

DASIS STATE DATA ADVISORY GROUP MEETING

**June 28–29, 2005
Cincinnati, Ohio**

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SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING

June 28–29, 2005

Cincinnati, Ohio

This was the 20th regional meeting to be held with State DASIS representatives. It included representatives from Delaware, Indiana, Maryland, Michigan, Missouri, Ohio and Pennsylvania, along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions, Inc. (Synectics). In addition, the meeting was attended by Stephenie Colston, Senior Advisor to the SAMHSA Administrator, and Javaid Kaiser, Chief of the Data Infrastructure Branch in the Center for Substance Abuse Treatment.

The DASIS regional meetings are held to provide an opportunity for face-to-face discussions among State DASIS representatives, the staff of OAS, and the DASIS contractors, Synectics and MPR. The meeting agenda, while planned beforehand to include items of mutual interest, is flexible to maximize the opportunity for discussing issues of particular importance to the State representatives in attendance. Through discussion and brief presentations, States are informed about recent SAMHSA and 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. For this meeting, the first day was devoted to National Outcome Measures (NOMS), including a description of SAMHSA's plans for modifying TEDS to collect data related to NOMS. State presentations were also focused on their ability to provide NOMS data through TEDS and their questions or concerns related to the provision of NOMS.

Opening

Charlene Lewis, acting Director of the Office of Applied Studies (OAS), gave opening remarks. She emphasized the importance of these meetings to OAS and the value SAMHSA receives from the State presentations and the interchange of ideas during the meeting with the State representatives. She welcomed and introduced Stephenie Colston and Javaid Kaiser, who are leading the SAMHSA efforts to develop NOMS.

SAMHSA Data Strategy and NOMS

Stephenie Colston discussed evaluation of SAMHSA data systems and development of a data strategy. In July 2003, SAMHSA established a working group to develop a data strategy. They hired consultants to evaluate current data systems and to develop the strategy. In the process, they interviewed key SAMHSA staff to get a comprehensive understanding of current systems and to develop ideas of what the data strategy should look like. It took several months and, in January 2004, they recommended a data strategy and a vision statement for the Agency. With respect to SAMHSA data, the consultants arrived at seven major findings:

- 1) SAMHSA lacks an enterprise model
- 2) SAMHSA lacks an information technology infrastructure to support data collection
- 3) SAMHSA has no standard data definitions
- 4) SAMHSA lacks the ability to provide data to policy managers and States in a timely manner

- 5) There is substantial overlap in the data that are collected,
- 6) SAMHSA should be more involved in behavior health issues and establishing national standards
- 7) SAMHSA conducts studies that don't justify high precision or cost.

A second contractor was hired to do a gap analysis to identify data needs. Their analysis determined that SAMHSA has 33 data sets and information sources, but the contractor believed that the Agency's data priorities lack context, and data systems could be more efficient.

As a result of the studies, SAMHSA established an enterprise architecture based on service components to define the agency functions and to make the business process more efficient. This should make data collection more efficient, cut costs, reduce the burden on the States and grantees, improve data quality and increase technical support. Under enterprise architecture, SAMHSA reviewed all 33 data sources and mapped their data elements to the national outcome measures. They found that more than 40% of data elements did not match to outcome measures.

To date, working with NASADAD, 80% of the outcome measures have been identified, and will be phased in during a 3-year period, ending in September 2007. The agency goal is to collect outcome measures for all funded services and to coordinate data contracts to reduce waste.

SAMHSA has identified the next steps as:

1. Develop National Outcome Measures (NOMS)
2. Consolidate the GPRA (Government Performance Results Act) and PART (Program Assessment Rating Tool)
3. Re-align SAMHSA Resources to facilitate State data collection of NOMS

Accountability using NOMS came out of the ATR (Access to Recovery) Grants. From this, SAMHSA intends to develop standard definitions and move toward aggregated national data.

Ms. Colston posed a question to the States as to whether there should be an abstinence measure for mental health. That is, is drug abstinence a valid outcome measure for mental health clients? The response from the States was mixed. It was noted that substance abuse information is not always collected for mental health patients, and that collection of that information is inconsistent, at best. The validity of the information is also suspect, since mental health patients do not reliably report substance use. It was estimated that substance abuse might be relevant for less than 10 percent of mental health patients. Michigan, for example, considers reduction in substance use part of the treatment goals for dual diagnosed clients, but does not consider it to be an outcome measure.

In response to a question about States' need for funds to build their data infrastructures, Ms. Colston stated that SAMHSA is reprioritizing their plans for providing technical assistance funds, so that more funds will be available to help States develop their data systems.

State Outcomes Measurement and Management System (SOMMS)

Javaid Kaiser described the background and purpose of the State Outcomes Measurement and Management System (SOMMS). He stated that the general goal of this program is to collect outcome measures in mental health and substance abuse treatment, while trying to avoid duplication of data that is submitted by several different groups of grantees in the States.

Each State needs to have a viable and functional IT system. To reduce burden, a crosswalk between GPRA/PART/NOMS data elements is being developed. Only data that are needed for Federal and State purposes should be collected, and duplicate reporting should be eliminated. SAMHSA wants to support database management at the federal level and have the States follow the same database management procedures. To achieve that goal, a two-pronged approach has been proposed.

First, data collection will be done through modification of the DASIS contract, specifically through TEDS. This will go on for at least 4 years. By 2007, all States should be able to collect the NOMS data. It will be the States' responsibility to assure that the data are clean and that unique client ID numbers can track clients. For providing the NOMS, States will be provided annually with up to \$150,000, which is in addition to the current DASIS payments.

The second prong is technical assistance provided through the SOMMS contract. There are several tasks under this contract, including creating GPRA/PART/NOMS crosswalks, consulting professional groups and other consultants. This contract includes funds for infrastructure development and other technical assistance for States. States that cannot provide all or some of the outcome measures should seek assistance under this contract. Funds for infrastructure development will be based on need. This is like a financial aid package that SAMHSA provides to help States build a viable data infrastructure and submit the NOMS. Not only SOMMS resources, but also other technical assistance contracts will be brought into this fold (data infrastructure grants, block grant set asides, etc).

