November 23, 2020

To: Daniel Woody, Assistant Medical Group Administrator, San Francisco Service Area;
Laura Peterson, Assistant Medical Group Administrator, San Francisco Service Area;
Guy Chicoine, Medical Group Administrator, San Francisco Area
Maria Ansari, M.D., Physician in Chief, San Francisco;
Elizabeth Gebis, M.D., Co-Chief of Psychiatry;
David Chou, M.D., Co-Chief of Psychiatry;
Golee Abrishami, Co-Director of Psychiatry, San Francisco;
Noel Legorburu, Co-Director of Psychiatry, San Francisco;
Sofia Gonzalez, San Francisco, Director of Addiction Medicine and Recovery Services;
Deanne McCoy, San Francisco Area Compliance Officer.

Cc: Christian Meisner, Senior Vice President and Chief Human Resources officer of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals;
Jim Pruitt, Vice President, LMP and National Labor Relations, The Permanente Federation;
Agnes Amistoso, Regional Director Strategy & Programs, Regional Mental Health Administration, TPMG;
Lorraine Barrera, Labor Relations Consultant, TPMG;
Deborah Glasser, Labor Relations Consultant, TPMG;
Susan Lewitt, Labor Relations Consultant, TPMG;
Kisha Grove, Human Resources Director, San Francisco Service Area;
Grace Putulin, HRC, San Francisco Service Area

Dear Mr. Chicoine, Mr. Woody, Ms. Peterson, Dr. Ansari, Dr. Gebis, Dr. Chou, Dr. Abrishami, Dr. Legorburu, Dr. Gonzalez, Ms. McCoy:

It is our responsibility as licensed mental health professionals to inform you that our adult and child patient caseloads are too high to provide safe, ethical, and clinically appropriate care to our patients. In addition, many of our groups and classes, in both our Psychiatry, Integrated Behavioral Health (IBH) and Addiction Medicine and Recovery Services (AMRS) programs, are operating with patient numbers well beyond a size that allows clinicians to adequately attend to the needs of the patients.

Imagine your loved one is a Kaiser member in need of mental health care reaching out for individual therapy today; here are the steps they would have to go through:

1) Call to speak with our Triage staff who would provide a risk assessment. That person would book an appointment for an intake assessment visit. CA law requires a patient to be assessed within 10 business days.
2) Attend the visit with an Intake Assessment Coordinator. If they are assessed to be in need of treatment in the clinic, they would be booked another intake appointment, this time with a clinician who would become their treating therapist. (current wait time: 12-13 weeks).
3) Finally, have their intake appointment with their individual therapist. Make appointment for follow up visit for treatment. (current wait time: 6-12 weeks)

Your loved one would have to wait for 4-5 months to finish with the assessment process and start individual treatment. While they waited, their depression or anxiety would likely worsen, like many medical conditions that are not adequately treated. They might be booked into a group, but groups are also overbooked. In many cases, patients are not ready for groups to be the first line of care and would likely

fail to attend the group or drop out. The majority of groups are now booked out to February 2021. Concerningly, our crisis programs have also been impacted, leaving providers to hold high risk patients (frequently with psychosis or suicidal thoughts) on their own while they wait for an opening, usually several weeks out for our Intensive Outpatient Program and Rapid Symptom Reduction. Providers are no longer able to utilize groups to bridge care as the vast majority of groups offered in our clinic are not available for several months.

Management's inability to provide guidance or solutions forces each clinician to enforce a system of inadequate and unethical care on our patients over which we have little control. Forcing each individual clinician to inform patients of the lack of available treatment often negatively impacts the therapeutic alliance and gives many patients the message that they do not need or deserve treatment, after having had to wait several months to see a therapist.

With the pandemic came a 40% increase in alcohol sales, and likely, a similar rise in other substance use. AMRS is running groups that have 40-50 patients. SAMHSA (Substance Abuse and Mental Health Services Administration) recommends groups be a fraction of that size. Caseloads have increased dramatically, and the number of positions were reduced in the department. Patients are unable to get the individualized treatment that they need, and the group facilitators are not able to appropriately assess for risk. Clinicians have difficulty referring dually diagnosed patients for treatment in Psychiatry because of the long wait.

In IBH, clinicians are being asked to see 20 new patients and 20 return appointments per week, sacrificing treatment of patients for intake access. The sheer number of patients do not allow of individualized, ethical care. Patients who are suffering get a 30 minute intake and unable to see their clinicians again for 4-6 weeks. Clinician burnout and turnover are high.

We are unable to provide the services that meet our professions' standard of care. These practices violate legal parity mandates. California's new Mental Health Parity law "requires health plans and insurers to use specified clinical criteria and guidelines for level of care determinations and prohibits the application of additional, different or conflicting criteria." The care provided also does not support Kaiser's goal of health equity and exacerbates health disparities, which are often aligned with systemic racism. Patients who can afford private practice fees pay out of pocket for their mental health, while those without the financial means wait 6-12 weeks between appointments.

