New Jersey

Division of Mental Health and Addiction Services

Technical Review Report:
Center for Substance Abuse Treatment
Technical Review

Final Report

June 2017

Division of State and Community Assistance
Center for Substance Abuse Treatment

CONTENTS

I. INTRODUCTION

Exhibit I-1. State Technical Review Participants

AGENCY NAME:	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
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REVIEW PERIOD:	March 14–18, 2016
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Special Limitations

All findings and corresponding tables in this report are designed to capture the static nature of the Technical Review period (March 14–18, 2016), and do not necessarily reflect the current dynamics in New Jersey regarding Single State Agency (SSA) compliance. Please refer to Appendix C for more information on the purpose, methodology, and limitations of the Technical Review.

Organization of Appendices

Appendix A provides a list of the state and local personnel interviewed during the Technical Review. 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.

II. PROGRAMMATIC AND CLINICAL ELEMENTS OF THE STATE TECHNICAL REVIEW

The objective of this Technical Review is to describe the state's alcohol and drug treatment system; to inform the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) about system issues; to describe the state's readiness to collect, report, and use performance data, including National Outcome Measures (NOMs); and to identify areas in which technical assistance (TA) may help the state manage and improve their treatment system. This is accomplished by focusing on

- The organizational structure of the state alcohol and drug agency
- The policymaking structure of the state alcohol and drug agency
- External relationships
- Needs assessment and strategic planning
- Data management
- Financial management
- Quality management

In addition, after the full implementation of the Affordable Care Act (ACA), SAMHSA strongly recommends that Substance Abuse Prevention and Treatment Block Grant (SABG) funds be directed toward four purposes:

- To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- To fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- To fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. State authorities should make every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.

Therefore, Technical Reviews also focus on improving SAMHSA's understanding of the evolution of SABG as states implement health insurance coverage expansions following ACA.

A. ORGANIZATIONAL STRUCTURE OF THE STATE ALCOHOL AND DRUG AGENCY

This section describes the Single State Agency's (SSA) 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.

Methodology

Prior to the on-site review of the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS), the compliance team (TCT) reviewed documentation provided by DMHAS, including:

- The DMHAS website (http://www.state.nj.us/humanservices/dmhas/home/)
- The DHS 2015 organization chart (dated December 31, 2015)
- The DMHAS 2016 organization chart (dated January 2016)
- An overview of the Public Behavioral Health System at the State and Local Levels
- Behavioral Health/Primary Care Integration Initiatives and Opportunities
- The DMHAS Three-year Strategic Plan, 2014–2016
- Overview of the Interim Managing Entity
- Overview of the DMHAS Monitoring Process
- DMHAS Health Care Reform Projects and Significant Changes to Behavioral Health System
- Tuberculosis Surveillance Procedures for Substance Abuse Treatment Facilities
- DMHAS Treatment Standards Requirements

TCT also reviewed the following documents obtained during the on-site review or acquired through its research activities:

- State of New Jersey, Department of Human Services, Division of Mental Health and Addiction Services, State System Overview, March 14–18, 2016
- Transition to Fee-for-Services: Overview for Provider Meetings (dated February/March 2016)

During the 2-day visit at DHS DMHAS, TCT conducted interviews with the following staff:

- DHS Acting Commissioner
- DHS Assistant Commissioner
- DHS Acting Deputy Director
- DHS Medical Director
- Office of State Hospital Management Deputy Assistant Director
- DHMAS Director of Prevention and Early Intervention Services

- DMHAS Assistant Director, Planning, Research, Evaluation and Prevention
- DMHAS Research Scientist
- DMHAS Chief, Special Populations
- DMHAS Manager, Special Initiatives Women and Families
- DMHAS Office of Olmstead, Compliance, Prevention, Planning and Evaluation Deputy Assistant Director
- DMHAS Director of Quality Assurance
- DMHAS Addiction Recovery Advocate
- DMHAS Special Assistant for Community Affairs
- DMHAS Clinical Workforce Development Specialist
- Chief, Bureau of Contract Administration
- DMHAS Chief of Care Management
- DMHAS IT Manager
- DMHAS Office of Treatment and Recovery Support Deputy Assistant Director
- DMHAS Contract Monitoring Supervisor
- DMHAS State Opioid Authority HIV Coordinator
- DMHAS Office of Information Systems Assistant Division Director

Organizational Structure of the State Alcohol and Drug Agency

Organizational Structure, Placement, and Staffing of the Single State Agency

In 2011, the Division of Mental Health and the Division of Addiction Services merged to form the DMHAS. The decision to merge was guided by realization that a fragmented approach to care contributed to the stigma associated with mental health and substance use disorders and resulted in inefficient service delivery. DMHAS is the designated State Authority on Substance Abuse (SSA) and the State Mental Health Authority (SMA). As the SSA, DMHAS administers the SABG for New Jersey. DHMAS is one of eight divisions housed in DHS, each overseen by either a Director or an Assistant Commissioner. The other divisions are:

- Commission for the Blind and Visually Impaired (CBVI)
- Division of Aging Services (DoAS)
- Division of the Deaf and Hard of Hearing (DDHH)
- Division of Developmental Disabilities (DDD)
- Division of Disability Services (DDS)
- Division of Family Development (DFD)
- Division of Medical Assistance and Health Services (DMAHS)

The functional areas within DHS include:

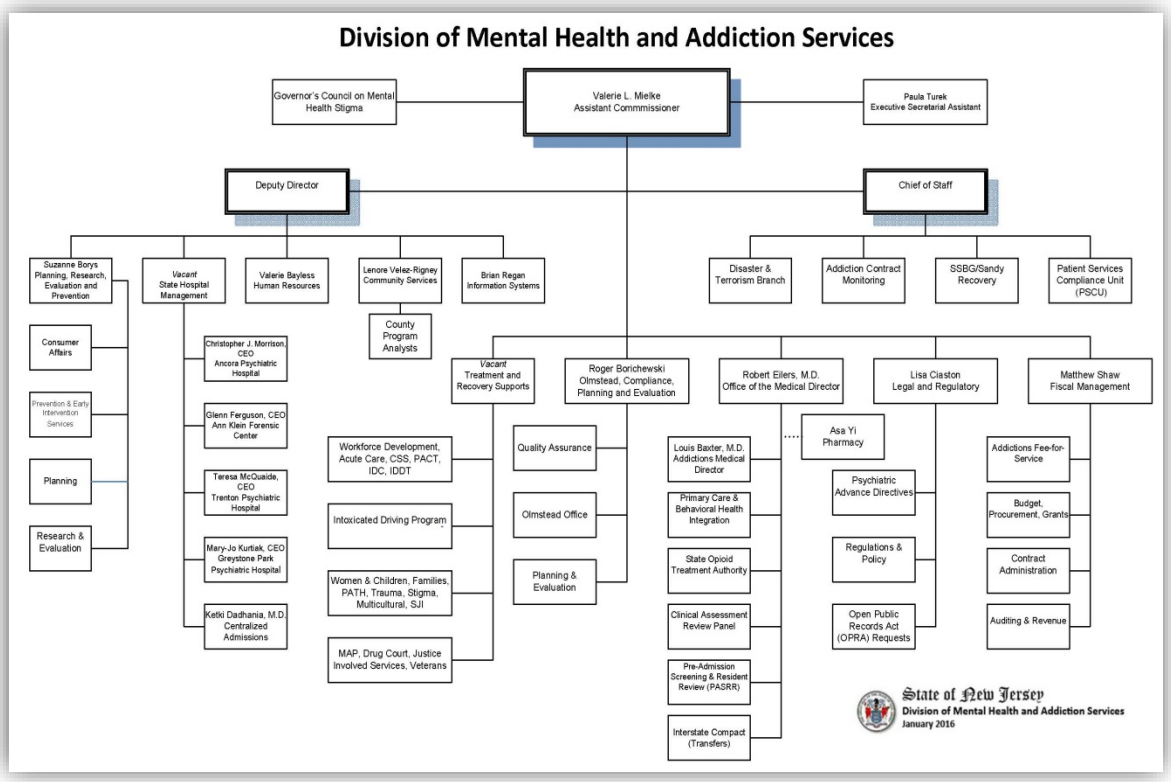
- Office of Program Integrity and Accountability
- Office of Contract Policy and Management
- Office of Information Systems

The DMHAS Assistant Commissioner reports to the DHS Commissioner who reports directly to the Governor. The primary areas of DMHAS include:

- Office of Planning, Research, Evaluation and Prevention (OPREP)
- Consumer Affairs
- Human Resources
- Community Services
- Office of Information Systems (OIS)
- Patient Services Compliance Unit
- Addiction Contract Monitoring
- Legal and Regulatory
- Fiscal Management
- Olmstead Compliance, Planning and Evaluation
- Treatment and Recovery Supports
- State Hospital Management
- New Jersey's adult system of community-based behavioral health services
- Program for Assertive Community Treatment (PACT)

Exhibit II-1 presents the DMHAS organizational chart.

Exhibit II-1. New Jersey Division of Mental Health and Addiction Services Organizational Chart



Since the 2011 merger, DMHAS has been navigating the process of integrating staff and services. Many DMHAS functions and staff remain bifurcated despite the merger. For example, Addiction Services and Mental Health Services have different data systems and funding allocations. Services provided for mental health clients, such as housing, may not be available to addiction services clients, unless these clients also fall under the auspices of mental health.

In addition to dichotomous roles and functions resulting from the merger, the Division faces other staff-related challenges. DMHAS reported difficulty recruiting and retaining qualified personnel. Although the Division provides numerous staff training and educational opportunities, state salaries are low, making it difficult to retain staff. DMHAS is also faced with a retiring workforce and the absence of a succession plan for capturing the institutional knowledge of long-term staff. Section D, Needs Assessment and Strategic Planning, further describes some of the Division's workforce challenges.

DMHAS began a change in its payment method for treatment services to a fee-for- service model in SFY 2010. There were a variety of initiatives (e.g., DUII, SJI, Drug Court, SPB, MAP, DOC,

MATI) added. In November 2013 the Recovery and Rebuilding Initiative (RRI) was added. On July 1, 2016, contracted outpatient methadone, intensive outpatient methadone and residential services reimbursed by SAPT Block Grant funds and the remaining providers with slot-based contracts with the exception of SABG women's set-aside services transitioned to fee-for-service. At the time of the compliance review, the state had not determined if women's services would also transition.

To manage the FFS process, the Governor announced the formation of an Interim Managing Entity (IME) for addictions in his January 2015 State of the State Address. Rutgers University Behavioral Health Care (UBHC) was tapped to serve as the IME. Once fully implemented, the IME will serve as the central point of contact for individuals seeking treatment for SUDs. The IME will conduct an initial telephone screening and then provide a referral to a provider for a full assessment. It will also manage capacity, maintain contact with individuals waiting for admissions to keep them engaged, and conduct follow-ups on admissions to detox to help clients access the next level of care. It is anticipated that the IME will ensure that individuals are receiving the right level of care for the right duration at the right intensity and allow the state to manage its resources across payers and across the continuum of care. To manage the influx of requests, UBHC will use its existing call center to triage and process requests for treatment. The capacity of IME to match clients to needed levels of care is discussed in more detail below in Section F, Quality Management and Substance Abuse Prevention and Treatment Block Grant Compliance.

Mission and Vision

As expressed in its mission statement, DMHAS, "in partnership with consumers, family members, providers and other stakeholders, promotes wellness and recovery for individuals managing a mental illness, substance use disorder or co-occurring disorder through a continuum of prevention, early intervention, treatment and recovery services delivered by a culturally competent and well trained workforce."[1] The vision of DMHAS is to have "an integrated mental health and substance abuse service system that provides a continuum of prevention, treatment and recovery supports to residents of New Jersey who have, or are at risk of, mental health, addictions or co-occurring disorders."[2]

Cultural and Ethnic Composition of Staff and Clients

At the time of the Compliance Review, DMHAS had 218 full-time equivalent employees (FTE). The racial and ethnic composition of DMHAS staff is shown in Table II-1.

[1] Source: DMHAS Website - http://www.state.nj.us/humanservices/dmhas/home/about/Mission_Statement.pdf

[2] Source: DMHAS Website - http://www.state.nj.us/humanservices/dmhas/home/about/Mission_Statement.pdf

Table II-1. Race/Ethnicity of SSA Staff

Category	Number	Percent
White	123	53
Black or African American	62	27
Native Hawaiian/Other Pacific Islander	0	0
Asian	30	13
American Indian/Alaskan Native	3	1
Persons who report more than one race	1	1
Unknown (Specify)	0	0
Not Hispanic or Latino	213	95
Hispanic or Latino	12	5

Table II-2 presents the race and ethnicity of clients served by the SSA in 2015, as reflected in the DMHAS client census.

Table II-2. Race/Ethnicity of Clients Served

Category (CY2015 public funded)	Number	Percent
White	36,214	69.79
Black or African American	13,869	26.73
Native Hawaiian/Other Pacific Islander	542	1.04
Asian	471	0.91
American Indian/Alaskan Native	282	0.55
Persons who report more than one race	1,027	2.00
Unknown (Specify)	509	0.98
Not Hispanic or Latino	42,677	86.24
Hispanic or Latino	5,156	13.76

Organizational Structure, Placement and Staffing of Provider Agencies

DMHAS provides comprehensive mental health and SUD prevention, early intervention, treatment, and recovery services through direct contracts with a variety of providers. The compliance team visited three service providers over two days. On the first day of provider visits, the team visited Paterson Counseling Center (PCC), and Straight and Narrow. Both programs are located in Paterson. It visited Good News for Women, located in Flemington, on the second day of the provider visits.

PCC was established in 1969 by Passaic County as an outreach and methadone program. From 1971 to 1984, it was a state-run facility, and became a nonprofit organization in 1984. In addition to methadone as a medication assisted treatment (MAT), PCC provides substance abuse counseling, HIV counseling, an employee assistance program, a DUI program, and perinatal care.

PCC is staffed with 40 FTEs. These consist of an executive director, clinical director, director of administrative services, director of HIV services and outreach, manager of IT/budget, an intake

counselor, substance abuse and mental health counselors, an obstetrician, a nurse, and administrative staff. While visiting PCC, the team conducted interviews with the executive director, director of admissions, and intake counselor. TCT toured the facility, including the methadone dosing area, the records room, and counseling areas; and reviewed the most recent customer satisfaction survey.

Staff members report that PCC has experienced a reduction in services due to funding limitations. It lost a significant amount of funding about 6 years ago. These funds had supported an obstetrician, a pediatrician, and 1.5 nurses, and had allowed the program to provide the full spectrum of prenatal services and medical care for children up to 2 years of age. Subsequent to the loss of funds, PCC established relationships with local hospitals and clinics to provide pre- and postnatal care to women and their children[3]. The staff expressed concerns about the IME rollout. The concerns focused on clients' access to services, the billing and reimbursement process, and a need for more training on the IME and for frequently asked questions (FAQs).

DMHAS and NJFamily Care held multiple trainings and issued monthly FAQs and newsletters through much of 2015 and 2016. Attendance at these trainings was not compulsory and some providers did not attend. Trainings were held in the northern, southern and central regions of the state and included seven IME rollout trainings, 14 clinical trainings on ASAM, ASAM LOCI and DSM-5 to prepare for the IME utilization management, and 11 IME utilization management trainings (which were filmed and later posted on YouTube). In addition, four newsletters and six FAQs were issued in 2015 to 2016.

Straight and Narrow has been in existence since 1954 and is an arm of Catholic Charities of the Diocese of Paterson. The program provides an array of services for men, women, and adolescents, including outpatient and residential SUD treatment, medical care, housing, childcare, and MAT. Alpha I, a 6- to 12-month program for women referred by drug court or other referral source; Alpha II, a 12-month residential treatment program for any pregnant and parenting woman (PPW) in need of treatment; and Alpha III, an intensive treatment program for PPWs with open Department of Children and Families' (DCF) Child Protection and Permanency cases. A component of Alpha III is the Mommy and Me program which provides child development and parenting education for new mothers. All of the programs allow women to bring their children into treatment with them. They also provide gender-specific treatment, on-site childcare, and on-site medical care for the women and children. Straight and Narrow provides transportation services to women admitted to the Mommy and Me Program. The program has provided residential treatment services to 376 PPWs. At the time of the compliance review, 95 women were enrolled in the three residential treatment programs.

The team met with the executive director, residential life director, admissions coordinator, coordinator of special initiatives, and the program supervisor. TCT also toured the women's

[3] DMHAS Staff provided the following response during the state comment period in reaction to PCC's statement that they experienced a funding reduction: "The funds were terminated because the services were available through other payment sources. While PCC experienced a decrease in their funding, the same services are available to the clients along with a fuller array of integrated service, through the PCC partnership with local hospitals and clinics."

residential area, the dosing and treatment areas, and the newly constructed halfway house, and reviewed a program brochure.

Good News for Women was founded in 1983, and provides short- and long-term residential treatment services for women. The program employs 12 FTEs, including an executive director, development director, administrative director, nursing supervisor, medical director, dietician, addictions counselor, intake coordinator, family program facilitator, house supervisor, and counselor intern. The program offers group and individual counseling, family centered therapy, life skills building, and case management services. Women must be substance free before entering the program. Good News for Women does not manage or provide MAT. The team interviewed the executive director, intake coordinator/addictions counselor, and the house manager. TCT also toured the facility, including the residential living quarters.

The monitoring review team conducted an impromptu visit to UBHC, the newly implemented IME, located in Piscataway Township. The IME "will be responsible for maintaining a call center for individual and provider inquiries related to government assistance in accessing treatment. The IME will play an active role in managing consumers by screening for client financial and clinical eligibility for services, provide utilization management based on clinical need, and care coordination to improve client access to care. Using information supplied by DMHAS and NJ FamilyCare, UBHC will develop, implement and maintain a bed management system specific to addiction services. The system will be used to track treatment capacity and allow UBHC to make targeted referrals." (New Jersey Office of Legislative Services, 2015). DHS established the IME to manage the new fee-for-service structure for addiction services. The monitoring review team toured the call center and observed several real time calls. The visit allowed the team to observe the length of time needed to answer calls, how calls are routed, and the technology used by supervisors to monitor calls when assistance is needed. The review team reviewed IME brochures, factsheets, and an overview provided by the SSA. The IME is also discussed below and in Section F.

Treatment Capacity

At the time of the Compliance Review, DMHAS provided SABG funding to 166 providers that delivered substance abuse treatment services in 259 locations. Residential services are provided by 47 of these facilities. Among these, 12 provide residential services to only women; five provide services to pregnant women and women with children.

The 46,441 clients that received substance abuse treatment services[4] as of December 31, 2014, presented the following characteristics:

- 49 percent reported heroin and other opiates as their primary drug; 27 percent reported alcohol.
- 13 percent had planned to receive methadone; 5 percent would receive Suboxone.

[4] State of New Jersey, DHS DMHAS State System Overview (Dated March 14-16, 2016)

- 45 percent were admitted for outpatient services.

The race and ethnicity and age demographics of the clients indicated that:

- 61 percent were white
- 22 percent were black
- 15 percent were of Hispanic origin[5]
- 3 percent were under the age of 18
- 8 percent were age 18–21
- 31 percent were 22–29 years old
- 53 percent were between the ages of 30–54
- 6 percent were over the age of 55 years

Table II-3 provides a detailed breakdown of the DMHAS-funded sites.

Table II-3. Number of SSA-Funded Sites throughout the State

		Location		Populations Served	
Type of Service	Total Number of Sites	Urban Sites	Rural Sites	Adults	Adolescents
Detoxification, 24-Hour Hospital Inpatient	1	1	0	1	0
Detoxification, 24-Hour Free-Standing	9	7	2	8	1
Detoxification, Ambulatory	1	1	0	1	0
Rehabilitation, Residential, Hospital	0	0	0	0	0
Rehabilitation, Residential, Long-Term (more than 30 days)	32	28	4	25	7
Rehabilitation, Residential, Short-Term	15	12	3	13	2
Rehabilitation, Intensive Outpatient	193	188	5		
Rehabilitation, Non-Intensive Outpatient	218	211	7		
Halfway/Transitional Housing	27	25	2	27	0
Opioid Replacement Therapy	33	31	2		
Opioid Detoxification	33	31	2		

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 decision making. This section also addresses health insurance expansion policy following the Affordable Care Act and how programs are being implemented on a state level.

[5] Strengths and Needs of the Service System to Address the Specific Populations

Methodology

The TCT gathered information on the State's policymaking structure through a review of documents provided by DMHAS prior to the site visit, information presented by the DMHAS staff during the entrance conference, and on-site interviews with key DMHAS staff.

Policymaking Structure of the State Alcohol and Drug Agency

DMHAS leadership is responsible for setting policy and developing a strategic plan with advice from various committees and councils. The policy team—composed of 20 staff from the executive management team and 40 staff from the senior management team—establishes program policy and budgets, conducts strategic planning, addresses cross department collaboration and new initiatives, and provides troubleshooting. The following committees and councils provide feedback to the policy team:

- Professional Advisory Committee for Addictions (PAC). PAC meets monthly to make recommendations relevant to prevention, early intervention, treatment and recovery of SUDs and addictions. Its 30 members represent different levels of care (including treatment), trade organizations, practice groups related to treatment, state senior staff, executive management team, licensing, Medicaid, and the IME. Most recently PAC was instrumental in developing the structure and functioning of the IME and the New Jersey Substance Abuse Monitoring System (NJSAMS).
- Behavioral Health Planning Council (BHPC). The Council is composed of mental health and substance abuse advocacy agencies, providers, consumers, family members, and state staff from various departments and divisions. BHC reviews, and provides feedback, approval, and support for the block grant application. It underwent a major effort to increase addictions representation to 50 percent, which includes consumers, addiction providers, and state addictions specialists.
- County alcohol and drug abuse directors (CADADs). CADADs address issues related to policy planning, cost sharing for deductibles, and copays.
- Citizen Advisory Council (CAC). The CAC was formed to remove barriers to treatment and long-term recovery management. It is composed of consumers and citizens who are at risk for, struggling with, or otherwise affected by addiction. CAC focuses on providing input and guidance to DMHAS in developing policies and procedures.
- Statewide Consumer Advisory Committee (SCAC). Comprising a diverse group of emerging leaders who are in recovery, the SCAC provides DMHAS with feedback on recovery and wellness-oriented systems. SCAC also works with DMHAS on many aspects of the transformation to FFS, including assisting with focus groups to identify outcomes and other elements of service delivery.
- Multicultural Services Group (MSG). The MSG consists of consumers, providers, training agencies, and stakeholders committed to cultural and linguistic competency in the mental health and addictions system of care. MSG provides a structure through which New Jersey's multicultural populations can communicate their needs within DMHAS, and ensures that cultural competency is a part of any policymaking.

DMHAS convenes workgroups of subject matter experts, providers, consumers, and family members to help design, redesign, or promulgate regulations. Draft regulations undergo an internal review before dissemination to consumers, councils, and committees for comments and feedback. Subsequent to the internal review, the draft regulation goes to the Office of the Governor for vetting and is posted for public comment. DMHAS also meets with provider groups that are tasked with reviewing and developing policy specifically related to rates. At the time of the Compliance Monitoring Review, DMHAS had begun to revise the regulation for outpatient providers to have one rather than two licenses for mental health and substance abuse. The substance abuse license will include outpatient and partial care services.

Since the last SAMHSA visit, DMHAS has convened several workgroups to develop its current strategic plan and implement the FFS rate setting process. It hired an outside actuarial company to assess provider feedback about the rate setting process. The 2-year process also involved working with providers to obtain feedback about the rates. The new rates were submitted for budget approval during the second week of February 2016. Pending budget approval, the new rates were scheduled to become effective July 1, 2016. Some of the providers participating in this review raised concerns about cash flow subsequent to the FFS structure. Currently, providers are paid 110 percent of their contract in advance. Under the new system providers will receive two months' upfront reimbursement to address cash flow issues.

Staff stated that DMHAS has a strong relationship with DMAHS which is where the Office of Medicaid is housed. The two agencies have worked well together on the FFS transition to ensure it moves toward implementation in an integrated manner. DMHAS and DMAHS are working on the Medicaid waiver that will be renewed in 2017. Since New Jersey became a Medicaid expansion state, DMHAS has been working on Trueup[6] which allows clients receiving services under Medicaid Part A to receive the same services under the expansion program and for providers to get the same reimbursement. The DMHAS is also pursuing presumptive Medicaid eligibility that will enable providers to be reimbursed within 72 hours of submission, thereby addressing their concerns about cash flow.

[6] Trueup is a process under Medicaid expansion that allows clients receiving services under Medicaid Part A to receive those same Medicaid Part A services under the expansion program, while also allowing the providers to receive the same rate of reimbursement as they would under Medicaid Part A. A true-up adjustment is based on a comparison of the true costs from the base year to the amount that was paid by applying the per diem rate that was in effect at the time to the total resident days. See Department of Human Services Legislative Budget, http://www.njleg.state.nj.us/legislativepub/budget_2016/DHS_response.pdf.

Table II-4. Services Funded by SABG and Medicaid as a Result of Medicaid Expansion

Substance Abuse Services Paid for by Medicaid for Injection Drug Users and Pregnant and Parenting Women	Substance Abuse Services Paid for by SABG for Injection Drug Users and Pregnant and Parenting Women	Services Covered by Both Medicaid and SABG for Injection Drug Users and Pregnant and Parenting Women	Services Previously Paid for by SABG but Now Paid for by Medicaid for Injection Drug Users and Pregnant and Parenting Women	New or Alternative Services Paid for by SABG	New Populations Eligible for Services as a Result of Medicaid Expansion
Assessment	Assessment	Assessment	N/A	N/A	*ABP, Plan A
Outpatient Methadone and non-Methadone opioid treatment services including but not limited to buprenorphine/buprenorphine-naloxone	Outpatient Methadone	Outpatient Methadone			*ABP, Plan A
Intensive Outpatient Methadone and non-Methadone opioid treatment services including but not limited to buprenorphine/buprenorphine-naloxone.	Intensive Outpatient Methadone	Intensive Outpatient Methadone			*ABP, Plan A
Inpatient or Residential Withdrawal Management (for ages 18 to 21st birthday and ages 65 and over – due to IMD exclusion)	Inpatient Withdrawal Management	Inpatient Withdrawal Management			*ABP, Plan A
Short Term Residential	Residential	Residential			*ABP, Plan A
Intensive Outpatient and Partial Care	Intensive Outpatient	Intensive Outpatient			*ABP, Plan A
Case Management and Recovery supports may be covered pending CMS waiver authority in 2019	Case Management / Recovery Supports				

*On January 1, 2014, the Division of Medical Assistance and Health Services (DMAHS) , the State Medicaid Agency expanded the New Jersey Family Care (NJFC) program to offer healthcare to parents, single adults and childless couples ages 19 to 64, with incomes up to 133% of the Federal Poverty Level (FPL). The new federal healthcare law requires the creation of an

Alternative Benefit Plan (ABP) for the NJFC expansion population. The ABP includes all NJFC State Plan benefits, as well as some additional substance abuse services.

Effective July 1, 2016, access to SUD treatment services will be expanded to include NJFC Plan A beneficiaries. All SUD treatment services listed will be available as FFS benefits for NJFC Plan A and ABP beneficiaries.

Substance abuse treatment services provided to the ABP population, as well as medication-assisted treatment for substance abuse provided to NJFC Plan A beneficiaries, will be coordinated by the IME in response to inquiries received through its Call Center. The IME will also authorize services for State-funded substance abuse treatment services. These services will continue to be funded by DMHAS for New Jersey residents not eligible to receive NJFC/Medicaid coverage

C. EXTERNAL RELATIONSHIPS

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

Methodology

The Compliance Monitoring Review team gathered information for this section through a review of documents provided by DMHAS prior to the site visit and information obtained during on-site interviews with key DMHAS and treatment providers' staff.

External Relationships

Staff stated that DMHAS has forged strong partnerships and collaborations with other agencies to coordinate the delivery of services to special needs populations. The division has formal memoranda of agreements (MOAs) with the following agencies:

- Department of Health to provide behavioral and mental health preparedness activities for at-risk populations and first responders; for the tobacco age of sale enforcement (TASE) program; and to provide Super Storm Sandy Module.
- NJ State Parole Board to provide substance abuse treatment services, including MAT, intensive outpatient, urinalysis, and short- and long-term residential treatment services to parolees.
- Rutgers University UBHC to serve as the IME for substance use services and for the development and oversight of an effectiveness study of substance abuse prevention services for children with conduct disorder.
- Rutgers Robert Wood Johnson Medical School to provide rapid HIV and other infectious disease testing and to provide SBIRT services.
- Rowan University of Osteopathic Medicine to provide SBIRT services and to provide clinical training in substance use disorders for its psychiatric program.

- Rutgers University Center for Alcohol Studies, Education, and Training to provide alcohol and drug counselor education, and training for OORP and SBIRT.
- Children's System of Care to provide technical assistance for the behavioral health home (BHH) learning collaborative.
- Rutgers University, School of Social Work for the provision of educational program leading to a certificate of community-based planning and to provide evaluation for the following: CCBHC, Hagedorn State Hospital discharges, involuntary outpatient commitment (IOC) program, MATOP, OORP, Partnerships for Success in Prevention (PFS), SBIRT, and State Prevention Enhancement (SPE).
- The College of New Jersey to provide Intoxicated Driver Resource Center (IDRC) curriculum.
- Rutgers University Robert Wood Johnson Medical School for the NJ Household Survey of Drug Use and Health 2015 and to provide training for MATOP.
- Rutgers University Bloustein Center for Survey Research for the Middle School Survey and NJSAMS.
- New Jersey Department of Education for the student health survey.
- Office of Attorney General for the veteran's pilot initiative in Atlantic County.

DMHAS also has partnerships with:

- Department of Children and Families (DCF)
- NJ Division of Children's System of Care
- Department of Community Affairs (housing/homeless)
- New Jersey Housing and Mortgage Financing Agency (NJMHFA)
- Division of Vocational Rehabilitation Services (DVRS)
- Department of Corrections
- NJ Judiciary, Administrative Office of the Courts
- Department of Education
- Attorney General's Office/State Police

The division also works collaboratively with the following stakeholders and consumer and family groups:

- NJ Behavioral Health Planning Council
- County Drug and Alcohol Director's Association
- County Mental Health Administrator's Association
- Professional Advisory Committee
- Citizen's Advisory Council
- Statewide Consumer Advisory Committee
- Coalition of Mental Health Consumer Organizations
- Consumer Panel Support Network

- NJ Connect for Recovery
- National Alliance on Mental Illness New Jersey

DMHAS conducts quarterly provider meetings with addiction treatment and prevention providers, mental health providers, and county commissioners to discuss gaps in services. Representatives from the MAT and PPW programs visited by TCT during the review actively participate in these meetings. The program staff indicated that the meetings provide a good opportunity to learn about and provide feedback on state initiatives and changes that impact service delivery and funding.

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.

