

VISIONS

May, 2006

NAATP Visions is the official newsletter of the National Association of Addiction Treatment Providers (NAATP),

WE ARE GATHERING IN PALM BEACH, FL!

Every 365 days, the National Association of Addiction Treatment Providers gathers for its annual leadership conference and annual meeting. This year, the annual leadership conference is being held in Palm Beach, FL. Since this is the *official conference issue of the newsletter*, you will find some of the key information related to the conference in this publication.

The PGA National Resort & Spa is the location for this 2006 conference. This destination resort features a splendid spa as well as manicured grounds which include five golf courses and the resort is only minutes from the Atlantic Ocean. Because the demand has been so great for the conference, the Palm Beach Gardens Marriott has been contracted to be used as an over flow hotel. While not optimal, it continues to demonstrate the attraction which has been developed for the NAATP annual leadership conference.

Some of the highlights for Saturday (May 20) include the annual golf outing featuring a number of prizes sponsored by Keith Fierman and John Southworth, an NAATP Board meeting, the setting up of a record 90+ exhibitors and an opening reception sponsored by Bradford Health Services for the new organizations which have joined NAATP. This year over 50 new members who have joined NAATP during the past 15 months will be recognized.

The opening plenary session on Sunday morning will feature Mr. Louie Gravance, a former Disney executive. His presentation will focus on *creating a service environment*. This very important topic will set the tone for the entire conference which will focus on creating cultures which offer high value service to our patients and customers. The noon roundtable lunches will feature lunches for CEO's, Marketing Directors, Medical

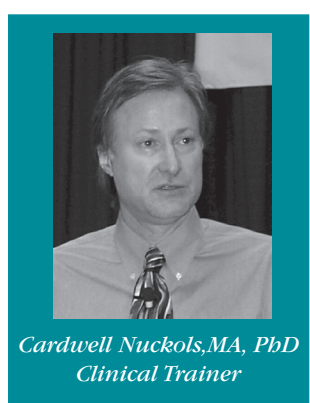
Directors and Physicians, IT staff, and CFO's. The afternoon has been intentionally left open for the conference participants to enjoy what the area has to offer.

Sunday evening will again be the setting for the traditional board reception where networking becomes natural and where the Michael Q. Ford Journalism Award will be presented to Rabbi Abraham Twerski, M.D., Susan Cheever and Christopher Kennedy Lawford. The evening will conclude with entertainment by Songs of Hope, Awareness and Recovery for Everyone featuring Ashley Cleveland, Billy Yates and Michael Johnson.

Monday will find the conference first focusing on Managed Care as a panel, moderated by Renée Popovits, updates the members on the activity of NAATP as well as projections for the future. The second plenary presentation will be by Cardwell Nuckols who will lead the attendees through the new science and how this helps us understand the recovery process. *From Discovery to Recovery: The Neuroscience of recovery and Empathy* will be the topic of his presentation. This presentation will be followed by the annual awards luncheon where Mark Gold, M.D. will receive the Nelson J. Bradley Life Time Achievement Award and the James W. West M.D. Quality Improvement Award will be presented to *Talbott Recovery Campus and Little Hill-Alina Lodge*. The American College of Addiction Treatment Administrators Administrator of the Year Award will also be presented.

Monday evening will feature a relaxing evening dinner cruise which will include a four hour cruise with dinner buffet and DJ.

Tuesday, the final day of the conference, will conclude with the unveiling of the NAATP Managed Care Took Kit, a practical



Cardwell Nuckols, MA, PhD
Clinical Trainer



Louie Gravance,
former Disney Executive

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THE WAIT IS OVER...

THE NAATP MANAGED CARE TOOL KIT IS HERE!

What began as an idea, a concept and a desire to provide value and service to the membership of the National Association of Addiction Treatment Providers has resulted in a 200 plus page Managed Care Tool Kit exclusively developed for NAATP Members. Your board of directors took this idea and fine tuned it, the managed care task focus group which met in Las Vegas in September, 2005 framed the outline and the leadership of the NAATP managed care task force, shepherded it through seven drafts, and now it is printed and ready for distribution.

As part of the NAATP 2006 Annual Leadership Conference in Palm Springs, FL, the managed care tool kit will be "released" to the members of NAATP along with a presentation on how to maximize the use of this resource. The tool kit has been developed to provide definitions and information around key concepts which are critical in the managed care relationship as well as providing a number of sample check lists, forms, and tools which NAATP members have found useful in their relationship to managed care. The tool kit is just one component in a multi dimensional strategy developed by NAATP to address the multifaceted issues related to managed care as it has been manifested in the addiction treatment world.

