NUHW NATIONAL UNION OF HEALTHCARE WORKERS
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July 17, 2025

Mary Watanabe, Director
Dan Southard, Chief Deputy Director
Sarah Ream, General Counsel
Sonia Fernandes, Deputy Director, Office of Enforcement
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Dear Ms. Watanabe, Mr. Southard, Ms. Ream, and Ms. Fernandes:

On behalf of the National Union of Healthcare Workers (NUHW), I am submitting a complaint regarding Kaiser Foundation Health Plan's ("Kaiser's") implementation of a new behavioral health telephone triage system in Northern California that illegally assigns unlicensed and untrained clerical staff to triage Kaiser enrollees with mental health and substance use disorders. On April 8, 2025, NUHW filed a complaint with DMHC regarding Kaiser's implementation of an illegal telephone triage system in Southern California. Each week, Kaiser's practices expose thousands of enrollees with mental health and substance use disorders to serious risks to their health and safety as well as treatment delays.

## I. Summary

Beginning January 2024, Kaiser's Northern California region implemented a new method by which it provides telephone triage services to enrollees with mental health and substance use disorders (MH/SUDs).

Formerly, telephone triage assessments were provided by licensed non-physician behavioral health therapists (e.g., Clinical Psychologists with either a PhD or PsyD or masters-level therapists such as Licensed Clinical Social Workers and Licensed Marriage & Family Therapists) who were specially trained in triage. In many of Kaiser's Northern California service areas, Kaiser hired licensed therapists specifically for triage duties and assigned them job titles of "Triage Clinician." Triage Clinicians formed "Triage Teams," which were considered by Kaiser to constitute a specialty area within Kaiser's Psychiatry Department. In smaller service areas, Kaiser trained therapists to provide telephone triage services as well as emergency psychiatric services in hospital emergency rooms.

In addition to licensed therapists' graduate degrees (conferred after two to seven years of education), post-graduate supervised practice, and, in the case of more senior clinicians, years of experience in clinical practice, Kaiser also provided intensive training for therapists new to the triage role. Each newly assigned triage therapist spent four weeks observing a seasoned triage therapist providing triage services. The mentoring therapist then observed the trainee therapist providing triage services to patients. New triage therapists were taught the nuances of scheduling

patients for various types of appointments as well as determining appropriate levels of care. After the initial four weeks of training, new triage therapists received ongoing support with the understanding that it generally took one year before new triage therapists were fully competent in their duties. (See Appendix A for Kaiser's job description for a psychologist in the Triage Department, which lists extensive screening, assessment, and care coordination duties as well as required educational qualifications and licensure.)

Triage clinicians typically spent 10 to 15 minutes (sometimes longer) during a telephone encounter with a new patient (or family member of a dependent child) seeking behavioral health services. During this call, clinicians took a brief history, conducted a risk assessment (including a screen for self harm or harm to others), provided a preliminary diagnosis, and determined the appropriate next step in care. Depending on symptoms, the triage clinician could send patients in crisis to the emergency room, schedule patients who were at risk, but not in crisis, for urgent appointments within 48 hours, or schedule non-urgent therapy appointments within 10 business days. Triage clinicians could also make referrals to an external provider as well as schedule appointments with specialty departments like the Addiction Medicine and Recovery Services (AMRS). Finally, triage clinicians provided education and answered questions to help patients navigate Kaiser's behavioral health system and understand what to expect next.

In all of these determinations clinicians used their education, training, knowledge of evidence-based practice and professionally recognized standards of care, and clinical judgment to assess symptoms, risks and resiliencies, and medical necessity (including level of care needs). Licensed clinicians were able to identify tone of voice, speech cadence, affect, and reported behaviors that further informed their assessment. When speaking to parents of pediatric patients, clinicians could pose questions about a child's or adolescent's behaviors, habits, and changes in sleep, appetite, and activity level.

After the call with a triage clinician, patients started on a trajectory of care tailored to their unique presentation. The appropriateness of this trajectory was paramount because inappropriate triage can result in emotionally, physically, and financially costly delays in care. These delays can worsen patient outcomes or cause patients to drop out of care due to frustration, fatigue, or unmanaged symptoms. In the worst case scenario, patients can risk serious injury or death if a crisis situation is not promptly identified.

In contrast to this system of triage by licensed clinicians, as required by law, under the new telephone triage system, enrollees are triaged by unlicensed clerical staff who are only required to possess a high school diploma and who do not hold advanced degrees in social work or psychology. Unlicensed clerical staff are called Telephone Service Representatives (TSRs) and work from home as part of the virtual Appointment and Advice Call Center (AACC). They respond to patients calling the "One Mental Health" telephone line that Kaiser set up in January 2024 for enrollees seeking behavior health services.

During phone calls that typically last less than three minutes, TSRs pose scripted triage questions to patients to assess the severity of their condition, including asking about suicidal ideation, thoughts of harming others, and depression and anxiety. Patient responses are used by the TSR to make clinical decisions about their condition, determine when the enrollees need to be seen by licensed medical professionals, and schedule enrollees' subsequent appointments.

If a patient screens positively on a assessment question about thoughts of harm to self or others, TSRs are instructed to immediately transfer the patient to Kaiser's Regional Triage Center for further triage by a licensed clinician. Starting in April 2025, TSRs were also assigned to schedule patients for urgent (within 48 hours) appointments with a therapist if TSRs determined patients were at risk, but not in an immediate crisis.

Finally, TSRs also refer patients to external providers like the virtual therapy providers AbleTo, Grow Therapy, Two Chairs, and Little Otter (for children) as well as schedule patients with specific Kaiser treatment programs like Achieving Depression and Anxiety Patient-Centered Treatment (ADAPT). Referring to an external provider or booking into ADAPT requires TSRs to make clinical determinations that patients' symptom severity is "mild to moderate," which constitutes the eligibility criteria for these two types of referrals in Kaiser's behavioral health model of care.

**All of these triage decisions throughout TSRs' phone calls are clinical determinations violating the legal requirement that triage be conducted by a licensed healthcare professional. According to therapists, these determinations are not reviewed nor co-signed by a licensed clinician.**

Each week, Kaiser uses this illegal system to triage thousands of enrollees with behavioral health disorders.

Kaiser's illegal triage system exposes enrollees to serious risks to health and safety as well as treatment delays. According to therapists, this system often mistakenly assesses the urgency of patients' treatment needs. Patients with urgent conditions often are triaged as having non-urgent ones, thereby causing them to wait two weeks for an appointment rather than 48 hours, as required by state law.

Typically, Kaiser's triaging errors are only discovered weeks after faulty triage assessments, thereby forcing patients to endure (at least) multi-week treatment delays and/or inappropriate and inadequate services (for which they still incur out-of-pocket costs).

During the last 18 months, NUHW has attempted to engage Kaiser over this new triage system by, among other things, formally requesting to bargain over these changes and sending Kaiser multiple requests for information about the type of work TSRs are being assigned. To date, Kaiser has refused to bargain over this triage system and has not responded to information requests.

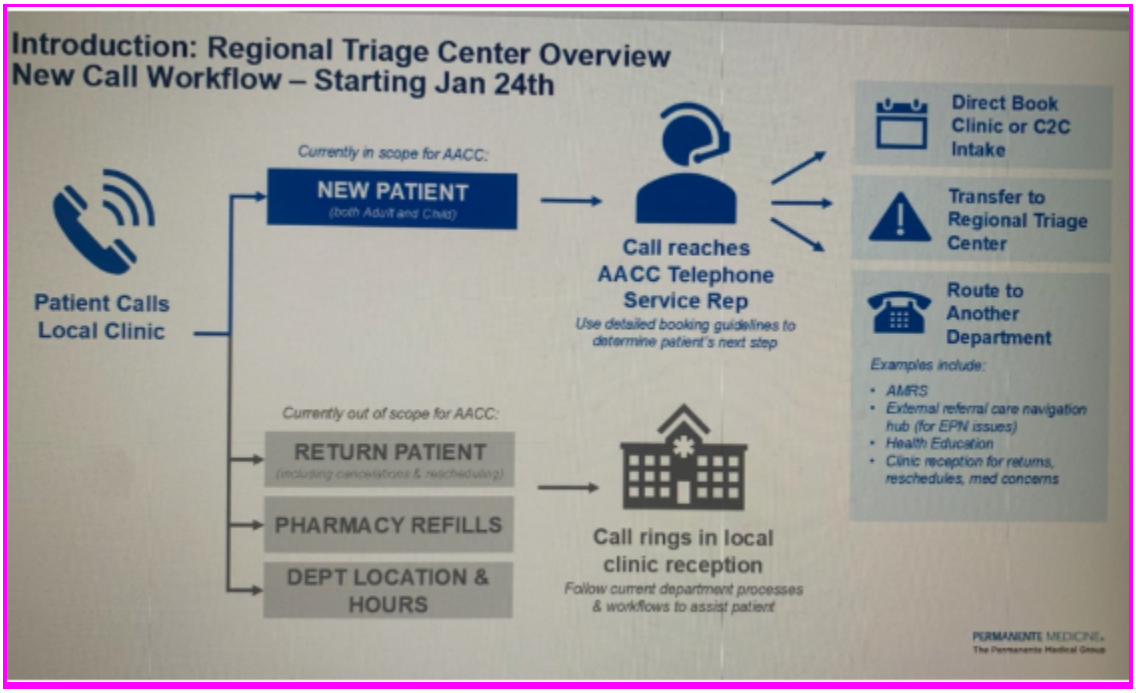
As discussed below in more detail, Kaiser's triage system violates California law and exposes tens of thousands of enrollees to serious risk of harm and injury. NUHW requests that DMHC immediately intervene.

