Ray A. Mateo, Partner

November 7, 2025

Via Email ( )
, Supervising Auditor
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, NJ 08625-0025

Re: Bonnie Brae

Dear Mr. :

This law firm represents Bonnie Brae in connection with the Office of the State Comptroller, Medicaid Fraud Division's ("OSC") audit of Bonnie Brae. Please accept this letter, and the additional documentation (BB-CK-2902 – 2913) submitted herewith, as Bonnie Brae's response to the Draft Audit Report dated October 9, 2025 ("DAR"). Without waiving any defenses or objections to OSC's findings, we have also attached a proposed Corrective Action Plan as Exhibit A hereto and incorporate by reference our previously submitted comments and objections in response to OSC's Summary of Findings dated February 13, 2025 ("SOF"), including the expert report from , LCSW, the former Deputy Division Director and Manager of all Out-of-Home treatment (behavioral health, substance use, and developmental disabilities) within the New Jersey Department of Children and Families ("DCF"), Children's System of Care ("CSOC") dated June 30, 2025 (the " Expert Report") (collectively the "Prior Submissions").

Bonnie Brae appreciates the role of the OSC in ensuring accountability. However, the SOF and DAR misrepresent fundamental facts and paint a misleading picture of a respected non-profit's century-long record of excellence. The findings rely on narrow interpretations of documentation standards that ignore both the complex realities of residential behavioral health care and the State's own prior approvals of Bonnie Brae's practices.

The DAR completely discounts the strong performance outcomes and transparency Bonnie Brae demonstrated throughout the audit process. Simply put, the DAR substitutes bureaucratic box-checking for meaningful evaluation – and in doing so, unfairly undermines the work of dedicated professionals who delivered high-quality, uninterrupted care to New Jersey's most vulnerable youth under extraordinary circumstances.

Moreover, the OSC's analysis fails to account for critical context. The DAR analyzes Bonnie Brae's documentation practices from 2020 through 2021, the height of the COVID-19 pandemic. This was a time when residential care providers across New Jersey were adapting to unprecedented operational challenges and evolving state guidance. Since that time, Bonnie Brae has implemented and enforced policies and practices that render some of the points raised by the audit moot.

EXECUTIVE SUMMARY

Bonnie Brae is a non-profit corporation that was founded in 1915 by the Honorable Harry V. Osborne, an Essex County Court Judge. Its mission then, as it remains today, is to provide comprehensive care, education, and a safe place for historically underserved youth and families in crisis. Throughout its more than one-hundred-year existence, Bonnie Brae has transformed the lives of over 13,000 youth and families.

Bonnie Brae is Joint Commission accredited and has a long track record of compliance -- regularly passing the myriad of license inspections, surveys, and national accreditations that come with being a health care provider in the highly regulated residential treatment center industry.

Within this industry, Bonnie Brae handles the most challenging cases and is a "go-to agency when CSOC need[] assistance with a challenging youth." [redacted] Expert Report at p. 2. At the time of their admission, 67% of Bonnie Brae residents had been abused, neglected, or witnessed violence inside or outside the home, 64% had been runaways, 70% were taking psychotropic medications, and 95% had school problems, including multiple suspensions, expulsions, and truancy. Despite handling such multi-faceted and complex cases, Bonnie Brae is "renowned for its exceptional track record in achieving positive outcomes." *Id.* It regularly meets or exceeds the service outcome measures outlined in Annex A of its contracts with DCF. Indeed, for 2020, the focus of the audit, the average length of stay was 9.5 months; over 88% of residents were successfully discharged to a less restrictive setting; 97% of residents had a 90% or higher attendance rate at school; 100% of residents showed improvement on identified strength and needs domains from the time of admission to discharge; and 92% had no subsequent contact with the justice system. Bonnie Brae's "campus is immaculate, the youth are engaged and satisfied, care managers are equally pleased, and youth are able to return home sooner." *Id.* at p. 3. In a 2021 satisfaction survey of 75 DCF-contracted caseworkers assigned to Bonnie Brae residents, 99% or more agreed with the following statements:

- Overall, I am satisfied with the services the child receives
- The child's family gets the help they want for him
- The services the child and his family receive are right for them
- The people helping the child stick by the family no matter what
- I feel the child has someone to talk to when he is troubled

BB-CK-2904; see also BB-CK-2906 (similar satisfaction reported by DCF-contracted caseworkers in most recent survey available).

These are the "true measure[s]" of "contract compliance and programmatic success" and for which Bonnie Brae represents the "gold standard." [redacted] Expert Report at p. 3.

Eschewing the true measures of contract compliance, OSC attempts to paint a different picture of Bonnie Brae. Indeed, the DAR is riddled with gratuitous language in its findings, including an unsupported theory of "impossible hours" by case managers. Despite OSC's claims to the contrary, Bonnie Brae's case managers did not misrepresent the number of case management hours they worked; rather, Bonnie Brae supplied the proper number of case manager

full-time equivalents (FTEs) as set forth in its contracts. Bonnie Brae also did not provide overlapping therapy and did not maintain a second, "alternative" set of records as OSC suggests.

Bonnie Brae, as it has throughout the audit, acknowledges that its documentation practices and electronic health records system (EHR) have room for improvement, but objects to OSC's findings that go beyond such documentation issues. It is important to note that Bonnie Brae has made great strides in its documentation practices since the audited time period. It has implemented rigorous quality controls, modernized its documentation systems, hired additional staff members, including a new Clinical Director, strengthened staffing oversight, and invested in compliance training across all levels of the organization. Going forward, Bonnie Brae looks forward to working with DCF on even further enhancements.

Audit Finding - A(1)
Bonnie Brae's Case Managers Never Represented to DCF That They Worked Upwards of 430 Hours a Month.

As its lead point, OSC alleges that Bonnie Brae's case managers represented that they worked a "highly improbable and, in some cases, simply impossible" number of hours. DAR at pp. 7, 11. That is simply not the case. This erroneous and highly inflammatory conclusion:

(i) ignores that case management activities at Bonnie Brae are not performed exclusively by the designated case manager, but instead by a large, cross-departmental team,

(ii) misreads and grossly mischaracterizes Bonnie Brae's case management summary form – a one-page, internal document that was signed by the designated case manager as verification that Bonnie Brae collectively (and not the case manager individually) performed the required case management activities,

(iii) disregards the contract between the parties, which specifically identified the number of case management FTEs that Bonnie Brae was required (and did) provide, and

(iv) disregards the DCF-approved Program Staffing Summary Reports ("PSSRs") – the ***only*** document submitted to DCF where Bonnie Brae represented the number of hours, and the percentage of time Bonnie Brae's case managers were expected (and did) spend on case management activities.

First, as explained in our Prior Submissions and the Exit Conference, Bonnie Brae relies on a large, cross-departmental team to perform case management services. As the person with the closest and most direct relationship with the residents in his or her respective cottage, the designated case manager oversees this team and personally performs some of the case management services for his or her residents, but not all of them. This point should not be controversial.

Bonnie Brae is a large residential treatment provider. It is not a five-bed residential home where a single person may handle all the home's case management activities. Rather, Bonnie Brae

employs 316 people and, over the years, has built a significant organizational infrastructure. Unlike smaller facilities, Bonnie Brae possesses multiple specialized departments, such as a clinical department, admissions department, transition specialists, finance department, medical records department, health office, residential department, and quality department, among others. When a case management activity involves one of these functions, a staff member in the appropriate department performs the service. Thus, dozens of Bonnie Brae employees contribute to Bonnie Brae's case management service hours and deliverables –not just the designated case manager.

Besides this being completely logical, this should come as no surprise as DCF recognized during its 2015 audit that Bonnie Brae's case management "involve various functions." *See* 2015 Audit at p. 15. Indeed, Mr. [redacted] – the person who co-led the project to develop the staffing grid and rates for the contracts at issue and oversaw contract compliance – acknowledged that "[i]n a large residential facility like Bonnie Brae, case management activities are typically performed by a team of staff, rather than placing all responsibilities on a single individual, which would be inefficient, impractical, and costly." *See* [redacted] Expert Report at p.3. Mr. [redacted] also explained that "[f]rom DCF's perspective, residential treatment facilities were afforded the flexibility to develop a system and infrastructure that worked best for their particular organization so long as adequate personnel were available to meet the diverse case management needs of the youth." *Id.* at p. 4. It should be plain that at Bonnie Brae, an organization with 316 employees, case management services were not solely performed by its case managers and that DCF understood and approved of this approach.[1]

Second, OSC bases its "impossible hour" theory on its incorrect reading of Bonnie Brae's one-page case management summary form. As will be discussed more herein, Bonnie Brae, with the approval of DCF, "developed a weekly Case Management services summary documentation form to be completed by the Clinical staff." The "summary form is a one-page, checklist" with "standardized times" for common case management activities. *See* 2015 audit at p. 16. The summary form was just that – a summary document. It was maintained for internal verification purposes only and was not, and was never intended to be, a formal claim form submitted to a payor for payment as OSC seems to treat it. In fact, the weekly-signed case management summary forms were never submitted to DCF at all.

