

New Jersey

UNIFORM APPLICATION

FY 2021 Substance Abuse Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

I: State Information

State Information

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III. Expenditure Period

State Expenditure Period

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To 6/30/2020

Block Grant Expenditure Period

From 10/1/2017

To 9/30/2019

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II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #:	1
Priority Area:	Pregnant Women/Women with Dependent Children
Priority Type:	SAT
Population(s):	PWWDC

Goal of the priority area:

To expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children.

Strategies to attain the goal:

- Annual provider meetings include licensed women’s treatment providers who provide gender specific treatment and system partners. Attendees, the Division of Mental Health and Addiction Services (DMHAS) women’s treatment coordinator, representatives from NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Initiative (WFNJ-SAI) and other relevant stakeholders. Meeting address issues related to best practices such as retention, engagement, access and referrals, recovery supports, medication assisted treatment, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS) and training needs.
 - Professional development – women’s treatment provider contract requirements include service elements and language from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) “Guidance to States: Treatment Standards for Women with Substance Use Disorders” document that emphasizes best practice. Contracted providers are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. Contracted women’s treatment providers new staff are required to complete National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials “Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals” and document completion of tutorials in their employee personnel files.
 - Plans of Safe Care - women’s treatment provider contract language requires providers to develop Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan shall be included in the woman’s file.
 - In Depth Technical Assistance (IDTA). In 2014 as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey applied for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey Department of Human Services (DHS)/DMHAS as the lead State agency partnered with DCF and Department of Health (DOH) and submitted a successful application for IDTA (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.
- The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, substance use disorder (SUD)/mental health (MH) system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4Ps+ Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Three workgroups convened: (1) Data Workgroup looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS. (2) Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening. (3) Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and

perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. The IDTA commenced in 2017, however DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the Birthing Hospital Survey, and apply these findings to the Project ECHO program design.

In late Fall of 2018, Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO (Extension for Community Outcomes) for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant’s first year of life. DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments.

- Maternal Wrap Around Program (MWRAP) – MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. The Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. MWRAP is a statewide program located in seven regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of pregnant women or women with children entering substance abuse treatment.
Baseline Measurement:	SFY 2019: 32,276 admissions count
First-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance abuse treatment in SFY 2020 by 1%.
Second-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance abuse treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.
New Second-year target/outcome measurement(if needed):	A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of pregnant women and women with children from SFY 2019 – 2021 will be tracked by the SSA’s New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA’s real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client’s admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

SFY 2019: 32,276 admissions count
SFY 2020: 28,629 admissions count

In SFY 2020, there were 3,647 less admissions than in SFY 2019 or an approximately 11.30% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person.

How first year target was achieved (optional):

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

To expand access to comprehensive treatment, including Medication Assisted Treatment (MAT), in combination with other treatment modalities, for individuals with an opioid use disorder, including persons who inject drugs (PWID), through mobile medication units and other innovative approaches.

Strategies to attain the goal:

- Referral to substance use disorder (SUD) treatment from statewide Harm Reduction Centers (HRCs) that are operational throughout New Jersey.
- Providing services in convenient locations, specifically utilizing mobile medication units, in order to reduce barriers and engage individuals in care as easily as possible.
- Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD).
- Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through a planned statewide public awareness campaign as well as public presentations on this topic.
- Contracts to three regional providers to provide community education and trainings for individuals at risk for an OUD, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance.
- Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed SUD treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
- Contracts awarded to implement an opioid overdose recovery program with recovery specialists and patient navigators in all 21 counties for individuals who present in emergency departments following an opioid overdose reversal with naloxone in order to link them to treatment or other recovery support services in their communities.
- Contracts awarded to 11 providers for the Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment including MAT.
- Maternal Wraparound Program (M-WRAP) provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for M-WRAP services during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers provide care coordination and warm hand-offs to appropriate service providers when necessary. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The M-WRAP program covers all 21 counties of NJ and alleviates barriers through comprehensive care coordination using a multi-system approach with the goal to improve outcomes for pregnant/postpartum opioid dependent women and their children.
- In September 2016, DMHAS was awarded a five-year grant to "Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)" from SAMHSA to implement the Opioid Overdose Prevention Network (OOPN) initiative which entails the development and implementation of a comprehensive prescription drug/ opioid overdose prevention program which includes Naloxone training and distribution. Plans are to train 3,000 individuals and distribute 2,500 naloxone kits annually.
- In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations

needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.

- In May 2017, SAMHSA awarded \$12,999,621 through the State Targeted Response (STR) to New Jersey annually for two years. The program aims to address the opioid crisis by increasing access to treatment, reduce unmet treatment need and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD. A major activity of the grant is to implement and expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of MAT. To address these objectives, a new State Targeted Opioid Response Initiative (STORI) fee-for-service (FFS) treatment initiative was developed within the existing addiction fee for service treatment network, which provides access to treatment for under-insured and uninsured clients. It includes a wide range of services, specifically including MAT. DMHAS was awarded a no-cost extension for the STR grant to continue funding the STORI FFS treatment for part of SFY 2020.
- In September 2018, SAMHSA awarded \$21.5 million through the State Opioid Response (SOR) to New Jersey annually for two years to continue to address the opioid crisis. The key objectives of the SOR grant are to increase access to MAT, reduce unmet treatment need and reduce opioid related deaths.
- In March 2019, DMHAS received notification from SAMHSA that its plan for an additional \$11.2 million was approved through the SOR Grant for the period through FFY 2020. DMHAS submitted a plan proposing to use the SOR supplemental award to fund additional treatment, recovery support, prevention and education/training efforts to address the opioid epidemic.
- As part of SOR funding, the Low Threshold Buprenorphine Induction program (Low Threshold) is designed to make Buprenorphine treatment easily accessible to individuals who access syringes at Harm Reduction Centers (HRCs) located at South Jersey AIDS Alliance (SJAA) in Atlantic City and the Visiting Nurse Association (VNA) of Central Jersey in Asbury Park. Through the Low Threshold program, individuals will be offered same day, immediate enrollment in Buprenorphine treatment and care management services. The program will offer services to individuals who seek this type of service in a safe and nonjudgmental environment, despite continued drug use or lapses in care.
- As part of SOR and state funding, DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community.
- An attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State plans to hold a total of 16 trainings through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 in an effort to train over 1,000 prescribers in CY 2019.
- Interim Services have been a requirement of provider contracts, but a new initiative allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following a SUD assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative agencies enrolled in the Block Grant initiatives were required to provide this service. Once launched in October 2019, funding for Interim Services will be open to all contracted FFS providers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of PWID entering treatment.
Baseline Measurement:	SFY 2019: 29,053 admissions count
First-year target/outcome measurement:	Increase the number of PWID entering treatment by 1%.
Second-year target/outcome measurement:	Increase the number of PWID entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.
New Second-year target/outcome measurement(if needed):	A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of PWID in SFY 2019 through SFY 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client’s admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

SFY 2019: 29,053 admissions count
SFY 2020: 25,391 admissions count

In SFY 2020, there were 3,662 less admissions than in SFY 2019 or an approximately 12.60% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, therefore are not required to enter data into our NJSAMS reporting system.

How first year target was achieved (optional):

- Indicator #:** 2
- Indicator:** Increase the number of heroin and other opiate dependent individuals entering treatment.
- Baseline Measurement:** SFY 2019: 47,007 admissions count
- First-year target/outcome measurement:** Increase the number of heroin and other opiate dependent individuals entering treatment by 1%.
- Second-year target/outcome measurement:** Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.
- New Second-year target/outcome measurement(if needed):** A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of opiate dependent individuals in SFY 2019 and SFY 2021 will be tracked by the SSA’s New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA’s real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client’s admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

SFY 2019: 47,007 admissions count
SFY 2020: 43,038 admissions count

In SFY 2020, there were 3,969 less admissions than in SFY 2019 or an approximately 8.44% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, therefore are not required to enter data into our NJSAMS reporting system.

How first year target was achieved (optional):

Priority #: 3
Priority Area: Heroin/Opioid Users
Priority Type: SAT
Population(s): Other

Goal of the priority area:

To ensure medication assisted treatment (MAT) is provided as an option to individuals with an opioid use disorder (OUD) who are entering into substance use disorder (SUD) treatment.

Strategies to attain the goal:

- Utilize a public awareness campaign focusing on reducing stigma/discrimination regarding MAT to assist in engaging individuals with an OUD, their families, friends, loved ones, providers and other community members so that they understand the use of MAT is a best practice in the treatment of an OUD.
- Buprenorphine Medical Support- This new initiative will focus on the challenges faced by licensed ambulatory SUD programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Ambulatory SUD treatment programs will be expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations. Agencies will be required to receive referrals from other programs that offer MAT where clients stabilized on MAT.
- DMHAS will continue its Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can apply for the enhancement by submitting applications to DMHAS and are reviewed for approval on a quarterly basis.
- DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
- DMHAS will continue to distribute American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services.
- DMHAS has a Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School to develop a train-the-trainer program on MAT, the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. The goal of this project is to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to the community.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of heroin/other opiate admissions for whom MAT was planned.
Baseline Measurement:	SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned.

First-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%

Second-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

New Second-year target/outcome measurement(if needed): A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2019 - 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned
SFY 2020: 19,134 heroin/other opiate admissions for whom MAT was planned

In SFY 2020, there were 1,753 less heroin/other opiate admissions for whom MAT was planned than in SFY 2019 or an approximately 8.39% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, therefore are not required to enter data into our NJSAMS reporting system.

How first year target was achieved (optional):

Priority #: 4
Priority Area: Tobacco
Priority Type: SAP
Population(s): PP, Other (Persons aged 12 – 17)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report using any type of tobacco product in the past month

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions

are all required to address tobacco use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address tobacco use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Enhance Barriers/Reduce Access - Increase education among merchants who sell tobacco products.
- Enhance Barriers/Reduce Access – Work with municipal and county government to ban smoking from restaurants and other public places, including schools, workplaces, and hospitals.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that tobacco laws are enforced at the local level.
- Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state tobacco control with details regarding how outlet density and location impact tobacco availability to youth.
- Modify/Change Policies – Enhance or create policies related to smoking among 12-17 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of tobacco use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of tobacco use through by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Legislation

- The State of New Jersey enacted a statute to raise the age to sell tobacco products from persons 19 years of age to 21 years of age effective November 1, 2017 (P.L.2017, Chapter 118).

Additionally, DMHAS funds community-based services targeting high-risk individuals or groups in each of New Jersey’s 21 counties. Many of these providers are also focused on the prevention of tobacco use among youth.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Past month tobacco product use (any) among persons aged 12 to 17.
Baseline Measurement: According to 2016-2017 NSDUH data, 4.14 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.
First-year target/outcome measurement: A reduction of .50% below the baseline measure.
Second-year target/outcome measurement: An additional reduction of .25% below the first year measure.
New Second-year target/outcome measurement(if needed):

Data Source:

National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

According to 2017-2018 NSDUH data, 3.59 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey. The measure was .55 percent less than in the previous year

Priority #: 5
Priority Area: Alcohol
Priority Type: SAP
Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report binge drinking in the past month

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
- Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
- Modify/Change Policies – Enhance or create policies related to underage drinking among 12-17 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of underage drinking by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of underage drinking by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Alcohol Use in the Past Month by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 5.48 percent of the target population reported binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .20% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .20% below the baseline measure.

New Second-year target/outcome measurement(if needed):

Data Source:

Binge Alcohol Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-

medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

According to 2017-2018 NSDUH data, 5.77 percent of the target population reported binge drinking during the month prior to participating in the survey. The number for 2016-2017 was 5.48 percent.

Research on binge drinking has shown it to be a behavior that is strongly related to social circumstances. Binge drinking is more prevalent among males, and occurs at much higher rates in specific social environments. Interventions designed to change perceptions of harm and acceptability of binge drinking are particularly important for young people in high risk circumstances. Therefore, DMHAS-funded prevention agencies and coalitions will intensify their efforts by implementing additional evidence-based programs and approaches designed to affect perceptions among 12-17 year olds.

How first year target was achieved (optional):

Priority #: 6
Priority Area: Marijuana
Priority Type: SAP
Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Decrease the percentage of persons aged 12 – 17 who report Marijuana Use in the Past Year.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address marijuana use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address marijuana use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that marijuana use and possession laws are enforced at the local level.
- Modify/Change Policies – Enhance or create policies, laws, and ordinances related to marijuana use among 12-17 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of marijuana use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of marijuana use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Marijuana Use in the Past Year by persons aged 12-17.
Baseline Measurement: According to 2016-2017 NSDUH data, 10.28 percent of the target population reported marijuana use during the year prior to participating in the survey.

