



**NATIONAL ASSOCIATION**  
OF  
**ADDICTION TREATMENT PROVIDERS**

Voice. Vision. Leadership.

# Strategic Plan

For the Three-Year Period 2019 through 2021

## Leading in A New Era

Steady Leadership, Secure Infrastructure, Committed Principles,  
and Comprehensive Strategic Program Delivery



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*Addendum: A History of The National Association 1978 to Present*

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## I. 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 2019 through 2021. The plan is a guide for the execution of NAATP's mission from broad goals to specific measurable objectives. The plan was prepared by the NAATP Executive Director in consultation with a NAATP Strategic Planning Committee and NAATP's Strategic Advisor. It was approved and adopted by the NAATP Board of Directors.

The plan reflects the NAATP belief that our association's role is to provide values-based vision, leadership, services, and advocacy for a professional field that is evolving in terms of clinical method and business structure, fragmented, and in need of guidance. NAATP is ideally situated to carry out this role as a mature organization (founded in 1978) comprised of professional staff and overseen by a Board of Directors that represents the addiction treatment providers in our country. Please refer to the *Addendum* to this plan for a history of NAATP since its founding. The *Addendum* describes the work of the association as its existence has paralleled and influenced the addiction treatment field at large.

The subject matter of NAATP's work is the treatment of the disease of Addiction, a/k/a Substance Use Disorder (SUD). Addiction exists in the United States as an enormous health care issue that is not adequately addressed by our health care system. Addiction is a primary, and chronic brain disease with biological, psychological, social, and spiritual manifestations. Addiction is best treated by comprehensive multifaceted interventions that address all of the components of the disease and its manifestations. Our health care system fails to do so on a broad scale. While many people receive high quality care from high quality providers, including NAATP members, most people who suffer from addiction do not.

Statistics have remained relatively steady over recent years that as few as 10% of individuals who suffer from addiction receive adequate care. This is disproportionately low compared to treatment of other health care disorders. This treatment gap is related to a payment gap. Unlike most healthcare, government funding is the primary source of payment for addiction care and that funding is inadequate. Private insurance does not adequately close this gap. It pays a disproportionately low percentage of addiction care relative to other health disorders. The Mental Health Parity and Addiction Equity Act (MHPAEA), enacted to address both the treatment and payment gaps, remains largely unrealized.

Addiction, untreated, results in serious harm and can and often does result in death. Yet the disease is treatable, and we believe treatment works. The goal of addiction treatment is wellness which we call recovery. Recovery can be defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. While approximately 25 million individuals are believed to suffer from addiction, just as many identify as being in recovery. It is, therefore, the goal of NAATP to

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serve our member facilities while working to support and grow an addiction treatment system that provides the best possible care to the largest possible number of people. NAATP is a *Trade Association Plus*.

As a professional membership society of addiction treatment providers, our role is to promote the welfare of that society. This can occur in numerous ways and can and does occur in terms of trade association service. Trade associations promote the success of an industry by serving its operators' needs. The needs of the addiction treatment provider are wide-ranging from day-to-day operational technical assistance to the more global concern of defining the very nature of addiction treatment itself.

This three-year period, 2019–2021, provides an opportunity for NAATP to build on the stabilization and re-emergence of success of the previous three years during which time the association completed a successful reorganization under a plan called *Defining our Association, Securing our Foundation, Building our Infrastructure, and Delivering our Service*. The goals of that plan were fully and successfully completed and exceeded.

As we begin this next period of service, we have in our possession, therefore, an association that is financially sound and with a steadily increasing membership base, a comprehensive menu of program services, a competent and growing professional staff, and an engaged and a dedicated Board of Directors. This plan builds on our work with a new call to *Steady Leadership, Secure Infrastructure, Committed Principles, and Comprehensive Strategic Program Delivery*, which serves as the title of our plan. As we look to the years ahead, it is important that we, as an association, continue to maintain our operational gains, sustain and extend our product and service offerings for members, and strategically scale our external communications to capture greater influence.

A hallmark of our previous three years is the development and implementation of an Ethics Program which has had a profound influence on our field and our association. It has, to a large degree, redefined NAATP as the values-based voice among treatment providers, policy makers, the media, and to the public. Through the stance of ethics, NAATP developed its current stronger voice.

Our field experienced such a severe ethical crisis that NAATP came to believe that we must address the issue by creating and enforcing within our membership clear and absolute professionalism and ethics standards. We did this by adopting NAATP Ethics Code 2.0 followed by the creation of a comprehensive program called the Quality Assurance Initiative (QAI). These efforts resulted in the unusual undertaking of removing numerous members of the association at considerable financial loss and strictly evaluating ongoing membership for ethical compliance through a rigorous application process and public complaint and review forum.

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The response to our ethics and quality assurance efforts was overwhelmingly positive. Our membership and the broader addiction community, together with the press and policy-makers, embraced and applauded the work as necessary and courageous. NAATP National 2018, the 40<sup>th</sup> Anniversary year for NAATP's Annual Addiction Leadership Conference, proved to be a crossroads and watershed event in which a record number of attendees participated, and an era of unity and enthusiasm seemed to begin. NAATP arrived, again, as a relevant and valuable association. This was due in no small part the community's embrace of ethical requirements for membership and the visible absence of members that no longer qualified for membership.

With the Ethics Code operational, NAATP began to build its Quality Assurance Program with the centerpiece of an operational guidebook that would define the core competencies of treatment operations. This centerpiece would be called the Quality Assurance Guidebook, scheduled for release in 2019.

One of the key competencies of the guidebook is to be a guideline for treatment outcomes tracking. At the core of this guideline will be the NAATP Outcomes Toolkit. The Toolkit, scheduled for release in early 2019, is based on the important work of the Outcomes Pilot Program (The OPP) that was completed in December of 2018.

Moving forward into the current phase of work, therefore, we ask ourselves, what next? The answer, in large part is obvious based on our success to this point: More and Better. Strategically stated: Maintain, Sustain, Extend, and Strategically Scale. That is the essence of Strategic Plan 2019-2021.

The plan encompasses ongoing assessments of current programs and plans to refine and advance them further. The plan also looks closely at ongoing resource management and allocation and ensuring that the organization's scope of services is well-suited to its mission and vision. This approach allows leadership to continually assess, invest in, and align NAATP resources to meet the changing landscape of addiction treatment.