Methodology

Prior to the on-site review, the TCT reviewed documentation provided by DMHAS. Documents reviewed for this section of the report include:

- The DHS website (http://www.state.nj.us/humanservices/)
- The DMHAS website (http://www.state.nj.us/humanservices/dmhas/home/)
- The IME website (http://www.state.nj.us/humanservices/dmhas/initiatives/managed/)
- The DMHAS Three Year Strategic Plan, January 2014–December 2016
- The DMHAS Strategic Plan 2014–2016 (draft dated August 8, 2014)
- Planning Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations document (SABG application)
- County Planning document
- The 2009 New Jersey Household Survey on Drug Use and Health
- Intoxicated Driving Program 2013 Statistical Summary Report (dated October 2014)
- New Jersey Chartbook of Substance Abuse Related Social Indicators, Atlantic County, May 2013
- Office of Research, Planning, Evaluation, and Prevention Research Plan: 2012 to 2016 (dated January 2016)
- Substance Abuse Overview 2014 Statewide (dated May 2015)
- Substance Abuse Overview 2014 Atlantic County (dated May 2015)
- DHS/DMHAS Substance Abuse Treatment State Performance Report, July 1, 2014–June 30, 2015 (dated October 2015)
- DHS/DMHAS Substance Abuse Treatment Provider Performance Report, July 1, 2014–June 30, 2015 (dated October 2015)
- NJSAMS Report (dated May 2011)

TCT also reviewed the following information provided during and subsequent to the Compliance Review or acquired through its research activities:

- DHS/DMHSA State System Overview, New Jersey Site Visit, March 14–18, 2016
- NJSAMS Description
- NJSAMS Article
- NJSAMS Quarterly Provider Meeting Points
- New Jersey Prescription Monitoring Program (NJPMP) website (http://www.nj.gov/lps/ca2/pmp/)
- List of modifications to NJSAMS

During the 2-day visit at DMHAS, TCT conducted interviews with the following staff:

- DHS DMHAS Assistant Commissioner
- DMHAS Acting Deputy Director
- OPREP Assistant Director
- DMHAS State Opioid Treatment Authority and Human Immunodeficiency Virus (HIV) Coordinator
- Office of Treatment and Recovery Supports Special Initiatives Manager
- DMHAS Research Scientist and County Planning Program Manager
- DMHAS Addiction Recovery Advocate
- Four DMHAS Research Scientists I
- DMHAS Research Scientist III

As discussed above in Section A, the Technical Review team spent 2 days at providers selected by DMHAS, and also conducted an impromptu visit to the IME.

Needs Assessment and Strategic Planning

Needs Assessment

Data drives the DMHAS needs assessment process. The division has access to several federal, state, and local data management sources and systems, and uses this information to inform SUD treatment needs, unmet needs, and service gaps. NJSAMS serves as the primary data source and all contracted providers are required to use the reporting system. Data from the following SSA-administered surveys also are used in the needs assessment:

- New Jersey Household Survey on Drug Use and Health (NJ-HSDUH)
- New Jersey High School and Middle School Risk and Protective Factor Surveys
- Co-occurring Survey
- Older Adults Survey
- Veterans Survey

The 2009 NJ-HSDUH had a sample size of 14,000 and was large enough to obtain county-level estimates. DMHAS planned to conduct another NJ-HSDUH in 2014; however, due to a change in state procurement policy by the Office of Management and Budget (OMB) and the Division of Purchase and Property, DMHAS was unable to proceed as planned in 2014.

In 2016, DMHAS revised the questionnaire to reflect DSM-V diagnostic criteria, introduced a new section focused on co-occurring mental illnesses, and reduced the random sample size from 14,000 to 1,050 respondents. This sample size produced state-level estimates only. In 2018, and, in order to comply with the aforementioned changes in procurement policy, NJ-HSDUH will conduct a three year survey collecting 2,700 completed interviews annually for a total of 8,100 households or 386 per county.

The 2018-2020 household survey will be supplemented by 4 studies of populations at special risk of substance abuse that are likely to be underrepresented in the NJ-HSDUH:

1) An Opioid Overdose Study,
2) Student Athlete Study,
3) Prisoner Re-entry Study,
4) Medical and Recreational Marijuana Users Study.

Additionally, in 2012, DMHAS, Office of PREP, conducted a survey of substance use by Older Adults Survey because of the data gap for this population. The next Older Adults Survey was conducted in 2016 and administered to approximately 1,400 respondents.

The DMHAS needs assessment process is global and does not involve stakeholders per se. The process relies on a variety of scientific methodologies that include social indicator data to develop risk indices to assess need; synthetic estimation techniques such as capture-recapture; and geographic information systems to provide a visual or spatial understanding of where a need may occur. The discussions conducted during this review suggest that county-level and provider feedback augments the NJSAMS data to inform the needs assessment process. DMHAS also solicits feedback from agencies and advisory councils such as the Governor's Council on Alcoholism and Drug Abuse (GCADA), Local Advisory Council on Alcoholism and Drug Abuse (LACADA), and the PAC.

Recommendation

The state has a wealth of data and DMHAS has access to several data sources. Research studies are ongoing and the resultant data are used for needs assessments. However, these research data are not consistently shared with the SUD treatment network or used strategically to address unmet needs, service gaps, or emerging trends. It is strongly recommended that DMHAS:

- Consider methods for sharing data from research studies and other sources with the entire SUD treatment network. Stakeholders can use this information to enhance their internal needs assessment and planning practices, inform their programming, and strengthen their data-driven decision making processes.

- Explore other opportunities to engage participation by, and collect feedback from, treatment network stakeholders in the division's needs assessment process.
- Use data for more targeted and strategic purposes to determine if specific unmet needs and service gaps are being addressed and to identify emerging trends. This will assist the division, its partners, and the SUD treatment stakeholders to make informed program modifications to address changes in substances of choice, demographics, staffing patterns, treatment therapies and evidence-based practices (EBPs).

New Jersey Prescription Monitoring Program (NJPMP)

DMHAS reports that data from the NJPMP could be a major resource. However, extracting data from the database is a challenge. NJPMP is housed in the New Jersey Department of Law and Public Safety, Division of Community Affairs (DCA), Office of the Attorney General (OAG). DMHAS staff persons expressed interest in using NJPMP data strategically but have found the database to be extremely large and difficult to navigate. The staff members are also unclear about the types and structure of the warehoused data. Pharmacies are required to report into the system daily. Physicians are required to register but are not mandated to implement reporting into NJPMP although they are encouraged to do so.

DMHAS partnered with the New Jersey Department of Military and Veterans Affairs (DMVA) for its Medication-Assisted Treatment Outreach Program (MATOP) under the CSAT Target Capacity Expansion: Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) grant. The grant is scheduled to commence in August 2016. The three MAT providers participating in MATOP will be required to report into NJPMP and the Government Performance and Results Act of 1993 (GPRA) Application System (GAS) for MATOP, which will be used to report on MATOP-related performance measures.

Recommendation

It is strongly recommended that DMHAS, in collaboration with the DCA, explore approaches to navigating through the NJPMP database and extracting the information for strategic use. Since MAT providers participating in MATOP will be reporting into NJPMP, access to the database will furnish rich and useful information. Examples of how these data can inform decision making include:

- Using NJPMP and MATOP data to examine treatment outcomes for clients being served in the program. This includes reviewing demographic information and exploring whether certain EBPs work for some client populations but not as well for others.
- Using overdose and Narcan™ (naloxone) reversal data to determine if these clients are accessing treatment. Consider exploring admission and treatment completion rates and outcomes achieved in various locations throughout the state (i.e., rural versus urban). Conduct outreach activities in communities where there is unmet need or service gaps, and create pathways into treatment for clients residing in these communities.

DMHAS also is strongly encouraged to work with its CSAT State Project Officer to explore how other states are using prescription drug monitoring programs (PDMP). Staff expressed an interest in learning how states have implemented comprehensive reporting requirements for prescribers and dispensers of prescription opiate medications, and tracking the sale of opiate medications to individuals, and doctor shopping practices to obtain pharmaceutical drugs.

Strategic Planning

County-level Planning

DMHAS oversees the SUD county comprehensive planning process, working in collaboration with the counties. As mandated by Alcohol Education, Rehabilitation, and Enforcement Fund (AEREF) legislation,
a Local Advisory Committee on Alcohol and Drug Abuse (LACADA) is established in each county and is responsible to present to the county authority, that is, the county Board of Freeholders, a county comprehensive plan (CCP) that relates the county's existing resources to the needs of persons living with, or at risk of developing or experiencing the recurrence of substance use disorder (SUD).

County Alcoholism and Drug Abuse Directors (CADADs) serve the LACADA as the individual primarily responsible for developing the CCP. CADADs submit a county comprehensive alcohol and drug abuse services plans to the division every four years. The plans must contain information on each county's approach to addressing the entire continuum of care—prevention, early intervention, treatment, and recovery support—and demonstrate identified priorities and needs supported by relevant data. The DMHAS and the counties work out a detailed protocol for counties to follow to produce a qualified comprehensive plan. An Annex A details county contractual obligations to the state under the AEREF program. Counties must spend funding allocations in accordance with their approved comprehensive plans.

The AEREF Program

Under the AEREF program, the state dedicates a portion of state revenue from the retail tax on alcoholic beverage sales to develop and implement comprehensive plans in the state's 21 counties. In addition, approximately $420,000 of AEREF is evenly divided among the counties to support the operational costs of the LACADAs for which CADADs develop the county plans.

DMHAS staffs expressed interest in exploring whether AEREF can be used to subsidize private insurance, annual deductibles, and copays. Currently, counties are not able to use AEREF for this purpose, which is a major challenge. DMHAS efforts are underway to research effective models for subsidies using similar payment structures and determine the impact of insurance deductibles and copays on restricting access to treatment.

As part of the county planning process, DMHAS provides counties with a compendium of data products and analyses:

1) state and county estimated adult treatment need including rankings for total, alcohol, drug, and heroin-use related treatment need; drug use treatment need is broken out for heroin, cocaine, marijuana, and all other drugs;
2) substance use related mortality;
3) county risk and protective factor ratios;
4) county specific household survey reports;
5) municipal relative needs assessment scores;
6) met and unmet treatment demand ratio tables and maps;
7) county treatment need-demand gaps ranked ordered;
8) barriers to treatment;
9) treatment provider map locating residential and outpatient services;
10) provider locations by urban, suburban, coastal, and rural settlement types;
11) origin/destination matrices by levels of care, (outpatient, opioid maintenance, residential, and withdrawal management services) and settlement types;
12) proportional maps of the matrices;
13) a list of state licensed treatment providers scored by their prior year's performance on nine National and State Outcomes Measures, to promote value based purchasing;
14) regional charts of need-capacity gaps; and
15) the distribution of payer sources by region and level of care.

Counties also receive the Treatment Demand Analysis (TDA), presented as a Microsoft PowerPoint slide show. The slide show is based on eight years of actual admissions data from 2005 to 2012, contains treatment demand projections over six years, 2013 through 2018. The TDA presents trends for the state and each individual county using the state trend as a benchmark to help DMHAS determine whether counties mirror state-level trends, or vary enough to warrant county level attention. Presently, the demand analysis is being updated using actual admissions data through 2017 and projecting admissions through 2023.

The admission trends are examined by:
1. Level of care,
2. Primary drug, including alcohol, used at admission,
3. Six "special" populations: women, youth, DUI arrestees, Parolees, persons living with disabilities, and workforce, as designated in the enabling legislation; and "Co-Occurring" cases, and seniors, as required by DMHAS administrative policy,
4. Primary drugs driving admissions of each special population.

DMHAS offers guidance on the CCP format and providesTA tailored to the needs of the county behavioral health planners. DMHAS and the counties agree upon certification requirements and review criteria to evaluate the county comprehensive plans. After review, DMHAS provides comments for identified problems or deficiencies. Plans are corrected and resubmitted for certification by the state before counties can issue requests for proposals (RFPs) for services. Per Annex A contracts, counties are required to produce publishable grade plans. The division also encourages counties to post comprehensive plans on county websites. DMHAS conveyed that the state is moving toward a performance-based planning process with the counties to build a

system of accountability for effective and efficient use of tax payer dollars. This process began in early 2015.

Funds are allocated to the counties using a statutory formula based on population data from the American Communities Survey, per capita income data from the Bureau of Economic Analysis, and estimated of treatment need based upon the state survey of alcohol treatment need and a synthetic estimate of drug treatment need derived from drug treatment admissions in two separate years of treatment admissions data (using capture-recapture modelling). DMHAS contracts directly with providers for SABG-funded services. No SABG funds are allocated to the counties.

State-level Planning

Key Initiatives

Strategic planning at the state level involves examining data and trends around a particular issue and developing a plan to address the problem. DMHAS reported that reducing the treatment gap is a major challenge, and has been an area of concern for more than seven years. DMHAS wants to employ strategies outlined in the agency's strategic plan to address the issues. Challenges receiving the highest priority include:

- Opioid Epidemic—Approximately 49 percent of treatment admissions are for heroin and other opiates. Changes in demographics are occurring and younger client populations (e.g. those between the ages of 18 and 25) demonstrate a disinterest in traditional opioid treatment therapies such as methadone. in favor office-based opioid treatment services that provide MAT using Suboxone® or Vivitrol®. Legislation to change bundled rates went into effect SFY 2017 on July 1, 2016, and improved reimbursement for MAT services. The improved reimbursement rates have resulted in an increase in the number of admissions and unique clients of opioid outpatient and opioid intensive outpatient services from SFY 2016 to SFY 2017. The number of opioid outpatient and opioid intensive outpatient admissions increased 9,454 in SFY 2016 to 10,989 in SFY 2017 for an increase of 16.24%. The number of unique clients of opioid outpatient and opioid intensive outpatient services increased from 8,208 in SFY 2016 to 8,949 in SFY 2017 for an increase of 9%.
- DMHAS is striving to educate the SUD treatment network on the benefits of MAT and treatment options other than methadone. In addition, the division is working on strategies to educate abstinence-based providers on the value of MAT.
- Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS)—The state is drafting a RFP for intensive case management with recovery support and wraparound services for pregnant and postpartum women who are opioid dependent. A case manager and recovery support specialist will follow the women and their infants and families for up to one year postpartum.

In a changing environment, DMHAS is using the strategic planning process to address and reduce disparities in services between substance abuse and mental health. Pursuant to the

national health reform legislation, the division is exploring methods to use county and SABG funds saved as a result of Medicaid expansion. Planning is underway to divert funds for more prevention, early intervention, and recovery support activities. Other initiatives being pursued by DMHAS include:

- Certified Community Behavioral Health Clinics (CCBHC). The state received a 1-year federal grant for this initiative. The CCBHC grant was awarded to 24 states and includes a demonstration project component. Grantees must apply to participate in the demonstration project and only eight states were selected. Currently, seven New Jersey agencies are eligible to become CCBHCs. DMHAS is requiring agencies to be dually licensed to provide mental health and SUD treatment services. The division also would like to incorporate elements of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model into the CCBHC structure.
- Substance Abuse Recovery Supports. DMHAS is pursuing the addition of more recovery support services for SUD clients. Recovery support services for SUDs are not as abundant as are those for mental health disorders. There are 33 mental health community wellness centers in the state—30 within the community at large and 3 in the state psychiatric hospital system. There are only two Addiction Recovery Centers for SUDs.
- Supportive Housing. New Jersey has adopted a Housing First Model and is striving to reduce the imbalance of supportive housing services for SUD clients compared to mental health services consumers. Presently, there are approximately 5,000 supportive housing units for mental health disorders and only 72 units for SUDs.

Workforce Planning

Similar to other states, DMHAS is working to address its workforce development challenges. The DMHAS Three Year Strategic Plan (January 2014–December 2016) identifies workforce development as a priority. DMHAS reported problems with turnover and uneven quality of skills among county level employees. To address this concern, the division instituted standards to enhance the skill level of individuals being hired to provide SUD treatment planning. The skills requirements for a potential CADAD candidate are included in the county's Annex A contracts (planning as a skill is included in the job description). This practice has resulted in enhanced skill sets for county SUD services planners. Since the implementation of the standards, new personnel being hired at the county level have skill sets that are conducive to data analysis and planning.

DMHAS, in conjunction with the Rutgers University continuing education department, implemented an education, training, and technical assistance (ETTA) initiative for county planners. The program was initially offered to CADADs but has been expanded to include County Mental Health Administrators and DMHAS staff responsible for monitoring SUD treatment agencies. Planners who successfully complete the program earn a Certificate in Community-based Planning from the Rutgers University School of Social Work. ETTA will be evaluated during fiscal year 2016 to determine if the program is meeting participants' needs and has improved the quality of county plans.

Provider staffs expressed concerns about workforce development and the number of qualified

staff persons available to provide client services. The board of directors for one provider is in the process of developing a strategic plan that will include workforce succession planning and the documentation of roles and responsibilities.

Recommendation

Workforce development is a priority area in the DMHAS strategic plan. However, the TCT found that succession planning processes to address workforce shrinkage due to resignations, retirements, and attrition are not in place at either the state or providers. It is strongly recommended that the state develop a succession plan at the state level. Additionally, processes and procedures should be documented to ensure that this knowledge remains within the organization and is transferred to the new workforce. It is also strongly recommended that the state consider requiring succession planning in the providers' Annex A contract (similar to the requirement for cultural competency plans).

E. DATA MANAGEMENT

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

Methodology

Prior to the on-site review, the TCT reviewed the following documents provided by DMHAS:

- New Jersey Guest and Emergency Medication System (GEMS) for Opioid Treatment Programs (OTP) Training Reference, Version 2016-01 (last update January 6, 2016)
- DMHAS Office of Information Systems (OIS) User's Reference Manual, NJSAMS 3.2: DSM-5 (updated January 19, 2016)
- DMHAS GPRA Application System (GAS) User Manual (dated December 1, 2015)
- DMHAS Office of Information Systems Technical Design Document, GPRA Application System (GAS) (dated November 25, 2015)
- DMHAS Office of Information Systems (OIS) New Jersey Substance Abuse Monitoring System-Interim Managing Entity, NJSAMS 3.3 Service Provider Reference (updated January 19, 2016)
- DMHAS Office of Information Systems Data Link for NJSAMS (updated February 12, 2016)
- DMHAS Office of Information Systems (OIS) Data Link for GPRA (MATOP)
- DMHAS Office of Information Systems (OIS) Data Link for SBIRT

DMHSA provided an additional document during the Office of Information Systems (OIS) Microsoft PowerPoint presentation (dated March 2016).

The methodology for this section is further detailed in the Needs Assessment and Strategic Planning section of this report. The Technical Review team also observed a demonstration of NJSAMS, the state's primary data management system for SUD treatment services data collection and reporting.

Data Management

Data Systems

NJSAMS is the largest data collection and reporting management information system (MIS) used by DMHAS and the SUD treatment network. The application is a secure, real-time, web-based system. As mandated by New Jersey Administrative Code (N.J.A.C.), all licensed SUD treatment providers are required to enter data directly into NJSAMS regardless of funding source. The NJSAMS website is hosted by Rutgers University under a MOA with DMHAS.

NJSAMS was developed in house, has been functional since 2002, and has approximately 50,000 users. The system helps track clients as they move through the state's addictions treatment agencies and facilities. The system:

- Collects client demographic information.
- Contains treatment services and various referrals.
- Complies with federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 Code of Federal Regulations (CFR), Part 2, regulations.
- Collects basic financial documentation.
- Contains a built-in Ticket Management System (TMS) so users can notify OIS when problems occur.

As previously described, NJSAMS is the major data source for the DMHAS needs assessment and strategic planning processes. NJSAMS is not used for billing purposes and financial information is not stored in the application.

Staffing for NJSAMS is composed of contractors on the Rutgers University MOA and includes 5.5 FTEs and a 0.5 in-house FTE. These persons have access to system data in testing environments; data cannot be changed in a production environment. The number of staff reported to the Technical Review team is for FY2016 and is expected to remain flat for FY2017. The existing servers for NJSAMS reside with the state and DMHAS installs its own software. Rutgers University maintains the server boards and database backups.

In July 2015, NJSAMS underwent a significant architectural upgrade in preparation for IME implementation and to meet the needs of a performance management environment. New features include IME user roles for UBHC to accurately manage clients' level of care throughout the treatment continuum. Significant user functionality upgrades (not tied to the IME role) occurred in November 2015 to address system lags, integrate the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), and upgrade the Level of Care Index-2R (LOCI-2R) to

LOCI-3. Additional system updates include bringing NJSAMS into a .NET environment, separating information technology (IT) and research functions, and incorporating and enforcing business rules. Data entry has been structured in a logical format and entries must be completed in logical tiers. The application is composed of several modules of which the following must be completed prior to treatment admission:

- Division of Addiction Services Income Eligibility (DASIE) Registration
- Immediate Need Profile (INP)
- UNCOPE (screening tool for alcohol and drug misuse or dependence)
- DASIE Income and Program Eligibility
- Addiction Severity Index (ASI), Version 5 (optional)
- Biopsychosocial (optional)
- DSM-5
- LOCI-3

Other data management systems used by DMHAS for outcomes reporting and performance management include:

- Prevention Outcome Measurements System—Web-based system for prevention and early intervention programs.
- GEMS—Centralized, web-based system that interfaces with OTP clinical management and dosing software systems. Interfaces with NJSAMS; when a client is admitted to an OTP, key data fields in NJSAMS will automatically transfer to GEMS.
- GAS—Houses two modules: the GAS for SBIRT and GAS for MATOP. GAS for MATOP was implemented in January 2016 and monitors performance on the SAMHSA-funded MAT-PDOA grant.
- Contract Information Management System.

These data systems do not interface but are interdependent. Data are pre-populated from key fields in NJSAMS as a referral form to other data systems. NJSAMS does not have a direct interface with the Medicaid system. DMAHS has provided DMHAS with a web service so it can interact with the Medicaid system in real time. Functionality for a direct interface will be added in the future.

NJSAMS does not have wait list management functionality. The IME monitors clients waiting for admission to treatment. Priority populations are taken into treatment immediately and not placed on a wait list. NJSAMS does not track the specific SABG interim services as delineated in §96.131. However, the services are documented in the system as a funding source, which is the actual slot (e.g., contract slot in a PPW program).

Data Collection and Reporting

Approximately 150 contracted and 200 non-contracted SUD treatment providers enter data into NJSAMS. Any entity licensed through the Office of Licensing (OOL) to provide SUD treatment services is required to report into NJSAMS, and requirements are delineated in N.J.A.C. However, some for-profit agencies (not funded by DMHAS) are not in compliance with the mandated data reporting requirements. This may become an issue for the OOL to address; DMHAS had no knowledge of these agencies being sanctioned by OOL for reporting violations.

Timeliness and Accuracy of Data

All data within NJSAMS are real time and must be entered immediately to receive preauthorizations and approvals for treatment. Preauthorizations are not required for clients who have private insurance. The modules in NJSAMS automatically perform edits and data validations on each field to ensure data integrity. For example, validations are completed on the year to ensure that admission dates are within a certain range and discharge dates are in the future. Untimely entries may result in delayed treatment admissions and reimbursement for providers, and compromise clients' seamless movement through the continuum of care.

DMHAS staff report instances of data inconsistencies and lag times in NJSAMS. The most significant current data issue is problems with clients who previously entered the system using a valid Social Security Number (SSN), and reenter the system years later using the same name and address but a different SSN. DMHAS developed a process to work around this issue in which clients receive services but are placed in an interim status designation. Although these clients may be able to receive services initially, the interim status designation may cause some future delays with service accessibility as clients move through the treatment continuum.

NJSAMS has a built-in TMS for users who are experiencing problems. Since January 2014, OIS has obtained approximately 20,000 trouble tickets through TMS; all have been resolved. The average resolution time for a trouble ticket is approximately three days. Experiences similar to those described by state staffs also were conveyed by provider staff.

DMHAS indicates that TMS trouble tickets for NJSAMS are minimal and addressed in a timely manner. However, TCT interviews and observations suggest additional concerns with both NJSAMS and TMS, as follows:

- Challenges with discharging clients from one treatment facility or level of care and enrollment into a new facility or level of care. System end users must complete a manual discharge and NJSAMS does not allow the entry of retroactive dates.
- Trouble tickets issued through TMS are sometimes closed without being addressed. This results in reissuance of a new ticket and possible service delays;
- NJSAMS does not consistently provide notification that an admission has been processed. Users must navigate through the system to find the confirmation.

- Issues with completing some of the discharge information. For example, a "no" response to the discharge inquiry about drug use during the past 30 days prompts the system to continue to request information on drug use within the past 30 days.
- TMS does not provide a designated point-of-contact or facilitate two-way communication between system end users and OIS for efficient and effective resolution of problems.

DMHAS is strongly encouraged to address these concerns. Failure to do so could greatly impact business operations and reduce the efficiency and effectiveness of service provision throughout the SUD treatment network, and ultimately impact clients' ability to access care and move seamlessly through the treatment continuum.

Recommendation

End users expressed that technical support for NJSAMS and TMS can be unresponsive or time consuming. They cited concerns about trouble ticket cancellations, lack of responses to emails, and being frustrated with telephone technical support. It is strongly recommended that OIS consider reviewing TMS data for trends such as the most common problems experienced and the amount of time required to resolve issues. Based on those analyses, OIS could develop FAQs that can be used by system end users to help resolve issues. In addition, OIS should consider instituting a chat box feature within NJSAMS that allows end users to work with technical support staff to resolve issues in real time. If a problem cannot be resolved through the chat box, the problem should be escalated through TMS. OIS should also consider developing and implementing analytics to monitor the effectiveness and efficiency of trouble ticket resolution through TMS, and use the analytics in TMS continuous quality improvement (CQI) processes.

NJSAMS has partnered with the IME Team in the Office of the Medical Director to assist in the review and response to tickets. The IME Team responds to tickets which are submitted as technical issues but are actually programmatic in nature. This has expedited some of the responses.

Use of Client Data

NJSAMS contains a report module for every client entered into the system. Examples of types of reports generated include:

- DASIE registration report
- INP report
- Summary report
- Addiction Severity Index (ASI) narrative and ASI Lite reports
- LOCI-2R completed and LOCI-3 reports
- Admissions and discharge reports

Information on client outcomes also is tracked in NJSAMS and monthly downloads of outcomes data are provided to OPREP for review, analyses, research, and management and decision-making purposes. OPREP also uses NJSAMS for the state's needs assessment process.

Provider staffs report that running simple reports, such as the number of admissions by level of care, from NJSAMS is relatively easy. The capability to generate customized reports in NJSAMS is not available to end users. Requested custom reports are furnished through OIS.

Protection of Client Data

Each client entered into NJSAMS has a unique identifier that is system generated and is a combination of characters from the client's last name, first name, partial SSN, date of birth, and gender.

Access to NJSAMS is based on user roles. For example, a receptionist will not have the same level of access as a clinician. User roles have been instituted for provider agencies but the state does not dictate how they will be implemented at the provider level. It is each provider agency's responsibility to ensure that appropriate staff person has access based on user roles. The state is more stringent with the IME and has dictated NJSAMS user roles and levels.

Within DMHAS, program, technical, and IT staffs have different NJSAMS user roles which gives them the ability to see different types of data and client-based data. No staff member has direct access to the database. For example, the 5.5 and 0.5 FTEs have access to the development environment and stage the test environment, and can query the production database. However, they do not have the ability to write or change data in the production environment.

To protect client information and maintain continuity of service provision during catastrophic events, such as Hurricane Sandy, and other system outages, the IME developed a continuity of operations plan (COOP) that was required and submitted as part of the MOA with DMHAS. Providers visited during this review have either developed or are in the process of developing COOPs to address events that could impact client access and continuity of care.

NJSAMS does not have direct links to other state data systems and data are not shared with other state entities or external agencies. There is a real-time interface with Computer Sciences Corporation, the fiscal agent for DMHAS.

DMHAS uses uniform billing data to match clients in the system with hospital data. A unique identifier is constructed based on knowledge of which variables are in both data sets and coded so that first names are not used in order to protect client confidentiality (there is no access to individual client identifiers). This enables DMHAS to review medical usage and emergency department usage data. This analytical method is frequently used by the division and used to support prevention and treatment planning.

DMHAS expressed interest in reviewing mortality data sets and would like to link its data sets to mortality data sets. The linkage would facilitate finding out the extent to which the disease of

addiction is causing early death and calculating years of productive life lost for people who have the disease compared to those who do not. However, this analysis is difficult because mortality data sets are delayed for approximately two years. DMHAS is working on a study with DMAHS to examine SEI and NAS data to determine whether the mothers of SEI and NAS children are in the human services system and need to be the DMHAS treatment system.

Data Management Systems Training

Extensive training is conducted with each new rollout of NJSAMS. Various levels of training include internal testing training for program staff and user acceptance testing (UAT) training with provider agencies.

During the release of a major system upgrade such as the one that occurred in May 2015, the state conducts a multi-day training session. In April 2016, over 800 providers attended a 6-day training session (4/22/16, 4/25/16, 4/29/16, 5/2/16, 5/5/16, and 5/6/16). Since this series of trainings with the 3.4 NJSAMS release, on-going trainings continue with every NJSAMS update, both face-to-face and via webinar, with both technical and clinical staff present to assist providers. Half of each day focuses on program elements and the other half focuses on the actual system application. Trainings include information on the reasons for system changes and how the changes fit into the agency's overall mission and vision. Training sites are located in the northern, central, and southern regions of the state. In addition, user guides are developed and posted online and trainings are recorded and made available via YouTube.

Trainings are not mandatory but attendance can be tracked by user and through the registration process. Participants receive a test identifier for completing system trainings. System users can only participate in the test environments or perform UAT if they participate in system trainings and receive the test identifier. Provider staff expressed the need for more training on topics that are more relevant to their programming. Some of the identified training needs include conversion of stays from short- to long-term, IME authorizations, competencies required to complete specific modules such as the DSM-5 and ASI, and operating in a FFS environment.

Recommendation

It is important to have well trained staff who are able to efficiently and effectively navigate NJSAMS. The addition and implementation of the IME structure elevates this need. NJSAMS training is not mandated by the state; however, one of the visited providers requires training for system end users. It is strongly recommended that DMHAS consider other training options for users such as:

- Developing a training of trainers (TOT) program and have provider agencies designate one or two staff members, such as the clinical supervisor and credentialed counselor, go through the formal trainings when there are system upgrades. These TOTs can, in turn, train internal provider staffs on the system modifications.
- Conducting more frequent training webinars.

- Developing training guides on various topics in addition to the Microsoft PowerPoint presentations for distribution to the provider network.

National Outcomes Measures Reporting and Use of Outcome Data

NJSAMS collects NOMs data that are used to report Treatment Episode Data Set (TEDS) admission and discharge data. GAS also collects NOMs data for discretionary grants (SBIRT and MAT-PDOA). NOMs data elements also are conveyed and collected throughout the provider network; however, some provider staffs interviewed are unaware of their significance.

DMHAS staff members report the use of NOMs data in management decision making processes. The state has developed Provider Performance Reports as a CQI initiative to improve client services. The reports include data on admissions, discharges, and state outcome measures (SOMs), which are similar to NOMs. Measures include:

- Abstinence from alcohol
- Abstinence from drugs
- Enrollment in school and job training
- Employment
- Number of arrests
- Homelessness

Statewide data are included for all measures to facilitate comparisons with individual provider programs. Provider Performance Reports are generated twice per year. In addition, CADADs are able to use the reports to inform decision making regarding programming and the purchasing of services (performance-based contracts). Legislation is pending for the production of an annual statewide public performance report. The report will contain outcomes on all SUD treatment agencies in the state for all levels of care:

- Outpatient
- Intensive outpatient
- Residential (long- and short-term)
- Partial hospitalization
- Halfway house
- Detoxification

Table II-6 illustrates SSA's readiness to report currently defined NOMs. .

Table II-5. Collection of Currently Defined NOMs[7]

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			
Social Connectedness	X			

Other data and measures important to the state include:

- Number of PPW clients in treatment (especially clients who have children with SEI and NAS).
- Number of clients with opioid SUDs accessing MAT services.
- Reductions in smoking and the use of tobacco products from admission to discharge for clients in treatment.
- Number of overdose deaths.
- Recovery zone outcomes (keeping clients in recovery for longer periods of time and moving them appropriately through the continuum of care to mitigate the chance of relapse).

Recently, DMHAS implemented a new Opioid Overdose Recovery Program initiative. The program, which is emergency department-based and examines naloxone reversals, commenced in January 2016 at four agencies in four counties. DHMAS staff persons report already seeing positive client outcomes. More detailed information on the Opioid Overdose Recovery Program is provided in the Technology Transfer section of this report.

Technical Assistance Requests

MAT Needs of Emerging and Younger Client Populations

DMHAS is requesting TA or information on how to address the needs and wishes of emerging and younger client populations who are interested in office-based MAT services. DMHAS reports that these clients are more inclined to inject opiates and find the requirements pertaining to methadone treatment, such as daily dosing at a treatment facility, to be inconvenient. DMHAS would like information on how to get these clients into treatment and keep them engaged, especially if methadone is the only available treatment option.