Moreover, nowhere on the form does the case manager expressly represent or certify that all case management activities referenced were personally performed. By electronically signing the summary sheet, the case manager did not, and never intended to, indicate that he/she personally performed all of the listed case management services, let alone make such a representation to DCF,

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[1] Further to this point, during the 2015 audit, DCF, after acknowledging Bonnie Brae's case management services involved "various functions," recommended that Bonnie Brae institute a "system of internal controls [which] ***may*** include the assignment of a Case Manager to insure that each youth receives the required 5.5 hours per week of case management." *See* DCF 2015 Audit at p. 15 (emphasis added). Thus, DCF did not even require Bonnie Brae to assign case managers to a youth's file and within the context of this recommendation clearly envisioned the role of a case manager, if one was assigned, as overseeing the organization's various functions and confirming that case management activities were performed.

as OSC maintains. Rather, as the person responsible for overseeing cross-departmental case management activities, the designated case manager merely signed the form to confirm that the requisite services and hours were performed by the case management team – this is exactly what Bonnie Brae proposed in its 2015 corrective plan by stating that the form would be "completed by the Clinical staff." *See* 2015 audit at p. 16. The fact that Bonnie Brae did not require each staff member in its 316-person organization who assisted with a resident's case management to sign an internal one-page summary form does not mean that the case manager was the only individual providing case management services. Contrary to OSC's claim, the internal summary form does not reveal the number of case management hours personally performed by the designated case manager. Instead, the annual PSSRs, which OSC did not consider in this analysis, indicate the amount of time the designated case manager was expected to spend on such activities. If this information had been taken into consideration, it would have demonstrated that the designated case managers had sufficient capacity to fulfill their allotted case management hours and that Bonnie Brae provided the contractually required number of case manager FTEs.

Third, despite OSC's claim that Bonnie Brae was plagued by "significant staffing deficiencies," Bonnie Brae complied with the contract and supplied the agreed-upon case management resources. Though not referenced in the DAR, each of the contracts at issue contained a staffing grid, which specified the number of FTEs required for different positions. As Mr. [redacted] explained, the staffing grid was "used as a mechanism to determine an inclusive rate for providers to have particular staff on hand" – i.e., providers were compensated for having an "appropriate mix of staff … to achieve … program directives;" and requiring *more* FTEs would have thus necessarily resulted in *higher* reimbursement rates. [redacted] Expert Report at p. 4. For case management, the contracts collectively called for 4.2 case manager FTEs (which equates to 170 total per week by the designated case managers) to service 93 children, as the contract excerpts below demonstrate.

<u>SPECIALTY BEDS (2.2 FTEs)</u>

Medicaid Provider #: [redacted] Agency Name: BRAE, BONNIE .
Contract Number: 17BJZR Program Type: SPEC
Contract Start Date: 07/01/2016 Contract End Date: 06/30/2021

TREATMENT TEAM MEMBERS TO CHILD RATIOS

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	2.20	88.00	49	5.50

RTC (1.2 FTEs)

Medicaid Provider #: [redacted] Agency Name: BONNIE BRAE
Contract Number: 18FDZR Program Type: RTC
Contract Start Date: 07/01/2017 Contract End Date: 06/30/2022

TREATMENT TEAM MEMBERS TO CHILD RATIOS

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	1.20	47.00	25	5.50

RTC – Behavioral Health/Substance Use (.86 FTEs)

Medicaid Provider #: [redacted] Agency Name: BONNIE BRAE- CO-OCCURRING RTC
Contract Number: 18FDZR Program Type: RTC-BH/SU
Contract Start Date: 07/01/2017 Contract End Date: 06/30/2022

TREATMENT TEAM MEMBERS TO CHILD RATIOS

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	0.86	35.00	19	5.50

At 5.5 hours per child per week, the contracts require a total of 511.5 weekly case management hours (93 x 5.5) but only provide for (and base the reimbursement schedule on) 170 weekly case manager hours. Thus, on their face, the contracts seemingly created a significant staffing shortage of 341.5 hours per week, equivalent to 8.5 FTEs. Put differently, under a strict mathematical approach that treats case management activities as an individualized service, a residential treatment center would need to source 300% more case management hours and FTEs than specified in the contract (and for which they were paid) to meet the service requirements. The contract, however, was not intended to be interpreted in this manner, and the parties did not intend to create such an obvious discrepancy. Nevertheless, this is exactly how OSC interprets the contract when it claims that Bonnie Brae needed 10 *additional* FTEs (for a total of 14.2 FTEs) to perform the work indicated on the case management summary forms, even though the contract itself only called for 4.2 FTEs. *See* DAR at p. 8.

The flaw in OSC's approach can be explained by two main points:

(i) the staffing grid accounted for the fact that others at Bonnie Brae, besides the case managers, would perform case management services -- as we've explained, Bonnie Brae case managers oversee the delivery of case management services but do not personally perform all such services. As the staffing grid demonstrates, the

dedicated case managers were expected to perform 170 of the required 511.5 weekly case management hours; and

(ii) some case management activities are performed at the group level rather than on an individualized basis; therefore, an approach that strictly equates one hour of staff member time to one hour of case management service misses the mark. From a mathematical perspective, if, for example, one hour of service is delivered in a group format of five youth, five hours of service have been delivered. In fact, we shared with OSC communications with DCF that showed an agreement between the parties that case management services were performed 25% on an individual basis and 75% on a group basis. In the email thread with DCF, Bonnie Brae explained that a portion of case management services are "delivered in a group format," such as "transportation coordination, daily scheduling, organizing family visits, group social/educational appointments and outings, clothing inventory and shopping, etc." *See* BB-CK-2408 – 2411.

Understanding these two points is essential in reconciling the contracts' staffing requirements with the required service hours. OSC, however, improperly neglected these points and calculated case management service hours in a way that conflicted with the contracts' express terms and staffing ratios as well as the parties' long-established course of dealing. This led to their faulty conclusion that Bonnie Brae needed 10 additional FTEs to deliver the services outlined in its case management summary forms.

Lastly, OSC's approach to case management service hours also conflicts with the DCF-approved PSSRs. On an annual basis, Bonnie Brae submitted PSSRs for DCF's review and approval, which specifically identified the percentage of time and number of hours each designated case manager was required to devote to case management activities. This was the only document submitted by Bonnie Brae to DCF that specifically represented how many hours each of its case managers would dedicate to case management activities.

As the relevant sections of the approved 2020 PSSRs show (copied below), Bonnie Brae's designated case managers were generally expected to spend between 14.50 and 20 hours per week in a standard 40-hour work week (or 36.2% and 50% of their time) on case management activities for the 93 beds/residents covered by the contracts.

CONTRACT - 17BJZR

CASE MANAGEMENT																							
[redacted]	Case Management	MA	Psych Studies	LSW	Case Management. Delivery of service hours will vary.	FT(40)	17.50%	RTC, Co-Occurring RTC			9:30 AM	11:00 AM	9:30 AM	11:30 AM	9:30 AM	10:30 AM	9:30 AM	11:30 AM	9:30 AM	10:00 AM			7.00
[redacted]	Case Management	MSW	Social Work	LAC, LCADC, LPC	Case Management. Delivery of service	FT(40)	36.20%				1:00 PM	3:00 PM	10:00 AM	12:30 PM	10:00 AM	2:00 PM	10:00 AM	2:00 PM	10:00 AM	12:00 PM			14.50
[redacted]	Case Management	MA	Mental Health Counseling	LAC, LCADC, LPC	Case Management. Delivery of service	FT(40)	36.20%				12:00 PM	2:00 PM	9:00 AM	11:30 AM	9:00 AM	1:00 PM	1:00 PM	5:00 PM	1:00 PM	3:00 PM			14.50
[redacted]	Case Management	MA	Counseling	LAC	Case Management. Delivery of service	FT(40)	36.20%				1:00 PM	3:00 PM	9:00 AM	11:30 AM	9:00 AM	1:00 PM	11:00 AM	3:00 PM	9:00 AM	11:00 AM			14.50
[redacted]	Case Management	MA	Social Work	LAC. 6yrs exp	Case Management. Delivery of service	FT(40)	36.20%				8:00 AM	10:00 AM	12:00 PM	2:30 PM	11:00 AM	3:00 PM	10:00 AM	2:00 PM	9:00 AM	11:00 AM			14.50
[redacted]	Case Management	MSW	Social Work	LSW <1 year	Case Management. Delivery of service	FT(40)	36.20%				12:00 PM	2:00 PM	11:00 AM	1:30 PM	8:30 AM	12:30 PM	1:00 PM	5:00 PM	9:00 AM	11:00 AM			14.50