Our extension of policy advocacy will be an important piece of the work. While NAATP significantly increased its work in this area in the past phase, the NAATP Policy Advocacy Program is still relatively small and requires development in order for our voice to be optimally effective.

It is our belief that this plan will guide our association, its members, and the addiction treatment industry at large, by continuing to improve access to high-quality ethical care, even as new voices and influences join the conversation and the winds of healthcare once again shift. To be successful is to continue to accelerate the organizational gains of the past few years, while insulating NAATP and its members from potentially deleterious changes to addiction treatment, and while growing our share of voice and ability to reach key influencers.

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Calls to “fix” addiction treatment and insert simplistic rating systems for example, offer both opportunity for NAATP members as well as pose a real challenge.

As longstanding steady providers of addiction treatment services know, Addiction is not responsive to silver-bullet solutions, and should not be viewed through the limited lens of acute interventions, medication and harm reduction alone. Likewise, ideological resistance to new evidence-based practices will be counterproductive. Ideal addiction treatment begins with lifesaving intervention and continues with compressive treatment along a continuum toward recovery and a full life. Our philosophy must be based on what already works while embracing that which can work better.

The themes of maintain, sustain, extend and strategically scale will guide the association in the pivotal years ahead as follows:

A. Maintain

NAATP will maintain its ethical standards and continue to raise the bar within the membership. We will maintain momentum in defining clear, objective standards and communicate those. We will continue to maintain the financial wellness built over the prior years to preserve the organization’s livelihood in the event of a downturn and in the face of increased merger and acquisition activity.

B. Sustain and Extend

This includes, having built new products and a strong service offering, sustaining those offerings and looking for opportunities to refine and extend them. We will continue delivering on the defined product set and taking feedback so that new versions incorporate that feedback. We will continue assessing bodies of knowledge, existing products and services provided by other organizations. We will evaluate the body of knowledge outside The National Association for increased share of voice and thought leadership.

C. Strategically and Sensibly Scale

Having looked at market challenges, NAATP can scale new opportunities in a strategic and sensible way. This includes being able to look at strategic partnerships to advance NAATP’s share of voice along with most meaningful and best aligned partners. Additionally, as the market once again evolves and role of healthcare asserts itself, it will be incumbent upon NAATP to look at how our members’ worlds will change with this new, heavy influence in the market. NAATP has a dynamic opportunity to serve its members during this evolution, being the voice of the industry and a guide, coach, and convener addressing how member organizations can navigate this change. The responsibility is ours to ensure that as the voice

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of the industry, NAATP is dominant in the dialogue, presenting its unique vantage point, as key audiences make decisions about policy and access.

NAATP looks forward to this next phase of our work through Strategic Plan 2019 – 2021. We are grateful for the opportunity to serve our members and develop our field through the further professional maturation of our association. We are dedicated to this work and honored by the opportunity and responsibility to do it well.

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## II. Today's Addiction Treatment Provider Environment

The following factors represent significant environmental conditions that influence NAATP's work.

- Addiction/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.
- 20.7 million people needed treatment in 2017 (12 and older) for SUD (SAMHSA, NSDUH TEDS, 2017). Of those who needed treatment for SUD, 12.2% received specialty treatment (i.e., our membership) for their disease (SAMHSA, NSDUH TEDS, 2017).
- An estimated 88,000 people (approximately 62,000 men and 26,000 women) die from alcohol-related causes annually, making alcohol the third leading preventable cause of death in the United States (NIAA, 2019).
- According to results from the 2017 National Survey on Drug Use and Health (NSDUH), an estimated 2 million Americans misused prescription pain relievers for the first time within the past year, which averages to approximately 5,480 initiates per day. Additionally, more than one million misused prescription stimulants, 1.5 million misused tranquilizers, and 271,000 misused sedatives for the first time (NSDUH, 2017).
- According to the National Institute on Drug Abuse (NIDA), every day, more than 130 people in the United States die after overdosing on opioids. The misuse and addiction to opioids is a serious national crisis that affects public health, social and economic welfare. The CDC estimates that the total "economic burden" of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement (NIDA, 2019).
- Drug and alcohol related costs in the U.S. exceed \$740 billion annually (NIDA, 2019; USHHS, CDC, NDIC).
- The majority of people who need addiction services do not receive them. Of those who receive some type of treatment, only 12% received non-hospital residential addiction care, according to SAMHSA's National Survey of Substance Abuse Treatment Services. (2017 TEDS, Data on Substance Abuse Treatment Facilities).
- According to the Surgeon General's most recent report (2018), approximately 50% of adults who once met diagnostic criteria for a SUD — or about 25 million people — are



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currently in stable remission (1 year or longer). Even so, remission from a substance use disorder can take several years and multiple episodes of treatment, RSS, and/or mutual aid.

- Addiction is recognized as a disease in federal policy and the mainstream treatment community, including NAATP, AMA, ASAM, APA, CDC, ONDCP, NIDA, and SAMHSA.
- Addiction is recognized as a chronic disease in federal policy and the mainstream treatment community, including NAATP, AMA, ASAM, APA, CDC, ONDCP, NIDA, and SAMHSA.
- Addiction is still often treated as an acute disease. Emergency room visits have continued to grow over the last ten years, aligning with the increase in opioid overdoses and the ongoing crisis from opioids (CDC, 2018).
- Addiction has historically been 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. In the United States, the most recent report by the Bureau of Justice Statistics estimate that 58% of adults who have been in state prisons and 63% of people who have been sentenced to jail have drug use disorders (Tsai & Gu, 2019).
- Despite disease recognition, addiction remains a negatively stigmatized disease which inhibits treatment and recovery.
- 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 include a social-spiritual, 12-step component to treatment. It is not clear whether federal policy and the health care industry value this component as part of psychosocial care.
- Medication-Assisted Treatment (MAT) has become a “gold standard”, as Dr. Nora Volkow advocates (2017), for treatment of opioid use disorder. To what extent federal, state, and healthcare policy will go in using medications for treatment and forgo behavioral, multiphasic models of treatment has yet to be seen. NAATP is working with stakeholders to ensure that membership is well represented at the table as policy continues to be formed regarding MAT. (Note: MAT as a descriptor of the use of medication as a component of treatment is increasingly seen as an inadequate if not inaccurate term.)
  1. The Surgeon General’s Report (2018) provides some insight into the current federal climate regarding MAT: “The use of opioid agonist medications to treat opioid use

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disorders has always had its critics. Many people, including some policymakers, authorities in the criminal justice system, and treatment providers, have viewed maintenance treatments as ‘substituting one substance for another’ and have adhered instead to an abstinence-only philosophy that avoids the use of medications, especially those that activate opioid receptors. Such views are not scientifically supported; the research clearly demonstrates that MAT leads to better treatment outcomes compared to behavioral treatments alone. Moreover, withholding medications greatly increases the risk of relapse to illicit opioid use and overdose death. Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.”

