

WHAT HAVE WE LEARNED FROM THE AUGUST RECESS?

HealthCare Reform meets Town Hall Meetings

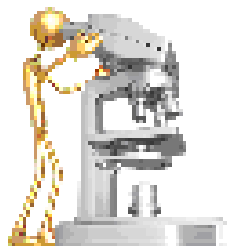
The optimism of the spring over the ability to actually affect major health care reform has now merged into the hard reality of the late summer months and the difficulty in crafting any significant new direction in the way in which health care is delivered and financed in this country. The spring saw a general (albeit fragile) consensus that the health care system in our country needed attention and that now was the time to initiate reform. The consensus was built around the reality that:

- We have over 40 million individuals in this country with no health insurance and who classify as “un or under insured”, and
- The continuing rising costs to provide health care and to provide insurance must be addressed if we are to have a long term affordable and sustainable health care system in this country.

With these two realities as the driving forces behind the discussions, and energy, the enthusiasm for healthcare reform was birthed. But that was last spring! Those days of new growth, of budding trees and of warming days quickly faded to the hot summer and the reality that initiatives, all legislation, all reforms are political. Because of this, we spent a long summer and an even longer August with little real progress to show for the effort.

As if this daunting task was not difficult enough, the August death of Senator Ted Kennedy has added another layer of complication to the issue. Shortly after Senator Kennedy's death, Senator Orin Hatch suggested that Senator Kennedy was the only Democrat who could have successfully negotiated a compromise bill on health care. Those are not very encouraging words!

As with almost every other issue, it eventually boils down to “getting elected”. It becomes difficult to step back and ask what really



needs to be done in order to provide better health care for the entire country. Instead, legislators have already begun to take note of the election cycle and the question of what position can I carve out on this issue which will better get me elected has become an overwhelming urge for so many working in both houses of the Congress and on both sides of the aisle.

At the end of the day, the process may get tripped up over the use of the term reform. In the spring this seemed like a very noble goal and certainly reform was the buzz word chosen by almost everyone. But we soon learned that what people really wanted was the old system with just more of the resources allocated to their special interest. That is not reform!

1. Will we be able to provide some sort of coverage to those 40 plus million Americans who currently have no health insurance?
2. Will we be able to effectively reshape the way in which health care is delivered so that we do not compromise on the quality of care provided but do dramatically limit the skyrocketing costs of healthcare?
3. Will we be able to significantly reduce the cost of providing health insurance (health insurance premiums) so that we continue to have all of our business and industries remain competitive in the world market and individuals who need to purchase health insurance can also afford the costs?

These remain the questions we face as the August legislative recess is rapidly coming to a close and Congress gathers again after Labor Day. The questions have not changed, but the debate and rhetoric has. It is clear that many persons support healthcare reform, but only if it does not change the way in which they currently access and pay for health care. This reform process is a very difficult process and will ultimately be built on an appeal to a moral obligation to provide health care to every one and not just some!

Where does this leave addiction provider organizations? It leaves us just where we were in the spring. Our message must continue to be:

- A benefit that provides health care treatment for the disease of addictive disease disorders must be in every health care plan offered to all Americans;
- All persons diagnosed with the addictive disease disorders must have access to treatment which is reimbursed

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as **RJH** sees it....

WE ARE WHAT WE READ AT LEAST SORT OF!

One of the great traditions of the summer months is to take a look at “recommended” reading lists. Many major publications publish featured reading lists. These lists then find their way into the backpacks, brief cases, suitcases, boxes etc that persons take to the “shore” that is east coast language for “the beach”, lake cottages, mountain retreats or other places that individuals have found to be helpful for them to refresh and recharge their batteries.

For many persons, one of the first places to check is the New York Times Best Seller List. This has become a sort of guideline as to your current reading material. “Am I reading books which have topped the Times best seller list in either fiction on non fiction”, is a question often asked. “Will I see others reading the same books at my favorite summer reading “station”, is another question we ask.

All of this suggests that to some extent, we are or we at least to some extent become what we read. That material, those magazines, or the books which we stuff into our briefcases, or tuck under our arms before we get comfortable to enjoy the setting and the information in the reading material usually finds its way into our thinking, our conversations and our behavior.

Because of this, I began to think, what do health care administrators and executives who specialize in addiction treatment read? Some of you may think that I have spent too much time in the sun and not enough time reading, but I believe the question makes a good point.

1. Do we really think of ourselves as health care professionals who specialize in addiction treatment, and
2. What do we read to maintain the skill sets necessary to carry out our responsibilities?

Given all of the talk, activity and debate about health care reform (see page 1), it seems fairly important for the executives of addiction treatment organizations to have a clear sense about their professional identity. In the larger panorama of health care, there is little debate, ambiguity, or disagreement about the identity of hospital and health system executives. They think of themselves first as executives of health care organizations. Not only do they identify themselves in that way, but they do so in order to form peer relationships with others who identify themselves in the same way. Do you see yourself as a health care executive who specializes in addiction treatment and do you identify yourself as a peer with the other executives who provide leadership to organizations that deliver addiction treatment? Put another way, what is your professional identity?

