NUHW
NATIONAL UNION OF HEALTHCARE WORKERS

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November 10, 2015

Shelley Rouillard, Director
Carol Ventura, Deputy Director—Office of Enforcement
Andrew George, Deputy Director— Health Center
James A. Willis, Senior Counsel
Laura Dooley, Chief of Plan Surveys
Jim Haigh, Senior Council—Office of Enforcement
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: COMPLAINT REGARDING KAISER PERMANENTE'S MENTAL HEALTH SERVICES

Dear Ms. Rouillard, Ms. Ventura, Mr. George, Mr. Willis, Ms. Dooley and Mr. Haigh:

On behalf of NUHW, I am writing to request that the Department of Managed Health Care (DMHC) investigate Kaiser Permanente's additional reported violations of California's laws and regulations governing its provision of mental health services to California residents.

The reported violations – which are detailed in the attached internal documents prepared by Kaiser – pertain to Kaiser's practice of steering mental health patients into group, rather than one-on-one, treatment appointments in order to boost Kaiser's profits at the expense of patients' care.

According to one document, Kaiser's group treatment appointments – in which a single therapist treats a group of often more than a dozen patients during a one-hour appointment – cost Kaiser "80% less than a 1:1 appointment." Kaiser saves $42.42 per patient when its patients are treated in groups rather than in one-on-one appointments, according to the document. The patients who are treated in Kaiser's group appointments have diagnoses ranging from Major Depressive Disorder and Post Traumatic Stress Disorder to Bipolar Disorder and Suicidal Ideation. The document details the role of Kaiser's administrative and financial personnel in directing clinics' operational practices in order to steer patients into cheaper group therapy appointments without consideration for patients' clinical needs. These practices and Kaiser's improper interference in clinical decisions are ongoing.

In a second document, Kaiser reports that patients at one of its Southern California mental health clinics were "unable to receive clinically effective treatment due to long waits in between appointments with their therapist." The document details Kaiser's decision to utilize group treatment appointments and "overbooking" in response to Kaiser's inability to provide timely and clinically appropriate care to patients. Overbooking is a practice by which Kaiser schedules or "books" two or more patients to attend the same one-on-one treatment appointment with a single therapist, which typically is 30 minutes in duration. If two or more patients arrive at the clinic for the same overbooked appointment, then Kaiser instructs the treating therapist to divide the 30-minute appointment among the multiple patients, thereby shortcutting their care and treatment. Kaiser personnel report that Kaiser is currently overbooking mental health patients at multiple clinics across California.

The aforementioned internal documents are attached in Exhibits A and B. The documents point to multiple apparent violations of California law as detailed below. Of particular concern is Kaiser's prioritization of its financial goals over the delivery of clinically appropriate care to its patients.

- **§ 1300.70(b)(1)(D)**: HMOs cannot withhold or delay appropriate care from their patients for any reason, "including a potential financial gain and/or incentive."
- **§ 1300.70(b)(1)(A)**: HMOs are required to ensure that patients receive "a level of care which meets professionally recognized standards of practice."
- **§ 1300.70(b)(2)(H)(2)**: HMOs are required to "detect and correct under-service" by its providers, "including under-utilization of specialist services."
- **§ 1300.70(a)(1):** HMOs must monitor the quality of care provided to its members, identify problems, and take effective action to improve care where deficiencies are identified, including accessibility, availability, and continuity of care. See also § 1300.70(a)(3), § 1300.70(b)(1)(D), § 1300.70(b)(2)(G)(3), § 1300.70(c)(1), § 1300.70(c)(5), and § 1300.70(d)(3).
- **§1300.74.72 (California Mental Health Parity Act)**: HMOs that offer coverage for mental health or substance use disorders are required to provide the same level of benefits that they do for general medical treatment.

Kaiser's apparent violations overlap with the DMHC's ongoing investigation of Kaiser's mental health services, known as DMHC Enforcement Matter No. 11-543, as well as the DMHC's "Cease and Desist Order" issued against Kaiser in June of 2013.

A. Exhibit A

Exhibit A is a 15-page document entitled "Mental Health Rapid Access Group Utilization" dated September 2013 and labeled "Confidential & For Internal Use Only." The document, which

bears the logo of Kaiser Permanent's "Improvement Institute," pertains to Kaiser's mental health clinic in Walnut Creek, California and identifies the names of "Improvement Advisors" on its second page, including Darolyn Nollsch, Diane Coppa, and Frank Mewborn. Apparently, none of these individuals is licensed to practice medicine.

Kaiser's Improvement Institute is staffed by management consultants charged with boosting Kaiser's financial performance. The Institute reportedly produced $330 million in "savings" for Kaiser in 2014, according to Rhonda Alfaro, a former director of operations at Kaiser's Improvement Institute until April 2015.

The document describes the scope and content of a project carried out by Kaiser officials designed to increase patients' utilization of group rather than one-on-one treatment appointments. According to the document, the clinic's patients wait more than a month for treatment appointments.[1] On page 11, the document states that the "Average wait time for return 1:1 appointment = 4-6 weeks."

In an apparent response to the clinic's inability to provide timely and appropriate treatment appointments to its mental health patients, Kaiser executed a set of operational changes in late 2012 soon after the DMHC notified Kaiser of its violation of California's Timely Access Regulations and other standards.

On page 1, the document describes the goals and expected outcomes of its operational changes. For example, it states, "Outcome Measures: Increased attendance at groups" and "Process Measures: Providers refer patients to Rapid Access groups." It describes Kaiser's "Project SMART Goal" as "Increase average utilization of the three Walnut Creek Rapid Access Groups by August 1, 2013 from an average of 12.9 to 17 patients per week." Also on page 1, the document states, "Expected Financial Impact: Possible decrease in 1:1 appointments with providers leading to decreased FTE costs."

On page 11, the document describes the financial savings that Kaiser enjoys as a result of treating its patients in group appointments:

> **"Groups are a more cost effective method for seeing patients. Per patient, a group appointment costs 80% less than a 1:1 appointment."**

Notably, the document does not contain any discussion of the clinical needs of Kaiser's patients, the clinical effectiveness of group appointments versus individual appointments, and other

[1] Today, Kaiser's clinicians at multiple clinics across California report that their patients, many with acute diagnoses, typically wait 4-10 weeks for treatment appointments due to Kaiser's understaffing of its mental health services and its inadequate provider network.

clinical considerations regarding the delivery of optimal treatment attuned to patients' individual diagnoses and circumstances. Instead, the document focuses on Kaiser's goal of optimizing its profitability by treating more patients in group appointments.

The document notes that Kaiser's cost for providing a one-on-one appointment to a patient is $53.30, while the cost of a "Group appointment" is $10.88. According to the footnote on page 11, the "Cost per patient [is] based on the average hourly rate for LCSW, MFT, PhD, PsyD. Source: TPMG Controller's Office."

According to the document, Kaiser achieves a "Savings per Patient" of $42.42 when patients receive treatment in groups rather than one-on-one appointments with a therapist. The document also calculates this clinic's "Savings per Year" ($21,210) when just 10 additional patients per week receive treatment through groups rather than one-on-one appointments.

The document also indicates that Kaiser officials are fully aware that patients typically prefer one-on-one treatment appointments over group appointments. On page 4 ("Assessment Results"), the document describes the process experienced by a typical Kaiser mental health patient, which includes in part the following:

- "Patient arrives for 1:1 appointment with therapist."
- "Therapist assesses patient need."
- "Patient asks for weekly treatment."
- "Therapist informs patient of weekly group therapy."
- "Patient shares feelings about group therapy."
- "Patients express anxiety about groups."

On page 8, the document describes seven operational changes implemented by Kaiser to boost patients' utilization of group appointments. On page 10, the document describes the dates on which each of the operational changes was implemented during 2013, as well as the clinic's performance with respect to the project's outcome measures.

On page 12, the document describes a "Sustainability Plan" by which the clinic's management personnel have continued to implement the operational changes. According to Kaiser personnel, these operational changes remain in effect today at Kaiser's Walnut Creek clinic.

