

**Treatment Outcomes and Performance Pilot Studies Enhancement (TOPPS II)**  
**Meeting #3 of the Steering Committee**

February 4–5, 1999  
Baltimore, Maryland

The TOPPS II Steering Committee met for the third time to continue developing and refining the inter-State treatment outcomes measures; to resolve the timing of the T<sub>1</sub>, T<sub>2</sub>, and T<sub>3</sub> data collection points; and to begin collaboration within and among the Primary, Secondary, and Augmented Project States.<sup>1</sup>

**BACKGROUND**

At the conclusion of the second Steering Committee meeting (held December 3–4, 1998), the 19 TOPPS II Project States had agreed to a 9-month postadmission T<sub>2</sub> for the Inter-State study. They had also agreed, in principle, to a core set of common data elements, including the following: items from the ASI and TEDS (some slightly modified); legal status and women-and-children items to be worked out after the meeting by subcommittees (chaired, respectively, by Terri Anderson of Massachusetts and Janet Zwick of Iowa); and items to be pretested and refined by DeltaMetrics before the start of the third Steering Committee meeting.

In the interval between the two meetings, the group decided to depart from the common 9-month postadmission T<sub>2</sub>. It was also discussed that the core data elements may be of little value to the Secondary States. Further, the Augmented States will be using data sets much richer than the core set. These decisions were based, in large part, on DeltaMetrics' survey of the participating States. Richard V. Weiss, Ph.D., of DeltaMetrics presented the results of this survey at the third

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<sup>1</sup>For the purposes of the TOPPS II project, the 19 States are described as Primary, Secondary or Augmented States. The Primary States are Arkansas, California, Connecticut, Illinois, Iowa, Kentucky, Massachusetts, Missouri, New Hampshire, New Jersey, Rhode Island, Utah, and Virginia. These States have proposed to gather data directly from clients served by providers that are fully or partially funded by the State SAPT Block Grant. During this December meeting it was agreed that they will gather data at various points: admission/intake, during treatment, at discharge from the modality, and during followup at a specified time (whether 6 months postdischarge, 9 months postadmission, or any other timeframe). Most Primary States are using either the ASI or some form of ASI. Four States are using their own assessment tools. Some are using additional instruments, including TSR (an instrument to gather data during treatment at specified time periods).

The TOPPS II Augmented States are Arizona, New York, and Texas. These States will collect primary data, which they will augment with supplementary data from secondary sources.

The Secondary States are Oklahoma, Maryland, and Washington. These States are mostly relying on data gathered from interagency sources. Most will not gather any primary data at any time during a client's treatment episode, at discharge, or postdischarge. Secondary data are not likely to match the type of client data gathered by the Primary or Augmented States.

Steering Committee meeting. Following are the highlights of Dr. Weiss's presentation.

- ! Seven States gave an unqualified Yes to adopting a nine-month post-admission followup. Five gave qualified Yes. Their concern was over the utility of such a time frame. Five States said No. Their concern was over the usefulness of the nine-months post-admission, particularly in the context of Federal, State, and general research. States also indicated that this timeframe would not give a comparable followup period for people who were discharged at various points in time.
- ! Seven States gave a unqualified Yes to adopting discharge as a followup point in addition to or instead of the nine month post-admission followup. Six States said No. They primarily objected because of their belief that discharge as a followup point does not have a lot of meaning, primarily because people are in a controlled environment or in a controlled setting between their admission and discharge. Also people in treatment were sometimes administratively discharged and were difficult to track.
- ! Very few patients in inpatient settings are still in that modality after six months, about 25 percent. In the longer term inpatient settings, there are as many as 60 percent still in treatment after six months; and in halfway and group homes, approximately 80 percent are still in treatment. In outpatient there are approximately more than 50 percent in treatment after six months.
- ! At nine months, the numbers decline in outpatient settings.
- ! At 12 months, the number of patients in inpatient treatment is reduced to nearly five percent, and in longer term settings, fewer than ten percent. At 12 months in outpatient settings, as many as 70 percent have left treatment. And in the more intensive outpatient setting, 15 percent are still in treatment.

Before the third Steering Committee, DeltaMetrics drafted a second set of common data elements, attempting to capture the essence of the originally agreed-upon items, using ASI and TEDs items wherever possible, and using items that have been previously tested.

This one-page draft instrument was made for repeat administration, and it covers two timeframes: past 30 days and past 6 months. "Past 30 days" is the limit of people's recall for items such as "how many days have you committed crimes?" "Past 6 months" is useful for items such as arrests and hospitalizations, which are meaningless in shorter timeframes. Additionally, States would have the prerogative of adding more timeframes (by adding another column to the instrument).

