NEW YORK STATE
OFFICE OF ALCOHOLISM
AND
SUBSTANCE ABUSE SERVICES
1450 Western Avenue
Albany, New York 12203-3526

September 21, 2006

Yelena Mamedova-Braz, MD, Medical Director
Mrs. Maya Gurevich, Administrative Director
Community Related Services, Inc.
99-07 Queens Boulevard, 2nd Floor
Rego Park, NY 11374

Re: NOTICE OF INTENT TO REVOKE
OASAS Operating Certificate No. 051110726

Dear Dr. Braz and Mrs. Gurevich:

Please take notice that the NYS Office of Alcoholism and Substance Abuse Services (OASAS) intends to revoke the above-referenced OASAS Operating Certificate for:

(a) failure of Community Related Services, Inc. (CRS) to comply with the terms of its Operating Certificate and with the provisions of applicable statutes, rules or regulations;
(b) inappropriate and/or potentially fraudulent billing to the New York State Medical Assistance Program (Medicaid) based on inappropriate admission and scheduling of patients;
(c) unethical supervisory and staff administrative and treatment practices that exploit patients for the financial benefit of CRS owners and counselors;
(d) inappropriate and/or potentially fraudulent transfer of program assets by CRS to a related company to counteract a potential claim by the New York State Office of the Attorney General - Medicaid Fraud Control Unit;
(e) failure of CRS to notify or seek OASAS approval for the transfer of 50 percent of ownership/shares; and
(f) as set forth below, the numerous violations by CRS of applicable OASAS regulations found in 14 NYCRR Part 800 et. seq.:

BACKGROUND

The OASAS Bureau of Enforcement (BOE) conducted a targeted investigation at Community Related Services, Inc. in Forest Hills from March 22, 2006 through April 19, 2006. In addition, interviews were conducted with current and former CRS staff on March 27, 2006,

April 11, 2006 and May 3, 2006 through May 5, 2006. Prior to the initiating the field work, investigators reviewed various OASAS internal records, e-Med NY Medicaid claims data, and corporation/entity data obtained from the New York State Department of State; and conducted surveillance to monitor the flow of patients in and out of the facility.

Concerns that prompted the targeted investigation included the following:

- CRS transferred 50 percent of CRS' ownership without OASAS approval;
- Huge time lags existed between dates of service and dates of Medicaid billing. For the period 2001-2004 CRS' billing lag ranged from 14.8 months to 21.9 months. The high of 21.9 months was for 2003. The system-wide average billing lag for 2003 was 2.92 months;
- A highly questionable reserve for uncollectible Medicaid billings reported in the provider's annual financial statements was noted. CRS created 50% reserves on income that had a historical collection record of 100%.
- With the combination of major billing lags and an extremely large reserve for uncollectible Medicaid billings, Medicaid income reflected in this for-profit provider's annual financial statements appears to have been seriously under-reported;
- Dramatic fluctuations occurred in Medicaid billing, though service delivery was steady. An analysis of CRS Medicaid billing indicated that, though their service volume for 2002-2004 was steady at around $11,000,000 annually, their billings through 2005 fluctuated from $5,000,000 to $19,000,000 per year;
- CRS has highest average number of visits per recipient in the OASAS outpatient system by far (152 per year vs. the system-wide average of 34.4 visits per year).
- Patients' length of stay in the clinic average over 20 months. Average length of stay for the system is about 3.7 months including "short stays" (4 visits or less) and 4.7 months excluding short stays. Those figures for CRS are 20.9 months and 21 months;
- Patient services (on a visits per week basis) do not decline over time; and
- There are almost no "short stays" in the clinic (only nine short stays out of 1182 patients, the system-wide average is 32%).

Investigators initially identified a sample of 100 case records of CRS patients selected from the program's then current roster. A preliminary review revealed that CRS routinely treated patients through multiple admissions (average of two to four per patient) with extensive lengths of stay (18 months to two years per admission). The admissions/re-admissions occurred from CRS' inception in 1998 through the 2006 investigation. A detailed review was conducted on 50 of the 100 cases identified. Significant recurring and systemic program violations and violations of ethics were noted regarding CRS' admission/re-admission, clinical services, treatment planning, utilization review and discharge practices.

In addition to performing case record reviews and interviews, investigators assessed CRS' policies and procedures, management systems, time and attendance and payroll records, recent tax returns and financial statements.

TARGETED INVESTIGATION – SUMMARY OF FINDINGS

I. CRS ENGAGEMENT IN FRAUD AND OTHER UNETHICAL PRACTICES

Finding # 1: Fraudulent and/or Abusive Billing of the New York State Medical Assistance Program -- CRS billed the New York State Medical Assistance Program for services rendered to patients who were not in need of chemical dependence treatment and/or for chemical dependence services at a level of intensity totally unrelated to the patients' patterns of use/abuse. Patients presenting with minimal alcohol use and/or histories were admitted by CRS into the Chemical Dependence Outpatient Service and assigned an intensive treatment regimen of generally four to five days of service per week. Patients remained in treatment at the same level of service intensity until their discharge, generally 18 to 24 months after admission.

CRS also inappropriately billed Medicaid for services that were not reimbursable. Specifically, review of CRS' group attendance sheets showed that CRS regularly billed for services that did not constitute a threshold visit, and were therefore ineligible for reimbursement. Group meetings documented in case records as "educational sessions" were primarily informational in content, but were billed as "group counseling" in violation of 822.10 (g) (5).

