

DASIS STATE DATA ADVISORY GROUP MEETING

**February 4–5, 2003
Savannah, Georgia**

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SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING
February 4–5, 2003
Savannah, Georgia

This was the 13th Regional Meeting to be held with State DASIS representatives. It included representatives from Florida, Georgia, North Carolina, Puerto Rico, and South Carolina, 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 iterated the importance and the weight his office and the contracting staff place on the comments and suggestions offered at these regional meetings. He noted that the comments and suggestions are taken seriously, and that products and outgrowths 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.

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. Twenty percent of the facilities were new, which indicates the fluidity of the treatment system. Of the States participating at the Regional Meeting, all had excellent response rates with Alabama and Georgia having a 100 percent, response rate. Dr. Goldstone noted that the Locator was put on the Internet to make the treatment information more readily available to the public. OAS has found another benefit of the Locator is that it serves as an incentive to participate in the N-SSATS. Treatment facilities are anxious to appear in the Locator and that has made a real difference in facility participation.

During a discussion concerning duplicate facilities in I-SATS and N-SSATS, OAS stated that Synectics staff contacts States when there is a question about a facility being a duplicate. If it is determined that a facility is a duplicate, it is removed from N-SSATS and I-SATS. Identifying duplicates can be very difficult, as was illustrated by a situation described by the Florida representative. On a few occasions, Florida has received two different tax IDs for what is essentially the same substance abuse treatment agency. The agency operated a for-profit entity and a not-for-profit entity at the same location, and each had its own tax ID. Technically, the two entities treated different clients; for example, in the morning the staff worked for the non-

* The representative for Alabama was unable to attend the Regional Meeting due to a sudden illness.

profit arm and in the afternoon for the for-profit arm. Thus, the same agency appeared twice in Florida's file of treatment agencies. For I-SATS and N-SSATS purposes, this would likely be considered one facility. If the state or the agency preferred to list the for-profit and not-for-profit facilities separately, some differentiation in the facility name would be required so that it was clear these were not the same facility.

In the 2002 N-SSATS, three modes of data collection were used. In addition to mail and telephone, N-SSATS was put on the Internet. Nationally, about 48 percent of the sample responded by mail, 18 percent by the telephone, and 18 percent by Internet (13 percent were closed or ineligible, and only 3 percent were non-respondents). Collecting data via the phone is the most expensive mode, and using the web is the least expensive. The pattern of responses by reporting mode among the States represented at the Regional Meeting were similar, except for Puerto Rico, where 21 percent of responses were received by mail, 5 percent by phone, and 57 percent through the web. MPR noted that in Puerto Rico, 87 percent of those facilities with Internet access completed the questionnaire on the Internet. Dr. Goldstone suggested that a small study be done to determine why those who have access to the web did not use it to complete the questionnaire. Ms. Trunzo noted that an experiment is planned with the 2003 survey related to this. Florida commented that facilities might not be inclined to complete the survey on the Internet if the Internet version looks substantially different than the paper version.

The 2003 N-SSATS will include a small experiment designed to see if respondents are more likely to use the Internet if the mail option is not initially offered. Most facilities will be sent the mail questionnaire and information about how to respond by Internet, so they know immediately that they can respond using either mode. For the test, about 2500 facilities will not receive a paper questionnaire in the initial mailing. They will receive only information on how to complete the N-SSATS using the Internet and a cover letter explaining the advantages of completing it on the Internet. However, since some facilities that will be randomized into the sample will not have access to the Internet, it will be mentioned in the letter that a paper version of the questionnaire will be mailed approximately two weeks later to those who do not complete the questionnaire on the Internet. MPR noted that it takes approximately 35 minutes to complete the web-based form, which is similar to the time needed to complete the paper form.

The Internet version of the questionnaire is quite similar to the mail questionnaire, but has built-in edits to minimize mistakes. This will save time and money in collecting and processing the data. In the 2002 N-SSATS, MPR experimented with three versions of the Internet questionnaire. One version had no edits; it accepted any response given by the facility. A second version had some edits and consistency checks that alerted respondents to errors, but allowed them to continue without making corrections. The third version displayed the errors and required respondents to fix the errors before they could continue with the form. MPR found that the percentage of respondents who completed each of the three versions was basically the same and, therefore, they decided to use the third method in the 2003 N-SSATS.

