TRIAGE AS TREATMENT: PHANTOM MENTAL HEALTH SERVICES AT KAISER-PERMANENTE

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The American Psychological Association Practice Directorate's managed care legal strategy has culminated with a lawsuit involving the Virginia Academy of Clinical Psychologists against Care First and Value Options (Holloway, 2003). In this legal case, which has been partially resolved, it is alleged that Care First and its mental health subcontractor failed to provide the services it promised to consumers. This was accomplished, the lawsuit alleges, via the lowering of fees paid to providers with subsequent provider resignation resulting in a "phantom network." Holloway indicates that the lawsuit holds "the companies accountable for essentially putting profits ahead of patients--by not providing the services it provided to consumers or providers…."

The allegation that the push for profits resulted in the failure to provide mental health services to patients, brought to my mind a strike that took place at a Kaiser Permanente facility in Colorado (Herz, 1998). At this facility, treating clinicians were expected to integrate ten new patients a week into their caseloads. The question arose as to the adequacy of care that resulted from this policy. A group of clinicians staged a job action to protest what they felt were requirements that interfered with adequacy of services.

With that in mind, I decided to attempt to design a simple study that would look at the services Kaiser was offering and evaluate these services in regard to access and availability. A seven-item questionnaire was prepared (see Table 1). My intention was to call 3 or 4 random Kaiser facilities and speak to three clinicians: an intake clinician and two treating psychologists.

RESPONSE RATE

My first call began auspiciously enough with an intake worker at a Kaiser mental health facility in Colorado offering to answer the questions freely. After that, things became difficult. I was able to get only one other psychologist to answer the questions and finally I was referred to people at the facility who identified themselves as "administrators," who asked that I cease and desist my efforts to pursue the study. Reluctantly I did at this facility.

Phone calls to a Southern California Kaiser facility went nowhere. I was referred "upstairs" to administrators, some of whom asked that I submit my questions in advance. When I did, they did not get back to me. Along the way, I did speak to a psychiatrist in the regional administrative office. He advised that the survey would reveal that like any HMO, Kaiser was an "overburdened system."

My third effort was far more successful. I was able to complete the questionnaire with a Northern California facility with three very cooperative individuals, all of who happen to be psychologists.

Efforts at virtually every other facility I called were routinely met with resistance and/or referral to administrators who did not respond to my efforts to be allowed to contact potential respondents.

SURVEY RESULTS

In spite of the small response rate, there was some consistency in the answers provided and suggestions that the quality of care and accessibility problems that led to the strike in Colorado a few years ago still existed. To summarize the results, new patients are seen very quickly, usually the same day or immediately in an emergency. A two-week wait for an appointment is unusually long, based upon the five respondents. Regarding concerns that the length or frequency of individual treatment was restricted, some respondents mentioned this was a concern. Most clearly, at a Northern California facility, it was mentioned that the ubiquitous use of group psychotherapy compensated for limited access to individual treatment. The two Colorado respondents also emphasized the almost universal reliance on group psychotherapy. In this part of my research and in the subsequent investigations, there was a feeling that individual, weekly psychotherapy is, as one Northern California respondent put it, "not a covered benefit."

There was disagreement as to whether patients are informed of practices or circumstances that limit access to individual treatment and the frequency with which such treatment can be obtained (e.g. less than weekly individual therapy, even when weekly would be optimal). The question regarding the requirement of a certain number of intakes per week resulted in consistent answers. In the Colorado facility the number was eight and in the Northern California facility the number was seven.

The answer to question five suggested that, in fact, because of the large number of new patients, patients are not free to choose their own treatment modality. To the extent that they would like to have weekly individual (or

conjoint and/or family) visits, this is not an available treatment modality. Weekly sessions are a luxury afforded to very few. If one compares the seven or eight new patients to be integrated per week, subtracting out the fact that Kaiser utilizes a model that emphasizes group psychotherapy, no more than 24 hours per week are available in the schedule to provide individual psychotherapy. This was the highest number offered by any of the respondents to the last question; others indicated as few as 16 hours/wk available for individual therapy.

Discussion—Treating Clinicians are More Like Greeters than Treaters

Despite a small number of responders, the answers raise questions about what is going on in Kaiser facilities. I propose Kaiser attempts to look good by offering virtually no waiting list for new appointments. However, Kaiser comes off exceptionally badly, even as compared to other managed care plans, in the way they overburden the treating clinicians with new cases. The requirement that therapists have to handle seven or more new intakes per week makes weekly psychotherapy, other than group, a virtual impossibility. As each treating psychologist is expected to integrate seven or eight new patients into their case loads, the statement by one of the Northern California respondents that, "Kaiser treating clinicians are more like greeters than treaters" makes sense.

