November 6, 2020

To: Linsey Dicks, Medical Group Administrator, Diablo Service Area; Alan Chan, Assistant Medical Group Administrator, Diablo Service Area; Pravin Venketsamy, Area Director for Mental Health and Addiction Medicine, Diablo Service Area; Natasha Quackenbush, Psy.D., Antioch Director of Mental Health and Addiction Medicine & Recovery Services; Debra Mendlowitz, Ph.D., Pleasanton Site Director of Mental Health and Chemical Dependency Services; Lorena Roth, LCSW, Walnut Creek Director of Mental Health; Curtis Arthur, MFT, Walnut Creek Director of Addiction Medicine and Recovery Services; Eric J. Cano Kaminski, Area Compliance Officer, Diablo Service Area

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; Lavern Mitchell, Human Resources Director, Diablo Service Area; Johanna O'Guinn, HRC, Diablo Service Area;

Dear Mr. Dicks, Mr. Chan, Mr. Venketsamy, Dr. Quackenbush, Dr. Mendlowitz, Ms. Roth, Mr. Arthur, and Mr. Cano Kaminski,

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 Mental Health and Addiction Medicine and Recovery Services programs, are operating with patient numbers well beyond a size that allows clinicians to adequately attend to the needs of the patients.

Given the incredible increase we have seen in both demand for services and severity of symptoms in our patients, as well as the exodus of clinicians who can no longer survive in these working conditions, it is currently not possible for us to provide treatment in line with the Standards of Care of our profession. In our respective clinics in Antioch, Pleasanton, and Walnut Creek, our Generalists see patients for an assessment, and this is currently followed by a five to nine week or longer wait until we can provide an individual return appointment. While group treatment, without concurrent individual treatment, is not an appropriate or acceptable level of care for most patients, we are currently experiencing group sizes that are so large and group waitlists that are so long, that we cannot even offer these group services to our patients.

Clinicians across all teams are regularly booking patients into their lunch hours and IPC time, and it is standard practice to work late to attend to paperwork and returning phone calls. Even taking into account these unsustainable practices, we are still not able to provide safe, ethical, and clinically appropriate care to our patients. Management's inability to provide guidance or solutions to this situation 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. This is creating an environment that is crushing and demoralizing.

We often get the following response from the management when we raise the issue of long wait times for return appointments: "We would expect our therapists, if they thought a patient needed to be seen sooner, would elect to discuss it with their manager and look for alternative times and strategies... we have ways of accommodating this when it comes up." We are hereby informing you, our management team, that we all have extensive lists of patients requiring sooner individual return treatment appointments than we have been able to give them in our work days, even by working many hours of overtime. It is increasingly the case that many of us have a list of

patients (totaling more than 50 patients for numerous clinicians) who have no upcoming individual appointments because we are booked out over two to three months. We are also informing you that we are not able to address the individualized treatment needs for our patients when group and class sizes are so large. 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 Mental Health system.

Although we are working overtime in an effort to make up for severe understaffing and excessively large caseloads, this is not enough to provide safe, ethical, or clinically appropriate care for our patients. For these reasons, we request the following from Management:

1. Acknowledge the severe understaffing in both the Mental Health and Addiction Medicine and Recovery Services 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.
3. Immediately cease converting return appointments to new appointments until all of our current patients are provided with adequate and timely care.
4. Adhere to community standards and Medicare guidelines for appropriate group sizes within the Mental Health and Addiction Medicine and Recovery Services Departments.
5. Make no reductions to IOP, CCM, or Crisis treatment services to ensure there are appropriate and adequate services available to patients at all levels of care.
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, 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, no later than Friday, November 20th 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,