# II. Evidence

Kaiser started its new system of triaging patients in January 2024. The system was based on a workflow (photo below) in which patients calling their local Kaiser clinic seeking behavioral health services are routed through the "One Mental Health" line to the AACC where a TSR

answers their call. Initially, as this photo illustrates, only new patients were routed to the AACC and calls from returning patients trying to schedule, reschedule or cancel appointments were handled by the local clinic reception. Starting in February 2025, calls from returning patients were also routed to the AACC.

At the conclusion of their calls with patients, the TSRs book appointments for intake with a therapist, transfer the calls to the Regional Triage Center staffed by licensed therapists working remotely, or route the patient to health education classes, a specialty department like Addiction Medicine and Recovery Services (AMRS), or the external provider network. Recently, TSRs also started directly booking patients into urgent (within 48 hours) appointments.

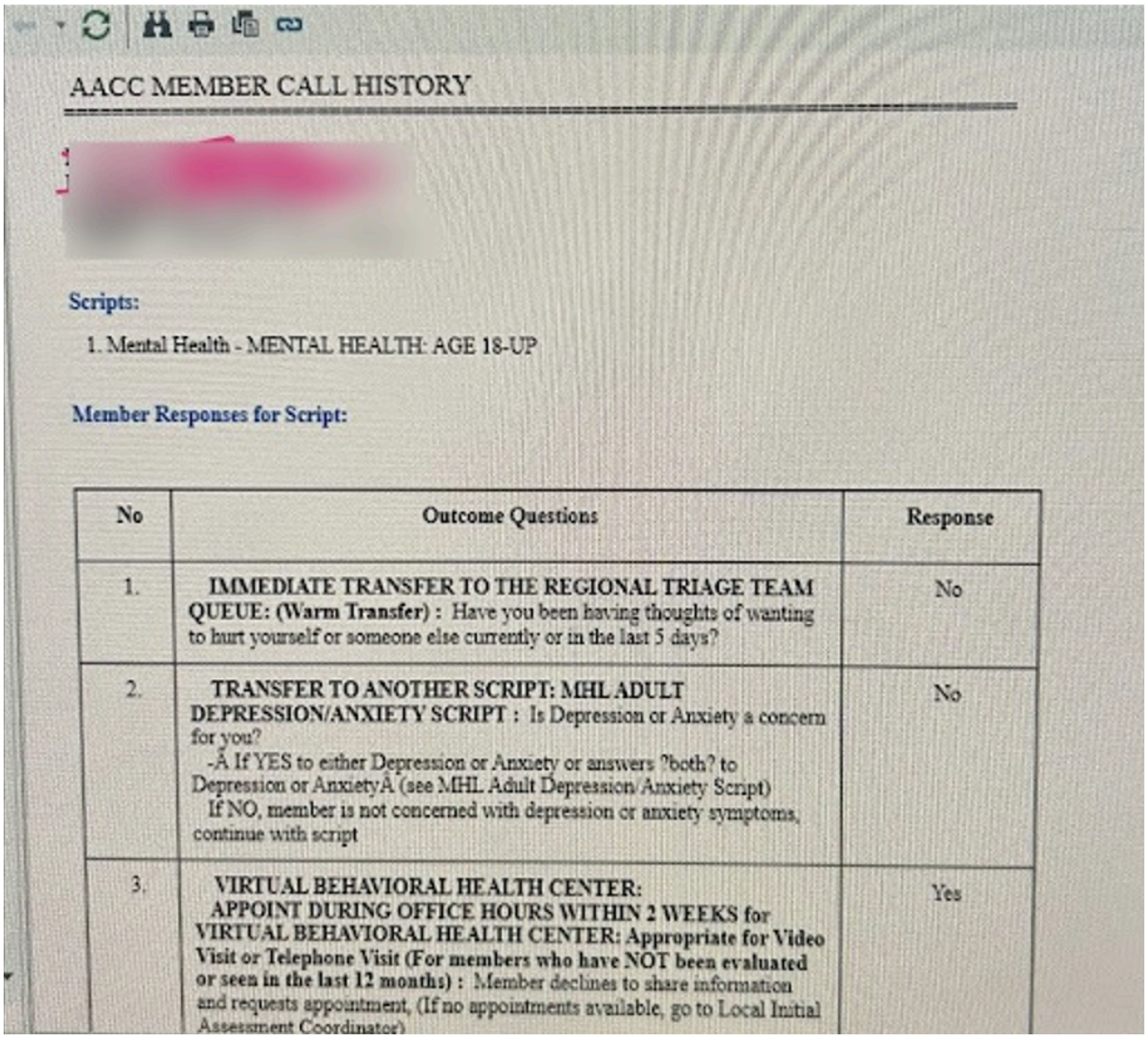



The above workflow clearly demonstrates that Kaiser's new system of managing calls from enrollees seeking behavioral healthcare is based on unlicensed TSRs triaging patients. After asking questions about their symptoms and condition, TSRs determine how soon an enrollee needs to be seen by a licensed medical professional and which type of care is appropriate. **This violates California law, which clearly designates triage as the exclusive purview of physicians, registered nurses, or other qualified health professionals, including licensed mental health clinicians.**

Under California law, an unlicensed person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, "an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional." Health & Safety Code § 1367.03(a)(8)(B)(i)(II)(iii). Additionally, triage and screening call waits may not exceed 30 minutes (Health & Safety Code §

1367.03(a)(8)(A) for patients to speak directly with a licensed medical professional. Health & Safety Code § 1367.03(e)(6).

Below are photos of Kaiser's TSR telephone triage scripts shared with NUHW by whistleblowers. (NUHW requested copies of TSR scripts from Kaiser but Kaiser refused to provide them.) The scripts (including a script for patients under age 18) make it clear that TSRs are screening and triaging patients by posing questions about their symptoms and condition and using responses to determine timing and type of appointment with a licensed clinician. Depending on patient responses, TSRs may pose anywhere from one to four questions (i.e. the scripts follow a branching structure in which patients' responses to a question may or may not trigger subsequent questions). Responses to these questions are documented by TSRs in patients' medical records.



