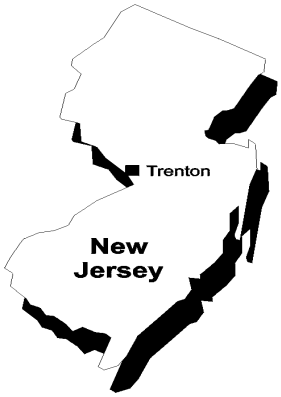
New Jersey

Division of Addiction Services

Technical Review Report:
Center for Substance Abuse Treatment (CSAT)
Core Technical Review

June 24, 2010



Prepared for
Division of State and Community Assistance
Center for Substance Abuse Treatment

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EXHIBITS

I. Executive Summary

Exhibit I-1. State Technical Review Participants

AGENCY NAME:	Division of Addiction Services New Jersey Department of Human Services
LOCATION:	Trenton, New Jersey
DIRECTOR:	Raquel Mazon Jeffers, M.P.H., Director
REVIEW PERIOD:	July 20–24, 2009
REVIEWERS:	Gwen Grams, Ph.D., Team Lead and Data Specialist Jeffery A. Hunter, M.B.A., M.P.H., C.P.A., C.F.P.™, Fiscal Specialist C. Ann Winger, M.S., Clinical Specialist
CSAT PERSONNEL:	Hal C. Krause, M.P.A., Government Project Officer (via teleconference) Gayle J. Saunders, Alternate Government Project Officer Alejandro A. Arias, Ed.D., M.A., C.P.P., Regional Team Leader and Acting State Project Officer (via teleconference)

Substance Abuse Prevention and Treatment (SAPT) Block Grant Compliance

The following tables illustrate the Technical Review team's findings with regard to SAPT Block Grant compliance. Table I-1 provides information on compliance with fiscal requirements. Table I-2 provides information on compliance with clinical requirements.

The Technical Review team found evidence that the Single State Authority (SSA) was in compliance with the following SAPT Block Grant fiscal requirements:

Table I-1. New Jersey Compliance with SAPT Block Grant Fiscal Requirements

Requirement	Specific Requirement	Evidence of Compliance	Evidence of Non-Compliance	Unknown/ Unable to Determine	Not Applicable (for Non HIV-Designated States)
Maintenance of Effort (MOE)	State	X			
	Pregnant women and women with dependent children	X			
	HIV	X			
	Tuberculosis (TB)	X (2005–2006, 2008)	X (2007)		

Requirement	Specific Requirement	Evidence of Compliance	Evidence of Non-Compliance	Unknown/ Unable to Determine	Not Applicable (for Non HIV-Designated States)
Set-Aside	Primary prevention	X			
	HIV	X			
Fiscal Management	Prohibited expenditures	X			
	Annual audit of New Jersey	X			
	Annual audit of intermediary	Not Applicable			
	Financial monitoring of intermediary	Not Applicable			
	Financial monitoring of treatment providers	X			

The Technical Review team found evidence that the SSA was in compliance with the following SAPT Block Grant clinical requirements:

Table I-2. New Jersey Compliance with SAPT Block Grant Clinical Requirements

Requirement	Evidence of Compliance	Evidence of Non-Compliance	Unknown/Unable to Determine	Not Applicable (for Non HIV-Designated States)
Pregnant Substance-Abusing Women				
Admission preferences	X			
Interim services	X			
Pregnant Women and Women with Dependent Children				
Specialized services	X			
HIV				
Early intervention testing and counseling services	X			
Confidentiality				
42 Code of Federal Regulations (CFR) and Health Insurance Portability and Accountability Act of 1996 (HIPAA)	X			

National Outcome Measures (NOMs)

Table I-3 illustrates the SSA's readiness to report NOMs that are currently defined.

Table I-3. Collection of Currently Defined NOMs

Measure	Currently Collected	Plans to Collect	No Plans to Collect	Unknown/Unable to Determine
Abstinence	X			
Employment/Education	X			
Access/Capacity	X			
Retention	X			
Criminal Justice	X			
Housing	X			

Table I-4 illustrates the SSA's readiness to report NOMs that are yet to be defined.

Table I-4. Collection of Other NOMs

Measure	Currently Collected	Plans to Collect	No Plans to Collect	Unknown/Unable to Determine
Social Connectedness	X			
Cost Effectiveness		Currently, the SSA is able to calculate cost effectiveness and can start reporting this measure when it is fully defined		
Perception of Care	The SSA requires providers to collect perception of care surveys			
Evidence-Based Practices (EBP)		When defined		

Performance-Based Management Capacity

The Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) issued a 2004 report titled, *Performance Management: Improving State Systems Through Information-Based Decisionmaking*. This report includes a "capacity assessment matrix," which provides guidelines for determining readiness to implement performance-based management. The capacity assessment matrix contains four dimensions—Provider Capacity, Data Systems Capacity, Cultural Capacity, and Analysis and Management Capacity. The guidelines for determining the State's level of implementation are contained in Appendix D. Using the SAMHSA guidelines, the Technical Review team assessed New Jersey to be at the following stages of implementation:

Provider Capacity

Description	Level of Implementation
Capacity of providers within the system to implement performance management	Basic to Advanced
Evidence	
All providers visited during the Technical Review collected and reported required standardized data to the SSA, including the Addiction Severity Index (ASI) and Level of Care Index (LOCI) assessments. The providers varied in their capacities to use these data for planning and decisionmaking.	

Data Systems Capacity

Description	Level of Implementation
Capacity of stakeholders for collecting, moving, and manipulating data	Advanced
Evidence	
Data on all clients receiving care in licensed facilities are collected at admission and discharge. Service data for approximately 25 percent of clients, those whose care is paid fee-for-service (FFS), are collected during treatment. Admission and discharge data are linked at the client level, and SSA staff use performance management data to make clinical adjustments. Edits are built into the data entry system, which is Web-based. Data have been linked to other State data for special ad hoc projects.	

Cultural Capacity

Description	Level of Implementation
Internal culture regarding the use of data in planning and decisionmaking	Advanced
Evidence	
SSA leadership and staff view performance management techniques as effective tools. Quality assurance (QA) measures are in place and are consistently defined in measurable terms. QA processes are integrated into planning and decisionmaking. The workforce has skills to apply performance management and the SSA has allocated sufficient staff to performance management.	

Analysis and Management Capacity

Description	Level of Implementation
Capacity to use data to manage services and influence practices at multiple levels	Advanced
Evidence	
The SSA provides timely comparison data by program, region, and State. The SSA has a specified process for taking action after review of data, and identifies outliers and discusses/provides onsite technical assistance (TA). Analytical/management staff throughout the SSA are dedicated to performance management activities. The SSA trains its own and provider staff on performance management.	

Organization of Appendices

Appendix A provides a list of the State and local personnel interviewed during the Technical Review, as well as CSAT personnel who were involved in the entrance and/or exit conference.
Appendix B provides a reference list of acronyms relevant to the State of New Jersey.
Appendix C includes the purpose, methodology, and limitations of the Technical Review.
Appendix D provides the SAMHSA Performance Management Capacity Assessment Matrix Guidelines.

II. Core Elements of the State Technical Review

The objective of this Technical Review is to describe the State alcohol and drug system; to inform CSAT about issues related to the State's readiness to collect, report, and use performance data, including NOMs; and to manage and improve the State treatment system. This is accomplished by focusing on:

- Organizational Structure of the State Alcohol and Drug Agency
- Policymaking Structure of the State Alcohol and Drug Agency
- External Relationships
- Needs Assessment and Strategic Planning
- Data Management
- Financial Management
- Quality Management and SAPT Block Grant Compliance

A. Organizational Structure of the State Alcohol and Drug Agency

This section describes the SSA's organizational structure and how the structure enhances the State's ability to use performance measures and make data-driven decisions. This section also assesses how the State's organizational structure impacts its readiness to collect, report, and use NOMs.

The New Jersey Department of Human Services (DHS) is the parent agency to the Division of Addiction Services (DAS), which is the designated SSA. DHS is a multi-service agency that includes seven major programmatic Divisions in addition to DAS, as follows:

- Division of the Deaf and Hard of Hearing (DDHH)
- Division of Developmental Disabilities (DDD)
- Division of Disability Services (DDS)
- Division of Family Development (DFD includes Temporary Assistance for Needy Families [TANF] and Food Stamps)
- Division of Medical Assistance and Health Services (DMAHS; includes Medicaid)
- Commission for the Blind and Visually Impaired
- Division of Mental Health Services (DMHS; includes adult but not adolescent behavioral health programs)

The DHS Commissioner holds a cabinet-level post and reports directly to the Governor of New Jersey. Two Deputy Commissioners and the Chief of Staff report to the Commissioner. The DAS Director reports to one of the Deputy Commissioners, therefore, the DAS Director is three levels removed from the Governor.

DAS is well situated within DHS where it benefits from strong relationships with sister divisions of DMHS, DFD, and DMHAS. In addition, DAS has received strong leadership support as it implements the recommendations set forth in the 2007 Office of Inspector General (OIG) Report (http://www.state.nj.us/oig/pdf/News%20Release%20DAS%20Financial%20Review.pdf).

DAS staff stated that the DHS Commissioner is a strong advocate for addiction issues while recognizing that the Division itself needs the time and the opportunity to heal from the repercussions of the OIG Report. Currently, DAS has 128 full-time equivalents (FTE), a number that is down over the past 2 years from a peak of 146. The FTEs are organized into eight offices. Five of the eight offices report to the DAS Director (the Office of the Director; Quality Assurance [OQA]; Research, Planning, Evaluation, and Information Systems [ORPEIS]; Policy and Special Initiatives; and Administration). The other three offices report to the Deputy Director (Treatment and Recovery Support; Prevention and Early Intervention Services; and Licensure and Supportive Housing).

The DAS organizational structure includes OQA, which coordinates monthly QA meetings. However, DAS staff believe that quality management permeates all units and levels within the organization. DAS leadership and staff stated that performance management is and must be a part of each employee's job functions. Staff from each of the offices participate in 360 Degree Reviews (the 360 Degree Review Process is described in more detail in Section G of this report) that bring together data and information from diverse sources within DAS.

The DAS mission (quoted from the DAS Web site) includes the concepts of accountability and measurable results as follows:

> "The Division of Addiction Services (DAS) promotes the prevention and treatment of substance abuse and supports the recovery of individuals affected by the chronic disease of addiction. As the Single State Agency for substance abuse, DAS is responsible for regulating, licensing, monitoring, planning and funding substance abuse prevention, treatment and recovery support services in New Jersey.
>
> To achieve its mission, DAS provides leadership and collaborates with providers, consumers, and other stakeholders to develop and sustain a system of client-centered care that is accessible, culturally competent, accountable to the public, and grounded in best practices that yield measurable results."

DAS values, which DAS staff cite as critically important to the agency's recovery, are Transparency, Accountability, Quality, and Fairness. DAS staff believe that these values are the embodiment of performance management and data-driven decisionmaking. Staff stated that they use data to the extent possible to establish, defend, and uphold the implementation of all policies and management decisions.

DAS documents submitted during the pre-site visit phase of the Technical Review process show the cultural/ethnic composition of the agency closely reflects the cultural/ethnical composition of its clients.

Exhibit II-1. Cultural/Ethnic Composition of DAS and DAS Clients

	Agency Staff		Client Population	
Category	**Number**	**Percent**	**Number**	**Percent**
White (non-Hispanic)	76	59.0%	36,392	59.0%
Black (non-Hispanic)	36	28.0%	16,331	26.0%
Hispanic (white)	2	1.6%	8,886*	14.0%*
Hispanic (non-white)	5	3.9%		
Asian/Pacific Islander	8	6.2%		
Native Alaskan/American Indian	1	0.7%		
Other (specify)			521	1.0%

* Includes all clients of Hispanic origin, both white and non-white.

DAS's parent agency, DHS, requires all staff to participate in diversity training. One of these diversity trainings took place at the same time as the Technical Review. Cultural competency training is expected to become a requirement of the core curriculum for licensed clinical alcohol and drug counselors and certified alcohol and drug counselors in the near future, and DAS is supporting such a requirement. DAS staff stated that they would like to do more to promote culturally competent services in the field, and requested CSAT TA in this area.

DAS classifies its treatment services into four categories: Inpatient Services, Outpatient Services, Pre-Treatment Recovery Support, and Post-Treatment Recovery Support. The Treatment Episode Data Set (TEDS) shows that New Jersey reported just over 60,000 unique admissions to substance abuse treatment in Federal fiscal year 2008 (FFY08); this figure does not include recovery support clients who do not receive treatment. Services are delivered by a network of approximately 300 licensed treatment providers. Table II-1 shows the total number of treatment sites by location and population served.

Table II-1. Number of SSA-Liscensed Sites throughout the State

	Location			Population Served	
Type of Service	**Total Number of Sites**	**Urban Sites**	**Rural Sites**	**Adults**	**Adolescents**
Detoxification 24-hour Hospital Inpatient	2	2	0	2	2
Detoxification 24-hour Free Standing	10	10	0	10	0
Detoxification Ambulatory	0	0	0	0	0
Rehabilitation Residential Hospital	0	0	0	0	0
Rehabilitation Residential Long-Term	29	22	7	24	5
Rehabilitation Residential Short-Term	14	10	4	10	7

Type of Service	Location			Population Served	
	Total Number of Sites	Urban Sites	Rural Sites	Adults	Adolescents
Rehabilitation Intensive Outpatient	210	123	87	210	210
Rehabilitation Non-intensive Outpatient	256	139	117	256	256
Halfway/ Transitional Housing	21	16	5	21	0
Opioid Replacement Therapy	31	30	1	31	0
Opioid Detoxification	31	31	0	31	0

B. POLICYMAKING STRUCTURE OF THE STATE ALCOHOL AND DRUG AGENCY

This section addresses the State agency's policymaking structure and its input into the accomplishment of performance measurement, NOMs reporting, and data-driven management decisionmaking.

Internal policies may be proposed by any member of DAS staff. The DAS Office of Policy and Special Initiatives (OPSI) drafts and vets proposed internal policies among agency management and staff. The DAS Director has final sign-off on internal policies.

