

# **DASIS STATE DATA ADVISORY GROUP MEETING**

**June 10-11, 2003**

**Portland, Maine**

<b>Summary</b>	<b>Page 2</b>
<b>Agenda</b>	<b>Page 15</b>
<b>Participant list</b>	<b>Page 16</b>

**SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING**  
**February 10–11, 2003**  
**Portland, Maine**

This was the 14<sup>th</sup> Regional Meeting to be held with State DASIS representatives. It included representatives from Connecticut, Maine, New Hampshire, Rhode Island and Vermont, along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions, Inc. (Synectics).\*

The DASIS regional meetings are held to provide an opportunity for face-to-face discussions between State DASIS representatives and staff of OAS, and the DASIS contractors, Synectics and MPR. The meeting agenda is flexible to maximize the opportunity for discussing issues of particular importance to the State representatives. Through discussion and brief presentations, States are informed about recent OAS activities and are given an opportunity to share with OAS and each other their concerns and solutions to common problems in data collection and management of information.

### **Opening and Overview**

Dr. Goldstone of the Office of Applied Studies (OAS) gave the opening remarks. He emphasized the importance of these meetings and the importance of the collected data. He also noted that the OAS and contract staff are here to get advice, criticism and suggestions, and that this was not to be seen as a presentation, but an opportunity to give and take. He noted that the comments and suggestions from the meetings have been invaluable. He and his staff look to these meetings for advice and direction, and hope the participants will participate actively in the discussions. Dr. Goldstone mentioned to the group that the schedule of events had to change due to an unexpected situation. Charlene Lewis would be demonstrating the Substance Abuse and Mental Health Data Archive on the first day instead at the following day.

### **Demonstration of Online Data Analysis System**

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

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

Among the datasets available for download or analysis from the SAMDHA archives are TEDS, NHSDA, and DAWN.

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\* The representative for Maine was unable to attend the regional meeting.

Ms. Lewis also discussed the SAMHDA “How to” report, a Short Report, published in November 2001 that is designed to take a data user through the basic functions of SAMHDA and to demonstrate how to use the on-line analysis system.

The DASIS Short Reports were also briefly discussed. Their goal is to release one short report every week. Most reports are brief analyses of data, though five reports were developed to help people use the data and to make TEDS and N-SSATS data more accessible. The Short Reports have been very popular. The first issue of the short report, covering women in treatment for crack cocaine, was published in July 2001 and it continues to receive 150 hits every week on the web site.

A question was raised whether mapping was available on the SAMHDA web site. This generated a discussion of confidentiality and the disclosure of personal information that might enable one to identify an individual. The issue of liability was of major concern. Dr. Goldstone discussed the law as it now stands in terms of culpability for the release of information that may be used to identify individuals. The OAS is in the process of trying to develop methods whereby States and individual State-level analyst could use the data while ensuring the protection and confidentiality of the data. Provision in the SAMSHA law states that individually identifiable data may be made available only with the permission of the individual, and that the data can only be used for the purpose for which it was collected. There is a penalty provision in the law, specifically for federal employees who willfully make covered data available. The penalty is \$250,000 and 5 years in jail. The OAS views this as a good reason to be very careful.

If a system for releasing data to states can be approved, at a minimum, users will have to sign a statement acknowledging their understanding of the law and its penalties. The OAS may need to visit agencies from time to time to determine if storing procedures are adequate and other safeguards are in place.

Dr. Goldstone made a point that the government is spending much too much money on data collection to not take advantage of it, and that it is imperative to make this data available to the States so that they can use it.

### **N-SSATS Overview**

Geri Mooney and Barbara Rogers of Mathematica (MPR) reported on the N-SSATS. The 2002 N-SSATS response rate for State-approved facilities was 97 percent. Of all the facilities surveyed, 12.9 percent were closed or ineligible, which meant that in 2001 they provided services and in 2002 they no longer provided service for various reasons. The survey can either be completed by mail or web and, if the facility does not complete the survey in a reasonable time, they will be contacted by telephone and the survey will be completed by phone.

In a table showing response rates for the states in attendance, Vermont had an unusually high proportion of responses on the web. Dr. Goldstone commented that SAMHSA has been trying to get more surveys completed over the web, and wondered why Vermont was so different. Vermont indicated that they have many small providers that don't have Internet access, however, those that do use it.

