

Accelerating Family
Access to Substance Use
Disorder Recovery Programs
through Innovative Financing
and Partnership

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FAMILY FOCUSED RECOVERY MODEL DEFINITIONS

- **FFR:**
General reference to the FFR program and its recovery services, and states with existing FFR programs that do not currently reflect the envisioned “model” program.
- **VOA:**
Volunteers of America: the national non-profit that operates thousands of human services, housing and healthcare programs, including Family Focused Recovery for pregnant and parenting women with substance use disorder.
- **QV:**
Quantified Ventures: an outcomes-based capital firm that drives transformative health, social, and environmental impact by leveraging deep content expertise and extensive capital relationships to plan, finance, and develop high-impact projects and programs that deliver value to multiple public and private stakeholders.
- **Contributors:**
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- **ASAM:**
American Society of Addiction
- **SUD/OD:**
Substance/opioid use disorder

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OVERVIEW

According to the National Institute for Health Care Management (NIHCM), drug overdose deaths have nearly doubled in the last 10 years. In 2019 alone, 70,455 drug overdose deaths (approximately 200 lives lost every day) resulted from alcohol, prescription drugs, and non-prescription drugs, with 86% of these deaths involving opioids and/or stimulants¹. For women of childbearing age and their children, substance use disorder (SUD) is a particularly devastating problem that has profound and often life-long effects on their health, wellbeing, and economic stability. Treating SUD during pregnancy is complex because integrated care for both the pregnancy and the underlying SUD are critically important – as is the provision of other family supports. Treatment through comprehensive prenatal care and SUD programs can produce positive birth outcomes, including reductions in preterm deliveries, small-for-gestational age infants, and infants with low birth weight².

While pregnancy may motivate interest in and pursuit of SUD treatment, a variety of factors deter women from enrolling in conventional programs, including the stigma associated with SUD during pregnancy, their place and role in the family, complicated family relationships, and the fear of losing child custody. Given these barriers, medical professionals recommend integrated treatment programs inclusive of on-site prenatal care, along with parenting and children’s services, in combination with addiction and recovery services³. Despite the ever-increasing need for such holistic care models, there are relatively few programs designed for pregnant women – and those that exist struggle to keep pace with demand⁴.



Encouragingly, there is mounting evidence that existing programs produce strong results; they have helped families reduce substance use and improved children's health and safety⁵. Volunteers of America (VOA), a national non-profit with operations in 46 states, is one of the organizations that has been producing positive results for women and children for over 25 years. In 1993, and with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), VOA opened Freedom House, their first treatment program for pregnant and parenting women with SUD, along with their children, in Louisville, Kentucky. Since then, VOA Mid-States has adapted its model residential treatment program to address changing needs through the implementation of clinical best practices. As VOA's Center of Excellence for Family Focused Recovery (FFR), the Kentucky program guides replication of the FFR model, pilots new service elements and care techniques, partners with VOA National on financing innovations, and serves as a strong voice for promoting the model and the interests of those it serves. Unfortunately, inadequate and unsustainable revenue sources impede the growth of promising models like VOA's, which often struggle to operate at levels that meet the need of the communities they serve. Primarily funded through philanthropy, government contracts, and fee-for-service Medicaid that only partially cover program costs, VOA faces two significant challenges: (1) A lack of access to the upfront capital required to open new facilities, such as, building purchase or renovation; and (2) Insufficient and time restricted reimbursement for only a subset of services provided.

Collectively, these challenges severely constrain the ability of VOA to both launch and sustainably operate existing programs in new communities across the country that are in dire need of such solutions. This challenge has spurred a novel three-way collaboration between Humana, Quantified Ventures, an outcomes-based capital firm, and VOA National Office to build capacity among VOA affiliates to sustainably scale this life-saving program.

