

# **DASIS STATE DATA ADVISORY GROUP MEETING**

**October 27–29, 2003  
Memphis, Tennessee**

## **States in Attendance:**

**Alabama  
Arkansas  
District of Columbia  
Kentucky  
Mississippi  
Tennessee  
Virginia  
West Virginia**

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**SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING**  
**October 27–29, 2003**  
**Memphis, Tennessee**

This was the 15<sup>th</sup> Regional Meeting to be held with State DASIS representatives. It included representatives from Alabama, Arkansas, District of Columbia, Kentucky, Mississippi, Tennessee, Virginia, and West Virginia, along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions, Inc. (Synectics).\*

The DASIS regional meetings are held to provide an opportunity for face-to-face discussions between State DASIS representatives and staff of OAS, and the DASIS contractors, Synectics and MPR. The meeting agenda is flexible to maximize the opportunity for discussing 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.

**Opening and Overview**

Dr. Goldstone of the Office of Applied Studies (OAS) gave the opening remarks. He emphasized the importance of these meetings and the importance of the collected data. He also noted that the OAS and contract staff are here to get advice, criticism and suggestions, and that this was not to be seen as a presentation, but an opportunity to give and take. He noted that the comments and suggestions from the meetings have been invaluable. He and his staff look to these meetings for advice and direction, and hope the participants will participate actively in the discussions. Dr. Goldstone emphasized that the schedule of events is flexible and may change depending on the direction the group takes during discussions. He noted that discussion will primarily focus on DASIS, but that data on the Household Survey and DAWN will be presented, as well as information on HIPPA and the SAMHDA on-line data archive.

**National Survey of Substance Abuse Treatment Services (N-SSATS) Overview**

Geri Mooney and Barbara Rogers of Mathematica (MPR) reported on the 2003 N-SSATS. There were 13,950 facilities in the survey, of which 80 percent were State approved. The 2003 N-SSATS response rate for State-approved facilities was 97 percent. There was a 98 percent response rate for the States attending the meeting. Of all the facilities surveyed, 12.5 percent were closed or ineligible, which meant that in 2002 these facilities provided services and in 2003 they no longer provided service for various reasons. The survey can either be completed by mail questionnaire or on a web site. If the facility does not complete the survey in a reasonable time, they are telephoned and the survey is completed using a computer assisted telephone interview system.

The questionnaire includes a question about whether facilities have access to the Internet, and 86 percent of the respondents answered that they do. It was noted that that over 90 percent of the facilities in Alabama, Arizona, Tennessee and Virginia reported having

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Internet access. However, less than 1/3 of all facilities surveyed nationally choose to use the Internet to complete the survey. The initial cost to set-up a web survey is quite expensive and, therefore, the more facilities that choose to use the Internet to complete the survey, the better and less expensive it will become. A significant advantage of using the Internet is that the on-line program ensures that the questionnaire is completed without errors. MPR believes that additional responding facilities will begin to use the web questionnaire once they become more familiar with it.

During a typical N-SSATS cycle, 10 to 12 percent of the facilities are found to have been closed for various reasons. To ensure that all facilities that may provide treatment services are surveyed, several methods are employed to identify new facilities. For example, survey respondents provide names of related facilities that have not been surveyed. Also, each State provides names on a regular basis of newly licensed facilities in their State. In addition, the treatment facility list is augmented annually using the files of the American Business Index and the American Hospital Association. Once potentially new treatment facilities are identified, their names and addresses are sent to MPR to be screened. Of all the facilities surveyed in the N-SSATS, sixty-seven percent have been retained over the past 5 years. As noted by Dr. Goldstone, approximately one-third of the facilities in the N-SSATS have changed, representing an incredible turnover.

A brief discussion ensued concerning inclusion of solo private practitioners in the survey. As a rule, private practitioners are excluded from the N-SSATS and, unless the State specifically requests that private practitioners be included in the survey, they will not be included.

In a related matter, Dr. Goldstone noted that the names of all facilities added to the I-SATS are sent to the State for review prior to their inclusion in the Directory or the Locator. Unless the State designates a facility as "State approved", the facility will be left out of the Directory and Locator. Since the Facility Locator is used by the public and receives 6500 or more hits a week, it is important to keep it current. Many of the facilities see the Locator as a marketing source and a way to attract clients and, therefore, want to be included.