Medicaid claims data also revealed that CRS patients had received chemical dependence treatment at other outpatient facilities. These previous treatment episodes were not documented in CRS records and, in some cases, the patient had reportedly successfully completed treatment at the other service prior to entering treatment at CRS less than a week later. Some of the patients had treatment episodes that totaled eight years with only brief periods between episodes. All of these treatment stays were billed to Medicaid at a significant monetary cost to the system.

Finding # 2: CRS Provided Financial Incentive to Increase Patient Attendance --

- **Counselor Compensation Levels are Based on the Number of Billable Contacts They Produce** -- CRS does not have a formalized time and attendance procedure. The program does not maintain written documentation of employee attendance which records the daily arrival and departure time of each employee or the type of leave granted to each employee who is absent from work. In this regard, there is no way to verify the work schedules for any of the staff employed at the service. Administration and the support staff admitted that each counselor's productivity is tracked via the progress notes they submit. These documents are also used to determine the amount of the counselors' bi-weekly paychecks, resulting in a "piece-work" or "commission" system of compensation. This compensation system was seen as a significant factor in the extraordinarily high service volume provided to patients with minimal chemical dependence histories and an example of CRS' treatment and administrative practices designed to exploit patients for the financial gain of the ownership and counseling staff.

- **Patient Payments for Attendance** -- Patient's were being compensated $4.00 per day of attendance, ostensibly for carfare reimbursement. Notations in staff meeting minutes dated January 21, 2004, March 30th, April 6th and November 11th of 2005, identified Dr. Braz, Medical Director, Ms. Pelts, Program Director, and Ms. Gurevich, Administrative Director,

as the persons processing, coordinating and/or approving patients' use of ambulette services. A review of Medicaid data and CRS' carfare disbursement log revealed that 20 percent of the sampled patients received $4.00 in daily carfare from CRS despite the fact that they received transportation from an ambulette company on the same day. In addition, surveillance conducted prior to the initiation of OASAS work at the CRS facility disclosed that many patients appeared to be arriving at and leaving the facility on foot, and walking to their homes in the neighborhood.

Finding # 3: CRS Ownership Engaged in the Wrongful/Fraudulent Transfer of Program Funds to Counteract a Potential Claim by the Office of the New York State Attorney General Medicaid Fraud Control Unit -- A CRS Independent Auditors Report, Financial Statement for the Year Ended December 31, 2004 contained a note regarding *Related Party Transactions*. In that note, it was stated that CRS had provided an interest free loan in the amount of $3,520,000 to a company also co-owned by Mrs. Gurevich and Dr. Braz, Advanced Community Services, Inc. During a May 4, 2006 interview, Mrs. Gurevich was questioned regarding the purpose of the $3.52 million loan. She stated that the loan was initiated after she and Dr. Braz became aware that CRS was under investigation by the NYS Office of the Attorney General - Medicaid Fraud Control Unit. She stated that the purpose of the loan was to ensure that operating funds were available to her and Dr. Braz in the event the investigation by the Attorney General resulted in the seizure of CRS' funds. The loan was a wrongful transfer of program funds and a fraud against a known and potential creditor.

Finding # 4: CRS Supervisory and Administrative Staff Impeded the OASAS Investigation -- CRS staff failed to fully cooperate with OASAS at the onset of the investigation and were resistant throughout. Program staff obstructed and/or delayed the process by denying investigators full access to the facility and the materials contained within, as follows:

- When investigators initially entered CRS, Elizaveta Pelts, Program Director was unable to answer basic questions about the program and its operations. Ms. Pelts acted as if she didn't understand the policies and procedures associated with the day to day clinical operations of the program. When asked direct questions, she was evasive and her answers were vague. She presented nervousness and confusion and would not answer any of our questions directly or accommodate any our requests until Dr. Braz and Mrs. Gurevich arrived.
- Vera Polykanova, Clinical Supervisor, refused to allow investigative staff to enter the case record storage rooms to retrieve records even after OASAS staff explained their legal authority to conduct the investigation, and the program's legal responsibility to cooperate. Ms. Polykanova was combative and maintained the position that OASAS staff had no right to be at the program.
- As the field investigation continued, both administrative and clerical staff continued to delay the process by not answering direct questions or by providing ambiguous information to investigators.
- Office Manager, Helen Rodova and Mikhail (a clerical staff member in charge of the records in "Archive Room I"), were instructed to retrieve all of the active and inactive files for all of the clients identified by OASAS. They identified three locations where these records were stored. One room contained active records and two rooms, labeled "Archive Room I and II", contained inactive records. They ultimately provided the investigators with a number of case

record files, but subsequent discoveries determined that they had not provided complete records for all of the patients in the sample.

- Upon further assessment of the facility, Investigators discovered additional record storage rooms in another section of the building. Investigators requested that these rooms be opened and found that three rooms contained additional case records. Maya Gurevich was questioned about the status of these records and why they had not been identified earlier. Ms. Gurevich could not provide a reasonable explanation for her and/or her staff's failure to acknowledge the existence of these rooms to OASAS although a number of the records requested were stored in the undisclosed rooms.
- Staff meeting minutes and staff interviews with administration revealed that, while the service routinely conducts mental health evaluations and re-certifications to assist patients applying for or recertifying SSI benefits, no proof of this assistance is documented in the patient records. During an interview Dr. Braz provided contradictory information about the procedure for filling out these documents. She initially stated that only she and the two part-time psychiatrists were authorized to fill out the documents for SSI. When asked if the supervisor, Vera Polykanova, was involved with the process, Dr. Braz stated that she was not; however she recanted this statement when investigators produced a copy of staff meeting minutes dated April 6, 2005, that identified Ms. Polykanova as the person who should be filling out documents from SSI. When Dr. Braz was asked why SSI documents were not included as part of the case record, she stated that copies of the forms were kept in a separate file at the facility; however, she did not provide an explanation for the programs failure to add these critical documents to the case record or its failure to document the program's involvement with the process. Additional proof of this practice was found in staff meeting minutes dated May 6, 2004.