On page 14 ("Project Results Summary"), the document describes the "results" of its operational changes: namely, increasing patient's attendance at the clinic's "Rapid Access Groups" "from an average of 12.9 patients in April to an average of 18.2 patients by August."

Under California law, Kaiser cannot withhold or delay appropriate care from its patients for any reason, "including a potential financial gain and/or incentive." Furthermore, Kaiser's administrative and financial personnel cannot interfere with the clinical judgment and treatment plans of licensed providers, who are responsible for diagnosing and treating patients according to professionally recognized standards of practice. Furthermore, Kaiser must provide timely and appropriate care to its patients that's designed to address the individual diagnoses and conditions of those patients.

As you know, providers and patients have already documented their concerns regarding Kaiser's over-use of group treatment appointments. In November of 2011, NUHW reported clinicians' findings regarding Kaiser's overreliance on group therapy in NUHW's complaint to the DMHC, entitled "Care Delayed, Care Denied." The report stated in part of the following:

> "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% of Kaiser clinicians report that patients are either frequently or very frequently 'assigned to group therapy even though individual therapy may be more appropriate.'"[2]

Furthermore, Kaiser's patients allege in multiple class-action lawsuits that Kaiser's over-reliance on group treatment appointments is directly connected to substandard treatment as well as the suicides of multiple Kaiser enrollees.[3]

B. Exhibit B

Exhibit B is an 11-page document entitled "Psychiatry Access" dated December 7, 2012. It also bears the logo of Kaiser Permanent's "Improvement Institute." The document pertains to Kaiser's mental health clinic in Downey, California and identifies the names of "Lead Improvement Advisor" Rhonda Alfaro. Apparently, Ms. Alfaro is not licensed to practice medicine.

On page 3, the document articulates the following "Problem Statement:"

> **"Patients are unable to receive clinically effective treatment due to long waits in between appointments with their therapists."**

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[2] NUHW, "Care Delayed, Care Denied: Kaiser Permanente's Failure to Provide Timely and Appropriate Mental Health Services," November 2011, p. 2.

[3] Futterman v. Kaiser Foundation Health Plan, Inc., Alameda County Superior Court, Case No. RG13697775; S.F. v. Kaiser Foundation Health Plan, Inc., Los Angeles County Superior Court, Case No. BC597518.

On page 4, the document states that first-time patients experience a 24-day wait for a non-urgent "intake assessment" appointments, which exceeds the 14-day maximum timeframe in California's Timely Access Regulations.

On page 5 ("Assessment Results - Fishbone Diagram"), the document identifies additional systemic failures affecting the treatment of mental health patients including the following:

- "Long Wait Time for Therapy Appts."
- "Slots not set aside for specific Txt [treatment] paths."
- "Pts. [Patients] are not booked according to Txt [treatment] need."
- "No clear Txt [treatment] provided to patients."
- "No defined evidence based practices."
- "Current Access does not allow for Short Term Therapy."
- "Patients are unaware of time limit of Txt [treatment] Plan."

On page 6 ("Voice of the Customer"), the document states in part: "Found out that patients were frustrated with the long wait time..."

On page 7 ("What Changes Lead to Improvement?"), the document details several of Kaiser's operational changes designed to address the aforementioned "problem statement" including overbooking patients into appointments and having managers set limits on the number of treatment appointments available to patients.

On page 9 ("Financial Impact"), the document details the "Estimated Financial Benefit" from these operational changes. According to the document, Kaiser's Downey mental health clinic is expected to increase its supply of appointments by 10% "through over books and group appts." The document states: "Net gain in available hours: 800 additional hours available with no increase in current FTEs." Given the average $43 per hour cost of a non-M.D. provider, the document describes the project's "estimated financial benefit" as $34,440 at the Downey clinic.

On page 10 ("Sustainability Plan"), the document details the persons responsible for various "actions" and the frequency with which these actions and other "items" are undertaken. For example, "Action 3" is described as "Review Census of Provider Clinics to make sure they are being overbooked." Steven Morones and Edna Clayton are described as the persons responsible for carrying out this action on a weekly basis.

C. Complaint Request

With respect to the practices detailed in the attached internal documents, NUHW urgently requests that the DMHC employ its full statutory authority to investigate Kaiser's reported violations of California's laws and regulations governing its provision of mental health services. Furthermore, we call on the DMHC to compel Kaiser to comply with the DMHC's "Cease and Desist Order" issued in June of 2013. In February of 2015, DMHC investigators released the results of its follow-up survey in which it determined that Kaiser is committing ongoing "serious" and "significant" violations of California law affecting thousands of patients across California.

Given the impact of substandard care on patients' health and safety, we request that the DMHC urgently investigate these matters. We stand ready to offer any assistance that may be helpful to the Department's investigation. We futher request that the DMHC make its findings known to the general public and that it seek appropriate relief for Kaiser members if it ultimately determines that Kaiser has breached its responsibilities.

We and California's consumers thank you in advance for your prompt attention to this matter.

Respectfully,

Sal Rosselli, President

Attachments

EXHIBIT A

Mental Health Rapid Access Group Utilization

Improvement Advisor: Madeline McGinley, PsyD, Darolyn Nollsch
PI Director / Lead IA: Diane Coppa
Mentor: Frank Mewborn

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Location: NCAL DSA Walnut Creek
Date: September 2013

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Project Planning Charter

Project Name: Mental Health Rapid Access Group Utilization	**Charter Date:** April 2013
Improvement Advisor: Madeline McGinley, Darolyn Nollsch	**Facility:** Diablo Service Area, Walnut Creek Mental Health Department
PI Director / Lead IA: Diane Coppa	**Mentor:** Frank Mewborn

Project SMART Goal: Increase average utilization of the three Walnut Creek Rapid Access Groups by August 1, 2013, from an average of 12.9 to 17 patients (total of three groups) per week

Problem Statement and Business Case

Problem Statement	Currently, there is low utilization of the Rapid Access groups. The purpose of the groups is to offer members rapid access to care when they need support in between, or in addition to, their 1:1 therapist appointments.
Customer Benefit	Improved access to immediate care for patients
Expected Financial Impact	Possible decrease in 1:1 appointments with providers leading to decreased FTE costs
Other Business Benefit	

Project Team

- Sponsors: Mary Staunton, MD, Michael Lim, Director
- Champions: Catharine Kibira, Mental Health/Chemical Dependency Manager
- Project Co-Leads [Process Owners]: Lori Ono, Rick LaBelle, Rick Carson
- Front-Line: Walnut Creek Mental Health Adult Team
- Project Oversight:

Project Timeline and Key Milestones

- Assess:
  - Baseline Data Obtained
  - Project Kick-Off
  - Project Charter Completed
  - Process Map Completed
  - Voice of the Customer Obtained
- Identify Changes:
  - Cause and Effect Developed
  - Start PDSA Action Plans
- Test:
  - PDSA Action Plans Completed
- Implement:
  - Sustainability Plan Completed
  - Training and Communication Plans
  - Financial Impact Validated by Finance
  - Project Storyboard Complete and Submitted
  - Spread Plan

Project Measures

- Outcome Measures: Increased attendance at groups
- Process Measures: Providers refer patients to Rapid Access groups
- Balancing Measures: Need for 1:1 appointments with therapists may decrease; Attendance at other groups may decrease; Overall group program improved

Project Scope

- In Scope: This project includes the three Walnut Creek Mental Health Adult Rapid Access Groups (offered every Monday, Tuesday and Thursday).
- Out of Scope: The other groups offered by the WCR Mental Health Adult Team are not included in this project.