CONTRACT - 18 FDZR

CASE MANAGEMENT																							
	Case Management	MA	Psych Studies	LSW Supervision by .. 2 year plan to	Case Management. Delivery of service hours will vary.	FT (40)	20%	RTC MICA, SPEC			2:00 PM	4:00 PM	2:00 PM	4:00 PM	2:00 PM	4:00 PM	12:30 PM	2:30 PM	1:00 PM	2:00 PM			9.00
	Case Management	MSW	Social Work	LSW. LCSW within 2 years under clinicl supervision of LCSW.	Case Management. Delivery of service hours will vary.	FT (40)	50%				1:00 PM	5:00 PM	9:00 AM	1:00 PM	9:00 AM	1:00 PM	9:00 AM	1:00 PM	9:00 AM	1:00 PM			20.00
	Case Management	MSW	Social Work	LSW. LCSW within 2 years under clinical supervision of LCSW. 6 yrs. exp	Case Management. Delivery of service hours will vary.	FT (40)	50%				1:00 PM	5:00 PM	9:00 AM	1:00 PM	9:00 AM	12:30 PM	9:00 AM	2:00 PM	9:00 AM	12:30 PM			20.00
	Case Management	MSW	Social Work	LSW. 2 year plan for LCSW licensure supervised by , LCSW. 1 1/2 yrs. exp	Case Management, Delivery of service hours will vary	FT (40)	50%				12:00 PM	4:00 PM	11:00 AM	3:00 PM	8:30 AM	12:30 PM	1:00 PM	5:00 PM	9:00 AM	1:00 PM			20.00
	Case Management	MSW	Social Work	LSW. 2 year plan to otain LCSW under supervision of LCSW 5 years exp	Case Management. Delivery of service hours will vary.	FT (40)	50%				11:00 AM	4:00 PM	11:00 AM	3:00 PM	11:00 AM	3:30 PM	9:00 AM	12:30 PM	9:00 AM	12:00 PM			20.00

Pursuant to the 2020 approved PSSRs, the parties agreed that Bonnie Brae's designated case managers would collectively allocate 168.5 hours per week (the equivalent of 4.2 FTEs) on case management activities to service 93 residents. As such, the weekly hour/FTE commitments in the approved PSSRs tracked the contract staffing grid requirements outlined above – the PSSRs in the contracts' other years similarly aligned with the staffing grid as well. Thus, each year the parties reaffirmed the number of case management hours Bonnie Brae's designated case managers were expected to perform and, by doing so, reinforced that the calculation of case management service hours is more nuanced than OSC's approach.

And, despite OSC's view that Bonnie Brae had a "significant staffing shortage" and needed 10 more FTEs (or a total of more than 14 FTEs even though the contract called for 4.2 FTEs) to perform the case management services enumerated on the case management summary forms, Bonnie Brae's designated case managers had sufficient capacity to perform the expected number of case management service hours per the staffing grid and PSSRs.

Table I below shows, for February 2020, the total number of hours worked by each case manager, the percentage of those hours that were expected to be spent on case management services per the applicable PSSR and then calculates the expected number of case management hours to be performed during the month based on such percentages. Using the data from Table IV of the DAR, the fifth column shows the number of therapy hours worked (actual) by the case manager and then lastly calculates each case manager's capacity to perform case management services by subtracting their respective number of therapy hours from their total hours worked. As the table shows, the case managers assigned to cottages[2] were collectively expected to perform 513 hours of case management services under the contracts and PSSRs and had the capacity to perform 530 hours of case management services. Thus, Bonnie Brae's case managers had ample bandwidth to perform their contractually expected share of case management services.

[2] The chart does not reflect any floater case managers who were not assigned to any particular cottage but filled in where needed due to employee absences or service-related reasons.

Table I: Case Manager Capacity to Perform Contractually Required Case Management Hours (February 2020)

Cottage/ Case Manager	Hours Worked (Actual)	Percentage of time to be devoted to Case Management Activities per PSSR	Expected Case Management Hours Based on Total Hours Worked	Therapy Hours Worked (Actual)	Available Hours for Case Management Activities (*Hours worked – therapy hours worked*)
[redacted]	144	36.2%	52	100	44
[redacted]	144	36.2%	52	98	46
[redacted]	152	50%	76	76	76
[redacted]	152	36.2%	55	84	68
[redacted]	160	50%	80	81	79
[redacted]	128	50%	64	77	51
[redacted]	160	36.2%	58	80	80
[redacted]	152	50%	76	66	86
TOTAL			**513**		**530**

Based on the foregoing points above, we respectfully request that OSC remove section A(1) from the final audit report. Consistent with the contract and PSSRs, Bonnie Brae assigned the proper number of FTEs to perform the contractual case management services. It was not required to supply an additional 10 FTEs (a 333% increase) to meet its contractual obligations. Rather, the assigned case managers had sufficient capacity to perform their expected number of weekly case management hours as defined by the staffing grid and PSSRs. Moreover, the notion that Bonnie Brae was plagued with staffing shortages and its case managers compensated by falsely claiming to work upwards of 436 hours per month fails to recognize that case management activities are performed by a large, cross-departmental team and do not reside exclusively in the designated case managers. It is also based on a flawed reading of Bonnie Brae's case management summary form, which was nothing more than an internal, one-page, summary verification form and not a representation by the case manager of personal hours worked, as well as a plainly incorrect approach to calculating case management service hours, which diverged dramatically from the staffing grid and PSSRs. As such, this section, which is superfluous to OSC's overall finding regarding Bonnie Brae's purported documentation deficiencies, should be excised from the final report.

Audit Finding - A(2)
Bonnie Brae Used Its Case Management Summary Form in a Manner Reasonably Believed to Be Acceptable to DCF

As OSC observes, the case management summary form did not "record specific times when [case management] activities occurred." DAR at p. 10. Bonnie Brae does not contest this finding. The case management summary form, however, was never intended to track time with such

precision. Rather, Bonnie Brae used the form in the way it believed in good faith was approved and acceptable to DCF.

The case management summary form, as noted in the DAR, was developed in response to Bonnie Brae's 2015 DCF audit. As a way to better document and confirm Bonnie Brae's weekly performance of case management activities, DCF accepted Bonnie Brae's proposed corrective action of utilizing a summary form that "identifies all Case Management services that are delivered with standardized times, when applicable, such as the times identified for preparation of treatment plans and treatment team meetings and allows for documentation of discrete times spent delivering ***other*** Case Management services." 2015 Audit at p. 16 (emphasis added).

As shown below, the summary form developed as part of the 2015 audit corrective action plan lists twelve separate categories of activities with a conservative standardized projection of the weekly time spent throughout the organization across the tasks.

Case Management - Weekly Activities

TASK & Hours/Minutes per resident

TX planning - 1 hour

Transfer Meetings (AM, PM) - 30 minutes

Cottage staff meetings - 15 minutes

Weekend Projected Plan/ Home Visits (Planning & Debriefing) - 30 minutes

Incident report (review & signature) - 30 minutes

Phone calls - 30 minutes

Progress Notes Documentation - 1 hour

Correspondence - 1 hour
*(Routine: e-mails, Contact/Visitors list, Invite and cover letters for treatment team)
*(External Correspondence: Letters for court, DCPP, Medicaid, SSI, etc.)

Monthly Treatment Plan - 30 min/wk

Financial Oversight - 15 minutes
*(WEP, W2's, money requests, transportation vouchers, etc.)

Total number of weekly case management hours provided: 6.0 hours

Total number of contracted weekly case management hours required: 5.5 hours

Community Program - Additional Weekly Case Management Activities, School registration and coordination: 45 minutes

Total number of weekly case management hours provided by the Community Programs: 6 hours and 45 minutes

To understand why Bonnie Brae proposed, and DCF approved, this approach requires an appreciation of the broad scope of case management services performed at large residential treatment centers like Bonnie Brae. Case management services, by their nature, are difficult to define. The contract does not define the term and, in fact, offers scant details regarding the expected services. More specifically, as can be seen in the contract excerpt below, the only case management services identified in the contracts are family orientation, admission documentation,

participation in monthly treatment team meetings, and ad hoc psycho educational activities. *See* Contracts at Exhibit E, Part A – Minimum Staffing Requirements Grid.

Position	Qualifications	Other Requirements	Hours/youth/week
Case Manager-Bachelors Level Practitioner	Bachelor's level with 3-5 years of relevant experience or unlicensed Master's level with 1 year of related experience	-Family orientation (within 1st 24 hours) -Review and signature of all required paperwork (within 48 hours) -On-site family psycho educational activities consistent w/ comprehensive treatment & discharge plan (as needed/monthly) -Attend treatment team meetings (monthly)	5.5 hours per week per youth;

Besides the monthly treatment team meeting, the specific activities identified in the contracts either occur on admission or an as-needed basis and plainly do not lend themselves to predictable scheduling, consistent hour tracking, or collectively comprise anything close to 5.5 hours per week per youth.

