

DASIS STATE DATA ADVISORY GROUP MEETING

**April 5-7, 2004
Portland, Oregon**

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SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING

April 5-8, 2004
Portland, Oregon

This was the 16th Regional Meeting to be held with State DASIS representatives. It included representatives from California, Hawaii, Idaho, Nevada, Oregon and Washington, along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions, Inc. (Synectics). The representative from Alaska was unable to attend.

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

Deborah Trunzo of the Office of Applied Studies (OAS) gave the opening remarks. She emphasized the importance of these meetings to OAS and the importance of the collected data to SAMHSA for the documentation of substance abuse treatment services. Deborah reminded the group that comments and suggestions at these meetings often result in substantive changes in the DASIS programs. For example, suggestions from the last regional meeting resulted in revisions to the TEDS discharge data guidelines to emphasize the importance of reporting “date of last contact” as well as “date of discharge”.

Deborah Trunzo emphasized that the schedule of events is flexible and that participants are encouraged to fully participate in discussions.

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

Geri Mooney and Barbara Rogers of Mathematica (MPR) reported on the 2003 N-SSATS. There were 14,018 facilities in the survey and the response rate was 97.4%, an excellent response rate. The overall response rate for States attending the meeting was 96% and Idaho had 100% participation. Of all the facilities surveyed, 13 percent were closed or ineligible. The survey could have been completed by mail questionnaire or on a web site. Facilities that did not complete the survey in a reasonable time were telephoned and the survey was completed using a computer assisted telephone interview (CATI) system. Forty-two percent of the facilities responded by mail, 23.6% by web and 18.5% were completed by CATI.

The 2003 N-SSATS questionnaire included a question about whether facilities have access to the Internet, and 89 percent of the respondents answered that they do. It was noted that over 97 percent of the facilities in Alaska reported Internet access. Overall, about 1/4 of all facilities

surveyed nationally choose to use the Internet to complete the survey. Among the States attending the meeting, providers in Hawaii had the highest web completion rate at 49 percent.

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 more cost effective it will become. A significant advantage of using the Internet is that the on-line edits in the program ensure that the questionnaire is completed without errors. MPR believes that additional facilities will begin to respond using the web questionnaire once they become more familiar with it. Of the people who responded by web in 2002, 60% responded by web in 2003.

Getting accurate client counts is one of our most important goals. As a measure of accuracy, we ask each respondent if they used actual client counts or estimates. Originally, we preferred that respondents reply by mail because more respondents reported “actual counts” when responding by mail questionnaires than by phone. However, the web is proving to be a worthy alternative to the mail. The percent of respondents reporting actual counts using the web was higher for all types of services, and for all settings (hospital inpatient, residential and outpatient) compared to the mail respondents.

The number of substance abuse treatment facilities has remained relatively constant over the years. The turnover during a typical N-SSATS annual cycle (facilities being closed for various reasons) has been about 10 to 12 percent for several years. Among the States attending, 85% of the facilities in the 2003 N-SSATS were in the previous year’s N-SSATS. However the variation in States ranged from 99% in Hawaii to 70% in Nevada.

2004 N-SSATS Questionnaire

Between March 29 and 31, 2004, MPR mailed the questionnaires for the 2004 N-SSATS. The questionnaire was essentially the same as 2003 questionnaire. The revisions focused on improved wording of questions and instructions. Last year’s questions concerning methadone and LAAM clients were revised to read “methadone or buprenorphine”. The question uses the phrase “dispensed by this facility”. It was pointed out that this may cause some confusion because, while methadone is dispensed, buprenorphine is prescribed by a physician and dispensed by a pharmacy and not by a facility.

Inventory of Substance Treatment Services (I-SATS)

Alicia McCoy reported on I-SATS and the importance of States keeping I-SATS current. The I-SATS has evolved since it was first started. It began as a database that contained State approved, treatment, prevention, and other non-treatment facilities. The I-SATS now contains four categories of facilities:

1. State approved facilities;
2. Non-State-approved facilities;
3. Non-State-approved facilities that the State designates as appropriate for inclusion in the National Directory and Facility Locator; and
4. Opioid Treatment Programs (OTPs) that are certified by CSAT.