Drawing on VOA's experience in Kentucky, this paper:

- **Highlights VOA's FFR model** and explores the challenges faced in sustaining and expanding its operations
- **Presents the paired innovation** of value-based purchasing (VBP) and outcomes-based financing to achieve upfront capital and ongoing revenue needs
- Discusses optimum policy and other enabling conditions to **scale this model into other states**

¹ National Institute for Health Care Management (NIHCM) foundation. (June 15, 2021). Dying from Drugs: A New Look at Overdose Deaths in the U.S. <https://nihcm.org/publications/dying-from-drugs-a-new-look-at-overdose-deaths-in-the-us>

² Patrick SW, Schiff DM, (2017). AAP Committee on Substance Use and Prevention. A Public Health Response to Opioid Use in Pregnancy. *Pediatrics*. 2017;139 (3):e20164070

³ Niccols, et al: (2012). Integrated programs for mothers with substance abuse issues: A systematic review of studies reporting on parenting outcomes. *Harm Reduction Journal* 2012 9:14

⁴ Patrick SW, Schiff DM, (2017). AAP Committee on Substance Use and Prevention. A Public Health Response to Opioid Use in Pregnancy. *Pediatrics*. 2017;139 (3):e20164070

⁵ Werner D, Young NK, Dennis K & Amatetti S. (2007). Family-Centered Treatment for Women with Substance Use Disorders- History, Key Elements and Challenges. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2007.



20%

According to *Health Affairs* (November 2021), from 2010 to 2017 the number of pregnant women with an opioid-related diagnosis at delivery, and the number of infants diagnosed with neonatal abstinence syndrome (NAS), approximately doubled nationwide, with infants younger than age one comprising nearly 20% of new foster care entries.

Loch, S.F., Stein, B.D., Ghertner, R., McNeer, E., Dupont, W.D., Smart, R., & Patrick, S. W. (doi: 10.1377/hlthaff.2021.00460)

Furthermore, JAMA reported that the rate of U.S. infants diagnosed with opioid withdrawal symptoms jumped significantly - from 2.8 to 14.4 per 1,000 hospital births between 2004 and 2014, and more than 80% of those infants treated for NAS have had their care paid for by Medicaid. Patrick SW, Schumacher RE, Benneyworth BD, Krans EE,

VOA FAMILY FOCUSED RECOVERY PROGRAM

Volunteers of America's nationally recognized treatment program for pregnant and parenting women at Freedom House in Kentucky addresses the SUD crisis with data-driven best practices that produce measurable results. It provides evidence-based, outcome-oriented, generational solutions that help moms, their children, and their broader communities to regain independence from substance use through ASAM -certified treatment and support. Freedom House offers comprehensive care, including individual and family therapy, peer support, and medication-assisted treatment, designed to help moms deliver healthy babies. With a focus on family unity, this model provides primary prevention for children - addressing and reducing childhood trauma and disrupting generational SUD. In 2020, VOA added a second Freedom House in Southeastern Kentucky, bringing treatment and services to a region at the epicenter of the opioid crisis. To further address current levels of need there and in other parts of the Kentucky, VOA plans additional expansion in the state.

The Model

The VOA Family Focused Recovery Model (FFR) consists of three phases of care that covers a period of up to three years. Phase one is intensive residential treatment (ASAM Level 3.5) which includes a full range of trauma-informed care and case management, peer support, coordination with medical care, along with withdrawal management and MAT. Women spend 40 hours per week in therapy sessions and focus solely on their recovery and bonding with their infant and children. Phase two is intensive outpatient with boarding (ASAM Level 2.0) where women spend 15-20 hours in intense therapy while still receiving housing assistance.

During phase two, women also evaluate career, educational and volunteer opportunities. Through all phases, support services include parenting skills and child development, educational remediation, employment and workforce development. Women also receive support for interactions with court and child welfare systems, housing and connection to community recovery services. Care is individualized to every woman's needs, with the typical stay in phases one and two lasting 120 days. The third phase is for women who are more advanced in their recovery and can live independently in apartments in VOA's transitional living or in nearby units, with continuing outpatient therapy, case management, and peer support. This final phase can last up to 18 months.

Family unity is a primary focus in the FFR model. Pregnant and parenting moms can bring children into treatment with no restriction on the age or number of children, and the children's services are age-appropriate and individualized. As a part of this program, VOA provides clinical treatment and support services for children residing with the mother, including assessments, childcare and recreation, medical care and prevention, and mental health and trauma services.