According to New Jersey Law, external rules must be adopted through a formal and inclusive process. Proposed rules, which may be drafted by agency staff with assistance from OPSI, are reviewed and proposed by DHS for publication in the New Jersey Register. Proposed rules are reviewed by an external agency and, if published, are subject to a minimum 30-day public comment period.
DAS receives policy guidance from both permanent and ad hoc advisory groups. According to DAS staff, the advisory groups provide valuable insights that lead to the development of strong policies. These advisory groups include the following (as listed on the DAS Web site):

- Adolescent Substance Abuse Treatment Task Force
- Advisory Committee for Programs for the Deaf, Hard of Hearing, and Disabled
- Citizens (Consumer) Advisory Council
- Co-Occurring Disorders Task Force
- New Jersey Statewide Coalition on Disabilities
- Professional (provider) Advisory Committee

New Jersey's 21 counties also receive direct alcohol and drug program funding from a special State fund. New Jersey Statutes (NJS 26:2BB-1) require the County Boards to establish Local Advisory Committees on Alcoholism and Drug Abuse (LACADA) to advise and guide the County Boards in setting policy and expending the funds. Additionally, the Statute requires LACADAs to create provider subcommittees.

A 2007 OIG report inspired a renewed interest among DAS staff to develop both internal and external policies that are fair and defensible (i.e., based on data). OPSI, which had been in existence for approximately 2.5 years at the time of the Technical Review, was established to both coordinate and inspire the development of these policies. OPSI staff stated that policies must be reviewed to assure conformity with the DAS mission and vision, including accountability and transparency, and must drive "the way we do the work."

While the DAS internal culture supports the implementation of data-driven management, DAS staff believe that the provider community varies in its response to this approach. While many providers welcome the introduction of accountability initiatives, some are fearful that data—particularly outcome and performance data—may be based on miscalculations and bad assumptions. DAS staff see its greatest challenge as obtaining a genuine spirit of open collaboration and a concomitant reduction of fear among the members of the provider community.

C. EXTERNAL RELATIONSHIPS

This section addresses relationships and linkages among the SSA, other agencies, and stakeholders.

DAS staff enumerated a number of primary stakeholders in the provision of substance abuse treatment services, including New Jersey's 21 counties; the range of law enforcement agencies (including police, courts, and corrections); other social welfare groups and agencies (including child and family protection, adolescent and adult mental health, and self-sufficiency programs such as TANF); providers; and consumers and their families.

The New Jersey Substance Abuse Monitoring System (NJSAMS), described in Section E of this report, is the primary vehicle used by DAS and its partners to collect information about substance abuse treatment services. NJSAMS collects all currently defined NOMs, and collected data are easily available to contributing agencies and DAS staff through a Web site.

DAS staff provided the information in table II-2 during the pre-site visit phase of the Technical Review process. The cooperative programs described in table II-2 (those with an active treatment component) use DAS's NJSAMS as a reporting vehicle.

DAS accesses and shares resources for treatment and recovery support services through outreach to external organizations and participation in interagency advisory groups. In a similar manner, local County Boards and LACADAs are directed by New Jersey Statutes and DAS (through planning guidance documents) to reach out and develop collaborative relationships with external agencies that share a stake in substance abuse treatment.

As shown in table II-2, DAS staff provided information about additional existing agreements with external agencies and organizations. These agreements, and the Network for the Improvement of Addiction Treatment (NIATx) agreement in particular, directly support the organization's capacity for performance management.

Table II-2. Existing Agreements with Other Agencies and Organizations

Agency	Formal or Informal	Purpose	Source of Funds	Amount of Funding
Administrative Office of the Courts	Formal	Drug Court	State	$24,482,000
Administrative Office of the Courts	Formal	Judges Training	State	$100,000
Department of Children and Families (DCF)	Formal	Child Welfare Program	State	$12,921,687
State Parole Board	Formal	Mutual Agreement Program (Prisoner Re-Entry)	State	$2,865,000
Department of Corrections (DOC)	Formal	Mutual Agreement Program (Prisoner Re-Entry)	State	$935,000
Juvenile Justice Commission (JJC)	Formal	Juvenile treatment services	State	$233,816
DMHS	Formal	Co-occurring substance abuse and mental health services	State	$720,625
DFD	Informal	Work First New Jersey-Substance Abuse Initiative (WFNJ-SAI)	Not applicable	$0—only oversight of the treatment network
Robert Wood Johnson Medical School	Formal	HIV Rapid Testing Services	Federal	$803,224
Rutgers University	Formal	Research and evaluation	State and Federal	$451,783
University of Wiscconsin	Informal	Introduce the NIATx process to the New Jersey treatment community	Federal	$25,250

DAS staff cited collaboration and participation in planning in health care reform initiatives as an ever-increasing priority. In particular, DAS staff will work to be involved in committees and task forces established to integrate physical and behavioral health care, to develop electronic health records, and to expand Medicaid funding for substance abuse treatment services. DAS staff also would like to develop collaborative projects with the Federally Qualified Health Centers (FQHC) located in New Jersey. DAS could benefit from CSAT-funded TA for peer-to-peer assistance to explore successful methodologies to integrate behavioral and physical health.

DAS also seeks an expanded collaborative role with the New Jersey Department of Consumer Affairs, Board of Marriage and Family Counselors, which oversees certification of addictions counselors. DAS staff described the Board as “overtaxed and under-resourced.” DAS staff would like to develop agreements to support and improve the Board’s capacity to manage the certification process.

DAS further seeks an expanded working relationship with the Division of Child Behavioral Health Services (DCBHS) within DCF. DCBHS supports a network of family-centered,

community-based services for children with behavior health issues, including problems with addictions. DAS staff believe that both organizations can learn from and support each other. DAS should consider the advantages and disadvantages of further collaboration with DCBHS and other agencies in coordinating adolescent treatment services. DAS also seeks to strengthen collaboration with the Governor's Council on Alcoholism and Drug Abuse. The Council distributes approximately $12 million in dedicated Drug Enforcement Demand Reduction (DEDR) funds directly to the county Departments of Health or Human Services.

D. NEEDS ASSESSMENT AND STRATEGIC PLANNING

This section addresses the State's needs assessment and strategic planning processes, including stakeholder involvement and use of performance measures.

New Jersey created a State Epidemiological Outcomes Workgroup (SEOW) under the auspices of its Center for Substance Abuse Prevention (CSAP) State Prevention Framework State Incentive Grant (SPF SIG). The SEOW published the New Jersey State Epidemiological Profile for Substance Abuse in 2007. Data were collected from the National Survey on Drug Use and Health (NSDUH), New Jersey School Surveys, NJSAMS, and a multitude of other New Jersey administration data sets. These data were used to inform DAS, as well as counties and communities, of the need for treatment as well as prevention.

For the past 3 years, DAS has operated under a series of 1-year operational plans. DAS staff have requested TA from CSAT to develop and implement a 3-year strategic planning process. In the absence of a long-term plan, DAS has developed and promulgated its long-term vision, which includes the following:

- Addiction is recognized as a biologically based chronic disease that can be effectively managed.
- Addiction is situated within a public health paradigm where:
    - Early detection and assessment protocols begin with client engagement
    - Prompt and effective treatment is provided meeting a standard of care
        - All substance abuse and mental health programs are competent to screen, assess, and address co-occurring mental health and substance abuse disorders
    - Prevention measures are employed throughout the life cycle and continuum
    - Consumers are active, informed, and educated participants in their own recovery
    - Collaboration occurs regularly with mental health and primary health care systems
    - The use of best practices is widespread, including the latest pharmacotherapeutic responses

- The financing of the system promotes client outcomes

DAS staff have requested TA to address DAS's vision that best practices will include pharmacotherapeutic responses. DAS would like assistance to encourage the use of medication-assisted treatment that is fully integrated within all substance abuse treatment services as well as in primary care settings, and to conduct forums for providers regarding medication assisted treatment in general, and medication-assisted treatment for women in particular.

New Jersey Statutes (NJS S26.2BB-1 et seq.) give authority and responsibility to New Jersey's 21 counties to plan for and manage some local services, which are funded directly through formula grants. The same Statutes give DAS the authority and responsibility to review and approve the county plans, including the funding components of those plans. County plans must by Statute emphasize services to youth, drivers under the influence, persons with disabilities, workers, persons whose crimes are related to substance abuse, and public information/education programs.

DAS requires counties to produce 4-year plans and provide annual updates to the plans. DAS also requires the counties to include logic models in the plans that describe goals, needs assessment, priorities, funding strategies, and client outcomes for prevention, early intervention, treatment, and recovery support. Plans are reviewed by five-member panels using objective criteria. If a plan is not approved by the panel, DAS staff provide the county with TA.

As part of this process, staff from ORPEIS provide the counties with data source books. The data source books provide treatment admission and discharge data by type of drug, sex, race/ethnicity, and a number of other relevant social and demographic variables.

E. DATA MANAGEMENT

This section addresses data management within the SSA by looking at clinical and fiscal reporting and the utilization of report; management information system (MIS) compatibility; collection and utilization of NOMs; and data definitions for key elements, processes, and practices that affect data quality.

DHS Office of Information Systems (OIS), which reports to the Assistant Commissioner for Operations, manages the DHS Web and server functions used by DAS. OIS also coordinates the DHS Information Technology (IT) Steering Committee, which recommends DHS-wide IT policy. DAS staff participate in the IT Steering Committee, which meets monthly. ORPEIS, which is embedded within DAS, provides all other DAS data and information system management support. OPRIS develops and maintains NJSAMS, which is used to collect and report TEDS.

NJSAMS (https://njsams.rutgers.edu/samsmain/mainhome.htm) is a Web-based program that collects data about all clients receiving treatment in licensed facilities (all treatment facilities are required to be licensed). Providers enter data directly into NJSAMS. Providers can use the NJSAMS export feature to receive these data back for use with their independent programs. NJSAMS includes a customizable report writing feature that is available to stakeholders. The menu includes admission and discharge information, and may be broken down by county, gender, type of drug, outcome at discharge, and modality.

NJSAMS collects client admission and discharge information, including TEDS and the currently defined NOMs. The Government Performance and Results Act of 1993 (GPRA) social connectedness indicator is collected as well. In addition to this, NJSAMS collects ASI, LOCI, and the Comprehensive Adolescent Severity Inventory (CASI) for adolescents. Additionally, NJSAMS collects encounter data for FFS clients, who currently represent approximately 25 percent of the total client population. Providers are required to enter NJSAMS admission data within 2 weeks of the admission event. Discharge data are to be entered within 30 days. Through the NJSAMS export feature, providers can retrieve these and all NJSAMS data for upload to their own independent systems.

DAS assures the timeliness, accuracy, and completeness of NJSAMS data through a variety of mechanisms, including a front-end data editing process. The process flags attempted data entry when data are logically inconsistent with previously entered information. The process also flags coding errors. Further data entry is frozen until errors are corrected. DAS staff also provide monthly training to provider staff who are responsible for data entry. Providers visited by the Technical Review team had participated in the training, and found the course to be effective and informative. Additional training is available through the DHS Web site, which includes NJSAMS training and online help pages.

DAS also assures the quality of NJSAMS data through annual onsite monitoring. Monitors use a checklist, which includes the following items:

- Whether all clients shown on the required client roster have been reported to NJSAMS
- Whether clients are appropriately discharged through NJSAMS
- Whether the agency has a policy on the use of NJSAMS
- Whether patient/client files contain completed NJSAMS information

DAS staff interviewed by the Technical Review team reported that client data are used equally effectively for general oversight, service quality improvement, provider performance comparisons, provider funding and contracting decisions, strategic planning, policymaking and policy decisions, utilization review, reporting Federal and other mandates, and internal initiatives. DHS has a data warehouse which DAS has just started using. DAS has done ad hoc studies in which data were linked to external data sets; however, this has not been done routinely.

DAS plans to expand NJSAMS in the near future to include treatment planning and progress note modules. DAS would benefit from TA to develop these modules in the context of an electronic health record. DAS also plans to develop the DAS Income Eligibility Module (DASIE), which will provide a consistent way for providers to determine whether clients are financially eligible for services. DAS would benefit from peer-to-peer assistance to learn more about similar modules that function well in other States.

F. FINANCIAL MANAGEMENT

This section reviews fiscal management responsibility; systems capabilities; and available documentation and established procedures, including provider reimbursement systems, funding sources and trends, and SSA fiscal management capacity and practices, particularly as they relate to the SAPT Block Grant.

The Director of the Office of Management and Budget (OMB) within the Department of Treasury issues and maintains State fiscal policy, the State computerized financial management system, and the State fiscal policies and procedures. The DHS Assistant Commissioner for Budget, Finance, and Administration issues and maintains fiscal policies and procedures and prepares financial statements and the budget. Staff from the Office of Finance, which is located within Budget, Finance, and Administration, draw down SAPT Block Grant funds. The DAS Administrative Services Unit (ASU) procures program services, tracks SAPT Block Grant expenditures, ensures compliance with SAPT Block Grant fiscal issues, and monitors DAS's finances. An independent firm performs the Single State Audit.

Financial Systems

The New Jersey Comprehensive Financial System (NJCFS) is the State's automated accounting system. OMB maintains NJCFS online fiscal policies and procedures that address Federal grants in general, but not the SAPT Block Grant specifically. NJCFS uses a uniform system of appropriation and revenue accounts to provide a standardized basis for appropriation and revenue accounting at all administrative levels and to facilitate analysis and reporting of accounting information for fiscal control.

NJCFS uses an Organization Code (OC), which is an independent four-digit sequential code that identifies Department and Division/Bureau/Agency/Institution. An OC is established for each agency or governmental entity consistent with a budgetary level of control adopted for budget purposes. ASU staff have configured the NJCFS to account for and report on SAPT Block Grant expenditures by Federal award period. DAS staff use OCs to track prevention, HIV, women's services, and administration expenditures out of the SAPT Block Grant.

DHS issues a Contract Reimbursement Manual that provides detailed instructions to provider agencies on fiscal issues. DAS staff recognize the need to develop succession planning strategies to ensure that critical SAPT Block Grant accounting and reporting functions are not disrupted by personnel transitions. Consequently, DAS staff are increasing efforts to train additional staff to perform duties associated with SAPT Block Grant management.

Procurement and Contracting

DAS follows a structured process for procuring services. DAS abides by the policies and procedures established by OMB and DHS. Alcohol and drug funds are allocated by DAS in spending plans for each DAS service area such as women's services and prevention. These spending plans are approved after the budget has been approved by the legislature. The spending plans identify specific providers of services to receive the alcohol and drug funds and are submitted to the ASU Director for approval. DAS distributes alcohol and drug funds to service providers through contracts which are awarded through the State's procurement process.

