New Jersey

Division of Mental Health and Addiction Services

Technical Review Report:
Center for Substance Abuse Treatment
Technical Review

October 2014

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

Contents

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EXHIBITS

I. Executive Summary

Exhibit I-1. State Technical Review Participants

AGENCY NAME:	Division of Mental Health and Addiction Services
LOCATION:	Trenton, New Jersey
DIRECTOR:	Lynn A. Kovich, M.Ed., Assistant Commissioner
REVIEW PERIOD:	August 19–24, 2012
REVIEWERS:	Lawrence Hobdy, M.S., Clinical Management Specialist Kimberly A. Beniquez, M.S., ICADC, ICCDPD, Public Health Advisor, State Project Officer Arnold Crozier, D.M., Public Health Advisor Donnell; Stewart, M.A., Public Health Advisor
DGM PERSONNEL:	Tracie Pogue, Financial Management Analyst

All findings and corresponding tables in this report are designed to capture the static nature of the Technical Review period (August 19–24, 2012), and do not necessarily reflect the current dynamics in New Jersey regarding Single State Authority (SSA) compliance. Please refer to Appendix C for more information on the purpose, methodology, and limitations of the Technical Review.

Substance Abuse Prevention and Treatment Block Grant Compliance

The following tables illustrate the Technical Review team's findings with regard to Substance Abuse Prevention and Treatment Block Grant (SABG) compliance. Table I-1 provides information on compliance with fiscal requirements. Table I-2 provides information on compliance with clinical requirements.

The Technical Review team found the following evidence regarding SSA compliance with the following SABG fiscal requirements:

Table I-1. New Jersey Compliance with SABG Fiscal Requirements

Requirement	Specific Requirement	Evidence of Compliance	Evidence of Non-Compliance	Unknown/ Unable to Determine	Not Applicable (for Non HIV-Designated States)
Maintenance of Effort (MOE)	State	X[1]	X[2]		
	Pregnant women and women with dependent children	X			
	Human immunodeficiency virus (HIV)	X			
	Tuberculosis (TB)	X			
Set-Aside	Primary prevention	X			
	HIV	X			
Fiscal Management	Prohibited expenditures		X[3]		
	Annual audit of New Jersey	X			
	Annual audit of intermediary	Not applicable			
	Financial monitoring of intermediary	Not applicable			
	Financial monitoring of treatment providers	X			

[1]The state met the MOE requirement for state fiscal year 2008 (SFY08), SFY09, and SFY10.

[2]The state did not meet the MOE requirement for SFY11.

[3]Review of subrecipient monitoring activities found that the SSA did not adequately monitor compliance with A-133 audit requirements. Specifically, the provider contracts do not list the SABG prohibited expenditures nor do the monitoring tools list the prohibited expenditures. Therefore, the SSA did not ensure provider compliance with SABG requirements, specifically activities allowed/un-allowed.

The Technical Review team found the following evidence regarding SSA compliance with the following SABG clinical requirements:

Table I-2. New Jersey Compliance with SABG Clinical Requirements

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

National Outcome Measures

Table I-3 illustrates the SSA's readiness to report National Outcome Measures (NOMs) that are currently defined.

Table I-3. Collection of Currently Defined NOMs

Measure	Currently Collected	Plans to Collect	No Plans to Collect	Unknown/Unable to Determine
Abstinence	X			
Employment/Education	X			
Access/Capacity	X			
Retention	X			
Criminal Justice	X			
Housing	X			
Social Connectedness	X			
Cost Effectiveness		X[1]		
Perception of Care	X[2]			
Evidence-Based Practices (EBPs)		X[3]		

[1]The SSA is able to calculate cost effectiveness and can report on this measure when it is fully defined.

[2]The SSA requires providers to conduct perception of care surveys.

[3]The SSA plans to collect and report on the EPBs measure when it is defined.

Appendix A provides a list of the state and local personnel interviewed during the Technical Review, as well as Center for Substance Abuse Treatment (CSAT) personnel who were involved in the entrance and/or exit conference. Appendix B provides a reference list of acronyms relevant to the state of New Jersey. Appendix C includes the purpose, methodology, and limitations of the Technical Review.

II. Elements of the State Technical Review

The objective of this Technical Review is to describe the state's alcohol and drug system; to inform the Substance Abuse and Mental Health Services Administration's 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 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, and
- quality management.

A. Organizational Structure of the State Alcohol and Drug Agency

This section describes the Single State Authority'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.

The Division of Mental Health and Addiction Services (DMHAS) is the designated SSA for New Jersey. The New Jersey Department of Human Services (DHS), the parent agency, is a multi-service agency that includes the following seven major programmatic divisions in addition to DMHAS:

- Division of the Deaf and Hard of Hearing;
- Division of Aging Services;
- Division of Developmental Disabilities;
- Division of Disability Services;
- Division of Family Development, which includes Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program;
- Division of Medical Assistance and Health Services, which includes Medicaid; and
- Commission for the Blind and Visually Impaired.

The DHS Commissioner reports directly to the Governor and is an advocate for addiction treatment, prevention, early intervention and recovery support services. DHS reported that

DMHAS employees are dedicated to New Jersey cities and communities in need of substance abuse treatment. Full-time equivalent staff are organized into the following offices: Office of the Assistant Commissioner; Office of Quality Assurance (OQA); Office of Research, Planning, Evaluation, Information Systems, and Technology (ORPEIST); Office of Information Technology; Office of Treatment and Recovery Support; Office of Licensure and Supportive Housing; and Office of Prevention, Early Intervention, and Community Services.

DMHAS staff indicated that performance management is driving employee functions in which quality management permeates all levels of the organization. Staff members meet monthly to address quality assurance issues in a 360 degree review process to advance treatment performance, and merge decisionmaking data and information from within the division. DMHAS' mission, vision and values as noted below:

Mission

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.

Vision

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. Thorough this new integrated system, DMHAS has the following expectations:

- The service system will provide access to appropriate and effective person-centered, culturally-competent services delivered by a welcoming and well-trained work force at any point of entry; and

- Consumers will be given the tools to achieve wellness and recovery, a sense of personal responsibility, and a meaningful role in the community.

DMHAS staffs reported transparency, accountability, quality, and fairness as critical organizational values, and asserted that these values are the foundation of performance management and data-driven decisionmaking. NOMs are collected by the New Jersey Substance Abuse Monitoring System (NJ-SAMS) and used to assess the effectiveness of treatment programs supported by the Substance Abuse Prevention and Treatment Block Grant (SABG).

Table II-1. Number of SSA-Licensed Sites Throughout the State

Type of Service	Total Number of Sites	Location		Populations Served	
		Urban Sites	Rural Sites	Adults	Adolescents
Detoxification, 24-Hour Hospital Inpatient	2	2	0	2	0
Detoxification, 24-Hour Free-Standing	10	10	0	9	1
Detoxification, Ambulatory	0	0	0	0	0
Rehabilitation, Residential, Hospital	0	0	0	0	0
Rehabilitation, Residential, Long-Term (more than 30 days)	39	19	10	31	8
Rehabilitation, Residential, Short-Term	21	7	10	19	2
Rehabilitation, Intensive Outpatient	257	147	110	257	257
Rehabilitation, Non-Intensive Outpatient	291	163	128	291	291
Halfway/Transitional Housing	24	12	10	24	0
Opioid Replacement Therapy	38	37	1	37	0
Opioid Detoxification	38	37	1	38	0

B. POLICYMAKING STRUCTURE OF THE STATE ALCOHOL AND DRUG AGENCY

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

The DMHAS Assistant Commissioner is responsible for policymaking. The Office of Legal and Regulatory drafts and proposes internal agency policies, which are then signed-off by the Assistant Commissioner, if appropriate. According to law, agency members may draft external rules and policies for New Jersey through a formal and inclusive process with the Office of Legal and Regulatory assistance. The new rules are assessed by an external agency, subject to a 30-day public comment period, and then reviewed before being signed-off by the Assistant Commissioner as a new policy or statute.

Policy guidance is received and encouraged by both ad hoc advisory groups and agency staff members. DMHAS reported that advisory groups provide positive influence on agency members that help them cultivate constructive policies. The ad hoc advisory groups that influence external policies include the Adolescent Task Force; Advisory Committee to Alcohol and Drug Programs for Deaf, Hard of Hearing, and Disabled; Citizens' Advisory Council; Co-Occurring Disorders Task Force; New Jersey Statewide Coalition on Disabilities; and Professional Advisory Committee.

C. EXTERNAL RELATIONSHIPS

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

DMHAS stakeholders, in the prevention and treatment of substance abuse disorders, include 21 New Jersey county social welfare agencies (i.e., welfare, family protection, adolescent and adult mental health, and TANF). External relationships also include law enforcement (i.e., police, courts, and corrections), as well as families, consumers, and providers.

NJ-SAMS is the primary program that collects NOMs data regarding substance abuse treatment programs and services. DMHAS shares information on recovery and resources for recovery support services with external agencies and interagency advisory groups to enhance program services in New Jersey communities. DMHAS staff reported that planning also is used to assist providers and law enforcement support services in the community.

DMHAS stated in their 2012 SABG application that there is a need for collaborative community agreements as substance abuse treatment initiatives are becoming an ever increasing priority. DMHAS staff indicated that DHS expands its influence with sister agencies through collaborative agreements. There are collaborative agreements in effect for interagency programs with the New Jersey Department of Corrections (NJDOC), Department of Children and Families, Division of Consumer Affairs (DCA) within the Department of Law and Public Safety (DLPS), State Board of Marriage and Family Therapy Examiners, and other family-centered programs.

The benefits of mutual agreements are seen in such programs as the Mutual Agreement Program (MAP), jointly developed between the New Jersey State Parole Board (SPB), NJDOC, and DMHAS, to help individuals on parole receive structured residential substance abuse treatment in the community. MAP assists convicted individuals in recovery and helps with addiction-related problems, diminishes recidivism, and reduces the overcrowding of jails and prisons.