40 HOURS
PER WEEK

in therapy sessions and focus solely on their recovery and bonding with their infant and children (Phase 1).

The VOA FFR model aligns with the US Department of Health & Human Services (DHHS) recommended expansion of consistent, evidence-based services for pregnant women with SUD and their children.

The VOA FFR model removes deterrents to treatment and promotes the adoption of evidence-based practices, including medical-assisted treatment.

Community Collaboration

VOA FFR programs are more than just treatment facilities. Through engagement in the community, VOA builds understanding and support for families impacted by SUD. They also collaborate to meet the complex needs of their clients, to develop new approaches and enhancements, and to advocate for women with SUD and their families. Recent examples in Kentucky include:

- **Collaboration with multiple service delivery systems:** Building community partnerships has been key to expanding recovery supports in communities, such as VOA's **close collaboration with the local hospital and primary healthcare provider, as well as the Health Department, Public Schools, and local civic and business leaders.**
- **Thought Leadership:** University research partners and VOA received a Robert Wood Johnson Foundation grant to study Freedom House's collaborative approach to improving outcomes for pregnant and parenting women in recovery. This study purposefully looked at the differences between the urban (Louisville) and rural (Clay County) sites through qualitative and quantitative research, they found that the overall strength of collaborations was similar, but that the rural area had a greater level of collaboration around purpose and a shared mission, while the urban area had a greater level of collaboration around finances, data and policy advocacy.
- **Advocacy:** VOA has a broad advocacy agenda and partners on issues impacting women and families, including **treatment as a sentencing alternative, improving conditions for pregnant incarcerated women, and reasonable accommodations for pregnant workers.**



Early Engagement Produces Results

The model encourages women to secure SUD treatment early in their pregnancy, producing successful results, including:

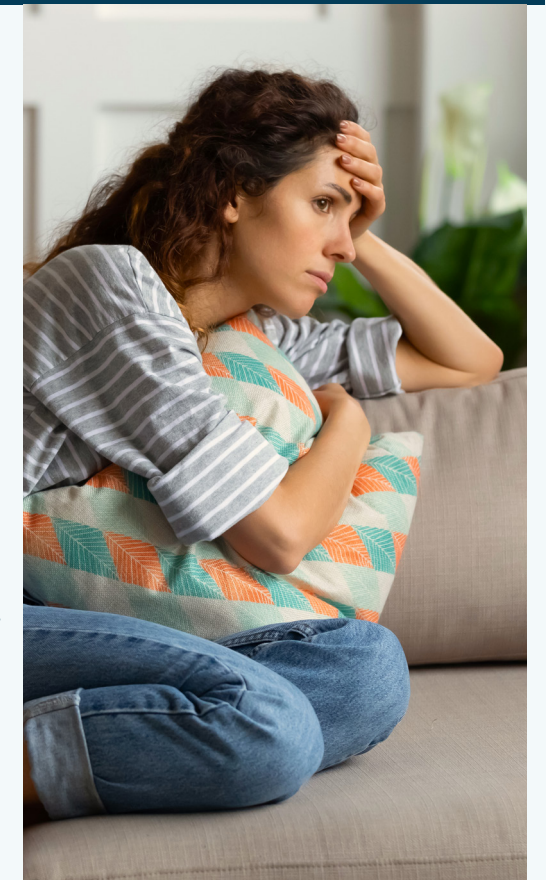
- Increasing the number of women who enter and complete intensive treatment prior to delivery, safeguarding the lives of the mother and baby.
- Increasing the number of full-term or healthy birthweight babies without neonatal abstinence syndrome (NAS).
- Reducing the number of out-of-home placements and utilization of high-cost services (e.g., NICU), as well as other outcomes for both women and their infants.

Every healthy baby born represents significant benefit for the family, and delivers savings to healthcare, particularly Medicaid. For example, babies born prematurely, or with illicit substances present in their systems, generally require lengthy stays in Neonatal Intensive Care Units (NICU), which cost an average of \$17,000 daily.