The structure of the tool kit is that there are a number of sections, each addressing a critical topic and then a "Managed Care" perspective, Key elements to manage the relationship, some do's and don'ts and some samples of effective solutions (from NAATP members). The publication of this tool kit has been done in a note book format so that we will be able to add additional "samples" or update sections as the tool kit is used by NAATP members. The goal of this project is to produce a product which does not just stay on a shelf, but which is referenced on a regular basis so that all of the NAATP members might maximize their relationship with managed care as they deliver quality addiction treatment and obtain reimbursement for the treatment delivered.

A number of the key sections of this Tool Kit include:

- ◆ Managed Care Business Development
- ◆ Contracting with Managed Care
- ◆ Billing and Collections
- ◆ Getting Paid by Managed Care Programs
- ◆ Utilization Review/Utilization Management
- ◆ Clinical Documentation Requirements
- ◆ Denials and Appeals
- ◆ Provider Self Assessment

As this project progressed, it became clear that a very critical aspect of the relationship with Managed Care was contracting. In individual conversations as well as in the focus

group meeting, this was affirmed with vigor. For many of the NAATP members, they did not have the depth in their organization to adequately attend to this process and then discovered that the contract drove their relationship with managed care. We are very fortunate to have had Renée Popovits and Jeff Hillis on the Managed Care Task Force. They undertook to write the section on contracting and to develop an invaluable check list for use by NAATP members. A very special thanks goes to Renée and to Jeff for their help in making this tool kit become more than a "shelf dust collector". Their help has made this a living and useful document!

The development of this tool kit was undertaken through a contract with Open Minds to help assemble the tool kit, to facilitate the focus group and to solicit the practical examples from the NAATP membership. Through their very professional approach to this and through the seven drafts, the relationship between Open Minds and NAATP evolved to one which was much more than a "contracted" relationship. Both NAATP and Open Minds benefited from this very important focus and conversation.

The cost for this initiative was underwritten in part by the voluntary "above dues" contributions made in 2005 by NAATP board members to this specific initiative. This contribution demonstrates the commitment of your Board as well as their desire to ensure that these projects move from idea to reality.

Finally, a copy of this tool kit will be made available to NAATP members attending the annual conference and then a copy of the tool kit will be mailed to all NAATP members. The plan from the beginning was to have this resource as a member benefit, and so we will not be circulating the tool kit beyond the membership of NAATP. If you are not a member of NAATP be sure to join today to receive this member benefit.

THAT'S THE PERSPECTIVE OF RJH

NAATP BOARD CLASS OF 2009 ELECTED

As per the by-laws, the membership of the National Association of Addiction Treatment Providers elects individuals to serve on the Board of Directors of the association. Persons are elected for a three year term of office. Their term begins at the annual conference each year. The following individuals have been elected to serve on the Board as part of the Class of 2009.

Russ Hagen, CEO, Chestnut Health Systems, Inc., Bloomington, IL
David Hillis, President/CEO AdCare Hospital of Worcester, Worcester, MA
Renée Popovits, President, Popovits and Robison, PC, Mokena, IL
Philip Eaton, President/CEO, Rosecrance Health Network, Rockford, IL
Ellen Breyer, President/CEO, Hazelden Foundation, Center City, MN
Helene Cross, President/CEO, Fairbanks, Indianapolis, IN
Carl Kester, CEO, Lakeside Recovery Centers, Inc., Kirkland, WA
Scott Munson, Executive Director, Sundown M Ranch, Yakima, WA
Benjamin Underwood, CEO, Talbot Recovery Campus, Atlanta, GA

Congratulations to the above 9 individuals who will be assuming their responsibilities as members of the Board of Directors for the class of 2009. They will assume these responsibilities at the NAATP board meeting on May 20, 2006.

CAREER OPPORTUNITIES

ADMISSIONS COORDINATOR

The right person for this position will be a dynamic individual with proficiency in receiving inquiry calls and assisting potential patients to transition into treatment. Candidate must have a proven and successful admissions history. Requires a unique blend of clinical skills and marketing.

Bachelors degree in related field, Masters a plus. Attention to detail, highly organized and strong computers skills a must. Responsibilities include assessing potential patients, contact with families and referral sources, and all necessary steps to compile clinical data to present to our Clinical Team.

