Department of Human Services
Division of Mental Health Services
Ann Klein Forensic Center

July 1, 2002 to May 11, 2004
The Honorable James E. McGreevey
Governor of New Jersey

The Honorable Richard J. Codey
President of the Senate

The Honorable Albio Sires
Speaker of the General Assembly

Mr. Albert Porroni
Executive Director
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Mental Health Services, Ann Klein Forensic Center for the period July 1, 2002 to May 11, 2004. If you would like a personal briefing, please call me at (609) 292-3700.

October 26, 2004
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Department of Human Services  
Division of Mental Health Services  
Ann Klein Forensic Center  

Scope  
We have completed an audit of the Department of Human Services, Division of Mental Health Services, Ann Klein Forensic Center for the period July 1, 2002 to May 11, 2004. Our audit included financial activities accounted for in the state’s General Fund and the non-budgeted accounts.

The mission of the center is to provide quality, comprehensive mental health services for individuals who require a secured treatment setting. Annual expenditures and revenues are $20 million and $3 million, respectively.

Objectives  
The objectives of our audit were to determine whether financial transactions were related to the center’s programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of the significant conditions noted in our prior report dated November 3, 1999.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology  
Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, administrative code, circular letters promulgated by the State Comptroller, and policies of the center. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our samples of financial transactions. We also read the budget message, reviewed financial trends, and
interviewed center personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample populations were sorted and transactions were judgmentally selected for testing.

To ascertain the status of findings included in our prior report, we identified corrective action, if any, taken by the center and walked through the system to determine if the corrective action was effective.

**Conclusions**

We found that the financial transactions included in our testing were related to the center’s programs, were reasonable, and were recorded properly in the accounting systems. We also found that the center has resolved the significant issues noted in our prior report. In making this determination, we noted matters concerning payroll and personnel meriting management’s attention.
Management needs to improve controls over overtime.

Medical Security Officers Staffing and Overtime

In order to maintain federal medicaid eligibility by allowing patients’ room doors to remain unlocked at night, the center hired 46 additional medical security officers (MSOs) in November 2002 at a cost of approximately $2.3 million. However, the center subsequently decided not to unlock the patients’ room doors at night, and voluntarily withdrew from the Medicaid program in June 2003. Despite their withdrawal from the program, the center retained the extra MSOs on the payroll. Throughout fiscal year 2004 normal attrition reduced the number of extra MSOs from 46 to 30 above the budgeted position level. Funded by transfers from the division, these additional 30 MSOs continue to cost approximately $1.5 million annually.

Overtime becomes necessary when daily staff levels fall below the operational standards level set by the center. The hiring of the additional MSOs at a cost of $2.3 million resulted in the reduction of overtime by $800,000 during calendar year 2003. With the availability of 30 extra MSOs, it would be expected that the $1.1 million in overtime incurred by the MSOs during calendar year 2003 would continue to decline in calendar year 2004. However, our projections indicate overtime payments for MSOs in calendar year 2004 will continue at calendar year 2003 levels. Management’s assertion that overtime costs are primarily driven by an increase in patient supervision could not be confirmed. Instead, our review suggests the primary cause of overtime is the high number of call-outs by the MSOs.

Our observations and review of the causes of MSOs overtime noted several control weaknesses and practices that management should address to further control or reduce overtime. A scheduling unit was formed in early 2003 to maintain the scheduling functions of both the nursing and MSO staff. During
our fieldwork, we noted the use of the scheduling software known as “Inovar” was not utilized in scheduling MSO staff. Management cited a shortage of one person, as well as software problems with the application, as the reason for not using the scheduling software. During our review, our tests further noted routinely undocumented overtime caused by missing logs used to support call-outs, and as recently as April 2004, confusion by the MSO supervisors regarding daily minimum staffing requirements.

