

DASIS STATE DATA ADVISORY GROUP MEETING
October 30-31, 2001
Minneapolis, Minnesota

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SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING
October 30-31, 2001
Minneapolis, Minnesota

This meeting was the tenth regional meeting to be held with State DASIS Representatives. It included representatives from Minnesota, Montana, North Dakota, South Dakota, Wisconsin, and Wyoming along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR) and Synectics for Management Decisions. Representatives from Idaho were unable to attend due to out-of-state travel limitations.

The DASIS Regional Meetings are held to provide an opportunity for State DASIS representatives to have face to face discussions with staff of OAS, Synectics and MPR. The meetings are scheduled for a day and a half, with a flexible agenda. States are informed about recent activities of OAS 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 through discussion and brief presentations.

Demonstration of National Directory Facility Locator

The Treatment facility Locator was updated in October 2001, with the information from the 2000 N-SSATS. With this update, for the first time, information about non-English treatment programs was added to the locator. The relevant N-SSATS question asked, "Are services provided in a language other than English? If yes, what language?" Respondents were allowed to write-in their answers. Efforts were made to screen out the use of interpreters and AT&T telephone services, since these are not treatment programs. Information on programs that offer assistance to the hearing impaired was also collected

States pointed out that all providers are required to have assistance available for non-English speaking clients through interpreters, staff or use of the AT&T service. Also mentioned was the probable confusion in provider's minds as to the difference between using these services for intake versus treatment. The 2000 survey question was revised after the 1999 survey to specifically pinpoint treatment programs. SAMHSA would appreciate feedback from States with any information they have about providers that have non-English speaking treatment programs. South Dakota mentioned that they have one treatment program for the deaf.

Demonstration of I-SATS Online Quick Retrieval

Synectics recently introduced a new feature to the I-SATS On-line system. States will now have the ability to search for facilities on the I-SATS by State, city, county, zip code or facility name or address. They may print the list of facilities that results from their search, or they can download all the facility information to their PC. In addition, facilities can be selected based on whether they are active or not, State approved or not, treatment or not, and TEDS reporter or not. Results of all the searches can be downloaded to an Excel file or an ASCII text file (tab or comma delimited). Access to the system will be limited to people within a State who have a password for the I-SATS On-line system and searches are limited to a searcher's own State facilities.

A question was raised by the representative from South Dakota as to whether our categories for type of service used the ASAM guidelines. The ASAM guidelines are not used because only a few States are using them. SAMHSA will keep monitoring this issue to see if their use becomes more universal.

A question was raised by a representative from Wisconsin about how Synectics handles new facilities that contact Synectics asking to be added to I-SATS. In this situation, Synectics contacts the State to see if the facility has State approval. If it does, it is added to the I-SATS as State approved. If it does not, it is added as non-approved. In either case, the facility will be surveyed in the next N-SSATS.

The 2000 N-SSATS and Mini N-SSATS

Geraldine Mooney of Mathematica Policy Research (MPR) provided handouts showing the response rates by State for the 2000 N-SSATS. The State-approved facility response rate for the U.S. was approximately 96%. The response rates for the States attending the meeting varied between 100% and 93%. The response rate has improved from 88 % to 96% since MPR started doing the survey. In addition to improved survey techniques and follow-up procedures, the introduction of the Treatment Locator has helped improve the response rate.

In the latter stages of the 2000 survey, MPR experimented with the use of a web- based version of the survey. The web-based survey was offered to 1,980 facilities that were non-respondents to the mail portion of the survey. Approximately 8 % of the places offered the web option responded using the web-based version.

Due to the length of time between full N-SSATS and the increased popularity of the Treatment Locator, OAS has instituted an abbreviated survey of newly identified facilities that are State approved. This abbreviated survey, called the Mini-N-SSATS, is conducted monthly. Each month, Synectics sends to MPR a list of newly identified State-approved facilities. MPR sends a letter by mail or fax to each facility, inviting the facility to call a toll-free number and complete a brief questionnaire if they wish to be added to the Treatment Facility Locator. The questionnaire collects only the basic information needed for listing the facility on the Locator. Since the Mini survey has been conducted, approximately 70% of the places have responded. Facilities are added to the locator approximately two months after they respond. In order to remain on the Locator, all facilities are required to complete the full annual N-SSATS.