## **DECISIONS REGARDING THE INTER-STATE COMMON DATA ELEMENTS**

During its third meeting, the Steering Committee revised the second draft common data elements and adopted the finished product (see Attachment A), with the understanding that DeltaMetrics would continue to pretest and refine it after the meeting. The Steering Committee's revisions to the second draft were based on several key discussion points, including the following:

- Previous history of treatment would be an important variable for doing case mix adjustment or predicting outcomes.
- The race/ethnic question should correspond to the U.S. Census items and those approved by OMB.
- Any question about number of children should include biological children, adoptive children, and children living with someone else because of a child protection court order or terminated parental rights
- The pregnancy question should be yes-no plus number of months pregnant, which yields richer data than a simple yes-no. The prenatal care question should concern the month of pregnancy during which care started, rather than total months of care.
- A question for student/vocational training information is needed, separate from employment pattern.
- Arrests are a cleaner measure than charges because they are less confusing to the client and more beneficial from a cost perspective. They should be defined as being “taken into the police station and fingerprinted.” Additional questions concerning the specific type of arrests would be optional.
- Questions about probation, parole, work release, and pending trials/sentencing are not useful enough to be in the core data set.
- Interviewers should receive laminated cards containing the various drug codes.
- Frequency-of-use codes should match TEDS choices.

### **DECISIONS REGARDING T<sub>1</sub>, T<sub>2</sub>, AND T<sub>3</sub>**

The Steering Committee agreed on two set timepoints (T<sub>1</sub> and T<sub>2</sub>) and a third variable timepoint (T<sub>3</sub>), for data collection.

- T<sub>1</sub>. All the Primary and Augmented States agreed to do T<sub>1</sub> data collection at admission. Admission refers to the time when a client starts receiving treatment from a modality (e.g., outpatient, intensive inpatient, residential, or inpatient) prior to which no treatment was received from any other modality for 30 days.
- At a minimum, the States will include the TEDS items that are in the core data set.
  - At a more desirable level, some will include all the items in the core data set.
  - Ideally, some will include the full ASI plus additional items.
- T<sub>2</sub>. All the States, including those doing secondary analyses, agreed to do some form of T<sub>2</sub>

data collection at discharge. No decision was made on an operational definition for discharge. It could refer to formal discharge from a treatment modality with a report signifying that the client has completed the treatment program. Discharge could be also administrative, which normally happens when a client drops out of an outpatient program.

- At a minimum, all States will include the three TEDS items on employment status, housing status, and frequency of alcohol and drug use. (Note: TEDS does not collect data related to any of the alcohol and drug use domains [problem areas] at discharge.)
- At a more desirable level, they will include data on type of discharge, length of stay, and referral
- At an even more desirable level, they will include the core data set

T<sub>3</sub>. T<sub>3</sub> will be variable from State to State. Once a State decides on a followup timepoint suitable to its needs, be it 9-month postadmission, 6-month postdischarge, or anything else, that State will collect data consistently for each client.

- At a minimum, they will include “TEDS-like” items.
- At a much more desirable level, they will include the items in the core data set.
- Ideally, they will include more items.

A poll of the Grantees revealed the following nonbinding plans for T<sub>3</sub>, subject to change following State AOD decisions:

**TOPPS II Proposed T<sub>3</sub> Timeframe by Primary States**

<b><u>States</u></b>	<b><u>T<sub>3</sub> initiation period</u></b>	<b><u>T<sub>3</sub> (days)</u></b>		
AZ	Postdischarge	30,	180,	270
CA	Postadmission		270	
CT (speciality study)	Postdischarge		180	
IL (may change)	Postadmission		270	
IA	Postdischarge		180	
KY	Postdischarge			360
MA (will consider T <sub>3</sub> after discussing with State)				
MO	Postadmission	180,		360
NJ	Postadmission			360
NY	Postdischarge		180	
TX	Postdischarge		180	
UT	Postdischarge		180	

RI	Postdischarge	180	
AR	Postdischarge	180	
NH	Postdischarge	180	
VA	Postadmission	180	360

MD (secondary State—can adopt any timeframe since using interagency linked/integrated data);  
 OK (same as above); WA (same as above)

**SECONDARY DATA ANALYSIS: Presentations by Tracy Leeper, M.A. (OK), William T. Rusinko (MD), Dwight McCall, Ph.D. (VA), Dario E. Longhi, Ph.D. (WA), and William J. Luchansky, Ph.D. (WA)**

The TOPPS II study is strengthened by the presence of both primary and secondary components because the two complement each other. By approaching the study from different directions, the two methodologies allow for comparisons. Both types of analysis face similar issues, such as deciding on time periods and definitions and considering similar domains. Secondary analysis has several advantages: it does not need informed consent because it involves administrative databases rather than direct client contact (although precautions, such as “data dumps,” are still taken); and it usually supplies the kind of cost and criminal justice data that legislatures want to hear. On the other hand, the data usually do not include information on substance use; they involve obtaining commitments from MIS staffs of numerous agencies; they require data cleaning; and they require development of matching algorithms to track people across multiple databases.