AACC MEMBER CALL HISTORY

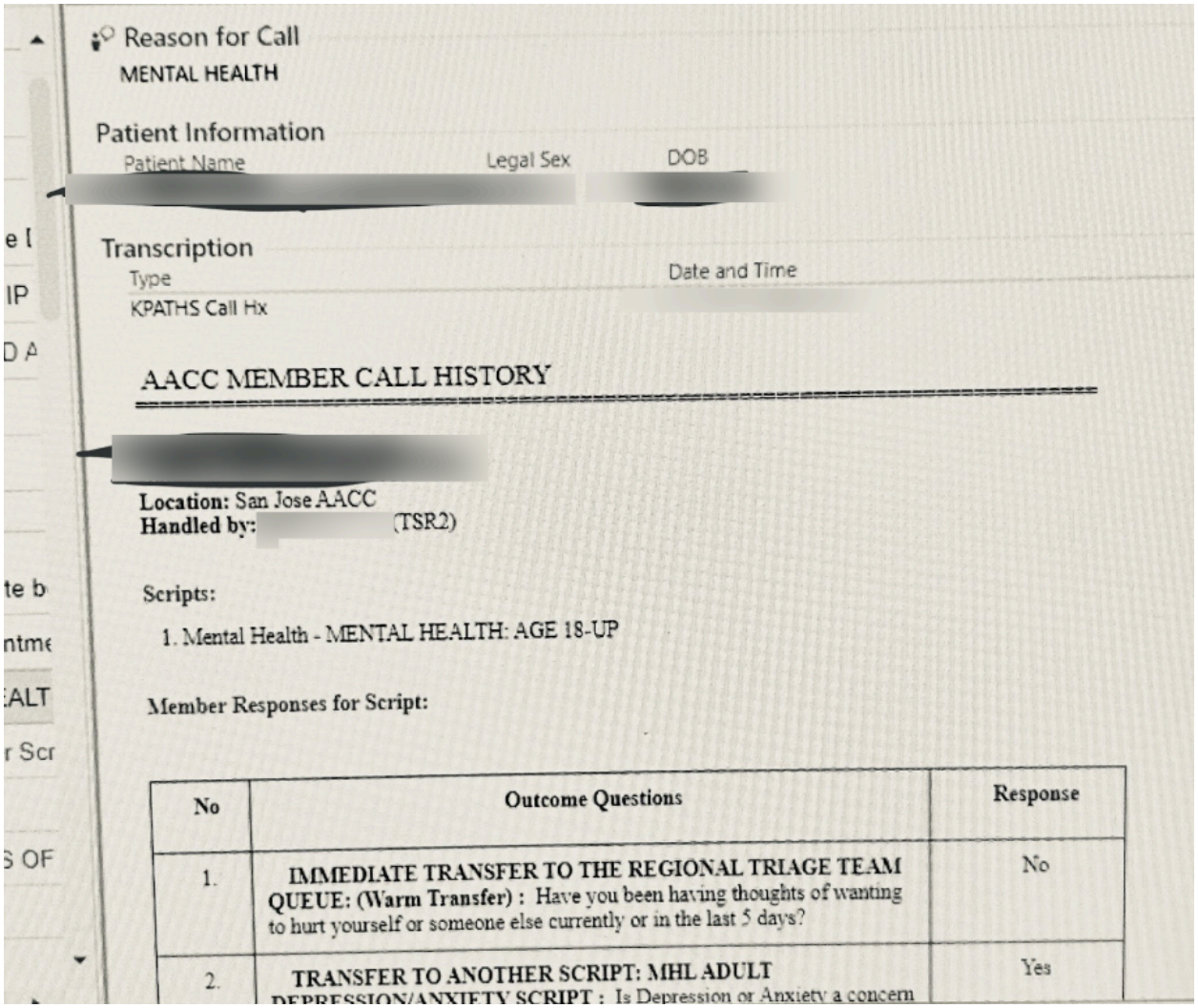
[redacted]

**Scripts:**

1. Mental Health - MENTAL HEALTH: AGE 18-UP

**Member Responses for Script:**

| No | Outcome Questions | Response |
|---|---|---|
| 1. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** Have you been having thoughts of wanting to hurt yourself or someone else currently or in the last 5 days? | No |
| 2. | **TRANSFER TO ANOTHER SCRIPT: MHL ADULT DEPRESSION/ANXIETY SCRIPT :** Is Depression or Anxiety a concern for you?<br>-Â If YES to either Depression or Anxiety or answers ?both? to Depression or AnxietyÂ (see MHL Adult Depression/Anxiety Script)<br>If NO, member is not concerned with depression or anxiety symptoms, continue with script | No |
| 3. | **VIRTUAL BEHAVIORAL HEALTH CENTER: APPOINT DURING OFFICE HOURS WITHIN 2 WEEKS for VIRTUAL BEHAVIORAL HEALTH CENTER: Appropriate for Video Visit or Telephone Visit (For members who have NOT been evaluated or seen in the last 12 months) :** Member declines to share information and requests appointment, (If no appointments available, go to Local Initial Assessment Coordinator) | Yes |



Reason for Call
MENTAL HEALTH

Patient Information
Patient Name | Legal Sex | DOB
[redacted]

Transcription
Type | Date and Time
KPATHS Call Hx

AACC MEMBER CALL HISTORY

[redacted]

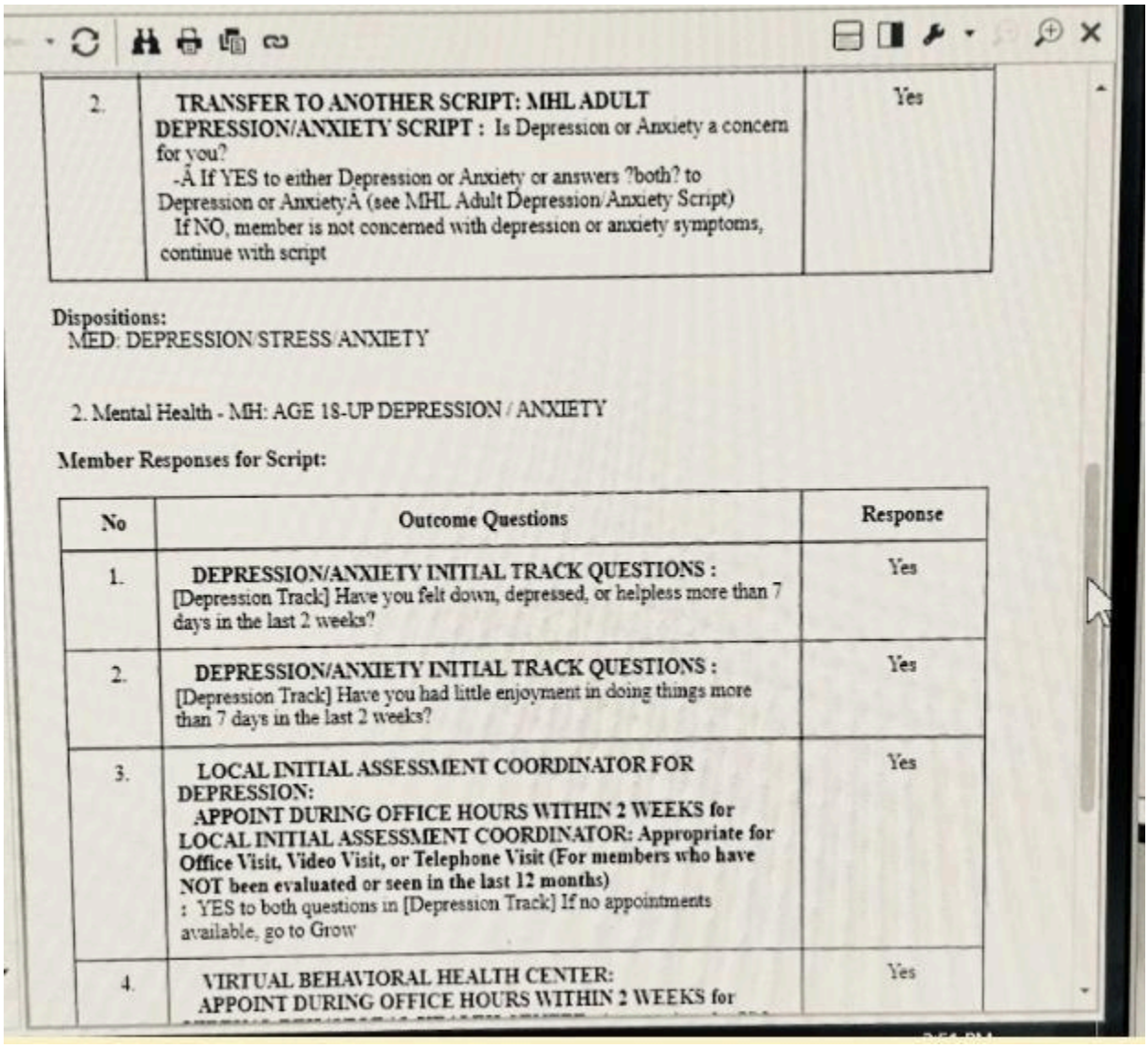
**Location:** San Jose AACC
**Handled by:** [redacted] (TSR2)

**Scripts:**

1. Mental Health - MENTAL HEALTH: AGE 18-UP

**Member Responses for Script:**

| No | Outcome Questions | Response |
|---|---|---|
| 1. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** Have you been having thoughts of wanting to hurt yourself or someone else currently or in the last 5 days? | No |
| 2. | **TRANSFER TO ANOTHER SCRIPT: MHL ADULT DEPRESSION/ANXIETY SCRIPT :** Is Depression or Anxiety a concern | Yes |