Since the mid 2000s, 272 babies have been born free of illicit drugs to moms served in KY FFR programs.

Historic Funding Model

VOA's FFR model began with a federal grant. Government grants and contracts, along with philanthropy, continued to be the primary funding sources until expansion of SUD services through the 1115 waiver in 2019. Medicaid slowly began growing with fee for service (FFS) payments from managed care companies. By 2020, Medicaid covered a significant portion of operating costs. However, FFS payments do not fully cover program costs. The unique needs of women with SUD, especially pregnant and parenting women, do not fit in the standard payment approach. While a challenge for FFS payment models, value-based care offers an opportunity to think differently about payment options; by focusing on outcomes attainment for the mom and baby, programs can attach performance payments to outcomes that reduce costs rather than focusing exclusively on the immediate costs of care delivery.

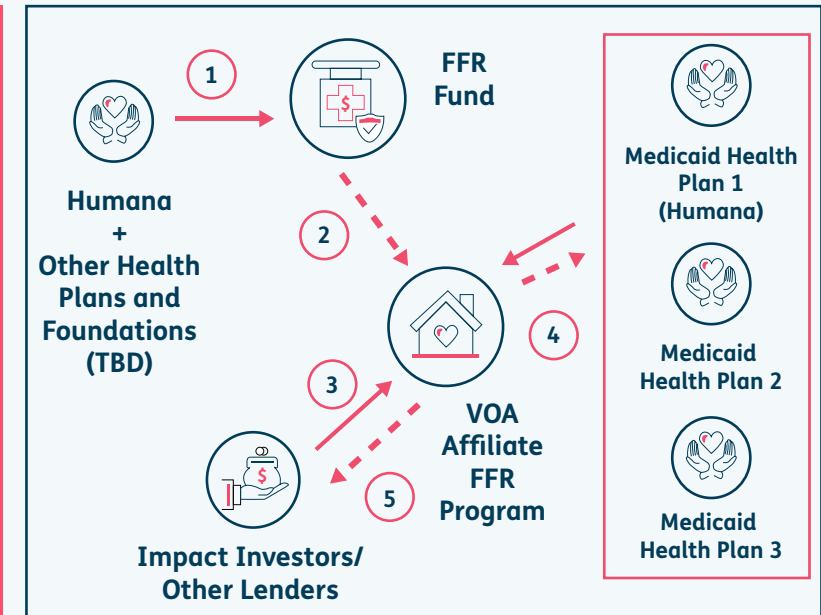


A PATH TO SUSTAINABLE OPERATIONS AND EXPANSION

Historically, FFR programs like the ones in Kentucky have not operated at levels that meet the need of the communities they serve due to inadequate and unsustainable revenue sources. VOA affiliates have faced two significant challenges:

- **A Lack of Access to the Upfront Capital Required to Open New Facilities (i.e., building purchase or renovation):** Historically, VOA programs have depended on public and private contributions to raise the necessary capital for buildings and start up costs, which is a process that is extremely slow, time-intensive, and challenging, given multiple competing priorities.
- **Insufficient and Time Restricted Reimbursement for Services Provided:** The lack of predictable, accessible, and sustainable operating funds for ongoing causes programs to cobble together resources from different government programs (e.g., fee for service Medicaid, TANF, block grants), as well as unpredictable donations and private grants. Even in states with optimal reimbursement and other financing structures, the real costs of operating the FFR program exceed VOA revenues, which inhibits capacity to offer enhanced program features at the scale necessary to meet the real need in the communities VOA serves.

Figure 1
FFR FUND
STRUCTURE



To address these dual challenges Humana, Quantified Ventures, and VOA National have collaborated to develop and deploy a financing structure that enables VOA affiliates and the MCO partners in their markets to tailor FFR programs to meet each community's unique needs, while adhering to a core model that drives key performance metrics. As illustrated in Figure 1 FFR Fund Structure, this structure provides a mechanism for VOA affiliates to establish a reliable and sustainable source of revenue that is partially tied to program performance.