All data are to be centralized in order to facilitate data linkage and make data available to States as well as Federal agencies. The SOMMS contract is primarily a technical assistance contract, and one of its important aspects is the use of technical assistance consultant groups. There are issues about costs, and how States will be compared to other States that need to be resolved.

Implementation of this program is scheduled to be completed over a 3-year period, and 1 year has gone, so the time frame is tight. With respect to data item definitions, we are starting with the TEDS admission data definitions, but we may find that some of the definitions need to be modified for discharge data.

In response to a question by the States, it was noted that combining TEDS admission and discharge data for submission by States has not been decided. The current system of separate submissions has some advantages and there may be problems with timeliness of submissions if the data are combined by the State before submission.

It was also noted by all States that a minimum of 2 years would be required to implement system changes to collect the NOMS, for those States not already collecting them.

DASIS Subcontracts for Implementing NOMS

Debbie Trunzo described the status of the SAMHSA plans to implement SOMMS subcontracts for reporting national outcome measures (NOMS). Working through a modification to the DASIS contract, each state will be eligible to receive \$150,000 per year for submission of the NOMS through TEDS. The details on how the payments will be made have not been determined, but they may be quarterly payments as the DASIS payments are now made.

Many of the NOMS variables have been identified, but the definitions need to be finalized. As the first step, SAMHSA will be finalizing the specific NOMS variables and their definitions. States will be invited to submit proposals that demonstrate their ability to submit the NOMS, and to meet specified performance criteria for data quality and timeliness. The data quality and timeliness standards will be discussed later.

Implementation of the SOMMS in the states is planned to be phased in over a 3-year period. Up to 32 states may participate in the first year. An additional 14 states may participate in the second year, and all states may participate by the third year. As noted earlier, those states that are unable to participate in years one or two will be eligible for technical assistance through a separate SOMMS contract specifically for that purpose. The SOMMS contract to provide technical assistance to states will be awarded in September. The DASIS contract also will be modified by then.

Indiana asked whether the payments for submission of NOMS variables are separate from the current DASIS payments.

Debbie Trunzo replied that the NOMS payments are in addition to the DASIS State Agreement payments, and that the DASIS payments would continue at their current level.

The new NOMS variables to be submitted through TEDS are as follows:

NOMS Measures at Admission

- All TEDS Admissions Minimum Data Set variables
- Possibly 2 TEDS Admissions Supplemental variables
 - Living arrangements
 - Detailed not in labor force
- New admissions variable
 - Arrests in past 30 days

NOMS Measures at Discharge

- All current TEDS discharge variables
- New discharge variables
 - Abstinence at discharge – Proposed
 - 1st, 2nd, 3rd substances (rank as recorded at admission)
 - Frequency of use at discharge of 1st, 2nd, 3rd substances
 - Living arrangements
 - Employment status
 - Detailed not in labor force
 - Arrests in past 30 days

Other NOMS Measure

- Number of persons served
 - Unique statewide client ID

Several states had questions about the abstinence measure. For one, it was pointed out that many clients drop out of treatment and providers lose contact. How will providers get drug use information (or any other discharge information) from dropouts during the last 30 days?

Maryland made several comments, noting that some providers consider abstinence to mean a reduction in use while in other places it is total abstinence, and looking at abstinence for each specific substance is also recommended since lumping all substances together may be misleading. And, of course, abstinence during residential treatment has a different meaning than abstinence during outpatient treatment.

The “detailed not in labor force” variable is intended to identify clients who are in school, retired or disabled. It will be useful for determining the appropriate denominator for calculating rates.

Charlene Lewis noted that some of these groups should be excluded from the denominator since they are not in the work force.

Delaware stated that there is a need to define “disability” under the employment variable, and raised the question: What are the disability criteria? Delaware also noted that some levels of the disabled are able to work, so guidelines for classifying persons as disabled are needed.

Pennsylvania agreed and asked how to code a client who is not in the labor force at admission, but gets some training during treatment and has a job at discharge.

Indiana noted that the T1 block grant table excludes the disability component of their employment data.

Debbie Trunzo asked the states whether it would be easier to collect, at discharge, variables that are already collected at admission, or to develop new variables. All states agreed that adding existing admissions variables to the discharge record would be easier.

She also asked whether any states now collect arrests during the past 30 days.

Pennsylvania stated that they collect, at admission, the number of arrests during the past 6 months. At discharge, the state collects information about arrests during treatment. In the event treatment is less than 30 days, they don't look back before the admission date. They also noted that there is a time lag in the judicial process that can affect the value of the data. For example, arrests can occur months after commission of a crime. Also, a client can be arrested for probation violation, so there would be an arrest but not a new crime. There is also the problem of client honesty. In Pennsylvania, there is no way to verify the information the clients give them at admission, so the usefulness of the data can be questioned. In Pennsylvania, collection of arrest data is not consistent among counties.

Ohio collects arrest information, but is primarily interested in arrests while in the treatment program. They noted the problem of clients being arrested but not tried until after treatment. Michigan collects "arrests during treatment", with no time restriction, and would have difficulty relating that information to the proposed 30-day period.

Continuing with her presentation, Debbie Trunzo noted the final NOMS data element, the number of persons served. This element requires that states have a unique client ID that will enable tabulation of an unduplicated count of clients over a defined period of time.

Indiana observed that the TEDS manual does not specify use of a particular client ID, but allowed each state to use an ID of their choosing. Debbie Trunzo stated that the federal government is specifically prohibited from using a national client ID.