DMHAS received TA from the MAT-PDOA SAMHSA grant to coordinate and hold a MAT Symposium entitled “Emerging MAT and Recovery Practices: Effective Change in the Young Adult Population” which was held on May 2, 2017.

[7] Data are based on self-report and no formal validation of responses is conducted.

Impact of the Disease of Addiction on the Workforce

DMHAS is requesting TA or information on measuring the impact of the disease of addiction on the workforce in terms of productivity, safety hazards, disruption, health care costs, and the effectiveness of employee assistance programs (EAP). The division also is interested in obtaining information or a menu of community cost offsets that are a consequence of effective SUD treatment, such as costs saved to the taxpayer in the immediate locality. DMHAS would ultimately like to conduct a cost-benefit analysis of treatment to explore the overall impact on crime statistics and workforce productivity.

F. QUALITY MANAGEMENT AND SUBSTANCE ABUSE PREVENTION AND TREATMENT 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 reviews SABG compliance to both ascertain the extent of compliance and show how level of compliance may affect quality of care throughout the system.

Methodology

Prior to the on-site review of DMHAS, the TCT reviewed the following documentation:

- New Jersey Administrative Codes
- DMHAS Three Year Strategic Plan: January 2014–December 2016 Workforce Development
- Overview of the IME
- Substance Abuse Prevention and Treatment Block Grant Draft Manual Template
- The Annex A of DMHS contracts for various levels of care
- Continued Stay and Discharge Criteria
- Continuum of Care Final
- Patient Placement Final
- Treatment Protocols
- Becoming a Licensed Clinical Alcohol and Drug Counselor (LCADC) or Certified Alcohol and Drug Counselor (CADC): Frequently Asked Questions Regarding the LCADC/CADC Process

Documents furnished to TCT during and subsequent to the Technical Review or acquired through its research activities include:

- MSG Blueprint for Action 2017-2018: Cultural and Diversity Within DMHAS System of Care
- NJ DMHAS Cultural and Diversity Self-Assessment and Cover Letter

- State of New Jersey, Department of Human Services, DMHAS—State System Overview for the NJ Site Visit March 14-18, 2016
- DMHAS Transition to Fee for Service Overview for Provider Meetings—February/March 2016
- DMHAS Addiction Contract Monitoring Unit Site Visit—Process
- IME Performance Measures

During the 2-day visit to DMHAS, interviews were conducted with the following individuals:

- Chief, Special Populations
- Director, Specialized Women's Services
- State Opioid Treatment Authority, Office of the Medical Director
- Chief, Office of Licensing
- Monitoring Unit Supervisor, Office of Prevention, Early Intervention and Community Services
- Manager, Special Initiatives, Women and Families
- Vice President, Outpatient Services, Rutgers University Behavioral Health Care
- Utilization Coordinator, Office of the Medical Director

As discussed in Section A, TCT also conducted discussions with staff at a MAT and two residential PPW treatment programs.

TCT had an informal discussion with several clients waiting outside the MAT program to receive their medication and convened a focus group with approximately six clients at one of the PPW residential programs. TCT reviewed copies of the MAT program and PPW treatment schedule, a small sample of group sign-in sheets, and a sample of clinical records at one of two PPW residential treatment programs.

Quality Management

Standards of Care

DMHAS draws from the state's administrative codes and an extensive array of contract annexes to convey the standards of care and treatment protocols that providers must implement. These conveyance vehicles include:

1. Standards for the licensure of residential and outpatient substance use disorders treatment facilities (N.J. A. C. Chapters 161A and B of Title 10)

2. Certification requirements for all persons presently practicing, those seeking to practice, and those seeking licensure or certification to engage in alcohol and drug counseling services (N.J. A. C. Chapter 34C of Title 13)
3. Annex A of the DMHAS providers' contracts that delineate standards of care for:
    - Medication Assistance Treatment Initiative's (MATI) Methadone Treatment
    - MATI Mobile Medication
    - Methadone IOP
    - Methadone Maintenance
    - Opioid Overdose Prevention
    - Outpatient
    - Oxford House
    - Perinatal
    - Recovery Centers
    - Short term Residential
    - Specialized Women's Services
    - Supportive Housing
    - Transitional Support
    - Women's Intensive Case Management
    - Women's Wrap Around

The standards of care and treatment protocols reviewed by TCT are instructive in guiding providers to comply with SABG requirements.

Evidence-Based Interventions (EBIs)

DMHAS staff reported that the Clinical Section of Annex A requires all contracted programs to provide culturally and linguistically appropriate and trauma informed interventions and services. Providers are instructed to select EBIs listed on the National Registry of Evidence-Based Programs and Practices. Other than Seeking Safety, DMHAS does not advocate the implementation of a specific EBI. The programs visited had implemented some combination of the following EBIs:

- Cognitive Behavioral Therapy (CBT)
- Seeking Safety
- Dialectical Behavioral Therapy (DBT)
- Motivational Interviewing (MI)
- Medication Assisted Treatment (MAT)

TCT consistently found that providers did not know whether the implemented EBIs were effective as they had not adopted a formal mechanism for measuring effectiveness. The

counselors at one program at which DBT had been implemented anecdotally reported a reduction in client symptomology associated with post-traumatic stress disorder (PTSD), the incidences of acting out behaviors, and the need for medication for depression.

DMHAS recognizes MAT as an EBI, especially for pregnant women and women with dependent children. However, a pregnant client who was addicted to opiates reported in a focus group conducted at one program that she was not allowed to be admitted into the program while being treated with methadone or Suboxone. The client also reported that she was referred to a detoxification facility where she was not offered MAT as an intervention.

Recommendation

DMHAS should encourage providers to submit a justification for the EBIs selected to ensure the interventions have been normed and validated on populations similar to those served by the provider. It is also recommended that DMHAS require that client perception of care surveys include questions about the efficacy of the EBIs. The collection and aggregation of data on the most frequently implemented EBIs can be crucial in identifying whether the clinical workforce is trained to implement EBIs with fidelity.

Provider Monitoring and Licensure/Certification

DMHAS has comprehensive practices and excellent stability at the staff program level, both of which are key elements to providing oversight of state and SABG-funded treatment providers. DMHAS's monitoring staff in the Addiction Contract Monitoring Unit have worked as Program Management Monitors (RRI PMOs) since 2005 and supervisory personnel have similar tenure.

DMHAS's monitoring process is similar to that used by SAMHSA. On-site monitoring reviews are based on a schedule developed several months in advance. PMOs complete a desk review before going on-site and use a tool to document findings. PMOs review monitoring reports from the previous year as a standard practice. RRI PMOs also inspect the most recent listing of provider personnel. PMOs then send an official letter to the provider documenting the day and details of the review.

DMHAS reported that the RRI PMOs and one supervisor monitor approximately 160 sub-recipients. To promote continuity, PMOs maintain the same caseload for a few years and access historical findings from on-site reviews from as far back as 2001. However, to ensure impartiality, the supervisor rotates review caseloads periodically.

PMOs are assigned caseloads for on-site reviews based on the size of the provider. On-site reviews include a two-person visit to all sites, or an interdisciplinary team of more than two staff for programs with multiple locations. Site visits may extend from one to three non-consecutive days, depending on the size and scope of the program. The review includes an exit conference to discuss preliminary findings, TA opportunities, and a report describing the findings. The RRI PMO discusses any findings with agency representatives at the conclusion of the site review. The DMHAS supervisor reports serious or egregious violations to the Office of Licensing. The Office

of Investigations (OI) is responsible for ensuring that the most serious allegations and suspicions of abuse, neglect, and exploitation are investigated and closed. The Critical Incident Management Unit facilitates and oversees the appropriate tracking, management, and organizational response to all reported unusual incidents, and administratively reviews individual agency reports involving abuse, neglect and exploitation not assigned to OI for closure.

A review of the checklist used on-site by PMOs reflects that the Annual Site Visit Monitoring Form (ASVMF) is comprehensive. The tool was revised since the 2009 SAMHSA review to include recommendations made to enhance SABG oversight. The ASVMF addresses a minimum of six issues: Rosters and NJSAMS; Facility/Program; Treatment Records; Counseling Services; Assessments; and Treatment Plans.

N.J.A.C. Chapters 161A and B of Title 10 convey standards for the licensure of residential and outpatient SUD treatment facilities. PMOs conduct one annual licensing site visit and announced or unannounced visits and periodic surveys of licensed facilities. During the survey visits, staff may review the physical plant, architectural plans, documents and client records, and conduct conferences or one-on-one interviews with staff and clients. The OOL visit includes an investigation of complaints of possible licensure violations of the facility, the facility's physical plant, clients, or staff.

Recommendations

While DMHAS has implemented sound practices to oversee SABG compliance, TCT's review of the ASVMF suggests some opportunities to improve the form as discussed below.

- *45 CFR §96.124: all programs providing specialized services for PPW must treat the family as a unit and therefore admit both women and their children into treatment.* TCT recommends that, in addition to accommodating both the mother and child in treatment, providers should also aim to provide services either on-site or by referral to fathers of the children, partners of the women, and other family members of the women and children. Specifically, the ASVMRF could ask the question as follows: "How does the program ensure that services are provided to the family as a whole? How does the program treat the family as a whole?"
- *45 CFR §96.126 (c): there must be a mechanism for maintaining contact with individuals awaiting admission and* [the program] *may only remove individuals from the wait list if they cannot be located or refuse treatment.* Specifically, the ASVMRF should ask, "How does the program maintain contact with individuals awaiting admission and how are these persons removed from the wait list?
- *45 CFR §96.126 (d): interim services must be available within 48 hours.* Although page 5 of 17 in the Treatment Records section form asks PMOs to describe or list interim services, the ASVMRF does not specify that those services must be offered within 48 hours. It would be a better practice to clearly delineate the federally defined minimum interim services as stipulated in 45 CFR §96.131 to ensure that PMOs are monitoring programs for SABG-defined interim services. Additionally, the ASVMRF should

specifically ask methadone maintenance programs and programs receiving funding under the women's set-aside "How does the program ensure that interim services are offered with 48 hours for persons who inject drugs and are awaiting admission?"

- *45 CFR §96.131(b): the availability of services for pregnant women, including the fact that such women receive admissions preference must be publicized*. Staff must be conversant about the admissions preferences and the availability of those services must be publicized. Admissions preferences must be visible in public areas and may be added to existing posters, program brochures, and websites. The ASVMRF should ask, "How does the program publicize admission preferences?"
- *45 CFR § 96.121(e): any entity that receives funding for intravenous drug abuse* [should] *carry out activities to encourage individuals in need of such treatment to undergo such treatment using outreach models that are scientifically sound, or if no such models are available which are applicable to the local situation, to use an approach which reasonably can be expected to be an effective outreach method.* The ASVMRF should ask programs serving persons who inject drugs questions such as, "Describe the outreach methodologies the program uses" and "How does the program ensure that those methodologies are scientifically sound or applicable to the local situation?"
- *45 CFR § 164.506*: *a covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.* On page 8 of 17 in the Human Immunodeficiency Virus (HIV) Testing section, DMHAS should be required to capture whether contracted providers include consent to treatment forms in client files to ensure that consent to treatment is obtained for the use and disclosure of a client's HIV status. Additionally as it pertains to HIV testing, page 13 of 17 of the ASVMRF asks PMOs to document if high risk clients who test negative for HIV/AIDS are offered retesting every six months. However, there does not appear to be data available or a mechanism to determine which clients are high risk clients for testing positive for HIV/AIDS.

During the exit conference, TCT recommended that DMHAS consider using responses from the providers' high risk behavior screening tools to make more data-informed choices about strategic decisions such as who should be retested every six months and how to determine resource deployment for testing sites. These issues are discussed below in the HIV and Pre- and Post-Test Counseling section of this report. Also, page 13 of 17 of the ASVMRF requires PMOs to document whether SABG sub-recipients have documented a client's HIV positive status if early intervention prevention (EIP)/HIV services are provided. While it is not required to change the language, it is suggested that DMHAS instruct SABG sub-recipients to replace the term, "HIV positive" with "immune system compromised." Using the recommended language further safeguards clients' protected health information (PHI) and mitigates stigma because the newly suggested term could refer to any disease compromising the client's immune system.

TCT found two additional instances in which monitoring of SABG sub-recipients could be improved. The most recent reports of the providers visited during the compliance review did not contain findings regarding outreach by the MAT program. Under *45 CFR §96.126, all such*

programs that receive funding for intravenous drug abuse are required to carry out activities to encourage individuals in need of such treatment to undergo such treatment. Those programs are required to use outreach models that are scientifically sound, or if no such models are available which are applicable to the local situation, to use an approach which reasonably can be expected to be an effective outreach method. The TCT on-site investigations revealed that the MAT program does not conduct outreach. The MAT program staff explained that conducting outreach as defined in 45 CFR §96.126 is not feasible because state funding has been reduced. The CEO advised that outreach is conducted by sub-recipients of Ryan White grant funding.

The report also did not cite findings regarding women who are maintained on methadone in residential treatment. Focus groups at one program—the PPW—suggest that these women are excluded from residential treatment. DMHAS is encouraged to explore this exclusion since residential treatment for women on methadone is an EBP for pregnant clients. The PPW is an abstinence-based program, including nicotine. Pregnant clients who are intravenous users of heroin on MAT (in the instant case, maintained on methadone) are not eligible for admission into the program. The practice of excluding women who are maintained on methadone from participating in residential treatment seems to be philosophical.

Accreditation

The Office of Licensing (OOL) operates under the Office of Program Integrity and Accountability (OPIA) and is the licensing and regulatory authority of the Department of Human Services. The OOL regulates, inspects, and provides TA to programs serving persons with mental illness and SUDs. OPIA licenses providers and conducts financial and program audits to assure compliance with DMHAS regulations (the role of OOL is discussed above). DMHAS reported that 18 agencies at 20 sites are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). One of the providers visited is in the process of becoming CARF accredited. DMHAS does not grant deemed status to substance abuse providers.

Utilization Management

Since January 2015, DMHAS has used the IME as the central point of entry for persons seeking treatment for SUDs. IME is designed to ensure individuals are receiving the appropriate level of care for the appropriate duration and at the appropriate intensity. DMHAS will continue to assess service utilization through multiple processes. These include:

- Periodic review of providers' utilization patterns via monthly reviews of provider agency rosters
- Reviews of provider data submitted to NJSAMS
- Site visits and DMHAS monitoring
- DMHAS internal review
- Contract coordinating meetings

The IME is expected to significantly improve the state's ability to manage the utilization of its resources across payers and across the continuum of care.

Provider utilization is calculated by a series of formulas that each provider enters into NJSAMS at the end of every month. For example, utilization of outpatient drug free slots in a given month is derived from the following formula:

$$\frac{Number\ of\ days\ on\ roster\ within\ a\ month}{7} \times 1$$

Providers reported some initial concerns whether the IME would supplant their ability to manage their own utilization. However, they also recognized that the IME could boost their utilization rates and reduce the burden on them to constantly keep capacity filled. At the time of the monitoring visit, the combined average utilization rate or level of service for PCC and Good News for Women was 93 percent for the 12 months in 2015. While this rate is commendable, the rate for the first and second quarters was below the contractually required 95 percent, at 88 percent and 91 percent, respectively.

Continuous Quality Improvement (state, intermediary, and provider levels)

DMHAS monitors whether providers have the following CQI requirements:

- A quality assurance (QA) committee
- Policies and procedures prescribing the frequency of committee meetings and how the meetings are documented
- A QA plan that describes the processes for conducting internal file reviews to assess quality and measures for client outcomes
- Client satisfaction surveys, including policies concerning the frequency with which the surveys are disseminated, and how the resulting information is used to improve service delivery
- Policies regarding the handling of grievances or complaints, critical incidents, and reportable events

Two of the three providers participating in the review had established a QA committee. All participating providers had policies for the handling grievances, complaints, critical incidents, and reportable events. The review revealed that customer satisfaction surveys were not uniformly disseminated across programs and the findings of those surveys were not published or disseminated to participants.

Workforce Development

Credentialing: Clinical Supervisors, Peer Specialists, and Recovery Coaches

One of DMHAS's FY 2014–2016 workforce development focal areas validates the efficacy of recovery mentors or peer specialists to mobilize important internal and external resources that

can initiate recovery and assist in recovery maintenance. In recognition of the important role of peer specialists across all stages of recovery, DMHAS is exploring the creation of a new credential that will broadens the existing Certified Recovery Support Practitioner (CRSP) credential that was initially designed for peers working in the mental health field. The new credential will be expanded to include peers helping individuals with primary substance use or co-occurring disorders. It serves as a vehicle for simultaneously increasing the number of MH/SA behavioral health staff and providing consumer training for peer certification, coaching, and advocacy. DMHAS is also seeking to strategically establish a competent workforce that is capable of addressing behavioral health issues regardless of clients' primary addiction, mental health, or co-occurring condition. Toward that end, DMHAS provides specialized training on the IMR, DSM-5, American Society of Addiction Medicine (ASAM), DBT, MAT, SBIRT, CBT, and MI.

At the time of this review, none of participating programs acknowledged augmenting their clinical teams with peer specialists. Staff at one program were unaware of peer specialists or recovery coaches.

Clinical Supervision

N.J.A.C. 13:34C-6.2 articulates DCA's definition of clinical supervision and describes requirements for provider compliance. The regulations prescribe the number of hours and by whom clinical supervision must be provided. For example, alcohol and drug interns are defined as persons who are in training under the clinical supervision of a qualified clinical supervisor and working toward completing the requirements of N.J.A.C.13:34C-2.3(b)3ii. Interns must receive at least 50 hours of face-to-face supervision per year. These supervisory hours must be provided by either:

- A New Jersey-licensed LCADC
- Aa New Jersey-licensed, ASAM-certified physician, or a psychiatrist with added qualifications in chemical dependency from the American Psychiatric Association
- A certified clinical supervisor (CSS)
- A New Jersey-certified advanced practice nurse, licensed psychologist, licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), or licensed professional counselor (LPC)

N.J. A.C. 10:161AB-1.9 (a) requires that agencies maintain a 50 percent ratio of LCADCs, CADCs, or other licensed professionals doing the work of alcohol and drug counseling nature within their scope of practice. The remaining 50 percent of staff will be considered counselor interns actively working towards LCADC or CADC status or towards another health professional license that includes work of alcohol and drug counseling nature within its scope of practice. TCT found that not all programs visited were in compliance.

N.J.A.C. 13:34C-6.2 also articulates the content of the written agreement that qualified clinical supervisors must have in place for persons to whom they are providing supervision. The written agreement must outline the planned hours of practice, planned hours of clinical supervision, and

the types of supervision that will be provided. Several clinicians at the programs visited stated they received some clinical supervision. However, none of the providers reported a formal clinical supervision protocol that comported with the required number of hours of face-to-face supervision. The regulations also require a qualified clinical supervisor to cosign all diagnostic summaries, treatment plans, and reports to courts, agencies, or other treatment providers prepared by alcohol and drug counselor interns. Clinical documents reviewed at the participating providers did not consistently allocate space for clinical supervisor signature.

Recommendations

Although the clinical supervision of group sessions at one program is provided by the LCADC and focuses on issues such as transference, counter transference, and the extent to which the counseling session aligns with the 12 core functions of treatment, those sessions were not always documented. The PMOs must consistently enforce compliance with the number of hours of clinical supervision provided to each counselor and document the modality of clinical supervision. These modalities may include any combination of the following:

- Documentation or records management (chart review, review of client outcomes and satisfaction)
- Individual case reviews and case management
- Group case conferences
- Staff monitoring and performance management (observation, mentoring, establishing employee performance plans, educational support)

More consistent monitoring of clinical supervision will better enable DMHAS to assess the quality of counseling services provided to clients.

DMHAS monitors must conduct more careful reviews to ensure agencies maintain a 50 percent ratio of LCADCs to, CADCs, or other licensed professionals doing the work of alcohol and drug counseling nature within their scope of practice. The remaining 50 percent of staff will be considered counselor interns actively working towards LCADC or CADC status or towards another health professional license that includes work of alcohol and drug counseling nature within its scope of practice as required by N.J.A.C.10:161AB-1.9 (a).

DMHAS must ensure that the signature of a qualified clinical supervisor is affixed to all clinical documentation.

State Initiatives to Monitor Providers' Ability to Ensure Personnel Comply with Licensure/Certification Requirements

DMHAS continues to fund the New Jersey Prevention Network (NJPN) to provide statewide alcohol and drug training for individuals interested in becoming an alcohol and drug counselor or for those already working in the field. DMHAS also provides opportunities for consumers and staff to participate in specialized training through its Addiction Training and Workforce Development (ATWD) Program. It provides scholarships to eligible individuals to participate in

addictions training or university or college academic course work. The ATWD has created a LCADC—CADC dashboard that graphically shows several key outcomes of NJPN's workforce development initiatives. For example, the dashboard showed that 582 persons were awarded a LCADC or CADC credential between 2006 and 2015. The report also indicates that the NJPN continues to actively recruit students from DMHAS-licensed agencies to participate in CADC classes.

DMHAS contracts obligate providers to ensure that staff persons attend DHHS-provided or sponsored trainings on the ASI and ASAM-PPC II, and on HIV counseling and testing. Mandatory in-service trainings at one provider heavily focus on strengthening staff aptitude with the 12 core functions. In-service workforce development opportunities at another provider focus on topics such as the DSM–5, stress management, self-care, CFR 42, and confidentiality.

Counselor Certification/Licensure

The N.J. A.C. does not specifically address certification reciprocity. However, N.J.A.C.13:34C-1.9 allows the State Board of Marriage and Family Therapy Examiners, upon recommendation of the Alcohol and Drug Counselor Committee, to grant a license or certification to any person who, at the time of application, is licensed or certified by a governmental agency or other comparable recognized certifying authority located in another state, territory or jurisdiction. The Committee must be satisfied that the licensure or certification requirements at the time of initial certification or licensure are substantially similar those of N.J.A.C.13:34C-1.9

Although the Addiction Professional Certification Board of New Jersey (APCBNJ) issues the following specialty certifications, of the ones listed below, DMHAS only requires the Certified Prevention Specialist, the Disaster Response Crisis, and the Certified Clinical Supervisor. All of the other certifications are voluntary and are not required in any of DMHAS' regulations or contracts.

- Certified Clinical Supervisor
- Disaster Response Crisis Counselor
- Certified Prevention Specialist
- Certified Criminal Justice Professional
- Co-Occurring Disorders Professional
- Co-Occurring Disorders Professional-Diplomate
- Chemical Dependency Associate
- Recovery Mentor Associate
- Associate Prevention Specialist
- Community Mental Health Associate
- Addiction Disability Specialist
- Women's Treatment Specialist

- Certified Tobacco Treatment Specialist

Despite a plethora of professional designations, the state reported a shortage of trained behavioral health professionals. The providers also remarked on the shortage of behavioral health professionals. They asserted that a lack of competitive salaries and inadequate local transportation are barriers to recruiting qualified clinicians who have experience working with clients with increasingly complex and severe addictions and co-occurring disorders. Reportedly, CADCs and LCADCs are most likely to be Caucasian, middle-aged, and female. Most have been employed by their current program for at least eight years. The providers view these staff as an asset because of their continuity of service delivery and institutional knowledge.

Recommendations

The specialty SUD workforce of the future will need to have an adequate understanding of SUD treatment and recently developed EBPs for SUD treatment. Concurrently, it must possess the knowledge and skills to provide appropriate recovery support services. While providers have retained some clinicians, their ability to recruit a younger and more diverse workforce has been stymied by low wages and a paucity of incentives for young professionals to choose the field of addiction as a career. Replicating a program such as Nebraska's Behavioral Health Education Center Network (BHECN) and working through the NJPN's Training and Workforce Development Initiative would heighten DMHAS's capacity to establish a pipeline beginning with high schoolers and actively market the opportunities available in the behavioral health field. The State of Nebraska developed BHECN to establish a potential staffing stream that begins to address the anticipated workforce shortage that will be confronted in the next 15 years. BHECN introduces students to behavioral health careers and recruits and mentors students from high school through college and professional school and into practice as behavioral health professionals. To date, 688 students have participated in the BHECN Ambassador Programs which started in April 2013.

It is also recommended that DMHAS develop strategies to increase compensation for the SUD treatment workforce. The SAMHSA career ladder for SUD counseling should be implemented in New Jersey.

Cultural Competency

In June 2015, DMHAS formed the Multi-Cultural Services Group (MSG) to devise strategies to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services and the staff who are providing such services. The MSG is comprised of behavioral health treatment providers, consumers, representatives of the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations, administrators, and academicians. In its 2017–2018 Blueprint for Action, MSG recommended that DMHAS formally adopt the CLAS Standards and outlined the following key activities for the division:

- Develop a cultural and diversity self-assessment tool that agency staff will use to conduct self-assessments and designate champions for using those tools.

- Survey the current status of Cultural Competency (CC) plans, compile a list of agencies with and without plans, and promote the state presence through the two Cultural Competence Training Centers to review and recommend areas for growth in the development of comprehensive CC plan. The goal is for all agencies to have a CC plan in place by 2018 contract.
- Develop policies regarding translation services and renew the available listings of certified language interpreters.
- Issue a Request for Proposals for a statewide consultant to develop a comprehensive training curriculum for cultural and linguistic competency.
- Examine agency board and staff compositions.

DMHAS requires that all funded organizations must:

- Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally competent work environment.
- Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
- Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent prevention staff that are trained and qualified to address the needs of the racial, ethnic, and other minority communities being served.
- Require and arrange for ongoing education and training for prevention staff in culturally and linguistically competent service delivery.
- Provide all clients with limited English proficiency access to bilingual prevention staff or interpretation services.
- Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
- Translate and make available signage and commonly used written client educational material and other materials for members of the predominant language groups in service areas.
- Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

The provider's cultural competency plans were not in place at the time of the review. As a result, TCT could not assess how well providers integrate and maintain cultural and lingual specificity in their clinical interventions. None of the providers reported having the capacity to offer client groups or individual counseling sessions in a language other than English. While the DMHAS staff appears to be racially and linguistically diverse, the provider's direct services staff was not always representative of the clients served.

For example, clients served by one of the programs are predominantly Caucasian and Hispanic pregnant women who are between the ages of 20 and 26 and have multiple children and long history of addiction and criminal justice involvement. The direct service staff was disproportionately middle-aged, Caucasian females. Although the site visit is merely a snapshot in time, demographic shifts in clients may result in a greater cultural and racial dissonance between staff and clients. This racial and cultural mismatch between clients and staff would be less significant if there was a very strategic and intentional training protocol that examined staff's individual biases and provided skills to enhance cultural proficiency on both organizational and individual levels.

Client Perception of Care

N.J.A.C. 10:161A- 9.2(a) requires providers to establish assessment measures that determine the effectiveness of and client satisfaction with treatment or services. These metrics must assess client adherence to and engagement with treatment and recovery support services. Since NJSAMS does not assess client satisfaction, DMHAS conducted a statewide continuous client satisfaction survey in 2006 and 2009. In 2016, it plans to launch an integrated consumer satisfaction survey at the MH Community Wellness Centers and two addiction recovery centers that incorporate SAMHSA's eight dimensions of wellness.

Results from the 2009 statewide survey highlighted important findings related to age, ethnicity, race, length of stay, and treatment modality. The survey found that Hispanic clients were much more satisfied with treatment outcomes than non-Hispanic clients. Black clients were less satisfied with program staff. While these findings are instructive, it is unclear whether those results have been translated in DMHAS training and TA opportunities to improve service delivery. A client focus group convened at one program confirmed that clients in certain racial groups experience greater dissatisfaction with some treatment staff than others.

This review also suggests that there are inconsistencies among providers about the collection and assessment of client perceptions of care. One program uses Survey Monkey to collect client satisfaction data each month. The data are compiled quarterly and distributed to the clinical directors who, in turn, discuss the results with clinicians. Clinicians reported that feedback from client satisfaction surveys is used to improve programming. Another program solicits client satisfaction only at discharge. A third program did not assess client satisfaction.

Recommendation

Determining client perceptions of care has become a critically important and well-researched component of CQI in addiction treatment. In an effort to ensure that contracted providers comply with N.J.A.C.10:161A- 9.2(a), DMHAS must implement a structured mechanism to determine the effectiveness of and client satisfaction with treatment or services. In addition to paper customer satisfaction forms, one provider in Placerville, California, uses tablets on which it has loaded its client satisfaction surveys and asks clients to complete the questionnaire online at various points during their episode of treatment. That provider has found that clients are eager to

complete short point-in-time surveys online and has an almost 100 percent rate of return. The program compiles the results which are sent to the state quarterly.

Expected and Current Counselor Caseload

The state's outpatient and residential licensure regulations in N.J. A. C., Chapters 161A and B of Title 10 establish minimum counselor to client ratios. Table II-6 presents the required counselor to client ratios for various levels of care (LOC).

Table II-6. Required Counselor to Client Ratios

Level of Care	Ratio of Counselors to Clients
Residential	
Short Term	1:8
Long Term	1:12
Halfway House	1:20
Outpatient	
Outpatient	1:35
Intensive Outpatient	1:24
Partial Care	1:12
Outpatient Detoxification	1:24
Opioid Treatment Phases I through III Opioid Treatment Phases IV through VI	1:35 1:50

All providers visited during the review were in compliance with the residential regulations for counselor to client ratios.

Clinical Evaluation

Matching Clients to Needed Services

The IME is being implemented in phases. It provides 24/7 phone line access to all callers, and will subsequently screen consumers to receive an authorized treatment assessment from a network provider. The provider will then conduct a full consumer assessment. Assessments provided for New Jersey Family Care Medicaid beneficiaries are billable under the applicable Current Procedural Terminology code. The team's visit to the IME confirmed that it has become the one-stop information and referral authorization service entity for consumer and substance abuse network provider access.

At the time of the visit, Phase II of the IME was about to be launched. In that phase, the IME will utilize ASAM Level of Care Inventory (LOCI) criteria to authorize addiction treatment placements and continuing care for individuals served through IME-managed DMHAS State initiatives, as well as through Medicaid managed providers for covered services. It is anticipated that transferring this responsibility to the IME will once again transform and centralize how

placements are made based on the assessed level of care. The level of care received will be based on capacity that will be managed by a centralized inventory of all available bed spaces or treatment slots.

Assessment

Pursuant to a 2006 licensing agreement, the ASAM LOCI became part of the NJSAMS and is electronically available to all licensed agencies. Program staff can also access the ASI which is embedded in NJSAMS.

Annex A of the DMHAS contracts with SABG providers stipulates that the following assessments must be included in each client's chart:

- Completed NJSAMS
- ASI
- DSM
- ASAM
- LOCI

Once the IME is fully implemented, DMHAS's goal is to transition to a system in which all initial screenings will be completed immediately by the IME. Subsequently, once admitted to an appropriate LOC, clients will receive a subjective battery of assessments. For example, a woman admitted to the Straight and Narrow program and assigned to a clinician will receive a more comprehensive biopsychosocial evaluation within the stipulated 72 hours. The biopsychosocial evaluation becomes the basis for the treatment plan which must be revised every 30 days.

Placement

DMHAS mandates that provider diagnoses and related placement decisions comply with the ASAM PPC–2R and the DSM-5. PMOs review a sample of client charts during their site visits to ensure that each client is admitted into the appropriate level of care based on ASAM criteria and assessed using the ASI. PMOs provide technical assistance and training to address inconsistencies in placement decisions or the documentation of those decisions.

The N.J. A. C. Title 10 standards require all licensed agencies to maintain and update a resource manual that staff use to make referrals. This requirement is designed to assist clinicians make appropriate level of care referrals. When fully implemented, the IME will ensure that all placements are expediently made and comply with ASAM and DSM criteria.

