DASIS STATE DATA ADVISORY GROUP MEETING

March 7–8, 2002
Philadelphia, Pennsylvania

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SUMMARY
DASIS STATE DATA ADVISORY GROUP MEETING
March 7–8, 2002
Philadelphia, Pennsylvania

This was the 11th regional meeting to be held with State DASIS representatives. It included representatives from Delaware, Maryland, Michigan, New Jersey, New York, Ohio, and Pennsylvania along with staff from the SAMHSA Office of Applied Studies (OAS), Synectics for Management Decisions (Synectics), and Mathematica Policy Research (MPR).

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 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 through discussion and brief presentations.

The meeting in Philadelphia followed a format that was similar to previous regional meetings.

2000 N-SSATS

MPR provided handouts showing the response rates by State for the 2000 N-SSATS. The response rates for the States attending the meeting were nearly 2 percent higher than the overall average. The national response rate for State-approved facilities was approximately 96 percent. In addition to improved survey techniques and follow-up procedures, the introduction of the Treatment Locator has helped improve the response rate, which has risen from 88 percent to 96 percent since MPR started doing the survey.

In the latter stages of the 2000 survey, MPR experimented with the use of a Web-based version of the questionnaire. The Web-based questionnaire was offered to 1,980 facilities that were nonrespondents to the mail version of the survey. Among the facilities with Internet access, 17.3 percent completed the Web-based version. When asked about numbers of clients served, Web respondents were more inclined than telephone respondents, but less inclined than mail respondents, to provide actual client counts. Given the importance of collecting actual client counts over estimates, MPR will do mode comparisons for the 2002 N-SSATS.

2002 N-SSATS

All 2002 N-SSATS sample members will be offered a Web-based version of the questionnaire. The already mailed advanced letter mentioned the Web option. A pink flyer will be included in the questionnaire packet that announces the Web option and provides each facility with its unique ID and password.

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 (hence no 2001 N-SSATS). All of the States attending the meeting have sent in their endorsement letters. The survey packet containing a questionnaire, cover letter, State endorsement letter, Web flyer, and FAQs will be sent out during the last week of March.

The 2002 N-SSATS questions include only modest changes. Most involve wording changes to accommodate the change in point prevalence date and some changes to clarify and update questions. For example: question 4 about methadone and LAAM has been revised to be broader and include other opioid programs; a number of additional language choices noted in the 2000 survey were added to the question on treatment services in other languages; and a new outpatient category—outpatient methadone/LAAM maintenance—was added because many facilities do not consider methadone maintenance to be treatment.

New items for 2002 include: (1) A question that separately identifies facilities that are primarily methadone maintenance programs; (2) A question on services for the hearing impaired; (3) A question about affiliation with a religious organization; and (4) A question regarding Internet access.

Collecting Cost of Treatment

Dr. Donald Goldstone discussed collecting data on the cost of treatment. In the past, OAS collected revenue data as a proxy for cost data. However, feedback from people in the field indicated that these data were not accurate. The questionnaires were sent to the facility administrator, who often did not know the cost or revenue, since the source of money and the cost of treatment were not data the administrator had in hand. So OAS stopped collecting this information, concluding that it was a guess and possibly a poor one.

A couple of years ago OAS instituted the Alcohol and Drug Services Study (ADSS) project, which was a special effort to collect cost data from a sample of facilities. This was done with Capital Consulting and Center for Substance Abuse Treatment (CSAT) support, and it used an accounting approach to get information. The questionnaire went to the business office. OAS believes these data are good. OAS is planning to repeat this effort with a separate survey directed to the business office and asking carefully structured questions.

Dr. Goldstone raised this issue because CSAT is concerned about the lack of interim data between ADSS and the future survey. Cost of treatment is an important number because it is used as a basis for estimating the number of additional people that can be treated with an increase in the Block Grant. It has major policy implications.

The States did not have any suggestions for better sources of cost of treatment data.