First-year target/outcome measurement: A reduction of .10% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .10% below the baseline measure.

New Second-year target/outcome measurement(if needed):

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

According to 2017-2018 NSDUH data, 11.07 percent of the target population reported marijuana use during the year prior to participating in the survey.

The increase was slight (.79 percent) and can possibly be attributed to easier access related to medical marijuana. When it becomes easier for people to get marijuana, it means that they use more and have more in their homes. This in turn means that those who don't have medical marijuana cards – including teens and young adults – have increased access to the drug and may be more inclined to use and abuse it.

On November 3, 2020, NJ legalized the recreational use of marijuana. The issue of access will increase dramatically and require a strong and unified approach from the prevention community. We will be guided by the successful efforts of other states that have faced the same challenge.

How first year target was achieved (optional):

Priority #: 7
Priority Area: Prescription Drugs
Priority Type: SAP
Population(s): PP, Other (All residents in New Jersey)

Goal of the priority area:

Decrease the percentage of persons who were prescribed opioids in the past year.

Strategies to attain the goal:

Education: Educational programs and webinars regarding CDC Guideline for Prescribing Opioids for Chronic Pain.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Opioid Dispensations in New Jersey.

Baseline Measurement: According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2018, 4,266,645 prescriptions for opioids were provided in New Jersey.

First-year target/outcome measurement: A reduction of 1% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .50% below the baseline measure.

New Second-year target/outcome measurement(if needed):

Data Source:

NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General)

New Data Source(if needed):

Description of Data:

Prescription Drug Monitoring Program data provided by the NJ Attorney General's Office

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2019, 3,990,809 prescriptions for opioids were provided in New Jersey.

6.46 percent fewer opioid prescriptions were written in 2019 than in 2018.

Priority #: 8

Priority Area: Heroin

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Increase the percentage of persons aged 12 – 17 who report perceptions of Great Risk from Trying Heroin Once or Twice

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (including heroin) among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address perceptions of risk regarding heroin use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that laws regarding the use of illegal substance (including heroin) are enforced at the local level.
- Modify/Change Policies – Enhance or create policies designed to increase perceptions of risk and harm related to the use of heroin among 12-17

years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of illegal substances (including heroin) by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of illegal substance and heroin use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 68.23 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

First-year target/outcome measurement: An increase of .50% above the baseline measure.

Second-year target/outcome measurement: An additional increase of .50% above the baseline measure.

New Second-year target/outcome measurement(if needed):

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

According to 2017-2018 NSDUH data, 68.32 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

The increase in perception of risk and harm related the use of heroin once or twice was negligible (.09 percent). However, in 2018 NJ-DMHAS implemented programs that focus specifically on the misuse of opioid pain relievers among adolescents. One program addresses perceptions of risk and harm regarding the use of opioid analgesics by young athletes for sports-related injuries. The positive effects of these programs would not yet be reflected in 2017-2018 NSDUH data.

How first year target was achieved (optional):

Priority #: 9

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase compliance rate of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation.

Strategies to attain the goal:

- Notifications. All block grant recipients will be notified of the contractual and regulatory requirements to screen all clients for TB symptoms. Methods used will be a formal letter to all block grant recipients and an overview presented at the next quarterly Professional Advisory Committee (PAC) and other upcoming Division/agency meetings.
- Ongoing monitoring. Monitors will review compliance during the annual site visit, and require an acceptable plan of correction for non-compliance. If repeat deficiencies are found, an alternate plan of correction and proof of implementation will be required.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Site Monitoring Report of DMHAS' SAPT Block Grant contracted agency indicating that client was offered a tuberculosis evaluation.

Baseline Measurement: According to SFY 2019 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 75% of the agencies that were monitored (27 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

First-year target/outcome measurement: An increase of 5% above the baseline measure.

Second-year target/outcome measurement: An additional increase of 5% above the baseline measure.

New Second-year target/outcome measurement(if needed):

Data Source:

Annual Site Monitoring Reports of DMHAS' SAPT Block Grant Contracted Agencies

New Data Source(if needed):

Description of Data:

The grants monitoring program at DMHAS monitor SAPT Block Grant recipients. Onsite visits are made to each SAPT Block Grant recipient a minimum of one time per calendar year. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

The planned agency notification and monitoring strategies were implemented.

According to SFY 2020 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 87% of the agencies that were monitored (26 of 30 agencies) were in compliance with offering every client a tuberculosis evaluation.

Priority #: 10

Priority Area: In coordination with New Jersey's Aligning Early Childhood with Medicaid (AECM) technical assistance project, DCF/ Children's System of Care (CSOC) will develop and implement screening, identification, and intervention among at risk children age 0-3

Priority Type: MHS

Population(s): SED

Goal of the priority area:

NJ Children's System of Care (CSOC) will collaborate with system partners to develop and implement screening, identification, and intervention among at risk children age 0-3.

Strategies to attain the goal:

New Jersey has joined Aligning Early Childhood and Medicaid, a multi-state initiative aimed at improving the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies (CHCS) in partnership with the National Association of Medicaid Directors and ZERO TO THREE. Through this 20-month initiative, participating states will:

1. Align state programs and investments between Medicaid and other early childhood systems to drive more strategic, evidence-based investments for infants and toddlers in low-income families; and
2. Demonstrate the value of early childhood cross-sector alignment for improving near- and long-term health and social outcomes.

NJ DCF/CSOC has identified the following goals:

1. Identify and adopt best practice standards to identify social-emotional, behavioral, and social determinant health risk in the pediatric medical home, including creating a plan to implement a strategy to increase capacity for stratified care coordination in the pediatric medical home to effect linkage to behavioral health and other services by January 2020.
2. Develop a written strategy, including programmatic recommendations and funding options to provide infant mental health services on a statewide basis by July 2020.
3. Drafting a State Plan Amendment expanding the use of care coordination and community health workers to ensure new mothers and their infants stay connected to physical and behavioral health care, and other health influencing benefits, such as food, housing and child care across the health care delivery system.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Completed plan for screening, care coordination, and development of infant mental health service capacity for at risk children age 0-3
Baseline Measurement:	To be determined after the first year of implementation of screening services to children age 0-3
First-year target/outcome measurement:	An increase in the percentage of children age 0-3 receiving screening services in SFY 2021. The percentage will be determined when the baseline measure is set.
Second-year target/outcome measurement:	An increase in the percentage of children age 0-3 receiving screening services in SFY 2022. The percentage will be determined when the baseline measure is set.

New Second-year target/outcome measurement(if needed):

Data Source:

DCF will implement their anticipated project-related goals(s) and activities, and track progress over time.
PerformCare NJ - the CSOC Administrative Services Organization

New Data Source(if needed):

Description of Data:

DCF self- assessment and written organizational plans.
The number of children age 0-3 receiving screening services during a specified state fiscal year.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

The baseline measurement of will be determined after the first year of implementation of screening services to children age 0-3.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 11

Priority Area: NJ Children's System of Care (CSOC) will continue to increase the integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance use challenges and chronic medical conditions

Priority Type: MHS

Population(s): SED

Goal of the priority area:

The New Jersey Children's System of Care (CSOC) will increase integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance use challenges and chronic medical conditions.

Strategies to attain the goal:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies promoting integrated health and behavioral health as a priority. Integrated care and wellness activities will be incorporated across the CSOC continuum by expanding existing integration models and exploring development of other primary health-behavioral health integration models.

Currently, NJ's Behavioral Health Homes (BHH) are operational in Bergen, Mercer, Cape/Atlantic, and Monmouth counties. Each BHH is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Each BHH employs Nurse Managers (1-40 ratio) and Health and Wellness coaches (1-65 ratio). Nurse Managers are required to hold a New Jersey Registered Nurse (RN) license or higher nursing credential. Health and Wellness Coaches are required to have a Bachelor's Degree and two years of experience in nutrition, health education or a related field.

BHH services are a "bridge" that connects prevention, primary care, and specialty care. Medical and wellness staff are integrated into the existing CMO Child Family Team (CFT) structure responsible for care coordination and comprehensive treatment planning for youth and their families which includes planning for the holistic needs of the youth. The CFT structure and approach (CMO, FSO, Family, Youth and other designated service providers and supports) enhanced with BHH RN, Health/Wellness Coach staffing plans for the holistic needs of a youth with both behavioral health and medical needs (inclusive of substance use and developmental and intellectual challenges). Nurse Manager and Health/Wellness staff communicate with youth's medical providers (primary care specialty providers, urgent or emergent medical care) and connect the medical domain and planning with the existing CFT process.

New Jersey is among the first states using Targeted Case Management (TCM) to deliver Behavioral Health Home services for youth only.

The structure of the CMO is a strategic fit for the health home program. The BHH Core Team builds on the current CMO array of staff with the intent to provide a holistic approach to care for children. This expanded team will constitute the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

During SFY 2018, 484 youth were enrolled in BHH services. To be eligible, youth must meet the criteria for CMO and have a qualifying medical condition which is inclusive of intellectual and developmental challenges as well as substance use.

Place background information on Certified Community Behavioral Health Clinics (CCBHCs) here. Include number of children served during SFY 2018

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased number of children, youth or young adults provided with integrated physical and behavioral health services.

Baseline Measurement: In SFY 2019 CSOC provided Behavioral Health Home services to 503 youth.

First-year target/outcome measurement: CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 528 youth.

Second-year target/outcome measurement: CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 554 youth.

New Second-year target/outcome measurement(if needed):

Data Source:

Performcare NJ - the NJ DCF/CSOC Administrative Services Organization

New Data Source(if needed):

Description of Data:

Number of youth receiving Behavioral Health Home/integrated physical and behavioral health services in a specified state fiscal year.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 12

Priority Area: NJ Children's System of Care (CSOC) will increase access to evidence-based services and supports across the CSOC service continuum

Priority Type: MHS

Population(s): SED

Goal of the priority area:

CSOC will increase access to evidence-based services and supports across the CSOC service continuum.

Strategies to attain the goal:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies building capacity to deliver evidence-based interventions and services as a priority. CSOC will support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out of home services

The Nicholson Foundation, in partnership with New Jersey Department of Children and Families (NJDCF), issued a Request for Proposals (RFP) to solicit proposals for a family-based recovery program from New Jersey-based mental health and substance use disorder treatment providers serving adults, families, and/or young children.

The goals of the In-Home Recovery Program (the Program) are to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months old and to expand the service array for these families through implementation of a specific evidence-informed, in-

home treatment program. Post-intervention changes on parental substance use and involvement with child protective services will be evaluated. The RFP process will result in one award for the implementation of two (2) Project sites within Ocean County, NJ managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019, for a budget not to exceed \$1,064,855.

An important objective of the Program is to demonstrate the effectiveness of a trauma informed in-home treatment for families involved with the NJDCF Division of Child Protection and Permanency (DCP&P) who have an index parent (client) with a substance use disorder and an index child (child) under the age of 36 months. Outcome measures will include parental substance use, child placement at discharge, and a client's repeat involvement with child protective services.

Key model components include toxicology testing (for clinical purposes only); positive reinforcement in the form of gift cards/vouchers for positive behavioral change (negative toxicology screen); collaboration with DCF regarding the clients progress, success, or any concerns about functioning; collaboration with MAT providers; outreach to support client's participation; utilization of standardized measures to inform and guide treatment, and identify and track symptoms over the course of the intervention; and tools for obtaining family history and the fit between the client and the clients family system.

Measures are divided into three domains: client, child, and parent-child relationship. Areas of focus in the three domains are as follows:

- a. client: depression, anxiety, post-traumatic stress, and childhood trauma history;
- b. child: development, resilience, behaviors, and trauma exposure; and
- c. parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

The full text of the RFP is available here:

<https://thenicholsonfoundation.org/news-and-resources/request-proposals-trauma-informed-recovery-program-ocean-county>

Additionally, the following evidence based programs are currently provided by CSOC

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, "whatever it takes" treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008. There are currently 5 CSOC-contracted agencies providing FFT/MST. During SFY XXXchildren, youth and young adult received FFT/MST services.

ARC-GROW Model

CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines.

FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Under New Jersey's child welfare modified settlement agreement (MSA), the State was required to seek approval from the federal government for a Medicaid rate structure "to support the use of new services for children and families, including community-based and evidence-based informed, or support practices, such as Functional Family Therapy and Multi-Systemic Therapy" (Section II.C.2 of the MSA).

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, "whatever it takes" treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008.

There are currently 5 CSOC-contracted agencies providing evidence-based practices.