The American Hospital Association, a trade association that represents organizations and systems that provide and

deliver health care, periodically recommends reading material to the executives of its member organizations. In a recent announcement, they recommended several titles, including:

Governance Titles



Management Titles



The exact titles are not as important as the fact that there is a list. Just as when the New York Times publishes its list, people sitting under umbrellas on a beach all know that others on that same beach will be reading the same book they are reading! So what are the books that Health Care Executives specializing in addiction treatment are reading?

The challenge I would offer is that before next summer, we need to have our own list of recommended readings for persons who think of themselves as health care executives specializing in addiction treatment. I believe that it will become increasingly critical for us to:

1. Make sure that our professional identity is firmly rooted in the tradition of health care executives, and
2. We continue to build a reservoir of reading material that will help us maintain that identity and that this identity is more uniformly understood.

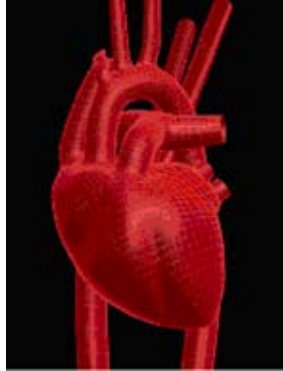
You can help! Send your recommended reading material to the NAATP office so that we can begin to assemble our reading list for 2010!

Ronald J. Hunsicker
President/CEO, NAATP

CONTINUED FROM PAGE 1

- by their health care plan; and
- We must recognize this as a chronic disease and allocate resources to manage the disease over the life of the individual with the disease.

It is this last point which places us in the reform movement! We must be prepared to radically alter the way in which we understand and deliver the health care response to this disease. We must put our best thinking into what life long management services will best make it possible for persons to sustain life long recovery. As with other chronic diseases, we cannot think of treatment only in terms of short term intense episodes. Treatment is life long and needs to be incorporated into a routine system in similar ways to what is happening with other chronic diseases. If we intend to support health care reform, then we also need to reform the way in which we deliver our services so that we can ultimately be part of the reform movement.



**RHODE ISLAND COUNCIL
ON ALCOHOLISM AND OTHER
DRUG DEPENDENCE
HONORS JAMES F. MCKENNA WITH
BRONZE KEY AWARD**

James F. McKenna, Vice President of Marketing and Development at AdCare Hospital, has been selected to receive the Rhode Island Council on Alcoholism and Other Drug Dependence's (RICAODD) Bronze Key Award. The Award will be presented at the Council's 40th Annual Community Services Awards Celebration September 17 at the West Valley Inn in West Warwick, Rhode Island.

Bronze Key Award is granted to affiliates of the National Council on Alcoholism and Other Drug Dependence for presentation to individuals who have made outstanding contributions to the field and their councils. Mr. McKenna is such an individual. Mr. McKenna joined the management team at AdCare Hospital in 1991 and has over 30 years of experience in the field of addiction and behavioral healthcare management.

He is a past executive director of the Alcohol Council of Fall River, MA, as well as a founding member of Drug and Alcohol Treatment Associates (DATA) in Rhode Island and the Massachusetts Association of Alcohol and Drug Abuse Counselors (MAADAC). He is also a veteran member on the Board of Directors of Steppingstone, a provider of residential substance abuse programs in Fall River and New Bedford, MA, and a member on the Board of Directors of Caritas, a provider of residential and outpatient substance abuse treatment in Rhode Island.

A licensed and certified social worker, a licensed alcohol and drug counselor, and a board certified interventionist, Mr. McKenna earned a bachelor's degree in social science from Roger Williams University in Rhode Island and a master's degree in education from the University of Massachusetts. He is an instructor in the Westfield State College Addiction Counselor Program at AdCare Hospital.



**JASPER G. CHEN SEE, M.D. VOLUNTEER
LEADERSHIP AWARD**

For the third consecutive year, the NAATP Annual Leadership Conference will be the venue for the presentation of the **Jasper G. Chen See, M.D. Volunteer Leadership Award**. This very prestigious award recognizes individuals who have provided exceptional volunteer leadership in the area of addiction treatment through board membership and philanthropy. The presentation of this award will take place at the board/celebrity reception by a Caron Treatment Center executive to individuals who are nominated by NAATP member organizations. This award recognizes individuals who serve on the board of NAATP member organizations as well as provide outstanding leadership to their communities.





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...anytime, anyplace.”*

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Treatment Coordination

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Post-treatment recovery

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“I am more appreciative

than words can express.”



“Thank you for giving me my life back!”

DRS. PIKE AND NG CERTIFIED BY NEW ADDICTION MEDICINE BOARD

American Board of Addiction Medicine to Address Significant, Unmet Need

Ronald F. Pike, M.D., medical director, and Richard P. Ng, M.D., an attending physician at AdCare Hospital, are among the first physicians in the United States to be certified by the American Board of Addiction Medicine (ABAM), a new independent medical specialty board.