Abigail Reynolds, PsyD, Antioch Child Team, (current return appt wait time is 4-6 weeks)
Adam Front, PhD, Walnut Creek AMRS
Adam Harrison, LCSW, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Adriana Abril, LMFT, Walnut Creek Adult Team Generalist (current return appt wait time is 4-6 weeks)
Alberto Matias, PhD, Antioch Adult Team
Alena Schabes PsyD, Antioch Child Team (current return appt wait time is 4-6 weeks)
Alex Sloan, PsyD, Walnut Creek IOP
Alexandra Crockett, PsyD, Walnut Creek AMRS
Allison Delorefice, PhD, Pleasanton Adult Team (current return appt wait time is 7-9 weeks)
Amy Cohen, PhD, Walnut Creek Adult Team (current return appt wait time is 5-7 weeks)
Andrea Mar, LMFT, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Andria Cremolini, MFT, Walnut Creek Child Team
Ann Matsumoto, LCSW, Antioch Adult Team
Ann Schiebert, PsyD, Walnut Creek AMRS
Annette Mears, PsyD, Antioch IOP and Adult Team (current return appt wait time is 7-9 weeks)
Arwin Cotas-Girard, PsyD, Antioch Child Team
Brenda Luna, Antioch Adult Case Management
Brooke Rawdin, PsyD, Walnut Creek IOP

Catherine Fan PhD, Walnut Creek Central Triage, Diablo Service Area
Catherine Little, LMFT, Walnut Creek AMRS
Catherine Logsdon, Walnut Creek AMRS
Charles Bultman, LMFT, Walnut Creek Adult Team (current return appt wait time is 4-6 weeks)
Chinue Brown, PsyD, Antioch Child Team (current return appt wait time is 4-6 weeks)
Chris Domke, PsyD, Walnut Creek
Chris Emory Brown, LMFT, Pleasanton Adult Case Management
Christine Frances Lyng, LCSW, Walnut Creek Women's Health
Christopher Jensen, Ph.D., Walnut Creek Child Team (current return appt wait time is 4-6 weeks)
Christopher S. Jones, LMFT, Antioch AMRS
Claudia wathen, Psy.D, Walnut Creek AMRS
Colin Boylan, LPCC, Pleasanton Adult Team (current return appt wait time is 4-6 weeks)
Constance Mayer, LMFT, Pleasanton Child Team (current return appt wait time is 4-6 weeks)
Cori L. Pansarasa, PsyD, Walnut Creek Central Triage, Diablo Service Area
Corin Ponn, Walnut Creek IOP/CM
Corinne Young, PsyD, Walnut Creek PSY/AMRS
Corissa White, PsyD, Antioch Adult Team, 4-6 weeks
Cris Avila, LMFT, Antioch (current return appt wait time is 7-9 weeks)
Crissy Bankston, PSYD, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Dahlia Magdy, PsyD, Walnut Creek Eating Disorders
Dana A Priebe, PsyD, Walnut Creek Triage and Crisis Teams
Dean Picone, PhD, Pleasanton Adult Team (current return appt wait time is 7-9 weeks)
Diane Manning, LCSW, Pleasanton Child Team
Dominic Gonzales, LMFT, Walnut Creek Child Team
Elizabeth Noel Nabeshima Psy.D., Walnut Creek Adult IOP
Emily Hirsch, LCSW, Walnut Creek Central Triage, Diablo Service Area
Erika Falk, PsyD, Pleasanton Adult Crisis
Erin Peterson, LMFT, Walnut Creek Child Team (current return appt wait time is 4-6 weeks)
Feyi Momoh, LCSW, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Genevieve Green, LMFT, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Heather Caruso-Maxey, PhD, Pleasanton Child Team (current return appt wait time is 7-9 weeks)
Helen Muscolo, MFT, Walnut Creek Central Triage, Diablo Service Area
Jane Leung, LMFT, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Jason Reynolds, PsyD, Walnut Creek IOP
Jean Mirando, LMFT, Walnut Creek Adult Team (current return appt wait time is 4-6 weeks)
Jennifer Barkin, PsyD, Walnut Creek AMRS
Jennifer Caldwell-Hernandez, MFT, Walnut Creek Central Triage, Diablo Service Area
Jessica Bergstrom, Psy.D, Walnut Creek Adult Team Generalist ((current return appt wait time is 7-9 weeks)
Jessica Lande, Psy.D, Walnut Creek Behavioral Medicine
JeTaime Austin, MFT, Pleasanton Adult (current return appt wait time is 7-9 weeks)
Joanna Jeremy, LMFT, Antioch Child Team (current return appt wait time is 4-6 weeks)
Joanna Mendoza, PsyD, Antioch Child Team (current return appt wait time is 7-9 weeks)
Judi Warehouse LMFT, Walnut Creek Crisis Team and HCLS
Judith A Hampshire, LMFT, Walnut Creek
Julia Gallichio, LCSW, Pleasanton (current return appt wait time is 4-6 weeks)
Julia S. Avedisian, MFT, Walnut Creek Central Triage, Diablo Service Area
K Benjamin Knipe, PsyD, Pleasanton Child Team (current return appt wait time is 4-6 weeks)
Kalana Greer, Psy.D., Antioch Adult Team (current return appt wait time is 10+ weeks)
Karen Lau, LCSW, Pleasanton Adult (current return appt wait time is 4-6 weeks)
Karen Silverman, LCSW, Antioch Adult Team (current return appt wait time is 7-9 weeks)
Karlene Alves, PsyD, Antioch Child Team