As Mr. ██████ explained in his report and based on his role in developing and enforcing the contract, the contract's lack of detail was intentional:

> The Contract defines case management services very generally…The Contract was structured this way because case management services cover a broad range of activities designed to offer individualized support and assist youth in gaining access to needed medical, social, educational, and other services that address their unique circumstances. It involves a wide variety of everyday activities, like ensuring that residents attend school, receive medical care, and have their daily needs met, as well as coordinating transportation for family visits, court hearings, and medical appointments. It also involves coordination and communication, as applicable, with families, foster families, child welfare workers, probation officers, court officials, family support organizations, care management organizations, medical providers, and schools. For example, case management services could entail spending a day in court with a resident or something more routine like making sure a resident has clean and seasonally appropriate clothes or their preferred toothpaste or soap. In short, case management services cover hard to define ancillary activities that help individuals navigate the treatment process, connect with necessary resources, and ultimately achieve positive and lasting recovery.
> ██████ Expert Report at p. 3.

Mr. ██████'s description of the intended scope of the contract's case management services is consistent with common regulatory definitions of the term in other contexts. *See, e.g.,* N.J.A.C. 10:73-1.2 (defining case management services as "services which assist a beneficiary of Medicaid/NJ Family Care or a child, youth, or young adult receiving services from the Children's

System of Care (CSOC) in gaining access to needed medical, social, educational, and other services."); 42 C.F.R. §440.169 ("Case management services means services furnished to assist individuals…in gaining access to needed medical, social, educational, and other services."). Bonnie Brae's delivery of case management services followed this standard definition. To help OSC appreciate the wide range of case management activities it performs on a regular basis, Bonnie Brae prepared a detailed case management chart that identified the different activities, the department/person responsible for the task, and a more precise approximation of the average time spent on those activities. Overall, the chart spans 23 pages and lists 93 discrete activities ranging from coordination of visitations and medical/legal appointments to activities associated with Joint Care Reviews to more routine scheduling, documentation, and communications.

Once the sheer breadth and *ad hoc* nature of these activities at a large residential treatment center like Bonnie Brae is recognized, the use of a summary form with standardized time projections becomes more understandable. DCF indeed appreciated the "impracticality of rigidly documenting case management activities" and logging "numerous every day, routine tasks that independently may not be very time-consuming, such as obtaining toothpaste or procuring a permission slip for the youth." [redacted] Expert Report at p. 4. Mr. [redacted] explained that:

> these types of ad hoc activities are impractical to track on a minute-by-minute basis. In my experience, if an agency was adequately staffed and residents were progressing in their treatment, like at Bonnie Brae, the residents were undoubtedly receiving the necessary case management services. Otherwise, the residents would not be in a position to achieve such positive outcomes. In other words, documenting every minute of staff time is nearly impossible due to the ad hoc nature of case management activities and communications with stakeholders (including family, physicians, courts, and probation officers) and was not the focus of DCF. DCF's focus was on the residents having the necessary case management support, as much or as little as needed, to allow the residents to return home or transition to a lower-intensity service with the shortest feasible length of stay.

From DCF's perspective, meeting service outcomes – which Bonnie Brae regularly accomplished – was the primary goal of the contract and served as prima facie evidence that the residents were receiving the necessary case management services. These outcomes could not have been achieved without a residential treatment center performing the "hard to define ancillary activities that help individuals navigate the treatment process, [and] connect with necessary resources." *Id.* at p.3.

Because "DCF's focus, was on achieving qualitative outcomes that are not measured by counting minutes" and "[d]ue to the impracticality of documenting this type of ad hoc support, DCF approved Bonnie Brae's use of a summary Case Management Checklist with standardized times (even though the standardized times were just projections) as part of their 2015 action plan." *Id.* at pp. 2, 4. OSC misattributes Mr. [redacted]'s personal knowledge to counsel, dismissively labeling that insight as "not tenable." DAR at p. 10. However, Mr. [redacted], the former Deputy Director of DCF who was instrumental in creating the contract and overseeing its compliance during the 2015 audit, is far better positioned to comment on DCF's actions during his tenure than OSC, which lacks firsthand knowledge or a credible basis to opine on DCF's decisions in 2015.

Moreover, OSC's finding that "Bonnie Brae did not use [the case management summary] form in the manner as approved by DCF and as Bonnie Brae proposed to do in response to the 2015 audit" because the form "lacked discrete time entries or individualized information" is also misplaced. DAR at p. 11. As the 2015 audit report states, Bonnie Brae proposed using a "Case Management services summary form [which] identifies all Case Management services that are delivered with standardized times, when applicable, such as the times identified for preparation of treatment plans and treatment team meetings, and allows for documentation of discrete times spent delivering other Case Management services." 2015 Audit at p. 16. The weekly case management summary form is structured exactly as written. It enumerates Bonnie Brae's twelve most common case management activities with standardized times for each category. Bonnie Brae could have supplemented this form by adding discrete times spent on "***other*** Case Management services" (i.e., services that are not already on the standard one-page summary checklist). However, such supplementation of other services was not required in the action plan, and Bonnie Brae relied in good faith on the fact that DCF found the summary form with standardized times acceptable. Additionally, as represented in its 2015 corrective action plan, Bonnie Brae's medical records and clinical teams conducted weekly audits. As the case management activities chart indicates, the Medical Records team devotes approximately 2.5 hours per week to auditing clinical and psychiatric charts, and the Medical Records team, Clinical Team, and Quality Department spend another approximately 2.5 hours per week auditing EHR records. Documents reflecting near daily audits of clinical and case management notes were produced to OSC at BB-CK-2235 – 2257 despite OSC's claim that "Bonnie Brae did not produce evidence that it performed any weekly audits of its case management services." DAR at p. 11. As such, Bonnie Brae complied with its 2015 audit action plan, which did not require the "discrete time entries" that OSC seeks to impose ten years after the fact.

Audit Finding - A(3)
The Case Management Materials Produced During the Audit Demonstrate That Bonnie Brae Performed the Activities Listed on the Case Management Summary Form

In response to OSC's audit request for case management documentation, Bonnie Brae produced the relevant case management summary forms as it reasonably believed such forms were sufficient per the 2015 audit. As a result, Bonnie Brae did not believe it was necessary to produce, and OSC did not specifically request, the supporting documentation to the summary form. While Bonnie Brae would have complied with any request, providing such documentation for each of the 93 residents enrolled in on-campus programs would have been an extremely cumbersome and time-consuming task. This process would have required gathering thousands of pages of documents related to routine daily activities from multiple departments and employees, as well as conducting an extensive email review, since much of the staff's work and coordination occurs via email.

Against this backdrop and having only received the case management summary forms from Bonnie Brae, OSC expressed "significant concern" in its SOF "as to whether Bonnie Brae provided the listed [case management] services and, if so, the effectiveness of these services given the lack of specific information about what took place." DAR at p. 10. To address this purported concern and disabuse the misimpression that residents were not receiving case management services,

Bonnie Brae assembled case management packets for 6 residents and offered to go through the burdensome exercise for the other 87 residents if OSC wanted to review such information.

More specifically, Bonnie Brae produced the following categories of documents and explained the effort, coordination, and process that is involved with each activity: (1) comprehensive monthly treatment plans, (2) therapeutic leave documents, (3) weekend projected schedules, (4) incident reports, (5) memos to chart reflecting calls, (6) correspondence with guardians and other stakeholders, (7) PerformCare notes capturing interactions between the case management organization and Bonnie Brae, (8) treatment discharge plans, (9) nursing notes, (10) child satisfaction surveys, (11) mental health assessments, (12) youth appointment calendars, (13) visitor sign-in sheets, (14) van shuttle schedules, (15) financial oversight tracker, and (16) chart audits. This production for just six of the 93 residents was approximately 2500 pages. Bonnie Brae also offered to pull staff member emails to show the extensive internal and external case management communications occurring on a regular basis.

These documents are not in any way "alternative records" as OSC pejoratively and recklessly calls them, as if trying to suggest that Bonnie Brae maintained a secret, second set of books or otherwise concocted records to respond to the SOF. DAR at p.1. That notion is absurd. The records were maintained in the normal course of business and made at or near the time of the event by, or from information transmitted by, a person with knowledge of the matter. The documents were not created after the fact or for the purposes of the audit, and nothing on the face of the documents suggests anything to the contrary.

They are also not "conflicting" records and do not contradict the case management summary form. The documents were *not* produced as a proxy to count case management minutes, as OSC attempts to do, because many of the documents do not quantify the amount of time spent on an activity. The documents, rather, were produced to show that the activities on the case management summary form – and other unlisted case management activities that were identified on the case management chart – were occurring on a regular basis. As such, the documents are supportive and do not in any way contradict or conflict with the case management summary form.