As an estimate of data quality, respondents in the N-SSATS are asked if client counts provided in the survey are actual counts or estimates. In past surveys, mail responses have had the highest percentage of actual counts, but in 2002 the percentage of web responses providing actual counts

was similar to or better than mail responses. However, overall, the percent reporting actual counts has declined from 62 percent in 2000 to 57 percent in 2002.

MPR outlined plans for the 2003 N-SSATS. The point prevalence date for the 2003 survey is March 31, 2003, and the advance letters are mailed 6 weeks prior to that date. As in previous surveys, States have been asked to provide endorsement letters. Two letters were requested from some States, one for facilities selected for the web survey experiment and the other for facilities receiving the paper questionnaire in the initial mailing. For most facilities, survey questionnaires are sent a week before the point prevalence date, with a second questionnaire mailed to non-respondents about two months later. In June, MPR will make reminder telephone calls to non-responding facilities. In July, those who have not yet completed the survey will be contacted by telephone and asked to complete the survey over the telephone. Data collection will end in October. It was suggested that facilities be alerted in the advance letter that the survey will ask about the number of clients treated at the facility on the point prevalence date, and that this alert should be included in everything that is sent to the facilities.

MPR reviewed the 2003 N-SSATS questionnaire and pointed out the new and revised data items. Some examples are provided below:

- The “Instruction Page” was changed to read “Please read this entire page before completing the questionnaire.”
- The most important information is now in blue boxes, since MPR found during the pre-test that facilities were more likely to read the information put into the blue boxes than they were other information.
- The definition of “Halfway house” has been expanded to include “other transitional housing.”
- The addition of a new item on outpatient capacity.

There was some discussion of question 15 concerning treatment programs for specially designated groups. Some participants suggested that question 15.1, which reads “Adolescents (less than age 18),” should be changed since Medicaid considers clients are adolescents through age 20. After extensive discussion, the decision was made to drop the definition.

There was also discussion about the confusion that can arise between the types of clients a facility accepts and the types of clients for which a facility offers special programs. MPR mentioned that facilities are now being asked first about which specific groups are accepted at a facility, and then if there is a special program for that group. Dr. Goldstone emphasized the need to make this distinction in the N-SSATS data reports. Ms. Trunzo suggested adding a note to the Locator to the effect that a facility’s having special programs for certain groups does not mean that the facility accepts no other types of clients. Synectics will investigate ways to do this.

There was also some discussion about question 27d, which asks, “The number you recorded in the OUTPATIENT TOTAL BOX (question 27a) represents clients enrolled in outpatient substance abuse treatment at this facility on March 31, 2003. Did this facility have the capacity to accommodate a larger outpatient enrollment on March 31, 2003?” If “yes,” question 27e provides a worksheet to assist the respondent in calculating the number of additional outpatients that could have been enrolled in treatment on March 31. Dr. Goldstone commented that this

question was added at the request of the Office of National Drug Control Policy (ONDCP) because they need a measure of "capacity". OAS has tried to collect this information in the past, but "outpatient capacity" is a nebulous concept and can be misleading. Many providers have said that this question cannot be answered accurately.

The Florida representative asked how States can get a copy of the N-SSATS database. Ms Trunzo stated that all the N-SSATS data are made available on the SAMHSA web site as public use files. It usually takes about a year after data collection to finalize the data and write the report. After the report has been approved for release by the Department and by SAMHSA, the file is placed on the web for public consumption. Data for each individual state are routinely sent to the State on CD as soon as editing and imputations are complete.

There was a brief discussion on the procedures for putting newly identified facilities onto the Locator. MPR explained that information about facilities identified during the N-SSATS is sent to the Synectics I-SATS database manager. The database manager sends the information to the state for a decision on State approval, and adds the facility to the survey file for the next N-SSATS or mini-N-SSATS (an abbreviated N-SSATS). If the new facility is state approved and responds to the N-SSATS (or mini N-SSATS), it is added to the Locator during monthly updates.

Locator

Florida asked if States can download the information that is on the Locator. In response, it was explained that the Locator information can be downloaded to a file by using the Locator's "List search" function, which allows selection of facilities by geographic area and certain facility service characteristics. The selected facilities are displayed on the screen and may then be printed as a list or downloaded to a file in Excel or ASCII text formats.