MPR continued by stating that Vermont's percentage of mail responses is the same as the national average and that every year they expect the web response to increase. MPR believes that additional people will begin to use the web once they become more familiar with it.

Questions ensued surrounding access to the Internet. Connecticut, for example, asked how Internet access is defined. MPR responded by stating that questionnaires are sent to individual facilities and the facility is asked if they have Internet access. Ms. Trunzo commented that some respondents may have lost track

of the location for which they're supposed to be answering. Massachusetts wanted to know whether a respondent could start the survey and stop before completing it on the Internet and later return to finish it. The answer was yes. It was also stated that this capability would allow, for example, the director of the facility to go to another person who can answer a question and return later to complete the questionnaire. Vermont indicated that some of their real small providers wouldn't do the web because they only have dial-up access while others are on a hub with T1 access.

MPR described the web experiment that they conducted during the 2002 N-SSATS in which they tested three versions of the web questionnaire. The three versions were:

- 1) Level one version with no error prompts,
- 2) Level two version with error prompts, but respondents could proceed without correcting the error
- 3) Level three version where the respondent had to correct the error before they moved forward.

The respondents were randomly assigned to one of the three versions and, after several hundred respondents had been assigned to each level, they found no significant difference in completion rates among the levels. As a result of that outcome, the 2003 N-SSATS is using only the level three version of the questionnaire.

Economically, the web completes will save money. During the 2003 survey, an experiment is being conducted to test a method for encouraging respondents to complete the survey on the web. In several states, respondents were provided with the web address and instructions before being provided with the mail questionnaire. After allowing 2 weeks for web participation, those not responding were sent the mail version of the questionnaire.

Initially, the experimental web group was behind in total completions, but as of this meeting, their completion rate is the same as all other respondents. The experimental group does, however, have a higher proportion of web completes than the other respondents by about 10 percentage points.

Dr. Goldstone queried if we get better results from web respondents. Ms. Rogers stated that they believe they are getting slightly better data from the web than the hard copy form. From the editing perspective, of course, the web questionnaires have been "pre-edited" so are much better than the mail questionnaires. Ms. Trunzo emphasized that start-up costs of programming the web questionnaire are high, so they need a higher response rate in order for the web version to begin to save money.

MPR continued with their presentation and discussed how the respondents completed their surveys in past years. In 2000 and 2002, the majority of responses were by mail, and the least by web. However, respondents appear to be moving towards accepting the web, especially as they get experience using it. MPR does not believe that they are pulling many respondents from the phone to the web, because phone respondents are procrastinators and will be so regardless of data collection mode.

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

The goal is to keep the questionnaire the same from year to year. However, changes in terminology or improvements in data collection are unavoidable since we must stay current. There were a few noteworthy changes to the 2003 N-SSATS questionnaire. A question on Buprenorphine was added this year in addition to a question that was there several years ago – residential beds for clients' children. In Question 15, we simply want to know what facilities provide specially designed programs for special groups. The questionnaire first asks if the facility treats a special group, then the question is asked if the facility has a specially designed program for the special group. The term "dual-diagnosis" was changed to "co-occurring mental and substance abuse disorder". MPR conducted research to determine if co-

occurring met ASAM criteria, and got different opinions from different people within a facility as to whether the facility was “dual-diagnosis capable.” Ms. Trunzo clarified the latter statement by noting that the main reason the survey question is asked is that the information is included in the Locator because the public wants to know. Dr. Goldstone added that this is a policy question, not just a Locator issue, and goes to the heart of the use of the funds.

Continuing with a review of the 2003 the questionnaire, residential treatment was divided into two categories of “30 days or less” and “more than 30 days”. Question 20 was added which recognize that some facilities have free treatment for all clients. Question 27 was revised to better capture the correct information we are seeking. It was determined from past experience that if a facility is simply asked their outpatient capacity, the numbers were meaningless. It was decided to ask the facility how many clients they treat and how many clients they think they could treat on the point prevalence date. Those numbers are then added together. This question was discarded some years ago because it was unreliable. However, it is back in the questionnaire because of needs expressed by the Office of Management and Budget. Providers and States have indicated that the information is not very useful, and has no inherent validity. Dr. Goldstone commented that facilities have conveyed to him that when they are in trouble and in need of additional space, they rent another room and hire another counselor. There is no real limit to how many clients they can treat.