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

Agencies Serving	Formal or Informal	Purpose	Source of Funding	Estimated Amount of Funding
Center on Addiction and Substance Abuse	Formal	A 4-year/4-month contract to evaluate three pilot programs for treatment and supportive services for opiate-addicted clients	State funds	$2,419,799
CSC Covansys	Formal	A 3-year contract for fiscal agent to provide claims processing, including receipt, adjudication, payment, and reporting for fee-for-service (FFS) operation of addiction services	State funds (various FFS initiatives)	$502,836

Agencies Serving	Formal or Informal	Purpose	Source of Funding	Estimated Amount of Funding
Division of Youth and Family Services (DYFS)	Formal	Annual memorandum of agreement (MOA) for coordinated, enhanced child welfare substance abuse treatment services for children and families with DYFS cases	State funds	$13,753,335
Department of Health and Senior Services (DHSS)	Formal	Annual MOA for human immunodeficiency virus (HIV) screening for clients in state-funded substance abuse treatment programs and diagnostic tests and services for HIV positive clients in HIV EIS programs	Federal funds	$50,000
DLPS Juvenile Justice Commission (JJC)	Formal	Annual MOA to administer and provide residential treatment services for certain juveniles involved in the juvenile justice system, including juveniles under JJC's direct custody and care	State funds	$233,816
SPB	Formal	Annual MOA to purchase, on a FFS basis, the full continuum of care for parolees	State funds	$2,618,000
Division of Mental Health (DMH)—Care Plus	Formal	Annual MOA between DMH and the Division of Addiction Services (DAS) for co-occurring treatment services	State funds	$88,283
DMH—Maryville	Formal	Annual MOA between DMH and DAS for co-occurring treatment services	State funds	$190,123
NJDOC	Formal	Annual MOA to purchase, on a FFS basis, community-based residential substance abuse treatment for state inmates	State funds	$890,000
Rutgers Center for Alcohol Studies, Education, and Training Division	Formal	Alcohol and drug counselor education for initial and renewal education for licensed and certified counselors and treatment professionals in New Jersey	Federal funds	$26,195

Agencies Serving	Formal or Informal	Purpose	Source of Funding	Estimated Amount of Funding
Rutgers Center for Alcohol Studies, Education, and Training Division	Formal	A 3-year MOA for the Rutgers School of Social Work to provide Masters-level alcohol and drug counselor education within a dual degree program	State funds	$3,400,000
Rutgers University	Formal	A 23-month contract for middle school and high school drug and alcohol study	Federal funds	$472,601
Rutgers University	Formal	A 3-year contract for NJ-SAMS development maintenance; provides the ability to report NOMs related to Substance Abuse and Mental Health Services Administration (SAMHSA)-funded prevention services	Federal funds	$1,301,948
University of Medicine and Dentistry of New Jersey	Formal	A 15-month MOA for rapid HIV testing services	Federal funds	$864,979
University of Medicine and Dentistry of New Jersey	Formal	An 18-month MOA for assessment, counseling, and nicotine replacement treatment for staff and participants in residential programs	Federal funds	$650,000

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.

The New Jersey Legislature has determined that the most need provoking problem facing state residents is alcohol and drugs, as described in New Jersey Statute (NJS) 26:2BB-1. The legislature finds that the cooperation and active participation by all communities is needed to achieve the goal of reducing alcohol and drug use throughout the state. NJS 26:2BB-1 authorizes New Jersey's 21 counties to plan and manage local services for the treatment of individuals with alcohol and drug abuse-related problems, which is funded by formal grant funds. DMHAS has developed a County Comprehensive Plan (CCP) to address unmet needs for alcohol and substance abuse in New Jersey. Across the full spectrum of care, CCP provides county residents with client-centered and Recovery-Oriented Systems of Care conveniently located in communities. Based on a 2010 report on co-occurring disorders (COD), DMHAS added CODs treatment and services for senior populations to the list of unmet needs.

County leaders are encouraged to prepare CCPs for alcohol and drug issues on the basis of a documented need for treatment services in counties across the state. Due to the growing substance abuse population in the state's counties, CCP identifies current and emerging county drug use trends and the availability of substance abuse prevention, early intervention, treatment, and recovery support services across the continuum. DMHAS reported that CCP explores the needs of youth, drivers under the influence, people with disabilities, employees, women, and criminal offenders for early intervention, prevention, and treatment services.

NJ-SAMS is the management program that collects data for the federal Drug and Alcohol Services Information System as part of DMHAS strategic planning. The ORPEIST Information Systems and Technology Unit is responsible for the State Outcome Measurement and Management System (SOMMS) subcontract. SOMMS collects and reports NOMs for substance abuse treatment in New Jersey, and supports the effectiveness of substance abuse programs supported by SABG. NJ-SAMS also supports the Prevention Outcomes Management System (POMS) and the Contract Information Management System (CIMS).

The New Jersey Legislature also established the Alcohol, Education, Rehabilitation, and Enforcement Fund (AEREF) (P.L. 1983, c531 as amended by chapter 51 of P.L. 1983). AEREF requires counties to produce a reasonable plan to expend state dollars to identify treatment needs and close identified system and service gaps. DMHAS reported that AEREF is a non-lapsing, revolving fund equaling 10.75 percent of annual revenues from taxes received on the sale of alcohol in New Jersey. This fund helps deliver comprehensive treatment to alcohol and drug addicted individuals based on community needs and a planning process. Counties must contribute at least 25 percent of their respective annual AEREF allocation when counties contribute revenues.

E. DATA MANAGEMENT

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

DMHAS uses current technology to advance the development of an information system that is flexible and designed to allow for future growth. The NJ-SAMS is Web-based, runs on Structured Query Language 2008 operating in a dot net (.NET) framework, and is Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 Code of Federal Regulations (CFR) compliant. In order to protect NJ-SAMS, servers for the system are housed in the computer center at Rutgers University under a MOA with DMHAS, and protected by both the DMHAS Cisco and Rutgers Cisco firewalls. The DHS Office of Information Technology manages the DHS web and some server functions used by DMHAS, and helps to coordinate the information technology (IT) Steering Committee that recommends DHS IT policies. The IT Steering Committee meets monthly.

DMHAS provides effective monthly training to provider staff responsible for client care. There is additional online training through the DHS Web site that includes NJ-SAMS data entry training.

ORPEIST developed and maintains NJ-SAMS, which is used to collect Treatment Episode Data Set (TEDS) and NOMs. NJ-SAMS provides customized data by county on requested information (i.e., admissions, discharges and discharge outcomes, gender, drug use, and modality) that can be produced for stakeholders by accessing the Web site.

NJ-SAMS was developed to provide information on substance abuse treatment admission as a real-time, Web-based substance abuse data collection reporting system. NJ-SAMS collects basic demographic, financial, clinical, and service information on clients in New Jersey. In 2010, there were approximately 72,000 admissions into treatment with approximately 346 services providers reporting into NJ-SAMS, representing 491 sites with 4,095 users who are password-registered to access NJ-SAMS information. The type of information that can be acquired includes demographic, administrative and management, clinical, and treatment data; financial reports; and outcome measures.

NJ-SAMS is the primary alcohol and drug treatment monitoring information system used for meeting federal, state, county, and local reporting needs. Additionally, since 2009, NJ-SAMS has been enhanced with five new IT systems that support performance management capacity:

- POMS;
- CIMS;
- Guest and Emergency Medication System;
- Clinician Roster Information System ; and
- IDP Client Information System.

NJ-SAMS appears to satisfy the SAMHSA requirements for the reporting of outcome treatment episodes for SABG recipients. DMHAS maintains that the ORPEIST Information Systems and Technology Unit supports program development by maintaining information systems, which support program management operations in all divisions such as substance abuse prevention services, drug courts, and contract management systems, as well as NOMs.

F. FINANCIAL MANAGEMENT

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

Organization

DMHAS is the SSA for substance abuse disorders and the State Mental Health Authority (SMHA) for mental health disorders. DMHAS is responsible for the coordination, administration, management, and supervision of the institutional and community public mental health system; and is responsible for regulating, monitoring, planning, and funding substance abuse prevention, treatment, and recovery support services. DMHAS operates five psychiatric hospitals and monitors inpatient services provided by public hospitals and psychiatric units in local general hospitals. DMHAS also oversees state gambling prevention and treatment resources and the state-funded Intoxicated Driving Program. Services are provided through contracts with approximately 280 private non-profit agencies for community mental health and addiction services. The DMHAS Assistant Commissioner reports directly to the DHS Commissioner, with the department holding a Cabinet-level position.

The Office of Fiscal and Management Operations (OFMO) within DMHAS is responsible for all fiscal operations. OFMO prepares budget requests and community and state hospital spending plans; administers third-party contracts; administers reimbursement of county hospitals; develops and maintains division cost allocation plans; and administers the fiscal aspects of federal and other grants, including SABG.

The state's accounting system is the New Jersey Comprehensive Financial System. This system tracks SABG by federal fiscal year, as well as by unit and organization code. The accounting system segregates costs/indirect costs for each grant period via a cost center. Contracts for services are issued statewide directly to local providers via DMHAS.

Fiscal Operations

DMHAS allocates alcohol and drug funds in spending plans for each DMHAS funded service. These spending plans are approved after the budget has been legislatively determined. The spending plans identify specific providers of services to receive alcohol and drug funds and are submitted to the Chief Financial Officer for approval. DMHAS distributes the alcohol and drug funds to service providers through contracts, which are awarded via the state's procurement process. DMHAS awards a portion of funds annually to DHSS for TB and HIV services, and these funds also are distributed through procured contracts.

DMHAS relies on contract language to convey SABG regulations to providers and allocates federal and state funds on an annual funding schedule. Additionally, providers reported they are informed of the federal portion of SABG funding awarded by DMHAS via a Notice of Award Letter.

