<p>“Yes, increase in homelessness, lowered overall well being, increase in co-morbid health problems, for some increase in crime, increase in some suicidality or homicidality (although some of this is inevitable).”</p>		<p>Southern California</p>
<p>“Two suicides in 14 months by a gun to the head.”</p>	<p>MFT</p>	<p>Northern California</p>
<p>“One of many of which I am aware. Therapist said patient would receive a call to check in and for scheduling another appt. Patient contemplating suicide. No call came. Suicide attempt very close to being made. A chance interruption. “</p>	<p>Psychologist</p>	<p>Northern California</p>
<p>“I have had two particular cases of late that had negative outcomes with DCFS [Department of Children and Family Services] because they were not able to have the frequency of visits that DCFS and the family court was expecting. In one case, I was confronted by a DCFS worker that they were having a meeting to determine whether or not to remove children and that the DCFS team was appalled by the frequency of visits at Kaiser plus what appeared to be poor communication and coordination of care between the KMHC inpatient, KMHC PHP, and outpatient psychiatry (that those three tx [treatment] teams had no access to each others notes or dates of tx nor was there clear discharge summaries or hand-offs to each level of care). This lack of coordination at first made it seem like the patient was lying about her treatment attendance when actually it was in part my fault as I had no access to the dates of treatment for the other programs.”</p>	<p>LCSW</p>	<p>Southern California</p>

Appendix E – Survey Results by Region

OUT OF 10 PATIENTS, HOW MANY ARE ROUTINELY REQUIRED TO WAIT 2 WEEKS OR MORE FOR RETURN APPOINTMENTS?

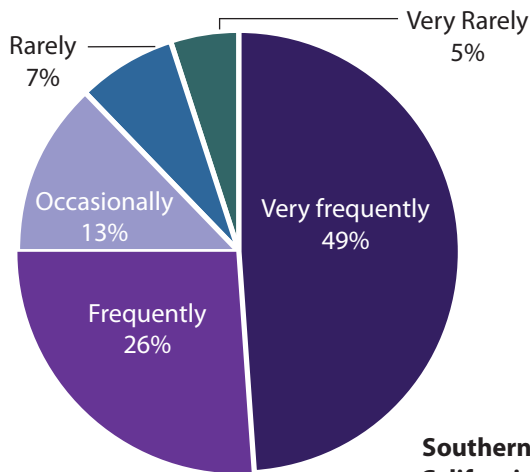


Southern California

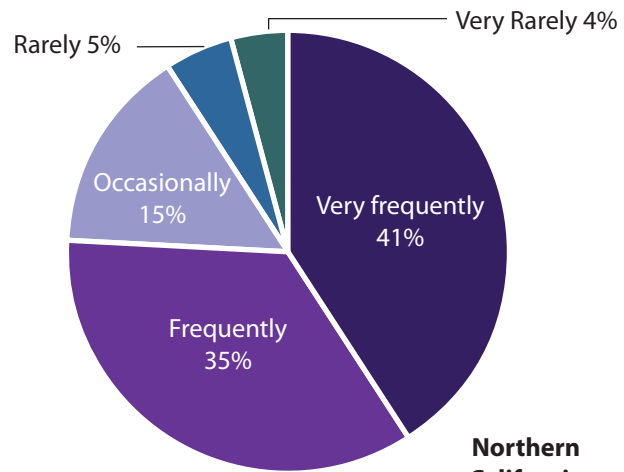


Northern California

HOW OFTEN ARE YOU FORCED TO SCHEDULE RETURN APPOINTMENTS FURTHER INTO THE FUTURE THAN YOU BELIEVE APPROPRIATE?

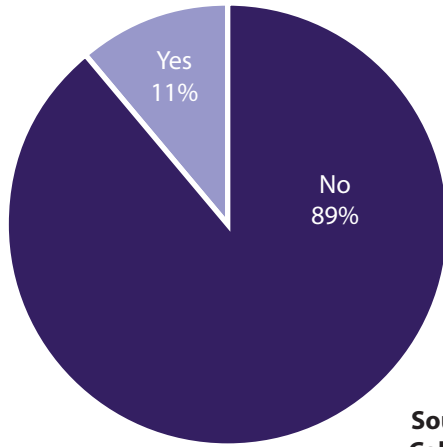


Southern California

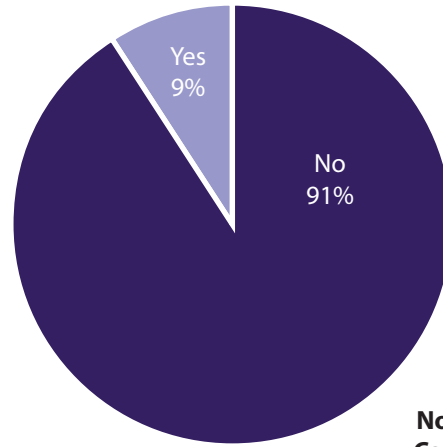


Northern California

AT YOUR CLINIC IS THERE SUFFICIENT STAFFING TO PROVIDE PATIENTS WITH TIMELY RETURN VISITS?