Kathy Ray, LCSW,LCSW, Walnut Creek Child Team (current return appt wait time is 4-6 weeks)
Kenneth Gregg, LCSW, Walnut Creek Adult Team (current return appt wait time is 4-6 weeks)
Kira Torre, MFT, Pleasanton AMRS
Kristi Reimer, Psychologist, Walnut Creek Central Triage, Diablo Service Area
Lais Shirgul, PsyD, Walnut Creek Child Team
Lauren Erickson, LMFT, Walnut Creek (current return appt wait time is 4-6 weeks)
Lauren Madlock, Psy.D., Antioch Adult Team (current return appt wait time is 4-6 weeks)
Leslie Wasserman, LCSW, Walnut Creek Crisis team
Lianne Zerbe, LCSW, Pleasanton
Linda Mackinson, LCSW, Pleasanton Early Start
Lori Ono, PhD, Walnut Creek IOP/CM
Lori S Gant, LCSW, Antioch IOP
Maria Garay, LMFT, Walnut Creek Adult Team Generalist (current return appt wait time is 7-9 weeks)
Mary Valentina Mornard, LMFT, Walnut Creek Eating Disorders
Matt Haynes, LCSW, Walnut Creek AMRS
Michael Fitzpatrick, PsyD, Pleasanton (current return appt wait time is 4-6 weeks)
Miriam Walter PsyD, Park Shadelands Dept of Medicine
Nadesdye Valdes, LMFT, Antioch AMRS
Nardine Azab, MFT, Walnut Creek Child Team
Natasha Gadinsky, PsyD, Walnut Creek Adult IOP
Nicole Ng PhD, Pleasanton Adult Team (current return appt wait time is 7-9 weeks)
Olayinka Rahman, PsyD, Antioch Adult Team (current return appt wait time is 4-6 weeks)
Paddy Poupeney, LMFT, Walnut Creek AMRS
Parbdeep Sandhanwalia, Walnut Creek Case Management
Pat Campbell, Ph.D., Licensed Psychologist, Walnut Creek AMRS
Phillip Lowe, Psy.D, Walnut Creek Adult Team (current return appt wait time is 4-6 weeks)
Phylis Kramer, PhD, San Ramon Behavior Medicine
Rachel Steinberg, PSY D, Walnut Creek
Renee Dahlke Zaloumis, LCSW, Walnut Creek Central Triage, Diablo Service Area
Renee Hawley, LCSW, Walnut Creek Central Triage, Diablo Service Area
Richard Freed, Ph.D., Antioch Child Team
Rita L Smith, PhD, Walnut Creek Child Team
Rob Park, PsyD, Antioch
Robert Keith Schroeder LMFT, LAADC, Walnut Creek AMRS
Rosemary Donalson PsyD, Walnut Creek Adult Team (current return appt wait time is 4-6 weeks)
Ryan Adams, Psy.D., Pleasanton Child Team (current return appt wait time is 4-6 weeks)
Ryan Adams, Psy.D., Pleasanton Child Team (current return appt wait time is 4-6 weeks)
Ryan Kolakoski, Walnut Creek Adult and Child Teams (current return appt wait time is 4-6 weeks)
Shannon Maximov, LCSW, Walnut Creek Case Management
Shelby K. Smith, PsyD, Walnut Creek AMRS
Stephanie Gade, PhD, Walnut Creek Clinical Case Management
Stephanie Sanders, LCSW, Pleasanton Child Team (current return appt wait time is 4-6 weeks)
Sue Doster, LCSW, Walnut Creek AMRS
Wendy Paik, PsyD, Walnut Creek Child Team (current return appt wait time is 4-6 weeks)

