



Unlocking the Potential of Recovery Community Organizations and Peer Recovery Support Services

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“The community is the soil in which alcohol and other drug problems grow or fail to grow and in which the resolutions to such problems thrive or fail thrive over time.”

William White
Emeritus Senior Research Consultant,
Chestnut Health Systems



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RECOMMENDED CITATION

Peyson, R., Smith, K.D., Castedo de Martell, S. (2022) *Unlocking the Potential of Recovery Community Organizations and Peer Recovery Support Services*. Faces & Voices of Recovery.
<https://facesandvoicesofrecovery.org/publication/unlocking-the-potential-of-recovery-community-organizations-and-peer-recovery-support-services/>



Executive Summary

The shift toward recognizing addiction as a chronic disease has placed greater focus on Peer Recovery Support Services (PRSS). Since the 2010 release of the Faces & Voices of Recovery (FVR) report, *Addiction Recovery Peer Service Roles: Recovery Management in Health Reform*, Certified Peer Specialists delivering recovery services (peer workers) have become key components of interventions designed to improve recovery outcomes. The inclusion of peer workers has become the best practice, and a number of interventions utilizing them have demonstrated compelling outcomes. Of course, this progress was built on the earlier development of peer recovery support services and a long history of peer-based efforts, dating back to the 1800s, as described well by William White in his 2009 paper on the history, theory, practice, and evaluation of peer support in SUD recovery (W.L. White, 2009).

Spurred by efforts to improve the Triple Aim of healthcare, delivery-system and reimbursement innovations have emerged in the addiction recovery space. Some of these innovations incorporate peer workers as design features. However, these innovations face a wide variety of systemic barriers that constrain their regional effectiveness and diffusion. For example, health insurance churning may limit the continuity of recovery support during the full five-year period that science suggests is needed for full recovery. Moreover, for those living in low-resource communities, recovery capital—the internal and external resources needed to sustain recovery—may be far more challenging to draw upon. Without a long-term strategy to address such inequities, peer recovery support will not realize its potential transformational impact.

This report lays out the key issues underlying the need for action to bring about broad systemic changes. First, we discuss the emergence of peer workers as distinct from counselors, social workers, and care coordinators. While offering evidence of the beneficial impact of peer recovery workers, we stress the critical need for fidelity to recovery principles and values for maximum effectiveness. A peer-to-peer relationship based on trust and the presence of someone with lived experience during the recovery journey makes peer workers unique. Trying to match a peer receiving services with peer coaches who best reflect the receiving peer's lived experience, culture, and race is important for achieving successful outcomes. This highlights the need for a greater diversity in the PRSS delivery field. While peer-to-peer relationships also impact health at multiple levels of the socioecological model (i.e., at the individual, family, community, and societal levels), current systems have not adequately valued the social benefits of non-transactional relationships based on trust.

Second, we survey various reimbursement and financing practices for peer recovery services. In addition to the wide variability across states in financing peer recovery services, we find little evidence that reimbursement levels are adequate to cover RCOs' administrative costs. More importantly, we find that peer workers' compensation levels are often below the living wage and fail to compensate for other positive outcomes that are unmeasured, unmeasurable, or ignored by payers. Unfortunately, reimbursement levels are not set based on the actual value that emerges from the delivery of peer recovery support, nor

are they based on the outcomes. The broad system changes that are needed require a paradigm shift in understanding the transformational potential of peer workers that matches the science of addiction and recognition of addiction as a chronic disease. This requires more than just targeting policies and practices governing reimbursement levels.

Notwithstanding reimbursement policies and practices, we believe that peer workers are systematically undervalued in ways similar to other occupations, such as childcare and home healthcare workers. This provided further impetus for considering creative strategies to address what appears to be a complex social phenomenon. As William White noted, the issue of disproportionate pay for people in recovery has pervaded the modern history of addiction treatment and continues today (Olmstead et al., 2005, 2007).

Third, we summarize some of the trends that can be used as leverage for transformative systems change. This was the foundation for a theory of change that posits that by understanding and leveraging the dynamics emerging from these trends, Recovery Community Organizations (RCOs) can intervene in complex systems that shape substance use and recovery. By engaging with key stakeholders and promoting a compelling vision for peer workers in recovery-ready communities, RCOs can nurture new dynamics that ensure that existing trends move toward genuinely transformative systems change. Crucially, this involves RCOs playing a central role in addressing the social determinants of health in coalition with local, regional, and national stakeholders, for example, by building recovery-ready communities and advocating on behalf of peer workers.

We identify two leverage points where recovery community leadership can foster greater value: appropriate utilization and adequate compensation for peer recovery support. Based on our underlying theory of change, we expect these recovery-community-led actions to uplift the peer worker profession, greatly reduce the re-occurrence of substance use through peer and other recovery supports, and foster the development of recovery-ready communities across the US.

However, the recovery community cannot do so alone. This report is a call to action for Faces & Voices of Recovery, RCOs, government agencies, payers, philanthropists, and stakeholders from other sectors to work collaboratively to bring about lasting, transformative change in the U.S. Our recommendations are grouped into four action areas designed to nurture systems change: (1) laws and regulations, (2) organizational capacity-building and community development, (3) workforce development, and (4) leadership development. Over time, these actions can support RCO efforts to shift systems from their current suboptimal state to robust recovery-ready communities. We hope our report will become a catalyst for reinvigorating the RCO and peer movement, ultimately leading to improved health and well-being.



Introduction

This report was initially conceived as focusing on how Peer Recovery Support Services (PRSS) were financed, looking at current payment models, and recommending which payment model was the best fit for PRSS. However, we found that, currently, no single payment model can be said to be a good fit; it is more complicated.

Therefore, we took a step back and thought about how we could address the need for a reimbursement system that better reflects the science of addiction, better meets the need for sustainable funding for PRSS and recovery community organizations (RCOs), and allows for greater availability and access to PRSS. We wanted to approach this through a public health lens given our commitment to and interest in public health.

We recognize the need for delivery system reform and greater integration of behavioral health into primary care. Throughout this report, we discuss the PRSS and substance use continuum of care in the context of the Triple Aim: (1) to improve the quality of the individual patient experience, (2) to improve health outcomes at the population level, and (3) to reduce the per capita costs of healthcare and work toward efficiency (Berwick et al., 2008). We also note the call to create The Quadruple Aim of Healthcare (Sikka et al., 2015) by acknowledging the critical role of the workforce in healthcare transformation. The Quadruple Aim adds a fourth aim to improve the experience of providing care.