Finding # 5: Failure to Notify OASAS of the Transfer of Ownership/Shares -- CRS officials failed to notify OASAS of the transfer of 50 percent of the program's ownership and control to Mrs. Maya Gurevich. Such action (transfer of ten percent or more of stock) is subject to full review and approval by OASAS.

Finding # 6: Failure to Provide Services That Respect the Dignity of Patients and Are Non-Discriminatory -- CRS' clinical and administrative staff presented a derogatory and discriminatory view of the patients enrolled in the program. CRS staff consistently presented the Investigators with a very negative assessment of the patients based on their different ethnic and cultural backgrounds. During interviews, staff described their patients in very demeaning and demoralizing terms. Russian born counselors compared themselves to their patients. The counselors categorized themselves as "real Russians" and made the distinction between the ethnicity of the patients and their own ethnicity. Interviews revealed that the clinical staff regarded the patients as unsophisticated and incapable of understanding the treatment process due to their extensive "limitations". Dr. Braz, the Medical Director/owner of the program, stated that the patients' limitations were due to intermarriage. These marriages, according to Dr. Braz, produce generation after generation of mentally disabled individuals who lack the capacity to function successfully and independently. The organizations underlying assessment of these patients reflected prejudices and ethnic stereotyping that appeared to be an attempt to justify the exploitative treatment the patients were receiving.

Finding # 7: Program CASACs and CASAC Trainees Engaged in Misconduct and Did Not Adhere to the Ethical Standards Defined in the Part 853 Canon of Ethical Principles -- Counselors acted contrary to the interests of patients in direct violation of OASAS regulations and national standards of professional competence and moral codes. Counselors did not respect the integrity nor protect the welfare of the population with whom they were working. The treatment practices they engaged in served to systematically exploit their patients. They established excessive treatment schedules for patients in such manner as to exploit the patient for the financial gain of the counselor and ownership of the program. They practiced fraudulently, with gross incompetence and with gross negligence on a regular basis by consistently failing to engage in meaningful discharge planning contrary to the interests of their patients.

CASAC-Trainees, who had been physicians in Russia, were providing patients at CRS with medical advice and examinations. Staff members acknowledged that this was true. Staff shared that some of their patients at CRS had been their patients in Russia where they treated them as physicians. None of these individuals was licensed as a physician in the United States. According to OASAS credentialing regulations, "a counselor credentialed by OASAS is not authorized to substitute for other professionals in an alcoholism and substance abuse service but shall function as a member of multi-disciplinary teams which include, but are not limited to, other qualified health professionals offering such services." [853.3(b)]

Alcoholism and Substance Abuse Counselors at CRS did not demonstrate that they were of such character and competence as to give reasonable assurance of their ability to continue to function as Credentialed Alcoholism and Substance Abuse Counselors in accordance with accepted standards including the Canon of Ethical Principles as contained Part 853 Regulations.

Finding # 8: Program Social Workers Did Not Adhere to the Ethical Standards Defined by the National Association for Social Workers' (NASW) Code of Ethics -- The Licensed Social Workers, currently and formerly employed by CRS, failed to adhere to the NASW Code of Ethics and, as a result, contributed to the unethical practices on the part of the organization and the exploitation of the patients being served. The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. Social Workers also seek to enhance the capacity of people to address their own needs. Professional ethics are at the core of social work and assist the social work profession in assessing whether social workers have engaged in unethical conduct. The *NASW Code of Ethics* sets forth the values, principles and standards to guide the conduct of Social Workers.

Licensed Social Workers at CRS failed to adhere to the Code of Ethics in the following ways:

- **Commitment to Patients -** Social Workers' were not fulfilling their primary responsibility to promote the well-being of patients; in general patients' interests should be primary, however, the Social Workers at CRS participated in a system which was designed to exploit the patients for the financial benefit of the organization. [Code of Ethics 1.01]
- **Self-Determination-** Social Workers did not respect and promote the right of patients to self-determination and assist patients in their efforts to identify and clarify their goals. As discussed in the previous finding, Social Work staff at CRS characterized the patient

population in a manner that described them as inherently defective human beings and incapable of self-determination. [Code of Ethics 1.02]

- **Termination of Services -** Social Workers should terminate services to patients and professional relationships with them when such services and relationships are no longer required or no longer serve the patients' needs or interests**.** The revolving door admissions into the same service that had not addressed the patient's needs, in all cases over years of treatment, coupled with the absence of adequate discharge planning demonstrated Social Work staff's failure to adhere to this ethical principle. [Code of Ethics 1.16(a)]
- **Dishonesty, Fraud, and Deception -**Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception. The Social Workers failure to adhere to this ethical standard is self evident in the context of CRS overall operations and the supervisory role CRS Social Workers play. [Code of Ethics 4.04]

Finding #9: Yelena Mamedova-Braz, MD, Medical Director, Did Not Adhere to the Professional Standards Defined by New York's Education Law and OASAS Regulations -- NYS Education Law, Article 131-A defines "professional misconduct" by physicians operating in New York State. Examples of medical misconduct include: practicing fraudulently, practicing with gross incompetence or gross negligence; filing a false report; performing services not authorized by the patient; harassing, abusing or intimidating a patient; and ordering excessive tests. [Title 8, Article 131, Section 6524]

As the owner and Medical Director of CRS, Dr. Braz willfully violated and failed to comply with substantial provisions of federal and state laws, rules, and regulations governing the following:

- the practice of medicine in New York State;
- the oversight of medical services provided within a chemical dependence outpatient service;
- the submission of Medicaid claims for services for which documentation of medical necessity is required; and
- the terms of the OASAS Operating Certificate and the oversight of the 822 outpatient service.