Driver Diagram for MH Adult Team Group PI Project

Aim Statement

Increase average utilization of the Walnut Creek Mental Health Department's Rapid Access groups by August 1, 2013, from an average of 12.9 to 17 patients per week

Primary Drivers	Secondary Drivers	Actions
Provider awareness about groups	• Providers know content and purpose of groups • Providers know how to best utilize these groups as part of their treatment plans	• Train staff on purpose/content of groups at adult team meetings • Email reminders weekly to providers about groups and times offered • Place flyers on share drive and in offices • Share best practices on use of groups
Patient awareness about groups	• Information about groups is available to patients • Providers communicate information about groups to patients	• Update flyers with more descriptive information • Place flyers in waiting room • Ask providers to give flyers to patients, as appropriate
Patient satisfaction with groups	• Patients express satisfaction with group • Patients routinely attend group • Groups are held at times convenient for patients	• Conduct a patient satisfaction survey • Conduct a patient survey asking patients why they do not accept referrals to group
Availability of groups	• Groups are covered by alternate provider if leader is not able to attend • Groups are held at times convenient for patients • Group rooms are available	• Develop back-up coverage plan • Conduct a patient survey asking patients about why/why not accept referral to group

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Achieving Results through a Culture of Excellence

Outcome

Achieve High Perceived Value and Differentiation at a Competitive Price

Value = (Quality + Service + Access)/Price

MD and non-MD leaders are able to see important issues and drive big results by engaging their teams to:

1. Understand the patient experience
2. Identify bottle necks and offer improvement ideas
3. Minimize practice variation if it doesn't add value
4. Create reliable processes so high perceived value and high performance is sustained

DSA 2013 Key Drivers

Leader Sponsorship, Prioritization, Alignment & Investment	Leaders • Ensure priorities are aligned with value equation • Experience PI – "Aha" moment • Model and communicate consistent message • Share results and recognize high performance • Ensure time and resources needed to support improvement efforts
Skills Development	• Training is experiential and linked to high priority initiatives • IAs are available to train, mentor and/or facilitate • Job instruction documentation (and continuous review) ensures consistent execution of value added tasks with no variation and sustained results • Easy access to web tools
Consulting Improvement Expertise and Capability	• Grow internal expertise • Make expertise available
Integration	• Chiefs, managers and cross functional teams come together to solve problems • KFH/TPMG have forum to identify common goals and leverage learnings and resources
Data Transparency & Interpretation	• Data is linked to patient experience • Easy access to operational data • Tools to interpret • Data is transparent
People	• Hiring & Reinforcing Excellence

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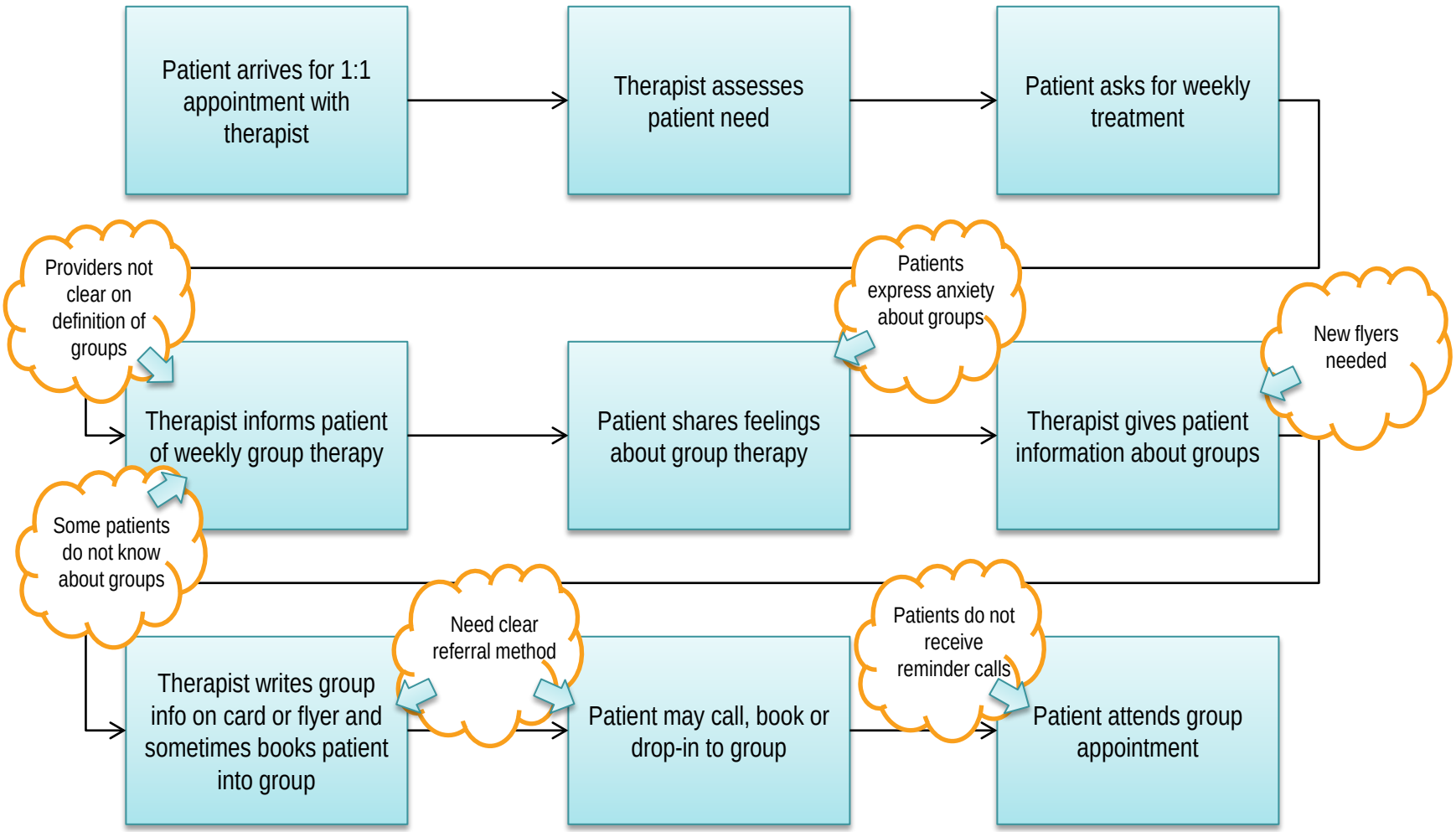
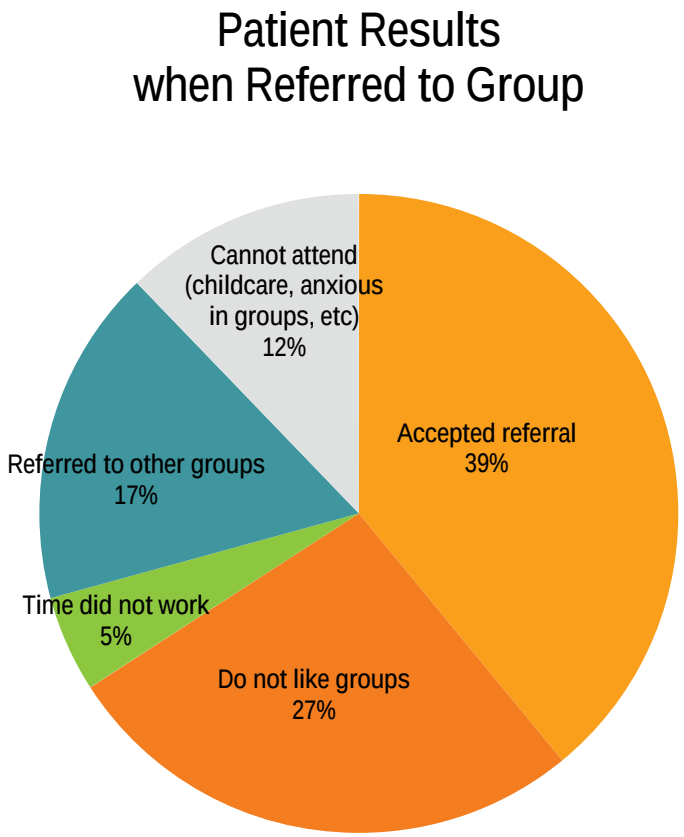
Assessment Results