The Virginia representative questioned which programs would be listed in the I-SATS (and on the Facility Locator) if a facility has six programs currently on-going at six locations. Dr. Goldstone explained that it is OAS's intention to list the physical location of each treatment program/facility. The major reason for this is that it enables mapping in the Treatment Locator of an accurate address and physical location of every place providing treatment. However, there are facilities that want the public to contact only a central intake location. These facilities are resistant to having different addresses and phone numbers for their various individual locations. To accommodate these situations, the central intake telephone number is listed as the contact number for all locations. Dr. Goldstone continued by explaining that listing only a centralized intake location in the Locator doesn't help OAS provide the public with treatment options. As an example, an individual located in a rural area looking for a treatment facility might not find a local

facility if only the centralized location, possibly forty miles away, is the only facility listed.

### **Outpatient Capacity Responses**

Ms. Rogers initiated a discussion concerning the collection of outpatient capacity data in the 2003 N-SSATS. She explained that there are different definitions for outpatient capacity. In 2003, the N-SSATS questionnaire asked the facility about active clients on March 31 and, considering resources, whether the facility would have the capacity to accommodate a larger outpatient enrollment. If so, the facility was asked to estimate how many additional clients it could accommodate. Two-thirds of the facilities said they could accommodate additional clients.

The Virginia representative expressed surprise at this figure. Their treatment facility waiting list numbers are large because they don't have the capacity to comprehensively treat all individuals requiring treatment. Many of their clients are receiving minimum services, though they need more. He stated that he did not believe that the N-SSATS capacity data for Virginia were accurate. He doubted that the facility capacity estimates were taken from the facility's MIS system. Dr. Goldstone commented that capacity data, particularly outpatient capacity, are problematic for a number of reasons. In many instances the data are guesstimates provided by facility staff who do not check with the business office to get accurate data. Dr. Goldstone noted that bad data are worse than no data, and bad policy can be made by using invalid numbers.

The District of Columbia representative stated that they have a "living" waiting list with continuous additions and deletions. They maintain two types of lists, 1) a methadone list, and 2) a substance abuse inpatient treatment list. However, they do not have an outpatient list. The Tennessee representative mentioned that additional capacity exists in their State, but that it is among providers that the State is unable to contract with.

Ms. Mooney made a point that there is no problem in collecting numbers in a survey, but surveyors must always be concerned with the accuracy of those numbers. For client counts, respondents in the N-SSATS are asked if the numbers they provide were estimated or actual counts. It was found that the proportion of estimated and actual numbers reported varied depending on the mode of response and type of facility. When facilities responded using the mail mode, 70 percent of the responses were actual numbers, whereas in the phone mode there were many more estimates. The numbers received using the web-based questionnaire seem to be about as accurate as when using the mail.

### **2003 N-SSATS Current Status, Major Milestones and New Questionnaire Items**

The milestones for the 2004 N-SSATS are almost identical with those for the 2003 N-SSATS. The States are kept apprized of all actions concerning the N-SSATS. The States' involvement in the survey includes providing a letter of support that is sent to the facilities surveyed, and possibly providing assistance to gain the participation of reluctant facilities. The State N-SSATS representative may also be asked to review non-State approved respondents to determine if they should be State approved.

Dr. Goldstone and Dr. Mooney noted the shift in the beginning of the N-SSATS field period from the fall to the spring. The reason for the shift was to enable the completion of the data collection in the same calendar year. The shift was also preferred by many facilities because they receive many requests for information in the fall from other agencies. The N-SSATS data report is published in the year following data collection.

Continuing with a review of the 2004 questionnaire, the Virginia representative suggested that the question on capacity (question 27d) be changed to a yes/no format. He suggested that there might be a definition issue. How the facility responds will depend on how one defines capacity. He suggested that a better approach might be to ask about how many additional clients could be treated if the facility had adequate resources. Dr. Goldstone stated that he does not think that there is a set of questions that will give a meaningful capacity number. The ability of respondents to understand, interpret and respond to a capacity question, particularly for outpatient capacity, presents major problems. However, OAS will seriously consider any suggestions the States have to fix these problems and to construct a meaningful capacity question.

### **Demonstration of Treatment Facility Locator**

The discussion began with Ms. Trunzo stating that the Locator is SAMHSA's most public face to the world. The value of the Locator is directly related to what is on it. Recently, additional features were added to the Locator. There is now a combined "quick and detailed" search on the Locator. Previously, users of the Locator were over-looking the ability to conduct a detailed search using a variety of facility characteristics as selection filters. Ms. Trunzo demonstrated how selecting the detailed search option directly from within the simple search option enables the user to target the search by limiting it to selected search parameters. She also discussed the Locator's new link for the Buprenorphine Physician Locator (BPL) and noted that the BPL web site works the same way as the Treatment Facility Locator. This is a very useful addition to the Locator since many people are looking for alternatives to methadone, and buprenorphine may be the answer for some.