2. Insurance agencies are already denying payment for residential treatment that is not in-network or part of value-based agreements between payors and payees and preferring to pay for a cheaper option in MAT and outpatient services. Seven major payers in Pennsylvania alone (Aetna, Capital Blue Cross, Geisinger, Highmark, Independence Blue Cross, UPMC and United Healthcare) have removed prior authorization requirements for prescribing MAT for substance use disorder.
- The addiction treatment industry has grown from a cottage industry in the early 20<sup>th</sup> century to a health care profession as evidenced by:
    1. Physicians may now become Board Certified in Addiction Medicine.
    2. Counselors may, and are typically required by states, to be credentialed in addiction counseling.
    3. Treatment providers must typically be state licensed to provide addiction care.
    4. 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.
  - The number of treatment programs is on the rise and competition among treatment providers is significant. There may be as many as 15,000 programs in the U.S. as of 2019.
  - The quality of care by treatment providers varies widely.
  - “Well-supported evidence” (as defined by the CDC) shows that the current SUD workforce does not have the capacity to meet the existing need for integrated health care, and the current general health care workforce is undertrained to deal with substance use-related problems. Health care now requires a new, larger, more diverse workforce with the skills to prevent, identify, and treat substance use disorders, providing “personalized care” through integrated care delivery (Surgeon General, 2018).

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- Addiction treatment is not regulated under a uniform national system but rather on a state by state basis.
  - 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.
  - Federal Parity Law now requires that insurers who cover addiction must do so on par with other covered diseases.
  - Federal Parity Law is not substantially implemented, enforced, or uniformly honored by insurers.
  - The Affordable Care Act (ACA) provides funding for addiction treatment by requiring addiction coverage in insurance policies sold on the exchanges, making Parity Law more widespread.
  - The availability of greater funding for addiction care enables providers to deliver more care and better care to patients.
  - The availability of greater funding for addiction care generates more providers, some of which may be more concerned with profit than quality care. The addiction treatment industry is estimated to bring in annual revenue of \$35 billion (ABC News, 2016).
  - Unethical to illegal treatment program marketing practices are not uncommon and such practices damage the public image of treatment and harm good providers.
  - NAATP has industry “competition” for its policy, member services, public service, and educational work from other organizations.
  - Use of Health IT is expanding to support greater communication and collaboration among providers in an attempt to foster collaborative care. It has the potential to improve accessibility to care and improve coordination efforts, provide health outcomes, recovery monitoring, and improve engagement for difficult to access and non-traditional patients, particularly in rural settings (US DHHS, 2016).
  - From 2015 forward, as a response to the opioid crisis in the United States, the treatment industry saw an increase in mergers, acquisitions, new treatment programs opening, recovery residences starting up, and MAT services increasing in all areas of treatment except for independent OTP/MAT clinics (SAMHSA, NSSATS, 2017).

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- While much of business activity from 2015 to 2018 has proven to be beneficial for those with SUD, the treatment field saw a large influx of bad players, profiteers, and patient brokers, all of which required policy responses from leadership.
  - Our field experienced such a severe ethical crisis that NAATP came to believe that we must address the issue by creating and enforcing within our membership clear and absolute professionalism and ethics standards. NAATP Ethics Code 2.0 was created, followed by the comprehensive program, the Quality Assurance Initiative (QAI) (2019). These efforts resulted in the unusual undertaking of removing numerous members of the association at considerable financial loss and strictly evaluating ongoing membership for ethical compliance through a rigorous application process and public complaint and review forum.
  - The science of pharmacology to treat addiction can enhance recovery through drugs that address the addiction brain disease component. There are several FDA approved medications now available that help in the detoxification process from alcohol and opioids, and they are effective in helping patients enter and engage in the treatment recovery process:
    - Buprenorphine
      - *Suboxone*: Buprenorphine-Naloxone – partial agonist/partial antagonist – can be used both during detox and ongoing for maintenance
      - *Subutex*: Buprenorphine-HCL – partial agonist- typically used during induction, or the detox process, and for those who cannot tolerate naloxone. Used for pregnant clients.
    - Naloxone: used to reverse an opioid overdose. A full antagonist puts person into withdraw but is life-saving.
    - Methadone: full agonist, opioid maintenance therapy/replacement
    - Naltrexone:
      - *ReVia and Vivitrol*
      - Primarily used to manage alcohol or opioid dependence.
      - An opioid-dependent person should not receive it before detoxification.
    - Disulfiram: *Antabuse* – induces acute sensitivity to alcohol.
    - Acamprosate: *Campral* - is thought to stabilize chemical signaling in the brain that would otherwise be disrupted by alcohol withdrawal.
  - The science of pharmacology to treat addiction can affect recovery by placing undue reliance on drugs in lieu of the social and spiritual components of recovery.

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- 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.
  - Co-morbid treatment, integrated treatment for co-occurring disorders often involving cognitive behavioral therapy strategies to boost interpersonal and coping skills and using approaches that support motivation and functional recovery, comorbid drug use is now commonplace in addiction care although widely varied in scope and delivery (see DDCAT evaluations).
  - The concept of the Continuum of Care is widely accepted now in the treatment provider industry and NAATP members largely model the continuum of care.
  - The integration of addiction care into behavioral healthcare and the healthcare system at large brings recognition, validation, greater resources, and better care.
  - 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.
    1. The mainstream healthcare industry may not appreciate the value of psychosocial care and use Medically Assisted Treatment (MAT) in isolation, and in fact, views medication alone as a gold standard, not necessarily MAT (see Volkow, 2017).
    2. The federal healthcare policy community views mainstream healthcare as a conduit for providing quality management of SUDs, suggesting that integrating SUD care into mainstream health care as the way of the future (DHHS, 2016; Surgeon General, 2018).
  - Influential policy voices including ASAM, SAMHSA, NIDA, and ONDCP state that addiction treatment should include psychosocial elements, but many centers may not implement psychosocial care.
  - 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.
  - 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 largely applicable. Integrated care is more commonly used now.
  - Addiction providers are widely varied in organizational size and composition.