Client Movement between Levels of Care

Prior to the IME, providers used the results of the ASAM LOCI and ASI, in addition to other assessment findings, to determine when a client was eligible to move between LOCs. Subsequent to implementing the IME, providers will complete an assessment that justifies LOC movement,

seeks UBHC review or assistance for placements, and obtains prior authorization for assessments. The IME will provide a central point that will facilitate the transition between the different LOCs. It will make daily calls to clients that cannot be placed in the clinically indicated LOC who are waiting for admission to treatment. These calls will keep those individuals engaged and supported while waiting for care. The IME will also follow up on admissions to detox to assist in getting those individuals to the needed level of care.

The providers reported that clinical supervisors discuss recommendations to move clients to lower levels of care such as outpatient or intensive outpatient during and after completion of a residential episode of care. The supervisors discuss these recommendations in full team staff meetings.

Use of Client Placement Data in Management Decisions

Providers indicated that information from the assessment instruments and NJSAMS is used to fine tune the anticipated case management and ancillary services clients need to be successful in treatment. Provider management teams use information from client assessments to inform the agency's decisions about formal or informal outreach activities, targeting additional agencies with which business agreements or interagency agreements should be made.

Chart Review

TCT conducted a review of approximately six charts at three DMHAS provider agencies. These reviews revealed that progress notes, ASI assessments, medical history, medical notes, and treatment plans were located in the files. Nursing orders dosages, and take home assignments are also documented. All charts contained the appropriate disclosures and releases of information as required by 42 CFR Part 2 and HIPAA.

The review of clinical records revealed that client satisfaction surveys are not consistently placed in client charts. The treatment plan goals found in five of the six charts were not always connected to assessment findings. For example, the mental health status examination conducted at assessment for two clients revealed a history of depression and suicidal ideation. However, neither of the treatment plans included specific goals and clinical interventions to address those psychiatric diagnoses. The treatment plan in one chart did not contain the client's signature. While the timing of the initial treatment plan occurs within the first 30 days, the frequencies with which the reviews and updates to the treatment plan occurred were not consistent. Sometimes, the treatment plan updates seemed to be a duplicate of the original plan.

Recommendation

N.J.A.C.13:34C-6.2 requires a qualified clinical supervisor to cosign all diagnostic summaries, treatment plans, and reports to courts, agencies, or other treatment providers prepared by alcohol and drug counselor interns. TCT recommends that DMHAS carefully review the quality of the initial treatment plans and their updates. TCT also encourages providers to review client charts to identify and address co-occurring issues of severe mental illness such as bipolar disorder,

traumatic brain injury, or schizophrenia. DSM-5 codes should be assigned to each mental health or substance abuse disorder.

Unannounced Compliance Check Calls

To increase the sample of providers reviewed, TCT team has implemented an Unannounced Compliance Call Protocol. Using information contained in CSAT's Statewide Entity Inventory and obtained from the SSA, TCT randomly selects a sample of providers to receive the unannounced compliance calls. These providers include those participating in the on-site visit and others located in various regions of the state. The following providers were selected to receive an unannounced compliance call:

- Good News Home for Women (also received an on-site visit)
- Newark Renaissance House Women's Residential Program
- New Hope Foundation's Epiphany House
- Patterson Counseling (also received an on-site visit)
- Straight and Narrow Mommy and Me Program (also received an on-site visit)
- The Lennard Clinic

The primary goals of the unannounced compliance calls are to assess the staffs':

- Professionalism and accuracy in describing the service array offered by the provider
- Ability to allow the caller to guide and redirect the treatment options presented
- Ability to discuss barriers to treatment and the level of behavioral health integration in the substance abuse treatment milieu

The calls also provide opportunity to assess staff knowledge about the following SABG requirements:

- Access to care standards
    - Timely access to care for services within reasonable geographic distances
    - Family- and client-centered and trauma-informed care that emphasizes personal self-determination
    - Capacity management (wait list management systems)
- Admission Preferences
    - Pregnant IDU
    - Pregnant substance abusers
    - Intravenous substance abusers
    - All other substance abusers
    - Individuals receiving services related to communicable diseases such as tuberculosis (TB) and HIV
- Specialized Services for PPW
    - Case Management (45 CFR 96.124)

    - Therapeutic services for children (45 CFR 96.124) that address their developmental needs and issues of sexual and physical abuse and neglect;
    - Child care (45 CFR 96.124)
    - Education components that provide or arrange for educational or vocation training and life skills resources, TB and HIV education and counseling, education and information on the effects of alcohol and drug use during pregnancy and breast feeding, parent skills building, and child development information
    - Primary medical care and primary pediatric care (45 CFR 96.124)
    - Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services
    - Transportation (96 CFR 96.124)
- Interim Services (45 CFR 96.121 and 96.131)
    - HIV and TB
    - The risks of needle sharing
    - The risks of transmission to sexual partners and infants
    - Steps to be taken to ensure HIV transmission does not occur
    - Referrals to HIV and TB, as necessary
    - The effects of alcohol and other drug use on the fetus, and referrals to prenatal care

The findings of the calls and any recommended training and technical assistance will be addressed in greater detail in the compliance section of this report. Copies of the reports from each call can be found in Appendix D.

Data Used in the Treatment Service Delivery System

Clinical Outcomes and Benchmarks

DMHAS has produced the Substance Use Treatment Provider Performance Report every year since 2006. The report compares the overall performance of each addiction treatment provider with the statewide average performance based on national outcome measures for each level of care. (See Appendix E for the July 1, 2014–June 30, 2015 State Performance Report). Using their percentile scores on each outcome measure, agencies can compare their performance relative to other agencies. These reports are emailed to over 200 providers; since 2014, providers can download the report from NJSAMS. The report also includes data on the following national and state outcome measures:

- Percentage of clients abstinent from alcohol on admission and discharge
- Percentage of clients abstinent from drugs on admission and discharge
- Percentage of clients employed at admission and discharge

- Percentage of clients enrolled in school or a job training program at admission and discharge
- Percentage of clients who are homeless at admission and discharge
- Average length of client treatment

DMHAS reports that OPREP also uses NJSAMS data to develop a statewide Substance Abuse Overview which covers the following:

- State totals for Substance Abuse Admissions
- Substance Abuse Admissions by County and Primary Drug
- Substance Abuse Admissions by Primary Drug within County
- Maps for Number of Substance Abuse Admission by County of Residence
- First time Clients by County of Residence and Primary Drug
- Admissions by Age Group, Gender, and Primary Drug
- State Totals for Substance Abuse Treatment Discharges

These data are illustrative of substance abuse admissions by county and by primary drug. The report does not contain a contextual analysis of the factors that serve as facilitators or barriers to treatment engagement. The report also does not discuss the outreach methodologies used to engage first-time users in DMHAS-funded programs. These data have the potential to be useful if leveraged to help counties and their providers design their programming to address trends in the primary drugs of choice of clients who are admitted and those who are discharged.

Providers can compare their individual outcome indicators from admission to discharge in the NOMs and SOMs categories listed above with all other providers within their LOC. This assumes that providers collect the same data required to be uploaded in NJSAMS for the purposes of internal analysis and comparison with state outcomes. Operationally, the providers visited focused on some but not all of the uploaded data sets. For example, the CQI Committee at Straight and Narrow focuses its outcome indicator analyses on the numbers of clients completing versus those administratively discharged or those leaving against medical advice. These data sets are compared month to month and year to year to identify themes and trends in the numbers and percentages of program completers. PCC focuses on data regarding retention rates for pregnant women, the birth weight of their babies, and the presence of NAS.

Provider Clinical Reporting

DMHAS staff reported that the first public statewide comparison Annual Provider Performance report will soon be published. The Performance Reports will include information on key State Outcome Measures (SOMs), which are based on the original NOMs by level of care. This statewide comparative provider performance report will also provide the state averages for each outcome measure. For the individual Provider Performance Reports, percentile rankings are included so agencies can see where they rank relative to their peers. Statewide averages are also provided so individual agencies could compare their performance with state performance on each

required SOM. For example, in March 2012, the Provider Performance Report for calendar year 2011 showed that among the 13 providers delivering short-term residential services, at Agency 123456 63.9 percent of clients were abstinent from alcohol at admission versus 99.9 percent who were abstinent at discharge. When compared with the state's percentages, at 62.7 percent and 99.9 percent at admission and discharge respectively, Agency 123456 is on par with the state. On the other hand, when compared to the state's percentages for the clients arrested in 30 days prior to admission vs discharge, Agency 123456 had a higher percentage of clients who had been arrested in the prior 30 days at 10.4 percent compared to the state's 8.2 percent. A few of the providers visited reported that they utilized the existing DMHAS Provider Performance Reports to inform their CQI process, help them monitor client outcomes, and prioritize system improvements. Most providers did not. It is recommended that DMHAS provide significant training and re-training on how all providers can use these data to determine what training and TA they may need to improve their capacity to meet and exceed SOMs.

State Outcome Measure (SOM)	Percentile		Agency 123456*			State		
	Difference (Diff)	Discharge	Diff	Admission (Adm)	Discharge (Dis)	Diff	Adm	Dis
The absolute percent change of clients abstinent from alcohol at admission vs. discharge	54	23	36%	63.9%	99.9%	37.2%	62.7%	99.9%
Absolute percent change of client arrested in prior 30 days at admission vs at discharge	69	31	-1.8%	10.4%	3.1%	-3.6%	8.2%	4.6%

*Provider ID numbers and agency names were omitted from the report provided to the TCT.

Substance Abuse Prevention and Treatment Block Grant Compliance

Confidentiality of Protected Health Information and Client Data

"The State is required to have in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity which is receiving amounts from the grant and such a system shall be in compliance with all applicable State and Federal laws and regulations, including 42 CFR part 2." —45 CFR, Part 96; Interim Final Rule

The Health Insurance Portability and Accountability Act of 1996 includes Administrative Simplification provisions for the electronic exchange of certain administrative and financial transactions and for the security and privacy of health information. Regulations pertaining to healthcare providers establish Standards for Privacy of Individually Identifiable Health Information regarding the use and disclosure of protected health information. It also establishes some patient rights, including individuals' access to records.

Methodology

Prior to the on-site review, TCT reviewed the following documentation:

- Substance Abuse Prevention and Treatment Block Grant Draft Manual Template
- The Annex A contracts for various LOCs
- Annual Site Visit Confirmation Letter
- Annual Site Visit Monitoring Review Form Template_Rev 2015
- Annual Site Visit POC Acceptance letter_rev2015
- Client File Review Form Revised_022015
- Site Visit POC Template_09.2010
- Monitoring Process Word document

During the 2-day on-site review with DMHAS staff, TCT conducted the following interviews:

- Chief, Special Populations
- Director Quality Assurance
- Chief, Bureau of Contract Administration
- Chief of Care Management, Office of Medical Director
- State Opioid Treatment Authority/HIV Coordinator
- Contract Monitor Supervisor

As discussed above in Section A, TCT also visited three treatment providers.

Protected Health Information (PHI)

Annex A of the DMHAS contract requires programs to meet the standards prescribed by the confidentiality of alcohol and drug abuse patient records, as promulgated in 42 CFR Part 2 in Part 96, Subpart L; Interim Final Rule. The Annexes reviewed, including Annex A, do not specifically require contracted treatment providers to obtain consent to treat clients for an addiction or to test clients to determine HIV status. TCT observed that consent to treat forms were contained in client records at the PPW residential program. The release of information incorporated all elements required by 42 CFR. (The team reviewed clinical records at one of the two participating residential treatment providers. It did not review records at the MAT program.)

Preventing Inappropriate Disclosure of Patient Records

The providers visited during the review transmit confidential and PHI electronically and via faxes. Tours of each facility confirmed that providers secure fax machines in locations to which clients have limited or no access. However, the tours did not observe evidence of provider practices to ensure that intended recipients receive faxes. TCT noted that including a facsimile cover on a faxed document is a good practice. It also shared easily implemented practices to more diligently safeguard confidential client information. These practices include, for example, calling the intended receipt to alert them to an incoming fax and following up to ensure receipt of the transmission.

Only one of the three providers transmits encrypted emails. Encrypting emails should be a standard practice to mitigate breach of PHI. While not a violation of confidentiality of alcohol and drug abuse patient records, one residential program incorrectly referenced 42 CFR as 42 CRF in the releases of information (ROI).

TCT conducted an informal conversation with several residents waiting outside for the MAT provider to receive their methadone. These clients inquired whether their “right to confidentiality” was violated by the program’s practice of requiring them to wait in front of the building in a long line until they could receive their medication The building is located in a busy and heavily trafficked area. A few clients reported receiving text messages from friends on several occasions asking why they were standing in a line outside the building. The name of the building is prominently displayed on its front and nothing suggests that it is a MAT provider. However, TCT could easily conclude that the building was a methadone clinic because of the long line of clients assembled outside. Requiring clients to wait outside a nondescript building is not a violation of 42 CFR. However, to maintain the dignity and privacy of clients waiting to receive their medication, the MAT program should consider a less visible entrance (perhaps in the back of the building) or another solution to the long lines and lack of privacy.

Table II-7. Release of Client Information

A written consent to a disclosure under 42 CFR, Part 2 must include:	Evidence of Compliance	Evidence of Non-Compliance	Unknown/ Unable to Determine
Name or general designation of the program or person permitted to make the disclosure	X		
Name or title of the individual or the name of the organization to which disclosure is to be made	X		
Name of the client	X		
Purpose of the disclosure	X		
How much and what kind of information is to be disclosed	X		
Signature of the client, or if client is a minor or incompetent, signature of person who is authorized to give consent or sign in lieu of the client	X		
Date on which the consent is signed	X		
Statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it	X		
Date, event, or condition upon which the consent will expire if not revoked before	X		

Data Sharing and Management

DMHAS does not have stand-alone data use agreements but informally shares information with DMAHS. DMHAS staff indicated that a data sharing agreement is not necessary because both divisions are located within DOH. DMHAS has an agreement, although not a formal data sharing agreement, to receive the DOH hospital billing records. The agreement details the parameters for using the data. DMHAS uses the DOH hospital data to analyze emergency room and inpatient information.

Future data sharing agreements will be developed between the DOH and the State Police to share information on EMS naloxone deployments. The division will also establish data sharing agreements with the Department of Children and Families to allow the OPREP Assistant Division Director to link substance abuse treatment data with child welfare data. This linkage will enable DMHAS to review the impact of treatment on child welfare outcomes. Although the State Police is willing to share certain data sets without a formal agreement, attorneys for both agencies are working to develop a formal agreement that allows sharing a broader data set.

Table II-8. Protected Health Information

Safeguards to Protect Client Health Information	Evidence of Compliance	Evidence of Non-Compliance	Unknown/ Unable to Determine
Written records are located in a secure room	X		
Written record are stored in a locked file cabinet, safe, or container when not in use	X		
Data are de-identified (aggregate statistical data stripped of individual identifiers and therefore require no individual privacy protection and are not covered by the Privacy Rule)		X[8]	

Monitoring

The annual on-site monitoring visits conducted by PMOs provide opportunities to assess providers' compliance with federal confidentiality requirements. The ASVMF allows PMOs to document whether providers have implemented procedures to comply with state and federal laws and regulations (42 CFR Part II and HIPAA); confidentiality; the storage of client files; and information; and for retention and disposal of confidential client information. The form does not capture the processes providers use to operationalize procedures such as annual staff trainings, ensuring receipt of emails by the intended recipient, or encrypting emails to mitigate compromising electronically sent PHI.

DMHAS licensing staff review providers Bill of Rights documents during and on-site licensing surveys. PMOs observe 42 CFR workflow during contract on-site compliance reviews. These staff note whether the following client protection practices are being observed:

- Noise machines are located in hallways to ensure that confidential conversations between counselors and clients cannot be overheard.
- Client records are not left on a counselor's desk when office doors are open.
- Confidential client information is not displayed openly on computers.

Licensing staff also observe the processes for securing faxes if one is received during the site visit. These observations focus on whether faxes are left on the machine or are secured and immediately delivered to the intended recipient.

Recommendations

Staff interviews conducted during the review and email exchanges with the Assistant Division Director for OPREP confirmed that DMHAS does not have any formal data sharing agreements. However, DMHAS shares data with the state Medicaid office and anticipates accessing

[8] Data are transmitted electronically by providers and Rutgers (invoices) without encryption.

additional data sets from the state police. Because they are both located within DHS, a formal data sharing agreement between DMHAS and DMAHS is not required. However, it is always a good practice to develop formal data sharing agreements to ensure compliance with 42 CFR and the HIPAA requirements. Documenting the scope of data sharing to clearly detail who is permitted to use or receive the data sets and how the data may be used is important to ensuring continuity and compliance. Formally delineating the scope of data sharing should also include language that requires the recipient to:

- 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 of 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.
- Ensure that data are de-identified. As indicated in the HIPAA Privacy Rule (45 CFR 164.514[b]), when sharing data with another entity, the agency should ensure that data are de-identified (e.g., the agency shares only aggregate statistical data stripped of individual identifiers), require no individual privacy protection, are not covered by the Privacy Rule and/or presented in a limited data set in which the health information is not directly identifiable.

The providers participating in the visits currently comply with and operationalize 42 CFR, Part 2 in Part 96, Subpart L; Interim Final Rule. However, because protection of client information is paramount, it is further recommended that DMHAS revise its ASVMF to include examples that facilitate practical application of the law. DMHAS staff provided good examples of how surveyors and PMOs observe workflow for compliance with 42CFR and HIPAA. However, these observations do not appear to be universally applied and seem to be individually driven depending who is conducting the visit. The provider contracts should also stipulate that the programs must demonstrate practical application of 42 CFR and HIPAA through trainings, in-services, and in their policy and procedure manual.

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

> *Designated States must provide "(1) appropriate pretest counseling for HIV and AIDS; (2) testing of individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease; (3) appropriate post-test counseling; and (4) the therapeutic measures described in Paragraph 2 of this definition." §96.121—45 CFR, Part 96; Interim Final Rule*

Methodology

Prior to the on-site review, the TCT reviewed the following documentation:

- Substance Abuse Prevention and Treatment Block Grant Draft Manual Template
- Annex A HIV Case Management
- Annex A HIV EIP
- Annual Site Visit Monitoring Review Form Template_Rev 2015
- Annual Site Visit POC Acceptance letter_rev2015
- Client File Review Form Revised_022015
- SMOA Rutgers RWJ Rapid HIV Testing
- Monitoring Process Word document

During the 2-day visit with staff, the team conducted interviews with the State Opioid Treatment Authority/HIV Coordinator and the Contract Monitor Supervisor

As discussed earlier, the team also visited a MAT facility that provides EIS/HIV services. During the visit, the team conducted staff interviews and a facility tour and engaged in an informal discussion with clients waiting to receive their medication.

HIV Early Intervention Services (HIV/EIS)

DMHAS has historically funded HIV/EIS specialist positions at 17 OTPs and one prevention provider. Most of the sites are located in Patterson, Trenton, Jersey City, Newark, New Brunswick in the northern and central part of the state (Appendix F provides a complete list of sites and locations). Most of the programs are strategically located in densely populated areas that have the highest rates of HIV infection. One program is located in a rural area. This dispersion of programs has led to a service gap in the southern part of the state. A for-profit OTP has inquired about the possibility of opening a program in Gloucester County, located south of Camden, which would provide improved access to OTP in this underserved area.

TCT visited one of 17 OTP locations that offer HIV/EIS. Through staff interviews and reviews of on-site materials, TCT verified that staff administer rapid testing followed by rapid, rapid testing to confirm the rapid test results. Rapid, rapid testing confirms the results of the initial rapid test within 15 to 20 minutes, ensuring that clients have results of a false positive or confirmation before leaving the facility. This enables the provider to develop and implement a plan of care almost immediately, engaging clients quickly into an HIV care program.

The OTP also provides HIV/AIDS pre- and post-test counseling at the time of testing. It provides education on behaviors that can reduce the risk of contracting and transmitting HIV/AIDS and decreasing the risk of perinatal transmission. The education also focuses on the importance of notifying sex and needle sharing partners. As required by its DMHAS contract, the OTP has a

range of options for medical management of HIV, formalized through a MOU with Ryan White grant-funded agencies. Much of the medical management care through collaborating agencies involves physical examinations, testing to monitor client's CB4 count and opportunistic infections, administering viral load tests, and prescribing anti-HIV medication, such as antiretroviral therapy (ART).

Clients have access to medical management through Gilead Sciences, a pharmaceutical company that offers medication it developed for HIV-positive clients. Gilead Sciences states that the medication mitigates the transmission of HIV between partners when one partner is positive. Gilead Sciences also produces a pocket-sized guide that explains the importance of starting HIV treatment and provides this same information on YouTube and an app, all of which TCT reviewed. Gilead's pocket-size guides, index cards with the app, and other material were visible on tables at the provider and accessible to clients receiving services.

Number of Individuals Testing Positive for a HIV-Designated State

The OTP staff estimate that 60 to 65 percent of clients receive HIV pre-test counseling and are subsequently tested for HIV. Staff members believe that those tested are at highest risk to contract and transmit HIV/AIDS. However, the staff did not offer data to support their contention.

The team discussed at length with the State Opioid Treatment Authority (SOTA) the finding that only three clients tested at the DMHAS stationary and mobile sites were positive for HIV. New Jersey is an HIV designated state. The SOTA theorized that MI could improve the number of clients being tested. The low number of clients testing positive suggests that those at highest risk are not being tested and more clients should be tested. TCT suggests that OTPs adopt the 2006 Centers for Disease Control and Prevention (CDC) recommendation to use opt-out screening[9] for HIV testing for everyone between the ages of 13-64 and for all pregnant women. The CDC recommendation would require that HIV tests be done routinely unless a patient explicitly refuses to take an HIV test. The CDC also recommends eliminating the "requirements for pretesting counseling, informed consent and post-test counseling." According to CDC, opt-out screening for HIV:

- Will help more people find out if they have HIV[10]
- Will help those infected with HIV find out earlier, when treatment works best[11]
- Can further decrease the number of babies born with HIV[12]
- Can reduce stigma associated with HIV testing[13]

[9] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,
[10] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,
[11] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,
[12] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,
[13] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,

- Will enable those who are infected to take steps to protect the health of their partners[14]

Neither the OTP program nor DMHAS compares data from the HIV/STD Risk Behavior screening tool to the actual number of clients being tested. Such an analysis would compare and contrast the percentage of clients engaged in high risk behavior to the number of clients that are tested. This data comparison offers a tool for all OTPs and the state to assess whether the percentage of individuals testing corresponds to those involved in high risk behavior to contract and transmit HIV/STDs.

According to the OTP staff, men who have sex with men (MSM) represent the highest risk for contracting and transmitting HIV, followed by heterosexuals and IDUs. These suppositions are consistent with national data. The 2015 New Jersey Update: *The Status of HIV among Men Who Have Sex with Men,*[15]states that MSM between the ages of 13 to 24 and 25 to 35 who are African-American and Hispanic are the subgroups at highest risk for contracting HIV.

While DMHAS has a strategy to deploy testing, there does not appear to be a specific outreach approach to these at-risk populations. The SOTA attempts to stay informed and address overlapping activities between DMHAS and the DOH/Division of HIV, STDs, and TB by participating in a quarterly HIV Coordinators conference call when he can. However, because of the tremendous demands on his schedule, his involvement in this meeting is episodic. The Division of HIV, STDs and TBs may be reaching at-risk populations. However, closer coordination is required to determine the efficacy of its efforts. The SOTA also attempts to keep abreast of efforts to broaden testing in the southern part of the state through his membership in the New Jersey Aids Partnerships (NJAP). Currently, NJAP is focused on expanding testing to the migrant population.

Collaboration meetings attended by the Division of HIV, STDs and TBs and local substance abuse treatment providers also focus on coordinating testing at various sites to avoid duplication. Minutes are taken at some collaboration meetings, but not consistently. The SOTA receives a copy when minutes are available. Receiving the minutes on a consistent basis could serve as an additional data source to help inform DMHAS where to deploy testing to avoid duplication and more efficiently and strategically spend SABG and SGF funds for testing.

DMHAS has a MOA with Rutgers—Robert Wood Johnson (RWJ) Medical School, Department of Pathology and Laboratory Medicine to facilitate HIV mobile rapid testing at four licensed residential substance abuse treatment facilities statewide. DMHAS has contracts with 18 other licensed treatment providers and a single prevention agency to provide testing through an MOA. Navigators funded by DOH/Division of HIV, STDs, and TBs also go on-site to licensed treatment agencies to test, provide counseling, and link clients to services. DMHAS testing is not necessarily offered in neighborhoods, locations, or areas frequented by African American and Hispanic men between the ages of 13 and 35.

[14] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,
[15] http://nj.gov/health/aids/documents/men_sex_men_summary_2015.pdf

Table II-9. Conveyance and Monitoring of HIV EIS and Pre- and Post-Test Counseling

Requirement	Evidence of Compliance		Evidence of Non-Compliance		Unknown/ Unable to Determine	
	Conveyance	Monitoring	Conveyance	Monitoring	Conveyance	Monitoring
Appropriate pre-test counseling for HIV and AIDS	X	X				
Testing of individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease	X	X				
Appropriate post-test counseling	X	X				
Appropriate therapeutic measures	X	X				

HIV Pre- and Post-Test Counseling

State Medical Director for Alcohol and Drug Services

DMHAS's State Medical Director (SMD) for alcohol and drug services has served in the position for at least 20 years. The SMD attended the SAMHSA entrance conference, participated in some of the interviews and appears to be readily available and accessible to consult with DMHAS staff.

State Written Protocols for Pre- and Post-Test Counseling and an Informed Consent Form for Testing

DMHAS adopted the Division of HIV, STDs and TBs protocols for pre- and post-testing protocols and its informed consent form for testing. The pre- and post-testing counseling protocols do not require a standard curriculum to provide counseling. However, the protocols require staff delivering the counseling to participate in 5-day training by the Division of HIV, STDs and TBs as a prerequisite for certification. Certification must be renewed every 5 years. Although DMHAS has adopted Division of HIV, STDs and TBs protocols for pre- and post-testing and informed consent, it is recommended that leadership review CDC's 2006 recommendation to use opt-out screening[16] for HIV testing for all pregnant women and everyone between the ages of 13 and 64 years.

[16] Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,

State Policy Regarding Confidentiality, Testing, and Reporting HIV Results

All HIV testing in New Jersey is confidential. Clients must sign a consent form to be tested and PMOs verify that clients have signed informed consents to be tested for HIV during their on-site monitoring reviews. Positive HIV tests are reports to the Division of HIV, STDs and TBs and to CDC.

Recommendation

DMHAS has been strategic and thoughtful in deployment of resources to deliver comprehensive HIV/EIS. This strategy has undoubtedly resulted in an impressively low number of newly diagnosed HIV-positive residents. Only three clients have tested positive in state fiscal year (SFY) 2015. However, the small number of positive results is concerning since it could reflect a need to develop a more robust approach to engage higher risk populations. DMHAS should assess if it is reaching the intended and highest risk populations for HIV/AIDS and STDs by comparing data from the HIV/STD Risk Behavior Screening tool to the number of clients actually testing. Information from this tool could also provide insight into strategies to improve outreach and engagement outcomes, including testing, among high risk populations.

HIV/EIS-funded providers also have low pre-test counseling to conversion rates for testing for HIV. TCT discussed concern regarding the extremely low number of people testing positive in SFY15 and opportunities to better assess whether the population at risk is being reached. Data from the screening tools can supplement the information gathered from client focus groups conducted by Rutgers to explore barriers and reasons why more clients are not taking advantage of HIV testing.

Opioid Treatment

> *Opioid Treatment Programs must meet federal standards in accordance with Part 8—Certification of Opioid Treatment Programs, Subpart B, Section 8.12 Federal Opioid Treatment Standards.*

Methodology

Prior to the on-site review of DMHAS, TCT reviewed the following documentation:

- Substance Abuse Prevention and Treatment Block Grant Draft Manual Template
- Annual Site Visit Monitoring Review Form Template_Rev 2015
- Annual Site Visit POC Acceptance letter_rev2015
- Client File Review Form Revised_022015
- Monitoring Process Word document

During the 2-day visit at the state, the team conducted interviews with the SOTA/HIV Coordinator and the Contract Monitor Supervisor. TCT also visited a MAT that provides

EIS/HIV.

Opioid Treatment Program Standards

Table II-10. Opioid Treatment Program Standards

Do program policies and procedures for opioid treatment meet federal standards (Part 8—Certification of Opioid Treatment Programs, Subpart B, Section 8.12 Federal Opioid Treatment Standards) related to the following:	Yes	No
Patient admission criteria	X	
Diversion control plan	X	
Treatment requirements	X	
Medical, counseling, vocational, and educational services	X	
Initial medical examination	X	
Services for pregnant women	X	
Initial and periodic assessment reflected in treatment plan	X	
Drug testing	X	
Initial dosage levels	X	
Take-home policies—eligibility and procedures	X	

Capacity of Treatment for Intravenous Substance Abusers

> *"States must require programs that receive funding under the grant and treat individuals for intravenous substance abuse to provide to the State, upon reaching 90 percent of its capacity to admit individuals to the program, a notification of that fact within seven days." §96.126—45 CFR, Part 96; Interim Final Rule.*

Table II-11. OTP Capacity and Interim Services

Opioid Treatment Program Capacity	Number of Clients		
What is the current OTP client census?	683		
What is the maximum number of clients the OTP can accommodate?	683		
Capacity and Interim Services Provision	**Yes**	**No**	**Unknown/ Unable to Determine**
Is there a process or procedure in place for when the OTP reaches 90 percent capacity?	Yes		
What happens when the OTP reaches 90 percent capacity? • Notifies the state within 7 days that 90 percent capacity has been reached.	[17]		
• Places the client on a wait list	Yes		
• Nothing			
• Other (please specify)			
If client is placed on a wait list, are interim services provided while the client is awaiting admission to treatment?	No		
Which interim services are provided? • Human immunodeficiency virus (HIV) and tuberculosis (TB)		X	
• The risks of needle sharing		X	
• The risks of transmission to sexual partners and infants		X	
• Steps that can be taken to ensure that HIV transmission does not occur		X	
• Referrals to HIV and TB services, if necessary		X	

[17] Notify SOTA

Table II-12. Capacity Management and Treatment Services for Injection Drug Users

Requirement	Evidence of Compliance		Evidence of Non-Compliance		Unknown/ Unable to Determine	
	Conveyance	Monitoring	Conveyance	Monitoring	Conveyance	Monitoring
State has a capacity management program.	X					
State has established a wait list management program, which provides systematic reporting of treatment demand.						
Wait list includes a unique patient identifier for each injection drug abuser seeking treatment, including those receiving interim services, while awaiting admission to such treatment.						
States are required to ensure that programs receiving funds for treatment services to injection drug users carry out activities to encourage individuals in need of such treatment to undergo such treatment. Programs are required to use outreach models that are scientifically sound; or if no such models are available, which are applicable to the local situation, a program may use an approach that reasonably can be expected to be an effective outreach method. The model shall require that outreach efforts include the following: Selecting, training, and supervising outreach workers	X			X		
Contracting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements, including 42 CFR, Part 2	X			X		
Promoting awareness among intravenous drug abusers about the relationship between injection drug abuse and communicable diseases such as HIV	X			X		

Requirement	Evidence of Compliance		Evidence of Non-Compliance		Unknown/ Unable to Determine	
	Conveyance	Monitoring	Conveyance	Monitoring	Conveyance	Monitoring
Recommending steps that can be taken to ensure that HIV transmission does not occur	X			X		
Encouraging entry into treatment.	X			X		

The OTP executive director stated that the program stopped conducting street outreach targeted to persons who inject drugs when state funding was reduced. TCT was informed that Ryan White grant funded-providers conduct extensive outreach, including street outreach.

Recommendations

Publically funded OTP staff statewide, including front line staff, should be trained on interim services and all other SABG requirements for OTP programs. DMHAS should convene the training periodically to ensure that new hires are aware of the requirements. While TCT understands the difficulty of unfunded mandates, all publically funded OTPs are required to conduct some sort of outreach within reason, given budgetary constraints. The outreach could be as innocuous as reaching out to places where populations at risk for IDUs or active injecting users are detained or are located, such as local jails, homeless shelters, and community corrections facilities.