For example, the case management summary form lists treatment planning and the monthly treatment plan as two of the standard weekly activities and assigns a "standardized time" of 1.5 hours per week for the activities – the same standardized time DCF credited Bonnie Brae for these activities in the 2015 audit, but for which OSC provides no credit. *See* 2015 Audit at p. 15. To show that this work was performed, Bonnie Brae produced a copy of the thorough monthly treatment plan and other documents showing the scheduling/participation by Bonnie Brae resources in the monthly treatment plan meeting. As explained in our Prior Submissions and Exit Conference and as should have been evident from the document itself, the treatment plan is constantly updated throughout the month and tracks the residents' progress on clinical, medical, school, social/recreational, and work experience matters. It also reflects the treatment team's current recommendations for an appropriate treatment regimen. Creating this comprehensive document requires treatment team interactions and discourse, along with frequent updates and interactions between the case manager and clinical, medical, school, and cottage resources.

DCF, as experts in the field with familiarity of the treatment plan process and the significant amount of time, resources, and coordination it requires, credited Bonnie Brae with 1.5 hours per week for such activities in 2015 along with another hour per week for preparation and completion of Joint Care Reviews, and Bonnie Brae incorporated such standardized times in its case management summary form. Lacking a similar background, OSC did not credit Bonnie Brae for any treatment plan-related time despite being presented with proof that the treatment plan tasks listed on the case management summary form were, in fact, performed. While the treatment plan and related scheduling documents may not help OSC quantify the precise time spent on these activities, it does not logically track that the production of these materials conflicts with the case management summary form. To the contrary, the documents support the form as they show the activity took place.

Along these same lines, and as another example, Bonnie Brae produced weekend projected schedules in support of the line item on the case management summary form regarding "weekend projected plan/home visits (planning & debriefing) – 30 minutes." As explained in the Prior Submissions and the Exit Conference, this schedule is updated every weekend to reflect which residents are going home for the weekend and which residents are remaining on campus. To create the schedule, Bonnie Brae confirms the resident's eligibility to go home based on a level of supervision review, confirms the visit with the resident's guardian along with the time of departure and method of travel, ensures the resident's departure is consistent with the agreed upon travel plan, makes appropriate staffing arrangements for the residents remaining on campus, and then debriefs with the guardian and residents during and/or after the visit. Again, OSC did not credit Bonnie Brae for any time for this activity although it undoubtedly occurred presumably because Bonnie Brae did not track the date and time each of these different steps was accomplished. OSC took the same approach for the other categories of backup documentation produced by Bonnie Brae – only crediting those activities that were documented with a time component. *See* DAR at pp. 11-12.

While we understand (though do not agree with) OSC's approach and finding that Bonnie Brae did not "properly document[] that [it] had provided the contractually required five and a half hours per week of case management services to each youth" because it did not log the time spent on every activity, we strongly object to OSC's speculative and erroneous suggestions throughout the DAR that based on this perceived documentation deficiency residents did not receive proper care or were somehow "adversely affected." DAR at pages 6, 11, 12. OSC simply has no basis or expertise to make such sweeping conclusions regarding treatment, which happen to be contrary to Bonnie Brae's positive service outcome metrics, sterling industry reputation, glowing caseworker satisfaction surveys, and Mr. [redacted]'s first-hand observations regarding Bonnie Brae's "gold standard" quality of care. *See* [redacted] Expert Report at pp. 2-3; *see also* BB-CK-2902 – 2907.

Audit Finding - A(4)
Bonnie Brae's Clinicians Did Not Improperly Render Overlapping Individual Therapy Sessions.

In this section, OSC, focusing on the header of the EHR records, claims that "Bonnie Brae improperly rendered overlapping [individual therapy] sessions." DAR at pp. 13-14. Based on its

EHR records, Bonnie Brae understands why it may appear that its clinicians performed overlapping services. That, however, was not the case.

As OSC notes, the Service Date/Time fields for weekly individual therapy in the EHR records often overlapped across cottage members. In contrast, the body of the note typically indicated something different, such as individual therapy taking place over the course of the week or the session being rescheduled or canceled. We provided additional context during the Exit Conference to explain this apparent conflict.

Specifically, as previously explained, the audit helped Bonnie Brae discover a flaw in the setup of its EHR system, which has since been remedied. Based on the way the EHR platform was structured, an activity needed to be scheduled in advance in the system before an electronic note could be generated. To facilitate this process, the EHR team scheduled upcoming events in the system, which allowed clinicians or case managers to go into the system and create an electronic note after the event took place. As it turned out, this approach was flawed because the Service Date/Time fields in the note automatically populated with the date and time scheduled in the system by the EHR team. For group therapy sessions, which took place on recurring dates and times, this did not pose a problem as the Service Date/Time fields reflected the actual date and time of the service. However, for activities that did not take place on a set schedule, like individual therapy or case management, this structure presented a challenge. The EHR team addressed this challenge by programming events without a fixed or routine schedule in the EHR system for Fridays. As a result, at the end of each week, the clinician or case manager would receive a scheduling reminder to create a note memorializing the weekly activity. Based on the way the system was structured, the Service Date/Time fields in the note for such non-fixed events were automatically populated with the Friday control date. Clinicians were not trained on how to change these fields, as it was a convoluted, complex, and time-consuming process. Instead, they were instructed to reflect any changes to the scheduled date and time in the body of the note.

Because individual therapy usually does not take place during a set block of time, this approach often led clinicians to insert a statement in the body of the individual therapy notes indicating that therapy occurred throughout the course of the week. From decades of experience and best practices, Bonnie Brae learned that its patient population generally does not tolerate lengthy one-hour blocks of individual therapy well. Rather, individual therapy for at-risk youth is most effective in smaller intervals, which allows the clinicians to be more flexible and respond to issues as they arise in the moment. This approach is referred to as life space therapy and is a well-established therapeutic technique. As Mr. ████ explained:

> in the context of a residential treatment facility working with at-risk youth, it is challenging for youth with behavioral issues to engage in extended therapy sessions. Facilities like Bonnie Brae focus on a therapeutic approach known as Life Space Counseling, using everyday situations and interactions to help youth learn from challenging behaviors and build positive relationships. This approach allows for shorter therapy sessions (sometimes only 10-15 minutes) as needed, rather than scheduled one-hour sessions.

████ Expert Report at p. 5.

During the audit period, the progress notes did not reflect the date and times of these 10- and 15-minute increments but only generally stated that therapy was performed throughout the week.[3] This is no longer the case. As part of its corrective action, Bonnie Brae has implemented changes to better track the date/times during the week the clinician interacts with a resident, along with the substance of each such incremental meeting.

Prior to the audit, Bonnie Brae prioritized the resident's individualized monthly treatment plan over documenting every interaction. The monthly treatment plan is a live document that is updated regularly throughout the course of the month and tracks, among many other things, the residents' clinical progress against emotional, behavioral, family, and discharge goals. This process acts as a safeguard and check and balance to ensure that the contractual services are being provided, and the residents are progressing through their treatment goals. Mr. [redacted] described the critical importance of the treatment plan process in evaluating clinical progress and contract compliance:

> DCF monitored facilities' compliance by reviewing treatment plans and often attending Child and Family Team (CFT) meetings. The treatment plans and CFT meetings are essential in developing the array of interventions a youth may need. … Clinicians are not required to document every interaction; instead, they rely on weekly documentation in treatment plans to track progress. The use of treatment plans, outcomes of CFT meetings, and other diagnostic information are fundamental to providing effective care. While DCF values routine documentation by clinicians and staff, the emphasis on metrics is secondary to clinical oversight by qualified staff and detailed treatment plan documentation.
>
> [redacted] Expert Report at p. 5.

Bonnie Brae thus rightfully placed its focus on the treatment plan over "document[ing] every interaction." Nevertheless, Bonnie Brae understands OSC's findings regarding its EHR flaw that led to inaccurate date/time fields and the lack of detail in its progress notes and has implemented appropriate corrective actions. Bonnie Brae, however, objects to the various gratuitous comments sprinkled throughout this section, questioning the "quality of care" delivered even though OSC never evaluated Bonnie Brae's performance under the contracts' service outcome metrics and lacks the foundation to make such claims. *Id.* Mr. [redacted], who has treatment expertise and a foundation to opine on this issue as the former Deputy Director of DCF, has a very different view of Bonnie Brae. In his professional judgment, "Bonnie Brae's outcomes represent the gold standard." [redacted] Expert Report at p. 3. Stated differently, "it is the treatment outcomes that truly matter, which was an area where Bonnie Brae excelled." *Id.* at p. 2. This sentiment is echoed by the DCF-contracted caseworkers who universally are "satisfied with the services the child receives" and find residents are "doing better in school and/or work," "get[] along better with peers and other people," and are "able to cope when things go wrong." BB-CK-2907. As such, we respectfully request that such unnecessary and unfounded comments be removed from the final audit report.

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[3] We acknowledge the MICA notes lacked similar language but note that life space counseling was practiced with MICA residents.

Audit Findings – A(5) and (6)
Alleged Discrepancies in Youth and Clinical Coordinator Attendance and Progress Note Documentation.

These findings reference purported discrepancies between the date/time fields of progress notes and the attendance records for clinical coordinators and residents. Both of these issues are largely driven by the flawed EHR system discussed in our response to Section A(4).