Additional comments and concerns, submitted anonymously:

*"**I have specifically asked for help regarding this matter for many months without any help, solutions or support.** I have given ideas and they were disregarded."*

*"I and my colleagues in Addiction Medicine are putting in unreasonable amounts of overtime and managing **groups and caseloads that are so large that clinical effectiveness is vastly decreased**. In a time when our patients need us more, our availability is less, and many of us are on the road to burnout. We are being pressured to spread ourselves thinner and thinner for coverage of our groups and other services, and when we cry out for relief through increases in staffing or even per diem staffing, we are told that is impossible."*

*"Something has to give as the **current situation is unsustainable**."*

*"**Groups are suffering, clinicians are suffering, patients are suffering. We need support**."*

*"I do not feel able to provide enough support for pts between appointments. We are not able to provide enough groups (providers have no additional time to take on more groups due to case loads) for pts. **I cannot refer to appropriate treatment such as Case Management or IOP as needed** either, as these teams are overburdened as well. Because appts are so far apart, I make brief check in calls to pts using my IPC time. However, I am **then unable to have any time available when a pt contacts me in crisis** (something I would usually do during IPC time), and I am not able to contact them as quickly as would be clinically indicated. I feel that my pts are not getting the level of care and treatment they deserve and are entitled to."*

*"It has been very difficult to help patients who are stepping down from intensive services to generalists to be seen in a timely manner. **Those patients end up waiting for many weeks in between appointments, resulting in escalation in symptoms and crises**. It feels unethical to let patients go from IOP services to being seen once every 1-2 months. These patients need a lot of support to remain stable and with the current acuity and severity that patients have been presenting with, **it's almost impossible to continue stabilizing them with current generalists' schedules**. These patients are bound to end up again in hospitals or higher levels of care. We need better access for these acute patients in order for intensive treatment to be successful."*

*"My current availability is 6 weeks out for my morning and afternoon appointments, while it is 7 weeks out for my evening appointments. I have little time to chart as I am spending every free moment in between sessions reaching out to patients who need to be seen much more frequently. **I am exhausted and burnt-out, and I am tired of having to apologize to my patients that Kaiser's standard of care is incongruent with evidence based practices.**"*

*"Triage team is consistently understaffed which limits our ability to outreach to patients in an equitable and timely manner. **Patients are ending up in the emergency department because we cannot get to them in time. Patients often have to wait up to six days for the first outreach for triage.** Not only is this unethical care for our patients, it is causing burn out within the team."*

*"We are experiencing an unprecedented mental health crisis right now and **I'm booked full and have even created a wait list for my return appointments**. To try to handle this nightmare without catastrophic consequences I've now taken on the burden of managing all of my appointments without the help of admin so I can triage the most acute patients. In the past two weeks I've had my inbox flooded with old patients who need to return, in addition to my current patients and new patients yet to be seen. Parents messaging me, rightfully upset because their kids are struggling and the frequency at which they should be seen is impossible to provide. I've rebooked RCF2s as much as I can, which increases my workload and decreases my '10 min to write a note,' and in spite of these strategies, I'm still booked out until December. In the past few weeks, I've initiated two welfare checks, one on my own time after seeing and then responding to urgent messages (because I have*

to complete notes and do care coordination on my own time). My patients are struggling and I cannot see them with the frequency needed to address their symptoms. I've been sick, my daughter has been sick, and last night my beloved pet who had been in the ER for three days passed away at 4am, and instead of being able to call in sick to handle grieving children, I went to work because I couldn't imagine where I'd put the patients I would've had to cancel. I'm not sure how to fix this but ***I'm drowning and hitting my own breaking point****. Kaiser needs to provide some sort of immediate relief before their clinicians burn out and quit. This is unsustainable."*