Synectics receives the names of new facilities and information to update facilities through a number of different sources. With the emergence of the Facility Locator, many facilities that

wish to be listed contact Synectics directly through email and telephone. States send us new facilities and updates to facilities through the I-SATS On-Line. During the N-SSATS, new facilities are reported by other members of provider “networks”. Also during the N-SSATS, facilities provide changes to name, address, and other data items. All of this information is used to update the I-SATS file.

In addition, Synectics and MPR periodically comb lists of hospitals and business listings of substance abuse providers to find facilities not currently listed in the I-SATS that provide substance abuse treatment or detoxification services. These facilities are contacted to confirm that they provide appropriate services before being added to the I-SATS. They are also referred to the State before they can be designated as State approved.

When Synectics receives a request to be listed in the I-SATS directly from a facility, we first search the I-SATS to determine if the facility is currently in the I-SATS. If the facility is not in the I-SATS database, we add it as a non-State approved facility. We then email the facility’s information to the State so they can determine if it is State approved. The State receives these emails mostly from Tara Davis. When Tara receives a response from the State regarding whether or not the facility is State approved, she completes a field in the I-SATS database to document that the State has reviewed the facility for approval.

The National Directory is updated annually using the information from the latest N-SSATS and the current information from the I-SATS. The Facility Locator is updated annually with N-SSATS data, but it is also updated monthly. State approved facilities that are added to the I-SATS between cycles of the N-SSATS are surveyed using an abbreviated version of the N-SSATS, called the Mini-N-SSATS. Respondents to the Mini N-SSATS are added to the Locator during a monthly update. Other facility updates are also made during the monthly updates, such as name, address and phone number changes, and closures.

Because facilities are available to the public on the Facility Locator and in the National Directory, it is very important that we keep up-to-date information for the facilities in the I-SATS. The IQRS (I-SATS Quick Retrieval System) and the I-SATS On-Line allow States to see an up-to-the-minute record of what we currently have in the I-SATS and make changes using the I-SATS On-Line, if necessary. When changes are submitted using the I-SATS On-Line, the changes go into a staging table for Synectics to review before updating the actual I-SATS database. When there are discrepancies between the information submitted by the State and information submitted by the facility, Tara sends the State an email and works with the State to reconcile the information.

The IQRS is available for States to download a list of all their facilities on the I-SATS. (Jim DeLozier will demonstrate the IQRS later in the meeting). For convenience, we have used the IQRS to print a list of the non-approved facilities for each State in attendance. At your convenience, please review these facilities to be sure none of them should be State approved. You can use the I-SATS On-line to make changes, as you deem appropriate. Remember that we rely on the States to keep the I-SATS up-to-date, and consequently to keep the facility Locator and National Directory up-to-date.

National Provider Identifier

Deborah Trunzo described the regulation on a National Provider Number (NPI) that was issued in January. This regulation designates the NPI as the standard unique identifier for health care providers. The compliance date for all covered entities is May 23, 2007. The NPI will be a 10-digit number, but not a smart number with any embedded information. There will be two types of numbers, one for individuals and one for organizations. The organization category is the one that is of most interest to the DASIS program. Basically, the agency assigning the NPI will ask for much the same identifying information as we collect for the I-SATS. Facilities will be expected to keep the NPI data up to date and, within 30 days, must notify when there is a change.

Every provider that submits electronic health information will get a number that they will keep forever. The individual provider has the responsibility to apply for the number. There will be subsequent announcements on the process. Our concern is that, eventually, this will have an impact on the I-SATS. Since legacy numbers will not be permitted, it will become pointless to keep two types of numbering systems. Complicating the situation from our perspective is that some providers are not covered entities. Non-covered entities can apply for the number, but they don't have to.