New Jersey uses a competitive bid process to select new service providers. A request for proposal (RFP) is issued, which specifies all requirements and deliverables. A review committee recommends the bidder with the best combination of quality and cost to DAS. The DAS Director makes the final selection and approves the contract in the spending plan. The review committee includes individuals having expertise in the service to be funded. No one with a financial or a vested interest in the selection of a specific bidder participates in a review

committee. Contracts and FFS agreements are renewable annually for 3 years at the option of DAS. DAS uses a letter of agreement to govern arrangements for FFS reimbursement.

Each contract agreement specifies the SAPT Block Grant requirements and prohibited acts including the provider's reporting, billing, and SAPT Block Grant compliance requirements. The contract agreement delineates the source of funding by account code to allow the provider to differentiate between SAPT Block Grant funds, State funds, and other sources of funding.

ASU Payment Services staff receive authorization from the ASU Contract staff to pay or to continue to pay a provider agency. A payment analysis is made and then a cash disbursement transaction is entered into NJCFS. The ASU Payment Supervisor then reviews and provides final approval on the disbursement. The following day payment is processed from the New Jersey Department of Treasury and is executed to the provider agency. All of the provider agencies visited by the Technical Review team commented favorably on the reliability of DAS payment mechanisms.

DAS staff have developed hybrid contract mechanisms and a comprehensive review process to promote increased provider productivity, efficiency, and accountability. The contract of the adolescent provider visited by the Technical Review team had been converted to a hybrid contract (advance payment and cost reimbursement) due to underutilization of slots that had been previously funded by advance payments.

DAS also is in the process of entering into a contract with a new fiscal agent to manage FFS payments to providers. This change is designed to streamline the payment process and increase provider accountability.

Conveyance of SAPT Block Grant Compliance

The Technical Review team made the following observations regarding DAS's conveyance of SAPT Block Grant requirements to provider agencies:

- DAS contracts do not specifically identify SAPT Block Grant funding by Catalog of Federal Domestic Assistance (CFDA) number, nor do the contracts convey SAPT Block Grant prohibited expenditures. Other SAPT Block Grant requirements are included throughout the contract language.

- The women's provider's contract indicated that the award was funded by the SAPT Block Grant. The adolescent provider's contract did not identify funding sources.

- The women's provider visited by the Technical Review team includes a significant faith-based component featuring a mandatory weekly prayer session. Per Charitable Choice regulations, SAPT Block Grant-funded faith-based organizations are prohibited from using SAPT Block Grant funds for inherently religious activities such as worship, religious instruction, and/or proselytization. Organizations can engage in such religious activities only if the activities are offered separately, in time or location, from SAPT Block Grant-funded activities and participation in the activities is voluntary. The Technical Review Fiscal Specialist recommends that the State develop policies and procedures to ensure that provider agencies are in compliance with Charitable Choice requirements. The State also may benefit from CSAT-funded TA.

Fiscal Monitoring

ASU contract staff are responsible for fiscal monitoring of providers. Providers are required to submit monthly/quarterly and annual reports of expenditures to ASU contract staff. Using a protocol, ASU contract staff review the monthly/quarterly reports and may make adjustments in payments to providers on the basis of the review. ASU contract staff review the annual reports, determine whether any amount is due to/from the provider, and take the appropriate action to resolve any issues.

ASU staff conduct regular desk fiscal reviews of DAS-funded providers using a protocol. The protocol includes questions about the SAPT Block Grant requirements. Data examined in the annual onsite fiscal reviews include the following categories:

- Minutes from the Board of Directors' Meetings
- A-133 Audit
- Conflict of Interest Policy
- Personnel Policy
- Procurement Policy
- Position Description
- Inventory System
- Executive Order 134
- Ownership Disclosure Form
- Fiscal Systems (Cash Receipts, Accounts Receivable, Accounts Payable, Petty Cash, Bank Reconciliations, Payroll, General Ledger, Travel Logs, Vehicle Records, etc.)

Information from the annual onsite fiscal reviews is reviewed by the DAS Administrative Services staff and written feedback is sent to the providers, including recommendations for improvement. Additonally, the results of regular desk fiscal reviews are discussed in DAS bi-weekly management meetings and may be included in a special report on provider issues.

All providers visited by the Technical Review team indicated that they had been subject to DAS/DHS reviews. The women's provider indicated that DAS staff had conducted a telephone review. Staff of the opioid treatment provider reported being the subject of multiple DAS clinical and fiscal reviews over the last 3 years, including a cost incurred audit conducted by an outside certified public accountant (CPA) firm that uncovered no major findings. The opioid treatment provider subsequently hired an outside CPA firm to totally revamp its financial management system. The firm has been successful in strengthening internal controls and improving the documentation of financial transactions. The firm also has implemented a new accounting system and automated major accounting processes.

State Single Audit

An independent audit firm conducts the Single State Audit of the State of New Jersey. The latest audit, issued July 16, 2009, covers the year ended June 30, 2008. The auditors reported that DAS "…did not ensure that the expenditure and audit reports submitted by subrecipients were completed and reviewed and approved timely by both a reviewer and supervisor, and that site visits over subrecipients were conducted by a monitor, and reviewed and approved timely by a supervisor." The auditors opined that, as a result of the reported condition, DAS

"…subrecipients may not be conforming with performance goals, administrative standards, financial management rules, eligibility, and other Federal requirements." The independent audit firm recommended that DAS "… strengthen its procedures to ensure that all expenditure and audit reports for subrecipients are completed and reviewed and approved timely by both the reviewer and supervisor and site visits for subrecipients are conducted by a monitor and reviewed and approved by a supervisor."

DAS management indicated that DAS would implement the following corrective actions to address this finding:

- Issue a regular electronic bulletin to all agencies to remind them that they must submit a quarterly expenditure report and a final expenditure report, on time, with all fields complete in order for payment to be released. The bulletin also will indicate when the single audit is due.

- Withhold payments subsequent to the report due date until reports are submitted and complete.

- Document the follow up of non-submitted or incomplete reports in the file or by e-mail.

- Implement written procedures by August 31, 2009, to ensure that a supervisor is reviewing and following up receipt of reports as a prerequisite for payment, and the review of reports.

- Develop and implement comprehensive written procedures to ensure that all prevention contract monitoring site visits have been conducted, documented, and are signed off by both the monitor and the monitor's supervisor.

- Review tracking records in unit staff meetings to ensure timely completion.

- Procure all prevention services through contracts, which require formal review.

- Adapt a uniform, formal monitoring process for all prevention contracts.

- Develop standard monitoring tools for all prevention contracts that review specific deliverables for each contracted service.

The auditors reported that "There is a lack of effective internal control requiring signed documentation of personal services transactions and maintaining such documentation." The auditors opined that "Personal services expenditures may not be appropriately reviewed and approved and may not be appropriately allocated or documented." The auditors recommended that "…the Department strengthen internal controls over the process for proper review and authorization of personal services expenditures and to ensure supporting documentation for personal services expenditures is properly maintained." DHS staff reported that they were in the process of implementing upgraded timekeeping procedures to address this finding.

Provider Single Audits

All State agencies that disburse Federal grant, State grant, or State aid funds to recipients that expend $500,000 or more in Federal financial assistance or State financial assistance within a State fiscal year must require these recipients to have annual single audits or program-specific audits performed in accordance with the Act, Amendments, OMB Circular No. A-133 Revised, and State policy. It should be noted that the Federal government will not pay for a single audit for any recipient that expends less than $500,000 of Federal funds. All State agencies that disburse Federal grant, State grant, or State aid funds to recipients that expend less than $500,000 in Federal or State financial assistance within their fiscal year, but expend $100,000 or more in State and/or Federal financial assistance within their fiscal year, must require these recipients to have either a financial statement audit performed in accordance with Government Auditing Standards (Yellow Book) or a program-specific audit performed in accordance with the Act, Amendments, OMB Circular No. A-133 Revised, and State policy. Program-specific audits in accordance with OMB Circular No. A-133 Revised can be elected when a recipient expends Federal or State awards under only one Federal or State program and the Federal or State program's laws, regulations, or grant agreements do not require a financial statement audit of the grantee.

If a State funding department determines that a financial statement audit in accordance with Government Auditing Standards will not provide adequate monitoring for their department's funds, each department has the responsibility to perform other monitoring procedures. Such procedures include onsite visits, reviews of documentation supporting requests for reimbursement, and limited scope audits as outlined in OMB Circular No. A-133 Revised.

ASU staff are responsible for monitoring providers' compliance with the A-133 Audit requirements. Providers are required to submit copies of A-133 Audits to DAS and the DHS Audit Unit. The DHS Audit Unit conducts a desk review of the A-133 Audits and follows up on issues such as SAPT Block Grant compliance issues and questionable costs. The A-133 Audits and the subsequent desk reviews include the SAPT Block Grant requirements. DAS uses the results of the desk reviews to determine whether the provider is to refund any questionable costs and whether the provider is eligible to continue to receive payments from the State.

The fiscal solvency of provider agencies is reviewed on the basis of the desk reviews of the A-133 audits conducted by DAS and DHS Audit staff. ASU staff review and approve monthly/quarterly and annual expenditures, provide regular desk fiscal reviews, and engage in discussions regarding the agencies' fiscal and programmatic concerns in DAS' biweekly management meetings. In addition, DAS engages the services of an independent CPA or DHS Auditors to conduct fiscal reviews of providers as needed. The agreed upon procedures for the fiscal reviews duplicate procedures required in the A-133 Audits. The implementation of these risk assessment approaches target DHS audit resources toward the providers most in need of monitoring and review.

Table II-3. Summary of State Alcohol and Drug Expenditures by Revenue Source

Revenue Source	SFY07	SFY08
State General Fund	$83,808,000	$94,635,000

Revenue Source	SFY07	SFY08
Other State Funds	$22,066,000	$23,028,000
SAPT Block Grant	$57,066,000	$44,161,000
Medicaid Funds	$0	$0
Other Federal Funds	$4,346,000	$3,026,000
Other (Insurance, Client fees)	$8,930,227	$9,335,525
Total	$176,216,227	$174,185,525

Table II-3 presents a summary of State alcohol and drug expenditures by revenue source of State funding for alcohol and drug treatment and prevention services for State fiscal years 2007 and 2008 (SFY07 and SFY08). Total alcohol and drug expenditures were $176,216,227 for SFY07 and $174,185,525 for SFY08. Total alcohol and drug expenditures decreased by $2,030,702 or 1.15 percent from SFY07 to SFY08.

G. QUALITY MANAGEMENT AND SAPT BLOCK GRANT COMPLIANCE

This section provides a broad review of quality management practices in the SSA beginning with the more typical quality assurance domains such as service system quality, credentials of providers and clinicians, and clinical monitoring and performance management. The latter section bridges the divide between the clinical and fiscal domains and reviews SAPT Block Grant compliance to both ascertain the extent of compliance and show how level of compliance may affect quality of care throughout the system.

Quality Management

Best Practices

- **Standards of Care and Treatment Protocols**—DAS uses the following standards of care and/or treatment protocols.

    - New Jersey Manual of Standards for Licensing—The Standards contain requirements for both State and Federal regulations and provider programmatic compliance. The Standards address provider policy and procedure manuals, staffing ratios, client charts, staff credentials, and personnel files.

    - Control Guidelines for Drug Treatment Personnel—The Guidelines provide specifications for provider staff regarding infection control and universal procedures.

    - TB Testing and Surveillance Guidelines—The Guidelines provide specific guidance in counseling clients in regards to TB. Testing is addressed to determine whether the individual has been infected with mycobacterium tuberculosis (MTB) and to determine the appropriate form of treatment. Processes for referring clients infected by MTB to appropriate medical evaluation and treatment are addressed.

- DAS Administrative Bulletin 4-2007—The Bulletin serves to augment the Federal guidelines as issued by the Food and Drug Administration (FDA) in the use of buprenorphine (suboxone and subutex) to treat opiate dependent clients. The Buprenorphine Guidelines contained within the Bulletin emphasize that buprenorphine is an adjunct to treatment and not to be used in lieu of a full treatment experience consisting of detoxification treatment and/or maintenance, counseling and education, and aftercare counseling.

- Counseling and Testing Protocol and Procedure Manual—The Manual provides procedures for the counseling and testing of clients for HIV/AIDS.

- Guidelines for the Medical Management of HIV/AIDS—Issued by the Department of Health and Senior Services (DHSS), Division of AIDS Prevention and Control (dated December 2001), the document provides procedures for the medical management of HIV/AIDS.

Provider contracts reference the required adherence to the regulations/guidelines contained within the documents based on the modality of funded care.

- **Provider Licensure/Certification**—The DAS Licensure and Supportive Housing Unit licenses all providers who offer substance abuse treatment in New Jersey, while the Department of Community Affairs, Division of Codes and Standards approves all structural plans. DAS is one of the last divisions within DHS to retain the authority for provider licensure (this function is centralized for the remainder of DHS) and DAS staff value the responsibility in light of the impact for provider growth and leverage for decisionmaking.

  Currently, DAS licenses approximately 280 outpatient and 60 residential treatment providers. However, DAS staff reported expending the greater part of their treatment dollars on residential treatment versus outpatient treatment services. Staff are making concerted efforts to place more emphasis on the use of outpatient treatment services coupled with case management when appropriate.

  DAS averages 10 to 15 new and amended licensure applications per month. Most of these applications are for outpatient treatment services. DAS conducts informational reviews for interested applicants once per month wherein the requirements for licensure are discussed.

  Providers undergo biennial reviews following initial licensure. Licensure visits entail a thorough review of provider policies and procedures, personnel, supervisory practices and safety, and random sample chart reviews.

  Staff within the Licensure and Supportive Housing Unit include an architect, a construction code inspector, and three FTEs who conduct onsite provider licensure visits. One of the three FTEs conducts methadone provider visits; the second FTE conducts all other outpatient treatment provider visits; while the third FTE conducts residential treatment site visits. Residential treatment licensing regulations have recently been revised and outpatient or ambulatory regulations are currently under formal review.

- **Accreditation**—DAS encourages providers to achieve accreditation; however, accreditation is not mandatory. DAS staff reported that approximately 75 to 80 percent of providers are accredited; however, accredited providers are not granted status in lieu of DAS licensure.

- **Utilization Management**—DAS uses several current efforts to manage service utilization and has planned future efforts to do the same. Both the current and planned processes are described below.

    - Placement Procedures—NJSAMS has a Web form version of the LOCI. The index supports the use of the American Society of Addiction Medicine, Patient Placement Criteria, Second Edition, Revised (ASAM PPC-2R) for placement and continued stay. LOCI is completed prior to contacting DAS to request client continued stays or extensions. DAS licensure and provider onsite monitoring visits are used to ensure that client placement aligns with the LOCI recommended placement.