A discussion on buprenorphine ensued with Dr. Goldstone stating that it is his understanding that between 30 and 35 clients is the maximum number of patients a physician certified to dispense buprenorphine can treat, and there are many physicians who receive multiple calls to which they cannot respond. It is hoped that CSAT will modify its regulations to allow additional clients to be served by buprenorphine certified physicians.

Ms. Trunzo stated that she believed that the regulations have been modified so that some facilities can now provide buprenorphine, specifically Opioid Treatment Programs. She added that OAS was planning to add a question to the 2004 N-SSATS to determine how many clients receive buprenorphine treatment from facilities.

Dr. Goldstone asked whether facilities needed to be certified in order to dispense buprenorphine. The Virginia representative replied that facilities have to have a waiver, but that many are reluctant to provide services.

Continuing with her Treatment Locator demonstration, Ms. Trunzo mentioned that OAS receives a significant number of inquiries by e-mail from people looking for treatment, which are often referred to the State's substance abuse office. It is important for the State representatives to periodically look at the State contact information that is provided on the Treatment Locator web site to ensure that OAS has the most current and correct information.

### **Demonstration of the DASIS Project Home Page and I-SATS Quick Retrieval**

Mr. DeLozier demonstrated the DASIS Project Home Page and the I-SATS Quick Retrieval system. The DASIS website was designed a few years ago to assist the State's in their DASIS participation. There was a concerted attempt to put everything on the web site that the States could need for the various DASIS components. Anyone from the States can gain access to the DASIS site as long as the State approves them for access and they receive a password. Participants were invited to make suggestions for additions and improvements to the site.

### **I-SATS Quick Retrieval System**

Mr. DeLozier continued with a demonstration of the I-SATS Quick Retrieval System (IQRS), a relatively new feature of the I-SATS On-line. He pointed out that the I-SATS includes all substance abuse services facilities and halfway houses known to SAMHSA, including State-approved and non-approved facilities. In addition, the I-SATS includes facilities that were previously active but are currently inactive or closed and some non-treatment facilities. By contrast, the N-SSATS universe is a subset of the I-SATS facilities, consisting of active treatment facilities and halfway houses. The facilities included on the Locator are a subset of the N-SSATS, consisting of those facilities that complete the N-SSATS and are State-approved.

Like the Locator's "List search," the IQRS allows selection of facilities by geographic area with "filtering" by certain facility service characteristics. The search results may be printed or downloaded to an Excel or ASCII text file. This is a password-protected system, and States may only search for facilities within their State. I-SATS users in each State already have a password, but those in need of one should contact Alicia McCoy at Synectics. Instructions for using the IQRS are provided on the I-SATS on-line web site and in the I-SATS User's Manual. (All DASIS manuals can be downloaded from the DASIS web site at <http://wwwdasis.samhsa.gov>).

The IQRS is useful to the State representative responsible for updating the I-SATS. It provides a current list of facilities on the I-SATS, with detailed information for each facility. Since the I-SATS is updated using a variety of sources, it enables States to see changes and additions from non-State sources, preventing duplication and redundancy. One specific use is to facilitate finding the ID's for particular facilities so the facilities can be accessed in the I-SATS On-line. A method for doing this was demonstrated using two browser pages opened side-by-side. In one page the IQRS is opened and relevant facilities searched and displayed on the screen. In the other page, the I-SATS On-line is opened to the facility change selection page. The facility ID can be found using the IQRS. It can then be copied and pasted into the ID field for the I-SATS On-line and the

facility updated. Specific instructions for this procedure have been sent to all the States in an email.

Ms. Trunzo added that it is extremely important to keep the I-SATS system updated and that the major reason for developing the I-SATS On-line system was to make it easier for the States to keep their I-SATS data current. In particular, it is important for the States to categorize all of their treatment facilities as either State approved or not approved, since the State is the only source of that information.

Dr. Henderson began a discussion concerning TEDS reporting. She is often asked to estimate what percent of all substance abuse treatment admissions are included in TEDS reporting. She explained that, originally, all of the information in the I-SATS and in TEDS was from the States, and the facilities reporting to TEDS corresponded pretty well with the facilities in the N-SSATS. However, since the advent of the Locator, facilities are added to the N-SSATS from sources other than the States. The N-SSATS questionnaire goes to every facility that is thought to deliver treatment services, whether or not they report data to TEDS. Of particular concern are treatment services providers that have multiple locations serving clients. For such providers, the N-SSATS questionnaire is sent to each location. However, it is not always clear which locations report data to TEDS, so there is no reliable way of linking I-SATS and TEDS reporting facilities. She went on to ask if States could review their N-SSATS facilities and determine which are included in their TEDS data.

