



NATIONAL ASSOCIATION
OF
ADDICTION TREATMENT PROVIDERS

Voice. Vision. Leadership.

Strategic Plan

For the Three-Year Period 2016 through 2018

Defining. Securing. Building. Delivering.

*Defining our Association, Securing our Foundation,
Building our Infrastructure, and Delivering our Service*



NAATP

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Executive Summary

This strategic plan contains the mission, vision, values, goals, and objectives of the National Association of Addiction Treatment Providers (NAATP) for the three-year period 2016 – 2018. It is the product of 37 years of operation and it is well informed by the expertise of its Board of Directors, staff, membership, and numerous other stakeholders. The plan is a guide for the execution of NAATP’s mission from broad policy goals to measurable objectives.

The plan was adopted and implemented following a six-month transition period that included the hiring of a new Executive Director, moving of the NAATP office to Denver, Colorado, installation of new NAATP staff and contractors, and a thorough review of NAATP’s operation and effectiveness. At the time of the plan’s adoption, NAATP was also engaged in a rebranding process scheduled to complete in May of 2016.

The plan incorporates much of NAATP’s historically effective practices including the continuation of the national addiction leadership conference and salary survey and incorporates new objectives such as an ethics complaint process and a multi-center national treatment outcomes study.

Key components of the plan include the following:

- Mission: To provide leadership, advocacy, training, and member support services to assure the availability and highest quality of addiction treatment.
- Vision: NAATP is the leading voice of addiction treatment providers.
- Values: We value a comprehensive model of care that addresses the medical, bio-psycho-social and spiritual needs of individuals and families impacted by the disease of addiction. We value research driven, evidence based treatment interventions that integrate the sciences of medicine, therapy and spirituality.
- Goals: NAATP’s five broad goals within the three operational areas of administration, development, and program are:

Administration

Evaluate, stabilize, strengthen, and build NAATP administrative structures to ensure high quality, reliable, durable, efficient, and transferable association operation.



Development

Establish and promote NAATP as a modern, state of the art, powerful, persuasive, and authoritative addiction profession leader.

Program

Member Service

Provide services to our members that enhance their abilities to deliver high quality addiction treatment services.

Policy Advocacy

Conduct policy advocacy activity that supports the existence, financial health, and professional and public status of addiction treatment providers.

Public Service

Develop and deliver a public service in the form of addiction awareness and substantive education.

Following the delineation of goals, the plan next lists 39 objectives by which the goals will be achieved. Not included in this strategic plan document are numerous implementation actions to be carried out by staff and work committees which are part of the association's annual operating plans.

It is our belief that this plan will guide our association, and in turn its member addiction service providers and the addiction service industry at large, through the next complex and challenging period of addiction treatment provider service.

The plan begins with considerable information on the history of our field and the current environment in which we work. We believed it was important to provide this context in order to inform our actions at a time of critical decision-making in our industry.

Marvin Ventrell
Executive Director
National Association of Addiction Treatment Providers
Denver, Colorado

I. The Current Addiction Treatment Provider Environment

The following factors represent many of the environmental realities that influence NAATP's work by aiding our effectiveness, inhibiting our effectiveness, or both.

1. Addiction, also called Substance Use Disorder SUD, exists in the U.S. as a serious national social, economic, and public health crisis that is not adequately addressed in public policy or treatment delivery. Key data on addiction impact include:
 - Journal of the American Medical Association (JAMA), reports that alcohol use disorders (AUD) affect more people than any other substance or mental health disorder. (JAMA Psychiatry 2015). According to the same study, of the 32.6 million people with AUD, only 7.7% percent sought treatment. SAMHSA similarly reports that only 6.3% of individuals 12 and older with alcohol dependence or abuse received treatment the year prior to being surveyed. (SAMSHA, Center for Behavioral Health Statistics and Quality 2013).
 - 23 million Americans 12 and older require treatment for Substance Use Disorder (SUD) (excluding tobacco). Only 10% of these receive treatment at a specialty facility. Compare that to the 29 million Americans who suffer from diabetes, of which 85% receive dedicated medical care (Centers for Disease Control and Prevention, CDC, 2014).
 - Non-medical use of prescription drugs is growing, with an estimated 48 million people age 12 and older using prescription drugs for non-medical purposes; 20% of the US population, (NCAD 2015). The addictive qualities of many of these drugs are alarming, particularly opiates. Barbara Krantz, MD/FASAM/ABAM writes that, "One hundred people die every day in this country from accidental drug overdoses. Every year more than 16,500 people in the U.S. die, specifically, from prescription opiates. Every 19 minutes, a death occurs. These deaths exceed those from heroin and cocaine combined." The National Institute on Drug Addiction (NIDA) estimates 2.6 million Americans had an opioid addiction in 2012.
 - Addiction rates and deaths from illicit drugs have been rising steadily and are at alarming levels. According to the CDC, over 14,000 people died from illicit drug overdoses in 2013, and over 8000 of those were from heroin alone. 42,982 people died from some type of drug overdose in 2013 (Caron reporting from CDC). The CDC estimates that approximately 80,000 people die from alcohol related deaths each year.
 - Drug and alcohol related costs in the U.S. exceed \$400 billion annually (USHHS, CDC, NDIC).

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- The majority of people who need addiction services do not receive them. Of those who receive some type of treatment, only 9% received non hospital residential addiction care, according to SAMHSA's National Survey of Substance Abuse Treatment Services. (N-SSATS; 2013 Data on Substance Abuse Treatment Facilities). Similarly, according to the National Institutes of Health (NIH) 2011 study, 23.5 million people age 12 or older needed addiction treatment and only 11.2% received it in a specialized facility.
 - Survey data released in 2011 by the Partnership for Drug-Free Kids and The New York State Office of Alcoholism and Substance Abuse Services (OASAS) (2011) show that 10 percent of all American adults, ages 18 and older, consider themselves to be in recovery from drug or alcohol abuse problems. These nationally representative findings indicate that there are 23.5 million American adults who are overcoming an involvement with drugs or alcohol that they once considered to be problematic. According to the new survey funded by OASAS, 10 percent of adults surveyed said yes to the question, "Did you once have a problem with drugs or alcohol, but no longer do?"
2. Addiction is recognized as a disease in federal policy and the mainstream treatment community, including NAATP, AMA, ASAM, APA, ONDCP, NIDA, and SAMHSA.
 3. Addiction is recognized as a chronic disease in federal policy and the mainstream treatment community, including NAATP, AMA, ASAM, APA, ONDCP, NIDA, and SAMHSA
 4. Addiction is still often treated as an acute disease.
 5. Addiction is largely addressed in the U.S., at least de facto, as a criminal matter. William White has said that the U.S. has tried to "incarcerate our way out" of the addiction crisis.
 6. Despite disease recognition, addiction remains a negatively stigmatized disease which inhibits treatment and recovery.
 7. The mainstream treatment community and federal policy recognizes that the response to the disease of addiction should be multifaceted and include, medical, psychological and social (psychosocial) components. The majority of treatment providers who are traditional NAATP members add a spiritual component to treatment (12-step "Minnesota model"). It is not clear whether federal policy and the health care industry value the spiritual component as part of psychosocial care.