In addition to collecting the NOMS data elements, there are two major factors that will be used to assess states that apply for a NOMS contract. The first is the state's ability to provide the data in a timely manner. This involves how frequently data are submitted, and how current the data are. Specifics are to be determined, but it is likely that the data will need to be submitted either monthly or quarterly. It is also likely that States will be expected to submit data within 3 months of the end of the quarter in which the event occurred. For example, admissions in January through March (the first calendar quarter) would need to be submitted by the end of June (the end of the next quarter).

The second factor relates to data quality. As with the timeliness specifications, the quality requirements are to be determined. Possible measures of quality include the following:

- In year 1 - At least 95% response rate for all current TEDS data elements and 80% for new data elements.
- In year 2 - At least 95% response rate for all TEDS data elements.
- At least 90% of discharge records can be matched with an admission record.

- In year 1 – The volume of discharge records must be at least 80% of the number of admission record.
- In year 2 - The volume of discharge records must be at least 90% of the number of admission record.

States participating in the SOMMS will also be expected to maintain the TEDS crosswalk and to make corrections to any data that do not pass edits in the TEDS processing. The contractor will process the data submissions just as they now process the TEDS data submissions, which includes providing the state with a processing report. Any records rejected or errors identified during the TEDS processing must be corrected and resubmitted within a specified time frame, e.g., within 60 days of notification by the contractor.

As you can see, the basic structure for SOMMS participation has been established, but many of the details are yet to be determined. Your questions and views on all of this are welcome.

STATE PRESENTATIONS

Delaware

The Delaware Division of Substance Abuse and Mental Health has created a database of substance abuse and mental health data. This “data mart” (called DAMART) includes data on episodes of care (both admission and discharge data), services provided and other information, and uses unique client identifiers. Both substance abuse and mental health data are kept separated, but they can be merged. The overlap of Substance Abuse and Mental Health clients is approximately 8 to 10 % within any given year. In Delaware’s system, an episode is an admission/discharge sequence for each level of care and can be linked to Medicaid to determine a client’s Medicaid eligibility status. Among other uses, the DAMART is used to produce a variety of administrative reports.

Admission and discharge records are kept in pairs in the State’s data system, so matching admissions and discharges will not be an issue. Delaware does not yet send discharge data to TEDS, but has the data and will begin to send it.

The State is in need of a clinical care information system, oriented towards the clinicians for its State programs. There is currently a private SA treatment contractor that has a good data system and providers may not want to change. Other providers may be interested in a shared system. The State is looking at WITS and other public domain systems.

In the State system, providers get a report card on their episode data. For a few months, the reports cards were not sent out and the provider reporting began going down. Only about 75% of the fields were being completed accurately, so the State set a quality improvement goal to have providers complete at least 95% of the fields. Many of the providers have taken the lead and want to comply. When report cards were resumed, the providers’ reporting rates increased. This is evidence that feedback to the providers is important and promotes better data submissions.

With respect to collection of outcome measures, Delaware now collects data for some of the NOMS, but others must be added to their system. They estimate that it will require an 18 to 24 month lead-time to make changes to their system.

To begin reporting the NOMS, they must add the discharge component to their TEDS reporting. They currently collect the drug use matrix at admission and discharge, so they have information on “abstinence”. They also collect employment information that will provide the NOMS related to changes in employment and schooling.

Criminal justice involvement is a new item. It can be added to the admission and discharge forms, but it will require several months lead-time. The State notes that there are several levels or types of criminal justice involvement, such as on probation, charges pending, etc. The definition of this item needs to be carefully considered.

The NOM “Stability in Housing” is available since the client form collects “residential arrangements” at admission and discharge. Also, the State believes it can produce the “access to services” measure. Since the State has a unique identifier, they can produce an unduplicated count of individuals served. They can use their Household survey to get a “those in need” denominator. For the “retention in treatment” measure, they can calculate length of stay with the discharge and admission dates.

“Increased social support of recovery” will be a new item for Delaware. This, too, can be added to the client forms with enough lead-time, once the variable(s) for this measure have been defined.

Regarding “Client perception of care”, the State does an annual client satisfaction survey for a 15% sample of clients. Cost effectiveness (average cost) is available for Delaware because they calculate this when completing the ATR grant application.

Finally, for “Use of evidence based practices”, Delaware requires its providers to use evidence based practices and to identify the practices they use in their programs.

Indiana

Indiana has an integrated, modular “data mart”. It includes data from a variety of sources that can be used to generate block grant reports and a variety of other reports. Data sources include the CSDS (Community Services Data System), consumer surveys and State hospital data. The TEDS data are extracted from the CSDS. The CSDS was built 5 years ago using State data infrastructure dollars.

The State uses the COGNOS PowerPlay system to generate reports. With this system, the user can pick the data item and, with little training, go into the system and easily create reports. It has improved reporting time dramatically.

The State’s dream is to have one data stream for producing block grant reports, TEDS data and NOMS. Indiana believes they can produce NOMS 1 through 6 and 9 with current data. To

make the necessary changes to the data system to collect all of the NOMS will take 24-26 months.

Indiana has both admission and discharge TEDS data, but discharge data are not 'true' discharge data. To construct a discharge record, they use "reassessment" data and a '30-day rule'. That is, if it has been 30 days since a client had a service, then the client is considered to have been discharged. The date of the last service is used as the discharge date. However, the State wants to find a way to get true discharge data, through it will be a big challenge and a huge change for providers.

The State currently has in their CSDS the data needed for some of the NOMS. Specifically:

NOM #1 (abstinence) – State collects drug and alcohol use at admission and at discharge, so can measure change in abstinence.

NOM #2 (employment) – State collects employment status at admission and discharge, so can assess change in employment. State does not collect the detailed not in labor force information at this time, but it can be collected.

NOM #3 (arrests) – State collects number of arrests in prior 30 days at admission and at discharge, so can measure change.

NOM #4 (living arrangements)– State collects "homeless" information. This may provide living arrangements measure, though not in the detail currently collected in TEDS.

NOM #5 (penetration rate) – State can get unduplicated count of clients receiving treatment.

