Profit Making in Not-for-Profit Care: Part III

The Case of Queens County Neuropsychiatric Institute, Inc.

New York State Commission on Quality of Care
for the Mentally Disabled

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NYS Commission
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Preface

In delivering community-based mental health services, New York State relies heavily on a network of not-for-profit agencies that operate residential and non-residential programs to meet the needs of persons with mental illness and their families. In doing so, the state relies upon the mission and commitment of these agencies to the care and treatment of persons with mental illness, upon their boards of directors to maintain vigilance in carrying out their mission, and upon the competence and integrity of independent accountants who perform the required annual audits and express opinions on the accuracy of the financial statements of these agencies, which are largely financed with public funds.

The sheer number of agencies involved in the delivery of these services, and the limited staff within the Office of Mental Health (OMH) who are assigned the responsibility for certification and monitoring of these agencies make the state heavily dependant upon the reliability of each link in this chain of accountability. As the state continues to implement a policy of downsizing government and deregulation of the service system, this dependence will necessarily increase.

For the most part, not-for-profit agencies have proved to be reliable, dependable and cost-effective partners with state and local government agencies in meeting the needs of persons with mental illness and their families for high quality services in the community. However, as periodic investigations by the Commission have revealed,[1] this chain of reliance is only as strong as its weakest link.

The case of Queens County Neuropsychiatric Institute, Inc. illustrates anew the risks to quality care and to public funds when this reliance is misplaced. In this case, a not-for-profit psychiatric clinic, Queens County Neuropsychiatric Institute (QCNI), serving a low income clientele and generating its fees primarily from the Medicaid program, was found to be providing services of questionable quality to recipients while producing excessive salaries and other forms of compensation to its founding principal.

Findings

I. Quality of Services

- The Commission found no evidence that many of the persons being served by this clinic were eligible for services, as there was a lack of information to support the diagnosis of serious mental illness. (pp. 5-8)
- In one-third of the records reviewed, there was no written treatment plan. Health information to determine a patient's medical status was not routinely gathered, creating a risk of harm when psychotropic medications are prescribed. (pp. 8-9)
- Assessments and treatment plans were not updated or revised through the sometimes lengthy course of treatment. In some cases, the same treatment plans were used years after they were initially developed without

[1] *Profit Making in Not-For-Profit Care: A Review of the Operations and Financial Practices of Brooklyn Psychosocial Rehabilitation Institute, Inc., October 1986; Profit Making in Not-for-Profit Corporations: A Challenge to Regulators*, December 1989; *Exploiting the Vulnerable: The Case of HI-LI Manor Home for the Aged and Regulation by the NYS Department of Social Services*, May 1992; *Missing Accountability: The Case of Community Living Alternative, Inc.*, June 1994.

any evident evaluation of their effectiveness. (pp. 9-13)

- In 43 percent of the cases reviewed, there were no discharge criteria in the discharge plans. (pp. 13-14)
- Progress notes required by law were generally non-informative and in many instances substantially or entirely illegible, making it impossible to review the patient's progress. (pp. 14, 27)
- The foregoing deficiencies were not identified or corrected by agency clinical supervisors, although many of the treatment documents were signed by psychiatrists. Nor did quality assurance or utilization review processes address these problems. (pp. 15-18)
- Although an OMH certification review identified many of these deficiencies, one year later the Commission found that the problems in treatment planning, utilization review and discharge planning were still evident. (pp. 19-23)

II. Improper Medicaid Billings

Approximately $600,000 or 19 percent of the $3.2 million claimed for psychiatric services to Medicaid recipients from 1992 to 1994 by QCNI did not adhere to federal and state legal requirements concerning acceptable record keeping. In these cases, there were either no progress notes to support the claims, or no documentation for the duration of the visit, or the records were illegible making it difficult to determine the extent of services for which payment was claimed. (pp. 25-28)

III. Executive Compensation

Excessive compensation, and large, unjustified and apparently unauthorized payments were made to the QCNI's founding principal. Compensation levels of other senior executives, while not excessive *per se*, require closer scrutiny as to their reasonableness, since the executive director did not have the requisite authority to perform his job and because of the questionableness of the actual hours worked by the medical director given all of his other employment obligations. (pp. 29-30)

Founding Principal

- The $130,000+ yearly compensation paid to QCNI's founder for part-time employment was over 70 percent higher than the salary paid executives in similar-sized mental hygiene agencies in New York City. He also had a rent-free apartment provided by the agency. (pp. 30-33)
- Approximately $490,000 in annuities were misappropriated by the founder who acted with the agency's "independent" accountant to conceal the transactions and mislead its board of directors. (pp. 33-34)
- Despite these annuities, annual deficits and a substantially depleted fund balance at the agency, the founding principal and his family were guaranteed a minimum retirement benefit of $600,000. (pp. 34-35)

Executive Director

- While the compensation of the executive director was not significantly out of line with heads of similar size mental hygiene agencies in New York City, he did not functionin this capacity and received income on which taxes may be due. (pp. 35-37)

Medical Director

- The medical director was simultaneously employed as a full-time psychiatrist at Bronx Children's Psychiatric Center, enrolled there in its Extra Service Program for additional work, and employed by

QCNI or paid as a consultant. He received compensation of $249,000 in 1994 and $229,000 in 1995 from QCNI, a private hospital, and the state for work weeks averaging 83 hours. There were many periods when he reportedly was working at two different locations at the same time, or working more than 24 hours in a single day, suggesting that he could not have worked all the hours for which he was paid. (pp. 37-39)

IV. Board of Directors

The QCNI board failed in its duty to oversee the agency's affairs and to protect its assets by assuring that compensation levels and retirement benefits for its founding principal were reasonable. It also failed to comply with applicable laws and governmental regulations (e.g., annual independent audits and board approval of business transactions with executives) that might have prevented the dissipation of corporate funds or assets for the personal benefit of key executives. (pp. 40-42)

V. Role of Independent Accountant

QCNI's CPA firm was not "independent" and participated in a scheme to redirect public funds intended for services to the agency's founding principal. It attempted to conceal his misappropriation of agency assets through improper accounting entries and by issuing "unqualified" opinions on financial statements (i.e., the CPA's assurance that an audit was done and the statements are not misleading) when, in fact, no audit work was performed. It also failed to report the total compensation of certain agency employees to federal and state tax agencies. (pp. 42-45)

VI. Conclusion

As has been the case in several previous Commission investigations, the Commission once again has uncovered a not-for-profit agency, certified to provide care and treatment to persons with mental illness, subordinating its avowed beneficent purpose to become an engine for the personal enrichment of its corporate principal. As in previous investigations, the Commission found the same ingredients that have characterized other instances of diversion of public funds to private profit:

- A dominant person serving in a position of leadership in the agency — in this case a psychiatrist who was the founder of the agency — who engaged in or directed financial decisions for his own personal benefit;
- A weak board of directors that either did not grasp its fiduciary responsibilities or failed to carry them out vigilantly; and
- An accountant who failed to meet his professional responsibilities in conducting independent audits and in providing unbiased financial opinions. Instead, the accountant helped conceal from the board and the state certifying agency, OMH, material financial transactions that diverted agency assets to the founding principal.

In this report, the Commission has made a number of recommendations to the OMH to address the specific problem at QCNI.

In addition, the Commission is referring its findings to:

- *The Department of Law:* to assure that the board of this not-for-profit corporation is revamped and organized to perform its duties consistent with its corporate and licensed purpose; to recoup funds

from the corporation that were misappropriated and for possible criminal actions related to the apparent frauds against the corporation.

- *U.S. Attorney for the Eastern District of New York:* for possible criminal violations related to the misappropriation of medical assistance funds.
- *State Education Department:* for apparent gross violations of regulations relating to the practice of public accountancy.
- *State Department of Social Services:* for recoupment of some $600,000 in medical assistance payments improperly received by QCNI for undocumented services.
- *Office of Mental Health:* to assure the provision of meaningful psychiatric services at this clinic and compliance with the terms of its operating certificate, and review of outside employment practices by employees participating in its extra service compensation program.
- *Internal Revenue Service and State Department of Taxation and Finance:* for possible violations of tax laws.
- *State Office of Inspector General:* for possible falsification of state time and attendance records relating to numerous services that could not have been rendered at the same time at different employment locations.

A draft of the report was reviewed by OMH which substantially concurred with the Commission's findings. OMH's responses to the Commission's recommendations are included following the specific recommendations. A draft of this report was also reviewed by QCNI's board of directors. Specific responses or comments from QCNI on the Commission's report are included in pertinent sections of the body of the report.

This report represents the unanimous opinion of the members of the Commission.

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Introduction

Background

In its 1977 enabling statute, the Commission on Quality of Care for the Mentally Disabled was expressly required to "review the cost effect of mental hygiene programs and procedures provided for by law with particular attention to the efficiency, effectiveness and economy in the management, supervision and delivery of such programs. Such reviews may include ... determining reasons for rising costs and possible means of controlling them..." (NY Mental Hygiene Law, §45.07 (b)).

Recognizing the important need for impartial fiscal assessments in the mental hygiene system, the *1985-86 Executive Budget* appropriated funds for the Commission "to enhance its fiscal investigations/cost analysis capabilities." Subsequently, as its studies began to increasingly find a linkage between poor care and the malexpenditure of public funds, the State Legislature further expanded the Commission's "watchdog" role when it appropriated funds for investigating and auditing "incidents of Medicaid fraud and abuse" (Chapter 50, Laws of 1987) and "suspected misuses of public funds by programs or facilities licensed by an office of the department of mental hygiene" (Chapter 50, Laws of 1993).

During a recent study of freestanding mental health clinics, Commission fiscal staff visited clinics throughout the state to look behind reported cost and productivity figures in order to gain an understanding of high- and low-cost clinic operating practices.[2] The Commission was hopeful that in reviewing operating practices at efficient clinics (and, conversely, by observing the factors that drive up unit costs at high-cost clinics) there might be opportunities to replicate sound operating practices statewide.

One of the clinics visited was the Queens County Neuropsychiatric Institute, Inc. (QCNI), which provides outpatient psychiatric services mostly to recipients with very low or no income. Revenues for QCNI—

2 *Why Do Psychiatric Clinic Costs Vary by 1030%?: A Review of the Efficiency of Freestanding Clinics*, May 1996.

mainly (87%) generated by Medicaid—from 1992 to 1995 averaged $1.186 million while expenses, which exceeded revenues, averaged $1.216 million. This clinic was selected because it appeared to be one of the more efficient clinics licensed by the state Office of Mental Health (OMH). Its 1992 cost of $46.84 for a 30-minute individual psychotherapy session was less than half the statewide average of $96.26, and its output per clinician at 10 visits per day was almost three times the statewide clinic average of 3.86 visits.

Nevertheless, as explained in this report, the Commission's review found that this seeming efficiency represented by these statistics concealed a clinic program rife with serious problems in the quality of the high-volume services it delivered, improper billings to the Medicaid program that account for almost one-fifth of its Medicaid income, diversion of agency assets to senior executives, failure of the board of directors to exercise its fiduciary responsibilities, and unprofessional conduct by the agency's certified public accountant (CPA) who helped conceal financial irregularities from the board of directors and state regulators.

The financial and program oversight systems that should have acted to safeguard the integrity and performance of this not-for-profit agency did not work. At QCNI, the Commission found the internal safeguards were so flawed that they invited profit-making abuses and indifference to program quality by senior executives. While OMH's certification review identified some of the problems in quality of care at this program, these problems remained essentially uncorrected as the certification was renewed for another 24 months.

Corporate Background

Queens County Neuropsychiatric Institute, Inc., located at 37-64 72nd Street in Jackson Heights, New York, was incorporated as a not-for-profit corporation in 1962. As required by OMH regulations (14 NYCRR 587), QCNI provides treatment to adults diagnosed with mental illness and to children diagnosed with emotional disturbance. Health screening and referral, medication therapy, medication education, symptom management, and psychiatric rehabilitation readiness determination and referral are services the clinic is required to provide.

QCNI was founded by Dr. David Lehine who has held several titles at the agency, including executive director, medical director, "consultant psychiatrist" and, since May 1996, vice-president of the board of directors. The agency's executive director is Joseph Melman and its medical director is Dr. Gomes Arantes.

The clinic owns and operates out of a three-story building, with the first two floors being used for office space and treatment rooms. Dr. Lehine, while maintaining residences in the State of Florida and in upstate New York, occupies the third floor of the clinic, rent-free. The agency also owns a similar adjacent building which it rents to an agency run by Catholic Charities of the Diocese of Brooklyn.

Scope of the Commission's Review

Using OMH regulations (14 NYCRR 587) as a framework, the Commission undertook a programmatic review of the clinic in April 1996 which included an on-site review of records and discussions with the executive director. Commission staff reviewed the case records of 23 past and present recipients of the clinic's services and the admission documentation on 10 additional individuals recently admitted or seeking admission to the clinic. The individuals in the study sample were largely chosen randomly, although Commission staff specifically reviewed the records of all members of the same family who were in therapy when a single member was drawn randomly for study. The Commission staff also reviewed the randomly selected records of seven children, with special attention to the use of medications.

A financial review was conducted of the various books and records of QCNI generally for the period January 1, 1992 to December 31, 1995. The Commission examined the agency's spending practices and its claiming procedures under the Medicaid program for services provided during calendar years 1992, 1993 and 1994. Using a statistically valid sample, 382 claims for clinic services were randomly selected for review to determine whether the agency was complying with applicable laws, regulations, and policies promulgated by the state pursuant to federal statute.[3]

Throughout the course of these reviews, the senior executives of QCNI were responsive to most requests for information. Some records regarding transactions benefitting Dr. Lehine were reported to be missing, requiring the Commission to subpoena records from several banks and insurance companies. Additionally, the agency made available the services of its independent accountant who provided supplemental information to help assure the accuracy of this report.

[3] Subsection 1396 (a) (27) of Title 42, United States Code, requires individuals providing medical assistance (i.e., Medicaid), "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan..."

In New York, the Department of Social Services (DSS) is required to promulgate and maintain these standards as well as to establish guidelines to ensure that physicians maintain proper records. Among the standards promulgated by DSS are requirements in 18 NYCRR 540.7 (a) (10) which state that "[i]n the case of bills for physician services, physicians are required to maintain complete, legible records in English for each patient treated." The subdivision lists what information medical records must contain at a minimum, including "the patient's chief complaint or reason for each visit...the patient's pertinent medical history as appropriate to each visit, and findings obtained from any physical examination conducted that day...a recording of any progress of a patient, including patient response to treatment...a statement as to whether or not the patient is expected to return for further treatment, and treatment planned, and the time frames for return appointments..."