    - Hybrid Contract Policy—In January 2009, DAS introduced the Hybrid Contract Policy in an effort to maximize service availability from providers that are funded through a slot format. The Hybrid Contract places a portion of a slot funded contract on a unit cost reimbursement method of payment, without altering the total value of the contract. The contract is intended to rectify underutilization on the part of providers.

      DAS uses a uniform methodology to calculate actual utilization of contracted treatment slots that includes the number of clients served, the number of service days provided, and the number of face-to-face client contacts expected within each funded modality or ASAM PPC-2R level of care. Providers by contract are expected to maintain a preset census and provide the required amount of client contact. Providers falling below the contract expectation for 6 months are placed on Hybrid Status and given a maximum of 6 months to bring utilization up to the contract stated expectation while being paid in an alternate status or unit cost reimbursement versus being paid on a slot status. The policy allows DAS to redirect funds from a provider experiencing prolonged underutilization to another provider who can better ensure the maximum level of client services.

    - Performance-Based Contracts—DAS recently initiated a first set of performance-based contracts where the SSA pays providers for client retention rates. The goal is to move to more Pay for Performance contracts with a concerted focus on clinical outcomes.

    - Pay for Performance Contracts—DAS wants to reform its funding distribution and enhance its ability for making data-driven decisions regarding the delivery of substance abuse treatment services. DAS wants to increase the use of Pay for Performance contracts in order to reduce cost and to fund more specifically the number and types of services that best support the vision it holds for the State's continuum of care. The philosophy of DAS is explained in the Care Management Section that follows.

- Care Management as Supported by Fiscal Agent Contract—The principles of care management include coordination and management of services in order to reduce fragmentation and to avoid the use of unnecessary services. The goal of care management is to ensure that treatment is available and accessible as a quick response to need at lower levels of intensity in order to keep clients in a "recovery zone." The recovery zone consists of treatment and recovery supports designed for a continuous response to the chronic nature of the illness, thereby avoiding acute episodes of care.

  DAS plans to consolidate three existing lead agencies into a fiscal agent (FA) contract to further its goals regarding care management and the promotion of best practice treatment, improved clinical outcomes, and effective utilization and management of State resources. The FA will pre-authorize client services based on ASAM PPC-2R. Unique client needs will be addressed using "enhanced" targeted case management service packages. The service packages will have annual cap amounts by level of care.

  The enhanced targeted case management service packages will be intended to keep clients in the recovery zone. The targeted case management service packages will include the following menus of choice for clients needing medication-assisted treatment and/or co-occurring services and/or recovery support services:

  - Medication-assisted treatment packages could include medication monitoring, medical follow up, medication monitoring, and/or physical exam.

  - Co-occurring services for the dually diagnosed could include crisis intervention, clinical consultations, medication monitoring, and/or prescription reimbursements.

  - Recovery support services could include recovery mentor support, transportation, and/or physical exam.

  The FA will collect and capture more complete data for utilization management from FFS contracts. DAS staff see this effort as a re-tooling process for the agency and an opportunity for staff to use data in a more complete fashion when managing service utilization and tracking clinical outcomes.

- **Continuous Quality Improvement (State, intermediary, and provider levels)**—DAS uses the Program Improvement Committee (PIC) for continued QA. The PIC function is overseen by OQA and is chaired by the DAS QA Coordinator of the Complaint and Reportable Event Management Unit. Members of the PIC are representative of all applicable units/offices within DAS participating as needed.

  The DAS OQA has developed a 360 Degree Review Process over the past 3 years. The 360 Degree Review Process consists of a cross-unit quality assurance effort that provides a multidimensional review of like modality provider agencies and their QA and service functioning. The 360 Degree Review Process covers contract expenditures and

reporting; A-133 Audits and financial health; board consistency; performance on service delivery and outcome measures (NOMs); performance on licensing; contract performance; utilization management; complaints/critical incidents; and any other relevant information. Results of the 360 Degree Review Process are used to determine continued funding of providers, TA needs, increased monitoring requirements, and corrective action needed. Providers found to be out of compliance can face the potential of losing funds. Many changes in contracts and services were made as a result of this process.

Additional utilization management data will soon be available to DAS as a result of the FA Contract described above. DAS might consider expansion of the role of the PIC and/or 360 Degree Review processes to include this new information. Currently, the PIC and the 360 Degree Review processes provide a valuable foundation for highlighting and correcting issues at the provider level and making funding decisions. Utilization data could serve to better identify systemic issues or patterns and trends that could improve service delivery overall within the State's continuum of care.

In 2007, DAS developed a "Substance Abuse Treatment Provider Performance Report" for provider agencies funded by DAS. The report includes admission and discharge data by modality for the specific agency, as well as NOMs data for each modality provided by the agency compared with State averages. Ensuring that the data included in the reports accurately reflect the work of the providers is an important goal. For providers requiring help with data reporting through NJSAMS, the Division offers TA and training on its use to ensure consistency.

DAS Licensure Regulations require that providers implement a written QA plan that is reviewed annually and revised as necessary. Providers visited during the Technical Review each had formal QA programs. Some of the goals of the performance improvement teams consisted of: maintenance of required contract utilization rates, earlier appointments for women needing prenatal care, improvement in the quality of clinical records, and the creation of a 12-week Tobacco Program (smoking cessation and hazards of) for adolescents.

- **EBP—**DAS encourages; however does not require, the use of specific best practices on the part of all providers. DAS does require the use of the following best practices for certain providers:

    - Providers that serve pregnant women and women with dependent children are required to use the Strengthening Families Program and Trauma Informed Services using the Seeking Safety Model.

    - Suboxone treatment providers are required to have client participation in a 12-week Cognitive/Behavioral/Motivational counseling curriculum.

    - Treatment Improvement Protocol (TIP) 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs,* is specifically referenced in the current Outpatient Substance Abuse Treatment Licensure Regulations and provider compliance is required.

DAS is requesting CSAT-funded TA for purposes of achieving systems integration of medication-assisted therapy. DAS wants to promote a growing understanding and acceptance of opioid addiction as a treatable medical disorder among providers statewide. Best practices used by providers visited during the Technical Review include Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Stages of Change, Rational Emotive Therapy, and Reality Therapy. The SSA now has a pilot learning collaborative using the NIATx Model. There are currently 11 provider agencies participating in the pilot in an effort to focus more on client retention rates.

DAS works closely with the Central East Addiction Technology Transfer Center (CEATTC) to deliver evidence-based, best-practice education to the field. CEATTC also conducts a Leadership Institute for managers and supervisors employed in DAS-funded agencies. The Leadership Institute is an intense leadership preparation program designed to cultivate the development of future addiction leaders. DAS has five individuals from provider agencies who have attended the Leadership Institute. The work of one of the five individuals who developed a clinical supervision package for implementation at the opioid treatment provider visited during the Technical Review is highlighted in the Technology Transfer section of this report.

Workforce Development

- **Counselor Certification/Licensure**—DAS funds a Workforce Development Initiative, through its contract with the New Jersey Prevention Network (NJPN), to organize and manage a statewide training and education system for persons delivering alcohol, tobacco, and other drug services. NJPN offers courses for counselor certification and trainings for re-certification credits in approximately 11 sites across the State.

  DAS works with the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners, which is responsible for counselor certification in the State of New Jersey. The Board is actually located within the Department of Law and Public Safety, Division of Consumer Affairs. The Board within the Division of Consumer Affairs regulates counselor certification efforts for the Licensed Clinical Alcohol and Drug Counselor (LCADC) and Certified Alcohol and Drug Counselor (CADC).

  The State Board of Marriage and Family Therapy Examiners looks to the Addiction Professional Certification Board (APCB) of New Jersey to administer all oral and written exams for counselor certification and also relies on the APCB to conduct educational reviews for all course work completed by applicants seeking counselor certification. In addition, APCB processes reciprocity between New Jersey and other boards who have a reciprocal credential with the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA). All instructors used by NJPN are Master's Degree level clinicians and are approved to teach courses by the APCB of New Jersey. APCB also has approved the 270-hour core course curriculum for counselor certification. In addition, APCB has credentials for which it is responsible and issues certificates for the following:

  - Certified Clinical Supervisor (CCS)
  - Certified Prevention Specialist (CPS)

- Co-Occurring Disorder Professional Diplomate (CCDP-Diplomate)
- Certified Tobacco Treatment Specialist (CTTS)
- Criminal Justice Counselor (CJC)
- Chemical Dependency Associate (CDA, including Recovery Mentor Associate [RMA])
- Associate Prevention Specialist (APS)
- Co-Occurring Disorder Professional (CCDP)
- Community Mental Health Associate (CMHA)
- Disaster Response Crisis Counselor (DRCC)
- Addiction Disability Specialist (ADS)
- Woman's Treatment Specialist (WTS)
- Certified Criminal Justice Professional (CCJP)

Due to limited employees at both the State Board and APCB, the processing of counselor certification applications is slow. DAS and provider staff indicated that a significant number of individuals seeking certification have difficulty passing both the written and oral exams as given by APCB. DAS in unison with the NJPN are developing a QA effort to determine strategic interventions that will hopefully improve the application and certification process.

DAS is currently working to implement a new Workforce Development Initiative that will attract Masters' Degree-level clinicians. The planned Workforce Development Initiative will serve as a recruitment tool by offering tuition reimbursement to individuals in attendance at graduate school who may be interested in pursuing dual licensure for LCADC or Licensed Professional Counselor. The Workforce Development Initiative also will subsidize practicum placements for interested students at DAS-funded provider sites that can result in full-time employment.

- **Clinical Supervision**—Licensure regulations require that every provider will employ at least one director of substance abuse counseling who is responsible for the following:

  - Developing a QA plan for counseling services

  - Providing and documenting of clinical supervision at least 1 hour per week to all clinical staff

  - Ensuring that counseling services are evidence-based or based on objective information consistent with recognized treatment principles and practices

  - Orienting and assessing of counseling staff

  - Ensuring that all counseling staff are properly licensed or credentialed

  - Participating in the identification of quality care indications and the collection and review of data to monitor staff and program performance

  - Ensuring that clinical staff are being supervised by the appropriately credentialed staff

Annex A of all provider contracts contains the following statement regarding clinical supervision:

"A supervision schedule shall be maintained and submitted to DAS on a quarterly basis; all clinical supervision shall be documented, and include date, name of supervisor and supervisee, and cases reviewed." Also, "supervisors shall ensure compliance with Title 45, Chapter 6 Clinical Supervision in the New Jersey Office of the Attorney General, Division of Consumer Affairs, State Board of marriage and Family Therapy Examiners Alcohol and Drug Counselor Committee, Statutes and Regulations."

All providers visited by the Technical Review team employed clinical supervisors who used a variety of clinical supervisory tools, including individual and group case reviews, client chart reviews, tracking of client satisfaction results regarding client counseling experience, mentoring, and observation.

- **Clinical Documentation (treatment planning, progress notes, discharge summaries)**—DAS conducts annual onsite and biennial licensure reviews where client documentation is reviewed and feedback is given to provider staff. The peer review process also provides feedback regarding the clarity, thoroughness, and timeliness of clinical documentation. DAS staff indicated that clinical documentation is an area that needs improvement and plans are forthcoming to deliver training on the development of treatment plans based on assessments and the writing of progress notes that address treatment plan goals.

- **Cultural Competency**—Per Contract Annex A, all providers should appoint staff members to coordinate and/or provide cultural competence/sensitivity skills training annually to all staff. DAS also offers annual training in cultural competency and counselor certification requires training in cultural competency for initial application as well as for continuing education requirements. Through its prevention RFP, DAS currently funds a provider agency that may be interested in also serving as a statewide TA advisor to assist other providers in the development of cultural competency training. DAS staff indicated that this is an area for which they would like to receive CSAT-sponsored TA.

  DAS funds substance abuse programs for individuals who are deaf, hard of hearing, or have a disability. In addition, Public Law 1995, Chapter 318 established the "Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing, and Disabled." The legislation has initiated a committee consisting of five members who are either deaf, hard of hearing, or disabled; two members of the public with an interest in issues relating to alcohol and drug abuse; and one representative from the following entities: The Governor's Council on Alcoholism and Drug Abuse, Developmental Disabilities Council, Division of Vocational Rehabilitation Services, DDHH, and DDS. A DAS staff member attends each quarterly meeting.

  The Statewide Coalition on Disabilities and Addictions also addresses special concerns and needs of individuals who are disabled and who are experiencing substance abuse issues. The Coalition is comprised of agencies and individuals interested in learning and

sharing resources with other professionals about disabilities and addiction issues. This advisory coalition meets on a quarterly basis and the public is invited to attend this meeting.

- **Expected and Current Counselor Caseload**—Outpatient Licensing Regulations require that programs maintain an average ratio of substance abuse counselors to clients on the basis of each program's daily census, as follows:

Program	Ratio
Outpatient	1:35
Intensive outpatient	1:24
Partial care	1:12
Outpatient detoxification	1:24
Opioid treatment (no more than 35 in Phase I-III)	1:50

Group counseling sessions are not to more than 12 persons per group per Annex A, which is part of all provider contracts. All outpatient treatment providers visited during the Technical Review maintained the above ratios or less. The residential women-specific program visited had two counselors and a capacity of 12 women. There was no indication that counselor caseloads were of concern to counselors.

Clinical Evaluation

- **Assessment**—Upon entering an inpatient treatment program, an intake assessment is completed using ASI. The intake assessment consists of medical, laboratory, and nursing services, provision of nutritional information, and discussion and signing of all consents and releases for treatment services. CASI is used for adolescent assessment.

- **Placement**—Providers complete an ASAM PPC-2R multidimensional level of care review using the LOCI tool in NJSAMS at the time of admission and for continued stay.

- **Matching Clients to Services Needed**—Counselors are responsible for reassessing clients throughout the treatment episode according to the ASAM PPC-2R to determine the need for continued services, transfer, or discharge/transfer. The DAS onsite monitoring tool requires site visit reviewers to examine charts to ensure that clients are admitted to the appropriate level of care based on ASAM PPC-2R. DAS reviewers are able to provide TA to agencies that are not appropriately using ASAM PPC-2R.

- **Use of Client Placement Data in Management Decisions**—DAS is moving towards assessing placements and length of stay patterns in order to establish length of stay criteria for provider contracts. The FA Contract will provide in depth data regarding units of service and length of stay patterns. DAS staff reported that the State-monitoring unit and providers will receive additional training in ASAM PPC-2R through CEATTC.

- **Client Movement Between Levels of Care**—Providers visited during the Technical Review indicated that ASAM PPC-2R is used in making decisions regarding client movement between levels of care along with treatment team decisionmaking.