Ms. Trunzo noted that the most frequent question received from the Locator users is “where can I get treatment at low or no cost.” This resulted in adding the question on whether the facility provides treatment at no cost or on a sliding scale. This appears to be a hot question for the public.

The representative from Connecticut suggested that there should be better ways to use data sources when making policy decisions. Resources to bring all of these data sources together are needed. He continued by asking when the PPGs for Block Grants are coming since they also have questions like “do you conduct testing for HIV and mental health services.”

Dr. Goldstone stated that there have been discussions recently about using TEDS instead of imposing a separate system for PPGs by modifying TEDS to do some things it does not now do. In those discussions, it seems clear that OAS has the software to extract the data in addition to the capacity using the TEDS system. Within TEDS there is also the Supplementary Data Set, which provides the capacity to collect additional data items. However, we cannot make big changes in the basic TEDS system, in part because different States have different requirements and different capabilities. TEDS is based on admission forms which are driven by different factors, including payment. We cannot decide to collect data at the Federal level and expect the State systems to immediately accommodate. Changes must be reasonably conservative and reasonably consistent with what exists now.

The Connecticut representative asked whether there are ways to leverage what is already being done instead of putting the burden on the States. Dr. Goldstone replied that TEDS gets you a long way down the road and that if we can get complete discharge data sets, with the supplemental variables, we are almost there. TEDS will never be able to provide a description of client’s social setting. We are unable to efficiently ask that in the administrative context. PPGs were worked out in part with the State directors. The State directors may not understand the complexities. There should be some give and take to what you will be willing to accept for PPGs.

Dr. Henderson commented that it sounds like the Connecticut representative is asking for facility level data. She made note that we won’t be able to get that information from TEDS, however, we may be able to get it from N-SSATS.

Connecticut continued by stating that decisions are needed soon. He noted that there are some service level data for PPGs (as opposed to client-level data), and that they currently include things like HIV and TB testing. Finally, he asked whether they could use this point-in-time survey rather than collecting annually.

Dr Goldstone explained that N-SSATS allows you to answer some questions that are not available elsewhere. If N-SSATS and TEDS are combined, many of the PPGs data requirements are available without imposing additional burdens on the states. Ms. Trunzo added that, currently on N-SSATS, it is asked whether HIV/AIDS, TB testing is conducted. Dr. Goldstone continued by reiterating that we have been hesitant to make any changes in the TEDS data system. Some States are still “hard wired” and use a main frame, so it is understood that it may be very difficult for some States to make changes. These data sets are a compromise between what is needed and what can be collected easily.

MPR made note that the N-SSATS 2002 data are being sent to the States on CD, with State-approved and non-approved data in separate files, within the next 2 weeks. Ms. Trunzo added that if the States have comments on the content or format, or ways to make the data more usable, please let us know.

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

The discussion began with Dr. Goldstone asking whether States knew who was providing buprenorphine and if this information could be added to the Locator as we get it in the survey. The representatives from the States engaged in conversation concerning how different States are. In MA, the Department of Public Health has responsibility for providing information on who is providing buprenorphine, but it is in a different physical location and difficult to coordinate with them. MA is resistant to any medication, including methadone. The legislature has proposed a ban on contracting with agencies that provide methadone. It is very political. MA believes that calmer heads will prevail, but the average recovery home is drug-free.

In Connecticut they are trying to push out methadone users earlier to detoxification and residential settings. There are too many repeat admissions and cycling through the system. Connecticut also asks if buprenorphine requires the same certificates as those needed for the methadone process. In Rhode Island, the representative made a point that they do not get information concerning buprenorphine from private doctors because they do not want it advertised that they use it.

Continuing with the discussion, Dr. Goldstone asked all of the participants whether facilities are certified to provide buprenorphine as a facility or is the clinicians in them certified individually. He also stated that his office would do what it can to ensure that this information is made known as soon as possible. Dr. Goldstone then queried the participants on whether they were aware of the Locator and if they, in fact, use it. The response was generally, yes; they did know about it and use it.