Quality of Care Findings

The Commission's program review found a clinic that is extremely poorly administered and which does little to effectively ensure the quality of the service it provides. Admission assessments were scanty; some diagnoses were questionable; treatment plans were either non-existent or contained unmeasurable and unsuitable objectives; therapists' notes were often not related to the treatment plan; some physician and therapist notes were not legible; and utilization review was cursory at best.

QCNI opened with the intent of providing psychiatric services particularly to those "who were not poor enough to receive free service in a hospital, but not wealthy enough to afford private psychiatric help."[4] According to the executive director, the clinic serves almost 1,200 individuals, approximately five percent of whom are children. Verbal therapy is provided in Spanish, Italian, French, Russian, and Yiddish as well as English to recipients from many cultures, some of whom are first-generation immigrants. Almost 90 percent of the recipients receive Medicaid benefits which pay for their clinic services.

Nine physicians, including a full-time medical director, and 18 therapists, most of whom are social workers employed part-time at the clinic, provide services six days a week, including Saturday and evening hours for appointments. Most consumers receive 35 minutes of verbal therapy from a social worker, and consumers are scheduled every 40 to 45 minutes. Psychiatrists spend 15 minutes with individuals for medication management and 30 minutes for verbal therapy if they are the person's primary therapist as well.

The regulations (14 NYCRR 587.15) require that all services rendered be documented in a treatment record which must be legible and periodically reviewed for quality and completeness. Each case file must contain a pre-admission screening of the individual, diagnosis, on-going assessments, a treatment plan with periodic revisions, dated progress notes related to the goals and objectives specified in the treatment plan, dated and signed records of all medications prescribed, and a discharge plan. When an individual is discharged, a discharge summary must be written and the individual should be provided referrals to other programs and services as appropriate.

Commission Program Review

The Commission's program review found a clinic that is extremely poorly administered and which does little to effectively ensure the quality of the service it provides. Admission assessments were scanty; some diagnoses were ques-

[4] 1991 certification information supplied to OMH

tionable; treatment plans were either non-existent or contained unmeasurable and unsuitable objectives; therapists' notes were often not related to the treatment plan; some physician and therapist notes were not legible; and utilization review was cursory at best. *Taken as a whole, these problems raise elemental questions about whether or not some of the adult consumers receiving therapy actually have a mental illness or the children have an emotional disturbance.* Further, they raise obvious questions about the quality of the treatment being provided and the need for referrals to more appropriate services.

It would be an incomplete picture of the work of this clinic not to acknowledge its vital role in the life of some of the consumers in the Commission's study sample. The clinic provides a lifeline for some recipients who have significant problems and no other supports.

The findings reported in the following pages present the evidence from the sample case records for raising these questions. The report offers an explanation why neither the program nor OMH has identified and addressed these problems.

First, however, it would be an incomplete picture of the work of this clinic not to acknowledge its vital role in the life of some of the consumers in the Commission's study sample. The clinic provides a lifeline for some recipients who have significant problems and no other supports. These individuals live in poverty and are overwhelmed by circumstances they cannot overcome. The men frequently are physically disabled and are unable to hold a full-time job; the women are often single parents. It was common for both the men and the women to have been victims of physical or sexual abuse, or to have been abandoned as children. Many have insufficient education, and some have received only a few years of education as children in their native land, making them illiterate or only semi-literate in both English and their native language (*see* box #1). Not surprisingly, these men and women suffer from various forms of depression. Some are treated with verbal therapy and some with verbal therapy and medication. All are given much-needed support by their therapist.

Considering the critical role of the clinic in the lives of a number of the individuals in the Commission's study sample, and precisely because of the severity of their needs, one is left to speculate how much more consumers might be benefitting if the clinic were properly managed and clinical services were focused on realistic treatment objectives and integrated with other necessary supports.

Assessments and Diagnosis

The failure of the clinic to perform comprehensive assessments at the onset of treatment and to revise the evaluations as consumers gain skills and resolve problems has led to unsubstantiated diagnoses and admission decisions, and the failure to refer individuals to more appropriate services.

The clinical assessment forms the basis for establishing the diagnosis and treatment plan.[5] It is a continual process of identifying an individual's

[5] 14 NYCRR 587.4(c)(2).

Box #1

M.R. finished second grade in Colombia and has had no subsequent schooling in the United States. At 40 she was forced to leave her job because of poor medical health. She lives alone in a single room, having left her husband of 20 years. She is having difficulty maintaining a relationship with her only daughter, believing that persons close to her victimize her with harsh words.

Born in the Dominican Republic 49 years ago, F.M. attended only grammar school. He is unable to work, suffering from a variety of somatic complaints. Although he lived with his girlfriend for 12 years and had two children, the family is no longer together. He intermittently abuses alcohol.

G.M. never finished high school and had a child at a young age. The daughter ran away in her middle teens and has not reappeared in the succeeding months. G.M. misses her daughter greatly and suffers because others in her family believe she is to blame for her daughter's disappearance.

As the mother of three developmentally disabled children and the spouse of a man who keeps leaving and reentering her life, T.M. is suffering from depression and is being treated with medication. Her family circumstances and her lack of education beyond grammar school leave her feeling trapped.

behavioral strengths and weaknesses, problems, and service needs. Assessments are made through observation and evaluation of the individual's current mental, physical and behavioral condition and history. Logically, inadequate or inaccurate assessments undermine diagnoses and the likelihood of successful treatment.

The Commission's study sample revealed that, with few exceptions, initial assessments were usually one page in length and contained extremely little information. In some instances, the information was so scanty that it was not a sufficient basis for diagnosis of mental illness for an adult or of emotional disturbance for a child. Further, in none of the case records studied was there evidence of any change or modification of the initial assessment, even after years of therapy, and in only three case records was there any mention of an individual's strengths. Finally, very little attention was paid to the physical health of individuals or the medications QCNI reported they were taking.

Scanty Information

The information below is from an assessment for a nine-year-old girl brought in by her mother because the youngster felt that her older sister did not like her and was jealous of her, and because she fought with her younger sibling

(presenting problem as described on assessment form). It and the following case illustrate the paucity of information upon which clinicians at QCNI determined the children were seriously emotionally disturbed (subsequent to the date of this evaluation, regulations no longer require evidence of *serious* emotional disturbance) and determined a tentative diagnosis.

Basic Identifying Information: *Name, age, etc.*
Attitude: *Cooperative*
Affect: *Appropriate*
Verbal Content: *English/Spanish*
Memory: *Good*
Intelligence, Insight, Judgement: *Fair*
Health: *Good*
School: *Lists school, grade 3*
Prior Psychiatric Treatment: *Here at our clinic*
Family History: *Mother 31, father 4_ live together but under difficult marital stress due to father's jealousy and controlling wife.*
Summary: *9-year-old Hispanic girl suffers from mild hyperactivity and irritability and in conflict with siblings.*
Diagnostic Impression: *Adjustment disorder with mixed disturbance of emotion and conduct.*

The assessment of this child's sister, brought to the clinic the same day by her mother, is equally terse and contains even less information upon which to make a diagnosis of severe emotional disturbance. The 12-year-old is described as "mildly hyperactive. Patient in conflict as she acts like she knows it all. Patient feels mother has unrealistic expectations of her. She has recently improved academically. Student of the month." This youth also received a diagnosis of adjustment disorder with mixed disturbance of emotion and conduct.

It is important to note that according to the Diagnostic and Statistical Manual which describes criteria for the formulation of diagnoses, an adjustment disorder diagnosis requires an identifiable stressor within three months of the onset of symptoms which causes *marked distress or significant impairment.* In neither case did the assessments of these young girls identify a stressor or demonstrate that the children were in marked distress or significantly impaired.

Similarly a 14-year-old was diagnosed with attention deficit/ hyperactivity disorder (ADHD), although the assessment makes no mention of hyperactivity and describes no hyperactive behavior. The only note in the meager assessment that even remotely suggests such behavior states that the boy "has a history of difficulty in school." The child was referred to

QCNI by the court because of his acting-out behavior. His mother believed he might be "mixed up in drugs." Although no symptoms consistent with the diagnostic criteria were evident in the therapist's assessment of the child, the diagnosis of ADHD was co-signed by the psychiatrist.

These children were not exceptions. Of the nine records of persons seeking admission where a diagnosis had been made, there was insufficient evidence to support the diagnosis (using DSM-IV criteria) in five cases.[6]

Health Screening

For individuals taking some medications, a careful assessment of health status is necessary to ensure that their mental health symptoms are not caused by a physical illness, and to ensure that psychoactive medications are not contraindicated for the individual.

Regulations define health screening as the gathering of data concerning the consumer's past and current medical status. Health screening is a service the outpatient clinic is required to perform. The QCNI assessment form calls for health information which may be supplied by the consumer or obtained with the participation of the consumer. Regulations further state that the assessment of physical health status shall be integrated into the consumer's treatment plan. In some instances, QCNI consumers filled out a form which asked about chronic medical conditions, surgeries, serious injuries and medications. In other case files reviewed, this form was not present; however, in the intake assessment, the consumer's health was noted as "good" or "patient will bring in form" (i.e., a physical exam form supplied by the clinic to be completed by the consumer's medical doctor).

For healthy individuals, a cursory review of their health status usually poses no risk of harm. However, for individuals with significant histories of current acute or chronic conditions and for individuals taking some medications, a careful assessment of health status is necessary to ensure that their mental health symptoms are not caused by a physical illness, and to ensure that psychoactive medications are not contraindicated for the individual, should the psychiatrist wish to prescribe them.

Individuals in the Commission's sample for whom more conscientious attention to medical issues was needed include:

- A 49-year-old man stated upon admission to the clinic that he had many medical problems for which he receives treatment at Booth Hospital. He complained of frequent headaches (which he believes result from a head injury he sustained during a mugging), stomach pains, leg and back pain, and insomnia. Although the assessment states that the clinic should request medical reports from Booth Hospital, there is no material from the hospital in the case record, no copy of a letter requesting the information, and no consent signed by the consumer

[6] In the agency's September 3, 1996 reply to the draft of this report, the author stated: "Failure of the intake worker and/or therapist to record all significant observations is often a problem in the field; however, it does not necessarily follow that this undermines diagnoses or leads to unsuccessful treatment and, therefore, is a faulty conclusion drawn from a weak premise."

The Commission believes the extreme scantiness of "significant observations" in many of the sampled assessments thwarts the ability to provide and monitor treatment.

allowing the hospital to release medical records to the clinic. The intake assessment states that this man's main reason for coming to the clinic "is because he is trying to have his application for disability approved." He remained a patient for 15 months although he had no treatment plan. He received anti-psychotic medication and was most consistently diagnosed as having a generalized anxiety disorder although, at one point in treatment, the psychiatrist entered a "rule-out malingering" diagnosis.

- A young woman taking a prescription appetite suppressant was not asked who was prescribing it. No medical records were requested.
- A recently admitted man advised the therapist during the assessment that he was taking Cardizem (anti-hypertensive medication), Trental (medication for treatment of chronic occlusive arterial disease of the limbs), Prozac (an anti-depressant) and Xanax (an anti-anxiety agent). The therapist did not ask where he was getting the psychoactive medications and there is no evidence in the case file that any medical or psychiatric records were requested. The clinic changed his medication regimen, discontinuing the Xanax and adding Navane (an anti-psychotic medication) and Cogentin (for relief of the side-effects of the Navane).
- An 11-year-old boy at the clinic is receiving 75 mg./day of Pamelor, an antidepressant medication, daily. This drug is not recommended for children, and the adolescent dosage is generally 30-50 mg./day. The QCNI therapist began requesting complete blood work and an electrocardiogram on this child in September 1995. At the time of the Commission's review in April 1996, the testing had not yet been done, but the medication was still being prescribed. When he questioned the therapist at the request of Commission reviewers, the executive director also learned that no blood levels for the medication had been done.[7]

In no *sampled case record was there evidence of assessments having been revised as clinicians learned more information or as consumers developed additional strengths and addressed problems. In some instances, clinicians used assessments from previous admissions (with no revisions) when individuals requested readmission to the clinic several years later.*

Assessment Updates

In *no* sampled case record was there evidence of assessments having been revised as clinicians learned more information or as consumers developed additional strengths and addressed problems. In some instances, clinicians used assessments from previous admissions (with no revisions) when individuals requested readmission to the clinic several years later. In one

[7] In reply, QCNI noted that the regulations require health screening to be provided consistent with the patients' conditions and needs. The agency further added that its screening practices are adequate, for the most part.

The Commission's review revealed that the health screening procedures are inadequate for those patients with more complex health needs and/or who are receiving certain medications—the very people who are most at risk.

sampled case, a 1988 assessment was used to direct treatment planning in 1992 when a person reapplied for admission. In another instance, a two-year-old assessment was used when a person reapplied. One individual in the Commission's sample has been in treatment since 1980 with no revisions in the assessment in her case record.

Treatment Planning

The failure to write treatment plans in over one-third of the case records in the Commission's sample and the failure in all records to write measurable, incremental individualized treatment objectives revealed little attention was paid to the planning and evaluation of treatment with consumers.

Commission staff found serious deficiencies in treatment planning. In fact, no treatment plan was found in eight of the 21 sample records (38%) where consumers had been admitted long enough that a treatment plan was required.

With the completion of initial assessments and the development of a diagnosis, the consumer (to the extent he/she chooses) and the clinician are required to compose a treatment plan with specific treatment goals and objectives and criteria for discharge planning. Regulations require that the treatment plan be completed prior to the fourth visit after admission or within 30 days, whichever occurs first. Treatment plans are to be reviewed and revised as necessary every three months.

Commission staff found serious deficiencies in treatment planning. In fact, no treatment plan was found in eight of the 21 sample records (38%) where consumers had been admitted long enough that a treatment plan was required. In another case, the same treatment plan was used for each of three admissions over three years; the treatment goals for these admissions included "feel less anxious, less depressed, build self-esteem." In the records where treatment plans were present, many contained a hodgepodge of goals and objectives.

Treatment goals are brief statements of a changed condition that the therapist intends to bring about in the consumer. For example, typical appropriate goals found in QCNI records included "reduce anxiety, depressive trends and panic attacks," "feel less angry," and "feel less nervous." Treatment objectives should state behaviors which can be seen or heard, or other behaviors which are manifestations of progress toward a goal. For example, a goal of "reduce anger" could be followed by an objective which states "consumer will talk about anger with her sister" or "consumer will ask her sister why she stays away from home so often." While many people can share a treatment goal, treatment objectives individualize a treatment plan. Applying these general guidelines most liberally, in the Commission's sample of 13 case records containing treatment plans, acceptable goals had been formulated in nine (69%); however, *not one* of the 13 case records contained appropriate objectives. In an extreme case, "medication," "individual psychotherapy," and "psychiatric evaluation" were listed as treatment objectives, rather than as interventions or treatment modalities.

