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**Pro Hac Vice motion forthcoming*

Attorneys for Plaintiff Kayla Lovdahl

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN JOAQUIN – STOCKTON BRANCH

KAYLA LOVDAHL, an individual Plaintiff, v. KAISER FOUNDATION HOSPITALS, INC., a California Corporation, THE PERMANENTE MEDICAL GROUP, INC., a California Corporation, LISA KRISTINE TAYLOR, M.D., an individual, WINNIE MAO YIU TONG, M.D., an individual, SUSANNE E. WATSON, PHD., an individual, MIRNA ESCALANTE, M.D., an individual, and DOES 1 through 50, inclusive, Defendants.	Case No.: STK-CV-UMM-2023-0006100 **COMPLAINT FOR:** **1. MEDICAL NEGLIGENCE** **2. MEDICAL NEGLIGENCE – HOSPITAL/MEDICAL GROUP** **JURY TRIAL DEMANDED**

Plaintiff Kayla Lovdahl, an individual ("Plaintiff" or "Kayla"), brings this Complaint against Defendants KAISER FOUNDATION HOSPITALS, INC., a California Corporation, THE PERMANENTE MEDICAL GROUP, INC., a California Corporation, (collectively, the "Institutional Defendants") LISA KRISTINE TAYLOR, M.D., an individual, WINNIE MAO YIU TONG, M.D., an individual, SUSANNE E. WATSON, PHD., an individual, and MIRNA ESCALANTE, M.D., an individual, (collectively, the "Defendant Providers"), (the Defendant Providers and the Institutional Defendants are collectively referred to as the "Defendants"), and DOES 1 through 50, alleging as follows:

INTRODUCTION

1. This case is about a team of doctors (i.e., the Defendants) who decided to perform a damaging, imitation sex change experiment on Kayla, then a twelve-year-old vulnerable girl struggling with complex mental health co-morbidities, who needed care, attention, and psychotherapy, not cross-sex hormones and mutilating surgery.

2. Kayla is a biological female who suffered from a complex, multi-faceted array of mental health symptoms as a child and adolescent. Her presentation of symptoms and concerns included, among other things, recurrent intense anxiety and panic, extreme mood fluctuations, self-harm, problems at school resulting in suspensions, oppositional behavior, defiant behavior, interpersonal peer relationship problems, anger, depression, crying spells, significant appetite changes, irritability, agitation, decreased energy, panic with hyperventilation, confusion, nausea, nightmares, explosive temper outbursts, poor concentration, and gender dysphoria. Many of these symptoms are compatible with undiagnosed and untreated bipolar disorder, a diagnosis Kayla's mother repeatedly brought to the Defendant's attention because of her own diagnosis with this condition. Kayla and her parents struggled consistently with Kayla's mental health issues, regularly seeking assistance, but never received adequate treatment for her mental health issues.

3. In early adolescence around age 11, Kayla was exposed to online transgender influencers who prompted Kayla to entertain the erroneous belief that she was transgender. As a result, Kayla informed her parents that she was a boy. Prior to being exposed to online influences, Kayla never had expressed to anyone that she was transgender. Her parents didn't know what to do

and promptly sought guidance from various doctors and eventually the Defendants. Three Kaiser doctors, including Defendant Dr. Escalante, advised Kayla and her parents that Kayla was too young for cross-sex hormones. But Kayla and her parents eventually were referred to Defendants Dr. Watson, Dr. Taylor, and Dr. Tong, who immediately, and negligently, affirmed Kayla's self-diagnosed transgenderism without adequate psychological evaluation. They instead promptly placed her on puberty blockers and testosterone at age 12, and performed a double mastectomy within six months at age 13. This all occurred after Dr. Watson determined in a single, 75-minute transition evaluation that Kayla was transgender.

4. Defendants did not question, elicit, or attempt to understand the psychological events that led Kayla to the mistaken belief that she was transgender, nor did they evaluate, appreciate, or treat her multi-faceted presentation of co-morbid symptoms. Instead, Defendants assumed that Kayla, a twelve-year-old emotionally troubled girl, knew best what she needed to improve her mental health and figuratively handed her the prescription pad. There is no other area of medicine where doctors will surgically remove a perfectly healthy body part and intentionally induce a diseased state of the pituitary gland misfunction based simply on the young adolescent patient's wishes.

5. Defendants were horribly, and inexcusably wrong, as Kayla was not transgender and was not a person that any reasonable physician could ascertain would permanently maintain a transgender identity. Consequently, she detransitioned when she was 17 years old, and she eventually started regular psychotherapy sessions for her mental health symptoms, which is the care she should have been receiving all along.

6. Needless to say, Defendants breached the relevant standards of care in Kayla's case by rushing her into this failed transition experiment. They should have performed an extensive psychological evaluation with an aim to designing a treatment process for her conspicuous co-morbidities. The evaluation also should have considered her developmental state as an early adolescent, inexperienced with ordinary pubertal life processes. Defendants either naively assumed that all of her emotional problems were due to her new gender dysphoria, even though her cross-gender identification was new, or that the diagnosis of gender dysphoria immediately required hormonal and surgical treatment, which is clinically naïve and dangerously presumptive.

7. Among others, three critical facts establish that Defendants should not have recommended or performed transition "treatment" on Kayla and that Defendants thereby breached the standard of care in this regard.

8. First, desistence in childhood cross gender identities is well studied and demonstrates that around 80%-90% of gender dysphoria cases involving minors resolve by adulthood, with gender identity realigning to biological sex. It is impossible to predict which cases of gender dysphoria in minors will resolve, so it is never advisable to perform chemical/surgical transition on young adolescent. The vast majority of cross-gender identified children, if medically treated in early adolescence risk regretting the decision after they are old enough to realize their losses. It is an ethically untenable position to encourage medical transition in young adolescents knowing the high rate of desistence that occurs without treatment.

9. Second, minors with co-morbid health symptoms, such as Kayla, are at a particularly high risk for dissatisfaction and complications. They should be treated with regular psychological and/or psychiatric treatment at least until the individual reaches a far greater level of cognitive maturational capacity and has acquired a mental state that will allow them to appreciate the significance of the decision they are making. Even in adulthood, co-morbid mental health symptoms are a serious contra-indication of any chemical/surgical transition treatment. Kayla's providers entirely failed to evaluate, appreciate, treat and consider her serious co-morbid mental health symptoms.

10. Third, the medical studies in this area regarding minors, particularly minor girls, are dubious at best and do not indicate improved mental health outcomes from this affirmation treatment. One of the best studies in this area is a 30-year, population-based study of adults in Sweden, which found that transgender individuals who chemically/surgically "transition" have poor mental health outcomes, increased psychiatric morbidity, suicidality, and a 19-fold increased rate of suicide as compared with the general population (40-fold for biological females). A 2023 smaller scale 2-year study of adolescents found a 49-fold increased rate of suicide as compared with the general population; in that study, two of the participants actually committed suicide and suicidality was the most common side-effect of this so called "treatment." The study had numerous issues, including a

lack of a control group and a serious risk of research bias, but it still showed unacceptably high suicide rights for completed treatment in this area. In general, there is a lack of adequate studies in this area and a lack of any control group studies. The current research is low to very low quality, particularly in regards to minors, and there is even less research involving minor girls.

11. Defendants also failed to provide Kayla and her parents with proper informed consent. Informed consent is a process that takes considerable time to understand the consequences and psychiatric and additional medical risks for this type of "treatment." The standard of care requires regular therapy sessions over an extended period of time after a comprehensive assessment of the developmental and diagnostic mental health condition of the patient. Defendants did not provide regular in-depth therapy to Kayla, which entirely prevented the possibility of her provision of informed consent. Defendants provided only crisis-oriented psychotherapy, which was widely spaced until the next request from the parents. Defendants did not recognize the glaring need for a more committed approach to healing this disturbed young female and/or failed to provide such treatment. There were no in-depth meetings with the parents to discuss the short and long-term harms and hoped-for benefits of this affirmation treatment, well before the next medical or surgical step was undertaken. Defendants obscured and concealed important information from the patient and her parents such as the following: the conflicting studies in this area; the significant evidence demonstrating poor mental health outcomes; the existence of only low to very low-quality studies purportedly supporting hormonal interventions and the absence of control groups in such studies; the significant likelihood that desired outcomes would not be attained; the significant possibility of desistence, detransition and regret; and the lack of accurate models for predicting desistence and detransition. They also did not disclose the significant health risks associated with a biological female taking off-label puberty blockers and high doses of powerful male hormone drugs having many effects other than those desired. Furthermore, Defendants falsely and authoritatively represented opposite facts, including that Kayla's dysphoria would never resolve unless she chemically/surgically transitioned, and that she represented a high-risk of suicide unless she transitioned. These were material, false representations. Defendants' coercion, concealment, misrepresentations, and manipulation are appalling and represent an egregious breach of the standard of care. This

misconduct also constitutes fraud, malice, and oppression.

12. At age 17 years old, Kayla began a period of detransition and no longer identifies as a male. Unfortunately, as a result of the so-called transgender "treatment" that Defendants performed on Kayla, she now has deep physical and emotional wounds and severe regrets. Kayla has suffered physically, socially, neurologically, and psychologically. Among other harms, she has suffered mutilation to her body, fertility risks, health risks, and lost opportunities for social and physical development along with her peers, and at key developmental milestones that can never be regained.

13. Defendants were not "caring" for Kayla; they were experimenting on her.

PARTIES

14. At all times relevant herein, Plaintiff Kayla, an individual, was a resident of the County of San Joaquin, State of California.

15. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Lisa Kristine Taylor, M.D. ("Dr. Taylor"), was a physician duly licensed by the State of California to practice medicine in California. On information and belief, Dr. Taylor practices medicine primarily in Oakland, California, but accepted the Plaintiff as a patient and assisted with providing a course of experimental transgender medical treatment on Plaintiff that occurred at least in part in or around Stockton, California, and caused substantial injury to Plaintiff in or around Stockton, California.

16. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Winnie Mao Yiu Tong, M.D. ("Dr. Tong"), was a physician duly licensed by the State of California to practice medicine in California. On information and belief, Dr. Tong practices primarily in San Francisco, California, but accepted the Plaintiff as a patient and assisted with providing a course of experimental transgender medical "treatment" to Plaintiff that occurred at least in part in or around Stockton, California and caused substantial injury to Plaintiff in or around Stockton, California.

17. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Susanne E. Watson, PhD ("Dr. Watson"), was a psychologist duly licensed by the State of California to practice medicine in California. On information and belief, Dr. Watson

practices primarily in Oakland, California, but accepted the Plaintiff as a patient and assisted with providing a course of experimental transgender medical "treatment" to Plaintiff that occurred at least in part in or around Stockton, California and caused substantial injury to Plaintiff in or around Stockton, California.

18. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Mirna Escalante, M.D. ("Dr. Escalante"), was a physician duly licensed by the State of California to practice medicine in California. On information and belief, Dr. Escalante practices primarily in Roseville, California, but accepted the Plaintiff as a patient and assisted with providing a course of experimental transgender medical "treatment" to Plaintiff that occurred at least in part in or around Stockton, California and caused substantial injury to Plaintiff in or around Stockton, California.

19. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant The Permanente Medical Group, Inc. ("Medical Group"), is, and at all times mentioned in this complaint was, a California professional medical corporation with its executive offices located in Oakland, California. On information and belief, the Medical Group is the medical group through which Drs. Watson, Taylor, Tong, and Escalante collaborated to provide a course of experimental transgender medical "treatment" to Plaintiff that occurred and caused substantial injury to Plaintiff at least in substantial part in or around Stockton, California.

20. Plaintiff is informed and believes and thereon alleges that at all relevant times alleged herein, Defendant Kaiser Foundation Hospitals ("Kaiser Hospitals") is, and at all times mentioned in this complaint was, a California corporation operating in Northern California, with executive offices located in Oakland, California. On information and belief, Kaiser Hospitals is the hospital network through which experimental transgender medical treatment was provided by Drs. Watson, Taylor, Tong, and Escalante to Plaintiff, causing substantial injury to Plaintiff in or around Stockton, California.

21. Plaintiff is ignorant of the true names and capacities of defendants sued herein as DOES 1 through 50, inclusive, and therefore sues these defendants by such fictitious names. Plaintiff will amend her Complaint to allege their true names and capacities and causes of action against said

fictitiously named defendants when the same have been ascertained. Plaintiff is informed and believes and thereon alleges that each of the defendants designated herein as a "DOE" is responsible in some manner and liable herein to Plaintiff for her injuries.

22. Plaintiff is informed and believes and thereon alleges that at all times herein mentioned all of the DOES were the agents, servants and employees of their co-defendants and in doing the things hereinafter alleged were acting within the course and scope of their authority as such agents, servants and employees with the authorization, permission and consent of their co-defendants, except where stated otherwise below. Each of these acts and failures to act is alleged against each Defendant whether acting individually, jointly, or severally. Each of the Defendants or their alter egos agreed and conspired with the others in the commission of these acts or failures to act and fully ratified those acts.

23. At all times mentioned herein, each Defendant was the agent and employee of each and all of the other defendants and, in performing the acts herein alleged, was acting within the course and scope of such agency and employment. Plaintiffs are informed and believe that all of the wrongful acts alleged herein were authorized and/or ratified by officers, directors or other managerial agents of Defendants.

24. On March 16, 2023, Kayla sent a notice of intent to sue letter to the Defendants. The statutorily prescribed 90-day hold period for litigation has expired.

JURISDICTION AND VENUE

25. This Court has jurisdiction over this matter, and venue is proper, because a substantial portion of the injury and experimental medical treatment upon which this action is based occurred in San Joaquin County, State of California, in or around the city of Stockton.

26. The amount in controversy exceeds the jurisdictional minimum of this Court.

GENERAL ALLEGATIONS

27. Kayla is a biological female who had a complex array of mental health symptoms as a child and adolescent. From ages 6 to 11 years old, Kayla had a few intermittent and irregular psychiatric/psychological counseling sessions with various different providers for the following symptoms/conditions: anxiety issues, extreme mood fluctuations, self-harm, problems at school

resulting in suspensions, social issues, oppositional behavior, defiant behavior, anger, and related issues. Both of Kayla's parents expressed to her providers the family history of mental health issues, including Kayla's mother being bi-polar. Kayla's mother repeatedly expressed to Defendants that she believed her daughter may also be bi-polar and sought counseling in this regard, but did not receive it. Her daughter also never received a thorough evaluation by a child psychiatrist who would have been more knowledgeable about bipolar disturbances in children and might have provided a trial of medication to calm an agitated bipolar disturbance, as a trial to ascertain the diagnosis definitively.

28. When Kayla was 11, on or around April 26, 2016, Dr. Meridee Loomer saw Kayla and reviewed her file. Dr. Loomer noted that Kayla's mother had been requesting mental health services beginning in 2011, when Kayla was around 6 years old, due to school issues and because Kayla had written on her papers about wanting to die. Dr. Loomer also noted that there had not been any consistent psychotherapy services for Kayla.

29. At age 11, around this same time, Kayla heard about transgenderism, did extensive "research" online, and self-diagnosed that she was actually a "boy," and that transitioning would be the solution to all of her mental health struggles. She informed Dr. Loomer privately at her April 26, 2016, visit that she was a boy and that she preferred to be named "Kyle."

30. A few months later, Kayla's parents discovered that she thought she was transgender and they wanted to do the "right thing" for Kayla. In July 2016, Kayla's mother called Kaiser and sought counseling and requested puberty blockers. Kayla's mother naively and also erroneously believed that Kayla being "transgender" explained a lot of her problems. Kayla immediately started wrapping her breasts with a binder and began socially transitioning, including changing her name to Kyle. Kayla's mother felt that Kayla was happier after "coming out," and tried to get an appointment with a provider who could discuss puberty blockers.

31. A couple of months later, around September 14, 2016, Kayla had a visit with Dr. Doreen Samelson, who counseled them that since Kayla was past Tanner Stage II (the first stage of puberty), she was not a candidate for puberty blockers and <u>was not ready for cross-sex hormones</u>. Kayla received a contraceptive shortly thereafter to reduce her periods. Kayla had two more follow-up visits with Dr. Loomer reporting improvement in mood since "coming out."

32. On October 31, 2016, Kayla's mother called Kaiser about puberty blockers again and was informed that a certain Dr. Hoe would be willing to prescribe puberty blockers, although Kayla was too young for cross-sex hormones.

33. The next day, Kayla's mother also called Kaiser seeking a medication evaluation for Kayla's pre-existing mental health issues. She noted that Kayla had mood swings her whole life, periods of agitation and anger, went for periods with very little sleep, and that she was not doing well in school.