While the Triple Aim is of fundamental importance, we also recognize the need to improve the healthcare system's ability to address social determinants of health (SDOH) and community wellness and diseases of despair (Case & Deaton, 2015). For example: the U.S. Department of Health and Human Services report, *Healthy People 2030* (2019), speaks to the need for an increased emphasis on SDOH in order to improve our nation's health. However, the Triple Aim does not explicitly require a focus on health equity (Berwick et al., 2008). Notwithstanding that, reducing health disparities is considered one aspect of improved quality (Aim 1), and models developed to address the Triple Aim, such as Accountable Care Organizations, are also better equipped to incorporate ethical and culturally competent practices into new delivery system reforms (Betancourt et al., 2014).

We recognize that communities heavily populated by people of color, neighborhoods of ethnic groups, communities on indigenous tribal lands, and many rural communities face significant additional barriers to health care, much less accessing peer recovery support services. It is important for recovery communities to collaborate with other groups to address these equity and justice issues. One way to do this is to ensure that the recovery community is involved in the design, development, and implementation of innovative models of care that have the capacity and are incentivized to address health disparities. This can help ensure equity when innovative care models become a routine part of the healthcare system.

New reimbursement approaches are required to support the development of a robust network of providers at the scale required to address the substance abuse crisis and its root causes. Our analysis suggests that the current rates and methods of payment negatively impact the availability and accessibility of PRSS. We need a delivery system that provides adequate pay for PRSS, covers the indirect costs of providing PRSS, and supports the development of a robust network of recovery support service providers if we are to impact the health of communities.

In this report, we propose that PRSS and RCOs are effective means of addressing SDOH, community wellness, and diseases of despair at a community level, as they work to meet the needs of individuals struggling with addiction and associated social components of this disease. SUD peer workers who work in a Recovery Community Organization are uniquely positioned to provide long-term engagement and an environment in which connection and healing can occur. Recovery Community Organizations that are built on recovery values and principles are organized in a way that supports the effective delivery of PRSS. In fact, it is quite possible that the observed variability of evaluative research on PRSS may be the result of failure to consider key structural factors that impact an organization's ability to deliver effective PRSS.

As communities across our country search for solutions to the opioid epidemic, there is a need to identify strategies that go beyond reform of the healthcare system. In addition, as a country, we need to identify effective strategies for addressing the impact of COVID on substance use, mental health, and the healthcare workforce. Furthermore, our understanding of the impact of the social and structural determinants of health on individuals and communities suggests the need for prevention and recovery services to work collaboratively.

This report describes the changes we have seen in PRSS since the 2010 paper released by Faces & Voices of Recovery and the Office of National Drug Control Policy, *Addiction Recovery Peer Service Roles: Recovery Management in Health Reform*, and the shift toward recognizing addiction as a chronic disease that benefits from a population health approach of disease management (Delphin-Rittmon, 2021; Saitz et al., 2008). It is time to integrate prevention, harm reduction, early intervention, treatment, and long-term recovery support, as appropriate for any chronic illness. Many leaders have called for such a system change for years, and it is time for leaders in the recovery movement and beyond to address this challenge.

The remainder of this paper is organized into four sections. Section I provides a brief overview of the following: the evidence base for PRSS; the understanding of and need for long-term engagement of people with addiction, as well as an emphasis on the social determinants of health; the role of RCOs; and the need for standards based on principles and values of PRSS. Section II reviews current methods of payment for PRSS in the United States. Section III presents strategies for developing PRSS as a profession while promoting delivery systems and payment reforms that better fit the science and need for long-term engagement of people with addiction. These strategies are designed to help ensure that peer workers and RCOs play a leading role in improving recovery at the individual and community levels. Section IV provides recommendations for supporting these ideas.



SECTION I: Developments in Peer Recovery Support Services Since 2010

In July 2010, FVR and the White House Office of National Drug Control Policy held a roundtable on Peer Recovery Support Services. The result of this roundtable was a report entitled *Addiction Recovery Peer Service Roles: Recovery Management in Health Reform*. The purpose of this report was to “raise the profile of new services developed by recovery community organizations (RCOs) to support people in or seeking recovery from addiction – services that exemplify this new recovery orientation” (Faces & Voices of Recovery, 2010, p. 1). These roundtable deliberations were instrumental in the development of a more focused peer service continuum and service-specific roles. The roundtable also reflected a change in thinking about recovery at the federal level.

Many sectors of the substance use continuum of care were adopting this peer-driven, recovery-oriented culture of recovery. This sea change is exemplified by the following passage from SAMHSA’s 2010 *Resource Guide*:

Recovery support services (RSS) are non-clinical services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal, and other resources that facilitate recovery and wellness in order to reduce or eliminate environmental or personal barriers to recovery. RSS include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people in and seeking recovery and their families.

— (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010, p. 7)

It should be noted that later definitions of recovery include emotional support as a key component of the model, including social, affiliational, and instrumental peer support (Bringing Recovery Supports to Scale - Technical Assistance Center Strategy [BRSS-TACS], 2017).

This context for understanding and addressing substance use represented an important shift away from providing only clinically based services rooted in a medical model of care and focused on “the problem.” This shift broadened the continuum of care to include a solution-focused public health perspective that gave voice to the individual in recovery, as well as the larger recovery community, including family members and allies, what William White refers to as “Friends of Recovery” (W. L. White, 2013, p.1). The recovery movement harnessed the power of personal, family and community recovery capital. In addition, the existence and legitimacy of multiple pathways and styles of recovery were increasingly embraced.

A key element of this paradigm shift was the recognition that addiction is not an acute illness, but a primary, chronic disease of the brain that impacts reward motivation, memory and related neural circuitry leading to characteristic biological, psychological, social, and spiritual manifestations. Instead of the standard “single dose of treatment,” it has become clear that long-term engagement is essential for successful recovery (Volkow et al., 2016). This needed change in understanding addiction as a chronic illness had been identified by many authors for over 20 years, calling for the development of a recovery-oriented system of care, recovery management, post-treatment recovery check-ups and related support services, and chronic disease management of addiction. Today, acute care models of SUD treatment are recognized as limited, but they persist as the standard of care. There remains much to do, and change has been slow. However, recovery has emerged as an organizing paradigm and governing model for addressing alcohol and drug issues, with a shift in focus from pathology to resilience and recovery and from problem to solution (Dennis & Scott, 2007; McLellan et al., 2000; Saitz et al., 2008; Volkow et al., 2016); W.L. White et al., 2002).

Recovery-focused systems transformation is the process through which behavioral health organizations shift their historical focus on acute or palliative care (serial episodes of brief biopsychosocial stabilization or sustained amelioration of personal pathology and its related social costs) toward support for long-term recovery and enhanced quality of personal/family life in recovery. Systems transformation initiatives are dramatically changing service goals and philosophies, funding and regulatory policies, service practices, constituency relationships, and approaches to performance measurement and monitoring.