Generally, treatment plans were revised quarterly as required and were signed by the consumer, the clinician and a psychiatrist. In a few instances, the psychiatrist played "catch up," signing two or three updates covering a half-

year or more on the same day for a single consumer. Far more consequential, however, the treatment plan revisions followed the same pattern as the original treatment plan. Objectives were no more specific and progress, or lack thereof, was reported in general terms. The January 1996 treatment plan update for a 50-year-old man admitted during the summer of 1995 is typical:

> **Changes:** *None*
> **Focus in the future:** *Same*
> **Degree to which treatment implemented:** *Treatment plan was implemented*

In addition to the pattern of multiple admissions, the Commission's sample revealed that some consumers have been receiving services for years with little or no documented improvement and yet with no modifications to their treatment plans.

Not surprisingly, with inadequate assessments and poor treatment planning, some individuals moved in and out of treatment fairly frequently; for others, treatment was continuous, but unfocused and with no evidence of success. In these instances, case notes are primarily a barometer of the consumer's mood on the day of the visit. If the consumer is feeling less miserable, progress is reported. If the individual is not doing well, the note lists the current symptoms. Most typically this pattern repeats until the consumer stops coming and is discharged, lapses into alcohol or drug abuse and is referred for detoxification services, or the individual requires hospitalization for mental illness.

Of the ten cases of recently screened individuals in the sample, three had received prior treatment at QCNI. Of the established patients in the Commission's sample, five of 23 consumers had also received prior treatment at QCNI. One child, for example, was admitted for several weeks at age six, for several months at age seven, and for nearly a year at age nine. This child's mother followed the same admission and discharge pattern. In summary, 30 percent of the new admissions and 22 percent of the established consumers had received prior treatment at the clinic.

In addition to the pattern of multiple admissions, the Commission's sample revealed that some consumers have been receiving services for years with little or no documented improvement and yet with no modifications to their treatment plans. Treatment notes following approximately 77 visits over a two-year period showed no improvement for a 43-year-old woman with a generalized anxiety disorder. Most of the notes are very brief and state that the woman feels tense and depressed, and has low self-esteem brought on, in large measure, by abandonment by her husband who also took away her children. There is no indication from the notes that the therapist was providing this woman with any direction or suggestions for improving her self-esteem and lifting her depression. A housing crisis precipitated the woman's discharge when she was forced into a shelter in another borough and met someone described as her new case manager.

The most striking example of extended therapy involves a family of two children and their mother. Each member of the family has been in therapy at the clinic for at least 13 years, with the children entering therapy at age five. Both children are developmentally disabled and were brought to the clinic by their mother, in part, because they did not speak clearly or in full sentences. There is no treatment plan in the record of the young woman who is now 20 years old. The treatment plan of the young man, who is presently 19, was last formulated in 1988 with a note that the goals should be achieved in nine months (*see* box #2). The mother's treatment plan was also last formulated in 1988. Both plans have been reviewed quarterly and are signed by the consumer or parent, the therapist and the psychiatrist.

The list of deficiencies in these three case records is long and there is little to praise. However, the point is not that this mother, suffering from depression and treated with medication, does not or did not require verbal therapy as well. Rather, the fault lies in the failure of the clinic to get her and her children the alternative services they needed.

The Commission recognizes that it is extremely demanding to parent a disabled child and almost unbearably difficult to be the single parent of two developmentally disabled children when one has very limited money and less than an eighth-grade education. This mother clearly needed parenting training and perhaps a support group of other families raising children with disabilities. The children at age five did not need verbal therapy; their delayed speech required remedial speech and language training and their problems relating to other children would have been addressed more directly in a socialization group. As a young child with a limited ability for abstract thinking, talking with a therapist about sharing, for example, is not nearly as effective as being with other children, watching their interactions, experiencing positive reinforcement for sharing and feeling the negative consequences of possessiveness.

Box #2

C.J. entered therapy 14 years ago at age 5. At the time, he could not speak clearly and was subsequently determined to be developmentally disabled. The treatment plan in the current record lists as goals the improvement of C.J.'s attention span and motivating him to do his homework. The record contains 27 updates to this original treatment plan.

The first 16 notes written by his therapist beginning in early 1990 are illegible. Fifteen months and approximately 74 visits later, the therapist was focusing on the 14-year-old's reluctance to take a bath and generally improve his hygiene. Some seven months and 21 visits after that (May 1992), taking a bath was still an issue in therapy. In 1993, 16 months and 55 sessions later, the therapist was still focusing on hygiene and bath issues and promised to keep this focus. Nearly a year and 18 sessions later (September 1994), it is clear that the therapist kept to the plan: bathing and hygiene were still being talked about. Up to 1996, bathing, an issue first broached in 1991 (per current case record) when C.J. was 14, remains a focus of frequent therapy sessions for this 19-year-old.

Combining the socialization group with a parenting class, one might have created a powerful tool for change. Instead, as demonstrated below in excerpts (each quoted in its entirety) from the young girl's record beginning when she was 14, verbal therapy alone continued for years with little apparent progress:

March 1991: *Patient has problem with mother. She doesn't do things for herself at home and her mother has to do everything for her. Patient was (unreadable) and cooperative.*

March 1992: *Patient looking depressed and needy. Spoke softly and depressed. Still unable to take care of her hygiene— a subject of many past discussions.*

March 1993: *Patient friendly and receptive. Attitude toward therapist was positive. Provided with support.*

March 1994: *Session focused on evaluating her to improve her overall functioning. Continues to make consistent progress. (Unreadable) study program has been very beneficial. She seemed more confident and attitude more positive.*

March 1995: *Patient having problem with boyfriend. She seemed depressed. Still defiant and aggressive toward mother. Provided (unreadable). She was receptive.*

March 1996: *Patient still defiant towards mother and this continues to be a source of many conflicts. Discussed ways to minimize these problems.*

Discharge Planning

Discharge planning was seriously flawed with no discharge criteria specified in 43 percent of the relevant cases in the Commission's sample, and the remainder were characterized by non-specific, non-individualized criteria.

The same lack of specificity that characterized the goals and objectives of the treatment plans was also evident in the criteria for discharge, a regulatory component of the treatment plan. In the eight sampled records where there were *no* treatment plans, there were *no* discharge criteria and, in one additional record, this section was simply left blank. In four other records, the discharge criterion was noted as "once patient has reached goals." "When patient is not depressed" and "improved functioning" and "improved social interactions" were also cited as discharge criteria. Notably, and likely related to deficiencies in treatment and discharge planning,

in the Commission sample of 10 records of persons who were no longer receiving services in the clinic, successful completion of therapy was the listed reason for discharge in only one case.

Record Maintenance

Commission staff asked the executive director how senior clinicians were able to evaluate treatment provided by this therapist for utilization review purposes (as required by the regulations) when one could not read the records. He responded that while he knew the therapist's notes were not readable, he could not fire someone for bad handwriting.

Illegible record notes and notes that do not relate to treatment objectives thwart quality assurance efforts.

As noted earlier, regulations require that a legible progress note be written after each therapy session which relates to the goals and objectives of treatment. Because treatment goals and objectives were poorly defined at QCNI, it is not surprising that progress notes in the 22 relevant case records generally did not relate to them. Rather, the notes were short, stating such non-specific information as "talking about anger," and "exploring self-esteem." In other records, the notes were somewhat longer, but repetitive, with the consumer making the same complaints and presenting the same problems session after session. In four records (18%), the notes did provide the reader a sense of what was going on in therapy and showed some evidence that progress was being made or, at least, that the therapist was providing some direction to the therapy.

In contrast, in four other records most notes were entirely or substantially illegible, and the reader could not figure out what was going on during the sessions. For example, in one record, the sequence of notes covering five sessions was not readable; in another record, six months of notes were not readable. In a third record, the case notes of the primary therapist for 15 sessions covering three months were unreadable, a fact conceded by the executive director.

These latter notes were so extremely illegible (resembling simply lines of loops) that Commission reviewers examined three additional case files maintained by this therapist, who has since left the agency. The notes were equally illegible in each. The first file reviewed (of a ten-year-old boy) contained 10 months of illegible notes; the second file, one year of illegible notes; and, the third file, nearly two years of illegible notes. Commission staff asked the executive director how senior clinicians were able to evaluate treatment provided by this therapist for utilization review purposes (as required by the regulations) when one could not read the records. He responded that while he knew the therapist's notes were not readable, he could not fire someone for bad handwriting. Unfortunately, at one point in the last few years, this therapist was working 54.5 hours a week at the clinic, writing notes no one else could read. (Certification information supplied to OMH by the clinic in April 1995.)

Quality Assurance, Training and Clinical Supervision

QCNI has no effective quality assurance system and no program of clinical supervision despite the fact that over one-fourth of the agency's income was used to pay for senior clinicians who logically should have assumed these responsibilities.

The review of the sampled case records, chosen largely at random, revealed sufficient numbers with serious deficiencies to indicate systemic problems in assessment, treatment planning, discharge planning and the maintenance of records. This finding raises basic concerns, in particular cases, about the very need for and efficacy of treatment. Faced with systemic deficiencies in fundamental programmatic operations, one questions how it is that the clinic did not identify and correct these problems and why the OMH certification reviews did not reveal the deficiencies in treatment which were violations of regulations.

The answer to the first question is that QCNI has no effective quality assurance system and no program of clinical supervision despite the fact that over one-fourth of the agency's income was used to pay for senior clinicians who logically should have assumed these responsibilities. The OMH certification process did not uncover the problems because the certification review was not carefully performed and the reviewer did not follow the written protocol.

Agency Internal Quality Assurance

Quality assurance measures at QCNI are woefully inadequate and fail to ensure meaningful compliance with OMH regulations.

According to the executive director, two internal review systems ensure the quality of treatment at the clinic. One is the review of essential treatment documents by a psychiatrist. Initial assessments including diagnosis, treatment plans and periodic revisions, and discharge summaries are all signed by a psychiatrist. The second is a formal utilization review of each consumer's record undertaken periodically.

In response to questions from Commission reviewers, the agency's executive director explained that the agency does not generate any data on consumer demographics, length of treatment, reason for discharge, or any

other variable that might indicate areas of strength or weakness in the program. He further saw no purpose to the collection of such data and noted that "paper does not treat people."

The utilization review procedure, required by regulations, is designed to ensure that qualified clinicians read essential parts of each record to answer the following four questions:

- Does the consumer require continued treatment at this level or at this clinic to improve his/her emotional condition?
- Should the patient be discharged or referred to a different type of program?
- Is there a viable alternative program available?
- Is the current diagnosis appropriate?

At QCNI, a check in either the YES or NO box following each question is all that is required, along with the reviewer's signature and date. According to the executive director, all newly admitted consumers are evaluated on the last Friday of the month. Persons already in treatment are reviewed in alphabetical order, approximately 45 a week. Only the executive director, a psychiatrist or the full-time Ph.D. psychologist perform the reviews.

One can only speculate how the reviewer determined that the consumer needed continued treatment when he/she could not read the record.

Performed as intended in the regulations, the review and sign-off by the psychiatrist and utilization review should be sufficient to guarantee compliance with minimum standards as delineated in the regulations. In practice, however, at QCNI they do not.

A psychiatrist does, in fact, sign assessments which contain a diagnosis, but the assessments are terse and incomplete and in some cases fail to provide sufficient information to support a diagnosis. A psychiatrist does sign treatment plans, but the objectives are not specific, measurable or individualized, and revisions are commonly perfunctory repetitions of the initially deficient plan. Psychiatrists do sign discharge plans, but apparently do not consider whether the therapist's summary of treatment is a sufficient accounting of treatment to determine whether referrals for other services are necessary or treatment has been successful.

Like the signature of the psychiatrist on the essential treatment documents, the checked boxes on the Utilization Review form also do not ensure thoughtful review of the issues in question. For example, the three case records cited above with illegible therapy notes written by the clinician no longer employed by the agency were reviewed by qualified QCNI staff using the Utilization Review questions on ten different occasions. The single record with nearly two years of illegible notes was reviewed six times. One can only speculate how the reviewer determined that the consumer needed continued treatment when he/she could not read the record.

Clinical Supervision and Training

Consistent with the absence of effective quality assurance measures, QCNI provides no effective supervision of clinicians.

According to the executive director, there is no formal process for clinical supervision at QCNI. The part-time social workers at the clinic are not assigned to specific psychiatrists or supervising clinicians. If a social worker or other clinician wants a consultation with a psychiatrist around a particular case, the clinician can request one. In the sampled case records, there were instances where clinicians requested assessments of a consumer's need for medication and other instances where clinicians requested permission from a psychiatrist to begin discharge of a consumer because of his/her failure to come for appointments. Commission reviewers did not see treatment consultation in any of the 30 records reviewed.

After the need was brought to the agency's attention during the 1995 OMH certification review, QCNI has been performing annual performance evaluations on employees. The form devised for this purpose requires only check marks and the occasional short phrase to describe deficiencies in performance. In view of the lack of oversight of the work products of the therapists—case records, disability applications, referrals and requests for information—it is questionable how accurate the evaluations are or how meaningful they are to the staff.

As seen in the Commission's sample, combined with the lack of clinical supervision and peer review, the absence of quality assurance measures result in questionable admission, treatment and discharge practices.

When questioned about on-going staff training, the executive director noted that several years ago at the insistence of OMH, the clinic provided cultural sensitivity training for staff, an issue it already handled quite competently with its multi-cultural employees. This is the only training that has been provided. Recognizing that staff members did not know how to write treatment goals and objectives, the executive director recently distributed professional literature to all staff on the subject.

In summary, focused quality assurance measures undertaken by competent staff with the intention of identifying strengths and correcting deficiencies in treatment are lacking at QCNI. As seen in the Commission's sample, combined with the lack of clinical supervision and peer review, the absence of quality assurance measures result in questionable admission, treatment and discharge practices. Treatment is proposed for persons who may not be mentally ill based on incomplete assessments, and clinicians fail to establish and revise treatment objectives. Discharges frequently occur for reasons other than the attainment of therapeutic goals, and re-entry into therapy at the clinic or markedly extended therapy is common.

It is the failure of the clinic over many years to maintain any effective quality assurance and clinical supervision measures that results in the long list of deficiencies evident from the Commission's review. It is the subver-

sion of the intent of the regulations which require an effective Utilization Review process and the periodic review of treatment plans "for quality and completeness" (14 NYCRR 587.15) which permits the agency to turn a blind eye to its problems.[8]

[8] QCNI noted, in its reply, that clinical supervision of licensed treatment is not required by OMH regulations. This reply misses the point. Regulations require the agency to ensure that individuals receive "clinically appropriate care and treatment that is suited to their needs and skillfully, safely and humanely administered" (14NYCRR 587.7). When clinicians cannot/do not write adequate assessments and competent treatment and discharge plans, professional supervision is essential.