- **Service Delivery Driven by Client Assessment**—DAS annual provider monitoring visits and licensure biennial reviews include a random sampling of chart reviews to determine how well assessment results are reflected in treatment plans. Providers visited during the Technical Review discussed how clinical assessments drove the development of the treatment plan. Provider staff also indicated that DAS monitoring and licensure reviews included a review of treatment plans based on clinical assessments.

- **Chart Review**—Continuum of care planning begins at the time of admission. A review process between staff and/or other systems treating the same client is used to update individualized treatment plans. Each provider visited during the Technical Review used clinical supervision and in-house QA processes to review clinical records on a regular basis.

  DAS staff reported that there is a need among some treatment providers to improve treatment planning efforts. This also was noted by the Technical Review team at one provider site visited during the Technical Review. The client files were loose-leafed and not bound. Some treatment plans did not always address all assessed needs. Releases of Information Forms were found in client files and some forms were completed appropriately. In one client record, there were two Release of Information Forms signed by the client and dated; however, the name of the agency that is to make the disclosure and the nature of the information to be disclosed was not completed. In addition, in this same client record, another client's information was mistakenly filed. The treatment plan did not account for all assessed client needs.

Data Used in the Treatment Service Delivery System

- **Client Perception of Care Results**—DAS conducted client satisfaction surveys and generated results in reports dated 2008 and 2009, and hopes to continue the effort in the future. The survey is based on the Mental Health Statistical Improvement Program (MHSIP) satisfaction survey. The survey uses NJSAMS admission records as the sample frame. A random sampling program is built into NJSAMS, and the sample is drawn from new clients admitted into treatment. When a client is selected, the provider is notified through NJSAMS and asked to download the questionnaire from the Web site and distribute the questionnaire to the client(s) either at discharge or 6 weeks following intake. After the survey is completed it is sealed and mailed to DAS by the client, using a prepaid envelope. A Spanish version is available for Hispanic clients.

  The items in MHSIP are grouped into four domains—satisfaction, access, appropriateness, and outcome. The ratings for the satisfaction domain in the 2009 report (for surveys conducted in SFY06 and SFY07) are similar for both years and indicate that clients are very satisfied with substance abuse treatment, with over 80 percent of the respondents rating their satisfaction as either "agree" or "strongly agree" for most of the items. In 2006, there were a total of 1,017 survey respondents and in 2007 a total of 942 respondents. Survey items regarding satisfaction include the following:

  1) I am satisfied with the services I received here
  2) If I had other treatment options, I would still come back here for services

3) Most of the services I receive here are helpful
4) The counseling I receive here is helpful

Providers visited during the Technical Review indicated that the results for their specific agency are shared with staff and efforts are conducted to change processes, if possible, based on client feedback found within the client satisfaction surveys.

DAS staff include a part-time Consumer and Recovery Advocate (RA). The RA is responsible for the Citizens Advisory Council (CAC) that provides input to DAS regarding consumer concerns. The RA also works with consumers who believe they are experiencing discrimination during treatment participation. The RA provides input to DAS training efforts in an effort to promote an understanding of addiction and to help overcome resistance to the use of medications in evidence-based prevention, treatment, and recovery practices. DAS also is planning to hire a facilitator who will work with the CAC and the RA to provide meeting facilitation, ongoing TA, leadership training, and project development for the CAC.

- **Clinical Outcomes and Benchmarks**—DAS staff generate suppositions regarding clinical outcomes, performance expectations, and benchmarks and then test them internally by using the PIC resources. DAS monitors NOMs for each provider and generates reports for provider distribution and for use by the PIC. Having implemented the NIATx Model within some provider sites, DAS will be using these data to measure client access and retention rates. As of January 2009, all FFS providers using NJSAMS are reporting service encounter data.

  DAS staff indicated that approximately 1.5 years ago they began to notice that the engagement and retention rates for adolescent treatment were not acceptable. Early in 2009, DAS established an Adolescent Task Force with representatives from DCF, JJC, the Department of Education (DOE), and DHS, along with other county and provider representatives. The purpose of the task force is to make recommendations regarding best practices in order to establish a more competent treatment network for adolescents and to further integrate the adolescent substance abuse treatment system. The task force has established three subcommittees to focus on best practices, workforce development, and clinical outcomes. DAS would like assistance from CSAT in how to proceed in establishing a better system of care for adolescents.

- **Provider Clinical Reporting**—Providers visited by the Technical Review team indicated that they reported monthly census rosters for all clients served and a monthly client roster for DAS funded clients only. DAS in turn uses this data to determine provider capacity levels and adherence to provider contract requirements.

- **Provider Monitoring**—The DAS QA Monitoring Unit conducts annual site visits to each funded provider. A 17-page guideline review document is used and the information is fed to the PIC for purposes of QA and continued quality improvement. The Guidelines contain SAPT Block Grant clinical requirements. Corrective action plans (CAP) are used to follow up on findings and TA is delivered when warranted.

  DAS conducts a peer review process that uses credentialed professionals from the field to assure the quality of care that is delivered to substance abuse patients and to improve

the system of care. Interested individuals submit applications to DAS to become a peer reviewer and, if selected, perceive the selection to be of significant value and are proud to participate. The peer review process generates independent suggestions for service delivery improvement.

SAPT Block Grant Compliance

Obligated and Expended Funds

The NJCFS User Guide defines "obligated" funds as the "total of encumbrances and expenditures." Provider contracts and purchase orders are considered to be obligating documents for SAPT Block Grant funds. This matches CSAT's definition. An encumbrance is defined as "an accounting event that reserves funds, thereby decreasing available budget." An encumbrance creates a "legal obligation to purchase." An expenditure is defined as "a liability for goods and services purchased and received."

During the FFY05 SAPT Block Grant obligation and expenditure period, the State obligated $47,251,367 and expended $47,251,367. During the FFY06 SAPT Block Grant obligation and expenditure period, the State obligated $46,768,908 and expended $46,768,908. During the FFY07 SAPT Block Grant obligation and expenditure period, the State obligated $46,778,415 and expended $46,778,415.

State staff provided Fund Usage Statements developed from NJCFS data to support the amounts reported. The reports reconcile to the amounts reported by the State on the Financial Status Reports (standard form 269) for the years under review. The Technical Review team could not determine if the reported expenditures for the years under review are equal to the amounts drawn down.

Table II-4. Summary of Obligated and Expended Funds

Federal Fiscal Year	Total Award	Obligation Period	Amount Obligated	Expenditure Period	Amount Expended
FFY05	$47,251,367	10/1/04–9/30/06	$47,251,367	10/1/04–9/30/06	$47,251,367
FFY06	$46,768,908	10/1/05–9/30/07	$46,768,908	10/1/05–9/30/07	$46,768,908
FFY07	$46,778,415	10/1/06–9/30/08	$46,778,415	10/1/06–9/30/08	$46,778,415

State MOE

The State includes State general funds and other State funds in the definition of MOE expenditures. State staff reported that this definition has been applied consistently. State MOE expenditures do not include all DAS State funds identified in table II-3. DAS has not included expenditures from the Essex and Union County Delaney Hall and Intoxicated Driving Program Unit in the computation of the State MOE. The State has included expenditures from interagency agreements with other State agencies in the computation. The Technical Review Fiscal Specialist was unable to obtain a clear understanding of the rationale for the inclusions and exclusions and has requested further clarification from the State. The Technical Review

team recommends that DAS staff review with the CSAT State Project Office (SPO) the methodology used to compute State MOE.

During SFY05, the State expended $82,133,000 on State MOE activities. During SFY06, the State expended $77,141,000 on State MOE activities, an amount that is equal to MOE expenditures for SFY06 reported on Table I of the FFY09 SAPT Block Grant application. During SFY07, the State expended $81,406,000 on State MOE activities, an amount that is equal to MOE expenditures for SFY07 reported on Table I of the FFY09 SAPT Block Grant application. During SFY08, the State expended $93,335,000 on State MOE activities, an amount that is greater than the expenditure requirement and equal to the MOE expenditures for SFY08 reported on Table I of the FFY09 SAPT Block Grant application. DAS met the State MOE requirement for SFY07 and SFY08. State staff provided spreadsheets developed with data extracted from NJCFS to document State MOE expenditures.

Table II-5. State MOE Expenditures[1]

Period[2]	State Expenditures	Previous 2-Year Average Expenditures	Percent Over/(Under) MOE Requirements
SFY05	$82,133,000	—	—
SFY06	$77,141,000	—	—
SFY07	$81,406,000	$79,637,000	2.22%
SFY08	$93,335,000	$79,273,500	17.74%

[1]Actual expenditures listed under the "State Expenditures" column are averaged, and the average of the 2-year period is placed in the "Previous 2-Year Average Expenditures" column on the line next to the fiscal year studied.

[2]The State fiscal year listed in table II-5 should cover the two most recently completed State fiscal years.

Primary Prevention Services and Set-Aside

When asked to provide a definition of primary prevention, DAS staff provided the Technical Review team with the Institute of Medicine (IOM) definitions of universal, selective, and indicated prevention, which are included on the DAS's Web site. The IOM prevention model is an alternative paradigm that does not define "primary prevention." In the *Performance Partnership Grant Core Technical Review report* (dated January 17, 2007), the Technical Review team reported that DAS defines primary prevention as "multiple prevention strategies aimed at systems and people which/who are not addicted and not in need of treatment and determined to be at risk of developing abuse of alcohol, drugs and/or other substances."

During the FFY05 SAPT Block Grant obligation and expenditure period, the State expended $11,362,350 for primary prevention services. The amount was above the required minimum. During the FFY06 SAPT Block Grant obligation and expenditure period, the State expended $13,233,863 for primary prevention services. The amount was above the required minimum and equal to the amount reported on Form 4 of the FFY09 SAPT Block Grant application. During FFY07 SAPT Block Grant obligation and expenditure period, the State expended $13,825,144 for primary prevention services. The amount was above the required minimum.

DAS staff provided Fund Usage Statements developed from NJCFS data to document the amount of primary prevention expenditures reported. The State met the prevention services expenditure requirement for all years under review. Table II-6 compares actual prevention expenditures for FFY06 and FFY07 from SAPT Block Grant funds with the 20 percent minimum requirement.

Table II-6. Twenty Percent Primary Prevention Set-Aside

Year	SAPT Block Grant Award	20 Percent Set-Aside	Actual Expenditure	Difference
FFY05	$47,251,367	$9,450,273	$11,362,350	$1,912,077
FFY06	$46,768,908	$9,353,782	$13,233,863	$3,880,081
FFY07	$46,778,415	$9,355,683	$13,825,144	$4,469,461

MOE Expenditures for Pregnant Women and Women with Dependent Children

The State's base for FFY94 is $6,497,485 as reported in the *Performance Partnership Grant Core Technical Review report* (dated January 17, 2007). DAS staff provided the Technical Review team with the following description of the methodology used to determine the base:

> *"*The base amount was derived specifically as follows: (1) to the FFY 1992 PW/WDC expenditure base of $2,752,187: (2) add five percent of the FFY 1993 SAPT Block Grant award (i.e., 5% X $37,452,980, or $1,872,649) in order to establish the FFY 1993 PW/WDC base of $4,624,836; (3) add five percent of the FFY 1994 SAPT Block Grant award (i.e., 5% X $37,452,980, or $1,872,649) to the FFY 1993 PW/WDC base of $4,624,836, resulting in a FFY 1994 PW/WDC expenditure baseline of $6,497,485.*"*

DAS staff indicated that they had reported combined SAPT Block Grant and State expenditures for women's services from FFY08 on Table IV of the FFY09 SAPT Block Grant application. Previously, DAS reported only SAPT Block Grant expenditures. The revised presentation includes State expenditures for women and children's services under the supervision of DCF and the Division of Youth and Family Services (DYFS).

During FFY06, the State expended $15,670,207 on services for pregnant women and women with dependent children. Of the amount expended, $7,816,988 was from State funds and $7,853,219 was from the SAPT Block Grant. The amount expended was greater than the minimum required and equal to the amount reported on Table IV in the FFY09 SAPT Block Grant application. During FFY07, the State expended $20,791,602 on services for pregnant women and women with dependent children. Of the amount expended, $11,248,831 was from State funds and $9,542,771 was from the SAPT Block Grant. The amount expended was greater than the minimum required and less than the amount reported on Table IV in the FFY09 SAPT Block Grant application. During FFY08, the State expended $16,442,746 on services for pregnant women and women with dependent children. Of the amount expended, $10,095,299 was from State funds and $6,347,447 was from the SAPT Block Grant. The amount expended was greater than the minimum required and greater than the amount reported on Table IV in the FFY09 SAPT Block Grant application. DAS staff provided spreadsheets developed from NJCFS reports to support the expenditures reported.

DAS staff reported that the State has been able to provide substance abuse treatment; primary medical care, including prenatal care; childcare while women are receiving substance abuse treatment; and primary pediatric care for women's children, including immunizations; gender-specific substance-abuse treatment and other therapeutic interventions; therapeutic interventions for children in custody of women in treatment; case management services; and transportation services with women's services funds. However, the Technical Review team did not visit a provider that was funded to provide specialized women's services and was therefore unable to review the State's compliance with these requirements first hand.

Table II-7. Base Calculation for Pregnant Women and Women with Dependent Children

Period	Base From Prior Year	State Expenditures for Women's Services	SAPT Block Grant Expenditures for Women's Services	SAPT Block Grant Award	5 Percent of Award	State Expenditures Above Previous Year Expenditures	Total Base for Following Year
FFY92			$2,752,187				$2,752,187
FFY93	$2,752,187			$37,452,980	$1,872,649	$0	$4,624,836
FFY94	$4,624,836			$37,452,980	$1,872,649	$0	$6,497,485

Table II-8. MOE Expenditures for Pregnant Women and Women with Dependent Children

Period	Required Expenditure	Actual Expenditure	Difference	Percentage of Difference	SAPT Block Grant	State
FFY05	$6,497,485	Need Information				
FFY06	$6,497,485	$15,670,207	$9,172,722	141.17%	$7,853,219	$7,816,988
FFY07	$6,497,485	$20,791,602	$14,294,117	219.99%	$9,542,771	$11,248,831
FFY08	$6,497,485	$16,442,746	$9,945,261	153.06%	$6,347,447	$10,095,299

HIV MOE

New Jersey became designated for HIV in 1993, and the State is currently an HIV-designated State. DAS staff provided the following description of the methodology used to compute the HIV early intervention services (EIS) base amount:

> "In 1994, DAS coordinated with the fiscal and program representatives of the Division of AIDS Prevention and Control (DOAPC) within the New Jersey Department of Health (now the Department of Health and Senior Services) in order to establish a reasonable HIV MOE base for SFY 1993 for HIV early intervention services. This effort was based on a review of State expenditures during SFY 1991 and SFY 1992, respectively, for early intervention services relating to HIV, consistent with the definition provided at 45 CFR Part 96.121, and which were provided at substance abuse treatment facilities. After establishing the HIV MOE

base, DAS then reviewed the State expenditures by DOAPC during SFY 1993 for comparable services to ensure compliance with the HIV MOE requirement. A summary of these reviews follows.