Provider Operations

DMHAS uses a competitive bid process to select new service providers. A request for proposal (RFP) is issued, which specifies all requirements and deliverables. A review committee recommends the bidder with the best combination of quality and cost to DMHAS. The DMHAS

Assistant Commissioner makes the final selection and approves the contract in the spending plan. The review committee includes individuals having expertise in the service to be funded. No one with a financial or a vested interest in the selection of a specific bidder participates in the review committee. Contracts and FFS agreements are renewable annually for 3 years at the option of DMHAS, and DMHAS uses a letter of agreement to govern arrangements for FFS reimbursement.

Each contract agreement specifies SABG requirements, including the provider's reporting and billing obligations. The contract agreement delineates the source of funding by account code, so the provider is able to differentiate between SABG funds, state funds, and other sources of funding.

Providers log into CIMS and link to the SABG requirements through www.cfda.gov. Providers also may link to the state's contract/grant manuals, general information about contract policy and management, contract applications, third-party contract amendments and budget guidelines, and cost allocation plans.

All fiscal reports and expenses are entered into CIMS and transmitted to DMHAS for review and approval. CIMS warns providers to enter expenses in a timely manner or payments will be suspended. DMHAS reviews expenses and fiscal reports via CIMS.

Monitoring

DMHAS Administrative Services Contract (ASC) staff members are responsible for fiscal monitoring of providers. In general, providers submit monthly/quarterly and annual reports of expenditures to ASC staff, and staff review the reports and make adjustments in payments to providers on the basis of the review. Additionally, ASC staff review annual reports to determine if any amount is due to/from the provider.

DMHAS reported conducting annual fiscal reviews until recently via the 360 Contract Review. The 360 Contract Review process included staff from various divisions at DMHAS, and assignments were made to responsible parties for follow-up of identified issues/problems. The 360 Contract Review resulted in a Financial Risk Assessment being completed on providers. Items monitored included expenditures/revenue trends, timeliness of financial reporting, occurrence of fraud, date of last audit, management/staff capabilities and turnover, evaluation of operating deficiencies, audit management letters, debt ratio, and complaints and investigations.

Based on the resulting score, providers were rated at a risk level, which indicated whether the provider needed an onsite review or closer follow-up. DMHAS reported that the 360 Contract Review process has not been conducted in the last 8 months due to the merger of the Division of Addiction Services and the Division of Mental Health Services, which began July 1, 2010. The divisions are in the process of co-locating and continue to merge division regulations, licensing, and contract requirements. DMHAS expressed its desire to reinstate 360 Contract Review monitoring.

Audits

The state's most recent Office of Management and Budget Circular A-133 audit completed was for fiscal year ended June 30, 2011. The SABG was audited as a major program. One new audit finding was made for federal fiscal year 2011 (FFY11) regarding maintenance of effort (MOE). Auditors recommended procedures be developed and implemented to ensure compliance with LOE requirements. In response, DMHAS formulated written policies to document MOE methodology and requested a waiver dated January 30, 2012, which was approved by SAMHSA on April 11, 2012.

One other audit finding for FFY11 related to subrecipient monitoring regarding the timely performance of provider site visits. Auditors determined one provider site visit occurred outside of the required timeframe due to unavailability of provider staff. SAMHSA is presently addressing this finding with DMHAS through the audit resolution process.

In FFY09 and FFY10, the SABG was audited as a major program, and findings were made for both years. In FFY10, audit findings related to one contract administrator not using the same standardized template to record contract payments for the SABG as all other administrators. This was fully corrected. In FFY09 and FFY10, some quarterly Reports of Expenditures (ROEs) for the SABG were not submitted timely. Subsequently, the state developed the computerized CIMS, which corrected this finding by issuing auto-generated messages to warn providers of late reports and ultimately suspension of payments if ROEs are not submitted timely.

Independent provider audits are completed annually and audit reports are provided to the cognizant division and the DMHAS Close-Out Unit (COU) in OFMO. COU is responsible for tracking corrective action plans and resolution of audit findings. Providers are notified of audit requirements through contract language and standardized language in state policy regarding contract administration. Providers interviewed during the Technical Review were aware of the A-133 audit requirements; however, the providers were unaware of the specific prohibited expenditures pertaining to the SABG.

Closed Years and Appropriations

As of this Technical Review, the most recent closed SABG years were FFY09 and FFY10. SABG appropriations and expenditures were $46,941,463 for FFY09. For FFY10, appropriations and expenditures were $47,103,249.

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

Revenue Source	State Fiscal Year 2009	State Fiscal Year 2010
State General Funds	$98,374,039	$81,291,681
Other State Funds (specify)	$10,465,555	$19,754,024

Revenue Source	State Fiscal Year 2009	State Fiscal Year 2010
SABG Funds	$46,941,463	$47,103,249
Other Federal Funds (specify)	$2,082,429	$2,127,949
Medicaid Funds	$0	$0
Other (specify)	$10,789,118	$13,223,592
Total	$168,652,604	$163,500,495

Methodology

CSAT Division of Grants Management (DGM) staff interviewed DMHAS senior fiscal officers and staff, and attempted to gather and trace documentation supporting amounts reported on DMHAS's SABG application for the two most current closed book years (FFY09 and FFY10). The DMHAS supervisor of contract monitoring was interviewed and copies of the monitoring reports for vendors were obtained. DGM staff also met with fiscal representatives from DHSS to obtain maintenance of effort (MOE) information and calculations for TB and HIV expenditures.

Site visits were conducted at a methadone maintenance program; a program offering specialized women's services; and a detoxification, residential, inpatient, and outpatient program. At the providers, DGM staff interviewed the fiscal managers to identify their procedures for contracting, funding, and reporting to DMHAS.

Observations

1. **Subrecipient Monitoring—Allowable/Unallowable Expenses**

- Condition: Review of subrecipient monitoring activities found that DMHAS did not adequately monitor compliance with A-133 audit requirements. Specifically, the provider contracts do not list the SABG prohibited expenditures nor do the monitoring tools list the prohibited expenditures. Therefore, DMHAS did not ensure providers were in compliance with prohibited expenditure requirements.

- Criteria: DMHAS is responsible for fiscal monitoring of providers to ensure they meet SABG requirements and are appropriately spending funds, including prohibited expenditures. According to A-133 § 200, non-federal entities that expend $500,000 or more in a year in federal awards shall have an audit for that year in accordance with A-133. According to § 400(d) Pass-through entity responsibilities, a pass-through entity shall, among other things, perform the following for the federal awards it makes:

  (1) Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contracts or grant agreements, as well as any supplemental requirements imposed by the pass-through entity. (This includes

requirements pertaining to Activities Allowed or Unallowed referenced in 45 CFR 96.130, 96.135, and 54.4.);

(2) Monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved;

(3) Ensure that subrecipients expending $500,000 or more in federal awards during the subrecipient's fiscal year have met the audit requirements for that fiscal year;

(4) Issue a management decision on audit findings within 6 months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action; and

(5) Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

- Cause: Provider contracts do not communicate SABG prohibited expenditures; therefore, DMHAS did not ensure provider compliance with SABG requirements, specifically activities allowed/un-allowed.

- Recommendation: DGM recommends DMHAS: (1) document the SABG-specific prohibited expenditures on provider contracts or letters of agreement, and 2) ensure A-133 provider compliance regarding subrecipient responsibilities as they pertain to allowed/unallowed activities.

2. HIV MOE Verification

- Condition: The state did meet the HIV requirement for state fiscal year 2009 (SFY09) and SFY10 per MOE summary calculation tables for SFY09–10 provided by DHSS. Additionally, the numbers reported on the 2012 SABG 2012 application matched the numbers provided during the Technical Review. However, the state relied on DHSS self-reporting the numbers rather than requiring supporting documentation from the state's accounting system. Per the 2012 SABG application, the HIV MOE base is $165,583. For SFY09, the state expended $498,830. For SFY10, the state expended $498,830.

- Criteria: New Jersey must maintain expenditures at not less than the calculated SFY92 base amount of $165,583 (reported in its fiscal year 1993 application) for HIV MOE (45 CFR 96.128, (d) (2) (f)).

- Cause: DMHAS did not validate, with supporting documentation, the HIV MOE data provided by DHSS until requested by the Technical Review team. Historically, DMHAS

has relied on DHSS self-reporting without validating the data via accounting system documentation.

- Recommendation: DMHAS should validate future HIV MOE data provided by DHSS or other governmental units via accounting system documentation with approvals by lines of authority.

3. TB MOE Verification

- Condition: The State did meet the TB requirement for SFY09 and SFY10 per MOE summary calculation tables for SFY09–10 provided by DHSS. Additionally, the numbers reported on the 2012 SABG application matched the numbers provided during the Technical Review. Per the 2012 SABG application, the TB MOE base is $219,949. For SFY09, the state expended $291,184. For SFY10, the state expended $324,565. However, the state relied on DHSS self-reporting the numbers rather than requiring supporting documentation from the state's accounting system.

- Criteria: New Jersey must maintain expenditures at not less than the calculated SFY92 base amount of $219,949 (reported in its fiscal year 1993 application for TB MOE (45 CFR 96.127 (c)).

- Cause: DMHAS did not validate, with supporting documentation, the TB MOE data provided by DHSS until requested by the Technical Review team. Historically, DMHAS has relied on DHSS self-reporting without validating the data via accounting system documentation.

- Recommendations: DMHAS should establish policies and procedures to validate future TB MOE data provided by DHSS or other governmental units via accounting system documentation with approvals by lines of authority.