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8. The addiction treatment industry has grown from a cottage industry in the early 20th century to a profession as evidenced by:
 - a. Physicians may now become Board Certified in Addiction Medicine.
 - b. Counselors may, and are typically required by states, to be credentialed in addiction counseling.
 - c. Treatment providers must typically be state licensed to provide addiction care.
 - d. Formal and rigorous accreditation is available to treatment providers by CARF and/or the Joint Commission both of which are respected by the addiction treatment industry.
 9. The numbers of treatment programs are on the rise and competition among treatment providers is significant. There may be as many as 75,000 treatment programs in the U.S.
 10. Unethical to illegal treatment program marketing practices are commonplace and such practices damage the public image of treatment and harm good providers.
 11. The quality of care by treatment providers varies widely.
 12. Addiction treatment is not regulated under a uniform national system but rather on a state by state basis.
 13. Despite a traditional lack of public addiction disease exposure, there is now growing national awareness brought about, at least in part, by the recovery community organizing and becoming vocal.
 14. Federal Parity Law now requires that insurers who cover addiction must do so on par with other covered diseases.
 15. Federal Parity Law is not honored by insurers in many cases although we have not assembled comprehensive violation instances yet.
 16. The Affordable Care Act (ACA) provides funding for addiction treatment by requiring addiction coverage in insurance policies sold on the exchanges, making Parity Law even more widespread.
 17. The availability of greater funding for addiction care enables providers to provide more care and better care to patients.
 18. The availability of greater funding for addiction care generates more providers, some of which may be more concerned with profit than quality care.

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19. The science of pharmacology to treat addiction can enhance recovery through drugs that address the addiction brain disease component.
 20. The science of pharmacology to treat addiction can harm recovery by placing undue reliance on drugs in lieu of the social and spiritual components of recovery.
 21. The addiction industry is fractured in its response to addiction over the application of science and social and spiritual care; the field can be polarized at the extremes.
 22. Co-morbid treatment is now commonplace in addiction care although widely varied in scope and delivery.
 23. The principle of ROSC – Recovery Oriented Systems of Care – and the concept of the Continuum of Care are widely accepted now in the treatment provider industry.
 24. The integration of addiction care into behavioral healthcare and the healthcare system at large brings recognition, validation, greater resources, and better care.
 25. The integration of addiction care into behavioral healthcare and the healthcare system at large brings concern that the specialized value of addiction care will be compromised. The mainstream healthcare industry may not appreciate the value of psychosocial care and use Medically Assisted Treatment (MAT) in isolation.
 26. Influential policy voices including ASAM, SAMHSA, NIDA, and ONDCP state that addiction treatment should include psychosocial elements but may not implement psychosocial care in application.
 27. Addiction treatment providers who have historically utilized 12-step recovery methods as the underlying model of care may not give adequate credence to medical and pharmacological methods in reliance on psychosocial care in isolation.
 28. The primary residential addiction treatment model has historically been the Minnesota Multiphasic Model which is a “12 step plus” model. The term is not necessarily used to describe the primary model now although it may in fact be the correct descriptor.
 29. Addiction providers are widely varied in organizational size and composition.
 30. The addiction provider industry has failed to adequately measure its outcomes.
 31. The addiction provider industry is now beginning to measure its outcomes.

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32. The majority of treatment providers across the entire continuum of care are not NAATP members.
 33. NAATP has significant industry competition for its policy, member services, public service, and educational work from other organizations.
 34. NAATP lost traction in recent years because of operational difficulties and lack of leadership. Many in the field and in policy making may not currently see NAATP as an important and effective organization.
 35. A dedicated Board of Directors has kept NAATP alive and relevant. The Board has paved the way for a new and improved NAATP.
 36. A new NAATP staff has been installed and promises to improve NAATP's reputation and effectiveness.

II. A Brief History of NAATP at 38¹

In addition to current environment, history provides necessary context and guidance for our strategy and actions. Without an accurate understanding of who we are and where we have been, we plan poorly for the future. The following section details important events in the development of our field and NAATP's place in it.

In 1944, Ms. Marty Mann, a pioneer of Alcoholics Anonymous, founded the National Committee for Education on Alcoholism (NCEA) in the belief that she and NCEA could change the way America viewed alcoholism and the alcoholic. Mann and a generation of recovery advocates and visionary professionals spent the next decades laying the foundation for modern addiction treatment. There were four critical cornerstones of that foundation:

1. Growing cultural acceptance of the idea that the alcoholic was a sick person worthy of and capable of being helped,
2. The development of replicable models of addiction treatment, e.g., the Minnesota Model,
3. Landmark federal legislation championed by Senator Harold Hughes that provided government funding for community-based addiction treatment throughout the United States, and
4. Changes in insurance reimbursement policies championed by organizations, such as Kemper Insurance Companies, that provided for the treatment of alcoholism and other drug dependencies.

¹ NAATP was founded in 1978. Much of this section is adapted from the History of NAATP by William White.

Built upon that foundation were two overlapping systems of treatment: one public, one private. Studies by the Institute for Behavioral Research at the University of Georgia confirm what have long been the essential differences in these two systems. While public and private addiction treatment institutions have much in common, the latter are distinguished by income source (primarily private insurance and self-pay rather than governmental funding), client characteristics (greater affluence and a higher percentage of alcohol use disorders), characteristics of staff (higher levels of education and experience, higher rates of certification/licensure, higher salaries), and treatment methods (e.g., greater use of pharmacotherapies).