NOM #6 (retention) – State can calculate length of stay.

NOM #7 (Social support) – State has no data. Definition is an issue of concern.

NOM #8 (perception of care) – State has no data and questions if client satisfaction survey will be required.

NOM #9 (costs) – State computes cost of treatment for block grant purposes.

NOM #10 (evidence-based practice) - State has no data.

Maryland

In Maryland, each county or subdivision is required to have a drug and alcohol abuse council to plan, assess needs and make decisions. Selected outcomes data are collected and tabulated for the State and shown to the councils around the State. Example of the outcome tables will be shown as part of this presentation.

One major issue with compiling substance abuse data is that there is no standard definition of an active patient. Maryland has a strict "30-day rule", which means that clients who have not had a direct treatment service within 30 days must be discharged. However, other States vary with respect to when discharges occur. When clients are discharged under Maryland's rule, the date of last treatment is used as the discharge date.

The State collects the number of arrests during the past two years at admission, and uses these data to calculate arrest rates. To comply with the proposed NOM, the State will have to change the time frame to be arrests within the past 30 days and add this data item at discharge as well. Maryland does not currently collect the complete TEDS detailed not-in-labor-force information, so that will also have to be added to the State system.

The State sees a number of difficult issues with the abstinence NOM. In some places, it means a reduction in use while in other places it is total abstinence. It is also important to look at abstinence for each specific substance as opposed to lumping all substances together. Many patients come from a controlled environment where they don't have access to drugs, so that creates a problem with the meaning of reported use in the 30 days prior to admission. In addition, patients are often not forthcoming about drug use when they are first admitted. After some time in treatment, they report using more than initially reported, and counselors usually do not go back and fix the admission record. That results in drug use going up while in treatment due to the client not being honest at admission.

Maryland has relatively good data reporting by providers because providers must report their data as a condition of certification. Getting good data from the private providers is the most challenging.

The State has concerns about employment data. There is a wide variation in employment status by type of service. Employment status also has to do with the focus of the provider, in that some providers are focused on putting clients to work. When assessing improvement in employment status, clients who are not in the work force should not be included.

Maryland sees several problems with collecting the number of arrests in the past 30 days. For one, an arrest may be based on a warrant for an offense that occurred before the 30-day period. Arrests are also dependent on type of service. Residential clients, for example, are clearly not as likely to be arrested during treatment as outpatients. Finally, clarification is needed on how to handle treatment episodes shorter than 30 days.

Maryland's overall concern is that the NOMS will only be of value if there are clear and concise rules and standards alleviating any inconsistencies in interpretation.

Michigan

Michigan does not contract with providers, but with Regional Coordinating Agencies (CA's). Each of the 16 CA's has a network of providers, and there are 312 treatment providers in the State that operate through the CA's. The Salvation Army is the only direct contractor. There is no methadone provider in the northern part of the State, and a provider (detoxification) in the western part of the State closed recently, so the State is short of providers in methadone and detoxification.

Every admission record starts with a provider on the State's web-based system. The provider can take a snap shot of their data from the web-based system and then send their data to the State. One problem is that the provider's snap shot may not match the data sent to Michigan after it is sent.

In the State's old system, they had clients with multiple admissions within the same episode of treatment. Clients were admitted when they came in for detox, again when they went to residential, and again if they went to outpatient. They wanted a system that linked services to make this just one treatment episode, with one admission per episode and transfers for any

change in service or provider. During the past 2 plus years, they have changed their procedures so that each episode of treatment has one admission and one discharge. The new system was implemented on 6/20/2005. They are just beginning to receive the first data from that system and, thus far, the data are passing the edits. Things appear more promising than they did a year ago when the transfer option was incompatible with how providers reported clients. In this system, the discharge date is defined as the last day the client is seen.

The State established a treatment outcome workgroup to develop manuals, coding instructions and definitions, and placed this document on their web site. Using data from their old system, they have analyzed data from FY 01-04 on abstinence, employment, housing stability and retention. They are now waiting to see how well the new system works, and they plan to run a test on 6 months of FY 05 data for 5 of the NOMS (abstinence, employment, housing stability, access/capacity and retention).

The State revised their instructions for "Frequency of use" to better capture substance use. So, if the client answers "none" to substance use, a question box comes up and asks the question again to better get at the substances used. When a client changes modality, they are treated as a transfer and not an admission. If they change the level of care within 30 days, and if it is part of the same treatment plan, then the CA reports it as a transfer and not a new episode of care.

The most frequent length of stay is one day. Part of this is due to a business practice in which one provider does an intake only and then hands the client off to another, but the majority occur because clients come in for treatment and don't come back, either because they don't feel like they need treatment, they conclude that the treatment offered won't meet their needs, or for some other reason.

The State now collects arrest data at 6 months and 5 years. That will have to be changed if the proposed 30-day period for the NOM is adopted.

The State collected cost effectiveness data for several years, but stopped collecting it because they considered it impossible to interpret. They felt that they could not make assumptions about cost of treatment because some providers may be under-providing and some over-providing, or other reasons. Cost per case is not meaningful unless it is tied to an outcome measure.

Specific actions for developing NOMS capability include changing the time period for the arrests data and adding detailed not it work force (or education status) to the discharge record. The State thinks that Oct 1, 2005 is a bit ambitious to have the capability to provide the NOMS, but they plan to apply for the NOMS money sooner rather than later.