- Functional Family Therapy (FFT):

- Atlantic and Ocean Counties

Cape Counseling and Jewish Family Services

- Burlington and Ocean Counties

Community Treatment Solutions

- Cumberland, Gloucester and Salem Counties

Robins' Nest

- Multisystemic Therapy (MST):

- Camden County

Center for Family Services

- Hudson and Essex Counties

Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model

CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Under New Jersey's child welfare modified settlement agreement (MSA), the State was required to seek approval from the federal government for a Medicaid rate structure "to support the use of new services for children and families, including community-based and evidence-based informed, or

support practices, such as Functional Family Therapy and Multi-Systemic Therapy” (Section II.C.2 of the MSA).

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, “whatever it takes” treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008.

There are currently 5 CSOC-contracted agencies providing evidence-based practices.

• Functional Family Therapy (FFT):

- Atlantic and Ocean Counties

Cape Counseling and Jewish Family Services

- Burlington and Ocean Counties

Community Treatment Solutions

- Cumberland, Gloucester and Salem Counties

Robins’ Nest

• Multisystemic Therapy (MST):

- Camden County

Center for Family Services

- Hudson and Essex Counties

Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model

CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children’s Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

In coordination with the NJ Department of Children and Families, the Nicholson Foundation will fund one award for the implementation of the In-Home Recovery Program (IHRP) which provides two (2) Project sites managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

Baseline Measurement:

This in-home service does not exist within NJ DCF at this time

First-year target/outcome measurement:

Total number of families served between January 1, 2020 and June 30, 2020

Second-year target/outcome measurement:

Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

New Second-year target/outcome measurement(if needed):

Data Source:

Grant awardee

New Data Source(if needed):

Description of Data:

Total number of families served over the 18-month grant period. Target measurement is 36 families served.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain housing stability in community settings and improve utilization of housing service slots for mental health consumers served in Community Support Services (CSS).

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

The SMHA will utilize a number of strategies to help attain the objective.

1. The Office of Olmstead, Compliance, Planning, and Evaluation works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.
2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community.
3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider. Consumers will no longer be restricted to the same agency. This separation will also enable the SMHA to track expenditures, utilization, outcomes, and demands for services.
4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources.
5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team).

SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.

Baseline Measurement: The total number of clients served in CSS in SFY 2018 were 4,762. 80.72% of the total consumers served in CSS remained in CSS during SFY 2018. The total number of clients served in CSS in SFY 2019 will be available by September 2019. At that time, the percentage for SFY 2019 will be calculated.

First-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2020 will be no less than 85% of total consumers served in Community Support Services.

Second-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2021 will be no less than 87% of total consumers served in Community Support Services.

New Second-year target/outcome measurement(if needed):

Data Source:

The number of consumers served by Community Support Services is tracked by the SMHA's QCMR database starting SFY 2018.

New Data Source(if needed):

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. Currently 39 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

The QCMR emphasizes aggregate program processes and units of service/persons served, rather than individual consumer outcomes. Proposals awarded under current and forthcoming RFPs for Community Support Services will be monitored through contract negotiations. Data will be maintained through the QCMR database.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 14

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain housing stability in community settings and improve utilization of housing service slots for mental health consumers served in Community

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful meaningful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, supported education, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Improved Utilization of Housing Service Slots measured by occupancy rates of Community Support Services (CSS) housing units.
Baseline Measurement:	In SFY2019, the occupancy rate (of CSS housing units that are occupied and/or have a consumer assigned to them) was 95.9%. Conversely, the vacancy rate (state-funded CSS housing units that are vacant and/or have no consumers assigned to them) was 4.1%.
First-year target/outcome measurement:	In SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.
Second-year target/outcome measurement:	In SFY 2021, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

New Second-year target/outcome measurement(if needed):**Data Source:**

The 2019 baseline value was generated from newer and slightly improved Provider Weekly Reports. The denominator was the sum of capacity reported from 33 different CSS programs. The numerator was the number of needed assignments requested by those same organizations.

New Data Source(if needed):**Description of Data:**

For the 2020-2021 application, this priority indicator has been refined to focus on increased access to community-based housing among its largest segment—those served by Community Support Services (CSS). Although DMHAS has developed data systems (e.g., the Bed Enrollment Data System/BEDS) that are well-suited for the tracking of group homes and supervised apartments, different reporting mechanisms are preferable for the tracking of CSS housing—which is uniquely client-driven. Therefore, the data used for this indicator is from an analysis of Provider Weekly Reports, which are submitted to the SMHA on a weekly basis by each contracted CSS agency. Provider Weekly Vacancy Reports gather data from the community providers regarding their current census, current occupancy, and identify availability for state hospital assignments. These reports provide current information regarding active assignments, which includes any unforeseen post-assignment barriers, identifies any follow-up needed, and provides additional information used for tracking the progress of the assignment to allow for timely discharge and/or intervention. Prior to the development of this report, two of the three catchment areas implemented a similar tool. The new report has standardized the process in all three regions and across all providers. The Provider Weekly Vacancy Report provides information in order to validate the current BEDs Data System, as well as provide continuous updates to maintain its accuracy. This report is also used to develop and maintain the Hospital Vacancy Report, which is used for notifying state hospital treatment teams of bed vacancies and assignment opportunities. All DMHAS community providers were invited to participate in a webinar training on June 19, 2019. The Provider Weekly Vacancy Report went into effect on July 1st, 2019.

The 2019 values were calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY19.

New Description of Data:(if needed)**Data issues/caveats that affect outcome measures:**

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and the SMHA does not feel that the SFY19 occupancy rate of 95.9% would be materially different if/when all of the data was reported.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 15

Priority Area: First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Early treatment and intervention of psychosis helps change the trajectory of psychotic disorders in young adults by improving symptoms, reducing the likelihood of long-term disability and leading to productive independent meaningful lives.

Strategies to attain the goal:

Objectives will be addressed through the implementation of a Coordinated Specialty Care (CSC) model. CSC is an evidence-based recovery-oriented approach involving clients and family members as active participants. All services are highly coordinated with primary medical care.

New Jersey's CSC services are provided for youth and adults between the ages of 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. Since November 2016, three teams in New Jersey have been funded to provide CSC services. They cover all 21 counties using extensive outreach efforts. The three provider agencies are Oaks Integrated Care for Southern region, Rutgers University Behavioral Health Center for Central region, and CarePlus NJ for Northern region.

Each CSC team is comprised of six members, mostly masters level clinicians, who contribute to high levels of care. They take on the roles of Team Leader, Recovery Coach, Supported Employment and Education Specialist, Pharmacotherapist, Outreach and Referral Specialist, and Peer Support Specialist. The New Jersey CSC model emphasizes treatment through the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support (IPS), supported employment and supported education, peer support, case management, and family psychoeducation.

In SFY 2019, the three CSC programs had over 277 referrals and served 215 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2020-21 to support these three CSC teams in providing evidence-based services for individual with FEP. With increased demand for FEP services, the CSC programs have expanded from serving 35 clients to 70 clients per agency and increased clinical staff from 5.2 FTE to 6.8 FTE levels in FY 2019.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Medication adherence among clients who need psychotropic medication prescribed for FEP treatment.

Baseline Measurement: In SFY 2018, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 78.4% adhere to their medication regimen. In SFY 2019, out of 215 clients being served, 190 were taking or in need of antipsychotic medication. Among them, 86.8% (165) adhered to their psychotropic medication regimens.

First-year target/outcome measurement: In SFY 2020, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

Second-year target/outcome measurement: In SFY 2021, it is anticipated that at least 90% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

New Second-year target/outcome measurement(if needed):

Data Source:

The Division of Mental Health and Addiction Services (DMHAS) maintains a CSC clinical diagnostic database, which is used for tracking

medication monitoring in all 3 agencies.

New Data Source(if needed):

Description of Data:

The three CSC service providers submit the client level clinical diagnostic data quarterly to DMHAS. The CSC clinical diagnostic database tracks client referral and intake; functional status; program involvement; education and employment; medication and substance use; suicide ideation; hospitalization; and client discharge information.

The DMHAS is in the process of creating a comprehensive client level data system that includes data elements from all DMHAS contracted community programs. The client level data system will include all CSC program elements currently collected through the CSC clinical diagnostic database and additional measures required by federal and state data reporting and evaluation. The client level data will provide a detailed description of the FEP population receiving CSC services in New Jersey and will help capture the treatment and recovery progress of CSC clients so that DMHAS can improve services for early serious mental illness (ESMI) population in New Jersey.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Clients who participate in medication monitoring may not always be forthright with service providers about medication adherence patterns and this may introduce possible errors in data interpretation.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 16

Priority Area: System wide assessment for delivering services to diverse populations

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations.

Strategies to attain the goal:

Since 1985, the Division of Mental Health and Addiction Services (DMHAS) has had the commitment to improve services to individuals from diverse backgrounds, including LGBTQ. The mechanism for addressing these system needs began with the 2015 reformation of DMHAS' multicultural activities into a Multicultural Services Advisory Committee (MSAC). The MSAC has developed a process for systems assessment that will begin by surveying all contracted agencies about their existing planning and service delivery to diverse populations. As the SMHA reviewed the results of these surveys, gaps in service and needs for technical assistance (TA) were identified. Beginning in early 2016, TA groups were held in the north and south to assist agencies in formulating multicultural plans. Those plans became a part of the SMHA's contracting process in FY 2017 and have been followed by the DMHAS Multicultural Training and Technical Assistance Center each year to ensure that the plans continue to grow. In addition, in FY 2018, DMHAS contracted with a diversity consultant to provide administrative and research-based assistance with this initiative. The diversity consultant was charged with securing scholarly presenters for trainings and workshops to further educate and engage providers with completing their Cultural Competence Plan. The diversity consultant's role expanded in FY 2019 to include qualitative and quantitative analysis of data in order to present a more robust picture of DMHAS' agency gaps and trends leading to greater concentration of creating and sustaining a culture of inclusion.

The MSAC, with assistance from DMHAS and the diversity consultant, is developing a "Center for Cultural Competency Excellence" designation for agencies that meet exemplary criteria in addition to completing their Cultural Competency Plans.

Each mental health community provider is required to develop a Cultural Competence Plan describing the integration of cultural and linguistic competence throughout the organization, including direct attention to issues of gender, age, and culture. An organizational self-assessment helps

prioritize the steps needed to develop those congruent behaviors and improve culturally responsive services. The plan that results from that assessment, which has 47 items, should address all diverse groups that are served within the agency: for example, cultural, ethnic and linguistically diverse people, individuals who are deaf and hard of hearing, Lesbian, Gay, Bisexual, Transgender people, older people; and outline strategies for recruiting, hiring, retaining, and promoting culturally competent, diverse staff members; the use of interpreters or bilingual staff members; staff training, professional development, and education; fostering community involvement; facilities design and operation; development of cultural and diversity appropriate program materials; how to incorporate diverse treatment approaches; and development and implementation of supporting policies and procedures, including reassessment processes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Proportion of agencies that have three areas identified from their self-assessment included in their Cultural Competence Plans.

Baseline Measurement: The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competence Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2020. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.

First-year target/outcome measurement: Thirty (30) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for "Center for Cultural Competency Excellence" designation.

Second-year target/outcome measurement: Fifty percent (50%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency "Center for Cultural Competency Excellence" designations will be reviewed and awarded.

New Second-year target/outcome measurement(if needed):

Data Source:

Self assessments and written plans checked by SMHA, Multicultural Training and Technical Assistance Center staff, and analyzed by the diversity consultant.

New Data Source(if needed):

Description of Data:

The establishment of written organizational plans for addressing culture and diversity based upon agency self-assessment. The areas covered: Governance, Leadership, and Workforce; Communication and Language Assistance and Engagement, Continuous Improvement, and Accountability. Plans identify a minimum of at least three activities from these areas.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Some agencies have been reluctant to initiate a multicultural plan due to staffing demands, cultural competency misinformation, and fiscal issues. The addition of the diversity consultant and "Center for Cultural Competency Excellence" agency designation may help in this regard.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Footnotes:

Priority areas #10-16 of the State Mental Health Authority and the Children's System of Care are not applicable to this report.