According to the CDC, a survey conducted in June, 2020 found that 40% of US adults reported struggling with mental health or substance use. The increased demand for treatment has not been met with increased staffing or services. Failing to systemically address these concerns, which we have continually raised in a variety of forums, is unethical and constitutes poor patient care and a willful denial of serious inadequacies in the Kaiser Permanente system. Although we are working overtime in an effort to make up for severe understaffing and excessively large caseloads, it is not enough to provide safe, ethical, or clinically appropriate care for our patients. In addition to exacerbating factors from the pandemic, including several COVID- 19 exposures within our clinic, this work environment is crushing and demoralizing.

For all of these reasons, we request the following from Management:

1. Acknowledge the severe understaffing in both the Psychiatry, IBH and AMRS Departments, and act immediately to post positions to *increase* the number of staff in each department in addition to immediately replacing all currently open positions.

2. Immediately restrict the number of new patients added to our schedules and caseloads until we can adequately serve the patients we already have. Postpone plan to convert return appointments to new appointments until the patients in our caseloads receive proper care.

3. Provide a liaison and support to patients who are referred to outside providers so they can get the care that they need.

4. Adhere to community standards and Medicare and SAMHSA guidelines for appropriate group sizes within the Psychiatry, IBH and AMRS Departments.

5. Make no reductions to IOP and group staffing to ensure there are appropriate and adequate services available to patients at all levels of care. Create a crisis treatment team to address patients with urgent needs.

6. Refrain from advising us to define our treatment plans based on what care is available, and instead commit to working with us to deliver the medically necessary care required for each patient.

7. Provide support services, whenever and wherever possible, such as technical support for patients for video visits and groups, assistance with referrals and disability processes in AMRS, so that we can spend our limited time focusing on providing patient care, rather than on the various administrative duties with which we are currently tasked.

Please respond promptly, within 10 business days with a concrete plan to address these concerns and outline a workable solution or we will escalate these issues to the next level.

Thank you,

Kathryn Brown, MFT
Jonathan Oringher
Enrique A Olivella Vives
Tiffany Loggins PsyD
Jeffery M Chen-Harding MFT
Elizabeth Kennard, LMFT
Lisa Hopson, LMFT
Amy Rice, PhD, MFT
Eamonn R McKay, LMFT
J. Allison He, PhD
Cassandra Najarian, LMFT
Erik Bernecker, PhD
Sarika Bahl, PsyD
Christina Kyskan, PhD
JL Zbacnik, MFT
Anna Mikuriya Jungherr, LCSW
Marilyn Harding, LCSW
Alicia Cruz, mft
Caleb Birkhoff, MFT
David Meshel PhD.
Susan Siep
Samantha Canter LMFT
Christopher Vogt, LCSW
Barry Lee Forrest, LCSW
James. E Beauford. Psych
Nicole Colao-Vitolo, PsyD
Tomoko Kunita, LMFT
Sandy Chu, LCSW
Saba Omidvar, AMFT
Chi Keung Choi, LCSW

Gayl Dieckman LMFT
Victoria Solari, AMFT, APCC
Jeanine Seymour MFT
Jenna Moschetto PhD
Christin Mullen, LMFT
Gernanie Santiago, LMFT
Irina Slutsky
Carlos H Morales
Russ Nordmeyer, LMFT
Juliana Núñez-Saksa, Ph.D.
Todd Moldovan MFT
Victoria Meraz
Hillary Burke, PsyD
Ken H. Perez, Psy.D.
Wendy Skillern, LCSW
Pauline Chan, LCSW
Robin Neville LCSW
Mehreen Zahoor, LMFT
Ann Tran, PhD
Helen Star, MFT
Tina Dietz PhD
Kelly Marie Lennon, LCSW
Luis Cornejo, LMFT
Erik Bromberg, LCSW
Ashley Woodhull, PhD
Kathleen Hardisty, LCSW
Brian Wolfe LMFT
Michelle Deely, MFT
Adam Jacobson, LCSW
Emily Schwartz
Raquel Garcia,LMFT
Whitney Lynch, Psy.D.
Kit Choi,Lcsw
Runa Korde, PhD
Heidi Brunette, PsyD

Additional comments and concerns, submitted anonymously:

It is a horrendous ethical violation when we are asked, and in many cases told, to inform patients who are begging for more care that there is simply nothing to be done. It goes against every reason why I became a mental health clinician.

This is not sustainable. I would love to be proud of working for KP mental health but ***all I do is defend a system that doesn't work for my patients. Force booking risk patients is not the answer.***

I am an IAC on the Adult Psychiatry team. As of today secondary intakes are booking on Feb 4th.There are no HED classes or Psychiatry groups available until January. I have no resources to build a treatment plan.

My patient's husband died unexpectedly in August and he is struggling with grief, depression and anxiety. He completed an intake appointment with a C2C clinician in October and was told that the next available appointment with a female therapist in the Department of Psychiatry is in January 2021. What is he to do

to manage until then? His depression will only get worse the longer he waits for services, the very services that he pays for with his monthly premium. He is doing the opposite of “thriving”. This is unacceptable.