What facilities should be included in I-SATS and N-SSATS?

A listing of non-State approved facilities that indicated in the survey they were approved by the State Substance Abuse Agency was distributed to each of the States at the meeting. Some States examining the listing indicated that some of the listed facilities were "satellite" facilities that really were not separate from another approved facility. This was particularly true for South Dakota.

This led to a wide ranging discussion about the relationship between State recognized facilities, facilities in I-SATS, facilities reporting to TEDS, and the relationship with block grant information. OAS stated that its goal is to have each separate treatment site listed in I-SATS and to have each site complete an annual N-SSATS questionnaire. However, satellite facilities are

generally not considered independent facilities that should be listed separately. Rather, it is expected that they are part of another "main" facility, and that satellite data will be included in the main facility data during the N-SSATS. A discussion followed about how a "satellite" is defined, and whether it would be desirable to include satellites in the Treatment Locator even though they are not independent of a main facility. OAS agreed to study these issues and explore the possibility of adding satellites to the Locator for States that want them added.

Another aspect of this issue is the concept of facility "networks." These are groups of administratively linked facilities, generally linked by common ownership or management. During the N-SSATS, facilities are asked if they belong to a "network" of related facilities. Identified networks are coded as such during the survey and linked in the survey data file and in the I-SATS by a common "parent ID." Synectics and MPR make every effort to maintain a complete file of networks, but it is difficult to keep up with all the changes.

Hopefully with the new query system attached to the I-SATS On-line, States will be able to keep the I-SATS listings comparable to the State listings.

Another problem noted is that the DASIS data are meant to relate to and support block grant reporting, but there isn't always a 100 % correspondence between facilities reporting to TEDS and those included in block grant reporting.

The 2002 N-SSATS

Planned changes to the N-SSATS for the 2002 data collection were presented and discussed. The point prevalence date for the next N-SSATS has been moved from October 1 to March 29, 2002. States will be asked for endorsement letters in January, and advance letters will be mailed to the facilities in mid-February. The questionnaire will be mailed near the end of March, and data collection will continue to the latter part of September.

Only modest changes to the survey questions are planned for 2002. Most changes involve wording changes to accommodate the change in prevalence date and some changes to clarify and update the questions on Methadone/LAAM. In addition, the question on treatment services in other languages has been reorganized. A separate question on services for the hearing impaired has been added, and check boxes for the most common languages have been added to the "other language" treatment services question.

There are currently only two new questions planned for 2002. They are:

- Is this facility affiliated with a religious organization?
- Does this facility have Internet access?

For the 2002 survey, the web-based version of the survey will be offered to all respondents.

Currently, the Directory and the Locator do not include treatment places that treat only incarcerated clients on the basis that the public cannot be treated there. However, the representatives from South Dakota and Wisconsin suggested other scenarios in which listing places that only serve incarcerated clients would be helpful. For instance, an arrestee or his family may want the arrestee sent to a jail or prison that has a treatment program. Wisconsin has

a treatment alternative program where prisoners work or go to treatment and are jailed the rest of the time.

Unfortunately, the listing of substance abuse programs in jails and prisons varies greatly by States. The list maintained by the Department of Justice is much more complete. SAMHSA used this list for the 1997 Correctional Survey. States indicated that they would be interested in receiving an electronic list of places in the correctional survey. This list was never made public, but based on these comments OAS will reconsider this question. The report is available on the web at www.samhsa.gov or can be obtained by writing to the OAS.

State Presentations

Minnesota

Minnesota is utilizing TEDS data in an outcome monitoring system. On a sample of admissions, Minnesota is collecting some additional data with a six-month follow up. Clients must provide consent, and treatment programs are assigned a minimum sample size that they must meet. Data collection is done by the treatment staff except for the follow up which is done under contract. Unlike Oklahoma and Washington, Minnesota does not link with other administrative data. All admissions will have TEDS intake, history and discharge data. A sample of client admissions that agree to cooperate will have an Addiction Severity Index (ASI), a treatment service record and a six-month post discharge phone interview assessing functioning and outcomes in several areas. Clients are linked by a cryptogram. Results of the study indicate that the best predictor of abstinence is completion of treatment. Adolescents do better than adults. Minnesota no longer collects outcomes data but does collect treatment completion as part of TEDS. Treatment completion could serve as a useful proxy for favorable outcomes in the absence of 6-month posttreatment outcomes data.