It is further recommended that DMHAS submit its outreach plan to TCT before the start of the 2017 calendar year in January 2017.

Admission Preferences for Pregnant Women

> *States must assure that "pregnant women are provided preference in admission to treatment centers as provided by §96.131, and are provided interim services as necessary and as required by law." —45 CFR, Part 96; Interim Final Rule*

Conveyance and Monitoring of Admission Preferences Requirements and Interim Services Provision

Table II-13. SSA Conveyance and Monitoring of Admission Preferences for Pregnant Women

Requirement	Evidence of Compliance		Evidence of Non-Compliance		Unknown/ Unable to Determine	
	Conveyance	Monitoring	Conveyance	Monitoring	Conveyance	Monitoring
Pregnant women are provided preference in admission to treatment centers	X[18]	X[19]				
Pregnant women are provided interim services as necessary and as required by law	X[20]	X[21]				
Admission preferences are publicized at facilities. This may be accomplished by means of street outreach programs; ongoing public service announcements (radio/television); regular advertisements in local/regional print media; posters placed in targeted areas; and frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers, and social service agencies.	X[22]	X[23]				

Findings from the Unannounced Compliance Check Calls on Admission Preferences

New Hope Foundation's Epiphany House and Straight and Narrow's Alpha I Program Finding

During the unannounced compliance calls, the respondents at Epiphany House and Straight and Narrow were asked if a fictional prospective client who was pregnant and an IDU would be given priority for treatment admission. The respondent at Epiphany House stated that "there was a 2 week or longer wait list for a bed space for women." The employee at Straight and Narrow stated that "there was a 2 to 4 week waiting period and, therefore, the client would be placed on the wait list." These responses suggest that neither employee was aware that 45 CFR §96.131 mandates that pregnant injecting substance abusers are placed at the top of the waiting list.

[18] In contracts and Annexes
[19] Annual On-site Reviews
[20] In contracts and Annexes
[21] Not consistently
[22] In contracts and Annexes
[23] Could be improved

Recommendation

All employees should be trained on the requirements of 45 CFR §96.131—requirements for admission preference. The training is especially important for personnel who interact with clients, conduct screenings and assessments, coordinate intake and admissions, answer the phone, or provide information to the public. These trainings are important to ensuring that staff respond appropriately when a prospective client is a member of a priority population.

Knowledge of Interim Services and Wait List

Table II-14. Treatment Provider Knowledge and Provision of Interim Services

Knowledge of Interim services includes counseling and education about:	Knowledgeable	Unknowledgeable	Unknown/ Unable to Determine
HIV and TB		X	
The risks of needle sharing		X	
The risks of transmission to sexual partners and infants		X	
Steps that can be taken to ensure that HIV transmission does not occur		X	
Referrals to HIV and TB services, if necessary		X	
The effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women		X	
Provision of Interim Services	**Evidence of Compliance**	**Evidence of Non-Compliance**	**Unknown/ Unable to Determine**
HIV and TB	X		
The risks of needle sharing	X		
The risks of transmission to sexual partners and infants	X		
Steps that can be taken to ensure that HIV transmission does not occur	X		
Referrals to HIV and TB services, if necessary	X		
The effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women	X		
Wait List	**How Many Clients on the Wait List?**	**How Many Days on the Wait List?**	**Did Program Document Interim Services If More than 48 Hours?**
Pregnant		NA	
Pregnant Injection Drug User		NA	

At the time of the review, no pregnant clients were on the wait list but interviews with provider staff indicate that pregnant clients have been placed on a wait list where the wait for an intake exceeded 48 hours. During the wait period, clients were not offered interim services as defined in 42 CFR §96.131. Some of the wait-listed clients resided outside of the immediate area, making the provision of interim services impractical. However, clients local to the provider, particularly for women without prenatal care, should be offered interim services and encouraged to follow up with the local health department for testing. It is unlikely that individuals will be placed on the wait list and not informed about interim services once the IME starts to triage clients. DMHAS should convey the expectation to contracted providers that interim services should be offered and that clients living out of the area should be educated over the phone about interim services and encouraged to follow up with their local health department, or Federally Qualified Health Center.

Findings from the Unannounced Compliance Check Calls on Interim Services

NEW HOPE FOUNDATION'S EPIPHANY HOUSE, NEW JERSEY AND STRAIGHT AND NARROW'S ALPHA I PROGRAM FINDING

The persons with whom the unannounced compliance calls were conducted were asked about interim services that are available to a pregnant IDU while waiting for a bed space. The respondent at one program stated that "the client could contact the outpatient program for services if she wanted to" or "she could be referred to a couple of detox facilities." The staff person at the other program responded that "there may be some outpatient services available, but the client would have to contact the outpatient program herself." Neither employee appeared to know that 45 CFR §96.126 defines interim services as including counseling and education on the following:

- HIV and TB
- The risks of needle sharing
- The risks of transmission to sexual partners
- Steps to be taken to ensure that HIV transmission does not occur
- The effects of alcohol and drugs on the fetus

Recommendations

Employees of all contracted providers should receive training on SABG requirements for interim services for priority clients in accordance with 45 CFR § 96.126. Providers should ensure that the training is provided to employees who interact with clients, including those who conduct screening and assessments, coordinate intake and admissions, answer the phone, or provide information to the public.

Providers should also identify the mechanisms that will be employed to offer education, counseling, and referrals as specified in 45 CFR §96.126. These mechanisms might include, for example, an on-site module or series of modules in pre-treatment readiness groups, or a module in a community-based OP or IOP. The ASVMF includes questions that ask whether interim

services are offered to every prospective client awaiting a bed space in accordance with 45 CFR § 96.126. However, the form does not specify the required interim services. The Notable Practices section of this report provides information on other states' interim services.

Specialized Services for Pregnant Women and Women with Dependent Children

> *"At a minimum, States are required to ensure that treatment programs receiving funding from the Block Grant set aside for pregnant women and women with dependent children for such services also provide or arrange for the following: (1) primary medical care for women who are receiving substance abuse services, including prenatal care, and while women are receiving such treatment, child care; (2) primary pediatric care for their children including immunizations; (3) gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services; (4) therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect; and (5) sufficient case management and transportation services to ensure that women and their children have access to the services provided by (1) through (4)." §96.124—45 CFR, Part 96; Interim Final Rule*

Conveyance and Monitoring of Specialized Services Requirements and Service Provision

Table II-15. SSA Conveyance and Monitoring of Specialized Services for Pregnant and Parenting Women

Requirement	Evidence of Compliance		Evidence of Non-Compliance		Unknown/ Unable to Determine	
	Conveyance	Monitoring	Conveyance	Monitoring	Conveyance	Monitoring
(1) Primary medical care for women who are receiving substance abuse services, including prenatal care, and while women are receiving such treatment, child care	X					
(2) Primary pediatric care for their children including immunizations	X					
(3) Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services	X					

Requirement	Evidence of Compliance		Evidence of Non-Compliance		Unknown/ Unable to Determine	
	Conveyance	Monitoring	Conveyance	Monitoring	Conveyance	Monitoring
(4) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect	X					
(5) Sufficient case management and transportation services to ensure that women and their children have access to the services provided by (1) through (4)	X					

Table II-16. Provider Provision of Specialized Services for Pregnant and Parenting Women

Requirement	Evidence of Compliance	Evidence of Non-Compliance	Unknown/ Unable to Determine
(1) Primary medical care for women who are receiving substance abuse services, including prenatal care, and while women are receiving such treatment, child care	X		
(2) Primary pediatric care for their children including immunizations	X		
(3) Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services	X		
(4) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect	X		
(5) Sufficient case management and transportation services to ensure that women and their children have access to the services provided by (1) through (4)	X		

Findings from the Unannounced Compliance Check Calls on Interim Services

NEW HOPE FOUNDATION'S EPIPHANY HOUSE, NEW JERSEY

FINDINGS

TCT asked the employee answering the unannounced compliance call to describe the types of specialized services that were available to the prospective client who was a pregnant IDU. The employee could not provide any details except to mention that the program was a 28-day residential program once clients were released from detox. The employee did not mention any of the specialized services mandated under 45 CFR §96.124.

Recommendation

Staff should be trained on the 45 CFR §96.124 requirements for specialized services for pregnant women and women with dependent children to ensure that they can appropriately respond to general questions about the interventions offered by the provider.

Access and Location of Programs

TCT shared with the DMHAS Assistant Commissioner several concerns related to the accessibility of services, particularly at the MAT, PPW, and detoxification programs. These concerns included the following:

- Loss of in-house specialized medical providers in addiction management subsequent to loss of DMHAS funding
- Closure of Barnet Hospital which reduced client access to local medical services
- Lack of understanding about the nuances of MAT among local practicing doctors treating pregnant clients since the loss of MAT in-house medical staff
- An abstinence philosophy that bars pregnant clients receiving MAT from being accepted into treatment
- Alleged requirement that clients undergo involuntary withdrawal before admission to a detoxification provider

The Assistant Commissioner provided TCT an update after the on-site monitoring review on the status of DMHAS's inquiry into these concerns. Her verbatim response was as follows:

Saint Clare's (now Prime HealthCare)
Just by way of background, Saint Clare's Hospital was recently purchased by a for-profit organization known as Prime HealthCare.

We have reached out to the NJ Department of Health's manager over the complaints unit who will conduct an investigation. The detox program is also licensed by our Department of Human Services, Office of Licensing (OOL). They (OOL) recently conducted a site visit and did note that the length of time individuals are in their detox program is 2–3 days. They did not see any

evidence that individuals needed to be in withdrawal before they are admitted to the program, however they do start Suboxone on the first day of an individual's admission to the program. We have asked the OOL to explore the requirement for individuals to be in withdrawal prior to admission. The OOL site visit report, with citations, will be issued to Prime HealthCare and the organization will then be required to submit a plan of correction.

Paterson Counseling

We had a conversation with Paterson Counseling about the difficulty they are having in accessing primary care for pregnant women who have an opioid addiction. In response to our conversation we are following up in a number of areas: (1) We learned that they are not in network with any of the managed care organizations (MCO) here in NJ, so they are unable to bill Medicaid for primary health services. They stated that they reached out to the MCOs in the past without response. NJ's Division of Medical Assistance and Health Services (Medicaid) manages the contracts for the MCOs that participate in Medicaid. We reached out to our Medicaid office to ask for assistance in linking Paterson Counseling to the MCOs. The Medical Director for Medicaid, Dr. Lind, has reached out to Bob Alexander (Executive Director of Paterson Counseling) to learn more about their challenges and issues and to provide assistance. (2) We recommended to Mr. Alexander and his staff that they should reach out to their colleague in the southern part of the state to learn about the strategies that this organization used to forge partnerships with primary care providers to support the needs of the women and children they serve. (3) The Division of Mental Health and Addiction Services is a recipient of In Depth Technical Assistance (IDTA) from SAMHSA in the area of Neonatal Abstinence Syndrome/Substance Exposed Infants. As a part of the IDTA initiative we will be convening a forum that will highlight the various projects being implemented across NJ and discussing changes that we will be embarking upon in response to the results of the birth survey we administered. We extended an invitation to Mr. Alexander so that someone from Paterson Counseling can participate in this forum to hear about the initiatives that are underway here in NJ to address this issue. We encouraged him to also invite someone from the primary care clinic that they refer their pregnant mothers to for prenatal care so that they can become more aware of the initiatives that are occurring across the state.

What we did not expressly share with Mr. Alexander is that we will be issuing an RFP for Intensive Case Management with Recovery Supports for Pregnant/Postpartum Women who have an Opioid Dependence. We will issue a minimum of two awards, possibly three, to cover the entire state. This will be an additional resource that Paterson Counseling will be able to access.

Naloxone Availability at Chain Pharmacies

One of the recommendations made at the exit conference was that NJ needs to be more proactive in making naloxone available through partnerships with CVS and other chain pharmacies. CVS already made naloxone available in New Jersey. The DMHAS Medical Director, Department of Human Services Chief of Pharmaceutical Services and State Opioid Treatment Authority will reach out to the Department of Health's Deputy Commissioner for Public Health Services to work together to reach out to the Board of Pharmacy and chain pharmacy associations to move this initiative forward. You mentioned that other states have successfully partnered with their

Board of Pharmacy to move this agenda forward. Can you suggest some states that we should contact to learn more about their efforts?

Table II-17. Statewide 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	6	3	2	11	11
Outpatient Treatment					
Intensive Outpatient Treatment	7	7	7	7	7
Therapeutic Community					
Halfway/Transitional Housing					
Other – Methadone Maintenance	15	15	15	15	15
Other – Case Management/ Recovery Supports	4	4	4	4	4

I. FINANCIAL ELEMENTS OF THE STATE TECHNICAL REVIEW

A. FINANCIAL MANAGEMENT

This section presents the results of the Substance Abuse and Mental Health Services Administration's (SAMHSA) review of the Division of Mental Health and Addiction Services' (DMHAS) fiscal management policies and procedures (P&Ps), information systems, expenditure reports, and supporting documentation related to the state's management of the Substance Abuse Prevention and Treatment Block Grant (SABG).

Objective, Scope, and Methodology

Objective

The objectives were to (1) assess the state's ability to accurately account for and report on SABG and related non-federal expenditures, and (2) determine if the state has complied with grant requirements regarding:

- Activities allowed or unallowed;
- Allowable costs and cost principles;
- Level of effort;
- Earmarking;
- Period of availability of federal funds;
- Financial reporting;
- Special tests and provisions; and
- Sub-recipient monitoring.

Scope

Seven key components of the state's grants management system were reviewed including (1) federal cash management, (2) allocation of federal resources, (3) federal financial reporting, (4) procurement of substance use disorder (SUD) services, (5) sub-award and contract management, (6) sub-recipient monitoring, and (7) SABG compliance. The state's expenditure of SABG funds from the federal fiscal year 2011 (FFY11) through FFY14 awards and related non-federal expenditures for state fiscal year 2011 (SFY11) through SFY15 also were reviewed.

Methodology

Prior to the onsite visit documents provided by DMHAS were reviewed including several tables that reported expenditures for the periods under review. On site, interviews with DMHAS staff were conducted to review the agency's P&Ps related to the seven key system components described above. Documentation for expenditures reported in DMHAS' financial management

systems also was reviewed and those expenditures traced to reports submitted to SAMHSA. In addition, site visits were conducted of three SABG-funded providers: Paterson Counseling, Straight and Narrow Alpha Program, and Good News Home for Woman. During those visits reviews of (1) DMHAS' contracting and sub-recipient monitoring practices, (2) the capability of the sub-recipients to manage block grant funds, and (3) sub-recipient compliance with the terms and conditions of their awards were performed.

Observations

1. **Required Disclosures Not Included in Sub-recipient Agreements (SABG)**

   - **Condition:** In the New Jersey single audit report (SAR) for 2015, the auditors reported that DMHAS did not identify the Catalog of Federal Domestic Assistance (CFDA) title and number or the award name and number for three of the 23 sub-recipients selected for testing.

   - **Criteria:** According to Office of Management and Budget (OMB) Circular A-133 § 400 (d), a pass-through entity is responsible for Award Identification—at the time of the award—identifying to the sub-recipient the federal award information (e.g., CFDA title and number, award name, name of federal agency) and applicable compliance requirements.

   - **Cause:** DMHAS did not have sufficient fiscal controls and accounting procedures to ensure that sub-award agreements contained required disclosures.

   - **Recommendation:** DMHAS should develop and implement P&Ps to ensure that all federal award information is disclosed in sub-recipient awards as required.

2. **SABG and Community Mental Health Services Block Grant (MHBG) Compliance Requirements Not Addressed in P&Ps**

   - **Condition**: During the period under review, DMHAS did not maintain adequate written P&Ps that addressed how the agency complied with SABG and MHBG fiscal requirements including set-asides, maintenance of effort (MOE), federal financial reporting, sub-recipient monitoring, period of availability, allowable and unallowable activities, cash management, and peer reviews. DMHAS staff did provide the review team with a document entitled *Description of Methodologies Used to Calculate Expenditures for Tables 8 through 11* and *Mental Health Block Grant (MHBG) Allocation Methodology and Application Process–Fiscal Instructions*, which was written during the site visit.

- **Criteria**:

    - 45 Code of Federal Regulations (CFR) 96.30 requires that "fiscal controls and accounting procedures be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant."

    - The statutes published at 42 United States Code (USC) 300x *et seq* and the implementing regulations published at 45 CFR part 96 address activities allowed or unallowed, allowable costs and costs principles, MOE and set-aside requirements, period of availability of federal funds, financial reporting requirements, and independent peer reviews.

- **Cause**: DMHAS did not have sufficient fiscal controls and accounting procedures to ensure that the agency develops and implements P&Ps that addressed the SABG and MHBG compliance requirements.

- **Recommendation**: DMHAS should complete and implement comprehensive P&Ps to address the SABG and MHBG fiscal compliance requirements and ensure that the staff administering MHBG and SABG awards is knowledgeable of those requirements. DMHAS should also consider obtaining SAMHSA-sponsored training on block grant requirements to ensure the staff is adequately knowledgeable of the associated requirements.

3. Financial Reporting—Inadequate Supporting Documentation for SABG and MHBG Expenditures Reported to SAMHSA

- **Condition**: DMHAS staff did not have adequate supporting documentation of the methodologies they used to develop MHBG and SABG expenditure reports. In particular, there was limited documentation of the procedures staff used to develop business objects queries.

- **Criteria**: 45 CFR Part 96 § 30(a) states that fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

- **Cause**: DMHAS did not have sufficient fiscal controls and accounting procedures to ensure that DMHAS retained adequate supporting documentation for expenditures reported to SAMHSA.

- **Recommendation**: DMHAS should develop sufficient fiscal controls and accounting procedures to ensure staff maintains sufficient documentation for expenditures reported to SAMHSA.

4. Inconsistent Reporting of SABG Expenditures

- **Condition:** There were multiple inconsistencies in the SABG expenditures reported to SAMHSA on related reports as follows:

  - On Pre-site Table 2, *Summary of State Alcohol & Drug Expenditures by Revenue Sources*, DMHAS reported expending $39,192,072 of SABG funds during SFY14 and $46,479,126 of SABG funds during SFY15. The reported expenditure amounts were equal to the amounts reported on Table 2, *State Agency Expenditure Report* (SAER) in the FFY15 and FFY16 *SABG Behavioral Health Reports* (SBHR) but less than the amount reported on the *Schedule of Expenditures of Federal Awards* (SEFA) in the State of New Jersey single audit reports (SAR) for the same periods ($45,776,472; $47,494,347). DMHAS staff indicated that they were unable to reconcile the differences because (1) they were unaware of the source of the numbers that had been reported in the SAR and (2) they did not participate in the process of preparing that report.

  - On Pre-site Table 3, Obligations and Expenditures, DMHAS reported that $46,658,839 of FFY11 SABG funds had been awarded by SAMHSA. The pre-site reported award amount was more than the amount stated on the FFY11 Notice of Grant Award ($46,685,830) and the amount reported on standard form (S.F.) 425, Federal Financial Report (FFR) for FFY11 ($46,685,830).

  - On Pre-site Table 4, *SABG Earmarked and Restricted Expenditures*, Pre-site Table 5, *Primary Prevention Expenditures by Strategy/IOM*, and Pre-site Table 6 *Primary Prevention Expenditures by IOM category*, DMHAS reported expending $11,140,617 of FFY11 SABG funds on primary prevention services. The reported expenditures were less than the amounts reported on Table 4B, *State Agency SABG Expenditure Compliance Report* (ECR) in the FFY14 SBHR ($11,167,608); less than the amounts reported on Table 6a, *Primary Prevention Expenditures Checklist* in the FFY14 SBHR ($11,771,606); and less than the amounts reported on Table 6b, *Primary Prevention Expenditures by IOM Category*, in the FFY 2014 SBHR ($11,751,879).

  - On Pre-site Table 5, *Primary Prevention Expenditures by Strategy/IOM*, DMHAS reported expending $11,140,617 of FFY11 funds on primary prevention services strategies as identified in the table below. The reported expenditures did not reconcile to the amounts reported on Table 6a, *SABG Primary Prevention Expenditures by Strategy/IOM* in the FFY 2014 SBHR as follows:

Comparison of Reported FFY11 Prevention Expenditures by Strategy/IOM		
	Pre-site Table 5	2014 BHR Table 6a
Information Dissemination	$891,248	$941,728
Education	$5,570,308	$5,885,804
Alternatives	$445,624	$470,864
Problem Identification and Referral	$334,218	$353,148
Community-based Processes	$668,436	$706,296
Environmental	$3,230,782	$3,413,766
Section 1928—Tobacco		
Total	$11,140,616	$11,771,606

- Per Pre-site Table 6, *Primary Prevention Expenditures Checklist by IOM Category*, DMHAS reported expending $11,140,617 of FFY11 SABG funds on primary prevention services categories as presented in the table below. The reported expenditures differed from the amounts DMHAS reported on Table 6b, *Primary Prevention Expenditures by IOM Category*, in the FFY14 SBHR as follows:

Comparison of Reported FFY11 Prevention Expenditures by IOM Category		
	Pre-site Table 6	2014 BHR Table 6b
Universal Direct	$3,282,186	$1,699,180
Universal Indirect	$1,809,774	$3,864,080
Selective	$2,253,273	$2,305,412
Indicated	$3,795,384	$3,883,207
Total	$11,140,617	$11,751,879

- On Pre-site Table 7, *SABG MOE Expenditures*, DMHAS initially reported state MOE expenditures for SFY11–SFY15 that differed from amounts DMHAS had reported on Tables 9A/8A, *Maintenance of Effort for State Expenditures for SAPT*, in the 2014–2016 SBHR. After the conclusion of the site visit, DMHAS provided a corrected Pre-site Table 7 with supporting documentation that reported expenditures consistent with the amounts reported in the SBHRs.

- **Criteria:** §30(a) of 45 CFR Part 96states that fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant. Sections 22, 24, 27, 30, and 31 of 42 USC 300x identify SABG and related MOE expenditure requirements.

- **Cause:** DMHAS lacked adequate internal controls to ensure that obligations and expenditures were reported consistently to SAMHSA in federal financial reports, Payment Management System (PMS) reports, single audit reports, and SBHRs. In addition, DMHAS had no policies or procedures to ensure that the reports were complete and accurate before submitting reports to SAMHSA.

- **Recommendation:** DMHAS should develop appropriate internal controls to ensure that (1) expenditures are reported consistently for related reporting requirements, (2) adjustments and modifications to previously reported expenditures are adequately documented, and (3) prior year reports are revised accordingly. DMHAS must also confer with their Center for Substance Abuse Treatment (CSAT) State Project Officer (SPO) to determine which tables in the SBHRs need to be updated based on the results of this review.

5. Inadequate Monitoring of Sub-recipient Audit Reports and Corrective Action Plans (SABG, MHBG)

- **Condition:** DMHAS did not monitor the implementation of corrective action plans by grantees. Also, in the SFY14 SAR for the state of New Jersey, the auditors indicated that DMHAS did not ensure timely receipt and accurate review of audit reports.[24] DMHAS did not conduct desk reviews within the required 6-month period for four of six OMB Circular A-133 reports and desk reviews tested.

- **Criteria:** The following criteria are applicable:

  - Per § 352(d) of 45 CFR Part 75, pass-through entities must monitor the activities of the sub-recipient as necessary to ensure that the sub-award is used for authorized purposes, in compliance with federal statues, regulations, and the terms and conditions of the sub-award; and that sub-award performance goals are achieved. Pass-through entity monitoring of the sub-recipient must include following-up and ensuring that the sub-recipient takes timely and appropriate action on all deficiencies pertaining to the federal award provided to the sub-recipient from the pass-through entity detected through audits, onsite reviews, and other means.

  - Per § 508 of 45 CFR Part 75, Auditee responsibilities, the auditee must promptly follow up and take corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan.

  - Per the DMHAS document entitled *Review of Agency Annual Audit Reports, Corrective Action Plan and Issuance of Management Decision of Audit Findings and Index to Internal Policy Manual*, dated November 1, 2002, DMHAS required providers to submit three copies of their annual SARs to DMHAS. Staff is required to perform a "fiscal viability analysis" comprised of a report review and performance of general financial ratios analysis. The policy manual also indicated that state staff would track and follow up on any corrective actions required for findings pertaining to DMHAS.

[24] Per DMHAS and after the SAMHSA site visit concluded, the DHS Fiscal Office added a full-time Grants Specialist. This individual along with the addition of an Audit Specialist (which is underway) should create sufficient resources to monitor the implementation of corrective action plans.

- Per the *Auditing and Community Contracts Settlement Unit Community Agency close-out/Disposition Review Program*, providers were required to submit a corrective action plan to address each audit finding in the current year's single audit report.

- According to A-133 400 (d), Pass-through entity responsibilities, a pass-through entity shall (1) ensure that sub-recipients expending $500,000 or more in federal awards during the sub-recipient's fiscal year have met the audit requirements of OMB Circular A-133 and that the required audits are completed within 9 months of the end of the sub-recipient' s audit period, (2) issue a management decision on audit findings within 6 months after receipt of the sub-recipient's audit report, and (3) ensure that the sub-recipient takes timely and appropriate corrective action on all audit findings. In cases of continued inability or unwillingness of a sub-recipient to have the required audits, the pass-through entity shall take appropriate action using sanctions.

- **Cause:** DMHAS did not have adequate personnel resources to monitor the implementation of corrective action plans by grantees. In addition, existing personnel did not follow agency policies and procedures.

- **Recommendation:** DMHAS should ensure that staff abides by the agency's P&Ps on audit review.

6. Insufficient State MOE Expenditures (SABG[25])

- **Condition:** On Pre-site Table 7, SABG MOE Expenditures, DMHAS reported expending $102,294,416 to satisfy the SABG state MOE requirement for SFY15. The amount expended was 3.85 percent less than the required amount ($106,386,933). Also, in the SFY15 SAR for the state of New Jersey, the auditors indicated that DMHAS did not meet the MOE requirements for the statewide MOE calculation and the expenditures were less than the required calculated amount. We noted that in February 2016, the month before our review was conducted that the State submitted a waiver request to SAMHSA for the state MOE.

- **Criteria:** 42 USC 300x-30; 45 CFR sections 96.121 and 96.134; and *Federal Register*, July 6, 2001, (66 FR 35658) and November 23, 2001, (66 FR 58746-58747) identify the MOE expenditures requirements for state expenditures for authorized activities and substance abuse treatment services. The principal agency of a state for carrying out authorized activities shall for each fiscal year maintain aggregate state expenditures by the principal agency for authorized activities at a level that is not less than the average level of such expenditures maintained by the state for the 2-year period preceding the

[25] This condition will not change, especially since this is a repeat finding per the Single Audit Report in SFY 15. However, we made note to add the above comment to recognize the waiver request to SAMHSA a month before our review was conducted.

fiscal year for which the state is applying for the grant.

- **Cause:** DMHAS did not have adequate internal controls to ensure that the state maintained expenditure levels in accordance with SABG requirements. The State explained that material compliance and exclusion of funds led to a shift in funding from DMHAS to Department of Children & Families (DCF).

- **Recommendation:** DMHAS must develop and implement internal accounting controls to ensure the state MOE requirement is met. DMHAS staff should also confer with the SPO for New Jersey to determine what corrective actions need to be taken to remedy the issue. In addition, the State should follow up whether SAMHSA has made a decision regarding the State's state MOE waiver request submitted February 2016 for SFY 2015.

7. Insufficient SFY15 MOE Expenditures for Tuberculosis (TB) Services (SABG)

- **Condition:** On Pre-site Table 7, SABG MOE Expenditures for TB, DMHAS reported expending $200,243 to satisfy the SABG state TB MOE requirement for SFY15. The amount expended was 5.63 percent less than the required amount ($219,948). In addition, in the SFY15 SAR for the state of New Jersey, the auditors indicated that DMHAS did not meet the TB MOE for that year. We noted that in May 2016, two months after our review was conducted that the State submitted a request waiver to SAMHSA for TB MOE waiver during SFY 2015.

- **Criteria:** Per 42 USC 300x-24; 45 CFR section 96.127, the states shall maintain expenditures of non-federal amounts for TB services at a level that is not less than an average of such expenditures maintained by the state for the 2-year period preceding the first fiscal year for which the state receives such a grant.

- **Cause:** DMHAS did not have adequate internal controls to ensure compliance with SABG TB MOE expenditure requirements. Also, the State explained that the population of individuals with the co-morbidity for TB had decreased by almost half since SFY 2012.

- **Recommendation:** DMHAS should develop and implement fiscal controls and accounting procedures to ensure that the agency complies with SABG MOE expenditure requirements. DMHAS staff should also confer with the SPO for New Jersey to determine what corrective actions need to be taken to remedy the issue. In addition, the State should follow up whether SAMHSA has made a decision regarding the State's TB MOE waiver request submitted May 2016 for SFY 2015.

9. Inadequate Monitoring of Sub-awardee Suspension and Debarment Status (SABG)

- **Condition:** The state's audit firm reported a qualified, material weakness in the 2015 and 2014 SARs regarding suspension and debarment certifications. The auditors reported

that there were no suspension and debarment certifications included in the contract files of four of the 25 selected sub-recipients.

- **Criteria:** Per 45 CFR §75.213, Suspension and debarment, non-federal entities are subject to the non-procurement debarment and suspension regulations implementing Executive Orders 12549 and 12689, 2 CFR parts 180 and 376. These regulations restrict awards, sub-awards and contracts with certain parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in federal assistance programs or activities.

- **Cause:** DMHAS did not have adequate internal controls to ensure their contractors were in compliance with suspension and debarment regulations.

- **Recommendation:** DMHAS should develop and implement P&Ps to ensure that the each contractor is vetted and adhere to suspension and debarment guidelines.

B. SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT COMPLIANCE

Substance Abuse Prevention and Treatment Block Grant Expenditure Analysis

Single State Agency Expenditures

Table III-1. Summary of State Alcohol and Drug Expenditures by Revenue Source

Revenue Source	State Fiscal Year 2014	State Fiscal Year 2015
State General Funds	$105,327,776	$102,294,416
Other State Funds (specify)		
SABG Funds	$45,776,472	$46,479,126
Other Federal Funds (specify)	$5,409,058	$5,463,887
Medicaid Funds		
Other (specify)		
Total	$156,513,306	$154,237,429

Obligated and Expended Funds

Table III-2. Summary of Obligated and Expended Funds[26]

Federal Fiscal Year	Total Award	Obligation Period	Amount Obligated	Expenditure Period	Amount Expended
FFY11	$46,658,839	10/01/10–09/30/12	$46,658,839	10/01/10–09/30/12	$46,658,839
FFY12	$46,585,408	10/01/11–09/30/13	$46,585,408	10/01/11–09/30/13	$46,585,408
FFY13	$44,113,252	10/01/12–09/30/14	$44,113,252	10/01/12–09/30/14	$44,113,252
FFY14	$46,349,018	10/01/13–09/30/15	$46,349,018	10/01/13–09/30/15	$46,349,018

State Maintenance of Effort

Table III-3. State MOE Expenditures[27]

Period[28]	State Expenditures[29]	Previous 2-Year Average Expenditures	Difference	Percent Over/(Under) MOE Requirements
SFY11	$98,453,797			
SFY12	$102,776,928			
SFY13	$107,446,089	$100,615,363	$6,830,727	6.79%
SFY14	$105,327,776	$105,111,509	$216,268	0.21%
SFY15	$102,294,416	$106,386,933	($4,092,517)	(3.85%)

[26] Any amounts awarded to the state for a fiscal year shall be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were awarded (42 USC 300x–62).
[27] The state shall for each fiscal year maintain aggregate state expenditures for authorized activities by the principal agency at a level that is not less than the average level of such expenditures maintained by the state for the 2 state fiscal years preceding the fiscal year for which the state is applying for the grant (42 USC 300x–30).
[28] The state fiscal year listed in Table III-3 should cover the two most recently completed state fiscal years.
[29] Actual expenditures listed under the "State Expenditures" column are averaged, and the average of the 2-year period is placed in the "Previous Two-Year Average Expenditures" column on the line next to the fiscal year studied.