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

This table provides a report of SABG and State expenditures by the State Substance Abuse Authority during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds for authorized activities to prevent and treat substance use disorder. For detailed instructions, refer to those in the Block Grant Application System (BGAS)

Expenditure Period Start Date: 7/1/2019 Expenditure Period End Date: 6/30/2020

Activity (See instructions for entering expenses in Row 1)	A. SA Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	\$28,757,421.00		\$0.00	\$10,828,775.00	\$122,753,911.00	\$0.00	\$0.00
a. Pregnant Women and Women with Dependent Children*	\$5,511,080.00		\$0.00	\$0.00	\$2,151,719.00	\$0.00	\$0.00
b. All Other	\$23,246,341.00		\$0.00	\$10,828,775.00	\$120,602,192.00	\$0.00	\$0.00
2. Substance Abuse Primary Prevention	\$10,827,917.00		\$0.00	\$6,376,917.00	\$1,996,075.00	\$0.00	\$0.00
3. Tuberculosis Services	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)**	\$1,738,129.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$1,511,023.00		\$0.00	\$144,927.00	\$875,107.00	\$0.00	\$0.00
11. Total	\$42,834,490.00	\$0.00	\$0.00	\$17,350,619.00	\$125,625,093.00	\$0.00	\$0.00

*Prevention other than primary prevention

**Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

Actual Estimated

Please identify which of the information in is estimated rather than actual:

Column E. State Funds are estimated. The data in column E is estimated.

The State Substance Abuse Authority spent zero dollars on TB services in the state for SFY19 (whether SABG or state funds).

\$124,781 was the total amount of TA Supplement expenditures from the FFY 2019 NOA, Issue Date of 09/24/19, for the SABG Administrative Supplement for Technical Assistance for the Expenditure Period End Date of September 30, 2020.

Identify the date by when all estimates can be replaced with actual expenditures: 06/01/2021

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

HIV EIS expenditures were for services performed prior to the end of the program, 9/30/2019, and paid in SFY 2020.

III: Expenditure Reports

Table 3A SABG – Syringe Services Program

Expenditure Start Date: 07/01/2019 Expenditure End Date: 06/30/2020

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SAPT Block Grant funds are not used for Syringe Services Programs.

III: Expenditure Reports

Table 3B SABG – Syringe Services Program

Expenditure Start Date: 07/01/2019 Expenditure End Date: 06/30/2020

[Please enter total number of individuals served]

Syringe Service Program Name	# of Unique Individuals Served		HIV Testing	Treatment for Substance Use Conditions	Treatment for Physical Health	STD Testing	Hep C
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SAPT Block Grant funds are not used for Syringe Services Programs.

III: Expenditure Reports

Table 4 - State Agency SABG Expenditure Compliance Report

This table provides a description of SABG expenditures for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in BGAS. Only one column is to be filled in each year.

Expenditure Period Start Date: 10/1/2017 Expenditure Period End Date: 9/30/2019

Expenditure Category	FY 2018 SA Block Grant Award
1. Substance Abuse Prevention* and Treatment	\$31,016,817.00
2. Primary Prevention	\$10,320,661.00
3. Tuberculosis Services	\$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)**	\$2,847,454.00
5. Administration (excluding program/provider level)	\$2,283,398.00
Total	\$46,468,330.00

*Prevention other than Primary Prevention

**Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The \$10,320,661 listed in Primary Prevention is the sum of Table 5b SAPT BG (\$8,835,870) and Table 6 Prevention SA (\$1,484,791). Please refer to those table to see a further breakdown of Primary Prevention expenditures by Resource Development and the Institute of Medicine (ICM) sub-categories.

III: Expenditure Reports

Table 5a - SABG Primary Prevention Expenditures Checklist

The State or jurisdiction must complete either SABG Table 5a and/or 5b. There are six primary prevention strategies typically funded by principal agencies administering the SABG. Expenditures within each of the six strategies or Institute of Medicine Model (IOM) should be directly associated with the cost of completing the activity or task. For example, information dissemination may include the cost of developing pamphlets, the time of participating staff and/or the cost of public service announcements, etc. If a state or jurisdiction employs strategies not covered by these six categories, please report them under "Other," each in a separate row.

Expenditure Period Start Date: Expenditure Period End Date:

Strategy	IOM Target	SA Block Grant Award	Other Federal	State	Local	Other
Information Dissemination	Selective					
Information Dissemination	Indicated					
Information Dissemination	Universal					
Information Dissemination	Unspecified					
Information Dissemination	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Education	Selective					
Education	Indicated					
Education	Universal					
Education	Unspecified					
Education	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Alternatives	Selective					
Alternatives	Indicated					
Alternatives	Universal					
Alternatives	Unspecified					
Alternatives	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Problem Identification and Referral	Selective					
Problem Identification and Referral	Indicated					
Problem Identification and Referral	Universal					
Problem Identification and Referral	Unspecified					
Problem Identification and Referral	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Community-Based Process	Selective					
Community-Based Process	Indicated					
Community-Based Process	Universal					
Community-Based Process	Unspecified					
Community-Based Process	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Environmental	Selective					
Environmental	Indicated					
Environmental	Universal					
Environmental	Unspecified					
Environmental	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Section 1926 Tobacco	Selective	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Section 1926 Tobacco	Indicated	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Section 1926 Tobacco	Universal	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Section 1926 Tobacco	Unspecified	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Section 1926 Tobacco	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	Selective					
Other	Indicated					
Other	Universal					
Other	Unspecified					
Other	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Grand Total					

Section 1926 – Tobacco: Costs associated with the Synar Program Pursuant to the January 19, 1996 federal regulation “Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants, Final Rule” (45 CFR § 96.130), a state may not use the SABG to fund the enforcement of its statute, except that it may expend funds from its primary prevention set aside of its Block Grant allotment under 45 CFR §96.124(b)(1) for carrying out the administrative aspects of the requirements, such as the development of the sample design and the conducting of the inspections. States should include any non-SABG funds* that were allotted for Synar activities in the appropriate columns under 7 below.

*Please list all sources, if possible (e.g., Centers for Disease Control and Prevention, Block Grant, foundations, etc.)

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DMHAS has selected the option to complete Table 5b, rather than Table 5a, however, as required we are reporting the amount spent on Section 1926 Tobacco, herein, on Table 5a, which as indicated above is \$0 for each column.

III: Expenditure Reports

Table 5b - SABG Primary Prevention Expenditures by Institute of Medicine (IOM) Categories

The state or jurisdiction must complete SABG Table 5b if it chooses to report SUD primary prevention activities utilizing the IOM Model of Universal, Selective and Indicated. Indicate how much funding supported each of the IOM classifications of Universal, Selective, or Indicated. Include all funding sources (e.g., Centers for Disease Control and Prevention Block Grant, foundations).

Expenditure Period Start Date: 10/1/2017 Expenditure Period End Date: 9/30/2019

Activity	SA Block Grant Award	Other Federal Funds	State Funds	Local Funds	Other
Universal Direct	\$1,767,174.00	\$3,153,960.00	\$0.00		
Universal Indirect	\$2,827,478.00		\$2,000,000.00		
Selective	\$2,650,761.00	\$1,620,992.00	\$762,597.00		
Indicated	\$1,590,457.00		\$1,630,140.00		
Column Total	\$8,835,870.00	\$4,774,952.00	\$4,392,737.00	\$0.00	\$0.00

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

III: Expenditure Reports

Table 5c - SABG Primary Prevention Priorities and Special Population Categories

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2018 SABG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2017 Expenditure Period End Date: 9/30/2019

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input checked="" type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

Footnotes:

III: Expenditure Reports

Table 6 - Resource Development Expenditure Checklist

Expenditure Period Start Date: 10/1/2017 Expenditure Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	\$0.00	\$1,537,342.00	\$0.00	\$0.00
2. Infrastructure Support	\$0.00	\$0.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$0.00	\$36,923.00	\$16,036.00	\$0.00
4. Planning Council Activities (MHBG required, SABG optional)	\$0.00	\$340,630.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$0.00	\$186,755.00	\$0.00	\$0.00
6. Research and Evaluation	\$0.00	\$2,760,635.00	\$1,468,755.00	\$0.00
7. Training and Education	\$0.00	\$0.00	\$0.00	\$0.00
8. Total	\$0.00	\$4,862,285.00	\$1,484,791.00	\$0.00

*SABG combined, showing amounts for non-direct services/system development when you cannot separate out the amounts devoted specifically to treatment or prevention. For the combined column, do not include any amounts listed in the prevention and treatment columns.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) used for SABG Prevention Resource Development Activities for SABG Prevention, Column C, and/or SABG Combined, Column D = \$1,484,791.

Amount of SABG Administration funds (from Table 4, Row 5) used for SABG Prevention Resource Development Activities Activities for SABG Prevention, Column C, and/or SABG Combined, Column D = \$0.

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

This table provides a report of the sub-recipients of SABG funds including community- and faith-based organizations which provided SUD prevention activities and treatment services, as well as intermediaries/administrative service organizations. Table 7 excludes resource development expenditures.

Expenditure Period Start Date: 10/1/2017 Expenditure Period End Date: 9/30/2019

Entity Number	I-BHS ID (formerly I-SATS)	i	Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	Source of Funds SAPT Block Grant					
									A. All SA Block Grant Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program
100776	NJ101850	X	01	Atlantic Prevention Resources Inc - Individual and Group Counseling	1416 North Main Street	Pleasantville	NJ	08232	\$224,033	\$0	\$0	\$224,033	\$0	\$0
100883	NJ101680	✓	01	ATLANTICARE BEHAVIORAL HEALTH	6010 Black Horse Pike Suite B-10	Egg Harbor Township	NJ	08234	\$54,555	\$54,555	\$35,055	\$0	\$0	\$0
306175	NJ101797	X	04	CAMDEN COUNTY COUNCIL ON	1 Alpha Avenue Suite 22	Voorhees	NJ	08043	\$245,208	\$0	\$0	\$245,208	\$0	\$0
750133	NJ750133	X	05	Cape May Council on - Alcoholism and Drug Abuse Inc	3819 New Jersey Avenue	Wildwood	NJ	08260	\$399,886	\$0	\$0	\$399,886	\$0	\$0
900247	NJ102278	X	Mercer County	CATHOLIC CHARITIES	383 WEST STATE STREET	TRENTON	NJ	08618	\$102,392	\$0	\$0	\$102,392	\$0	\$0
100853	NJ100853	X	Sussex County	Center for Prevention and Counseling	61 Spring Street	Newton	NJ	07860	\$301,308	\$0	\$0	\$301,308	\$0	\$0
101804	NJ101804	X	Warren County	COMMUNITY PREVENTION RESOURCES	20 West Washington Avenue	WASHINGTON	NJ	07882	\$142,700	\$0	\$0	\$142,700	\$0	\$0
305300	NJ100756	X	07	CURA INCORPORATED	35 Lincoln Park, P.O. Box 180	Newark	NJ	07101	\$1,193,511	\$1,193,511	\$185,046	\$0	\$0	\$0
306167	NJ306167	✓	Middlesex County	Damon House Inc	105 Joyce Kilmer Avenue	New Brunswick	NJ	08901	\$386,576	\$386,576	\$0	\$0	\$0	\$0
300236	NJ100477	X	Monmouth County	DISCOVERY INSTITUTE	80 Conover Road	Marlboro	NJ	07746	\$663,310	\$663,310	\$0	\$0	\$0	\$0
102679	NJ102679	X	Passaic County	Dismas House for Drug Rehabilitation	508 Straight St.	Paterson	NJ	07503	\$1,021,078	\$1,021,078	\$0	\$0	\$0	\$0
300806	NJ300806	X	07	East Orange Substance Abuse Trt Prog	110 South Grove Street Floor 3	East Orange	NJ	07018	\$371,627	\$371,627	\$21,590	\$0	\$0	\$0
101329	NJ101329	X	Passaic County	Evas Kitchen and Sheltering Prog Inc - Halfway House for Men	393 Main Street	Paterson	NJ	07501	\$306,696	\$306,696	\$306,696	\$0	\$0	\$0
300855	NJ300855	✓	07	Family Connections Inc	395 South Center Street	Orange	NJ	07050	\$394,167	\$0	\$0	\$394,167	\$0	\$0
902635	NJ902635	X	Warren County	Family Guidance Center of Warren Cnty	492 Route 57 West	Washington	NJ	07882	\$189,563	\$189,563	\$150,563	\$0	\$0	\$0
101162	NJ101162	✓	Hunterdon County	FREEDOM HOUSE	2004 State Route 31 Unit 1	Clinton	NJ	08809	\$44,806	\$44,806	\$44,806	\$0	\$0	\$0
101477	NJ101477	✓	Hunterdon County	Good News Home for Women	33 Bartles Corner Road	Flemington	NJ	08822	\$533,997	\$533,997	\$533,997	\$0	\$0	\$0
306357	NJ306357	X	04	Hispanic Family Center of Southern NJ - New Jersey Substance Abuse Services	2700 Westfield Avenue	Camden	NJ	08105	\$272,000	\$0	\$0	\$272,000	\$0	\$0
104232	NJ750216	X	Hunterdon County	HUNTERDON PREVENTION RESOURCES	4 Walter Foran Boulevard Suite 410	Flemington	NJ	08822	\$292,875	\$0	\$0	\$292,875	\$0	\$0
100420	NJ100420	X	07	Integrity House Inc - Mens Facility	105 Lincoln Park	Newark	NJ	07102	\$2,243,391	\$2,230,087	\$0	\$0	\$13,304	\$0
306209	NJ306209	X	09	Inter County Council on Drug/Alc Abuse - Administration/Drug Free Counseling	480 Kearny Avenue	Kearny	NJ	07032	\$302,620	\$227,020	\$21,590	\$0	\$75,600	\$0