Demonstration of National Directory Facility Locator

The Treatment Facility Locator (http://findtreatment.samhsa.gov/) was updated in October 2001 with information from the 2000 N-SSATS. For the first time, information about non-English treatment programs has been added to the Locator. The survey question asked was, “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 providers' minds as to the difference between using these services for intake versus treatment. It was mentioned that the 2002 survey question was revised 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 On-line Quick Retrieval

Synectics demonstrated a new feature on the I-SATS On-line system that allows States to search I-SATS for facilities 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 status (active, non-active), state approval (approved, not approved), and whether or not they are a TEDS reporter. Results of all the searches can be downloaded to an Excel file or a text file (tab or comma delimited). Access to the system is 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.

State Presentations

Delaware

The State of Delaware has two divisions that handle publicly funded substance abuse treatment: the Division of Substance Abuse and Mental Health (DSAMH) for adults and the Division of Child Mental Health Services (DCMHS) for adolescents 18 and under. The divisions are working together on a 3-year Center for Mental Health Services (CMHS) data infrastructure grant. The final phase will be to adopt as many of the 16-State mental health performance indicators as possible for its substance abuse population. Part of the project will be to use a probabilistic population estimation technique to link records between the substance abuse treatment systems and other public systems, such as the Department of Corrections.

DSAMH has a data mart to facilitate the availability of data. Substance abuse and mental health data are in the system, and can be linked with a common identifier. Service data have been added to the episode data.

Delaware participated in a 3-year Integrated Database (IDB) project with Oklahoma and Washington State; this project was funded by SAMHSA. The project was designed to link and integrate substance abuse, mental health, and Medicaid-funded behavioral health services to develop a more accurate picture of the behavioral health services being provided to clients. A byproduct of the study is an algorithm based on a statistical model to link records. The final data files for calendar years 1996, 1997, and 1998 were released the week of March 4, 2002.

Delaware used the TEDS feedback tables to compare the State data with the national data for calendar years 1999–2001. There were two primary differences between the Delaware and the national averages: Delaware reported a higher percentage of detoxification services than the national average (55 percent versus 23 percent) and a higher percent of Delaware admissions reported heroin as their primary substance problem than the national average (28 percent versus

14 percent). While the higher level of heroin use was expected, the higher level of detoxification services was not, and it will be investigated further.

A major analysis of DSAMH episode data found 30 fields that weren't being used. In July 2001 DSAMH dropped those fields and added three new fields. That meant a 6-month setback in getting the TEDS data out.

DSAMH is working with a contractor to develop specifications for a system that will generate discharge data for TEDS. DSAMH will be able to submit years of historic data.

The Division of Child Mental Health Services (DCMHS) combines mental health and substance abuse services in one division. DCMHS has a complex information system, built primarily with federal money. Since kids grow into adults, it is important to share data within the State. The DCMHS system differs from the adult system in that it is a managed care system ("care assurance system"), and it is part of the Medicaid program. Services are contracted. All mental health providers are community organizations.

The State has started some intensive outpatient and day programs. "Intensive" refers to where the treatment is offered, rather than the number of hours; it is more likely to be provided on street corners, in the home, by a team and aides. DCMHS also has, within the juvenile justice system, a licensed residential program. All other residential programs are out of State. Among the challenges DCMHS faces is the integration of data from the wellness clinics (located in the majority of high schools) and the juvenile drug court.

Maryland

In Maryland all programs are required to report; about 48 percent of the programs are funded by the State. Maryland is in the process of testing some ideas to improve the current system. A major change will be to convert those reporting programs still using paper (currently 100 out of 330) to electronic submissions, and develop a Web-based reporting system.

The objectives of the revised system are reliability, timeliness, and usability of the data. The system is moving from service category to treatment setting and treatment type (similar to the old modality/environment axis) and will have better performance measures. Some of the new items on the admission record are:

- inquiry about how recently the latest prior treatment took place;
- a revised primary source of referral which is more detailed than the TEDS requirements;
- separation of non-opiate from opiate replacement detoxification;
- addition of "on leave from employment" as another employment status; and,
- an item on the number of days of use during the most intensive period of abuse prior to admission.

On the discharge record, a category of incomplete treatment due to health problems has been added to the reasons for discharge. The process of reporting transfers will be simplified.

Michigan

Data reporting in Michigan has undergone considerable change due to some organizational changes, reporting policy changes, and system changes. The new administrative organization

combines substance abuse with mental health, but the treatment, prevention, contracts, and research and evaluation units have all been put into separate divisions and/or bureaus. This is a critical change and could affect how each of the units work and communicate with each other. Further organizational changes are likely.