Ms. Trunzo discussed the volume of hits received on the web site per week (6,500) and that links can be provided to other web sites and telephone numbers if there is a particular web page or telephone number the States wish people to contact. Specific hot lines can also be added to SSA information. Dr. Goldstone explained that this is not a tool exclusively for patients, but it is there to help the State representatives. Some States use it in lieu of their own system since they are the one who update it.

Mr. DeLozier explained that all State contact information can be found on the Locator, and that periodically the data are sent out to the States for a review. He also told the State representatives that contact would be made with each State in an effort to determine if the State has a hot line number or a particular web page that they wanted linked to the web site. Mr. DeLozier informed the participants that the process of contacting all of the States and updating the web site would take a little time.

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

Mr. DeLozier demonstrated the DASIS Project Home Page and the I-SATS Quick Retrieval system. He also explained that anyone from the States can gain access to the DASIS site as long as the State approves them for access and they receive a password.

### **I-SATS**

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

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

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

Ms. McCoy briefly discussed the procedures taken to update the I-SATS and how the data from the N-SSATS is used to assist in this process. It was also explained that I-SATS is not linked to the locator because the public cannot have access to it. Ms. Trunzo also conveyed to the States that the I-SATS on-line will be more up to date than the Locator. There is a time lag for the Locator. Some facilities opt out of the Locator, however I-SATS on-line includes all facilities whereas the Locator is State-approved or not.

### **Satellite facilities and Providing Treatment in Remote/Rural Areas**

Ms. McCoy discussed concerns around the definition States have for satellites. She explained that e-mails were disseminated to a group of States that asked them how they defined satellites. SMDI defines them as facilities with limited staff and hours, more often in remote or rural areas, and having limited or scaled back hours of operation. Some States define satellites as facilities that are part of a network. Many of these facilities can and do provide data to N-SSATS.

Massachusetts explained that they define satellites as a smaller part of a larger agency and that they would want the satellite to be added to the Locator. Ms. McCoy explained that SMDI considers Massachusetts

definition of satellites as a network and not a satellite site and that our purpose is to try and find facilities not on the I-SATS.

It is important to map locations so that people can find treatment in their particular areas. Therefore, we need the address for each facility. It is also important to get information on mobile clinics.

In Massachusetts, they have what they call “dosing vans.” However, you must enroll to use them at the facility from which the mobile van originates or goes out. The State representative will look into how they are reported on I-SATS and get back with SMDI.

New Hampshire was unable to remember if they had any satellite sites other than one. However, they made it clear that any facility with a separate physical address has its own I-SATS number.

The discussion continued with how the States received clients at the satellite sites. In Vermont, the client is required to go to the main facility where they are then discharged and readmitted to the satellite site with a separate I-SATS number.

In Connecticut, they have facilities with multiple services with one intake that they would consider to be a satellite. They think of satellites as occasional services with small numbers in a remote location.

## **State Presentations**

### ***Connecticut***

The State of Connecticut DMHAS has an array of data systems because of the historical way data items were collected or stored. Attachment 1 to their presentation shows the various ways that data are currently sent into the system. DMHAS is currently trying to simplify and consolidate databases, applications, and dictionary values. The State has found web-based data input to be problematic in that a sophisticated system is needed in order to have appropriate edits and the ability to look and see data that has been input. The State has been developing a Provider Access System (DPAS), a Visual Basic application used through a Citrix thin client, for about a year. This system has the ability to allow providers to input and review the data they have submitted. The State now has 106 mental health agencies using it, and expects to have another 76 substance abuse providers using the system in the next five months. This application is primarily used by smaller private non-profit agencies for data input as larger agencies have sophisticated MIS systems and typically send data extracts of their client information. All providers, regardless of size or method of data transmission, can review their data with the DPAS application.

It has been a challenge and long-term effort to have provider agencies review their data and provide feedback or make corrections, even though they are given the necessary reports and tools. This effort is driven by the need for quality improvement since good data are needed to make good treatment, contracting, and performance measure analyses. The State has run a series of trainings and large meetings to demonstrate and provide hands on experiences with the applications and the data. This has been a labor intensive but productive process.