Voice of the Customer

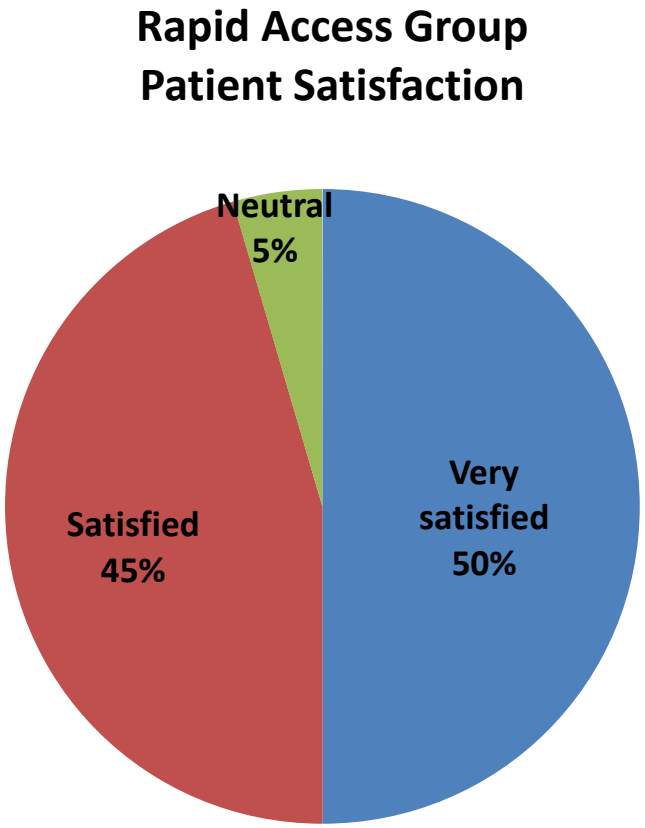
Customer Groups	*Customer Needs & Wants*	*Translation into specific Customer Requirements*
Mental Health patients	• Immediate access to care when needed. • Know about rapid access groups and how to get rapid access to care. • Groups occur as scheduled – no cancellations.	• Flyers with information about rapid access care available and easy to understand. • Accurate communication from providers about rapid access care. • Back-up provider coverage workflow in place for groups.
Mental Health providers	• Excellent patient care. • Immediate access to care for patients, when appropriate. • Awareness of groups. • Clear definition and referral guidelines for groups. • Clear method of referring and booking patients. • Understanding the benefits of group therapy.	• Rapid Access groups available for referral (Rapid Access groups listed on the Mental Health schedule). • Purpose/content of group education session conducted for providers. • Flyers easily available. • Best practices shared on the benefit and use of group therapy.
Executive sponsors	Exceptional mental health care.	

Voice of the Customer



Based on 41 patient responses to referrals collected 7/15-7/19/2013

Voice of the Customer



Based on 22 patient responses to a satisfaction survey conducted during Rapid Access Groups 6/10-6/27/2013

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What Changes Lead to Improvement?

Change Concept	*PDSAs*	*Adopt, Adapt, Abandon?*
Outline purpose and structure of groups for patients	Update flyers with more descriptive information	Adopted
Give patient information about groups	Place flyers in waiting rooms and provider offices	Adopted
Communicate information and educate staff about groups	Educate staff about purpose, structure and importance of groups; weekly email reminders sent out	Adopted
Increase rapid access group curriculum options for patients	Change Monday group to curriculum-based group	Adapted
Educate staff about ways to explain and “sell” groups to anxious patients	Providers share best practices	Adopted
Ensure groups are not cancelled	Developed back-up coverage workflow	Adopted
Remind registered patients about group appointments	Receptionist calls registered patients to remind them about groups	Adopted

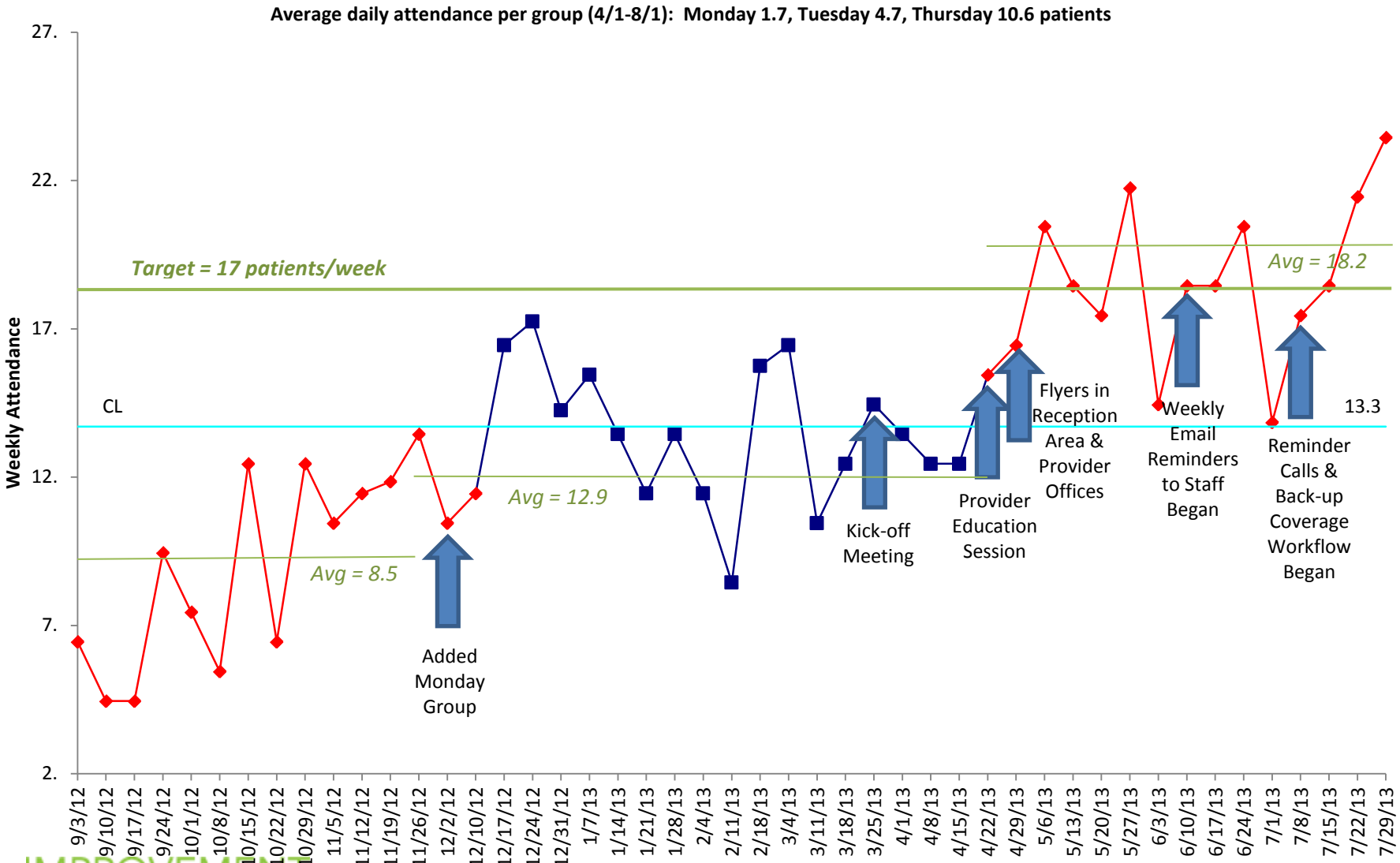
How Will We Know a Change Is an Improvement?

Family of Measures

Measure	Operational Definition (How is the measure calculated?)	Type (outcome, process, balancing)	Data Collection Plan (How will you collect data & how frequently)
Attendance in groups	Number of patients per group	Outcome	Manager will count attendance each week
Volume of referrals to groups	Number of referrals made to groups	Process	Providers will tally referrals made to drop-in groups per week
Overall group program process	Number of times groups are cancelled	Process	Manager will count the number of times groups are cancelled each month
Number of attendees per day of week (are 3 groups/week too many?)	Number of patients per group per day of week	Balancing	Manager will count attendance by day of week

Rapid Access Group Weekly Attendance

Average weekly attendance increased as changes were made



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Financial Impact

1. Improved access to rapid care at no added cost.

Average wait time for initial 1:1 appointment =	10 business days
Average wait time for return 1:1 appointment =	4-6 weeks
Wait time for a rapid access group appointment =	0-1 business day

2. Groups are a more cost effective method for seeing patients.

   Per patient, a group appointment costs 80% less than a 1:1 appointment.