When NAATP was founded in 1978, there was no organization or association representing the interests of private sector addiction treatment providers, especially in the area of uniform insurance benefits. Over the years, the private sector has grown to be characterized more by its revenue source than any other characteristics.

Many professional and trade associations were formed in the 1970s representing organizations and service roles within public sector addiction treatment. In January 1978, 21 individuals representing private addiction treatment programs met in San Pedro, California to form what became the National Association for Alcoholism Treatment Programs (NAATP).

NAATP history has paralleled the times in which we addiction professionals worked. NAATP had an exciting and optimistic birth, a turbulent adolescence, a near death experience, and resurrection and maturation into one of the most vibrant voices representing the field of addiction treatment. Then, following leadership difficulties, it again found its footing and positioned itself as the necessary and valuable representative of addiction treatment providers in the 2nd decade of the 21st century.

NAATP's Founding and Developmental Years (1978 – 1988)

The 1970s witnessed enormous changes in attitudes and policies towards addiction treatment. The National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse had been founded and were channeling federal dollars through new state addiction agencies to local communities to build, staff, operate, and evaluate addiction treatment. Insurance companies were beginning to expand insurance coverage for alcoholism treatment-coverage that spread from accredited hospital-based programs to freestanding programs as well as the first extension of coverage from inpatient to outpatient care. The number of public and private treatment programs exploded, and the professions of addiction medicine and addiction counseling were poised to come of age.

It was a heady time in the field, as noted persons from all walks of life publicly declared their recovery from alcoholism as part of the National Council of Alcoholism's Operation Understanding in 1976. Those stepping forward to put a face on alcoholism recovery included

astronaut “Buzz” Aldrin, actor Dick Van Dyke, and Congressman Wilbur Mills. Two years later, First Lady Betty Ford announced to the nation her treatment and recovery for dependence on alcohol and other drugs. For the advocates who had worked tirelessly through the 1940s, 1950s, and 1960s, it seemed their dreams were becoming a reality in the 1970s.

The 1970s witnessed a rapid promulgation of professional associations, trade associations, and organizations representing specialty sectors and roles within the field. It was within this context that a small number of private alcoholism treatment providers began meeting in California in 1976 and 1977 to discuss the potential of forming an organization of addiction treatment programs whose services were supported primarily by private (insurance reimbursement and self-pay) rather than by public funding.

“We needed an association because we were all shooting in the dark at this time. All of us were in recovery and had some education on the counseling side of things, but none of us had any business background whatsoever. For years, I didn’t even know it was a business. I just thought we were doing this altruistically. I knew we had to make some money, but that was not the goal. The goal was just to get people into recovery. So the five of us got together regularly to compare what we were doing and the idea of an association grew out of those meetings.” Len Baltzer

In September 1976, twelve program directors began meeting in California to discuss the possibility of establishing an association of private non-profit alcoholism programs. An organizational meeting was held in March 1977, attended by Len Baltzer (St. Joseph Hospital), Hank Clark (Brea Neuropsychiatric Hospital), Jim Fulton (San Pedro Peninsula Hospital), Wade Potsch (St. Jude’s Hospital), and Bob Scott (Beverly Manor). It was decided to create an association of private alcoholism treatment providers in the State of California. As discussions continued throughout 1977 about how to fund the new organization, Advanced Health Systems (a subsidiary of Petroline Corporation that had recently purchased most of the Raleigh Hills hospitals) agreed to fund the association until it was self-supporting if the association was established on a national basis.

These early meetings generated a formal proposal in January 1978 to form the National Association for Alcoholism Treatment Programs (NAATP). The first official meeting of NAATP was held January 26, 1978, at San Pedro Peninsula Hospital in San Pedro, California. James E. Fulton, Jr. hosted the meeting with 21 persons in attendance. The first formal meeting of the newly incorporated organization was held on March 27, 1978, with the first general meeting held March 31, 1978. An initiation fee for joining NAATP was set at \$200, and subsequent annual dues were set at \$50.

The purposes of the National Association of Alcoholism Treatment Programs shall be as follows: (a) to meet periodically and develop methods of communication so that experience and methodologies in alcoholism treatment can be shared and programs

improved; (b) to provide a professional identification and common voice for private alcoholism treatment programs; (c) to identify and respond to needs of its membership constituency; (d) to promote the credibility of private interests in the field; (e) to improve, enhance, and communicate the state-of-the-art in alcoholism to benefit the field and society; (f) to provide direction and shape to the alcoholism disciplines; (g) to develop improved standards and techniques in providing services; (h) to provide continuous growth and outreach. *NAATP By-Laws*.

NAATP's first annual meeting was held in conjunction with NCA in St. Louis in June of 1978, and was followed by a direct mail campaign to increase membership beyond its 40 founding institutions. Later that year, annual dues were reset at \$600 for institutions and \$200 for individuals. The 1979 NAATP operating budget was \$38,600. Beginning in August 1978, James F. Bailey of Advanced Health Systems provided technical support to NAATP and served as its Executive Director. In 1982, NAATP became financially independent of Advanced Health Systems, established itself as an independent trade association, and changed its name to the National Association of Alcoholism Treatment Providers. NAATP grew rapidly in the 1980s. Board Member Harry Swift, representing Hazelden, would be able to say:

"I was very impressed early on. Here were people who were competitors in the marketplace but who were coming together in meetings and agreeing on what we needed to do as a field. They were able to set aside their personal and institutional issues and focus on the big picture. NAATP really served a useful purpose bringing competitors together and creating a structure where they could work together on important issues."

Throughout 1979 and 1980, an emerging infrastructure emerged for the now growing NAATP. NAATP's first newsletter – *The Private Line* – began its regular publication. Quarterly board meetings continued, and the NAATP annual meeting continued to be hosted with the National Council on Alcoholism. An annual award was established (the Jay Lewis Journalism Award), and the first NAATP training seminars were offered to its members. The latter sparked interest in more formal education for program administrators and led to a proposal to establish the American College of Addiction Treatment Administrators (ACATA). There was a genuine interest among the early executives in addiction treatment to establish themselves as peers and professionals in the area of health care administration. ACATA was modeled after the well-established American College of Health Care Executives North American College of Alcoholism Program Administrators.