The impact of this shifting paradigm is outlined in a paper entitled *The Role of Partnership in Recovery-Oriented Systems of Care: The Philadelphia Experience*:

These efforts are marked by:

- unprecedented levels of participation of recovering people and their families at all levels of system decision-making.
- increased integration of addiction treatment, mental health, and primary healthcare.
- integration of professionally directed clinical services and peer-based recovery support services.
- new organizational partners (recovery community organizations, recovery homes, recovery schools, recovery industries, and recovery ministries/churches).
- assertive approaches to sustained recovery management (Lamb et al., 2009. p1.)

White, Boyle, and Loveland’s (2003) paper on Behavioral Health Recovery Management speaks to the need to change the model to one of disease management to match the science of addiction.

Recovery management reconfigures services by offering an expanded range of services earlier than traditional intervention occurs and sustaining them long after traditional treatment services have been terminated. Recovery management is not a new rationale for larger doses of residential/inpatient treatment or more outpatient counseling sessions. It is instead a call to wrap these traditional services in a larger web of pre-treatment, in-treatment, and post-treatment recovery support services that are delivered in the community. This is not to say that treatment and recovery support services cannot be delivered in a residential or outpatient setting, but that eventually, people must apply and refine the skills of recovery management in their natural living environments. Recovery management, with its emphasis on building and preserving recovery capital, extends the time over which services are delivered, but shifts the emphasis of these services from high-intensity, high-cost crisis stabilization services to proactive, lower intensity, and more sustained recovery support services. Expanding the Service Continuum Recovery management models extends the current continuum of care for addiction by including: 1) pre-treatment (recovery priming) services, 2) recovery mentoring through primary treatment, and 3) sustained post-treatment recovery support services.

— (W.L. White et al., 2003, p. 3)

In summary, the paradigm shift toward a recovery orientation and the developments in PRSS since 2010 have focused primarily on two of the three Triple Aims: improving the patient experience of care (Aim 1) and improving the health of the public (Aim 2). Developed in 2008, the Institute for Healthcare Improvement's Triple Aim framework influenced thinking about how behavioral health services ought to be delivered to people with SUD (Berwick et al., 2008). The framework promotes health system changes to improve the quality and population health outcomes at lower costs. For example, efforts to reduce the costs associated with substance use through primary prevention, harm reduction, and relapse prevention are consistent with this framework.

There has also been a paradigm shift among providers regarding the need for cultural humility as a necessary condition for delivering culturally congruent services and producing culturally congruent outcomes. While recognizing the importance of cultural competence in supporting quality of care among diverse populations (Betancourt, 2006), many recognize the importance of cultural humility and accountability as crucial for achieving health equity (Lekas et al., 2020). Accessing empathy and humility (Cabello-De la Garcia 2018) are the cutting-edge of provider efforts to improve quality outcomes for diverse populations, and this new emphasis is consistent with recovery values.

Recovery-oriented systems of care are a promising practice that may provide better care for patients and close gaps in an all-too-often-disjointed system. The

recovery orientation recognizes that the recovery process is lifelong, reflecting a substantially different approach from acute care services, resulting in improved patient experience. Furthermore, the expansion of PRSS and proliferation of RCOs and recovery-oriented systems of care over the past decade have helped make recovery more accessible to more of the population. Community-based RCOs and peer workers embedded in their recovery communities go beyond addressing the immediate need for substance use cessation to help people address the Social Determinants of Health (SDOH) challenges that present barriers to lifelong recovery. The growth of local recovery community organizations and other new community-based recovery support institutions is well situated to address SDOH and build recovery-friendly communities.

The role of peer workers is distinct from other roles in the provision of services to individuals impacted by addiction. According to a 2020 Government Accountability Office (GAO) report, SAMHSA notes that peer providers are not intended to duplicate or replace therapists, case managers, or other members of a treatment team. Peer providers can complement clinical treatment by offering non-clinical services to support recovery (United States Government Accountability Office, 2020). SAMHSA also states in this GAO report that PRSS may also serve as an alternative, rather than as a complement, to clinical treatment for SUD. For example, PRSS may function as an alternative for individuals who decline clinical treatment for SUD. In the same report, the Office of National Drug Control Policy noted that when peer providers stay engaged with individuals who decline treatment, the possibility of future treatment engagement can be maintained. (For a detailed description of the role of peer workers and PRSS, please see Appendix A. and W. L. White, 2006, 2009).

The next section provides an overview of the evidence for the effectiveness of PRSS that has emerged since SAMHSA's 2010 review. These updates have greatly advanced PRSS as an evidence-based intervention and contributed to its expansion to almost every US state, and coverage under Medicaid in most US states. However, the third Triple Aim – reducing per capita costs and addressing questions of population-level efficiency – has not yet been adequately addressed. We will explore these gaps and present what is currently known about PRSS costs and efficiency in the subsequent sections of this report.

PRSS as an Evidence-Based Intervention

A great deal of research has been conducted on the effectiveness of peer workers in treating chronic illnesses. The University of North Carolina's Peers for Progress Program, located in the Department of Health Behavior in the Gillings School of Global Public Health, was established in November 2015. Peers for Progress was founded in 2006 initially as a program of the American Academy of Family Physicians Foundation in conjunction with the American Academy of Family Physicians. The research they cite clearly demonstrates that peer support is a critical and effective strategy for ongoing healthcare and sustained behavior change for people with chronic diseases and other conditions, and its benefits can be extended to community, organizational and societal levels (Peers for Progress, n.d.).

Overall, studies have found that utilizing PRSS:

- decreases morbidity and mortality rates.
- increases life expectancy.
- increases knowledge of a disease.
- improves self-efficacy.
- improves self-reported health status and self-care skills, including medication adherence.
- reduces use of emergency services (Walker & Peterson, 2021).

Research on patients with cancer, cardiovascular disease, diabetes, dementia, hypertension, asthma, depression, and other mental illnesses has shown the effectiveness of peer support in learning how to manage a long-term chronic illness (Peers for Progress, n.d.). Additionally, peer providers of recovery support services report that, as a result of providing this support, they themselves experience “less depression, heightened self-esteem and self-efficacy, and improved quality of life” (Peers for Progress, n.d.).

The University of Michigan’s Behavioral Health Workforce Research Center found that peer workers, including Certified Peer Specialists, Peer Support Specialists, and Recovery Coaches, provide a variety of services that help patients:

- reduce symptoms and hospitalizations.
- increase social support and community participation.
- decrease the length of hospital stays and reduces the costs of services.
- improve well-being, self-esteem, and social functioning.
- encourage better recovery outcomes (Gaiser et al., 2021; Videka et al., 2019).

In a report on Peer Support Programs to Manage Chronic Disease, it was found that:

“Peer support is so effective in part because of the non-hierarchical, reciprocal relationship created through the sharing of experiences and knowledge with others who have faced or are facing similar challenges. This exchange promotes mastery of self-care behaviors and improves disease outcomes.”