The State substance abuse agency was given a legislative mandate in July 1999 to collect service data across state-operated and funded substance abuse treatment, prevention, and intervention programs. This required developing uniform policies and procedures for collecting, standardizing, managing and evaluating data. The legislation requires the substance abuse agency to establish and maintain a central repository, and submit a report to the legislature every 2 years. This initiative was a new undertaking and was to be accomplished within existing appropriations. Two committees were established: the first the

Interagency Policy Steering Committee to determine and direct policy-relevant data analysis, and the second the Interagency Operational Workgroup to provide logistical support.

Of primary interest to the legislature, is examining substance abuse service demographics, trends and client outcomes across state agencies. Additionally, the legislature is interested in linking persons across various state systems such as welfare, criminal justice and child protective services to those receiving substance abuse services. The first effort to link information used a model developed by Bristol Observatory using probabilistic population estimation (PPE). This method can't identify individuals, but can determine the likelihood of someone being in two different databases within a 95% confidence interval using only DOB and gender. The benefits of the model are that the costs are modest and confidentiality, for the most part, is not an issue.

### ***Massachusetts***

The State data infrastructure is intended to collect, store and analyze substance abuse data that are needed by funding entities. It is also designed to support federal and state reporting requirements. This can sometimes conflict with what providers want to report, and with the best interest of clients.

The Governor has proposed to reorganize the state's Executive Office of Health and Human Services. There are currently 15 agencies in HHS reporting separately to the Governor. In the proposed structure (which is currently declined by legislature), the BSAS would be in the Department of Public Health. There, it would be more closely allied with other funding agencies and mental health programs. The Bureau is the licensing authority for substance abuse treatment facilities and counselors. It is also responsible for payment of services to indigent clients and clients using long-term residential services.

The Bureau's Substance Abuse Management System (SAMIS) combines electronic (client) and paper (billing) data collection. Substance abuse treatment providers report data, but the system does not include mental health information. All admissions and discharges are reported, and licensing information is also entered into the system. An algorithm is used to link admissions and discharges within facility/agency because the client ID is unique within provider. It is very difficult in the SAMIS to amend data elements and to develop integrated analyses. .

The SAMIS data quality is good but it is hard to identify clients. Trends are available for admissions, but not for individuals. Since 1992, total admissions have gone up, primarily because detoxification admissions have increased. The number of outpatient and residential admissions has been relative constant, largely because of bed capacity and managed care.

In FY02, the state tried to identify clients entering the detoxification system to determine how many individuals were treated. (See appendix B for results of the analysis). Because of the limitations of the system, this analysis took several weeks to complete.

To overcome the limitations of the SAMIS, the state is moving to a Service Tracking and Electronic Payment System (STEPS). This system will provide for collection of TEDS data, incorporate treatment information, and allow for specialty data collection. Data will be collected once for multiple users and uses. It will be accessible for authorized users to the minimum data needed, and will speed client eligibility determinations. Its integrated data architecture will enable data to be shared with agencies outside Public Health, especially the comptroller's office. STEPS will also provide greater analytical capability and enable better coordination within BSAS since the same data system will be used for all contracting providers.

### ***New Hampshire***

The New Hampshire Division of Alcohol and Drug Abuse Prevention and Recovery is the smallest division in the New Hampshire Department of Health and Human Services. Obtaining adequate funding for its data systems has been difficult. The Division currently operates several small systems that are Access-based and use paper-based data collection. The facilities send their data using paper forms, which are manually entered into the database. This is a very labor-intensive process. The State is now trying to migrate to an SQL server and do some batch processing to make the processing more efficient.

The state has many of the same problems expressed by other states. Developing methods for safe and efficient data transmission is a major goal for the state. They have experimented with Acrobat forms and e-mail, but have not yet decided on a method. They do not think that web based data entry is useful since the technology for efficient data collection is not yet available. The state also has problems similar to other state in identifying individuals. They have a legislative mandate to collect data and provide reports to the legislature, but have difficulty providing data on unduplicated counts of individuals.

### ***Rhode Island***

Historically, the State started with a data system that included NCR forms filled out at the provider level, which was sent to the State for data entry. The agency was downsized, and lost data entry staff. The State then went to DBIV, a DOS-based system. When that became unusable, they moved to an Access program. The state is considering a move to an SQL server in the new two years

Currently, providers have TEDS and State data items built into their systems or they extract the data and send to the state on diskette. Data submissions are encrypted and sent to the State's main server where the data are cleaned. Processing routines detect errors, which staff review and correct by contacting the providers. Programming routines provide reports and data files that are used for TEDS, calculation of utilization rates, grant preparation, and for monitoring contract and treatment plan compliance.