100461	NJ100461	✘	Mercer County	IRON RECOVERY AND WELLNESS CEN	132 Perry Street	Trenton	NJ	08618	\$15,835	\$15,835	\$15,835	\$0	\$0	\$0
300103	NJ300103	✔	01	JOHN BROOKS RECOVERY CENTER	1315 Pacific Avenue	Atlantic City	NJ	08401	\$2,633,787	\$2,398,528	\$38,862	\$0	\$235,259	\$0
100156	NJ100156	✘	Monmouth County	JSAS HEALTHCARE INC.	685 Neptune Boulevard Suite 101	Neptune	NJ	07753	\$1,549,737	\$1,384,971	\$67,289	\$0	\$164,766	\$0
100404	NJ100404	✘	07	LENNARD CLINIC INC.	164 Blanchard Street	Newark	NJ	07105	\$1,603,411	\$1,017,561	\$181,356	\$0	\$585,850	\$0
902924	NJ902924	✘	Mercer County	Mercer Council on Alcoholism and - Drug Addiction	408 Bellevue Avenue	Trenton	NJ	08618	\$355,194	\$19,500	\$0	\$335,694	\$0	\$0
100651	NJ100651	✘	Morris County	Morris County Aftercare Center - Resource Center of Chemically Dependent	273 East Main Street	Denville	NJ	07834	\$872,765	\$872,765	\$0	\$0	\$0	\$0
101818	NJ101818	✘	Morris County	Morris County Prevention is Key	25 West Main Street	Rockaway	NJ	07866	\$408,000	\$0	\$0	\$408,000	\$0	\$0
750299	NJ101301	✘	Mercer County	National Council on Alcoholism and - Drug Dependence	60 South Fullerton Avenue	ROBBINSVILLE	NJ	08691	\$299,180	\$0	\$0	\$299,180	\$0	\$0
103309	NJ103309	✘	09	National Council on Alcoholism and - Drug Dependence/Hudson County	309-311 Newark Avenue	EAST BRUNSWICK	NJ	08816	\$892,459	\$0	\$0	\$892,459	\$0	\$0
302026	NJ302026	✔	Middlesex County	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	\$1,128,778	\$1,012,780	\$56,134	\$0	\$115,998	\$0
100461	NJ100461	✔	Morris County	New Horizon Treatment Services Inc	132 Perry Street	Trenton	NJ	08618	\$556,282	\$556,282	\$0	\$0	\$0	\$0
759802	NJ100858	✘	Ocean County	NEW JERSEY PREVENTION NETWORK	150 AIRPORT ROAD	LAKEWOOD	NJ	08701	\$1,496,965	\$991,310	\$0	\$505,655	\$0	\$0
306092	NJ306092	✘	07	Newark Renaissance House Inc	50 Norfolk Street	Newark	NJ	07103	\$349,610	\$349,610	\$349,610	\$0	\$0	\$0
101821	NJ101821	✘	07	North Jersey Community Research Initiative	393 Central Ave	Newark	NJ	07103	\$225,000	\$0	\$0	\$225,000	\$0	\$0
100487	NJ100487	✔	Passaic County	Northeast Life Skills Associates Inc	121 Howe Avenue	Passaic	NJ	07055	\$364,243	\$364,243	\$22,670	\$0	\$0	\$0
100503	NJ100503	✘	Union County	Organization for Recovery Inc	519 North Avenue	Plainfield	NJ	07060	\$598,591	\$598,591	\$0	\$0	\$0	\$0
100495	NJ100495	✔	Passaic County	Paterson Counseling Center Inc	319-321 Main Street	Paterson	NJ	07505	\$769,912	\$577,415	\$99,314	\$0	\$192,497	\$0
101295	NJ101295	✔	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701	\$60,210	\$60,210	\$60,210	\$0	\$0	\$0
101308	NJ101308	✘	Monmouth County	PREVENTION FIRST	1405 Highway 35	Ocean	NJ	07712	\$185,167	\$0	\$0	\$185,167	\$0	\$0
750802	NJ750802	✘	Union County	Prevention Links Inc	35 Walnut Avenue Suite 17	Clark	NJ	07066	\$432,500	\$0	\$0	\$432,500	\$0	\$0
999031	NJ101823	✘	03	PREVENTION PLUS OF BURLINGTON	1824 ROUTE 38 EAST	LUMBERTON	NJ	08048	\$427,041	\$0	\$0	\$427,041	\$0	\$0
750687	NJ750687	✔	Morris County	Rescue Mission of Trenton	98 Carroll Street P.O. Box 790	Trenton	NJ	08605	\$77,706	\$77,706	\$0	\$0	\$0	\$0
1234	NJ104315	✘	Middlesex County	RUTGERS THE STATE UNIV RBHS	100 JOYCE KILMER AVE	PISCATAWAY	NJ	08854	\$1,029,058	\$39,137	\$39,137	\$0	\$989,921	\$0
104315	NJ102934	✘	Middlesex County	RUTGERS THE STATE UNIVERSITY OF NJ	33 Knightsbridge Road 2nd Fl East Wing	Piscataway	NJ	08854	\$5,790	\$0	\$0	\$5,790	\$0	\$0
100164	NJ301069	✘	Ocean County	Seashore Family Services of New Jersey	35 Beaverson Boulevard Suite 6-A	Brick	NJ	08723	\$175,307	\$175,307	\$175,307	\$0	\$0	\$0
750612	NJ750612	✘	Somerset County	Somerset Council on - Alcoholism and Drug Dependency Inc	34 West Main Street Suite 307	Somerville	NJ	08876	\$149,494	\$0	\$0	\$149,494	\$0	\$0
100693	NJ100693	✔	Somerset County	Somerset Treatment Services	118 West End Avenue	Somerville	NJ	08876	\$430,728	\$349,728	\$21,590	\$0	\$81,000	\$0
100677	NJ100677	✘	04	South Jersey Drug Treatment Center	162 Sunny Slope Drive, P.O. Box 867	Bridgeton	NJ	08302	\$255,209	\$230,047	\$0	\$0	\$25,162	\$0

109876	NJ109876	✘	04	Southern New Jersey Perinatal Cooperative	2500 McClellan Ave	Pennsauken	NJ	08109	\$275,776	\$275,776	\$275,776	\$0	\$0	\$0
306316	NJ306316	✔	09	Spectrum Healthcare Inc	74-80 Pacific Avenue	Jersey City	NJ	07304	\$1,536,974	\$1,328,666	\$120,904	\$0	\$208,308	\$0
105072	NJ100095	✘	01	St. Barnabas Health Care Inst. for Prevention	1695 US HIGHWAY 9	TOMS RIVER	NJ	08754	\$905,436	\$97,500	\$0	\$807,936	\$0	\$0
999074	NJ102679	✘	Passaic County	STRAIGHT & NARROW INC	508 Straight Street, P.O. Box 2738	Paterson	NJ	07501	\$2,467,224	\$2,409,202	\$1,555,278	\$0	\$58,022	\$0
101830	NJ101830	✘	02	The Center for Alcohol and - Drug Resource	241 Main Street	PARAMUS	NJ	07652	\$675,100	\$19,500	\$0	\$655,600	\$0	\$0
107771	NJ107771	✘	Somerset County	THE CENTER FOR GREAT EXPECTATIONS	19 Dellwood Lane Suite B	Somerset	NJ	08873	\$171,417	\$171,417	\$171,417	\$0	\$0	\$0
102467	NJ102467	✘	03	THE NEW HOPE FOUNDATION INC	80 Conover Road	Marlboro	NJ	07746	\$822,415	\$822,415	\$822,415	\$0	\$0	\$0
101309	NJ101309	✘	06	THE SOUTHWEST COUNCIL INC.	1405 North Delsea Drive	Vineland	NJ	08360	\$845,572	\$0	\$0	\$845,572	\$0	\$0
750729	NJ750729	✔	07	TURNING POINT INC	15 Bloomfield Avenue Suite 104	Verona	NJ	07044	\$1,778,468	\$1,778,468	\$415,201	\$0	\$0	\$0
100939	NJ100939	✘	04	Urban Renewal Corp Sussex House	224 Sussex Avenue	CAMDEN	NJ	08102	\$1,039,003	\$937,236	\$21,590	\$0	\$101,767	\$0
371203	NJ102452	✘	Passaic County	WAYNE COUNSELING CTR INC	1022 Hamburg Turnpike	Wayne	NJ	07470	\$184,525	\$0	\$0	\$184,525	\$0	\$0
101836	NJ101836	✘	Passaic County	William Paterson University	300 Pompton Road	Wayne	NJ	07444	\$101,688	\$0	\$0	\$101,688	\$0	\$0
Total									\$37,837,856	\$26,154,532	\$5,809,238	\$8,835,870	\$2,847,454	\$0

* Indicates the imported record has an error.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SUD Prevention and Treatment

This Maintenance of Effort table provides a description of non-federal expenditures to include funds appropriated by the state legislature; revenue funds (e.g., alcohol, tobacco, and gambling taxes; asset seizures); state Medicaid match expenditures; and third-party reimbursement (e.g., insurance payments) for authorized activities to prevent and treat SUDs flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2019 Expenditure Period End Date: 06/30/2020

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period (A)	Expenditures (B)	<u>B1(2018) + B2(2019)</u> 2 (C)
SFY 2018 (1)	\$122,158,062.00	
SFY 2019 (2)	\$119,512,134.00	\$120,835,098.00
SFY 2020 (3)	\$155,469,198.00	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2018 Yes No

SFY 2019 Yes No

SFY 2020 Yes No

Did the state or jurisdiction have any **non-recurring expenditures** as described in 42 U.S.C. § 300x-30(b) for a specific purpose which were not included in the MOE calculation?

Yes No

If yes, specify the amount and the State fiscal year: _____

If yes, SFY: _____

Did the state or jurisdiction include these funds in previous year MOE calculations?

Yes No

When did the State or Jurisdiction submit an official request to SAMHSA to exclude these funds from the MOE calculations? _____

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance abuse prevention and treatment 42 U.S.C. §300x-30

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2020 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

This Attachment explains how the following four SAPT Maintenance of Effort expenditure entries are calculated:

Table 8a - Maintenance of Effort for State Expenditures for SAPT

Table 8d - Expenditures for Services to Pregnant Women and Women with Dependent Children

It also summarizes the original procedures used to calculate the base amounts, which are the benchmarks against which current MOE expenditures are measured.

REQUIREMENTS for STATEWIDE MOE: 45 CFR Part § 96.134

The Secretary of the US Department of Health and Human Services (HHS) may make a Block Grant (BG) for a fiscal year only if the State involved submits to the Secretary information sufficient for the Secretary to make the determination required . . . which includes the dollar amount reflecting the aggregate State expenditures by the principal agency for authorized activities for the two State fiscal years preceding the fiscal year for which the State is applying for the grant. The base shall be calculated using Generally Accepted Accounting Principles and the composition of the base shall be applied consistently from year to year.