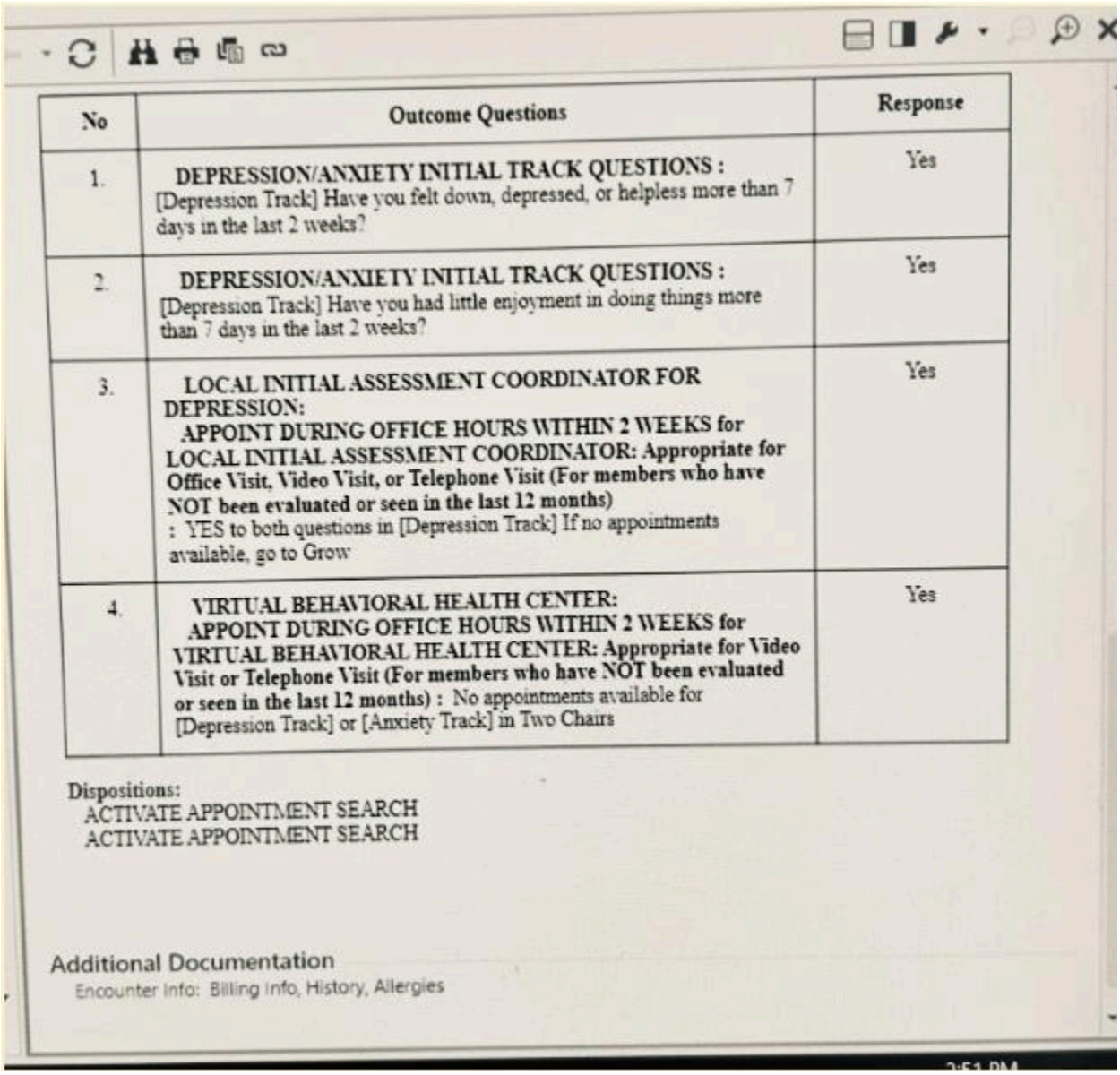
| | | |
|---|---|---|
| 2. | **TRANSFER TO ANOTHER SCRIPT: MHL ADULT DEPRESSION/ANXIETY SCRIPT :** Is Depression or Anxiety a concern for you?<br>-Â If YES to either Depression or Anxiety or answers ?both? to Depression or AnxietyÂ (see MHL Adult Depression/Anxiety Script)<br>If NO, member is not concerned with depression or anxiety symptoms, continue with script | Yes |

**Dispositions:**
MED: DEPRESSION/STRESS/ANXIETY

2. Mental Health - MH: AGE 18-UP DEPRESSION / ANXIETY

**Member Responses for Script:**

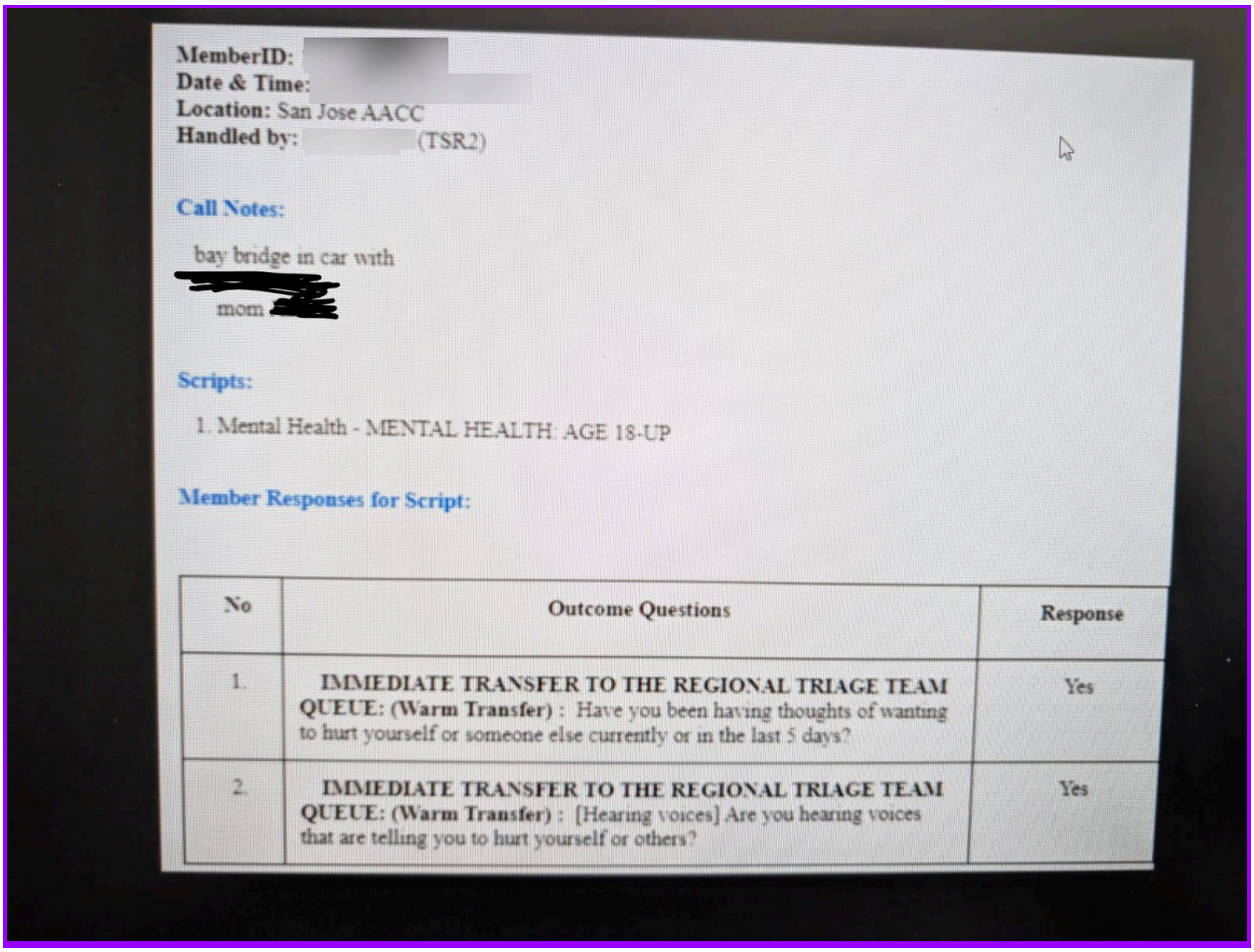
| No | Outcome Questions | Response |
|---|---|---|
| 1. | **DEPRESSION/ANXIETY INITIAL TRACK QUESTIONS :** [Depression Track] Have you felt down, depressed, or helpless more than 7 days in the last 2 weeks? | Yes |
| 2. | **DEPRESSION/ANXIETY INITIAL TRACK QUESTIONS :** [Depression Track] Have you had little enjoyment in doing things more than 7 days in the last 2 weeks? | Yes |
| 3. | **LOCAL INITIAL ASSESSMENT COORDINATOR FOR DEPRESSION:**<br>**APPOINT DURING OFFICE HOURS WITHIN 2 WEEKS for LOCAL INITIAL ASSESSMENT COORDINATOR: Appropriate for Office Visit, Video Visit, or Telephone Visit (For members who have NOT been evaluated or seen in the last 12 months)**<br>: YES to both questions in [Depression Track] If no appointments available, go to Grow | Yes |
| 4. | **VIRTUAL BEHAVIORAL HEALTH CENTER:**<br>**APPOINT DURING OFFICE HOURS WITHIN 2 WEEKS for** | Yes |