— (Heisler, 2006, p. 8)

In addition, they found that both the intensity and mechanisms linking peer support to improved health outcomes are different from, and probably complementary to, those provided by clinical care services from professional healthcare providers (Heisler, 2006). Peer workers provide a level of hope and understanding that cannot be provided by someone who lacks personal, lived experience with the condition.

Similar to other chronic conditions, serious SUD often requires ongoing monitoring and recovery management to support continued remission, as well as providing early re-intervention should reinstatement of the disorder occur (Dennis & Scott, 2007; Kelly & White, 2011). This observation is one of the principal reasons why ongoing PRSS are recommended following medical stabilization and short-term care.

There has been dramatic growth in recovery-focused research, with profound results for the design of addiction treatment and recovery support services. In August 2017, Dr. John Kelly, with the Recovery Research Institute of Harvard, published his *Report of Findings from a Systematic Review of the Scientific Literature on Recovery Support Services in the United States* (SAMHSA & Recovery Research Institute, 2017). In his paper, Dr. Kelly provides a brief rationale for why recovery support services are essential to addressing substance use disorders, including the impact of alcohol and other drug use on the brain and changes in the nervous and neuroendocrine systems. He notes the psychosocial impact of substance use disorders on educational attainment, employment skills, social relationships, and involvement in criminal justice can leave individuals isolated from family and friends. These deficits in recovery resources, often referred to as “recovery capital” (Cloud & Garfield, 2004; Cloud & Granfield, 2008), can in turn create hopelessness, which can decrease resolve and the ability to tolerate and meet the demands and challenges of early recovery. Further, it can take an additional 4-5 years before the risk of meeting the criteria for SUD in the next year drops below 15% (the annual risk for SUD in the general population), as the central nervous system is repaired (Dennis & Scott, 2007; Kelly & White, 2011). In fact, earlier research by Kelly and Hoepfner (2015) indicates that higher recovery capital is associated with lower levels of cortisol, the body’s main stress hormone, which can support continued remission.

Specifically, the current body of research suggests that people receiving a PRSS may experience the following:

- Improved access to social supports (Andreas et al., 2010; Boisvert et al., 2008; O’Connell et al., 2017)
- Improved relationships with treatment providers and social supports (Eddie, et al., 2019)
- Increased treatment retention, treatment engagement and treatment satisfaction (Eddie et al., 2019; Magidson et al., 2021)
- Greater housing stability (Ja et al., 2009)
- Decreased criminal justice involvement (Mangrum, 2008; Rowe et al., 2007)
- Decreased emergency service utilization (Kamon & Turner, 2013; Magidson et al., 2021)
- Reduced relapse rates (Eddie, et al., 2019, Boisvert et al., 2008)
- Reduced re-hospitalization rates (Mangrum et al., 2018; Min et al., 2007)
- Reduced substance use (Armitage et al., 2010; Bernstein et al., 2005; Boyd et al., 2005; Eddie et al., 2019; Kamon & Turner, 2013; Magidson et al., 2021; Mangrum, 2008; Mangrum et al., 2018; O’Connell et al., 2017; Rowe et al., 2007)

Additional outcome data on PRSS are reported in the University of Texas Study, Fiscal Year 2017 Final Recovery Support Services Project (Mangrum et al., 2018). Evaluations of PRSS outcomes, called recovery coaching in the study, were conducted on the outcomes of 1,226 individual participants who enrolled in long-term recovery coaching and had completed the 3-, 6-, 9-, and 12-month check-up interviews following enrollment. Participant outcomes were examined in the following domains:

- Housing status
- Employment status and wages
- Abstinence or reduced substance use
- Improvement in recovery capital

The results from the 2018 evaluation by Mangrum and colleagues are encouraging and again reflect SAMHSA's model of recovery domains. Long-term recovery coaching participants demonstrated improvements at check-up points in a wide range of life domains, including:

- Housing status, with 54% of long-term coaching participants owning or renting their own living quarters at 12-month check-up, as compared to 32% at enrollment in long-term coaching.
- Overall employment, which increased from 27% at enrollment to 60% at 12-month check-up.
- Average monthly wages of employed participants, which increased from \$258 per month at enrollment to \$881 at 12-month check-up.

Additional positive outcomes for long-term recovery coaching participants included the following.

- 83% of participants were abstinent or had reductions in substance use at 12-month check-up.
- 71% had improved recovery capital at 12-month check-up.
- Healthcare service utilization decreased over the first 12 months of recovery coaching in outpatient settings (4,242 visits at enrollment; 835 visits at 12-month check-up), inpatient settings (9,362 days at enrollment; 1,122 days at 12-month check-up) and emergency rooms (433 visits at enrollment; 162 visits at 12-month check-up), saving an estimated \$3,518,948 in healthcare costs. This represents a 74% reduction in healthcare costs for 1,226 individuals between enrollment (\$4,745,073) and 12 months following enrollment (\$1,226,125) (Mangrum et al., 2018).

Another analysis of cost savings was completed by the Capital Area Behavioral Health Collaborative, Inc. (Capital Area Behavioral Health Collaborative, 2014). The purpose of the Recovery Specialist Program (RSP) analysis was to determine whether participation in the RSP led to a decrease in the utilization of Inpatient/ Non-Hospital Drug and Alcohol (D&A) services during participation in the RSP and after discharge from the program along with a subsequent decrease in costs. The RSP services were provided by the RASE Project, an RCO in Harrisburg, PA. The RSP provided one-on-one peer support to help individuals stay on the path to recovery. The Recovery Specialist worked with the participants to create recovery goals that included improved housing, vocational skills, and continuation of traditional treatment. The ultimate goal of the RSP was to increase an individual's recovery capital and improve their level of life functioning, thus aiding their ability to sustain recovery.

CABHC utilized encounter data from RASE for consumers who received services from June 2012 to August 30, 2013. Evaluation of the cost efficacy of the RSP examined the use of D&A services prior to and during the 15 months of the study. The study found that consumers utilized \$77,414 of D&A services prior to their participation in the RSP. If consumers utilized a similar amount of services during the entire reporting period without access to the RSP, total costs would have been approximately \$232,242. The actual total cost of service during the report period for all three categories, including the RSP, totaled \$192,073. The difference is a cost saving of 17% or \$40,169 for the 40 consumers in the study group. Additional savings would be generated over a longer period of time, as a result of consumers being more successful on their path towards recovery and utilizing fewer D&A services. The study found that the total costs for D&A services after participation in the RSP decreased by 58% compared to the costs for similar services prior to RSP.