Regarding the resident attendance discrepancy, as stated above, upcoming therapy sessions were scheduled in the EHR system in advance. This often took place before Bonnie Brae received notice that a resident would be going home on therapeutic leave. In these situations, because the date/time field was pre-populated with the scheduled date and time, the clinician was supposed to indicate the resident's absence in the body of the note. Some of the clinicians, however, were not as diligent as they should have been about indicating absences. The issue, however, has been fixed as the EHR settings have been changed, and clinicians are now required to keep signed attendance sheets for therapy sessions.

Moreover, we also note that calculating therapeutic leave is nuanced, which may not have been completely factored into OSC's analysis. A resident is considered to be on therapeutic leave based on their location at 11:59 pm. Thus, a resident may still attend a therapy session on days they are listed as being on therapeutic leave – it would depend on the time of the therapy session as compared to the time the resident leaves the facility. And, from an economic perspective, Bonnie Brae is paid the same rate whether the resident is classified as being on leave or present, meaning there is no financial incentive to classify a resident one way or the other. Any mistakes were clearly of an administrative nature.

As for the ten instances of a clinical coordinator being absent on days when the date/time field of the progress note indicated that group therapy was performed, this too relates to the prior settings in the EHR. If a session was rescheduled or canceled altogether, the clinician was supposed to indicate such information in the body of the note. This did not occur on the ten occasions identified by OSC. The issue has since been fixed. Bonnie Brae has also put in place more robust weekly audits by the quality assurance and clinical supervisory team to ensure compliance with the contract and to confirm that the progress notes are consistent with attendance sheets.

Audit Finding – (A)(7)
Alleged Cloned Progress Notes

OSC alleges that two clinical coordinators generated identical group therapy notes for four group sessions in February 2020 and three group sessions in February 2021. Bonnie Brae does not condone the copying of notes from week to week, however we object to the statement in the DAR that the clinician "used a template that was not based on the actual therapy provided." As explained during the Exit Conference and in our Prior Submissions, it is common for group therapy sessions to address the same topics in back-to-back sessions or for one cottage to cover a similar group topic as another cottage, especially for important subjects like boundaries and

accountability, which were covered by [redacted] in February 2020, and respecting peers and staff, which was covered by [redacted] in February 2021.

Bonnie Brae recognizes that the clinician should have provided more session-specific details in the progress notes, should not have copied a model from another clinician, and should have clearly included a notation that the group was continuing its discussion from a prior session. However, the lack of such detail in the progress notes does not in any way mean, as OSC maintains, that the notes do not reflect the actual therapy provided or the topics covered by the group. To avoid this issue from reoccurring, Bonnie Brae has implemented processes to ensure that group therapy notes are more robust going forward, including the establishment of an internal committee to audit a sampling of group therapy notes, track findings, and respond accordingly.

SECTION B

Audit Finding – B(1)
Bonnie Brae Generally Made the Required Minimum Therapy Hours Available to its Residents and Their Families

OSC contends that Bonnie Brae failed to provide the required clinical therapy hours for some of its residents – 13 of 101 residents in February 2020 and 8 of 26 residents in February 2021. Bonnie Brae conducted its own independent analysis and arrived at a different calculation for most of the residents in question. As outlined in our Prior Submissions, the majority of these residents met the required clinical therapy hours. In fact, several of the residents far exceeded the minimum requirements.

In reviewing the supporting documentation, we note that OSC continues to not give Bonnie Brae credit in some instances for scheduled Family Group Therapy sessions that did not take place because the family did not attend the scheduled event, and that OSC reversed credit for some sessions previously credited in the SOF. First, the family therapy time should be credited to Bonnie Brae. The organization made efforts to arrange and staff the service, but for reasons outside of Bonnie Brae's control, the session did not take place. The DAR implies that these services were not rendered due to Bonnie Brae's shortcomings; however, the fact is that the services were made available, but the families in these instances failed to attend their scheduled session.

As the treatment plans indicate, the treatment team plots a course of monthly therapy for each resident. This is done with complete transparency to the resident, the resident's guardian(s), and the State's care management organization and unified case management worker. In fact, one hundred percent of surveyed DCF-contracted caseworkers indicated that they help decide the child's treatment goals and participate in the child's treatment. *See* BB-CK-2907; *See also* BB-CK-00020 (excerpted below for an example of treatment plan course of treatment); BB-CK-00025 (showing resident, resident's mother, and CMO/UCM worker signature on treatment plan).

Treatment Recommendations:	Treatment team recommends Emotional Management group 2x per week and individual therapy to address emotional management issues. Team recommends family therapy 2x per month to address family issues. Team would like to address [redacted] academic issues through participation in on campus school program. In addition, the team recommends trauma survivor group, psychosexual education and extra-curricular activities.

Where a family is unwilling to engage in family therapy, it is not clinically appropriate to alter the individualized and thoroughly vetted treatment plan and substitute the family therapy hours with another form of therapy. As Mr. [redacted] observed, "[f]orcing residents to participate in inappropriate services or undergo lengthy therapy sessions can be clinically harmful." [redacted] Expert Report at p. 5. Thus, Bonnie Brae should not be penalized for refusing to add clinically inappropriate services that would conflict with a resident's treatment plan to compensate for a family's lack of attendance.

Second, it is unclear why OSC reversed credit for certain therapy sessions. We have resubmitted documentation for those sessions and ask that OSC reconsider its reversal. *See* BB-CK-2908 – 2913.

On a separate note, as referenced in our Prior Submission, there are three residents in February 2021—specifically [redacted], [redacted], and [redacted]—who fell short of their respective clinical hours because they were admitted to Bonnie Brae during that particular month. As we explained in the Prior Submissions, as part of Bonnie Brae's COVID protocols in effect in February 2021, new residents started off in quarantine in a separate cottage until they were cleared to move into the milieu, which delayed the start of full therapy services. Moreover, new admittees undergo an onboarding process, including orientation, completion of admission paperwork, and clinical evaluations for group assignments. The treatment team must first make an "individualized, needs driven assessment" before therapy starts in full as a "one-sized fits all approach" is clinically inappropriate. [redacted] Expert Report at 2. Consequently, during the pandemic, it took a week or longer after admission for a resident to be assigned and fully integrated into therapy groups. The circumstances surrounding these three residents were isolated incidents related to their admission dates and should not be counted against Bonnie Brae's contract compliance.

Audit Finding – B(2)
Residents Met the Required Minimum Psychiatric Hours

OSC claims that residents in the SPEC program received 11.25 minutes less face-to-face psychiatric services per week than contractually required. More specifically, OSC contends that Bonnie Brae provided 45 minutes of face-to-face psychiatric care per week to SPEC residents rather than the contractually allotted 56.25 minutes. That is not so.

During the audited time period, psychiatric services consisted of two separate activities: psychiatric care group therapy and current mental status check.[4] As the progress notes indicate,

[4] As discussed during the Exit Conference, Bonnie Brae changed its clinical model for delivering psychiatric services in 2023 and stopped performing group psychiatric therapy in favor of individualized therapy.

the weekly group therapy sessions spanned 45 minutes. The current mental status check was a separate activity of at least 15 minutes where the psychiatric staff reviewed and logged the resident's appearance, motor activity, attitude, speech, mood, affect, thought process, thought content, concentration, and assessed whether the resident possessed any suicidal or homicidal ideations. The individual checks were sometimes performed before or after the group sessions and sometimes on different dates altogether.

Because the current mental status check did not regularly occur at a scheduled time, the EHR team scheduled the mental status check within the EHR system for the same time as the psychiatric group session. This was done as a reminder to the psychiatric staff to perform such checks and, as stated above, the event needed to be scheduled in the system before an electronic note could be generated. This approach led to the date/time field for the current mental status electronic record to automatically populate with the same date and time as the group therapy session. Although the records show that the current mental status checks were performed, OSC gave Bonnie Brae no credit for the activity. Consequently, the purported shortfall is attributable to the flawed setup in the EHR system and is not indicative of a lack of service.

Audit Finding - SECTION C
The Two Unlicensed Coordinators Were Promptly Addressed

Bonnie Brae acknowledges that it briefly employed two unlicensed clinical coordinators. The DAR, however, lacks context and does not set forth the reasons for the issues or Bonnie Brae's prompt corrective actions.

The first unlicensed clinician, [redacted], was conditionally hired as a clinical coordinator on September 9, 2019, subject to her receiving an LCSW license within 90 days and she worked under the direct supervision of Bonnie Brae's then-Clinical Director. Bonnie Brae disclosed [redacted]'s hiring to DCF in its September 30, 2019, SPEC PSSR. When [redacted] did not earn her license within the allotted time, she was granted a short extension to pass the licensing exam. OSC asserts that Bonnie Brae did not disclose this extension to DCF, but as documents produced during the audit demonstrate, Bonnie Brae was encouraged by its contract administrator to provide interim staffing updates and changes via email or telephonically rather than through the formal PSSR process. Consistent with Bonnie Brae's practices and strong rapport with its contract administrator, it is far more likely that the one-time extension was vetted with the contract administrator rather than unilaterally granted by Bonnie Brae.