| No | Outcome Questions | Response |
|---|---|---|
| 1. | **DEPRESSION/ANXIETY INITIAL TRACK QUESTIONS :** [Depression Track] Have you felt down, depressed, or helpless more than 7 days in the last 2 weeks? | Yes |
| 2. | **DEPRESSION/ANXIETY INITIAL TRACK QUESTIONS :** [Depression Track] Have you had little enjoyment in doing things more than 7 days in the last 2 weeks? | Yes |
| 3. | **LOCAL INITIAL ASSESSMENT COORDINATOR FOR DEPRESSION: APPOINT DURING OFFICE HOURS WITHIN 2 WEEKS for LOCAL INITIAL ASSESSMENT COORDINATOR: Appropriate for Office Visit, Video Visit, or Telephone Visit (For members who have NOT been evaluated or seen in the last 12 months)** : YES to both questions in [Depression Track] If no appointments available, go to Grow | Yes |
| 4. | **VIRTUAL BEHAVIORAL HEALTH CENTER: APPOINT DURING OFFICE HOURS WITHIN 2 WEEKS for VIRTUAL BEHAVIORAL HEALTH CENTER: Appropriate for Video Visit or Telephone Visit (For members who have NOT been evaluated or seen in the last 12 months) :** No appointments available for [Depression Track] or [Anxiety Track] in Two Chairs | Yes |

**Dispositions:**
ACTIVATE APPOINTMENT SEARCH
ACTIVATE APPOINTMENT SEARCH

Additional Documentation
Encounter Info: Billing Info, History, Allergies



**MemberID:** [redacted]
**Date & Time:** [redacted]
**Location:** San Jose AACC
**Handled by:** [redacted] (TSR2)

**Call Notes:**

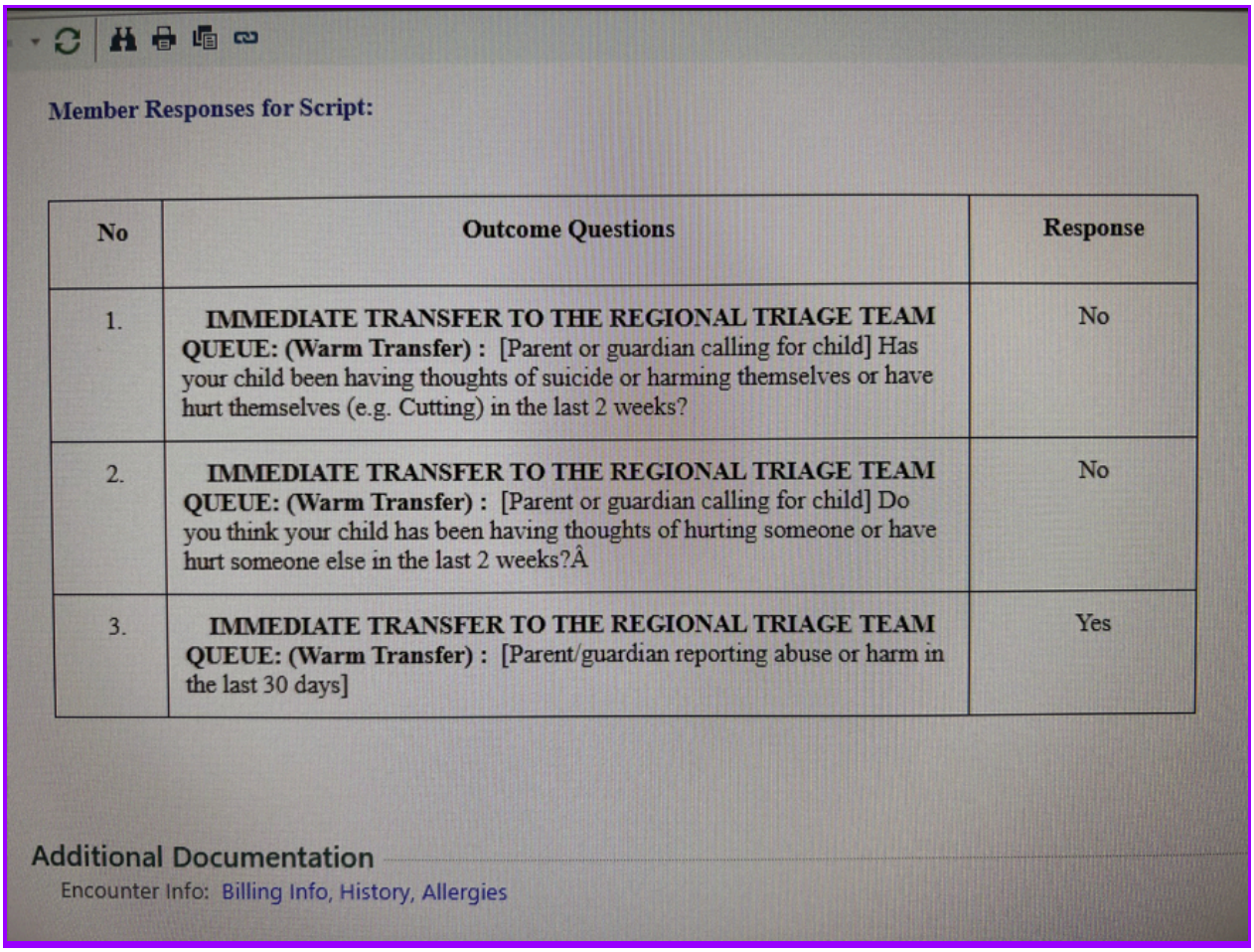
bay bridge in car with [redacted] mom [redacted]

**Scripts:**

1. Mental Health - MENTAL HEALTH: AGE 18-UP

**Member Responses for Script:**

| No | Outcome Questions | Response |
|---|---|---|
| 1. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** Have you been having thoughts of wanting to hurt yourself or someone else currently or in the last 5 days? | Yes |
| 2. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** [Hearing voices] Are you hearing voices that are telling you to hurt yourself or others? | Yes |



**Member Responses for Script:**

| No | Outcome Questions | Response |
|---|---|---|
| 1. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** [Parent or guardian calling for child] Has your child been having thoughts of suicide or harming themselves or have hurt themselves (e.g. Cutting) in the last 2 weeks? | No |
| 2. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** [Parent or guardian calling for child] Do you think your child has been having thoughts of hurting someone or have hurt someone else in the last 2 weeks?Â | No |
| 3. | **IMMEDIATE TRANSFER TO THE REGIONAL TRIAGE TEAM QUEUE: (Warm Transfer) :** [Parent/guardian reporting abuse or harm in the last 30 days] | Yes |

Additional Documentation

Encounter Info: Billing Info, History, Allergies

The adult script includes questions about thoughts of wanting to hurt self or others (a screen for suicidal and homical ideation) and anxiety and depression. If patients express that anxiety and/or depression are a concern, they are asked additional questions about their symptoms during the preceding two weeks. These questions are drawn from the Patient Health Questionnaire (PHQ-9), which is a nine-item questionnaire used to screen for and assess the severity of depression.