Primary Prevention Services and Set-Aside

Table III-4. Twenty Percent Primary Prevention Set-Aside[30]

Year	SABG Award	20 Percent Set-Aside	Actual Expenditure	Difference
FFY11	$46,658,839	$9,331,767.80	$11,140,617	$1,808,849
FFY12	$46,585,408	$9,317,081.60	$13,487,397	$4,170,315
FFY13	$44,113,252	$8,822,650.40	$12,011,726	$3,189,076
FFY14	$46,349,018	$9,269,803.60	$11,893,565	$2,623,761

Table III-5. Primary Prevention Expenditures Checklist[31]

Prevention Strategies	Institute of Medicine Target	FFY11	FFY12	FFY13	FFY14
1. Information Dissemination	Universal	$222,812	NA	NA	NA
	Selective	$334,218	NA	NA	NA
	Indicated	$334,218	NA	NA	NA
	Unspecified		NA	NA	NA
2. Education	Universal	$1,336,874	NA	NA	NA
	Selective	$1,671,092	NA	NA	NA
	Indicated	$2,562,342	NA	NA	NA
	Unspecified		NA	NA	NA
3. Alternatives	Universal	$222,812	NA	NA	NA
	Selective	$222,812	NA	NA	NA
	Indicated		NA	NA	NA
	Unspecified		NA	NA	NA
4. Problem Identification and Referral	Universal		NA	NA	NA
	Selective		NA	NA	NA
	Indicated	$334,218	NA	NA	NA
	Unspecified		NA	NA	NA

[30] The state shall expend not less than 20 percent of SABG for primary prevention programs for individuals who do not require treatment of substance abuse (42 USC 300x–22).
[31] DMHAS was not required to report on both Table III-5 and Table III-6.

Prevention Strategies	Institute of Medicine Target	FFY11	FFY12	FFY13	FFY14
5. Community-Based Processes	Universal	$111,406	NA	NA	NA
	Selective	$222,812	NA	NA	NA
	Indicated	$334,218	NA	NA	NA
	Unspecified		NA	NA	NA
6. Environmental	Universal	$2,785,157	NA	NA	NA
	Selective	$445,625	NA	NA	NA
	Indicated		NA	NA	NA
	Unspecified		NA	NA	NA
7. Section 1926—Tobacco	Universal		NA	NA	NA
	Selective		NA	NA	NA
	Indicated		NA	NA	NA
	Unspecified		NA	NA	NA
8. Other	Universal		NA	NA	NA
	Selective		NA	NA	NA
	Indicated		NA	NA	NA
	Unspecified		NA	NA	NA
Total Prevention Expenditures		$11,140,616	NA	NA	NA

Table III-6. Primary Prevention Expenditures by IOM Category

Activity	SABG Award Year			
	FFY 2011	FFY 2012	FFY 2013	FFY 2014
Universal Direct	$3,282,186	$2,209,870	$2,097,775	$2,025,031
Universal Indirect	$1,809,774	$3,318,608	$3,150,272	$3,041,031
Selective	$2,253,273	$2,425,537	$2,302,502	$2,222,658
Indicated	$3,795,384	$3,741,518	$3,551,731	$3,428,568
Total Prevention Expenditures	$11,140,617	$11,695,533	$11,102,280	$10,717,288

Maintenance of Effort Expenditures for Pregnant Women and Women with Dependent Children

Table III-7. Base Calculation for Pregnant Women and Women with Dependent Children[32]

Period	Base From Prior Year	State Expenditures for Women's Services	SABG Expenditures for Women's Services	SABG 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		$4,624,836
FFY94	$4,624,836			$37,452,980	$1,872,649		$6,497,485

Table III-8. MOE Expenditures for Pregnant Women and Women with Dependent Children[33]

Period	Required Expenditure	Actual Expenditure	Difference	Percentage of Difference
SFY11	$6,497,485	$16,578,077	$10,080,592	155%
SFY12	$6,497,485	$16,338,471	$9,840,986	151%
SFY13	$6,497,485	$17,109,338	$10,611,853	163%
SFY14	$6,497,485	$16,552,432	$10,054,947	155%
SFY15	$6,497,485	$16,142,161	$9,644,676	148%

[32] The state must maintain expenditures at not less than the calculated fiscal year 1994 base amount of substance abuse treatment services for pregnant women and women with dependent children (42 USC 300x–27).
[33] The state must maintain expenditures at not less than the calculated fiscal year 1994 base amount of substance abuse treatment services for pregnant women and women with dependent children (42 USC 300x–27).

Human Immunodeficiency Virus Maintenance of Effort (as required, for designated states only)

Table III-9. HIV MOE Base Calculation[34]

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	$143,954			
SFY92	$187,211			$165,583

Table III-10. HIV MOE Expenditures[35]

Period	State HIV Expenditures	Percent of HIV Clients Who Are Substance Abusers	State HIV Funds for Substance Abusers	MOE Base	Difference
SFY11	$2,334,292	21.04%	$491,200	$165,583	$325,617
SFY12	$2,329,270	24.18%	$563,205	$165,583	$397,622
SFY13	$2,205,663	24.18%	$533,350	$165,583	$367,767
SFY14	$2,317,451	23.00%	$533,000	$165,583	$367,417
SFY15	$2,318,956	17.24%	$399,750	$165,583	$234,167

[34] Designated states shall maintain expenditures of non-federal amounts for HIV services at a level that is not less than the average level of such expenditures maintained by the state for the 2-year period preceding the first fiscal for which state receives such a grant (42 USC 300x–30).
[35] Designated states shall maintain expenditures of non-federal amounts for HIV services at a level that is not less than the average level of such expenditures maintained by the state for the 2-year period preceding the first fiscal for which state receives such a grant (42 USC 300x–30).

Human Immunodeficiency Virus Set-Aside

Table III-11. HIV Set-Aside Expenditures[36]

Period	SABG Award	Required Percentage	Required Expenditure	Actual Expenditure	Difference
FFY11	$46,658,830	5.00%	$2,334,292	$2,334,292	$0
FFY12	$46,585,408	5.00%	$2,329,270	$2,329,270	$0
FFY13	$44,113,252	5.00%	$2,205,663	$2,205,663	$0
FFY14	$46,349,018	5.00%	$2,317,451	$2,317,451	$0

Tuberculosis Maintenance of Effort

Table III-12. TB MOE Base Calculation[37]

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		$208,556	
SFY92	$1,752,586		$231,341	$219,949

[36] Designated states shall expend not less than 2 percent and not more than 5 percent of the award to carry out one or more projects to make available to individuals early intervention services for HIV disease at the sites where the individuals are undergoing substance abuse treatment (42 USC 300X–24).

[37] The state shall maintain expenditures for non-federal amounts for tuberculosis services at a level that is not less than an average of such expenditures maintained by the state for the 2-year period preceding the first fiscal year for which the state services such a grant (42 USC 300x–24; 45 CFR § 96.127).

Table III-13. TB MOE Expenditures[38]

Period	State TB Expenditure	Percent of TB Clients Who Are Substance Abusers	State TB Funds for Substance Abusers	MOE Base	Difference
SFY11	$3,758,480	6.16%	$231,522	$219,948	$11,573
SFY12	$2,994,234	10.40%	$311,401	$219,948	$91,452
SFY13	$3,036,424	8.96%	$272,064	$219,948	$52,115
SFY14	$3,250,250	7.40%	$240,519	$219,948	$20,570
SFY15	$3,556,716	5.63%	$200,243	$219, 948	-$19,705

Administrative Expenses

Table III-14. SABG Administrative Expenditures[39]

Period	Maximum Allowable Expenditure	Actual Expenditure	Difference	Percentage of Difference
FFY11	$2,332,942	$1,182,550	$1,150,392	49%
FFY12	$2,329,270	$818,045	$1,511,225	65%
FFY13	$2,205,663	$833,848	$1,371,815	62%
FFY14	$2,317,451	$1,279,099	$1,038,352	45%

[38] The state shall maintain expenditures for non-federal amounts for TB services at a level that is not less than an average of such expenditures maintained by the state for the 2-year period preceding the first fiscal year for which the state services such a grant (42 USC 300x–24; 45 CFR § 96.127).
[39] The state may not expend more than 5 percent of the grant to pay the costs administering the grant (42 USC 300x–31; 45 CFR § 96.135 (b) (1)).

II. IMPACT OF TECHNICAL ASSISTANCE AND TECHNOLOGY TRANSFER

A. TECHNICAL ASSISTANCE RECOMMENDATIONS MADE DURING PREVIOUS TECHNICAL REVIEWS

New Jersey's previous Technical Review occurred in August 2012 and resulted in three TA recommendations. These recommendations are detailed in Table IV-1.

Table IV-1. TA Addressing Prior Technical Review Recommendations

Technical Review Recommendation	TA Status/Impact	Funder (CSAT/Other)
Substance Abuse Prevention and Treatment Block Grant (SABG) Financial Management—The Division of Mental Health and Addiction Services (DMHAS) could benefit from Center for Substance Abuse Treatment (CSAT)-funded TA to address fiscal management of SABG requirements in collaboration with the Administrative Services Contract (ASC).		
Strategic Mapping and Visioning—DMHAS has requested CSAT-funded TA in strategic visioning and mapping in order to: • More clearly identify what an integrated system in New Jersey would look like in terms of management and organizational functions, practice, delivery platforms, and financing. • Identify the features of the current system that support integration. • Identify opportunities to streamline fiscal reporting and policies that will reduce burden and achieve efficiencies in local service delivery and administration. • Identify what opportunities exist to implement a combined agency culture (e.g., cross-agency training and in-service technology transfer).		

Technical Review Recommendation	TA Status/Impact	Funder (CSAT/Other)
• Anticipate how providers will need to be positioned in the emerging post health care reform environment. • Identify opportunities to improve service coordination and integration at the local level through integrated program policy development. *(TA requested by New Jersey)*		
Cultural Competency—DMHAS has requested CSAT-funded TA to enhance the provider system's capacity to deliver culturally and linguistically competent services. TA may occur in many different forms ranging from TA in developing a cultural competency plan to working with the Northeast and Caribbean Addiction Technology Transfer Center to provide training and education to providers. *(TA requested by New Jersey)*		

New Jersey has not received other CSAT-funded TA deliveries since the last Technical Review.

Table IV-2. Other CSAT-Funded Technical Assistance

Area Addressed by CSAT-Funded TA	TA Status/Impact

B. TECHNOLOGY TRANSFER

Opioid Overdose Recovery Program

In January 2016, DMHAS implemented a new Opioid Overdose Recovery Program initiative at four agencies in four counties. The program is emergency department-based and examines naloxone reversals. Navigators and recovery coaches follow clients who have experienced a naloxone reversal for up to 8 weeks. This important component pairs potential clients with a

coach who has had similar experiences. The coaches provide support and assist the client toward the path to long-term recovery. Some municipalities require first responders to bring clients with reversals to the emergency department. This practice increases the opportunity to connect the individual with treatment services.

Clients who were initially very resistant to treatment are now being connected to detoxification services. DMHAS reports that they are now beginning to see clients move from detoxification into treatment services. The division is looking to expand this program and the Governor's proposed 2017 budget expands the program to six additional counties.

III. TECHNICAL ASSISTANCE RECOMMENDATIONS

Tables V-1 and V-2 on page 96 are to be completed by the designated state official responsible for advising the Center for Substance Abuse Treatment (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 the TA Government Project Officer and CSAT staffs 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. The final version of the Technical Review report will include updated information on the state's TA priorities and delivery timeframe preferences.

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

Needs Assessment

The state has a wealth of data and DMHAS has access to several data sources. Research studies are ongoing and the resultant data are used for needs assessment purposes. However, these research data are not consistently shared with the SUD treatment network or used strategically to address unmet needs, service gaps, or emerging trends. It is strongly recommended that DMHAS:

- Consider methods for sharing data from research studies and other sources with the entire SUD treatment network. Stakeholders can use this information to enhance their internal needs assessment and planning practices, inform their programming, and strengthen their data-driven decision making processes.
- Explore other opportunities to engage participation by, and collect feedback from treatment network stakeholders in the division's needs assessment process.
- Use data for more targeted and strategic purposes to determine if specific unmet needs and service gaps are being addressed and to identify emerging trends. This will assist the division, its partners, and the SUD treatment stakeholders to make informed program modifications to address changes in substances of choice, demographics, staffing patterns, treatment therapies and evidence-based practices (EBPs).

New Jersey Prescription Monitoring Program

It is strongly recommended that DMHAS, in collaboration with DCA, explore approaches to navigating through the New Jersey Prescription Monitoring Program (NJPMP) database and extracting the information for strategic use. Since MAT providers participating in MATOP will be reporting into NJPMP, access to the database will furnish rich and useful information. Examples of how these data can inform decision making include:

- Using NJPMP and MATOP data to examine treatment outcomes for clients being served in the program. This includes reviewing demographic information and exploring whether certain EBPs work for some client populations but not as well for others.
- Using overdose and Narcan™ (naloxone) reversal data to determine if these clients are accessing treatment. Consider exploring admission and treatment completion rates and outcomes achieved in various locations throughout the state (i.e., rural versus urban). Conduct outreach activities in communities where there is unmet need or service gaps, and create pathways into treatment for clients residing in these communities.

DMHAS also is strongly encouraged to work with its CSAT State Project Officer to explore how other states are using PDMPs. Staff expressed an interest in learning how states have implemented comprehensive reporting requirements for prescribers and dispensers of prescription opiate medications, and tracked the sale of opiate medications to individuals, and tracked doctor shopping practices.

State-level Planning—Workforce Planning

Workforce development is a priority area in the DMHAS strategic plan. However, the TCT found that succession planning processes to address workforce shrinkage due to resignations, retirements, and attrition are not in place at either the state or provider levels. Processes and procedures should be documented to ensure that this knowledge remains within the organization and is transferred to the new workforce. It is also strongly recommended that the state consider making succession planning a requirement in the providers' Annex A contract (similar to the requirement for cultural competency plans).

Timeliness and Accuracy of Data

End users expressed that technical support for the NJSAMS and TMS can be unresponsive or time consuming. They cited concerns about trouble ticket cancellations, lack of responses to emails, and being frustrated with telephone technical support. It is strongly recommended that the Office of Information Systems (OIS) consider reviewing TMS data for trends such as the most common problems experienced and the amount of time required to resolve issues. Based on those analyses, OIS could develop FAQs that can be used by system end users to help resolve issues. In addition, OIS should consider instituting a chat box feature within NJSAMS that allows end users to work with technical support staff to resolve issues in real time. If a problem cannot be resolved through the chat box the problem should be escalated. OIS should also consider developing and implementing analytics to monitor the effectiveness and efficiency of trouble ticket resolution through TMS, and use the analytics in TMS continuous quality improvement (CQI) processes.

Data Management Systems Training

It is important to have well trained staff who are able to efficiently and effectively navigate NJSAMS. The addition and implementation of the IME structure elevates this need. NJSAMS training is not mandated by the state; however, one of the visited providers requires training for

system end users. It is strongly recommended that DMHAS consider other training options for users such as:

- Developing a training of trainers (TOT) program and having provider agencies designate one or two staff members, such as the clinical supervisor and credentialed counselor go through the formal trainings when there are system upgrades. These TOTs can, in turn, train internal provider staffs on the system modifications.
- Conducting more training webinars.
- Developing training guides on various topics in addition to the Microsoft PowerPoint presentations for distribution to the provider network.

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

MAT Needs of Emerging and Younger Client Populations

DMHAS is requesting TA or information on how to address the needs and wishes of emerging and younger client populations who are interested in office-based MAT services. DMHAS staffs report that these clients are more inclined to inject opiates and find the requirements pertaining to methadone treatment such as daily dosing at a treatment facility to be inconvenient. DMHAS would like information on how to get these clients into treatment and keep them engaged, especially if methadone is the only available treatment option.

Impact of the Disease of Addiction on the Workforce

DMHAS is requesting TA or information on measuring the impact of the disease of addiction on the workforce in terms of productivity, safety hazards, disruption, health care costs, and the effectiveness of employee assistance programs (EAP). The division also is interested in obtaining information or a menu of community cost offsets that are a consequence of effective SUD treatment, such as costs saved to the tax payer in the immediate locality. DMHAS would ultimately like to conduct a cost-benefit analysis of treatment to explore the overall impact on crime statistics and workforce productivity.

Instructions for the Designated State Agency Official

1. Please review the summary of TA and State-Requested Technical Review recommendations.
2. Please assign a priority number to each TA activity and specify the date (month and year) when you want the TA to be delivered and the State-Requested Technical Review to be conducted.
3. Please sign and send the form to the Technical Review Team Lead as soon as you have made your decisions. If you prefer, you may include the form when you send your Draft 1 report comments to the Team Lead.

Table V-1. New Jersey TA Recommendations Summary[40]

State's TA Priority Number	Technical Review Team's TA Recommendations	State's Preference for TA Delivery (Month/Year)

Table V-2. TA Requested by New Jersey

State's TA Priority Number	TA Requested by New Jersey	State's Preference for TA Delivery (Month/Year)
	Medication-Assisted Treatment Needs of Emerging and Younger Client Populations	
	Impact of the Disease of Addiction on the Workforce	

State Director Signature: _____ Date: _____

[40] There are no recommendations requiring CSAT technical assistance.

APPENDIX A. NEW JERSEY INTERVIEWEE LIST

Representative	Organization
Robert J. Alexander, Executive Director	Paterson Counseling Center, Inc.
Fred Bahrenburg, Fiscal Analyst	Division of Mental Health and Addiction Services
Chiara Barone	Paterson Counseling Center, Inc.
Kathi Bedard, M.A., LCADC, Chief, Special Populations	Division of Mental Health and Addiction Services
Jason Bell	Division of Mental Health and Addiction Services
Shevon Bey, Residential Life Director	Straight and Narrow, Inc.
Roger Borichowski, Acting Deputy Director	Division of Mental Health and Addiction Services
Suzanne Borys, Ed.D., Assistant Director, Office of Planning, Research, Evaluation, and Prevention	Division of Mental Health and Addiction Services
Adam Bucon, L.S.W., State Opioid Treatment Authority and HIV Coordinator	Division of Mental Health and Addiction Services
Dan Burns, Chief Financial Officer	CPC Behavioral Healthcare
Elizabeth Connolly, Acting Commissioner	New Jersey Department of Human Services
Elizabeth A. Conte, M.A., LPC, LCADC, Clinical Workforce Development Specialist	Division of Mental Health and Addiction Services
Rosita M. Cornejo, M.P.H., RDN, CPRP, Director of Quality Assurance	Division of Mental Health and Addiction Services
Robert P. Culleton, Ph.D., Research Scientist I, County Planning Program Manager, Office of Planning, Research, Evaluation, and Prevention	Division of Mental Health and Addiction Services
Ann H. Davis, CDP, CCM, Administrative Director	Good News Home for Women
Sherry R. Dolan, Research Scientist I, Office of Planning, Research, Evaluation, and Prevention	Division of Mental Health and Addiction Services
Joseph F. Duffy, Executive Director	Straight and Narrow, Inc.
Robert Eilers, M.D., Medical Director, Office of the Medical Director	Division of Mental Health and Addiction Services
Norma Feliciano, Director of Nursing	Straight and Narrow, Inc.
Steven Fishbein	Division of Mental Health and Addiction Services
Vicki Fresolone, LCSW, LCADC, Chief of Care Management, Office of the Medical Director	Division of Mental Health and Addiction Services
Nitin Garg, IT Manager, Office of Information Systems	Division of Mental Health and Addiction Services

Representative	Organization
A. Garris, Clinic Director	Paterson Counseling Center, Inc.
Betty Garrison, Chief Financial Officer	Legacy Treatment Services
Kathleen Goat-Delgado, M.A., LPC, LCADC, Contract Monitoring Supervisor	Division of Mental Health and Addiction Services
Manuel Guantez, Psy.D., LCADC, Vice President, Outpatient Services	Rutgers University Behavioral Health Care
Donald K. Hallcon, Ph.D., Director of Prevention and Early Intervention Services	Division of Mental Health and Addiction Services
Kyu Kyu Hlaing, Research Scientist I, Office of Information Systems	Division of Mental Health and Addiction Services
Nancy Hopkins, Manager, Fee for Service Network/Substance Abuse	Division of Mental Health and Addiction Services
Mark Kruszczynski, Ph.D., Research Scientist, Office of Olmstead, Compliance, Planning, and Evaluation	Division of Mental Health and Addiction Services
S. Kuhn, IT Manager and Budgets	Paterson Counseling Center, Inc.
Dana Laclair, Intake Coordinator and Addictions Counselor	Good News Home for Women
Yunqing Li, Ph.D., Research Scientist, Office of Olmstead, Compliance, Planning, and Evaluation	Division of Mental Health and Addiction Services
Ann Miamidian, Vice President, Risk Management	Legacy Treatment Services
Valerie Mielke, M.S.W., Assistant Commissioner	New Jersey Department of Human Services, Division of Mental Health and Addiction Services
Donna Migliorino, R.N., M.P.H., CNA, Deputy Assistant Director, Office of Olmstead, Compliance, Planning, and Evaluation	Division of Mental Health and Addiction Services
Margaret Molnar, B.S., Special Assistant for Consumer Affairs	Division of Mental Health and Addiction Services
Cindy Musso, CADC, Case Manager	Good News Home for Women
Eden Nguyentan, Admissions Coordinator	Straight and Narrow, Inc.
Angela Nikolovski, Coordinator of Special Initiatives	Straight and Narrow, Inc.
Domenica Nicosia, Research Scientist	Division of Mental Health and Addiction Services
Dharmesh Parikh, Chief Financial Officer	Straight and Narrow, Inc.
Toni Pericoloso, Management Information System	Division of Mental Health and Addiction Services
Mahesh Phadke, Office of Information Systems	Division of Mental Health and Addiction Services

Representative	Organization
Laura Pierce-Foglia, Analyst I, HCF	Division of Mental Health and Addiction Services
Patricia Pirylis, Vice President, Fiscal Affairs	Oaks Integrated Service
Suzanne Rainier, M.S.W., Chief, Bureau of Contract Administration	Division of Mental Health and Addiction Services
Brian G. Regan. M.S.C.S., Assistant Division Director, Office of Information Systems	Division of Mental Health and Addiction Services
Harry Reyes, LPC, LCADC, Deputy Assistant Director, Office of Treatment and Recovery Supports	Division of Mental Health and Addiction Services
Reina Rivas, Human Resources Director	Straight and Narrow, Inc.
John Roundtree, M.B.A., Fiscal Analyst	Division of Mental Health and Addiction Services
Patrick Ruff, M.A., LCADC, Addiction Recovery Advocate	Division of Mental Health and Addiction Services
Vera Sansone, Chief Executive Officer	CPC Behavioral Healthcare
Stella Santora, Chief Information Officer	CPC Behavioral Healthcare
Christine K. Scalise, M.A., LPC, LCADC, Manager, Special Initiatives, Women, and Families, Office of Treatment and Recovery Supports	Division of Mental Health and Addiction Services
Matt Shaw, Chief Financial Officer	Division of Mental Health and Addiction Services
Jing Shi, Research Scientist III	Division of Mental Health and Addiction Services
Mian Shi, Accounting Supervisor	Division of Mental Health and Addiction Services
Qindi Shi, Chief Financial Officer	Oaks Integrated Service
Donna Stefanick, M.A., LCADC, Addictions Counselor	Good News Home for Women
Maria Szivos, House Supervisor and Safety Compliance Officer	Good News Home for Women
Tony Tarr, Chief, Auditing and Contract Settlement	Division of Mental Health and Addiction Services
Denise Taylor, R.N., Nursing Supervisor	Good News Home for Women
Gina Tortorelli, Program Supervisor	Straight and Narrow, Inc.
Thomas Tracy, Chief Strategy Officer	Oaks Integrated Service
Andre Valenti, Deputy Assistant Director, Office of the State Hospital	Division of Mental Health and Addiction Services
K. Walker, Director of HIV/AIDS Services and Community Outreach	Paterson Counseling Center, Inc.

Representative	Organization
Yvette Washington, Director of Administrative Services	Paterson Counseling Center, Inc.
John J. White, LPC, LCADC, ACS, Utilization Coordinator, Office of the Medical Director	Division of Mental Health and Addiction Services
Ernestine Winfrey, M.S.W., M.Div., LCSW, ACSW, LCADC, CCS, Executive Director	Good News Home for Women
Tiffany Woodard, Clinical Director	Straight and Narrow, Inc.
Limei Zhu, Research Scientist I, Office of Planning, Research, Evaluation, and Prevention	Division of Mental Health and Addiction Services

APPENDIX B. ACRONYMS RELEVANT TO THE NEW JERSEY TECHNICAL REVIEW

AEREF	Alcohol Education, Rehabilitation, and Enforcement Fund
ASC	Administrative Services Contract
ASI	Addiction Severity Index
CADAD	county alcohol and drug abuse director
CCBHC	certified community behavioral health clinic
CFDA	Catalog of Federal Domestic Assistance
CFR	Code of Federal Regulations
COOP	continuity of operations plan
CQI	continuous quality improvement
CSAT	Center for Substance Abuse Treatment
DASIE	Division of Addiction Services Income Eligibility
DHS	Department of Human Services
DMAHS	Division of Medical Assistance and Health Services
DMHAS	Division of Mental Health and Addiction Services
DMVA	Department of military and Veterans Affairs
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
EAP	employee assistance program
EBPs	evidence-based practices
ECR	Expenditure Compliance Report
EIS	early intervention services
ETTA	education, training, and technical assistance
FAQs	frequently asked questions
FFR	Federal Financial Report
FFS	fee-for-service
FFY	federal fiscal year
FTE	full-time equivalent
GAS	GPRA Application System
GCADA	Governor's Council on Alcoholism and Drug Abuse
GEMS	Guest and Emergency Medication System
GPRA	Government Performance and Results Act of 1993
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	human immunodeficiency virus
IME	Interim Managing Entity
INP	Immediate Need Profile

IOM	Institute of Medicine
IT	information technology
LACADA	Local Advisory Council on Alcoholism and Drug Abuse
LOCI-2R	Level of Care Index-2R
LOCI-3	Level of Care Index-3
MAT	medication-assisted treatment
MATOP	Medication-Assisted Treatment Outreach Program
MAT-PDOA	Medication-Assisted Treatment-Prescription Drug and Opioid Addiction
MHBG	Community Mental Health Services Block Grant
MIS	management information system
MOA	memorandum of agreement
MOE	maintenance of effort
NAS	neonatal abstinence syndrome
N.J.A.C.	New Jersey Administrative Code
NJ-HSDUH	New Jersey Household Survey on Drug Use and Health
NJPMP	New Jersey Prescription Monitoring Program
NJSAMS	New Jersey Substance Abuse Monitoring System
NOMs	National Outcome Measures
OIS	Office of Information Systems
OMB	Office of Management and Budget
OOL	Office of Licensing
OPREP	Office of Planning, Research, Evaluation, and Prevention
P&Ps	policies and procedures
PAC	Professional Advisory Council
PDMP	prescription drug monitoring program
PMS	Payment Management System
PPW	pregnant and parenting women
RFP	request for proposals
SABG	Substance Abuse Prevention and Treatment Block Grant
SAER	State Agency Expenditure Report
SAR	single audit report
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHR	SABG Behavioral Health Report
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEFA	Schedule of Expenditures of Federal Awards
SEI	substance exposed infant
S.F.	standard form
SFY	state fiscal year

SOMs	state outcome measures
SPO	State Project Officer
SSA	Single State Agency
SSDP	State Systems Development Program
SSN	Social Security Number
SUD	substance use disorder
TA	technical assistance
TB	tuberculosis
TEDS	Treatment Episode Data Set
TMS	Ticket Management System
TOT	training of trainers
UBHC	University Behavioral Health Care
USC	United States Code

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 Block Grant (SABG) 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 in-depth review, and CSAT Technical Reviews, in which CSAT identifies certain issues for review. This review of the New Jersey Division of Mental Health and Addiction Services (DMHAS) is a CSAT 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 the CSAT Division of State and Community Assistance, Performance Measurement Branch. The intended audience is CSAT and the Single State Agency (SSA) responsible for delivering services supported by SABG 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 on-site review, the reviewers examine documents provided by 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 SSA for review and comment. A final report is then produced that incorporates the corrections and revisions agreed to by DMHAS, 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 SABG compliance requirements.

The findings represent organizational development and compliance issues identified in the SABG (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 SABG. This report is intended solely for the use of CSAT, the State of New Jersey, and their appropriate designees.

D. SPECIAL LIMITATIONS

All findings and corresponding tables in this report are designed to capture the static nature of the Technical Review period (March 14–18, 2016), and do not necessarily reflect the current dynamics in New Jersey regarding SSA compliance.

APPENDIX D. UNANNOUNCED COMPLIANCE MONITORING CALL REPORTS

Unannounced Compliance Monitoring Call Report

New Jersey

Good News Home for Women

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Management Branch (PMB) Compliance Team
Authored by: Suzette Brann and Ann Rodrigues

Unannounced Compliance Monitoring Call Report for Good News Home for Women

Date of Calls:	Call 1: February 26, 2016, 1:45–1:48 p.m.; Call 2: March 4, 2016, 2:46 p.m.; Calls 3 and 4: March 10, 2016, 10:42 a.m.
Call Recorded:	Yes
Telephone Number:	908-806-4220 Ext. 223
Address:	33 Bartles Corner Road, Flemington, NJ 08822
Employee Name(s):	Dana
PMB Compliance Team Names:	Suzette Brann, Ann Rodrigues, and Chinomso Nwachuku
Caller(s):	Suzette Brann and Chinomso Nwachuku
Scorer(s):	Ann Rodrigues
Scenario Selected:	Delores
Final Score:	Not applicable (NA)

Please indicate if the employee(s) completed the following during the Unannounced Compliance Monitoring Call check. Each statement is worth three points. Once the scores have been entered, transfer the totals from each section and enter them in the summary rating table below.

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Professional	The employee was courteous.	NA
	The employee supplied his/her name.	NA
	The employee spoke clearly and professionally.	NA
	TOTAL	NA
Client-directed	The employee allowed the caller to direct the type of treatment selected (Detoxification Treatment Center).	NA

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	The employee did not try to redirect or change the caller's choice.	NA
	The employee did not dismiss the caller's choice.	NA
	TOTAL	NA
Accurate	The employee asked questions to determine the caller's needs.	NA
	The employee provided information that was corroborated by information provided by website or other sources.	NA
	The employee answered the questions posed in accordance with information provided by website or other services.	NA
	TOTAL	NA
Appropriate	The information provided was relevant to the treatment options the caller was requesting.	NA
	The employee allowed the caller to guide/redirect the treatment options.	NA
	The employee discussed all possible options available, even treatment options available through other providers.	NA
	TOTAL	NA
Safety	The employee stayed within his/her scope of work.	NA
	The options provided discussed any barriers to treatment.	NA
	The recommended treatment/service options included options to treat mental health issues.	NA
	TOTAL	NA
Service Set Up	Could a screening appointment be scheduled within 24/48/72 hours?	NA
	If space was not available, would the employee have placed the client/caller on a wait list?	NA
	If space was not available, the employee provided options for interim services.	NA
	TOTAL	NA

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	If caller indicates that they were non-English speaker or needed TTA/TTY, accommodations were made.	NA

Summary Rating Table	Not Acceptable (1–4)	Somewhat Acceptable (5–7)	Acceptable (8–9)
Professional	NA	NA	NA
Client-directed	NA	NA	NA
Accurate	NA	NA	NA
Appropriate	NA	NA	NA
Safety	NA	NA	NA
Service Set Up	NA	NA	NA
Overall	NA	NA	NA

Overall Impressions Section

Include impressions of the following with quotes or examples from your conversation:

1. Did the employee(s) you spoke to represent the agency well?

Call 1: Left message for Dana to return the call; she returned the call on February 26, 2016, at 4:33 pm.