The American Board of Addiction Medicine (ABAM) has begun to certify addiction medicine physicians from several specialties, including emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine, psychiatry, neurology and surgery. There was previously only addiction-related board certification for psychiatrists. ABAM sets standards for physician education, assesses physicians' knowledge, and requires and tracks life-long continuing education. "We want addiction prevention, screening, intervention and treatment to become routine aspects of medical care, available virtually any place health care is provided," said Kevin B. Kunz, MD, President of the American Board of Addiction Medicine.

Although one in five Americans entering the health care system has a substance abuse problem, there has never been a medical specialty board, drawn from all areas of medicine, dedicated to certifying addiction specialists. Now, patients have a way to find specialized medical care for substance use disorders related to alcohol, tobacco and other addicting drugs, including some prescription medications.

"Physicians are often at a loss for what to do about substance use and addiction issues, and may even misdiagnose the problem," said Kevin B. Kunz, MD, President of the American Board of Addiction Medicine. "We hope to change this by creating a cadre of thousands of specialized physicians across medical specialties."

Drs. Ronald F. Pike and Richard P. Ng Certified by American Board of Addiction Medicine / 2

Studies show that fewer than one in five physicians consider themselves adequately prepared to diagnose alcoholism or other drug use disorders. Physician training is sorely lacking. Separate courses in addiction medicine are rarely taught in medi-



Richard P. Ng, M.D.

cal school, and there are no addiction medicine residencies among the 8,200 American Council for Graduate Medical Education (ACGME) accredited residency programs in the nation's hospitals.

"The American Board of Addiction Medicine will provide assurance to the American public that Addiction Medicine physicians have the knowledge and skills to prevent, recognize and treat addiction," said Dr.

Kunz. "ABAM-certified physicians will also be able to address common medical or psychiatric conditions related to the use of addictive substances."

"Years of scientific research have proven drug addiction is a brain disease caused by biological, environmental and developmental factors—a disease which can have far reaching medical consequences. Given the proper training, tools, and resources, physicians can be the first line of defense against substance abuse and addiction—identifying drug use early, preventing its escalation to abuse and addiction, and referring patients in need to treatment," said Nora D. Volkow, MD, Director of the National Institute on Drug Abuse.

Dr. Ronald F. Pike is medical director at AdCare Hospital, New England's most comprehensive provider of alcohol and drug abuse treatment. He is a past president of the Massachusetts Society of Addiction Medicine (MSAM), a past director of the American Society of Addiction Medicine's (ASAM's) New England Region, and a member of ASAM's national board. Dr. Pike is on staff at University of Massachusetts Memorial Health Care Center and Worcester Medical Center; an affiliate of the University of Massachusetts Medical School's Family and Community Medicine Department and an associate in its Department of Psychiatry.

Dr. Richard P. Ng joined AdCare Hospital's medical staff in February of 2009. He has extensive experience and training in acute-care and outpatient addiction medicine. Dr. Ng is a graduate of Harvard University and earned his medical degree from Tufts University School of Medicine, where he has been a Clinical Instructor of Medicine since 1987. He is certified by the American Board of Internal Medicine; the American Society for Addiction Medicine (ASAM); and the Buprenorphine Physician Provider Network.



Ronald F. Pike, M.D.

VISIONS

DO YOU KNOW ABOUT THE CERTIFICATION PROCESS?

GETTING READY FOR ELECTRONIC HEALTH
RECORDS IS BOTH COMPLEX AND COMPLICATED!



One of the most challenging and at the same time confusing issues facing addiction treatment providers is health information technology. To just stay on top of the technology advances is daunting enough. However, to remain ahead of the regulatory and reporting changes which are initiated becomes a Herculean task! To understand these changes and their implications is absolutely essential to successfully operating in today's environment.

SATVA (The Software and Technology Vendors Association) is a trade organization for vendors of behavioral health and human services software and information technology. Its members have a genuine concern for promoting the use of effective information technology in behavioral health and human services; helping to formulate and support quality improvement for the highest industry standards; and facilitating the delivery of more efficient and effective consumer services through use of information technology.

SATVA has put together this **BEHAVIORAL HEALTH SOFTWARE CERTIFICATION WATCH** which will help you navigate the complex and often confusing area of certification.

In order to be compliant with federal regulations, your software and information technology will need to be "certified", as will all software and information technology used by health care providers.

SATVA will periodically update their information so that you have the best information from which to make your decisions. The latest copy of the **Certification Watch** can be found on the NAATP Web site at <http://www.naatp.org/productsservices/index.php>.

FIELD MODEL OF INTERVENTION INTRODUCED BY JANE EIGNER MINTZ

Jane Eigner Mintz, one of the country's leading interventionists and counselors, is breaking new ground in the intervention, addiction and behavioral health fields. Having a successful intervention practice for a number of years, she has chosen to take that expertise and fulfill a need critical to the intervention and therapeutic communities as a whole.

Jane has created FMI, the Field Model of Intervention, which specializes in the clinical and crisis-oriented issues associated with intervention. FMI offers the most comprehensive assessment, case development and implementation strategies for the clinically complex and reactive client. And, there's more...

While being a ground-breaking intervention strategy already certified for a full 14 hours of CME credit toward BRI (Board Registered Interventionist) credentialing requirements, FMI promises to change the future for this industry in another way.