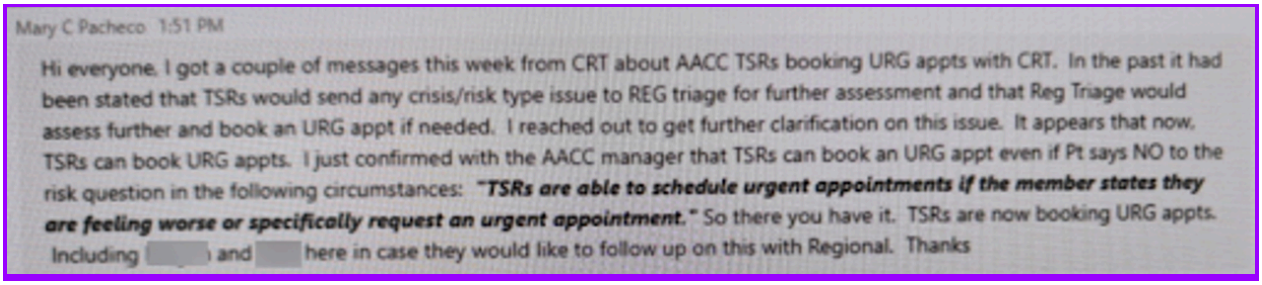
One adult script also includes a question asking whether the patient is "hearing voices that are telling you to hurt yourself or others." According to therapists, this question is a screen for psychosis, which is a high-risk patient presentation unlicensed TSRs are particularly ill-equipped to manage.

The pediatric script asks patients' parents whether their child is having thoughts of suicide or harming themselves or has hurt themselves (cutting) in the last two weeks. Parents are also asked if they think their child is having thoughts of hurting someone else or has hurt someone else during the last two weeks. Finally, parents are asked about abuse or harm in the last thirty days.

TSRs use answers to these questions to evaluate patients' conditions and decide when patients should be seen by licensed clinicians, either immediately via "warm transfer" to the Regional Triage Team or within ten business days by scheduling an appointment for an intake with the

Virtual Behavioral Health Center or a local clinic, or when patients should be referred to the external provider network.

TSRs are also able to book patients into urgent appointments within 48 hours. This is evidenced below by the photo of a message to staff written by Mary Pacheco, PhD, a manager in the Kaiser Oakland Department of Psychiatry. In this message, Dr. Pacheco states multiple times that TSRs can book "URG" (urgent) appointments. Dr. Pacheco also states that if patients say "they are feeling worse or specifically request an urgent appointment," TSRs can directly book patients into an urgent appointment. This denies patients an immediate assessment from a licensed clinician to determine whether or not they will be safe while awaiting an urgent appointment up to two days later. (Multiple therapists who conduct urgent appointments corroborate Dr. Pacheco's message. In the message below, the term "CRT" refers to the "Crisis Team" at the Kaiser Oakland Department of Psychiatry.)


Mary C Pacheco 1:51 PM

Hi everyone. I got a couple of messages this week from CRT about AACC TSRs booking URG appts with CRT. In the past it had been stated that TSRs would send any crisis/risk type issue to REG triage for further assessment and that Reg Triage would assess further and book an URG appt if needed. I reached out to get further clarification on this issue. It appears that now, TSRs can book URG appts. I just confirmed with the AACC manager that TSRs can book an URG appt even if Pt says NO to the risk question in the following circumstances: ***"TSRs are able to schedule urgent appointments if the member states they are feeling worse or specifically request an urgent appointment."*** So there you have it. TSRs are now booking URG appts. Including [redacted] and [redacted] here in case they would like to follow up on this with Regional. Thanks

**Not only are TSRs deciding when a patient should see a licensed clinician, they are also making decisions about the type of appointments a patient should receive. TSRs determine the patient's severity of symptoms and condition, and subsequently, what type of care is clinically appropriate. These determinations are well outside the scope of an unlicensed healthcare worker and constitute additional violations of California law, including the Business & Professions Code.**

For example, therapists report that TSRs are referring new patients to the external provider network including Able To (a virtual therapy provider). In Kaiser's model of behavioral healthcare, patients referred to its external provider network must have mild to moderate symptoms of depression or anxiety and cannot have more severe presentations including suicidal ideation, major depression, or severe, uncontrollable anxiety. TSRs can also directly book patients into the Achieving Depression and Anxiety Patient-Centered Treatment (ADAPT) program which is a structured, time-limited therapy program at Kaiser available to patients who meet certain criteria:

> "Eligible participants will be ≥ 18 years old with mild to moderate-severe depressive symptoms as measured by the Patient Health Questionnaire-9. Exclusion criteria include acute suicide risk and serious mental health comorbidities."[1]

Therapists report that TSRs can even directly refer patients to a new ADAPT pilot program for specific phobias. In other words, TSRs–with no license or education in behavioral health–can assess that a patient has symptomatology consistent with a phobia and then schedule them for a phobia-specific course of treatment.

This type of decision making performed by TSRs is analogous to an unlicensed receptionist at a primary care office asking a patient (who is just there to make a doctor's appointment) a few questions about symptoms (questions they don't have the education or professional experience to pose), and then booking them into a 12-week diabetes management program with a registered dietician. The patient then leaves the office without an appointment with a physician, who can order diagnostic lab work and prescribe appropriate treatment if the patient actually has diabetes.

In addition to the TSR triage system being illegal, for adult patients, it also relies on a defective screening questionnaire. The first question in the "MENTAL HEALTH: AGE 18-UP" script (see above) asks, "Have you been having thoughts of wanting to hurt yourself or someone else currently or in the last 5 days?" According to therapists, five days is not an evidence-based nor validated time period for screening for suicidal ideation. This short time window could miss high-risk patients because a suicide attempt or thoughts of hurting self or others took place at a time prior to the five-day mark. Unlicensed TSRs are particularly ill equipped to use such a faulty triage script because they lack the training and experience necessary to ask supplementary questions to identify high-risk patients.

An example from a Kaiser therapist who conducts intake appointments booked by TSRs illustrates the serious risk of unlicensed TSRs screening patients for suicidal ideation. On March 13, 2025, NUHW received an objection to assignment (OTA) form from a therapist in Northern California. OTAs are completed by NUHW members to document unsafe conditions for workers and/or patients and to report these conditions to management. The OTA is included below (identifying information for the therapist has been redacted):

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There is a new OTA submission from ---------- at Kaiser IBHS.

Name:
Email:

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[1] See a description of Kaiser's elibility criteria for the ADAPT prgram here: https://divisionofresearch.kaiserpermanente.org/publications/evaluating-implementation-and-outcomes-of-the-achieving-depression-and-anxiety-patient-centered-treatment-collaborative-care-program-in-a-large-integrated-health-care-system-a-mixed-methods-observat/

Phone:
Facility:
Dept or Unit Occurred: Adult Psych
Assignment Date: 03/12/2025
Reasons for Objection:
Assignment poses risk to health and safety of staff, coworkers, and patients (e.g. inadequate PPE)

Objection Explanation:

Patient came in for a scheduled initial intake. Patient is a new member. Patient called into the AACC line to book appt. While assessing patient, patient disclosed that patient had attempted suicide on about a month ago and called into Kaiser for help a week later. Patient did not get an appointment until a couple weeks later which was the appt with me. Patient ended up being placed on a 5150 because she had active suicidal thoughts and was admitted into a hospital same day.

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A follow-up interview with the therapist who completed the above OTA revealed that the patient was a new adult patient who called Kaiser seeking behavioral health services. Their call was answered by an unlicensed TSR who followed the triage script included above for patients over 18 years old. At the time of the patient's call with the TSR, they had recently attempted suicide via pill overdose. This suicide attempt occured in the preceding two weeks but not within five days of the call, so when asked about thoughts of self-harm in the past five days the patient responded, "no." As the patient's high risk for suicide was not identified, the patient was not immediately transferred to a licensed clinician for further triage nor directed to go to the emergency department.

Instead, the patient was booked for an intake appointment more than one week later. When the patient presented for this in-person intake appointment, the therapist had to place the patient on an involuntary 72-hour psychiatric "5150" hold within minutes of the appointment starting. The patient (who had been having thoughts of self-harm persistently since their phone call with a TSR) went to the emergency room via ambulance and was subsequently hospitalized.

This example clearly demonstrates why Kaiser's illegal triage of patients by unlicensed TSRs poses such a grave threat of injury and death to patients. TSRs do not have the requisite training to effectively assess for suicidality, which requires more than just the ability to read a single scripted question (and in this case, a flawed, non-evidence based question).

In contrast, licensed clinicians conducting telephone triage know how to ask multiple questions to reliably determine whether a patient is at risk or in crisis. They can also evaluate aspects of the patient's voice, speech rhythm and pattern, demeanor, and reported behaviors and changes in activity patterns that are warning signs for suicidality or other high-risk concerns but are not captured by responses to scripted questions that are analyzed by unlicensed staff.