Some employees who have sustained injuries and are medically cleared to return to work are placed on adjusted work duty (light duty) status by attending physicians. Historically, the center has assigned these employees to the loading dock area, where they do not contribute to the minimum staffing requirements. Management has decided there are not positions in which these employees can safely work and be counted towards operational standards. Because the state continues to be liable for these employees while at work, management may consider not allowing these employees to return to work until fully capable and medically cleared to do so. During the 13-month period ending March 2004, over 7,100 hours were lost due to employees on adjusted duty status. In April 2004, the single monthly total increased to 1,592 hours. Those 14 months of lost productivity equate to approximately $217,000 or four full-time unproductive employees.

A management practice allows MSO supervisors to unofficially report to duty one half hour before their scheduled starting time and stay one half hour after the end of their shifts for organizational purposes. These same employees were allowed to work through their lunch giving them, in effect, 2 hours of daily overtime “built-in” to their schedules. In response to our observations, management began requiring supervisors to take one half hour lunch breaks, but still allows the organizational 1 hour of overtime during their shifts. Based upon statistics provided by management, the
potential annual overtime costs for this practice is between $50,000 and $140,000.

**Recommendation**

Management should be pro-active in its efforts to control and reduce overtime costs. Management needs to address the control weakness in not having MSO scheduling done by an independent unit. The Inovar staff should assume full control over the scheduling function for the MSOs. When used as intended, call-outs and scheduling changes can be professionally managed and confusion over shift minimums will be eliminated. Both of these factors will help to reduce overtime. Management also needs to implement procedures that address adjusted work duty assignments and, where possible, the reassignment of staff to meet operational standards with minimal overtime costs. A review by management is needed for the practice that allows one half hour before and after a shift for MSO supervisors. Scheduling of MSO staff by the Inovar staff should impact the supervisor’s need for organizational purpose time. In addition, management should review its policy for working during lunch. Supervisors should be required to take an hour lunch each day. When working through lunch is required, exceptions to the lunch-hour policy should be documented.
Dear Mr. Fair:

We appreciate the opportunity to respond to the contents of the Audit Report for the Ann Klein Forensic Center (AKFC) for the period July 1, 2002 to May 11, 2004, and request that it be made part of the Final Report for issuance. Our comments relate to pages 3 to 5 of the Draft Report.

**Hiring Additional Medical Security Officers (MSO’s)**

The issue of the additional Medical Security Officers (MSO’s) first arose from a Center for Medicare and Medicaid Services (CMS) ruling that having patient rooms locked during the night was a violation of their seclusion policy. The Division did not seek additional State positions for AKFC, but rather transferred positions from other hospitals. After concluding that unlocking the wards compromised patient and staff safety, we reverted back to the original practice and, as a result, had no choice but to voluntarily withdraw from Medicare certification for AKFC effective June 30, 2003. To avoid the effects of a layoff, the additional MSO’s are being normally attrited over time and positions are being returned to the original facilities as that attrition occurs.

The Report noted that the hiring of 46 MSO’s in November 2002 cost about $2.3 million, and that the remaining 30 MSO’s continue to cost approximately $1.5 million annually. This apparently assumes that all 46 were new hires. 13 of the MSO’s were simply converted from 80% part-timers to full time employees. New MSO’s are hired as recruits at an approximate salary of $30,000, and then promoted after a year to the Senior MSO title at a starting salary of about $35,000. Therefore, we would estimate the annual direct salary cost of the 46 positions in the range of $1.1 to $1.3 million. (33 @ $30,000/ $35,000 + 13 @ $30,000/ $35,000 x 20%). Again, these were not new positions to the Division but those temporarily transferred from other facilities.

**Control of Overtime**

It was also noted that in calendar year 2003, due to the hiring of the 46 MSO’s, the overtime was reduced by $800,000. The Report asserts: “With the availability of 30 extra MSOs it would be expected that the $1.1 million in overtime incurred by the MSOs during calendar year 2003 would continue to decline in calendar year 2004. However, our projections indicate overtime payments for MSOs in calendar year 2004 will continue at calendar year 2003 levels.”
While we agree with the amounts specified in the Report, the reduction of $800,000 in overtime was the result of the "extra" 46 MSO’s in calendar year 2003. Maintaining the same level of projected overtime with 16 fewer MSO’s on staff, and recognizing that additional attrition is also expected, is the result of improved overtime controls.