The Facility Locator includes only State-approved facilities that responded to the last N-SSATS. While this is likely to be about 95 percent of all State-approved facilities, States can obtain a printed list or file of all facilities in their State that are on the I-SATS by using the I-SATS Quick Retrieval System (IQRS) available on I-SATS On-line. (See section on I-SATS below).

Florida also asked if mental health facilities that provide substance abuse treatment are included on the Locator. OAS said that they are, but mentioned that the Locator does have a link to the CMHS Mental Health Services Locator (<http://www.mentalhealth.org/databases/>).

Deborah Trunzo demonstrated several new features on the Locator and reviewed its current usage patterns. The overall hit rate for the Locator web site is over 6,000 hits per week. In 1999, the hit rate was 600 per week, and it increased from 4,000 to 6,000 over the last year. Many comments and questions are received by email each week through the Locator. Synectics has assigned an individual to answer questions; however, when questions are received that Synectics cannot answer, the questions are forwarded to the States.

An important new feature recently added to the Locator is a link to the Buprenorphine Physician Locator. The Buprenorphine Physician Locator is analogous to the Treatment Facility Locator and lists physicians who have been approved to prescribe buprenorphine. As of early February, 650 physicians nationwide were authorized to prescribe this medication. Clients currently on

methadone maintenance can go to a physician to get buprenorphine instead of going to a methadone clinic. However, each doctor can treat a maximum of 30 patients.

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 will be sent to all the states in an email.

State Presentations

Florida

Florida is developing and piloting an on-line data collection system called "Unity One" that uses cache as a web engine with an SQL server for data storage. Unity one is HIPAA compliant and provides for both data entry and bulk file processing. If data records are incomplete, the program will hold the data for 45 days. There are no payments for incomplete records. The program retains all data elements required by DASIS. The State, District, and providers designed the data collection procedures. Thus far, the system has worked very well. The system took less than 5 months from the time of development to implementation. Florida is now in the process of flushing out problems. For example, drug selections are out of date. The system is extremely flexible in that providers can add their own data elements that they can see and others cannot.

Florida has some concerns with HIPAA, for example, data definitions that don't match TEDS data. Florida decided that all data collection will comply with HIPAA and that the State will crosswalk back to meet TEDS and other Federal reporting requirements. For example, for ethnicity, Florida cross-walked its old codes to HIPAA, leaving the State's definitions as broad as possible.

Florida has been proactive in planning ahead on their data reporting. The biggest change is in how providers will have to do business. Florida's Child and Families Department is a HIPAA covered entity, as per a decision by the Secretary of the agency, because part of the agency pays for services. A legal decision was made by Florida that they do not pay for substance abuse treatment for clients, but that they purchase services.

Georgia

Last year Georgia served more than 185,000 clients. Services are provided across the State through eight hospitals and various private providers. The State maintains two systems. Mental Health/Mental Retardation Information System (MHMRIS) is basic consumer data—background, demographics, enrollment, and release information. A supplemental form for substance abuse providers includes SAMHSA-required items (types of services, who uses, how many, etc.). The second system is a performance measurement and evaluation system (PERMES). It monitors 25 performance indicators and outcome measures, such as accessibility, availability, satisfaction, responsiveness, level of substance abuse, services penetration, 90-day readmit rate, and employment. Most are collected through a special instrument annually. The state did a survey of 1600 clients in 2002. Georgia also administers an ASI index, and the results are used in performance-based contracting and block grants. Georgia expects to play a role in performance partnership grants.

Georgia's current mental health system is mainframe-based, and most providers access it through the Internet. Some community service boards send data overnight, and Georgia hopes to get to 5-minute processing. Phase two—a system redesign—may begin in about a month. The hope is to integrate it into other systems. The State hopes to have its new system operational in 18 months. Georgia is trying to make it easy for service providers to access and report data. Budget constraints are the biggest problem.