The establishment of value-based contracting arrangements between a VOA Affiliate and each participating MCO, allows VOA to tie at least a portion of their payment to performance on a set of pre-agreed outcomes valued by all parties. This arrangement also provides VOA affiliates with the collateral (i.e., contracted revenue) needed to access previously unavailable sources of impact investment capital. Through the Fund structure depicted above, VOA affiliates can access capital in one of three⁶ ways:

- 1) FFR Fund as Sole Lender:** The VOA affiliates can tap directly into the FFR fund, which has been established with seed funding from Humana, for the exclusive purpose of leveraging non-grant mechanisms to capitalize FFR programs. If the level of capital required is modest (below \$500,000), the FFR Fund can serve as the sole lender.
- 2) FFR Fund as Subordinate Lender:** The VOA affiliates can alternatively use the FFR Fund as a credit enhancement to unlock larger pools of external capital (e.g., loans from other impact investors, Community Development Finance Institutions) when the capital need is greater.
- 3) FFR Fund as Guarantor Against Performance Losses:** The VOA affiliates can mitigate against performance-based revenue loss by using the FFR Fund as a guarantee mechanism, allowing them to access a set payment level from the Fund, should the achievement of anticipated performance outcomes be compromised by program ramp-up and adjustment periods.

⁶ Under certain conditions, VOA affiliates can engage the Fund through a combination of options 2 and 3.

Regardless of how the FFR Fund is used, it serves to mitigate and more evenly distribute program performance and financial risk across all involved parties.

A key benefit of this financing structure is that it aligns the interests of all parties around a common set of prioritized outcome measures. Specifically, it empowers and incentivizes local VOA affiliates to optimize FFR service delivery to meet a set of key performance indicators for the women and children served, while engaging in-market Medicaid health plans for financial support for these outcomes. It also promotes the advancement of compelling payment models that encourage program innovation to address critical individual and population health challenges, while creating significant cost savings for the communities served, the partner MCOs, and ultimately, the state Medicaid agency. Aside from the primary aim of delivering sustainable, scalable capital to VOA affiliates so they can expand services to women with SUD and their families, the FFR Fund:

- Enables private and public entities to drive a greater portion of their spending toward programs that deliver desired outcomes for individual participants and their communities.
- Mitigates and redistributes both financial and performance risks by aligning all parties around a shared set of goals and tying outcomes-based funding streams to improved health. This method of financing creates a strong incentive for results achievement, while granting service providers like VOA the autonomy to adjust operations and resources for greatest impact.
- Promotes continuous enhancement opportunities and reinvestment potential for high-impact programs, and accelerates the adoption of innovative payment models.

VOA's FFR program is an ideal candidate for this financing structure, as it has the potential to deliver substantial benefits to several parties beyond the clients served, has a demonstrated track record of impact, and produces both near and longer-term outcomes that translate into meaningful economic terms. For example, data from the Kentucky programs indicate that, **73% of program participants are still in recovery at 6 months post-completion** (program exit), which is generally about a year after program entry. The remaining 27% are either lost to follow-up or may have returned to use.

The impact for infants born to mothers in the program is also significant; nearly 90% of babies born to mothers in (or having completed) the program entirely avoid NICU stays. **As NICU stays cost \$17,000 per baby, on average**, the ability to reduce or avoid NICU stays represents significant cost savings to the parties responsible for payment, including managed MCOs.

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OPTIMIZING CONDITIONS FOR FAMILY FOCUSED RECOVERY

For FFR programs to be viable, sustainable, and replicable at scale, the financing criteria and associated mechanism is not the only ingredient necessary for success. Several conditions can favorably position a state for the Family Focused Recovery model - making some communities a better choice for replication of VOA's comprehensive treatment and innovative financing models. Where conditions are not favorable, communities have the opportunity to mitigate challenges while planning for new or expanded FFR programming. Specifically, states can work to create a supportive structure by taking the following steps:

- **Recognize Unmet Need:** States need to prioritize SUD treatment for pregnant and parenting women statewide, or at least in high-need regions of the state; these are identified through key health and birth outcome rates (e.g. low birth weight, infant mortality, drug overdose mortality, preterm birth, and NAS). Where key health metrics demonstrate unmet need, and there is a persistent lack of residential SUD treatment supply for women with their children, the case for this type of program is clear.
- **Prioritize Payment Innovation:** States that encourage payment innovation with key partners to improve quality and reduce costs will be more receptive and collaborative partners. Specifically, Medicaid MCO interest in accelerated adoption of value-based payment arrangements is a key enabling condition.