It pains me to say this because I firmly believe that the therapists on our staff are talented and skilled, but I would not recommend KP mental health services to anyone who asked me, because of the egregious delays being able to access regular evidence-based individual therapy. Seeing your provider once every 4-6 weeks is appropriate for maintenance and relapse prevention work AFTER you have already completed a course of weekly therapy. Most research supported therapy trials are 12-16 weeks of weekly therapy. I do not see myself working for this organization much longer given this ethical discrepancy in what I know is good care and what I am able to provide in Kaiser. I know many of my colleagues feel the same way and that Kaiser’s reputation in the professional mental health community is suffering. How will you replace your ranks if your staff have nothing good to say about working here? Hire more therapists. ***Hire more administrative support staff for your therapists. Focus on employee retention. Or get ready for the worst staff turnover in the middle of a mental health crisis in middle of the worst global pandemic.***

The current ratio of 1:1 for returns with IBH is unsustainable and results in high clinician turnover. The team does not have adequate staffing.

I had 16 parents in my IOP group and it is hard to run this group on my own when my co-facilitator is out.

Our patients wait, and wait, and wait for an appointment, then wait more for a return appointment. We don’t meet access guidelines or the standard of care. The system that Kaiser Permanente has created is negligent and dangerous.

We need more staff if we have any chance of meeting the needs of our patients.

Need more IPC time to write notes and do case conceptualization. We need more IPC time to integrate virtual systems.

I worry about patient suicides happening for those patients who become despondent and discouraged from lack of access to care. I worry about external referral for outside services with patients who become too depressed or anxious to follow-up with care and suicide, and I happen to be last point of contact referring a patient out when care in-house to see a new therapist next available is Feb 2021. Kaiser SF PSY needs to hire therapist, fill vacant positions for therapist providers who have left the clinic or hire temp work at minimum. Kaiser is failing to step-up, especially during a pandemic. Kaiser now it is your turn, a call-to-action, do more, we therapists depend on you for a solution today to improve and increase access to care, and so do Kaiser patients who need mental health care now.

I am tired of telling my patients that I cannot meet with them again for another 10 weeks. That's about 5 appointments in one year. 90% of them don't want to be in a group. They know and I know that what we have to offer them is inadequate. They deserve better. With proper staffing and hiring, we can give them better.

I want to provide consistent care for patients that need it but it is really hard.

There are a lot of intake appts available but not returns.
My patient wanted an appointment in psychiatry dept with provider before January. Provider was already booked into February.

Seeing so many of my peers leave this year has planted a seed. Every single day I fight the urge to leave Kaiser. There are days where I think I am putting my license on the line and I feel unethical at times. I feel

shame and anger. ***It is frustrating to hear patients say that they have had great experiences through other Kaiser departments, except psychiatry, particularly now when the nation and the world is collectively experiencing a traumatic event, and they need psychiatric services and more support.*** It is soul crushing to say to a patient that I cannot see them for weeks particularly if they have been waiting for months to be seen after their first intake with an IAC. It is soul crushing to tell a patient that the next available secondary intake is in February or that my next follow up appointment is in 7 to 8 weeks. Groups are no longer an option to help clinicians supplement treatment. Groups are so overbooked and so many have long waiting lists. Even if a patient is appropriate for group they have to wait approximately 2 months to start. The constant feeling of failing patients because you cannot provide them with the care that they need is difficult. Not to mention a lack of options and resources. Patients feel unseen, unheard, abandoned, and invalidated. I feel the same way. I feel unseen, unheard, abandoned, and invalidated by local and regional management and the way they have chosen to meet this moment. Please reevaluate your priorities. Please help us.

We have 4 providers (retired/resigned) with no hiring, and now with 3 providers on leave, another 1 will take maternity leave in Jan, there is still no promise from management to hire new providers for adult team. Our intake has been booked till Feb, not ethnical for Pt to wait for 10-12 weeks for a through assessment. And the 7 providers' patients also need someone to follow up.

I am an IAC on the Adult Psychiatry team. As of today secondary intakes are booking on Feb 4th.There are no HED classes or Psychiatry groups available until January. I have no resources to build a treatment plan.

The Permanente Medical Group/Leadership/Management has unjustly and inequitably burdened clinicians in AMRS compensated 32 hours a week and 36 hours a week to provide the same workload as their compensated 40 hours a week peers. Given the impact of COVID, Assessment Team clinicians have had to carry more workload over the past year than the Day Treatment Team clinicians ---(who are themselves weighted with an excessive workload of large groups of high acuity and complex cases)--- such that 32-hour and 36-hour A Teamers have been unfairly expected to continue this gross imbalance to date, without any additional compensation, despite the excessive overtime it requires to complete this load. This inequity is extremely costly to the welfare of the clinicians, the AMRS team/clinic, and a most definite detriment to patient care.