34. Dr. Mirna Escalante M.D., an endocrinologist, reviewed this call, and noted the mental disorder running in the family and that she suspected that Kayla had a mood disorder. Dr. Escalante informed Kayla and her parents that puberty blockers cannot be used indefinitely, and that testosterone cannot be started until age 16.

35. A couple of days later on November 3, 2016, Dr. Divina Flores saw Kayla to treat her mood swings, anger, sadness, and lack of known triggers. The notes mention that Kayla would write sad notes at age 6-7, that Kayla does not get much sleep, that her sleep has been irregular since being a baby, that Kayla sees figures or things passing on the side when she doesn't get enough sleep, and that she has strange reoccurring nightmares. Dr. Flores also noted symptoms of depression, mania, abuse from peers, obesity, poor social skills, and that Kayla had few friends. Dr. Flores prescribed Risperidone, but Kayla had bad physical side effects from it. Therefore, Kayla's mother wanted to stop the medication and change doctors. Dr. Flores instructed Kayla to discontinue the drug.

36. A couple of days later on November 8th and 9th, 2016, Kayla's mother called Kaiser and spoke with three different providers who had never seen Kayla before. The notes of those calls included the following:

> "**Depression symptoms that include: depressed mood, crying spells, significant appetite change, irritability, agitation, decreased energy, problems related to social environment and Personal changes** Mother stated pt is in the process of being a male from a female. **Mother stated pt has been getting up upset and unable to manage his depression sxs**."

> **"Pt's moods are changing frequently, pt has been "distraught." Pt having significant anxiety as well, not calming down or listening to Mom.** Pt is currently at maternal grandmother's home, and Mom intends to pick him up to bring him directly into the Stk Cpy office to be seen today. **When asked about concerns re: self/other harm, she states that he has made statements such as "what's the point," or "I**

> **should just drink bleach" recently but not today**. Mom mentions that pt reportedly had a **knife** in his hand a couple of months ago, though was not doing anything w/ it, gave it to Mom."
>
> "Kyle has problems with Oppositional/Defiant problems that include: oppositional, defiant, argumentative, irritable, angry, blaming of others, easily annoyed and spiteful and vindictive. Panic symptoms that include: trouble breathing, shaking and confusion"
>
> "Patient presented to urgent services after his mother called Kaiser Psychiatry Triage yesterday and today **reporting concerns over her son's agitation/labile behavior, mood fluctuations, and potential for self-harm/harming others**. Patient's reported that her son has been having **unprovoked anger outbursts where he's been lashing out (i.e. cursing) at her mostly and others**. His mood has fluctuated in the past few months and he's been experiencing panic attacks where he gets **shortness of breath, starts shaking, and gets confused**."

(Emphasis added).

37. A week later, on November 15, 2016, Dr. Escalante ordered the puberty blockers, but mentioned that Kayla cannot start cross-sex hormones until 16 years old. After the injection, Kayla had increased mood changes and severe hot flashes, and Kayla's mother called Kaiser seeking psychiatric assistance for Kayla, but she did not receive any course of psychotherapy or psychiatric treatment.

38. Instead, Kayla and her mother eventually ended up in the hands of Defendant Watson. Defendant Watson told them that there were no age limits on cross-sex hormones or a mastectomy in Kaiser's policies and counseled them to proceed with physical transition. Dr. Watson had three phone calls with Kayla's mother by this point, though there had been no formal consultation or visit yet.

39. On March 29, 2017, Dr. Watson performed a 75-minute evaluation session of Kayla, concluding that she was transgender and that she should receive chemical/surgical transition treatment. Dr. Watson also diagnosed social anxiety and recommended treating social anxiety after transitioning. Dr. Watson otherwise ignored and failed to evaluate and treat Kayla's complex pre-existing array of co-morbid symptoms. Kayla was then referred for a mastectomy.

40. On May 1, 2017, at **12 years old**, Kayla consulted with Winnie Tong M.D., a plastic surgeon, who concluded after 30 minutes that Kayla is a good candidate for surgery. On the same date, Watson formally approved and recommended Kayla for bilateral mastectomies (so called "top surgery").

41. In additional consultations thereafter, Dr. Escalante expressed concern for starting Kayla on testosterone and noted that she has never started a child of Kayla's age on testosterone. Dr. Escalante further noted that "Kyle is still very young, and [we] have to proceed with caution."

42. Kayla was then transferred out of Dr. Escalante's care to the Oakland clinic under Dr. Kristine Taylor. Dr. Taylor immediately started Kayla on testosterone. On June 6, 2017, Kayla had her first dose of testosterone. Two days later on June 8, 2017, Kayla's mother reported to Dr. Watson increased anger and frustration and related issues. Her mother expressed concern that this indicates bipolar illness, but said that she thought that it was more likely related to gender dysphoria.

43. Dr. Taylor and Dr. Watson did not evaluate or treat these mood swings. In the next few months, Kayla was seen by about four different mental health providers. Kayla's mood was noted to be improved at various times, but her pre-existing complex array of mental health issues was noted to continue to include suicidal ideation, cutting, anger, depression, mood swings, and related issues. Kayla was also being forced by her mother to attend pride clinic events, but she didn't want to do so, and said she didn't feel "pride." She expressed this lack of "pride" to her providers.

44. On July 11, 2017, Kayla had counseling regarding fertility, and it is noted that she **"[d]oes not know if [she] wishes to be a parent in the future."**

45. On September 22, 2017, after Kayla just turned age 13, Dr. Tong performed a double mastectomy on her. Kayla had no sexual relationships prior to this time, and had no concept of being a parent, and had no idea what it might mean to lose her ability to breastfeed a baby in the future. Here is a picture of Kayla in the hospital soon after the operation:

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46. Kayla's mother felt that her symptoms had improved after the surgery, but Kayla continued to have social anxiety, low motivation, loneliness, lack of friends, and no interest in seeing a therapist. She described herself at this time as "a loner, [who] just really [doesn't] like anyone else" and who does not engage with other peers.

47. Also, gradually her anxiety and irritable mood symptoms increased so that Kayla's mother described her improvement after "top surgery" as only "slightly improved" approximately a year later. It is noted that her moods go down two days prior to each testosterone injection and then go back up. It is also noted that Kayla continued to have the following symptoms: hyperventilation, nausea, nightmares, anger outbursts in which Kayla would punch holes in the wall, suicidal ideation, appetite swings, energy swings, excessive anxiety or worry, excessive fear of social situations, repeated nightmares, and explosive temper outbursts. She was assessed with having "mood disorder with depressive features and social anxiety," and she was seeking medication management. Some medications seemed to improve Kayla's mood at various times, although the side effects of drowsiness were problematic. Prozac seemed to be the best medication for Kayla at that time.

48. Eventually, Kayla had also started having sexual relationships with biological males. Consequently, she had an IUD placed around December 16, 2020.

49. Eventually, Kayla started to realize that her mental health issues were not related to being transgender or being "born in the wrong body." She realized that she just had anxiety and mood disorder issues that needed to be addressed with proper mental health treatment. Kayla stopped injecting testosterone around the middle of 2021, while beginning a period of detransition. Thereafter, she stopped all contact and services with the Kaiser Proud Clinic where she had been receiving ongoing evaluation for her transition. It is worth observing that while the Defendants cooperate with efficiently providing hormones and surgery, they leave it entirely up to the patient to decide to stop the treatment. These Defendants had ample evidence prior to and after the mastectomies that Kayla's significant mental health problems continued to impair her mood regulation, social relationships, educational progress, and her self-protection. Nonetheless, they never raised the issue with the parents or with Kayla that this treatment was not working out as hoped and never recommended an alternative approach, which they should have done.

50. In August 2022, Kayla sought regular psychological counseling to assist with her mental health issues. She has been treating with two providers every 2-4 weeks from August 2022 to present. She was diagnosed with Social Anxiety Disorder and Mood Disorder with depressive features. She finally received regular psychotherapy counseling to address her depression, panic, anxiety and related symptoms, which is what she needed all along. A few months later her files were evaluated by a psychologist and endocrinologist, both of whom determined that Defendants breached the standard of care in their treatment of Kayla.

<u>Negligence Issues – Lack of Proper Psychological Evaluation</u>

51. Defendants were grossly negligent in that they failed to adequately assess, evaluate, appreciate, and treat Kayla's extensive co-morbid pre-existing mental health and related symptoms as discussed above. Kayla needed regular, extensive psychotherapy and/or psychiatric medication and/or counseling. Defendants grossly breached the standard of care by failing provide much needed psychotherapy and/or psychiatric treatment and by wrongly subjecting Kayla to a permanent, invasive, unstudied, off-label, high-risk, imitation sex change experiment that ultimately failed, resulting in permanent disfigurement and bodily mutilation. Recommending Kayla for risky, permanent physical transition to a male appearance, in light of Kayla's serious history of comorbid

mental health symptoms was gross breach of the standard of care.

52. In addition to the foregoing, Kayla's providers failed to address very basic aspects of Kayla's mental health and related issues. Kayla's providers did not try to address or treat her body dysmorphia and self-image issues. They did nothing to try to help her feel more comfortable in her own body. Her providers never addressed the bullying that she experienced and never taught her skills for coping with these issues. They did nothing to advise Kayla that puberty can be a difficult change for many people, particularly girls. They did not advise or discuss that it is normal to experience increased negative emotions, confusion regarding bodily changes, increased social trouble, and related issues with the onset of puberty. Instead, they essentially handed Kayla the prescription pad, and allowed her naïve, emotional, childish, rollercoaster of feelings to dictate the so-called "treatment" that she would receive. Defendants failed to educate the desperate-to-help mother about the uncertainties and controversies involved in cross-sex treatment; they led her to believe that puberty blockers, testosterone and the removal of breasts were the best and only form of effective treatment for Kayla. Thus, Defendants privileged their interests in supporting and medically treating this young maladapted person over a larger consideration of adolescent development and what was actually in Kayla's and her family's best interests in the long run. This is negligent medical care.

Negligence Issues – Risks

53. **High Desistence Rates:** Desistence is a critical issue and risk in this area. Eleven studies of childhood gender dysphoria have been conducted, including three large-scale follow-up studies and eight smaller studies.[1] Collectively, these studies establish a desistence rate somewhere between 62% to 97.5% of cases averaging to around an 80-90% desistence rate.[2] The largest study

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[1] Buttons, C., *Finland's Leading Gender Dysphoria Expert Says 4 Out Of 5 Children Grow Out Of Gender Confusion*, THE DAILY WIRE (Feb 2023); Korte, A., et al., *Gender Identity Disorders in Childhood and Adolescence*, DTSCH ARZTEBL INT. (Nov. 2008) (DOI: 10.3238/arztebl.2008.0834); Cantor, J., *Do Trans-Kids Stay Trans- When They Grow Up?* SEXOLOGY TODAY (http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html (accessed Feb. 7, 2023)) (summarizing the eleven studies of desistence including three large scale follow-up studies and eight smaller scall studies).

[2] *Ibid*.

found a desistence rate of approximately 92%. In sum, a well-established body of research demonstrates that gender dysphoria in children will desist by adulthood in approximately 62%-97.5% of cases, with the person's mental state shifting to align with the person's biological sex.[3] The American Psychiatric Association DSM-5 identifies these same desistence rates based on these studies.[4] Desistence of gender dysphoria cases that first present in later adolescence are not well studied. Nevertheless, medically significant desistence/detransition[5] rates have been identified, and in recent years, the rate of desistence/detransition for later adolescent onset gender dysphoria is accelerating.[6] Additionally, later onset gender dysphoria typically does not indicate a "core gender identity conflict," which typically must exist for a person to experience transgender feelings as an adult. Furthermore, and of great importance, there are no diagnostic criteria and no models for predicting which cases of gender dysphoria will desist and which cases will persist.[7] It is essentially a dice role with very low odds of success. Indeed, one parent of a transgender patient of Dr. Watson asked Dr. Watson how she determines who will benefit from hormone treatment. In response, Defendant Watson laughed and replied, ***"there's no criteria, but you kind of get a sense of it."*** This is not the practice of evidenced based medicine, this is child experimentation.

54. **Unimproved Psychological Condition:** Lack of improved psychiatric morbidity is another critical issue and risk in this area. Among others, one key study in this area is a high quality,

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[3] *Ibid*.

[4] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition Text Revision DSM-5-TR™*, AMERICAN PSYCHIATRIC ASSOCIATOIN PUBLISHING, page 517 (https://ebooks.appi.org/epubreader/diagnostic-statistical-manual-mental-disorders-fifth-edition-text-revision-dsm5tr).

[5] Desistence refers to those who desist from gender dysphoria without undergoing any type of transition; detransition refers to those who undergo transition to a cross-sex identity and then detransition back to their original sexual identity.

[6] Levine, S., et al., Reconsidering informed Consent for Trans-Identified Children, Adolescents, and Young Adults, JOURNAL OF SEX & MARITAL THERAPY (March 2022) (DOI: 10.1080/0092623X.2022.2046221).

[7] Korte, A., et al., *Gender Identity Disorders in Childhood and Adolescence*, DTSCH ARZTEBL INT. (Nov. 2008) (DOI: 10.3238/arztebl.2008.0834); Levine, S., et al., Reconsidering informed Consent for Trans-Identified Children, Adolescents, and Young Adults, JOURNAL OF SEX & MARITAL THERAPY (March 2022) (DOI: 10.1080/0092623X.2022.2046221).

30-year, large scale, population-based study, out of Sweden.[8] This study found increased psychiatric morbidity, increased suicidality, and a 19-fold increased rate of completed suicide as compared with the general population for transgender individuals "treated" with transition chemicals and surgery. When this data set was analyzed by biological sex, the suicide rate for females who were presenting themselves as men was 40-fold higher than controls. This data has been available since 2011. A recent study by Chen et al. (2023) affirmed the previous indicators of a significant increase in mortality among gender dysphoric adolescents and young adults treated with cross sex hormones and surgery as it indicated approximately a 49 times increased suicide rate as compared with the general population.[9]

55. **Risks Outweigh Benefits:** This "treatment" had been previously and repeatedly tried without success both in the U.S. and in other countries.[10] Among others, the negative results caused the U.S. transgender clinic at Johns Hopkins Hospital to shut down decades ago, and also caused the Tavistock Transgender Clinic in England to shut down recently.[11] The National Health Service in

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[8] Dhejne, C., et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE (Feb. 2011) (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885)

[9] Chen, D., et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, N. ENGL. J. MED. (Jan 2023) (https://www.nejm.org/doi/10.1056/NEJMoa2206297). In this recent two-year study of 315 youth age 12-20 years of age treated with cross-sex hormones, suicidal ideation was the most common adverse event and two participants actually committed suicide. This establishes a suicide rate of 0.634%. This rate is approximately a 49 times higher completed suicide rate than the general population suicide rate of 0.013%. Although the study purports to claim the outcomes were positive for this treatment, the fact that two participants committed suicide does not justify such a conclusion. The "treatment" clearly was not successful. Additionally, the hypothesized results of the study were dramatically modified upon conclusion of the study, indicating a high risk of research bias and an attempt by the authors to morph their study around the statistically significant results that support their aim of validating this type of treatment while excluding from the study original hypotheses that were not supported by the results of the study.

[10] *Independent Review of Gender Identity Service for Children and Young People: Interim Report,* THE CASS REVIEW (February 2022) (https://cass.independent-review.uk/publications/interim-report/ (accessed Feb. 10, 2023); Chapman, M., *Johns Hopkins Psychiatrist: Transgender is 'mental disorder;' Sex Change 'biologically impossible'*, CNSNEWS.COM (June 21, 2015) https://www.cnsnews.com/article/national/michael-w-chapman/johns-hopkins-psychiatrist-transgender-mental-disorder-sex (last accessed February 7, 2023).

[11] Ibid.

England has restricted the use of puberty blockers exclusively to clinical research settings.[12] Finland, Sweden, England, France, Belgium, and Florida's Boards of Medicine, have all conducted systematic reviews of the relevant literature and concluded that the risks far outweigh any supposed benefits.[13] Additionally, approximately twenty states of the United States of America have enacted legislation restricting medical transition treatment for minors at the time of the filing of this complaint.

56. **Lack of Adequate Research**: There are only low to very low-quality studies of transgender treatment and there has been very little study of minor girls, yet some U.S.-based medical groups are publishing guidelines recommending this treatment.[14] The low quality means the studies

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[12] NHS England, *Implementing advice from the Cass Review* (updated June 2023) https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/ (accessed June 12, 2023).

[13] Buttons, C., *Finland's Leading Gender Dysphoria Expert Says 4 Out Of 5 Children Grow Out Of Gender Confusion*, THE DAILY WIRE (Feb. 2023).