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- The make-up of treatment centers across the US are comprised of mostly outpatient services. The following data from the NSSATS (2017) provides insight:
    1. Clients in outpatient treatment made up 89 to 91 percent of all clients each year. (The number of outpatient clients increased from 1,016,913 in 2007 to 1,238,654 in 2017.)
    2. Clients in residential (non-hospital) treatment made up 7 to 9 percent of all clients each year. (The number of residential [non-hospital] clients decreased from 103,709 in 2007 to 99,881 in 2017.)
    3. Clients in hospital inpatient treatment made up 1 to 2 percent of all clients each year. (The number of hospital inpatient clients increased from 14,803 in 2007 to 17,480 in 2017.)
  - The majority of treatment providers across the entire continuum of care are not NAATP members. There are approximately 15,000 treatment providers in the US, while NAATP only represents a small fraction of this (SAMHSA, 2019).
  - The addiction provider industry has failed to adequately measure its outcomes. Until the recent completion of the Outcomes Pilot Program (2019), the most recent outcomes research was completed in the 1990's with the DATOS study.
  - The addiction provider industry is now beginning to measure its outcomes and The National Association has completed the Outcomes Pilot Program and Outcomes Toolkit. The toolkit, available to membership as of 2019, is a guide to implementation of outcomes research for treatment programs across the US and sets a standard for measuring outcomes for residential treatment.
  - According to the Outcomes Pilot Program (OPP) (NAATP, 2019), longer engagement in treatment means longer term sobriety and recovery from SUD for patients.
  - The OPP also found that those in longer term recovery more frequently engaged in peer support activities and 12-step communities.
  - Next steps on NAATP's Outcomes Program will consider specific Toolkit implementation mechanisms, primarily software programs that track and report patient data during and post treatment.

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- The continuum of care is endorsed as a necessary integrated process to help individuals recover from SUD (SAMSHA, CDC, NIAAA, ASAM, Surgeon General, Presidential Opioid Commission, ONDCP).
  - The seminal and ongoing longitudinal social science research (over 80 years) in the commonly called “Harvard Cohort Study”, started by George Vaillant et al. (1938), has shown that there are four factors helpful for the long-term recovery from addiction. These factors are the basis for best practices suggested for the treatment of SUD and recovery support systems - Recovery Oriented Systems of Care (ROSC) (SAMSHA), the Elements of Recovery study (2014), Principles of Relapse Prevention, and Minnesota Multiphasic Treatment.
    1. New loving relationships
    2. Creating hope and self-esteem with a sense purpose
    3. Accountability and a new view of negative effects of the drug on the individual (a change in mental attitude toward the drug)
    4. New social support and engagement
  - NAATP stands in its 5<sup>th</sup> decade as a unique and essential advocate and guardian of addiction treatment that produces recovery in its fullest form wherein patients realize a transformation from life ending illness to the wellness of full potential and value.

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### 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
9. Addiction industry development and publishing of outcomes measurement



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#### IV. NAATP Mission, Vision and Values

In September of 2018 the NAATP Board of Directors Executive Committee and ED convened a strategic review of the organization's mission, vision and values. The mission and values remain constant. The vision statement has been updated to acknowledge improved access to high-quality, effective, and ethical care as a top-line vision of success.

*Vision: To improve the world's access to effective and ethical addiction treatment.*

*Mission: To provide leadership, advocacy, training, and member support services to ensure the availability and highest quality of addiction treatment.*

*Values: Summary Value Statement: We value a comprehensive model of care that addresses the medical, bio-psycho-social-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.*

1. 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.
2. 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.
3. We value the history of significant contributions made by 12-step abstinence-based treatment to the sobriety of over twenty million Americans in recovery.
4. 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).
5. We value abstinence from substance abuse 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.

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However, medication alone is never sufficient to maintain long term recovery.

6. We value outcome data that assesses the efficacy of treatment interventions.
7. We value education and training that promotes understanding of a continuum of care that embraces these values.

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## V. Landscape Review and SWOT Analysis

### *Strengths:*

1. NAATP represents a significant voice, inclusive of approximately 900 treatment facilities.
2. NAATP members possess a unique perspective on addiction treatment, informed by more than 40 years of expertise.
3. Taken together, no other organization has both NAATP's rich, historic understanding of the addiction treatment field — as well as the operational capacity and reach of NAATP members.
4. The organization's rebuilding work over the prior three years has allowed the organization to emerge with a newfound legitimacy; NAATP is now experiencing growing membership numbers and new momentum.
5. Importantly, the organization's willingness to closely evaluate and address ethical standards across the industry, and its membership, has allowed NAATP to establish itself as the professional voice of high-quality, ethical care. NAATP is emerging as a strong "moral authority" in care.
6. NAATP is composed of committed leaders and members, who prioritize comprehensive, holistic care delivered with dignity and professionalism. The organization is not born of opportunism.
7. The organization's ability to have impact is outsized compared to its budget and staff. As one board member framed it, "pound for pound NAATP is very tough." This trait is complemented by NAATP's ability to be nimble and responsive to changing market conditions.
8. Board members note the organization's leadership, including the direction taken by the ED, in addition to the caliber and professionalism of staff, as indicators of the organization's strength.
9. The organization sits in a solid financial position entering 2019, with a solid balance sheet, reserves and operating budget.

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*Weaknesses:*

1. NAATP is not entirely divorced of all prior reputation issues. Acknowledgment and cognizance that the renewed legitimacy is hard-earned, but can be quickly erased without continued commitment, is important in the years ahead.
2. Additionally, there is a perception that lacking major research and/or data, the organization lacks gravitas. This perception has the ability to grow in the coming three years given the increasing role of data and business intelligence (BI) tools.
3. NAATP's commitment to ethical standards of care brings an urgency to the definition of that care and calls for the need to have consistent measurable standards and guidelines for NAATP membership.
4. While NAATP leadership and staff are agile and nimble, staff and budget capacity are limited. New, high-profile entrants (e.g. Shatterproof) have accessed significant fundraising sources and networks.
5. An oftentimes misguided, though well-intentioned, understanding of the addiction treatment field continues to be perpetuated. The opportunity for holistic care to be devalued in the coming years may even grow, as a focus on medication-assisted treatment (MAT) and medication-only treatment (MOT) continues to garner support.
6. Key audiences lack awareness of the broad continuum of care and diverse funding sources utilized by NAATP members (e.g. only self-pay, standalone funding.)
7. A lack of diversity persists within NAATP member organizations and leadership. Not unlike many organizations, there is a need to attract the next generation of leadership, and to diversify the organization's representation.