A licensed therapist's skillset in screening and triaging is especially important when interviewing parents of pediatric patients. High-risk children and adolescents rarely tell their parents that they are depressed, anxious, or are having thoughts of wanting to hurt themselves or others. Instead pediatric patients often exhibit red flag symptoms like excessive sleeping, changes in demeanor, appetite, or attention, withdrawal from social activities, poor hygiene, trouble in school, loss of friendships, and risky behaviors. Parents may not know these symptoms are worthy of reporting until a trained therapist asks about them.

**In sum, TSRs do not have the training, skill, education, and license to triage and screen behavioral health patients, let alone high-risk ones.**

Notably, when a patient presents to a behavioral health clinic in person to seek services for the first time or when a returning patient walks in due to worsening symptoms, they are triaged by a licensed clinician on duty and not the clinic receptionist (with equivalent education and training as a TSR). Similarly, in the emergency department setting, Kaiser policy specifies that screenings, including those for behavioral health conditions, must be performed by a "Qualified Medical Professional," which it defines as a "healthcare professional designated in the Professional Staff Bylaws, Rules & Regulations (and consistent with state licensure) to perform medical screening examinations."[2] Kaiser clearly knows (but ignores) that its substandard and disparate telephone triage system is illegal.

**Since January 2025, therapists have reported over 70 examples of Kaiser's illegal triage system resulting in negative care outcomes for patients**. According to therapists, these 70 examples are just a snapshot of inappropriate and illegal triage occurring on a daily basis across Northern California. Some of these situations involved high-risk patients being missed while others underscored three additional problems: costly delays in care, counterproductive and retraumatizing interactions, and lack of patient education. Summaries of each problem appear below and therapists are available to speak with DMHC investigators to further discuss them.

**Delays in Care:**

As discussed above, TSRs determine the type of care patients should receive and when that care should start. Therapists report that often these determinations are inappropriate as TSRs lack the requisite education, training, and professional expertise to accurately and effectively engage in

[2] "Emergency Medical Screening Examination, Treatment, and Transfer." https://kpnational.policytech.com/dotNet/documents/?docid=9767&app=pt&source=browse&public=true

triage. This results in treatment delays as patients find themselves booked into appointments that don't meet their needs. This can delay care by weeks or even months.

In some cases, TSRs fail to appropriately identify the level of care a patient needs resulting in dangerous delays in emergent or urgent care. Therapists also report that TSRs routinely fail to accurately determine the type of care a patient needs resulting in delays in the initiation of the most appropriate and, in some cases, specialized treatment. For example, therapists have reported that TSRs miss addiction issues and, in turn, patients are not appropriately referred to Addiction Medicine and Recovery Services (AMRS). These patients are instead scheduled for intake appointments for therapy up to ten business days later. It is not until this intake appointment with a licensed clinician–who is trained in assessing for addiction–that the patient obtains a referral to AMRS. This significantly extends patients' waits for initial appointments to actually address a substance use disorder.

Delays are also common as a result of TSRs inappropriately referring patients to Kaiser's external provider network. Patients referred to external providers are supposed to have a presentation that is "mild to moderate," while patients with more severe symptoms are supposed to be cared for by Kaiser clinicians. However, according to therapists, TSRs routinely refer patients with severe presentations outside of Kaiser. When these patients have an intake or first appointment with a licensed external provider, their more severe symptomatology becomes clear and they are referred back to Kaiser. This shuffle back and forth to Kaiser unlawfully delays access to critically needed care.

Therapists who conduct intakes have also reported that they are being scheduled for an unprecedented number of inappropriate appointments with patients who have conditions that require other forms of specialty care including cognitive disorders, eating disorders, psychosis, or schizophrenia. Again, this delays the initiation of the type of treatment a patient actually needs, which can lead to decompensation, injury, or death.

As a result of the above examples of inappropriate and illegal triage, patients may incur copayments and need to take time off from work for unnecessary appointments.

**Counterproductive and Retraumatizing Interactions:**

According to therapists, many patients assume that the TSR answering their initial call and posing screening questions about their symptoms is actually a licensed therapist. TSRs, who introduce themselves with the title "Mental Health Representative," likely contribute to this confusion because patients unfamiliar with the different behavioral health professional titles could easily get the impression they are speaking with a licensed clinician. In turn, patients–some of whom are desperate for help and someone to talk to about their feelings–may do more than just answer "yes" or "no" to questions posed by TSRs. Instead, patients may start describing their history of mental health diagnoses, express feelings of grief, anger, isolation, or loss, and/or

share past adverse life experiences (including abuse) and related trauma. TSRs, who lack appropriate education and training, routinely mismanage these encounters.

One especially problematic type of patient interaction with a TSR occurs when patients recount traumatic histories. According to therapists, TSRs often allow patients to share at length about past or current trauma even though the TSRs lack the skillset to guide these conversations in an evidence-based, structured, and therapeutic way. In other words, patients recount and relive trauma for no therapeutic purpose, which can trigger symptoms and result in retraumatization.

**Lack of Patient Education:**

Prior to January 2024, when licensed clinicians were still answering phone calls from new patients, a key part of their role was to educate patients about Kaiser's model of behavioral healthcare. This anticipatory guidance, including instructions on how to complete a required online questionnaire (called Lucet) prior to their first appointment, prepared patients for subsequent appointments and helped them navigate Kaiser's system, which often involves multiple encounters with different clinicians. Licensed triage clinicians also routinely assisted patients referred to the external provider network by educating them on the steps they needed to take to establish care with an external provider.

Expectation-setting and support for navigating care are especially important for mental health patients. Many of these patients are hesitant to seek care due to stigma or have symptoms that make them more likely to become confused, overwhelmed, or drop out of care altogether. TSRs, who are not trained in patient education and care coordination, cannot effectively support this patient population, particularly during a scripted phone call that is only supposed to last a few minutes.

# III. Applicable Laws

A plan shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in subdivision (e). Cal. Health & Safety Code § 1367.03(a)(8).

California law clearly states that a "triage" or "screening" is "to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care." Health & Safety Code 1367.03(e)(6).[3]

[3] Other portions of this statute similarly indicate that licensed providers shall provide telephone triage or screening by speaking with enrollees over the telephone, including subsections 8(B)(i) (health plans shall require MH/SUD **providers** to maintain a procedure for triaging or screening enrollee telephone calls), 8(B)(i)(I) (return phone calls to enrollees shall be made by a **provider**), and 8(B)(i)(II) (health plans shall disclose to enrollees how to contact or call **providers** who have agreed to be on call to triage or screen by phone).

"Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee's need for care. Cal. Health & Saf. Code § 1367.03(e)(5)

An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, "an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional." Health & Safety Code 1367.03(a)(8)(B)(i)(II)(iii)

A plan shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes. Health & Safety Code 1367.03(a)(8)(A)

"Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care. Health & Safety Code 1367.03(e)(6)

According to DMHC's 88-page, non-routine survey of Kaiser's behavioral health services issued in February 2025:

> Professionally recognized standards of practice require clinicians to conduct a suicide risk screening and/or assessment for all enrollees receiving MH/SUD services during **triage**, intake, and as indicated thereafter.[34,35] Furthermore, for enrollees who have a documented risk of suicide, a level of care that is appropriate to the enrollees' assessed risk must be delivered in a timely manner…
>
> The Department determined the Plan failed to demonstrate its QA program includes sufficient level of oversight to ensure enrollees receive suicide risk screening, assessment, and treatment consistent with professionally recognized standards of practice. (p. 66, emphasis added)

DMHC cites the following sources for its footnotes 34 and 35:

34 Simon, Robert I. "Suicide Risk Assessment: What is the Standard of Care?" Journal American Academy Psychiatry Law, Volume 30, pages 340-344, 2002.

35 The Joint Commission, "the nation's oldest and largest standards-setting and accrediting body in health care," introduced a national patient safety goal for suicide prevention. Joint Commission FAQs. Behavioral health care organizations are required to screen all patients using a validated screening tool. The PHQ-9 is one of several specifically mentioned examples. Further, an evidence-based risk assessment is required following a positive screen for thoughts of suicide. The Columbia Suicide Severity Rating Scale is one of the examples listed as an

evidence-based risk assessment tool. The Joint Commission. National Patient Safety Goal for suicide prevention: NPSG 15.01.01, EP 2. R3 Report: Issue 18, May 2019, pages 2-3.

Health care service plans must ensure that their networks have adequate capacity and availability of licensed providers to offer enrollees appointments for covered services that meet specific timeframes. Health & Saf. Code, § 1367.03, subd. (a)(5); Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (c).