The Field Model of Intervention is the **FIRST AND ONLY** certified ON-LINE training program in the intervention and addiction fields accredited by the Association for Intervention Specialists Certification Board (AISCBS), as well as NAADAC, the Association for Addiction Professionals.

Starting August 15, 2009 intervention, addiction and behavioral health professionals will be able to create an account, purchase their training module and begin their certification training. There will also be an option to purchase the supervision hours to complete the process of receiving the BRI-I and BRI-II licensure requirement.

THOMAS MCLELLAN NEW DEPUTY DIRECTOR OF ONDCP

Tom McLellan is the Deputy Director of the White House Office of National Drug Control Policy (ONDCP), where he will assist in the formulation and implementation of the President's National Drug Control Strategy. ONDCP Director Kerlikowske cited McLellan's tremendous background, understanding and experience, "His knowledge and experience in preventing and treating substance abuse is critical to the development of comprehensive, science-based drug control policies and will help us broaden our response to drug issues by emphasizing both public health and public safety concerns," he said.



CARON TREATMENT CENTERS TO OPEN ADULT PRIMARY RESIDENTIAL PROGRAM IN DALLAS FACILITY MARKS CARON'S EXPANSION INTO THE SOUTHWEST

CARON TREATMENT CENTERS, a leading nonprofit provider of alcohol and drug treatment, will open a 40-bed residential treatment facility just north of Dallas. The residential facility, which will be known as Caron Texas, is expected to open in July of 2010 and will treat an adult primary population with co-occurring addiction and mental illnesses.

"We're excited to extend Caron's brand of quality addiction treatment into Texas," said Doug Tieman, Caron's President and CEO. "We look forward to serving Dallas and the surrounding communities and helping those struggling with the disease of addiction and their families to achieve recovery for life."

In keeping with the Caron treatment model, Caron Texas will offer a multi-disciplinary treatment approach including detoxification, a full behavioral, medical, psychiatric and spiritual continuum of care, and gender separate and gender specific programs. Incoming patients will go through detoxification as needed and will also receive a medical and behavioral assessment by Caron's licensed clinical staff. Caron's staff to patient ratio is among the highest in the country - with one counselor for every five patients.

The minimum length of stay at Caron Texas will be four weeks with extended care options available. The 28,000-square-foot facility is set on 40 acres and will offer many amenities including a fitness center and a swimming pool.

"It's an honor to help bring quality treatment to the people of Texas," said Garrett Smith, a leading Dallas businessman who is leasing the facility to Caron. "When we started this project we had a vision for making a difference and now Caron will see that through to fruition."

As with its Pennsylvania and Florida facilities, Caron puts a major emphasis on treating the family as part of the treatment and recovery process. Family members will attend a five-day educational and therapeutic program to learn about the disease of addiction and develop tools for their own recovery.

"I've seen firsthand the impact of addiction on the family and know the great work Caron does in saving lives and helping families heal," said James Olan Hutcheson, President and Founder of ReGENERATION Partners, a Dallas-based family business consulting group, and a Caron Renaissance Board Member.

Caron believes in educating parents and children about the disease of addiction and will work with both public and private schools to provide its award-winning Student Assistance Program throughout the Dallas market. As part of its grass roots mission, Caron also works with the surrounding community to help improve access to care by providing discounted treatment for those who meet required admissions criteria. In its last fiscal year, Caron provided nearly \$9 million in scholarships for addiction treatment to those who could not otherwise afford it.

Caron Texas will be staffed by highly skilled and credentialed clinicians. In addition, the nonprofit is in the process of establishing an advisory board of community leaders and donors. Announcements will be forthcoming throughout the next year. For more information, please visit <http://www.carontexas.org>.

WELCOME NEW MEMBERS

Ledgehill Treatment Centre
Lawrencetown, Nova Scotia

Breathing Space Thailand
Chiang Mai

Laguna Azul Center
Panama

Cove Creek Center
Sugar Grove, NC

Channah Thailand
Chonburi, Thailand

Origins Recovery Centers
Dallas, TX

Marin Services for Women
Greenbrae, CA

Deer Creek Recovery Center
Nacogdoches, TX

269 Days Left till the 2010 NAATP Annual Leadership Conference!



- Exhibit spaces going fast – Contact Sherry Anderson at sanderson@naatp.org for remaining availability
- Remember NAATP Golf Outing on May 22, 2010
- Conference Registration will be available around December 1, 2009
- Opportunities available to sponsor events



MAY 22-25, 2010
La Cantera Resort
San Antonio, Texas

NAATP ISSUES CALL TO CONTRIBUTE TO POLITICAL ACTION COMMITTEE ED DIEHL CHAIRS THE NAATP PAC AND MAKES THE FIRST CONTRIBUTION

Ed Diehl announced at the 2009 NAATP annual conference, the launch of the NAATP Political Action Committee. This was followed by a letter from Mr. Diehl to all members. That letter is included below. If you have not yet made your contribution to the NAATP PAC, be sure to contact the NAATP office for the PAC brochure. The PAC receives individual contributions!