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APPROPRIATIONS COMMITTEES BEGIN WORK ON FY 2007 FUNDING BILLS; HOUSE APPROPRIATIONS CHAIRMAN ANNOUNCES SUBCOMMITTEE ALLOCATIONS, INCLUDING ADDITIONAL FUNDING FOR THE LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION SUBCOMMITTEE



The House and Senate Appropriations Committees have begun efforts to determine the funding priorities and amounts for programs in the FY 2007 federal budget. On May 4th, House Appropriations Chairman Jerry Lewis (R-CA) released funding allocations for the 11 House Appropriations Subcommittees. These allocations are the funding levels that each of the 11 Subcommittees can spend on the federal programs within their jurisdiction. In a statement announcing the release of the subcommittee allocations, Chairman Lewis acknowledged the current tight budget environment but expressed that the allocations would ensure that Congress would adequately fund priority programs. Chairman Lewis also repeated his intention that all of the funding bills be individually approved by the full U.S. House of Representatives before the July 4th Congressional recess.

Under Chairman Lewis's subcommittee allocations, the Labor, Health and Human Services, and Education (Labor HHS) Subcommittee, which has jurisdiction over key addiction prevention and treatment programs, will be given \$141.93 billion for programs in those federal agencies, \$4.136 billion over the President's FY 2007 budget request and \$.843 billion over last year's enacted amount. Prior to release of the allocations, Chairman Lewis had indicated his intention to shift \$4 billion from proposed defense and foreign aid spending to the Labor HHS spending bill. This shift in funding would bring spending in the Labor HHS spending bill to roughly where it was in FY 2006 before a one percent across-the-board cut was applied to most discretionary spending programs.

The appropriations bill that includes funding for programs in the Department of Justice would also receive a small increase over last year's funding levels. Under Chairman Lewis's allocations, the Science, State, Justice and Commerce Subcommittee will receive \$59.84 billion, \$.11 billion over the President's budget request and \$2.63 billion over last year's allocation.

The House has not yet approved a budget resolution but may vote on a resolution during the week of May 8th. If the House doesn't approve a budget resolution there are other ways the House could approve a cap on discretionary spending. The Senate-approved budget resolution, which is \$17 billion over the \$873 billion discretionary spending cap proposed in President Bush's FY 2007 budget, includes \$7 billion that was secured by Senators Arlen Specter (R-PA) and Tom Harkin (D-IA) for health, education and labor funding.

The House Labor HHS Appropriations Subcommittee is scheduled to mark up its spending bill on June 7th, with a House Appropriations Committee mark-up and a House floor vote planned for subsequent weeks in June. However, due to the many initiatives still left on the legislative agenda for the 109th Congress, timing is still extremely uncertain. The Senate Appropriations Committee has not yet released a schedule of hearings. The full chart of House Appropriations Subcommittee allocations can be found at: <http://appropriations.house.gov/files/302bscof.pdf>.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Releases Results of COMBINE Study; Patients Receiving Naltrexone, Specialized Alcohol Counseling or Both Demonstrate Best Outcomes

On Tuesday May 2nd, the National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (NIAAA) released the results from "Combining Medications and Behavioral Interventions for Alcoholism" (The COMBINE Study). According to NIAAA, COMBINE is the largest clinical trial ever conducted of pharmacologic and behavioral treatments for alcohol dependence. Results from the NIH supported study show that patients who received the medication naltrexone, specialized alcohol counseling, or both demonstrated the best outcomes after 16 weeks of outpatient treatment. All patients also received Medical Management (MM), an intervention consisting of nine brief, structured outpatient sessions provided by a health care professional.

Other highlights of the study include:

- At 16 weeks, all groups substantially reduced drinking during treatment; overall the percent of days abstinent tripled from 25 to 73 percent, and alcohol consumption per week decreased by 80 percent

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Matthew Kelly,
Author

resource for maximizing your understanding of and relationship to managed care. The final presentation will be by Matthew Kelly who will address the issue *Are you Thriving or just Surviving?*

In between all of this there will be hall way conversations, exhibit hall excitement, continental breakfasts and much more. If you are not reading this newsletter in Palm Beach, FL, you have missed a wonderful

event. Plan now for 2007 when the conference will be **May 19-22, 2007 in San Diego, CA!**

The 2006 Scientific Conference of the Research Society on Alcoholism will be held at the Marriott Waterfront Hotel, Baltimore, MD from June 23 - 29

This meeting allows scientists and clinicians conducting alcohol-related research from across the country, and around the world, to present their latest findings in alcohol research through poster and symposia presentation. This year the RSA Lecture Series, held at the conference hotel, June 23 and 24 will precede the meeting. Individual lectures containing current, prominent scientists in the alcohol research field will present cutting edge research from the biomedical and psychosocial areas of alcohol research and alcoholism.