In January 1980, Senator Frank Moss was hired as a Washington-based lobbyist. Most importantly, NAATP membership growth afforded the opportunity to hire a full time Executive Director, Michael Q. Ford.

As the first full-time executive director of NAATP, one of the strong points of Michael Ford was his ability to create an atmosphere for sharing information. Michael was a big proponent of getting independent data on addiction treatment outcomes, and his support for NAATP to do a MEDSTAT study was one of the first efforts to validate the cost-benefit of addiction treatment.

One word summarizes NAATP and the larger addiction treatment field in the mid-1980s: Growth! NAATP membership went from 339 members to more than 650 members in 45 states just four years later. NAATP's growth reflected the growth in private alcoholism treatment programs in the United States, both hospital-based and free-standing, and an increase in the number of programs with mixed private/public funding seeking membership in NAATP. Membership also grew via the proprietary chains.

This growth improved access to addiction treatment, but also fueled competition. A hospital-based program that once served a whole region of a state suddenly found itself with half a dozen regional competitors. Such competition triggered the modern treatment field's first marketing wars. The growth in membership during this period also required NAATP to add staff, including Laurie Poul, NAATP's first Associate Director.

NAATP played a critical role in elevating the quality of operations of this growing network of treatment institutions. The field was rapidly growing, but it was still naïve and unsophisticated. NAATP tried to shape the funding and regulatory environment at the same time we tried to help programs meet the increasingly rigorous standards. We achieved the former by both influencing the emerging Joint Commission on Accreditation of Hospitals (JCAHO) standards for alcoholism programs and by encouraging an alternative to these standards through the Council on Accreditation of Rehabilitation Facilities (CARF). We achieved the latter by providing training to our members on clinical processes such as assessment, treatment planning, service documentation, and utilization review and quality improvement.

The key issues for NAATP members during this period were professional legitimacy via JCAHO or CARF accreditation, the certification/licensure of clinical staff, achieving financial stability in the face of inconsistent reimbursement policies, maintenance of high service utilization rates, and quality enhancement.

In addition to its advocacy and training activities to address these issues, NAATP also developed a NAATP Advertising Code of Ethics (approved in 1985). In 1984, NAATP completed five years of development work in incorporating ACATA. While ACATA was birthed and developed by the leadership of NAATP, this organization soon incorporated itself and contracted with a management company to carry out the business of this professional society. NAATP came of age in many ways in the mid-80's.

During this period, it:

- Reached its peak growth
- Began hosting its own national conference independent of other conferences (beginning in 1983)
- Developed new awards programs (e.g., the NAATP Outstanding Service Award that was later renamed the Nelson J. Bradley Outstanding Service Award)
- Developed products aimed at elevating service quality (e.g., a clinical supervision of alcoholism treatment manual)
- Became a national advocacy force

NAATP's advocacy activities in this period included influential position statements on alcoholism insurance benefits and Medicare reimbursement for alcoholism treatment. In 1987, NAATP scored a major victory when JCAHO Board of Commissioners accepted the changes in standards that had been recommended by NAATP. That same year (1987), NAATP filed an Amicus Curiae with the Supreme Court in support of Petitioners Traynor and McKelvey opposing the Veteran's Administration's regulatory definition of alcoholism as "willful misconduct." This act, perhaps more than any other, marked NAATP's emergence as a major player in national-level policy advocacy.

NAATP activities reflected responses to broad changes in the field. In response to demands for improved admission and level of care placement decisions, NAATP began work on "Development of Admission criteria for Discrete Levels of Care in Chemical Dependency Treatment" – a product that was turned over to the American Society of Addiction Medicine in 1991 and became a standard in the field.

In 1987 NAATP changed its name from the National Association of Alcoholism Treatment Programs to the National Association of Addiction Treatment Providers. This name change reflected the near complete integration of the treatment of alcoholism and other drug dependencies and the dissolution of what had been the separate fields of alcoholism treatment and drug abuse treatment. In 1988, NAATP celebrated its tenth anniversary at the annual conference in Chicago.

A final milestone in NAATP's first ten years offered an omen of what was to come. In January 1988, NAATP reported on a study of hospital-based treatment units noting that the percentage of units making a profit declined from 62.7% in 1987 to 50.9% in 1988. What could not be predicted was how rapidly that trend would escalate and if private addiction treatment programs and NAATP could survive. In the coming years, the capacity for survival of NAATP and its constituency organizations would be rigorously tested.

The Field and NAATP in Crisis (1989-1996)

As NAATP entered its second decade, much of the business of the association continued. NAATP's membership exceeded 650, annual meetings and training activities continued, and NAATP introduced a new trade journal for its members, the *NAATP Review*, and published a book, "The Road to Recovery", by Milan Korcok, with a forward by Betty Ford. The NAATP board expanded with the addition of Dr. William Hawthorne who served as a non-voting member representing the American Society of Addiction Medicine. In 1990 the NAATP Public Policy Committee formulated three guiding elements for public policy statements:

- Alcoholism and other drug dependency must be addressed primarily as a public health problem
- Access to appropriate care, delivered by credentialed professionals, must be provided to persons dependent on alcohol and other drugs.
- Public and private funding must be significantly increased and policies improved to provide adequate levels of care for persons dependent on alcohol and other drugs.

NAATP continued an experiment in organizing state and regional chapters with more than 15 such chapters operating by 1991. Like many other organizations, NAATP struggled with its structure in terms of an emphasis on a national focus or a regional focus. The chapters emerged and grew as it became easier to encourage and support regional rather than national travel. Some regional chapters focused on very specific regional issues which provided a natural rallying point. The chapter structure allowed for a representative from the Council of Chapter Chairs to also sit on the board of directors of NAATP. While the chapter structure encouraged growth, it was also the source of struggle between a strong national organization and a more regionally focused association. When some organizations choose to only join the chapters and not the national association, the NAATP board committed itself to building a strong national presence and allocated fewer resources to continue the chapter structure.

These routine activities belied awareness of a larger crisis in the field that was brewing. That crisis was captured in a single phrase – managed care – and it was an issue that dominated NAATP and the larger field in the early 1990s. Two early signs of the coming crisis were a drop in NAATP membership between 1989 and 1990 and a headline in the Fall 1990 issue of *NAATP Review* entitled "Where have all the patients gone?" The headline signaled the declining occupancy rates in inpatient addiction treatment units across the country. Those changing rates were a product of externally imposed limits on lengths of stay, which rapidly went from 28 days to 21 days to 14 days and lower.