[14] See Ludvigsson, J., et al, A systematic review of hormone treatment for children with gender dysphoria and recommendations for research, ACTA PAEDIATRICA (April 2023) https://doi.org/10.1111/apa.16791; See e.g. Hembree, W., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM (Sept. 2017); (The endocrine society guidelines in "Section 2.0 Treatment of Adolescents" recommend the use of puberty blockers and cross-sex hormones for adolescents who meet the diagnostic criteria for gender incongruence. Each of the recommendations is designated with the symbols "⨁⨁○○" or " ⨁○○○." The section titled "Method of Development of Evidence-Based Clinical Practice Guidelines" explains that the recommendations/suggestions designated by the symbol "⨁⨁○○" means that the recommendation is based on **low quality evidence** and the recommendations designated with the symbol ""⨁○○○" are based on **very low-quality evidence**. So, the endocrine society acknowledges that the supporting studies for these guidelines are low to very low quality studies). See also Buttons, C., *Finland's Leading Gender Dysphoria Expert Says 4 Out Of 5 Children Grow Out Of Gender Confusion*, THE DAILY WIRE (Feb 2023); Abbruzzese, E., *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed* JOURNAL OF SEX & MARITAL THERAPY (2022) (https://doi.org/10.1080/0092623X.2022.2150346).

It is worth noting that the 2009 version of the endocrine society guidelines did not recommend treatment with cross-sex hormones until at least the age of 16 and did not recommend a breast mastectomy until at least age 18. See e.g. Hembree, W., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM (Sept. 2009). This change in the clinical guidelines did not reflect a change in scientific knowledge, but instead reflected a downgrade in the quality of the supporting evidence. The 2009 guidelines are identified as being based on low to moderate quality evidence, whereas the 2017 guidelines are identified as being based on low to very low-quality present a high possibility of containing erroneous conclusions regarding efficacy for "treatment" and present a significant risk that patients undergoing this treatment will not experience the purported/intended effects.[15]

57. **Medical Risks:** There are many other known and unknown risks of administering puberty blockers and cross-sex hormones. These include, among others: sterility, painful intercourse, impairment of orgasm, reduced bone development and inability to obtain peak or maximum bone density, stopped or stunted growth of the pelvic bones for reproductive purposes, increased risk of osteoporosis and debilitating spine and hip fractures as an adult, increased morbidity and death in older age due to increased risk of hip fracture, negative and unknown effects on brain development, emotional lability such as crying, irritability, impatience, anger, aggression, and reports of suicidal ideation and attempt.

58. Additional risks associated with testosterone include, among others: serious cardiovascular and psychiatric adverse reactions, significant weight gain, increased or decreased libido, headache, anxiety, depression, and generalized paresthesia, premature closure of boney epiphyses with termination of growth causing inability to reach full height for adolescents, and pulmonary embolism (i.e., blood clots in the lungs). There is a study of transitioned females (i.e. transgender men) in which all of the individuals who reported adverse drug reactions suffered cardiovascular events, and of those reports, 50% of cases involved pulmonary embolism. The labeling also notes risk of liver disfunction, stating that prolonged use of high doses of androgens has been associated with development of hepatic adenomas (benign tumors), hepatocellular carcinoma (cancer), and peliosis hepatis (generation of blood-filled cavities in the liver that may rupture)—all potentially life-threatening complications.

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evidence. In order to suggest this "treatment" for lower age groups, the endocrine society shifted away from higher quality evidence relying instead on lower quality evidence.

In Kayla's case, had she not undergone any of this "treatment" until she was 16-18, the serious and permanent harm that she suffered would never have occurred. Kayla's case is a prime example demonstrating the higher quality of the prior clinical guidelines.

[15] Levine, S., et al., *Reconsidering informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, JOURNAL OF SEX & MARITAL THERAPY (March 2022) (DOI: 10.1080/0092623X.2022.2046221).

59. Specifically for females, studies of transitioned females taking testosterone have shown a nearly 5-fold increased risk of myocardial infarction. Females can also develop unhealthy, high levels of red blood cells which create an increased risk for cardiovascular disease, coronary heart disease, and death due to both. Other affects include irreversible changes to the vocal cords and Adam's apple, deepening of the voice, abnormal hair growth, and male pattern balding of the scalp. Additional risks include polycystic ovaries, atrophy of the lining of the uterus, and increased risks of ovarian and breast cancer.

60. **American Society of Plastic Surgeons**: The American Society of Plastic Surgeon's Policy Statement for aesthetic breast surgery in teenagers[16] states as follows:

> "Recommendations: Adolescent candidates for (purely) aesthetic breast augmentation should be at least 18 years of age. Breast augmentation that is done for aesthetic reasons is best delayed until the patient has sufficient emotional and physical maturity to make an informed decision based on an understanding of the factors involved in this procedure. This includes being realistic about the surgery, expected outcome and possible additional surgeries. In considering emotional maturity for breast augmentation, the patients should request the procedure for themselves, not to satisfy another's perception of the patient. In addition, they should demonstrate sufficient emotional maturity to understand all aspects of this surgery. This would include having realistic expectations of the procedure itself, the outcome and the potential for future surgeries. Adolescent patients need to understand that, while implants can be surgically removed, the procedure may leave permanent changes on the body, including scarring and tissue changes."

Although Kayla was not seeking augmentation, the need for emotional and physical maturity to make a decision to totally remove one's breasts applies even more dramatically to her situation.

61. **Induced Endocrine Disorder**: The administration of Lupron Depot stopped Kayla's natural progression of puberty, and medically induced various endocrine disorders, including among others, hypogonadotropic hypogonadism.[17] This condition is a pituitary gland dysfunction, wherein the female ovaries or male testes produce little or no sex hormones. This dysfunction requires

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[16] American Society of Plastic Surgeons, *Policy Statement Breast Augmentation in Teenagers* (approved 2004, reaffirmed 2015) (https://www.plasticsurgery.org/documents/Health-Policy/Positions/policy-statement_breast-augmentation-in-teenagers.pdf).

[17] https://www.pennmedicine.org/for-patients-and-visitors/patient-information/conditions-treated-a-to-z/hypogonadotropichypogonadism#:~:text=Definition,the%20pituitary%20gland%20or%20hypothalamus.

chemical treatment to correct and can be otherwise caused by damage to the pituitary gland from surgery, injury, tumor, radiation, genetic defects, heroin use, abuse of opiate medicines, iron overload, and other causes. Kayla's pituitary gland was not malfunctioning. To the contrary, it was functioning normally and was producing proper hormones to further her normal biological development. Defendants introduced these chemical interventions to disrupt the proper functioning of Kayla's pituitary gland, intentionally inducing various endocrine disorders in the process. In prescribing testosterone, Defendants also caused Kayla to develop more masculine characteristics, to suffer severe atrophy and damage to her reproductive organs, and other harms.

62. **The use of Lupron Depot and testosterone to treat "gender dysphoria" is also not approved by the FDA and is an off-label use.**

Informed Consent Issues

63. Defendants were also grossly negligent in that they failed to provide Kayla with proper informed consent. In order to provide proper informed consent, regular psychotherapy for a significant period of time was necessary to properly evaluate, understand, and diagnose Kayla's full psychological condition. Without understanding Kayla's current psychological condition fully, Defendants could not possibly provide Kayla and her parents with proper informed consent as Defendants themselves failed to properly evaluate Kayla's condition and the options and risks of various types of treatment.

64. Additionally, Kayla's providers should have, but failed to provide her with informed consent regarding: (1) desistence/detransition rates, the studies indicating 80%-90% desistence for minors, and the likely possibility of detransition and regret; (2) the inability of her providers to predict whether Kayla would detransition; (3) the existence of only low quality studies in this area and the significant likelihood that "transitioning" would not achieve the hoped for benefit; (4) the lack of studies for 12 year old girls and general lack of any longitudinal studies performed with control groups for this type of treatment; (5) the experimental nature of this so called "treatment;" (6) the option of performing psychotherapy instead; and (7) the high quality evidence indicating that transition does not resolve psychiatric morbidity, suicidality, and suicide rates, which continue to be substantially increased as compared with the general population.

65. Defendants also deliberately ignored and failed to meaningfully discuss with Kayla that sex-reassignment is not physically possible even with surgery. There is no way to surgically replace functioning biological female organs with functioning biological male organs. A transitioned female can never produce biological children with a female and vice versa. At best, surgery and chemical treatment can modify a female body to mimic and appear more like a male body and vice versa. Defendants knew that this treatment was not a viable option and does not produce good mental health outcomes, yet they sent Kayla down this path of mutilation and regret without advising her of any other options and without warning her of the significant risks. The best option for a person who does not have a core-gender identity conflict is always for the person to desist from a gender dysphoric mental state and re-align their mental state with their biological sex. But, this information was never conveyed to Kayla, or her parents, nor was she allowed time and psychotherapy to see if this would happen for her.

66. Instead of fully disclosing this important relevant information and giving Kayla time to explore these issues with psychotherapy, Kayla's providers automatically affirmed that she was transgender without any meaningful evaluation and then provided her with false opposite information. They told her that her mental health and gender dysphoria symptoms would <u>not</u> resolve without chemical/surgical transition, which was contrary to important and reliable clinical research regarding desistence. They falsely stated that she presented an increased suicide risk if she did not transition, contrary to important and reliable clinical research demonstrating that poor mental health outcomes and significantly increased suicide risk persist even with transition.

67. They further failed to inform her of the significant increased suicide risk that would continue to exist even after completing transition. Furthermore, they coerced Kayla and her parents to undergo this treatment regimen by indicating that "it is better to have a live son than a dead daughter." These coercive statements boxed Kayla and her parents into a false decision-making matrix, further undermining the informed consent process.

68. Kayla's providers should have and did not adequately disclose or discuss many known health risks associated with puberty blockers and cross-sex hormone treatment including, but not limited to, the following: *permanent fertility loss, painful intercourse, impairment of orgasm, stopped*

or stunted widening and growth of the pelvic bones for reproductive purposes, increased risk of osteoporosis and debilitating spine and hip fractures as an adult, increased morbidity and death in older age due to increased risk of hip fracture, negative and unknown effects on brain development, emotional lability such as crying, irritability, impatience, anger, and aggression, and reports of suicidal ideation and attempt.

69. They also failed to identify and discuss risks noted in the testosterone drug labeling including, but not limited to, the following: "serious cardiovascular and psychiatric adverse reactions," "increased or decreased libido, headache, anxiety, depression, and generalized paresthesia," "pulmonary embolism" (i.e. blood clots in the lungs). There is a study of transgender men in which all of the individuals who reported adverse drug reactions reported cardiovascular events, and of those reports 50% of cases involved pulmonary embolism. The labeling also notes "risk of liver disfunction" stating that "prolonged use of high doses of androgens … has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [generation of blood-filled cavities in the liver that may rupture] – all potentially life-threatening complications."

70. Specifically for females, studies of transitioned females taking testosterone have shown a nearly 5-fold increased risk of myocardial infarction. Females can also develop unhealthy, high levels of red blood cells, which create an increased risk for cardiovascular disease, coronary heart disease, and death due to both. Additional risks that were not discussed include, polycystic ovaries, atrophy of the lining of the uterus, and increased risks of ovarian and breast cancer.

71. Additionally, informed consent for puberty blockers should warn that most patients go on to opposite sex hormones. Informed consent for opposite sex hormones like testosterone should warn that most go on to surgeries. This information was not provided.

72. There do not appear to be any written informed consent forms concerning Kayla's treatment, which although inadequate to establish informed consent alone, are still helpful to ensure and document that the extensive risks were discussed and addressed. The lack of any such forms further supports that there was grossly inadequate informed consent in this case. Since this treatment is experimental, involving off-label use of medications, it requires a more precise and exhaustive

informed consent, including in written form.

Institutional Defendant Issues

73. The Institutional Defendants are vicariously liable for the foregoing acts of their providers. These institutions are additionally liable for allowing such radical, inadequately studied, off-label, and essentially experimental treatment to occur on minors, including Kayla, at their facilities. They are also liable for failing to have adequate policies and procedures prohibiting and preventing the acts, omissions, failures of informed consent, fraudulent concealment, fraudulent misrepresentation, below the standard of care treatment, and other acts and omissions that occurred in Kayla's case, and as described in this complaint. Indeed, the Institutional Defendants not only have inadequate policies and procedures in place to prevent such treatment, but they actively promote, encourage, and advertise on their website that their facilities and providers offer transgender treatment, including for minors. They also actively promote, through misleading advertising, the false and manipulative idea that those with gender dysphoria who do not transition are at an increased risk for suicide. Consequently, the Institutional Defendants are jointly liable with the providers, but also have additional and separate bases for incurring liability for Kayla's damages.

74. Additionally, it appears that surgical/hormone treatment represented an easier more available treatment option to Defendants over regular interval psychotherapy. For over a decade, since 2013, the California Department of Managed Healthcare has conducted an ongoing investigation of Kaiser's inability to adequately staff mental health professionals, and this has been reported in the news.[18] The American Psychological Association has even sent a letter to the Kaiser Foundation Health discussing how Kaiser's lack of availability of follow-up mental health care falls below professional standards of care in this area.[19] Remarkably, there have been multiple protests wherein thousands of mental health professionals affiliated with Kaiser went on strike at various times, including in Oakland, California.[20] Also, hundreds of practitioners have left Kaiser for private

[18] See Exhibits 1-6, 8-12.

[19] See Exhibit 7

[20] See Exhibit 5,6, 10-12

practice apparently due to Kaiser's unethical practice of understaffing the mental health division.[21] Yet, Kaiser turned a record $8.1 billion profit in 2021 alone.[22]

75. Kayla's case occurred during this time when Kaiser was inadequately staffed with mental health care providers. It appears that this inadequate staffing, to make more profits, was a contributing factor to Defendants' inadequate mental health evaluation and psychotherapy treatment of Kayla. It also appears that this inadequate staffing contributed to the apparent favoritism for easy chemical/surgical treatment, rather than the critically needed psychotherapy in Kayla's case

76. In addition, from a financial and political perspective, patients such as Kayla who "transition" to appear more like the opposite sex represent a lucrative business and political opportunity for Defendants. Expanding and increasing the services of the transgender program at Oakland allows the Kaiser Foundation Hospitals, Inc. program and The Permanente Medical Group, Inc., Defendants to negotiate for increased plan benefits with the Kaiser Foundation Health Plan on a yearly basis. Additionally, Defendants have strong political incentives to increase and expand their transgender programs, at the expense of patients like Kayla who are not actually transgender. One of these political incentives is the Corporate Equality Index.[23] By expanding and increasing these transgender programs, Kaiser is able to satisfy powerful political and financial groups and is also able to maintain its "perfect" CEI scores.[24] Political ideology and financial incentive is driving this expansion of transgender treatment to minors such as Kayla, not sound medicine and science. This lifelong "treatment" regimen also provides a huge financial benefit to defendants' business associates in the related health care and pharmaceutical industries.

Damage Issues

77. As a result of the grossly negligent treatment performed, Kayla has suffered permanent irreversible mutilation and damage to her body, particularly the female characteristics of her body.

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[21] See Exhibit 10.

[22] Ibid.

[23] https://about.kaiserpermanente.org/news/another-perfect-score-on-2019-corporate-equality-index (last accessed June 2, 2023).

[24] https://nypost.com/2023/04/07/inside-the-woke-scoring-system-guiding-american-companies/ (accessed June 2, 2023).

The full scope and extent of her physical damage is currently being investigated. Nevertheless, a non-exhaustive summary of her past symptoms and ongoing issues is summarized here.

78. Kayla had an induced state of endocrine disease for a period of time which likely included the following: (1) Hypogonadotropic Hypogonadism, (2) Hyperandrogenism, (3) Hypoestrogenemia, (4) Erythrocytosis (leading to increased cardiovascular risk), and (5) an abnormal Complete Blood Count (CBC). As a result, she has at a higher risk of having various health complications as an adult. She also did not have the opportunity to develop as a female according to normal pubertal milestones. She is at an increased risk for being infertile or having fertility issues in the future. She has an increased risk with regard to carrying a child to term and having a natural, non-surgical delivery. She is at an increased risk for having bone related problems in the future including fractures, which in late adulthood creates a significant risk for premature death.

79. She suffered from serious pre-existing and inadequately treated mental health co-morbidities that continued throughout the period of her so-called "transition" and caused her great emotional distress and turmoil.

80. Kayla has a lower, more masculine voice, increased body and facial hair, more masculine features and body shape, and other changes. She has lost both of her breasts and will never be able to breastfeed a child. She has permanent scars on her chest and has lost the erogenous sensation in her breast area.