Montana

Montana's data system is the Alcohol and Drug Information System (ADIS). The ADIS collects admissions, transfer, discharge data and follow up information that is electronically submitted by the State Approved Providers.

The Chemical Dependency Bureau formats the data into Provider Profiles. The Profiles include demographic data as well as data on program effectiveness and benchmark measurements. The profile provides the State and the Provider a method to monitor effectiveness and identify trends. It is also a tool for communicating to stakeholders and is used during legislative sessions.

The profile includes a calculation of prevalence rates by provider geographic catchment area along with penetration rates by target populations that are requirements of the States' block grant. These data also provide the trend information needed to plan and respond to local and clinical needs, such as Montana's methamphetamine epidemic, access to services by IV drug users and women with dependent children, and infrastructure development of specialized programming. State and local providers use the information to target intervention strategies and enhance referral relationships with other agencies such as Child Protective Services, Criminal Justice, Welfare, Reform, Prenatal programs etc.

Montana continues to work to improve the ADIS system by integrating other databases into the system and by providing technical assistance to providers, particularly in the rural areas of the State. This area is critical in meeting Montana's block grant requirement and movement towards mandatory benchmarks.

South Dakota

The South Dakota Substance Abuse Division oversees treatment for substance abuse, gambling and prevention programs in South Dakota. State-funded services are restricted to people whose income is below 185% of the poverty guideline. A major emphasis in South Dakota is the impact of drug abuse on special populations. In 1997, there was a prevalence and needs assessment survey on Native American reservations in the State, and a telephone survey done of Native Americans living off the reservation. The survey identified the number of individuals needing treatment. Last fiscal year, the division provided services for 44 % of the native Americans who were in need of substance abuse service, and to 22% of the non-native population.

South Dakota operates specialized services for juveniles and adults within the corrections system. They operate programs for the dually-diagnosed (which is funded by the Division of Mental Health and Alcohol and Drug Abuse), four levels of programs for adolescents (structured outpatient treatment, day treatment, residential treatment and a 6 month aftercare program), programs for adult and juvenile pregnant women and their dependent children, and four levels of gambling treatment services.

The role of the substance abuse office is placement, preauthorization, and case management for the clients funded by the State insurance plan and by Division funds. South Dakota does outcome studies on those clients funded by the State. Outcome data for the correctional programs have been collected for over a decade, and for community based services for the last 6-7 years.

All the data go into the MIS system (prevention, treatment, contracted services, and non-contracted services). The State uses an old mainframe system that is expensive to modify, but funds are not available to change from the mainframe. They have a CSAT technical assistance grant to study their MIS and make recommendations. They also have a CSAT technical assistance grant to address penetration rates. The office receives criticism from the Native American populations on the issue of cultural competency, so they are working on developing a cultural competency assessment tool to assist providers in enhancing their programs.

North Dakota

North Dakota has a large white population similar to South Dakota. They have about 1% other minorities but the minority population is growing. The State has been concentrating on measuring and improving the services in rural counties. The counties had programs but they were not licensed. The purpose of the current program is to build capacity close to or on reservations in conjunction with a tribal government license held by human service centers. The sites are outlying sites of the centers. Staff is from the human service center, and they operate under center accreditation. This gives more stability to staffing and better integration of services.

In the effort to reduce inpatient treatment, the State is developing wrap-around services similar to the State mental health program. They use intensive case management to keep people out of the State hospital. Most human service centers have adolescent/young adult clients. The State has seen an increasing trend in young people in their facilities. It is unclear whether this is a result of more drug use or because their jobs don't give health insurance. Recently, more young adults are being seen for alcohol with drugs. Most of the caseload is alcohol, a little marijuana, and either methamphetamine or cocaine.