I am sending this letter to you as the chief executive of an NAATP member organization regarding a very exciting and important NAATP initiative. At the NAATP annual conference, I announced the launch of the NAATP **POLITICAL ACTION COMMITTEE**. This is consistent with our efforts over the past two years to increase our public policy activity and represents only the second Political Action Committee created by an addiction association. We believe that it will serve us well as we move forward. I have been asked and am honored to accept the invitation to chair the committee which will guide and direct the NAATP PAC. At the annual awards luncheon we launched this effort and had nearly \$5,000 pledged by those in attendance!

Now is the time to roll this out to the entire membership! Between now and September 1, we are asking you to give serious consideration to making a contribution to the NAATP PAC and to encourage all of your "salaried staff" to also make a contribution. Remember Political Action Committee's can only receive contributions from individuals. I am enclosing the NAATP PAC brochure which gives you all the particulars on this effort as well as some common questions and answers as well as a guideline regarding contributions. We will accept contributions to the NAATP PAC at any time, but each year we will designate a specific time frame as our "campaign". Between now and September 1 is the campaign for 2009.

If you have any questions, or if you would like additional brochures, contact either myself at ediehl@seabrookhouse.org or the NAATP office at 717-392-8480. I am pleased to announce that I made the very first contribution to the NAATP PAC and now invite you to join myself and your colleagues in ensuring that we continue to be recognized and have a voice in the political process as it impacts addiction treatment which is so very vital to all of us.

Sincerely,

Ed Diehl

HOSPITAL ADMINISTRATORS

Behavioral Health Care Corp seeks experienced administrators for its Florida and Ohio locations. A master's degree in Health Care Administration or related Clinical discipline is preferred. A working knowledge of JCAHO and Medicare regulations is essential for a successful candidate. Please send resume to: Tamiami.resume@yahoo.com

CONSTRUCTION MANAGER/ SUPERINTENDENT

Hospital Corporation seeks experienced construction manager to direct and oversee ongoing construction, renovations and building compliance programs for multi-hospital locations. Primary responsibilities are managing design and construction documents for compliance and completion, review all related safety codes and participate in development and monitoring quality assurance in all projects. Successful candidate will possess a thorough knowledge of construction processes, estimating techniques and safety procedures. Florida license as construction manager a plus. Send resume to: Tamiami.resume@yahoo.com

EXECUTIVE DIRECTOR POSITION AVAILABLE

Seeking **Executive Director** or Organization to develop and oversee the day to day operations of a young adult male and female for profit Residential Addiction Treatment Center located in California. Desirable candidate or organization will have experience in re-engineering an AODA treatment program into a full continuum of care Addiction Treatment Program, which will treat all Chemical Addictions, Process Addictions and Chronic Pain and Addictions.

Interested parties should email personal or organizational resume to wcoastprogram@gmail.com. Resume and or cover letter needs to outline specific experience with developing process addictions programs. Additionally, resume or cover letter should outline protocols and philosophy for treating chronic pain with people diagnosed with Chemical Addiction.

PARITY REGULATION COMMENTS NOW AVAILABLE

The first step in the long process of implementing addictive disease disorder and mental health parity was passage of the federal legislation in October of 2008. The second step is the formulation of the regulations needed to implement and carry out this legislation and the third step will be the promulgation of the regulations.

Throughout most of 2009, work has been going on in developing the necessary regulations. As part of this process, individuals and organizations were invited to submit comments regarding the legislation and specific aspects of the legislation which need to be addressed. Those submissions were made in May of 2009. This entire process has taken longer than anticipated and the delay has caused anxiety and speculation about what those regulations will finally reveal.

Recently the US Department of Labor, Employee Benefits Security Administration posted every comment received on the Mental Health Parity and Addiction Equity Act. The releasing of this information may signal that we are getting close to having the regulations also released.

407 associations/organizations/individuals posted comments. You can find the entire listing as well as the actual submissions from those 407 organizations at <http://www.dol.gov/ebsa/regs/cmt-MHPAEA.html>. There is a wide assortment of submissions including material from Managed Care/Behavioral Health Insurance Companies and Organizations. While I have not read all 407, I have sampled those submissions and it appears that they fall into four (4) categories or groups:

1. Individuals
2. Treatment Provider Organizations
3. Associations representing patients or treatment providers
4. Organizations or Associations associated with providing or managing insurance or business and industry coalitions purchasing insurance

With 407 submissions and the four categories listed above, the perspective is varied and specifically different! Generalization might be too simple but it does give some flavor to the material contained in these submissions.

Individuals - For the most part these submissions consist of brief descriptions of specific instances where individuals or family members needed addiction treatment or mental health treatment and the dollar or visit cap was imposed which compromised the treatment they received. In most instances these individual submissions referenced the same insurance policy which did not impose these restrictions on other diagnoses.

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Treatment Provider Organizations - Individual provider organizations submitted material which either supported positions taken by trade associations to which they belonged or articulated the negative impact of imposing treatment limits based on dollar caps or visit limits. There were also comments about the use of “medical necessity” as a tool to deny access to benefits. This group built a strong case that imprecise medical necessity definitions led to suspicion and distrust in the relationship between providers and insurers.