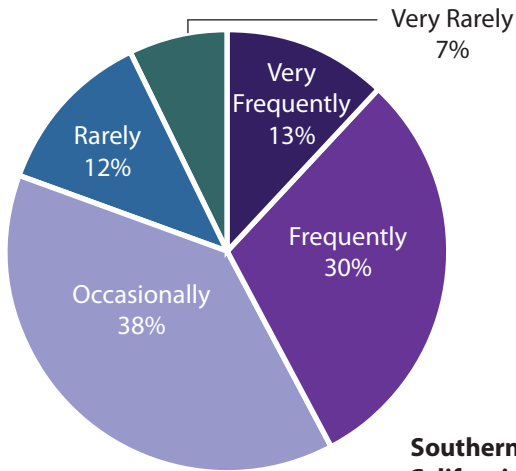


Southern California

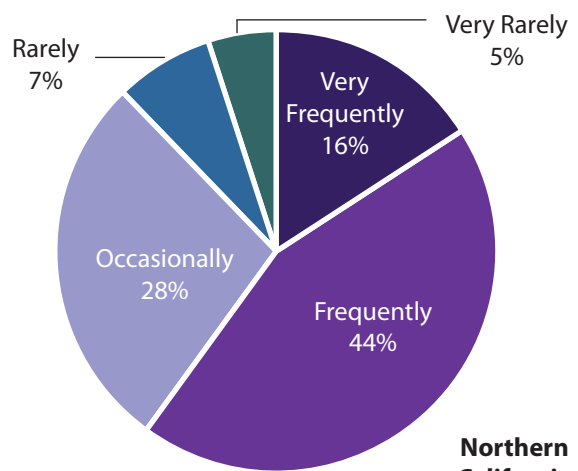


Northern California

HOW FREQUENTLY ARE PATIENTS ASSIGNED TO GROUP THERAPY EVEN THOUGH INDIVIDUAL THERAPY MAY BE MORE APPROPRIATE?

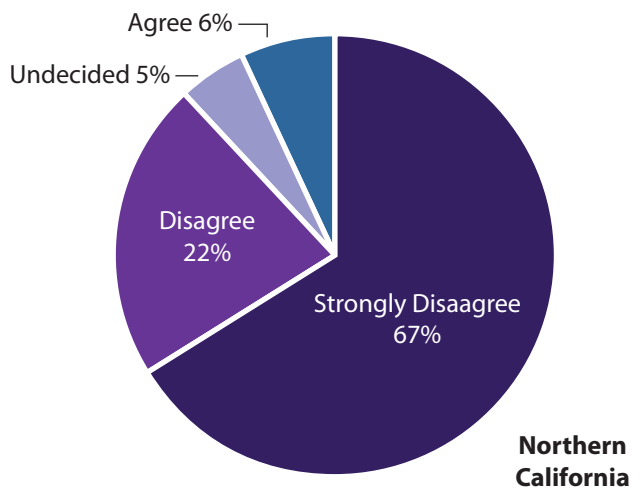
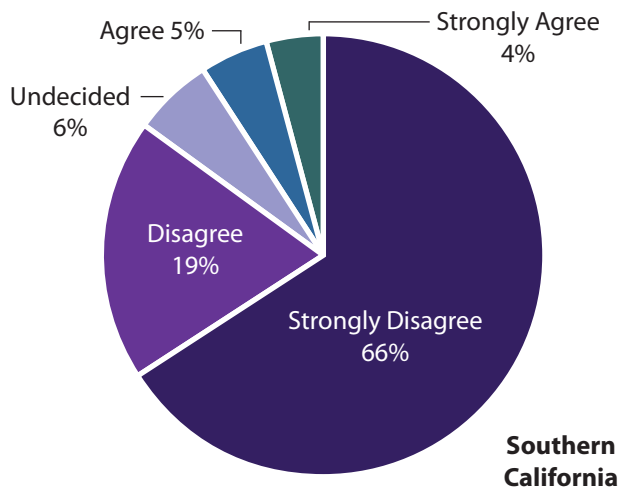


Southern California



Northern California

WEEKLY INDIVIDUAL PSYCHOTHERAPY SESSIONS ARE AVAILABLE TO THOSE WHO NEED IT.





NATIONAL UNION OF HEALTHCARE WORKERS

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