Type of Appointment	Cost per Patient
1:1 appointment with provider (1 hour appt)	$53.30
Group appointment (1 hour group)	$10.88

3. Increased attendance by 10 patients per week.

Savings per Patient	Savings per Year
$53.30 - $10.88 = $42.42	$42.42 x 10 pt/week x 50 weeks = $21,210

Notes:
Cost per patient based on average hourly rate for LCSW, MFT, PhD, PsyD. Source: TPMG Controller's Office.
Cost per patient is based on the average number of attendees per group between 9/2/12 and 8/1/13 (4.9 patients per rapid access group).
Group appointment cost is based on one provider leading group. In the case of a large class, two providers may be needed to lead group.

Sustainability Plan

Process Owner(s): Catharine Kibira, PhD, Madeline McGinley, PsyD
Daily Oversight: Madeline McGinley, PsyD
Location: Walnut Creek Mental Health Department

	Item	Action	Responsible Person	Frequency	Issues / Comments
Bundle of Actions	Action 1	Maintain flyers in waiting rooms/provider offices	Annie Stovall	Weekly	
	Action 2	Refine Back-up Coverage policy	Madeline McGinley	Ongoing	
	Action 3	Evaluate Rapid Access Group attendance/success; make changes as necessary	Madeline McGinley Rick Carson Catharine Kibira	Ongoing	
Data Analysis & Results	Gather Data	Count group attendance	Madeline McGinley	Weekly	
	Analyze Data	Monitor attendance data	Madeline McGinley Catharine Kibira	Monthly	
	Report Results	Include results in weekly reminder email	Madeline McGinley	Weekly	
Communication	Project Team	Provide feedback to management staff on the status of Rapid Access Groups	Lori Ono Rick LaBelle Rick Carson	Monthly	
	Department Leaders	Group updates at Adult Team meetings	Madeline McGinley	Weekly	
	Leadership	Continue to communicate the benefits of group therapy	Catharine Kibira		
	Other				
Training	Project Team Meetings	Staff education regarding group therapy	Catharine Kibira	Monthly	
	Huddles				
	Other				

Champion Signature:

Process Owner Signature:

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Moving Forward

- Key to Success
  - Involvement of entire Adult Team
    - Team contributed many innovative ideas
- Barriers
  - It was found that many patients were not familiar with group therapy
    - Solution: Providers shared best practices for informing patients about the benefits of group therapy
- Lessons learned
  - Involvement of entire team was important for buy-in when changes were proposed
- Next steps
  - Evaluate day, time and curriculum of Monday group; consider eliminating group
  - Spread learnings to entire Adult Team group program
  - Continue to educate staff and patients about the benefits of group therapy

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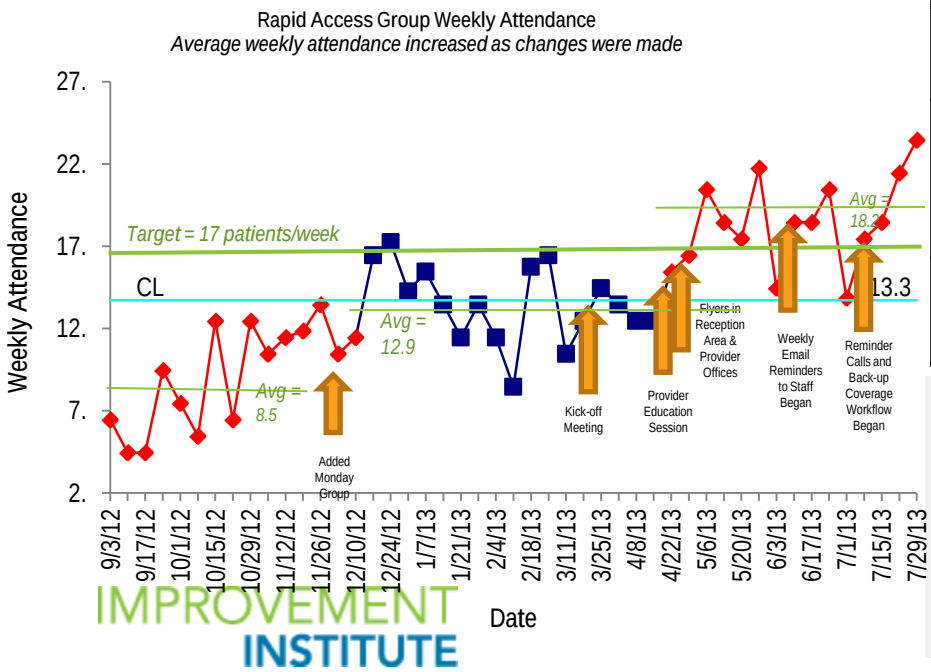
Project Results Summary

Lever: Increase attendance to Walnut Creek Mental Health Rapid Access Groups by improving communication to patients and providers, gathering information from patients, and sharing best practices among staff

"Evidence"/Expert Opinion/Basis: Increased attendance at Rapid Access Groups from an average of 12.9 patients to an average of 18.2 patients in three months.

Key Changes Applied:

- ✓Flyers with detailed information about groups were provided to patients and providers
- ✓Provided training session for providers on benefits of group therapy
- ✓Developed a Back-up Coverage plan to ensure no groups were cancelled



Source	• none
Key Assumptions	• Improved communication to providers would lead to increased attendance • Improved communication to patients would lead to increased attendance
Key Enablers	• Mental Health Adult Team
Sustainability Plan	• Maintain flyers in waiting rooms/provider offices • Refine Back-up Coverage policy • Evaluate group attendance/success (monitor attendance) • Continue feedback to staff
Contact	Improvement Advisors: Madeline McGInley, Darolyn Nollsch PI Director /Lead IA: Diane Coppa

Key Improvement Metrics: **Results**

Rapid Access Group Attendance	Increased from an average of 12.9 patients in April to and an average of 18.2 patients by August

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Attestation

With my electronic signature below, I attest the following:

- I have reviewed this document and confirm that it contains no protected health information (PHI), as defined here -- http://dms.kp.org/docushare/dsweb/Get/Document-1223053/What_is_PHI_handout.pdf
- I understand that failure to comply with KP policies, federal regulations, and state laws and regulations including those surrounding use of PHI can lead to disciplinary action – up to and including termination, personal fines, civil and criminal penalties and suspension of professional licenses.
- I have read the Principles of Responsibility, Kaiser Permanente's Code of Conduct -- https://wiki.kp.org/wiki/display/por/Home

Signature: Madeline McGinley, Darolyn Nollsch Date: 10/14/2013

EXHIBIT B

KAISER PERMANENTE®

Psychiatry Access

Improvement INSTITUTE

Improvement Advisor: Natali Clarke
PI Director / Lead IA: Rhonda Alfaro
Mentor: Maria Lee
Southern California Downey
December 7, 2012

Performance Improvement Project Summary

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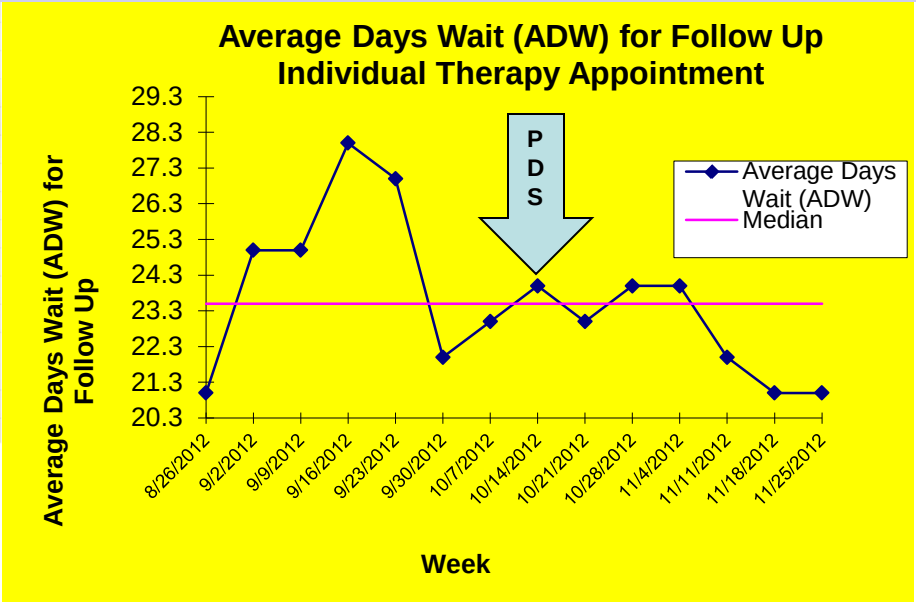
Lever: Reduce Average Days Wait between Individual Therapy Appointments from 21 days to 7 days.