*Opportunities:*

1. NAATP possesses the opportunity to continue to embrace ethical voices. The organization's commitment to a larger vision, rather than a narrow view, gives leadership a strong thought leadership position and platform.
2. The national focus on opiate addiction allows NAATP significant opportunities to elevate the organization's thought leadership platform. A

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key component of this success includes moving the dialogue from harm-reduction models toward greater awareness of holistic models, messages about continuum of care.

3. NAATP has an opportunity to continue to leverage recent advances in federal policy and advocacy. This strategy yielded significant national platforms for NAATP in the prior year, including congressional testimony from NAATP's executive director.
4. NAATP has built and delivered on a strong service offering in the last few years, expanding what has traditionally been provided to member organizations. Opportunity exists to continue to grow member services.
5. Partnering opportunities provide ample opportunity for NAATP to expand reach, impact and share of voice.

*Threats:*

1. The impact of big pharma on the industry is likely to be palpable in the coming years, leaving treatment providers to answer the broader philosophical question of whether they are a part of healthcare, and in what way.
2. Despite a focus on ensuring ethical behavior, the organization, and the industry as a whole, still runs the risk of being affiliated with bad actors. The promotion of ethical behavior by the national association, and the willingness to remove those demonstrating unethical business practices from membership, has reinforced the association's ability to message around ethics. But it does not entirely remove the risk.
3. NAATP must be clear in purpose and identity and, as one board member articulated, "not try to be all things to all people."

There are negative pre-conceptions and beliefs about for-profit centers that do a disservice to many NAATP member organizations.

4. Despite the appointment of NAATP's executive director and the addition of select full-time staff, capitalizing on new growth opportunities in the coming three years may require additional investments in infrastructure, technology, and personnel.

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5. The competitive landscape will continue to deliver new entrants and voices to the discussion of effective addiction treatment. NAATP's position could be diluted if the organization fails to effectively deliver a relevant message, reach key constituencies and provide a balanced view of care models.

*Macro Trends:*

1. Provider composition is changing. Merger and acquisition activity mean fewer small, independent treatment providers.
2. Healthcare at large is looking to address the issues of addiction, leaving treatment providers with questions around where integration might be possible.
3. Medication-only trends are growing in popularity and acceptance. This acceptance of medical-only approaches, if positioned as the go-to antidote for modern addiction treatment, could threaten referrals to, and reimbursement for, treatment centers that serve to treat the whole individual with holistic approaches and broad-based behavioral health programs.
4. The principle of operating an evidence-based practice continues to grow; the general trend toward data, analytics and insights will continue to expand, forcing businesses to ensure they have frameworks to capture, assess and report data, and providing consumers meaningful ways in which to interact with their own data. In this data-driven world, security will continue to be an ongoing risk.

*Competitive Review:*

1. NAATP has effectively positioned itself as the go-to association for the c-level executives of addiction care facilities, setting itself apart from other competitors. That said, significant new entrants to the field present potentially imposing "share of voice" challenges.
2. However, with an easy-to-access brand and message, other organizations have emerged that can be seen alternately as competitors and collaborators. NAATP must accurately assess such organizations and strategically ignore, combat, and collaborate with such groups from in the interests of NAATP and the treatment field at large.

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3. According to one organization's literature, the addiction treatment industry is largely based on rigid, outdated treatment philosophies rather than those proven to be effective. While criticism of some practices is legitimate, NAATP strongly disagrees with such a view and recognizes it is not based on a comprehensive understanding of addiction as a biological psychological, social, and spiritual disease.
  4. NAATP's members and board members hold often-differing viewpoints on the validity and market presence of such positions and the threat or opportunity such organizations present. NAATP desires to neither over-correct nor under-correct.
  5. It is useful to recognize the possibility of varying roles for NAATP as compared to other groups. NAATP is a long-standing institution. Other groups may simply be "movements." Movements may come and go, although they can also redirect an industry's work, in both positive and negative ways.
  6. A distinguishing feature of a competitive analysis in this regard is to see the work of NAATP and other groups as industry-facing vs. consumer-facing. NAATP is fundamentally and industry facing association.

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## VI. NAATP's Strategic Position

As noted earlier, NAATP possesses unrivaled historical perspective as well as significant U.S. reach. The time period 2019 — 2021 offers an opportunity to position NAATP as the industry's North Star. During this time, addiction treatment centers will be confronted with:

a) adapting to the increased presence of, and adoption by, the healthcare market b) upstarts with big name funders but differing definitions of recovery and c) an at-times concerning lack of perspective about what recovery looks like, where it has been in the past, and about what those hard-earned lessons mean for the future of recovery.

In this environment, NAATP, as an organization a) represents the historians of the industry, for better or worse b) represents the future of the industry, with expansive reach and c) has unique insights regarding the trends impacting addiction treatment, witnessing what is impacting recovery every day in treatment centers across the U.S. No other organization has this unique vantage point. Its reach is, in fact, the currency of the organization.

So what do we do with that vantage point and reach, with NAATP's currency?

1. Use it to inform, educate and influence about what true recovery looks like, what supports it and what fights against it. This education is targeted to other organizations, lawmakers, decisionmakers, and new market entrants.
2. Use it to increase access to recovery and ensure the influence of healthcare does not mean less access to recovery, a lesser quality of recovery and/or less recovery.

Leadership has vastly enhanced public policy and public awareness programs in the prior three years. There, however, are ample opportunities to position NAATP member insights and perspectives more frequently, and to a broader set of influencers.



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## VII. 2019 – 2021 Strategic Priorities

### Operational Excellence

1. Maintain excellence in selection of Board and Committee appointments, ensuring selections continue to represent the leaders of the addiction treatment industry.
2. Engage in the development of NAATP Board Members candidates who reflect the provider leadership along the continuum of care and recovery pathways.
3. Seek opportunities to develop board and committees with thoughtful consideration for diversity and the next generation of addiction industry leadership.
4. Ensure NAATP's programs are operationalized in a repeatable and consistent way, allowing the opportunity to streamline delivery.
5. Continue to invest in technology tools in order to enhance member services.
6. Leverage partners as needed in order to continue service delivery and growth.