The Virginia representatives said that Dr. Henderson's request would be easy to fulfill and that they have a list that has all the addresses for the satellites.

## **State Presentations**

### ***Alabama***

Alabama's presentation was based on their Client Admission Profile for the fiscal year October 2001 to October 2002. This is the 11<sup>th</sup> annual publication of the profile. The report covers 40 providers that receive State dollars in the State of Alabama covering approximately 20,000 admissions. The report provides feedback to the providers and shows them that their TEDS data are used and reported.

The report is 256 pages and is available on the Alabama website. The electronic data collection system started in 1991. The system is a DOS based clipper data collection and billing system. The system has built in edits. A data entry system with drop down boxes and automated fill-in's is provided for the smaller operations. Larger operations upload data to the State office or provide the data on diskette.

Since the system is used for billing, the reporting is virtually 100% complete. By having the report available on the Web with tables specific to the 40 providers, there is a great incentive for the providers to report accurate data.

All the tables provide the information by individually named provider. Variables include age at admission, gender, race, marital status, county of residence, employment status, source of income, and highest education, primary substance and length of use prior to first treatment.

### *Arkansas*

On July 1, 2003, the State's Alcohol and Drug Abuse Prevention (ADAP) program was transferred from the Department of Health to the Department of Human Services. The Division of Behavioral Health Services was created which includes ADAP and Mental Health. ADAP is in the transition period of a new division and new offices. In 1993, ADAP-funded treatment providers were scheduled for software installation to a dial-up modem with a 1-800 number for submission of Admission and Discharge Reports to the WANG/Alcohol & Drug Management Information System (ADMIS). The State currently continues to receive ADAP paper billing forms from the providers that are entered into the WANG/ADMIS system. A discrepancy report is run which lists any instances where services do not agree with the AR's and/or DR's. This comparison verifies the services. Presently, Arkansas has 47 licensed treatment centers and 32 are on-line. The system is maintained on a mainframe.

The State is working with DHS-IT to develop a web-based system, which will have several advantages for treatment centers/providers. They will have electronic billing, easy access to client follow-up information across different service systems (such as AOD treatment, DWI offenders, judicial systems), and can easily retrieve data for reports.

ADAP is in the process of developing a Data Management Section, which will be responsible for treatment outcomes and evaluation, compiling data reports, managing the federal reporting requirement activities, and projecting trends in AOD treatment and prevention services.

### *District of Columbia*

The District of Columbia presentation described a new initiative to improve their Substance Abuse Treatment System through an information-based decision making model. The system is designed to collect information that will answer the following questions:

- Are we getting what we are paying for?
- Are patients receiving appropriate care?
- Is there any reduction in substance use among patients?
- Have any social indicators, such as employment rates or income levels, improved?

The future of substance abuse programs depends upon the provision of quality care for public patients, which translates into cost-effective, performance-driven management. As budgets tighten, Federal and local governments are demanding that resources be devoted to the most effective substance programs.

The District of Columbia also intends to put more emphasis on monitoring treatment outcomes as opposed to monitoring the Substance Abuse Agency. This will enable the decision-makers to focus on client outcomes rather than just administrative process data.

This system will make it possible for the Department of Health to:

- meet Federal Mandates
- develop a Strategic Application for Long Term Planning
- document and Justify Funding Requests
- identify Changes in Services
- more Effectively Measure Outcome
- develop Partnership and Coordinate Resources

The Addiction Prevention and Recovery Administration (APRA) Data Management System provides a foundation on which to build a performance management approach to improving treatment results. Beginning in 1998, providers had dial up access to the Data Management System. In 2001, APRA installed IBM's WEBSPHERE-host on demand software and established a Web-based interface for treatment providers to connect to the Data Management System.

In 2003, APRA will become part of a centralized Information Management System under the Department of Health. This system will be developed over the next three years. Funding has been appropriated to improve the information technology infrastructure. Once developed, the data from the system will be used to manage Performance Partnership Grants, Block Grant Funds, the Drug Treatment Choice Program, Certification of State Treatment Providers, and other SSA functions.

### ***Kentucky***

Kentucky has several data collection efforts underway, all of which intersect to meet the needs for a more complete picture of substance abuse problems and treatment in the State. Most of these data collection elements have been in place for over 10 years. Current activity reflects continuing improvement and refinement of data collection. Data efforts include: Client, provider, and event data set information (used to complete TEDS), Substance abuse treatment outcomes study, provider surveys, State data infrastructure development, and regional needs assessments.