In any event, on February 24, 2020, after [redacted] notified Bonnie Brae that she failed the exam, she was reassigned to a temporary case manager role on that same date and DCF was contemporaneously notified of the change. Following [redacted]'s reassignment, OSC alleges that she provided clinical services for two additional days: February 25, 2020, and February 27, 2020. However, as OSC noted in Section A(6), [redacted] was absent on February 27, 2020, and did not perform any services on that day. A note was incorrectly generated for that date due to the aforementioned EHR system flaw, as the session was scheduled in the system prior to [redacted]'s reassignment. Thus, at most, there may have been a one-day lag time in the implementation of [redacted]'s reassignment.

The second unlicensed clinician, [REDACTED], was hired as a clinical coordinator on November 16, 2020. In accordance with its onboarding diligence process, Bonnie Brae conducted a license status search on the Division of Consumer Affairs ("DCA") website prior to hiring [REDACTED] DCA's database indicated that [REDACTED]'s license was "active" and that she was not subject to any board actions. *See* BB-CK-2407. Bonnie Brae relied on the search result in allowing [REDACTED] to begin employment four days later.

11/12/2020 Details

The State of New Jersey NJHome Services A-Z Departments/Agencies Office of the Attorney General OAGHome Agencies/Pro

Paul R. I
Acti

License Information

Accurate as of November 12, 2020 1:09 PM

Return to Search Results

Name: [REDACTED]

Address: Woodbridge,NJ

Profession/License Type: Social Work Examiners,Licensed Social Worker

License No: [REDACTED]

License Status: Active

Status Change Reason: License Issuance

Issue Date: 6/14/2017

Expiration Date: 8/31/2020

NO Board Actions. For more information contact New Jersey State Board of Social Work Examiners at (973) 504-6495

OSC contends that Bonnie Brae failed to properly verify [REDACTED]'s license because, at the bottom of the search page, and inconsistent with the "active" classification, the site also indicated a license expiration date of August 31, 2020. [REDACTED] however, was hired in the middle of the COVID-19 pandemic. During this public health emergency, the State and regulators were frequently providing grace periods and relaxing deadlines across various sectors and legal systems. Under these circumstances, it was not unreasonable for Bonnie Brae to accept DCA's public display of the active status of [REDACTED]'s license. Once Bonnie Brae learned that [REDACTED]'s license was, in fact, expired, it promptly terminated her employment. That said, Bonnie Brae has since implemented a new license verification policy to ensure this type of situation does not occur again.

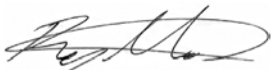
Lastly, it is important to note that both circumstances involving [REDACTED] and [REDACTED] were temporal in scope, predated OSC's audit, and were rectified through Bonnie Brae's internal system. Indeed, Bonnie Brae has already implemented robust processes to verify credentials for newly licensed professionals and requires monthly verification for all professional licenses for existing staff. Accordingly, Bonnie Brae's new verification policy will prevent any administrative oversight regarding its employees' licenses.

* * * *

As set forth above, Bonnie Brae faithfully complied with the true measure of contract compliance and programmatic success – it regularly met or exceeded the service outcome measures in its contracts with DCF. As Mr. ████ explained, "the real purpose of the Contract, and DCF's focus, was on achieving qualitative outcomes that are not measured by counting minutes. The Contract goals were, as they should be, focused on providing the best treatment with the shortest feasible length of stay, allowing youths to return home or transition to a lower-intensity service." ████ Expert Report at p. 2. Having met these qualitative metrics, DCF and residents received the benefit of the contracts. As such, we respectfully maintain that OSC's request of a full refund for all monies paid for the February 2020 and 2021 audited services is excessive.

Thank you for your consideration. Please contact us if you have any questions or have difficulty accessing any of the referenced documents.

Very truly yours,



Ray A. Mateo, Partner
Calcagni & Kanefsky LLP

Exhibit A

Bonnie Brae

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• www.bonnie-brae.org

November 7, 2025

Office of the State Comptroller (OSC)
State of New Jersey
New Jersey Department of Children and Families (DCF)

Re: Submission of Bonnie Brae Corrective Action Plan

Dear OSC and DCF Representatives,

On behalf of Bonnie Brae, I respectfully submit the organization's Corrective Action Plan in response to the recent audit findings issued by the Office of the State Comptroller and the Department of Children and Families.

While we may not fully concur with all aspects of the findings, we acknowledge and respect the determinations made and will comply accordingly. Bonnie Brae remains firmly committed to maintaining full adherence to all contractual, fiscal, and documentation standards. The attached plan outlines the corrective measures we are implementing to strengthen systems, ensure sustained compliance, and promote continuous quality improvement.

This plan reflects our values of transparency, accountability, and collaboration. It also establishes an Internal Audit and Compliance Oversight Committee, reporting directly to the Chief Executive Officer and the Board Finance Committee, to ensure long-term monitoring and execution.

We appreciate the guidance and oversight provided by OSC and DCF and look forward to ongoing partnership as we implement these actions. Please do not hesitate to contact me directly should additional information or documentation be required.

Sincerely,

Paul D. Rieger, MSW
Chief Executive Officer

Bonnie Brae

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Bonnie Brae – Audit Response and Corrective Action Plan
Date: November 7, 2025
Submitted to: Office of the State Comptroller (OSC) and New Jersey Department of Children and Families (DCF)
Prepared by: Paul D. Rieger, Chief Executive Officer – Bonnie Brae
In coordination with:
• Chief Financial Officer: [redacted]
• Chief Operating Officer: [redacted]
• Clinical Director: [redacted]
• Director of Quality Assurance and Improvement: [redacted]

SUMMARY STATEMENT

Bonnie Brae acknowledges receipt of the audit findings and recommendations and is fully committed to addressing each item in a transparent and compliant manner. Prior to the audit findings, Bonnie Brae proactively sought to address and innovate solutions for some of the issues identified in the audit. Specifically, our leadership team has initiated a corrective action process aimed at improving cross-departmental collaboration, independent consultation, strengthening internal controls, and ensuring sustainability.

The following corrective action plan outlines: (i) the work that Bonnie Brae has undertaken since 2021, (ii) the work performed since we were contacted in January 2025 regarding the Summary of Findings, and (iii) our responses to the Draft Audit Report recommendations.

CORRECTIVE ACTION PLAN

I. Enhancements Made Prior to the Issuance of the SOF (June 20, 2021 – January 2025)

- On rare occasions prior to the last quarter of calendar year 2022, Bonnie Brae hired Clinical Coordinators pending waivers or documentation from the NJ Boards, limiting their responsibilities strictly to case management and non-clinical duties. To further ensure that no individual inadvertently provides services beyond the scope of their license, Bonnie Brae has since discontinued this practice. All clinical staff now begin employment only after full licensure verification and Board documentation are confirmed.
- A second Assistant Clinical Director was added to the clinical department in July 2022 to lower the supervisory load, provide coverage in absences and enhance auditing of clinical documentation.
- A 'float' clinician position was approved and hired in March 2022 to enhance coverage in the clinical department.
- Psychiatric deliverables - The psychiatric staffing and contract deliverables were modified in the Spring of 2023. This was done in collaboration with the clinical

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department at CSOC/DCF. This work culminated in Bonnie Brae increasing staffing (adding 1.5 FTE, psychiatric APNs) and a contract modification.

- In February 2023, Bonnie Brae purchased iCentrix a software solution to add auditing and dashboard functionality to the Carelogic platform prioritizing an audit tracking system for the contract deliverables.
- In November 2023, the clinical department enhanced the Superuser training for our EHR platform, Carelogic, to include audit tracking through ICentrix. This evolved into weekly audit meetings starting in early 2024.
- In mid-2024 due to the delay in the iCentrix project an IT consultant was hired to develop audit reports from Carelogic by youth and clinician as well as reports on deliverable completion.
- Upgraded clinical department IT equipment to include laptops and signature pads.
- Focused on recruitment and retention of clinicians through training and compensation (periodically throughout the time period).

II. Enhancements from the receipt of the SOF to present:

January 2025

- Jan 22: Comptroller's preliminary audit feedback received — triggered corrective planning process.
- Jan 23: Leadership engaged legal and external audit consultants — established foundation for systematic corrective action.

February 2025

- Feb 14 & 19: Audit review meetings identified compliance and documentation potential areas of improvement.
- Feb 21: Updated policy for verifying licenses.
- Feb 24: Benchmarked documentation and staffing strategies with other providers.

March 2025

- Mar 10–11: Contract deliverables reviewed; clarifying questions sent to DCF.
- Mar 13: Executive Committee of Bonnie Brae's Board briefed on audit issues — ensured governance oversight.
- Mar 20: DAP note format implemented (this is a known clinical documentation note structure, implemented for consistency)

April 2025

- Apr 3–4: Two new clinical positions approved; SPEC deliverables plan developed — compliance roadmap established.
- Apr 9: Engaged external consultant [redacted] (Lean Six Sigma) — enhanced compliance expertise
- Apr 15: Phased Compliance Plan developed — structured approach to align deliverables.