In order to monitor this problem better, the State is trying to get hospitals to use e-codes in hospital emergency departments, and this is improving. In the last 3 years, the reporting has improved but the stigma of drug use results in some underreporting, e.g., listing caffeine poisoning instead of alcohol. Another piece of the picture that is outside the South Dakota substance abuse agency data collection is some outpatient clinic data. More places are open evenings so that folks don't have to go to the emergency room. In addition, the Indian Health Service data is outside the State system. They would like to include it in their overall analysis since there is probably 3 times the need on reservations as in the rest of the population. The same is true for the correctional and juvenile justice systems.

The State needs to improve its prevention programs. Data shows a large number of women of child-bearing age using alcohol and drugs. People on the reservation are unwilling to believe the data. The State has continued to emphasize women's programs on the reservations.

The State is struggling with an outcome study. They did a pilot study, and then instituted it statewide. However, problems have emerged in getting the proper processing procedures adopted statewide. Facilities collect the discharge data, then a contractor does a 6 months and 1 year follow up. Some facilities do well at getting people into the study. Motivation of facility has a lot to do with how many they sign up. Rural sites sign more up than central locations. Among those who sign up, the response rate is over 50 percent. However, the uneven sign up rate by provider will hamper the analysis of the results.

Hearing South Dakota describe their use of address information of the clients' collaterals is a good idea and one North Dakota can adopt to improve response rates. It is often easier to find family members than the client.

The DAWN system collects the kind of data that would be useful to the State if it collected data from more rural areas. I know it is difficult with a National sample to cover rural areas, but States like North Dakota would find it very helpful if it could be worked out.

Wisconsin

The 'Wisconsin idea' is local accountability and control. Wisconsin has a history of leading the way in social experiments. Examples are welfare reform, health insurance for the uninsured, and the long-term care system. The University of Wisconsin plays an important leadership role. Wisconsin has high adult education, and low poverty and unemployment rates. Badger Care is the State health insurance. Substance abuse is part of the Division of Supportive Living. Human services are county-based and funded through local boards, and the State provides no services. Wisconsin counties are autonomous, so the State does not direct counties to do any one thing.

The State has 650 certified treatment programs in 154 towns. The State council does a 4-year plan. The human resources reporting system, HSRS, is the MIS for social service, mental health, and substance abuse clients. The system is fourteen years old. The data can be entered in a dedicated online network or by batch reporting.

The State provides direction and requirements, but the counties decide how the requirements will be met. HSRS returns county-specific management reports monthly, as well as special reports and reports for State and Federal requirements. They are working to send TEDS electronically instead of by batch tape.

The HSRS is built in a series of integrated modules with core client and services data. It uses a standardized taxonomy, including uniform definitions and coding of all clients, and a statewide client ID based on name/DOB/sex. The ID can be assigned at any facility. Core services have 13 program clusters with 80 service types. Data are legislatively mandated with optional county use fields. For target groups (from taxonomy), the State spent \$67 million on AODA and, from the Block Grant, \$26million. A current issue is the new administrative code dealing with community substance abuse service standards and decertification of all 650 programs.

It is unlikely that all of these 650 programs are listed in I-SATS. The State updates I-SATS yearly, but they have no staff for ongoing updates or for matching the programs with the I-SATS listing.

In answer to a question about the downside of the decentralized system, the State noted the cost of extensive service and a limitation imposed by the counties to prohibit county to county comparisons.

After the presentation and during the question and answer period, Wisconsin asked why the current DASIS State agreements are one year rather than three years. The State prefers the three-year agreement because it is better for planning. In reply, OAS stated that the current agreement is for one year because of a limitation of the current DASIS contract between SAMHSA and Synectics.

Wyoming

Wyoming's web-based data system debuts this coming Thursday. It is a joint substance abuse/mental health database. The system is currently supported by mental health MIS funds, and they are looking for substance abuse MIS funding. In the data system's assessment module, they include ASI, Adult Functional Assessment Rating Scale (FARS) and Children Functional Assessment Rating Scale (CFARS). The substance abuse data elements are the TEDS data elements.