Staff meeting minutes and interviews confirmed that Dr. Braz was clearly the final authority responsible for the development and ongoing implementation of treatment practices designed to exploit patients for her personal financial gain. She was jointly responsible with co-owner Maya Gurevich for the development of a staff compensation model based on billable services produced. She, along with Mrs. Gurevich provided compensation directly to patients to encourage maximum attendance and submitted Medicaid claims for services for which documentation of medical necessity was not available. As Medical Director, she was ultimately responsible for the inappropriate admission and retention of patients who were not in need of chemical dependence treatment and/or for chemical dependence services at a level of intensity totally unrelated to the patients' patterns of use/abuse. In this role, she was also responsible for the oversight of a treatment system that clearly made no effort to plan for the discharge of patients who needed ongoing psychiatric care.

Finding #10: CRS Disregarded Patient Right to Confidentiality – English as a Second Language (ESL) classes were given to patients as part of CRS' treatment process. During

interviews, CRS staff stated that people in the community who were not patients attended as well. This is a violation of patient right to confidentiality as the sessions were held in commonly used program space during the busiest part of the day in an area that was highly trafficked by patients and staff. OASAS regulations prohibit the simultaneous use of a room for certified outpatient services and other activities.

II. INADEQUATE CLINICAL SERVICES AND PATIENT CASE RECORD DEFICIENCIES

Finding # 11: Questionable Level of Care Determinations and Inappropriate Admissions to Chemical Dependence Treatment -- Level of Care Determinations were conducted in a perfunctory manner. CRS assessment data did not corroborate that Level of Care Determinations accurately reflected the patients' need for outpatient chemical dependence services. In all 50 case records reviewed, evaluations of newly admitted or returning patients included chemical abuse histories that were questionable or not extensive enough to support an active abuse/dependence diagnosis. The records of many patients admitted/re-admitted and retained in the service indicated more serious mental health issues than issues with alcohol abuse, which would indicate the need for referral to a mental health provider. Their use of alcohol was either insignificant or related to their mental illness condition. The evaluations were also deficient in that they did not contain information necessary to develop the comprehensive individual treatment plans required by regulation. Evaluations did not contain sufficient information about the patients' chemical use, abuse and dependence history or history of previous treatment experiences, and did not provide conclusions or diagnostic summaries needed in order to document and support the clinical impressions and treatment recommendations.

Additionally, records of patients who have had multiple admissions did not contain accurate information about the number of times that the patient had received treatment previously at CRS or any other chemical dependence outpatient service. Patient case records contained erroneous, vague or incorrect information and/or timeframes regarding previous treatment.

Finding # 12: Inappropriate Retention of Patients in Treatment -- CRS admitted, re-admitted and retained patients in treatment despite clinical indications that the type of treatment service was not appropriate. Comprehensive evaluations and other supporting documentation revealed that patients were admitted into treatment who did not meet the criteria for admission. Additionally, patients being treated for alcohol abuse were retained at CRS even when they failed to respond to treatment, were not meeting identified goals and had significant mental and physical health problems. Patients returning to treatment after a brief discharge reported that their mental health had deteriorated and they resumed alcohol consumption in the attempt to alleviate symptoms of depression, grief and loss. These persons were readmitted into the CRS chemical dependence outpatient program despite the prevalence of their psychiatric and mental health symptoms. Further, they were treated an additional 18 to 24 months at the same level of intensity prescribed during their previous treatment episode(s).

Finding # 13: Deficient Treatment Plans and Treatment Plan Reviews – In all 50 case records reviewed, treatment plans were not individualized and were not reviewed and approved by a multi-disciplinary team. Plans did not support the maintenance of recovery, the attainment

of self-sufficiency and the improvement of the patient's quality of life. Goals and objectives were generalized and not measurable. Furthermore, as each patient was re-admitted into the service, the new treatment plans contained problems, goals and objectives that could not be distinguished from those found on previous plans. Clinicians failed to distinguish between patients who had no prior treatment and those who were in and out of treatment repeatedly. Goals and objectives were the same for all patients; not individualized and failed to consider the patients' prior treatment experiences.

Treatment plans were not reviewed and revised and/or modified through collaboration with the patient in order to ensure that they reflected current treatment needs. Patient interviews revealed that patients did not have a clear understanding of their diagnosis and treatment and could not clearly articulate the services that they were receiving or the goals and objectives they were working to achieve. Plans did not contain summaries of patients' progress in each of the specified goals and, despite reported positive progress and successful outcomes related to abstinence from alcohol use, patients were maintained at the same type and frequency of services with no definitive plan for discharge. Patients were retained in chemical dependence treatment at schedules of four to five days per week despite long periods of abstinence, compliance with program rules, and a questionable need for intensive services. Additionally, no referral arrangements were made to meet the significant family counseling, medical and/or mental health needs of CRS patients.