From Investigational Survey to Investigative Journalism

The effort to do a clean survey was sabotaged. Administrators did not provide access to intake or treating clinicians so the survey could be done. The clinicians who did answer the questions raised serious concerns about under treating and poor accessibility to individual psychotherapy. Because of this, it is reasonable to assume that Kaiser is withholding information about its policies. This assumption is given more credibility in light of the report by union officials following the Colorado job action in 1998 that clinicians were gagged to talk about certain Kaiser policies (Miller, personal communication). As it became clear the only way to do this survey at most Kaiser facilities would be with a Court Order requiring clinicians to answer truthfully and a Gag Order on administrative and public relations personnel, I decided to pursue only the fourth survey question to create discussion in other Kaiser facilities.

This question seemed to provide the greatest indication as to whether or not Kaiser is providing for the range of services necessary to provide adequate mental health care. A facility at each of the following locations was contacted: Georgia, suburban Washington, D.C., Ohio, Oregon, Hawaii and Southern California. In all cases I called indicating that I had a patient being transferred by his employer who needed to choose quickly between a fairly generous Kaiser mental health benefit and a somewhat less generous Blue Cross /Blue Shield plan. I indicated that I had contacted a colleague who worked at a Kaiser facility but not the one within proximity to where my patient was being transferred. I indicated I had been instructed to call the closest Kaiser mental health facility to my patient's new location and ask about the requirement of treating clinicians having to integrate a quota of new patients each week. Accordingly, my colleague suggested that this would give me a clear indication as to the adequacy of the services provided under the proposed Kaiser benefit.

Of the facilities I contacted, only one facility in Georgia indicated that there was no limitation on treatment and weekly psychotherapy. The person at the facility was of the opinion that a quota of new patients was not a requirement of treating clinicians. In Southern California, the respondent indicated that they did not know of a quota but added that weekly psychotherapy was not available except in a crisis. In all the other locations, there were quotas. In Northern Ohio, the new patient quota was ten and individual psychotherapy was something that they "don't traditionally do." In Oregon the number of new patients seen per week was seven but it was indicated that weekly psychotherapy was available. It was mentioned that outside treatment with specially contracted therapists was available for those with better benefits and those patients were more likely to have weekly, individual psychotherapy. This apparently was also true in the greater Washington, DC area. In the greater Washington, DC area, the person indicated the number of new patients seen per week was changing from six to seven but had previously been four. That person indicated it was rare for someone to be seen weekly due to the large volume of patients. In Hawaii, the quota was for seven to eight new patients to be integrated weekly.

Further Discussion – Triage as Treatment:

It should come as no surprise that at many of the Kaiser facilities I contacted, the initial patient evaluation is called "triage," not "intake."

According to the individual I spoke to in the DC area, Kaiser has a philosophy of wanting their clinicians to relate to patients in a way that generates the greatest satisfaction with services, rather than the greatest benefit to the patient. This leads to the cynical conclusion that Kaiser Permanente is committed to providing less than the standard of care but in a way that "cools the mark out." (Goffman, 1952) This phrase has to do with con artistry. It relates to how to deal with a person who has been the victim of

a con so as to calm them and make them less incendiary, perhaps even appreciative. This is a notion that should chill any clinician who has concern about providing adequate services to patients. And with this, there is one significant question that needs clarification. How is it that a large facility such as Kaiser does not create significant clinician outrage at their being required to offer phantom services?

As noted above, the settlement of the Colorado Kaiser job action involved "gagging" the clinicians. The appearance is of a company that causes clinicians to fear speaking out against conditions that might be considered sub-standard.

While it is my opinion that there are a number of clinicians who are very fearful that their deliberate or inadvertent critical comments could get them in trouble, it was also my impression there were a number of clinicians who bought the notion of patient satisfaction as the most important product and who genuinely felt by providing a pleasant demeanor, they would obtain better results than providing adequate treatment. The problem with Kaiser's emphasis on group psychotherapy is that there is little evidence that group psychotherapy fits most patients with some evidence clearly against such a primary modality. My experience and the experience of others is that many clients will forgo treatment rather than attend group psychotherapy. Successful group psychotherapy requires a strong commitment and those patients who are not committed drop out, deteriorating the quality and cohesion of group. At Kaiser, group psychotherapy is the way to pretend that patients are not kept on a waiting list. In sum, at Kaiser, mental health problems are, in my opinion, frequently under-treated, and I have concluded that attempts at member satisfaction are substituted for appropriate mental health treatment. Sitting just beneath the surface appears to be an attempt to save money.

To the point, a look at a Kaiser master contract indicates that outpatient visits/psychotherapy are provided for up to 20 individual and/or group psychotherapy visits per calendar year. However, many Kaiser benefits do not offer these limitations. In the contract I reviewed, beyond the limit of 20 visits, an additional 20 may be offered so long as they are for group psychotherapy if they "meet medical group criteria". Severe mental illness and serious emotional disturbance are given unlimited coverage. But in actual fact there is no way an individual could obtain up to 20 individual, psychotherapy visits/year at most Kaiser facilities due to the requirement for large numbers of new intakes each week. This discrepancy should be investigated.