"Programs were getting picked off and were closing one after another because of financial problems. It was so unexpected. The addiction field had become somewhat accepted, in large part because a number of famous people had come forward and talked about their addiction treatment and recovery. Addiction treatment had been

included in a number of states as required coverage for medical insurance, and the field had grown and had become more accepted and more professional. This attack on treatment by the insurance companies was like a tsunami. We thought we could fight it, but we were engulfed by it." William Hawthorne.

"The years 1992-96 were really critical. We witnessed the dismantling of Comp Care and the collapse of Parkside and other treatment systems large and small. Many of these systems had grown in such a highly leveraged way that they couldn't sustain themselves in the face of a downturn in occupancy precipitated by managed care. They simply didn't have the cash flow to sustain themselves. And in that transition, the managed care companies were demanding that someone fail in outpatient before they could be admitted to inpatient. But most programs of this time had no outpatient programs, or income from such programs could not offset the loss of income from inpatient revenues. While managed care was making unreasonable demands, the field was itself resisting developing alternative levels of care. We had this unfortunate reality that there weren't outpatient programs to send people to. The field simply wasn't ready for the speed at which this change was coming." Sam Muszynski.

The question of how to best respond to managed care created a real split within the NAATP membership.

Managed care was the first real divisive issue within NAATP. There were members who quickly said, "We gotta survive. We'll do whatever that takes." And there were members saying, "Over my dead body. We'll close the doors before we have someone dictate how we provide treatment." NAATP had a hard time issuing an official position because of this split. This issue also revealed our vulnerabilities. First, we failed to accurately read the environment. Some said, "Woe is me. All treatment is going to disappear," while others confidently predicted, "Managed care is a passing fad that will disappear in another year." Both of these predictions were wrong. Second, everyone else coming to the healthcare table had hard data. We had anecdotal stories. We could tell stories that would make you cry, but we couldn't give you any numbers. It was the end, I think, of the era when addiction providers closed their eyes to science. As an industry, we didn't have the ability to integrate existing treatment ideology with new scientific data and financial realities.

NAATP had worked hard to prevent, postpone, contain and then influence the emerging system of managed behavioral health care for some time, but it seemed like the crisis of managed care arrived overnight and rippled through the field with lightning speed. NAATP experienced sudden financial shortfalls in 1990 as membership began dropping as a result of decreased treatment revenues and the resulting closure of many addiction treatment programs.

NAATP was not passive in the face of this crisis. In 1991, it contracted with MEDSTAT to produce reports on treatment effectiveness. The MEDSTAT report, "Treatment is the Answer," constituted one of the early efforts to use hard data to support the effectiveness of addiction treatment. NAATP's role in generating early data on treatment effectiveness was a coming of age moment for the organization and the field it represented.

In the 1991 Spring issue of *NAATP Review*, Michael Ford outlined a 5-point plan for NAATP to counter what he characterized as the "war on addiction treatment". His plan called on NAATP to:

1. Affect public policy
2. Develop effectiveness data for treatment
3. Promote utilization of NAATP/ASAM patient placement criteria
4. Shape regulatory laws governing treatment and treatment reimbursement
5. Support the Society of Americans for Recovery (SOAR)

Soar was a national alcoholism policy advocacy organization founded by former Senator Harold Hughes. NAATP also surrendered its copyright on "Patient Placement Criteria for Adult and Adolescent Substance Use Disorders" to the American Society of Addiction Medicine in 1991. It was thought that these criteria would have greater credibility coming from ASAM rather than from a trade association of treatment providers.

Several long-time NAATP observers noted NAATP's role in helping its members adapt to the rapidly changing managed care environment.

"NAATP did an enormous job of trying to deal with managed care. Without NAATP, the effect of managed care on the field would have been far worse. It's still difficult for treatment centers to exist in the reimbursement environment, but it's getting better, and NAATP has played a role in that improvement." Harry Swift, Hazelden.

NAATP's near-death experience as an Association also altered relationships between members:

"There was a period at the height of managed care when people got very competitive and preoccupied with protecting their "trade secrets." But the threats we faced together through NAATP created a more collaborative model once again of sharing information and working together. We came to realize that the real challenges we had were not with each other but with the policy makers." Jerry Spicer, Board Member 1990s

1992 was a critical turning point in the history of NAATP. The NAATP Board made the decision to move the NAATP offices to Washington DC effective January 1, 1993, and closed its

California office in December 1992. Michael Ford chose not to make the transition to Washington. Sam L. Muszynski, Jr., NAATP's Legal Counsel, contracted to serve as managing director from his Washington DC office. The move was made quickly and within a cloud of mystery and rumor that generated strong feelings among board members.

In spite of this strained transition, NAATP continued to function from 93-96 under the joint leadership of Sam and key board members. Sam describes this period as follows:

“During this period, we raised the question of whether there were too many organizations in the field and the possible need to merge existing organizations into a new organization that could speak for the field with a united voice. An ad hoc committee was created to explore this option, and discussions were pursued with NAATP, ACATA, NATC, and ADPA. These discussions marked a period of heightened cooperation.”

As the crisis deepened for the field and for NAATP, many early members became reflective about the source of this crisis and suggested that it was rooted in part in excesses within the field. At a NAATP Board Retreat in October, 1995, Len Baltzer addressed the board about his concerns for the field and NAATP:

“I am neither naïve nor too old to recognize the many and rapid changes that are taking place in the field of alcoholism and drug addiction treatment. I believe there is a root cause to these changes, greed and arrogance. We (as a field) have moved from `how can I provide the best service to the greatest number of chemically dependent persons at the most reasonable costs` to `what will the market tolerate for the price of this bed...` Every decision we make as an Association needs to be justified by how will this decision help the chemically dependent person and their families, not how will this further my organization/facility or my career. Let us strive to eliminate the greed and arrogance, and return to why this association was founded.”

These years, 1995 and 96, were a test of financial survival, but they were also a test of NAATP's core values. During 95-96, the NAATP Board wrestled with whether to move back to a full time NAATP Director amidst growing concern about erosion of membership dues available to support NAATP. The April 96 treasurer report noted a budget deficit of \$22,000, and NAATP membership plummeted in 96 to a low of 86 members (many of whom were not paying their dues). There were serious discussions in late 96 about whether NAATP could even survive as an organization.