This study also found that the type of service utilized by consumers changed from pre-RSP to post-RSP. There was high utilization of Non-Hospital Residential Rehabilitation and Halfway services prior to RSP. After participating in the RSP, consumers decreased their use of non-hospital residential rehabilitation and halfway services, and increased their use of outpatient services. Intensive Outpatient services showed the greatest increase in utilization after RSP services. (Recovery Specialist Program study, CABHC, 2014)

The analysis of cost savings is an important first step toward addressing the third Triple Aim of Improving Healthcare: reducing per capita costs.

However, if we are to fully assess economic impact, any potential cost savings must be examined in combination with the effects of these savings on an individual's whole health; quality of life and other outcomes must be fully integrated into the analysis. It is also important to recognize that cost savings cannot be realized at the expense of peer worker job satisfaction, long-term job retention, and paying a living wage. As in many helping fields, when service delivery is informed by cost-saving measures resulting in underpaid and overworked staff, the patient/client/consumer/peer is adversely impacted, as are the outcomes. It will be impossible to build an experienced peer workforce, as peer workers leave the field to find more financially sustainable careers.

However, several variables make it challenging to assess the effectiveness of PRSS. In 2019, Eddie et al. conducted a systematic review of PRSS and noted that PRSS researchers face significant issues, including the inability to distinguish the effects of PRSS from other recovery support activities, heterogeneous populations, inconsistency in the definitions of peer workers and recovery coaches, and a lack of appropriate or any comparison groups (Eddie et al., 2019). Furthermore, role definitions for PRSS and the complexity of clinical boundaries for peers working in the field represent important implementation challenges (Eddie et al., 2019). Additionally, the language used to describe peers differs from state to state, resulting in additional inconsistencies that present challenges in measuring outcomes.

Race, ethnicity, and cultural factors also have an impact on assessing the effectiveness of PRSS and on the ability to realize its full potential. Barriers to access include transportation, distance to PRSS providers, distrust in the systems delivering services, and language, making it difficult to assess the effectiveness of services that may be informally delivered and underreported. In rural communities, even having access to Internet services can impact connection with peer workers, either formally or informally.

PRSS is currently delivered in a variety of settings, and this flexibility in service delivery settings is one of the features that make PRSS a promising intervention. In addition to traditional settings like recovery community organizations and SUD treatment centers, PRSS is also delivered in general medical settings (Cos et al., 2020; Magidson et al., 2021; Watson et al., 2020), in emergency departments and emergency medical services (Ashford, Meeks, et al., 2019; Fabiano et al., 2019; Gertner et al., 2021; Langabeer et al., 2021; McGuire et al., 2020), services for people experiencing homelessness (Bardwell et al., 2018; Miler et al., 2020; Powell, 2012; Satinsky et al., 2020), parent peer mentors in child welfare settings (Berrick et al., 2011; Choi, 2015; Ryan et al., 2016), criminal justice settings including drug courts (Belenko et al., 2021; Hamilton et al., 2022; Nixon, 2020), HIV services (Latkin, 1998; Purcell et al., 2007), college campuses (Mastroleo et al., 2008), and harm reduction services (Ashford et al., 2018). However, this heterogeneity of settings can also pose a further challenge to research efforts, in part because PRSS may be implemented differently across settings and because different outcomes may be targeted across settings.

Several other systematic reviews of the PRSS database have highlighted the substantial variability in the assessed outcomes across studies (Bassuk et al., 2016; Chapman et al., 2018; Eddie et al., 2019; Gaiser et al., 2021). This is, in part, reflective of a general movement away from abstinence as the only measure of success for substance use recovery, and toward the use of more holistic measures to address quality of life and SDOH improvement. This presents a challenge to reaching the gold standard of evidence – the synthesis of multiple experimental studies into a meta-analysis (Brownson et al., 2009) – because identical outcome measures are not used across studies.

Many definitions of recovery include three dimensions: 1) positive changes in the person-drug relationship as measured by diagnostic remission or abstinence, 2) progressive improvement in global health and functions, and 3) repair of the person-community relationship (sometimes captioned as “citizenship”). These dimensions are reflected in the manner in which the effectiveness of the PRSS is measured. Common outcomes of PRSS that are used as measures of effectiveness can be divided into three categories: substance use changes, changes in holistic quality of life for the individual, and changes in factors related to the social determinants of health and healthcare utilization. Substance use changes include traditional measures of abstinence but also reductions in substance use or changes in substance use patterns (e.g., not using intravenously, not drinking to intoxication, changes in the frequency of use, etc.). Changes in holistic quality of life may use established measures of quality of life employed across multiple types of health issues, such as the WHO’s or EuroQOL quality of life measures (EuroQol Group, 1990; Feng et al., 2021; Skevington et al., 2004), or the use of more emerging measures such as the Assessment of Recovery Capital (Groshkova et al., 2013; Vilsaint et al., 2017), measures of social support, self-efficacy, and the use of a variety of other individual-level psychosocial states, including community engagement. It is important to recognize that the third dimension of “citizenship” relates to building social capital, which creates an environment that supports greater social change and healthier communities (Betty Ford Institute Consensus Panel, 2007; W.L. White, 2007).

The third category of outcomes relates to the social determinants of health and healthcare utilization. These may be constructed to match SAMHSA’s supporting domains of recovery: health, home, purpose, and community (SAMHSA 2012). Healthcare utilization changes measured as outcomes are a critical first step toward understanding the efficiency of PRSS. These are often measured as reductions in the use of costly emergency or hospital resources, adherence to medications that keep an individual stable and healthy (such as mental health medications, medications for comorbidities such as diabetes or cardiovascular disease, or medications that help treat substance use disorder), engaging in or completing SUD treatment, and adhering to regular medical visits that might not be directly related to SUD (for example, consistently attending visits with a peer worker, seeing a primary care doctor to manage a physical health concern, or consistently attending therapy for mental health concerns). Thus, while most studies have not yet focused on the third Triple Aim, several studies reviewed in this section have recorded some outcomes that give us a start toward understanding PRSS efficiency.

Social Determinants of Health and Recovery

The Centers for Disease Control and Prevention (2021) state that SDOH are the conditions in which people are born, grow, live, work, and age, as well as the complex interrelated social structures and economic systems that shape these conditions. Social determinants of health include aspects of the social environment, physical environment, and health services. These factors are linked to a lack of opportunity and resources to protect, improve, and maintain health; these factors are mostly responsible for health inequities and unfair and avoidable differences in health status seen within and between populations,

especially underserved and marginalized communities. In 2021, the CMS issued guidance for states to address the social determinants of health in order to improve outcomes and lower costs. While recognizing the flexibility of states to design different services to address the SDOH, it encourages states to consider existing authorities that already allow for housing, transportation, education, employment, and other services that address the social determinants of health (Costello, 2021).