Substance Abuse Prevention and Treatment Block Grant Compliance

Obligated and Expended Funds

Table II-4. Summary of Obligated and Expended Funds

Federal Fiscal Year	Total Award	Obligation Period	Amount Obligated	Expenditure Period	Amount Expended
FFY09	$46,941,463	10/01/08–9/30/10	$46,941,463	10/01/08–9/30/10	$46,941,463
FFY10	$47,103,249	10/01/09–9/30/11	$47,103,249	10/01/09–9/30/11	$47,103,249

State Maintenance of Effort

Table II-5. State MOE Expenditures[1]

Period[2]	State Expenditures	Previous 2-Year Average Expenditures	Percent Over/(Under) MOE Requirements
SFY08	$93,334,838	$79,273,500	17.73%
SFY09	$94,885,816	$87,369,919	8.60%
SFY10	$104,390,576	$94,110,327	10.92%
SFY11	$98,869,026	$99,638,196	(0.77%)

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

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

Primary Prevention Services and Set-Aside

Table II-6 compares actual prevention expenditures for FFY09 and FFY10 from SABG funds with the 20 percent minimum requirement.

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

Year	SABG Award	20 Percent Set-Aside	Actual Expenditure	Difference
FFY09	$46,941,463	$9,388,293	$11,599,457	$2,211,164
FFY10	$47,103,249	$9,420,650	$10,741,397	$1,320,747

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

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

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

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
FFY93	$2,752,187			$37,452,980	$1,872,649	$0	$4,624,836
FFY94	$4,624,836			$37,452,980	$1,872,649	$0	$6,497,485

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

Period	Required Expenditure	Actual Expenditure	Difference	Percentage of Difference
FFY08	$6,497,485	$16,422,746	$9,945,261	153.06%
FFY09	$6,497,485	$19,463,166	$12,965,681	199.54%
FFY10	$6,497,485	$16,353,612	$9,856,127	151.69%

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

Table II-9. HIV MOE Base Calculation

Period	State HIV Expenditure	Percent of HIV Clients Who Are Substance Abusers	Amount of HIV Expenditures for Clients Who Are Substance Abusers	MOE Base
SFY91	$143,954			
SFY92	$187,211			$165,583

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

II-10. HIV MOE Expenditures

Period	State HIV Expenditures	Percent of HIV Clients Who Are Substance Abusers	State HIV Funds for Substance Abusers	MOE Base	Difference
SFY08 (Base)	$1,693,333	29.45%	$498,830	$165,583	$333,247

Period	State HIV Expenditures	Percent of HIV Clients Who Are Substance Abusers	State HIV Funds for Substance Abusers	MOE Base	Difference
SFY09	$2,347,073	21.25%	$498,830	$165,583	$333,247
SFY10	$2,355,162	21.18%	$498,830	$165,583	$333,247
SFY11	$2,347,073	23.33%	$547,521	$165,583	$381,938

Human Immunodeficiency Virus Set-Aside

Table II-11. HIV Set-Aside Percentage Calculation

SABG Award Year	Award Amount	Substance Abuse Portion of FFY91 Award	Difference	Percentage Change	HIV Set-Aside Percentage
FFY09	$46,941,463	$35,398,000	$11,543,463	32.61%	5.00%
FFY10	$47,103,249	$35,398,000	$11,705,249	33.06%	5.00%

Table II-12. HIV Set-Aside Expenditures

Period	SABG Award	Required Percentage	Required Expenditure	Actual Expenditure	Difference
FFY09	$46,941,463	5.00%	$2,347,073	$2,347,073	$0
FFY10	$47,103,249	5.00%	$2,355,162	$2,355,162	$0

Tuberculosis Maintenance of Effort

Table II-13. TB MOE Base Calculation

Period	State TB Expenditures	Percent of TB Clients Who Are Substance Abusers	Amount of TB Expenditures for Clients Who Are Substance Abusers	MOE Base
SFY91	$1,579,967		$208,556	
SFY92	$1,752,586		$231,341	$219,949

Table II-14. TB MOE Expenditures

Period	State TB Expenditure	Percent of TB Clients Who Are Substance Abusers	State TB Funds for Substance Abusers	MOE Base	Difference
SFY08	$3,317,629	11.40%	$378,210	$219,949	$158,261
SFY09	$3,385,855	8.60%	$291,184	$219,949	$71,235
SFY10	$3,688,243	8.80%	$324,565	$219,949	$104,616
SFY11	$3,586,630	6.80%	$243,891	$219,949	$23,942

G. 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.

Quality Management

Best Practices

Standards of Care

DMHAS's standards of care regulate the provision of alcohol and drug treatment for all levels of care. The standards lay out the minimum acceptable requirements for substance abuse treatment; are specific to each level of care; and describe facility and service requirements, staffing patterns, clinical supervision, and quality improvement.

Treatment Protocols

DMHAS promotes providers using a range of treatment protocols. A few examples include the use of the American Society of Addiction Medicine, Patient Placement Criteria, Second Edition, Revised (ASAM PPC-2R) to determine the appropriate level of care; and CSAT Treatment Improvement Protocols focused on medication-assisted treatment (MAT), acute and ambulatory detoxification, cultural responsiveness in treatment, and halfway house services.

DMHAS reports that they strive to place clients in the right level of treatment as determined by ASAM PPC-2R. Treatment protocol service includes inpatient treatment such as acute detoxification, short- and long-term residential treatment, and half-way house. DMHAS also states that providers offer outpatient treatment, EIS, ambulatory detoxification, day treatment,

partial hospitalization, and opioid maintenance to clients. Outpatient treatment is comprised of EIS, outpatient treatment, intensive outpatient (IOP) treatment, methadone IOP treatment, day treatment or partial hospitalization, ambulatory with motivational counseling and managed care coordination.

Provider Licensure/Certification

New Jersey Administrative Code (N.J.A.C.) 10:161A defines state standards for licensure of residential substance abuse treatment facilities, and N.J.A.C 10:161B stipulates licensure and certification standards for outpatient facilities in New Jersey. Since the merger of the mental health and addiction divisions, licensing responsibilities for providers has been placed within the Department of Human Services Office of Program Integrity and Accountability (OPIA), Office of Licensing (OOL).

Provider licenses also are assessed annually during an integrated review by a team of five representatives from DCA. Providers must maintain licensure to receive funding from the division.

Accreditation

In the past, the Office of Licensure and Supportive Housing within the Division of Addiction Services had responsibility for licensing providers. However, licensure of providers is now within the Department of Human Services, OPIA, and OOL. OPIA is composed of two units that license providers; the two units offer developmental disability licensing and mental health licensing of community providers. OPIA also conducts financial and program audits to assure compliance with DMHAS regulations. According to DMHAS staff, seven of their providers are accredited by the Commission on Accreditation of Rehabilitation Facilities and one by the Joint Commission.

Utilization Management

DMHAS's management of service utilization includes an external Hybrid Contract Policy and NJ-SAMS. The Hybrid Contract Policy assesses service utilization through periodic review of providers' utilization patterns via monthly reviews of provider agency rosters, review of the provider data submitted to NJ-SAMS, site visits and DMHAS monitoring, DMHAS internal review, and contract coordinating meetings.

Providers falling below the contract specifications are placed on probation for 6 months to improve performance based on DMHAS standards and expectations. The Hybrid Contract Policy allows DMHAS to redirect funds to providers that are functioning successfully, in order to continue to provide quality services to clients. As of the Technical Review, contract utilization is operating at 95 percent capacity.

Addiction Programmatic Monitoring Officers (APMO) make annual site visits and utilization findings are placed in the DMHAS provider files as documented by site visit report. If service

capacity falls below expected levels of service contained in the provider's contract, the agency in default would be provided a notification to take action to increase service utilization following the site visit review.

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

DMHAS reports that it relies on the services of two committees—Contract Coordinating and Program Improvement—to measure the services of providers; respond to critical incidents, complaints, and grievances; and ensure that effective services are provided to clients in treatment. DMHAS also uses a Quality Assurance Monitoring System (QAMS). QAMS records and scores agency adherence to specific contract requirements during program monitoring and site review visits. In addition, QAMS calculates compliance scores over time within and across agencies.

Evidence-Based Practices

DMHAS encourages all treatment providers to use evidence-based practices (EBPs) and requires agencies providing Suboxone® (brand name for buprenorphine and naloxone combination), serving pregnant women and women with dependent children, or delivering MAT to use specific evidence-based or best practices. Examples of evidence-based and best practices encouraged and required by DMHAS include Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) in conjunction with Suboxone® treatment. DMHAS monitors providers through an examination of clinical records, and interviews during the Technical Review with line staff reflect the use of Twelve Step Facilitation Therapy, MI, and the Stages of Change.

ORPEIST monitors the implementation of EBPs, program performance, and outcomes of promising practices. Emphasis on the importance of using EBPs in residential treatment facilities is stated in the New Jersey Manual of Standards for Licensure of Residential Substance Abuse Treatment Facilities.

Workforce Development

Counselor Certification/Licensure

DMHAS funds the New Jersey Prevention Network to provide statewide alcohol and drug training for individuals interested in becoming an alcohol and drug counselor or those already working in the field. DMHAS staff report that in N.J.A.C. 10:161A-1.9 (a), the clinical supervisor must maintain a 50 percent staff complement representing Licensed Clinical Addiction and Drug Counselors (LCADC), Certified Alcohol and Drug Counselors (CADC), or other licensed clinical professionals. DMHAS also asserts that 50 percent of the staff must be credentialed interns, substance abuse counselors, or counselors working towards LCADC or CADC credentialing. The Addiction Professional Certification Board of New Jersey (APCBNJ) issues the following certifications:

- Certified Clinical Supervisor,

- Certified Tobacco Treatment Specialist,
- Certified Prevention Specialist,
- Certified Criminal Justice Professional,
- Co-Occurring Disorders Professional,
- Co-Occurring Disorders Professional-Diplomat,
- Chemical Dependency Associate,
- Recovery Mentor Associate,
- Associate Prevention Specialist,
- Community Mental Health Associate,
- Addiction Disability Specialist,
- Women's Treatment Specialist, and
- Disaster Response Crisis Counselor.

DLPS DCA supervises 46 boards and committees that regulate more than 100 professions and occupations, which include physicians, social workers, nurses, and counselors. DCA grants licensure for LCADC, CADC, and Licensed Practicing Counselor (LPC).