Survival, Maturity, Vibrancy (1997-2008)

NAATP's resurrection after the program closings and membership erosion of the early 1990s required two things: 1. A dedicated core of board members who managed to breathe life into

what seemed a dying organization, and 2. The vision and dedication of new staff leader, Ron Hunsicker.

As NAATP revived itself, it unveiled a new logo, a new newsletter format (*Visions*), a new website, and a new mission statement:

The Mission of NAATP is to promote, assist and enhance the delivery of ethical, effective, research-based treatment for alcoholism and other drug addictions. NAATP will seek to accomplish this mission by: 1. Providing its members and the public with accurate, responsible information and other resources related to the treatment of these diseases; 2. Advocating for increased access to and availability of quality treatment for those who suffer from alcoholism and other drug addictions; and 3. Working in partnership with other organizations and individuals that share NAATP's mission and goals.

NAATP also continued its goal of reducing the proliferation of organizations in the addictions field by arranging in 1998 for the National Treatment Consortium to become a section of NAATP. The association also adopted *The Journal of Chemical Dependency Treatment* as the official journal of NAATP. The annual meeting in Baltimore, Maryland was highlighted by NIDA Director Dr. Alan Leshner's opening plenary "Addiction as a Brain Disease" and by workshops on confidentiality, new treatment alternatives, outcomes-based treatment and accessing the media.

As NAATP entered the new century, it seemed fitting to do so with a new vision, which the board adopted in 2000: The National Association of Addiction Treatment Providers shall be the organization that enables addiction treatment providers to grow and thrive in a changing healthcare environment. In 2002, the NAATP Executive Board refined that vision and amplified its mission statement.

NAATP envisions itself as a national association of addiction treatment providers dedicated to the recognition of alcohol and other drug addiction as a chronic yet treatable disease to which society responds by insuring the availability of affordable, scientifically and ethically sound treatment, the goal of which is abstinence and a new quality of living.

NAATP's mission is 1. To resource and support its member organizations by providing tools and services that help improve the quality of treatment, cost efficiency and effectiveness, 2. To assist the industry in achieving public recognition of the effectiveness of treatment and 3. To secure parity within the larger healthcare system.

To fulfill these aspirations, the association looked to new services that it could provide its members. Those services included benchmarking reports beginning in 1998 through which

organizations could compare themselves to others on key performance indicators, the first national salary survey (1999), and new awards programs to honor individual and institutional pioneers in the field.

In its search for additional revenue to support NAATP activities, the association negotiated in 2000 the rights to own and host future meetings of the SECAD – the South East Conference on Addictive Diseases, one of the oldest (1975) and best addiction training conferences in the country.

A major factor that helped NAATP restore its strong financial footing was its membership growth. NAATP is growing at a rate of 25-30 new members each year, with a membership retention rate of 90%. (Most of the lost membership is due to existing members merging with one another).

When NAATP celebrated its 25th anniversary in 2003, it did so from a position of financial stability and renewed faith regarding the future of itself and its member organizations. That same year, NAATP issued a *Statement of Principles and Values* that read as follows:

- As an organization, NAATP acknowledges that treatment providers have a variety of philosophies and approaches to the treatment of substance use disorders as defined in the current version of the DSM. Within this diversity, NAATP adheres to the following principles and values:
- We recognize substance dependence as a treatable chronic disease.
- Because the fundamental improvements in the quality of life and health for dependent individuals are achieved through abstinence from alcohol and other drugs of abuse, abstinence is the primary treatment goal for dependent persons.
- We recognize that engaging individuals in the treatment and recovery process may involve setting an assortment of primary goals. The preferred primary goal of this association is sustained abstinence.
- We value the importance of self-help groups for ongoing recovery, especially AA and related 12-step programs.
- We require adherence to strong ethical standards of conduct in every area.
- As an association and as treatment providers, we must act as advocates for all persons affected by addiction, so that recovery will always be an option for those who choose it. This includes not only adequate access for those in need of treatment, but also sufficient level and duration of services.
- We are committed to participation in national public policy development as it relates to addiction treatment and prevention.
- We value ongoing research and development that open avenues of innovation and learning.

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- As an organization and as providers, we strive to inform clients, families, and other stakeholders of the services required to address the needs of each individual as indicated by current standards of care and research findings.
 - We recognize that individuals suffering from a primary substance dependence diagnosis may also have a co-occurring mental health condition requiring evaluation and services as part of the treatment process.
 - Because family members are often affected by an individual's substance dependence, family involvement is critical to the long term management of this chronic disease.

In addition to the points emphasized above, we support the delivery of treatment services in accordance with the principles of effective treatment developed and published by NIDA for both alcohol and other drugs.

Through the opening decade of the new century, NAATP's renewed vibrancy was very evident in its well-attended annual conferences. The conference agendas of this period reveal a decreased emphasis on financial survival – a topic that had dominated the agenda in the early to mid-1990s – and a greater emphasis on quality of care. The latter was reflected in numerous keynotes and workshops on research to practice (e.g., new medication-based treatments) and the treatment of special populations, e.g., the treatment of women, adolescents, families, people of color, persons with co-occurring medical or psychiatric disorders, and persons referred from the criminal justice system.

The growing membership of NAATP and increased conference attendance reflected renewed growth in the larger field. The new century also witnessed renewed advocacy efforts by NAATP. These efforts included:

- Issuing position statements such as One Standard for All Addiction Treatment (2001) that addressed the issue of federal funding for "faith-based" approaches to addiction treatment.
- Working with Christopher Kennedy Lawford to author op ed pieces for national publication.
- Development of a Managed Care Tool Kit for its members as well as a strategy to respond to the managed care phenomena.

Progress and Challenges (2009-2014)

By 2009 NAATP was well established as leader in the field of addiction treatment and focused on the barriers for care with the goal of improving access for those in need. Collaborating with partners like ASAM and NAADAC, legislation improving the parity of coverage for addiction treatment was passed and implemented in Washington, D.C. NAATP established a full time

presence in Washington, DC for a continued advocacy on issues like parity and privacy in an electronic record as it relates to 42 CFR Part 2.