Healthcare plans now offer programs that address community-based PRSS, reflecting a new focus on the social determinants of health. Many peers have become adept at navigating difficult systems, as well as having a finger on the pulse of available community resources. What makes PRSS unique is not only targeting each of these supports to people in recovery, but also the PRSS provision of emotional support and cultivating a growing network of trust-based relationships in the community.

The four dimensions of recovery support services developed by SAMSHA reflect this approach:

- Health—overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- Home—having a stable and safe place to live
- Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society
- Community—having relationships and social networks that provide support, friendship, love, and hope (SAMHSA, 2012, p. 3)

As noted above in research from the University of North Carolina, peer work also benefits peer workers themselves. In addition, there are other benefits to joining the peer workforce. Individuals with a history of substance use disorders often have a higher prevalence of criminal justice involvement as well as problematic educational and employment records. As a result, individuals in recovery frequently experience stigma and loss of opportunities, even for those who have a well-established history of recovery. Certification as a peer worker represents a path to career options that turn closed doors into opportunities, the “peer-to-career pipeline.” While the pay scale for peer workers is low, it is often higher and represents more stable employment in comparison to other options available for individuals with a history of the challenges mentioned above. Better employment can lead to improvements in economic stability, safer housing, and other key social determinants of health. Considering the current opioid epidemic, PRSS represents a path to rebuilding many lives, as an increasing number of individuals find themselves on a path to recovery.

Fidelity to the Model

When delivering any intervention or model of care, ensuring that these services are delivered as designed is critical. This is especially true in new fields such as PRSS. As Eddie et al. (2019) noted, there is significant heterogeneity in the implementation of PRSS. This may be one of the strengths of PRSS, in that it is provided in many different settings. In addition, PRSS is delivered in different durations and intensities to different populations. However, this presents many challenges to establishing practices and training standards for each combination of variation along each of those axes, as well as presenting challenges to economic analyses and, as already discussed, evaluating outcomes. Some studies indicate that the setting and organizational structures and values may have a significant impact on the effectiveness of peer recovery support services being delivered.

Fidelity to the model refers to the degree to which a practice model is delivered as intended. The elements of the practice model must be present and recognizable. This is important because programs with high fidelity to the model produce superior outcomes for individuals who receive the services of that program (Hrouda, 2015; T. Mowbray et al., 2003).

Fidelity criteria should include aspects of structure and process; structure encompasses the framework for service delivery, and process comprises the way in which services are delivered. This can be reflected in developing standards against which service delivery may be measured, as they relate to both organizational variables as well as interactions between the provider and the individual receiving services. They reflect key elements tied to staff roles, qualifications, training, supervision, as well as key principles associated with peer interventions and ensuring that peer support retains its distinctive relational qualities, in comparison to clinical-patient relationships. These standards should also be trauma-informed and reflect the need for cultural congruence in the delivery of PRSS. However, it should be noted that there is some tension between manualizing/standardizing practice and the ethos of person-centered, peer-driven recovery support services.

In *Developing and Testing a Principle-Based Fidelity Index for Peer Support in Mental Health Services*, Gillard et al. (2021) noted that evidence suggests that the distinctive relational qualities of peer support, compared to clinical patient relationships, can be eroded in regulated healthcare environments. They further state that the measurement of fidelity in trials of peer support is lacking and report on the development and testing of a fidelity index for one-to-one peer support in mental health services, designed to assess fidelity to principles that characterize the distinctiveness of peer support. We believe that fidelity to the model is an important unmeasured variable in program evaluations, which likely suppresses the estimated impact of recovery support.

The authors state:

It has been widely argued that peer support in mental health services is grounded in peer-to-peer relationships that are highly distinctive from clinical-patient relationships, with peer-to-peer relationships underpinned by:

- a sense of connection between peers based on the recognition of shared experiences.
- reciprocity in the relationship whereby both parties learn from each other.
- validation and exchange of experiential knowledge rather than professionally acquired knowledge (Gillard et al., 2021, p. 1903).

Peer-to-peer relationships are based on shared power, mutual learning, connection, and validation. This helps replace old social connections that incentivize substance misuse. These new peer-based connections form the basis for cultivating new relationships with others outside the peer-to-peer relationship, which models the underlying values and ethics displayed by the PRSS. This is how social capital, particularly its relational dimensions, begins to be built and spread at the community level (Claridge, 2018). The Oxford Dictionary defines social capital as “the networks of relationships among people who live and work in a particular society that enable that society to exist and be successful.” William White’s 2009 monograph on PRSS describes in detail the theoretical principles undergirding peer helping in the context of addiction recovery, which is critical for distinguishing clinical services and non-clinical peer recovery support services.

The Role of Recovery Community Organizations in Delivering PRSS

As mentioned above, fidelity encompasses both structural and organizational variables. We believe this is key to delivering effective peer recovery support services. Research has indicated that organizational factors related to the implementation of peer support can impact the extent to which peer workers feel able to make use of their personal experiences in supporting others (Gillard et al., 2013).

The Peer Recovery Fidelity Assessment Model proposed by Gillard et al., is based on four principle-based domains:

- Building trusting relationships based on shared lived experience
- Reciprocity and mutuality
- Leadership, choice, and control
- Building strengths and making connections to the community (Gillard et al., 2021, p. 1903)

This work offers a critical perspective on the importance of developing an organizational culture based on recovery principles and values (see Appendix A). Organizations that lack this culture are unlikely to provide the kind of environment necessary to support peer staff and deliver effective peer services and support. In addition, recovery values and principals reflect the kind of culture that many wider communities seek, as they see rising rates of disease and despair in their neighborhoods. There has been a steady trend toward the loss of social connections and trust within communities. (Mackinko, James and Bargara Starfield, 2001)

Brown's body of work on healing, shame and vulnerability addresses these issues (Brown; 2015, 2021). In her research, she found that connection gives purpose and meaning to our lives and that we are biologically wired for connection. People with high levels of shame fear connecting with others; they fear that they are unworthy and not good enough. However, in order for connection to happen, human beings have to allow themselves to be seen, to find a way of becoming vulnerable, and accept themselves as worthy. When shame and a sense of unworthiness are present, humans numb themselves to avoid feeling vulnerable. Addiction is one way in which humans numb themselves.

In the recovery field we often say that "addiction=isolation and recovery=connection." We recognize that the work done by peer workers is relational. It rests on the ability of the peer worker to be authentic and vulnerable, to share stories, talk about their mistakes and what they have learned on their recovery journey, to come from a place of compassion and forgiveness and lead from the heart. This is what makes PRSS transformative. Because of their lived experience, peer workers are unique in their ability to establish relationships based on trust, compassion, and non-judgmental approaches. They can "see" the person seeking recovery for who they are and accept and care for them. For this to occur, the work environment in which peer recovery support services are delivered must be built on trust and provide a sense of safety, both for staff and for those seeking and receiving services. This includes not only people seeking recovery but also those who use drugs.