QCNI flatly denied any attempt to subvert regulations.

OMH Certification

The most recent OMH certification review of QCNI occurred in March 1995 and granted 24 months certification through March 1997. It will be evident that some of the results of the Commission's review do not agree with the certification report; had the Commission scored the agency on the certification performance indicators the score for passed items would have been much lower and the score for failed critical items would have been higher. Nonetheless, some major findings are in agreement. Both agencies found problems in treatment and discharge planning and in utilization review. However, the Commission's review of the certification work sheets and the reviewer's handwritten notes reveal that, had the reviewer followed OMH's protocol, the agency would not have been granted certification for 24 months and the certification evaluation itself would have been expanded to include the review of five additional records.

Certification Duration

The certification review focuses on five major categories of agency operations: Life Safety, Recipient Rights, Accessibility and Linkages, Program Operations, and Treatment Outcomes. The Life Safety evaluation involves a review of the environment, review of medication storage procedures, and attention to the functioning of the incident identification and review process. The performance criteria for the other four categories are judged on the review of five consumer records and other agency policies and documents. Each of the major categories is comprised of a number of performance indicators, some of which are identified as critical indicators. Each indicator is scored on a scale of 0-3 with 0 and 1 as failing scores and 2 and 3 as passing scores. (Whenever a criterion is "not applicable", it is scored as a 2). Failure to attain compliance with critical indicators carries additional scoring weight. The length of the certification depends on the agency's final score and can run from less than nine months to 36 months.

The final score is comprised of two numbers: the number of indicators passed and the number of critical indicators failed. Because the OMH certification reviewer neglected to mark a critical life safety indicator as failed, the certification was granted for 24 months instead of 18. The particular indicator referenced the agency's response to the NYS law requiring the report of suspected child abuse. The evaluator noted an instance of failure to report in her notes, but neglected to transfer this information to the work sheet. Consequently, she marked the agency in compliance with this requirement when, in fact, she had evidence that it had not been.

Certification Protocol

The protocol for the certification of an outpatient clinic requires OMH surveyors to review five case records. In fact, a conversation with the OMH certification staff person who conducted the March 1995 review at QCNI indicated that the agency was advised in writing a week in advance of the visit and requested to have ready certain policies and other documents and ten case records. Thus, *the agency* selected the records for review by the OMH certification staff and clearly had the opportunity to ensure near-perfect records.

What is most notable is that the Commission's review, like the certification report, revealed significant problems in the formulation of treatment plans, discharge planning and utilization review.

As shown in Figure 1, the review of the five case records focuses on the assessment of 16 features of treatment, covering assessments, treatment planning, discharge planning, and utilization review. Each indicator is scored for each record using 0-1 for a failing grade; 2-3 for a passing grade. According to the instructions to the evaluator on the work sheets, when two or more records out of the five fail a given performance indicator, the reviewer must review five additional records focusing on the deficient performance indicators.

Review of the data in Figure 1 reveals that all five records failed the indicators dealing with treatment plan goals and objectives (3.21), treatment plan revisions (3.22), recipient input into treatment planning (3.31), and evidence of discharge planning throughout treatment (3.41). In addition, three records each failed utilization review indicators (4.32 and 4.34). *Despite two or more case records failing six indicators, the evaluator reviewed no additional records.* This error was not caught when the certification work was reviewed by OMH supervisors.

While the Commission finds evidence that some scores are too lenient (e.g., passing marks for "progress notes related to treatment goals and objectives" when treatment plans did not establish goals and objectives and evidence of discrepancies between scores on the five records with very similar deficiency comments), what is most notable is that the Commission's review, like the certification report, revealed significant problems in the formulation of treatment plans, discharge planning and utilization review. It is unclear what the present certification status of QCNI would be had the OMH evaluator followed

Figure 1
OMH Certification Worksheet
March 1995

	Performance Indicator	Record Number 1	2	3	4	5
1.12	Doctor's medication orders are available	2	2	2	2	2
1.13	Recipients receive medication education	2	2	2	2	2
2.1	Written consents are present for release of information and special treatments	2	2	2	2	2
3.11	Assessments completed with recommendations for treatment	2	2	2	2	2
3.12	Assessments are updated to reflect current functioning levels based on response to treatment and other factors	1	2	2	2	2
3.21	Treatment plans identify goals and objectives	1	1	1	1	1
3.22	Treatment plans are revised based on current assessments and response to treatment	1	1	1	1	1
3.23	Progress notes are timely and related to goals and objectives	2	2	2	2	2
3.24	Services are provided per the treatment plan	2	2	2	2	2
3.31	Recipient has input into treatment plan	0	1	1	1	1
3.32	Families have input into treatment planning	2	2	2	2	2
3.41	Discharge planning is evident throughout treatment planning	0	1	0	1	1
4.31	Utilization Review (UR) was completed within time frames	2	0	2	2	2
4.32	UR completed prior to 40 visits	0	0	0	2	2
4.33	UR on treatment record completed by credentialed individual	2	2	2	2	2
4.34	UR process was individualized and comprehensive	0	1	1	2	2

0-1 failing score
2-3 passing score

the protocol and had the additional records showed the same systemic deficiencies.

Following the certification review, OMH identified eight areas for remediation and asked the clinic for a plan of correction. The citations and the QCNI response are reproduced in their entirety in Figure 2. In addressing implementation of the corrective actions, Commission reviewers were told that the cultural sensitivity training was completed. The executive director said the deficiencies in treatment planning were addressed by distribution of an article from a professional journal on writing treatment goals and objectives. It is unclear what measures, if any, were taken to address deficiencies in discharge planning, as Commission staff saw no improvement in the documentation of discharges in those records which contained multiple discharge summaries. While the utilization review for over 40 visits is addressed by the psychiatrist's count, the woefully inadequate utilization review for the suitability of consumer and treatment, defended by the agency in its plan of correction, remains unaddressed and unchallenged by OMH. As this is one of only two quality assurance mechanisms in place at the clinic, it deserves immediate attention.

In summary, the certification review conducted in March 1995, although flawed, identified substantial problems in treatment planning, discharge planning and utilization review. The plan of correction accepted by OMH inadequately addressed the deficiencies in its failure to identify completion dates for some items and in the absence of *any* corrective action to ensure that the unspecified training and reminders to staff had been effective in correcting the problem. Thus, predictably, the deficiencies remained uncorrected a year later at the time of the Commission's review.

Figure 2

Citations	Corrective Action Plan/ Anticipated Completion Date
The program does not review or document in the record individuals' needs for continued services over 40 visits per benefit year.	Staff psychiatrists will now note in the treatment record the need for continued service over 40 visits per benefit year.
The Utilization Review process is not individualized or comprehensive.	The format we use was recommended to us years ago and is used elsewhere. Where necessary, staff discussion is a part of the process.
The program does not provide staff with work performance evaluations that assure that staff are providing quality treatment and that the outcomes of the program are being met. The evaluation process currently in use does not verify that it was developed with staff's input and mutually agreed upon.	This area will be revamped completely to place us in accord with current procedures. Completion date by 6/15/95.
The program does not arrange for staff training to increase staff's cultural competence.	We have contracted for on-going staff training in this area. The first session was 4/26/95.
Treatment plans do not clearly state intended outcome(s) of the proposed treatment including obtainable goals and objectives based on assessment recommendations.	This area will be reviewed with staff and corrective action taken (training).
The treatment plan review process does not address the patient's progress or lack of progress.	Material has been distributed to help staff to more clearly define those areas.
Program recipients are not consistently offered opportunities to provide input into the development and revision of their treatment plans.	Program recipients will now sign off directly on the treatment plan and updates as these areas are developed.
Discharge planning based on established discharge criteria is not addressed throughout the recipient's length of stay.	Staff will be advised of this deficiency. Discharge planning is routinely addressed during treatment, albeit not always recorded.

Financial Findings

The state's regulatory and reimbursement framework for community-based OMH outpatient programs relies heavily for its integrity on not-for-profit agencies and a premise of provider self-regulation, based upon: the Commissioner's initial judgement of the character and competence of the operators; management of the property and affairs of the corporation by its board of directors; independent financial reviews by certified public accountants who are legally and ethically bound to be honest and accurate; and, ultimately, by law, particularly the New York Not-For-Profit Corporation Law [hereinafter N-PCL].

Monitored by boards of directors, voluntary agencies are expected to apply any incidental profits to maintain, expand or operate the agency consistent with its lawful purpose and not distribute "in any manner whatsoever" surpluses to its directors or officers.

When the state licenses not-for-profit agencies to operate psychiatric clinics, the expectation is that, by removing the pecuniary interest of operators, agencies will be better able to concentrate on public or client interests and profit-making abuses will be minimized. Monitored by boards of directors, voluntary agencies are expected to apply any incidental profits to maintain, expand or operate the agency consistent with its lawful purpose and not distribute "in any manner whatsoever" surpluses to its directors or officers.[9] In short, agency officials must at all times put the interests of the not-for-profit corporation ahead of any conflicting or inconsistent self-interest. In discharging their duties, board members whose major responsibility is to set agency policy and manage the agency may rely on information, opinions, reports or statements—including financial statements or other financial data—from persons competent in the matters presented, including officers, employees, counsel, board committees and public accountants.[10]

Building on this foundation of self-regulation, the principal means for evaluating the fiscal well-being and integrity of voluntary agencies is to have an annual audit of the agency conducted by an independent CPA. Through financial statements and management letters, the independent auditor expresses opinions on agency financial statements and makes recommendations to improve its financial management. It is the board's responsibility to ensure that an audit is conducted and that any recommendations are addressed.

[9] N-PCL, §508.

[10] N-PCL, §717(b).

In addition to these audits, voluntary agencies may also be subjected to audits by state and federal agencies that are responsible for their funding. In the case of QCNI, where 87 percent of its almost $1.2 million annual revenue came from Medicaid, it is the responsibility of DSS to assure that reimbursement for services is appropriate and supported by adequate documentation. However, in this bifurcated system, where OMH licenses and inspects the clinic and DSS audits claims for services, state audits of *spending* practices are not routinely conducted because, under a fixed fee-for-service reimbursement system, agencies are granted wide latitude in determining how best to expend resources in order to encourage efficiency.

At QCNI, the Commission found that the checks one would normally expect to find to ensure that funds were spent properly failed because: the board of directors was not vigilant in its oversight of the agency; the accountant was not independent and indeed aided in the inappropriate dissipation of agency assets; and, the state's inspection and audit surveys that should have suggested the need for a broader review of Medicaid services and program expenditures did not.

Improper Medicaid Billings

Approximately $600,000 or 19 percent of the $3.2 million claimed for psychiatric services to Medicaid recipients from 1992 to 1994 by QCNI did not adhere to federal and state legal requirements concerning acceptable record keeping. (Figure 3.)

QCNI operates a single psychiatric outpatient clinic for adults and children. From, January 1, 1992 through December 31, 1994, the agency provided 62,076 Medicaid visits and was reimbursed $3,175,621. Most of the services claimed were for face-to-face verbal therapy between a patient and a therapist generally lasting 35 minutes which were billed over the three-year period at a fee of about $53 per visit.

The Commission examined the agency's billing practices to determine agency compliance with federal and state regulations related to the medical assistance program. In order to receive Medicaid reimbursement, DSS regulations (18 NYCRR 517.3; 540.7) require fee-for-service providers, such as QCNI, to maintain records in accordance with certain criteria (e.g., disclosing the nature and extent of services furnished, recording the medical necessity for services, and ensuring that the records are complete and legible.) Additionally, OMH regulation (14 NYCRR 587.15) specifically states that there shall be a complete case record maintained for each patient admitted to an outpatient program and such records shall be maintained in accordance with recognized and acceptable principles of record keeping.

The Commission reviewed a statistically valid sample of 382 Medicaid-reimbursed claims submitted by QCNI for the period January 1, 1992 through December 31, 1994. The sample, which represented a 95 percent

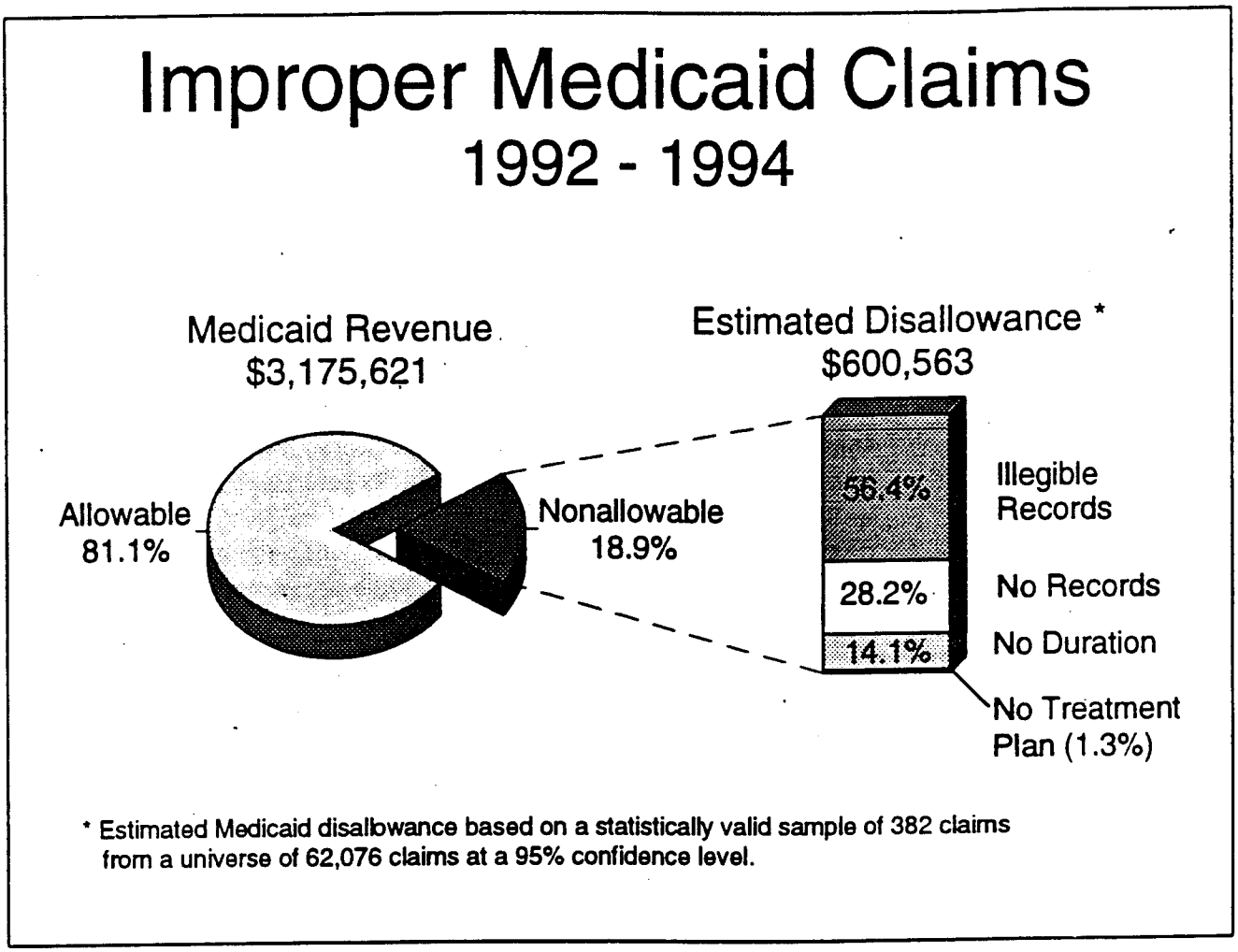


Figure 3

confidence level, was reviewed to determine whether QCNI complied with the various rules and regulations for reimbursement. The Commission found 78 instances where clinic records did not meet applicable state standards and thus were ineligible for reimbursement. Many of these deficiencies also were found during the Commission's program review and are illustrated earlier in the report. This error rate translates into a potential disallowance of $600,563 when projected to QCNI's total universe of claims during the three-year period reviewed,[11] as follows:

[11] On July 15, 1994, DSS issued a final audit report covering the review of claims paid by Medicaid from January 1, 1988 through December 31, 1989. This audit which found $50,337 in improper claims was "settled" at the "low value" of the confidence interval for $30,912. DSS denied claims because the agency failed to adhere to record keeping requirements but, unlike the Commission's audit, did not cover claims involving illegible records. DSS' final audit report did, however, hold in abeyance a decision on audit adjustments related to QCNI's "scheduling and conducting sessions one-half hour apart" which DSS said raised concerns that service requirements were "not being met." Later, QCNI modified its scheduling of visits to every 45 minutes. No subsequent actions were taken by DSS or OMH regarding the appropriateness of the services at this clinic.