81. Kayla constantly bound her breasts before the mastectomy, and without a break except for brief showers. She wore the tight binder even at night and had panic attacks when her mother tried to get her to take the binder off at night. She had skin irritation and severe mental distress as a result. Kayla's mother was constantly worried that she would stop breathing while sleeping with the binder on.

82. Monitoring and treatment for fertility issues will also be required, the full scope of which is unknown at this time. Kayla may need additional corrective surgery, and she may need further corrective hormone treatment. Monitoring and future treatment for osteoporosis is medically indicated. She may have trouble conceiving at some point in the future. Psychological monitoring and treatment pertaining to her regret over this experimental and disastrous transition treatment is

also indicated.

Appreciable Harm

83. Pursuant to C.C.P. § 340.5, the statute of limitations for medical malpractice actions in California begins to run from the date that "appreciable harm" is first manifested. (*See Drexler v. Petersen*, 4 Cal.App.5th 1181, 1190-91 (2016); *see also Brewer v. Remington*, 46 Cal.App.5th 14, 28-29 (2020).) Appreciable harm is manifested at "that point at which the damage has become evidenced in some significant fashion; when the damage has clearly surfaced and is noticeable. (*See Drexler, supra,* 4 Cal.App.5th at 1190-91.) "[I]t could well be that an injury or pathology will not manifest itself for some period after the last treatment by a physician." (*See id.*) When there is a mis-diagnosis, appreciable harm does not manifest until there is a proper diagnosis. (*See id.*) The question of appreciable harm is a question of fact for the jury. (*See Drexler, supra,* 4 Cal.App.5th at 1195-96.)

84. Here Defendants incorrectly advised Kayla that she was "transgender" and that she needed to receive chemical and surgical transition treatment to the opposite sex appearance in order to improve her mental health. Defendants further falsely informed Kayla that if she did not transition, her mental health condition would not improve. Defendants then "treated" Kayla with a course of puberty blockers, testosterone, and a double mastectomy. Defendants then falsely advised Kayla that she needed to continue with transition and her transgender identity in order to experience relief from her mental health symptoms. Tragically, Defendants' advice and treatment was wrong, ill advised, and grossly breached the standard of care as discussed herein. Kayla was not transgender, the so called "treatment" did not help her mental health symptoms, and she eventually began detransitioning in the middle of 2021. Kayla was unable to appreciate the harm and negligent treatment that Defendants had performed on her until well after she completed a period of detransition which took time. After a period of detransition, in August 2022, Kayla sought out a further mental health evaluation and was diagnosed with Social Anxiety Disorder and Mood Disorder with depressive features. She began receiving regular bi-weekly psychotherapy.

85. In late 2022, she received evaluations from a psychologist and endocrinologist who determined that the Defendants were negligent in their incorrect evaluation, diagnosis, and treatment

of Kayla's mental health symptoms. Furthermore, Defendants falsely and continuously represented that this integrated course of treatment was the only thing that would solve Kayla's serious mental health problems. These fraudulent statements by the Defendants, to this vulnerable and suggestible child, kept her from appreciating that this "treatment" was actually doing the exact opposite by causing her irreversible and permanent injury.

86. Here, Kayla did not and could not have possibly suffered appreciable harm until after her period of detransition and until she received a medical evaluation as to the negligent treatment performed by the Defendants. Consequently, appreciable harm did not occur and/or was not realized in this case until well within the three-year statutory timeline for minors filing a medical malpractice claim against the Defendants.

87. Furthermore, Defendants made false representations to Kayla regarding the success of her transition "treatment" and her continuing need for transition "treatment." This led her to believe that the chemical and surgical "treatment" she was receiving was beneficial to her and medically necessary, when in fact it was harming her and causing her long-term permanent damage. Despite their fiduciary duty to Kayla, Defendants also engaged in fraud and intentional concealment regarding numerous aspects of her care including among other things, the following: concealing and/or misrepresenting the risk of desistence/detransition, the lack of adequate studies, the substantial medical risks involved, the risk of suicide, and other issues discussed herein. These false statements concealed, prevented, and were intended to prevent, Kayla from discovering Defendants' negligent treatment and from taking legal action against Defendants. Thus, to the extent appreciable harm is found to have occurred outside the applicable statute of limitations, any such statute of limitations has been tolled and has no effect on barring Plaintiff's claims against Defendants in these unique circumstances. (*See Young v. Haines* (1986) 41 Cal.3d 883.)

FIRST CAUSE OF ACTION

MEDICAL NEGLIGENCE

(By Plaintiff Against All Defendants)

88. Plaintiff hereby incorporates each and every allegation previously set forth above as though fully set forth herein.

89. During all relevant times, Plaintiff was a patient of Defendants who undertook to supervise, treat, and provide medical care and medical facilities to Plaintiff as described herein. Defendants collaborated to perform a course of experimental chemical and surgical imitation sex change "treatment" on Plaintiff as described in detail above. In summary, Defendants intentionally induced in Plaintiff an endocrine disorder through the administration of puberty blockers, placed Plaintiff on cross-sex testosterone hormones, and collaborated to recommend and perform on Plaintiff a double mastectomy, all to her great harm.

90. By virtue of this doctor-patient relationship, Defendants owed Plaintiff a duty to exercise the level of skill, knowledge, and care in the evaluation, diagnosis, and treatment of Plaintiff that other reasonably careful providers in the same respective fields/specialties would use in similar circumstances. Defendants breached the standard of care as described in more detail above by, among other things: (1) failing to properly evaluate, assess, diagnose, discover, and treat Plaintiff's medical and mental health conditions, including, but not limited to, Plaintiffs' medical and mental health co-morbidities and symptoms that presented prior to and concurrent with her gender dysphoria symptoms; (2) failing to recognize and provide or refer Kayla to a qualified mental health care provider who could evaluate and treat her on a regular basis over an extended period of time; (3) grossly overemphasizing Plaintiff's gender dysphoria symptoms to the point of excluding and ignoring her co-morbidities, related symptoms, and their relevant treatment options; (4) failing to provide Plaintiff with competent informed consent regarding the treatment options available and the relevant risks and benefits of treatment; and (5) manipulating Plaintiff and her parents into a false decision-making matrix by deliberately obscuring relevant information, by presenting false and misleading information, and by thwarting their rational decision making process by grossly exaggerating the suicide risk when no such risk existed for Kayla.

91. Regarding informed consent, among other things, Defendants intentionally obscured and did not disclose the important potential results, risks of, and alternatives to this transition course of "treatment," as discussed and elaborated in detail above. In addition, Defendants intentionally obscured and failed to disclose relevant information regarding the existence of only low-quality studies purportedly supporting such treatment, and the existence of high-quality studies establishing

poor mental health outcomes for this treatment. They also affirmatively misrepresented that Plaintiff's symptoms would never resolve without this chemical/surgical transition, and failed to disclose and discuss the high desistence rates. Defendants also manipulated and derailed Plaintiff and her parent's rational decision-making process, boxing them into a false decision-making matrix by grossly exaggerating the suicide risk when no significant risk existed for Kayla. Defendants falsely represented that Kayla presented a high risk of suicide unless she transitioned. Defendants failed to adequately assess, evaluate, and diagnose Plaintiff's widely varied presentation of symptoms and co-morbidities, which fatally undermined and obstructed the possibility of Defendants providing Plaintiff with informed consent. The process of assessing, evaluating, diagnosing, and recommending treatment options, risks, and benefits, could not possibly have met the standard of care in the limited therapy sessions that occurred in Plaintiffs case. The same provider should have met with Kayla for an extended period of time in order to provide proper informed consent. Defendants did not discuss, evaluate, or inform Kayla as to alternate treatment options, and the related risks and benefits. Defendants failed to disclose to Kayla that her poor response to the so-called "treatment" was a major red flag for stopping the harmful treatment. These, among other issues, represent a gross breach of the standard of care and an egregious failure of informed consent. A reasonable person in Plaintiff's position would not have agreed to the transition treatment if properly and adequately informed of the risks. Plaintiff suffered harm and damage relating to numerous serious risks that should have been disclosed, discussed, and explained to her and her parents but were not disclosed.

92. As a direct and proximate cause of Defendants' breaches of the standard of care, Plaintiff sustained serious and permanent personal injuries, causing her general and special damages to be determined according to proof at trial.

93. The acts and omissions described in this complaint also constituted fraud, oppression, and malice. Defendants deliberately conveyed false information and obscured and concealed true information. Defendants failed to inform Plaintiff about the high likelihood of desistence and the significant risk of serious regret. Defendants failed to spend sufficient time with Plaintiff over an adequate period of time to evaluate her condition, and failed to inform her of the need for regular psychotherapy and the need for her to seek a competent therapist who could spend adequate time with

her. Defendants did not tell Kayla about the increased risk of suicide for transgender individuals receiving chemical/surgical transition treatment. Defendants did not tell her about the existence of high-quality evidence demonstrating poor mental health outcomes for this treatment and the existence of only low to very low-quality evidence purportedly supporting this treatment. Defendants did not tell her about all of the extensive health risks. Defendants experienced significant financial gain as their intended result. The Institutional Defendants knowingly authorized and ratified this substandard and fraudulent treatment of Plaintiff for their own financial benefit and the detriment of Kayla. These among other despicable acts and omissions support a finding of intentional fraud, malice, and oppression.

94. The harm that Plaintiff experienced in this case as a result of being improperly treated with chemical/surgical interventions rather than psychotherapy for her varied presentation of co-morbid symptoms, would not have occurred unless the Defendants were negligent. The fact that Plaintiff detransitioned so soon after the so-called treatment establishes *res ipsa loquitor* that Plaintiff was not transgender and that Defendants were guilty of medical malpractice in their evaluation, assessment and treatment of Plaintiff. Defendants' diagnoses, evaluation, and "treatment" of Kayla were *de facto* incorrect. Proper evaluation, diagnosis, informed consent, and treatment of Plaintiff that met the standard of care would never have started Plaintiff down this harmful path of physical transition that ultimately turned out to be a horrible experiment causing serious and irreversible injuries to Plaintiff.

95. The harm occurred while Plaintiff was under the care and control of Defendants, and Plaintiff's own voluntary actions were not a cause contributing to the events that harmed Plaintiff. Plaintiff was a minor incapable of understanding and evaluating the decisions she was making. Yet, her providers treated her as if she could understand the implications of the life-altering decisions that she was making, as described in greater detail above.

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SECOND CAUSE OF ACTION

MEDICAL NEGLIGENCE – HOSPITAL/MEDICAL GROUP

(By Plaintiff Against Kaiser Hospitals and Medical Group)

96. Plaintiff hereby incorporates each and every allegation previously set forth as though fully set forth herein.

97. The Institutional Defendants were a medical provider for Plaintiff and had a duty of reasonable care to Plaintiff. The Institutional Defendants had the obligation to select, maintain, and ensure the competence of the Defendant Providers. The Institutional Defendants also had the obligation to provide procedures, policies, facilities, supplies, and qualified personnel reasonably necessary for the treatment of Kayla. The Institutional Defendants breached these duties by failing to provide the requisite procedures, policies, facilities, supplies, and qualified personnel, and by failing to adequately select, maintain, and ensure the competence of the Defendant Providers. Among other things, the Institutional Defendants allowed the Defendant Providers to treat Plaintiff with radical, inadequately studied, off-label, and essentially experimental transition "treatment." The Institutional Defendants failed to have adequate policies and procedures in place to prevent the acts, omissions, failures of informed consent, fraudulent concealment, fraudulent misrepresentations, negligent treatment, and other breaches of the standard of care that occurred in regard to Plaintiff as described above. Furthermore, the Institutional Defendants not only have inadequate policies and procedures to prevent such harmful treatment of patients like Kayla, but they actively promote, encourage, and advertise on their website that their facilities and providers offer proper transgender treatment, including for minors.

98. The Institutional Defendants also failed to employ adequate mental health professionals. This inadequate staffing of mental health providers contributed to preventing Plaintiff from receiving regular psychotherapy evaluation, assessment, and treatment with the same provider, which was necessary in Plaintiff's case to meet the standard of care.

99. Among other acts and omissions, these breaches of the standard of care caused Plaintiff to suffer personal injury and resulting special and general damages according to proof at trial.

100. The despicable acts and omissions described in this complaint also constituted fraud, oppression, and malice. Defendants deliberately conveyed false information and obscured and concealed true information. Defendants failed to inform Plaintiff about the high likelihood of desistence and the significant risk of serious regret. Defendants failed to spend sufficient time with Plaintiff over an adequate period evaluating her condition and/or failed to inform her of the need for regular psychotherapy and the need for her to seek a competent therapist who could spend adequate time with her. Defendants did not tell her about the increased risk of suicide for transgender individuals receiving chemical/surgical transition treatment. Defendants did not tell her about the existence of high-quality evidence demonstrating poor mental health outcomes for this treatment and the existence of only low to very low-quality, or non-existent, evidence purportedly supporting this treatment. Defendants did not tell her about all of the extensive health risks. Defendants experienced significant financial gain as the intended result. The Institutional Defendants knowingly authorized and ratified this substandard and fraudulent treatment of Plaintiff. The Institutional Defendants knowingly failed to employ adequate mental health professionals to treat complex cases like Kayla. These deficiencies, among other despicable acts and omissions, support a finding of intentional fraud, malice, and oppression.

101. The harm that Plaintiff experienced in this case as a result of being improperly treated with chemical/surgical interventions rather than psychotherapy for her varied presentation of co-morbid symptoms, would not have occurred unless the Defendants were negligent. The fact that Plaintiff detransitioned so soon after the so-called treatment establishes *res ipsa loquitor* that Plaintiff was not transgender and that Defendants were intentional or negligent in their evaluation, assessment and treatment of Plaintiff. Defendants' diagnoses, evaluation, and "treatment" of Kayla were *de facto* incorrect. Proper evaluation, diagnosis, informed consent, and treatment of Plaintiff that met the standard of care would never have started Plaintiff down this harmful path of physical transition that ultimately turned out to be a horrible experiment causing irreversible and serious injuries to Plaintiff.

102. The harm occurred while Plaintiff was under the care and control of Defendants, and Plaintiff's own voluntary actions were not a cause contributing to the events that harmed Plaintiff. Plaintiff was a minor incapable of understanding and evaluating the decisions she was making, yet

her providers treated her as if she could understand the implications of the decisions that she was making as described in greater detail above.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendants according to law and according to proof, for the following:

1. General damages, in an amount according to proof at the time of trial;
2. Special damages for medical and related expenses, in an amount according to proof at the time of trial;
4. Pain and suffering, past and future, and mental anguish, past and future;
5. Pre-judgment interest on damages;
6. Costs of suit;
7. Such other and further relief as the court deems just and proper.

Respectfully Submitted,

LiMANDRI & JONNA, LLP

DHILLON LAW GROUP INC.

CENTER FOR AMERICAN LIBERTY

Dated: June 14, 2023 By: ______________________________

Charles S. LiMandri
Paul M. Jonna
Robert E. Weisenburger
Harmeet K. Dhillon
John-Paul S. Deol
Jesse D. Franklin-Murdock
Mark E. Trammell*

Attorneys for Plaintiff
Kayla Lovdahl

**Pro Hac Vice motion forthcoming*

*Admitted *Pro Hac Vice*

/ / /

/ / /

DEMAND FOR JURY TRIAL

Plaintiff Kayla Lovdahl demands a trial by jury on all claims.

Respectfully Submitted,

LiMANDRI & JONNA, LLP

DHILLON LAW GROUP INC.

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Attorneys for Plaintiff
Kayla Lovdahl
**Pro Hac Vice motion forthcoming*

EXHIBIT 1

CARE DELAYED, CARE DENIED:
Kaiser Permanente's Failure to Provide Timely and Appropriate Mental Health Services

A report of the National Union of Healthcare Workers
www.NUHW.org

November 2011

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Executive Summary

With more than 6.6 million members, Kaiser Permanente is California's largest HMO and plays a massive role in the state's healthcare delivery system by operating more than 35 hospitals and several hundred clinics across the state. Less well known, however, is Kaiser's role in providing mental health services to Californians. Ranking perhaps second only to the State of California, Kaiser is one of the state's largest providers of mental health services. The Oakland-based company guarantees its members a full array of inpatient, outpatient and emergency mental health services provided by several thousand mental health professionals. Each year, thousands of Kaiser's members seek treatment for conditions ranging from autism, anxiety and bi-polar disorder to depression, schizophrenia and suicidal ideation.

Despite Kaiser's pledge to provide comprehensive mental health services to its members, an in-depth analysis suggests that the HMO's mental health services are sorely understaffed and frequently fail to provide timely and appropriate care. Patients often experience lengthy delays in obtaining services, an overreliance on "group therapies," and frustrating obstacles that push many patients to forgo care or seek treatment elsewhere at their own cost.