### High-Value Program Delivery

1. Consistently deliver Member Service and Public Service programs.

### Programs That Raise the Floor and Demonstrate Efficacy

2. Raise the floor for addiction treatment and recovery, ensuring standards of care.
3. Continue to move the needle, in measurable ways, toward measuring and reporting outcomes.

### Amplify and Expand Influence

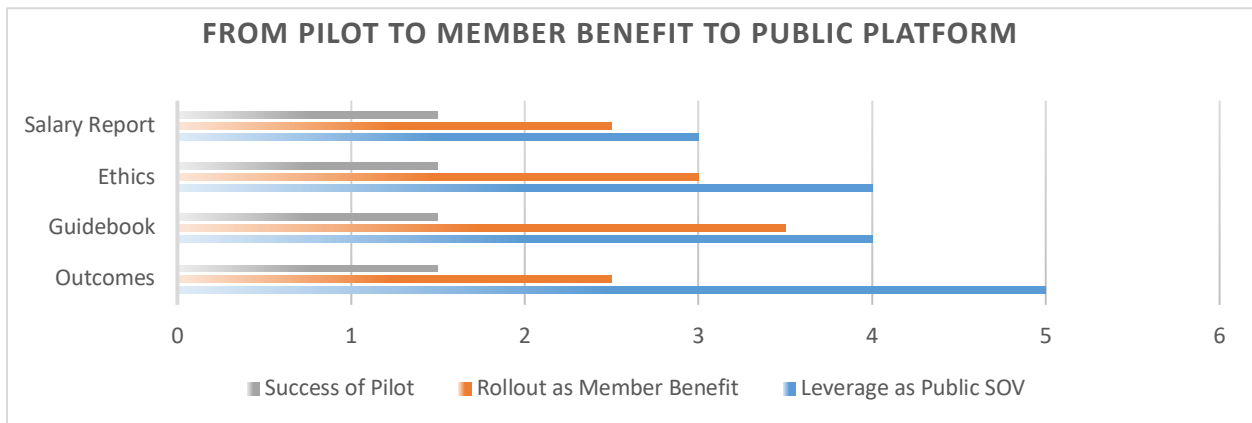
1. Leverage prior success (e.g. testifying in front of Congress) to create pathways to new influencers, inclusive of large insurance companies, bodies that set definitions of care.
2. Monitor and aim to influence the conversation around healthcare's role in recovery as that trend emerges and crystallizes; serve as the voice of holistic treatment and true recovery.
3. Assess carefully the opportunity to converge voices with strategic players, creating either a loose, or more formal coalition or network of voices around quality care.

In all endeavors, NAATP will continue to stake its ground on owning the voice of the provider organizations. This competitive position must be protected and not ceded to others. With a 40-year legacy, a board of industry leaders and a broad base of membership, this position is both authentic and credible. Translated, it means that NAATP serves as the conduit for industry information to external audiences and the convener of industry leaders. Perhaps more importantly, it also means that discussions of the industry's present-day realities and its future are incomplete if NAATP is not at the table, informing and guiding the discussion based on its

historical expertise, deep industry insights and modern footprint on addiction treatment. While others may gain attention and/or traction with consumer facing messaging, NAATP will continue to protect its legacy and leadership as the voice of provider organizations, and specifically, addiction industry leaders.

### VIII. Strategic Process

Due to limitations in both staff size and budget it is critical that NAATP employ a strategic approach to additions to its product and service portfolio. Strategy is not simply a statement of what will be focused on and where an organization can meet its goals, but also an acknowledgment of what tactics will not be pursued. NAATP will continue to heavily leverage an approach that concentrates on a) pilot programs b) programming provided to the full member base and c) publicizing those program successes and leveraging them for increased share of voice. The following matrix illustrates how NAATP products and services can move from successful pilot, to debut and rollout to the membership (allowing time and consideration to review, adjust and refine) and then how these programs can transcend membership benefit and be leveraged in external share of voice programs.



Using this approach, programs can be evaluated based on the following criteria:

1. Is this operationally sustainable for NAATP given staff size, budget, available support?
2. Does this activity provide longstanding value to a majority of NAATP members?
3. Does this initiative help NAATP grow its share of voice and level of influence with key constituencies critical to its success?

**IX. Strategic Snapshot**

**OUR LONG-TERM VISION**  
To improve the world’s access to effective and ethical addiction treatment

**OUR DAILY MISSION**  
To provide leadership, advocacy, training, and member support services that assure both the availability and quality of addiction treatment.

**STRATEGIC POSITION:**  
**OWN THE VOICE OF THE PROVIDER**  
NAATP will continue to stake its ground on owning the voice of the provider organizations. With a 40-year legacy, a board of industry leaders and a broad base of membership, this position is both authentic and credible.

**OUR THREE-YEAR STRATEGIC PRIORITIES**

<b>Operational Excellence</b>	<b>High-Value Program Delivery</b>	<b>Strategic Initiatives to Raise the Floor and Demonstrate Efficacy</b>	<b>Amplify and Expand Influence</b>
Maintain Operational Excellence, including Board Excellence and Development, NAATP Committees, and NAATP Staffing and NAATP Capabilities	Continue to produce programs of high member value, inclusive of: Education, Training and Convening; Resource Center; Recognition; Communication.	Actively develop strategic initiatives. Areas of emphasis include Ethics, Quality Assurance, Outcomes.	Position NAATP in the public domain, within the healthcare ecosystem, and with the legislative environment by Owning Provider Voice.  This includes continued public policy work, informing and influencing the healthcare ecosystem as healthcare’s role in addiction treatment grows, and exploring ways to increase share of voice through partnership.

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## X. Goals, Objectives, and Implementation Actions

### A. ASSOCIATION ADMINISTRATION

- Governance and Board of Directors

#### OPERATIONAL EXCELLENCE

**Goal 1 of 4: Maintain and evolve NAATP administrative structures to ensure high-quality, reliable, durable, efficient, and transferable association operation.**

1. Maintain an effective Board of Directors that provides governance, as well as fiscal and Executive Director oversight.
2. Maintain excellence in selection of Board and Committee appointments.
3. Ensure selections continue to represent the leaders of the addiction treatment industry.
  - a. Engage in the development of NAATP Board Member candidates who reflect provider leadership along the continuum of care and recovery pathways.
  - b. Seek opportunities to develop board and committees with thoughtful consideration for diversity and the next generation of addiction industry leadership.
4. Maintain committees composed predominantly of Board Members that promote effective and efficient task completion. Identify requirements for supplemental committees as needed. Standing committees include:
  - a. Executive and Governance
  - b. Finance
  - c. Education, Training, and Technical Assistance
  - d. Awards and Recognition
  - e. Policy Advocacy
  - f. Nominations and Elections
  - g. Publications and Communication
  - h. Ethics and Professionalism
  - i. Membership
  - j. Outcomes, Measurements, and Benchmarks
5. Conduct three in-person board meetings per year: Winter, Annual, and Fall.
6. Periodically assess By-Laws regarding NAATP membership criteria. Revise or adopt new criteria that address current realities and membership concerns.