"Evidence"/Expert Opinion/Basis: Meta-analysis studies indicate that a strong alliance developed in the early stages of the client/therapist relationship are essential to successful treatment outcomes*. Increased wait times impede alliance building. A reduction in wait time between therapy appointments will develop the patient/therapist alliance and result in improved treatment outcomes.

Key Changes Applied:

- ✓ Engagement Group – Group to discuss barriers to Txt for patients that chronically No Show Appts
- ✓ Provider Clinics – Providers will have a 2 hour "clinic" every other week where the can provide shorter appts or group appts to patients that are either in a "maintenance" stage of Txt or patients that have a similar diagnostic category
- ✓ Deliberate Template design – Making sure each provider knows how many sessions they can spend with each client after the initial intake. This understanding will allow for better Txt planning from the very beginning of Txt



Source	• *http://www.nrepp.samhsa.gov/Norcross.aspx - SAHMSA's National Registry of Evidence Based Programs and Practices
Key Assumptions	• No Shows clog up the system and need to be addressed • Templates are not designed to provide clinical pathways based on stages of txt or diagnoses • Patients are not being repatriated or routed to other depts, as needed
Key Enablers	• Strong Labor & Mgmt alliance • Incorporating front line staff
Sustainability Plan	• PI front line team is now an ongoing "Access Committee". The committee, led by the DA will continue to monitor impact of PDSA on Average Days Wait and use the Adapt, Abandon or Adopt method to determine changes.
Contact	Improvement Advisor: Natali Clarke PI Director /Lead IA: Rhonda Alfaro

Key Improvement Metrics:	**Results**
Average Days Wait for Individual F/U appts	Reduction from 25 to 21 days
Average Days Wait for Intake	Increase from 10 to 31 days **(This result may or may not be related to PDSA as changes to Intakes booking practices were mandated during the time of the PDSA)**
Patient Satisfaction with Access	5.45 on scale of 1 to 10

Driver Diagram Template—Downey Psychiatry Access

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Aim: Reduce the Average Days Wait for an Individual Therapy Appointment from 21 days to 7 days in by January 31, 2013 in the Downey Psychiatry Department.

Primary Drivers	Secondary Drivers	Initiatives & Metrics	Accountable Leader
Scheduling	Maintain: •Wait Lists •Sooner Appt Lists	•Work w/providers to manage Wait and Sooner Appt Lists •Work with Call Center agents to develop standard protocol	Natali Clarke, DA Karen Persip, ADA Access Committee
Factors Affecting Access	•DNK Rates (Highest for Intakes) •Unbooked/Open •Late Cancels •Indirect Time	•Reminder Calls •Engage patients in Group to discuss chronic DKA patterns •Track open slots by Provider	Natali Clarke, DA Karen Persip, ADA Access Committee
Self Referred Department	•Booking driven by patients •Patients are not repatriated back to non-specialty care	•Screen patients prior to Intake to determine if they need Psych Specialty Care •Repatriate back to Primary Care & Depression Care Program Template Change	Natali Clarke, DA Access Committee
Template Design	•Templates don't carve out clinical pathways based on stages of Txt. •Templates don't provide consistent ratio of Intake to Return visits	•Create shorter therapy appts for patients in a different stage of Txt •Provide therapists with information about # of return sessions for each Intake to ensure accurate Txt Planning	Natali Clarke, DA Access Committee
Staffing	• Insufficient Staffing Ratio Models • Work Stoppage •Turnover • Space limitations	•Develop staffing ratios w/Replacement factor built in •Ensure proper coverage •Track frequent call offs/Prof.Time by provider	Natali Clarke, DA Access Committee
Groups	•Closed vs Open Groups •Benefits of Group	•Assess Groups that are needed to meet pt needs.. •Assess w/c groups to cut	Natali Clarke, DA Access Committee

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Project Charter: Psychiatry Access for Individual Therapy Appts

Date: May 31, 2012

Improvement Advisor: Natali Clarke

Facility: Downey

PI Director: Rhonda Alfaro

Mentor: Maria Lee

Project SMART Goal

- Reduce the Weekly Average Days Wait for an Individual Therapy Appointment from 25 days to 7 days in by January 31, 2012 in the Downey Psychiatry Department. (Baseline period is September 1, 2012)

Problem Statement and Business Case

Problem Statement	Patients are unable to receive clinically effective treatment due to long waits in between appointments with their therapists
Business Case	
Customer Benefit	Quicker resolution of mental health issues. Reduced member service complaints. Increased employer group satisfaction b/c patients able to return to work sooner.
Expected Financial Impact	12% reduction in Net Loss (Net Loss is No Shows+Unbooked – Overbooks over Total Supply of Minutes) is equivalent to 800 annualized therapy hours. At an average of $43 an hour, this will result in approximately $35,000 in FTE savings.

Project Timeline and Key Milestones

- Assess: May 30 – June, 2012
  - Baseline Data Obtained: June 21, 2012
  - Project Kick-Off Completed: May 30, 2012
  - Process Map Completed: May 30, 2012
  - Project Charter Completed: May 30, 2012
  - Voice of the Customer Obtained: May 30, 2012
- Identify Changes: May – September 2012
  - Cause and Effect Developed: May 30, 2012
  - Develop PDSA Action Plans Started: June 28, 2012
- Test: October – December 2012
  - PDSA Action Plans Completed
- Implement: October 2012 – December 2012
  - Sustainability Plan Completed: October 2012
  - Training and Communication Plans: September – December 2012
  - Financial Impact Validated by Finance – December 2012
  - Project Storyboard Complete and Submitted: December 2012
  - Spread Plan: February 2013

Project Team

- Sponsors: Lynn Peacock, Downey AMCA
- Champions: David Kliger, MD, PIC Downey Psychiatry
- Project Co-Leads: Natali Clarke, DA, Barbara Styzens, CPM @ Orchard, Ford Loverin, CPM @ Norwalk
- Front-Line: David Kliger, MD @ PIC of Downey Psych, Mercedes Garcia, MD @ Asst PIC of Downey Psych, Ford Loverin, Clinical Program Manager @ Norwalk, Barbara Styzens, Clinical Program Manager @ Orchard, Karen Persip, Call Center ADA, Priscilla Allen, Clerical Supervisor, Amy Lee, LCSW Therapist @ Norwalk, Nick Fox, LCSW Therapist @ Norwalk, Karen Cavazos, LCSW Therapist @ Norwalk, Josue Gonzalez, Call Center Agent, Tarina Marie, Psych RN @ Orchard, Deborah Macheski, LCSW Case Manger @ Orchard, Charlotte Pasillas, LCSW & On Duty Therapist @ Orchard, CJ Kurumada, LCSW Therapist @ Orchard, Steven Morones, Master Scheduler
- Project Oversight: PI Committee

Project Measures

- Outcome Measures: Weekly Average Day Wait (ADW) for Individual Follow Up Appts (average # of days patients wait from the date the therapist determines they need to be seen to the actual date they were seen)
- Process Measures: Patient Satisfaction with Access – (1 to 10 scale, 1 being very dissatisfied and 10 being very satisfied)
- Balancing Measures: Average Day Wait for Consult (Intake) Appts (Average # of days patients wait from the date they first contact the department to the actual date they were seen)

Project Scope

- In Scope: Monitoring ADW for Individual Therapy, Tracking appropriate level of care, Identifying Training Opportunities, Monitoring use of Sooner Appt List (SAL), Distinguishing Definition of Follow Up vs. Routine, Target Date Errrors,
- As Needed: Workflow for Routine Appts, Group Census, Template Design, Appt Type Usage, Impact on other clinical services
- Out of Scope: Projecting needed FTEs, Changing other area's practices, Changing MD practices