The DASIS activity has involved closer integration and analysis of data from these sources. A Research Assistant has been hired at the University of Kentucky to begin development of more sophisticated analyses of outcome data factoring in service data on each client. The data will be matched to the needs assessment by region in order to provide the State with better information about service needs and the degree to which funds and service delivery match those needs. DASIS has also supported the surveys of provider systems to better understand the prevalence of dual diagnosis assessment and treatment services.

State data infrastructure development includes the development of PDA programs for the Kentucky Substance Abuse Treatment Outcomes Study (KTOS) and other clinical data collection activities. An adolescent outcome measure is currently being developed to better capture treatment activity in that unique population.

KTOS includes baseline data on 8,000 clients and follow-up data on 850 clients each year. Recently a computer version of KTOS for use on a handheld PDA was developed and beta-tested. This will lead to error free data due to the PDA program structure. Also, telephonic downloads of changes in the data collection instrument can be handled uniformly and rapidly throughout the system using this technology. Kentucky anticipates improvements in treatment outcome data collection as a result of this change.

Other PDA applications being considered are DUI and Case Management.

### *Mississippi*

The Mississippi Department of Mental Health (MDMH), Division of Alcohol and Drug Abuse (DADA) has several treatment programs funded and/or certified through their division. The programs are as follows:

- Community Mental Health Centers (CMHC): The 15 community mental health centers are the foundation of the alcohol and drug abuse delivery system because they provide a variety of services. The services include outpatient, residential alcohol and drug abuse treatment, and prevention services at the local level. Mississippi is composed of 82 counties and the mental health centers are placed strategically throughout the State.
- Psychiatric Hospitals: The 2 psychiatric hospitals provide alcohol and drug treatment for individuals that are chronically ill and need more intense care.
- Freestanding Programs: These 9 programs are smaller than the mental health centers and some offer services to special populations such as pregnant and parenting women, and youth and adolescents. The freestanding programs may receive funding from other State agencies, community service agencies and/or donations.
- Correctional Institution: The correctional institution is referred to as the Mississippi Department of Corrections. Large amounts of data are collected from the three locations operated by this agency.

### System of Electronic Data Reporting

The data collection instrument used in Mississippi to collect substance abuse data is called the Mississippi Substance Abuse Management Information System (MSAMIS). The MSAMIS is used in all of the alcohol and drug federal and/or State-funded treatment programs. The instrument captures and incorporates all of the TEDS admission/discharge minimum and optional data items. The Division of Alcohol and Drug Abuse collects client data from each State-funded provider on a monthly basis. Failure to report may result in cash reimbursements being withheld until quality data are received. Once quality data has been received, the data are recorded by (1) date received; (2) grant number according to type of service; and (3) date cash request was released.

The data are sent in three different formats: (1) electronic format, (2) diskette, and (3) paper. For example, six of the 15 Community Mental Health Centers use a common data system named Boston Technology Incorporated (BTI) to collect, manage, and submit data electronically to the DADA on a monthly basis. The remaining 9 mental health centers submit data on paper forms. The 9 free standing providers, 2 psychiatric hospitals, and the 1 correctional institution used a common PC-BASED data system to submit monthly data via diskettes to the DADA.

The system is designed to be flexible in order to take into account the wide variety of clients being served by an equally wide variety of programs. The MSAMIS provides Mississippi with current information that:

1. Describes the clients
2. Describes the treatment provided to the clients
3. Assists in planning
4. Helps to improve
5. Aids in evaluating substance abuse programs
6. Increases awareness
7. Is used by the governor, mayor, legislators, professors and all other interested parties to tell about substance use/abuse in Mississippi

#### Current Objectives

The DADA is in the process of updating its current data system (MSAMIS) to achieve the following:

1. Enhance the overall submission, data conversion and reporting of Treatment Episode Data Set (TEDS) to increase data integrity on the submission to SAMHSA and adequately meet all of the Health Insurance Portability and Accountability Act (HIPAA) requirements.
2. Refine the current MSAMIS to meet the new Federal Data and Performance Partnership Grant (PPG) requirements for the State of Mississippi and provide the necessary features to further the use of (DASIS) guidelines.
3. Allow our State funded regional community mental health centers, State psychiatric hospitals and free standing private providers to move from a paper format to an electronic format that will only allow electronic data that passes an intensive integrity and edit check to successfully upload to our MSAMIS system.

The DADA has received approval to purchase computers for the State psychiatric hospitals and freestanding private providers to enable them to submit data electronically and conduct archive and random data reporting. The new computers will also allow the State psychiatric hospitals and free standing private providers the capability to retrieve archived data and run reports for their individual programs that will help each provider in their planning.