During the transition stage, we will keep two numbers in I-SATS until the NPI becomes virtually universal. I think we can anticipate that there will be some problems identifying specific providers since there may not be a one-to-one correspondence between I-SATS identified providers and NPI identified providers. This might be complicated, because we have no influence over the providers. We will have to see how facilities register multiple locations within a network or multiple programs within a location. We may have to carry more than one number or sub-numbers if two of our I-SATS facilities have the same NPI number. It is also possible that some single providers in I-SATS will have two or more NPI numbers.

I-SATS Quick Retrieval System (IQRS)

Jim DeLozier demonstrated the IQRS. This system resulted from comments received at an earlier DASIS regional meeting. The IQRS was designed to be used by State representatives 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.

The IQRS allows selection of facilities by geographic area with "filtering" by certain facility service characteristics. The search results may be printed or downloaded. The printed output includes limited information presented in order by city within State. There is more information contained in the downloaded file than in the printed results. States can download and save the search results as an excel spreadsheet or text file, giving the ability to sort or aggregate records in a variety of ways. These files can also be used with the mail merge function of word processing programs to create catalogs and mailing labels with variables and layouts selected by the user.

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. The IQRS is very "user friendly", but instructions for using the

IQRS are provided on the IQRS web site and in the I-SATS User's Manual. (All DASIS manuals can be downloaded from the DASIS web site at <http://www.dasis.samhsa.gov>).

State Presentation: California – Jonathan Meltzer

In November 2003, the California Department of Alcohol and Drug Programs (CADP) added CADDWeb to its mainframe-based California Alcohol Drug and Data System (CADD). CADDWeb is a web-based application for entering and retrieving client admission and discharge reports. The purpose of CADDWeb is to provide small and medium counties who do not have their own automated system with an automated alternative to submitting hardcopy paper reports. In addition to the front-end web application, CADDWeb uses Oracle tables to store CADD data until it is transmitted to the mainframe CADD system for monthly processing and updating, and to make the data available for downloading to counties and providers.

In its initial implementation, CADDWeb is being used by nine counties who represent approximately 20 percent of the total CADD workload. Other hardcopy counties have indicated an interest in CADDWeb, and may be added once the initial implementation is completed.

One major advantage of CADDWeb over batch processing systems is that all data is edited at point of data entry, and only 'clean' records that pass the edits can be submitted from CADDWeb to CADD. Additionally, since this is a web application that does not require software to be installed on local systems, maintenance and upgrade costs are significantly reduced. More information regarding CADDWeb and other web applications is available on CADP's website at <http://www.adp.ca.gov>.

State Presentation: Hawaii – Virginia Jackson, Jun Zhang

Hawaii presented their experience of gearing up to meet the privacy and confidentiality requirements for their data system under HIPAA. The Attorney General ruled that the Hawaii Department of Health, Alcohol and Drug Abuse Division was a health plan under HIPAA.

The Alcohol and Drug Abuse Division (ADAD) hired a consultant to help write a RFP for a HIPAA-compliant off-the-shelf system as time and resources made it infeasible to rewrite the legacy TEDS data system in time to meet the HIPAA requirements for electronic transactions.

ADAD decided to purchase an "off the shelf" HIPAA compliant system with the intention of customizing it to produce TEDS data. Historically ADAD has not authorized services on a client-by-client basis, but instead contracts with a provider network to provide specific services at a set rate to individuals who meet ADAD guidelines. The off-the-shelf system was designed for an insurance setting where billing is on an individual service basis. ADAD pays providers for aggregated services upon submission of a monthly invoice.

The original plan conceived by the developer of the off-the shelf product didn't provide for the intended direct access by providers to submit data to the main database. After much deliberation, it was determined that providers needed the same system as ADAD with special security functions to limit access. The next step taken by the developers was to write custom

programs to meet TEDS reporting requirements. The system did produce a screen showing TEDS fields for the individual client. However, the system did not enable ADAD to aggregate the data for either TEDS reports or invoices. Although the system essentially had the essential HIPAA components, it failed to meet ADAD's requirements that it be capable of generating both aggregated invoices and TEDS reports, as well as being HIPAA-compliant.