Reports from providers during the Technical Review indicate that a barrier to client services involves problems with retaining line staff due to low wages and the lack of adequate local transportation. DMHAS states that training and staff development are important issues that are being addressed through their Workforce Development and Addiction Training Initiative. Because the future of behavioral health treatment will include a focus on co-occurring disorders, DMHAS has developed a comprehensive master's level training program through the Rutgers University School of Social Work and The Center for Alcohol Studies. In anticipation of these changes, the program prepares students for dual-licensure as both licensed clinical alcohol and drug counselors and other clinical licensed professionals (e.g., LPC, LSCW, LMFT, PysD,). As part of the program, individuals completing a practicum at a DHS OOL licensed substance abuse treatment facility will be granted a stipend. A primary goal of the program is to encourage permanent placement at agencies, and recruit ethnically diverse individuals that represent the population served.

Clinical Supervision

According to DMHAS staff, all clinical supervision must be documented with the name of the supervisor and the supervisee. Documentation also must contain the date and any case reviews assessed by the supervisor. A review of provider clinical documents and staff interviews revealed that clinical supervision is provided. Case management reports and supporting documentation submitted to DMHAS also provide information regarding supervisee clinical progress.

Clinical Documentation (treatment planning, progress notes, discharge summaries)

The clinical charts reveal that progress notes were appropriately documented for both individual therapy and group participation sessions. Client charts, except at one provider, are hard copies.

Providers have documentation of individualized treatment plans and one that appeared to be generic. Client charts include documentation on Addiction Severity Index (ASI) narrative reports, admission intakes, biopsychosocial assessments, medical history, and dosage documentation. Only one clinical record did not have release of information (ROI) documents. Charts also reflect that problem lists and screenings for methadone treatment are present, when appropriate.

Cultural Competency

DMHAS is committed to addressing the cultural needs of its multicultural population, as evidenced by the following policies and practices:

- Incorporation of a definition for cultural competence in the 2011 Mental Health Cultural Competence Training Centers RFP;
- Leadership collaboration with consumers;
- Emphasis on providers and stakeholders developing and maintaining a system of client-centered care that is accessible and culturally competent;
- Language in performance contracts stressing the importance of being sensitive to the needs of minority populations; and
- Requirement that all programs and services reflect the demographic needs of the community.

The Technical Review team made visits to several providers and found that provider agency documents demonstrate a cultural and ethnic composition of staff that reflect the cultural composition of the community and clients served.

Table II-15. Cultural and Ethnic Composition of DMHAS Staff and Clients

Category	Agency Staff	Agency Staff Percentage	Client Population	Client Population Percentage
White (Non-Hispanic)	135	60%	59,307	72.1%
Black (Non-Hispanic)	56	25%	21,405	26%
Hispanic or Latino	12	4.8%	12,262	14.89%
Native Hawaiian/Pacific Islander	0	0%	633	0.77%
Asian	15	6.2%	597	0.73%

Category	Agency Staff	Agency Staff Percentage	Client Population	Client Population Percentage
American Indian/Native Alaskan	0	0%	316	0.38%
Not Hispanic or Latino	0	0%	69,995	85.05%
Unknown	0	0%	41	0.0005%
Persons of More Than One Race	0	0%	5,522	6.71%

DMHAS has a long-standing commitment to the cultural competency of its workforce and provides cultural competency training on policy development and strategic planning, focusing on the mission, vision, and role of leadership; cultural and linguistic assessment and treatment planning; outreach technical assistance (TA); workforce development, supervision, and staff training; quality improvement, management, and monitoring; and service delivery, enabling supports, infrastructure building, and program management.

Training programs are developed to provide knowledge, skills, and needed changes to the scope of practice. Training workshops also are based on the assessment of linguistic and cultural needs of each agency and consumers.

Expected and Current Counselor Caseload

DMHAS asserted that no more than 12 clients may attend each therapy group session, and providers maintain a minimum of 7 hours of structured treatment activities to each client on a daily basis.

Program	Ratio
Outpatient	1:35
Intensive outpatient	1:24
Partial care	1:12
Outpatient detoxification	1:24
Opioid treatment	1:50

Clinical Evaluation

Assessment

DMHAS requires the use of ASI, Interviewer Severity Index, biopsychosocial screening tools, and the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV); and the level of care must be consistent with ASAM PPC-2R. A review of a small sample of clinical records reflects that providers follow DMHAS requirements for assessing clients.

Placement

DMHAS mandates that providers use ASAM PPC-2R to place clients in an appropriate level of care. In addition, ASAM PPC-2R is used for utilization review in order to continue client care in treatment.

Matching Clients to Services Needed

DMHAS supports ASAM PPC-2R in promoting client movement between levels of care. A review of clinical charts reflects that placement and services are driven by client assessment and treatment team progress reviews. In addition, DMHAS reports that certain community providers offer specialized services to women and the counselors are able to reassess the level of care that clients are receiving—as suggested by ASAM PPC-2R—to assure that an appropriate level of care is being provided. DMHAS site visit review teams also monitor treatment protocols by examining charts to determine if clients are receiving appropriate services and have been admitted into the proper level of care. TA is provided by DMHAS to provider agencies that require assistance in administering ASAM PPC-2R.

Use of Client Placement Data in Management Decisions

DMHAS indicates that with the development and application of QAMS and NJ-SAMS, and the establishment of ORPEIST, the agency is able to review provider compliance with contract agreements, statutes, and regulations. DMHAS also is able to analyze program issues to make appropriate management decisions that can improve the quality of care to clients in treatment. Providers are being trained on how to enter information into QAMS and NJ-SAMS to meet performance compliance measures and provide decisionmaking data to improve the quality of client care.

Client Movement Between Levels of Care

DMHAS uses ASAM PPC-2R to ensure that clients move appropriately between levels of care and services to ensure that clients are accounted for and followed in NJ-SAMS. To improve on level of care services, DMHAS uses a Web-based version of the Level of Care Index-2 Revised client placement for adults and adolescents, which supports ASAM PPC-2R.

Service Delivery Driven by Client Assessment

DMHAS staff report that information gathered from assessment and placement tools is used to improve services to clients. In addition, providers indicate that data gained from assessment instruments and NJ-SAMS analyses inform decisionmaking for service delivery improvements.

Chart Review

An examination of approximately three charts at three DMHAS provider agencies by the Technical Review team reveals that progress notes, ASI assessments, medical history, medical

notes, and treatment plans are in place. Providers also appear to adhere to 42 CFR, Part 2 and HIPAA regulations regarding the inappropriate disclosure of patient records. Client charts also reveal that purified protein derivative, HIV, and hepatitis C testing is offered to each client requesting substance abuse services. Physician orders and dosages, as well as take home assignments documentation, are inserted in client charts. Provider clients are given admission intake interviews and discharge summaries, when required.

The review of clinical records further reflect that client satisfaction surveys are not always inserted in client charts, and Release of Information documents in one chart examined during the review are not provided. One chart did reveal mental health issues on the presenting issues list; however, the mental health issues are not always documented on the presenting issues list. The Technical Review team 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.

Client mental health issues that would enhance substance abuse should be addressed on the presenting issues list. A treatment plan, and inclusion of mental health concerns on the presenting issues list, would alert addiction counselors and mental health therapists that these issues need to be addressed in treatment and should result in improved clinical outcomes. DSM-IV codes also should be assigned to each mental health or substance abuse disorder.

Data Used in the Treatment Service Delivery System

Client Perception of Care Results

The Perception of Care Survey started in 2005 by the New Jersey Infrastructure Project (NJIP) to provide statistical analysis and increase quality of care in agencies delivering community substance abuse treatment. NJIP modified the Perception of Care Survey based on the Mental Health Statistics Improvement Program (MHSIP) consumer satisfaction survey. DMHAS staff report receiving over 1,900 surveys since implementing the process in 2005. All clients receiving substance abuse treatment services in the state of New Jersey are the target population of the survey.

The survey instrument uses a self-report questionnaire regarding services received by the client. Review of the records for 2005 and 2006 indicate a response rate of 16.5 percent and 14.4 percent, respectively. Items in the MHSIP survey are grouped into four domains—access, appropriateness, satisfaction, and outcomes.

Clinical Outcomes and Benchmarks

As part of its Pay for Performance project with Drug Court long term residential providers, DMHAS examined data regarding the percentage of clients completing treatment using a statistical technique known as survival analysis. DMHAS used key points of retention of 21, 45, and 91 days to identify the completion rates. The completion rates were then used to establish benchmarks, which were then used as the baseline performance measures for contracted Drug

Court providers who had long term residential. In addition, DMHAS anticipates using NOMs measures to set benchmarks and performance targets within specific requirements to monitor and improve access to treatment, engagement, and retention in provider agencies.

Provider Clinical Reporting

Providers report monthly census rosters to DMHAS regarding admissions, discharges, and lengths of treatment in NJ-SAMS. DMHAS uses this information to determine provider capacity and adherence to state statutes and federal regulations. NJ-SAMS is a real-time, Web-based treatment outcome monitoring system that collects basic demographic, financial, clinical, and service information on all clients receiving SABG funds in New Jersey. DMHAS indicated that the NJ-SAMS Web site is hosted by the Rutgers University Computer Center under a MOA with DMHAS, and is HIPAA and 42 CFR, Part 2 compliant. Providers must have Internet access in order to provide client information to DMHAS for review.

NJ-SAMS is capable of producing NOMs, TEDS, and other data required in provider performance reports. NJ-SAMS Provider Performance reports are produced twice a year. DMHAS piloted NJ-SAMS in October 2002 and made the system available to providers for use in July 2005.