Drawing on a survey of hundreds of Kaiser's mental health clinicians as well as documentation from regulatory agencies, court filings, patients and frontline caregivers, this study finds that Kaiser frequently fails to comply with California laws aimed at protecting patients' timely access to appropriate services.[1] Furthermore, it finds that Kaiser's failures are systematic and often purposeful. Indeed, the scope and specifics of these failures are sufficiently grave as to merit investigation by state and federal authorities as well as actions for recovery of funds by public and private payers, including individual Kaiser members. For example, despite receiving more than $10 billion annually from Medicare to provide a full range of services, including mental health care, Kaiser appears to be miscoding patient evaluation procedures, which may result in fraudulent claims to the Medicare program.

> *"Treatment is "one size fits all" with overemphasis on medications, groups and educational classes in place of effective levels of scientifically-based, best practices care. [Patient] care treatment is too little in frequency, amount and/or duration…"*
>
> *-Kaiser Psychologist*

The study's key findings are the following:

- **Kaiser often violates California laws requiring HMOs to provide patients with "timely access" to appropriate mental health services.** Clinicians report that patients frequently endure waits of four weeks or longer for return appointments even though California law mandates a maximum wait time of 10 business days for both initial and return visits unless a licensed health professional has documented that a longer waiting time "will not have a detrimental impact on the health of the enrollee."[2] Furthermore, many clinicians report that patients' first appointments are often nothing more than group orientation sessions in which initial evaluations do not take place. When such evaluations finally do take place, clinicians report they are often cursory and insufficient, but nonetheless are coded as if they were thorough and complete. In a survey of 305 Kaiser clinicians, nearly 90 percent of the respondents reported there is insufficient staffing at their clinic to provide patients with timely return visits. More than 75 percent reported that they are either frequently or very frequently "forced to schedule return visits further into the future than you believe is appropriate."

- **Kaiser reportedly falsifies patient scheduling records in an effort to avoid being cited by state regulators for lengthy appointment delays.** Clinicians report that Kaiser often uses "shadow" scheduling records, deliberately miscategorized appointments, and false appointment cancellations to avoid detection of delays that exceed California's "timely access" requirements.

- **Kaiser often funnels patients into group therapy even when individual therapy would be more effective.** Kaiser often pressures its clinicians to assign patients to group therapy even when clinicians conclude that individual therapy may be more beneficial. More than 50 percent of Kaiser clinicians report that patients are either frequently or very frequently "assigned to group therapy even though individual therapy may be more appropriate."

- **Kaiser reportedly performs initial patient evaluations and other mental health services that not only fall short of recommended clinical standards, but are coded incorrectly in possible violation of Kaiser's contracts with both private and governmental purchasers.** In San Diego, Kaiser has reportedly directed clinicians to spend only half as much time as the clinically recommended minimum for interviewing, assessing and diagnosing patients. This reported "speed-up" of Kaiser's assessment procedures can have serious implications. For example, short-cut evaluations lasting only 20 to 30 minutes may result in the misdiagnosis of patients' conditions. Furthermore, Kaiser appears to be miscoding these procedures in a manner that may result in fraudulent claims to Medicare and other governmental and private purchasers. Interviews with clinicians indicate that Kaiser may be replicating this practice at many sites in California.

- **Kaiser's current mental health care deficiencies are part of an ongoing pattern of substandard care.** During recent years, government inspectors have cited Kaiser multiple times for failing to provide patients with timely access to mental health services. For example, in 2005 the California Department of Managed Health Care (DMHC) cited Kaiser for failing to provide its patients with timely access to mental health care. In 2010, Kaiser was fined $75,000 for unreasonably delaying a child's autism diagnosis for almost 11 months.

In short, Kaiser's systemic failures recall many of the well-documented abuses of HMOs from an earlier era – one that California believed its revised and expanded regulatory structure had long ago overcome. Kaiser is delivering this substandard care at the same time that the HMO is reporting record profits of $5.7 billion since 2009.[3]

The breadth and depth of Kaiser's failures call for state and federal authorities, as well as private payers, to act with deliberate speed to protect the interests of Kaiser enrollees and ensure they receive the mental health care to which they are entitled, and which they need.

As a first step, the California Department of Managed Health Care (DMHC), which regulates Kaiser's HMO plans, and the California

Department of Insurance (CDI), which regulates Kaiser's fee-for-service offerings, should initiate investigations to determine the full extent of Kaiser's regulatory violations and seek remedies as may be justified for Kaiser's violation of timely access standards, its failure to provide patients with clinically appropriate care, the insufficiency of its mental health provider network, and its non-compliance with mental health parity requirements, among other potential violations of state statutes and regulations.

As these investigations proceed, other public and private actions that merit consideration include:

- The State Attorney General initiating an investigation to determine whether any of Kaiser's failures to serve the mental health needs of its patients constitute "unfair business practices" under California Business and Professions Code §17200 or "false advertising" under §17500, and seeking appropriate remedies for any such violations. Additionally, state officials could initiate an investigation by the California Department of Justice's Medi-Cal Fraud Unit of Kaiser's potential false claims to Medi-Cal and Healthy Families and the potential breach of its specific contractual obligations or these programs' general conditions of participation.

- The Office of the Inspector General of the U.S. Department of Health and Human Services initiating an investigation of Kaiser's apparently false claims to the Medicare program for mental heath services provided under the Medicare Advantage program, and its possible violations of its specific contractual obligations or the programs' general conditions of participation.

- Other public and private payers who purchase health care coverage from Kaiser, most notably large public plans like the Federal Employee Health Benefits Program (FEHB) and the California Public Employees' Retirement System (CalPERS), pursuing audits of the treatment provided to plan members and seeking appropriate restitution for Kaiser's failures.

- The California Assembly's and Senate's Health Committees scheduling joint subject matter hearings to review the findings raised in this study and deliberate on what additional safeguards might help prevent the development of schemes to violate mental health patients' rights.

Finally, and most important, Kaiser should:

- Adopt the recommendations of its own mental health providers to increase staffing levels at mental health facilities, limit weekly initial intakes per clinician, and establish a binding system of dispute resolution for staffing problems that is managed by a neutral third party in order to ensure enough capacity to meet state requirements for timely access to appropriate care;

- Cease and desist from the inappropriate management of records, misuse of group therapy, and misrepresentation of orientation sessions and other triage mechanisms to evade its responsibilities to patients with mental health needs; and

- End the practice of 30-minute "intake" evaluations of mental health patients and ensure that patients receive appropriate assessments, properly documented, that conform to the clinical standards set forth by the American Psychological Association (APA) and the American Medical Association (AMA).

EXHIBIT 2

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

BEHAVIORAL HEALTH SERVICES

DATE ISSUED TO PLAN: MARCH 6, 2013
DATE ISSUED TO PUBLIC FILE: MARCH 18, 2013

Final Report of a Routine Medical Survey
Kaiser Foundation Health Plan, Inc.
Behavioral Health Services
March 6, 2013

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EXECUTIVE SUMMARY

On January 6, 2012, the California Department of Managed Health Care (the "Department") notified Kaiser Foundation Health Plan, Inc. (the "Plan") that its Routine Medical Survey had commenced, and requested the Plan to submit information regarding its health care delivery system.

The survey team conducted the onsite portion of the survey from March 12, 2012, through March 15, 2012, and from March 19, 2012, through March 22, 2012. The Department completed its investigatory phase and closed the survey on July 25, 2012.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care

The Department identified **four** deficiencies during the current Routine Medical Survey. The 2012 Survey Deficiencies table below notes the status of each deficiency.

2012 SURVEY DEFICIENCIES

#	DEFICIENCY STATEMENT
	ACCESS AND AVAILABILITY OF SERVICES
1	**The Plan does not ensure that its quality assurance systems accurately track, measure, and monitor the accessibility and availability of contracted providers pursuant to the timely access standards.** (Rules 1300.67.2.2(c)(1) and (5); Rule 1300.67.2.2(d).)
2	**The Plan does not sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes.** (Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d).)
	QUALITY MANAGEMENT/ ACCESS AND AVAILABILITY OF SERVICES
3	**The Plan's Quality Assurance Program does not ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.** (Rules 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(D); Rule 1300.70(b)(2)(G)(3); and Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)(3).)

	HEALTH EDUCATION SERVICES: MENTAL HEALTH PARITY
4	**The Plan does not provide accurate and understandable effective behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the Plan or health care organizations affiliated with the Plan.** (Section 1374.72; Rule 1300.67(f)(8); and Rule 1300.80(b)(6)(B).)

EXHIBIT 3

DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FOLLOW-UP REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

BEHAVIORAL HEALTH SERVICES

DATE ISSUED TO PLAN: FEBRUARY 13, 2015
DATE ISSUED TO PUBLIC FILE: FEBRUARY 24, 2015

Routine Survey Follow-Up Report
Kaiser Foundation Health Plan, Inc.
Behavioral Health Services
February 13, 2015

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EXECUTIVE SUMMARY

Background

On March 6, 2013, the Department of Managed Health Care ("Department") issued its Final Report concerning the routine medical survey of behavioral health services for Kaiser Foundation Health Plan, Inc. ("Kaiser" or "Plan".) In the Final Report, the Department identified four uncorrected deficiencies related to the Plan's delivery of mental health services to its enrollees and informed the Plan that a Follow-Up Survey would commence within six months.

Because of the serious nature of the deficiencies identified in the Final Report, the Division of Plan Surveys prepared an immediate referral to the Department's Office of Enforcement. The Office of Enforcement investigated the matter further, and then the Department issued a Cease and Desist Order commanding the Plan to cease from engaging in the conduct identified in the violations, and filed an Accusation imposing an administrative penalty in the amount of four million dollars ($4,000,000.00). Although the Plan requested a hearing concerning the administrative penalty, the Plan decided to pay the penalty shortly after the hearing commenced.

The Follow-Up Survey, to determine whether the Plan had fully corrected the outstanding deficiencies, commenced in July 2013. The onsite portion of the survey was conducted during October 2013, March 2014, and April 2014. Throughout the remainder of 2013 and 2014, the Division of Plan Surveys continued work on the Follow-Up Survey and held several meetings with representatives from the Plan to gather additional information concerning corrective actions the Plan had taken to address the deficiencies identified in the Final Report.

Summary of Deficiencies

The Department has determined that Deficiencies #1 and #2 have been corrected by the Plan. However, Deficiencies #3 and #4 have not been corrected.

In *Deficiency #1,* the Department found that the Plan failed to track and capture data necessary to determine whether mental health services are delivered within the timeframes specified in the Timely Access to Non-Emergency Health Care Services regulation, (Title 28, C.C.R., section 1300.67.2.2.). The Final Report identified four specific actions that prevented the Plan from capturing and tracking information needed to determine timely access compliance. In this Follow-Up Survey, the Department concludes that the Plan has taken steps to correct the problems identified in the Final Report.

However, during the Follow-Up Survey process, the Department identified an additional issue related to the Plan's tracking of timely access to services when enrollees receive services from externally-contracted providers. In late 2014, the Plan changed its processes so that it now tracks timely access for its largest and most frequently used external provider network in the Northern Region. The Department has informed the Plan that it needs to ensure that timely access is tracked for all externally-contracted providers to whom patients are referred for services. Additional review of the Plan's

	FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON MARCH 6, 2013	
#	**DEFICIENCY STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	ACCESS AND AVAILABILITY OF SERVICES	
1	**The Plan does not ensure that its quality assurance systems accurately track, measure, and monitor the accessibility and availability of contracted providers pursuant to the timely access standards.** Rules 1300.67.2.2(c)(1) and (5); Rule 1300.67.2.2(d)	**Corrected**
2	**The Plan does not sufficiently monitor the capacity and availability of its provider network in order to ensure that enrollee appointments are offered within the regulatory timeframes.** Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)	**Corrected**
	QUALITY MANAGEMENT/ACCESS AND AVAILABILITY OF SERVICES	
3	**The Plan's Quality Assurance Program does not ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.** Rules 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(D); Rule 1300.70(b)(2)(G)(3); and Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)(3)	**Not Corrected**
	HEALTH EDUCATION SERVICES: MENTAL HEALTH PARITY	
4	**The Plan does not provide accurate and understandable effective behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the Plan or health care organizations affiliated with the Plan.** Section 1374.72; Rule 1300.67(f)(8); and Rule 1300.80(b)(6)(B)	**Not Corrected**

SECTION III: SURVEY CONCLUSION

Based on all of the information provided and reviewed in connection with the Routine and Follow-Up Survey, the Department concludes that Deficiency #3 and Deficiency #4 remain uncorrected. The available information suggests that, although the Plan has taken steps in good faith to try to correct issues related to timely access to behavioral health services, significant and serious concerns remain.

The volatility in the Plan's monthly timely access reports reveal that the measures taken by the Plan to date are inadequate to provide consistent timely access to behavioral health care services for its enrollees. While the Department understands the unique hurdles the Plan continues to face in recruiting adequate staff and in using externally-contracted providers, these challenges do not relieve the Plan of its statutory obligation to take effective action to correct access and availability problems. The Plan's actions to date have not been adequate to ensure that its enrollees *consistently* have ready access to all mandated behavioral health services consistent with good professional standards of practice and established timely access standards.

Additionally, the Plan must take additional steps to ensure its providers immediately cease disseminating inaccurate information to enrollees concerning behavioral health benefits and coverage. That misleading health education information is disseminated verbally, and in writing, to patients by providers is of great concern to the Department.

The ongoing issues of Plan non-compliance have been referred to the Department's Office of Enforcement for further investigation and possible disciplinary action, based on the Plan's failure to correct Deficiencies #3 and #4.

In the event the Plan wishes to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**

Once logged in, follow the steps shown below to submit the Plan's response to the Follow-Up Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled**, 2012 Routine Behavioral Health Survey - Document Request.**
- Submit the response to the Follow-Up Report via the "DMHC Communication" tab.

Plan Response to the Follow-Up Report

EXHIBIT 4

DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

A FULL SERVICE HEALTH PLAN

DATE OF FINAL REPORT: JUNE 12, 2017

Final Report of a Routine Survey
Kaiser Foundation Health Plan, Inc.
A Full Service Health Plan
June 12, 2017

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EXECUTIVE SUMMARY

On December 15, 2015, the California Department of Managed Health Care (Department) notified Kaiser Foundation Health Plan, Inc. (Kaiser Permanente or the Plan) that its Routine Survey had commenced and requested the Plan submit information regarding its health care delivery system for both full service and behavioral health services. The survey team conducted the Southern California onsite survey from May 16, 2016 through May 20, 2016 and on March 30, 2017. The Department conducted the Northern California onsite survey from June 20, 2016 through June 24, 2016.

While onsite the Department reviewed plan documents and files for both full service and behavioral health services. For the Full Service survey, the Department's review period for files was from March 1, 2014 through January 15, 2016. For the Behavioral Health survey, the Department's review period for files was from December 1, 2014 through January 1, 2015.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (RX) Drug Coverage
Language Assistance

The Department identified **six** (**6**) deficiencies during the current Routine Survey. The 2016 Survey Deficiencies table below notes the status of each deficiency.

2016 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY ASSURANCE (QA) Southern California – Behavioral Health	
1	**The Plan does not consistently take effective action to improve care where deficiencies are identified, Plan follow-up where indicated, or monitor whether the provision and utilization of services meets professionally recognized standards of practice.** Section 1370; Rule 1300.70(a)(1); Rule 1300.70(a)(3).	**Not Corrected**

	QUALITY ASSURANCE (QA)/ACCESS AND AVAILABILITY OF SERVICES Southern and Northern California – Behavioral Health	
2	**The Plan's Quality Assurance Program does not ensure that effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.** Section 1370; Rules 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(D); Rule 1300.70(b)(2)(G)(3); and Rules 1300.67.2.2(c)(1) and (5); and Rule 1300.67.2.2(d)(3).	**Not Corrected**
	GRIEVANCES AND APPEALS Southern and Northern California – Full Service and Behavioral Health	
3	**The Plan does not immediately notify enrollees filing expedited grievances of their right to notify the Department of their grievance.** Section 1368.01(b); Rule 1300.68.01(a).	**Not Corrected**
4	**For expedited grievance decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guideline used by the Plan and the clinical reasons for the decision.** Section 1368(a)(5); Rule 1300.68(d)(4).	**Not Corrected**
	UTILIZATION MANAGEMENT Southern and Northern California – Full Service and Behavioral Health	
5	**The Plan does not consistently consider the "reasonable person" standard when evaluating the medical necessity of emergency services.** Section 1371.4(a)-(c); Rule 1300.67.2(c).	**Not Corrected**
6	**For decisions to deny emergency services based in whole or in part on medical necessity, the Plan does not consistently include in its written response a description of the criteria or guidelines used, and the clinical reasons for the decision.** Section 1367.01(h)(4).	**Not Corrected**

#3). The Plan submitted a corrective action plan in response to the Preliminary Report. The Department determined this deficiency was uncorrected at the time of the Final Report issued on March 18, 2013, and subsequently determined the deficiency remained uncorrected at the time of the Follow-Up Review conducted in the Fall of 2013 through Spring, 2014 as discussed in the Follow-Up Report issued to the Plan on February 13, 2015. As part of the Department's Follow-Up Review for deficiency #3, it reviewed the ability of enrollees to obtain follow-up appointments. The Department concluded enrollees faced barriers when obtaining appointments for behavioral health services including follow-up appointments. With respect to deficiency #3, the Department concluded in the Follow-Up Report that the Plan must implement a process for regularly tracking availability and timeliness of initial and follow-up appointments and take effective and timely action when problems are identified.