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Assessment Results – Baseline Process Stream Map

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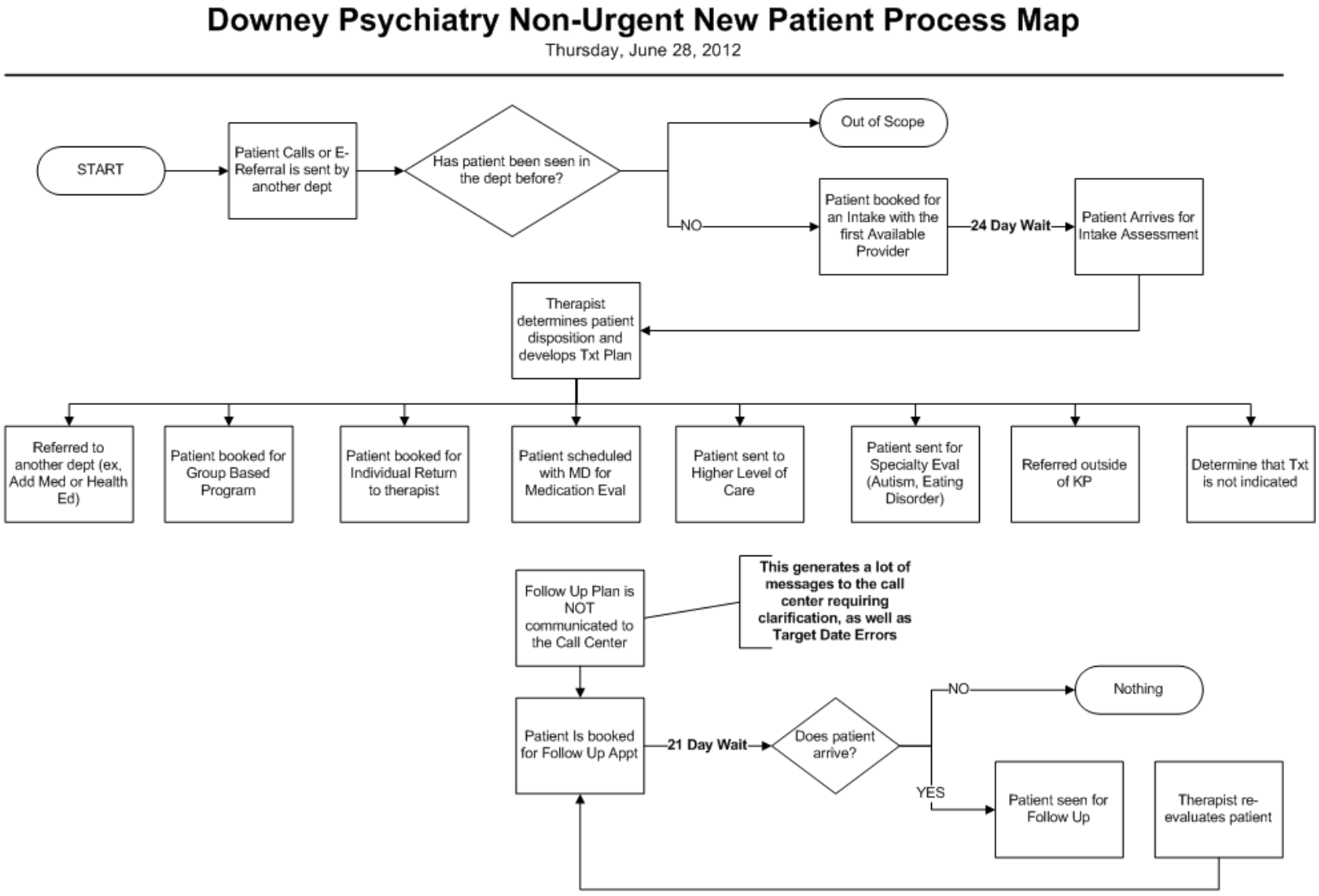

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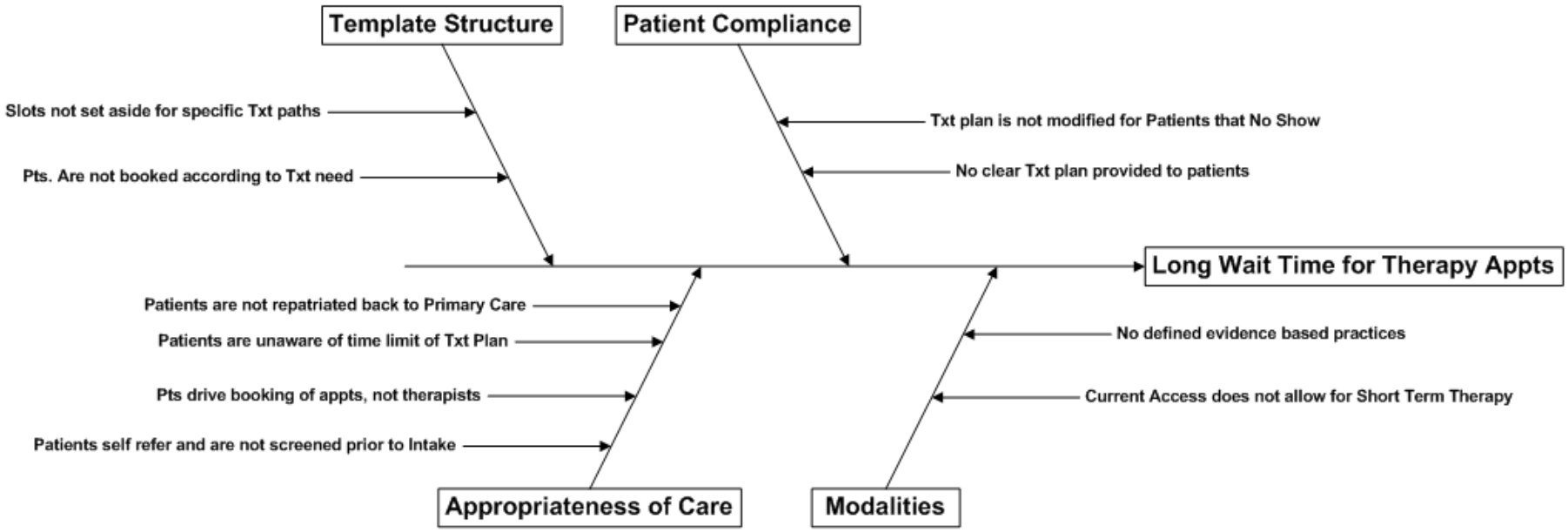
Assessment Results – Fishbone Diagram



Voice of the Customer

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Patient Satisfaction with Access – Although ADW captures HEDIS standards for Access, it does not capture patient's satisfaction with access or perception of access. In order to understand this we:

1. **Contacted patients that had complained about access to the department. Found out that patients were frustrated with the long wait time, but also when they did get in, *it was not the type of visit they were expecting, i.e., they wanted to see an MD only, they only wanted the couples class, etc, they were dealing with primarily substance abuse issues.***
2. **Created a Point of Survey questionnaire that is a proxy to the ASQ questionnaire, in order to obtain real time data during the PDSAs**

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What Changes Lead to Improvement?

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Change Concept	*PDSAs*	*Adopt, Adapt, Abandon?*
Remove system bottlenecks by reducing number of appointment supply consumed by patients that chronically No Show appts.	**Engagement Group -** Manage patients that chronically No Show by having them booked to an Engagement Group instead of to the Individual provider's schedule. The Engagement Group will focus on identifying barriers to patient engaging in treatment. By booking all of these patients to a group instead of an individual appointment, more appointments are available for individual therapy	**Adopted – This change has been very successful. Patients are able to realize the importance of compliance with treatment, and we are seeing a reduction in Average Days Wait.**
Improve Efficiency	**Provider Clinics -** Create new appointment slot concept (provider clinics) in providers schedules. These clinics are a new pathway and can serve patients that are in a later stage of treatment and don't require an hour of individual therapy. Because these are short appointments, these clinics can also be overbooked, creating even more supply	**These provider clinics just started on Dec 15 and we currently don't have enough date to determine if we should adopt, adapt or abandon**
Improve Efficiency	**Deliberate Template Design -** By looking at each individual provider's schedule, we were able to determine how many sessions they could spend with a patient after they did an Intake. By informing the providers of the number of sessions they have available, the provider is better able to develop a treatment plan and discharge the patient when appropriate, as opposed to continuously booking the patient.	**The template design is schedule to start Jan 15 and we currently don't have enough date to determine if we should adopt, adapt or abandon**

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How Will We Know a Change is an Improvement?