All substance abuse and mental health programs and the Wyoming State hospital are connected in a Wide Area Network. Legacy systems upload data via FTP for validation. Important features of the system are that community providers can generate real-time reports quickly and can access State-wide data.

Wyoming has done a lot with technology and few staff. There are only two staff working on all substance abuse/mental health information technology, though they are committed to making a positive difference.

In answer to a question about providers and their computer equipment, it seems that Wyoming is better off than some States. All the providers have computers originally given to them 6 years ago, and many have upgraded their computers. Some providers have T1 lines.

The representative from Wyoming is new to the job and the requirements of DASIS. She stated that she found the DASIS State Guidelines and the SAMHSA web site quite useful in learning about DASIS and the role of the State.

SAMHDA Online

Next on the agenda was a demonstration of the SAMHDA Online Data Analysis System. The description of the system has been reported in earlier State meeting summaries and will not be reported here.

The State of Montana had some experience using the SAMHDA system and found it useful, but they also had some problems and were unsure how to find help. Charlene Lewis of OAS noted that on the web site a toll free help line number is given and an E-mail contact address is provided.

A representative from North Dakota commented that county of residence would be useful in the data sets available on SAMHDA. Most States breakdown their data within the State by county. Deborah Trunzo of OAS responded that county of residence is not in the TEDS dataset because of confidentiality concerns. Several years ago, a survey indicated that about 15 States collect client county of residence. Nevertheless, the major problem is confidentiality. Once the county data are available to users, there is no control over how it is used. In small areas, it is possible to have only one or a few clients in some counties, which could compromise the confidentiality of those individuals. Some geographic analysis has been done using the county of the provider as a substitute for the client county. This approach is not perfect, but may be useful.

This is not a new problem or issue. OAS is experimenting with developing software that would identify and suppress small table cells, but this is a difficult problem and its success is not guaranteed.

General Discussion

Montana raised a question about satellite treatment facilities. They wondered why satellite facilities are not included in the N-SSATS. In Montana, satellites are an important source of care in some areas. Their satellites are open at specific days and times. There was discussion of what constitutes a satellite, and whether it would be desirable or not to include them in the N-SSATS and to list them in the Directory and Treatment Locator. This is something that will be investigated, and OAS will take this idea under consideration.

South Dakota and Wyoming indicated that their State data doesn't match well with the TEDS data. Synectics and the States will discuss this after the meeting to compare the data and determine there really are discrepancies and, if so, what might be their cause. States were

reminded that they should review the TEDS quarterly feedback reports, if they aren't doing so already. These reports are provided to the States as a means for them to compare their State data with the TEDS data to assure that they are the same. Discrepancies should be reported to Synectics so that errors in TEDS data can be corrected.

The meeting was concluded with presentations by Dr. Leigh Henderson of Synectics and Dr. Donald Goldstone of OAS on the uses of the DASIS, DAWN and NHSDA data

HIPPA and DAWN

The second day was devoted to presentations on the Health Insurance Portability and Accountability Act (HIPPA) and Drug Abuse Warning Network (DAWN)
Both of these presentations have been summarized in a previous Regional Meeting summary.

Some questions and answered that came up in the discussion of HIPPA are given below.

Q What is meant by an "electronic data submission for payment"?

Ans. Submission of a claim electronically is data submitted for payment.

Q Would a State be considered a "health plan" under HIPPA if there were contracts between a provider and the State?

Ans. It depends on whether the State meets the definition of health plan. If the State just makes grants, no.

Q Does a counselor acting as a provider need an ID?

Ans. Not if he/she doesn't bill separately.

Q What if the State wants to keep track of counselors and wants all counselors to have National Provider Identification?

Ans. Generally, the State already has a system for identifying counselors. HIPPA is not meant to replace State licensing, etc.

Q If a provider enrolls in Montana and decides to move to Minnesota, does he keep the same number?

Ans. Yes, it's a lifetime number that follows the provider. The intent is to replace multiple provider numbers.

Q Couldn't a group practice go either way? If it billed as a single entity, counselors wouldn't need an individual ID. If they billed for individual providers, they would.

Ans. That is correct. The Act is meant to give all individuals and facilities a number. It will be a 10-digit number. The final rule has been written but not issued. This is an unfunded mandate; you can't charge user fees. Funding will require legislation.