Provider Monitoring

Prevention providers are required to submit outcome information each month to DMHAS as required in their contract agreement. DMHAS uses POMS, a Web-based application to capture and process outcome data from funded prevention providers. DMHAS reports that ORPEIST monitors program performance, reviews provider documents for EBPs, reviews promising practices outcomes, and monitors the production of major planning documents for the division to be submitted to external sources (i.e., grants, annual reports, surveys, etc.). DMHAS asserts that ORPEIST provides substance abuse research studies and uses an array of planning tools to provide research data to providers. ORPEIST makes recommendations to providers on enhancing program development, outcomes, service delivery, and accountability. According to DMHAS, the Office of Prevention, Early Intervention and Community Services works with staff from DHS OPIA Office of Licensure (OOL) and Complaints and Reportable Events Management Unit, to conduct agency licensure and complaint site visit when requested.

DMHAS conducts at least one formal contract site visit annually to monitor prevention, treatment, and recovery support services provided by agencies. Members of PIC and the Contract Coordinating Committee conduct monitoring visits in response to identified deficiencies or the need for TA. Prior to the visit, APMOs examine providers most recently reviewed, providers cited for deficiencies, or previous provider site visit issues. APMOs review charts, file rosters, quality assurance plan, performance contract targets, quality of care, and FFS claims; and perform an exit conference with provider staff.

As previously described, the state developed QAMS, which supports the 360 Contract Review process. QAMS uses a provider identifier that can be linked to both CIMS and NJ-SAMS.

Substance Abuse Prevention and Treatment Block Grant Compliance

Confidentiality of Protected Health Information and Client Data

Protected Health Information

Confidentiality requirements are conveyed through federal regulations and contract agreements. Providers are monitored through site reviews and each year must meet the standards prescribed by the Confidentiality of Alcohol and Drug Abuse Patient Records in 42 CFR, Part 2.

All clients must sign an informed consent form prior to HIV testing. Clients may refuse to sign an informed consent form if they are going into treatment. Clients who decline testing sign a declaration regarding being counseled on the risk of HIV but have chosen not to be tested. The reason for refusal is documented in the client's records. Clients must request a ROI form if treatment information will be released to third party sources. ROI forms include name of the client, type of information to be released, to whom the information will be released, date of the ROI, expiration date of information, and client's signature.

NJ-SAMS collects important demographic, financial, clinical, and service information on clients. According to DMHAS staff, NJ-SAMS meets HIPAA and 42 CFR, Part 2 compliance requirements in collecting and providing data to the division. A review of records at each provider site by the Technical Review team reflects that providers are compliant in the following treatment areas:

- Admission data,
- Treatment plans,
- Treatment progress notes,
- Lab reports,
- Physician progress notes,
- Patient bill of rights,
- ROI forms,
- Discharge summaries, and
- Aftercare planning.

In addition, providers met the requirements of 42 CFR, Part 2 and HIPAA. DMHAS reviews provider records during annual onsite reviews for compliance with HIPAA regulations.

Data Sharing and Management

DMHAS providers use the Web-based NJ-SAMS. The system design provides users with current technology that delivers data to SAGB-funded agencies. The information provided meets federal requirements and is 42 CFR, Part 2 and HIPAA compliant with guidelines for confidentiality. According to DMHAS' Information Systems Overview of 2011, appropriate safeguards are in place. HIPAA violations discovered by PIC or APMOs are reported to the

provider and DMHAS. Client data are limited to clinicians who are working directly with the client for treatment purposes.

Monitoring

DMHAS staff report that the Office of Prevention, Early Intervention and Community Services monitor provider agencies for appropriate substance abuse services through provider reports, site visits and information collected during site visits. DMHAS staff also can assist staff from the DHS OPIA Complaints and Reportable Events Management Unit on their complaint site visits as requested.

Client charts reviewed at provider agencies indicate that client de-identification methods were being used in accordance to the HIPAA privacy rule and 42 CFR, Part 2, in documenting client information. DMHAS reports that client names, Social Security Numbers (SSN), and addresses are de-identified from client records in a manner such that only the agency is able to associate records with corresponding clients. DMHAS also reports that elements from client names and SSNs are used to create client identifiers.

Human Immunodeficiency Virus Early Intervention Services and Pre- and Post-Test Counseling

DMHAS reported that there are 17 licensed and funded substance abuse treatment facilities that provide outpatient HIV pre- and post-test services and treatment for clients in New Jersey. Counseling services address HIV high-risk reduction and promoting behaviors that diminish the risk of acquiring or transmitting HIV to others; discussions regarding the need to inform sex or injection needle partners of the risk of acquiring HIV and the need to seek counseling or treatment; ways to decrease the risk of HIV transmission; and treatment options for high-risk and HIV-infected individuals. Individuals receive treatment within 14 days if they are injection drug users and within 120 days of request for treatment if they are on a wait list.

DMHAS funds 20 methadone clinics in New Jersey that provide rapid testing and treatment referrals, when appropriate. DMHAS maintains a MOA with the Rutgers Robert Wood Johnson Medical School (RWJMS), enabling the provision of HIV counseling and pre- and post-test counseling for clients; monitoring of treatment programs and review of testing procedures; provision of storage areas; monitoring facility for staff certification; and HIV test kit inspections. Monthly program reports also are provided by RWJMS.

DMHAS reports that HIV and early intervention testing are offered by providers to include:

- Laboratory tests to determine the presence of HIV/acquired immunodeficiency syndrome (AIDS); and

- Counseling services, consisting of:
  - Counseling at the time of testing and at the time of receipt of test results regarding HIV/AIDS and risk reduction;
  - Individualized, multi-session HIV risk-reduction counseling to assist in initiating or sustaining behaviors or practices that eliminate or reduce the risk of acquiring or transmitting HIV;
  - Counseling HIV-infected individuals regarding notifying sex and needle sharing partners of the risk of infection and the need to seek counseling and testing services;
  - Counseling regarding decreasing the risk of perinatal transmission; and
  - Counseling HIV-infected individuals regarding treatment options.

DMHAS staff state that contracted providers are required to offer HIV case management to clients admitted into treatment, and provide HIV pre-test counseling (excluding those individuals previously identified as HIV positive) and offer onsite rapid HIV testing, when needed.

According to Annex A, Section III requirements, clients must be:

- Offered pre- and post-test counseling;
- Advised of the risk of HIV infection by certified HIV counselors;
- Provided negative or positive test results; and
- Offered HIV testing every 6 months and referred to an early intervention program or HIV Care Center in the community.

The contracted provider must have affiliation agreements with other health care providers for the treatment of individuals infected with HIV. Providers also must develop risk reduction plans for both HIV positive and HIV negative individuals.

The provider program visited by the Technical Review team provides services outlined in Annex A, Section III requirements. Provider contracts require that treatment facilities offer all clients HIV counseling and testing. Testing is offered during admission and every 6 months thereafter and documented in client records. Clients testing positive for HIV are offered services as previously described. HIV counselors at the visited program are certified or actively pursuing certification. Clinic physicians are licensed and trained in accordance to licensure standards and criteria.

Human Immunodeficiency Virus Services and Testing

According to the New Jersey SABG application, DMHAS funds 17 licensed HIV methadone substance abuse clinics in areas of greatest need for HIV EIS in New Jersey. Providers that offer EIS programming act in accordance with the medical management of HIV/AIDS issued by DMHAS, and maintain contact with other facilities that offer EIS.

DMHAS reports that confidentiality requirements are conveyed during staff orientation and through provider contracts and regulations. A review of clinical records by the Technical Review reflects that providers met HIPAA and 42 CFR, Part 2 requirements. Counselors are required to attend confidentiality training in adherence to regulations and are monitored by DMHAS during onsite reviews. Staff training is provided or sponsored by DHSS regarding HIV counseling and testing. Annex A requires providers and contracted treatment facilities to meet the standards stipulated by the Confidentiality of the Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, dated June 9, 1987. Records must be maintained, in accordance with New Jersey Statutes Annotated 26:8-5 et seq. for a minimum of 10 years and disposed of in a prescribed manner. DMHAS requires that providers establish linkages with other providers and offer referrals to providers with EIS.

The State Medical Director for alcohol and drug services is a consultant to DMHAS, as well as CSAT, regarding substance abuse treatment programs and services in New Jersey. The State Medical Director is licensed by a certified licensing board to practice medicine; a member of DLPS DCA; and works with DLPS DCA to supervise the activities of 46 boards and committees related to more than 100 professionals such as physicians, psychiatrist, nurses, and social workers. APCB provides 15 credentials for mental health and addiction services as part of its authority.

DMHAS reports that the services HIV-infected clients are referred to vary from agency to agency. Clients in need of treatment receive services that include post-test counseling, appropriate medical care, complete blood count service, cluster of differentiation 4 (or CD4) cell counts, viral load level analysis, chemical profile, and referral to an HIV Care Center based on individual needs.

Admission Preferences for Pregnant Women

The providers interviewed by the Technical Review team are all aware of SABG requirements for admission preferences for pregnant women and other special populations. Staff persons at the women's treatment program also are aware of the admission preferences requirements. DMHAS reports that requirements are conveyed to SABG-funded programs through licensing and accreditation requirements, letters of agreement, MOAs with contracted agencies, state statues and other regulations, and Web site postings. Interim services requirements for special populations are included in Section II, Subsection B of each provider contract. Clients are made aware of admission preferences requirements through a Bill of Rights posted on the wall of treatment agencies.

The DMHAS statewide Women's Steering Committee meets quarterly to identify barriers that women may experience when accessing treatment, such as homelessness or lack of adequate support. The Women's Steering Committee addresses provider issues such as coordinating care and EBPs for substance-abusing women, pregnant women, women with dependent children, and other special populations in the community. DMHAS reports that within 48 hours after pregnant substance-abusing women are placed on a wait list, providers are requested to provide interim services through Section II, Subsection B of their contracts.

DMHAS reports that monitoring of admission preferences requirements is completed using a monitoring review form during site visits. The monitoring review form contains language that assist APMOs in determining whether pregnant women and other special populations are receiving priority treatment as outlined in provider contracts, state regulations, and SABG requirements. General requirements pertaining to pregnant women and women with dependent children also are contained in Annex A. APMOs ensure through onsite reviews that individuals requesting referral service to a treatment provider receive service within 48 hours.