Assessment:

1. The Plan does not take effective and timely action when problems are identified for initial behavioral health appointment availability.

In order to address concerns regarding enrollee access to initial appointments raised in the 2012 Routine Survey, the Plan began tracking initial appointment access under an "Appointments within Standard" methodology. This measure reports, by Plan department and Plan medical center area, the percentage of initial appointments with wait times falling within the timeframe applicable to each appointment type set forth in Rule 1300.67.2.2(c)(5). The Plan set its threshold for corrective action for any medical center that falls below 80% of initial appointments occurring within the standards set forth in Rule 1300.67.2.2(c)(5). If a substantial drop occurs from one month to the next, the Plan takes action prior to any medical center falling below 80%.

Based on the data in Table 2 (below),[6] the Department determined that for the survey period, the Plan did not provide enrollees with timely access to initial appointments for behavioral health services or take effective action regarding these access problems when they were identified. While the Department acknowledges the Plan has significantly improved its compliance with regulatory timeframes,[7] Table 2 demonstrates that several medical centers (identified as A-E in Table 2) had rates for initial behavioral health appointments well below the Plan's internal 80% compliance standard for

[6] Table 2 represents data from a Plan document that tracks enrollee access to initial behavioral health appointments for physician and non-physician providers. The Department reviewed appointment information from four categories: 1) physician urgent 2) physician non-urgent 3) non-physician urgent 4) non-physician non-urgent. In addition, for those months where the table is blank, the Plan met its 80% threshold for access compliance.

[7] The Plan has enhanced its tracking reports to include the new measure on *Percentage Initiated to Seen*, regularly produces and disseminates these reports, improved the timeliness of its implementation of corrective actions, systematized the monitoring of corrective actions to ensure effectiveness, and implemented committee structures to conduct ongoing review of appointment availability. The Plan has also implemented a variety of corrective actions as it deems appropriate for various medical centers including hiring of additional staff, use of contracted providers, adding hours/appointments to individual therapists' schedules and temporarily sending staff from one Plan medical center to another to assist with resolving backlogs.

EXHIBIT 5

Kaiser Permanente mental health clinicians strike for better patient care

December 14, 2018 | 9:44 AM CST | BY MARILYN BECHTEL

Marilyn Bechtel/PW

OAKLAND, Calif. – As dawn broke over Kaiser Permanente's flagship Oakland Medical Center on Dec. 11, pickets with bright signs saying, "Don't deny my patients mental health care" were already marching and chanting in front of the facility, drawing honks of solidarity from passing cars.

The marchers were mental health clinicians, members of the National Union of Healthcare Workers (NUHW), protesting the long waits their patients must suffer between appointments, in sharp contrast to the prompt scheduling generally experienced by patients with physical illnesses.

Oakland's picketers were among some 4,000 psychologists, therapists, social workers, psychiatric nurses and addiction medicine specialists throughout California, striking the state's largest health care provider for five days, Dec. 10-14, and affecting over 100 Kaiser clinics and hospitals. Their demands included stepping up levels of mental health care staffing, as well as compensation matching that of other unionized Kaiser staff.

The NUHW workers have been without a contract since the end of September.

At noon, over 500 clinicians, union and community supporters – including members of the California Nurses Association and Stationary Engineers Local 39 who struck in sympathy with NUHW – joined in a spirited rally in front of the hospital.

Keynote speaker and leading mental health care advocate Patrick Kennedy told the strikers, "I don't know of another union in this country that represents and works on behalf of those with mental illness and addiction, as you do."

Calling mental illness "a public health epidemic," he told the strikers that while they are supporting their patients in seeking timely care, they are also raising an issue that's largely being ignored around the country, and that suffers from the shame and stigma which often affects patients seeking treatment.

Kennedy, a former U.S. Representative from Rhode Island, called equal treatment for those with mental illness a civil rights issue. H recalled his role while in Congress as a principal sponsor of the 2008 Mental Health Parity Act "that said the brain was part of the body – a radical notion." That legislation requires equal access to care and bans higher premiums and copays, and other forms of discrimination in care.

Sanmit Singh, a psychologist at Oakland's Child and Family Clinic, told the crowd: "I've been here for eight years, and I've always been booked out for four to six weeks." Mental health care shouldn't be a privilege, he said: "We have to compel Kaiser to do what's morally right and what they say they're supposed to do."

Marilyn Bechtel/PW

Jessica Dominguez, a licensed marriage and family therapist at Kaiser's Richmond facility, called attention to the disparities faced by Latinx patients, with services in Spanish even scarcer than those available in English.

California Nurses Association Co-President Zenia Cortez pointed to the "direct effect" the mental health staff shortage has for RNs and nurse practitioners "who see these same patients in Emergency Rooms, hospital units, and overwhelmingly through the call centers."

Oakland City Councilmember-elect Nikki Fortunato Bas told the crowd, "Oakland is a union town. We know Kaiser makes billions in net profits … It is time for Kaiser to step up and be a leader in the mental health sector."

NUHW says Kaiser has a history of forcing patients to endure long waits for therapy appointments. In 2013 California's Department of Managed Health Care fined the system $4 million for violating the state's Mental Health Parity Act, and after finding further violations in the following years, the agency required Kaiser to accept outside monitoring of its mental health services.

The union points out that Kaiser has one fulltime clinician for every 3,000 patients – a ratio unchanged over the last three years.

Marilyn Bechtel/PW

In a conversation after the rally, licensed social worker and NUHW Executive Board member Clement Papazian said the problem of limited and poor access to care creates "all kinds of chaos" as patients' conditions deteriorate.

"What happens when people can't get in for their routine appointments on a regular, frequent basis is that they start to become more acute," he said. "We see them come into our crisis service, our Emergency Room, and they start to overwhelm the intensive outpatient services aimed at some of our sicker people."

Over time, Papazian said, the whole system starts to break down, with people failing to improve, or dropping out of care and therapists trying to see their patients with the time they have but lengthening the intervals further and further.

"Now let's magnify this over decades – and that is why people are out on the street in such numbers, because they are fed up with Kaiser's hollow promises."

Papazian said he hopes Kaiser's executives will start paying real attention to patients' stories. After years of struggle and after workers finally went to state authorities over the crisis, Kaiser said it wanted to work with the clinicians to make the giant health provider a service leade

"But," he said, "our general perception is that their rhetoric just doesn't match their actions. That's why the clinicians are out on the streets."

The day's action concluded with a town hall meeting featuring patients' family members, clinicians and area political leaders who discussed California legislation to assure care is equal for both mental and physical health. That story will follow.

TAGS: health strikes workers

CONTRIBUTOR

Marilyn Bechtel

Marilyn Bechtel writes for *People's World* from the San Francisco Bay Area. She joined the PW staff in 1986 and currently participates as a volunteer. Marilyn Bechtel escribe para People's World desde el Área de la Bahía de San Francisco. Se unió al personal de PW en 1986 y actualmente participa como voluntaria.

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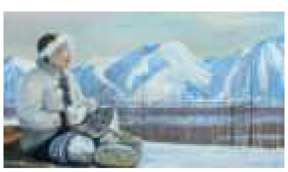

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EXHIBIT 6

HEALTH CARE

California Kaiser Mental Health Workers Launch Strike; Problems 'Keep Getting Worse'

December 16, 2019 · 6:12 PM ET


VANESSA ROMO

More than 4,000 Kaiser Permanente mental health professionals in California launched a five-day strike on Monday at Kaiser facilities across the state.

Psychologists, social workers, psychiatric nurses, addiction specialists and others represented by the National Union of Healthcare Workers say that Kaiser mental health clinics are severely understaffed, forcing some to work after hours to serve more patients. Meanwhile, they say, patients are forced to wait as long as two months for follow-up appointments because of inadequate staffing.

"We're striking because the problems that plague Kaiser's mental health system keep getting worse," said Kenneth Rogers, a Kaiser psychologist, in a statement.

"We don't have enough time to provide proper patient care which includes the preparation and follow up work that goes into every appointment. And patients are being forced to endure even longer wait times for appointments, while Kaiser sits on billions of dollars refusing to fix the problem," Rogers added.

Standing outside the San Leandro child outpatient clinic, clinical psychologist Michael Torres explained that he had joined the picket line to improve services for teenagers struggling with depression, anxiety or serious emotional trauma.

In an online video, Torres said, "I'm thinking of a teenager in my practice, who was tragically gang-raped. And that person had to wait three to five weeks in between sessions to see me for this trauma."

National Union of Healthcare Workers
@NUHW · Follow

Michael is a psychologist at @kpthrive. He spoke to us about the trauma of his patients and how urgently Kaiser needs to up its game with mental health care.

Watch on Twitter

12:22 PM · Dec 16, 2019

15 Reply Share this Tweet

Read 1 reply

He said the long delays prolong symptoms and exacerbate a patient's condition. "There is no nationally recognized standard practice that suggests three to five weeks in between sessions is OK."

Kaiser released a statement critical of employees for walking off the job while reassuring patients that all hospitals and medical offices will remain open throughout the strike.

"We apologize for any inconvenience caused by this unnecessary strike. We believe that NUHW's repeated call for short strikes is disruptive to patient access, operational care and service and is frankly irresponsible," Arlene Peasnall, senior vice president and interim chief human resources officer wrote in an emailed statement.

Peasnall added that Kaiser has been working with an external, neutral mediator to reach a collective bargaining agreement with the health care workers' union. According to Peasnall, the mediator recently delivered a proposed compromise to both sides. While she said it was being seriously considered by Kaiser, "the union has rejected it and announced plans to strike instead of working through the mediated process."

Monday's start of the strike marks a little over a year since the last time Kaiser mental health employees took to the streets. That strike also lasted five days. Union officials say clinicians have been working without a contract for more than a year.

As member station KPBS reported, last year Kaiser officials said therapist staffing was up by 30% from 2015. "That's more than 500 new therapists in California — even though there's a national shortage," the company said.

Projections from the American Psychological Association show that the existing psychologist supply is insufficient to meet needs for mental health services in the United States. The organization estimates that there are about 98,000 licensed psychologists.

In 2015, Kaiser agreed to pay a $4 million fine levied by state regulators because of inadequate access to its mental health services, KPBS reported.

This year's strike was meant to begin in November, but it was postponed after the sudden death of Kaiser CEO Bernard Tyson.

health care workers strike kaiser permanente california health care mental health

More Stories From NPR

EXHIBIT 7

January 27, 2020

<u>**VIA EMAIL**</u>

Ms. Shelley Rouillard
Director, California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Re: Kaiser Access to Mental Health Care

Dear Director Rouillard:

The American Psychological Association (APA), American Psychological Association Services, Inc. (APA Services), and the California Psychological Association (CPA)[1] would like to offer evidence and expertise in connection with very serious allegations from our members about extreme wait times for follow-up psychotherapy appointments for Kaiser Permanente of California (Kaiser) subscribers. Our concern is not only that Kaiser's practices violate California law, but also that Kaiser patients risk being harmed by Kaiser falling far below professional standards of care.

We ask you to consider these serious allegations and to take action to correct the disturbing deficiencies in care, which we have been unable to remedy through informal talks with Kaiser. We plan to participate in the January 31st meeting scheduled by the Department of Managed Health Care (DMHC) and hope to have additional opportunities to contribute to your consideration of this matter.

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[1] APA is the leading scientific and professional organization representing psychology in the United States, with more than 121,000 researchers, educators, clinicians, consultants and students as its members. APA Services is a legally separate companion organization to APA and supports advocacy and psychologists' economic and marketplace interests in ways that APA cannot. CPA is a 501(c)(6) non-profit professional association for licensed psychologists and others affiliated with the delivery of psychological services. CPA supports its members' professional interests, promotes and protects the science and practice of psychology, and advocates for the health and welfare of all Californians CPA represents the interests of approximately 17,000 psychologists licensed in California.

Summary of Core Allegation

In a letter to APA dated June 3, 2019 (attached) many members who work for Kaiser reported:

> Due to chronic understaffing at Kaiser's behavioral health services, our adult and child/adolescent patients—even those with complex and acute conditions such as Major Depressive Disorder-Chronic, Bipolar Disorder, Complex Post-Traumatic Stress Disorder, Eating Disorders—routinely wait 4-8 weeks between individual outpatient psychotherapy appointments with their non-physician licensed mental health clinician. At some Kaiser clinics, patients must wait as many as three to four months between appointments.

Our members believe that the company is so focused on meeting the specific time frames required under California law for *initial* appointments, e.g., 10 business days for non-urgent appointments with mental health care providers,[2] that it minimizes the importance of follow-up access. The latter is subject to less specific and non-quantitative regulatory standards – i.e. access to follow-up care must be provided consistent with "professionally recognized standards of practice" and "good professional practice."[3]

Our members also claim that Kaiser manipulates records and data on initial and follow-up care so that the company appears more compliant with applicable laws and regulations than it actually is. More disturbing are the allegations that the company intimidates or retaliates against psychologists who won't cooperate with its data manipulations, or who have raised follow-up access concerns internally and to outside entities like DMHC (including a psychologist who planned to be DMHC's witness in an administrative hearing against Kaiser).

Below is a brief overview of our relevant expertise that we would like to share with DMHC:

A. Clinical Expertise:

<u>Follow-up Appointments:</u> APA is the leading national authority on psychological care. In case DMHC would benefit from our input regarding "professionally recognized standards of practice" and "good professional practice" with respect to access to care, APA's position is that follow-up therapy appointments at 4-8 week or longer intervals, as alleged by our members, fall far below what is appropriate care for most patients. Psychotherapy efficacy and comparative effectiveness studies are typically based on once a week therapy (see, e.g., APA's Clinical Practice Guidelines for the Treatment of Depression and for the Treatment of Posttraumatic Stress Disorder).[4]

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[2] 28 CCR §1300.67.2.2(c)(5)(E)
[3] Health & Safety Code §1367(d); 28 CCR § 1300.70(b)(1)(A); 28 CCR §1300.67.2.2(c)(1)
[4] https://www.apa.org/depression-guideline/index,; https://www.apa.org/ptsd-guideline/index

Initial Assessments: While we have focused on our members' core allegation about access to follow-up care, we have also reviewed the National Union of Healthcare Workers' (NUHW) complaint to DMHC dated May 14, 2019 (attached) alleging that Kaiser "games" the requirement for initial assessments under 28 CCR §1300.67.2.2(c)(5)(E) by giving patients "short-cut" half-hour (or briefer) initial phone assessments.

Our position is that these short-cut assessments are inconsistent with professionally recognized standards of care for mental health evaluations. In practice, assessment interviews are generally done in person, last a minimum of 45 to 60 minutes, cover a wide range of psychosocial and health issues, and determine an initial diagnosis and treatment plan. According to the Centers for Medicare and Medicaid Services, a psychiatric diagnostic evaluation (CPT codes 90791-90792) includes the following: a complete medical and psychiatric history; a mental status examination; establishment of an initial diagnosis; evaluation of the patient's capacity to respond to treatment; and an initial treatment plan.[5] For a comprehensive guideline, please see the American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults.[6] For a guideline on standards of care in the delivery of telepsychology services, please see the American Psychological Association Guidelines for the Practice of Telepsychology.[7]

B. Legal and Insurance Expertise:

APA Services staff have been involved in access to psychological care issues for two decades. We have never seen such an egregious case of delayed access for follow-up appointments.