"I get 2-3 patients per week who are returning to care after previously ending treatment. This is the equivalent of seeing ***7-8 new patients per week****, which is unsustainable."*

"I am often one of the clinicians with the shortest wait times for return appointments and even I have seen an increase in wait times that has forced inadequate care onto my patients. There has been an increase of new patients coming in, an increase in severity of at least complexity among many patients already in treatment, as well as an increase in patients returning who had completed their episode of care but remain on our caseloads. ***This is a systemwide problem that can only be solved with a systemic level change.*** *Please take action now before more are harmed by the system."*

*"****I work in crisis and the current wait time for a pt to have an individual appt after a priority intake is 6 weeks!*** *Also, at this time IOP is not accepting new patients so someone that does not raise to the level of PHP, CASA, or criteria for a 5150 have to wait a long time to begin with an in-house WCR therapist. Groups are over flowing and have long wait times."*

*"****I am a Case manager and am booking returns 6 weeks out, completely unacceptable.****"*

*"****The pressure on our team is becoming UNBEARABLE. There is never enough staff or appointments.*** *Patients are constantly calling up in crisis and enraged. This is untenable as a work situation."*

"I recently had 63 unbooked appointments for patients due to the delay in schedule maintenance. That said, ***even when the appointments were opened I'm still booking out two months****. This creates an extremely negative impression of Kaiser in nearly every patient contact, even for those patients who have received quality care from me. This also makes for extremely poor quality of life for me. If I need a break to manage burnout, I can't book time off for 2 months unless I want to cancel on patients who are already upset that their appointments are booked out so far. If either my child or I am sick and need to miss work, I risk making a patient unseen for 4 months. This happens regularly. All of these issues stem from our egregious lack of return appointments."*

*"****There is too high of a wait time for suicidal patients****."*

"This was predictable and there was no obvious forward planning."

*"****In my 20 years here, this is the worst return access I have encountered****. Acuity is high and our team gets complicated patients, especially those who BMS can't handle in their brief model. It is unethical and simply immoral that our management is focusing now on discharging patients when we can't see them enough to provide any treatment. Recently, when a family member was seeking mental health care through Kaiser, my colleagues (an MD and a manager) encouraged me to pay out-of-pocket rather than put her through the Kaiser system. What does that tell you about how insiders feel about the services here?"*

"I'm frequently booking into my lunch or IPC time, ***groups can have 40+ people and facilitators are being told to follow up on endorsement of SI/HI from Tridiuum questionnaire when they don't have the time/resources to do so****- this means they have to end the group early and try and get the patient on the phone to assess, psychiatrists are asking therapists to follow up on SI despite therapists not having support staff (MAs,*

psych techs, RNs, pharmacists) like psychiatrists do, when generalists ask for extra support on a case through case management we are told their not available/the resource is limited, and C2C is not properly assessing medical necessity- it would be more useful to have local triage and more therapy staff. Everyday I'm worried my patients are going to commit suicide. ***I frequently think of quitting my job because I can't keep working for such an unethical company****."*

"The behavior medicine service has been forced to see acute psych patients in 30 min appt slots who are not Behavior Medicine patients. . When they are referred to MH clinics they speak with 3 different staff before their first mental health therapy appt. 4-8 weeks after their initial call. Patients give up, complain to their PCPs who then ask Behavior Medicine staff to treat these patients. ***Attrition is not treatment****. Behavior Medicine is not a triage service."*