Methodology: Calculation of SAPT Statewide Maintenance of Effort (MOE)

New Jersey's SAPT BG MOE is defined as general revenue and State dollars administered by the Division of Mental Health and Addiction Services (DMHAS), the SSA, within the New Jersey Department of Human Services including the following Appropriations and transfer accounts:

100-054-7700-158, (046-4290-158) Funds transferred from NJ Administrative Office of the Courts posted into this account

100-054-7700-161, (046-4290-161) Substance Abuse Treatment for DCP&P/Work First Mothers

100-054-7700-162, (046-4290-162) Community Based Substance Abuse Treatment and Prevention – State Share

100-054-7700-163, (046-4290-163) Medication Assisted Treatment Initiative

100-054-7700-165, (046-4290-165) Mutual Agreement Parolee Rehabilitation Project for Substance Abusers

100-054-7700-172, (046-4290-172) Addiction Licensing Fees

100-054-7700-175, (046-4290-175) Health Services Group

100-054-7700-176, (046-4290-176) Alcohol Education Rehabilitation and Enforcement Fund (AEREF)

100-054-7700-177, (046-4290-177) Drug Enforcement and Demand Reduction Fund; Program for the Deaf and Disabled

100-054-7700-178, (046-4290-178) Drug Enforcement and Demand Reduction Fund; Partnership for a Drug-Free NJ

100-046-4290-210, On Campus Recovery Programs
100-046-4290-212, Recovery Coach Program
100-046-4290-214, Decreasing Sub-Exposed Infants
100-046-4290-215, Consumer Helpline
100-054-7700-220, EAI -SP Purpose
100-054-7700-232, Recovery Housing
100-054-7700-240, Naloxone Distribution
100-054-7700-243, SUD Workforce Credentialing
100-054-7700-245, HIT Part 2
100-054-7700-247, Substance Exposed Infants
760-054-7700-001, (4290-001) AEREF; funding for the Local Alcohol Authorities Expansion Program
100-054-7700-231, Supportive Housing Subsidies
100-054-7700-238, HOPE ONE -ST AID GRTS
100-054-7700-241, Opioid Reduction Options
100-054-7700-242, Jail MAT Reentry Initiative
100-054-7700-244, IME Addiction Call Center
100-054-7700-246, Media Campaign
100-054-7700-251, County Opioid Initiatives

Some State MOE expenditures occur via interagency Memoranda of Agreements (MOA) with other State agencies better positioned to administer certain program functions. Expenditures from the New Jersey Administrative Office of the Court (AOC) expenditures are posted to 100-054-7700-158 (046-4290-158); Department of Corrections (DOC) and the State Parole Board (SPB) expenditures are posted to 100-054-7700-165 (046-4290-165).

Expenditures related to the Intoxicated Driver Resources Center Fund (100-054-7700-175 (046-4290-175)), the Compulsive Gambling fund (100-054-7700-164 (046-4290-164)), the Racing Commission Fees (100-054-7700-173 (046-4290-173)) and Internet Gambling (100-054-7700-193 (046-4290-193)) continue to be expressly excluded from New Jersey's SAPT Statewide MOE calculation as per past practice. Also excluded are Department of Treasury expenditures for rent, fringe benefits, and indirect costs.

New Jersey's MOE calculation also does not include construction costs for Request for Proposal (RFP) awards. This conforms to 42.U.S.C.300x-3 (a) and 45.C.F.R.96.135 (a), (3) and (d) barring the use of grant funds for the purchase of land, construction costs or to permanently improve (other than minor remodeling) any building or any other facility, or to purchase major medical equipment.

Process to calculate New Jersey SAPT Statewide MOE

New Jersey's State Fiscal Year (SFY) begins July 1 and runs through June 30. Prior to the beginning of each SFY, budget planning occurs that includes the identification of available resources from the SAPT MOE related accounts. Calculations are performed to closely project the total funds on hand for State SAPT MOE costs. Consideration is given to any changes in direct appropriations, revisions to MOA and MOU agreements with other agencies, and financial recording methodologies that may impact the MOE calculation. The projections are updated on the DMHAS quarterly spending plan reports presented to the Department of Human Services (DHS) senior management.

Monitoring occurs periodically (at least quarterly) to ascertain whether actual expenditures are in line with projections. This analysis is based on Year-To-Date encumbrances, expenditures and budgeted line-item amounts. The analysis also includes discussions with program officials who are best-positioned to have knowledge of problems with sub-grantees, work-schedule delays, and other issues that are likely to affect MOE spending. When the projection is finished, program officials are apprised of expenditures, obligations, projected expenditure deficiencies and other information that may impact the State MOE obligations. Any projected MOE deficiency is further reported to the DMHAS Chief Financial Officer.

No sooner than one month following the close of New Jersey's State Fiscal Year, a report is created. It is based on transactions downloaded from New Jersey's Comprehensive Financial System (NJCFIS). An analysis to identify the allowability of all reported expenditures is conducted by the financial analyst responsible for the SAPT grant. Supporting backup documentation is compiled to support any needed adjustments that are identified. Adjustments may be required because any MOA reimbursement to DHS from another State agency will reduce the reimbursed DHS account by an amount equal to the reimbursement. The reimbursement distorts actual expenditures; the adjustment removes the distortion while correcting the total. Any required adjustment is reviewed by management who either approves, amends, or disapproves the adjustment which the analyst then includes or excludes from the report, whatever the case may be. The analyst notes any adjustment to the report. Reconciliation is performed to prove correctness of the report. After review and approval of the final report by management, the final figures are entered in the appropriate boxes of WEBbGAS Table 8a, Maintenance of Effort for State Expenditures.

DESCRIPTION OF THE AMOUNTS AND METHODS USED TO CALCULATE THE BASE AMOUNT FOR SERVICES TO PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN (PW/WDC)

As first documented on page 23 of NJ's FFY 1995 SAPT Block Grant Application, the Division of Addiction Services (DAS), now the Division of Mental Health and Addiction Services (DMHAS), established \$2,752,187 in FFY 1992 for Alcohol Drug Abuse and Mental Health Services (ADMS) Block Grant funds as the revised base for FFY 1993 SAPT Block Grant expenditures for the provision of services for pregnant women and women with dependent children. This base was established by reviewing all grantees which were funded with FFY 1992 ADMS Block Grant funds, and which primarily provided treatment services designated for pregnant women and women with dependent children (PW/WDC). The review included both the actual amount of FFY 1992 ADMS Block Grant funds obligated/expended by each program, and the actual services provided by these grantees/entities consistent with guidelines specified in 45 CFR 96.124(e), i.e., primary medical care and referrals, child care, primary medical pediatrics, gender specific treatment, child care, interventions for children, case management and transportation, and simultaneous treatment for children.

The final base amount applicable to the FFY 1994 SAPT BG Award (and all subsequent awards) was calculated in the following manner:

1. Begin with the FFY 1992 PW/WDC expenditure base of \$2,752,187.

2. Calculate five percent of the FFY1993 SAPT BG award ($\$37,452,980 * 5\% = \$1,872,649$)
3. Sum 1992 base and Calculated amount to establish FFY-**1993 PW-WDC Base** ($\$2,752,187 + \$1,872,649 = \mathbf{\$4,624,836}$)
4. Calculate five percent of FFY-1994 SAPT BG award ($\$37,452,980 * 5\% = \$1,872,649$)
5. Sum 1993 Base and Calculated amount to establish FFY-**1994 PW-WDC Base** ($\$4,624,836 + \$1,872,649 = \mathbf{\$6,497,485}$).
6. The calculated amount of $\$6,497,485$ is the PW-WDC Base that shall be used in 1995 and all subsequent years.
7. The Base amount is prepopulated in Column A of WEBbGAS Table 8d.

Prior to FFY 2008, DAS reported only SAPT Block Grant expenditures expended from a single SAPT BG Award as the revenue source for meeting the PW/WDC MOE. In subsequent years, consistent with the implementing rule and emerging SAMHSA policy, DMHAS has utilized a mix of State and SAPT BG funds to report a complete calculation of expenditures comprising the PW/WDC expenditure requirement. Consistent with the operative instructions for Table 8d, DMHAS continues to report State and BG expenditures on a State Fiscal Year (SFY) basis, i.e. SFY 2019.

Pregnant Women and Women with Dependent Children MOE Funding

1. Prior to the beginning of each State Fiscal Year, available resources for PW-WDC MOE requirements are identified.
2. Total resources available for PW/WDC are calculated.
3. Changes in appropriation amounts, MOAs or MOUs with other state agencies are identified and analyzed. Their impact on the MOE is estimated.
4. Financial recording methodologies are analyzed and their impact is calculated.
5. A projection is prepared. It is reviewed by senior management.
6. Upon approval of the projection, the DMHAS quarterly spending plan reports is updated to reflect the projected amount.
7. PW/WDC expenditures are periodically monitored by the analyst responsible for the SAPT block grant to ensure MOE spending is consistent with meeting the MOE requirement.

At the conclusion of the SFY, a data report is generated by fund source and cost center to include PW/WDC costs. An MOE analysis is performed based on expenditures. New Jersey's PW/WDC MOE includes expenditures by DMHAS from both State and Federal SAPT BG dollars made during the prior 12-month SFY (7/1 through 6/30) time period. State accounts include funds appropriated to DHS:

- Work First Mothers account (100-054-7700-161).
- SAPT BG PW/WDC account set aside funds (100-054-7700-168, 100-046-4290-168) with lower level organization codes 4221,4228.

The DMHAS combined SAPT Block Grant and State expenditures specifically includes funds classified and targeted to services for PW/WDC during SFY 2019, based on object codes to properly classify those expenditures. For SFY 2020, it totals $\$7,662,799$ as documented in Row B on Table 8d in Web BGAS.

III: Expenditure Reports

Table 8b - Expenditures for Services to Pregnant Women and Women with Dependent Children

This Maintenance of Effort table provides a description of expenditures including SABG and state funds (e.g., state legislature appropriations; revenue funds; state Medicaid match funds; and third-party reimbursements) for specialized treatment and related services that meet the SABG requirements for pregnant women and women with dependent children flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2019 Expenditure Period End Date: 06/30/2020

Base

Period	Total Women's Base (A)
SFY 1994	\$ 6,497,485.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2018		\$ 7,104,031.00	
SFY 2019		\$ 7,425,987.00	
SFY 2020		\$ 7,662,799.00	<input type="radio"/> Actual <input checked="" type="radio"/> Estimated

Enter the amount the State plans to expend in SFY 2021 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women's Base (A) for Period of (SFY 1994)): \$ 7400000.00

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1).

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information (pursuant to Section 1929 of Title XIX, Part B, Subpart II of the PHS Act(42 U.S.C. § 300x29) about the primary prevention activities conducted by the entities listed on SABG Table 7.

Expenditure Period Start Date: 10/1/2017 Expenditure Period End Date: 9/30/2019

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Persons with Substance Use Disorders	2. Education	
	1. Parenting and family management	9
	2. Ongoing classroom and/or small group sessions	11
	4. Education programs for youth groups	7
	5. Mentors	4
	3. Alternatives	
	1. Drug free dances and parties	6
Violent and delinquent behavior	2. Education	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	5
	5. Mentors	6
Mental health problems	1. Information Dissemination	
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	9
	2. Education	
	2. Ongoing classroom and/or small group sessions	4
Economically disadvantaged	2. Education	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	5
Already using substances	2. Education	
	2. Ongoing classroom and/or small group sessions	3
	4. Problem Identification and Referral	
	1. Employee Assistance Programs	1
	5. Community-Based Process	
	3. Multi-agency coordination and collaboration/coalition	3
Homeless and/or runaway youth	2. Education	
	2. Ongoing classroom and/or small group sessions	1

	3. Alternatives	
	1. Drug free dances and parties	5
	2. Youth/adult leadership activities	4
	3. Community drop-in centers	3
	6. Recreation activities	12
18 to 25 year olds statewide	6. Environmental	
	5. Enactment of municipal ordinances, merchant education, beverage server trainings	21

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Footnotes:

IV: Population and Services Reports

Table 10 - Treatment Utilization Matrix

This table is intended to capture the count of persons with initial admissions and subsequent admission(s) to an episode of care.

Expenditure Period Start Date: 7/1/2019 Expenditure Period End Date: 6/30/2020

Level of Care	Number of Admissions \geq Number of Persons Served		Costs per Person (C, D & E)		
	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)					
1. Hospital Inpatient	130	127			
2. Free-Standing Residential	9892	7234			
REHABILITATION/RESIDENTIAL					
3. Hospital Inpatient	895	804			
4. Short-term (up to 30 days)	7712	6488			
5. Long-term (over 30 days)	5950	4789			
AMBULATORY (OUTPATIENT)					
6. Outpatient	17478	15885			
7. Intensive Outpatient	16928	14059			
8. Detoxification	894	798			
OUD MEDICATION ASSISTED TREATMENT					
9. OUD Medication-Assisted Detoxification	2528	2148			
10. OUD Medication-Assisted Treatment Outpatient	10177	7851			

In FY 2020 SAMHSA modified the "Level of Care" (LOC) and "Type of Treatment Service/Setting" to "Medication-Assisted Treatment" and "Medication-Assisted Treatment," respectively.

In prior SABG Reports, the LOC was entitled "Opioid Replacement Therapy" and the Type of Treatment Service/Setting included "Opioid Replacement Therapy," Row 9 and "ORT Outpatient," Row 10.