Call 2: March 4, 2016. Reached voicemail. No message left.

Call 3: March 10, 2016. Called and reached voicemail.

Call 4: Called and pressed extension for the Admissions Department and the call went to voicemail.

2. Were you transferred to a person who could give you information if he/she was not qualified to give you information?

No.

3. Was the employee professional, client-directed, accurate, appropriate, and knowledgeable about the agency's services?

NA

4. Did the employee give you information about the cost of services or Medicaid/Medicare coverage?

NA

5. Did the employee know the admission preferences?

NA

6. Did the employee mention if specialized services or referrals to specialized services were available? Can a pregnant woman bring her children? For example, were there groups for trauma and mental health diagnoses, child development, human immunodeficiency virus (HIV), etc.? Was there onsite opioid treatment?

NA

7. If no bed space was immediately available, did the employee give you information about the interim services available?

NA

8. Was clear information given about service set up and next steps?

NA

Summary Observations

Areas of Strength

Could not be assessed.

Areas Needing Improvement/Additional Training

The Good News Home for Women program is strongly encouraged to implement a phone system that ensures callers will speak to a live person within a reasonable time frame. Every voicemail system should give the caller the option to go back to the operator if they do not want to leave a

message. The inability to reach a live person, especially if a client is in crisis, can become a serious barrier to treatment. This is exacerbated by the fact that the voicemail message states "that the call will be returned within 1 business day and that leaving multiple messages could delay the process of getting a return call." Additionally, the inability to reach the Admissions Coordinator (assuming that Dana is that person), especially if a client is in crisis, may be a serious barrier to treatment initiation when he or she is deprived of the opportunity to inquire about how the Good News Home for Women Program could service his or her addiction needs. Likewise, a clinician calling on his or her client's behalf would find it very frustrating to call a program on different days and at different times and not be able to speak to a live person on the phone.

List of Programs for Unannounced Compliance Monitoring Calls

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Straight and Narrow Alpha I Program	Passaic	508 Straight Street Paterson, NJ 07503 973-345-6000 Ext. 6229 http://straightandnarrowinc.org/womanstx.php
New Hope Foundation Epiphany House	Monmouth	1110 Grand Avenue Asbury Park, NJ 07712 732-775-0720 http://www.newhopefoundation.org/addiction-recovery-services/rehabilitation-treatment-settings/residential-adult-care/
Good News Home for Women	Hunterdon	33 Bartles Corner Road, Flemington, NJ 08822 908-806-4220 http://www.goodnewshome.org/TreatmentProgram.aspx
Newark Renaissance House Women's Residential Program	Essex	62-80 Norfolk Street Newark, NJ 07103 973-623-3386 Ext. 366 http://www.nrh.org/index.php/our-programs

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
The Lennard Clinic	Essex	461 Frelinghuysen Ave Newark, NJ 07114 973-596-2850 http://thelennardclinic.org/services.html
Paterson Counseling	Passaic	319–321 Main Street, Paterson, NJ 07505 973-523-8316 http://patersoncounseling.org/home.php

Unannounced Compliance Monitoring Call Report

New Jersey

New Hope Foundation Epiphany House

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Management Branch (PMB) Compliance Team
Authored by: Ann Rodrigues and Suzette Brann

Unannounced Compliance Monitoring Call Report for New Hope Foundation Epiphany House

Date of Calls: February 26, 2016

Call Recorded: Yes

Telephone Number: 732-775-0720

Address: 1110 Grand Avenue, Ashbury Park, NJ 07712

Employee Name(s): Employees did not provide their names

PMB Compliance Team Names: Suzette Brann and Ann Rodrigues

Caller(s): Suzette Brann

Scorer(s): Ann Rodrigues

Scenario Selected: Cavelle

Final Score: 17/54

Please indicate if the employee(s) completed the following during the Unannounced Compliance Monitoring Call check. Each statement is worth three points. Once the scores have been entered, transfer the totals from each section and enter them in the summary rating table below.

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Professional	The employee was courteous.	1
	The employee supplied his/her name.	0
	The employee spoke clearly and professionally.	1
	TOTAL	2
Client-directed	The employee allowed the caller to direct the type of treatment selected (Detoxification Treatment Center).	1
	The employee did not try to redirect or change the caller's choice.	1

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	The employee did not dismiss the caller's choice.	1
	TOTAL	3
Accurate	The employee asked questions to determine the caller's needs.	1
	The employee provided information that was corroborated by information provided by website or other sources.	1
	The employee answered the questions posed in accordance with information provided by website or other services.	1
	TOTAL	3
Appropriate	The information provided was relevant to the treatment options the caller was requesting.	1
	The employee allowed the caller to guide/redirect the treatment options.	1
	The employee discussed all possible options available, even treatment options available through other providers.	1
	TOTAL	3
Safety	The employee stayed within his/her scope of work.	2
	The options provided discussed any barriers to treatment.	1
	The recommended treatment/service options included options to treat mental health issues.	1
	TOTAL	4
Service Set Up	Could a screening appointment be scheduled within 24/48/72 hours?	1
	If space was not available, would the employee have placed the client/caller on a wait list?	1
	If space was not available, the employee provided options for interim services.	0
	TOTAL	2
	If caller indicates that they were non-English speaker or needed TTA/TTY, accommodations were made.	NA

Summary Rating Table	Not Acceptable (1–4)	Somewhat Acceptable (5–7)	Acceptable (8–9)
Professional	2		
Client-directed	3		
Accurate	3		
Appropriate	3		
Safety	4		
Service Set Up	2		
Overall	17		

Overall Impressions Section

Include impressions of the following with quotes or examples from your conversation:

1. Did the employee(s) you spoke to represent the agency well?

Call 1: Reached voicemail when selected option "0" to speak to a person.

Call 2: For the second call, the caller was transferred to intake then transferred to a screener. Employees 1 and 2 did not provide their names. Employee 2 was the screener. Both employees were very short and abrupt.

2. Were you transferred to a person who could give you information if he/she was not qualified to give you information?

The caller was transferred from employee 1 intake to employee 2, who then transferred the caller to employee 3 in screening. Employee 3 provided very little information.

3. Was the employee professional, client-directed, accurate, appropriate, and knowledgeable about the agency's services?

No. All of the employees were rude, abrupt, and inpatient. Employee 3, the screener, was not knowledgeable about the services available.

4. Did the employee give you information about the cost of services or Medicaid/Medicare coverage?

No, she did not provide any information on Medicaid/Medicare coverage or eligibility. She did, however, state that they could look at the possible availability of county funds to pay for her treatment.

5. Did the employee know the admission preferences?

No, employee 3 was not aware of the admission preferences. Employee was advised that prospective client was an injecting drug user. She informed the caller that there was a 2 week or longer wait list for detoxification for women because they only have six female beds and a wait list of 400 people.

6. Did the employee mention if specialized services or referrals to specialized services were available? Can a pregnant woman bring her children? For example, were there groups for trauma and mental health diagnoses, child development, human immunodeficiency virus (HIV), etc.? Was there onsite opioid treatment?

Employee 3 did not mention any specialized services, even when specifically asked. She stated that the prospective client would have to go to detoxification then they would be able to transfer the client to the facility. She informed the caller that it is a 28-day program following detoxification.

7. If no bed space was immediately available, did the employee give you information about the interim services available?

No, she said “there was a minimum of a 2 week waiting period for detox” and when asked about interim services, the caller was told the prospective client “could contact the outpatient program for services if she wanted to” or she could refer her to a couple of detoxification facilities. She provided the contact information for two detoxification facilities, Bergen Pine and Summit Oak. She could not articulate what interim services were or if there were interim services were available.

8. Was clear information given about service set up and next steps?

No. Employee 3 did not provide any information on next steps or the admissions process.

Summary Observations

Areas of Strength

None.

Areas Needing Improvement/Additional Training

1. Employees did not provide the caller with their names. It is recommended that employees provide their name when answering the phone.

2. The caller had to make two calls to reach a live person. The first call resulted in a voicemail with no option to speak with a live person. The second call was answered by a live person but the caller was then transferred two times.

3. Employees were dismissive and inpatient. It is recommended that employees, especially those conducting screenings exercise compassion, patience, and demonstrate a willingness to listen to the clients. It is recommended that all employees go through customer service training with an emphasis on working with special populations.

4. Employee was not knowledgeable about the admissions priority. All employees, especially those who are providing information to potential clients, should be able to recognize when a prospective client is a member of a priority population. It is recommended that all employees be trained to identify when someone is a member of a priority population and to ask the questions necessary to assess whether a client should be given admission preferences based on their circumstances. Additionally, when dealing with priority populations, it is recommended that employees be able to provide information about interim services, when there is no space or immediate services available.

5. Employee was not able to provide information on the full array of services offered by New Hope Foundation Epiphany House. The website lists the following services:

    a. Adult Residential Care: Provides a variable length of stay (up to 90 days) required for the implementation of personalized treatment plans. Programs include medical assessment and management, individual and group counseling, targeted education, care for families and significant others, case management, discharge and aftercare planning, and appropriate referral and follow-up.

    b. Outpatient Addiction Treatment: Drug screening, assessment and referral, aftercare, individual, group and family counseling, drug-free workplace consultation and prevention, and education services also are available.

    c. Detoxification: Ensures a safe, medically-supervised withdrawal from alcohol and other substances in a comfortable, non-hospital setting. Medical and psychiatric care is provided and nurses and counselors are on-duty round the clock, 7 days a week, for crisis intervention, assessment and intake, counseling, continuing care planning, and appropriate referral.

    It is recommended that employees, especially those conducting intake and screenings, be able to provide information on all available services, including interim services when space is not available for either detoxification or residential treatment.

List of Programs for Unannounced Compliance Monitoring Calls

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Straight and Narrow Alpha I Program	Passaic	508 Straight Street Paterson, NJ 07503 973-345-6000 Ext. 6229 http://straightandnarrowinc.org/womanstx.php
New Hope Foundation Epiphany House	Monmouth	1110 Grand Avenue Asbury Park, NJ 07712 732-775-0720 http://www.newhopefoundation.org/addiction-recovery-services/rehabilitation-treatment-settings/residential-adult-care/
Good News Home for Women	Hunterdon	33 Bartles Corner Road, Flemington, NJ 08822 908-806-4220 http://www.goodnewshome.org/TreatmentProgram.aspx
Newark Renaissance House Women's Residential Program	Essex	62-80 Norfolk Street Newark, NJ 07103 973-623-3386 Ext. 366 http://www.nrh.org/index.php/our-programs
Lennard Clinic	Essex	461 Frelinghuysen Ave Newark, NJ 07114 973-596-2850 http://thelennardclinic.org/services.html
Paterson Counseling	Passaic	319–321 Main Street, Paterson, NJ 07505 973-523-8316 http://patersoncounseling.org/home.php

Unannounced Compliance Monitoring Call Report

New Jersey

Lennard Clinic

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Management Branch (PMB) Compliance Team
Authored by: Chinomso Nwachuku and Ann Rodrigues

Unannounced Compliance Monitoring Call Report for the Lennard Clinic

Date of Calls:	Call 1: February 26, 2016; Call 2: March 5, 2016; Call 3: March 10, 2016, 10:26 a.m.
Call Recorded:	Yes
Telephone Number:	973-596-2850
Address:	461 Frelinghuysen Avenue, Newark, NJ 07114
Employee Name(s):	Not applicable (NA)
PMB Compliance Team Names:	Chinomso Nwachuku, Suzette Brann, and Ann Rodrigues
Caller(s):	Chinomso Nwachuku
Scorer(s):	Ann Rodrigues and Chinomso Nwachuku
Scenario Selected:	Amira
Final Score:	Not Applicable (NA)

Please indicate if the employee(s) completed the following during the Unannounced Compliance Monitoring Call check. Each statement is worth three points. Once the scores have been entered, transfer the totals from each section and enter them in the summary rating table below.

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Professional	The employee was courteous.	NA
	The employee supplied his/her name.	NA
	The employee spoke clearly and professionally.	NA
	TOTAL	NA
Client-directed	The employee allowed the caller to direct the type of treatment selected (Detoxification Treatment Center).	NA

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	The employee did not try to redirect or change the caller's choice.	NA
	The employee did not dismiss the caller's choice.	NA
	TOTAL	NA
Accurate	The employee asked questions to determine the caller's needs.	NA
	The employee provided information that was corroborated by information provided by website or other sources.	NA
	The employee answered the questions posed in accordance with information provided by website or other services.	NA
	TOTAL	NA
Appropriate	The information provided was relevant to the treatment options the caller was requesting.	NA
	The employee allowed the caller to guide/redirect the treatment options.	NA
	The employee discussed all possible options available, even treatment options available through other providers.	NA
	TOTAL	NA
Safety	The employee stayed within his/her scope of work.	NA
	The options provided discussed any barriers to treatment.	NA
	The recommended treatment/service options included options to treat mental health issues.	NA
	TOTAL	NA
Service Set Up	Could a screening appointment be scheduled within 24/48/72 hours?	NA
	If space was not available, would the employee have placed the client/caller on a wait list?	NA
	If space was not available, the employee provided options for interim services.	NA
	TOTAL	NA

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	If caller indicates that they were non-English speaker or needed TTA/TTY, accommodations were made.	NA

Summary Rating Table	Not Acceptable (1–4)	Somewhat Acceptable (5–7)	Acceptable (8–9)
Professional	NA	NA	NA
Client-directed	NA	NA	NA
Accurate	NA	NA	NA
Appropriate	NA	NA	NA
Safety	NA	NA	NA
Service Set Up	NA	NA	NA
Overall	NA	NA	NA

Overall Impressions Section

Include impressions of the following with quotes or examples from your conversation:

1. Did the employee(s) you spoke to represent the agency well?

The employee who the caller spoke to did not represent the agency well based on the information provided below.

First Call: The caller entered a number provided on the prompt for after-hours operation, which led to the "nursing station." The caller spoke to Betty who then transferred the caller to the intake department. Betty did not identify herself until prompted by the caller. The caller was placed on silent hold for 6 minutes and 21 seconds and was not able to speak to a live person at the conclusion of the hold. The caller called back and spoke to Betty again and Betty informed the caller that most intake workers leave at 1:30 pm. Betty then reported that she will check on Simone's availability. Simone is the intake coordinator. The caller was then informed that if Simone is not available at that time, then the caller should call back on Monday, March 7, 2016.

Summary of All Calls: The caller called three times and was only able to speak to a live person one time out of the three times called. The caller called on different days of the week and at different times throughout the day. Furthermore, the extension number provided for the intake coordinator,

Simone, prompted the caller to leave a voicemail.

2. Were you transferred to a person who could give you information if he/she was not qualified to give you information?

No. The caller was placed on hold for over 6 minutes during the first call. In subsequent calls, the caller did not have an opportunity to speak to a live person. The caller was never able to speak with Simone, the intake coordinator.

3. Was the employee professional, client-directed, accurate, appropriate, and knowledgeable about the agency's services?

Betty did not provide information about the agency's services so there was no way to assess the accuracy and appropriateness of the information that she or any other employee would have provided.

4. Did the employee give you information about the cost of services or Medicaid/Medicare coverage?

No. Betty did not provide information about the cost of services or Medicaid/Medicare coverage.

5. Did the employee know the admission preferences?

NA

6. Did the employee mention if specialized services or referrals to specialized services were available? Can a pregnant woman bring her children? For example, were there groups for trauma and mental health diagnoses, child development, human immunodeficiency virus (HIV), etc.? Was there onsite opioid treatment?

NA

7. If no bed space was immediately available, did the employee give you information about the interim services available?

NA

8. Was clear information given about service set up and next steps?

NA

Summary Observations

Areas of Strength

Could not be assessed.

Areas Needing Improvement/Additional Training

The Lennard Clinic is strongly encouraged to implement a phone system that ensures that callers will be able to speak to a live person within a reasonable time frame. The inability to reach a live person, especially if a client is in crisis, can become a serious barrier to treatment. Additionally, the inability to reach the Intake Coordinator (assuming that is Simone's role), especially if a client is in crisis, may be a serious barrier to treatment initiation when he or she is deprived of the opportunity to inquire about how the Lennard Clinic could service his or her addiction needs. Likewise, a clinician calling on his or her client's behalf would find it very frustrating to call a program on different days and at different times and not be able to speak to a live person on the phone.

List of Programs for Unannounced Compliance Monitoring Calls

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Straight and Narrow Alpha I Program	Passaic	508 Straight Street Paterson, NJ 07503 973-345-6000 Ext. 6229 http://straightandnarrowinc.org/womanstx.php
New Hope Foundation Epiphany House	Monmouth	1110 Grand Avenue Asbury Park, NJ 07712 732-775-0720 http://www.newhopefoundation.org/addiction-recovery-services/rehabilitation-treatment-settings/residential-adult-care/
Good News Home for Women	Hunterdon	33 Bartles Corner Road, Flemington, NJ 08822 908-806-4220 http://www.goodnewshome.org/TreatmentProgram.aspx

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Newark Renaissance House Women's Residential Program	Essex	62-80 Norfolk Street Newark, NJ 07103 973-623-3386 Ext. 366 http://www.nrh.org/index.php/our-programs
Lennard Clinic	Essex	461 Frelinghuysen Ave Newark, NJ 07114 973-596-2850 http://thelennardclinic.org/services.html
Paterson Counseling	Passaic	319–321 Main Street, Paterson, NJ 07505 973-523-8316 http://patersoncounseling.org/home.php

Unannounced Compliance Monitoring Call Report

New Jersey

Newark Renaissance House
Women's Residential Program

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Management Branch (PMB) Compliance Team
Authored by: Suzette Brann and Ann Rodrigues

Unannounced Compliance Monitoring Call Report for Newark Renaissance House Women's Residential Program

Date of Calls:	Call 1: February 26, 2016, 1:52–1:53 p.m.; Call 2: March 5, 2016, 2:46 p.m.; Calls 3 and 4: March 10, 2016, 11:15 p.m. and 11:16–11:18 p.m.
Call Recorded:	Yes
Telephone Number:	973-623-3386 Ext. 366
Address:	62–80 Norfolk Street, Newark, NJ 07103
Employee Name(s):	Taneisha, Alissa
PMB Compliance Team Names:	Suzette Brann and Ann Rodrigues
Caller(s):	Ann Rodrigues
Scorer(s):	Suzette Brann
Scenario Selected:	Mary
Final Score:	Not applicable (NA)

Please indicate if the employee(s) completed the following during the Unannounced Compliance Monitoring Call check. Each statement is worth three points. Once the scores have been entered, transfer the totals from each section and enter them in the summary rating table below.

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Professional	The employee was courteous.	NA
	The employee supplied his/her name.	NA
	The employee spoke clearly and professionally.	NA
	TOTAL	NA

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Client-directed	The employee allowed the caller to direct the type of treatment selected (Detoxification Treatment Center).	NA
	The employee did not try to redirect or change the caller's choice.	NA
	The employee did not dismiss the caller's choice.	NA
	TOTAL	NA
Accurate	The employee asked questions to determine the caller's needs.	NA
	The employee provided information that was corroborated by information provided by website or other sources.	NA
	The employee answered the questions posed in accordance with information provided by website or other services.	NA
	TOTAL	NA
Appropriate	The information provided was relevant to the treatment options the caller was requesting.	NA
	The employee allowed the caller to guide/redirect the treatment options.	NA
	The employee discussed all possible options available, even treatment options available through other providers.	NA
	TOTAL	NA
Safety	The employee stayed within his/her scope of work.	NA
	The options provided discussed any barriers to treatment.	NA
	The recommended treatment/service options included options to treat mental health issues.	NA
	TOTAL	NA
Service Set Up	Could a screening appointment be scheduled within 24/48/72 hours?	NA
	If space was not available, would the employee have placed the client/caller on a wait list?	NA
	If space was not available, the employee provided options for interim services.	NA

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	TOTAL	NA
	If caller indicates that they were non-English speaker or needed TTA/TTY, accommodations were made.	NA

Summary Rating Table	Not Acceptable (1–4)	Somewhat Acceptable (5–7)	Acceptable (8–9)
Professional	NA	NA	NA
Client-directed	NA	NA	NA
Accurate	NA	NA	NA
Appropriate	NA	NA	NA
Safety	NA	NA	NA
Service Set Up	NA	NA	NA
Overall	NA	NA	NA

Overall Impressions Section

Include impressions of the following with quotes or examples from your conversation:

1. Did the employee(s) you spoke to represent the agency well?

The employee that the caller spoke to did not represent the agency well based on the information provided below.

Call 1: Taneisha answered the call and transferred the caller to the Women's Services division. Caller was not given the name of the person to whom she would be transferred. Constance's voicemail picked up the call. A message was not left. There was no option to go back to a live person once Constance's voicemail picked up.

Call 2: March 4, (973) 854-8325. Alissa answered the call and said that she was in Adolescent Services and that person to whom all questions concerning admission to the adult residential substance abuse program was Caroline Canada but that she would not be in until Monday, March 7, 2016.

Call 3: Called Caroline Canada and got her voicemail.

Call 4: Called Women's Admission's Department and got voicemail.

2. Were you transferred to a person who could give you information if he/she was not qualified to give you information?

No.

3. Was the employee professional, client-directed, accurate, appropriate, and knowledgeable about the agency's services?

Taneisha and Alissa did not provide information about the agency's services so there was no way to assess the accuracy and appropriateness of the information that she or any other employee would have provided.

4. Did the employee give you information about the cost of services or Medicaid/Medicare coverage?

No.

5. Did the employee know the admission preferences?

NA

6. Did the employee mention if specialized services or referrals to specialized services were available? Can a pregnant woman bring her children? For example, were there groups for trauma and mental health diagnoses, child development, human immunodeficiency virus (HIV), etc.? Was there onsite opioid treatment?

NA

7. If no bed space was immediately available, did the employee give you information about the interim services available?

NA

8. Was clear information given about service set up and next steps?

NA

Summary Observations

Areas of Strength

Could not be assessed.

Areas Needing Improvement/Additional Training

The Newark Renaissance House Women's Residential Program is strongly encouraged to provide more comprehensive training to its front-line staffs to ensure that more staffs would be able to answer basic questions about admission criteria and the agency's service array. Every voicemail system should give the caller the option to go back to the operator if they do not want to leave a message. The inability to reach the intake coordinator (assuming that is Ms. Canada's role), especially if a client is in crisis, may be a serious barrier to treatment initiation when he or she is deprived of the opportunity to inquire about how the Newark Renaissance House Women's Residential Program could service his or her addiction needs. Likewise, a clinician calling on his or her client's behalf would find it very frustrating to call a program on different days and at different times and not be able to speak to a live person on the phone.

List of Programs for Unannounced Compliance Monitoring Calls

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Straight and Narrow Alpha I Program	Passaic	508 Straight Street Paterson, NJ 07503 973-345-6000 Ext. 6229 http://straightandnarrowinc.org/womanstx.php
New Hope Foundation Epiphany House	Monmouth	1110 Grand Avenue Asbury Park, NJ 07712 732-775-0720 http://www.newhopefoundation.org/addiction-recovery-services/rehabilitation-treatment-settings/residential-adult-care/
Good News Home for Women	Hunterdon	33 Bartles Corner Road, Flemington, NJ 08822 908-806-4220 http://www.goodnewshome.org/TreatmentProgram.aspx

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Newark Renaissance House Women's Residential Program	Essex	62-80 Norfolk Street Newark, NJ 07103 973-623-3386 Ext. 366 http://www.nrh.org/index.php/our-programs
Lennard Clinic	Essex	461 Frelinghuysen Ave Newark, NJ 07114 973-596-2850 http://thelennardclinic.org/services.html
Paterson Counseling	Passaic	319–321 Main Street, Paterson, NJ 07505 973-523-8316 http://patersoncounseling.org/home.php

Unannounced Compliance Monitoring Call Report

New Jersey

Paterson Counseling

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Management Branch (PMB) Compliance Team
Authored by: Ann Rodrigues and Suzette Brann

Unannounced Compliance Monitoring Call Report for Paterson Counseling

Date of Calls: February 26, 2016

Call Recorded: No

Telephone Number: 973-523-8316

Address: 319–321 Main Street, Paterson, NJ 07505

Employee Name(s): Laquita and Kiera

PMB Compliance Team Names: Suzette Brann and Ann Rodrigues

Caller(s): Ann Rodrigues

Scorer(s): Suzette Brann

Scenario Selected: Marisol

Final Score: 48/54

Please indicate if the employee(s) completed the following during the Unannounced Compliance Monitoring Call check. Each statement is worth three points. Once the scores have been entered, transfer the totals from each section and enter them in the summary rating table below.

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Professional	The employee was courteous.	3
	The employee supplied his/her name.	3
	The employee spoke clearly and professionally.	3
	TOTAL	9
Client-directed	The employee allowed the caller to direct the type of treatment selected (Detoxification Treatment Center).	3
	The employee did not try to redirect or change the caller's choice.	3

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	The employee did not dismiss the caller's choice.	3
	TOTAL	9
Accurate	The employee asked questions to determine the caller's needs.	3
	The employee provided information that was corroborated by information provided by website or other sources.	3
	The employee answered the questions posed in accordance with information provided by website or other services.	3
	TOTAL	9
Appropriate	The information provided was relevant to the treatment options the caller was requesting.	3
	The employee allowed the caller to guide/redirect the treatment options.	3
	The employee discussed all possible options available, even treatment options available through other providers.	3
	TOTAL	9
Safety	The employee stayed within his/her scope of work.	3
	The options provided discussed any barriers to treatment.	3
	The recommended treatment/service options included options to treat mental health issues.	3
	TOTAL	9
Service Set Up	Could a screening appointment be scheduled within 24/48/72 hours?	Yes, 3
	If space was not available, would the employee have placed the client/caller on a wait list?	Not applicable (NA)
	If space was not available, the employee provided options for interim services.	NA
	TOTAL	3
	If caller indicates that they were non-English speaker or needed TTA/TTY, accommodations were made.	NA

Summary Rating Table	Not Acceptable (1–4)	Somewhat Acceptable (5–7)	Acceptable (8–9)
Professional			9
Client-directed			9
Accurate			9
Appropriate			9
Safety			9
Service Set Up	3[1]		
Overall	3		45

Overall Impressions Section

Include impressions of the following with quotes or examples from your conversation:

1. Did the employee(s) you spoke to represent the agency well?

Employee identified herself as Laquita. She listened to the caller needs and then explained that the caller needed to speak with a counselor. Laquita transferred the caller to Kiera.

2. Were you transferred to a person who could give you information if he/she was not qualified to give you information?

The caller was transferred to the intake counselor, Kiera. Kiera provided detailed information on the methadone program and the requirements for receiving services.

3. Was the employee professional, client-directed, accurate, appropriate, and knowledgeable about the agency's services?

Yes. Kiera listened to the caller's reasons for seeking treatment, specifically that the potential client was an injecting heroin user, 4 months pregnant, and human immunodeficiency virus (HIV) positive. She was able to contextualize Paterson's service offerings with the needs of the client in mind. Kiera was extremely professional and knowledgeable. She provided a thorough explanation of the services available, the intake process, and the requirements for receiving services. She discussed the number of group counseling sessions clients were required to attend as a condition of receiving

[1] The additional questions were not applicable.

services, the length of the program and the milestones, and the availability of a counselor specifically for pregnant women. She demonstrated her knowledge about the admission preferences by clearly stating that as a pregnant injecting heroin user, she would be given priority access to services. Kiera also stated that there was currently no wait list because they increased their admissions capacity. She informed the caller that the client may be eligible for same-day services if she has government issued photo identification and proof of pregnancy. Additionally, Kiera demonstrated her knowledge of other programs that are available to clients, including Eva's Village, which has shelter and inpatient services; Straight and Narrow's Mommy and Me program for women with children; and Turning Point, a detoxification center that uses a different methadone protocol. She detailed the relationship and coordination of services between Paterson and the other programs. Kiera noted that if a client was placed in another program such as a residential program that had its own methadone provider, the client could return to Paterson Counseling upon graduation to continue accessing methadone as clinically indicated. She also explained that Paterson did offer take homes. They initially receive take homes on Saturdays or Sundays; after 90 days they become eligible for take homes as long as they have been in compliance.

4. Did the employee give you information about the cost of services or Medicaid/Medicare coverage?

Yes. Kiera asked the right questions to determine the client's eligibility for Medicaid, Ryan White services for those who are HIV positive, and transportation services through Logisticare for those receiving Medicaid. They do not provide transportation services using Substance Abuse Prevention and Treatment Block Grant (SABG) funds or for non-Medicaid clients.

5. Did the employee know the admission preferences?

Yes.

6. Did the employee mention if specialized services or referrals to specialized services were available? Can a pregnant woman bring her children? For example, were there groups for trauma and mental health diagnoses, child development, human immunodeficiency virus (HIV), etc.? Was there onsite opioid treatment?

Yes. Kiera was well versed on their specialized services and the coordination of services with local inpatient residential treatment programs and their services.

7. If no bed space was immediately available, did the employee give you information about the interim services available?

NA. Same day services were available as of February 26, 2016.

8. Was clear information given about service set up and next steps?

Yes. The client was advised to come in at 6:00 a.m. for intake and assessment. The client would need to bring photo identification and proof of pregnancy. She also stated that the client could opt to bring in any counseling records or other medication when she presented to treatment so that Paterson Counseling would have a fuller picture of her needs.

Summary Observations

Areas of Strength

The intake counselor did an excellent job of detailing the available services, the admissions process, listening, and providing information relevant to the client's circumstances. Similar to the website, Kiera identified the following services:

1. Suboxone® (buprenorphine and naloxone),
2. Methadone maintenance therapy,
3. Mandatory substance abuse counseling,
4. Specialized counselor dedicated to pregnant women,
5. Prenatal care, and
6. An employee assistance program.

Kiera asked the appropriate questions to ascertain what services would be appropriate for the client and identified ways in which services could be coordinated to allow for the client to receive all clinically indicated services, including but not limited to inpatient and residential programming options. She was patient, knowledgeable, engaged, and took the time that was necessary to learn about the client and her needs and situation.

Areas Needing Improvement/Additional Training

None.

List of Programs for Unannounced Compliance Monitoring Calls

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Straight and Narrow Alpha I Program	Passaic	508 Straight Street Paterson, NJ 07503 973-345-6000 Ext. 6229 http://straightandnarrowinc.org/womanstx.php

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
New Hope Foundation Epiphany House	Monmouth	1110 Grand Avenue Asbury Park, NJ 07712 732-775-0720 http://www.newhopefoundation.org/addiction-recovery-services/rehabilitation-treatment-settings/residential-adult-care/
Good News Home for Women	Hunterdon	33 Bartles Corner Road, Flemington, NJ 08822 908-806-4220 http://www.goodnewshome.org/TreatmentProgram.aspx
Newark Renaissance House Women's Residential Program	Essex	62-80 Norfolk Street Newark, NJ 07103 973-623-3386 Ext. 366 http://www.nrh.org/index.php/our-programs
Lennard Clinic	Essex	461 Frelinghuysen Ave Newark, NJ 07114 973-596-2850 http://thelennardclinic.org/services.html
Paterson Counseling	Passaic	319–321 Main Street, Paterson, NJ 07505 973-523-8316 http://patersoncounseling.org/home.php

Unannounced Compliance Monitoring Call Report

New Jersey

Straight and Narrow Alpha I Program

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Management Branch (PMB) Compliance Team
Authored by: Ann Rodrigues and Suzette Brann

Unannounced Compliance Monitoring Call Report for Straight and Narrow Alpha I Program

Date of Calls: February 26, 2016

Call Recorded: Yes

Telephone Number: 973-345-6000

Address: 508 Straight Street, Paterson, NJ 07503

Employee Name(s): Matt, Morea, and Eden

PMB Compliance Team Names: Suzette Brann and Ann Rodrigues

Caller(s): Ann Rodrigues

Scorer(s): Suzette Brann

Scenario Selected: Amira

Final Score: 34/54

Please indicate if the employee(s) completed the following during the Unannounced Compliance Monitoring Call check. Each statement is worth three points. Once the scores have been entered, transfer the totals from each section and enter them in the summary rating table below.