Finding # 14: Failure to Provide Individualized Treatment -- CRS failed to provide patients with individualized treatment regimens to meet their unique needs. OASAS qualified health professional (QHP) Investigators question the legitimacy and viability of each admission, retention and discharge decision. Case record reviews determined that comprehensive evaluations, treatment plans and progress notes were repetitive, generic and failed to address the specific needs of the individual patients being served. In the majority of cases, psychiatric evaluations and information about the patient diagnosis and status were also indistinguishable, although often covering numerous treatment episodes over a period of years.

CRS supervisory staff played a critical role in the development of these clinically and ethically inappropriate practices. A former program supervisor stated during an interview that CRS counselors were taught to use certain clinical statements in the patient records and, once learned, they would rarely deviate from the format. It was also disclosed that when patients were re-admitted, the counselors would simply copy progress notes and other clinical writings from the patient's previous record into their new active record. There were no distinctions in treatment schedules from one patient to another, as counselors were allowed by program management to maintain caseloads of 30 to 35 patients, each attending treatment at the same level of intensity (five times a week).

Finding # 15: Failure to Provide Structured Treatment Services and Organized Program of Therapies and Activities -- CRS does not provide structured treatment services to its patients. During the investigation, OASAS requested a program schedule outlining the clinical services available to patients on a daily/weekly/monthly basis. Administrative and counseling staff could not produce a schedule. Dr. Braz and Mrs. Gurevich stated that each counselor manages their own schedule and is not required to share this schedule with administration.

Counselors stated that CRS has no schedule of sessions for those who attend the program, but patients are aware of the time that groups are run and attend when they choose. They also stated that group and individual sessions were basically determined by when and if the patients showed up.

As a result of the absence of structured treatment services, CRS fails to provide an organized, coordinated program of therapies that meet patients' needs. Instead, treatment is provided in a generic and substandard manner, often relegating patients diagnosed with recurrent and severe Axis I disorders to individual and group counseling by non-QHP staff. An essential clinical element of quality treatment is the provision of structure through the establishment of program milestones and the development and execution of treatment goals. Clinically, structure for patients should be created through program rules, scheduling of services delivery and the development, execution and review of treatment plans. The documentation of revision of goals due to achievement or failure is essential in evaluating patient progress. These features are lacking in the CRS treatment process. Additionally, group counseling sessions are generic in nature and are not conducted in phases (according to patients' time in treatment). Groups lacked thematic structure and did not relate to the clinical issues presented by this population (co-occurring disorders, elderly, Russian speaking immigrants). The program has no curriculum or planned sequencing of group topics.

Finding # 16: Failure to Provide Treatment According to the Plan -- CRS does not provide treatment as prescribed in patients' individual treatment plans. Active case records contained treatment plans with vague schedules (a range of days that patient will attend services instead of a definitive schedule); however, the inactive cases contained specific prescribed schedules that were not followed. Additional sessions and/or services were conducted indiscriminately. Urinalysis and breathalyzer tests -- not indicated in individual treatment plans -- were administered frequently and arbitrarily, without clinical justification, and the results of those tests were not utilized as a clinical tool in the treatment process. Finally, all of the records reviewed contained notes for psychiatric sessions that were not reflected on any of the treatment plans, and there was no evidence of consultation/collaboration between the clinicians involved.

Patient interviews revealed that a number of the patients were not receiving individual counseling as prescribed in their treatment plans. Of the 20 patients interviewed, six stated that they had individual counseling regularly; however, one of them said that the last session was only 15 minutes in duration. Eight patients stated that they never had individual counseling sessions with their counselors; four patients stated that they received individual counseling, but not on a weekly basis as outlined in their plans; and three stated that they could not recall when they last had an individual session.

Despite the identification of family discord/conflict in the majority of the charts reviewed, CRS failed to provide family counseling to patients, even when it was prescribed on their individual treatment plans. Staff interviews and clinical documentation revealed that most of the patients had serious family problems that required clinical intervention; however, CRS did not address this recurring patient need, either directly or through referral.

Finding # 17: Inadequate Progress Notes – In all 50 case records reviewed, progress notes were found to be deficient. Notes were vague and repetitive and did not provide a chronology of patients' progress in relation to the goals established in the individual treatment plans. Notes did not delineate the course and results of treatment and did not indicate the patients' participation in all significant services provided. Documentation about patients' participation or progress with ancillary services, such as English as a Second Language (ESL) classes, was not adequately recorded in the clinical record. Furthermore, notes were not instructive regarding patients' personal progress in treatment, had no continuity and did not reflect the full scope of the patients' treatment experiences. As previously stated in relation to clinical documentation, progress notes in one case record could not be differentiated from another. Given the numerous internal reviews conducted by CRS staff on patient progress notes and the absence of any sense of individuality, it is apparent upon review that the notes serve as little more than an audit trail for counselor compensation and Medicaid billing.

Finding # 18: Inadequate Utilization Review (UR) - CRS failed to adequately execute their utilization review policies and procedures. Limited documentation of utilization review was found in the patient charts. Where documentation was found, the review process was perfunctory, primarily a superficial review of the "charts" compliance and did not sufficiently evaluate whether the services provided to each patient were necessary, adequate, appropriate and/or effective.