North Carolina

North Carolina developed performance agreements with mental health agencies and keyed them to data collection. Then the State looked at TEDS data reporting and noticed that facilities were admitting clients but not completing the data requirements. North Carolina decided to develop a report that captures the information the facilities send in, then disseminate the report back to the facilities so they can see what data are missing. This report is the State's way to be proactive so that it can get more accurate information. The facilities know what time of the month the report is released and they can prepare for it. A facility can download the report before it is released, use the report to identify the missing information, and then report this information with their regular data submission. If the report is properly utilized they will never show up as a facility with missing data. Under the facility's performance agreement, the State is authorized to withhold funds until the data are complete; however, it has not done that yet. North Carolina requires compliance plans within 30 days if the facility is out of compliance. This again is the

State's way to enhance data integrity and be proactive while getting timely and accurate data. The State provides the facilities with this data tool so that they can update their information.

Other projects: North Carolina has a DWI system with 400 providers (100 public and 300 private enterprises). North Carolina contracted with the N. C. Department of Health and Human Services Division of Information Resource Management to develop a web-based system to have information sent electronically and on a real time basis to their agency. Prior to this, they had an antiquated form to certify information for licensure and no real time processing of data. There were 45,000 to 55,000 forms passing through their office per year from which they were unable to get any real value.

North Carolina is also involved in the TOPS I program, and collecting PPG-like data on 10,000 clients per year. This has been a paper-based program but the State is building a web-based system, which it hopes will help with data integrity issues.

Puerto Rico

Puerto Rico discussed progress on the Administracion de Servicios de Salud Mental y Contra La Adicción (ASSMCA—Mental Health and Anti-Addiction Administration) System Development Project. The project encompasses 5 stages: 1) needs assessment; 2) information requirement analysis; 3) database design and system development; 4) system implementation; and 5) post-implementation processes. The timetable to complete the implementation of the administrative database is December 2003, if all the project stages are done without any delay. The administrative database will be use by the statistical personnel to generate the reports required for the regulatory agencies and, also, by ASSMCA for current state interagency statistic projects, by private entities for condition and treatment related studies, and for other scientific purposes. The operational database, which includes complex requirements such as HIPAA, will be developed on a long-term basis. Puerto Rico's slide presentation is available for download by [selecting this hyperlink](#).

South Carolina

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is a cabinet-level State agency that has approximately 90 employees and contracts with 34 independent non-profit service providers for alcohol, tobacco and other drug abuse prevention, intervention and treatment services in all 46 counties of the state. All service providers use the same Windows-based client management software.

South Carolina only submits TEDS data for the 34 agencies with which it has contracts, even though there are many more substance abuse agencies in the State.

South Carolina's client database is called the Substance Abuse Agencies Management Information System (SAAMIS). Client (intake, admission, transfer, discharge and follow-up) and service (treatment and intervention services, and residential and detox bed days) data are submitted to DAODAS weekly by diskette. The State is moving to submission by encrypted e-mail and has long-term plans to move to a Web-based system.

Management Information and Research (MIR) is responsible for, among other things, DASIS, data maintenance, data analysis, performance management, agency IT management, and research studies.

The State government in South Carolina has recently sustained a number of budget reductions. DAODAS is a cabinet level agency that reports directly to the Governor. DAODAS has had two Governors and three agency directors over the past 4 years. MIR has been reorganized three times and has been reduced from 16 staff members to 11, and from a division to a section. Efforts to further streamline State government include the possibility of merging DAODAS with the Department of Mental Health or a combination of other health agencies.

The Department of Health and Environmental Control (DHEC) licenses the State's substance abuse treatment agencies. In the past, this has made it difficult to keep the I-SATS updated. DAODAS has made arrangements for DHEC to notify them by letter when a new facility opens or when a facility closes. Hopefully, this will allow better tracking for I-SATS.

Upcoming SAAMIS modifications include additions and changes to accommodate Government Performance and Results Act (GPRA) and Performance Partnership Grant (PPG) outcome measures. South Carolina has only recently received information on the new requirements and has not yet thoroughly reviewed the data. However, they reviewed several discrepancies between data elements collected for TEDS, GPRA and PPG. South Carolina plans to examine each measure to determine the easiest approach to accommodate all needs as simply as possible. For some measures this can easily be accomplished by collecting the most detailed options and mapping to broader options, but it appears that, in some cases, some of the options will not map cleanly. South Carolina suggested that it would be helpful if the departments within SAMHSA that are responsible for TEDS, GPRA and PPG could collaborate on needed measures. South Carolina's slide presentation is available by [selecting this hyperlink](#).