This means that leadership and management need to create such an environment and act as role models of authenticity and vulnerability, which is a very different style of leadership and management than that found in traditional healthcare or clinical settings. This leadership style is important because it sets the tone for the entire organization. Leadership needs to create a work environment that allows peer staff to be vulnerable and authentic, so that staff can engage in delivering effective peer recovery support services. And leaders need to engage with and invite the staff to co-create such an environment, because it must be an organizational effort in order to succeed. RCOs and other community-based organizations delivering PRSS based on recovery values and principles are best suited to support an effective peer workforce.

The importance of creating a work environment that supports the joy and meaning of work is addressed by Sikka, Morath and Leape in their article on the Quadruple Aim; care, health, cost and meaning in work (Sikka, R., Morath

JM, Leape,L, BMJ Qual Saf. Published online: 10.1136/bmjqs-2015-004160). They noted that the core of workforce engagement is the experience of joy and meaning in the work of healthcare.

“By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfilment that results from meaningful work.....an engaged staff that ‘think and act in a positive way about the work they do, the people they work with and the organization that they work in.’ The absence of joy and meaning experienced by the majority of the healthcare workforce is in part due to the threats of psychological and physical harm that are common in the work environment. The current dysfunctional health care work environment is in part a by-product of the gradual shift in healthcare from a public service to a business model that occurred in the latter half of the 20th century. Complex, intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement. These forces have led to an environment with lack of teamwork, disrespect between colleagues and lack of workforce engagement. The precondition for restoring joy and meaning is to ensure that the workforce has physical and psychological freedom from harm, neglect, and disrespect. For a health system aspiring to the Triple Aim, fulfilling this precondition must be a non-negotiable, enduring property of the system. It alone does not guarantee the achievement of joy and meaning, however the absence of a safe environment guarantees robbing people of joy and meaning in their work. Cultural freedom from physical and psychological harm is the right thing to do and it is smart economics because toxic environments impose real costs on the organization, its employees, physicians, patients and ultimately the entire population.”

This article was written in 2015, and today it rings true more than ever. Considering the pressures felt worldwide in delivering healthcare during the COVID pandemic, workplace environment issues in the healthcare system have reached critical thresholds. This Quadruple Aim speaks to why organizational structures that support a safe environment are especially critical for Recovery Community Organizations. As noted above, a work environment that not only supports finding joy and meaning in work but provides an environment that allows coaches to be authentic and vulnerable, embracing “complex, intimate caregiving relationships,” is essential to fulfilling the transformative nature of PRSS. In addition, accreditation standards built on the values and principles of recovery are essential for establishing organizations that support a successful peer workforce.

Development of National Standards for PRSS

In response to the need for peer-based work environments to further refine performance and build capacity, FVR hosted a meeting of RCO representatives and allies in January, 2011. The purpose of the meeting was to explore the possibility of establishing an accreditation system for organizations and programs providing peer recovery support services (PRSS).

In the meeting, the participants were asked to share their expertise, raise questions and considerations, provide their best thinking on issues, and make recommendations related to the issue of accreditation. The group showed congruent thinking and fundamental agreement that: (a) a process should be established to create an accreditation program, including the development of standards focusing initially on PRSS; (b) the process should include the formation of an advisory board, composed of key stakeholders and Faces & Voices Directors for planning and startup; and (c) that ultimately, an accrediting body should be established.

Based on the recommendations from this convening, the FVR Board of Directors established The Council on Accreditation of Peer Recovery Support Services (CAPRSS) in 2013 to develop and implement an accreditation system for Recovery Community Organizations and programs providing peer recovery support and other services and programs. The CAPRSS is the only accrediting body in the U.S. specifically designed for Recovery Community Organizations (RCOs) and other programs offering addiction Peer Recovery Support Services (PRSS). Recognizing that these standards were initially developed by a non-diverse group of individuals in recovery, FVR will be revisiting these standards in the near future to assess them using a diversity/equity/inclusion lens.

The primary goal of the CAPRSS accreditation process is to evaluate the level of competency in various domains that assess the peer service(s) being delivered. Accreditation is sponsored by a non-governmental agency in which trained external peer and expert reviewers evaluate an organization's conformance with pre-established performance standards. Although it is usually voluntary, it is often a requirement set by diverse funders and purchasers of services. As of January, 2022, there are twenty-five accredited organizations nationally, which will become eligible for re-accreditation every three years from their original accreditation designation date.

The CAPRSS assesses the organization/program's ability to deliver PRSS as follows:

- Examining their ability to create the infrastructure necessary for peer service delivery, including standards-driven continuous quality improvement
- Reviewing their ability to facilitate and disseminate promising, best, and ultimately evidence-based practices
- Assessing their ability to reinforce recovery-based values and principles that underlie peer services and making them valuable and effective in supporting long-term recovery

Initially, FVR focused on accrediting peer-run organizations. RCOs are peer run, and by definition, a minimum of 51% of their boards include peers and family members. However, as federal and state funding to address the opioid overdose crisis has increased, and many providers have sought to add peer recovery support services to their programs, FVR now accepts accreditation applications from organizations that are not peer-based and wish to add a peer-based recovery program, including treatment and criminal justice settings.

This decision has not been without controversy in the recovery community. Critics of this decision voice concern about the authenticity of PRSS delivered in organizations that lack a recovery orientation of services or a board made up of 51% of individuals in recovery or their allies. The power of lived experience to inform the core of an organization and the services they provide cannot be lost and is invaluable. However, RCOs whose services are not based on recovery values and principles will be missing key elements of an effective PRSS. And recovery programs located in treatment and other provider settings or organizations not calling themselves RCOs that fully understand and utilize recovery principles and values and support peer staff may be able to deliver effective PRSS. It is not so much the name of the organization that matters, as it is the culture of the organization and the environment they create for staff and those being served. Recovery Community Centers and Recovery Cafés are also a part of the recovery community, as are organizations whose focus is on harm reduction or people who use drugs. Faces & Voices of Recovery has taken the lead in providing support to a broader spectrum of organizations that desire to learn from and develop a recovery orientation. FVR is well positioned to lead in this arena; nevertheless, great care should be taken not to weaken the essential elements of the recovery movement as it grows.

However, for the strategies and recommendations discussed in Sections 3 and 4 to be successful, an organizational infrastructure and mission beyond operating a recovery program are needed. We believe that RCOs have the opportunity to distinguish themselves as leaders in supporting community health, living out the values that led to the creation of FVR. This report offers a blueprint for how RCOs can help bring about transformative systems change through peer-led leadership based on the principles and values of recovery.