The Report noted—"our review suggests the primary cause of overtime is the high number of call-outs by the MSO’s." The Report doesn’t provide any further comparative information to support the conclusion that the number of call-outs is "high." With the addition of the 46 full-time MSO’s in November 2002, it would follow that total call-outs would increase since these individuals would have the normal complement of leave time to use. We concur that call-outs have a significant impact on the incurrence of overtime, but any comprehensive evaluation of overtime would also have to consider numerous other factors such as the number of patients requiring 1-1 coverage, patients requiring transport to other facilities, coverage at local hospitals, leaves of absence, Workers’ Compensation, Jury Duty, etc..

The facility continues to focus heavily on MSO call-outs. The Employee Relations Coordinator works regularly with the MSO Supervisors to monitor and examine the justification for all call-outs. All efforts are being made to regulate call-outs in compliance with existing Department protocols and collective bargaining provisions.

The end of the third paragraph (top of pg.4) further states that overtime is affected by “confusion by the MSO supervisors regarding daily minimum staffing requirements.” We believe there is no confusion as to the daily minimum staffing requirements that clearly identify the number of MSO’s needed per shift based on clinical and programmatic needs. MSO Supervisors have had extensive experience in completing an Overtime Justification Form whenever overtime is used. One of the first items to complete on the form is the “Operational Minimum” for the respective shift(s). It is only in relation to that figure that the need (or not) for overtime can be determined.

**Inovar Scheduling**

The Report noted that the Inovar scheduling software program is not yet utilized for MSO scheduling. We concur that Inovar should assume all scheduling responsibilities for MSO’s and the facility is presently recruiting for two (2) Technical Assistant positions to assure that the scheduling office is properly staffed to accomplish this objective.

**Adjusted Work Duty (Light Duty)**

The Report noted that because of their compromised physical health, MSO’s on SLI but otherwise capable of performing meaningful tasks, cannot be counted as part of minimum direct care staffing needs since they would be medically unable to respond to emergencies and patient incidents. Accordingly, as their medical condition permits, an individual is assigned to adjusted duties in areas where there is no patient contact, such as the loading dock to control access to the building by operating electronic doors, at the front door to provide needed searches of persons entering the facility, or to attend training sessions which would otherwise have to be provided later when the officers returned to unlimited duty. By placing MSO’s on adjusted duty status whenever appropriate, the hospital receives valuable services and reduces costs which would be incurred were they to remain on SLI and not work but still being in full pay status.
The Report states that “over 7,100 hours were lost due to employees on adjusted duty status. In April of 2004, the single monthly total increased to 1592 hours. Those 14 months of lost productivity equate to approximately $217,000 or four full-time unproductive employees.” As noted above, the opposite is true since 7,100 hours of adjusted duty would have been lost if the employees remained out of work on SLI and still in full pay status. By requiring the employees to perform adjusted duties, 7,100 hours of productive work resulted, although those hours did not impact on overtime.

**MSO Supervisors—Lunch Breaks and Incidental Overtime**

For the period audited, the Report makes a valid criticism to the extent that Supervisors were allowed to report early to work, to stay late, and to work through lunch unnecessarily. While the facility has addressed and remedied these situations, the projected annual cost during the audited period is believed to be approximately $13,000 as opposed to the $50,000 to $140,000 identified in the Report.

**Recommendations**

We would like to comment on the three general Recommendations and other statements on the final page.

- **Use of Inovar/Control of Overtime**: As noted above, we concur that the Inovar software system should assume all scheduling responsibilities for the MSO’s, and staff are being recruited to implement the program. At the same time, management has been pro-active in its efforts to control overtime costs, call-outs are being appropriately managed, and there is no confusion with daily minimum staffing requirements.

- **Light Duty Assignments**: As detailed above, we are unable to agree with the audit conclusions regarding adjusted (light) duty, and believe the facility is prudent in returning appropriate employees to duty consistent with their medical condition as opposed to out-of-work full pay status.

- **Supervisors Work Hours**: We concur with the audit conclusions and have taken steps to eliminate these situations.

Sincerely,

[Signature]

Alan G. Kaufman, Director
Division of Mental Health Services