One policy change resulted in a substantial lowering in the number of clients that Michigan reports to TEDS. Facilities are now obligated to report admission and discharge data for only those clients whose substance abuse treatment services were paid (in whole or in part) by state administered funds instead of for all clients who received substance abuse services in programs funded by the State. The results of this policy change can be seen in the TEDS data: Michigan showed substantial reductions starting in FY 1999 admissions.

As part of a new State-sponsored software system (beginning 10/1/2001), the process for submitting records has changed. In the past, agencies submitted admission and discharge records throughout the year, and the data was aggregated for the State to use on an annual basis. Now, records are submitted monthly, and these records are required to meet certain "business rules." Records not meeting the criteria are rejected. The process also allows for records to be added to, changed, or deleted. Encounter data records are now required to summarize the type and number of units of service received each month for each recipient of services funded, in whole or in part, through MDCH contract funds. HIPAA records are expected to replace this reporting.

Record contents were revisited in FY 2001 (to bring content more in line with MH records) and some revisions in data items were made. New data reporting specifications were created along with upload procedures and related documentation. Data uploads into the new State database are submitted by regional coordinating agencies (CAs) monthly. CAs now submit their data electronically and can add, change, and/or delete client records (i.e., fix errors). A new federal crosswalk (TEDS) has been developed and data should be submitted more regularly in the future to Synectics.

With the implementation of managed care in Michigan, multiple sources of funding (Medicaid, State GF, federal block grant dollars) supporting specialty care services were consolidated under the authority of local, county-based sponsored entities (community mental health services programs and CAs). Currently, Substance Abuse Block Grant money goes to the CAs; Medicaid money goes first to MH and then some to the CAs. MH Block Grant money and State GF money go to MH. However, the Department is in the process of bidding out the management of Medicaid funds for specialty services. MDCH will award management contracts for each designated service area to a single mental health entity (although it may be comprised of affiliations of multiple existing organizations), which must manage all specialty services (mental health, developmental disabilities, and substance abuse). Michigan is currently processing and evaluating the 18 applications submitted. Total funding involved is as much as $1.1 billion. Further info and materials can be found on the MDCH Website (http://www.michigan.gov/mdch) under "Mental Health and Substance Abuse Services."

New Jersey

The current, paper-based version of the system has been in place 10 years. There are 300 designated alcohol/drug agencies, about 200 of which report to the NJ Department of Health and

Senior Services. On an annual basis, there are 54,000 admissions (45,000 unduplicated). Reporting lags by at least 6 months.

Plans have been made to go to a new Web-based system by the end of the year. The new system will have three parts: an admissions report, an abbreviated ASI that can be completed by clinician in the client's presence, and a discharge report.

The system will be an on-line monitoring system. Servers set up at Rutgers are providing a firewall and security. The admission and discharge records contain most of the TEDS data. ASI elements will include primary, secondary, and tertiary drugs, and legal issues. Currently we are examining the reasons for discharge and plan to expand them so that we can track level of care; for example, detox to residential to intensive outpatient to outpatient. New Jersey wants clinics to indicate that change on the record so it can know how long a client is in each of these services.

The system will track episodes; referral to another service will be a transfer. The system will assign a treatment level ID for all services. The TEDS ID plus suffix will indicate a specific level. There will be up to 850 different site IDs. If the client is referred to a clinic in another town, the system will track where the client is supposed to go. After a certain length of time, if no admission record has been received from that agency, the referral agency will be contacted to see if the client showed up. If the client has not, New Jersey will ask the referring agency to change the discharge record to indicate that the client left treatment.

The current system does not allow New Jersey to track the payer of a specific service; in the Web system the funding source will be attached to the admission record and to future record changes. Providers will be able to get their own data and to download the data for their own purposes.

The department has completed licensing standards for residential facilities and is now working on establishing licensing standards for outpatients. In terms of State approval for facilities, it was the speaker's opinion that someone reporting that they are doing treatment is a sufficient criterion to be listed in the *Directory*/Locator. The more options people have for treatment the better. New Jersey does not follow up to evaluate them.