Missouri

The State of Missouri Department of Mental Health is preparing for a new information system that will replace its current fragmented IT infrastructure. The CIMOR (Customer Information Management Outcomes and Reporting) system will replace over 200 of the Department's current systems including systems capturing consumer demographics, consumer assessments, programmatic data, as well as billing and service transactions. Such integration will significantly improve the Division of Alcohol and Drug Abuse's ability to report on TEDS data

items and the SAPT Block Grant performance measures / NOMS. Integration of program episode data with service data will allow the Division to determine length of stay, for example. Such calculations have been problematic with the current systems. In addition, built-in business rules, a more user-friendly interface, and reporting / monitoring tools are expected to improve the quality of the data that will be reported. For instance, CIMOR will link the treatment site, program, and service package such that services will be restricted based on program selection and program selection will be limited based on site selection. This linkage does not exist in the current systems. It is expected that CIMOR will go into production in July 2006, giving the Division a full fiscal year's worth of data for reporting in the FY 08 Block Grant application. Missouri will be requiring the GPRA tool for all of its treatment clients as of July 1st. Thus, they anticipate being able to report on performance items that they originally thought would not be available until after CIMOR becomes operational.

Ohio

Ohio has been collecting TEDS data for 15 years and has over 200 providers who report data to county boards which, in turn, submit the data to the State. The State "pre-scrubs" the data for errors and sends the results back to the boards. The State also creates data files and various reports for each board.

The State is beginning to collect the number of arrest for the past 30 days.

For the future, the State is creating an internet/extranet application so providers, boards, and the State can all access the data. The system will provide uniform reporting so that the State, boards, and providers will have access to uniform data. Each entity will have a module set up that allows access to the specific information it requires. Each entity can only access the designated, specific information. In designing the system, the State wants to provide the treatment providers timely access to the data. They expect it to be difficult to get providers to accept a new system, and want to get small applications operational quickly to show providers the usefulness of the system. Most importantly, they want to ensure that the data will meet providers' objectives. They believe that acceptance of the system and data quality are enhanced by feeding data back to the providers and by demonstrating the data's utility to the providers. They believe that the providers will see the value of reporting good client data when they are exposed to tables from the data they have reported. Many providers do not have the means to analyze their own data. Ohio hopes to provide a system that allows them a meaningful way to use data to improve treatment and recovery.

This web-based system is expected to be operational by July 1, 2007.

Charlene Lewis commented on the issue of provider buy-in. In looking at things SAMHSA can reasonably provide under technical assistance, would giving the providers State level data to compare with their own, or some kind of package like that, be helpful if States made it available to their providers?

Indiana replied that it would be helpful, because in meetings with providers they always say they need the data, but when asked what they need, they never really know what they want.

Delaware said that they had the same issue.

Pennsylvania

The issue that is on the mind of the Pennsylvania delegation is the plan to add discharge data to our TEDS data submission under our DASIS contract. We think we can comply partially with 5 of SAMHSA's proposed National Outcome Measures (NOMS). To report on all 10 fully will take a minimum of 5 years. We hope to qualify to have our data purchased under the new State Outcomes Measurement and Management System (SOMMS) subcontract. Our data system is obsolete and the money we obtain will contribute, although be far from sufficient to pay for, the changes we are hoping to accomplish to shift to completely new hardware and software platforms. As we make that shift, we will be able to add more of the SOMMS data elements, although there are a couple that will take longer to implement because they involve issues beyond data collection technology.

There is another important concern we wish to express. Our current data system does not have the capability to export discharge information in TEDS format. In order to submit discharge data, it requires creating export facility, which will require additional time and money. If we are able to submit discharge data, we are concerned with the manner in which our discharge data will be presented and interpreted. We ask that CSAT and the Office of Applied Studies (OAS) consider handling TEDS discharge data received through SOMMS much differently from the way they handle TEDS admission data.

Admissions data are regularly fed back to the States and the public in a very fine series of publications, which describe patterns of substance use, populations served and types of services rendered. Because the concepts involved have been straightforward and well understood, these publications have been very useful and relatively non-controversial. SAMHSA also posts tabulations of admission data for each State on the Internet, in a standard format.

The situation is different for discharge data. Service systems and the units of service which are to be associated with outcomes are not standard even within a single State such as Pennsylvania, let alone across multiple States. TEDS does not provide for case mix adjustment. There is no agreement on a single paradigm for describing the disease and how it should be treated. The focus of SAMHSA's proposed National Outcome Measures seems to assume an acute disease, treatable in a single episode with a little aftercare. Often, however, we have something more like a chronic disease. The addiction of the public client, with whom the Pennsylvania treatment system deals, is usually complicated by a number of social, developmental, health, and legal factors, which affect services needed and outcomes to be expected.

In this situation, flexibility and dialogue is called for in the preparation of DASIS data products that present TEDS discharge data, or the data will be simply uninterruptible. The only way to interpret such data with some degree of accuracy and meaning, will be to devise publications which allude to specific State circumstances, the implications of a chronic disease model, and the confounding effects of the factors mentioned above. Some sort of process of dialogue with the States to develop additional information about the factors affecting raw outcomes will be needed.

Pennsylvania certainly cannot be responsible for answering questions from the public about unedited tables posted on the Internet.

Now we will discuss our ability to submit NOMS outcome data, based on the SAMHSA letter received in early May. As we understand them, the 10 National Outcome Measures (NOMS) are as follows:

- **Abstinence and Employment:** We believe we have the TEDS items in our data set, with the possible exception of the “retention in school” response option for the employment outcome. Formally, there will be no problem, but most of our treatment episodes don’t involve clients coming from an unrestricted environment. Many are already working on their addiction when they reach our system and will be abstinent when they begin treatment. With employment there are interesting issues about who should be counted as potentially employable for purposes of outcomes.
- **Decreased Criminal Justice Involvement:** Currently, TEDS has no discharge item for criminal justice, and our admission data is different from the TEDS admission item. We can provide a measure, but it will not match the items we expect to see in the new TEDS discharge data set. This can be fixed - when and if we get funding for the new data system we need.
- **Increased Stability in Housing** is not on our data set, and currently TEDS has no discharge item for living situation. Once we know what will be in the TEDS discharge data set this can be fixed - when and if we get funding for the new data system we need.
- **Increased Access to Services:** The national household survey yields a penetration rate. We do not believe we can use TEDS data to improve upon this. In Pennsylvania there is a substantial private sector of providers of treatment services, which do not report TEDS data to the State. We would like to get all providers into a client-level reporting system, but that will require more than a new data system to accomplish. Regulatory and legislative changes will be needed.
- We can report on **Increased Retention in Treatment and Length of Stay.** We do have a unique client number, which allows us to link records and unduplicate clients. We do anticipate some controversy over this issue as we move the data system to a new platform. Moreover, we have no experience using it to link episodes. Meaningful episodes over which to calculate length of stay require the ability to bridge discharge episodes coming relatively close to each other as a client receives different services and passes through different stages of a treatment plan. This will be extremely difficult for us to do until we get funding for the new data system we need.
- **Increased Social Supports and Social Connectedness:** has not yet been defined in terms of collectable data.
- **Cost effectiveness:** We anticipate that combining costs with client data will be another outcome, which will require more than a new data system to accomplish, although this