The system compiles a single admission-discharge record. In an unusual process, clients can be "reverse discharged". This can occur when a discharged client reappears within 90 days of the discharge.

The system builds an historical database for each provider, and each provider can run reports for its own data. Canned reports are available for the most frequently asked questions. The process has been simplified because many providers have extensive staff turnover and do not have the capability to perform sophisticated analyses.

### ***Vermont***

The State's current administration has been supportive of substance abuse treatment as a means of cost avoidance. They believe that it is cheaper to take care of folks than to keep them in jail. They have added \$8 million targeted for treatment of substance abuse clients. Addition of these funds doesn't necessarily translate to increased staff in the Division of Alcohol and Drug Abuse Programs (ADAP), but it has provided significantly more money for treatment. There is currently an initiative to reorganize the Agency of Human Services. At the present time, ADAP is a division of the Department of Health but with a growing heroin problem in the State and the publicity surrounding substance abuse, there have been discussions about making it a department level agency. The director, Tom Perras, is retiring in September after many years of service, and he will be difficult to replace. ADAP presently has no budget for computer systems or equipment, so upgrading at this time is problematic. ADAP gets money under the DASIS agreement, but not much more.

The State has great difficulty getting substance abuse providers to send quality data. The substance abuse data system is antiquated and recently died. Since then, it has been rebuilt as an Access database. The

State helped to provide a full system for the provider facilities because they were using a paper-base system.

Currently the State receives admissions, services, and discharge data from about 30 contracted providers. They send their data on diskette to ADAP and the data are uploaded to the ADAP System. Some of these are mental health agencies that have complicated data collection systems. Basic reports are prepared from the data, and the admissions data are extracted for TEDS for submission to Synectics. The state collects discharge data, but does not send it to TEDS. At this time, the State is concentrating its efforts on getting good admissions data.

Data accuracy is an issue, and there are specific problems related to payment responsibility. A client may have 3<sup>rd</sup> party insurance when admitted, and then switch to Medicaid. Payment source is part of the admission record, which links to the services record but, when the insurance changes, the admission record has to be changed. This is not always done reliably, so there is always a concern with the accuracy of the information.

It is very difficult to make any change to the database because it requires each provider to change its system. This is made even more difficult because almost every provider has a different data system. Changes also impact the data system of the Department of Mental health and Development, so their cooperation is needed for any changes.

ADAP has received a State Data Infrastructure grant, but the work will be done under contract because the agency does not have the necessary staff. The agency is also looking at implementing the WITS database, but must make sure the providers will accept it.

One of ADAP's problems is that they have different databases for every thing they do. Their intention, therefore, is to add flexibility to any new data system that will allow integration of data from other programs. For example, the agency is doing work with co-occurring diagnoses, but in the current data system only one diagnosis can be recorded. Other current or planned programs to be included are the student assistant program, public inebriate program, drug courts and recovery centers.

ADAP is a health plan under HIPAA because they pay for services. Consequently, any new data system developed by ADAP must be HIPAA compliant.

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

Leigh Henderson gave a slide presentation on the Treatment Episode Data Set (TEDS), discussing year 2000 discharge data and also briefly discussing detoxification issues. For the 18 States submitting discharge data, 325,000 records can be linked to admission records.

The data showed the fewest records for opiates, which is due to the nature of the substance. Just over 50 percent completed treatment successfully. It was expected that treatment rates would vary by how one entered treatment, however, treatment rates were about the same at 50 percent. However, if a client was previously in treatment, he/she was more likely to complete treatment.

The presentation showed the significant role age plays in the treatment completion rate, showing that the older a client is the more likely it is that the client will complete treatment. Other variables such as median length of stay were also presented and discussed.

The Massachusetts representative stated his concerns that all of their treatment facilities are not yet comfortable in treating all substances. Discharge data alone does not provide them with the picture they

need to make decisions. They have found that under 20 percent of the clients who came out of detoxification were in some sort of treatment within one year.