During SFY 1991, SFY 1992, and SFY 1993, respectively, DOAPC, provided Health Service Grants to 20 drug treatment agencies, which were also funded by DAS to provide drug treatment services. A portion of the funds provided by DOAPC to these agencies were State funds expended for HIV early intervention services. The majority of these State funds were used to fund AIDS coordinators within the 20 drug treatment programs. These coordinators provided AIDS education, made community presentations, and provided case coordination and management. The case coordination and management function was determined to be consistent with the Federal early intervention services definition. The DOAPC provided documentation of the percentage of time which each AIDS coordinator spent on the case management function. These percentages ranged between 15 percent and 85 percent. It was also determined that on average 50 percent of the HIV positive clients served by these employees were symptomatic, and 50 percent were asymptomatic. Only the case management (CM) services provided to asymptomatic persons are consistent with the regulatory definition. Therefore, for SFY 1992 and SFY 1993 the calculated percentage of time that each AIDS coordinator spent providing case management services (e.g., 15% to 85%) to HIV positive clients who were asymptomatic (i.e., 50%) was multiplied by the State supported salary and fringe benefits paid to each AIDS coordinator. A clarifying assumption concerning the calculation of the asymptomatic percentage for SFY 1991 follows.

Until the early 1990s, the AIDS coordinators at publicly funded drug treatment clinics only provided case management services to HIV positive clients who were symptomatic. Subsequently, the percentage of their time which they provided to asymptomatic clients began to increase. Therefore, in calculating the SFY 1991 State expenditure, it was assumed that the percentage of asymptomatic clients receiving case management services was half of the percentage of asymptomatic clients receiving those services in SFY 1992 and thereafter (i.e., 50% x 50% = 25% for SFY 1991).

In addition, DOAPC provided limited funds for counseling and testing activities (CT) to three drug treatment facilities statewide during SFY 1991 and SFY 1992, respectively. This funding was not, however, provided in SFY 1993, or thereafter."

The State has changed the methodology for the computation of HIV MOE expenditures as well as the definition of those services. During SFY06, DHSS discontinued funding HIV case management services at treatment agencies. The DHSS Prevention and Education Unit now funds the Patient Incentive Program and Project Promise (PIPPP) at the opioid treatment provider visited by the Technical Review team. Expenditures from this contract are now used to satisfy the HIV EIS MOE requirement.

PIPPP focuses on reducing HIV transmission among high-risk target populations by altering clients' risky substance use and sexual behavior. The use of expenditures from the PIPPP program represents a significant modification of the State's definition of HIV MOE expenditures.

DAS staff reported that the CSAT SPO has approved the change in methodology. The Technical Review team recommends that DAS staff formally document the CSAT SPO approval of the change.

During SFY05, the State expended $303,761 of State funds on HIV EIS. The amount expended was equal to the minimum required. During SFY06, the State expended $483,935 on HIV EIS. The amount expended was greater than the minimum required. During SFY07, the State expended $491,200 on HIV EIS services. The amount expended was greater than the minimum required. During SFY08, the State expended $491,200 on HIV EIS services. The amount expended was greater than the minimum required and equal to the amount reported on Table III in the FFY09 SAPT Block Grant application. State staff provided spreadsheets developed from NJCFS data to document the amount of the expenditures.

Table II-9. HIV MOE Base Calculation

Period	State HIV Expenditure	Percent of HIV Clients Who Are Substance Abusers	Amount of HIV Expenditures for Clients Who Are Substance Abusers	MOE Base
SFY91	Not Available		$143,954	
SFY92	Not Available		$187,211	
				$165,583

Table II-10 compares actual spending for HIV services for individuals with substance use disorders with the required MOE.

II-10. HIV MOE Expenditures

Period	State HIV Expenditures	Percent of HIV Clients Who Are Substance Abusers	State HIV Funds for Substance Abusers	MOE Base	Difference
SFY05			$303,761	$165,583	$138,178
SFY06			$483,935	$165,583	$318,352
SFY07			$491,200	$165,583	$325,617
SFY08			$491,200	$165,583	$325,617

HIV Set-Aside

New Jersey is currently an HIV-designated State, and was HIV-designated for the three SAPT Block Grant award periods under review. As required, DAS expended SAPT Block Grant funds for HIV EIS. The State calculates its percentage using the methodology specified by SAPT regulations as indicated in Table II-11.

During the FFY05 SAPT Block Grant obligation and expenditure period, the State expended $2,362,568 for HIV EIS set-aside services. The amount of expenditures was equal to the required minimum. During the FFY06 SAPT Block Grant obligation and expenditure period, the

State expended $2,338,445 for HIV EIS set-aside services. The amount of expenditures was equal to the required minimum and equal to the amount reported on Form 4 in the FFY09 SAPT Block Grant application. During the FFY07 SAPT Block Grant obligation and expenditure period, the State expended $2,338,921 for HIV EIS set-aside services. The amount of expenditures was equal to the required minimum. State staff provided Fund Usage Statements developed from NJCFS data that documented the amount of HIV EIS expenditures for FFY05–FFY06.

Table II-11. HIV Set-Aside Percentage Calculation

SAPT Block Grant Award Year	Award Amount	Substance Abuse Portion of FFY91 Award	Difference	Percentage Change	HIV Set-Aside Percentage
FFY05	$47,251,367	$35,398,000	$11,853,367	33.49%	5.00%
FFY06	$46,768,908	$35,398,000	$11,370,908	32.12%	5.00%
FFY07	$46,447,415	$35,398,000	$11,049,415	31.21%	5.00%

Table II-12. HIV Set-Aside Expenditures

Period	SAPT Block Grant Award	Required Percentage	Required Expenditure	Actual Expenditure	Difference
FFY05	$47,251,367	5%	$2,362,568	$2,362,568	$0
FFY06	$46,768,908	5%	$2,338,445	$2,338,445	$0
FFY07	$46,778,415	5%	$2,338,921	$2,338,921	$0

TB MOE

DAS defines TB MOE expenditures as all non-Federal funds spent by the DHS Tuberculosis Program statewide for medical evaluation, diagnosis, treatment, and prevention services provided to individuals with substance use disorders with either diagnosed or suspected TB, and/or to individuals with substance use disorders who were at risk of developing TB because of their contact or reactor status. This definition has been applied consistently. In developing the 1993 MOE base, the State calculated these amounts to be $208,556 for SFY91 and $231,341 for SFY92, resulting in a 2-year average of $219,948. To calculate the TB non-Federal expenditures attributable to substance abuse, DHSS TB Program staff determine an appropriate percentage of TB expenditures which are allocable to substance abuse services. DHSS TB Program staff use substance abuse information from the Centers for Disease Control and Prevention (CDC) databases.

During SFY05, the State expended $271,431 from State funding sources for TB services to individuals with substance use disorders. The amount expended was greater than the required minimum. During SFY06, the State expended $232,996 from State funding sources for TB services to individuals with substance use disorders. The amount expended was greater than the required minimum. During SFY07, the State expended $126,003 from State funding

sources for TB services to individuals with substance use disorders. The amount expended was less than the required minimum. During SFY08, the State expended $242,620 from State funding sources for TB services to individuals with substance use disorders. The amount expended was greater than the required minimum and equal to the amount of expenditures reported on Table II in the FFY09 SAPT Block Grant application. DAS staff provided faxes from DHS and budget reports to document the amount of TB MOE expenditures. The Technical Review team recommends that DAS staff confer with the CSAT SPO to determine if any corrective action needs to be taken regarding the under-expenditure of TB MOE funds in SFY07.

Table II-13. TB MOE Base Calculation

Period	State TB Expenditures	Percent of TB Clients Who Are Substance Abusers	Amount of TB Expenditures for Clients Who Are Substance Abusers	MOE Base
SFY91	$1,579,967	13.20%	$208,556	
SFY92	$1,752,586	13.20%	$231,341	$219,948

Table II-14. TB MOE Expenditures

Period	State TB Expenditure	Percent of TB Clients Who Are Substance Abusers	State of TB Funds for Substance Abusers	MOE Base	Difference
SFY05			$271,431	$219,948	$51,483
SFY06			$232,996	$219,948	$13,048
SFY07			$126,003	$219,948	($93,945)
SFY08			$242,620	$219,948	$22,672

Confidentiality of Protected Health Information and Client Data

Protected Health Information (PHI)

Confidentiality requirements are conveyed to DAS staff during orientation. Confidentiality requirements are conveyed to provider staff through contracts and regulations. Counselors are required to participate in confidentiality training as part of the core curriculum for certification. Additionally, the DAS monitors compliance with confidentiality and HIPAA requirements during annual onsite reviews. HIPAA and 42 CFR Part 2 requirements were met. Unless ordered by the courts, any release of confidential client information requires specific informed consent.

Contracts with visited providers contained confidentiality requirements. All providers visited appeared to comply with requirements that records be stored in a locked location. All providers included release of information forms in clients' charts. However, forms at one of the providers visited by the Technical Review team failed to comply with all requirements in that: 1) forms did not contain specific information about the organization or individual to whom information would be released, and 2) forms did not contain specific information about the purpose of the release

of information. Additionally, some of the forms failed to contain expiration dates. The Technical Review team recommends that DAS should update providers regarding confidentiality requirements and supply sample forms that meet all confidentiality requirements. DAS also is requesting assistance with the provision of a HIPAA training for the field.

Data Sharing and Management

DHS has data-use agreements that establish who is permitted to use or receive limited data sets and provide that the recipient will:

- Not use or disclose the information other than as permitted by the agreement or as otherwise required by law
- Use appropriate safeguards to prevent uses of disclosures of the information that are inconsistent with the data-use agreement
- Report to the covered entity any use or disclosure of the information in violation of the agreement which it becomes aware
- Ensure that any agents to whom it provides the limited data set agree to the same restrictions and conditions that apply to the limited data set recipient with respect to such information
- Not attempt to re-identify the information or contact the individuals

When sharing data with another entity, DAS ensures that data are de-identified as indicated in the HIPAA Privacy Rule (45 CFR 164.514[b]).

Monitoring

DAS monitors compliance with Federal confidentiality requirements during annual onsite provider reviews. DAS ensures that data are de-identified prior to any release of client information.

HIV Early Intervention Services and Pre- and Post-Test Counseling

Currently, DAS funds HIV Specialist positions at 20 licensed methadone substance abuse treatment facilities statewide. Services are available in areas of the State that have the greatest need for these services. The 20 agencies provide outpatient treatment including pre- and post-test counseling and an availability of HIV testing for all clients. One agency is located in South Jersey, which is considered a more rural location within the State. Counseling services address the following:

- HIV risk-reduction to assist in initiating or sustaining behaviors or practices that eliminate or reduce the risk of acquiring or transmitting HIV

- Discussing with HIV-infected individuals the need to notify sex and needle sharing partners of the risk of infection and the need for these individuals to seek counseling and testing services

- Decreasing the risk of perinatal transmission when appropriate

- Counseling HIV-infected individuals regarding treatment options

DAS has a memorandum of agreement with the Robert Wood Johnson Medical School to provide Rapid HIV testing at 20 DAS-funded methadone treatment programs. The Robert Wood Johnson Medical School provides consultation, lab oversight, and authorization to ensure Rapid HIV testing for clients in all State-funded methadone treatment programs. The Robert Wood Johnson Medical School conducts monthly onsite reviews and inspections of locations where testing is provided to include, but not limited to, the review of testing procedures, storage area compliance, controls, inventory of test kits, unusual events, staff certification, etc. The Robert Wood Johnson Medical School submits monthly programmatic reports to DAS.

Annex A of provider contracts requires all providers to offer all clients HIV counseling and testing. Testing must be offered at the time of admission and every 6 months thereafter. Testing or refusal by a client to be tested is to be documented in the client record.
All clients testing positive for HIV, or self-reported as HIV positive, must receive an initial referral for appropriate HIV medical treatment and be referred at least quarterly for a follow-up consultation. Clients are to receive medical care for their HIV disease at an Early Intervention Program (EIP), HIV Care Center, or by a qualified physician selected by the client.

Each client receiving HIV Intensive Medical Early Intervention Services must receive lab tests to include at minimum a complete blood count (CBC), cluster of differentiation 4 (CD4) cell count (medical professionals refer to the CD4 count to decide when to begin treatment for HIV-infected patients), viral load, and chemical profile.

HIV Pre-Test and Post-Test Counseling

All HIV counseling and testing, by DAS contract, is provided as outlined in the *Counseling and Testing Services (CTS) Protocol and Procedure Manual* as issued by DHSS, Division of HIV/AIDS Services (DHAS). All clients are required to sign an informed consent form prior to testing. Clients who decline testing sign a declaration that they have been advised about the risk of HIV and have chosen not to be tested. The reason for refusal is documented in the client's chart.

All clients found to be HIV positive receive treatment using the Intensive Medical Early Intervention Service or are referred to an EIP or HIV Care Center in the community. Services provided at EIP sites are conducted according to the *Guidelines for the Medical Management of HIV/AIDS,* as issued by DHAS. The State requires programs to establish linkages with other service providers to provide EIS.

HIV Services and Testing

Clients who are HIV positive receive case management services based on a comprehensive assessment of the client's medical, social service, entitlement, and support needs. Client

referrals are made to appropriate services as identified by the comprehensive needs assessment and documentation of the referrals is noted in the client file. HIV Specialists are required to complete the DHAS course entitled *Introduction to HIV Prevention Counseling Skills and Practical Applications* and be certified as an HIV Specialist by DHAS.

HIV EIS providers are required to report persons testing positive for HIV to DHSS within 24 hours of receipt of the test results. The report includes the name, address, gender, race, and date of birth of the person found to be infected with HIV. Clients can access anonymous testing directly through DHSS labs. The DHSS Medical Director and the UMDNJ-RWJ Medical Director are both available for consultation to provider sites.