DMHAS requires that all contract agencies maintain a current monthly roster to show the number of active clients with information such as a client identifier, family income, gender, date of admission, discharge date, and findings. DMHAS does appear to have incentives or sanctions in place to ensure compliance with SABG requirements.

Specialized Services for Pregnant Women and Women with Dependent Children

DMHAS reports that specialized services for pregnant women and women with dependent children are ensured through SABG regulations and New Jersey state policies and procedures. The women's-specific provider visited by the Technical Review team reports that best practices are used in providing services to substance-abusing women and women with dependent children. The provider reports that treatment services are provided in accordance with contract language and include trauma-informed treatment, Seeking Safety, CBT, MI and stages of change, family-centered therapy, and rational emotive therapy.

DMHAS indicates that the implementation of the Women's Steering Committee has encouraged the establishment of a network of organizations that support women's services in New Jersey. Currently, there are 50 members on the Women's Steering Committee that include representatives from the Work First New Jersey-Substance Abuse Initiative and Department of Children and Families Division of Child Protection and Permanency and Division of Family Development as part of the Child Protection Substance Abuse Initiative. Providers reported low wages to support staff as a barrier to implementation.

The number of specialized programs for women, women with dependent children, and pregnant women are outlined in Table II-16.

Table II-16. 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	0	0	0		
Residential Treatment	4	4	6	3 urban	6
Outpatient Treatment	0	4	4	2 urban	9
Intensive Outpatient Treatment	6	6	6+	4 urban	6
Therapeutic Community	0	0	0	0	0
Halfway/Transitional Housing	1	2	2	2 urban	2
Other	16	16	16	12 urban	16

DMHAS reports that there are 16 contracted methadone programs that provide intensive services on an outpatient basis to pregnant women and women with dependent children. IOP treatment programs provide specialized services directly or by way of referral to pregnant women and women with dependent children.

DMHAS has treatment centers for substance-abusing women and women with dependent children across the state of New Jersey. According to DMHAS, provider sites for the treatment of pregnant women and women with dependent children can be found in Atlantic, Camden, Monmouth, Essex, Morris, Passaic, Union, and Burlington Counties in New Jersey, and other counties across the state as outlined in the 2012 SABG application. Currently, providers in 17 counties are receiving SABG funds.

Providers informed the Technical Review team that there is no formal wait list policy and providers have not experienced any problems admitting pregnant women and women with dependent children into treatment or interim services. However, DMHAS reports in the 2012 SABG application that SABG funds in FFY10 were not expended to support either a capacity management system or a wait list management program.

CIMS provides the division with number of slots or beds available for each program. The Pre-admission Module within NJ-SAMS is used for wait list management functions. Providers specify whether a client is eligible for admission but awaiting an available treatment slot or bed, or refer the client to another provider if the wait list is too long. Therefore, the capacity management process is available to all programs including agencies that offer services to pregnant women and women with dependent children. The women's treatment coordinator, when contacted, actively intervenes to ensure there is prompt placement of pregnant women and

other priority populations in appropriate treatment programs. The women's treatment coordinator identifies available slots or beds within funded agencies and follows-up with providers. Providers may benefit from and are encouraged to develop an agency wait list policy and maintain a wait list as an alternative client tool to ensure appropriate placement into treatment.

The provision of specialized services is ensured by special onsite monitoring by DMHAS, licensure/accreditation, contract monitoring, and formal program reports. All programs are carefully monitored by trained staff, and programs undergo annual site visits, which include chart reviews, client interviews, and buildings and grounds inspections. DMHAS reports that onsite monitoring of services for pregnant women and women with dependent children is outlined in contracts containing SABG funds.

The Women's Steering Committee coordinates a network in the support of services to children and the treatment of women with substance abuse issues. Providers offering services to special populations are required to advertise priority admissions for pregnant women and women with dependent children.

Providers offering treatment services to special populations are encouraged to use the following promising and EBPs:

- MI,
- Motivational Enhancement Therapy,
- CBT,
- Strengthening Families Program,
- Trauma-informed and trauma-specific treatment,
- Seeking Safety, and
- Family-centered treatment.

III. Impact of Technical Assistance and Technology Transfer

Technical Assistance Recommendations Made During Previous Technical Reviews

New Jersey's previous Technical Review occurred in July 2009 and resulted in nine technical assistance (TA) recommendations. These recommendations are detailed in table III-1.

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

Technical Review Recommendation	Technical Assistance Status/Impact	Funder (Center for Substance Abuse Treatment/Other)
Integration of Behavioral and Physical Health—The Division of Addiction Services (DAS) could benefit from Center for Substance Abuse Treatment (CSAT)-funded TA for peer-to-peer assistance to explore successful methodologies to integrate behavioral and physical health.	CSAT-funded TA was neither requested nor received to address this recommendation.	Not applicable
Development of New Jersey Substance Abuse Monitoring System (NJ-SAMS) Treatment Planning—DAS could benefit from CSAT-funded TA to develop NJ-SAMS treatment planning and progress note modules in the context of an electronic health record.	CSAT provided offsite and onsite TA services on March 18, 2011, and April 26, 2011, to assist the state in identifying the requirement for incorporating treatment planning and progress note modules into an electronic client record. TA also looked to examples in electronic behavioral health record systems in other treatment systems and organizations.	CSAT
Funding Streams—DAS could benefit from CSAT-funded TA for peer-to-peer assistance to develop methodologies to determine clients' financial eligibility for services.	CSAT-funded TA was neither requested nor received to address this recommendation.	Not applicable
Charitable Choice Compliance—DAS could benefit from developing policies and procedures to ensure that provider agencies are in compliance with Charitable Choice requirements. The state also may benefit from CSAT-funded TA.	CSAT-funded TA was neither requested nor received to address this recommendation.	Not applicable

Technical Review Recommendation	Technical Assistance Status/Impact	Funder (Center for Substance Abuse Treatment/Other)
Cultural Competency and Workforce Development—DAS has requested CSAT-funded TA in identifying methods for further enhancing cultural competency training efforts within the state. *(TA suggested by New Jersey)*	CSAT-funded TA was neither requested nor received to address this recommendation.	Not applicable
Data for System Improvement—DAS staff have requested CSAT-funded TA to develop capacity to analyze and use data, including outcome data, for system improvement. DAS could benefit from technical as well as peer-to-peer assistance to explore successful methodologies to share outcome data with consumers and families. *(TA suggested by New Jersey)*	TA was already in process prior to the development of a TA plan. TA will provide offsite and onsite assistance to help the state refine its data use plan and implement the refinements. The refinements may focus on opportunities to consolidate data pertaining to service quality, utilization, outcomes, and other performance indicators that will enable the state to plan, manage, and adjust services, policies, and funding. A major focus of the TA will be how to structure a quality improvement group and use the data to assess service quality. TA also will take into consideration opportunities to increase providers' acceptance and use of data as a management tool and increase stakeholder (consumers, referral sources, policymakers, etc.) and general public access to meaningful data.	CSAT
Development of Comprehensive 3-Year Plan—DAS staff have requested CSAT-funded TA to develop and implement a comprehensive 3-year plan. *(TA suggested by New Jersey)*	CSAT-funded TA was neither requested nor received to address this recommendation.	Not applicable
Medication-Assisted Treatment (MAT)—DAS has requested CSAT-funded TA to address and/or conduct forums for providers regarding MAT in general, and MAT for women in particular. *(TA suggested by New Jersey)*	CSAT-funded TA was neither requested nor received to address this recommendation.	Not applicable

Technical Review Recommendation	Technical Assistance Status/Impact	Funder (Center for Substance Abuse Treatment/Other)
Adolescent Treatment Service System—DAS has requested CSAT-funded TA in determining funding structures and further enhancing the systemic integration of the continuum of care for adolescents. DAS also could benefit from considering the advantages and disadvantages of further collaboration with other agencies in coordinating adolescent treatment services. *(TA suggested by New Jersey)*	CSAT provided offsite and onsite TA services on February 16, 2011, and May 24, 2011, to assist the state in identifying strategies to use to improve adolescent service demand and appropriateness. The aim of the TA was to ensure that clinical decisions regarding adolescent placement and services are clinically sound. TA focused on the following: 1) adolescent treatment instruments that would be the best option to help providers pinpoint clients' level of need; 2) placement criteria and processes that could help providers direct adolescents to the most appropriate levels of care; 3) evidence-based/best practices that are most effective with adolescents; 4) continuum of care that addresses the breadth of adolescent treatment needs; and 5) utilization management practices the state can use to ensure that adolescents are being directed to the most appropriate levels of care.	CSAT

New Jersey has received two other CSAT-funded TA deliveries since the last Technical Review. These deliveries are detailed in Table III-2.

Table III-2. Other CSAT-Funded Technical Assistance

Area Addressed by CSAT-Funded TA	TA Status/Impact
Integration of Substance Abuse and Mental Health Agencies	CSAT provided TA services on December 10, 2010, and August 25, 2011. Offsite, Web-based, and or telephonic support provided the state with background information on integrating substance abuse and mental health agencies. The assistance identified examples of successes, the critical factors that influenced the successes, methods of integration, and other lessons learned. The assistance included the following two components: 1) research and summarization of experiences of other states that have merged previously separate substance abuse and mental health agencies, and 2) convening one or more webinars or teleconferences with senior staff from other states that have merged substance abuse and mental health agencies.

Area Addressed by CSAT-Funded TA	TA Status/Impact
Medical Homes	CSAT provided offsite and onsite TA services and support July 13–14, 2011, to assist in outlining appropriate processes and components for establishing medical homes as a viable substance abuse service option. The TA involved the following: 1) helping the state structure its thinking regarding medical homes; 2) exploring the potential structure, staffing, and credentialing requirements; 3) identifying potential incentives and locations; and 3) identifying innovative thinking of other jurisdictions that have established medical homes.