Treatment Episode Data Set (TEDS)

Leigh Henderson gave a slide presentation on the Treatment Episode Data Set (TEDS), discussing year 2000 discharge data. For the 18 States for which this information is available, 325,000 records can be linked to admission records. TEDS requests very basic discharge information. Other information concerning the data collection process was briefly discussed.

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.

There was a brief discussion on coding of race categories for TEDS. The Federal OMB Standards for the classification of race became effective on January 1, 2003, for all Federal data collection. These standards specify the following five minimum race categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. In addition, the standards require that respondents in any Federal data collection be allowed to designate more than one race. Since most TEDS data are based on State collection of data, these standards may not apply. However, it is expected that many States will adopt these standards, making it necessary for TEDS to accommodate multiple race reporting.

Currently, the TEDS race categories comply with the minimum standards. However, the current data collection and coding procedures do not comply with the requirement for allowing multiple race designations. Two possible solutions to this problem were discussed. The first would maintain the current TEDS 2-character field for the race code, but would add codes for all two-race combinations, most three-race combinations, and a category for “all other race combinations.” The second possible solution would require adding new fields to the TEDS data record, one field for each race category. Under this system, each race category would be coded as “yes” or “no.” After some discussion, the consensus was that the first option was much preferred. The second option was rejected because of the difficulty, cost, and lengthy transition period that would be required for every State to change the TEDS record. Since several States have already started collecting multiple races, Synectics will begin developing new codes for the multiple race categories.

The Use 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, 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.

The South Carolina representative asked about getting raw NHSDA data for a State. Dr. Goldstone said States can currently get tables but not the raw data because of confidentiality restrictions. SAMHSA is exploring ways of sharing confidential data by entering into agreements with researchers that bind the researchers to the same obligations as SAMHSA as well as subjecting them to the same penalties. If this approach is approved, it will be possible to share data with the States for statistical purposes. Producing tables requested by the States is an obligation and service that OAS owes the States, and OAS does want to make data available to researchers in the field.

Caseload

The second day began with a brief discussion about a data collection problem in N-SSATS. States were asked to give their input concerning what constitutes a reasonable single-day outpatient client count at a facility that provides this type of care. 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 detox service at least once during the preceding month AND who were still enrolled as of the reference date. This issue was raised because of an effort to define “outliers” in N-SSATS data. In reviewing the 2002 N-SSATS data, MPR set 500 as the outlier point for outpatient clients. That is, facilities reporting outpatient client counts over 500 were identified as possibly having reported erroneous data. The Florida representative stated that they have eight agencies that handle 64 percent of their State’s clients at multiple locations and there are only two sites that may reach the 500 threshold. It was suggested that it might be helpful to get a gross sense of a facility’s staffing to use in evaluating the reasonableness of reported client counts. Dr. Goldstone pointed out that agencies define caseloads differently, and

unless everyone use a uniform definition, it will be difficult to come to terms with this issue. For example, a counselor may see 50 DWI clients two or three times a week for 8 weeks. This is not intensive work, and 50 would be an acceptable caseload. For intensive outpatient treatment, however, a counselor might see only 10 clients daily. Establishing parameters for outliers that effectively identify problematic data without an excessive number of false positives is, therefore, very difficult.

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).

Throughout the two-day meeting, 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.

Florida sees problems with transactions dealing with financial data in addition to privacy. Privacy will be a major problem for Georgia. Anyone with access to the system can access an individual’s records to determine if they have received services within the State, and this is not restricted to only those who really have a need to know. Also, service providers only want to submit enrollment data that is consistent with the information already in their systems.

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. Subsets 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 SAMHDA archives are TEDS, NHSDA, and DAWN.

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.