### Future Objectives

The DADA has plans eventually to have 100% electronic client data submission from all State-funded substance abuse treatment providers and web-based management information system for administration and providers to generate annual and ad-hoc reports using client data.

### *Tennessee*

The Bureau of Alcohol and Drug Abuse Services, located within the Department of Health, is responsible for the SAPT Block grant and related State maintenance of effort funding. Services are provided through contracts with approximately 70 non-profit or governmental entities that cover 95 counties. The contract agencies vary in their levels of sophistication, from small volunteer organizations to large multi-State, highly complex systems.

The current data system collects registration, admission, service encounter, and discharge data. For FY03, this included 24,786 new admissions within the fiscal year and a total of 866,306 records. A front-end, MS Access based, data entry system was developed and provided to the contract agencies to collect data. Basic requirements were established for computer systems, and agencies that did not have computers that met the requirements were provided funding to purchase them. Training sessions were held to walk through both the individual fields of data to be collected and the system itself. Data are submitted monthly, currently by disk, and processed at the State level. An impact of HIPAA has resulted in the Bureau becoming a clearinghouse for the contract agencies and providing translation of the data submitted into the required 837 format.

Contract services are reimbursed under both cost reimbursement and unit rate reimbursement. A financial system was developed for unit rate reimbursed services. It creates an electronic payment file that is then processed through the Department of Finance and Administration, effectively reducing keying errors and the length of payment processing.

In addition, management reports are available at both the contract agency level and the State level. As contract agencies identify needed reports, they are developed at the State level and distributed to all contract agencies for their individual use. At the State level, monthly, quarterly, and annual reports assist management in various ways including resource allocation, monitoring of service utilization and delivery patterns, contract compliance, and contract closeout.

The Bureau contracts with the University of Memphis for two outcome evaluation projects known as the:

- Tennessee Outcomes for Alcohol and Drug Abuse Services (TOADS) which focuses on treatment services delivered within the State, and
- Tennessee Alcohol and Drug Prevention Outcome Longitudinal Evaluation (TADPOLE), which focuses on prevention services, delivered within the State.

The treatment data collected is forwarded to the University of Memphis to be utilized in the TOADS project. Client's who volunteer are interviewed by TOADS staff via telephone 6 months after they were admitted for substance abuse treatment. Both, individual contract agency reports and a statewide report are prepared annually. Further information on the TOADS project may be located at [www.toads.memphis.edu](http://www.toads.memphis.edu).

### ***Virginia***

Virginia plans to use TEDS data to monitor the 40 Community Service Boards (CSB). Each of the Boards is independent and the data are collected through eight different systems on a quarterly basis. Virginia has tried several different systems to measure performance since 1992. In October 2002, all the CSB's were reporting data, although some of the data was of poor quality. Beginning in January 2003, the State office began providing feedback reports. Outcome reports were generated including reports on percent of clients reporting a reduction in the frequency of alcohol use, reduction in the frequency of use of other drugs, reduction in frequency of use of primary drug, reduction in frequency of use of secondary drug, and improvement in employment status.

In order for this system to have integrity, Virginia is devoting a full-time employee to managing the data and to supporting the collection and reporting of the data.

Virginia is confident that this data system will succeed where others have failed because:

- The system has a limited number of data items
- Data are collected at two points in time; admission and discharge
- Community Service Boards are getting feedback
- State personnel are visiting CSBs
- Collection of the TEDS data is a federal requirement

### ***West Virginia***

The "New Directions" data system was West Virginia's first effort to handle data collection under their managed care delivery system. The concept was promising, but the data collection document was cumbersome, 20-25 pages, so they had great difficulty getting provider compliance. It was a tiered system based on diagnosis that included demographic and clinical data, and required the providers to complete a series of forms. There was no incentive for providers. Because of the difficulties and resulting poor data quality, the State revised their system.

The method for authorizing care was revised, and the authority to deny payment to providers was granted. The West Virginia Care Connection system was developed, which required providers to report data for all clients, not just those receiving public funds. The data forms included demographic and clinical data, including all of the TEDS data items. Providers submit the data electronically to a State contractor. The contractor receives data files from providers, cleans and edits the data, and provides the state with a clean data file. The system has been operational for about six months. With payment tied to data reporting, providers are cooperative and data quality has improved. The state anticipates having the data to produce reports on clients in treatment and data tabulations

for the block grant reports. They also plan to produce provider level reports to feed back to the providers.

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

Dr. Henderson gave a slide presentation on the Treatment Episode Data Set (TEDS), discussing year 2000 discharge data. For the 18 States submitting year 2000 discharge data, 325,000 records could be linked to admission records. Data were presented displaying reasons for discharge by type of service, by primary substance, by referral source, and by prior treatment; treatment completion by age and primary substance; median length of stay by type of service and primary substance; and the distribution of type of service among treatment completers, according to primary substance.