During the May 5, 2006 interview of Fanya Veret, LMSW, who was responsible for conducting UR at CRS, she stated that she utilized case record documentation (primarily progress notes and treatment plan updates) as the primary mechanism for determining the appropriateness of admissions and continued retention of patients to the program. When confronted with OASAS' observation that CRS records did not provide adequate information upon which to make these decisions, she admitted that CRS progress notes are not comprehensive and lack sufficient information to determine patients' progress in treatment. As counselor's weekly compensation is specifically based on the number of patients they see during the week (see Finding #2), it is clear that safeguards to monitor the necessity of the frequency of patient visits are not in place. Furthermore, Ms**.** Veret acknowledged that treatment plan reviews do not address patient progress and other issues identified in the patient's case record and do not serve as an adequate basis upon which she can make a determination regarding the appropriateness of continued treatment at intensive levels. These deficiencies do not allow for the systematic monitoring of the appropriateness of admissions, the need for continued stay and/or the necessity for an alternative level of care.

Finding # 19: Failure to Conduct Discharge Planning -- CRS failed to provide discharge planning to patients enrolled in the program. Discharge planning did not begin upon admission, nor was it closely coordinated with the treatment plan, as required. There was no discussion of discharge until the end of each treatment episode and, more often than not, discharge was initiated by the patient. In the majority of cases reviewed, the discharge was abrupt and inadequately planned. Case records did not contain written discharge plans, consisting of all of the required elements. When discharged, patients were not provided with referrals and were not encouraged to access community services or supports in order to successfully reintegrate into the community. Case records and staff interviews revealed that patients receiving psychiatric

services from CRS were discharged with no referrals to an outside mental health service provider. These same patients were given a two month prescription for their psychotropic medications and were instructed to return to the CRS if additional assistance was needed. These discharge instructions left patients no other option than to return to CRS for treatment or go without prescribed medication.

Patient records contained discharge forms that contradicted clinicians' stated reasons for discharging the patients. Discharge summaries typically stated that a patient had successfully completed the program (met all or most treatment goals); however, discharge letters, sent to the patients' homes 30 days after the last face to face contact, stated that the patient left the program prematurely (against clinical advice) and would be terminated if contact with CRS was not re-established. While the letters did contain contact numbers for service providers in the community, the contact numbers were not accompanied by agency names or descriptions of the services they provide. In fact, one of the numbers listed as a viable resource for patients, is no longer in service.

Finding # 20: Failure to Arrange Linkage and Service Agreements; No Coordination of Care -- CRS failed to initiate and develop service agreements with outside community service providers to support patients' recovery during and after treatment. Moreover, the program has no written policies and procedures identifying specific providers and/or methods for coordination of the services between the agencies.

CRS does not have formal, fully executed, written contracts/agreements for consultants providing clinical services to the program. Psychiatrists evaluating, diagnosing and treating patients, have no contracts to delineate the specific services that they provide, the duration of such services or the corresponding procedures and protocols. Additionally, their rates of compensation, the procedures for billing and conditions for payment are not defined. The potential for mismanagement is elevated due to the absence of internal controls. During a staff interview with Rivko Pakanayeva, primary counselor, she stated that she does not refer patients to other agencies. Dr. Braz stated during an interview that patients were reluctant to attend programs outside of CRS and that they had difficulty forming other therapeutic relationships, especially with psychiatrists. Investigators found no evidence from the records or interviews that CRS was making any effort to address this resistance or to support re-integration of patients into the community after discharge. This failure by CRS administrators has contributed to the patients' inability to successfully transition from treatment to self-sufficiency.

Finding # 21: Inadequate Clinical Record-Keeping -- CRS failed to document recommendations, referrals and services provided for the patient's general health or for other special needs, including coordination with other agencies. While CRS routinely conducts mental health evaluations and re-certifications to assist patients applying for or recertifying SSI benefits, no proof of this assistance was documented in the patient records provided to the Investigators. Patient records given to Investigators were incomplete. The program was asked to provide the Investigators with all records associated with the patients identified in the sample. CRS staff did not provide Investigators with important information (SSI, public assistance applications and recertification documents etc.) requested. During an interview on May 4, 2006, Dr. Braz provided contradictory information about the procedure for filling out said documents and did

not provide an explanation for the program's failure to document the process of accessing SSI benefits for patients in the case records provided to the Investigators.

Finding # 22: Inadequate Medical Assessments, Physical Exams and Follow-Up -- CRS' target population -- elderly, Russian immigrants with co-occurring disorders -- presents with a complex constellation of medical and psychiatric problems. All of the patients within the sample of 50 had medical issues, some of which are chronic and progressive. Many were being treated with various medications or were subject to medical interventions that required monitoring and management. Despite these issues, the medical assessments completed by the CRS Medical Director were incomplete, inconclusive, and, in many cases, contained recommendations that were contradictory. When and if physical examinations were found in the case records, the exams were incomplete and did not contain conclusions and/or recommendations that allow for a full and adequate assessment of patients' medical history and/or needs. Finally, physical exams obtained from the patients' primary medical doctors were not reviewed and determined to be current and accurate, as required by regulation.

Finding # 23: Failure to Meet the Identified Needs of Special Population -- CRS does not adequately assess and address the needs of the special population of Russian Jewish immigrants that they serve. Current literature[1] identifies the Soviet Jewish family as a "family in transition," a diverse population of immigrants (ranging from the highly educated to proud craftsmen and workers), all of whom highly value their family structure. Researchers note that although alcoholism is a notorious Russian problem that affects various societal strata and was traditionally tolerated by the Russian and Soviet governments, the rates of alcoholism in Soviet Jewish families remains low even after immigration to the United States. Jewish families from Russia tend not to use alcohol to relieve tension; instead, they seek support and compassion through verbal expression of their emotional discomfort.

CRS does not utilize counseling strategies and modalities that match this patient population's needs. Furthermore, patients needing family counseling to stabilize and support the recovery process were not provided this critical service. As noted throughout patient records, the absence of this intervention led to continued familial conflicts and personal distress.