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- **Staffing**

1. Employ NAATP ED and staff adequate to ensure competent operation.
2. Ensure the quality and sustainability of NAATP staff by providing challenging, interesting, and well-compensated work.
3. Provide staff with comprehensive training, continuing education, and development opportunities.

- **Operation**

1. Maintain clear and succinct written operational policies and procedures (P&Ps) for all significant operational areas.
2. Ensure high-quality operation through the implementation of necessary equipment and independent contractors where appropriate.
3. Consider additional opportunities to leverage technology for communication, advocacy, and membership services.

- **Finance**

1. ED, DO, Board Treasurer, accounting firm, and the finance committee will post income and expenses and produce timely financial statements.
2. 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.
3. Produce an Association Annual Report or similar document.

- **Development**

1. Create and execute on an annual membership development plan
  - a. 2019 targets: 100 new member organizations; \$200K membership dues revenue

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## B. ASSOCIATION PROGRAM

### HIGH-VALUE PROGRAM DELIVERY

Goal 2 of 4: Provide useful, timely, high-quality services that engage, connect, inform, educate and guide our membership in realizing NAATP standards, values and practices.

- **Member Service**

1. Continue to execute a NAATP Publications Program
  - a. Publish *Addiction Leader* on a quarterly basis.
  - b. Provide the publication *Addiction and Drug Abuse Weekly (ADAW)* to our members as a member benefit through an agreement with ADAW.
  - c. Communicate NAATP news via the monthly *Insights* eNewsletter, supplemented by topical news announcements as needed.
  - d. Issue *Public Policy Updates (PPUs)* to inform membership of news and developments on key policy matters.
  - e. Issue *Director's Desk* communications as needed to provide leadership insights, commentary and perspective on industry issues.
2. Consistently provide a NAATP Education and Training Program including:
  - a. Annual National Leadership Conference
  - b. Select regional events
  - c. Web-based trainings
  - d. Consideration of additional formats and offerings, as needed
3. Run a NAATP Awards / Recognition Program.
4. Deliver a NAATP Resource Center that disseminates training, education, technical assistance and tools to our members.
5. Facilitate professional networking among our member organizations on a regular basis.
6. Regularly assess member benefits portfolio, as informed by member input. Refine portfolio as needed and continue to deliver appropriate member benefits.
  - a. Conduct a 2019 Listening Tour

- **Public Service**

1. Addiction Industry Directory
2. Consumer Resources
3. Media Relations

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## STRATEGIC INITIATIVES TO RAISE THE FLOOR AND DEMONSTRATE EFFICACY

**Goal 3 of 4: Actively develop strategic initiatives to define and drive best practices and treatment efficacy, with emphasis on Ethics, Quality Assurance and Outcomes.**

- **Quality Assurance Initiatives (QAI)**

1. Identify core competencies, develop guidelines and implementation resources
2. Publish QA Guidebook
3. Ethics
  - a. Regularly and actively engage in Ethics Code compliance and enforcement
  - b. Develop and release Ethics Code updates
4. Conduct and publish the Salary Survey as a means of providing industry norm for staff positions and compensation
5. Perform ongoing advertising practices monitoring, communication and advisory activity with Google and LegitScripts
6. Accreditation
  - a. Monitor adherence to accreditation requirement across membership
  - b. Enforce accreditation requirement for new applicants
  - c. With CARF and the Joint Commission, assist non-accredited providers in transitioning from provisional status to accreditation

- **Outcomes Initiatives**

1. Publish Outcomes Pilot study data
2. Release Outcomes Measurement Toolkit
3. Evolve prospectus of Outcomes offerings in a phased approach regarding Toolkit implementation
4. Evaluate Outcomes program possibilities of additional initial data set for mining, benchmarking, conclusions, and publications
5. Evaluate the need and capacity of additional outcomes studies

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## AMPLIFY AND EXPAND INFLUENCE

**Goal 4 of 4: Develop and communicate a powerful position for NAATP in the legislative environment, within the health care ecosystem, and in the public domain, through continued public policy work, strategic communications, and by exploring ways to increase share of voice through partnership.**

- **Legislative Environment**

1. Maintain a policy representative Individual or firm located in DC who / that has sophisticated training, education, experience, familiarity, access, and influence.
2. Regularly review and update as needed a NAATP policy/consensus statement or Policy Agenda that defines and guides NAATP policy action on key policy issues.
3. Engage in local advocacy through the NAATP State Advocacy Forum.
4. Promote the NAATP PAC.

- **Health Care Ecosystem**

1. Support the role of specialized addiction treatment within the context of health care reform and service integration initiatives.
  - a. Develop the message and strategy.
  - b. Identify specific policy venues at which NAATP should be represented.
  - c. Provide advocacy positions reactively and proactively.
2. Promote Addiction Service Payment Mechanisms.
  - a. Work with state and federal parity implementation and enforcement groups.
  - b. Leverage prior success (e.g. testifying in front of Congress) to create pathways to new influencers, inclusive of large insurance companies, bodies that set definitions of care.
3. Monitor and aim to influence the conversation around health care's role in recovery as that trend emerges and crystallizes; serve as the voice of holistic treatment and true recovery.

- **Public Domain**

1. Maintain an individual or communications firm, with reach and demonstrated ability to produce and place strategic content aimed at key influencers, to create annual plans.
2. Engage in ongoing influencer relations campaign, ensuring increased share of voice of NAATP leaders.



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- **Strategic Partnerships**

1. Assess carefully the opportunity to converge voices with strategic players, creating either a loose, or more formal coalition or network of voices.
2. Enhance policy alliances and joint public education efforts with key organizations within the field.

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## XI. 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 but rather are part of staff annual operating plans.

## XII. Plan Duration and The Next NAATP Strategic Plan

This plan is effective through December 31, 2021. The NAATP Executive Committee and the NAATP Executive Director will begin the process of creating the Strategic Plan for the period beginning January 1, 2022 in the summer of 2021.