Dr. Goldstone mentioned that OAS has been presenting data that include detoxification data as part of treatment admissions. He noted that detoxification is not a part of treatment, but rather is a medical emergency. He went on to discuss the possibility of separating out detoxification admissions from the treatment data and the potential issues that would follow that decision. It would change our trends data and change the picture of treatment. As it stands, we have no way of tracking clients who move from detoxification into treatment without a break in service. He then asked whether there is any way we can extract data to differentiate detoxification and treatment.

The Massachusetts representative stated that, as long as there is a unique client ID, they would be able to track clients. He went on to talk about his NEDS contract that is doing an 8-year longitudinal data analysis. Detoxification is too much of their system, both in dollars and use of other resources, not to collect. The question for them is, "How good a job are we doing of getting individuals who present at detoxification to stay in treatment?" They feel that they are wasting resources when the client continues to come back for detoxification 8 and 9 times in a year, but never get into a treatment program.

The Rhode Island representative mentioned that their detoxification system is in real-time. They look at levels of care, and are able to track if a referral was made and to where. It is necessary to have good clinical assessments up front to determine the level of care a client requires. They also find that in the winter months homeless people use detoxification as a shelter, and these factors must be considered when looking at detoxification.

In Connecticut, they feel that one must look at detoxification as a point of intervention. Any point in the system, when engaging with the addict, is an opportunity to help the addict and take him/her to the next level of treatment.

Ms. Truzo brought up an additional issue. She wanted to know what happens to clients that just "disappear" from treatment, and what kind of discharge reason is given for such clients.

The Rhode Island representative stated that they purge their records every 6 months. Anyone in outpatient treatment more than 1 year and in residential treatment more than 6 months since admission is administratively discharged. They send their providers a list of who was purged from their records. It is up to the providers to reactivate and fill out a request to continue treatment for a client that has been administratively discharged. They instituted this program because facilities were trying to pad utilization rates.

## **Day Two**

### **Measurement of outpatient clients**

The second day began with a brief discussion about a data collection problem in N-SSATS. MPR representatives were concerned that accurate client counts for outpatients were not being provided by some survey respondents. It is important to get a count of "active clients" on the point prevalence date. In the N-SSATS, the outpatient client count on the survey reference date is defined as the number of clients that were seen at the facility for a substance abuse or detoxification service at least once during the preceding month, and who were still enrolled as of the reference date.

In general, the State participants understood the definition of client count on the reference date, but understood why some providers would find it difficult to report that number. Many facilities routinely

report clients that are active and on their roles whether they have seen them in the past 30 days or not. Connecticut appeared confident that they have a good data information system and could provide OAS with the data it requires.

Ms. Truzo noted that every year OAS tweaks the client count question to better ensure they receive the correct information, and how every year they get questions back that indicate there are still definition issues on how to report the data. The counts reported in the N-SSATS are sometimes obviously wrong, usually much too high. It would be useful to know what the outer limits of credibility for one-day client counts, excluding methadone clients.

### **The Use of National Data**

The first agenda item of the second day was a slide presentation by Dr. Goldstone demonstrating SAMHSA's extensive use of data from the National Survey of Drug Use and Health (NSDUH—formerly called the National Household Survey of Drug Abuse, NHSDA), the Drug Abuse Warning Network (DAWN), and TEDS. One of the charts that Dr. Goldstone displayed showed the relationship between block grant allocations to States and the occurrence of substance abuse problems. While one would hope for a high correlation between substance abuse problems and resources, in fact, there was virtually no correlation.

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

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

Dr. Ball answered many specific questions on HIPAA-related issues: what kinds of organizations are considered "covered entities" under HIPAA, the need or lack of need for business associate agreements, the time frame in which new providers must be HIPAA compliant, health care provider identification numbers, the code sets (e.g., ICD-9-CM) that will be used, and status of individual patient identifiers.

### **Closing Remarks**

Dr. Goldstone ended the meeting by thanking the participants for their participation and urging them to feel free to contact OAS staff with any suggestions or problems they may have. He reiterated that the feedback OAS receives proves very useful and hoped that the State representatives find the exchange equally beneficial.



DASIS REGIONAL MEETING (continued)  
**Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**  
June 10-11, 2003  
**Portland, ME**

**Wednesday**

8:30 a.m. Continental breakfast

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

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

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

12:00 p.m. Adjourn

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**Portland, Maine**  
**June 10 & 11, 2003**

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