Q We get Medicaid/Medicare reimbursement. The billing is built into the system. If we transmit data to SAMHSA, are we covered?

Ans. This is an issue for the lawyers. In addition there is a place on the HIPPA website <http://www.hhs.gov/ocr/hippa> where you can submit questions.

Q TEDS is reporting information required by law. The same applies for DAWN. Could you also argue that TEDS data is important for research?

Ans. You probably could, but if you are a public health authority, you're probably better off using the statutory authority. DAWN is public health surveillance, therefore authorized by law.

Q Can we get a letter from SAMHSA authorizing data reporting?

Ans. HHS has been hesitant. DAWN hospitals have been asking questions about HIPPA and SAMHSA developed a short report that describes how the hospital can comply with HIPAA and still report to DAWN. SAMHSA has talked about doing more reports to address their other data systems, and will try to put out a similar document on DASIS reporting.

States actually have two roles, as public health surveillance and as a health care provider. There is the possibility that you are a covered entity. If you just give out Block Grant money you're not covered by HIPAA, but if you pay specific bills or provide direct services then you are covered. If you run a public health facility, then you're not covered.

DAWN

DAWN has been criticized for lack of timely data. In addition, the population is distributed differently now than it was when the original sample of 21 metro areas was selected 30 years ago. Steps are being taken to alleviate both of these problems.

Several of the States (all rural) find it frustrating that DAWN isn't able to help them. Unlike their State systems and TEDS, DAWN provides an early warning about new trends in drugs. This kind of information is very useful to planners and policy makers trying to be ready for new trends in drug use. OAS noted that DAWN is a system that focuses on large population areas, functioning as an early warning system that measures sentinel events. While OAS agrees that local area data are important, particularly in rural areas, it is impossible with the current budget to expand enough to add rural areas to the DAWN sample. However, it might be possible to develop a targeted rural sample that would be useful.

AGENDA
DASIS REGIONAL MEETING
Minnesota, Montana, North Dakota, South Dakota, Wisconsin, Wyoming
 October 30-31, 2001
Minneapolis, MN

Tuesday

- 8:30 a.m. Continental Breakfast
- 9:00 a.m. Welcome and Introduction..... *Donald Goldstone, OAS*
- 9:15 a.m. Inventory of Substance Abuse Treatment Services (I-SATS)
 \$ Demonstration of Treatment Facility Locator *Deborah Trunzo, OAS*
 \$ Demonstration of I-SATS Quick Retrieval *Jim Delozier, Synectics*
 \$ Discussion of State practices
- 10:00 a.m. National Survey of Substance Abuse Treatment Services *Geri Mooney & Barbara Rogers, MPR*
 \$ Schedule for 2002
 \$ Web questionnaire
 \$ New items
- 10:45 a.m. BREAK
- 11:00 a.m. State presentations *State participants - MN, MT, ND*
- 12:15 p.m. LUNCH
- 1:00 p.m. State presentations (continued)..... *State participants - SD, WI, WY*
- 2:15 p.m. Demonstration of the SAMHDA On-Line Data Analysis System *Charlene Lewis, OAS*
- 2:45 p.m. BREAK
- 3:00 p.m. The Use of National Data..... *Donald Goldstone, OAS*
 \$ NHSDA, TEDS, & DAWN
- 4:30 p.m. Adjourn

Wednesday

- 8:00 a.m. Continental breakfast
- 8:30 a.m. Treatment Episode Data Set
\$ Evaluating the TEDS Process.....*Peter Hurley/Jim DeLozier, Synectics*
\$ Applications of TEDS*Leigh Henderson, Synectics*
- 9:30 a.m. Health Insurance Portability and Accountability Act (HIPAA).....*Judy Ball, OAS*
\$ Transactions
\$ Identifiers
\$ Privacy
\$ Security
- 10:15 a.m. BREAK
- 10:30 a.m. HIPAA (continued).....*Judy Ball, OAS*
\$ Discussion and Questions
- 11:30 a.m. Wrap up.....*Donald Goldstone, OAS*
- 12:00 p.m. Adjourn