Associations representing patients or treatment providers - As can be imagined, a significant number of submissions came from patient advocacy organizations as well as organizations and associations that represented providers of treatment including the *National Association of Addiction Treatment Providers*. Since most of these groups were deeply involved in the crafting of the legislation, their case was an appeal to have the regulations reflect the intent of the legislation. Most often mentioned issues were around “out of network” activity, medical necessity transparency and accountability.

Organizations or Associations associated with providing or managing insurance or business and industry coalitions purchasing insurance - These submissions cluster around a number of themes that include:

1. Medical Management of the Benefit
2. Delay the implementation of the regulations and thus the legislation
3. Medical Management of Out of Network Benefits
4. Request for clarification and suggested definitions of “predominant” and “substantially all” which are in the passed legislation. By suggesting definitions of these terms the organizations seek to limit the impact.

Certainly there is much more contained within those 407 submissions, but this is a beginning summary. I would urge all of you to check out this site and randomly read some of the submissions. In the next weeks, we may well see some activity around the announcement of the regulations and I suspect that we will find ourselves both applauding those sections that we have supported and being critical of those that we have opposed. We must not find ourselves surprised and that is why it is important to read submissions from *all* sides of this important issue.

HAZELDEN TO OPEN NEW TREATMENT FACILITY IN FLORIDA

INNOVATIVE NEW COMMUNITY RECOVERY
CENTER IN NAPLES



Hazelden, one of the world’s largest and most respected private, nonprofit alcohol and drug addiction treatment centers, announced today that it will open a new treatment facility in Naples, Florida.

“We are thrilled to bring back to Florida Hazelden’s ongoing commitment to help more people find and sustain lifelong recovery from substance abuse,” said Mark Mishek, Hazelden president and CEO. “We are tremendously grateful for the warm reception we already are receiving in Naples.”

The new facility will open in March 2010 and will feature an innovative recovery community approach coordinating recovery principles in life and work. It will serve those needing intermediate level addiction treatment services with a lifestyle approach to recovery and programming for up to 18 months post treatment. The new center will also involve affiliations with Naples area medical, recovery and business organizations to help reduce treatment costs and provide a continuous support system at home, work and in the community. Hazelden and Naples Community Hospital have already reached an affiliation agreement to support drug and alcohol treatment in the community.

“We are deeply committed to the Naples and west coast region and will provide alumni and family programs, screenings and brief interventions, education presentations and other services that will be determined in collaboration with the community,” said Mishek.

Hazelden will be located in a newly constructed building near the Naples Community Hospital main campus and will initially provide treatment programs for adults with a total capacity of 48 residential beds and a full array of family and outpatient services.

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SATVA
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Innovative Technology Partners for the Behavioral Health and Human Services Community

THE APPLICATION FOR THE JAMES W. WEST, M.D. QUALITY IMPROVEMENT AWARD IS READY FOR COMPLETION



The NATP annual leadership conference will again be the site where we announce the recipients of the 2010 James W. West, M.D. Quality Improvement Award. This award was established in 2000 and has been used to recognize the work done by NAATP member organizations in the area of quality improvement. The award is supported by NAATP, the Vendome Group, LLC and the Betty Ford Center. Recipients of the 2010 award will be introduced and highlighted at the 2010 NAATP Annual Leadership Conference in San Antonio, Texas.

The deadline for receiving applications at the NAATP office is January 1, 2010. In order to receive your application contact Sherry Anderson at sanderson@naatp.org and an application will be provided to you. You can also obtain an application from the NAATP website by going to <http://www.naatp.org/conferences/awards.php> and then downloading the application.

Recipients of the award will also be featured in the April edition of the 2010 issue of Behavioral Healthcare. Be sure to request your application and submit your initiative in the area of Quality Improvement.

THE GREAT HEALTH CARE REFORM DEBATE: FIRST WE NEED TO KNOW WHAT WE'RE TALKING ABOUT

I'm a bit frustrated with the coverage of the health care debate-both what appears in advocacy advertising (save us from Harry and Louise!) and what passes for news. The problem with the debate is that most commentators don't seem to know the basic health care terms. So, as my public service to America (and to arm our advocates fighting for parity), I plan to do a little clarification. There are four basic terms that shape the debate: health care system; health insurance; universal coverage; and nationalized health care system. So here it goes:

Health Care System. The term refers to "a country's system of delivering services for the prevention and treatment of disease and for the promotion of physical and mental well-being," according to the Encyclopedia of American History. Our health care system is the entirety of health care professionals and provider organizations-from your primary care doctor, to the local community health center, to your community hospital, to the local MinuteClinic. The health care system is shaped by health care financing-but it is really about the 'what' and 'how' of service delivery.

There is lots of debate about expensive-versus-inexpensive health care system design. Is it really less expensive to have fewer provider organizations? Should we have a system with lots of health care professionals focused on prevention? Do hospitals really take more than their fair share from the system?

Health Insurance. Health insurance is defined by the Britannica Concise Encyclopedia as a "system for the advance financing of medical expenses through...a common fund to pay for...services specified in an insurance policy or law." Essentially, health insurance is how we finance consumer access (beyond private consumer payments) to the health care system. Lowest-cost health insurance has very high deductibles or very limited catastrophic coverage of medical conditions. Highest-cost health insurance has low deductibles (and copayments) with unlimited catastrophic coverage for medical conditions, palliative care, and rehabilitative services.