### **Discussion on Date of Discharge vs. Date of Last Contact**

Dr. Henderson raised a question concerning the collection of the “date of discharge” vs. the “date of last contact”. The issue is, when do treatment facilities terminate a treatment episode, and how do they determine the date of discharge, particularly for clients that drop out of treatment. Is the discharge date the day the client drops out of treatment or is a date assigned after some period of time has elapsed since the client was last seen? Since the date of discharge is used to calculate length of treatment, the method of determining a discharge date has important implications for the data analysis. One method to overcome this problem is to collect the client’s date of last contact, which can be used as the date of discharge. However, some States may not collect this information.

The Virginia representative responded that their facilities may keep a client’s record open for 180 days after last seeing the client. Dr. Henderson asked which discharge date is reported to TEDS when a client is discharged because he has not been seen for a specified length of time. The Virginia representative responded that the discharge date reported is the date at the end of the specified time interval. Therefore, the discharge date can be 180 days or more after the client was last treated.

In Virginia, the funding source for Mental Health and co-occurring disorders allows no contact with clients for 3 months and still reimburses for case management, so they have two different systems. Virginia’s substance abuse office wants cases closed within 30 days so they can determine how effective treatment is. They also don’t want false caseload reports that occur when cases are included for clients that have not been seen in months. The Virginia representative noted that their efforts to get cases closed in a timely manner was not aided by the TEDS Discharge Data Set specifications. Those specifications allow the reporting to TEDS of either date of discharge or date of last contact. Virginia wants to require providers to report date of last contact so they can have accurate information on length of treatment. They requested that the TEDS requirements be revised to require date of last contact and not allow a choice between that and discharge date.

The Alabama representative commented that they do not collect discharge data and do not plan to do so until the data elements are standardized. In Tennessee, their policy is to discharge residential clients who do not receive services after 24 hours, and the discharge

date must be the day after the last encounter date. In Mississippi, if a client does not come back within 90 days, the case file is closed. In the District of Columbia, their policy is to discharge outpatient clients if they miss a week and to discharge residential clients anytime they leave the facility without authorization.

Dr. Goldstone commented that he believes that if more than 50% of clients are not completing treatment, the agency is being negligent in not determining how best to keep these clients in treatment. The Alabama representative noted that their system is a fee-for-service system in which facilities do not have an incentive to keep a client in treatment. There is always another client to “fill the chair.” A possible way to minimize this problem would be to link the rate of reimbursement to time in treatment. For example, if a person is in treatment for a week, the facility is paid \$3.00 per hour, if in treatment for 2 weeks, the facility would be paid \$6.00 per hour, and so on.

The Federal Government has not seen the low level of treatment completion as an issue either, commented Dr. Goldstone. It is not well understood in Washington that half of the people entering treatment do not complete it. However, OAS does need to define the data elements so that they have meaning to everyone. It may be more valuable to have the date of last contact instead of the date of discharge. The Virginia representative agreed, noting that a Federal mandate is needed because, if the States are given an option, it will not work.

Dr. Henderson noted that there is a lot of pressure to collect data. The TEDS data are limited and imperfect, but it is important to get the best information possible from the data collected. TEDS data are not useful for outcomes studies. Outcome measures must be derived from other studies, and not TEDS.

In closing this discussion, the Virginia representative stated that they couldn't calculate the length of stay. To get an accurate length of stay, they must have specific guidelines. The TEDS data and definitions are being used to guide their decisions in their State, and it will be helpful if the TEDS specifications provided the States with a uniform definition. It was agreed that OAS would draft a revised definition of “discharge” for use in TEDS and send it to the State meeting participants for comments prior to issuing it for all the States. OAS will also consider whether the TEDS discharge specifications should require reporting of both the date of discharge and the date of last contact.

### **The Use of National Data - Measuring Substance Use, Abuse, and Treatment in America**

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.

Dr. Goldstone began by discussing the potential of the NSDUH data. The household survey included about 70,000 respondents in 2002, and was conducted by personal interview. Interviews were conducted by having respondents read or listen to questions

on a computer and provide answers directly on the computer. It is a user-friendly program. For some respondents, this was the first time they had used a computer and they commented on how easy it was. There were three changes to the survey in 2002. First, there were problems in declining response rates, so OAS introduced a \$30 incentive to those who would complete the survey. Second, OAS found that new interviewers got better response rates than experienced interviewers. Third, OAS changed the name of the survey to the National Survey of Drug Usage in Households (NSDUH). The end result was that the estimates of prevalence were higher than the comparable data from the 2001 survey. Because of the changes in the survey, it is not possible to compare the 2002 data with the data from previous years. Therefore, the 2002 data will be considered as base line data.