The changes inadvertently created a barrier for data analysis as one-to-one mapping of the data submitted in the FY 2020 Table 10 to the data submitted in prior Reports is not possible. In the current and future SABG Reports, the LOC is "OUD Medication Assisted Treatment" and the Types of Treatment Service/Setting will include "OUD Medication-Assisted Treatment Detoxification," Row 9 and "OUD Medication Assisted Treatment Outpatient," Row 10. OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment. OUD Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment. The change was made to better align with language that reflects not all medications used to treat opioid use disorder (OUD) are opioid-based and more importantly convey that medications do not merely substitute one drug for another.

Footnotes:

IV: Population and Services Reports

Table 11 - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions to and persons served in SABG-funded services.

Expenditure Period Start Date: 7/1/2019 Expenditure Period End Date: 6/30/2020

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKAN NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	361	188	75	58	27	2	0	4	3	0	1	3	0			103	150	51	55
2. 18 - 24	3460	1251	1012	751	289	26	12	38	9	22	9	25	16			1497	627	762	249
3. 25 - 44	25826	10686	8141	4255	1861	185	75	185	44	107	43	151	93			12175	3279	6819	1299
4. 45 - 64	13359	4578	3600	3453	1413	83	26	48	12	59	10	56	21			6745	1440	3252	339
5. 65 and Over	768	281	164	245	59	5	1	2	1	3	0	6	1			471	65	156	9
6. Total	43774	16984	12992	8762	3649	301	114	277	69	191	63	241	131	0	0	20991	5561	11040	1951
7. Pregnant Women	604		433		154		4		2		5		6				490		109
Number of persons served who were admitted in a period prior to the 12 month reporting period		17703																	
Number of persons served outside of the levels of care described on Table 10		83																	

Are the values reported in this table generated from a client based system with unique client identifiers? Yes No

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

IV: Population and Services Reports

Table 12 - SABG Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) in Designated States

Expenditure Period Start Date: 7/1/2019 Expenditure Period End Date: 6/30/2020

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: _____	Rural: _____
2. Total number of individuals tested through SAPT HIV EIS funded programs		
3. Total number of HIV tests conducted with SAPT HIV EIS funds		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

New Jersey is not a HIV designated state.

IV: Population and Services Reports

Table 13 - Charitable Choice

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services; (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the state to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary (services recipient) has no religious objection. The purpose of this table is to document how the state is complying with these provisions.

Expenditure Period Start Date: 7/1/2019 Expenditure Period End Date: 6/30/2020

Notice to Program Beneficiaries - Check all that apply:

- Used model notice provided in final regulation.
- Used notice developed by State (please attach a copy to the Report).
- State has disseminated notice to religious organizations that are providers.
- State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- State has developed specific referral system for this requirement.
- State has incorporated this requirement into existing referral system(s).
- SAMHSA's Behavioral Health Treatment Locator is used to help identify providers.
- Other networks and information systems are used to help identify providers.
- State maintains record of referrals made by religious organizations that are providers.

0 Enter the total number of referrals to other substance abuse providers ("alternative providers") necessitated by religious objection, as defined above, made during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Provide the total only. No information on specific referrals is required. If no alternative referrals were made, enter zero.

Provide a brief description (one paragraph) of any training for local governments and/or faith-based and/or community organizations that are providers on these requirements.

There were no additional trainings provided to local government and faith based and community organizations on these requirements for SFY 2020. In January 2020, all DMHAS addictions providers received correspondence indicating the Division's intent to monitor the provisions of the Charitable Choice Act. The correspondence included the model notice and the Charitable Choice law. In addition to the questionnaire portion of the annual site visit monitoring form (the form is sent to the agency prior to the review period and requires the agency to identify if they are, or are not faith-based in their approach to substance abuse treatment), all providers are required to submit quarterly referral logs to the Program Management Officers of the Contract Monitoring Unit in the event the agency receives a referral or request for transfer. In addition, the Program Management Officers of the Contract Monitoring Unit are required to complete an annual site visit to all of the contracted agencies. During the annual site visit, the Program Management Officers ask direct questions to executive staff members present at the opening interview pertaining to Charitable Choice referrals. The responses are recorded and documented in the annual site visit report. There were 0 Charitable Choice referrals for SFY 2020.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 14 - Treatment Performance Measure Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1,311	1,139
Total number of clients with non-missing values on employment/student status [denominator]	8,594	8,594
Percent of clients employed or student (full-time and part-time)	15.3 %	13.3 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		11,733
Number of CY 2019 discharges submitted:		11,704
Number of CY 2019 discharges linked to an admission:		9,697
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		8,969
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		8,594

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	990	1,919
Total number of clients with non-missing values on employment/student status [denominator]	6,643	6,643
Percent of clients employed or student (full-time and part-time)	14.9 %	28.9 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		8,244
Number of CY 2019 discharges submitted:		8,076
Number of CY 2019 discharges linked to an admission:		7,786
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,815

Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	6,643
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Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	11,716	13,679
Total number of clients with non-missing values on employment/student status [denominator]	20,515	20,515
Percent of clients employed or student (full-time and part-time)	57.1 %	66.7 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		34,789
Number of CY 2019 discharges submitted:		33,541
Number of CY 2019 discharges linked to an admission:		30,475
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		20,929
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		20,515

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	5,714	8,104
Total number of clients with non-missing values on employment/student status [denominator]	18,500	18,500
Percent of clients employed or student (full-time and part-time)	30.9 %	43.8 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		29,382
Number of CY 2019 discharges submitted:		29,710
Number of CY 2019 discharges linked to an admission:		25,552
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		19,117

Number of CY 2019 linked discharges eligible for this calculation (non-missing values):

18,500

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 15 - Treatment Performance Measure Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	6,926	8,167
Total number of clients with non-missing values on living arrangements [denominator]	8,598	8,598
Percent of clients in stable living situation	80.6 %	95.0 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		11,733
Number of CY 2019 discharges submitted:		11,704
Number of CY 2019 discharges linked to an admission:		9,697
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		8,969
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		8,598

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Long-term Residential(LR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	5,983	6,036
Total number of clients with non-missing values on living arrangements [denominator]	6,645	6,645
Percent of clients in stable living situation	90.0 %	90.8 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		8,244
Number of CY 2019 discharges submitted:		8,076
Number of CY 2019 discharges linked to an admission:		7,786
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,815
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		6,645

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Outpatient (OP)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	19,899	20,166
Total number of clients with non-missing values on living arrangements [denominator]	20,522	20,522
Percent of clients in stable living situation	97.0 %	98.3 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		34,789
Number of CY 2019 discharges submitted:		33,541
Number of CY 2019 discharges linked to an admission:		30,475
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		20,929
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		20,522

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Intensive Outpatient (IO)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	17,421	17,833
Total number of clients with non-missing values on living arrangements [denominator]	18,509	18,509
Percent of clients in stable living situation	94.1 %	96.3 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		29,382
Number of CY 2019 discharges submitted:		29,710
Number of CY 2019 discharges linked to an admission:		25,552
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		19,117
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		18,509

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Footnotes:

V: Performance Indicators and Accomplishments

Table 16 - Treatment Performance Measure Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	7,749	8,414
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	8,605	8,605
Percent of clients without arrests	90.1 %	97.8 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		11,733
Number of CY 2019 discharges submitted:		11,704
Number of CY 2019 discharges linked to an admission:		9,697
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		8,978
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		8,605

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	5,971	6,476
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	6,752	6,752
Percent of clients without arrests	88.4 %	95.9 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		8,244
Number of CY 2019 discharges submitted:		8,076
Number of CY 2019 discharges linked to an admission:		7,786
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,924

Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	6,752
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Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	20,292	20,334
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	20,986	20,986
Percent of clients without arrests	96.7 %	96.9 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		34,789
Number of CY 2019 discharges submitted:		33,541
Number of CY 2019 discharges linked to an admission:		30,475
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		21,415
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		20,986

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	17,979	18,256
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	19,091	19,091
Percent of clients without arrests	94.2 %	95.6 %
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		29,382
Number of CY 2019 discharges submitted:		29,710
Number of CY 2019 discharges linked to an admission:		25,552
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		19,709

Number of CY 2019 linked discharges eligible for this calculation (non-missing values):

19,091

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

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Footnotes:

V: Performance Indicators and Accomplishments

Table 17 - Treatment Performance Measure Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	4,661	8,127
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,155	8,155
Percent of clients abstinent from alcohol	57.2 %	99.7 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,466
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,494	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,661
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,661	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		100.0 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	11,733
Number of CY 2019 discharges submitted:	11,704
Number of CY 2019 discharges linked to an admission:	9,697
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	8,978
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	8,155

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	4,178	5,802
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,853	5,853
Percent of clients abstinent from alcohol	71.4 %	99.1 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,661
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,675	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,141
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,178	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.1 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	8,244
Number of CY 2019 discharges submitted:	8,076
Number of CY 2019 discharges linked to an admission:	7,786
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,924
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	5,853

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	10,925	14,073
All clients with non-missing values on at least one substance/frequency of use [denominator]	15,630	15,630
Percent of clients abstinent from alcohol	69.9 %	90.0 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,842
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,705	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		81.7 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		10,231
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	10,925	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.6 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	34,789
Number of CY 2019 discharges submitted:	33,541
Number of CY 2019 discharges linked to an admission:	30,475
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	21,415
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	15,630

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	9,088	11,560
All clients with non-missing values on at least one substance/frequency of use [denominator]	13,307	13,307
Percent of clients abstinent from alcohol	68.3 %	86.9 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,082
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,219	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		73.1 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		8,478
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	9,088	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.3 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	29,382
Number of CY 2019 discharges submitted:	29,710
Number of CY 2019 discharges linked to an admission:	25,552
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	19,709
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	13,307

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file [Records received through 2/1/2021]

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Footnotes:

V: Performance Indicators and Accomplishments

Table 18 - Treatment Performance Measure Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	2,107	8,104
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,155	8,155
Percent of clients abstinent from drugs	25.8 %	99.4 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		6,002
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,048	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		99.2 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,102
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,107	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		99.8 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	11,733
Number of CY 2019 discharges submitted:	11,704
Number of CY 2019 discharges linked to an admission:	9,697
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	8,978
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	8,155

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	2,913	5,609
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,853	5,853
Percent of clients abstinent from drugs	49.8 %	95.8 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,817
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,940	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		95.8 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,792
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,913	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		95.8 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	8,244
Number of CY 2019 discharges submitted:	8,076
Number of CY 2019 discharges linked to an admission:	7,786
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,924
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	5,853

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	10,819	12,894
All clients with non-missing values on at least one substance/frequency of use [denominator]	15,630	15,630
Percent of clients abstinent from drugs	69.2 %	82.5 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		3,148
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,811	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		65.4 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		9,746
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	10,819	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		90.1 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	34,789
Number of CY 2019 discharges submitted:	33,541
Number of CY 2019 discharges linked to an admission:	30,475
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	21,415
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	15,630

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	6,724	9,818
All clients with non-missing values on at least one substance/frequency of use [denominator]	13,307	13,307
Percent of clients abstinent from drugs	50.5 %	73.8 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,002
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,583	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		60.8 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		5,816
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,724	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		86.5 %

Notes (for this level of care):

Number of CY 2019 admissions submitted:	29,382
Number of CY 2019 discharges submitted:	29,710
Number of CY 2019 discharges linked to an admission:	25,552
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	19,709
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	13,307

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
 [Records received through 2/1/2021]

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Footnotes:

V: Performance Indicators and Accomplishments

Table 19 - Treatment Performance Measure Change in Social Support Of Recovery (From Admission to Discharge)

Short-term Residential(SR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,209	2,613
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	2,668	2,668
Percent of clients participating in self-help groups	45.3 %	97.9 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	52.6 %	
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		11,733
Number of CY 2019 discharges submitted:		11,704
Number of CY 2019 discharges linked to an admission:		9,697
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		8,978
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):		2,668

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Long-term Residential(LR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,662	3,022
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	3,089	3,089
Percent of clients participating in self-help groups	53.8 %	97.8 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	44.0 %	
Notes (for this level of care):		
Number of CY 2019 admissions submitted:		8,244
Number of CY 2019 discharges submitted:		8,076

Number of CY 2019 discharges linked to an admission:	7,786
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,924
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	3,089

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Outpatient (OP)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	3,752	4,527
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	9,542	9,542
Percent of clients participating in self-help groups	39.3 %	47.4 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	8.1 %	

Notes (for this level of care):

Number of CY 2019 admissions submitted:	34,789
Number of CY 2019 discharges submitted:	33,541
Number of CY 2019 discharges linked to an admission:	30,475
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	21,415
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	9,542

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

Intensive Outpatient (IO)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	3,132	4,083
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	7,313	7,313
Percent of clients participating in self-help groups	42.8 %	55.8 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	13.0 %	