The RSA Lecture Series is free to RSA members and those non-members attending the 2006 meeting. There is a \$15 fee /day for all attendees. The schedule of lectures is shown below. Handouts will be provided to registrants. Seating is limited, so early registration is advised. Online registration and mail-in registration forms may be found at: <http://www.rsoa.org> under meeting registration.

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- Naltrexone continued to show a small advantage for preventing relapse at 1 year after the end of active treatment
- Researchers found no effect on drinking of the medication acamprosate and no additive benefit from adding acamprosate to naltrexone

Additional information on this study and other alcohol research and publications are available at <http://www.niaaa.nih.gov/>.

2006 NAATP

NEW MEMBERS

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CENTER
HOUSTON, TX

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AHRQ STUDY: ALCOHOL ABUSE COST COMMUNITY HOSPITALS \$2B IN 2003

The following study reveals the costs related to alcohol abuse disorders within the health care system of this country. 3% of all hospital admissions had alcohol abuse as a concomitant condition.

Nearly 210,000 patients were treated for alcohol abuse disorders at community hospitals in the United States at a cost of about \$2 billion in 2003, according to a new study done by the Agency for Healthcare Research and Quality, an agency within the Department of Health and Human Services.

The study shows an additional 1.1 million hospital stays listed alcohol abuse as a concomitant condition, resulting in roughly three percent of all hospital stays in 2003.

Alcohol abuse was one of the top 25 conditions among all patients ages 18-64, according to the study. Adult patients under age 64 accounted for more than 90 percent of hospitalizations related to alcohol abuse, with patients ages 18-44 accounting for nearly half of all hospitalizations.

The study also shows that 25.5 percent of hospital stays related primarily to alcohol abuse disorders involved Medicaid beneficiaries, 21 percent involved the uninsured, 13 percent involved Medicare beneficiaries, 34 percent pertained to privately insured patients and seven percent dealt with other insurance.

Men accounted for almost three-fourths of all hospital stays for alcohol abuse disorders, which were one of the 25 most common reasons for hospitalization among men of all ages.

Among hospital stays that were mainly for alcohol abuse, 65 percent also involved a substance abuse disorder, 34 percent involved mood disorders and 11.5 percent involved alcohol-related liver disease.

The study looked at information from the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample, which is a nationwide database of inpatient stays.



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here's no doubt that treatment and our knowledge about addiction have improved over the last 50 years. So why have outcomes not changed significantly?

It is clear that completion of treatment, while a good first step, is just not enough, because as research and experience has told us; to improve effectiveness, we need to bridge the gap between treatment and the patient's return to family and community.

This requires a significant change in how treatment providers allocate resources. Obviously, this means we can no longer dedicate all of our resources to primary treatment alone, but instead must increase our support for what happens after primary treatment.

But before looking at the question of what resources are needed to improve outcomes, we need to have a very good idea of where we are. There is a challenge in defining outcomes and explaining them to the public. Providers need to do a much better job of telling people what they can expect when they come to us for help. The bottom line is that patients and their families should be able to see our outcomes, compare them, and expect the treatment they pay for to be effective.

Outcomes can be something of an uncomfortable subject for many providers. It takes time and money and a lot of hard work to design and implement the kind of system that can measure program effectiveness. So many treatment providers don't, or can't, put the effort into it that it requires. In addition, there is little external funding to pay for developing these measures, or the programs to improve them.

When there is no standardized method for reporting outcomes, the organizations that take the subject seriously can find themselves at a severe disadvantage in attracting and helping patients compared with those organizations that don't measure outcomes appropriately or accurately.

Consistent, effective measurement systems are critical, and we also need to show those outcomes to the world. For those who come to us for help, there can be no secrets about what they can expect. Outcome measures will make what providers do more transparent so patients' families and payers. Treating addiction has long been a mystery to the larger public, two-thirds of whom think addiction is a moral failing.