objective is very important to us and we are including it in our planning. Once data on the cost effectiveness by level of care or type of service is available, an issue which will arise relates to “cost bands” per person. Should we consider reducing our attempts to provide services to the most impaired people to keep our unit costs low?

- There is an eleventh outcome. We continue to work on another agenda from SAMHSA, relating to accounting for and improving services to persons with **co-occurring mental disorders**. While this is not in conflict with the 10 NOMS outcomes, this effort, too, requires resources and complicates our efforts to move our data system to a modern platform. PA is one of the COSIG States piloting performance measures for clients with co-occurring disorders.

As we move forward with data collection and reporting, we are respectfully requesting that SAMHSA and CSAT reevaluate the need for infrastructure dollars. These dollars must be sufficient to support States with treatment data systems. In order for SAMHSA to assure that dollars are wisely spent on systems that will provide national outcome measures, SAMHSA could develop criteria for data systems. In addition the dollars could be tied to the data the States are then able to report. By providing data infrastructure dollars SAMHSA would be assuring a winning solution for the States and SAMHSA. It is our expectation that technical assistance dollars being offered can be reallocated to States to contract with vendors to develop or enhance data systems. We are looking forward to working through these issues with you and your staff as we set out in pursuit of National Outcome Measures.

State and Sub-State Estimates from the National Survey on Drug Use and Health (NSDUH)

The target sample size for the NSDUH is 67,500 respondents annually. The sample is designed to provide State and some sub-State estimates. The overall response rate for the 2002–03 NSDUH was 71 percent. This ranges by age of respondent. Response rates for youths were the highest at 90 percent. The response rate for respondents 18–25 was 84 percent, and for respondents 26 and above it was 75 percent.

Subject to sample size limitations, direct estimates can be made at the national level for subgroups such as race, pregnant women, and for selected age groups. Estimates can also be made for States or metropolitan areas, but generally only for large States or metro areas, or by combining several years of data.

For a selected set of outcome measures, State estimates are made using a model-based method. The survey uses a technique called Hierarchical Bayes Estimates. These estimates are a weighted estimate made by combining direct estimates for the State with an estimate for a sub-State-based national regression model.

An evaluation of model-based versus direct estimates found that model-based estimates were more precise than direct estimates, but they are limited to certain pre-selected measures. Direct estimates may have a large sampling error but can be done for any variable and subgroup that has a sufficient sample size. Sufficient sample size usually requires combining more than one year of data.

OAS, working with CSAT and the States, has determined sub-State regions that are meaningful to the States. OAS will produce model-based estimates comparable to the ones produced for the States. They will be based on three years of data, from 1999, 2000, and 2001. Because of design changes in 2002, 2002 data cannot be combined with 2001 and earlier data. The sub-State areas require a minimum sample of 275. Preliminary sub-State areas were shown for the States attending the meeting.

Based on feedback from the States on the initial effort, OAS will revise the sub-State areas if needed and produce a second set of estimates based on 2002 to 2004 data.

State data variations

At the end of the first day of the meeting, a brief discussion was held on the potential problems of comparing data between States and the need for some explanation when State differences are due to particular, unique circumstances within a State. It was agreed that there is the potential for misunderstanding State data relative to US data or other State data, despite the warnings in TEDS publications that cross-State comparisons should not be made. There are cautions in the TEDS publications about State comparisons, as well as tables and footnotes that provide general information about State similarities and differences. It was agreed, however, that States should be given the opportunity to provide more definitive explanations for any data they deem to require such explanation, and that the explanations would become part of TEDS publications. OAS will explore possible mechanisms for enabling States to provide such explanations. One mechanism is the TEDS quarterly feedback tables, though there are some published data that are not included in those tables. OAS and Synectics will explore this issue further.

N-SSATS questionnaire review

There are a number of revisions that have been proposed for the 2007 N-SSATS questionnaire. OAS has suggestions and has received suggestions from others. In particular, CSAT has made suggestions for the addition of several questions. A pretest of the new questionnaire is planned for next year with a target of 200 completed surveys.

A summary of the questions and comments for each questionnaire item is provided in Attachment A.

National Provider Identifier

Deborah Trunzo, OAS, presented some information on the National Provider Identifier.

By regulation, all health care providers under HIPAA must apply for a national identifier that must be used with all HIPAA transactions. This identifier will include the facility's name, mailing address, telephone number, and will classify the "facility" as an individual provider, clinic, or facility. Another requirement is that the information be updated every 30 days. The goal is for each "facility" to have a lifelong ID number. This will have an impact on how SAMHSA and the States do business in DASIS. By May 23, 2007, covered providers must use their NPIs in standard transactions. Small health plans have until May 2008 to comply. OAS anticipates using the NPI as the facility identifier in the I-SATS, to the extent possible. Facilities

that are not covered entities under HIPAA may apply for a NPI, but are not required to. We will need to find a way to accommodate these facilities. Our timetable for adopting the NPI will depend to some extent on the extent to which States adopt the NPI in their systems. The details of transitioning to the NPI in DASIS have not been developed. More information about the NPI and the application process can be found at <https://nppes.cms.hhs.gov>.