- OMH regulation (14 NYCRR 587.15(a)(2)), requires that case records be maintained in accordance with recognized and acceptable principles of record keeping including being "complete and legible."[12] In its sample, there were 44 instances where records were *so poorly written* the extent of services provided could not be determined (see Figure 4). Although QCNI officials stated that they were aware of the problem for several years, there was no indication that this issue was being addressed. QCNI officials did attempt to substantiate the services by forwarding hand written or typed versions of 49 records questioned by the Commission, but in 44 instances it could not reasonably be determined that the transcriptions were accurate.
- 22 instances were found where QCNI billed for either a brief or regular visit, but there were *no progress notes in the medical charts* to support specific claim dates. OMH regulation (14 NYCRR 587.15(b)(8)) clearly states that in order to receive reimbursement a visit must be fully documented.
- 11 instances were found where *no duration of visit was recorded* in the case record. OMH regulation (14 NYCRR 587.15(b)(7)) states that case records shall include the type of service provided and the duration of the contact. In instances where it appeared that a therapy session did take place but no time was recorded, the Commission allowed the lower reimbursement for a brief visit of $26.50 instead of the $53.00 regular visit fee.
- One instance was found where a client's case record *lacked periodic treatment plan reviews* for the past five years. OMH regulation (14 NYCRR 587.13(g)(1)(ii)) requires that review of a client's treatment plan should occur every three months.[13]

[12] 18 NYCRR 540.7(a)(10). *See, supra*, Discussion p.3, footnote 3.

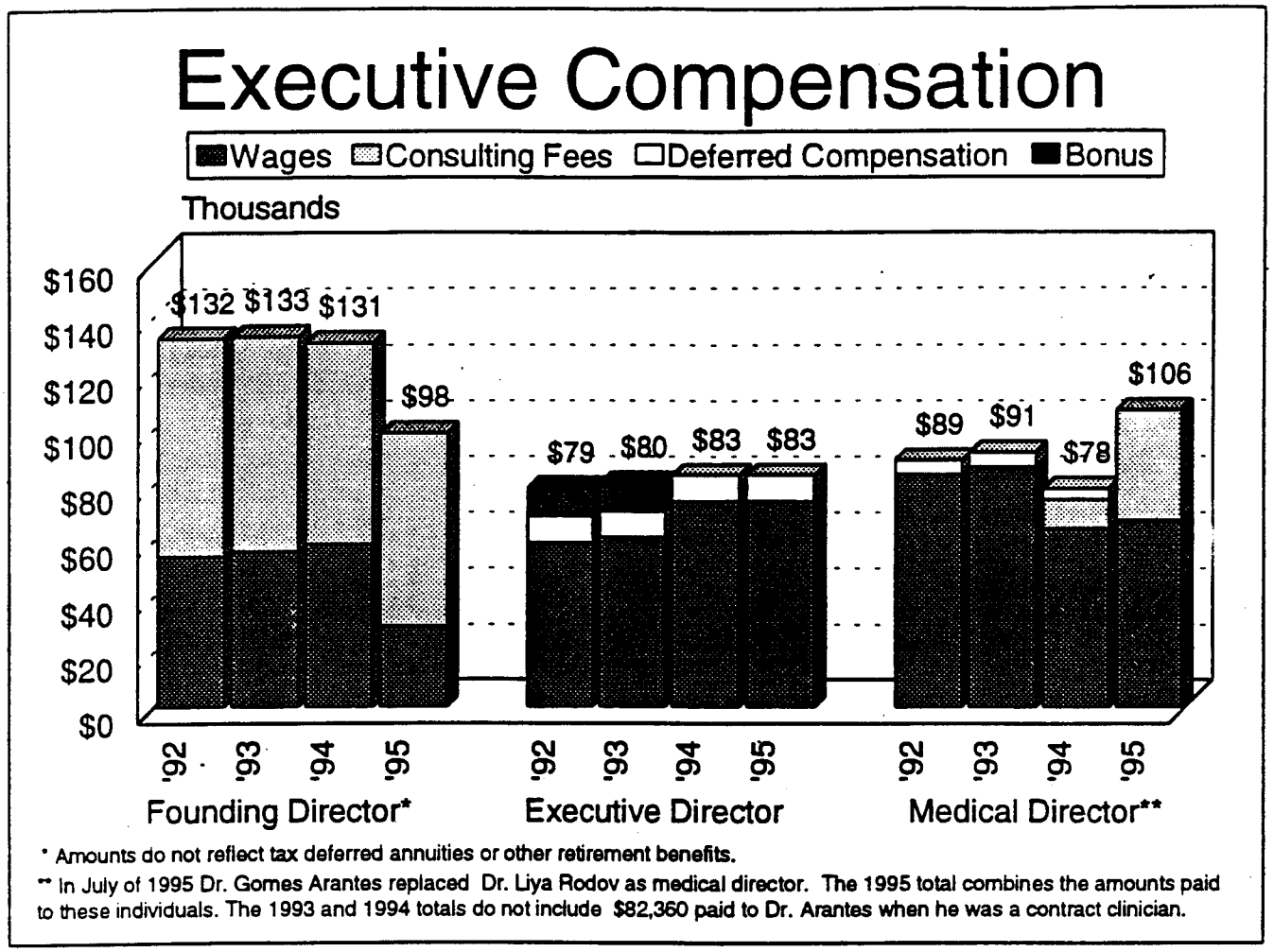
[13] In its response letter, while providing no factual basis to refute the Commission's findings, QCNI makes statements that it fears the consequences of the Commission's interpretation of another agency's regulations. While admitting it has not yet achieved perfect billing practices, QCNI says it strongly objects to and does not accept the Commission's findings.

QUEEN_ COUNTY NEUROPSYCHIATRIC INSTITUTE INC.

CASE No. 11540 PATIENT'S NAME

DATE MO.	DAY	YR.	SUBSEQUENT VISITS AND FINDINGS
MAR	4	1997	P.A.C. She called to cancel. [illegible] MSW.
MAR 1[illegible]		1992	Patient seen for 25 minutes. [illegible] (9) [illegible] MSW
MAR 18		1992	Patient seen for 30 minutes. [illegible] (10) [illegible] MSW
MAR 2[illegible]		1992	Patient seen for 35 minutes. [illegible] [illegible] MSW
APR 0[illegible]		1992	P.A.C. Date she called to cancel. [illegible] MSW

Figure 4



* Amounts do not reflect tax deferred annuities or other retirement benefits.

** In July of 1995 Dr. Gomes Arantes replaced Dr. Liya Rodov as medical director. The 1995 total combines the amounts paid to these individuals. The 1993 and 1994 totals do not include $82,360 paid to Dr. Arantes when he was a contract clinician.

Figure 5

Executive Compensation

The QCNI board of directors did not exercise its fiduciary obligation to protect the assets of the agency when excessive compensation, and large, unjustified and apparently unauthorized payments were made to the corporation's founding principal. Compensation levels of other senior executives, while not excessive per se, *require closer scrutiny (as to their reasonableness) in view of the Commission's findings that the executive director did not have the requisite authority to perform his job and because of the questionableness of the actual hours worked by the medical director given all of his other employment obligations. (Figure 5.)*

The N-PCL requires board members to discharge their duties in good faith and to use ordinary diligence, care and skill in managing corporate affairs.[14] One of the duties of the board is to elect or appoint officers, employees and other agents of the corporation, define their duties, and establish *reasonable* compensation of executives. While there is no absolute measure of inurement, reasonable compensation is generally assessed on factors such as: the nature of the employee's duties, the arm's-length relationship

[14] N-PCL, §717(a).

between the employee and employer, the salary of others in comparable positions, and the relationship of the compensation to the income of the agency. Reasonableness is determined after an individual's total compensation has been obtained. This would include: salary or wages, contributions to pension plans, deferred compensation, payment of personal expenses, and personal use of an organization's property.[15]

At QCNI, it appears the QCNI board of directors failed to ensure that the compensation of the agency's founding principal, Dr. Lehine, was reasonable or commensurate with the services performed for the agency. It does not appear that any arm's length negotiation was entered into between the board and Dr. Lehine and other senior executives or that employment contracts were entered into defining their duties and compensation arrangements. Further, it appears that the board was unaware of certain transactions that benefitted Dr. Lehine and others, thus impairing the board's ability to set reasonable compensation levels and raising questions about the vigilance of its oversight of this not-for-profit corporation or, conversely, whether agency "insiders" along with the CPA acted together to withhold financial information from the board.

From 1992 to 1995, almost 27 percent of QCNI's income was paid to its senior executives (founding principal, executive director, and medical director), not including annuity and retirement benefits paid to or due the founding principal which are of questionable propriety and were not adequately identified on the books of the agency. These other benefits significantly depleted the equity position and have weakened the fiscal viability of this corporation. (Figure 6.)

Founding Principal

(a) Excessive Compensation

The compensation paid to QCNI's founder for part-time employment was over 70 percent higher than the salary received by the highest-paid executives in similar-size mental hygiene agencies in New York City.

QCNI was founded in 1962 by Dr. David Lehine who has held various positions at the agency, including: executive director, medical director, "consultant psychiatrist," and vice-president of the board.[16] From 1992 through 1995, Dr. Lehine received $493,922 in salary and consulting fees as a part-time consultant psychiatrist. These monies were paid to him both as an employee and as an independent contractor to the agency even though the U.S. Internal Revenue Service (IRS) requires (Reg. §31.3401 (c)-1(f)) that corporate officers be

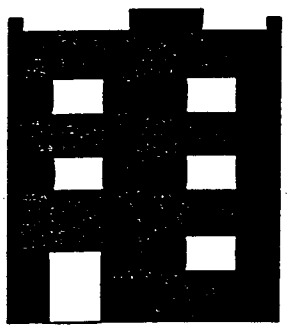
[15] *Tax-Exempt Organizations, Information on Selected Types of Organizations*, United States General Accounting Office, February 1995.

[16] According to the May 1996 board minutes, Dr. Lehine assumed the role of vice-president of the QCNI board of directors and agreed to begin to gradually phase out his patient caseload.

Executive Compensation

1992-1995 Revenue

$4.7 Mil



$1.3 Mil

1992-1995 Salaries, Consulting Fees and Bonuses

Dr. Lehine
$494,000
Joseph Melman
$325,000
Dr. Rodov
$274,000
Dr. Arantes
$172,000

Other Benefits Received or Due Dr. Lehine

$1.1 Mil

Annuities $490,000
(Purchased 1982-1994)

Retirement $600,000
($5,000/mo. Beginning 10/95)

Rent Free Apartment

Figure 6

treated as employees.[17] In addition, Dr. Lehine had a "rent free" apartment located on the third floor of the clinic building and, as noted below, received hundreds of thousands of dollars in unauthorized "tax deferred" annuities, and is due to receive substantial additional sums through a "retirement benefit."

According to the agency board minutes, Dr. Lehine assumed the role of consultant psychiatrist in April 1991. The board minutes note that he was responsible for the financial management of the clinic, supervising weekly staff meetings, liaison with the board, hiring and firing of staff, as well as seeing "his usual patients; about 10 a day." Thus, he had a controlling role in running the agency and was its *de facto* chief executive.[18]

A State Comptroller survey of the executive compensation of the highest paid officials of agencies licensed by offices of the Department of Mental Hygiene for the 1992-93 fiscal period found the median salary of executives running agencies with annual revenue ranging from $1 to $5 million in New York City was $74,729 (QCNI's revenue in 1992 and 1993 averaged about $1.2 million).[19] Dr. Lehine's salary and fees for his part-time employment and consultant services at the clinic during this time was over $130,000, not including the value of his rent-free apartment.[20, 21] Despite this compensation, he did not have a contract with the agency and was not required to submit documentation to support his consulting services other than for the services provided to recipients. Consequently, given the level of control by Dr. Lehine in fulfilling his duties and determining his own salary, the lack of board approval of the consultant arrangement, and the salaries of the highest paid officials in

[17] The IRS requires (Reg. §31.3401 (d)-1(h)) employers that pay taxable wages to workers who are employees to deduct and withhold certain payroll taxes and to pay the withheld amounts to the federal government. Paying individuals as independent contractors allows employees to avoid paying payroll taxes, (e.g., social security and Medicare taxes). Independent contractors can also deduct "business expenses" in amounts above what would be allowed for ordinary employees.

[18] At November 16, 1995 meeting with Commission staff, QCNI's CPA told Commission staff that Dr. Lehine controlled both the agency and its board and that "everyone" looked to him for guidance and direction.

[19] *Department of Mental Hygiene, Study of Executive Compensation in Not-For-Profit Corporations*, State of New York, Office of the State Comptroller, Division of Management Audit, Report 93-D-29, February 7, 1994.