In order to meet its TEDS reporting requirements, ADAD has adjusted to the situation by maintaining two reporting systems until such time as the off the shelf system can meet the TEDS reporting and aggregate billing requirements. ADAD has disconnected its billing function from its old legacy TEDS system and now only uses this system to collect and aggregate TEDS reports. Invoices are now being prepared non-electronically (manually). This arrangement has more than doubled the workload of both ADAD and service provider staff and cannot continue indefinitely. ADAD is exploring WITS to see if WITS, with a workable billing module, is a better alternative than continuing attempts to modify the off-the-shelf system.

State Presentation: Idaho – Don Corbridge, Jean Gonzales

The Idaho Department of Health and Welfare works with a Management Service Contractor (MSC), an intermediary who sub-contracts with the providers to deliver services to the clients. The provider screens the client and sends the screening information to the MSC for authorization. The MSC reviews the screening data and authorizes treatment. The MSC pays the provider on a fee for service basis. In turn the MSC invoices the department for the services.

Data for all reports are initiated by the provider and passed on through the intermediary to the Department. Data are transmitted three times a day over a secured dedicated line, and the department receives the data on a client within 48 hours of the service.

Idaho is collecting some outcome data. At the time of admission a client survey is done, and an "admission profile" created. For a sample of clients, a repeat survey is done 90 days post admission. The sample is a random proportional sample of admissions with a sample size of 100 a month and a yearly total of 1,200. Currently 24% of the sample has been contacted 90 days after admission. Participation results are to be reviewed and it is expected that an improved contact method can raise the contact rate to 50% of the sample.

The survey at both admission and 90 days post admission are conducted using Interactive Voice Response Technology. The system uses computerized taped scripts in both English and Spanish. Responses are given using touch-tone keypad. The survey gathers data on alcohol/drug use, STD risk behaviors, traffic accidents, living arrangements, suicidal risk, support group use, criminal history, health (use of emergency services) and work and/or school attendance.

Results compare the population at admission with the sample at 90 days post admission. The results are a single statewide percentage for the sample. As the contact rate for the sample grows, estimates can be made for special sub-populations.

State Presentation: Nevada – Jim Gibbs, Brad Towle

Nevada described their efforts to improve their current system, both in technology and content. The current system does not operate on operating systems newer than Windows 98, can only be

used by one person at a time at the provider level, and is not a user-friendly reporting system. In addition, the current State system does not track clients through levels of care, cannot provide discharge data, and does not track outcomes.

In modifying the current system, the Department wanted one that:

- Includes TEDS data
- Includes outcome data
- Meets Block Grant reporting needs
- Produces standardized user friendly data reports
- Enhances the quality of the data
- Does not overburden providers

The Department involved providers, members of the drug commission, the University and other stakeholders in the system in the process of selecting a new system. Nevada selected the WITS system because it facilitates monitoring scopes of work, includes outcomes data, allows selection of priority populations and waiting lists, and provides reports on the performance of each grant cycle. It also provides other very good tools, including an advanced electronic consent and referral system, data to support clinical and management decisions and standardizes client assessments. WITS is built on a new (.net) platform.

Nevada intends to proceed slowly to make sure the system is well tested before implementation. After initial tests, the plan is to start with 2 or 3 providers and then gradually bring others into the system.

State Presentation: Oregon – Janelle Jeggie, Ben Kahn

Recently, State services were reduced due to the economic downturn. Outpatient services were reduced by \$2.7 million and residential services by \$1.7 million. Oregon spends about \$22 million per biennium. In order to measure the effect of this downturn, a comparison was made between October –December 2000 with October –December 2003. The comparison was done using enrollment and termination data for adults only and excluding DUI clients. The data came from the Client Processing Monitoring System (CPMS), Oregon’s version of the Treatment Episode Data Set (TEDS).

In 2003, there were about 23% fewer enrollments. Minorities comprised a slightly larger percent of the total enrolled, going from 20% in 2000 to 23 % in 2003. These percents are higher than the general population, which is composed of 13% minority. There was also a 3% increase in the percentage of women enrolled between 2000 and 2003.