Status of TEDS Reporting

Currently Synectics uses four reports to monitor the frequency and quality of TEDS reporting.

- A processing report is generated each time an admission or discharge submission is received from a State. This report shows the number of records processed and any errors found, and it explains the reasons for the decision to accept or reject the records.
- A processing summary report is sent to OAS monthly, which summarizes the previous month's submission processing activity and provides a cumulative summary for TEDS reporting for each state.
- On a quarterly basis, individual State reports are prepared, showing the distribution of each TEDS variable for each of the last three years. These reports are Synectics' primary method of checking the quality of the data submitted. Each quarter, a report is sent to each State.
- If the State quarterly data report shows a significant problem or potential problem, Synectics sends a problem report to the State requesting clarification and correction.

Synectics is now tracking the match rate between admissions and discharges. Staff expects the match rate for discharges submitted to Synectics to be at least 90 percent for each State. Currently, 94 percent of the discharges submitted have a matching admission record. From the reverse perspective, however, only about 66 percent of the admission records have a matching discharge. Another general yardstick Synectics uses to evaluate reporting quality is to compare the number of discharges and admissions for a given time period. It expects that within a given year the number of admission records and discharge records should be about the same. Synectics will contact States with large differences to investigate the problem.

Synectics continually monitors each state's data submissions. If a State falls behind their established schedule, Synectics' Mayra Walker calls the State representative to find out the reason for the delay.

SAMHSA's goal is to have all the data from a State for one calendar year by the end of the following year. Therefore, the goal this year is to have all the 2004 data in by December 31, 2005. Meeting this time schedule enables the TEDS annual report to be produced in a reasonably timely manner.

Selected Findings from TEDS Data

Leigh Henderson, Synectics, reported on the TEDS discharge data for 2002.

The objective of this study of linked discharge and admission records for clients discharged in 2002 was to examine treatment completion and length of stay (LOS) within service type. Twenty-three States reported a total of 792,513 2002 discharge; 97 percent were linked to an

admission record from 1999-2002. Service types were, for non-methadone clients: outpatient, intensive outpatient, short-term residential, long-term residential, hospital residential, and detox. For methadone clients, services types were methadone outpatient and methadone detox.

Shorter-term treatment services had higher completion rates, and there was little difference between treatment completion for different primary substances or by age.

For LOS, the median seems to be a better measure than the average. The average LOS is always longer than the median, indicating a long right tail in the distribution. The median is less influenced than the average by extreme LOS due to clients having administrative closures often 60 or 90 days after last contact.

For each type of service, treatment completion rates and LOS were examined for association with TEDS socio-demographics, substance use, prior treatment, and treatment referral source variables. LOS was generally not associated with any of the variables, but treatment completion was associated with some of the variables in different service types.

Median LOS among non-methadone treatment completers ranged from 91 days for outpatient to 4 days for detox. Among treatment completers in other non-methadone service types, the median LOS for long-term residential was 71 days, intensive outpatient 52 days, short-term residential 24 days, and hospital residential, 20 days. Among methadone treatment completers, the median LOS for outpatient was 113 days and for detox, 35 days.

The presentation used non-methadone outpatient treatment to demonstrate the methods used. Among clients in outpatient treatment, the combined rate of treatment completion or transfer to further treatment was higher for men (43 percent vs. 37 percent), for Whites (46 percent, vs. 38 percent for Hispanics and 32 percent for Blacks). Completion/transfer rates by substance varied from a high of 50 percent for alcohol to 25 percent for opiates.

One of the more significant findings was the relationship between frequency of substance use at admission and completion/transfer rates. The rates dropped as frequency of use increased: while almost one half of clients reporting no use at admission completed treatment or transferred to further treatment, only 26 percent of those reporting daily use did so.

Examining completion/transfer rates by source of referral, the rates were highest for clients referred by employers or the criminal justice system (53 percent and 47 percent, respectively). The completion/transfer rates were relatively low for self/individual referrals and those referred by other substance abuse care providers (36 percent each), and lower still by those referred by other health care providers (28 percent). The highest completion/transfer rates by employment status were among those employed either full- or part-time (59 percent and 46 percent, respectively). The highest completion/transfer rate by education was among those with more than 12 years of education (47 percent).

In univariate logistic regression, all of the 10 factors examined were associated with completion of non-methadone outpatient treatment. In multiple conditional logistic regression, however, age was no longer a predictor of treatment, and all of the other variables (with the exception of age at

1st use of the primary substance) lost strength. In order of strength, the variables predicting completion of outpatient treatment were: less than daily use of the primary substance at treatment entry, referral through the criminal justice system, alcohol as a primary substance, being employed either full time or part time, being White, 1st of the primary substance at age 17 or older, not having been in treatment before, having 12 or more years of education, and being male.

The multiple logistic regression model was repeated for all the service types. While a different set of variables was associated with each service type, employment status and use of alcohol rather than drugs were consistent across all non-methadone service types.

Closing Remarks

Charlene thanked all the participants for their input during the meeting and expressed her appreciation for the work State participants did in developing and making their presentations. Once again the interaction was most useful to OAS and DASIS staff.

Attachment A
Summary of comments on new questions for 2007 N-SSATS questionnaire

Question	Comments
Hospital Inpatient and Residential Services, ASAM levels of care	ASAM Levels of Care - MD and DE facilities should understand the levels. In MI, some facilities will and some won't.
	Perhaps levels III.3 and III.1 can be combined. They are both similarly defined (health professionals available 24/7 by phone or on site) but their intensity of treatment is different. Both crosswalk to Residential Long-Term care.
	State of MD does not record ASAM levels of care for detox.
	Where will halfway houses put their service? They should probably be part of level III.1, but will they know it? MPR can ask ASAM if this is always true, if SAMHSA would like.
Outpatient Services, ASAM levels of care	No comments from meeting
	State of MD does not record ASAM levels of care for detox, which could cause inconsistencies between services offered and client count questions.
Does this facility detoxify clients from...(alcohol, opiates, etc.)	This is only a short list. What is the intent of this question? SAMHSA will ask CSAT.
	IN - One Director seems to have read this as "medical" detox and suggests we include "social" detox. He also mentions that there is no "medical" detox for cocaine.
Does this facility routinely use medications during detoxification?	Can this question be answered by looking at HI, RES and OP detox questions plus meth/buprenorphine questions?
	Also, there seemed to be some confusion regarding what medications are referred to, i.e. aspirin.