[20] During the course of the Commission's visits, information gathering and site visits were frequently delayed because of Dr. Lehine's central role but conflicting part-time status. From "appointment books," Commission staff were able to estimate that in 1994 and 1995, Dr. Lehine worked 60 to 70 percent time at the clinic.

[21] A charitable organization was denied recognition as a tax exempt entity because it provided a rent-free residence for the founder and his family and generally operated for the founder's personal benefit. (Athenagoras I Christian Union of the World, Inc., 55 TCM 781, Dec. 44,752(M), TC Memo 1988-196)

similar-size organizations in New York City, it appears Dr Lehine's compensation was excessive.[22, 23]

(b) Unauthorized Conversion of Agency Annuities

Approximately $490,000 of annuities were misappropriated by the agency's founder, who acted with the agency's "independent" accountant to conceal the transactions and mislead the board.

During the Commission's investigation, a series of unusual end-year accounting entries were found recorded in the agency's books which concealed large cash withdrawals from the not-for-profit corporation. While the entries clearly related to Dr. Lehine, the purpose of these payments and the period to which they related were not immediately apparent. When neither the agency's executive director nor independent accountant provided an adequate explanation or produced documentation to clarify these transactions, the Commission conducted its own independent review.

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22 The consultant arrangement with Dr. Lehine appears to violate §31.31(c)(1) and (2) of the NY Mental Hygiene Law (eff. Sept. 22, 1992) which requires that the material facts of any contract or other business transactions between an employee receiving a salary in excess of $30,000 be disclosed to and voted on by the board of directors of the licensed mental hygiene agency. Such transactions are voidable if subsequently determined not to be fair and reasonable. This legislation was enacted in the wake of the Commission's 1989 report on the New York Psychotherapy and Counseling Center (see, footnote 1) where less-than-arm's length business transactions were found to be a means by which not-for-profit corporation assets were misdirected to senior executives and their children.

23 QCNI's response states that the Commission has chosen to cite the agency's founder as its *de facto* chief executive to make a case for excessive compensation while ignoring the fact that he also actively functioned as a treating psychiatrist in the clinic. It argues that the Commission has unfairly compared the financial compensation of chief executives at other agencies with Dr. Lehine's compensation when in reality 75 percent of his compensation resulted from agency receipts of Medicaid reimbursement for his direct care services. Therefore, by excluding his direct care activities, QCNI says the Commission erroneously concluded that his compensation was excessive. It notes that in all his years at the agency, Dr. Lehine had never functioned only as an administrator and that psychiatrists employed by the state receive the same compensation plus 30 percent fringe benefits for working similar hours.

QCNI's assertions in this regard are misleading and incorrect. The Commission's report does note that Dr. Lehine in addition to his role in running the agency was expected to see about ten patients per day. The problem concerning Dr. Lehine's excessive compensation is not how Dr. Lehine spent his time but whether he received excess benefits for his services because of his insider status. The Commission knows that during the course of its investigation that Dr. Lehine spent substantial amounts of time at his Florida residence and his work schedules confirmed his part-time status at the clinic. Thus, as noted above, his salary for part-time work was substantially higher than the heads of comparable sized clinics in New York City and OMH's highest paid psychiatrists who received $98,000 in 1995 for a 40-hour regular work week. The argument that Dr. Lehine's salary should recognize the Medicaid income he produces is contrary to IRS conditions for 501(c)(3) agencies to maintain their tax exempt status; i.e., no part of the net earnings of a not-for-profit corporation may inure to the benefit of any insider.

After subpoenaing records from insurance companies and upon closer inspection, the Commission determined that the "adjusting entries" which had minimal or no written support were related to "tax deferred" annuities purchased by QCNI. The Commission's investigation found that from 1982 to 1994, QCNI purchased approximately $300,000 in tax deferred annuities which are a type of life insurance contract where a single premium is paid up front and interest accumulates on a tax deferred basis until the contract is settled.

While the annuities were initially recorded as assets of QCNI, these funds ($300,000) and investment earnings of approximately $190,000 were eventually distributed to Dr. Lehine. Not only was there no evidence of board approval for the purchase or subsequent distribution of these annuities, but also it appears that Dr. Lehine, with substantial assistance from the agency's "independent" accountant, intentionally misled the agency's board of directors as to the true nature of these funds.[24]

In board minutes dated February 16, 1994, Dr. Lehine described the annuities as "reserve funds" belonging to QCNI. Despite this statement to the agency's board, amounts in this account were being "written-off" by QCNI's accountant through year-end accounting entries designed to conceal the diversion of corporate resources to Dr. Lehine. Thus, instead of safeguarding the agency's interest, the CPA and Dr. Lehine acted to mislead the board and perhaps federal and state tax authorities as well.[25] A footnote in the 1995 financial statements did state that the investments were incorrectly included as assets of QCNI in prior periods and title was vested in the name of Dr. Lehine. However, without the approval of the agency's board of directors, the conversion of these corporate funds for Dr. Lehine's benefit represents a misappropriation of corporate assets.[26,27]

(c) Retirement Benefit

Dr. Lehine's $600,000 guaranteed retirement benefit when combined with the $490,000 of unauthorized annuities unjustly enriches him at the corporation's expense.

During its review of the minutes of the board of directors, the Commission became aware of another significant transaction benefiting Dr. Lehine. On

[24] *See*, footnote 22.

[25] If the annuity contracts are purchased through an IRS qualified retirement plan, income taxes may also be deferred on the purchase price. QCNI, however, did not maintain any such plan and an issue arises whether income taxes were paid by Dr. Lehine on the premiums and interest income related to these policies.

[26] *See*, footnote 22.

[27] QCNI's response indicates the board was unaware of actions taken by Dr. Lehine in the purchase and redemption of annuities. This reinforces the Commission's finding that the board failed in its fiduciary relationship to the agency. Moreover, there is no indication from the response of any intention to recoup the moneys that were misappropriated by the founding principal.

August 26, 1992, the board approved a resolution granting Dr. Lehine "retirement benefits" of $60,000 per year ($5,000 per month) to be paid for the rest of his life.[28] If the then 80-year old Dr. Lehine should die before receiving a minimum retirement benefit of $600,000 over a ten-year period, QCNI agreed to continue the payments to Dr. Lehine's survivor (i.e., his wife or son) for the remainder of the period. Dr. Lehine began receiving the monthly benefit in October 1995 upon the announcement of his retirement.[29]

The combined disposition of $1.1 million in annuities and retirement benefits for a single individual appears to be unjust enrichment at the corporation's expense, especially when weighed against the recent financial performance of the agency (in 1994 and 1995 the agency incurred deficits of $79,827 and $52,358, respectively). Moreover, the agency's reported fund balance of $513,945 as of December 31, 1995 was significantly overstated because the financial statements failed to accrue a liability for the retirement benefit obligation. The Commission estimates that the December 31, 1995 fund balance should have been $90,821 ($423,124 lower than the reported fund balance) in order to properly reflect the present value of the retirement commitment.[30,31]

Executive Director

While the compensation of the agency's executive director was not significantly out of line with heads of similar size mental hygiene agencies in New York City, he did not function in this capacity and received income which was not properly reported.

According to an OMH training manual, an executive director of an agency is responsible and accountable for the overall, daily operation of the agency.[32] Included among the broad administrative leadership duties of the executive director are the implementation of the policies of the board,

28 Although the resolution states that it incorporates prior resolutions and *limitations* made in two agreements dated September 1, 1979 and August 14, 1985, agency officials (i.e., Messrs. Lehine, Melman and board secretary) were unable to find the two prior agreements. Therefore, the Commission cannot determine what limitations the board may have placed on Dr. Lehine or whether these limitations are reflected in the current agreement.

29 In addition to the payments to Dr. Lehine, QCNI also made annual payments to two former employees although there was no board approval. The payments were improperly recorded on the agency's books as "consultant costs" because *no services were performed for the compensation received.* From 1992 to 1995, total payments of $51,700 were made to Nina Lopez Bow and Faye Caldwell who has served as the board secretary since at least 1990. Upon inquiry, QCNI's independent accountant, Marshall Lipner, said the compensation was actually pension payments authorized by Dr. Lehine for their past service to the agency.

30 The present value of the remaining 117 monthly payments of $5,000 expected to be paid to Dr. Lehine or his family calculated using a 7 percent discount rate.

31 QCNI's response letter states that on August 14, 1996, its board of directors "rescinded" Dr. Lehine's retirement benefit. However, the board minutes for this date indicate only that a motion was approved to "temporarily suspend" Dr. Lehine's monthly check of $5,000 and place it into a separate account.

32 *Board of Directors Training Manual, Not-For-Profit Corporations*, NYS Office of Mental Health, April 1993.

establishment of sound fiscal practices, preparation of annual budgets, ensuring compliance with the requirements of regulatory agencies and hiring and dismissal of staff.

However, QCNI's executive director, Joseph Melman, did not act in this capacity since, as previously stated, the agency's fiscal and human resource management responsibilities, as well as board liaison duties, were delegated to Dr. Lehine. Mr. Melman's main duties seemed to be split between those of a psychotherapist and office manager.[33]

The Commission's investigation found that, despite his appointment as executive director in 1986, and until Dr. Lehine's retirement in October 1995,[34] Mr. Melman had no access to vital agency financial records, did not have check-writing authority to pay agency expenses, was unaware of how much Dr. Lehine was being compensated, and failed to carry out the directives of the board as they relate to various financial duties. For example, even though the board decided to make Mr. Melman responsible for dispensing Dr. Lehine's monthly pension check, the Commission's investigation found that this wasn't occurring. In fact, when asked how much Dr. Lehine's monthly retirement benefit was, Mr. Melman said he didn't know. On several occasions, when the Commission made requests for routine financial information concerning the clinic, Mr. Melman had to get prior approval for their release from Dr. Lehine, although Dr. Lehine was in Florida at the time. In another instance, when the Commission sought access to agency financial records, Mr. Melman said he could not retrieve them because they were locked in Dr. Lehine's third floor apartment at the clinic. Mr. Melman said that Dr. Lehine would not give him a key to the apartment where the records were stored.

From 1992 to 1995, Mr. Melman was compensated $325,057 through salary, "deferred compensation" and "bonus" payments. During this four-year period, in addition to the $267,437 paid in salary, QCNI made payments on behalf of Mr. Melman to an individual investment account totaling $37,620. Mr. Melman told Commission fiscal investigators that the payments were made as part of a qualified pension plan and, thus, were deferred for income tax purposes. However, upon further inquiry, the Commission learned that QCNI

[33] Similar to its response on Dr. Lehine's salary, QCNI contends that the Commission's discussion of Mr. Melman's compensation should be dropped because he too provides direct treatment services to clinic patients. Moreover, criticizing his role as executive director is unfair since he functioned in this position as directed by Dr. Lehine.

[34] Board minutes indicate that Dr. Lehine retired on October 1, 1995, when he began collecting his retirement benefit, but it wasn't until May 1996, as the Commission was completing its investigation, that Dr. Lehine reportedly began to relinquish his control over agency administrative affairs. May 1996 board minutes indicate that, with Dr. Lehine' appointment to the board, Mr. Melman would "issue all checks in the future, Dr. Lehine would be unable to write any checks on the Institute accounts and this would include his own pension check." To keep a "tighter reign" on agency finances quarterly financial reports would be due from Mr. Melman, and two signatures (Mr. Melman's and one board member) would be required for any withdrawal from reserve funds. But the minutes indicated the board still seems willing to allow Dr. Lehine to continue to exercise influence over critical agency issues, as when it accepted his suggestion to retain the agency's CPA who acted with Dr. Lehine to keep certain financial transactions secret from the board.

did not have a qualified pension plan and the payments, which were being improperly classified by QCNI's accountant, should have been recorded on W-2 wage statements as income to Mr. Melman during the years paid.[35] Also, in 1992 and 1993, although no justification was recorded in the board minutes, Mr. Melman received two $10,000 bonus payments. QCNI did not issue IRS Form W-2s for either the deferred payments or the bonuses, which is the appropriate method of reporting such income.[36]

Medical Director

The medical director received compensation of $249,000 in 1994 and $229,000 in 1995 from QCNI and public sources for work weeks averaging 83 hours. There were many instances where reported work hours overlapped or there was no time to commute between jobs, suggesting that he could not possibly have worked all the hours he was paid.

QCNI's medical director is Dr. Gomes Arantes. Dr. Arantes initially began working at the clinic on a part-time basis in 1993 and, due to the ill-health of the clinic's previous medical director and her subsequent resignation, became the clinic's full-time medical director in July 1995. Similar to other professionals at the agency, during the two-year period from 1994 through 1995, Dr. Arantes was paid as both an employee of the agency and as an outside consultant.[37] During these respective years, Dr. Arantes received $77,440 and $89,410 in compensation.

QCNI, however, was not Dr. Arantes' only employment. During 1994 and 1995, he worked full-time at the Bronx Children's Psychiatric Center (BCPC) and, also in 1994, he worked part-time at Montefiore Medical Center's health services program at the Rikers Island correctional facility. Further, while employed at BCPC, Dr. Arantes received "extra-service" compensation for time spent in addition to his full-time work.[38] Dr. Arantes' total compensation from his state job in 1994 and 1995 was $138,539 and $139,574, respectively; his compensation for work at the Rikers Island in 1994 was $32,664. Dr. Arantes' compensation from these separate employments is summarized on Figure 7.

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35 In its response, QCNI asserts that it made contributions directly into a qualified retirement account. However, QCNI has been unable to produce the proper IRS documentation, e.g., IRS determination letter, to support its contention.

36 QCNI's response states that Mr. Melman is "under the impression" that taxes had been paid on the bonus money he received in 1992 and 1993.

37 *See, supra*, Discussion at p. 32, footnote 17 and at p. 33, footnote 22.

38 The OMH Physicians' Extra Service Program is the primary means of providing medical and psychiatric coverage to inpatients at OMH psychiatric centers on evening, night, weekend and holiday shifts. The program utilizes existing full-time OMH physicians beyond their normal 40-hour work week for extra service. According to records from the Bronx Children's Psychiatric Center, Dr. Arantes opted to work an additional 76 hours in each four-week payroll period under the Extra Service Program. Under this program, payments of regular wages are paid by OMH and extra-service wages are paid by the Research Foundation for Mental Hygiene, Inc., pursuant to a contract with OMH.