In 2010 NAATP faced a unique challenge when the CEO left the organization after the discovery of a misappropriation of funds. During this challenging time, members and board members worked together during the investigation, addressed questions and enhanced policies and procedures. The Board recognized that a different design for leadership was in order for NAATP to avoid future pitfalls and maintain a leadership position in the field. Past NAATP Board member and long-time Valley Hope CEO, Dennis Gilhousen, was selected as interim CEO. Mr. Gilhousen and the Board's Executive Committee worked with William White to document a vision and create a strategic plan for the organization.

Although the time period of 2011-2014 continued to have its challenges, progress was made. Back to back CEOs had short terms with NAATP, requiring the board to review its model for staffing and leadership. At the same time, the Board itself was very active in the operations of the association. Continued progress on national and state rules around parity, association growth, the beginning of a national outcome study, and a decision to allocate the resources necessary to build an organizational team are all hallmarks of this period.

Reemergence and Development (2015 – Present)

Following the organizational challenges of the previous period, the NAATP Board of Directors committed to empowering the association for success with new and enhanced staffing, financial resources, and strong accountability and transparency measures. While the board did excellent work managing the association during transition, it recognized that a highly effective organization requires a highly effective (educated, trained, experienced, and knowledgeable) staff directed by a professional chief executive. Following a comprehensive national search process, the board retained Marvin Ventrell as Executive Director, NAATP's fifth chief executive. Marvin's experience included a career as an attorney, law school instructor, addiction program director, and founder and CEO of two successful social service agencies. Marvin also identifies himself publicly as a person in long term recovery from addiction.

The tasks of the new staff included a review of all NAATP administrative and program activity, completion of an environmental scan of the current addiction industry, and preparation of a new strategic plan. The review revealed that while NAATP's recent program delivery had indeed been deficient, NAATP's historic mission, vision, values, and primary objectives were both relevant and necessary for the organization and the addiction industry to thrive. Surveys conducted by NAATP's branding firm revealed that NAATP had brand damage caused by recent inactivity but also that NAATP had a strong and loyal membership base and solid reputation.

NAATP's reemergence as the leading voice of the profession would require the rebuilding of internal operational systems, rebranding, development of a new website and member management system, and an integrated communications strategy. Within ten months of the installation of the new staff, NAATP had completed its move to Denver, Colorado, approved the new strategic plan, completed a branding process, begun work on the new website and member management system, and developed a member and stakeholder communications plan. Each of these initiatives scheduled to launch one year after installation of the new staff at the 2016 NAATP National Leadership Conference in May.

While building new systems and securing a strong foundation, NAATP also began delivering program service more aggressively in areas including member communications, news releases, visibility, social media, and conference program. In February of 2016, NAATP launched its Outcomes Treatment Study as well.

At the time of the adoption of this plan, NAATP was well poised to effectively meet the needs of its members, expand its membership base, and support the addiction treatment industry as a whole. This comes at a time when the field faces serious challenges including, access to care, new competition from the for profit sector, ethics and professionalism concerns, treatment modality integration, institutional integration, and unfavorable industry news coverage.

III. The Need for NAATP

The forgoing environmental view and NAATP history illustrate the need and niche for NAATP. In order to establish comprehensive policy, develop and promote best treatment practices, provide industry development resources, and improve public awareness, there is a need for a national organization that can represent the treatment provider industry as a strong and unified voice. No such other organization exists for these precise purposes. An effective NAATP will contribute to addressing the addiction problem by influencing:

1. Access to addiction treatment
2. Delivery of addiction treatment
3. Recognition of best service delivery practices in addiction treatment
4. Recognition of ethical practices in addiction care marketing and service delivery
5. Dissemination of addiction treatment information to the industry and the public
6. Education, training, and technical assistance
7. Public policy advocacy
8. Addiction industry unity, collaboration, and information sharing

IV. Mission

To provide leadership, advocacy, training, and other member support services to assure the availability and highest quality of addiction treatment.

V. Vision

NAATP is the leading voice of addiction treatment providers.

VI. Values

We value residential treatment's vital, necessary and essential place in the full continuum of care as a viable choice for the treatment of the disease of addiction.

We value a comprehensive model of care that addresses the medical, bio-psycho-social and spiritual needs of individuals and families impacted by the disease of addiction.

We value the history of significant contributions made by 12-step abstinence based treatment to the sobriety of over twenty million Americans in recovery.

We value research driven, evidence based treatment interventions that integrate the sciences of medicine, therapy and spirituality. (For example, pharmaceutical interventions including medications for reducing craving and withdrawal symptoms; psychosocial interventions including cognitive behavioral therapy and motivational interviewing; spiritual interventions including Twelve Step facilitated therapy and mindfulness meditation; behavioral interventions including nutrition and exercise).

We value abstinence from all abusable drugs as an optimal component of wellness and lifelong recovery. Depending on bio-psycho-social and economic factors, there may be persons who might require medication assisted treatment for extended periods of time and perhaps indefinitely. However, medication alone is never sufficient to maintain long term recovery.

We value outcome data that assesses the efficacy of treatment interventions.

We value education and training that promotes understanding of a continuum of care that embraces these values.

VII. Goals, Objectives, and Implementation Actions

A. Association Administration

Goal 1 of 5

Evaluate, stabilize, strengthen, and build NAATP administrative structures to ensure high quality, reliable, durable, efficient, and transferable association operation.

a. Governance and the Board of Directors

- Objective 1: Maintain an effective Board of Directors that provides governance and Executive Director and fiscal oversight.
- Objective 2: Formalize Board of Director procedures relative to selection, term, and service expectations.
- Objective 3: Establish the Board of Director's role in association fund and visibility development.
- Objective 4: Evaluate existing Board of Director skills to ensure the best uses of Board Member talent.
- Objective 5: Implement a committee structure with committees comprised predominantly of Board Members that promotes effective and efficient task completion.
- Objective 6: Conduct three in person board meetings per year: Winter, Annual, and Fall.
- Objective 7: Amend By-Laws regarding NAATP membership criteria and adopt new criteria that better reflect and address current realities and membership concerns.

b. Staffing

- Objective 8: Ensure the success of the association through the employment of a chief staff officer called the Executive Director (ED).