Health care service plans are required to have procedures in place for continuous review of the quality of care, performance of medical personnel, utilization of services and facilities, and costs. (Health & Saf. Code, § 1370.) To meet DMHC's requirements for a Quality Assurance program, the program must, in part, continuously review the quality of care provided to ensure that the level of care meets professionally recognized standards of practice, quality of care problems are identified and corrected, and appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason. Cal. Code Regs., tit. 28, § 1300.70, subd. (b)(1)(A)-(E).

- § 1300.70(b)(1)(D): Health plans 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): Health plans are required to ensure that patients receive "a level of care which meets professionally recognized standards of practice."
- § 1300.70(b)(2)(H)(2): Health plans are required to "detect and correct under-service" by its providers, "including under-utilization of specialist services."
- § 1300.70(a)(1): Health plans 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): Health plans 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.

Health plans must cover behavioral health services consistent with generally accepted standards of care and must ensure that enrollees do not face barriers to scheduling behavioral health appointments that do not exist for non-behavioral health appointments. Health & Saf. Code, §§ 1374.72(a), 1367.005(a)(2)(D), and 1374.76.

Health plans shall ensure that enrollees are provided with timely behavioral health care services that are consistent with each enrollee's treatment plan, individualized behavioral health care needs, good professional practice, and timely access standards. Health & Saf. Code, §§ 1367.03, 1374.72; Cal. Code Regs., tit. 28, §§ 1300.70, subds. (a)(3), (b)(1), (b)(2)(G), (b)(2)(H).

# IV. Request

California law mandates that triage be performed by licensed health professionals. As the above evidence demonstrates, Kaiser's system of telephone triage by unlicensed TSRs violates the law. NUHW requests that DMHC take urgent action to enforce California law and to protect the rights of Kaiser enrollees affected by Kaiser's illegal practices.

NUHW requests that DMHC immediately order Kaiser to cease and desist from violating California laws. We request that DMHC impose significant financial penalties on Kaiser for violating California law, especially given its serial violations as documented in DMHC's October 2023 settlement agreement with Kaiser.

Please contact me with any questions or requests.

Sincerely,

Fred Seavey

cc: Rob Bonta, Attorney General
Mike McGuire, Senate President Pro Tempore
Robert Rivas, Speaker of the Assembly
Kim Johnson, Secretary, California Health and Human Services Agency
Kimberly Chen, Acting Deputy Secretary for Program and Fiscal Affairs, CalHHS
Sen. Scott Wiener, Chair, Senate Select Committee on Mental Health
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Sen. Caroline Menjivar, Chair, Senate Health Committee
Don Moulds, CalPERS
Dr. Julia Logan, CalPERS

**Appendix A:**
**Job Description for A Psychologist in the Triage Department**

## Psychologist - Triage Department

[redacted]

[redacted]

### Description

Provides mental health assessment, diagnosis, treatment and crisis intervention services for adult and/or child members who present themselves from psychiatric evaluation with a broad range of mental health needs. Collaborates with treating physician, psychiatric and allied health professional team to plan and direct each individual member's treatment program.

***Essential Responsibilities:***

- Develops, implements, coordinates, and evaluates clinical treatment programs for the diagnosis, treatment, and/or referral of Health Plan members with acute or chronic mental illness. Participates in staff conferences to select, plan, and evaluate treatment programs. Provides outpatient psychotherapy to individuals, couples, families and groups. Instructs and counsels patients and their families regarding compliance with prescribed therapeutic regimens and adherence to prescribed medication regimens, within the scope of practice. May administer specialized therapeutic procedures, as appropriate. Provides appropriate support to member's family. May develop and conducts psychoeducational classes and groups.
- May conduct psychological assessments, including test administration, interpretation, and recommendations. Prepares intake summaries, treatment plans, and case summaries and maintains ongoing confidential records. Charts member's treatment and progress in accord with state and NCQA regulations and in keeping with accepted community standards. May be required to participate in the department on-call rotation.
- Collaborates with physicians in screening and evaluating patients for psychotropic medications, within the scope of practice. Utilizes resources of public and private agencies and community organizations to meet the needs of the member's treatment. May develop, implements, and evaluates behavioral medicine and health psychology programs in a variety of settings, including primary care. Provides consultation to other care providers and health educators on matters relating to mental health, health psychology and behavioral medicine. Provides clinical supervision to psychology doctoral interns, psychology postdoctoral residents, and other mental health trainees/fellows as necessary.
- May supervise Post Master's Fellows, Associate Clinical Social Workers, Associate Marriage Family Therapists or Associate Professional Clinical Counselors as needed if supervision course is completed.
- May provide appropriate support to member's family, including explanation of treatment, instructions in how to support treatment and interventions to increase acceptance of and adherence to treatment, at member's request.
- Utilizes resources of public and private agencies and community organizations to meet the needs of the member's treatment to include referral of the member and/or member's family to external resources, as appropriate. Participates in departmental program development, implementation and evaluation.
- Reports safety concerns to mandated reporting agencies

## Qualifications

**Basic Qualifications:**

Experience

- N/A

Education

- PhD/PsyD/EdD in Clinical Counseling, Health or School Psychology from an accredited college or university.

License, Certification, Registration

- Current valid license to practice psychology in the State of California or valid license to practice in a state in the United States and able to practice under Business and Professional Code Section 2946 (maximum of 180 days subject to the specifics of the regulation).
- Must have a National Provider Identifier (NPI) or obtain NPI, prior to employment start date.

**Additional Requirements:**

- Must be familiar with DSM-V as a means of diagnosis.
- Has experience in assessing, diagnosing and treating a broad range of psychiatric conditions.
- May be required to participate in the department on-call rotation.
- Knowledge of Evidence-Based Practice and psychotherapy research methods.
- Knowledge of the bio-psycho-social functions that contribute to mental health.
- Accuracy in diagnosing patients and developing effective treatment plans.
- Competence in individual, family and group psychotherapy.

- Professional maturity and ethical integrity necessary for assuming professional responsibilities.
- Commitment to quality of service, teamwork, and participation in a highly interactive multidisciplinary clinic.
- Ability to complete multiple tasks/objectives in a timely manner.
- Knowledge of social service agencies, state regulations and APA standards as it related to client treatment, patient rights and client/patient confidentiality.
- Previous clinical responsibilities to include psychological testing, diagnosis, crisis intervention, brief individual and group psychotherapy.
- Knowledge of psychological testing techniques, administration and interpretation.
- Excellent interpersonal and communication skills.
- Must be able to work in a Labor/Management Partnership.

**Preferred Qualifications:**

- Previous clinical responsibility to include crisis intervention, individual and group psychotherapy.
- Demonstrated experience in psychological evaluations of adults, children, adolescents, & families, including administering & writing up psychological testing & assessment batteries preferred.
- Demonstrated professional maturity and ethical integrity necessary for assuming professional responsibilities, preferred.
- Demonstrated commitment to quality of service, teamwork, and participation in a highly interactive multidisciplinary clinic, preferred.
- Demonstrated ability to complete multiple tasks/objectives in a timely manner, preferred
- Accuracy in diagnosing patients and developing effective treatment plans, preferred.
- Competence in individual, family and group psychotherapy, preferred.

This position supports Kaiser Permanente's code of conduct and compliance by adhering to all laws and regulations, accreditation and licensure requirements, and internal policies and procedures. Kaiser Permanente is proud to be an equal opportunity/affirmative.

[redacted]

**Primary Location** [redacted]

**Regular Scheduled Hours:** 40

**Shift:** Day

**Working Days:** Mon, Tue, Wed, Thu, Fri

**Start Time:** 08:30 AM

**End Time:** 05:00 PM

**Job Schedule:** Full-time

**Job Type:** Standard

**Employee Status:** Regular

**Job Level:** Individual Contributor

**Job Category:** Behavioral / Mental Health

**Public Department Name:**

**Travel:** No:

**Employee Group:** A05-IBHS|NUHW|NUHW Integ Behavioral Hlth Ser

**Posting Salary Low :** 62.47

**Posting Salary High:** 69.77

**Sign-on Bonus:**

Employee Referral Bonus:

Kaiser Permanente is an equal opportunity employer committed to a diverse and inclusive workforce. Applicants will receive consideration for employment without regard to race, color, religion, sex (including pregnancy), age, sexual orientation, national origin, marital status, parental status, ancestry, disability, gender identity, veteran status, genetic information, other distinguishing characteristics of diversity and inclusion, or any other protected status. External hires must pass a background check/drug screen. Qualified applicants with arrest and/or conviction records will be considered for employment in a manner consistent with federal and state laws, as well as applicable local ordinances, including but not limited to the San Francisco and Los Angeles Fair Chance Ordinances.

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