"Please take this letter as a call to your humanness and to the renunciation of oppression. A system that keeps patients in prolonged suffering knowingly by maintaining the illusion of treatment is oppressive. ***2 plus months of wait for a return appointment is not continuation of care. 2+ months of wait for a client to see their therapist with whom they took courage to trust, is abandonment per standard of care****. A transfer client waited 7 weeks to meet their new therapist only to be informed that their next appointment will be a longer wait. This is not treatment. Please do not make any more attempts to lie and hide the truth at least with your own employees. Let's work together to provide ethical care. If you choose not to, then remember, you are consciously choosing to be an oppressor and you won't be able to hide that truth from yourself. It could haunt you on your deathbed. Be wise. Thank you."*

"As a side note, lack of return appointments is not the same thing as number of patients seen. If a patient does not show up for my appointment that is out of my control. Let's say they were scheduled for a video visit. I wait 5-10 minutes and they don't show up, then I call them. They don't answer, and I leave a voicemail. It's now 10-15 minutes after the start of the session. Even if I called someone else immediately, and they were actually available (which is rarely the case as patients prefer booked appointments so they can fit them into their schedule, not last minute cold-calls), I still would not be able to have a full session with them. I understand the desire to use a seen-metric to determine clinic need, however this does not address the actual problem of not having available appointments. ***A seen-metric is the wrong yardstick to measure demand. Those patients who do show up for treatment suffer when there are no available appointments for them.*** *Please hear us. Please, this is not a political stunt. I couldn't care less for union/management politics. This a serious crisis."*

"It seems management at all levels are aiding and abetting KP's executives' continued and totally unethical practice of putting Pts and Clinicians at risk to protect profit sharing and bonuses. There is no other rational explanation for the current unfortunate but predictable situation than money. This is just a worsening of a chronic condition that has been going on for many years. It costs money to provide adequate care. Money that KP has but executives/management want to keep for themselves. ***Shameful and unethical.****"*

*"****I am booking out 9 weeks for follow up appointments and it would be further but I continue to book into my IPC. I get scheduled a new patient everyday, that's 5 a week. This is not the standard of care, this is a liability. It is becoming more of a liability to work for Kaiser under these circumstances.****"*

"A week ago I had a list of 45 plus patients that were waiting to be formally scheduled. Within a week there are no appointments again and the list is never ending. ***This is not fair to patients and is not safe ethical care.*** *Patients deserve safe available care and clinicians should be practicing ethically within the restrictions our boards dictate. It does not feel like my license is protected when I am not able to provide the care patients need and are entitled to because I cannot possibly manage the sheer volume of people on my caseload. Furthermore my schedule does not provide available and frequent enough appointments for this many patients. Please protect our patients and your clinicians."*

*"**I don't believe the complete answer to patients having earlier return appointments is to have therapists discharge more of their patients sooner, as is being suggested by management. For some patients, perhaps creating a sooner discharge plan might be clinically appropriate, but for many patients, there is an increase in their acuity during this Pandemic, and discharging them sooner, in order to free up more return appointments, is simply unethical. I also don't believe that pressuring therapists to discharge patients by requiring them to turn in a weekly spreadsheet, documenting which patients they have discharged on each day of that week, is very good for relationship building with management**. This Excel spreadsheet, due each week by the end of Friday, might be looked at as management's way of pushing their agenda of wanting therapists to discharge more of their patients before the patients are ready."*

*"**The generalists at my clinic have a wait time of 4-8 weeks and we have no access for psychiatry appointments now that staff keep leaving**."*

*"**Medication appointments for patients after they leave the hospital are now 4 weeks out. This is the worst it has ever been**."*

*"**In triage we are now at 5 days since pt called before receiving a triage call back whereas before the pandemic we could service 0-1 day for call back. The workload feels demoralizing as providers and is not the great patient care that fulfills Kaiser's commitment to excellence**. Furthermore, current patients are being diverted to Crisis team often because they are not able to access adequate return appointments with their generalists. This is concerning!"*

"Acknowledging that we are overworked and understaffed would definitely improve morale. The new schedule metric will only make this aspect of the work worse since it assumes we can and should be doing more than we already do."

"Not only waits between appointments are long but I also find myself doing a lot of case management when attempting to connect pts to psychiatry. Collaboration is low."