Unannounced Compliance Monitoring Call Scorecard Domains		Score
Professional	The employee was courteous.	3
	The employee supplied his/her name.	1
	The employee spoke clearly and professionally.	2
	TOTAL	6
Client-directed	The employee allowed the caller to direct the type of treatment selected (Detoxification Treatment Center).	2
	The employee did not try to redirect or change the caller's choice.	3

Unannounced Compliance Monitoring Call Scorecard Domains		Score
	The employee did not dismiss the caller's choice.	3
	TOTAL	8
Accurate	The employee asked questions to determine the caller's needs.	2
	The employee provided information that was corroborated by information provided by website or other sources.	2
	The employee answered the questions posed in accordance with information provided by website or other services.	1
	TOTAL	5
Appropriate	The information provided was relevant to the treatment options the caller was requesting.	2
	The employee allowed the caller to guide/redirect the treatment options.	2
	The employee discussed all possible options available, even treatment options available through other providers.	1
	TOTAL	5
Safety	The employee stayed within his/her scope of work.	2
	The options provided discussed any barriers to treatment.	1
	The recommended treatment/service options included options to treat mental health issues.	2
	TOTAL	5
Service Set Up	Could a screening appointment be scheduled within 24/48/72 hours?	3
	If space was not available, would the employee have placed the client/caller on a wait list?	2
	If space was not available, the employee provided options for interim services.	0
	TOTAL	5
	If caller indicates that they were non-English speaker or needed TTA/TTY, accommodations were made.	Not applicable (NA)

Summary Rating Table	Not Acceptable (1–4)	Somewhat Acceptable (5–7)	Acceptable (8–9)
Professional		6	
Client-directed			8
Accurate		5	
Appropriate		5	
Safety		5	
Service Set Up		5	
Overall		26	8

Overall Impressions Section

Include impressions of the following with quotes or examples from your conversation:

1. Did the employee(s) you spoke to represent the agency well?

Call 1: Reached voicemail when option to speak with an intake coordinator was selected. Once the caller reached the voicemail for the intake coordinator, there was no option to return to the main menu.

Call 2: The caller chose "0" and was transferred to Matt, who listened to the caller's needs. Matt then transferred the caller to Morea, a counseling intern, for the Alpha III Mommy and Me program. Upon being transferred, the caller reached Morea's voicemail.

Call 3: The caller direct dialed Ms. Evans' extension, 6533, and once again reached her voicemail.

Call 4: The caller selected "0" to reach and operator and was greeted by Matt, who once again was courteous and polite. He transferred the caller the adult residential treatment program. The caller was greeted by Eden from the adult residential treatment program. Eden only provided her name after being prompted.

2. Were you transferred to a person who could give you information if he/she was not qualified to give you information?

The caller was transferred on call 2 to the counseling intern for the Alpha III Mommy and Me program. On the fourth call, the caller was transferred to the adult residential treatment program

where the call was answered by Eden. Eden was able to provide limited and general information. She was unable to provide information about the specific needs of the client.

3. Was the employee professional, client-directed, accurate, appropriate, and knowledgeable about the agency's services?

Matt was professional, courteous, and listened to the caller's needs to determine the appropriate person to answer the caller's questions. Eden was professional, but could only provide limited information. She was knowledgeable about the basic services offered by the Straight and Narrow Alpha programs but was unable to speak about the eligibility criteria and admission process in detail.

4. Did the employee give you information about the cost of services or Medicaid/Medicare coverage?

No, she did not provide any information on Medicaid/Medicare coverage or eligibility.

5. Did the employee know the admission preferences?

Eden failed to demonstrate knowledge of the admission preferences despite prompting. She stated there was a 2–4 week waiting period. When asked about interim services for a pregnant, injecting drug using woman, she stated there may be some outpatient services available but the prospective client would have to contact the outpatient program. She gave no indication that she knew that the prospective client was a member of a priority population.

6. Did the employee mention if specialized services or referrals to specialized services were available? Can a pregnant woman bring her children? For example, were there groups for trauma and mental health diagnoses, child development, human immunodeficiency virus (HIV), etc.? Was there onsite opioid treatment?

According to Eden, the following services are provided by the Straight and Narrow Alpha Program:

1. 12-Step
2. Relapse prevention
3. Addiction education
4. Trauma-informed care/counseling
5. Mental health counseling
6. Mommy and Me program includes:
    a. 12-Step
    b. Relapse prevention and addiction education
    c. Parenting
    d. Work readiness
    e. Mom's group
    f. Family education group and
    g. Family management group
7. Medication-assistant treatment (MAT) services through their onsite clinic

She stated that she would have to consult with the Director of Women's Treatment to determine if the prospective client is eligible for the Mommy and Me program because it is typically for pregnant and parenting women who have an open Department of Human Services (DHS) case. The purpose

of having the child in treatment together was for the reunification of the parent and child or where there is a custody issue. Eden was not able to provide information on the other programs, Alpha I and II, for which the potential client may be eligible as a pregnant and parenting women who is an injecting drug user. Her focus was on the Mommy and Me program, for which the prospective client was not eligible since she did not have an open DHS case. Eden did not know enough about all of the Straight and Narrow programs to be able to determine which program would be most appropriate for a client with the specific needs being discussed.

7. If no bed space was immediately available, did the employee give you information about the interim services available?

No, she said "there was a 2–4 week waiting period" and when asked about interim services, the caller was told the prospective client "could contact the outpatient program for services if she wanted to."

8. Was clear information given about service set up and next steps?

Yes, Eden outlined the process for admission. She stated the prospective client may call to have an initial screening. After the initial screening, the information from the biopsychosocial is transferred to the medical review team for processing. Once the client is medically approved, she is notified to call and schedule an appointment for admission. She was not able to provide a timeline from screening to admission because she stated "…it varied based on the client's circumstances."

Summary Observations

Areas of Strength

Eden provided a general overview of the program. She provided more extensive details about the services offered by Straight and Narrow III, the Mommy and Me program. The services she listed were supported by the information detailed on the website, which included the following:

1. **Straight and Narrow Alpha Programs General Information:** Women in all three of Straight and Narrow's programs receive gender-specific treatment in an environment that is keenly attuned to the trauma they may have suffered and the mental health issues that may co-exist with their addictive behavior. Each program offers weekly individual, group and didactic sessions that include education about alcohol, tobacco, and other drugs; relapse prevention; anger management; and work readiness. General Educational Development (GED) is provided to anyone who does not have a high school diploma. Medical and psychiatric care is offered in-house for all women while children are seen at Straight and Narrow's pediatric suite.

   Women on psychotropic or necessary life-sustaining medications are welcome in all three programs. Infants and children in the Alpha I and III programs are cared for on site at the agency's licensed La Vida Child Care Center while their mothers are in treatment.

2. **Alpha III: Located in Paterson:**
    a. The Alpha III program is part of a statewide consortium that provides treatment pregnant women and women with children who are Work First participants and have an open DHS case.

    b. Women in the Alpha III program participate in an intensified treatment program that includes education about child development and parenting.

    c. Women on Methadone or Suboxone® (buprenorphine and naloxone) maintenance or detoxification are accepted into the program.

Areas Needing Improvement/Additional Training

1. Employee's name was provided after prompting. It is recommended that employees provide their name when answering the phone.

2. The caller had to make four calls to reach a person who could provide program information. The first three calls resulted in the voicemail for the counseling intern, Morea Evans, with no option to return to the operator. It is recommended that the phone system allow the caller to transfer to an operator when a voicemail is reached or that an alternative contact is provided with the option to transfer to another counselor or both. The inability to reach the person responsible for admissions, especially if a client is in crisis, may be a serious barrier to treatment initiation when he or she is deprived of the opportunity to inquire about how the Straight and Narrow Alpha I Program could service his or her addiction needs. Likewise, a clinician calling on his or her client's behalf would find it very frustrating to have to call a program four times before reaching someone who could answer his or her questions.

3. In accordance with federal requirements, the following is the hierarchy of the admission preferences and priority that should be accorded substance abuse clients seeking residential treatment:

    a. Pregnant injecting substance abusers,
    b. Pregnant substance abusers,
    c. Injecting substance abusers, and
    d. All other substance abusers.

    The employee was not knowledgeable about the admissions priority. All employees, especially those who are providing information to potential clients, should be able to recognize when a prospective client is a member of a priority population. It is recommended that all employees be trained to identify when someone is a member of a priority population and to ask the questions necessary to assess whether a client should be given admission preferences based on their circumstances.

4. According to 45 Code of Federal Regulations (CFR) 96.131, interim services are mandated for clients, especially those who are priority populations and who cannot be placed in a bed immediately. The employee did not seem to be aware of this federal guideline. It is recommended that employees be trained on the availability of interim services to which a member of a priority population will be referred when there is no space or immediate services available.

5. The employee was not able to provide information on the full array of services offered by Straight and Narrow that could service the needs of this client. Employees who are responding to questions from the public should be able to provide information on the full array of services available and identify the services that may be most appropriate for a prospective client (e.g., the employee provided information to a prospective client about the Mommy and Me program but the client is not eligible for this program, and the employees was unable to provide information on alternative programs or services). Although the website lists that child care is available through La Vida Child Care for infants and children of women in the Alpha I and III programs, Eden informed the caller that they did not offer child care services.

6. Eden was not able to provide the basic information about the services offered through the Alpha I and II programs as listed on their website. The website lists the following information about the Alpha I and II programs:

    a. Alpha I (located in Paterson):

        i. Alpha I offers a 6-month residential treatment program for women referred by the drug court and Mutual Agreement Programs, and a 12-month program for women referred by another source;

        ii. Pregnant women are accepted into the program and may keep their children with them after giving birth;

        iii. A woman without care for a pre-school child may apply to bring her child into treatment with her; and

        iv. Women on methadone or Suboxone® (buprenorphine and naloxone) maintenance or detoxification are accepted into the program.

    b. Alpha II (located in Secaucus) offers a 12- month residential treatment program for women and is located on the New Jersey Substance Abuse Treatment Campus.

    It is recommended employees disseminating information to the public or prospective clients are, at a minimum, familiar with the information contained on the website and be able to answer questions about those programs and services offered.

List of Programs for Unannounced Compliance Monitoring Calls

Program Name	County Served	Address, Telephone Number, Uniform Resource Locator (URL)
Straight and Narrow Alpha I Program	Passaic	508 Straight Street Paterson, NJ 07503 973-345-6000 Ext. 6229 http://straightandnarrowinc.org/womanstx.php
New Hope Foundation Epiphany House	Monmouth	1110 Grand Avenue Asbury Park, NJ 07712 732-775-0720 http://www.newhopefoundation.org/addiction-recovery-services/rehabilitation-treatment-settings/residential-adult-care/
Good News Home for Women	Hunterdon	33 Bartles Corner Road, Flemington, NJ 08822 908-806-4220 http://www.goodnewshome.org/TreatmentProgram.aspx
Newark Renaissance House Women's Residential Program	Essex	62-80 Norfolk Street Newark, NJ 07103 973-623-3386 Ext. 366 http://www.nrh.org/index.php/our-programs
Lennard Clinic	Essex	461 Frelinghuysen Ave Newark, NJ 07114 973-596-2850 http://thelennardclinic.org/services.html
Paterson Counseling	Passaic	319–321 Main Street, Paterson, NJ 07505 973-523-8316 http://patersoncounseling.org/home.php

APPENDIX E. DMHAS SUBSTANCE USE TREATMENT PROVIDER PERFORMANCE REPORT, JULY 1, 2014–JUNE 30, 2015

New Jersey Department of Human Services
Division of Mental Health and Addiction Services
Substance Abuse Treatment
State Performance Report

July 1, 2014 - June 30, 2015

October 2015

New Jersey Substance Abuse Monitoring System (NJSAMS)
Substance Abuse Treatment Admissions
State of New Jersey Totals

Admissions: 7/1/2014 - 6/30/2015

Primary Drug		
Alcohol	16,027	26%
Heroin & Other Opiates	29,917	49%
Cocaine	3,255	5%
Marijuana	9,697	16%
Other Drugs	2,022	3%
Intravenous Drug Users	20,881	31%
Level of Care		
Outpatient Care (OP)	21,029	31%
Intensive Outpatient (IOP)	16,147	24%
Partial Hospitalization	1,811	3%
Opioid Maintenance OP	7,369	11%
Opioid Maintenance IOP	563	1%
Extended Care	20	0%
Halfway House	1,911	3%
Long-Term Residential	3,251	5%
Short-Term Residential	6,708	10%
Hospital-Based Residential	17	0%
Detox Residential	7,146	11%
Detox Hospital Inpatient	22	0%
Detox Outpatient Non-Methadone	151	0%
Detox Outpatient Methadone	284	0%
Non-Traditional Program	4	0%
Early Intervention	877	1%
Meth./Subox. Planned in Treatment	12,815	19%
Referral Source		
Self-Referral	17,668	26%
Family/Friend	2,490	4%
Addiction Services Program	6,145	9%
Workforce NJ SAI	3,602	5%
DYFS	3,977	6%
Mental Health	956	1%
Criminal Justice	19,758	29%
IDRC	7,371	11%
Other	5,053	8%
Not Assessed	290	0%
Any Prior Treatment	27,799	41%
Race/Ethnicity		
White (non-Hispanic)	41,123	61%
Black (non-Hispanic)	14,707	22%
Hispanic Origin	10,424	15%
Other	964	1%
Not Assessed	86	0%

Sex		
Male	45,455	68%
Female	21,836	32%
Age at Admission		
Under 18	1,850	3%
18-21	5,355	8%
22-24	7,653	11%
25-29	12,878	19%
30-34	10,669	16%
35-44	13,290	20%
45-54	11,261	17%
55 and over	4,354	6%
Unknown	0	0%
Employment Status		
Unemployed	19,648	29%
Student	2,400	4%
Not in Labor Force	20,831	31%
Employed Full/Part Time	18,239	27%
Not Assessed	6,192	9%
Highest School Grade Completed		
Completed High School	31,433	47%
Some College	12,321	18%
Not Assessed	7,097	11%
Living Arrangement		
Homeless	3,116	5%
Dependent Living/Institution	8,287	12%
Independent Living	50,392	75%
Smoke Tobacco (Yes)	41,589	68%
Legal Problem*		
None	19,397	29%
Probation/Parole	17,063	25%
DWI License Susp.	7,719	11%
Drug Court	8,247	12%
Health Insurance at Admission*		
No Insurance	41,571	62%
Medicaid	19,353	29%
Medicare	1,248	2%
Private Insurance	6,733	10%
Other Insurance	2,191	3%
Treated in County of Residence	40,523	60%

County of Residence								
Atlantic	4,258	6%	Gloucester	2,712	4%	Ocean	6,902	10%
Bergen	2,888	4%	Hudson	3,875	6%	Passaic	3,993	6%
Burlington	2,672	4%	Hunterdon	820	1%	Salem	575	1%
Camden	5,237	8%	Mercer	2,258	3%	Somerset	1,734	3%
Cape May	2,239	3%	Middlesex	4,730	7%	Sussex	1,159	2%
Cumberland	1,969	3%	Monmouth	6,080	9%	Union	3,092	5%
Essex	5,698	8%	Morris	2,531	4%	Warren	935	1%
						Other	953	1%
Month of Admission								
January	5,472	8%	May	5,312	8%	September	5,906	9%
February	5,373	8%	June	5,964	9%	October	5,985	9%
March	6,058	9%	July	5,828	9%	November	5,011	7%
April	5,714	8%	August	5,349	8%	December	5,338	8%

**Totals may be greater than 100% because of multiple responses.*

Unduplicated Clients Admitted = 47,195

Total Admissions = 67,310

New Jersey Substance Abuse Monitoring System (NJSAMS)
Substance Abuse Treatment Discharges
State of New Jersey Totals

Discharges: 7/1/2014 - 6/30/2015

Level of Care		
Outpatient Care (OP)	20,631	32%
Intensive Outpatient (IOP)	15,750	24%
Partial Hospitalization	1,707	3%
Opioid Maintenance OP	6,447	10%
Opioid Maintenance IOP	443	1%
Extended Care	25	0%
Halfway House	1,901	3%
Long-Term Residential	3,280	5%
Short-Term Residential	6,747	10%
Hospital-Based Residential	16	0%
Detox Residential	7,049	11%
Detox Hospital Inpatient	66	0%
Detox Outpatient Non-Methadone	142	0%
Detox Outpatient Methadone	292	0%
Non-Traditional Program	28	0%
Early Intervention	878	1%
Sex		
Male	44,196	68%
Female	21,188	32%
Race/Ethnicity		
White	40,130	61%
Black	14,247	22%
Hispanic	9,931	15%
Other	896	1%
Not Assessed	192	0%
Age at Discharge		
Under 18	1,481	2%
18-21	5,082	8%
22-24	7,302	11%
25-29	12,664	19%
30-34	10,356	16%
35-44	13,057	20%
45-54	11,007	17%
55 and Over	4,453	7%
Unknown	0	0%
Reason for Discharge at Level of Care		
Treatment Plan Completed	33,191	51%

County Of Residence								
Atlantic	4,016	6%	Gloucester	2,705	4%	Ocean	6,724	10%
Bergen	2,747	4%	Hudson	3,645	6%	Passaic	3,724	6%
Burlington	2,386	4%	Hunterdon	821	1%	Salem	592	6%
Camden	5,208	8%	Mercer	2,291	4%	Somerset	1,711	3%
Cape May	2,195	3%	Middlesex	4,554	7%	Sussex	1,145	2%
Cumberland	1,945	3%	Monmouth	5,969	9%	Union	3,127	5%
Essex	5,434	8%	Morris	2,501	4%	Warren	939	1%
						Other	1,023	2%
Month of Discharge								
January	5,362	8%	May	5,591	9%	September	5,461	8%
February	5,081	8%	June	5,954	9%	October	5,626	9%
March	5,650	9%	July	5,640	9%	November	4,957	8%
April	5,560	9%	August	5,159	8%	December	5,361	8%

Significant Problems or Conditions		
Mental Health Problem	13,430	21%
Compulsive Gambling	184	0%
Physical Disability or Handicap	944	1%
Victim of Physical Abuse or Neglect	2,779	4%
Victim of Sexual Abuse	2,141	3%
Pregnancy	520	1%
Suicide Attempt	621	1%
Runaway Behavior	2,554	4%
Neglect or Abuse of Own Children	2,248	3%
Child of Substance Abuser	3,534	5%
Batterer	210	0%
Criminal Activity	10,888	17%
Other	2,557	4%
Client Goal Achievement at Discharge *		
Alcohol or Drug Problem	38,251	62%
Educational	14,762	60%
Employment or Vocational	16,254	55%
Family Situation	21,834	60%
Psychological or Mental Health	20,231	62%
Physical Health	19,642	68%
Legal	21,752	58%
Drug and Alcohol Use at Discharge		
Not Using Alcohol or Drugs	37,986	58%
Using Alcohol	3,708	6%
Using Drugs	10,774	16%
Unknown	14,512	22%
Arrested / Charged with Offense Since Admission		
	1,635	2%
Living Arrangement at Discharge		
Homeless	2,256	3%
Dependent Living/Institution	11,079	17%
Independent Living	50,236	77%
Employment Status at Discharge		
Unemployed	14,947	23%
Student	2,156	3%
Not in Labor Force	23,436	36%
Employed Full/Part Time	22,866	35%
Not Assessed	1,997	3%

* Percentage for goal achievment based on total clients for whom goal was applicable.
All other percentages are based on total discharges.

Unduplicated Clients Discharged = 45,969 **Total Discharges = 65,402**

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Standard/Traditional Outpatient

Discharges	*Admissions*
State	*State*
20,631	21,029

	State
Number of active clients on roster:	14,642

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	16.7%	75.7%	92.4%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	11.6%	76.1%	87.8%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	10.3%	45.9%	56.2%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.9%	11.1%	11.9%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	0.4%	2.0%	2.4%
6. Absolute percent change of clients homeless at admission vs. discharge:	-0.2%	1.7%	1.5%

	State
7. Average length of stay in days:	143
8. Unduplicated number of clients discharged in the time period covered by this review:	19,307
9. Percentage of clients completed treatment plan at this level of care:	54.1%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Intensive Outpatient

Discharges	*Admissions*
State	*State*
15,750	16,147

	State
Number of active clients on roster:	8,395

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	12.8%	78.6%	91.4%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	20.0%	58.8%	78.8%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	10.0%	25.0%	35.0%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	1.4%	5.7%	7.1%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-0.1%	3.5%	3.4%
6. Absolute percent change of clients homeless at admission vs. discharge:	-0.9%	4.2%	3.3%

	State
7. Average length of stay in days:	112
8. Unduplicated number of clients discharged in the time period covered by this review:	14,016
9. Percentage of clients completed treatment plan at this level of care:	36.7%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Partial Hospitalization

Discharges State
1,707

Admissions State
1,811

	State
Number of active clients on roster:	1,105

State Outcome Measures (SOMs)

	State Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	13.9%	76.9%	90.9%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	22.2%	57.8%	80.0%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	4.7%	9.4%	14.1%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.4%	4.6%	5.0%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-1.5%	4.7%	3.2%
6. Absolute percent change of clients homeless at admission vs. discharge:	-1.5%	10.1%	8.6%

	State
7. Average length of stay in days:	124
8. Unduplicated number of clients discharged in the time period covered by this review:	1,587
9. Percentage of clients completed treatment plan at this level of care:	37.5%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Transitional/Extended Care

Discharges	*Admissions*	
State	*State*	
25	20	**Number of active clients on roster:** 62

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	24.0%	76.0%	100.0%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	24.0%	76.0%	100.0%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	12.0%	20.0%	32.0%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	8.0%	20.0%	28.0%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	0.0%	0.0%	0.0%
6. Absolute percent change of clients homeless at admission vs. discharge:	-16.0%	20.0%	4.0%

	State
7. Average length of stay in days:	291
8. Unduplicated number of clients discharged in the time period covered by this review:	25
9. Percentage of clients completed treatment plan at this level of care:	60.0%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Halfway House

Discharges State
1,901

Admissions State
1,911

	State
Number of active clients on roster:	882

State Outcome Measures (SOMs)

	State Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	8.3%	89.4%	97.7%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	25.9%	64.0%	89.9%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	46.4%	2.5%	48.9%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	3.7%	0.9%	4.6%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	0.2%	2.2%	2.4%
6. Absolute percent change of clients homeless at admission vs. discharge:	4.1%	7.2%	11.3%

	State
7. Average length of stay in days:	154
8. Unduplicated number of clients discharged in the time period covered by this review:	1,822
9. Percentage of clients completed treatment plan at this level of care:	55.6%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Long-Term Residential

Discharges	*Admissions*	
State	*State*	
3,280	3,251	**Number of active clients on roster:** 1,684

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	11.1%	88.0%	99.0%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	47.4%	49.6%	97.1%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	0.9%	0.8%	1.7%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	4.8%	1.3%	6.2%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-1.5%	2.3%	0.8%
6. Absolute percent change of clients homeless at admission vs. discharge:	0.4%	10.0%	10.5%

	State
7. Average length of stay in days:	119
8. Unduplicated number of clients discharged in the time period covered by this review:	3,001
9. Percentage of clients completed treatment plan at this level of care:	52.6%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Short-Term Residential

Discharges	*Admissions*
State	*State*
6,747	6,708

	State
Number of active clients on roster:	844

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	25.1%	74.3%	99.4%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	72.5%	26.0%	98.5%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	-0.6%	9.2%	8.5%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	-0.1%	2.5%	2.4%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-6.3%	7.4%	1.0%
6. Absolute percent change of clients homeless at admission vs. discharge:	-5.3%	9.6%	4.3%

	State
7. Average length of stay in days:	24
8. Unduplicated number of clients discharged in the time period covered by this review:	6,163
9. Percentage of clients completed treatment plan at this level of care:	74.8%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Hospital-Based Residential

Discharges	*Admissions*
State	*State*
16	17

	State
Number of active clients on roster:	2

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	0.0%	87.5%	87.5%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	12.5%	81.3%	93.8%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	31.3%	18.8%	50.0%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.0%	0.0%	0.0%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	0.0%	0.0%	0.0%
6. Absolute percent change of clients homeless at admission vs. discharge:	0.0%	0.0%	0.0%

	State
7. Average length of stay in days:	14
8. Unduplicated number of clients discharged in the time period covered by this review:	16
9. Percentage of clients completed treatment plan at this level of care:	75.0%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Detox-Free Standing Residential

Discharges	*Admissions*
State	*State*
7,049	7,146

	State
Number of active clients on roster:	771

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	15.2%	84.3%	99.6%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	49.5%	50.0%	99.4%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	8.3%	7.3%	15.6%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.3%	0.9%	1.2%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-1.9%	3.5%	1.6%
6. Absolute percent change of clients homeless at admission vs. discharge:	-3.1%	5.6%	2.5%

	State
7. Average length of stay in days:	14
8. Unduplicated number of clients discharged in the time period covered by this review:	6,075
9. Percentage of clients completed treatment plan at this level of care:	83.7%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Detox-Hospital Inpatient

Discharges	*Admissions*
State	*State*
66	22

	State
Number of active clients on roster:	455

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	10.6%	80.3%	90.9%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	78.8%	12.1%	90.9%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	-1.5%	10.6%	9.1%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.0%	0.0%	0.0%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-4.5%	4.5%	0.0%
6. Absolute percent change of clients homeless at admission vs. discharge:	-30.3%	30.3%	0.0%

	State
7. Average length of stay in days:	594
8. Unduplicated number of clients discharged in the time period covered by this review:	66
9. Percentage of clients completed treatment plan at this level of care:	15.2%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Detox-Outpatient

Discharges	*Admissions*
State	*State*
142	151

	State
Number of active clients on roster:	25

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	14.8%	79.6%	94.4%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	48.6%	19.7%	68.3%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	-2.8%	52.8%	50.0%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.0%	6.3%	6.3%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	0.0%	2.8%	2.8%
6. Absolute percent change of clients homeless at admission vs. discharge:	-0.7%	0.7%	0.0%

	State
7. Average length of stay in days:	29
8. Unduplicated number of clients discharged in the time period covered by this review:	125
9. Percentage of clients completed treatment plan at this level of care:	66.9%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Opioid-Maintenance Outpatient

Discharges	*Admissions*
State	*State*
6,447	7,369

	State
Number of active clients on roster:	14,438

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	-0.6%	95.7%	95.1%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	32.4%	11.8%	44.2%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	3.3%	27.3%	30.6%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.6%	3.1%	3.7%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-1.0%	5.1%	4.1%
6. Absolute percent change of clients homeless at admission vs. discharge:	-0.9%	4.5%	3.6%

	State
7. Average length of stay in days:	606
8. Unduplicated number of clients discharged in the time period covered by this review:	5,980
9. Percentage of clients completed treatment plan at this level of care:	14.7%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Detox-Methadone Outpatient

Discharges	*Admissions*
State	*State*
292	284

	State
Number of active clients on roster:	348

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	1.0%	87.7%	88.7%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	29.8%	2.1%	31.8%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	0.0%	43.5%	43.5%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	0.0%	3.1%	3.1%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-1.4%	2.1%	0.7%
6. Absolute percent change of clients homeless at admission vs. discharge:	0.3%	1.4%	1.7%

	State
7. Average length of stay in days:	289
8. Unduplicated number of clients discharged in the time period covered by this review:	278
9. Percentage of clients completed treatment plan at this level of care:	15.4%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Non-Traditional Outpatient

Discharges	*Admissions*
State	*State*
28	4

	State
Number of active clients on roster:	425

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	14.3%	85.7%	100.0%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	71.4%	21.4%	92.9%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	-10.7%	17.9%	7.1%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	-3.6%	3.6%	0.0%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-3.6%	3.6%	0.0%
6. Absolute percent change of clients homeless at admission vs. discharge:	-7.1%	10.7%	3.6%

	State
7. Average length of stay in days:	1,451
8. Unduplicated number of clients discharged in the time period covered by this review:	28
9. Percentage of clients completed treatment plan at this level of care:	7.1%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Opioid-Maintenance IOP

Discharges	*Admissions*
State	*State*
443	563

	State
Number of active clients on roster:	865

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	-0.2%	93.0%	92.8%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	32.3%	16.7%	49.0%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	4.5%	17.6%	22.1%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	2.3%	2.3%	4.5%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	0.5%	5.2%	5.6%
6. Absolute percent change of clients homeless at admission vs. discharge:	-1.4%	7.4%	6.1%

	State
7. Average length of stay in days:	513
8. Unduplicated number of clients discharged in the time period covered by this review:	432
9. Percentage of clients completed treatment plan at this level of care:	25.5%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

Division of Mental Health and Addiction Services
Information Systems Management
State Performance Report
General Population

Level of Care: Early Intervention

Discharges	*Admissions*
State	*State*
878	877

	State
Number of active clients on roster:	761

State Outcome Measures (SOMs)

	State		
	Difference	Admission	Discharge
1. Absolute percent change of clients abstinent from alcohol at admission vs. discharge:	20.4%	70.7%	91.1%
2. Absolute percent change of clients abstinent from other drugs at admission vs. discharge:	3.5%	89.4%	92.9%
3. Absolute percent change of clients employed (FT/PT) at admission vs. discharge:	5.1%	59.8%	64.9%
4. Absolute percent change of clients enrolled (FT/PT) in school or job training program at admission vs. discharge:	2.2%	23.9%	26.1%
5. Absolute percent change of clients arrested in prior 30 days at admission vs. discharge:	-0.7%	1.1%	0.5%
6. Absolute percent change of clients homeless at admission vs. discharge:	-0.3%	0.3%	0.0%

	State
7. Average length of stay in days:	103
8. Unduplicated number of clients discharged in the time period covered by this review:	861
9. Percentage of clients completed treatment plan at this level of care:	73.2%

Report Date: 10/2/2015

Additional informative notes

Based on NJSAMS discharges from 07/01/2014 - 06/30/2015. Admissions are linked to the discharges that occurred during this time period. For outcome measures #1, #2, #3, #4 and #9, higher discharge percentages are best. For outcome measures #5 and #6, lower discharge percentages are best.

APPENDIX F. AGENCIES ALLOCATED FOR HIV SERVICES 2016

NJ DMHAS AGENCIES ALLOCATED FOR HIV/AIDS SERVICES

The Lennard Clinic
461 Frelinghuysen Ave
Newark, NJ 07114
(973) 596-2850

John Brooks Recovery Center
20 South Tennessee Ave
Atlantic City, NJ 08401
(609) 347-8615

JSAS Healthcare, Inc.
685 Neptune Blvd.
Neptune, NJ 07754
(732) 988-8877

Spectrum Healthcare
74 Pacific Ave
Jersey City, NJ 07304
(201) 451-2544

Paterson Counseling
319-321 Main St.
Paterson, NJ 07505
(973) 523-8316

Northeast Life Skills
121 Howe Ave
Passaic, NJ 07055
(973) 777-2962

New Horizon
132 Perry St.
Trenton, NJ 08602
(609) 394-8988

Straight and Narrow
508 Straight St.
Paterson, NJ 07503
(973) 345-6000

Somerset Treatment
118 West End Ave.
Somerville, NJ 08876
(908) 722-1232

Inter County Council
482 Kearny Ave.
Kearny, NJ 07032
(201) 998-7422

South Jersey
162 Sunny Slope Dr.
Bridgeton, NJ 08302
(856) 455-5441

Integrity
105 Lincoln Park
Newark, NJ 07102
(973)623-0600

New Brunswick Counseling
320 Suydam St.
New Brunswick, NJ 08901
(732) 246-4025

Organization for Recovery
519 North Ave.
Plainfield, NJ 07060
(908) 769-4700

Urban Treatment Associates
424-432 Market Street
Camden, NJ
(856) 225-0505