Finding # 24: Inadequate Policies and Procedures for Program Operations and Services -- CRS has not determined and established the required written policies, procedures and methods governing the provision of services to patients. CRS' Policy and Procedures Manual is outdated and non-responsive to the current OASAS Part 822 Chemical Dependence Outpatient Services regulations that govern its operation. Of particular concern is the absence of appropriate treatment procedures for CRS patients, virtually all, diagnosed with co-occurring disorders. Additionally, there are no policies and procedures in place identifying the nature and the scope of the services being offered.

Finding # 25: Inadequate Staff Training and Supervision -- CRS failed to provide adequate training and supervision to counseling staff. Interviews of counseling staff yielded inconsistent responses about the frequency of supervision. These responses ranged from "no supervision" to

[1] Monica McGoldrick, Joe Giordano & John K. Pearce, Ethnicity and Family Therapy, Guilford Press: New York, 1996.

"weekly supervision." Additionally, administration could not produce any documentation of required staff training activities. CRS employs 15 primary counselors who are CASAC Trainees. Each has a caseload of 30 to 35 patients and is responsible for the maintenance of their caseloads. OASAS requires that these staff members receive ongoing supervision and continuing education and training as part of the requirement for this credential; however, there was no evidence that this requirement was being met.

Finding # 26: Failure to Take Corrective Action to Address Physical Plant Deficiencies -- On November 18, 2005, OASAS Facility Evaluation and Inspection staff conducted an inspection at CRS and identified several physical plant deficiencies, including:

814.3(b) Water stained tiles in ceiling
814.3(d)(3) No posting of fire evacuation routes
814.3(d)(ii) Staff not trained in rapid evacuation and fire fighting equipment use
814.3(e)(4) No screens in office windows

A Corrective Action Plan dated December 12, 2005 was submitted to OASAS by Maya Gurevich, Administrative Director. However, CRS failed to take actions necessary to correct deficiencies noted in the November 18, 2005 Facility Inspection Report. At the time of the BOE site visit, CRS still had not corrected two out of four of the deficiencies.

III. ITEMIZED REGULATORY COMPLIANCE VIOLATIONS:

An in-depth review of the most recent admission for 50 of the 100 cases identified was conducted. Of these, the entire CRS treatment history of 22 patients was analyzed.

Patient Case Records

Violation 01: In 50 of 50 active case records reviewed, initial determinations were not adequately prepared. [822.3(a)(1-3)]

Violation 02: In 50 of 50 active case records reviewed, the level of care determinations were not conducted in a manner that accurately reflected the patients' need for outpatient chemical dependence services. [822.3(c) and (d)]

Violation 03: In 50 of 50 active case records reviewed, individuals were not determined to be able to achieve or maintain abstinence and recovery goals with the application of outpatient services. [822.3(f)(1-2)] **[Repeat violations were identified for 21 of the 22 full case history reviews.]**

Violation 04: In 50 of 50 active case records reviewed, the comprehensive evaluations did not contain all of the required elements. [822.4(a)(4)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 05: In 50 of 50 active case records reviewed, for those patients who did not have available medical histories and physical examinations had not been performed within six months, medical staff did not adequately assess them within three weeks of admission to determine the

need for complete physical examinations. [822.4(b)(1)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 06: In 50 of 50 active case records reviewed, treatment plans were not developed and approved by a multi-disciplinary team within 30 days of admission. [822.4(f)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 07: In 50 of 50 active case records reviewed, the individual treatment plans did not address patient needs in all of the required functional areas. [822.4(g)]

Violation 08: In 50 of 50 active case records reviewed, individual treatment plans did not contain evidence that they were based on the admitting evaluation and any additional evaluations found to be required. [822.4(l)(2)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 09: In 50 of 50 active case records reviewed, individual treatment plans did not contain adequate goals for each identified problem. [822.4(l)(3)]

Violation 10: In 50 of 50 active case records reviewed, individual treatment plans did not contain adequate and measurable objectives to be achieved while the patient was receiving services. [822.4(l)(4)]

Violation 11: In 50 of 50 active case records reviewed, individual treatment plans did not contain adequate schedules for the provision of all services prescribed to the patient. [822.4(l)(6)] Additional services, such as psychiatric treatment, urinalysis screens and ESL classes, were not documented in the treatment plan.

Violation 12: In 50 of 50 active case record reviewed, services were not provided according to the individual treatment plans. [822.4(q)]

Violation 13: In 50 of 50 active case records reviewed, individual treatment plans did not include a description of the additional services, particularly the vocational educational, or employment services needed by the patient and a plan for meeting those needs. [822.4(1)(9)]

Violation 14: In 50 of 50 active case records reviewed, where services were to be provided by any other entity or facility off-site, individual treatment plans did not contain a description of the nature of the service; a record that referral for such service had been made; results of the referral and/or procedures for ongoing coordination of care. [822.4(q)]

Violation 15: In 42 of 42 applicable active case records reviewed, individual treatment plans were not thoroughly reviewed and revised at least 90 calendar days from the date of the establishment of the treatment plan and no less often than each 90 calendar days thereafter. [822.4(n)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 16: In 42 of 42 applicable active case records reviewed, the individual treatment plan reviews did not contain evidence of review and revision by the responsible clinical staff member, nor did they contain summaries of the patients' progress in each of the specified goals. [822.4(n)]

Violation 17: In 50 of 50 active case records reviewed, there was no evidence of a case conference being conducted if patients had not responded to treatment or had not met goals defined in the treatment plan. [822.4(o)]