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

PARTICIPANT LIST

DASIS Regional Meeting Savannah, Georgia February 4 & 5, 2003

DASIS STATE REPRESENTATIVES

Alvin R. Bonner
Agency Team Leader
Georgia Department of Human Resources
Office of Information Technology
50 Hurt Plaza S.E.
Atlanta, GA 30303
Phone: 404.651.9843
Fax: N/A
E-Mail: abonner@dhr.state.ga.us

Joe Drop
REI Chief
Alabama DMH/MR, SASD
100 N. Union Street
P.O. Box 301410
Montgomery, AL 36130
Phone: 334.242.3966
Fax: 334.242.0759
E-Mail: jdrop@mh.state.al.us

Sherry Catledge
Automation Specialist
Florida Department of Children & Families
1317 Winewood Boulevard
Bldg. 6, Room 284
Tallahassee, FL 32399
Phone: 850.921.3059
Fax: 850.487.2239
E-Mail: sherry_catledge@dcf.state.fl.us

Carol Hammond
Director of Management Information
Support Services
South Carolina Department of Alcohol &
Other Drug Abuse Services
101 Business Park Boulevard
Columbia, SC 29203
Phone: 803.896.1168
Fax: 803.896.5557
E-Mail: chammond@daodas.state.sc.us

Spencer Clark
Director of Substance Abuse
Women's and Children's Services
North Carolina Division of MH/DD/SAS
325 N. Salisbury Street
Raleigh, NC 27603
Phone: 919.733.0696
Fax: 919.733.9455
E-Mail: spencer.clark@ncmail.net

Lisa S. Jennings
Special Projects Coordinator
DHR/MHDDAD/Decision Support Section
Suite 23-463
2 Peachtree Street, NW
Atlanta, Ga 30303
Phone: 404.463.6867
Fax: 404.657.2183
E-Mail: lsjennin@dhr.state.ga.us

PARTICIPANT LIST (Con't)

DASIS STATE REPRESENTATIVES (Con't)

Jose A. Lopez
Statistician
Mental Health and Antidrug Administration
P.O. Box 21414
San Juan, PR 00928-1414
Phone: 787.763.7575 Ext. 2331
Fax: 787.765.7104
E-Mail: joselo@assmca.gobierno.pr

Ida I. Rivera Melendez
MIS Director
Department of Mental Health
and Anti Addiction
P.O. Box 21414
San Juan, PR 00928-1414
Phone: 787.763.7575 Ext. 2476
Fax: 787.766.3152
E-Mail: irivera@assmca.gobierno.pr

Deborah Merrill
Branch Head, Data Operations
North Carolina Division of MH/DD/SAS
3019 Mail Service Center
Raleigh, NC 27699-3019
Phone: 919.733.4460
Fax: 919.508.0950
E-Mail: deborah.merrill@ncmail.net

Andrena Scott
Data Coordinator
South Carolina Department of Alcohol
and Drug Abuse
101 Business Park Boulevard
Columbia, SC 29203
Phone: 803.896.1158
Fax: 803.896.5557
E-Mail: ascott@daodas.state.sc.us

Ronald A. Morrell
Government Operations Consultant II
Florida Department of Children & Families
1317 Winewood Boulevard
Bldg. 6, Room 283
Tallahassee, FL 32399-0700
Phone: 850.410.1190
Fax: 850.413.6886
E-Mail: ronald_morrell@dcf.state.fl.us

PARTICIPANT LIST (Con't)

SAMHSA REPRESENTATIVES

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

Cathie Alderks
Statistician
301.443.9846
calderks@samhsa.gov

Donald Goldstone, MD
Director
301.443.1038
dgoldsto@samhsa.gov

Anita Gadzuk
Division Of Operations
301.443.0465
agadzuk@samhsa.gov

Judy Ball
DAWN Team Leader
301.443.1437
jball@samhsa.gov

Charlene Lewis
Public Health Analyst
301.443.2543
clewis@samhsa.gov

Deborah Trunzo
Dasis Team Leader
301.443.0525
dtrunzo@samhsa.gov

**Division of State and Community Assistance
Center for Substance Abuse Treatment
Rockwall II, Suite 880
5600 Fishers Lane
Rockville, MD 20857
Fax: 301.443.8345**

Hal C. Krause
Public Health Analyst
301.443.0488
hkrause@samhsa.gov

PARTICIPANT LIST (Con't)

CONTRACTOR STAFF

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

Jim DeLozier
Senior Consultant
703.807.2331
jimd@smdi.com

Peter Hurley
Project Manager
703.807.2347
peterh@smdi.com

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

Leigh Henderson
Senior Research Analyst
410.235.3096
leighh@smdi.com

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

Doren Walker
Senior Research
703.807.2314
dorenw@smdi.com

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

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

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