The data were also examined by living arrangement and there was an increase in the percentage of enrollments either homeless or living with parents (data exclude persons under age 18). More people were willing to report their monthly income in 2003 than in 2000 and the percentage without income increased from 36% to 41%. The percentage reporting “no job” increased from 66% to 72%.

The Oregon Health Plan (OHP) eliminated coverage for chemical dependency for the OHP standard population. As a result, the percent of the enrollees with coverage dropped from 44% to 28% and the percent with no coverage increased from 42% to 54%.

While demographics can help identify the type of client entering the system, they are not the whole picture. The next step was to look at outcome data. In comparing outcome data between 2000 and 2003, data from Treatment Outcome Improvement Reports (TOIR) were used. Three measures were examined: Retention (Clients in treatment for 90 days or more), Reduced Use (Clients who reduced /eliminated use of alcohol and/or other drugs), and Completed Treatment (Clients who completed at least 2/3 of their treatment plan and were not abusing alcohol and/or other drugs).

These data include both adults and youth as well as DUI clients. However, it excludes clients receiving detoxification services. A greater percentage of clients are staying longer in treatment now than in 2000, 65% are in treatment longer than 90 days as compared with only 38% in 2000. A greater percentage of clients (72% versus 58%) are leaving treatment programs with reduced use and, finally, a greater percentage of clients are completing treatment now than in 2000 (63% compared with 43%).

So, although expenditures have reduced enrollments, treatment effectiveness as measured by these variables has improved.

State Presentation: Washington State – Doug Allen and Fritz Wrede

Washington State presented their DASA Treatment Analyzer (DASA-TA), a Web-based reporting and query system providing access for Division of Alcohol and Substance abuse staff to access up-to-date, accurate and reliable data for tracking outcomes and other information about publicly funded clients.

The system information will be available to the staff of providers, counties, regions and the State. Client data will only be available in an aggregate form and on a need-to-know basis, with table cells suppressed for cells with small numbers. Output reports are provided at the State, regional, county and provider level.

Summary information about clients will include demo graphics, type of funding and primary drug use. Post discharge outcomes will include data on employment/wages, felony arrests, mental health service use, death and chemical dependency treatment re-entry.

The system provides standard preformatted tables and charts on selected topics of major interest. There is also a system to allow the user to build their own queries by selecting from drop down menus.

Some examples of the types of questions to which the system can provide answers are: What was the percentage of clients getting employed after outpatient treatment in 2000? Was it the same for men and women? How many clients were retained in opiate substitution treatment for 3, 6, 9 and 12 months after admission?

Treatment Episode Data Set (TEDS)

Leigh Henderson gave a slide presentation on the Treatment Episode Data Set (TEDS), discussing year 2000 discharge data to illustrate how the TEDS discharge data may be used. For 18 States submitting 2000 discharge data, about 325,000 records can be linked to admission records. More discharge data are being received for alcohol and less for the opiates. However, these are reasonably good data for the initial round of reporting, and new States continue to begin discharge data reporting. Currently, there are 31 States submitting discharge data to TEDS.

The first few slides show the results when we examined reason for discharge by “type of service”. As these slides indicate, there are significantly more transfers to other types of treatment in a controlled environment, such as residential treatment programs. Treatment completion is just under 50%, however, those admitted for opiates are less likely to complete treatment. This may be the result of clients in methadone treatment who are not discharged, but simply stay in treatment.

When a client is referred to treatment through the criminal justice system, it was initially believed that they would be more likely to stay in treatment, but this was not the result. Regardless of how a client got into treatment, there was about a 50% completion rate. However, the longer a client is in treatment, the greater the completion rate for all types of service.

By age, up through approximately 18 years old, the proportions of clients who complete treatment are similar. The completion rates begin to increase with age after 18 years. By substance of abuse, the worst completion rate was for opiates and the best completion rate was for alcohol admissions.