Notes (for this level of care):

Number of CY 2019 admissions submitted:	29,382
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Number of CY 2019 discharges submitted:	29,710
Number of CY 2019 discharges linked to an admission:	25,552
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	19,709
Number of CY 2019 linked discharges eligible for this calculation (non-missing values):	7,313

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file
[Records received through 2/1/2021]

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Footnotes:

V: Performance Indicators and Accomplishments

Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25 th Percentile	50 th Percentile (Median)	75 th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	4	3	3	3
2. Free-Standing Residential	7	4	5	6
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	31	4	34	56
4. Short-term (up to 30 days)	18	7	13	21
5. Long-term (over 30 days)	84	20	64	131
AMBULATORY (OUTPATIENT)				
6. Outpatient	120	47	86	138
7. Intensive Outpatient	77	26	54	92
8. Detoxification	17	9	14	16
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification	9	4	5	7
10. OUD Medication-Assisted Treatment Outpatient	209	44	100	241

Level of Care	2019 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	252	228
2. Free-Standing Residential	12215	8781
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	19	3
4. Short-term (up to 30 days)	11704	9697

5. Long-term (over 30 days)	8076	7786
AMBULATORY (OUTPATIENT)		
6. Outpatient	33541	21464
7. Intensive Outpatient	29710	19750
8. Detoxification	1340	919
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification	0	2926
10. OUD Medication-Assisted Treatment Outpatient	0	14813

Source: SAMHSA/CBHSQ TEDS CY 2019 admissions file and CY 2019 linked discharge file

[Records received through 2/1/2021]

SAMHSA's Treatment Episode Data Set (TEDS) data are used to pre-populate the tables that comprise SAMHSA's National Outcome Measures (NOMs) and include Table 20 – Retention – Length of Stay (in Days) of Clients Completing Treatment. In FY 2020, SAMHSA modified the "Level of Care" (LOC) and "Type of Treatment Service/Setting" for Opioid Replacement Therapy/Medication-Assisted Treatment in Table 20.

In prior SABG Reports, the LOC was entitled "Opioid Replacement Therapy" and the Type of Treatment Service/Setting included "Opioid Replacement Therapy," Row 9 and "ORT Outpatient," Row 10. The LOC was changed to "Medication-Assisted Treatment" and the Treatment Service/Setting was changed to "Medication-Assisted Treatment."

The changes inadvertently created a barrier for data analysis as one-to-one mapping of the data submitted in the FY 2020 Table 20 to the TEDS data submitted to CBHSQ via Eagle Technologies is not possible. In the current and future SABG Reports, the LOC is "OUD Medication Assisted Treatment" and the Types of Treatment Service/Setting will include "OUD Medication-Assisted Treatment Detoxification," Row 9 and "OUD Medication Assisted Treatment Outpatient," Row 10. OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment. OUD Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment . The change was made to better align with language that reflects not all medications used to treat opioid use disorder (OUD) are opioid-based and more importantly convey that medications do not merely substitute one drug for another.

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Footnotes:

V: Performance Indicators and Accomplishments

TABLE 21 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY - ABSTINENCE FROM DRUG USE/ALCOHOL USE MEASURE: 30-DAY USE

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. 30-day Alcohol Use	<p>Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used alcohol during the past 30 days.</p>		
	Age 12 - 20 - CY 2017 - 2018	22.1	
	Age 21+ - CY 2017 - 2018	56.3	
2. 30-day Cigarette Use	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.</p>		
	Age 12 - 17 - CY 2017 - 2018	1.4	
	Age 18+ - CY 2017 - 2018	17.0	
3. 30-day Use of Other Tobacco Products	<p>Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products]^[1]?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).</p>		
	Age 12 - 17 - CY 2017 - 2018	2.4	
	Age 18+ - CY 2017 - 2018	6.3	
4. 30-day Use of Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.</p>		
	Age 12 - 17 - CY 2017 - 2018	5.9	
	Age 18+ - CY 2017 - 2018	7.9	
5. 30-day Use of Illegal Drugs Other Than Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug]^[2]</p> <p>Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).</p>		
	Age 12 - 17 - CY 2017 - 2018	1.2	

	Age 18+ - CY 2017 - 2018	2.4	
--	--------------------------	-----	--

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

[2]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 22 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY-ABSTINENCE FROM DRUG USE/ALCOHOL USE; MEASURE: PERCEPTION OF RISK/HARM OF USE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
1. Perception of Risk From Alcohol	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 20 - CY 2017 - 2018	78.6	
	Age 21+ - CY 2017 - 2018	83.5	
2. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day? [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2017 - 2018	91.1	
	Age 18+ - CY 2017 - 2018	93.9	
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2017 - 2018	69.0	
	Age 18+ - CY 2017 - 2018	60.1	

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 23 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY-ABSTINENCE FROM DRUG USE/ALCOHOL USE; MEASURE: AGE OF FIRST USE

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Age at First Use of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of alcohol.</p>		
	Age 12 - 20 - CY 2017 - 2018		
	Age 21+ - CY 2017 - 2018		
2. Age at First Use of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of cigarettes.</p>		
	Age 12 - 17 - CY 2017 - 2018	14.3	
	Age 18+ - CY 2017 - 2018	16.3	
3. Age at First Use of Tobacco Products Other Than Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product]^[1]?[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of tobacco products other than cigarettes.</p>		
	Age 12 - 17 - CY 2017 - 2018	14.2	
	Age 18+ - CY 2017 - 2018	23.2	
4. Age at First Use of Marijuana or Hashish	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of marijuana or hashish.</p>		
	Age 12 - 17 - CY 2017 - 2018	14.7	
	Age 18+ - CY 2017 - 2018	18.2	
5. Age at First Use Heroin	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of heroin.</p>		
	Age 12 - 17 - CY 2017 - 2018	11.0	
	Age 18+ - CY 2017 - 2018	25.1	
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever]^[2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.</p>		

Age 12 - 17 - CY 2017 - 2018	14.8	
Age 18+ - CY 2017 - 2018	31.4	

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 24 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY-ABSTINENCE FROM DRUG USE/ALCOHOL USE; MEASURE: PERCEPTION OF DISAPPROVAL/ATTITUDES

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
1. Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2017 - 2018	96.2	
2. Perception of Peer Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>		
	Age 12 - 17 - CY 2017 - 2018	93.1	
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2017 - 2018	79.4	
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2017 - 2018	79.6	
5. Disapproval of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 20 - CY 2017 - 2018	92.3	

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 25 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: EMPLOYMENT/EDUCATION; MEASURE: PERCEPTION OF WORKPLACE POLICY

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Perception of Workplace Policy	<p>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]"</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>		
	Age 15 - 17 - CY 2017 - 2018	18.4	
	Age 18+ - CY 2017 - 2018	28.7	

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 26 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN - EMPLOYMENT/EDUCATION; MEASURE: AVERAGE DAILY SCHOOL ATTENDANCE RATE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Average Daily School Attendance Rate	<p>Source: National Center for Education Statistics, Common Core of Data: <i>The National Public Education Finance Survey</i> available for download at http://nces.ed.gov/ccd/stfis.asp.</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>		
	School Year 2017	94.5	

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 27 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: CRIME AND CRIMINAL JUSTICE MEASURE: ALCOHOL-RELATED TRAFFIC FATALITIES

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Alcohol-Related Traffic Fatalities	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2018	28.2	

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 28 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: CRIME AND CRIMINAL JUSTICE MEASURE: ALCOHOL- AND DRUG-RELATED ARRESTS

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol- and Drug-Related Arrests	<p>Source: Federal Bureau of Investigation Uniform Crime Reports</p> <p>Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.</p>		
	CY 2018	27.8	

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 29 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: SOCIAL CONNECTEDNESS; MEASURE: FAMILY COMMUNICATIONS AROUND DRUG AND ALCOHOL USE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
1. Family Communications Around Drug and Alcohol Use (Youth)	<p>Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.?[Response options: Yes, No]"</p> <p>Outcome Reported: Percent reporting having talked with a parent.</p>		
	Age 12 - 17 - CY 2017 - 2018	62.6	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?^[1][Response options: 0 times, 1 to 2 times, a few times, many times]"</p> <p>Outcome Reported: Percent of parents reporting that they have talked to their child.</p>		
	Age 18+ - CY 2017 - 2018	88.6	

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 30 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN - RETENTION MEASURE: PERCENTAGE OF YOUTH SEEING, READING, WATCHING, OR LISTENING TO A PREVENTION MESSAGE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] ^[1] ? Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2017 - 2018	91.4	

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context
 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 31-35 - Reporting Period - Start and End Dates for Information Reported on Tables 31, 32, 33, 34, and 35

Reporting Period Start and End Dates for Information Reported on Tables 33, 34, 35, 36 and 37

Please indicate the reporting period for each of the following NOMS.

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2018	12/31/2018
2. Table 32 - SUBSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies? Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2018	12/31/2018
3. Table 33 (Optional) - SUBSTANCE ABUSE PREVENTION - Number of Persons Served by Type of Intervention	1/1/2018	12/31/2018
4. Table 34 - Substance Abuse Prevention - Evidence-Based Programs and Strategies by Type of Intervention	1/1/2018	12/31/2018
5. Table 35 - Total SUBSTANCE ABUSE PREVENTION Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on SUBSTANCE ABUSE PREVENTION Evidence-Based Programs/Strategies	10/1/2017	9/30/2019

General Questions Regarding Prevention NOMS Reporting

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

New Jersey's web-based Prevention Outcomes Management System (POMS) and manual process

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Those participants are only included in the more than one race category.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	134,000
0-4	7,504
5-11	61,613
12-14	19,028
15-17	13,936
18-20	4,368
21-24	2,587
25-44	16,254
45-64	4,288
65 and over	4,422
Age Not Known	0
B. Gender	134,000
Male	65,660
Female	68,340
Gender Unknown	0
C. Race	134,000
White	48,240
Black or African American	35,162
Native Hawaiian/Other Pacific Islander	104
Asian	5,628
American Indian/Alaska Native	150
More Than One Race (not OMB required)	7,504

Race Not Known or Other (not OMB required)	37,212
D. Ethnicity	134,000
Hispanic or Latino	41,540
Not Hispanic or Latino	92,460
Ethnicity Unknown	0

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 32 - SUBSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies, Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	431650
0-4	7150
5-11	42000
12-14	101000
15-17	72415
18-20	41700
21-24	26885
25-44	84900
45-64	38600
65 and over	17000
Age Not Known	0
B. Gender	431650
Male	211509
Female	220141
Gender Unknown	0
C. Race	431650
White	241200
Black or African American	101900
Native Hawaiian/Other Pacific Islander	160
Asian	40070
American Indian/Alaska Native	315
More Than One Race (not OMB required)	22000

Race Not Known or Other (not OMB required)	26005
D. Ethnicity	431650
Hispanic or Latino	133812
Not Hispanic or Latino	297838
Ethnicity Unknown	0

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 33 (Optional) - SUBSTANCE ABUSE PREVENTION - Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	96000	N/A
2. Universal Indirect	N/A	431650
3. Selective	21000	N/A
4. Indicated	17000	N/A
5. Total	134000	431650

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 34 - Substance Abuse Prevention - Evidence-Based Programs and Strategies by Type of Intervention

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, **Identifying and Selecting Evidence-based Interventions**, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1:
The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
 - Guideline 2:
The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
 - Guideline 3:
The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
 - Guideline 4:
The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

All prevention programs and strategies must meet at least one of the criteria above.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Contracts with funded agencies and coalitions specify the program or strategy being used.

Table 34 - SUBSTANCE ABUSE PREVENTION Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	12	6	18	13	6	37
2. Total number of Programs and Strategies Funded	12	6	18	13	6	37
3. Percent of Evidence-Based Programs and Strategies	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Table 35 - Total SUBSTANCE ABUSE PREVENTION Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on SUBSTANCE ABUSE PREVENTION Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 12	\$ 1,802,577
Universal Indirect	Total # 6	\$ 2,884,124
Selective	Total # 13	\$ 2,703,866
Indicated	Total # 6	\$ 1,622,320
	Total EBPs: 37	Total Dollars Spent: \$9,012,887.34

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

V: Performance Indicators and Accomplishments

Prevention Attachments

Submission Uploads

FFY 2021 Prevention Attachment Category A:		
File	Version	Date Added

FFY 2021 Prevention Attachment Category B:		
File	Version	Date Added

FFY 2021 Prevention Attachment Category C:		
File	Version	Date Added

FFY 2021 Prevention Attachment Category D:		
File	Version	Date Added

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes: