

# **DASIS STATE DATA ADVISORY GROUP MEETING**

**July 9–10, 2002  
Chicago, Illinois**

*(Click on item to move to that page)*

<b>Table of Contents</b>	<b>Page 2</b>
<b>Appendix A</b>	<b>Page 20</b>
<b>Agenda</b>	<b>Page 21</b>
<b>Participant List</b>	<b>Page 22</b>

## Table of Contents

N-SSATS .....	3
"Treatment" Definition.....	4
Relationship of I-SATS, N-SSATS, and the Directory/Locator Files .....	5
State Updates of I-SATS and Directory/Locator .....	6
Satellite Facilities .....	7
Demonstration of Redesigned DASIS Home Page .....	8
Demonstration of I-SATS Quick Retrieval.....	9
State Presentations.....	9
Illinois.....	9
Iowa.....	10
Kansas .....	10
Indiana.....	11
Nebraska.....	11
Missouri.....	12
Treatment Episode Data Set (TEDS).....	13
Status of Discharge Reporting.....	14
Additions to TEDS Data Set .....	15
Outpatient Capacity Measure.....	15
The Use of National Data.....	15
Substance Abuse and Mental Health Data Archive (SAMHDA) Presentation.....	16
SAMHSA's Web Resources.....	17
Health Insurance Portability and Accountability Act (HIPAA) Presentation.....	17
Demonstration of DAWN Web Site.....	18
Closing Remarks.....	18

# **SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING**

**July 9–10, 2002**

**Chicago, Illinois**

This was the 12<sup>th</sup> Regional Meeting to be held with State DASIS representatives. It included representatives<sup>1</sup> from Indiana, Illinois, Iowa, Kansas, Missouri, and Nebraska, along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions (Synectics).

The DASIS regional meetings are held to provide an opportunity for face-to-face discussions between State DASIS representatives and staff of OAS, Synectics, and MPR. The meeting agenda<sup>2</sup> is flexible to maximize the opportunity for discussion of issues of particular importance to the State representatives. Through discussion and brief presentations, States are informed about recent OAS activities and are given an opportunity to share with OAS and each other their concerns and solutions to common problems in data collection and management of information.

## **N-SSATS**

After welcoming and introductory remarks by Dr. Goldstone, Barbara Rogers of MPR reviewed the current schedule and status of the 2002 N-SSATS. Ms. Rogers noted that this year the N-SSATS had a point prevalence date of March 29 instead of October 1, the date used in previous N-SSATS and UFDS surveys. This change was instituted to avoid the December holidays, and because States had suggested that the Spring-Summer period was less busy than the Fall-Winter period for most facilities. The N-SSATS data collection and processing cycle runs for six months, so the survey was about in the middle of the current cycle in July. The 2002 survey includes a little more than 14,410 State approved facilities and 3,000 non-State approved facilities. The N-SSATS response rate is generally about 95 percent. As of the time of the meeting, there had been two questionnaire mailings, but intensive follow-up procedures had not started. The overall response rate at that time was 58 percent, with most of the States in attendance above that rate.

Ms. Rogers explained that data collection was primarily by mail, though the 2002 survey had a "Web" option for facilities with Internet capability. Facilities that failed to respond by either mail or the Web after several reminders would be contacted by telephone and, when feasible, would complete their questionnaire by telephone.

States were asked to assist in gaining facility cooperation. In addition to sending a letter before the survey begins, States were asked to encourage response from nonresponding facilities midway through the survey. This year, MPR planned send lists of nonrespondents to the States about mid-July, asking them to contact the facilities to urge their cooperation. Many States have the resources to do this and it would be a great help in boosting response.

---

<sup>1</sup> See list of participants beginning on page 22.

<sup>2</sup> See agenda on page 21.

Ms. Rogers noted that every facility was given the option of completing the questionnaire on the Web. Each facility was provided with the Web site URL and a unique ID and password. As of the time of the meeting, about one-fourth of all completed questionnaires were done on the Web. Of the 2,176 facilities that completed questionnaires on the Web, about 72 percent completed questionnaires by mail in prior survey years, while 12 percent had completed questionnaires by phone.

As a measure of data quality, it was suggested that the client counts for the Web responses be compared to the counts received by mail in the 2000 N-SSATS.

A small Web experiment was done at the beginning of the N-SSATS to assess how controlled the Web questionnaire could be without causing respondents to "break-off," or stop before completing the survey. To assess this, respondents were randomly assigned to one of three conditions:

- Condition 1: Respondents proceeded through the questionnaire with no internal error, consistency, or nonresponse checks.
- Condition 2: Respondents were prompted or given an error message any time there was an error or inconsistency, but could go on without correcting the problem.
- Condition 3: Respondents were prompted or given an error message any time there was an error or inconsistency, and had to correct the problem before moving on.

After several hundred responses for each condition, there were essentially no differences in the proportion of break-offs among the three conditions. Since condition 3 had the greatest potential for eliminating many errors and subsequent editing problems, this condition was adopted for all further Web respondents.

One concern about Web responses was that respondents might not be able or willing to look-up actual client count information, and would be more likely to provide estimated counts. However, in reviewing current responses, it was found that 57 percent of Web responses reported providing "actual" counts, a rate comparable to the 52 percent reported in mail responses in previous surveys.

### **"Treatment" Definition**

Ms. Rogers noted a difficulty providing N-SSATS respondents with a clear definition of substance abuse "treatment." This is a concern because the N-SSATS is designed to include only facilities that provide substance abuse treatment, and the Directory and Treatment Facility Locator also only include facilities that provide treatment. However, some facilities in the N-SSATS appear to be misinterpreting the definition of "treatment" used in the survey. Some facilities, for example, may consider "assessment and referral" as treatment.

This is related to another problem, namely, that there are differences in the way States define "treatment." This results in differences in the types of facilities that States include

in the I-SATS and, subsequently, are included in the N-SSATS. For example, some States consider detoxification and "early intervention services" as treatment; others consider halfway houses as treatment providers. These are continuing problems, and States were asked for ideas to overcome or at least minimize them.

It was pointed out that this problem is further exacerbated by the States' need for information related to their Block Grants. Some non-treatment facilities are added to the I-SATS because an I-SATS ID (i.e., an NFR number) is needed for the facility. Prevention facilities are an example. While these can be added to the I-SATS as non-treatment and, therefore, would not be in the N-SSATS, often they are added as treatment. One suggestion was for the State not to enter these facilities as State approved. That is, if a State needs to add a prevention-only or other non-treatment facility to the I-SATS in order to get the ID number, they should add them as non-State approved and check the appropriate "non-treatment" box for the services offered. This would assure that these facilities would not be included in N-SSATS and would never appear in the Directory or Locator.

It was suggested that ASAM is now looking at pre-treatment services, and that SAMHSA should consider whether assessment and referral services should be re-introduced into the survey. It was also suggested that the use of the term "Non-hospital residential" might be seen as degrading by some facilities, and that SAMHSA should consider using another designation for these facilities.

#### **Relationship of I-SATS, N-SSATS, and the Directory/Locator Files**

During the discussion, some confusion was noted between the I-SATS and the Directory/Locator, and how the N-SSATS relates to these. The following explanation was provided as clarification.

The I-SATS is a database of ALL substance abuse treatment facilities known to SAMHSA. The I-SATS includes State approved and non-State approved facilities. It includes all treatment facilities added by the States and added by SAMHSA through other sources (e.g., facilities identified during the N-SSATS and special augmentation procedures). It also includes some non-treatment facilities added by States, such as prevention only facilities. It includes, for historical reasons, "inactive" facilities (facilities that were active but have been closed). The I-SATS database is not accessible to the public. Individual State information is available to that State's representatives with an ID and password. States make additions and changes to the I-SATS using the I-SATS On-line. States can access the entire I-SATS for their State using the IQRS, a feature of the I-SATS On-line.

The N-SSATS is conducted among a subset of the I-SATS. The N-SSATS universe consists of all active facilities on the I-SATS that are classified as "treatment" providers as well as halfway houses. Both State approved and non-approved facilities are included.

The National Directory and Treatment Facility Locator include only facilities that are 1) State approved, 2) respond to the N-SSATS, and 3) provide treatment. The information

displayed in the Directory and Locator includes contact data (name, address, and phone numbers) and selected services data. The contact information is maintained in the I-SATS. Changes to facility contact data made in the I-SATS are generally made to the Locator during monthly updates. The services data provided in the Directory and Locator are collected in the N-SSATS and are updated after each survey cycle. The Directory and Locator, of course, are available to the public.

### **State Updates of I-SATS and Directory/Locator**

The discussion turned to the best way for States to help in updating the I-SATS, particularly in assigning "State approved" or "non-State approved" status to facilities. Over the past few years, SAMHSA has encouraged States to update the I-SATS regularly, preferably on a monthly basis, and most States now do this. States that update less frequently sometimes find that the review and update process is difficult because of the large number of facilities involved. However, State additions and changes to the I-SATS are less problematic to SAMHSA than having States review changes and new facilities identified from other (non-State) sources. All new facilities added to the I-SATS by SAMHSA must be reviewed by the State to determine if they are approved or not. (Changes in facility information are sent for review only when the State has requested them). How difficult the review process is varies by State. To ease the review effort, Synectics adopted the policy of sending States the names of newly identified facilities on a flow basis, so the number of facilities to be reviewed at one time is generally small. In addition, a "date of last update" has been added to the I-SATS record so that State reviewers can easily determine those facilities that they have previously reviewed.

The most difficult time for States is at the end of the N-SSATS data collection period because many changes and new facilities are identified during the survey. New facilities must be reviewed for approval status in a relatively short time period to determine if they can be added to the Directory and Locator. It was suggested that it might be more efficient for States to review all of their facilities prior to the N-SSATS. It was noted by Synectics that this is the procedure that was followed several years ago, but is no longer done because: 1) reviewing the entire I-SATS was burdensome for some States, and 2) frequent State updates have resulted in most States now being relatively up-to-date prior to the survey. Pre-survey reviews also do not resolve the problem of reviewing facilities identified during the survey.

There was general agreement that most States benefit from receiving additions and changes on a flow basis, and that transmission of the information by email is the most effective method. Synectics, however, will accommodate the needs of any State that prefers another arrangement.

One area of concern expressed by Dr. Goldstone is State review of changes in facility information. SAMHSA's policy is that all information included in the Directory or Locator must have been approved by the State. Therefore, when a name, address, or telephone change is determined during the N-SSATS or submitted directly by the facility, there should be a procedure for transmitting that information to the States for their review

and concurrence. This procedure is now in place for only Illinois and Ohio, because they are the only States that have requested it. To do this for all States, however, would present some significant problems. For example, it would require considerable effort for both the States and Synectics since there are thousands of changes each year. During each cycle of N-SSATS, for example, about 8,000 facilities have one or more changes. In addition, the information in the I-SATS for some States is often more current than the State information, raising the possibility that changes would be rejected by States and replaced with old information. It was also noted that names and addresses are sometimes modified for entry in the I-SATS following specific conventions so that facilities have unique names and addresses. These modified names or addresses could be rejected by States, destroying the standardization procedures and introducing duplicates or apparent duplicates.

The principle remains, however, that only State-approved facility information is eligible for the Directory and Locator. Synectics will study this problem and recommend alternative procedures for accomplishing that goal.

### **Satellite Facilities**

Thus far, SAMHSA has not actively sought the inclusion of "satellite" facilities on the Directory or Locator. However, arguments in favor of their inclusion were presented by some States, as they were at previous Regional Meetings. In general, "satellites" operate on a part-time basis. Their records, mail, and telephone services are maintained elsewhere at a "parent" location. It is generally not appropriate to include them in the N-SSATS since their client counts are included in the survey responses of the parent location. Having these places in the Directory and Locator, however, could meet a real public need. Particularly in rural areas, a satellite location may be the only reasonably close source of treatment for many people. It was pointed out that, if the Locator's goal is to show available sources of treatment, omitting satellite locations omits important sources for many States.

SAMHSA does not know how many States have facilities that operate as satellites. After the Minneapolis Regional Meeting in October, 2001, an email was sent to the participant States asking if they had an interest in adding satellites to the I-SATS. Little interest was expressed at that time. However, it appears that satellites are important sources of treatment in selected States and their addition to the Locator should be explored. The desirability of adding them to the Directory is less clear because of their transient nature. Several caveats were discussed for adding satellites to the Locator. First, satellite locations do not respond to N-SSATS so that their entry in the Locator would be without the full range of service descriptors. Second, some indication that the location is not operational full-time is needed. Third, the phone number included with the facility listing must be the number of the central (parent) location that is answered at least during normal business hours.

SAMHSA and Synectics will explore the need for satellite listings in all the States and develop a plan for adding them to the Directory and Locator.

There is also an increasing number of "home-based" and "Web-based" treatment programs. While some of these are thought to be sources of quality care, most are an unknown quantity. The general feeling of the group was that these will not be covered by payment systems and will ultimately fail. They should not be included in the I-SATS or N-SSATS.

Dr. Geri Mooney distributed examples of the N-SSATS response summary information that is sent to each State at the end of the survey. Included are summary tables and "outlier" tables. States are also sent lists of all responding facilities. When these are sent to the States, they are asked to review them to see if the data look "reasonably accurate." They are also asked to review the "outlier" data for specific facilities and, from their knowledge of the facilities, indicate if the data are grossly inaccurate. These materials are sent to the State's N-SSATS representative.

In the past, when these materials were sent to the States, very few States provided feedback about the data. The States were asked what could be done to elicit better response. Most State representatives in attendance had not seen these materials because they were sent to the State N-SSATS representative. They agreed that response would be improved if the materials were sent to the DASIS manager in the State, and if they were sent by email. The manager could see that the materials were routed to the proper person and oversee the response. However, it was pointed out that some of the information was not verifiable, depending on the State's data systems. For example, data for individual facilities is not available to some States, and some don't have tabulations that correspond to the N-SSATS data.

In the future, MPR will send the N-SSATS materials to the DASIS manager as well as the N-SSATS representative by email and regular mail. The States were requested to send to MPR any suggestion for improving the data presentation or for providing more useful information.

### **Demonstration of Redesigned DASIS Home Page**

Jim DeLozier demonstrated the new DASIS Home Page. The URL for the page is: <http://www.dasis.samhsa.gov>. Since the Web site was designed to meet the need of State DASIS personnel, suggestions were solicited from all States for new materials or changes to make it more responsive to those needs. The main tabs available on the DASIS Home Page are:

- DASIS News: Provides a link to recent DASIS news and developments and a link to a State-specific N-SSATS response rate table.
- About DASIS: Provides a summary description of the DASIS programs.
- DASIS Contacts: Displays a list of the OAS, Synectics, and MPR personnel, and links to the file of State contacts.
- I-SATS On-Line: Links to I-SATS information, including the I-SATS On-line and IQRS.
- TEDS: Provides links to the most current TEDS manuals, State crosswalks, and TEDS tables and reports.

N-SSATS: Provides links to the N-SSATS State response rates, questionnaires from current and previous surveys, the schedule for the current survey, and N-SSATS data reports.

### **Demonstration of I-SATS Quick Retrieval**

Mr. DeLozier provided a brief demonstration of the I-SATS Quick Retrieval System (IQRS). The IQRS was designed to provide the States with a method of downloading a file or a list of all I-SATS facilities in their State. Most in attendance had used this system. It is available through the I-SATS On-line, so an ID and password are required. Some or all facilities in the State can be selected for download. Selection by zip, city, county, name, or address is possible. The types of facilities selected can be controlled by treatment or not, active or inactive, State approved or not, and by TEDS reporter or not. States should find this useful for displaying exactly what is in the I-SATS at any point in time. This capacity will be particularly helpful when updating the I-SATS.

### **State Presentations**

#### *Illinois*

Illinois is suffering a severe economic decline, and it is expected to continue into FY 2003. The Illinois Department of Human Services, including the Office of Alcoholism and Substance Abuse (OASA), has sustained a number of budget reductions. Several changes have taken place over the past few years with OASA again assuming responsibility for licensure of all non-acute care ATOD treatment. The I-SATS ID number has been integrated into this system, making enrollment and cross-indexing easier.

The Division of Planning and Performance Management within OASA is responsible for, among other things, DASIS, the Block Grant, data analysis, performance management, STNAP (Needs Assessments), and all State plans. This allows an integrated approach to the use of treatment and other data. The State's substance abuse data system is a Cobol mainframe-based system. Data are transferred from the mainframe on a periodic basis. Once a State fiscal year has closed, these relational databases make a rich source of data and information. However use of real-time data is, at best, limited. The State has found that the closer the data are to the analyst, the easier they are to use, and the more they are used. Ad hoc reports can be available in a matter of a few minutes. These relational databases can also be linked to the contracting databases for easy update of contract information. Links are also being established to the licensing and Capacity Management systems.

Illinois is interested in developing a Web-based reporting system, and is very interested in what CSAT is doing and making available to States. The State has incorporated these possibilities in its planning for HIPAA compliance.

There are a number of projects in the Office including needs assessment surveys: intake at the Illinois Department of Corrections; Illinois probationers; Medicaid recipients; an Illinois Household survey; intake at the juvenile corrections facility; and a patient survey

of recipients of services funded by the Illinois Office of Mental Health. The upcoming household survey has been expanded to include residents down to age 16 to identify treatment needs for younger Illinois residents. Illinois will also be linking treatment data to public health, morbidity, and mortality data through social security number. The State uses SAMHSA core protocols with some customized additions. All studies are available upon request or at the University of Illinois Survey Research Lab Web site.

### ***Iowa***

Recent trends in Iowa show more clients entering treatment and length of time in treatment shortening. Use of methamphetamine seems to be increasing. Iowa is participating in a CSAT Needs Development Grant. That project includes an adult household survey as well as development of a Web-based reporting system. State plans include the addition of substance abuse data to a statewide data warehouse.

The State also conducts a school youth telephone survey among youths in the 6<sup>th</sup>, 8<sup>th</sup>, and 11<sup>th</sup> grades every three years. The next cycle will be completed this fall.

### ***Kansas***

Kansas uses several programs including the Kansas Client Placement Criteria (KCPC), Addiction Severity Index (ASI), Treatment Billing System (TBS), and Support Call Log. When a client comes for treatment in Kansas, a KCPC is completed on the client either at the program level or at the Regional Alcohol and Drug Assessment Center (RADAC). The RADAC determines the kind of service the client is to receive and how long the client may receive it. If a funded provider has completed the KCPC for a client, then approval by the RADAC is needed. The RADAC monitors the client's progress throughout the treatment by a "Continue Stay Review" (CSR). This information is put into the KCPC along with certain other information that comes to the State, and then returned to the provider. Selected information in the KCPC is moved into the ASI in order to evaluate the outcome. The providers use the Treatment Billing System to report all billing transactions and to submit information to the State for payment.

Based on last year's legislation, the State now collects data from treatment centers on persons who need treatment and have been in jail for their fourth DUI. This legislation created a provider network supported by the centers with the money coming from the Department of Corrections. This is now providing hard-hitting information from those non-funded providers who are part of the provider network for that target population. The State's next move is to get information from those non-funded providers who also provide Medicaid services.

The funded providers are required to provide the State with information on individuals who are not funded by the State. That information has to be put into the KCPC, so that the State has information on both funded and non-funded clients. Before going to this system, the State did collect data from all the providers by paper, but that was cumbersome. However, since some of the non-funded providers did not have computer systems, the State chose not to collect data from the non-funded providers. Talks are in progress for getting those providers to send that information into the State again.

The State has a call log (via Internet or modem) which allows the provider to enter queries when they have a problem or question. The State can access the call log and review the problem before talking to the provider. This allows the appropriate State personnel to look at entries to the call log and solve the problems. Providers don't have to wait for a specific person to address their problem.

The data come to the State through a "Citrix" system that is available 24 hours a day. Since data are submitted for clients that were admitted the previous day, the State has access to current data. The provider has to submit the data to get permission to keep the client in their system as well as to get approval in order to get paid.

In summary, the State has a multipurpose data set containing intake questionnaire data, asset criteria, request authorization, federal block grant data, State level data, regional level data, provider level data, and billing data. This system is the State's outcome tool and is readable and standardized. There is information available for immediate data tabulation and for client tracking. The State is currently looking for a Web-based application system in order to work with one system.

### ***Indiana***

The State data system is called the CSDS (Community Services Data System). Its development started with the TEDS data key fields. All providers in the system are independent non-profit organizations whose clients qualify for the Hoosier Assurance Plan (HAP), along with SED (Seriously Emotionally Disturbed Children) clients under the DAWN project. Even though there is variation in the provider systems, the State data system interfaces with the provider systems. Changes to the provider systems required to meet State needs are funded by the providers. This is an Internet-based system that is protected by an assigned ID and password. The client has a unique identifier that includes name, social security number, and date of birth in an encrypted format.

Providers who need data for their clients can access the data in their own systems. Most providers have IT staff and can run data tables for their internal use. Indiana does not release data for individual providers, so a provider cannot compare its data with that of other providers. The State receives data from about 43 managed care organizations, each of which collects data from their individual treatment providers and transmits the data to the State. The State uses the data to produce provider report cards that provide an assessment of provider performance.

Indiana reviews errors on Synectics TEDS submission reports and makes corrections as needed through the provider systems. Currently, the State is having a problem with duplication errors. The State does not yet submit discharge data.

### ***Nebraska***

There was a large drop in the number of admissions when managed care was introduced. The chart (see appendix A) shows the number of treatment admissions from 1983 to 2002. Note the large drop in reported admissions from 1997 to 1998. The State

representative reported that this drop was a result of changing from a State-operated data system that recorded admissions to programs funded by the State to a managed care system. Under the initial managed care contract, persons “authorized” for services were entered into the managed care providers data system. The managed care firm selected by the State was Magellan Behavioral Health. In subsequent years, more clients became “registered” (i.e., clients received services in an agency that has State funding) with Magellan Behavioral Health. However the number of registered and authorized clients is not getting entered into the data system because most agencies would need to do double data entry to provide this information. The State has only control on “authorized” clients because it pays for specific numbers of services for these clients on a unit basis.

Magellan Behavioral Health is both the authorizing agent for the State and maintains the database of client information. This database is used by the State to report for both the Mental Health and Substance Abuse Block Grant. The data system is Web-based. Provider staff have a password to access the system and enter information. A list of authorized clients is maintained by Magellan Behavioral Health.

In response to a question about whether the drop in admissions is real or a decline in the reporting of data, the representative replied that the drop is primarily due to a lack of reporting. The managed care firm was not able to bring up a system that could collect the information immediately. As a result, the State lost information on clients who were not authorized. They started with residential programs and brought the outpatient services on-line the next year. On any given day, there are approximately 6,100 clients in the State in substance abuse treatment (National Household survey data).

Needs assessment numbers have gone sky high. The number of persons served, however, has remained somewhat flat. The State can tabulate admissions rates by county, but those rates are questionable because it does not know for sure if the clients are being served in the appropriate service or in a service to meet immediate need.

In Nebraska, providers can log onto the Magellan Web site to get information on their facilities. They cannot get regional information or Statewide averages. Magellan sends data on CD every month to the State, but the State relies on Magellan to analyze the data and write reports. Nebraska reported that the legislature was being called to special session to balance the budget. Substance abuse treatment and prevention programs may take a cut in the balancing effort.

### ***Missouri***

Missouri reviewed the history of its substance abuse data collection. Before the 1980s, ADA services were provided at outpatient ADA units. Services data were collected in the outpatient services units. As Title XX federal funds became available for purchasing services, a second services information system was introduced to collect purchase of services data. These systems fell short of providing ADA with adequate tools to meet the requirements of federal regulations. In 1989, the DMH (Department of Mental Health) introduced another approach to data collection. It was referred to as the Client-Based Information System (CBIS). The major impacts of the new system were:

1. Client name, SSN, and a unique identifier were incorporated; and
2. Computers were made available to POS contract providers for direct, on-line input of billing transactions.

In May 1998, the first of a four-phase CBIS program was implemented. The final three phases were not funded.

In the early 1990s, DMH introduced the Client Tracking, Registration, Admission and Commitment (CTRAC) system so that it could run on the State Data Center hardware. CTRAC contains demographic, episode, diagnostic, and validation information. Data from the system are fed into the DMH central Symmetrical Processor (SP), their data warehouse. This allows rapid access by ADA staff using SAS or Microsoft ACCESS software.

ADA clients are all clients with substance abuse problems who are in need of assistance to overcome those problems. Codependents of the primary abuser are also eligible for services.

In order to be paid for the services, a provider must enter the required data into the CTRAC system. This is mostly done in an on-line, real time mode. It is the port of entry for the client into the DMH database. The client is assigned a permanent Statewide ID number. The numbers are assigned sequentially. If a client is identified as having been admitted previously, much of the client demographic information is already in the system.

Currently, the DMH is preparing for yet another change in the information system. This new and revolutionary initiative is referred to as the Customer Information Management, Outcomes, and Reporting (CIMOR) system. It is expected to start in June 2003 and may take several months to be fully operational. Data will be accessed for reporting through the Internet sites.

### **Treatment Episode Data Set (TEDS)**

Dr. Goldstone discussed the various State-to-State differences in the TEDS data set. Efforts to count the number of individuals in treatment are difficult because there is no unique client identifier. Even counting the number of admissions to treatment is difficult because of the differences in how "admission" is defined and reported in the States. There is also a difference in what treatment admissions are reported to TEDS. Some States, for example, report all clients admitted to facilities receiving public funds, while others report only those clients who receive public funds. It is difficult to know how to fill the information gap about people not included in the system. Theoretically, States could be forced to provide data for all admissions by penalizing them through the block grant, since the law allows the Secretary to make admission data a requirement for getting block grant money. But, practically, this is not feasible, and the DASIS program is built on a Federal-State cooperative arrangement. These are continuing problems that need to be addressed on a State-by-State basis.

The State representatives noted that even if all States submit to OAS data on all client admissions to facilities receiving public funds, there are still no data from client admissions to facilities that do not get any block grant or State funding. Some States have tied TEDS reporting requirements to their licensure procedures, but most do not.

SAMHSA is also concerned about inconsistency in TEDS reporting over the past couple of years. The inconsistency is due to many factors, but it is primarily due to changes in State data systems. While system changes have provided an opportunity to improve TEDS reporting, they have also led to reporting delays and data gaps during the transition period from the old to new systems.

There are other reporting inconsistencies in some States due to a variety of causes other than system changes. Synectics has made an effort over the past year to identify reporting problems and to correct or document them for each State. Graphs and tables of State data covering all years of TEDS data have been sent to the States. These data can be used to identify potential TEDS data problems. The States have reviewed these data and many have been able to correct problems or to document their cause. From these responses, a State-by-State explanation of TEDS anomalies and problems has been compiled that can be provided to the data user for a better understanding of the data. This is a continuing effort that includes quarterly "feedback" tables that are sent to all the States at the end of each calendar quarter. These are provided in an effort to identify potential reporting problems early so that corrections are possible.

TEDS reporting delays are also an issue. Most States submit data within six months of the admission date, but a few take much longer. This becomes an issue when SAMHSA begins the annual TEDS report. SAMHSA would like to cut off data receipts one year after the report year (e.g., cut off 2001 data reporting in December 2002), but generally that is not possible because several States will not have completed submission of all 2001 data.

State representatives suggested TEDS reporting might improve if a letter was sent periodically to the States reminding them about the importance of collecting client data on all clients and from all providers.

### **Status of Discharge Reporting**

SAMHSA's goal is to have all States participating in the TEDS discharge system by the end of 2003. There are now 18 States reporting discharge data and about 10 other States that are actively preparing for data submission; about 5 States say they do not collect discharge data.

To illustrate how the discharge data might be used, OAS is planning to publish several discharge tables in the next TEDS annual report. (An example of the tables was distributed to the meeting attendees). These tables will be prepared from the data submitted by States now providing data regularly. Since it is important that the meaning

of the discharge data be clear, it was agreed that the data must be presented carefully and with a full explanation of what they do and do not mean.

### **Additions to TEDS Data Set**

The States were asked how much disruption would be caused by the addition of new data items to TEDS, to meet new information needs; for example, a new drug category or a new treatment category.

The TEDS data set was established more than 10 years ago, but SAMHSA has been very leery of altering the data because the costs for some States would be consequential. For some States, it would be a terrible burden, even though it would be very beneficial to performance measures. The States at this meeting are on the cutting edge of data collection technology, but many other States are less advanced. Changes for some States are problematic because of low funding and staff levels, and because their systems are often built on older software and hardware. Trying to keep data flowing, OAS has taken into account the fact that the States are at different stages and have different capabilities.

It was noted by the State representatives that the type of change matters. A new category to an existing variable, for example, would be much easier to deal with than a new data item. For the States at the meeting, there was agreement that changes could be made with enough lead-time, preferably six months to a year. They suggested that, if changes were made, it would be helpful if they were introduced on a regularly scheduled basis, perhaps the same month each year. It was noted, however, that implementing changes could be costly, particularly if change is required at the provider level, and that SAMHSA should be cautious about any change.

### **Outpatient Capacity Measure**

Dr Goldstone discussed the problem of measuring outpatient treatment capacity. There is interest in knowing how many people could actually be treated. This question was dropped from the N-SSATS four years ago. Capacity is difficult to measure because providers have said that they could accommodate an indeterminate number of clients by just adding chairs, more counselors, and renting additional space. This issue was raised at the Philadelphia meeting and the universal response was that a question on capacity would not yield anything of any value. The State representatives were asked if they had a different perspective.

The State representatives noted that capacity is less of a problem with residential treatment, but even there the use of "swing beds" makes measuring capacity problematic. They also agreed that the concept of outpatient capacity is no longer useful or meaningful.

### **The Use of National Data**

The last agenda item of the first day was a slide presentation by Dr. Goldstone demonstrating SAMHSA's extensive use of data from the National Survey of Drug Use and Health (NSDUH—formerly called the National Household Survey of Drug Abuse,

NHSDA), the Drug Abuse Warning Network (DAWN), and TEDS. Also included were findings from New York before and after September 11<sup>th</sup> and from the Texas Household Survey data. The slides covered three topics:

- 1) data collection required of SAMHSA by statute;
- 2) drug use and treatment data from NSDUH, DAWN, and TEDS; and
- 3) the treatment gap as estimated from the household survey.

Several questions were raised during the presentation:

- Q. In DAWN, does "drug use" by an emergency room patient mean that the drug was the cause of the emergency room visit?
- A. No, the visit may have any cause. The patient is included in DAWN if the medical record indicates that the patient mentioned use of a drug or a drug was found in the patient's system. In a typical emergency room visit in which a drug is mentioned, multiple drugs are mentioned. Information on alcohol use is not reported in DAWN, though next year the use of alcohol by underage drinkers will be reported.
- Q. From the Household Survey, you estimate the treatment gap to be 1.8 percent of the population. Was this figure compared with data from any of the State-specific household surveys?
- A. No. Attempts at comparison were not successful, primarily due to different timings and methodologies. The 1.8 percent is a conservative estimate because this is a household survey and the estimate is based on people who have an address.
- Q. When did the 2002 Household Survey begin?
- A. In January.

### **Substance Abuse and Mental Health Data Archive (SAMHDA) Presentation**

The second day began with a demonstration of the SAMHDA Online Data Analysis System (<http://www.icpsr.umich.edu/SAMHDA>). This system makes it easy for users to analyze any data set in the archives. The demonstration focused on recent improvements, including a new home page, a revised public-use file for TEDS data, color-coded tables, and "save variables" (including re-codes). The description of the system has been reported in earlier Regional Meeting summaries and will not be reported here.

Questions and answers during the presentation are as follows:

- Q. Are the Household Survey Data available by State?
- A. Not at the present because of confidentiality issues. We are working on an agreement that would allow restricted use of State data. This would require a user to sign an agreement of confidentiality and to get approval of the intended use by SAMHSA. Some cost will also be involved. SAMHSA will establish criteria for determining which requests for State data get approved and which will not.

- Q. For TEDS data, how can we compare States when there is no standard for the TEDS admission record?
- A. There are standards for TEDS. In fact the original intent of TEDS was to establish a standard data set for all States. The problem is that not all States are able to meet those standards. Therefore, State comparisons must be made cautiously because the State data systems may not be comparable. The State TEDS crosswalks are helpful for determining this. On a national level, some of the State variations "wash out." Therefore, it is more appropriate to compare a State's data with the national data. If differences exist between the State and national data, it is generally possible to identify the differences that are due to some unique feature of the State's data system.
- Q. The problem of client admissions and transfers complicates TEDS comparisons. How should States handle this in the TEDS submissions?
- A. TEDS has an "episode of treatment" model that assumes a single admission at the beginning of treatment and a single discharge at the end of treatment. Client movement during an episode of treatment between types of treatment or between providers is considered a "transfer". This is the model for many States. However, in some States, the movement during an episode of treatment is not a transfer, but a discharge and another new admission. Thus, for those States, a client can have multiple admissions during a single episode of treatment. How each State handles this issue is documented and published in each TEDS annual report.

### **SAMHSA's Web Resources**

SAMHDA's Home page has been averaging 30,000 hits per month for data. The level of activity over last five years has multiplied by a factor of 6.

SAMHSA has published 33 issues in the DASIS Short Report series since July 2001. There have been about 6,000 downloads of the short reports each week. States are invited to suggest topics for the short reports.

Web activity on the Treatment Facility Locator has increased 300 percent since 2001. It also generates a high volume of emails from the public with specific questions about kinds of treatment and how to access treatment. Since the State substance abuse agency phone number and email address are on the Locator, States are also getting requests from the public.

States were reminded to keep their DASIS contact information current by notifying Synectics when DASIS personnel change or when agency addresses change.

### **Health Insurance Portability and Accountability Act (HIPAA) Presentation**

Judy Ball made a presentation on the Health Insurance Portability and Accountability Act (HIPAA). The States have expressed considerable interest on the effects of HIPAA. This presentation has been summarized in a previous report and will not be reported here.

Questions and comments during the presentation are as follows:

- Q. Does a provider in a network need one provider number or one number for each component of the network?
- A. It has not been determined yet whether the number will be assigned to an individual, to a physical location (building), or to a network.
- Q. Since TEDS is collected under a law requiring submission of the data, would TEDS data be considered a public health surveillance/investigation? Section 505 requires information on admission to treatment facilities. Is that sufficient to allow or permit the disclosure of information?
- A. There are circumstances where protected health identified information can be disclosed by a covered entity to an organization. TEDS may fall under public health surveillance/investigation or health oversight activities.

SAMHSA gets the TEDS data secondhand. There are two instances where a covered entity might provide the information. They are health oversight and disclosure by law. Both of these probably apply to TEDS. In addition, any information that is disclosed to SAMHSA by TEDS is protected by yet another disclosure law, the law prohibiting SAMHSA to disclose its data. If you are a covered entity, you can disclose TEDS data to SAMHSA because SAMHSA is a public health agency identified by law to receive the information and there is another law in effect that prevents SAMHSA from disclosing that information.

#### **Demonstration of DAWN Web Site**

Ms. Ball gave a brief demonstration of the new DAWN Web site that just went live on Monday. The Web site URL is [www.dawninfo.net](http://www.dawninfo.net).

#### **Closing Remarks**

The meeting was concluded with an open discussion. The issue of TEDS timeliness was raised and States expressed the need for having TEDS data available more quickly. SAMHSA noted that they have made efforts to release data more quickly, though the policy has been not to provide data until it is officially released through a SAMHSA publication. SAMHSA now has a Web site with selected TEDS data that has the most current data available for each State. The Web site address is:

<http://www.dasis.samhsa.gov/webt/newmapv1.htm>

The data presented here is updated periodically on a State-by-State basis so that the most current data for each State is available. Public-use files, however, are still not released until the data are officially released.

Currently, the 2000 TEDS Annual Report is in draft status. Since all of the 2000 data were not submitted until early in 2002, the TEDS data could not be published until almost two years after the data year. In addition, the time required for federal clearances and publication has increased recently.

The States asked if it was possible to get national TEDS data that are more current than data in the published reports. SAMHSA noted that they want to expedite release of the data, and have decided to release selected data on request prior to the official release of the whole data set. If a State wants specific national tabulations, they should make their request to Deborah Trunzo.

Dr. Goldstone closed the meeting by thanking the participants for their input and urging them to do all they can to improve TEDS coverage. He asked that they try to impress upon their State policymakers the importance of these data for national planning and as input in decisions on the amount of money in the block grants.

**Appendix A**  
**Treatment Admissions - 1983-2002**  
 State of Nebraska Funded Substance Abuse Programs

Fiscal Year	Total Admissions (d+e)	Primary Substance at Admission		Primary Drug at Admission			
		Total Alcohol	Total Drug	Heroin	Meth-amphetamine	Cocaine	Marijuana
			(e-(f+g+h+i))=other				
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
1983	18712	17571	1141				
1984	17921	15459	2462	129	166	134	1026
1985	19135	17298	1837	114	178	119	986
1986	22000	18757	3243	37	310	288	1907
1987	21325	19288	2037	108	167	370	841
1988	21784	19563	2221	117	136	400	885
1989	25503	22942	2561	110	209	623	935
1990	25512	22894	2618	90	210	699	926
1991	25051	22750	2301	89	177	502	803
1992	26534	24138	2396	214	67	753	882
1993	22791	19737	3054	77	30	731	837
1994	22091	18849	3242	84	38	902	972
1995	21438	17939	3499	115	318	1073	1086
1996	20007	16470	3537	104	491	817	1267
1997	20049	16136	3913	95	645	839	1582
1998	7832	6211	1621	69	472	462	472
1999	13555	10696	2859	40	740	718	1150
2000	13345	10589	2756	20	765	748	998
2001	14143	10954	3189	29	1158	765	950
2002*	11245	8438	2807	27	1144	614	805

\*to 3/31/02

AGENDA

**DASIS REGIONAL MEETING**  
**Indiana, Illinois, Iowa, Kansas, Missouri, Nebraska**

July 9-10, 2002

**Chicago, IL**

**Thursday**

8:30 a.m. Continental Breakfast

9:00 a.m. Welcome and Introduction ..... *Donald Goldstone, OAS*

9:15 a.m. National Survey of Substance Abuse Treatment Services (N-SSATS)..... *Geri Mooney, MPR,*  
*Barbara Rogers, MPR*  
*Donald Goldstone, OAS*

- Schedule for 2002
- Web questionnaire
- Determining whether a facility provides “treatment”
- Outpatient capacity revisited
- Collecting data on cost of treatment

10:00 a.m. Inventory of Substance Abuse Treatment Services (I-SATS)..... *Deborah Trunzo, OAS*  
*Jim Delozier, Synectics*

- Demonstration of Treatment Facility Locator
- Demonstration of redesigned DASIS project home page
- Demonstration of I-SATS Quick Retrieval
- State approval of facilities

11:00 a.m. BREAK

11:15 a.m. State Presentations ..... State participants – *IL, IN, IO*

12:30 p.m. LUNCH

1:15 p.m. State Presentations (continued) ..... *State participants – KS, MO, NE*

2:15 p.m. Treatment Episode Data Set (TEDS)..... *Donald Goldstone, OAS*  
*Jim Delozier, Synectics*

- TEDS coverage and discrepancies between data sets
- Consistency in TEDS reporting
- Proposed addition of Ecstasy
- Detoxification vs. treatment admissions
- Status of discharge reporting

3:30 p.m. BREAK

3:45 p.m. The Use of National Data ..... *Donald Goldstone, OAS*  
*Leigh Henderson, Synectics*

- NSDUH, TEDS, & DAWN

4:30 p.m. Adjourn

# PARTICIPANT LIST

**DASIS Regional Meeting  
Chicago, Illinois  
July 9 – 10, 2002**

---

---

## SAMHSA STATE REPRESENTATIVES

Oscar Boyer-Colon  
Statistical Research Specialist III  
Illinois Department of Human  
Services, Office of Alcoholism and  
Substance Abuse  
100 W. Randolph Street, Suite 5-600  
Chicago, IL 60601  
Phone: 312.814.1509  
Fax: 312.814.2419  
E-Mail: dhsas58@dhs.state.il.us

Donna Doolin  
Assistant Director of Substance Abuse  
Prevention, Treatment and Recovery  
State of Kansas  
MH/SAPTR  
915 SW Harrison (D.S.O.B.), 10th Floor N  
Topeka, KS 66612  
Phone: 785.296.6807  
Fax: 785.296.7275  
E-Mail: dxmd@srskansas.org

Robert Bussard  
Research Analyst  
Nebraska Office of Mental Health and  
Substance Abuse  
P.O. Box 94728  
Lincoln, NE 68509  
Phone: 402.479.5572  
Fax: 402.479.5162  
E-Mail: bob.bussard@hhss.state.ne.us

Barth Ihenacho  
Research Analyst IV  
Missouri Department of Mental Health  
Division of Alcohol and Drug Abuse  
1706 E. Elm Street  
Jefferson City, MO 65102  
Phone: 573.751.8039  
Fax:  
E-Mail: mzihenb@mail.dmh.state.mo.us

Lonnie Cleland  
Program Planner II  
Iowa Department of Public Health  
321 E. 12th Street  
Lucas State Office Bldg.  
Des Moines, IA 50319  
Phone: 515.281.4643  
Fax: 515.281.4535  
E-Mail: lcleland@idph.state.ia.us

Lillian Pickup  
Administrator, Division Of Planning and  
Performance Management  
Illinois DHS, Office of Alcoholism and  
Substance Abuse  
100 W. Randolph Street, Suite 5-600  
Chicago, IL 60601  
Phone: 312.814.2436  
Fax: 312.814.2419  
E-Mail: dhsas16@dhs.state.il.us

## **PARTICIPANT LIST (Con't)**

### **SAMHSA STATE REPRESENTATIVES**

Romana Ploss  
DMHA OPP Program Coordinator  
Division of Mental Health and Addiction  
(State of Indiana)  
402 W. Washington Street Room W353  
Indianapolis, IN 46204  
Phone: 317.233.5444  
Fax: 317.233.3472  
E-Mail: rploss@fssa.state.in.us

Melanie Whitter  
Associate Director  
Illinois Department of Human Services  
Office of Alcoholism and Substance Abuse  
100 W. Randolph Street, Suite 5-600  
Chicago, IL 60601  
Phone: 312.814.2300  
Fax: 312.814.2419  
E-Mail: dhsas48@dhs.state.il.us

Shirley Sherretts  
Microcomputer Support Tech I  
State of Kansas  
SRS/HCP - PERT  
915 SW Harrison (D.S.O.B.), 10th Floor  
Topeka, KS 66612  
Phone: 785.296.4576  
Fax: 785.296.7275  
E-Mail: sas@srskansas.org

Janet Zwick  
Deputy Director  
Iowa Department of Public Health  
321 E. 12th Street  
Des Moines, IA 50319  
Phone: 515.281.4417  
Fax: 515.281.4535  
E-Mail: jzwick@idph.state.ia.us

## SAMHSA REPRESENTATIVES

**Substance Abuse and Mental Health Services Administration (SAMHSA)  
Office of Applied Studies (OAS)  
5600 Fishers Lane, Parklawn Building, Room 16-105  
Rockville, MD 20857  
Fax: 301.443.9847**

**Cathie Alderks**  
Statistician  
301.443.9846  
calderks@samhsa.gov

**Donald Goldstone, MD**  
Director  
301.443.1038  
dgoldsto@samhsa.gov

**Anita Gadzuk**  
Div. Of Operations  
301.443.0465  
agadzuk@samhsa.gov

**Judy Ball**  
DAWN Team Leader  
301.443.1437  
jball@samhsa.gov

**Charlene Lewis**  
Public Health Analyst  
301.443.2543  
clewis@samhsa.gov

**Deborah Trunzo**  
Dasis Team Leader  
301.443.0525  
dtrunzo@samhsa.gov

---

---

## CONTRACTOR STAFF

**Synectics for Management Decisions, Inc.  
1901 North Moore Street, Suite 900  
Arlington, VA 22209  
Fax: 703.528.2857**

**Jim DeLozier**  
Senior Consultant  
703.807.2331  
jimd@smdi.com

**Peter Hurley**  
Project Manager  
703.807.2347  
peterh@smdi.com

**Alicia McCoy**  
I-SATS Database Manager  
703.807.2329  
aliciam@smdi.com

**Leigh Henderson**  
Senior Research Analyst  
410.235.3096  
leighh@smdi.com

**Heidi J. Kral**  
Conference Manager  
703.807.2323  
[heidik@smdi.com](mailto:heidik@smdi.com)

## Mathematica Policy Research, Inc.

**P. O. Box 2393  
Princeton, NJ 08543-2393**

**Fax: 609.799.0005**

**Geri Mooney**  
Vice President  
609.275.2359  
gmooney@mathematica-mpr.com

**Barbara Roger** Survey Research  
609.275.2249  
brogers@mathematica-mpr.com