Looking at all client records, the data indicated that marijuana admissions had a longer median length of stay in treatment than did opiate admissions. Since this phenomenon doesn't make sense, we looked at the type of treatment provided. The median length of stay by type of treatment showed that the majority of marijuana admissions receive outpatient treatment and few receive detoxification services. Furthermore, the length of stay for opiate admissions appeared to be unusually short. Again looking at the data according to the type of service, it was clear that length of stay for opiate clients was short because a large proportion of the admissions were for detoxification which has a median length of stay of only four days.

Monitoring TEDS Data

Jim DeLozier distributed the latest monthly TEDS production report. The production reports show the TEDS data submission status for each State. This report is provided to the Office of Applied Studies so they can monitor TEDS operations. The report shows how recent the States' data are, how long it has been since a TEDS file was submitted, and the number of records received to date. Synectics uses this report to monitor each State's performance. When there is a significant lag in data submissions, gaps in data or other data quality issue, Synectics contacts the State to determine the reason for the problem.

As more and more States submit discharge data and we begin discharge data analysis, our attention has been directed to monitoring the completeness and quality of the discharge data.

About half of the States are submitting discharge data and most others are expecting to begin submitting discharges to TEDS within a year. Among the States attending this meeting, Idaho has submitted their first file recently, and Alaska will be sending a test file very soon. Each month we are adding a State or two.

We monitor several aspects of the discharge data submissions, but our primary focus is on the percent of discharges that are matched with admission records (which should be close to 100%) and a comparison between the number of admission and discharge records submitted in a calendar year. While we don't expect there to be one discharge for every admission, the number of discharges and admissions should be relatively close over time.

A brief summary of the discharge information collected in the 2003 DASIS Annual Report was also distributed and discussed. This information focused on the State discharge policies and the procedures followed to collect and report discharge data. The great variability among the States with respect to discharge data policies was the most striking finding.

Analysis of the discharge data, particularly length of stay in treatment and reason for discharge data, is of great interest to SAMHSA and others. The quality and utility of these analyses are dependent on the quality of the TEDS data. We are dependent on each State to send us good quality data in a timely fashion, and all States are urged to continue working toward improving their TEDS data.

Closing Remarks

Deborah Trunzo ended the meeting by thanking the attendees for their participation. All States are encouraged to contact OAS, Synectics or MPR staff with any suggestions or problems they may have.

DASIS REGIONAL MEETING

**Alaska, California, Hawaii, Idaho, Nevada, Oregon, Washington
April 6-7, 2004**

Portland, OR

Tuesday

8:30 a.m. Continental Breakfast

9:00 a.m. Welcome and Introduction.....*Deborah Trunzo, OAS*

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

- \$ Response rates 2003 *Barbara Rogers, MPR***
- \$ Conducting N-SSATS on the Web**
- \$ Client counts**
- \$ Milestones for 2004 survey**
- \$ 2004 questionnaire**

10:15 a.m. Inventory of Substance Abuse Treatment Services (I-SATS).....*Alicia McCoy, Synectics*

- \$ Importance of I-SATS updates *Jim DeLozier, Synectics***
- \$ Approved vs. non-approved facilities and process for review *Deborah Trunzo, OAS***
- \$ Impact of Access to Recovery program on State licensing practices and I-SATS**
- \$ Impact of National Provider Identifier on I-SATS**

10:45 a.m. BREAK

11:00 a.m. Inventory of Substance Abuse Treatment Services (I-SATS) - *continued*

- \$ Demonstration of I-SATS Quick Retrieval System (IQRS)**
- \$ Demonstration of redesigned DASIS project home page**

11:25 a.m. State Presentations*State participants - AK, CA, HI*

12:30 p.m. LUNCH

1:15 p.m. State Presentations*State participants - ID, NV, OR, WA*

2:30 p.m. BREAK

2:45 p.m. State Presentations - *continued*

3:45 p.m. Day One Wrap-up Discussion

4:00 p.m. Adjourn

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**DASIS Regional Meeting
Portland, Oregon
April 6 & 7, 2004**

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