We also have years of experience evaluating disparities in access to care under mental health parity laws. Kaiser's access to *medical* care seems to be very adequate, leaving the company with a dramatic disparity between good access to medical care and terrible access to mental health care. We can't see any good reason for this disparity that would save the company from a parity law violation. The only explanation that Kaiser offered us was to cite a State of California study indicating an 11% shortage of psychologists and other (non-psychiatrist) mental health providers, but the study actually referred to a projected shortage *a decade from now*.[8] We believe that Kaiser could hire more therapists readily if it admitted that this problem exists and chose to commit some of its ample resources to fixing it.[9]

---

[5] https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31887_33/Outpatient_Psych_Fact_Sheet09.18.14.pdf
[6] https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426760
[7] https://www.apa.org/practice/guidelines/telepsychology
[8] https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf at 10
[9] See, e.g., https://californiahealthline.org/news/bruising-labor-battles-put-kaiser-permanentes-reputation-on-the-line/

Conclusion

Kaiser's lack of timely access to mental health care has been in the news lately, but APA Services has been investigating and evaluating our members' concerns, and consulting with CPA, for the past 6 months. APA Services initially approached Kaiser with our core concerns about access to follow-up care in an effort to resolve the issue informally and collaboratively. The company's adamant denial that it has a follow-up access problem (combined with the data manipulation and intimidation/retaliation concerns) made an informal resolution unworkable; hence we are reaching out to you.

We would like to discuss these serious allegations with DMHC (and the monitor that DMHC has assigned to Kaiser's compliance if appropriate), to share more detailed information and expertise, and to urge DMHC to take action to resolve these problems and ensure appropriate access to mental health care for Kaiser patients. We look forward to participating in the January 31st meeting and to further communication on this matter.

Thank you for your attention to our concerns.

Jared L Skillings

Jared Skillings, Ph.D.
Chief of Professional Practice
American Psychological Association
American Psychological Association Services, Inc.

Alan Nessman

Alan Nessman
Senior Special Counsel
Legal and Regulatory Affairs/Practice Directorate
American Psychological Association
American Psychological Association Services, Inc.

Jo Linder-Crow, PhD

Jo Linder-Crow, PhD
Chief Executive Officer l California Psychological Association

Attachments:

June 3, 2019 letter from Kaiser psychologists to APA (psychologists' names removed)

May 14, 2019 letter from NUHW to DMHC

EXHIBIT 8

DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

DBA KAISER PERMANENTE

A FULL SERVICE HEALTH PLAN

FEBRUARY 11, 2021

Routine Survey Final Report
Kaiser Foundation Health Plan, Inc.
DBA Kaiser Permanente
A Full Service Health Plan

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EXECUTIVE SUMMARY

On November 16, 2018, the California Department of Managed Health Care (Department) notified Kaiser Foundation Health Plan, Inc. dba Kaiser Permanente (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from April 15, 2019 through April 20, 2019 in the Northern California region, and May 6, 2019 through May 10, 2019 in the Southern California region.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Prescription (Rx) Drug Coverage
Language Assistance

BEHAVIORAL HEALTH STATUS SUMMARY

The Department identified deficiencies in the Plan's Behavioral Health Quality Assurance (QA) Program in both the 2012 and 2016 Routine Medical Surveys. On July 18, 2017, the Plan entered into a three year Settlement Agreement with the Department, which included corrective action plan deliverables. By entering into the Settlement Agreement, the Plan agreed to improve its Behavioral Health QA program and to ensure effective action was taken to improve care where deficiencies are identified, including in areas of accessibility, availability, and continuity of care. The Settlement Agreement required the Plan to engage the services of a consultant to assist and monitor the Plan's Behavioral Health QA program. The Plan and the consultant were required to work together in order to achieve the goals of the Settlement Agreement. The Plan and consultant were required to focus on six specific "Corrective Action Areas," which are described in the Settlement Agreement and summarized below:

- Improved documentation of the Plan's quality improvement efforts for access compliance;
- Improved transparency in behavioral health appointment access compliance measurement;
- Improved monitoring of member impact as a result of insufficient access and associated real time member remediation;
- Fully implemented systematic process to monitor follow-up appointment access and adherence to the enrollee's treatment plan;
- Improved internal corrective action plan development; and
- Improved integration of external provider access data and oversight.

During the 2016 Routine Follow-Up Survey, the Department determined that the Plan had undertaken appropriate efforts under the terms of the Settlement Agreement to begin correcting these deficiencies. The Department noted these deficiencies as pended in the Follow-Up Survey Report, which was issued to the Plan on January 30, 2019. The Plan's corrective actions noted during the Follow-Up Survey included:

- Development of yearly work plans with the designated expert consultant for the first two years of the consultation period.
- Improved timely access compliance measurement mechanism that delineates when appointments that do not meet timely access standards result from member choice or lack of availability.
- Implementation of improved/revised internal corrective action plan process.
- Implementation of improved monitoring and remediation activities related to impact of when enrollees are not offered a timely appointment.
- Implementation of follow-up appointment monitoring process regarding adherence to an enrollee's treatment plan.
- Implementation of improved data monitoring of external (contracted) network access.
- Updated QA documents, policies and procedures.

For this 2019 Routine Survey, the Department reviewed the Plan's statewide behavioral health QA processes. Although the Department identified one QA deficiency in this 2019 Routine Survey, it is different from the behavioral health QA deficiencies noted in the 2016 Final and Follow-Up Survey Reports.

The Department's assessment included areas related to the Plan's Behavioral Health QA and its Access and Availability of Services for both Northern and Southern California. To assess Behavioral Health QA, the Department reviewed relevant Plan documents including behavioral health files involving potential quality issues (BH PQI files). Based on the BH PQI file review, the Department did not find a deficiency regarding the Plan's failure to follow-up on its corrective action plans (CAPs) intended to improve access to behavioral health appointments as noted in Deficiency #1 of the 2016 Routine Final Report.

To assess Access and Availability of Services, the Department reviewed the following documents:

- Plan policies and procedures related to Appointment Access and the Plan's Monitoring for Access and Availability of Appointments
- The Plan's Access Committee guidelines
- Internal monthly Plan tracking reports on the timeliness of initial appointments with physician and non-physician behavioral health providers for 2017-2018

Based on a review of the Plan's internal monthly initial appointments with physician and non-physician behavioral health providers tracking reports, the Department did not find a basis to cite the Plan for an access deficiency in the 2019 Routine Survey. In Deficiency #2 of the 2016 Routine Final Report, the Plan failed to provide enrollees with timely access to initial appointments for behavioral health services and failed to take effective action when access problems were identified. In the 2019 Routine Survey, the Department found while some rates for initial behavioral health appointments with non-physician providers fell below the Plan's internal compliance standard for multiple months, the Plan has a process for regularly tracking availability and timeliness of behavioral health initial appointments. In addition, when a particular facility fell below the Plan's threshold for two consecutive months, the Plan took effective and timely action, as described in the Plan's Quality Assurance Program.

Accordingly, in the 2019 Routine Survey, the Department determined the Plan has undertaken appropriate efforts to address Deficiencies #1 and #2 in the 2016 Routine Final and Follow-Up Survey Reports.

2019 Routine Survey Deficiencies

The Department identified **seven** deficiencies during the Routine Survey. The 2019 Survey Deficiencies Table below notes the status of each deficiency.

2019 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	
	QUALITY ASSURANCE (Statewide)	
1	**The Plan fails to ensure that the quality of care provided is reviewed, problems are identified and effective action is taken to improve care where deficiencies are identified.** Rule 1300.70(a)(1); Rule 1300.70(b)(1)(B).	Not Corrected
	GRIEVANCES AND APPEALS (Statewide)	
2	**The Plan's grievance system does not consistently monitor whether grievances are resolved in favor of the enrollee or the Plan.** Section 1368(a)(1); Rule 1300.68(e)(1).	Not Corrected
3	**The Plan does not ensure all oral expressions of dissatisfaction are considered grievances, and therefore does not ensure adequate consideration of enrollee grievances and rectification when appropriate.** Section 1368(a)(1); Rule 1300.68(a)(1).	Not Corrected
4	**For grievances involving delay, denial or modification of health care services, the Plan's response does not describe the criteria used and clinical reasons for the decision related to medical necessity.** Section 1368(a)(5); Rule 1300.68(d)(4).	Not Corrected

	UTILIZATION MANAGEMENT (Statewide)	
5	**The Plan does not systematically and routinely analyze utilization data to monitor potential over- and under-utilization of services. (Statewide)** Rule 1300.70(a)(3) and Rule 1300.70(c).	**Not Corrected**
6	**The Plan failed to demonstrate it complies with post-stabilization care requirements. (Northern California)** Sections 1262.8(f)(1), 1371.4(b), 1371.4 (d), 1371.4 (j)(1), 1371.4 (j)(3), 1371.4 (j)(2)(B), (C); 1386(b)(1); Rules 1300.71.4(a), (b)(1) – (3), (d).	**Not Corrected**
	PRESCRIPTION (RX) DRUG COVERAGE (Statewide)	
7	**The Plan does not update its formulary on a monthly basis.** Section 1367.205(a)(1) to (3).	**Not Corrected**

EXHIBIT 9

HEALTH & MEDICINE

Kaiser behavioral health care on the hot seat after California complaints

BY CATHIE ANDERSON

UPDATED MAY 23, 2022 9:47 AM

Kaiser Permanente Behavioral health clinicians rallied on Dec. 19, 2019 at the California Capitol before taking to downtown Sacramento streets.

BY **ALYSSA HODENFIELD** | **CATHIE ANDERSON**

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In an unexpected move, the California Department of Managed Health Care informed Kaiser Permanente that it will be examining whether the company is providing adequate mental health care services to its 9.4 million California members.

"This non-routine survey is based on complaints received from enrollees, providers, and other stakeholders concerning the plan's behavioral health operations," said Amanda Levy, the department's deputy director of health policy and stakeholder relations.

Levy said regulators would evaluate Kaiser's internal and external provider networks, timely access to care, processes for intake and follow-up appointments, appointment scheduling processes, levels of care and associated decision-making processes, medical record documentation and retention practices, and monitoring of urgent appointments.

Leaders of Kaiser Permanente issued a statement through Steve Shivinsky, the director of national media relations. In part, he said: "We appreciate the DMHC's interest and accountability in understanding how we are working to deliver clinically appropriate care to those who rely on us for their mental health services. We welcome the opportunity to review our performance and collaborate on new areas for improvement."

Kaiser's mental health clinicians, represented by the National Union of Healthcare Workers, have complained that their clients face weeks-long waits before they can get successive appointments and grueling schedules that leave clinicians little time to write notes or to connect patients to wraparound services.

"We have been pushing Kaiser Permanente to increase staffing and invest more in behavioral health care so that we can actually address the needs of our patients, but Kaiser keeps refusing," said psychologist Ken Rogers, a leader for the union in the Sacramento region. "Hopefully this investigation will finally force Kaiser to stop denying that it's failing its behavioral health patients and start working with us to improve its services."

In a news release issued Thursday, union leaders pointed to past fines and settlement agreements that the health care giant had signed with the Department of Managed Health Care, including one from 2013 when the company agreed to pay $4 million and to take corrective actions after the agency found it had failed to provide timely access to mental health care.

State records also show that regulators found issues with timely access to behavioral health services and availability of the care during a routine survey in 2016, but by 2019, Kaiser had instituted a corrective action plan that regulators said was working to alleviate the issues.

Regulators cited Kaiser for seven other deficiencies in the 2019 survey, mainly focused on how the company handled consumer complaints and monitored whether they were effectively resolved.

Regulators were conducting a follow-up inspection to determine whether Kaiser had corrected these deficiencies when it announced the non-routine survey to determine whether the company complied with laws requiring timely access to behavioral health care.

SHARP INCREASE IN KAISER COMPLAINTS

The California Department of Managed Health Care "help center received a 20% increase in behavioral health complaints for Kaiser in 2021 compared to 2020," wrote Rachel Arrezola, a spokesperson for the department, in response to a Bee inquiry. The department "is committed to ensuring enrollees have appropriate access to behavioral health care when they need it."

Kaiser's Shivinsky said: "We believe that a thoughtful, impartial review can help us and other health plans in California address challenges we are all facing. We know that we cannot solve the challenges of the national mental health crisis on our own and look forward to collaboration from across the mental health community."

Both the company and the union noted that California and the nation as a whole have seen a spike in demand for behavioral health services amid the COVID-19 epidemic.

The nonprofit Mental Health America estimated that more than 2.5 million youth in the U.S. have severe depression, and Black, indigenous and other youth of color are at the greatest risk.

In another key measure of mental health, the Centers for Disease Control and Prevention reported earlier this month that fatal overdoses have soared by 15% in 2021 with over 107,000 Americans dying. This follows upon a 30% increase in such deaths in 2020.

NEW CALIFORNIA LAW REQUIRES TIMELY APPOINTMENTS

Union officials said it's past time that Kaiser got its act together in managing behavioral health services. They warned state officials that the company was woefully unprepared to comply with a new state law that goes into effect July 1 requiring that health plans accommodate mental health therapy appointments within 10 business days unless the treating clinician determines that a longer wait would not be detrimental.

Already, union officials said, a 2020 survey of Kaiser clinicians found that, on a daily basis, 65% of respondents are scheduling their patients for return appointments further into the future than is clinically appropriate.

Shivinsky said Kaiser has been on a multiyear journey to improve the way mental health care is delivered, but like other providers, it has faced challenges amid a national shortage of clinicians in the field. The company has expanded its ability to provide virtual care to patients who want it; embedded mental health professionals in primary care clinics, pediatric settings, and emergency departments; and expanded collaborative care programs for patients who have anxiety and depression diagnoses.

"Despite all these efforts, we continue to face the same challenges others do," Shivinsky said. "We haven't solved the problems facing mental health care, and the pandemic has set us all back."

Arrezola said that consumers should file a grievance with their plan if they are not getting timely access to behavioral care. If they are not satisfied with their health plan's response or have been in their plan's grievance system for longer than 30 days for non-urgent issues, she said, they should contact the DMHC Help Center for assistance at (888) 466-2219 or www.HealthHelp.ca.gov.

This story was originally published May 21, 2022 5:25 AM.

FOLLOW MORE OF OUR REPORTING ON HEALTH CARE WORKERS

EXHIBIT 10

Visalia Times Delta

CALIFORNIA

Kaiser therapists flee California health giant as mental health patients languish

Jack Ross and Kristy Hutchings Capital & Main

Published 3:04 p.m. PT Aug. 1, 2022

When Susan Whitney was a therapist at Kaiser Permanente, her colleagues missed working in prison.

Whitney's co-workers first practiced mental health care in the region's penitentiaries before joining the state's largest health care provider. Working conditions for therapists at Kaiser were so deplorable, Whitney says, that her colleagues wanted to go back.

"They can provide better care," says Whitney, who retired from Kaiser in late 2021. "It's a better work environment."

Mental health practitioners at Kaiser are so overburdened with patients that waiting periods between appointments can be six weeks or more, according to therapists who spoke with Capital & Main. (Industry standards mean therapists outside Kaiser generally see patients on a weekly or bi-weekly basis, though cases vary.)

Mental health crisis among youth: California lawmakers target social media addiction

Now California's Department of Managed Health Care (DMHC) has launched a "non-routine survey" to determine whether Kaiser is offering adequate behavioral health care.

When asked about its access issues, Kaiser points to a nationwide shortage of mental health care practitioners.

"The need for mental health care in America has never been greater and at the same time harder to deliver," Kaiser representatives said in May. "Across the United States, mental health experts have reported the demand for mental health services has increased as much as 30% since the beginning of the pandemic."

Kaiser says it has prioritized filling hundreds of therapist vacancies in California.

“We recently launched a $500,000 recruiting initiative to source and hire clinicians to fill more than 1,000 open mental health clinician positions across Kaiser Permanente, more than 400 of which are in California,” Yener Balan, Kaiser’s vice president of behavioral health and specialty services, told Capital & Main in a March 29 statement.

“The challenge we face is that all mental health providers are drawing from the same, limited pool of talent.”

Read more: California makes it easier for low-income residents to get and keep free health coverage

Kaiser, whose mental health care deficiencies have been well documented, turned an $8.1 billion profit in 2021, a company record. In 2021, the Fitch credit ratings agency rated Kaiser bonds AA- for the company’s “track record of sound and consistent profitability.”

Susan Whitney attributes Kaiser’s staffing shortage to “a combination of greed and the lingering stigma over treating mental health the same as physical health.”

“I cannot believe that they would treat physical health issues in the same way,” she says.

Caseloads reached into hundreds, some say

Emily Ryan, a licensed clinical social worker, began working at Kaiser in Sacramento in 2005. Her caseload at Kaiser was “horrendous,” she says.

“I could believe that there is difficulty for them [hiring today], that there’s a shortage of every kind of worker right now,” she says. “In 2005 there was not. In 2008, when we had the economic crisis, there most certainly was not, and we were having the same exact problems.”

Therapist Mickey Fitzpatrick, who worked in the Bay Area town of Pleasanton, says he had caseloads into the hundreds at Kaiser before he left for private practice. “If even a fraction of those new clients wanted to meet as frequently as is recommended, I didn’t have the availability to see folks for multiple weeks to months at a time,” he says.