IV. Technical Assistance and State-Requested Technical Review Recommendations

Tables IV-1 and IV-2 on page 44 were reviewed by the designated state official responsible for advising the Center for Substance Abuse Treatment (CSAT) on the state agency's technical assistance (TA) and State-Requested Technical Review needs, following a review of Draft 1 of the Technical Review report. The purpose of including this form in the Draft 1 Technical Review report is to help expedite TA planning and delivery by giving CSAT staff an early alert on the state's needs. However, CSAT recognizes that TA priorities can change over time. Consequently, the state may reorder its priorities or change the scope of its TA requests during the TA planning and implementation process. This final version of the Technical Review report includes updated information on the state's TA priorities and delivery timeframe preferences.

TECHNICAL ASSISTANCE AND STATE-REQUESTED TECHNICAL REVIEW RECOMMENDATIONS

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

- **Data Management System**— The Division of Mental Health and Addiction Services (DMHAS) should continue with its re-engineering of the New Jersey Substance Abuse Monitoring System (NJ-SAMS) to make the system more user-friendly and efficient, and to aid in decreasing the administrative burden attached to the system's current use.

- **Behavioral Health Integration**—DMHAS could benefit from collaborating with their CSAT State Project Officer (SPO) to identify states that have successfully integrated behavioral health structures, and to identify the common integration challenges these states had to address. Information resulting from this process could provide DMHAS with options on how to best address their current and future integration challenges and needs.

- **Wait List Management**—DMHAS could benefit from instituting a real-time wait list system to help ensure priority populations are admitted to the appropriate level of care in a timely manner.

- **Allowable/Unallowable Expenses**—DMHAS could benefit from: (1) documenting Substance Abuse Prevention and Treatment Block Grant (SABG)-specific prohibited expenditures on provider contracts or letters of agreement, (2) ensuring A-133 provider compliance regarding subrecipient responsibilities as they pertain to allowed/un-allowed activities, and (3) identifying the SABG Catalogue of Federal Domestic Assistance number and amount of federal funds awarded on provider contracts.

- **Human Immunodeficiency Virus (HIV) Maintenance of Effort (MOE) Verification**—DMHAS could benefit from validating future HIV MOE data provided by the Department of Health and Senior Services (DHSS) or other governmental units via accounting system documentation with approvals by lines of authority.

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

- **SABG Financial Management**—DMHAS could benefit from CSAT-funded TA to address fiscal management of SABG requirements in collaboration with the Administrative Services Contract (ASC).

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

- **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., through cross-agency training and in-service technology transfer);
  - Anticipate how providers will need to be positioned in the emerging post health care reform environment; and
  - Identify opportunities to improve service coordination and integration at the local level through integrated program policy development.
- **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 raging 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.

Table IV-1. New Jersey TA Recommendations Summary[1]

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

Table IV-2. TA Requested by New Jersey[2]

State's TA Priority Number	TA Requested by New Jersey	State's Preference for TA Delivery (Month/Year)
	Strategic Mapping and Visioning	
	Cultural Competency	

[1] The state did not prioritize the TA recommendations listed in Table IV-1 or provide timeframes for TA delivery based on the recommendations.

[2] The state did not prioritize the TA requests listed in Table IV-2 or provide timeframes for TA delivery based on the requests.

Appendix A. New Jersey Interviewee List

Representative	Organization
Steve Adams, Assistant Director	Office of Fiscal and Management Operations
Dr. Louis Baxter, Addictions Medical Director	Office of the Medical Director
Valerie Bayless	Office of Human Resources
Roger Borichewski, Assistant Director	Office of Prevention, Early Intervention and Community Services
Suzanne Borys, Assistant Director	Office of Research, Planning and Evaluation
Adam Bucon, HIV/TB Coordinator	Office of Care Management
Lisa Ciaston	Office of Legal and Regulator
Elizabeth Conte, Training Coordinator	Office of Quality Assurance
Jean DeVitto, Chief, Mental Health and Addiction Services Licensing	DHS Office of Licensing
Loretta Dutton, HIV/AIDS Coordinator	Department of Health
Robert Eilers, MD, Medical Director	Office of the Medical Director
Adrienne Fessler-Belli	Disaster and Terrorism Branch
Vicki Fresolone, Special Assistant	Office of the DMHAS Assistant Commissioner
Nitin Garg, IT Manager	Office of Information Technology
H. Jeff Garvin, Administrative Analyst	Department of Health
Kathleen Goat Delgado, Supervising Program Management Officer	Office of Prevention, Early Intervention and Community Services
Jose Gonzalez, Contract Administrator	Office of Fiscal and Management Operations
Mollie Greene, Assistant Director	Office of Care Management
Manuel Guantez, Executive Director	Turning Point
Ed Higgins, Executive Director	JSAS Healthcare, Inc.
Nancy Hopkins, FFS Program Manager	Office of Care Management
Philip Horowitz, Executive Director	Sunrise House Foundation

Lynn A. Kovich, Assistant Commissioner	Office of the DMHAS Assistant Commissioner
Valerie Larosiliere, Assistant Commissioner	Office of Treatment and Recovery Supports
Raquel Mazon Jeffers, Deputy Director	Office of the Deputy Director
Donna Migliorino, Planning Coordinator	Office of Research, Planning and Evaluation
Geralyn Molinari, FFS Program Manager	Office of Care Management
Brian Moss, Fiscal Resources Manager	Office of Fiscal and Management Operation
Robin Nighland, Adolescent Treatment Coordinator	Office of Treatment and Recovery Supports
Thomas Privett, TB Coordinator	Department of Health
Harry Reyes, Deputy Assistant Director	Office of Treatment and Recovery
Roy Roldan, Assistant Director	Office of Information Technology
Christine Scalise, Women's Treatment Coordinator	Office of Treatment and Recovery Supports
Mian Shi, Section Supervisor, Fiscal Resources	Office of Fiscal and Management Operations
Dona Sinton, Executive Assistant	Office of the Deputy Director
John Whitenack, Assistant Director	Office of State Hospital Management

Appendix B. Acronyms Relevant to the New Jersey Technical Review

AEREF	Alcohol, Education, Rehabilitation, and Enforcement Fund
AIDS	acquired immunodeficiency syndrome
APCB	Addiction Professional Certification Board
APMO	Addiction Programmatic Monitoring Officer
ASAM PPC-2R	American Society of Addiction Medicine, Patient Placement Criteria, Second Edition, Revised
ASC	Administrative Services Contract
ASI	Addiction Severity Index
CADC	Certified Alcohol and Drug Counselor
CBT	Cognitive Behavioral Therapy
CCP	County Comprehensive Plan
CFR	Code of Federal Regulations
CIMS	Contract Information Management System
COD	co-occurring disorder
COU	Close-Out Unit
CSAT	Center for Substance Abuse Treatment
DAS	Division of Addiction Services
DCA	Division of Consumer Affairs
DGM	Division of Grants Management
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DLPS	Department of Law and Public Safety
DMH	Division of Mental Health
DMHAS	Division of Mental Health and Addiction Services
DSM-IV	*Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition
DYFS	Division of Youth and Family Services
EBPs	evidence-based practices
EIS	early intervention services
FFS	fee-for-service
FFY	federal fiscal year
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	human immunodeficiency virus
IOP	intensive outpatient
IT	information technology

JJC	Juvenile Justice Commission
LCADC	Licensed Clinical Addiction and Drug Counselor
LOE	level of effort
LPC	Licensed Practicing Counselor
MAP	Mutual Agreement Program
MAT	medication-assisted treatment
MHSIP	Mental Health Statistics Improvement Program
MI	Motivational Interviewing
MOA	memorandum of agreement
MOE	maintenance of effort
N.J.A.C.	New Jersey Administrative Code
NJDOC	New Jersey Department of Corrections
NJIP	New Jersey Infrastructure Project
NJS	New Jersey Statute
NJ-SAMS	New Jersey Substance Abuse Monitoring System
NOMs	National Outcome Measures
OFMO	Office of Fiscal and Management Operations
OPIA	Office of Program Integrity and Accountability
OPSI	Office of Policy and Special Initiatives
OQA	Office of Quality Assurance
ORPEIST	Office of Research, Planning, Evaluation, Information Systems, and Technology
PIC	Program Improvement Committee
POMS	Prevention Outcome Management System
QAMS	Quality Assurance Monitoring System
RFP	request for proposal
ROEs	Reports of Expenditures
ROI	release of information
RWJMS	Robert Wood Johnson Medical School
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SFY	state fiscal year
SOMMS	State Outcome Measurement and Management System
SPB	New Jersey State Parole Board
SPO	State Project Officer
SSA	Single State Authority

SSDP	State Systems Development Program
SSN	Social Security Number
TA	technical assistance
TANF	Temporary Assistance for Needy Families
TB	tuberculosis
TEDS	Treatment Episode Data Set

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 indepth 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]; and
- 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 Authority (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 onsite review, the reviewers examine documents provided by the SSA. Additional documents describing agency and program operations are obtained on site and reviewed either at that time or following the site visit. A primary component of the Technical Review process is a series of interviews conducted

on site with the state agency, intermediary agency (if appropriate), and local provider staff members responsible for the areas under review.

At the completion of the site visit, the reviewers conduct an exit conference with State officials to discuss preliminary findings and TA recommendations. Following the site review, the reviewers complete the analysis of all documentation and generate a draft report that integrates these findings with the results of the site visit. This draft is submitted to CSAT and the SSA for review and comment. A final report is then produced that incorporates the corrections and revisions agreed to by the 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. All findings and corresponding tables in this report are designed to capture the static nature of the review period in (August 19–24, 2012), and do not necessarily reflect the current dynamics in New Jersey regarding SSA compliance. This report is intended solely for the use of CSAT, the state of New Jersey, and their appropriate designees.