"I acknowledge that a big part of the problem is the loss of multiple staff members on the WCR Adult MH team and that these positions are being posted and interviewed for. I also would like to say I notice management working hard and being pretty flexible to meet our needs and deliver patient care. That said, I see a petition for increased staffing and it's hard not to sign it. Of course, providers would be happier, more engaged, stay for longer, and our patients would receive better care if our staffing were to improve."

"We do not have adequate staffing to provide enough individual and group therapy appointments. In addition, replacing two full time staff with two intake staff does not adequately address the problem."

"I'm getting patients who are mis-triaged into my specialist addiction appointments due to no room in the generalist schedules and hints of any substance use, which is inappropriate."

*"**Can you imagine bringing your child in for mental health treatment when you are very concerned about them and then being told that unless your child is at imminent risk of suicide the soonest available return appointment is 5 weeks away?! This is not treatment. It is inappropriate care for the vast majority of the patients I see.** I have many patients who have tried to access mental health. One is waiting 6 weeks in between appts, two others waited weeks in WCR then saw a therapist once, and she informed them she was leaving Kaiser. They were on a waitlist to see someone else, no one ever contacted them."*

"I am concerned about the plan to put IOP on diversion with only referrals from hospitals to be accepted and cutting one Community Stabilization group rather than work with existing case managers to maintain this valuable resource to decompensating clients and the generalists and crisis team trying to serve them."

*"**The managing of the group lists should not be a duty given to adult generalists. It can take me over an hour (at least) upon completion of the group to manage the list and remove participants who have not attended twice in a row. The group database management is an added administrative duty creating an unfair burden on clinicians**. I constantly have patients wanting to know where they are on waiting lists, why they have gotten emails about the groups, or who are having technical problems. It adds several hours to my work load each week."*

"There are higher acuity patients showing up at outpatient intakes."

"Having patients in crisis (who refuse crisis services) wait a month for an appointment is unacceptable. Seeing patients monthly is not therapy it is a check in."

*"**Beginning with initial contact with triage, it takes appx 2 months for a patient to finally meet with their therapist. After this initial session with me, they will have to wait 6 to 8 more weeks for our second therapy appointment.** The majority of my IPC is all booked up. I have very little open time in my work day. More and more patients are reaching out in crisis and I don't have any space to reach out to them because my IPC is booked up already. All groups have waitlists AT LEAST 2-3 weeks long. So, in the 6-8 week time frame to wait for me, they are still needing to wait even just to attend a group in the meantime. My caseload increases by 5 new patients per week, I average discharging 1 to 2 patients per week. This is a very uneven ratio of caseload flow. I run the PTSD "class", we have 30 to 40 people in attendance. It takes about 45 mins to check people in. I do my best to try to track attendance (a bit tricky because of the logistics) so that I can drop the non-attenders in order to try to keep the waitlist as low as possible. This is also a very timely process."*

"I am still getting the same number of new patients per week, while I have fewer return appts built into my schedule due to providing more group services, as well as offering specialized therapy services."

Our group size at night is always between 22-28 clients. When someone is off, you work alone. I work an average of 6 hours overtime a week (I am part time-26 hours) to do paperwork. Work 32 hours/paid 26 hours."

"Our department's groups haven gotten huge and we are at times told to defer referrals to IOP or other mental health services due to overload/inadequate staffing."

*"**As a psychologist in a specialty clinic, we feel the impact of lack of availability in the mental health department. Patients say they are coming to us only because they could not get into mental health**, and our caseloads are reflecting that."*

"Please look within and then and only then can you see with clarity the web you've weaved. Thank you."

*"I have great concerns about the profoundly long wait times for adult patients. **I've talked with very depressed parents who are being treated on the Antioch Adult Team and they describe the tragic experience of not being able to see their provider for two months.**"*

*"Higher outpatient caseloads almost always affect the hospital because **people come to the ED when they can't get outpatient services**. Our biggest issues right now are increased caseloads and acuity and most especially increased wait times for placement of patients who are on psych holds. This creates a number of downstream problems: obviously, patient care suffers when pts are routinely sitting in the ED for days with acute psych concerns, and ED staff and resources are being poorly used in caring for these non-medical cases."*