## XIII. Plan Adoption

This plan was drafted by the NAATP Executive Director under the guidance of the NAATP Strategic Plan Committee. It was approved by the NAATP Board of Directors.

### *Strategic Plan Committee*

Art VanDivier, Board Chair and Strategic Plan Chair  
Marvin Ventrell, Executive Director  
Jennifer Dulles, Facilitator  
John Driscoll  
Phil Eaton  
Robert Ferguson  
Carl Kester  
Cathy Palm  
Ray Tamasi

### *NAATP Board of Directors*

Paul Alexander, Northbound Treatment Services  
Paul Bacharach, Gateway Rehab  
Thomas Britton, Gateway Foundation  
Jay Crosson, Cumberland Heights  
Edward Diehl, Seabrook  
John Driscoll, Hazelden Betty Ford Foundation  
Philip Eaton, Rosecrance Health Network  
Robert Ferguson, Alpha 180 and Jaywalker Lodge  
Gary Fisher, Cirque Lodge  
Rebecca Flood, Ashley Treatment Centers

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Pat George, Valley Hope Foundation  
Paul Hackman, Pavillon  
Carl Kester, Lakeside-Milam Recovery Centers  
Scott Munson, Sundown M Ranch  
Cathy Palm, Tully Hill Corporation  
Annie Peters, Harmony Foundation  
Pamela Rodriguez, TASC  
David Rotenberg, Caron Treatment Centers  
Debbie Sanford, Pine Grove Behavioral Health & Addiction Services  
W. Clay Simmons, Bradford Health Services  
Raymond Tamasi, Gosnold on Cape Cod  
Art VanDivier, La Hacienda Treatment Center  
Marvin Ventrell, NAATP Executive Director  
Jaime Vinck, Sierra Tucson  
Nanette Zumwalt, Hired Power

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## Addendum

### *A History of NAATP at 41<sup>1</sup>*

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.

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

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<sup>1</sup> NAATP was founded in 1978. parts of this section are adapted from the History of NAATP by William White.

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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 2<sup>nd</sup> decade of the 21<sup>st</sup> 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.

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“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,

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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.

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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



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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.

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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.

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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)

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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.”

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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.

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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).

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When NAATP celebrated its 25<sup>th</sup> 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.
- 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.

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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 focused on the barriers to care with the goal of improving access. 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 stronger 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 and daunting challenge when the CEO left the organization after the discovery of a significant misappropriation of funds. During this challenging time, association members and board members worked together through a comprehensive investigation, utilizing outside professional services as well. Through the diligence and financial expertise of the board Executive Committee, led by Board Chair Cathy Palm, and with the full support of the board, the amount of misappropriations of funds was accurately identified. Remarkably, the misappropriated funds were recovered and NAATP's financial accounts were restored.

The experience led to enhanced association finance policies and procedures and a practice of financial transparency. The recovered resources allowed the association to move forward to the success that was to come.



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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 (2015-2018)***

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 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 rebranding process, begun work on the new website and member management system, and developed a member and stakeholder communications

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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. With time and attention, the new brand was launched, complete with a website with a strong association management function and opportunities for member to member engagement.

It was during this era that the NAATP began evaluating and laying the groundwork for some of the organization's most critical work to date. In February of 2016, NAATP launched its Outcomes Pilot Program. This three-year undertaking was borne out of NAATP's prior strategy sessions addressing the paucity of verifiable research for patient addiction treatment outcomes. The study, directed by outcomes manager was designed to include multiple treatment sites, a significant patient population, and a normed assessment instrument that would consider not only sobriety but numerous life quality measures. The study proved feasible and in October 2016 NAATP joined with Omni Institute to complete the three-year study and research. As the study drew to a close, the team had collected data from across the country, at eight pilot sites, and from 748 participants. The results of this Outcomes Pilot Project and its associated Toolkit was set for publication in the Spring 2019.

The Outcomes Pilot Project was hardly the only program conceptualized and developed by NAATP in these years. A focus on ethical business practices formally brought greater ethical standards to bear, with adoption being made a requirement of all members. Additional changes to the NAATP Bylaws included adopting language that stipulated accreditation. While the vast majority of the existing membership was accredited, just under 50 member organizations were granted provisional status and given a grace period in which to come into compliance. Working closely with CARF and the Joint Commission, NAATP provided a conduit and pathway to bring all members into alignment.

A hallmark of this period was the development and implementation of an Ethics Program which has had a profound influence on our field and our association. It has, to a large degree, redefined NAATP as the values-based voice among treatment providers, policy makers, the media, and to the public. Through the stance of ethics, NAATP developed its current stronger voice.

Our field experienced such a severe ethical crisis that NAATP came to believe that we must address the issue by creating and enforcing within our membership clear and absolute professionalism and ethics standards. We did this by adopting NAATP Ethics Code 2.0 followed by the creation of a comprehensive program called the Quality Assurance Initiative (QAI). These efforts resulted in the unusual undertaking of removing numerous members of the association at considerable financial loss and strictly evaluating ongoing membership for

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ethical compliance through a rigorous application process and public complaint and review forum.

The response to our ethics and quality assurance efforts was overwhelmingly positive. Our membership and the broader addiction community, together with the press and policy-makers, embraced and applauded the work as necessary and courageous. NAATP National 2018, the 40<sup>th</sup> Anniversary year for NAATP's Annual Addiction Leadership Conference, proved to be a crossroads and watershed event in which a record number of attendees participated, and an era of unity and enthusiasm seemed to begin. NAATP had arrived, again, as a relevant and valuable association. This was due in no small part the community's embrace of ethical requirements for membership and the visible absence of members that no longer qualified for membership.

With the Ethics Code operational, NAATP began to build its Quality Assurance Program with the centerpiece of an operational guidebook that would define the core competencies of treatment operations. This centerpiece would be called the Quality Assurance Guidebook, scheduled for release in 2019.

### **Leading in a New Era (2019 Forward)**

At the time of the adoption of this plan, NAATP is moving beyond its rebuilding, has emerged with strength and is moving beyond core association benefits to strategic programs that raise the floor of the industry and place a stake in the ground of demonstrating and promoting efficacy. The future years will hold serious challenges, as access to care, new competition from the for-profit sector, treatment modality integration, institutional integration, and online marketing bring new concerns. With attention to strategic priorities, NAATP will continue to not only forge its path, but prove its place in leading the addiction treatment industry forward.

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