The big debate right now is what kind of health insurance should be 'standard.' Does everyone get very limited medical coverage? Do we tax the employer-sponsored health insurance that offers extended coverage? Should we provide vouchers and/or tax credits for Americans to purchase low-cost, high-deductible health insurance-and leave the rest up to the individual?

Universal Coverage. Universal coverage is the general concept that all Americans should have some form of health insurance. By definition, it is "health insurance coverage for all persons in a state or country, rather than for some subset of the population," according to reference.md. "It may extend to the

unemployed as well as to the employed; to aliens as well as to citizens; for pre-existing conditions as well as for current illnesses; for mental as well as for physical conditions."

Most stakeholders in the health reform debate agree-we want universal coverage. We don't want citizens dying of treatable diseases like pneumonia or failing to get low-cost support services for chronic diseases. The question in the universal coverage debate is coverage of what (see "health insurance" above)? The cheap way to attain universal coverage is to mandate that all people must have health insurance coverage (like we do with auto insurance) and provide 'subsidized' insurance for the very poor and tax credits (but not payment for the health insurance) for everyone else. The expensive way to attain universal coverage is to mandate that all people have coverage-and provide 'subsidized' insurance for everyone.

Nationalized Health Care System. The concept "nationalized health care system" is complex one with varying definitions. Even locating a solid definition online is a daunting task. Nonetheless, there are three options for a nationalized health care system in the United States. The first, which doesn't have much traction in the current debate, is a nationally run health care system (like the United Kingdom) where health care professionals are actually government employees. The second option is a system where all health insurance plans are operated by government (i.e. the debate over the 'public plan'), but the health care system (professionals and provider organizations) are private entities-like Medicare fee-for-service. The third option is a system where the administration of national coverage is operated by the government, but the actual health insurance plan can have either private sector or public sector sponsors-like the Federal Employee Health Benefit Plan.

If we're ever going to move along the discussion of parity for mental health and addictive disorders in national health policy, we first need to make sure that we're all using the same terms in the discussion. What we're looking for is policy mandating that all forms of health insurance (Medicare, Medicaid, commercial health insurance plans, employer health benefit plans, etc.) will have equal coverage for behavioral disorders. So speak up-and be sure to ask all parties to clarify their terms. Let the debate begin!

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VISIONS

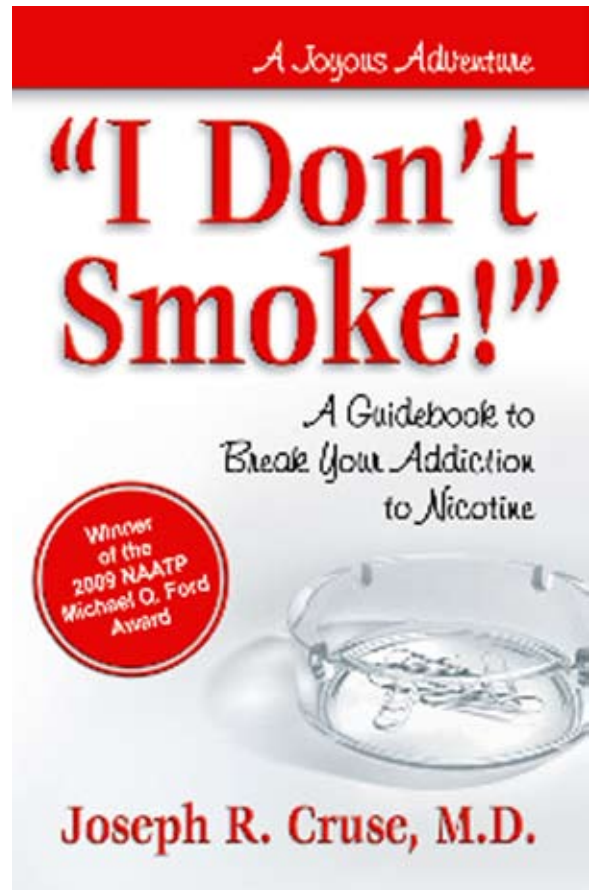
WILLIAM C. MOYERS TAKES ON ADDITIONAL RESPONSIBILITIES AT HAZELDEN

MOYERS BECOMES VICE PRESIDENT OF
FOUNDATION RELATIONS FOR HAZELDEN

Mark Mishek, President and CEO of Hazelden recently announced the appointment of William C. Moyers as Vice President of Foundation Relations for Hazelden. In this new role, William will lead Hazelden's development efforts in addition to continuing to provide leadership of Hazelden's Center for Public Advocacy. William will assume his new duties effective September 1.

William brings a deep understanding and strong commitment to advocacy, philanthropy, and "carrying the message" about recovery to his role as Vice President of Foundation Relations. He is well known to our donors, alumni, and to the larger Hazelden community. He also has a proven track record in bringing major contributions to Hazelden. Over his career at Hazelden, William has connected us with donors and been part of cultivation and solicitation of well over \$2 million.