The New Jersey Department of Justice does a high school survey every 3 years, and the State is starting to get middle-school data. New Jersey receives a grant to do a needs assessment study every 3 to 5 years. The State is also about to start a new state NHSDA: New Jersey is the ninth largest State in population and the cutoff for State-level data from NHSDA is at the eighth largest State.

According to New Jersey's Alcohol and Drug Abuse Data System (ADADS), 47 percent of current treatment admissions have heroin as the primary substance of abuse. When ADADS started, most admissions had alcohol as the primary substance. Many were co-addicted to cocaine. The decrease in alcohol admissions coincided with a decrease in hospital detox admissions. Managed care has helped in reducing the revolving door of hospital detox, where people with alcohol problems were admitted and then discharged without follow-up. Under managed care, hospital detox for alcohol is not allowed. There have been significant changes in the use of heroin in New Jersey: injection has decreased and inhalation has increased, and the purity of heroin has increased from 3–4 percent to 70–80 percent.

Ohio

TEDS Reporting Status: Ohio is pleased with the success of the MACSIS claims system. This system provides a basis for claims payment for both substance abuse and mental health. This is one of the largest public payment systems in the nation, with 650,000 enrollees and $104 million in AOD claims processed over the past year.

The collection of TEDS admission and discharge data has not been as successful. Currently only 25 percent of admissions have been collected during the last 2 fiscal years. While the quality of the data that has been collected is good, Ohio has been having a great deal of trouble in motivating the Boards and the Providers to consistently send in their data. Despite the fact that the collection of admission and discharge data is a Federal and State mandate, in addition to being a certification requirement of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), many of the Boards and Providers treat the submission of admission and discharge data as secondary to that of reporting their claims.

ODADAS realizes the importance of the admission and discharge data. Because the Department is under tight budget constraints, it is necessary to have this information available in order to justify current and projected needs. In addition, the ability to provide immediate and accurate answers to legislatures and news media is essential to the success of the department.

With this in mind, ODADAS senior management is reviewing its policy for reporting admission and discharge data as well as other key reporting requirements. Proposals are being drafted that will ensure that the admission and discharge data will become part of the funding arrangements between ODADAS and the Boards and between the Boards and their providers. The policy proposal will allow Boards and Providers up to 60 days after servicing a client to submit admission data to the State. Failure to do so will result in the withholding of non-Medicaid funding.

ODADAS hopes to improve its ability to produce more analytical reports. Since not many data are currently reported, the Department has limited capabilities in producing meaningful statewide reports regarding client demographic data. The Department's future plans call for the development of a relational data warehouse with claims, admission/discharge, and outcome data that will eventually provide a total client history. Another ODADAS goal is to develop Web-based reporting that will allow Boards and Providers throughout the State to produce their own data reports with the ability to compare against other counties.

MAC-Search Demonstration: Ohio demonstrated their new Web-based Provider program directory. MAC-Search is an on-line tool used for searching Provider demographic and program information. It was developed using Active Server Pages (ASP). The data are housed within an Oracle database. The information is extracted from several in-house systems, including the Certification and MACSIS systems. Currently under development is the centralization of these backend systems. Ohio is also reviewing the use of E-form technology as a means for allowing the Providers to update their own data directly into the system. ODADAS is constantly reviewing the MAC-Search system to ensure that it is user-friendly. The system receives several hundred hits a day. However, since ODADAS does not collect cookies from its Website, it is

difficult to know just how many are from business affiliates and professionals versus the general public.

Pennsylvania

Pennsylvania has a decentralized system with 50 local administrative units called Single County Authorities that contract with providers. There are approximately 800 licensed providers, 512 contracted with the single county authorities. Providers at a single site may have more than one license, so fewer than 512 providers actually submit data. There are also 150 prevention providers that send data to the State. Data are supposed to be sent from any facility that receives any Department of Health public funding, but that doesn't happen. Approximately 353 of the 512 contracted programs report. Some may not report because they have no clients, or think they have waivers. Some only report publicly funded clients. A small handful report all their clients. Our goal is full reporting for any licensed facility.

The Department receives lots of questions from legislators regarding the size of the substance abuse providers, but they can't be answered. The Department estimates that it gets reporting on 30 percent of all the clients. There are 69,939 treatment episodes, unduplicated about 52,390. Statewide alcohol is the number one problem, but heroin is catching up along the interstate corridor, especially in rural counties.