90%

of babies born to mothers in (or having completed) the program entirely avoid NICU stays.



*“A coordinated, multidisciplinary approach without criminal sanctions has the **best chance of helping infants and families.** It is important to advocate for this often-marginalized group of patients, particularly in terms of **working to improve availability of treatment and to ensure that pregnant women with opioid use disorder who seek prenatal care are not criminalized.**”*

American College of Obstetricians and Gynecologists, and American Society of Addiction

- **Extend Length of Medicaid Coverage:** For women to fully benefit from treatment, **they should be eligible for Medicaid throughout their pregnancy, and for at least 12 months postpartum.** The first year postpartum, when a new mother is vulnerable and many of the maternity supports and services fall away, is recognized as a pivotal juncture that requires coverage.
- **Use Waivers and Other CMS Financing Options:** States should take advantage of CMS waiver opportunities that allow for the adoption of ASAM Criteria for treating pregnant women with SUD. Here states can establish reasonable rates for SUD treatment, at all levels of residential treatment for women with their children – providing an incentive for ASAM Level of Care Certification. Further, states can encourage flexibility in residential treatment stays during pregnancy, recognizing the increased risk of transitions prior to delivery.
- **Commit Resources for Non-Clinical Services:** While insurance coverage is a critical piece of funding for family-centered treatment, **essential non-clinical services, particularly housing (for mom) and room and board (for her children), are needed.** States should look at the full-picture of what is required for family-centered treatment and work across agencies to identify and dedicate needed resources.

- Stays in family-centered treatment are usually 3-4 months long and include both ASAM Levels 3 and 2. Housing, both transitional and longer-term recovery, is necessary for many families. **In the FFR model families can transition seamlessly from in-patient treatment (ASAM Level 3) to transitional housing** in the same facility or on-site where they may continue intensive outpatient treatment (ASAM Level 2) and MAT. States are committing flexible resources, such as State Opioid Response (SOR) grant funding, block grants, state funds and CDC funding for this transitional housing, and some are also supporting longer-term recovery housing for families.
- Covering the cost of room and board for children presents a significant challenge when parents enter treatment with children. Policy-level collaboration is needed to address this challenge. Families are often involved in child welfare and other systems; this can add complexity but may also offer resources. For example, TANF funding may be available in some states; others use title IV-E foster care funds for children in foster care with their parent, and some look to a reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) for potential funding to cover this important program feature.

In Kentucky, VOA works with the courts to **divert women from incarceration into SUD Treatment.** VOA is also partnering with the Department for Community Based Services (DCBS) of the Kentucky Cabinet for Health and Family Services to pilot an innovative approach that imbeds a VOA clinician in the local DCBS offices. This clinician **works with families who are struggling with SUD, along-side the case workers and investigators, encouraging treatment and keeping the family together whenever possible.**

- **Incentivize SUD Treatment:** When a state promotes a public health approach and incentivizes pregnant women with SUD to seek medical care (rather subjecting them to punitive treatment), **they can achieve significantly improved health outcomes.** Concerns about fetal drug exposure have led to laws designed to deter pregnant women from using illicit substances by punishing those that do⁷. Almost half of the states have enacted child-welfare statutes that consider substance use during pregnancy to be child abuse


This flawed policy fails to recognize the root causes of SUD and, simply put, does not work. Instead of deterring pregnant women from using drugs as intended, these policies have discouraged women from accessing SUD treatment, and lead to higher NAS rates⁸. Encouragingly, many of the same states with punitive policies, such as Kentucky, also encourage SUD treatment programs for pregnant women. There are collaborative initiatives in both the courts and child welfare systems that incentivize women to enter SUD treatment while retaining child custody.