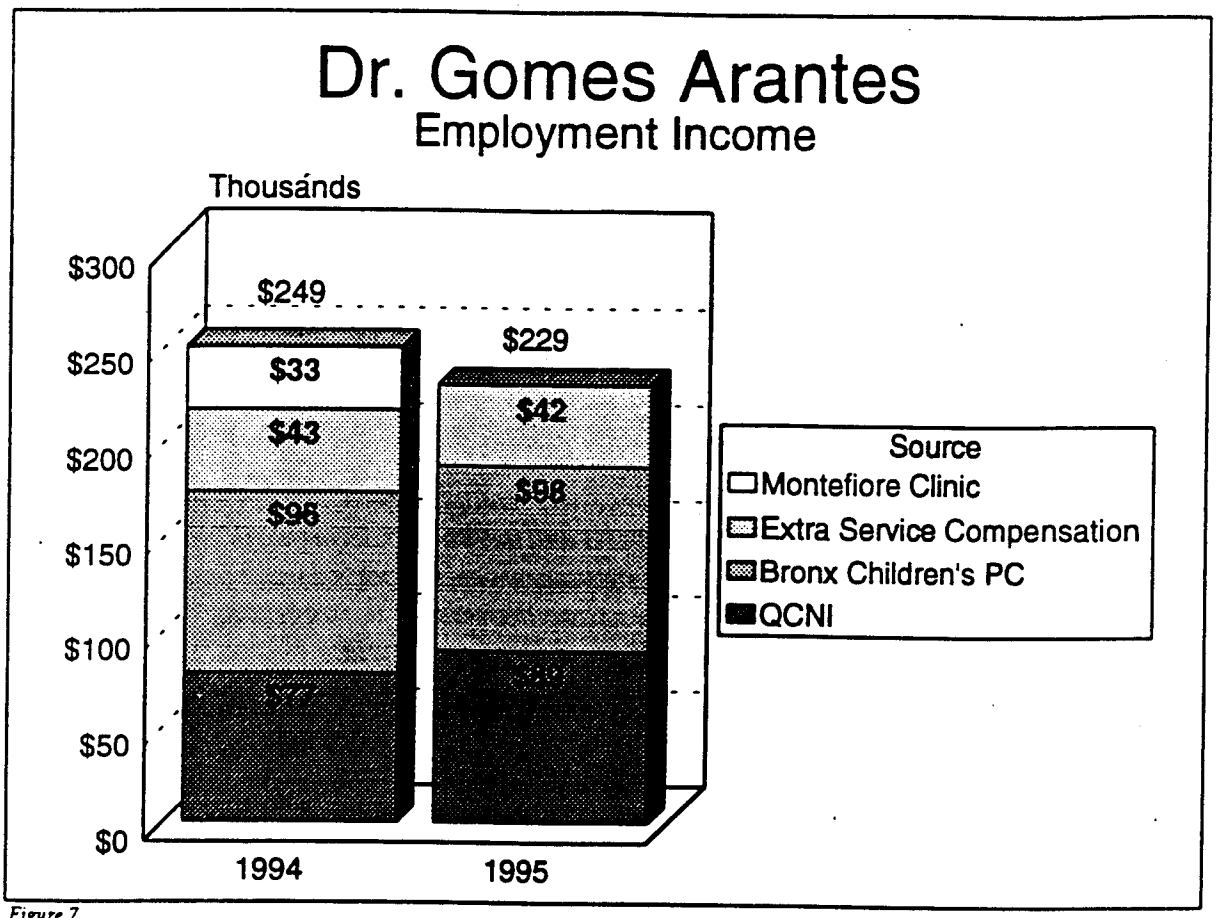

Figure 7

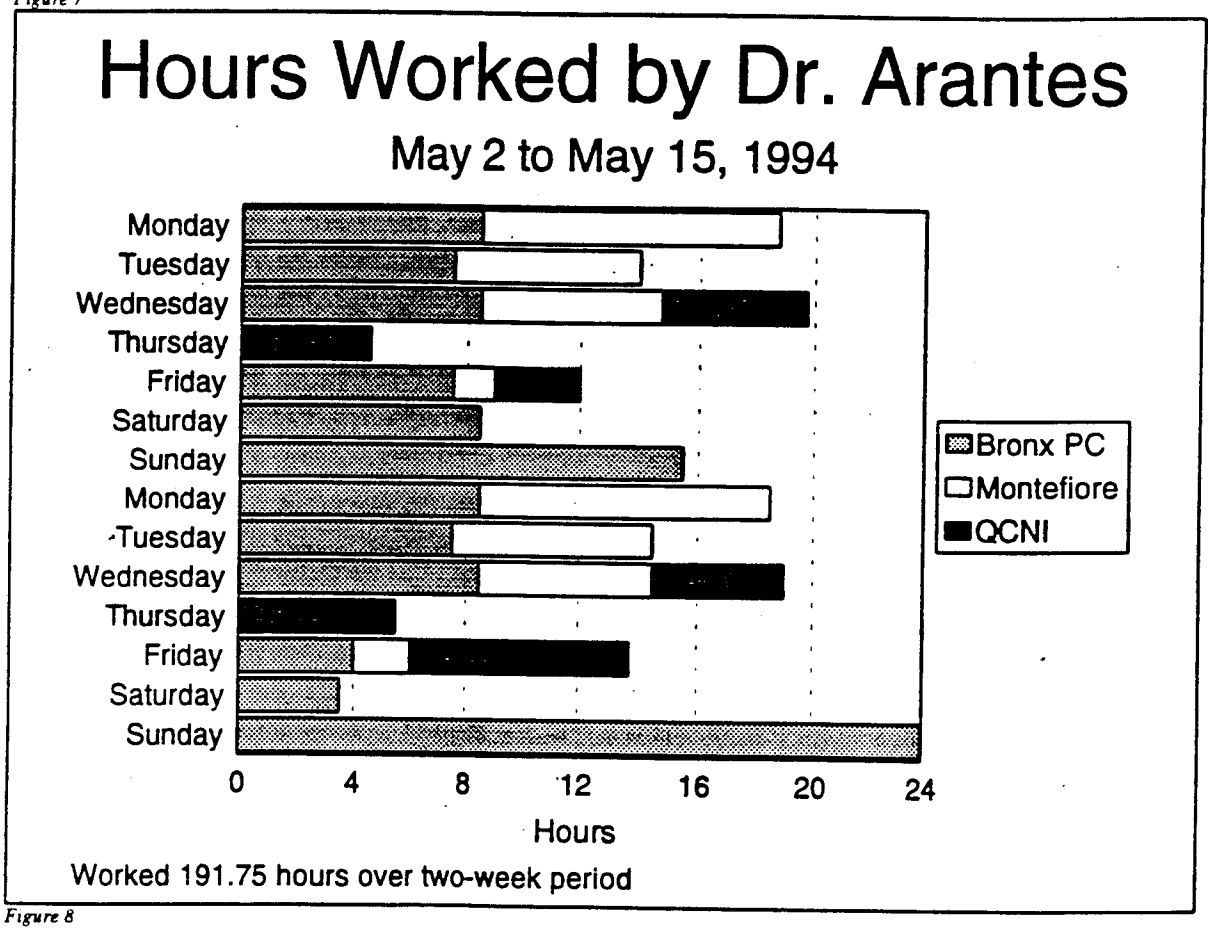

Figure 8

In view of the numerous hours Dr. Arantes worked (see, for example, Figure 8), the Commission conducted an analysis of his time and attendance at his various work locations to determine whether there was any reason to doubt the *bona fide* nature of his employment and pay.[39] The analysis revealed:

- In 1994 and 1995, Dr. Arantes worked an average of 83 hours per week, or over two times a normal 40-hour work week.
- On those days actually worked, Dr. Arantes averaged 14 hours per day for the two years reviewed. During one four-day period in 1994, Dr. Arantes was recorded as working 84 of the 96 hours available, leaving only three hours per day for personal activities, including travel between work sites.
- There were 42 instances where the records reflect that Dr. Arantes *worked at two different locations at the same time.* This does not include time for commuting between jobs. When commuting time is considered, the number of instances increases to 97.
- The records reflect that there were five instances where Dr. Arantes worked *more than 24 hours in one day.* On one day, Dr. Arantes recorded that he worked *28.5 hours.*
- In 1994, when Dr. Arantes worked at the BCPC, Montefiore and QCNI, there were five instances when he was paid for sick leave from Montefiore, yet worked at another location during that time.

These findings indicate that Dr. Arantes could not possibly have worked all the hours he was paid for, and further suggest the entries on his state time and attendance records may not be proper and correct.[40]

[39] The Commission's analysis is based on documentation that existed at the various agencies where Dr. Arantes worked. In some instances, although Dr. Arantes was paid for services provided, no documentation existed to support the time spent. For instance, at QCNI, although Dr. Arantes was paid as both a full-time employee and as a consultant, the agency only had records to support the time that was spent as a consultant. The agency had no documentation to support the time spent as an employee although he was expected to work 40 hours per week according to OMH certification records.

[40] QCNI's response letter contends there is no reason to question the hours worked or compensation of the medical director during his employment at QCNI. It suggests that the Commission should focus its attention on the problems with his hours and compensation for overlapping work at the other agencies.

Board of Directors

The QCNI board failed in its duty to oversee the agency's affairs and to protect its assets by assuring that compensation levels and retirement benefits for its founding principal were reasonable. It also failed to comply with applicable governmental laws and regulations (e.g., annual independent audits and board approval of business transactions with executives) that might have prevented the disposition of corporate funds or assets for the personal benefit of key executives.

OMH licenses and regulates more than 1,200 agencies to provide services to persons with mental illness. In regulating this industry, the state cannot rely on monitoring and enforcement alone to ensure quality care and assure fiscal integrity. There are too many providers and not enough state resources to effectively and consistently act as a reliable safeguard. Instead, the state needs and expects to rely on other outside sources to ensure that quality care is provided in a cost-effective manner and that fraud and abuse are minimized. One of the most integral resources that the state relies upon in overseeing this large system is an agency's board of directors which has the legal responsibility for managing the corporation.[41]

The board of directors is responsible for setting agency policy and assisting staff and administration in carrying out its mission. As fiduciaries, the members of the board have two paramount duties: loyalty and care.[42] Loyalty means that the board must put the interest of the corporation above self-interest and give priority to the corporation over *all* other parties. The duty of care means that the board must in good faith act with a degree of diligence, skill and care which ordinarily prudent persons would exercise under similar circumstances in like positions. In discharging their duties, directors are expected to rely on information, opinions, reports or statements prepared by others, including employees of the corporation, counsel, public accountants, or other persons, as well as committees of the board.

Although QCNI was incorporated in 1962, the agency was able to furnish the Commission with minutes of board meetings only since 1990. The minutes obtained indicated the board, while interested in the management of the agency, was less concerned about monitoring the use of its assets. It seems the board did not obtain adequate information to protect against the self-serving acts of its founding principal (e.g., approval of his consultant fees and deferred compensation as required by MHL §31.31). While the Commission has no evidence the board willfully sanctioned or had any knowledge of the "material facts" of the compensation transactions involving Dr. Lehine, boards are chargeable with the knowledge they might have possessed had they acted diligently.[43]

[41] N-PCL §701.

[42] *Board of Directors Training Manual, Not-For-Profit Corporations*, NYS Office of Mental Health, April 1993. *See, also*, N-PCL §717(a) and (b).

[43] Corporate directors are chargeable with knowledge they actually possessed or might have possessed had they diligently discharged their functions, and ignorance of illegal acts resulting from inattention does not exculpate (*Van Schaick v. Aron*, 1939, 170 Misc. 520, 10 N.Y.S.2nd 550).

From 1990 through 1995, QCNI's board consisted of five members. During this six-year period, only one new member joined the board to replace a long-term member who had resigned. Other than this one change, the composition of the board remained unchanged, elections were never held, and officers were not routinely rotated. When the board's treasurer/secretary resigned in 1991, the board, upon the recommendation of Dr. Lehine, filled this office with another member (Faye Caldwell) who had been a long-time employee of the agency.[44] Although the minutes are not clear, at some point another member became the treasurer and Ms. Caldwell continued as secretary to the board.

The minutes reflect, over the six years, the board met quarterly and that Dr. Lehine attended virtually every meeting and presented a report on the status of the agency. These reports however, contained very little information relating to the finances of the corporation. At one meeting (May 11, 1994), the minutes note a financial statement was presented to the board, but this was "unaudited" since, despite an OMH regulation (14 NYCRR 587.6(n)) requiring annual financial audits, the agency never had one until 1996 when the Commission began to question the agency's CPA.[45] Consequently, it is unlikely the board was fully informed of the corporation's financial condition.

Not only was the board not informed on financial issues, but also it was misled by Dr. Lehine about certain financial transactions. For instance, at a February 16, 1994 board meeting, one member asked about money market accounts of the clinic. At the time, Dr. Lehine informed the board that in addition to various money market accounts in QCNI's name, the agency had a New York Life Insurance annuity account. Dr. Lehine explained that the annuities were "reserve funds deposited in the name of the Institute but that *he was the only one responsible for them.*" In reality, these funds were hardly reserve funds for the clinic, but rather annuities purchased with agency funds by Dr. Lehine for his own benefit. The annuities, totaling $490,000 ($300,000 premium and investment income of $190,000), were eventually all distributed to Dr. Lehine.

The areas where the board failed to exercise reasonable diligence in carrying out its duties concerning the corporation's fiscal affairs are summarized below:

- Agency assets were not safeguarded when $300,000 in annuities were purchased for Dr. Lehine without any apparent formal board approval.
- Although QCNI has no formal retirement plan, the board granted Dr. Lehine a "retirement benefit" which guarantees a minimum payment of $600,000. The agreement called for guaranteed payments of $60,000

[44] In a May 1996 board meeting, QCNI's board president resigned due to an illness. The board had its first election since, at least, 1990 and elected another member to be president. During this meeting, the board also nominated and elected Dr. Lehine to become a vice-president of the board.

[45] After the Commission inquired about the lack of audited financial statements for the period under review, QCNI's CPA issued audited financial statements for the period ended December 31, 1995.

annually for the remainder of his life. Should Dr. Lehine die within the first ten years of this agreement, the benefit would continue to be paid to either his surviving spouse or son for the remainder of the ten-year period. This sum when combined with the annuity distributions appears to be unjust enrichment for the controlling principal at the expense of the not-for-profit corporation.

- Agency executives were paid bonuses, deferred compensation and other benefits without apparent board approval. In certain instances, these amounts were not properly reported to the IRS, thus making it uncertain whether taxes were paid on the income.
- Two former employees received "informal pension" payments without apparent knowledge or approval of the board (albeit one employee receiving payments is a board member) as these payments are recorded on the books as consultant costs.
- OMH requires agencies to have annual audits conducted of their books and records. Over its 33-year history, according to the agency's CPA, QCNI never had an independent audit of its finances until 1995 when the Commission began its investigation.[46]

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Gross Professional Misconduct by QCNI's Accountant

Over its 18-year history, the Commission has issued a series of reports detailing examples of fraud and abuse occurring in the State's mental hygiene system. Most of these cases have involved not-for-profit agencies that have subordinated the needs of the individuals they serve to the financial interests of their own executives. Whether through inflated salaries, related party transactions or other forms of self-dealing, these providers have profited at the expense of those individuals whom they are charged with helping. While the scope and methods used to perpetrate these schemes vary, one element appears consistently: in every instance, the agency's certified public accountant failed either to detect or to disclose financial wrongdoing occurring within the agency. QCNI is no exception.