The Department has a 10-year old DOS-based FoxPro system, which it is going to upgrade to a Web-based system. The FoxPro system has Y2K problems and printer problems, and it is also decentralized, so fixes have to be made on all the individual installations. The Department hopes to have the Web-based system pilot tested by July and implemented by January, 2003, although that may be a little optimistic. The Department has talked about how to build bridges between the county mainframe system and its system, but the new system should remove this problem.

New York

Having discussed New York's evaluation system at the last meeting, this time the presentation focused on the use of client data in planning for opiate services. New York used a Center for Substance Abuse Treatment (CSAT) needs assessment grant to estimate the opiate users not in treatment and prepare a prevalence estimate of opiate abuse. Estimates were prepared for New York City and the rest of the State. Client data were used to estimate the number of unique opiate users in treatment during 2000. Planning goals were set using capture/recapture methodology and consensus panels to determine the demand for opiate services. These numbers were compared to determine the treatment gap in New York City and the rest of the State.

Client data were also examined to look for trends in opiate admissions. Admissions in upstate New York increased for clients with primary or secondary use of heroin. Looking at trends between 1995 and 2001 among clients with opiates as a primary substance, an increasing percentage were referred from the criminal justice system, had major physical health problems, and were treated for mental health problems. Opiate admission rates per 10,000 population for New York counties were mapped for 1996, 1998, and 2000. These data showed an increase in opiate admissions moving outside New York City and other upstate urban areas into more suburban and rural counties.

Treatment Episode Data Set (TEDS)

Measuring the Treatment Gap and Discrepancies between Data Sets

In preparing an estimate of the treatment gap for the SAMHSA administrator, OAS had to estimate the number of persons in treatment. The NHSDA gave OAS an estimate of approximately 800,000 in a year. Raising the estimate to 850,000 to account for the populations not covered by NHSDA and multiplying that estimate by 1.63 (the estimate of admissions per year) yielded approximately 1.4 million admissions, which was very close to the TEDS estimate of 1.7 million. The estimate from N-SSATS is closer to 4 million. OAS knows that the TEDS data underestimate admissions because TEDS does not cover many private facilities and private pay clients. Consequently, OAS does not have any one reliable estimate of how many admissions there are in a year.

By statute, OAS should be able to account for all the people receiving treatment. This number is very important for policy and planning for the States as well as nationally.

OAS compared counts between N-SSATS and TEDS in 1998 for California and New York, and the counts were very different.

Dr. Goldstone asked the States if making data collection a requirement would help them. The response was that mandates do not help. Most facilities do not have the time to do additional reporting—unless there was some payoff for them, they would not participate.

Race Categories in TEDS

Beginning in 2003, the Office of Management and Budget (OMB) will require Federal agencies to include “multiple race” categories when they collect race data. OMB has ruled out asking respondents for their “principal race.” Currently TEDS has no provision for this. States can do what they want unless it involves federal funding, and then the OMB requirements apply. OAS will be preparing some guidelines for reporting race.

Uses of National Data

The last agenda item of the first day was a slide presentation by Dr. Goldstone demonstrating SAMHSA’s extensive use of data from the National Survey of Drug Use and Health (NSDUH—formerly called the National Household Survey of Drug Abuse, or NHSDA), the Drug Abuse Warning Network (DAWN), and TEDS. The slides covered three topics: 1) the data collection required of SAMHSA by statute; 2) drug use and treatment data from NSDUH, DAWN, and TEDS; and 3) the treatment gap as estimated from the household survey.

The household survey had a sample augmentation this year to study the effects of the September 11 terrorist attack. Estimates will be available in late spring. Bob Ball mentioned that New York State has some studies underway. Anecdotal information suggests that the sale of calming agents rose dramatically.

A comparison was made between the 1999 State drug usage estimates for Texas for ages 18 to 24 and 25 to 34 with some usage estimates from a Texas survey, and the estimates were very close.

The DAWN data reports for the medical examiner component and the emergency department component have been redesigned. The sample has been expanded to cover 48 metropolitan areas rather than 21. The medical examiner report was released 2 weeks ago, and the emergency department report will be available in mid-March.

All of the reports are available on the Web.