The HIV EIS clinic visited during the Technical Review provides case management services for all clients in treatment for HIV/AIDS. Case Managers refer clients to appropriate community agencies for financial assistance, housing, clothing, prescription benefits, food, legal, furniture, and entitlement benefits. Vocational assessment, training, and placement referrals also are made.

DAS has initiated the Needle Exchange Treatment Initiative (NETI) with $10 million being appropriated through the Bloodborne Disease Harm Reduction Act signed in December 2006. NETI provides mobile medication, outreach, office-based services, and supportive housing. To be eligible for the program, a client's total household income must be at or below 250 percent of the Federal poverty level. In addition, the client must:

1) Be a resident of New Jersey

2) Have a history of injection drug use

3) Test positive for opiates or have a documented 1-year history of opioid dependence (Individuals who have recently been incarcerated or in residential treatment may not test positive for opiates)

4) Be able to provide proof of identification to prevent dual enrollment in medication-assisted treatment

5) Not currently be enrolled as a client in an opioid maintenance treatment (OMT) program or a client under the care of a physician prescribing Suboxone

6) Not have been enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone within the past thirty (30) days.

Clients who are referred by SEPs and are either pregnant, homeless, or at risk of being homeless, are given priority consideration for admission.

Admission Preferences for Pregnant Women

State staff interviewed by the Technical Review team were aware of the SAPT Block Grant admission preferences requirement for pregnant women and the requirement that pregnant women receive "interim" services within 48 hours after being placed on a wait list. Both the admission preferences requirement and the interim services requirement are clearly stated in

provider contracts and both are monitored by provider onsite reviews as conducted by DAS staff. Non-adherence to the two above requirements can result in sanctions; however, due to the strong provider network within the State, sanctions have not been necessary.

Provider contracts require that if a provider is at full-funded capacity and unable to admit pregnant women, the provider must refer such women to another facility or make interim services available within 48 hours. At a minimum, interim services include counseling and education about HIV and TB; the risks of needle sharing; the risks of transmission to sexual partners and infants; and education about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services. Interim services for pregnant women also include counseling on the effects of alcohol and drug use on the fetus and referral for prenatal care. DAS staff reported that 47 women-specific providers are funded by DAS and, of these, 35 receive SAPT Block Grant dollars.

Specialized Services for Pregnant Women and Women with Dependent Children

Specialized treatment for pregnant women and women with dependent children is ensured by clearly stated contract language and is monitored by the DAS OQA Treatment and Prevention onsite provider reviews. The DAS Web site also provides a directory for women-specific service providers. All providers are required to advertise priority admissions for pregnant substance-abusing women.

Best practices used by providers who serve pregnant women and women with dependent children are contractually required to include trauma-informed/trauma-specific treatment services using the Seeking Safety Model and Family Centered Treatment. The women-specific provider visited during the Technical Review also reports using CBT, Motivational Interviewing, Stages of Change, and Rational Emotive Therapy.

Programs are located to ensure service coverage for most of the women who need these services. There is not a waiting list for services for pregnant women and women with dependent children. Capacity is managed by provider submissions of client rosters on a monthly basis and oversight and monitoring on the part of the DAS Women's Service Coordinator. DAS staff reported no access or barriers to treatment for pregnant women and women with dependent children. The women-specific provider visited during the Technical Review indicated that local barriers are no local transportation services and low pay for support staff.

This provider reported that the program admits substance-abusing women who are often working to regain custody of their children. The program does not admit women with children due to facility limitations. The facility has a capacity of 12 beds. Program staff also reported not admitting pregnant women; however, the program does facilitate the placement of pregnant women and women with children. It is unclear to the Technical Review Clinical Specialist why the program does not admit pregnant women. The program has a full-time registered nurse and a designated Medical Director who could potentially address the needs of pregnant women. When the lack of admissions for pregnant women was discussed, provider staff indicated that the designated service area population did not perceive the community to have any type of substance abuse problems and that continuous outreach efforts to individuals, local organizations, and the community have not proven to change this concept. Since the Technical

Review, DAS reportedly has worked with the provider to amend its policy and ensure compliance.

DAS has implemented the Women's Steering Committee to ensure a network of interested individuals in support of women's services. The Women's Steering Committee consists of approximately 50 members that represent provider agencies statewide, as well as sister State agencies that deliver services to women and children. Committee members include representatives from DYFS as part of the Child Protection Substance Abuse Initiative (CPSAI), maternal health consortiums, and WFNJ-SAI.

DAS staff were selected to provide input to the Women's Services Network (WSN), a component of the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) National Treatment Network (NTN). The WSN Women's Treatment Standards Subcommittee has drafted a document containing standards to guide States in treatment of women with substance use disorders. DAS also has recently been awarded an indepth TA grant from the National Center for Substance Abuse and Child Welfare (NCSACW).

Table II-15. Specialized Programs for Women, Women with Children, and Pregnant Women

Service Type	Women Only	Women with Children	Pregnant Women	Number of Urban and Rural	Total Number of Programs
Detoxification Treatment					
Residential Treatment	4	2	6		
Outpatient Treatment		11	11		
Intensive Outpatient Treatment	11	11	11		
Therapeutic Community					
Halfway/Transitional Housing	1	2	2		
Other—opioid replacement therapy*	17	17	17		

*DAS has contracts with 17 methadone programs that deliver treatment services on an intensive outpatient basis to pregnant women and women with dependent children who use methadone. The methadone intensive outpatient treatment programs are contracted to provide specialized services either directly or through referral to pregnant women and women with dependent children on methadone.

III. Impact of Technical Assistance and Technology Transfer

A. Technical Assistance Recommendations Made During the Previous Core Elements and State-Requested Technical Review

New Jersey's previous Core Elements Technical Review occurred in June 2006 and resulted in three TA recommendations. These recommendations are detailed in table III-1.

Table III-1. Technical Assistance Addressing Prior Core Elements Technical Review Recommendations

Core Elements Technical Review Recommendation	TA Status/Impact	Funder (CSAT/Other)
Provider Report Card	CSAT-funded TA provided support for the State to explore provider performance assessment options. The telephonic TA was delivered between May 2007 and April 2008.	CSAT
Review of SAPT Block Grant Fiscal and Clinical Requirements	SSA has implemented this recommendation on its own initiative.	Not Applicable
Documenting Monitoring Procedures	SSA has implemented this recommendation on its own initiative.	Not Applicable

In December 2006, New Jersey participated in a State-Requested Technical Review that examined the quality assurance system. No TA recommendations resulted from this review.

New Jersey has received five other CSAT-funded TA deliveries since the last Core Elements Technical Review. These deliveries are detailed in table III-2.

Table III-2. Other CSAT-Funded Technical Assistance

Area Addressed by CSAT-Funded TA	TA Status/Impact
SAPT Block Grant Trainings	CSAT-funded TA provided support for the delivery of a series of four 1-day SAPT Block Grant trainings. The training for State staff occurred on August 6, 2007, and had an attendance of 47 participants. Three provider trainings occurred on August 7, 23, and 24, 2007, in Princeton, NJ (67 participants), West Windsor, NJ (74 participants), and Mt. Laurel, NJ (32 participants) respectively.
Provider Performance Assessments	CSAT-funded TA provided support for the State to explore provider performance assessment options. The telephonic TA was delivered between May 2007 and April 2008.
Quality Improvement Indicators and Instruments	CSAT-funded TA was to assist the State in developing quality improvement indicators and instruments. However, the State withdrew the TA request prior to implementation.
Contract Incentive/Sanction System	CSAT-funded TA provided assistance with the development of a new contract incentive/sanction system. The onsite portion of the TA delivery occurred on September 20–21, 2007, in Freehold and Trenton, NJ.
Fee-for-Service Conversion	As of May 29, 2009, the State is working with CSAT to implement this TA delivery.

B. TECHNOLOGY TRANSFER

Clinical Supervision Model

As part of the CEATTC Leadership Institute, a clinical supervisor at a DAS-funded Opioid Treatment Program (OTP) developed a clinical supervision project that has been implemented within the OTP. As a result of successful implementation the author of the project has developed a clinical supervision course. The 6-hour clinical supervision training is entitled "Practical Applications of Clinical Supervision." The course uses a didactic lecture format with exercises for practical application and has been offered statewide on four different occasions as part of the Workforce Development Initiative within the State of New Jersey. Participants leave with an objectively based, time-lined blueprint to bring back to their respective organization in order to enact clinical supervision change.

Peer Review Process

DAS has a competitive peer review process. The position of "peer reviewer" is perceived to be a prestigious appointment. Peer reviewers appear to pursue these duties with exceptional diligence.

Medical Directors' Quarterly Case Reviews

The DAS Medical Director conducts quarterly medical directors' meetings at which case studies are reviewed. Attendance, participation, and responses have been "exceptional."

IV. Technical Assistance and State-Requested Technical Review Recommendations

Tables IV-1and IV-2 on page 49 were reviewed by the designated State official responsible for advising CSAT on the State agency's TA and State-Requested Technical Review needs, following a review of Draft 1 of the Technical Review report. The purpose of including this form in the Draft 1 Technical Review report is to help expedite TA planning and delivery by giving CSAT staff an early alert on the State's needs. However, CSAT recognizes that TA priorities can change over time. Consequently, the State may reorder its priorities or change the scope of its TA requests during the TA planning and implementation process. This final version of the Technical Review report includes updated information on the State's TA priorities and delivery timeframe preferences.

TECHNICAL ASSISTANCE AND STATE-REQUESTED TECHNICAL REVIEW RECOMMENDATIONS

The following are more detailed descriptions of the Technical Review team's recommendations for New Jersey that do not require CSAT-funded TA:

- **Coordination of Adolescent Treatment Services**—DAS could benefit from considering the advantages and disadvantages of further collaboration with DCBHS and other agencies in coordinating adolescent treatment services.

- **Integration of Utilization Management Data to Performance Improvement**—DAS could benefit from considering the expansion of the current data reviewed by the PIC and/or 360 Degree Review processes to include the new FA provider utilization data.

- **Counselor Certification and Application Processes**—DAS could benefit from continuing current efforts to streamline the counselor certification application. Working with NJPN to determine strategic interventions could improve the State Board and the APCB application and certification processes for provider staff.

- **Treatment Plan Development Training**—DAS could benefit from considering, as part of the Workforce Development Initiative, adding training regarding the development of treatment plans based on clinical assessment results. Emphasis could be given to the development of observable, measurable, time-lined action steps or plan objectives.

- **Determine State MOE Methodology**—DAS could benefit from conferring with the CSAT SPO to determine if the methodology used to compute State MOE needs to be amended.

- **HIV MOE Methodology—**DAS could benefit from conferring with the CSAT SPO to obtain formal written approval for the new methodology used to compute HIV MOE.

- **TB MOE Funds**—DAS could benefit from conferring with the CSAT SPO to determine if any corrective action needs to be taken regarding the under-expenditure of TB MOE funds in SFY07.

- **Update Confidentiality Requirements for Providers**—DAS could benefit from updating providers regarding confidentiality requirements and supplying sample forms that meet all confidentiality requirements.

- **Facilitate Admissions of Pregnant Women**—DAS could benefit from considering further discussions or TA with the women-specific provider visited during the Technical Review to facilitate the admission of pregnant women.

The following are more detailed descriptions of the Technical Review team's TA recommendations for New Jersey:

- **Integration of Behavioral and Physical Health**—DAS could benefit from CSAT-funded TA for peer-to-peer assistance to explore successful methodologies to integrate behavioral and physical health.

- **Development of NJSAMS Treatment Planning**—DAS could benefit from CSAT-funded TA to develop NJSAMS treatment planning and progress note modules in the context of an electronic health record.

- **Funding Streams**—DAS could benefit from CSAT-funded TA for peer-to-peer assistance to develop methodologies to determine clients' financial eligibility for services.

- **Charitable Choice Compliance**—DAS could benefit from developing policies and procedures to ensure that provider agencies are in compliance with Charitable Choice requirements. The State also may benefit from CSAT-funded TA.

The following are detailed descriptions of TA requested by New Jersey:

- **Cultural Competency and Workforce Development**—DAS has requested CSAT-funded TA in identifying methods for further enhancing cultural competency training efforts within the State.

- **Data for System Improvement**—DAS staff have requested CSAT-funded TA to develop capacity to analyze and use data, including outcome data, for system improvement. DAS could benefit from technical as well as peer-to-peer assistance to explore successful methodologies to share outcome data with consumers and families.

- **Development of Comprehensive 3-Year Plan**—DAS staff have requested CSAT-funded TA to develop and implement a comprehensive 3-year plan.

- **Medication-Assisted Treatment**—DAS has requested CSAT-funded TA to address and/or conduct forums for providers regarding medication-assisted treatment in general, and medication-assisted treatment for women in particular.

- **Adolescent Treatment Service System**—DAS has requested CSAT-funded TA in determining funding structures and further enhancing the systemic integration of the continuum of care for adolescents. DAS also could benefit from considering the

advantages and disadvantages of further collaboration with other agencies in coordinating adolescent treatment services.

Table IV-1. New Jersey TA Recommendations Summary

State's TA Priority Number	Technical Review Team's TA Recommendations	State's Preference for TA Delivery (Month/Year)
*	Integration of Behavioral and Physical Health	*
*	Development of NJSAMS Treatment Planning	*
*	Funding Streams	*
*	Charitable Choice Compliance	*

*After reviewing draft 1 of the Technical Review report, the State did not prioritize this TA recommendation or provide timeframes for TA delivery based on this recommendation.

Table IV-2. TA Requested by New Jersey

State's TA Priority Number	TA Requested by New Jersey	State's Preference for TA Delivery (Month/Year)
*	Cultural Competency and Workforce Development	*
*	Data for System Improvement	*
*	Development of Comprehensive 3-Year Plan	*
*	Medication-Assisted Treatment	*
*	Adolescent Treatment Service System	*

*After reviewing draft 1 of the Technical Review report, the State did not prioritize this TA request or provide timeframes for TA delivery based on this request.