May 2025

- May 6: Group schedule designed for SPEC implementation.
- May 20: SPEC staffing increased from 7 to 8 clinicians.

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- May 2025: Benchmarked practices with peer provider [redacted] — expanded creative therapy modalities.

June 2025
- Jun 2: New SPEC Clinical Coordinator hired
- Jun 2025: Two additional clinical positions approved — increased bandwidth.

July 2025
- Jul 21: [redacted] group structure realigned.
- Jul 22: SPEC Clinical Deliverables Workgroup established — instituted weekly cross-departmental oversight.
- Jul 2025: State initiated review of contract deliverables — informed next phase of planning. Bonnie Brae is part of the state workgroup for reviewing and updating contract deliverables.

August 2025
- Aug 18: Assistant Clinical Director appointed; two new SPEC clinicians hired — ensured continuity and expansion.
- Aug 18: Draft *Clinical Handbook* and *Vacancy Coverage Plan* developed — formalized sustainability framework.
- Aug 25: New Clinical Director hired (start date October 6).

September 2025
- Sep 4–5: Clinical Focus Group schedule finalized in CareLogic.
- Sep 8–9: Documentation audit completed and reviewed; staff-specific corrective timelines established.
- Sep 15: Focus and Track groups implemented in multiple cottages.
- Sep 18–19: HR accountability meetings initiated; Performance Improvement Plan implemented.
- Sep 28: Per-diem clinician job description developed for flexible coverage.

October 2025
- Oct 2: Supervised Hours Policy issued — linked documentation completion to accrual of hours.
- Oct 6: New Clinical Director began — unified leadership and accountability.
- Oct 6: Documentation Compliance Assistant position posted.
- Oct 20: Temporary Case Coverage Policy drafted — ensured deliverables maintained during vacancies.
- Oct 28: Clinical temp agency engaged as contingency staffing measure.

November 2025
- Nov 3: Recruitment/retention recommendations
- Nov 5: Clinical Director reported full compliance for face-to-face deliverables under SPEC.

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III. Enhancements in Progress/Response to OSC Recommendations

1. Case Management Summary Form Revision

Audit Recommendation: Revise the Case Management Summary Form to accurately reflect tasks performed, hours provided, and responsible staff.

Actions:

- Going forward, each designated clinician or case manager will be required to write a narrative summary of individualized case management activities.

- The QA Department will oversee the development of the new case management section and the COO and Clinical Director will develop and implement staff training on proper use.
- Monitoring and Accountability:
  QA will oversee staff training completion. The Director of Quality Assurance, COO, and Clinical Director will develop and facilitate training, which will also be incorporated into the Clinical Handbook. A signed attendance sheet will be maintained in the corrective action file.
- Responsible Party: COO, Clinical and Director of Quality Assurance and Improvement

2. Compliance with Required Case Management and Clinical Hours

Audit Recommendation: Ensure compliance with the minimum required case management and clinical therapy hours.

Actions:

- Develop a new model and staffing complement for delivering case management: Bonnie Brae has developed an integrated case management framework designed to provide a more unified and sustainable approach to coordinating admissions, treatment planning, medical services, discharge, and aftercare. The model is intended to align with contract case-management expectations and includes provisions to help maintain continuity of services during vacancies, absences, or documentation delays.
- Each youth will participate in weekly case-management groups led by designated case managers, representing approximately one-third of required service hours, with the remainder covered through individualized, group, and collateral activities across specialized roles.
- The continuum integrates existing, repurposed, and new case management positions—including Medical, Education, Quality, and Discharge Planning Case Managers—supported by clinicians and medical records staff.
- Case Management Oversight: Case management documentation reports will be generated by the QAI Department and presented to the Clinical Director and COO for review and follow-up. Supervisors will utilize an audit tool during regular supervision to review content accuracy. Weekly compliance audits and cross-program quality

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reviews will verify that required case-management hours are met and documentation is completed accurately and on time.

- Clinical Therapy Enhancement: Four new clinician positions have been added to our 93-bed main campus. Three are assigned to the SPEC program—which requires the most clinical hours and represents 52.7% of campus beds—reducing caseloads from up to 14 to 7 (a 50% decrease). The fourth clinician is added to RTC BH/SU services, where caseloads are smaller and require about 25% fewer hours. The first two positions were approved 4/1/25 and the second 2 were added 6/1/25
- This expansion increased clinical capacity by 60% for SPEC, 14.3% for RTC and RTC BH/SU, and 33.3% overall across campus contracts.
- To prevent service interruptions, clinical vacancies are now covered collaboratively, with cases distributed among multiple clinicians. Combined with enhanced case management resources, this provides greater flexibility and consistency
- Expanded the number of clinical track and focus groups and standardized approach to documentation to ensure accurate service records.
- Clinical Service Oversight: Clinical documentation completion and service delivery are tracked weekly through compliance audits. A dedicated position has been established to conduct routine compliance audits across all programs. The Clinical Director and QAI Department review these findings to verify that required clinical hours are met and documentation is completed accurately and on time.
- Responsible Party: COO, Clinical Director and QAI Director

3. Independent Third-Party Monitor

Audit Recommendation: Retain an independent third-party monitor approved by OSC to review case management, clinical, and psychiatric documentation.

Actions:

- As part of a negotiated resolution and subject to agreement on the scope and duration of the monitorship, Bonnie Brae will consider retaining an independent monitor to review case management, clinical, and psychiatric documentation.
- Responsible Party: CEO with Legal Counsel

4. Documentation of Therapy Sessions

Audit Recommendation: Ensure progress notes document actual time, date, and duration of sessions.

Actions:

- The EHR system will be updated to ensure all notes reflect actual time, date, and session duration.
- Clinical Director and QAI Department will develop and facilitate training on new documentation standards and retain attendance records.

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- Time has been scheduled on the master calendar each week for all clinicians to complete documentation.
- Monitoring and Accountability: A pilot audit tool has been developed for use by the Clinical Director and Assistant Clinical Directors during supervision to review sample notes and confirm that required elements—including time, date, and session duration—are accurate. Accountability expectations for clinicians will be reinforced through supervision, performance evaluation, and corrective action processes. Clinicians must be current on documentation to accrue hours toward independent licensure.
- Responsible Party: COO, Clinical and Director of Quality Assurance and Improvement

5. Weekly Audits of Progress Notes

Audit Recommendation: Implement random weekly audits of progress notes.

Actions:

- Weekly compliance audits now track clinical documentation and service delivery to confirm accuracy and timely completion of all required hours
- Quality audit of random sample of progress notes weekly.
- An internal committee has been established to operationalize these audits, document policies and procedures and track/respond to the audits
- Monitoring and Accountability: An internal committee has been established to operationalize audits, track findings, and respond. Audit results will be reviewed monthly in Leadership Meetings to ensure follow-through
- Responsible Party: COO, Clinical and Director of Quality Assurance and Improvement

6. Psychiatric Session Scheduling

Audit Recommendation: Ensure sufficient time is allocated for psychiatric sessions.

Actions:

- Scheduling and documentation processes will be reviewed to ensure adequate time is allocated for all psychiatric sessions.
- Conduct workload and scheduling review.
- Adjust psychiatric coverage if necessary to meet face-to-face requirements.
- Enhanced in Spring 2023 through collaboration with CSOC clinical and contracting departments. CSOC approved enhancements and modified contract.
- When sessions are shorter than scheduled, the reason and clinical justification will be documented.
- Monitoring and Accountability: QAI will report on completion of notes for the Medical Director's review and follow-up. The Medical Director will conduct and/or review monthly sample audits to verify session duration, documentation completeness, and clinical justification.
- Responsible Party: Medical Director, CEO, COO and Director of QAI

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7. Licensure Verification and Documentation

Audit Recommendation: Verify and maintain current licensure documentation.

Actions:

- Human Resources has enhanced verification processes.
- Updated the process for verifying licensed professionals at Bonnie Brae (Policy Updated 2/21/25)
- Monitoring and Accountability**:** HR will maintain a licensure tracking log. Random file audits will be conducted biannually to confirm valid licensure documentation.
- Responsible Party: HR and Director of Quality Assurance and Improvement.

8. Staff Training on Documentation Practices

Audit Recommendation: Provide regular staff training on documentation practices.

Actions:

- Comprehensive documentation training will be embedded in professional development processes.
- Develop and deliver annual Documentation Accuracy Training.
- Require completion by all licensed and clinical staff.
- Monitoring and Accountability: Compliance will be included as a performance evaluation metric.
- Responsible Party: COO, Clinical Director, HR Director

OSC Note - *Supporting documentation (pages 33 to 44) attached to the provider's response has been omitted to maintain confidentiality.*