Violation 18: In 6 of 6 applicable active case records reviewed, comprehensive evaluations were not updated every fourth treatment plan review. [822.4(n)]

Violation 19: In 50 of 50 active case records reviewed, progress notes did not provide a chronology of patients' progress in relation to the goals established in the individual treatment plan and delineate the course and results of treatment. [822.4(s)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 20: In 50 of 50 active case records reviewed, the discharge planning process did not begin upon admission, was not closely coordinated with the treatment plan and was not included in the patients' records. [822.4(t)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 21: In 5 of 5 applicable inactive case records reviewed, the discharge plans were not completed. [822.4(t)] **[Repeat violations were identified for 22 of the 22 full case history reviews.]**

Violation 22: In 5 of 5 applicable inactive case records reviewed, case records did not contain discharge summaries that included the course and results of treatment, within 30 days of the patients discharge. [822.4(x)]

Service Management

Violation 23: The service does not have a quality improvement plan which includes findings of other management activities, surveys of patients' satisfaction and analysis of treatment outcome data. [822.6(c)(1)(i-iv)]

Violation 24: The service does not prepare an annual report documenting the effectiveness and efficiency of the service in relation to its goals and provide recommendations for improvement in its services to patients, as well as recommended changes in its policies and procedures. [822.6(c)(2)]

Violation 25: The Policy and Procedure Manual did include up-to-date policies, procedures and methods governing the provision of services and other required elements. [822.2(a)]

Facility Standards

Violation 26: CRS does not have current policies and procedures that conform to all applicable laws and ordinances regarding fire and general safety. [814.3(b)]

Violation 27: CRS' floor plan is not current and accurate and does not specify the functions of each of the rooms. [814.3(c)(2)]

Violation 28: CRS' fire drills are not conducted in accordance with OASAS regulations. Drills are not conducted monthly. The last recorded fire drill was January 11, 2006. Written reports of fire drills do not contain the number of participants or the length of time for each evacuation. [814.3(d)(1-2)]

Violation 29: CRS does not have posted fire regulations and evacuation routes. [814.3(d)(3)]
[Repeat citation from Facility Inspection conducted on November 11, 2005]

Violation 30: CRS used an un-vented, open space heater at the front entrance of the facility. [814.3(d)(7)]

Violation 31: CRS had no screens on windows used for ventilation purposes. [822.3(e)(4)]
[Repeat citation from Facility Inspection conducted on November 11, 2005]

Violation 32: During the field investigation, OASAS observed walkers, motorized chairs and buggies being left at the bottom of the stairwell leading into the facility. This practice is hazardous and could potentially cause serious injury. [814.2(a)(1)]

Violation 33: CRS' second means of egress poses a safety hazard for staff and program participants as the stairwell is extremely steep and has sharp objects at its base that can potentially cause serious injury. [814.2(a)(1)]

General and Other Standards

Violation 34: [Finding #1] – CRS billed Medicaid for services that do not qualify as threshold visits and did not fully document content and outcomes of services in the individual patients' treatment records. [822.10(d), (f) & (g)]

Violation 35: [Finding #4] -- CRS staff failed to fully cooperate with OASAS at the onset of the investigation and were resistant throughout. [MHL § 32.17(c)]

Violation 36 [Finding #5]: CRS did not seek full review and approval by OASAS for transfer of ten percent or more of stock. [810.5(a)(2)]

Violation 37 [Finding #12]: Patients were inappropriately retained in treatment. [822.4(c)(6)]

Violation 38 [Finding # 15]: CRS failed to provide structured treatment services and organized program of therapies and activities to patients. [822.2(e)]

Violation 39 [Finding # 16]: CRS failed to provide treatment according to the patients' treatment plans. [822.4(m)]

Violation 40 [Finding #18]: CRS has inadequate utilization review procedures. [822.6(b)]

Violation 41 [Finding #20]: CRS failed to arrange linkages and service agreements with outside community service providers to support patients' recovery during and after treatment. [822.2(d)]

Violation 42 [Finding #21]: CRS failed to document recommendations, referrals and services provided for the patient's general health or for other special needs, including coordination with other agencies. [822.5(a)(7)]

Violation 43 [Finding # 24]: CRS has not determined and established the required written policies, procedures and methods governing the provision of services to patients. [822.2(a)]

Violation 44 [Finding #25]: CRS failed to provide adequate training and supervision to counseling staff. [822.7(c); 822.7(k)]

Violation 45 [Finding #10]: CRS used shared space for certified outpatient services and other services simultaneously. [814.6(a)(2)]

PLEASE TAKE NOTICE that it is the intention of OASAS not to renew and to revoke the Operating Certificate held by Community Related Services, Inc. for the reasons set forth herein, pursuant to law.

PLEASE TAKE NOTICE that it is also the intention of OASAS to impose a fine in this amount of **$16,591,300** as authorized pursuant to 14 NYCRR Part 810.15(d)(4).

In accordance with Mental Hygiene Law Section 32.21(a), you have the opportunity to be heard prior to the OASAS determination to revoke its Operating Certificates and impose a fine pursuant to 14 NYCRR Part 810.15(d)(4). This decision will be made at the principal office of OASAS, 1450 Western Avenue in Albany. If you choose to exercise your right to be heard, you must do so in writing, addressed to Richard R. Hogle, Esq., Associate Counsel, OASAS, 1450 Western Avenue, Albany, New York 12203. Written comments, if any, must be received by **September 29, 2006.**

Sincerely,

Henry F. Zwack
Executive Deputy Commissioner