Appendix A. New Jersey Interviewee List

Representative	Organization
Audrea C. Akins, Primary Care Clinician	The Good News Home for Women
Marnie Alston, Director of Nursing	The Lennard Clinic, Inc.
Suni L. Anand, Chief Financial Officer	The Lennard Clinic, Inc.
Phyllis Bass, Director of Administrative Services	The Lennard Clinic, Inc.
Tanya Baughinghouse, Director of Clinical Services	The Lennard Clinic, Inc.
Monica Bell, IT Director	The Lennard Clinic, Inc.
Lewis Borselliino, Manager	Administrative Services, Division of Addiction Services, New Jersey Department of Human Services
Suzanne Borys, Manager	Research, Planning, Evaluation, and Information Systems, Division of Addiction Services, New Jersey Department of Human Services
Adam Bucon, Program Coordinator	Quality Assurance Office, Division of Addiction Services, New Jersey Department of Human Services
Barbara Burke-McAllister, Quality Assurance Coordinator	Division of Addiction Services, New Jersey Department of Human Services
Keith Collins, Data Processing Programmer	Division of Research, Planning, Evaluation, and Information Systems, Division of Addiction Services, New Jersey Department of Human Services
Tony Comerford, President and Chief Executive Officer	New Hope Foundation
Elizabeth Conte, Workforce Development and Training Coordinator	Quality Assurance Office, Division of Addiction Services, New Jersey Department of Human Services
Thomas Diaz, Program Officer	Licensure and Supportive Housing, Division of Addiction Services, New Jersey Department of Human Services
Kathy Goat-Delgado, Supervisor of Monitoring	Quality Assurance Office, Division of Addiction Services, New Jersey Department of Human Services
Elissa Goldstein, Adolescent Director	New Hope Foundation, Secaucus
Mollie Greene, Deputy Director	Quality Assurance for Treatment and Prevention, Division of Addiction Services, New Jersey Department of Human Services

Representative	Organization
Bobbie Hau, IT Director	New Hope Foundation
Kyu Kyu Hlaing, Research Scientist	Division of Research, Planning, Evaluation, and Information Systems, Division of Addiction Services, New Jersey Department of Human Services
Calliean Jones-Lewis, Executive Administrative Assistant	The Lennard Clinic, Inc.
L.E. “Jim” Keller, Treasurer and Chief Financial Officer	The Good News Home for Women
Joseph P. Laurelli, M.D., Medical Director	The Lennard Clinic, Inc.
Raquel Mazon Jeffers, Director	Division of Addiction Services, New Jersey Department of Human Services
Geralyn Molinari, Program Manager	Office of Treatment, Division of Addiction Services, New Jersey Department of Human Services
Carmen Moncrieffe, Special Assistant	The Lennard Clinic, Inc.
Robin Nighland, Coordinator of Adolescent Treatment	Office of Treatment, Division of Addiction Services, New Jersey Department of Human Services
Fatima Olneira	The Lennard Clinic, Inc.
Garcia Outlaw, Outpatient Counselor	The Lennard Clinic, Inc.
Samuel Roberson, Director of Human Resources	The Lennard Clinic, Inc.
Dave Roden, Vice President and Chief Operating Officer	New Hope Foundation
John Rountree, Section Supervisor	Administrative Services, Division of Addiction Services, New Jersey Department of Human Services
Marge Ruchaevsky, Chief Financial Officer	New Hope Foundation
Gloria G. Santos, Supervisor of Licensing Inspection	Licensure and Supportive Housing, Division of Addiction Services, New Jersey Department of Human Services
Gayle J. Saunders, Alternate Government Project Officer	CSAT
Chris Scalise, Manager	Office of Treatment, Division of Addiction Services, New Jersey Department of Human Services
Dona Sinton, Executive Assistant to the Director	Division of Addiction Services, New Jersey Department of Human Services

Representative	Organization
Edy Tenninger, Clinic Manager	The Lennard Clinic, Inc.
Cindy Thomas, Principal	New Hope Foundation School
Maiysha Ware, Director of Safety	The Lennard Clinic, Inc.
Lewis Ware, Chief Executive Officer	The Lennard Clinic, Inc.
Ernestine Winfrey, Executive Director and Clinical Supervisor	The Good News Home for Women
Tina Witkop, Adolescent Director	New Hope Foundation, Marlboro

Appendix B. Acronyms Relevant to the New Jersey Technical Review

ADS	Addiction Disability Specialist
APCB	Addiction Professional Certification Board
APS	Associate Prevention Specialist
ASAM PPC-2R	American Society of Addiction Medicine, Patient Placement Criteria, Second Edition, Revised
ASI	Addiction Severity Index
ASU	Administrative Services Unit
CAC	Citizens Advisory Council
CADC	Certified Alcohol and Drug Counselor
CAP	corrective action plan
CASI	Comprehensive Adolescent Severity Inventory
CBC	complete blood count
CBT	Cognitive Behavioral Therapy
CCDP	Co-Occurring Disorder Professional
CCDP-Diplomate	Co-Occurring Disorder Professional Diplomate
CCJP	Certified Criminal Justice Professional
CCS	Certified Clinical Supervisor
CD4	cluster of differentiation 4
CDA	Chemical Dependency Associate
CDC	Centers for Disease Control and Prevention
CEATTC	Central East Addiction Technology Transfer Center
CFDA	Catalog of Federal Domestic Assistance
CFR	Code of Federal Regulations
CJC	Criminal Justice Counselor
CM	case management
CMHA	Community Mental Health Associate
CPA	certified public accountant
CPS	Certified Prevention Specialist
CPSAI	Child Protection Substance Abuse Initiative
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CTS	Counseling and Testing Services
CTTS	Certified Tobacco Treatment Specialist
DAS	Division of Addiction Services
DASIE	DAS Income Eligibility Module
DCBHS	Division of Child Behavioral Health Services
DCF	Department of Children and Families
DEDR	Drug Enforcement Demand Reduction
DDD	Division of Developmental Disabilities
DDHH	Division of the Deaf and Hard of Hearing
DDS	Division of Disability Services
DFD	Division of Family Development

DHAS	Division of HIV/AIDS Services
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DMAHS	Division of Medical Assistance and Health Services
DMHS	Division of Mental Health Services
DOAPC	Division of AIDS Prevention and Control
DOC	Department of Corrections
DOE	Department of Education
DRCC	Disaster Response Crisis Counselor
DYFS	Division of Youth and Family Services
EBP	evidence-based practices
EIP	Early Intervention Program
EIS	early intervention services
FA	fiscal agent
FDA	Food and Drug Administration
FFS	fee-for-service
FFY	Federal fiscal year
FQHC	Federally Qualified Health Centers
FTE	full-time equivalent
GPRA	Government Performance and Results Act of 1993
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICRC/AODA	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.
IOM	Institute of Medicine
IT	information technology
JJC	Juvenile Justice Commission
LACADA	Local Advisory Committees on Alcohol and Drug Abuse
LCADC	Licensed Clinical Alcohol and Drug Counselor
LOCI	Level of Care Index
MHSIP	Mental Health Statistical Improvement Program
MIS	management information system
MOE	maintenance of effort
MTB	mycobacterium tuberculosis
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NETI	Needle Exchange Treatment Initiative
NIATx	Network for the Improvement of Addiction Treatment
NJCFS	New Jersey Comprehensive Financial System
NJPN	New Jersey Prevention Network
NJSAMS	New Jersey Substance Abuse Monitoring System

NOMs	National Outcome Measures
NSDUH	National Survey on Drug Use and Health
NTN	National Treatment Network
OC	Organization Code
OIG	Office of the Inspector General
OIS	Office of Information Systems
OMB	Office of Management and Budget
OPSI	Office of Policy and Special Initiatives
OQA	Office of Quality Assurance
ORPEIS	Office of Planning, Research, Evaluation, and Information Systems
OTP	Opioid Treatment Program
PHI	Protected Health Information
PIC	Program Improvement Committee
PIPPP	Patient Incentive Program and Project Promise
PMS	Payment Management System
QA	Quality Assurance
RA	Consumer and Recovery Advocate
RFP	request for proposal
RMA	Recovery Mentor Associate
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SEOW	State Epidemiological Outcomes Workgroup
SFY	State fiscal year
SPF SIG	State Prevention Framework State Incentive Grant
SPO	State Project Officer
SSA	Single State Authority
SSDP	State Systems Development Program
TA	technical assistance
TANF	Temporary Assistance for Needy Families
TB	tuberculosis
TEDS	Treatment Episode Data Set
TIP	Treatment Improvement Protocol
WFNJ-SAI	Work First New Jersey-Substance Abuse Initiative
WSN	Women's Services Network
WTS	Woman's Treatment Specialist

Appendix C. Purpose, Methodology, and Limitations of the Technical Review

A. Purpose of the Technical Review

The State Systems Development Program (SSDP) was initiated by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance the viability and effectiveness of national and State-level substance abuse service delivery systems. The Technical Reviews project is one of SSDP's major components— an assessment of statewide systems that examines system strengths, identifies major operational issues, and measures progress toward meeting Substance Abuse Prevention and Treatment (SAPT) Block Grant objectives. The project focuses on providing SAMHSA, CSAT, and the States with a framework for effective technical assistance (TA), technology transfer, and new policy initiatives.

Two types of reviews are conducted through the Technical Reviews project: State-Requested Reviews, in which States identify their most pressing concerns and select one or more issues for indepth review, and CSAT Core Technical Reviews, in which CSAT identifies certain issues for review. This review of the New Jersey Division of Addiction Services (DAS) is a CSAT Core Technical Review, which addresses the following issues:

- Organizational structure of the State alcohol and drug agency
- Policymaking structure of the State alcohol and drug agency
- External relationships
- Needs assessment and strategic planning
- Data management
- Financial management
- Quality management
- Impact of TA
- Technology transfer [as appropriate]
- State strengths, challenges, and recommendations

B. Methodology

The Technical Review is conducted by an independent contractor on behalf of CSAT. The intended audience is CSAT and the Single State Authority (SSA) responsible for delivering services supported by SAPT Block Grant funds.

The first step in the Technical Review process is the formation of a team composed of specialists with expertise related to the issues under review. Prior to the onsite review, the reviewers examine documents provided by the SSA. Additional documents describing agency and program operations are obtained on site and reviewed either at that time or following the site visit. A primary component of the Technical Review process is a series of interviews conducted on site with the State agency, intermediary agency (if appropriate), and local provider staff members responsible for the areas under review.

At the completion of the site visit, the reviewers conduct an exit conference with State officials to discuss preliminary findings and TA recommendations. Following the site review, the reviewers complete the analysis of all documentation and generate a draft report that integrates these findings with the results of the site visit. This draft is submitted to CSAT and the SSA for review and comment. A final report is then produced that incorporates the corrections and revisions agreed to by DAS, CSAT, and the reviewers.

C. GENERAL LIMITATIONS

The information presented in the Technical Review reports is based on extensive analysis of the interviews conducted at State agencies and local service providers and a review of available documents. The scope and depth of the review are limited by the amount and quality of the documentation and the amount of time spent on site.

The findings in this Technical Review report do not constitute audit findings and should not be used for that purpose. The fiscal information included is based on data provided by the agencies reviewed. While the reviewers attempt to verify key information on site, the fiscal review is not an audit and is not conducted according to generally accepted auditing standards issued by the American Institute of Certified Public Accountants or Government Auditing Standards issued by the Comptroller General of the United States. Those standards require planning and performing an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement and also whether material noncompliance with the requirements referred to above occurred. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, and also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, resulting in the issuance of an opinion. Because our procedures do not constitute an audit, we are not expressing an opinion on either the financial statements or on the receipts, obligations, and expenditures incurred for the specific SAPT Block Grant compliance requirements.

The findings represent organizational development and compliance issues identified in the SAPT Block Grant (Catalogue of Federal Domestic Assistance Number 93.959), and they are intended to serve as the basis for TA developmental action plans to improve the State's capacity to deliver the services required under the SAPT Block Grant. This report is intended solely for the use of CSAT, the State of New Jersey, and their appropriate designees.

Appendix D. Substance Abuse and Mental Health Services Administration Performance Management Capacity Assessment Matrix Guidelines

Capacity	Current level of implementation			
	Basic	**Intermediate**	**Advanced**	**Expert**
Provider Capacity. Capacity of providers within a system to implement performance management.	Provider collects standardized data.	Management within the provider agency uses data for planning and decisionmaking.	Provider collects performance management data.	Clients use data to select program.
Data Systems Capacity. Capacity of stakeholders for collecting; moving; and manipulating data, including collecting data to meet management needs, transmitting and storing data, and linking data across other data systems.	Data are collected at admission. System meets Treatment Episode Data Set (TEDS) requirements. Data are used for other Federal reporting (e.g., Block Grant). Paper or diskette system is used. Paper/diskette is mailed to lead agency. Time between data collection and data entry is approximately 30 days. Data are cleaned by lead agency (e.g., Single State Authority [SSA], sub-State entity). Lead agency links data at provider level. Provider maintains unique client identification number.	Data are collected at admission and discharge. Provider uses electronic data system. State alcohol and other drugs data system uses unique client identification number. Lead agency generates error reports.	Admission and discharge data are linked at client level. Followup performance management data are collected at multiple points in time. Provider has skill set to use performance management data to make clinical adjustments. Data edits are built into the data entry system. Client-level data can be linked to other behavioral healthcare data. Data are linked to other State data for special projects.	Client-level data are routinely linked to other State data systems (e.g., criminal justice, employment). Statewide system uses a Web-based data entry system. Data system provides “real time” reports. Analyses adjust for case mix.

Capacity	Current level of implementation			
	Basic	Intermediate	Advanced	Expert
Cultural Capacity. Internal culture of agency (e.g., SSA and State entity provider organization) regarding the use of data in planning and policymaking.	Agency activities focus on meeting compliance. Agency has data available.	Leadership reviews monthly data reports. Agency has allocated some staff to performance management.	Agency has a defined performance management process. Performance improvement projects are underway. Performance processes are integrated into planning and decisionmaking. Workforce has skills to apply performance management. Agency has allocated sufficient staff to performance management.	Performance management system is viewed as an effective tool. Performance measures are consistently defined in measurable terms. Performance measures have been implemented. Agency has implemented a continuous improvement process. Agency shared collaborative role/responsibility for performance management with multiple agencies serving target population. Agency provides Web access for all appropriate staff. Agency invests in information technology as needed.
Analysis and Management Capacity. Capacity of the agency to use data to manage services and influence practices at multiple levels, including analytic capacity and processes, roles, and protocols for action.	Agency collects data. Agency meets minimal Federal data requirements. Agency submits raw data to reporting agency.	Agency analyzes and distributes data. Agency distributes program-level data. Agency has an action plan for improving data quality.	Agency has analytical/management staff dedicated to performance management activities. Agency provides timely comparison data by program, region, and State. Agency has a specified process for taking action after review of data. Agency identifies outliers and discusses/provides onsite technical assistance (TA). Agency trains systemwide staff on performance management. Agency trains own staff on performance management.	Providers have the ability to go online for comparison reports. SSA runs cost-effectiveness and offset analyses. Agency uses performance measures to manage contracts. Agency regularly engages in performance contracting.