PARTICIPANT LIST

DASIS Regional Meeting Minneapolis, Minnesota October 30 - 31, 2001

SAMHSA STATE REPRESENTATIVES

Stephen Asche
Research Scientist
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155-3865
Phone: 651.296.4339
Fax: 651.215.5754
E-Mail: stephen.e.asche@state.mn.us

Ruth Diehl
IS Supervisor
State of Wisconsin
Department of Health & Family Services
Room 518
P.O. Box 7851
Madison, WI 5707
Phone: 608.266.7576
Fax: 608.267.2437
E-Mail: diehla@dhfs.stte.wi.us

Carl Haerle
Information Technology Specialist
Minnesota Department of Human Services
Performance Measurement and Quality
Improvement
444 Lafayette Road
St. Paul, MN 55155-3823
Phone: 651.296.4614
Fax: 651.215.5754
E-Mail: carl.haerle@state.mn.us

Mary LeTang
Program Analyst
Department of Public Health & Human
Services
AMDD/Operations
555 Fuller
P.O. Box 202905
Helena, MT 59620-2905
Phone: 406.444.9635
Fax: 406.444.9389
E-Mail: mletang@state.mt.us

Roland Mena
Chemical Dependency Bureau Chief
Department of Public Health & Human
Services
AMDD/Operations
555 Fuller
P.O. Box 202905
Helena, MT 59620-2905
Phone: 406.444.6981
Fax: 406.444.9389
E-Mail: rmena@state.mt.us

Rick Ruecking
Research Analyst
Wisconsin Department of Health & Family
Services
Room 518
1 West Wilson Street
Madison, WI 53707
Phone: 608.267.0213
Fax: 608.267.2437
E-Mail: rueckrb@dhfs.state.wi.us

Heather Sachse
IT Specialist
Department of Health
Wyoming Substance Abuse Division
2424 Pioneer Avenue, Suite 306
Cheyenne, WY 82002
Phone: 307.777.6492
Fax: 307.777.7006
E-Mail: hsachs@state.wy.us

Gilbert Sudbeck
Director
Department of Human Services
Division of Alcohol & Drug Abuse
East Highway 34, Hillsvie Plaza
C/O 500 East Capitol
Pierre, SD 57501-5070
Phone: 605.773.3123
Fax: 605.773.5483
E-Mail: gib.sudbeck@state.sd.us

Jackie Shepherd
South Dakota Department of Human
Services
Office of Budget & Finance
Hillsvie Plaza
3800 East Hwy 34
c/o 500 East Capitol
Pierre, SD 57501-5070
Phone: 605.773.3146
Fax: 605.773.7076
E-Mail: jackie.shepherd@state.sd.us

Sue Tohm
State Needs Assessment Coordinator
Department of Human Services
Division of Mental Health & Substance
Abuse Services
600 South 2nd Street
Suite 1E
Bismarck, ND 58504-5729
Phone: 701.328.8921
Fax: 701.328.8969
E-Mail: sotohs@state.nd.us

SAMHSA REPRESENTATIVES

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

Cathie Alderks
Statistician
301.443.9846
calderks@samhsa.gov

Donald Goldstone, MD
Director
301.443.1038
dgoldsto@samhsa.gov

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

Judy Ball
DAWN Team Leader
301.443.1437
jball@samhsa.gov

Charlene Lewis
Public Health Analyst
301.443.2543
clewis@samhsa.gov

Deborah Trunzo
Dasis Team Leader
301.443.0525
dtrunzo@samhsa.gov

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

Jim DeLozier
Senior Consultant
703.807.2331
jimd@smdi.com

Peter Hurley
Project Manager
703.807.2347
peterh@smdi.com

Leigh Henderson
Senior Research Analyst
410.235.3096
leighh@smdi.com

Heidi J. Kral
Conference Manager
703.807.2323
heidik@smdi.com

Jim Larson
Senior Consultant
410.693.4533
jiml@smdi.com

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

Mathematica Policy Research, Inc.
P. O. Box 2393
Princeton, NJ 08543-2393
Fax: 609.799.0005

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

Barbara Rogers
Survey Research
609.275.2249
brogers@mathematica-mpr.com