Does Kaiser Violate the Law?

Kaiser Permanente walks a very fine line with regard to violation of law. While there is a clear violation of morality by not offering services Kaiser patients need, the question as to whether they violate the law probably will not get addressed by regulators. This is despite the fact Kaiser indi-

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cates in its plan documents that individual psychotherapy of up to 20 or more visits a year is something patients are entitled to. The failure to actually provide individual psychotherapy does not get Kaiser within the purview of State regulators. The main reason for this is clear. State regulators receive complaints from health consumers. Yet, mental health consumers are probably the least likely individuals to complain about the inadequacies of mental health care, so these concerns fail to come to the attention of regulators.

Additionally, in this writer's experience in New Jersey, state regulators refuse to listen to the complaints of health care providers against managed care organizations. Their assumption is that health care providers do not like managed care organizations and therefore will make complaints. Sadly, this disempowers health care providers whose aim is to see more adequate services provided.. It is probably true in each of the states where Kaiser services are offered that provider complaints will land on regulator's deaf ears.

It is hoped consumers will be alerted to the inadequacy of services provided at Kaiser by those who read this article. Affected consumers are urged to make contact with state regulators. If consumers confront regulators, they will be forced to review the issue of phantom mental health services at Kaiser facilities.

Is there Another Way to Address Kaiser's Deficiencies?

While considering this question, I got a letter from Kelli Kane, LCSW, Manager of Behavioral Health for Kaiser Permanente-Colorado Region. She writes, "An independent research company measures patient satisfaction for the Behavioral Health Department on a quarterly basis. This past quarter 90% of our patients rated their overall satisfaction with our service as excellent or good. 87% of our patients stated their needs were met extremely or very well. 93% of our patients were satisfied with the amount of time they spent with their therapist."

Once again, Kaiser may be very good at generating patient satisfaction data. I'm sure Kaiser therapists are excellent ambassadors for their employer. They'd better be if they wish to keep their jobs. Kaiser's independent research pursues patient satisfaction data, not patient outcome. There is a difference. Ms. Kane continues, "Patient satisfaction with their initial appointment access and appointment frequency was at a record high of 86%. Our routine access for a new appointment is 14 calendar days for a psychiatrist and 8 calendar days for a clinician. This is the NCQA benchmark and exceeds the community standard."

As mentioned above, Kaiser's intake abilities are excellent. Patients are seen quickly and triaged (to use their term) quickly. That is both their strength and their deficiency. Her consideration of NCQA goes on to say that, "HEDIS (Health Plan Employer Data and Information Set) was developed by NCQA and is a set of standardized performance measures designed to ensure that consumers have the information they need to reliably compare the performance of health care plans. Our HEDIS scores rank us as one of the top health plans in the nation."

I called NCQA and spoke to Barry Scholl of NCQA Marketing and Communication. He indicated that, "what is important to NCQA is that health plans are making treatment decisions that are based on the best available medical evidence and are appropriate to the individual's particular needs." I shared with him my findings and my concerns that Kaiser's one size fits most philosophy goes against NCQA's priority that treatment decisions are appropriate to the patients particular needs. He allowed that NCQA has very limited standards to evaluate mental health treatment in the plans they accredit. They are working on them. I offered to help and gave him my contact number so they can speak to me and am holding my breath waiting.

References

Goffman, Erving, (1952). On Cooling the Mark Out. Psychiatry: Journal of Interpersonal Relations 15:4, pp 451-463.

Herz, Gordon, (1998). Therapists Dodge Bullet – Kaiser Permanente Holds Smoking Gun. Retrieved December 8, m 2003, from http://www.drherz.us/ProfessionalResources.htm. Holloway, Jennifer Daw, (2003). Virginia Managed-Care Finally Heads to Trial: Monitor on Psychology 34:4 p. 24.

Kane, Kelli, personal communication.

Miller, Ivan, personal communication.

Scholl, Barry, personal communication.

TABLE 1: Seven Item Questionnaire

1. How soon can somebody be seen?
   a. In an emergency
   b. In a non-emergency
      i.Adult
      ii. Child
2. Are there any situations or circumstances that result in restricting the length or frequency of individual treatment? What are these situations and/or circumstances?
3. Are patients informed of these practices, if so, how?
4. Is there a policy or practice that requires a number of intakes per week per treating practitioner?
5. Are patients free to choose the treatment modality (e.g., individual, family, couple or group psychotherapy) that they will be most comfortable with?
6. Are weekly individual psychotherapy sessions available to those who need it (e.g. a bona fide DSM IV Axis I diagnosis)?
7. Putting aside times for ongoing group psychotherapy and staff meetings, new intake appointments, administrative functions such as report preparation, etc, how many hours remain per week for ongoing individual, conjoint or family therapy for the average therapist?