Dr Goldstone presented a variety of data tabulations from the NSDUH to demonstrate the breadth and depth of the data and to demonstrate how the States might look at their State data.

## **Day Two**

### **Drug Abuse Warning Network (DAWN) and Health Insurance Portability and Accountability Act (HIPAA)**

Dr. Ball began her presentation by describing the redesign of DAWN. She explained that DAWN still collects data from emergency departments, but now includes all types of drug-related cases, including adverse effects. With the expansion of DAWN, the number of users of the data is also expanding. However, there is no requirement for hospitals to participate in DAWN.

In several cities, including Birmingham, AL, Washington, DC, Louisville, KY, Jackson, MS, and Norfolk, VA, medical examiners have been participating in the DAWN program. There are plans for DAWN to expand the medical examiner component of the system into many other metropolitan areas. The system is designed to collect all types of drug related deaths, not just drug abuse deaths.

The benefits of DAWN will include real time access of de-identified data. It is hoped that DAWN will eventually serve as an early warning system that will be able to detect emerging problems while they are still small, flag sudden increases in adverse events, identify new patterns of drug use, and discover aberrant trends early. Some of the challenges of DAWN are: recognition by researchers and policymakers of its untapped value; the struggle to have drug abuse recognized by the health community as a mainstream public health problem; the stigma associated with abuse; competition with others for dwindling resources; and, HIPAA privacy requirements.

Getting hospitals to sign up has been extraordinarily difficult. OAS pays hospitals a \$1000 per year access fee, 10 cents per chart reviewed, and one dollar for each chart submitted. OAS has struggled to recruit sample hospitals. If hospitals in a metropolitan

area do not provide data, DAWN can't make estimates for that area, and the national estimates are adversely affected. Because of the improvements to DAWN, the data set has become very valuable. DAWN data provides insight into problems that other data sources can't provide. While there are other surveys, such as the Monitoring the Future school survey, and the NSDUH, DAWN provides a unique look at emerging drug use.

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

Dr. Ball also made a presentation on HIPAA and its associated regulations. This presentation has been summarized in a previous Regional Meeting summary report and will not be reported here. (See Summary of Portland, OR meeting, July 2001).

### **Substance Abuse and Mental Health Data Archive - Demonstration of the on-line Data Analysis System**

Dr. Charlene Lewis of SAMHSA described and demonstrated the system available to the public for on-line analysis of substance abuse data. The Substance Abuse and Mental Health Data Archive (SAMHDA) was designed to provide researchers, academics, policymakers, service providers, and others with ready access to substance abuse and mental health data. Through the SAMHDA web site, substance abuse data with complete documentation can be downloaded from the Internet (<http://www.icpsr.umich.edu/SAMHDA/index.html>). Datasets are in SAS and SPSS format, and documentation is in PDF format.

In addition to data downloads, the system provides for direct on-line analysis of the data. The Data Analysis System (DAS) was developed by the University of California at Berkeley, specifically for use on the Internet. Users can compute frequencies, cross tabulations, means, and correlations using procedures that are user friendly. Subsets of data files can be constructed and downloaded to a local PC. Existing variables can be recoded or recomputed to create custom variables. These variables are saved online for 30 days. Customized datasets and codebooks can be downloaded. The documentation includes a title page, codebook notes, weighting information, bibliographic citation(s) and data disclaimer, and descriptions of imputations, data anomalies, and data problems.

Planned Improvements: New data sets: (TEDS 2001, NSDUH 2002, NCS-II national co-morbidity study).

### **Closing Remarks**

Dr. Goldstone ended the meeting by thanking the participants for their participation and urging them to feel free to contact OAS staff with any suggestions or problems they may have.



**Wednesday**

8:30 a.m. Continental Breakfast

9:00 a.m. Health Insurance Portability and Accountability Act (HIPAA) ..... *Judy Ball, OAS*  
    \$ Transactions, Identifiers, Privacy, Security  
    \$ Implications for State data systems

10:15 a.m. Substance Abuse and Mental Health Data Archive (SAMHDA) ..... *Charlene Lewis, OAS*  
    \$ Demonstration of the on-line Data Analysis System  
    \$ Application of system to State's TEDS files  
    \$ OAS Short Reports

11:00 a.m. Wrap-up Discussion..... *Donald Goldstone, OAS*

12:00 p.m. Adjourn

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**DASIS Regional Meeting  
Memphis, Tennessee  
October 28 & 29, 2003**

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