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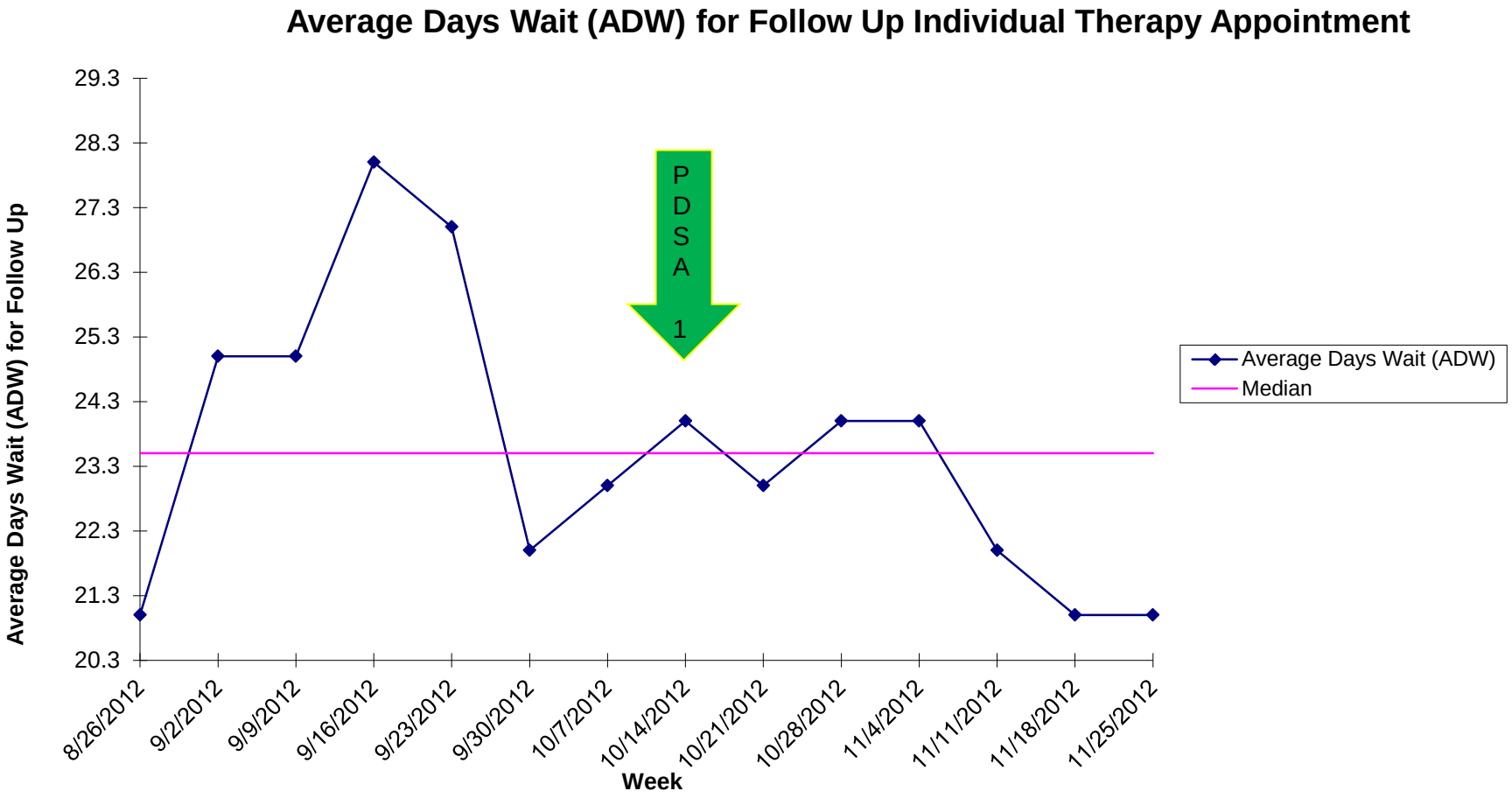

*PDSA 1 started Oct 15 so there are not enough data points yet to determine if there is a Special Cause. PDSA 2 will be implemented on Dec 15, PDSA 3 will be implemented on Jan 15.

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Financial Impact

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Soft Financial Benefit

FTE Capacity Change – Increase in 10% appt supply through overbooks and group appts.	.38 FTE	$34,440 12-month Financial Impact	•FTE: $43 an hour on avg. •10% increase in appt supply through overbooks. •Net gain in available hours: 800 additional hours available with no increase in current FTEs Key Assumptions

Estimated Financial Benefit = $34,440

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Sustainability Plan

Process Owner(s): Natali Clarke, DA

Daily Oversight: Ford Loverin & Barbara Styzens, CPM

Locations: Orchard & Norwalk Psychiatry

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	Item	Action	Responsible Person	Frequency
Bundle of Actions	Action 1	Train and Reinforce Policy & Procedures for Engagement Group	Karen Persip, Call Center ADA	Quarterly or as needed when new staff are on-boarded
	Action 2	Provide therapists with up to date ratios of Intakes to Returns	Steven Morones, Edna Clayton – Master Schedulers	Yearly or any time a provider adds or reduces a service (such a groups)
	Action 3	Review Census of Provider Clinics to make sure they are being overbooked	Steven Morones, Edna Clayton, Master Schedulers	Weekly on a pro-active basis
Data Analysis & Results	Gather Data	ADW for Follow Up & Intake. ASQ for Patient Satisfaction with Access	Natali Clarke, DA	Weekly
	Analyze Data	Update Run & Control Charts	Natali Clarke, DA	Weekly
	Report Results	Report at Access Meetings		Bi-Monthly
Communication	Project Team	Officially changed to an ongoing “Access Committee” Will continue to review PDSAs and develop new PDSAs	Natali Clarke, DA	Bi-Monthly
	Department Leaders	Administrative Meetings & Email	Natali Clarke, BarbaraStyzens & Ford Loverin, Clinical Program Managers (CPM)	Bi-Monthly & As needed
	Leadership	One on One & 4 pack Meetings	Natali Clarke, DA	Monthly
Training	Project Team Meetings	Keep up dated notebook with P&Ps	Karen Persip, ADA	Review 2x a Year or as needed with new changes
	Huddles	Bring up workflow issues regarding PDSAs and how to improve upon them	Barbara Styzens & Ford Loverin, (CPM)	Daily
	Other	Clerical Meetings & Staff Meetings	Natali Clarke, Barabar Styzens & Ford Loverin, CPM	Monthly

Moving Forward

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- **Key to Success**
  - Engage front line staff from the beginning
  - Spend time explaining IA model to front line staff and ensuring they understand the tools and what the data will show
  - Spend sufficient amount of time brainstorming goal and measurements as a group. This gets everyone on board at the beginning and moves the process along faster
  - Using In Scope/Out of Scope technique. This really guides process when "scope creep" starts to happen
  - Documenting and providing aids for workflow changes.
  - Having sufficient time to meet as a group.
- **Barriers**
  - Getting volunteers to be the tests of change. The process used took too long, so we should have began it earlier
  - Communicating the tests of change to all staff so they understand why the volunteers are doing something different than the rest of the clinic.
- **Lessons learned**
  - Don't pick tests of change that are complicated. Even though they sound good on paper, if it is not easily understandable, it's probably too complicated to be considered a small test of change.
  - Communicate, communicate, communicate! You can't communicate the change enough. Doing this helps keep the data cleaner!

- **Next steps**
  - Continue with our 3rd test of change
  - Brainstorm additional tests of changes to improve Follow Up Access
  - Continue monitoring data and sharing data with group and staff
  - Next initiative for portfolio is Average Days Wait for Intakes

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