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- Objective 9: Complete the move of NAATP national headquarters to Denver, Colorado.
 - Objective 10: Empower the ED to employ NAATP staff adequate to ensure competent operation.
 - Objective 11: Ensure the quality and sustainability of NAATP staff by providing challenging, interesting, and well compensated work.
 - Objective 12: Provide staff with comprehensive training, continuing education, and development opportunity.

c. Operation

- Objective 13: Produce clear and succinct written operational policies and procedures (P&Ps) for all significant operational areas.
- Objective 14: Ensure high quality operation through the implementation of necessary equipment and independent contractors where appropriate.
- Objective 15: Increase use of technology for communication, advocacy, and membership services.

d. Finance

- Objective 16: Develop a protocol whereby the ED, DO, Board Treasurer, accounting firm, and the finance committee post income and expenses and produce timely financial statements.
- Objective 17: Prepare annual calendar year budgets that conform to nonprofit membership association budget protocols that are approved to take effect prior to the start of the calendar year.
- Objective 18. Produce an Association Annual Report or similar document.

B. Association Development

a. Branding and Visibility

Goal 2 of 5

Establish and promote the image of NAATP as a modern, state of the art, powerful, persuasive, and authoritative addiction profession leader.

Objective 1: Evaluate NAATP's brand, establish an accurate, clear, modern, and appealing brand image and message, and disseminate the brand widely.

b. Fund Development

Objective 1: Execute a program revenue process that produces revenue income from member dues, education and training, or other sources.

Objective 2: Explore the revenue sources of gifts and grants (individual, corporate, private foundation, public foundation), major gifts, and small gifts.

C. Association Program

a. Member Service

Goal 3 of 5

Provide services to our members that enhance their abilities to deliver high quality addiction treatment services.

Objective 1: Develop and run a NAATP Publications Program.

Objective 2: Develop and run a NAATP Education and Training Program.

Objective 3: Produce a Comprehensive Treatment Outcomes Study.

Objective 4: Complete periodic Industry Salary Surveys.

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- Objective 5: Asses the value of additional benchmarking in addition to Outcomes and Salary.
 - Objective 6: Run a NAATP Awards / Recognition Program.
 - Objective 7: Create and deliver a NAATP Resource Center Program that disseminates training, education and technical assistance to our members.
 - Objective 8: Facilitate professional networking among our member organizations on a regular basis.
 - Objective 9: Assess current member benefits and deliver appropriate member benefits.
 - Objective 10: Enter into formal and informal collaboration agreements with like-missioned organizations.
 - Objective 11: Establish and Publish Industry Ethics Guidelines including a NAATP Complaint Policy and Procedure.
 - Objective 12: Build NAATP Membership.

b. Policy Advocacy

Goal 4 of 5

Conduct policy advocacy activity that supports the existence, financial health, and professional and public status of addiction treatment providers.

- Objective 1: Maintain a Policy Representative Individual or Firm located in Washington, DC who / that has sophisticated training, education, experience, familiarity, access, and influence.
- Objective 2: Create policy/consensus statement or Policy Agenda that defines and guides NAATP policy action on key policy issues.
- Objective 3: Support the role of specialized addiction treatment within the context of health care reform and service integration initiatives.

Objective 4: Enhance policy alliances and joint public education efforts with key organizations within the field to present a united front on national issues.

Objective 5: Promote Addiction Service Payment Mechanisms

Objective 6: Promote the NAATP PAC

c. Public Service

Goal 5 of 5

In addition to the program priorities of Member Service and Policy Advocacy, develop and deliver a public service in the form of addiction awareness and substantive education.

Objective 1: Identify and implement services that can be reasonably provided to the public.

VIII. Creating Annual Operating Plans

This strategic plan provides organizational definition and objectives for a three-year period. Implementation detail, except where specifically indicated as an Implementation Action for clarity, is not, for the most part included in this document.

In addition to this plan, the NAATP Staff will produce Annual Operating Plans to guide association operation, which plans should include clear direction for the execution of objectives during a calendar year.

IX. Plan Duration and The Next NAATP Strategic Plan

This plan is effective through December 31, 2018. The NAATP Executive Committee and the NAATP Executive Director will begin the process of creating the Strategic Plan for the period beginning January 1, 2019 in the summer of 2018.

X. Plan Adoption

This plan was drafted by the NAATP Executive Director and reviewed and modified by the NAATP Executive Committee at a strategic planning session in Denver on September 15, 2015. Thereafter, the plan was presented to the full NAATP Board of Directors at the October 5, 2015 Fall Board Meeting. This was followed by a 30-day comment period during which Board Members who wished to do so submitted comments that were

considered and incorporated in this draft. The plan was adopted by unanimous vote of the NAATP Board of Directors at the NAATP 2016 Winter Meeting.

Executive Committee/Drafting Committee

Carl Kester, Chair of the Board of Directors
Art VanDivier, Vice Chair
John Driscoll, Treasurer
Bob Ferguson, Secretary
Kermit Dahlen, Past Chair
Marvin Ventrell, Executive Director

Approved by the NAATP Board of Directors on February 22, 2016

Jerry Crowder, President/CEO - Bradford Health Services Corporate Office
Kermit Dahlen, President/CEO - Jackson Recovery Centers, Inc.
Edward Diehl, President - Seabrook House, Inc.
John Driscoll, Executive Director - Hazelden Foundation
Philip Eaton, President/CEO - Rosecrance Health Network
Robert Ferguson, CEO - Jaywalker Lodge
Gary Fisher, COO - Cirque Lodge
Rebecca Flood, Executive Director/CEO - New Directions for Women, Inc.
Pat George, President & CEO - Valley Hope Foundation
Paul Hackman, CEO - Pavillon
Russell Hagen, CEO - Chestnut Health Systems, Inc.
Carl Kester, President and CEO - Lakeside-Milam Recovery Centers
Scott Munson, Executive Director - Sundown M Ranch
Cathy Palm, Executive Director - Tully Hill Corporation
Peter Polanca, Executive VP and COO - TASC Treatment Alternatives for Safe Communities
Debbie Sanford, CEO - Pine Grove Behavioral Health & Addiction Services
Raymond Tamasi, CEO - Gosnold on Cape Cod
Art VanDivier, Executive Director - La Hacienda Treatment Center
Rob Waggener, President/CEO - Foundations Recovery Network
Barbara Woods, CEO - Casa Palmera
Nanette Zumwalt, President – Hired Power

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