The Washington State study examines the domains of employment, medical cost offsets (including services for dual diagnosis clients), and criminal justice (including juvenile justice costs). Early results, at various followup timepoints, on a sample of about 1,200-1,500 clients included the following outcomes: people who had completed treatment had much higher earnings than those who had not; if they had also completed 3-6 months of vocational services, their employment and earnings outcomes were even better; and both treatment-completed groups, when tracked across time, had higher job retentions than the comparison group. Even after 5 years, 50 percent of the group that had completed treatment as well as vocational services were still employed. (“Completed treatment” referred to particular persons completing their individual plan; in general, however, outcomes were higher for people who had completed at least 30 days of treatment.) While many years were spent in developing the study’s architecture, it currently runs efficiently and inexpensively: on employment outcomes, it costs each of four divisions \$20,000 a year to follow 500,000 people every quarter for up to 7 years.

The Oklahoma study has dealt with startup issues similar to those of the Washington study. The Maryland study is just getting started and has gotten commitments from several databases, including Medicaid, utilization, employment status, employment security, criminal justice, hospitalization utilization, and mortality data.

A request was made that the Technical Assistance Center obtain published literature on secondary

data analyses issues, such as matching across files. Distribution might be via the upcoming TOPPS II web site.

## **BREAKOUT GROUP REPORTS**

During the course of the meeting, the Steering Committee broke into four groups in order to decide on commonalities in their protocols and the feasibility of working together.

Representatives of each group reported back as follows:

- **Secondary States**—Oklahoma is taking the organizational lead of the group and plans to design a listserv to be a vehicle for preliminary work. Washington has already developed a matrix of all the States' domains. The group is planning to meet in Washington in the spring to identify common data elements and integrate the data from all involved States into one or more databases. They will probably break into domain-based working subgroups on criminal justice, employment, and medical utilization. The group has already agreed on employment because it is usually collected in the same manner. They will also examine timelines, the content of data available in each State, confidentiality, human subject regulations, linkages, and analytical issues with the administrative datasets..
- **Utah Consortium**—The group will try to automate the Recent Treatment Scale (RTS) in their data system in order to minimize problems with transmitting and collecting data. They discussed the logistics of collecting secondary data. Each State will examine their two primary areas—criminal justice activity and employment. They will meet again sometime in April.
- **ASI States**—The group decided not to depart from the already standardized ASI: they will add to their existing ASI questions any other TEDS questions or questions about criminal justice, living arrangements, or women-and-children issues. The ASI itself may soon be updated: the severity scores, generally used for clinical intensity judgments, may be supplemented or replaced by a new “clinical factor” score to allow comparison across the seven domains of functioning; and the existing composite score methodology may be replaced by a standardized “evaluation factor” score that will similarly allow comparisons across domains. An automated version of the ASI is currently being developed.
- **MIS States**—Connecticut, Kentucky, Illinois, and Massachusetts are each developing, testing, or implementing modifications to their statewide management information system (MIS). They plan to work together in several areas of common interest: developing their Internet technology capacity; reporting system-generated information back to providers; and determining types of service analyses to help manage and develop more efficient and effective programs.

## **EXPERIENCE WITH MEDSTAT: Joan Dilonardo, Ph.D., CSAT**

The Integrated Data Project was begun in the Office of Managed Care as part of a multipronged attempt to develop cost information by integrating data across State mental health, State AOD, and Medicaid. Three States are participating (Delaware, Oklahoma, and Washington), and 33 different kinds of files are being examined. The project offers several tips to the TOPPS II participants: obtain advance hard copies of the files to be examined; run some frequencies; determine which kinds of fields are usually filled versus which are missing; and, in setting up relationships with other agencies, check on their plans for updating and upgrading their databases. The project has developed a data dictionary and a probabilistic matching algorithm, both of which will be included in an upcoming web site.

**STATEWIDE SURVEYS ON CLIENT SATISFACTION: Presentations by Christina A. Dye (AZ), Ann M. Froio, M.A. (AZ), Donna C. Nelson (MO), Michelle R. Jenson, M.S. (UT), Dwight L. McCall, Ph.D. (VA), Marc C. Goldberg, Ph.D. (VA)**

Arizona, Missouri, Utah, and Virginia are the four TOPPS II States that measure some form of client satisfaction on a statewide basis. Virginia and Utah will be using the same instrument—the Mental Health and Substance Outpatient and Psychosocial Services (MHSIP)—for TOPPS II. Representatives from those four States described their surveys, methodologies, and some of their findings. (Detailed reports on the Arizona and Virginia surveys were distributed at the meeting. For additional copies, please contact the Technical Assistance Center.)

**SURVEY OF STATES ON CLIENT SATISFACTION MEASUREMENT THROUGHOUT THE NATION: Toni Krupski, Ph.D. (WA)**

Washington State surveyed the 55 NASADAD members to determine what the various States are doing to assess client satisfaction. The survey produced a 62-percent response rate (34 States). It found that relatively few states currently conduct standardized statewide client satisfaction surveys. Most surveys are conducted during treatment by treatment center staff. The advantage of that timepoint is that it maximizes the proportion of clients completing the survey. It has two disadvantages, however: clients may be less likely to respond critically; and clients may be surveyed too early in the treatment process to have an accurate perspective on treatment. (A summary of the survey findings was distributed at the meeting. For a copy, please contact the Technical Assistance Center.)

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