Role of the Independent Auditor

Because OMH lacks sufficient resources to conduct audits of all providers, it must rely on the independence and objectivity of the CPA in conducting financial audits of not-for-profit agencies. OMH regulation 14 NYCRR 587.6(n) requires that all service providers undergo an annual financial audit in

[46] In its response letter, the QCNI board said it is appreciative of the Commission's assessment and is making efforts to improve its performance.

accordance with Generally Accepted Auditing Standards (GAAS). Such audits are to be conducted by an independent CPA and the resulting audited financial statements are to be submitted to OMH along with the provider's consolidated fiscal report (CFR). Without such independent verification of financial data, agencies would in effect be reporting on themselves.

Generally accepted auditing standards govern the independent auditor's responsibilities for an audit engagement. Under these standards, an audit engagement must be designed to provide reasonable assurance that material errors and irregularities will be detected. And, while auditors are required to conduct their audits with a degree of professional skepticism, having in mind the possibility of fraud, they are not specifically required to identify illegal acts, since a fraud audit is beyond the auditor's normal scope of investigation. Nevertheless, where the auditor has knowledge of fraud, there has always been an affirmative obligation to bring such matters to the attention of the board of directors.

False Reports and Concealment of Illegal Acts

QCNI's CPA firm was not "independent" and participated in a scheme to redirect public funds intended for services to the agency's founding principal. It attempted to conceal this misappropriation of agency assets through improper accounting entries and by issuing "unqualified opinions" on financial statements (i.e., the CPA's assurance that an audit was done and the statements were not misleading) when, in fact, no audit work was performed. It also failed to properly report accrued retirement benefits, and total compensation of certain agency employees which raises questions as to whether income taxes were paid on this income.

During the Commission's review of the spending practices of QCNI, evidence was found to suggest that the agency's auditors, Lipner, Gordon and Co., failed to comply with professional standards in the conduct of their audits. Specifically, it appears the firm failed to comply with GAAS by issuing unqualified audit opinions for the years ended June 30, 1992, 1993 and 1994 without conducting audits of the agency's books and records. Additionally, through the use of improper accounting entries and false financial reports, there is reason to believe the CPA firm assisted the agency's founder, Dr. David Lehine, in concealing his misappropriation of agency funds.

Commission investigators initially became concerned that the required audits had not been conducted when the agency's certified cost reports for the years ended June 30, 1992, 1993 and 1994 were examined. Although no financial statements were submitted *for these periods*, Lipner, Gordon and Co. misled OMH by signing the audit opinions contained in these cost reports as if it had conducted audits in accordance with GAAS. The financial statements actually attached to the cost reports were prepared on a calendar year basis and indicated a level of service less than that of an audit (i.e., compilation and

review). Compilation and review engagements are *not* conducted in accordance with GAAS and are substantially less in scope than an audit. Subsequent examination of the CPA firm's work papers confirmed that it conducted no audits of QCNI. Investigators found no audit programs, internal control work or any other indication that required auditing procedures had been performed. In fact, the work papers contained checklists and questionnaires which clearly showed that only a review (1992 and 1993) or compilation (1994) was performed, and even this work appeared to be substandard.

In signing the audit opinions on QCNI's cost reports without conducting any audit work, there was a gross violation of GAAS. Failure to comply with GAAS constitutes unprofessional conduct in the practice of public accountancy as defined in State Education Department (SED) regulation (8 NYCRR 29.10). Such conduct could result in the suspension or revocation of the professional licenses of those CPAs associated with the erroneous opinions.

The Commission believes that the CPAs' actions in this case go beyond unprofessional conduct. *Fraud* occurs when a CPA issues a report on financial statements, knowing that the financial statements are false. Issuing an audit report which states that the audit was conducted in accordance with GAAS is fraudulent if the CPA *knowingly failed* to comply with procedures required by GAAS.[47] Mr. Marshall Lipner, a partner in the firm, admitted he knew that his firm was not conducting audits in accordance with GAAS.

In addition to his violations of professional and ethical standards in the conduct of his audits of QCNI, the Commission's examination revealed other instances of misconduct by the CPAs. On two occasions, journal entries were posted to "fund balance" totaling $75,000 in an apparent attempt to conceal cash withdrawals made by Dr. Lehine. By using the fund balance account, the CPAs avoided reporting these amounts as expenditures on QCNI's financial statements, IRS filings, and certified cost reports. The Commission is aware that Mr. Lipner knew the nature of these transactions and, as an experienced accountant, he should have known that his handling of these transactions would effectively hide them from users of QCNI's financial reports.

The CPAs also helped to obscure from government scrutiny the total compensation paid to Dr. Lehine and other QCNI officials. Because QCNI paid Dr. Lehine both as an employee and as an independent contractor,[48] only a portion of his compensation, approximately $56,000 per year, was disclosed on the audited CFR. The remainder of his compensation, approximately $75,000 per year, was aggregated on the CFR with payments to independent contractors. By failing to report this information properly, the CPAs effectively hid from government oversight the total compensation paid to Dr. Lehine.

Another significant arrangement not properly reported on the agency financial statements pertains to Dr. Lehine's $5,000 per month retirement benefit. Generally Accepted Accounting Principles (GAAP) dictate that a liability pertaining to this commitment should have been recorded, but QCNI's financial statements failed to contain any such accrual. The Commission

[47] Miller's Comprehensive GAAS Guide, §112.04.

[48] This practice appears to violate IRS regulation §31.3401.

believes that the proper recording of the liability would bring the December 31, 1995 fund balance down to $90,821 rather than the reported amount of $513,945, creating a significantly different financial picture of the agency.

As previously noted, two other QCNI employees also received unreported income through informal "deferred compensation" and bonus arrangements. Between 1992 and 1995, Joseph Melman received in excess of $58,000 and Liya Rodov, a full-time psychiatrist, more than $14,000 under these informal arrangements. These amounts, paid in addition to their regular salaries, were not included in total compensation for income tax reporting purposes. Additionally, these amounts were not reported on QCNI's Form 990 as required by IRS regulation.

Finally, a board member, Faye Caldwell, received approximately $10,000 per year in 1992, 1993 and 1994. While she was issued a Form 1099 for these amounts, the compensation was not disclosed as required on the agency's IRS Form 990.

In all of these instances, the CPAs must have been aware of the amounts paid and the nature of the transactions. The firm's work papers contained schedules detailing all of the above transactions and Mr. Lipner discussed each of these transactions in a meeting with Commission fiscal investigators at his office. Ignoring information in the firm's possession, inaccurate IRS W-2s, 1099s, 990s and OMH-certified cost reports were prepared.[49]

[49] At its August 14, 1996 board meeting, a motion was passed to discharge the agency's accountant.

Conclusion

The lesson of QCNI is simple: What could have been a clinic offering competent and necessary services for persons with mental illness, most of whom have very limited personal resources, has instead become a high-volume program providing service of questionable benefit to recipients while providing generous levels of compensation to its founding director. Avoiding detection through the deceptive practices of the accountant, taxpayers have financed the salary and consulting fees for the founding director from 1992 through 1995 in amounts equalling nearly a half-million dollars. As if this were not sufficient, the taxpayers also "purchased" for him $300,000 in "tax deferred" annuities, gave him a rent-free apartment, and guaranteed him or his family at least $600,000 in retirement benefits.

As this report documents, these fiscal abuses are only a few of many. It is no surprise then that under the leadership of individuals operating under this "medicaid mill" ethic, consumers are provided inferior service because administrators fail to take the time and exercise the leadership and judgement to take minimally adequate actions to review the quality of care and supervise clinicians.

In the absence of quality assurance measures, clinicians have been permitted to admit individuals into treatment without sufficient information to support the decision or diagnosis. They have been permitted to keep individuals in treatment for long periods of time (in some instances over 10 years) without identifying treatment objectives. They have been permitted to readmit consumers and use treatment plans that are years old and left from previous admissions. They have failed to refer individuals to more appropriate services. Each of these actions has been co-signed by a psychiatrist.

The evidence is considerable that the executive director and the medical director have failed in their responsibilities to take reasonable measures to ensure that individuals receive "clinically appropriate care and treatment that is suited to their needs and skillfully, safely and humanely administered...."(14 NYCRR 587.7) In failing to ensure that appropriate policies and procedures are in place to support these functions, the governing body has also failed in its responsibilities.[50]

[50] QCNI in its response letter said it does not take kindly to the Commission's labeling QCNI as a Medicaid mill and strongly objects to the characterization. It disagrees also with the conclusion that its executive director and medical director failed in their responsibilities to ensure clinically appropriate care and treatment to its patient population. And it asserts that, while the Commission has found "technical problems," it is unfair to conclude these led to inappropriate treatment.

Recommendations

Agency Recommendations

The Commission's review occurred one year after the OMH certification review and revealed evidence that the agency has failed to improve its performance in several critical areas of treatment planning and provision. The Commission therefore recommends that the QCNI undertake a major quality assurance effort. This should begin with the submission of a plan to OMH and the Commission which includes specific tasks, the responsible staff member, and time frames for completion of measures to ensure the following:

- As treatment plans come due for revision quarterly, the therapists will be required to formulate a comprehensive treatment plan with goals and objectives, and the medical director or senior psychiatrists will review each. In addition, at this time, through review of the record and interviews with therapists, senior psychiatrists will ensure that each adult receiving service has a *bona fide* diagnosis of mental illness and each child has an emotional disturbance. This review is to be documented in the case record, including a rationale for the determination and the signature of the reviewing psychiatrist.
- The utilization review format will be revised to require specific information in response to each of the four questions (not simply check marks in a box) to support the determination that this individual is in need of continued treatment and that the treatment being provided best serves his/her needs.
- Assessment, treatment plan, treatment plan revision, and discharge summary forms will be revised to include directions to the therapist identifying what information is being solicited. For example, in the OMH uniform case record, the discharge criteria/plan states, "For each of the following areas, identify the changes that must occur before the patient may be discharged (i.e., the discharge criteria) and the patient's service needs on discharge." The form then lists five domains: mental health, physical health, rehabilitation (living, working, educational, social/leisure), social supports, and financial. The Commission is not suggesting that the OMH forms are directly applicable to QCNI, only that the program use the forms as models

with the objective of revising its central treatment record documents to provide guidance to users of the forms.

- Medical and psychiatric records will be secured when this is advisable.
- The clinic will develop policies and procedures for the clinical supervision of therapists.
- The administrator of the clinic will explore services available in the area such as church groups, parenting classes, support groups for immigrants, single-parents, victims or perpetrators of domestic violence, etc. and make this information known to the therapists so that consumers may be linked up with additional or alternative services.[51]

OMH Recommendations

- OMH should provide QCNI with technical assistance in writing the quality assurance plan as needed.

OMH Response

OMH has arranged for a follow-up visit to QCNI to be conducted on October 8 and 9, 1996. The exit summary phase of the visit will provide direct feedback and technical assistance to the agency. If further help is requested, OMH will work with the provider to arrange for appropriate assistance or training.

- Prior to the next certification review (March 1997), OMH should review implementation of the QCNI quality assurance plan using a minimum sample of ten records selected by the reviewer. The results of this review should be shared with QCNI and the Commission.

OMH Response

OMH believes it is important to visit this program in the near future to verify its current status, and to initiate technical assistance. OMH protocols which require random selection of records will be followed. It will notify the Commission of the results of all visits to this program through the 1997 certification renewal visit.

[51] QCNI's letter notes that the Commission's recommendations are well-intentioned and helpful. Its board will direct the agency's administrative and professional staff to incorporate the recommendations into QCNI's daily on-going activities.

- OMH should change its procedures to ensure that certification staff choose the records for review during certification inspections.

OMH Response

OMH procedures routinely require certification staff to select patient records during inspections. This and other crucial aspects of our on-site protocols will be reinforced through staff training. Specifically, sessions will be held at each of the three OMH certification field offices during October, 1996.

- OMH should modify its "Application for Approval of Outside Employment" form to require that employees in addition to listing regular work hours also list extra service hours. The "Dual Employment/Extra Service Approval Form" should be similarly modified to require a complete listing of the name and location, and days and hours of any outside employment or private professional practice. This added information is necessary so that the approving officer will be more fully aware of the overall work activities of the requesting employee.

OMH Response

The Outside Employment form includes a section for hours worked in non-OMH jobs. Modifications to reflect hours in the Physician Extra Service Program would not result in the collection of other useful information since extra service schedules are variable and change frequently. The "Dual Employment/Extra Service Approval" form is an Office of the State Comptroller's (OSC) form and is designed, as we understand it, to give prior notice that a state employee is on two state payrolls at the same time. Questions concerning this form should be directed to OSC.

In addition, the OMH Investigation Unit is reviewing Dr. Arantes' time and attendance records at Bronx Children's Psychiatric Center and will pursue disciplinary action if warranted.

- OMH should take efforts to ensure that public funds are utilized only to enhance the services to consumers by:
  - considering avenues to place compensation limits on salaries paid from public funds to senior executives of licensed mental hygiene providers to assure salary and other benefits are reasonable and in line with similar size agencies;
  - making available annual public reports on the 100 highest compensated employees in its licensed programs.

OMH Response

OMH is reviewing the utility of establishing regulations or fiscal requirements which cap salaries where mental health funds are paid to an agency. Current statutes do not permit the placement of caps on salaries where Medicaid is the primary revenue source and no other OMH funds are received. OMH is willing to participate in an interagency review of the need for such a change.

Referrals

- *The Department of Law:* to assure that the board of this not-for-profit corporation is revamped and organized to perform its duties consistent with its corporate and licensed purpose; to recoup funds from the corporation that were misappropriated and for possible criminal actions related to the apparent frauds against the corporation.
- *U.S. Attorney for the Eastern District of New York:* for possible criminal violations related to the misappropriation of medical assistance funds.
- *State Education Department:* for apparent gross violations of regulations relating to the practice of public accountancy.
- *State Department of Social Services:* for recoupment of some $600,000 in medical assistance payments improperly received by QCNI for undocumented services.
- *Office of Mental Health:* to assure the provision of meaningful psychiatric services at this clinic and compliance with the terms of its operating certificate, and review of outside employment practices by employees participating in its extra service compensation program.
- *Internal Revenue Service and State Department of Taxation and Finance:* for possible violations of tax laws.
- *State Office of Inspector General*: for possible falsification of state time and attendance records relating to numerous services that could not have been rendered at the same time at different employment locations.

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at [redacted]

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TDD)

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