Innovative programming that improves effectiveness requires a capital investment (and probably an operational subsidy for years to come), and that is something that non-profits, in particular, find difficult to manage. While fundraising has always been an additional revenue stream for non-profits, donors have historically been more interested in supporting annual needs, patient aid or building construction – private contributions for research and development or IT infrastructure are hard to come by. (And it is worth noting that the healthcare industry is nearly a decade behind other industries when it comes to adapting technology. IT makes up 10 percent of budgets for biotech and pharmaceutical companies, but a mere two to five

percent for healthcare, and less than that for some in this field.)

A commitment to research and technology is not optional. In addition to outcomes research and electronic service delivery there is also growing emphasis on evidence-based practice (EBP) and the accountability that this will require.

While EBP may be relatively new in addiction treatment, starting first with prevention efforts (the result of government funding efforts), it is certainly well established in the medical field and in mental health agencies.

Verification of how EBP has moved into the addiction treatment field can be found in the recent work of the federal Substance Abuse and Mental Health Services Administration, which has been developing a national outcome monitoring system for all SAMHSA-funded programs, based on its chosen national outcomes measures. SAMHSA will require all community-funded programs to report how they utilize evidence-based practices, with the goal of full reporting by all states by the end of 2007.

Last summer, Charles Curie announced SAMHSA's web-based resource to help federal and state agencies facilitate EBP decision-making, saying: "This is the very beginning of a data reporting system that ultimately will provide a comprehensive state-by-state picture of mental health and substance abuse service system results." A tall order, to be sure, but one that is needed.

Other funders are requiring similar accountability. The state of Oregon, for example, now requires that state agencies can receive funding only if they demonstrate that at least 25 percent of that funding is spent on EBP programming. Blue Cross and Blue Shield of Minnesota, our state's largest health insurer, has gone to a tiered plan that gives patients a financial incentive to use facilities with better cost efficiency and adherence to evidence-based methods of health care.

This is only the beginning. As state agencies become more accountable, treatment centers will need to do the same. Obviously, mandated legislative practices are often adopted by third-party payers. As a result, it is reasonable to expect that insurance companies are going to require documented use of evidence-based practices before treatment is funded.

The future is clear. As the treatment field is increasingly held accountable for its practices and outcomes, providers must be positioned to meet consumer expectations and anticipated regulatory requirements for scientifically sound, effective treatment services.

ELLEN BREYER, PRESIDENT/CEO
HAZELDEN FOUNDATION

UPCOMING EVENTS FOR YOUR CALENDER

The **National Association of Addiction Treatment Providers** will present their annual **Leadership Conference, May 19-23, 2006 in West Palm Beach, FL.** For more information, visit www.naatp.org.

The Society for Prevention Research will hold its 14th Annual meeting in **San Antonio, TX on May 21-June 2.** "Applying Prevention Science to Reduce Health Disparities" will present the latest in prevention science from across international regions in many areas, including epidemiology, etiology, prevention intervention trials, demonstration projects, policy research, clinical trails and prevention - related basic research. For more information, visit www.preventionresearch.org/meeting.php.

The National Conference on Addiction & Criminal Behavior will be held at the St. Louis Hilton by the Ballpark, **St. Louis, Missouri, September 17-20, 2006.** Approved for 23.5 continuing education units. For registration information call 800-851-5406 or online at www.gwcinc.com.

The Ben Franklin Institute will hold a Summit For Clinical Excellence **June 8-11** in Monterey, California /Adolescent conference; **September 14-17** in New York, NY; **September 28-October 1** in Tempe, AZ/Adolescent/Young Adult; **October 27-30**

in Scottsdale, AZ. For more information call (800) 643 - 0797 or www.BFISummit.com

The 22nd Annual National Rural Institute on Alcohol and Drug Abuse will take place **June 4-8** at the University of Wisconsin Stout in **Menomonee, WS.** This year's conference will focus on methamphetamine abuse and will include in-depth tracks, mini workshops and special topic sessions. For information about scholarships and attendance visit, www.uwstout.edu/solutions/conf/nri/.

The State Association of Addiction Services (SAAS) will sponsor its first national conference for executive and senior managers in addiction services, titled "Forging our Future: Meeting the Challenges of Leadership." The conference is scheduled for **July 9-12 in Chicago.** Discussions will include competition and new markets, workforce needs and forging partnerships. Visit www.saasnet.org for program and registration information, or call 202-546-4600.

The National Association of Addiction Treatment Providers presents the **South East Conference on Addictive Diseases (SECAD)** in **Atlanta, GA, November 29 - December 1, 2006.** This will be the 31st SECAD! For more information, visit www.naatp.org/secad.

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