Substance Abuse and Mental Health Data Archive (SAMHDA) Online
The second day began with a demonstration of the SAMHDA Online Data Analysis System (http://www.icpsr.umich.edu/SAMHDA). This system makes it easy for users to analyze any data set in the archives. The description of the system has been reported in earlier State meeting summaries and will not be reported here.

Currently the latest TEDS data in the archive is 1999. There is a considerable time delay between when States submit data and when the TEDS data are available in the archive. This delay is caused by two factors: one is the delay between the reporting of data by a State and the time that SAMHSA has the data available from all the States for a specific year; the second is the time to prepare a data file that will meet confidentiality requirements. SAMHSA is required by statute to protect the identity of individuals both directly and indirectly.

Consequently OAS is interested in exploring with the States the possibility of making more recent data available in the archive if it would be useful to States. The data would be the most recent data submitted to Synectics and would only be available to the submitting State. Delaware indicated that they may have some analysts that would be interested but Pennsylvania, New York, and New Jersey indicated that they have adequate systems. There may be some interest if OAS could find a way to make available comparable State data so States could compare their data with other States' data.

States made favorable comments about the short reports.

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

In answer to a question about national provider numbers, Judy indicated that SAMHSA would not have to replace the I-SATS number but would be wise to do so. At this time the issue of who will operate the database of facilities has not been decided. Some people feel the operator should be a private entity, as it is for the database of Internet domain names; others feel it should be HCFA, because HCFA already does this for Medicaid providers.

Another question was whether the HIPAA system would have provision for organizations that had multiple facility sites. The answer is that the HIPAA system will track "brick and mortar" facilities as well as individuals, and there is a provision for tracking internal components.

Until recently individual ID information was suspended, but after September 11 there has been increasing interest in a national ID card. It is possible that this may renew interest in HIPAA.

Bob Ball said that it has been their interpretation that once an entity is touched by HIPAA all protected health information is covered. TEDS data are from covered entities; therefore, the data are covered and the submission has to be secure. However, once the State receives the data it is a different matter.

Covered entities can release information to some organizations under certain conditions. However, an important issue is whether or not data in TEDS (or DAWN) are seen as public health surveillance systems or as research only, since different criteria apply.

If research waivers are needed, waivers would be granted by Institutional Review Boards.

States found that this presentation very helpful. The New York State representatives felt that it was the most comprehensive they had seen and requested the slides. They intend to put them on their HIPAA Website.

Closing Remarks

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

AGENDA

DASIS REGIONAL MEETING
Delaware, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania
March 7-8, 2002

Philadelphia, PA

Thursday

8:30 a.m. Continental Breakfast

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

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

- Schedule for 2002
- Web questionnaire
- New items in 2002
- Outpatient capacity revisited
- Collecting data on cost of treatment

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

- Demonstration of Treatment Facility Locator
- Approaches to handling non-English speakers
- Demonstration of I-SATS Quick Retrieval
- State approval of facilities

11:00 a.m. BREAK

11:15 a.m. State presentations.....*State participants - DE, MD, MI, NJ,*

12:30 p.m. LUNCH

1:15 p.m. State presentations (continued) .....*State participants - NY, OH, PA*

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

- TEDS coverage and discrepanices between data sets
- Erosion in TEDS reporting
- Race categories in TEDS
- Detoxification vs. treatment admissions
- Status of discharge reporting

AGENDA (Con't)

DASIS REGIONAL MEETING
Delaware, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania
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3:30 p.m. BREAK

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

- NSDUH, TEDS, & DAWN

4:30 p.m. Adjourn

Friday

8:30 a.m. Continental breakfast

9:00 a.m. Substance Abuse and Mental Health Data Archive .....*Charlene Lewis, OAS*

- Demonstration of the on-line Data Analysis System
- Application of system to State=s TEDS files
- OAS Short Reports

10:00 a.m. Health Insurance Portability and Accountability Act (HIPAA).....*Judy Ball, OAS*

- Transactions, Identifiers, Privacy, Security
- Implications for State data systems

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

12:00 p.m. Adjourn

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DASIS Regional Meeting
Philadelphia, PA
March 7 & 8, 2002

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DASIS Regional Meeting
Philadelphia, PA
March 7 & 8, 2002

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