	PA - In a written comment, PA indicated they would like to know what other types of programs (other than detox) are using medication-assisted treatment approaches.
	This question may be deleted.
Which of the following services are provided by this facility...(long list of ATR services added)?	No comments on this question.
Treatment approaches (12-step program, etc.)	Attendees didn't know what "a combination of approaches" means...so many possibilities.
	IN - One director said this was good because a facility should have a clear evidence-based approach that drives the treatment, "A combination of approaches" was not a category on the version this director reviewed...although "Eclectic" was on his version.
	One attendee mentioned an approach: Rational Emotive
	SAMHSA will talk with CSAT to learn more about the intent of this question.
Over the course of their treatment at this facility, approximately what percent of substance abuse treatment clients receive...both individual AND group counseling; individual counseling only; group counseling only?	Most facilities will say "both." Why is this question needed?
	PA said this is an important question but probably 80% of facilities will say "both."
	IN - One director said this would take some time to calculate.
Listed below are a variety of clinical practices that are used at substance abuse treatment facilities. For each practice, please mark the box that best describes how often that practice is used at this facility. (Supportive-expressive psychotherapy counseling, etc.)	I did not write down any notes at the meeting for this question. From what I remember, these were the issues: The frequencies are very vague and open to interpretation. Categories 1 through 8 are not mutually exclusive. For example, family/couples counseling may be conducted using a behavioral management approach.

	IN - One director said this question was open for a great deal of subjectivity. He suggested a rewording: In addition to your identified primary evidence-based treatment approach, which of the following clinical practices are also utilized at your facility?
	General question...What is the difference between "treatment approaches" and "clinical practices?" Will respondents know the difference? Are these just words we are using that may not have a definite meaning in the industry?
Are any of the following practices a part of this facility's regular procedures? (Required continuing education for staff, etc.)	Are these practices correlated with State funding? If so, we should not ask.
Types of payment accepted...ATR vouchers	I did not record any disagreement with this question at the meeting.
Approximately what percent of the substance abuse treatment clients enrolled at this facility on March 30, 2007, had a diagnosed co-occurring substance abuse and mental health disorder?	Underline "approximately" because it will be difficult to get an actual percentage.
	Many facilities do not "diagnose" mental health, so they won't know.
	Clients may be "screened" for MH but, without a psychiatrist on staff, they would not be "diagnosed."
	Do we want those screened for a co-occurring disorder or do we want to limit the question to those actually "diagnosed?"
	Do we want those screened for a co-occurring disorder or do we want to limit the question to those actually "diagnosed?"
	One suggestion was to ask if clients are receiving medications for a MH disorder?
	PA - In a written comment, PA indicated they would like to see a standard criteria for defining "co-occurring."

	IN - One director commented that this would be a very tedious, manual effort to count.
How many of the 12-month treatment admissions included in the question above were funded by ATR vouchers?	This could be difficult to calculate. Charlene will check with ONDCP to find out what exactly they would like to get from this question.
	IN - One director commented that it would be difficult to identify who is paying by these vouchers. A system would have to be put in place to answer this question.
National Provider Identifier	All of the discussion on this topic occurred during SAMHSA's presentation.

DASIS REGIONAL MEETING

Delaware, Indiana, Maryland, Michigan, Missouri, Ohio, Pennsylvania

June 28-29, 2005

Cincinnati, OH

Tuesday

- 8:00 a.m. Continental Breakfast
- 8:30 a.m. Welcome and Introductions*Charlene Lewis, SAMHSA*
- 8:45 a.m. SAMHSA Data Strategy and NOMS *Stephenie Colston, SAMHSA*
- 9:30 a.m. States Outcome Measurement &
Management System (SOMMS)..... *Javaid Kaiser, SAMHSA*
- 10:00 a.m. BREAK
- 10:15 a.m. DASIS Subcontracts for Implementing NOMS..... *Deborah Trunzo, SAMHSA*
- 10:45 a.m. State Presentations on Readiness to Report NOMs.....*DE, IN, MD*
- 12:00 p.m. LUNCH
- 1:00 p.m. State Presentations – continued*MI, MO, OH, PA*
- 2:45 p.m. BREAK
- 3:00 p.m. Sub-state Estimates from the NSDUH*Doug Wright, SAMHSA*
- 4:00 p.m. Adjourn

Wednesday

- 8:00 a.m. Continental Breakfast
- 8:30 a.m. National Survey of Substance Abuse Treatment Services
(N-SSATS).....*Geri Mooney and Barbara Rogers, MPR*
\$ 2005 survey status
\$ Plans for redesign of 2007 survey
\$ Discussion of proposed new questions for 2007
- 9:45 a.m. Inventory of Substance Abuse Treatment Services (I-SATS)
\$ Approved vs. non-approved facilities -
process for review*Jim Delozier, Synectics*
\$ National Provider Identifier.....*Deborah Trunzo, SAMHSA*
- 10:15 a.m. BREAK
- 10:30 a.m. Treatment Episode Data Set (TEDS)*Leigh Henderson, Synectics*
\$ The status of Discharge Data Set and
monitoring discharge submissions.....*Jim Delozier, Synectics*
\$ Recent findings from TEDS
- 11:45 a.m. Wrap-up
- 12:00 pm. Adjourn

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Cincinnati, Ohio

June 28 & 29, 2005

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