- **Proactively Work to Reduce Fear and Stigma:** Clear and accurate information can address a pregnant woman's fear that seeking help will lead to family separation and out of home placements. Conversely, punitive state laws generate fear. The federal child protection legislation, CAPTA can exacerbate concern of Child Welfare involvement because of its requirement to notify Child Welfare of prenatal substance exposure, which some people confuse with "reporting child abuse." The requirement for "plans of safe care" may also sound threatening unless hospitals, medical, and treatment providers have an accurate understanding of laws and reporting responsibilities.

Effective and culturally competent messaging can help to address the stigma pregnant women with SUD face, particularly in communities where gender-specific SUD treatment is new.

H

16



When Freedom house opened in rural Eastern, Kentucky, it was new to the region; many of the women were new to recovery programs and hesitant about seeking services. To counteract this stigma, VOA engaged women in recovery to proactively reach out and connect to their peers in the community. With support from the Humana Foundation, they are taking some of the messaging and other lessons learned from that experience to launch an innovative marketing campaign that encourages women to seek help. Using a variety of strategies, VOA is sharing messaging that seeking treatment is a courageous decision that is good for the moms and their children and that builds stronger families.

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- **Cultivate Recovery Supports in the Community:** Services and resources that promote long-term recovery, such as education, employment, housing, peer supports, 12-step groups, and re-entry support services need to be available, accessible, and well coordinated⁹. For example, leaders in Clay County Kentucky recognized their community's needs and invited VOA to develop a range of recovery services. With local partners VOA opened a Recovery Community Center, as a sober communal gathering and educational space; a Family Recovery Program to unite families involved with child protective services; and secured a federal workforce development grant for individuals in recovery.



⁹ Stone R. Pregnant women and substance abuse: fear, stigma and barriers to care. Health Justice. 2015 Dec; 3:2.

CONCLUSION

In the last two years of the COVID pandemic, rates of SUD, social isolation, and economic insecurity have compounded to exacerbate the nation's overdose epidemic; and women are increasingly impacted. Absent family-centered treatment programs, pregnant women with SUD face risks to both themselves and their children. **Integrated treatment programs that combine SUD treatment where parents and children remain together, along with pre-natal care, parenting and children's services are sorely needed.** Despite the urgent need for such services, and evidence of their effectiveness, several policy and financing challenges impede the scale of holistic care programs like VOA's.

Because family-centered care does not fit neatly with a single funding source, these programs struggle to secure and sustain funding – both to capitalize the initial acquisition of physical space, and also to maintain net positive revenues during ongoing operations. VOA national identified several affiliates across the country that, despite significant community need, were challenged with both accessing upfront capital required for additional facilities, and sufficient operating funds to cover all services provided.

Through the collaboration between Humana, Quantified Ventures, and Volunteers of America, the parties have devised a novel financing approach that pairs value-based purchasing (VBP) with outcomes-based financing. This approach addresses both capital needs, and provides an accountability structure that focuses all parties on the attainment of desired

outcomes for the mom and baby. VOA benefits by access to low-cost capital and full coverage of operating costs, and in-market Medicaid MCOs benefit by achieving enhanced population health outcomes and systemic cost containment. The experience in Kentucky demonstrates how states can leverage the VOA FFR model using VBP and outcomes-based financing, and it also identifies other conditions that favorably position a state for replication of these comprehensive treatment and innovative financing models.

State policymakers have an opportunity to address both maternal and infant health goals and child welfare goals while simultaneously reducing significant healthcare and social program costs. By implementing the FFR model of care and directly addressing the State's specific healthcare challenges and offering VBP opportunities and outcomes-based financing, the state can achieve positive outcomes, comparable to those of Kentucky. Supporting the FFR care delivery model is not a strategy undertaken by a single department, but calls for systems to partner to achieve improved outcomes for the whole family and to maximize limited resources.

⁹ Ashford RD et al. Building recovery ready communities: the recovery ready ecosystem model and community framework, Addition Research & Theory, 2019.

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