Prior to joining Hazelden in 1996, William was an award-winning journalist with CNN, Newsday and various other news organizations around the country. He is the author of the bestselling memoir, *Broken*, and a popular recovery journal/DVD, *A New Day, A New Life*. William has appeared on Larry King Live (CNN), The Today Show (NBC), and The Oprah Winfrey Show. His work has been featured in *The New York Times*, *Chicago Tribune*, *The Los Angeles Times*, and *Newsweek* magazine. He also writes Beyond Addiction, a nationally syndicated column on addiction-related issues for Creators Syndicate.



“I Don’t Smoke” by Joe Cruse, M.D. has just be re-released and is now available as an HCl publication. Dr. Cruse received the 2009 Michael Q. Ford Journalism award for this publication

NAATP - OUR ASSOCIATION

I have had the distinct pleasure of serving on the board of NAATP for a number of years. It has been and continues to be a wonderful experience, highlighted by the opportunity to get to know and work with bright, committed and talented leaders in our field. Together with our exceptional CEO, Ron Hunsicker, NAATP continues to grow and mature as an addiction association.

Our new Chairperson, Ms. Cathy Palm, has asked me to chair the membership committee. I humbly agreed, knowing that Ron does most of the work and that I could not refuse the request of a person I respect so much.

As the new membership chair I would like to focus not only on increasing our membership but on attempting to connect the membership in meaningful ways to learn from each others experience. While NAATP has many benefits for its members, such as, the benchmark survey, the salary survey, public policy advocacy, SECAD, and our wonderful annual meeting, the single most valuable benefit is the networking and sharing that can happen as a result of meeting people throughout the country with similar interests.

At our last annual meeting I had the pleasure of leading the CEO roundtable and interesting ideas about improving membership benefits were raised. Two of the ideas raised were a website enhancement which could assist members in making connections and the possibility of an outcome product.

We continue to explore these ideas and others to enhance membership benefit. I would encourage you to reach out to the members that have similar interest and philosophical orientation and create informal or formal networks. I would encourage

you to contact me or Ron with ideas on how NAATP can continue to improve.

It is our association and we make it what it is. Let's connect and share.

I can be contacted at kdahlen@jacksonrecovery.com and Ron can be reached at rhunsicker@naatp.org.

Kermit Dahlen
President/CEO
Jackson Recovery
Board Member NAATP

Upcoming Events

The Ben Franklin Institute will host The Summit for Clinical Excellence Conference, October 1 - 4, 2009 in San Diego, CA. Go to www.bfisummit.com or call 1-800-643-0797 for more information.

The Ben Franklin Institute will host The Summit for Clinical Excellence Conference, October 22 - 25, 2009 in Scottsdale, AZ. Go to www.bfisummit.com or call 1-800-643-0797 for more information

SEPT 19 2009 ART OF RECOVERY EXPO, PHOENIX CONVENTION CENTER. 10 AM 5PM FREE TO THE PUBLIC. CELEBRATING NATIONAL RECOVERY MONTH.

HAYMARKET CENTER will present the **2009 AUTUMN WORKSHOP SERIES** starting on **SEPTEMBER 12, 2009, THRU OCTOBER 31, 2009 (SELECTED SATURDAYS)** at Haymarket Center's new training center, 22 N. Sangamon, **CHICAGO, ILLINOIS**. Topics include: Eating Disorders and Addictions; Food For Thought; The Basics of Spirituality; Understanding and Treating Sexual Addiction/Compulsivity; In Search of the Conscience: Counseling Clients With Antisocial Personality Disorders; and Female DUI Offenders - For the Sake of Public Safety and Her Children, We Must Intervene!! For more information, contact Carol Blyskal at (312) 226-7984 x314 or view our website at www.hcenter.org. Pre-registration is required.

US Journal Training will host its **15TH ANNUAL COUNSELING SKILLS CONFERENCE, SEPTEMBER**

10-12, 2009 in Las Vegas, NV. For more information, visit www.usjt.com or call 800-441-5569.

US Journal Training will host its **4TH ANNUAL NEUROSCIENCE MEETS RECOVERY CONFERENCE, OCTOBER 8-10, 2009** in Las Vegas, NV. For more information, visit www.usjt.com or call 800-441-5569.

US Journal Training will host its **NORTHEAST CONFERENCE ON BEHAVIORAL HEALTH AND ADDICTIVE DISORDERS (WITH A SPECIAL TRACK ON YOUNG ADULTS), OCTOBER 26-28, 2009** in Philadelphia, PA. For more information, visit www.usjt.com or call 800-441-5569.

The **SUBSTANCE ABUSE PROGRAM ADMINISTRATORS (SAPAA)** will hold its 2009 annual conference on **SEPTEMBER 14-17** in **AUSTIN, TEXAS**. For more information, visit www.sapaa.com.

The **SECAD 2010** will be held **FEBRUARY 21-24, 2010** at the Gaylord Opryland in **NASHVILLE, TN**. For more information see www.secad10.com.

THE NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS (NAATP) will hold its 2010 Annual Addiction Treatment Leadership Conference on **MAY 22-25, 2010** in **SAN ANTONIO, TX**.

NAATP VISIONS

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