In rural Kern County, Kaiser employs 35 mental health workers to serve approximately 100,000 Kaiser members, according to data from the National Union of Healthcare Workers. There is no cap on the number of cases therapists can take on, and they face a regular onslaught of new patients.

“I have co-workers who’ve worked when they were very ill, but they felt like if they canceled one day, their patients would have to wait another six to eight weeks,” says Whitney. “People are waking up in the middle of the night worrying about patients.”

Exodus to more lucrative private practice?

American health plans limit access to mental health care to keep expenses down, according to Richard G. Frank, a senior fellow at the Brookings Institution and director of the USC-Brookings Schaeffer Initiative for Health Policy. Other health care organizations have been accused of undermining their mental health care by not hiring enough therapists — or insufficiently reimbursing the ones they do have for counseling sessions — driving an exodus to more lucrative private practice.

This is by design, says Frank. Mental health patients are more expensive than physical health patients — not because the cost of care is higher, but because mental health patients tend to come with substantial physical health needs, too.

A 2020 study by the consulting company Milliman Inc. reviewed 21 million insurance holders and found that behavioral health patients cost plans 3.5 times more than patients without behavioral health needs.

Experts: The new 988 mental health hotline could make 'all the difference'

“Ever since mental health started being covered by insurance in the ’60s and ’70s, the incentives have been to avoid enrolling people with mental illness in your plan,” says Frank.

Over time, parity laws mandating that health plans offer mental health care on par with their physical health care have grown increasingly strict. On Oct. 8, 2021, Gov. Gavin Newsom signed SB 221, which requires that follow-up appointments for mental health sessions be scheduled within 10 days of the previous session.

When asked about proceeding against Kaiser under the new law, the California Attorney General’s Office declined to comment, citing “a potential or ongoing investigation.”

Regulation and enforcement of health plans in California falls to the Department of Managed Health Care, which fined Kaiser $4 million in 2013 for overbooking its therapists.
Kaiser settled with the DMHC in 2017 following millions of dollars in fines and a litany of enforcement actions imposed against the company. The settlement established a six-point plan to address mental health access issues and forced Kaiser to hire a consultant to oversee the process.

Following the settlement, Kaiser established Connect 2 Care, a system of call centers, to shorten wait times for new mental health patients. Therapists interviewed by Capital & Main said Kaiser created its call centers merely to satisfy regulators, and Connect 2 Care has been criticized by the American Psychological Association.

In May 2022, the agency informed Kaiser of its investigation into the health care giant's mental health services.

Read more: Heat especially harms people with mental and behavioral health conditions, experts say

"We appreciate the DMHC's interest and accountability in understanding how we are working to deliver clinically appropriate care to those who rely on us for their mental health services," Kaiser wrote in a statement.

"Kaiser Permanente is meeting California's regulatory standard for initial appointments for mental health and wellness on average more than 90% of the time. We encourage therapists to document treatment recommendations, including both initial appointments and follow-up appointment frequency, and to escalate any challenges in scheduling to their manager, per the established process."

Kaiser's network of mental health practitioners may be even less robust than the numbers it touts. A 2021 lawsuit filed against Kaiser by the San Diego City Attorney's Office alleged that more than 30% of the therapists listed in Kaiser's directory were not actually available to patients: Some were listed with the wrong contact information, some had retired, some were not practicing within Kaiser's network, and some were not practicing altogether.

"Kaiser's grossly inaccurate provider directories harm their own customers' personal health, as well as their pocketbooks, while unlawfully and unfairly enabling the company to shed more costly enrollees to the detriment of its market competitors," the city of San Diego asserted in its lawsuit.

San Diego also filed lawsuits against two other major providers, Molina Healthcare of California and Health Net, for maintaining inaccurate directories of mental health care practitioners.

Hundreds have left in recent years

Data from the National Union of Healthcare Workers, which represents Kaiser therapists, found practitioners have left Kaiser in steadily increasing numbers over the past three years:

From June 2019 to November 2020, 469 practitioners left Kaiser, with annual turnover rates hovering around 8% per year in Northern California and 5% per year in Southern California. From December 2020 through May 2022, 850 practitioners left Kaiser, and the average annual turnover rate was more than 12% in Northern California and 10% in Southern California.

Kaiser mental health practitioners and experts told Capital & Main that working conditions are to blame for the exodus of therapists from the company. Ex-Kaiser therapist Mickey Fitzpatrick handily beats his old hourly rate, he says, which was $73.73 in April of 2021, after 10 years at the plan. In the Bay Area, therapists regularly charge $250 or more for 50 minute sessions.

“My graduates want to go to Kaiser for work, and they do,” says Dr. Gilbert Newman, vice president for academic affairs at the Wright Institute, a private graduate school for psychology in California. “They often leave Kaiser because they don’t like the work they do. They don’t like being told you can’t see people enough to help them.”

Kaiser therapists can get in trouble with their managers when they recommend clients for regular follow-up appointments. In November of 2021, marriage and family therapist Tanya Veluz was summoned into a meeting with three of her superiors after she recommended patients for return sessions. The managers went through a list of those clients, questioning their need for care.

“They went through each case,” Veluz recalls, “and for a couple where the distress was really high they said, ‘Makes sense, we understand why you would want more support for this case.’ Every other case they challenged my clinical decisions. ‘Well … the questionnaire doesn’t indicate the level of distress you’re asking for.’”

The managers also questioned her estimates for the duration of her patients’ treatment, Veluz says. Trauma patients, Veluz felt, would need sessions for two to six months.

According to Veluz, her manager told her it was impossible to know for how long a patient would need treatment. Veluz disagreed, citing her clinical experience as well as “plenty of research” supporting her diagnoses. She says one manager threatened her license.

When asked about the incident, Kaiser representatives did not directly comment. On July 19, the company said it is on a “multiyear journey to improve the way mental health care is delivered in America today” and has been expanding its virtual care and placing mental health professionals in medical settings. The company has “escalation procedures to support our therapists if they are unable to schedule a needed follow up appointment" and a "dedicated phone line."

Ken Harlander, a licensed marriage and family therapist, practiced at Kaiser's Bakersfield clinic with Susan Whitney, and left for private practice last year. Harlander avoided delays between appointments at Kaiser by booking returning clients in spots reserved for new patients, which got him summoned to "the principal's office," he says.

"That was what happened if you tried to push back," he says. "When you would ask, 'Why are we selling a product we can't really provide?' you would get no answers."

Richard G. Frank agrees that post-pandemic demand bolsters Kaiser's shortage argument, but says insurance plans' refusal to compete with private practice is the real culprit behind practitioner shortages.

"I think there's a kernel of truth there, but I think it's exaggerated," he says. "What health plans typically claim is that they can't hire all the people they would like to hire at the current rate of pay. That's not the same thing as saying, 'Gee, there are none available.'"

But for Ken Harlander, it wasn't the pay that drove him to private practice — the company's excellent benefits made up for lower hourly wages. Harlander says he left because Kaiser overbooked him and prevented him from doing his job effectively.

"It's just been so good to not work there anymore," he says. "I actually practice good therapy."

Because of its benefits, Kaiser always has willing applicants, according to Harlander. "People would rather work at Kaiser than the county or Medi-Cal work," he says. "They could open slots and hire people away if they wanted to. They wouldn't even have to change their pay structure. If they said we're hiring five therapists, they'd get five candidates right now."

Exhibit 11-A

‘It’s atrocious’: Parents and therapists lambast Kaiser’s youth services

Ariana Bindman, SFGATE

Updated: Aug. 16, 2022 4:39 p.m.

Kaiser workers strike at the Oakland Medical Center to protest the HMO's "unethical" working conditions on Aug. 16, 2022.
Ariana Bindman

More than 2,000 mental health clinicians continued to strike at Kaiser Permanente hospitals across Northern California on Tuesday to protest the health care provider’s “unethical” working conditions. On the front lines of the strike at the Oakland Medical Center, SFGATE spoke to several therapists and psychologists who are speaking out on the inhospitable working conditions that are allegedly harming both patients and practitioners.

Alex Klein, a child psychologist who's worked at the Oakland Medical Center for the past seven years, said he is frustrated with Kaiser's current practices and the delays in care.

"If anything, it's been worsening since Kaiser has not been able to make suitable working conditions for clinicians," he said.

According to Klein, his colleagues are burnt out and leaving altogether. As staff dwindles, kids with "significant needs" who should be seen weekly sometimes wait two months or longer for appointments. By failing to support clinicians, he said that Kaiser is subsequently failing to support kids who are suicidal or dealing with conditions like PTSD, OCD, anxiety and depression.

In response to complaints from the picket line about the lack of staff, Kaiser said in a written statement that it has hired 200 new clinicians since January 2021 and has spent $500,000 to recruit more staff. Representatives also say that Kaiser will continue to prioritize urgent and emergency cases during the strike. “We are working hard to ensure that every patient who needs care this week receives it,” they wrote in another statement.

“Despite all that we are doing, we, like others, are challenged to meet the demand and know more must be done,” Deb Catsavas, senior vice president of human resources at Kaiser Permanente, said in the statement. “We are focused on continuing to find new ways to meet our members’ and patients’ mental health needs.”

The National Union of Healthcare Workers — which represents the striking clinicians — said enough progress hasn’t been made. The union said Kaiser rejected a proposal that would have helped increase staffing and decrease wait times for appointments. Despite Kaiser’s statements that it is committed to “bargaining in good faith,” therapists said that sometimes the HMO doesn’t show up to their bargaining sessions at all.

Meanwhile, Klein said the pandemic is exacerbating the youth mental health crisis, which is the leading cause of disability and poor life outcomes, according to government data. The U.S. Centers for Disease Control and Prevention found that from 2009 to 2019, high school students reported experiencing increased feelings of sadness and hopelessness. The pandemic worsened the crisis. “We’ve seen a huge increase in anxiety, in depression, particularly with youth — children and teens,” Klein continued.

Jason Lechner, a marriage and family therapist, and Charles Aquilina, a psychologist who works in addiction medicine, both agreed that the pandemic increased the need for mental health services for both kids and adults.

"It made an already difficult problem worse because access to care, access to return appointments and follow-up care was really an issue even before so many people needed it," Lechner said. Aquilina said that physical isolation and excessive screen time is affecting youth in particular, and that substance abuse among teenagers is also on the rise.

Because of long wait times and staffing issues, some parents said they can no longer rely on Kaiser at all.

One mother, Marie, who requested to not use her full name, called the level of care her teenage son received at the Vallejo Kaiser during a mental health crisis "deplorable."

"Just to speak to the psychiatrist that was assigned to him took an act of God," she continue

Even though multiple professionals told her that her son needed to see a mental health practitioner at least two or three times a week, Marie said that Kaiser offered to see him just once a month. She knew her son couldn't afford to wait that long and she put together a patchwork of services outside of Kaiser for him over the course of about six years.

“We spent nearly $500,000 out of pocket until he was 18 years old due to lack of response and quality mental health care from Kaiser,” she wrote.

Over the phone, Marie told SFGATE that she took her son to see doctors at Stanford and UCLA, paying $2,400 for three sessions in Northern California and then $45,000 for a month-long evaluation at the University of Utah. Had her friend not given her a $200,000 personal loan, she said, she wouldn't have been able to save her child's life — but even that wasn't enough. Amid other financial troubles during the pandemic, she had to sell her own home.

“We have no retirement now,” Marie said. “We spent what we had. But was it worth it? Of course. I always told my son I will do whatever it takes to see him through this.”

Barbara McDonald, who spoke with SFGATE for a previous story, had a similar story. She spent $45,000 on services outside of Kaiser due to unpredictable cancellations and delays. “It feels completely negligent,” McDonald said.

“They have got to throw away their handbook with how they operate for adolescent psychology,” Marie said. “It's atrocious.”

Exhibit 11-B

Bloomberg Government

Kaiser to Boost California Therapist Numbers Under New Contract

By Tiffany Stecker / October 21, 2022 03:00AM ET / Bloomberg Law

Kaiser Permanente will be required to hire more mental health therapists and increase crisis services under a new four-year contract ratified by the therapists' union Thursday.

The agreement, which covers about 2,000 therapists for the nonprofit HMO in Northern California and the state's Central Valley, concludes the longest strike of mental health workers in history.

The standoff began in August with the therapists protesting Kaiser's inability to provide regular and timely behavioral health care to members, with some patients waiting months for follow-up treatment after an initial assessment.

"It took much longer than it should have to reach this agreement, but, in the end, we succeeded in securing important improvements in patient care that Kaiser negotiators told us across the bargaining table that they'd never agree to," Jennifer Browning, a licensed clinical social worker and member of the National Union of Healthcare Workers' bargaining committee, said in a statement.

The agreement is retroactive to September 2021, when the existing contract expired, and will end September 2025. It provides:

- Therapists with two additional hours per week to respond to patient emails and voice messages, contact social services agencies, and perform other duties;
- A 50-cent-per-hour raise for bilingual therapists, and;
- An increase in the duration of initial mental assessments for children, from 60 minutes to 90 minutes.

Must Follow Committee

The agreement doesn't specify how many people Kaiser must hire in the coming years. But it holds management and labor responsible for adopting a plan to better treat specific diagnoses and requires Kaiser to implement the recommendations from those committees. Several of those panels have a mandate to increase staffing, union spokesman Matt Artz said.

California Therapists, Kaiser Agree to End Strike Over Staffing

That requirement could be Kaiser's best chance to offer better care, said Sarah Soroken, a triage and crisis therapist with the provider.

“They can’t just take in the recommendations and not do anything with them,” Soroken said in an interview.

A spokesman for Kaiser Permanente declined to comment at the time of publication.

The union began its California strike on Aug. 15 and accused Kaiser of violating a new state law (S.B. 221) to guarantee timely care for mental health patients. Kaiser members often wait months for follow-up appointments after an initial assessment, according to the HMO’s own data.

Sen. Scott Wiener (D), the author of the timely care law, said that the settlement is a positive step to improve services.

“This resolution seems solid and creates a lot of leverage for the unions to make sure Kaiser is doing better,” he said in an interview.

To contact the reporter on this story: Tiffany Stecker in Sacramento, Calif. at tstecker@bgov.com

EXHIBIT 12

HEALTHCAREDIVE

DIVE BRIEF

California probes Kaiser over enrollee access to mental health appointments

Published Aug. 29, 2022

By Susan Kelly
Contributor

Dive Brief:

- The California Department of Managed Health Care has launched a targeted enforcement investigation into whether Kaiser Permanente health plans are providing patients with timely access to appointments, as required by law, during a strike by mental health clinicians at the system's facilities, a DMHC spokeswoman confirmed in an email to Healthcare Dive on Sunday.
- The probe follows a complaint earlier this month by the National Union of Healthcare Workers to the DMHC that accused Kaiser Foundation Health Plan of illegally canceling behavioral health services for thousands of enrollees in Northern California in response to the impending strike by non-physician clinicians. The strike by DMHC-represented clinicians began on Aug. 15.
- Kaiser Permanente, in an emailed statement, told Healthcare Dive that it is using every resource available to ensure it meets members' mental health needs. "We welcome the opportunity to review the steps we have taken to prepare for and manage

through the union's efforts to disrupt mental health care," spokesman Marc Brown said.

Dive Insight:

The more than 2,000 mental health therapists on strike will remain off the job until Kaiser increases staffing at its clinics and ends "dangerously long" wait times for therapy sessions, according to the NUHW. The union contends Kaiser is breaking California law and violating clinical standards by making patients wait months to start therapy and four to eight weeks between appointments.

California law requires health plans to arrange for care to be provided out of network if timely access to mental health services is unavailable from in-network providers.

DMHC spokeswoman Rachel Arrezola said the department notified Kaiser on Aug. 22 that it had opened an enforcement investigation. The DMHC will continue to monitor the plan closely during the strike to ensure it is in compliance with the law, she said.

"The DMHC is concerned about the potential for immediate harm to enrollees based on the very serious nature of allegations that the plan is not providing timely appointments to enrollees required by the law," Arrezola said.

Brown said 40% of Kaiser's clinicians are caring for members instead of striking, "with more returning each day." In addition, Kaiser Permanente psychiatrists, clinical managers and other licensed clinicians have stepped in to meet with people needing care. Kaiser is also working toward agreements with hundreds of community-based mental health providers to open their schedules for at least two months to be able to treat more of Kaiser’s patients, he said.

“We appreciate the DMHC’s interest and accountability in understanding how we are working to deliver clinically appropriate mental health care during NUHW’s unnecessary strike,” Brown said.

Kaiser Permanente mental health clinicians in Hawaii were planning to begin a strike Monday, joining California therapists in calling for the system to address access-to-care issues.