SECTION 2: Funding Peer Recovery Support Services

There are a variety of ways that peer recovery support services are financed in the United States. This section first presents information on federal funding, beginning with information on Medicaid benefits, roles, codes, rates, providers, and settings, followed by information on other federal funding provided by HRSA, NIH and the DOE. We then review the information on non-federal funding.

PRSS and Federal Funding

Currently, Medicaid, which is jointly funded by federal and state governments, is used in most states to pay for most PRSS. In August 2020, the United States Government Accounting Office (GAO) issued a report on Medicaid Coverage of Peer Support Services for Adults (United States Government Accountability Office [US GAO], 2020). The GAO estimated that 19.3 million adults have a substance use disorder (SUD) and about 4 million of these individuals are enrolled in Medicaid. The GAO notes that, in 2007, the Center for Medicaid Services (CMS) recognized that the experiences of peer providers could be an important component of effective treatment and provided information on how states could cover peer support services in their Medicaid programs.

While it was reported that only 37 states covered peer support services for adults with SUDs, there were actually 43 states in total. This variance can be attributed to six of these states using two authorities to cover the services. According to the Centers for Medicare and Medicaid Services, states can use the 1915 (c) waiver and the 1915 (i) state plan authorities to cover peer support services. However, the Medicaid and CHIP Payment and Access Commission (MACPAC) did not identify any states using these authorities to cover peer support for adults with a primary diagnosis of SUD at the time of data collection. Additionally, they referred to the District of Columbia as a state.

The GAO report (2020) and other data (see Table 1 on following page) indicate that 43 states covered peer support services for adults with SUD in their Medicaid programs. States that choose to cover peer support services in their Medicaid programs have several different options.

- States may choose to include coverage for PRSS under their state Medicaid Plans, which must be approved by CMS in order for states to receive the federal share of the Medicaid payments they make.
- States may seek permission from CMS to provide PRSS under waivers or demonstrations, which allow states to set aside certain, otherwise applicable, federal Medicaid requirements.

These various Medicaid strategies represent a significant challenge to sustainable funding for peer recovery support services. Issues include the lack of a common definition for PRSS, low reimbursement rates paid by Medicaid for PRSS, and lack of adequate compensation for peer workers. The use of waivers

reflects that states are trying to find ways to “work around” the system to pay for these valuable services. To develop a robust national delivery system for the PRSS, these issues must be addressed.

Table 1

Optional Medicaid Funding Authorities Available to States for Providing Peer Support Services

TITLE AND NUMBER OF STATES USING THIS AUTHORITY	AUTHORIZING STATUTE	DESCRIPTION
<p>State plan rehabilitative services</p> <p>23 States use this</p>	<p>Social Security Act 1905(a)(13)</p>	<p>Allows a state to cover, under its state plan, medical or remedial services recommended by a physician or other licensed health care provider, to reduce physical or mental disability, and restore a Medicaid beneficiary to the best possible functional level.</p>
<p>Medicaid Demonstration</p> <p>9 States use this</p>	<p>SSA 1115</p>	<p>Allows the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstration projects that, in the Secretary’s judgment, are likely to assist in promoting Medicaid objectives.</p>
<p>Certified Community Behavioral Health Clinics (CCBHC’s) Demonstration</p> <p>8 States use this</p>	<p>Protecting Access to Medicare Act of 2014</p> <p>Section 223 as amended</p>	<p>Authorizes funding for eight states for a 2-year demonstration or through November 30, 2020, whichever is longer, to certify and reimburse CCBHCs, which must provide access to a comprehensive range of treatment and recovery support services, including peer support services. Allows selected states to certify and reimburse clinics that provide a comprehensive range of treatment and recovery services, including PRSS.</p>
<p>Non-Medicaid Services Waiver</p> <p>3 States use this</p>	<p>SSA 1915(b)(3)</p>	<p>Allows states to use savings accrued from the utilization of cost-effective Medicaid managed care programs to furnish additional services to beneficiaries over and above those in its state plan.</p>

Source: US GAO, 2020.

PRSS Settings and Medicaid

There is also considerable variety regarding where adults with SUD are able to receive Medicaid-covered PRSS. Data on this was available to the GAO for 25 states and data from MACPAC was used (US GAO, 2020). Of these 25 states, at least 19 allowed PRSS to be delivered in multiple settings. Depending on the state, PRSS can be delivered in a clinical setting, such as a behavioral health clinic, in a residential treatment facility, or in hospital emergency departments. It can also include PRSS being delivered in non-clinical settings such as homes, workplaces, places of worship, and parks. Harm reduction programs and street outreach programs may also be used for PRSS delivery.

The most frequently cited settings for peer support were outpatient provider sites such as behavioral health clinics and substance use treatment centers. In addition, PRSS is frequently provided on a one-to-one basis. However, the MACPAC data also indicated that at least 16 states covered PRSS provided to groups, including other adults with SUD or members of the beneficiary's family or support network.

The GAO (2020) also selected three states to study in more detail; Colorado, Missouri, and Oregon. These states offered PRSS as a complement to, rather than as an alternative to, clinical treatment for SUD. Some of the findings are as follows.

- Missouri reported that peer providers were part of a treatment team that worked in conjunction with doctors, nurses, therapists, and case managers.
- Colorado and Oregon reported that PRSS was offered only as part of a treatment plan.
- All three states covered PRSS as a “stand-alone” service, billed by clinics where the peer providers worked, in 15-minute increments.
- None of these states allowed peer providers to bill Medicaid independently. None of the states required prior authorization in order to provide PRSS.
- Colorado paid five Medicaid MCOs capitated monthly payments to coordinate care and administer behavioral health services, including PRSS, under a 1915(b)(3) waiver. State officials noted that there were no incentives in their contracts with the five Regional Accountable Entities (RAE) to encourage the use of PRSS, and they were not required to contract with facilities that had peer providers on staff. However, they noted that there might be an inherent incentive for RAEs to provide PRSS since they are paid a capitated rate and that PRSS might prevent individuals from escalating to higher, more expensive levels of care.
- Missouri combined a CCBHC demonstration option with their rehabilitative services state plan to provide PRSS using a fee-for-service system. SUD services were carved out of the managed care contracts held by the state. Missouri also used a 1115 demonstration option for specific community health centers in St. Louis County, using capitated benefits.

- Oregon paid 15 Medicaid MCOs, called Coordinated Care Organizations, capitated payments to deliver both physical and behavioral health services, including PRSS, under their rehabilitative services state plan and CCBHC demonstrations. While there were no built-in requirements for the CCOs to have peer providers available, state officials stated that doing so might help the CCOs meet certain performance expectations, such as reducing emergency department use. As of December 2019, Oregon was in the process of applying for an 1115 demonstration that would allow PRSS to be provided by community-based peer-run organizations, led by individuals with lived experience of mental health or substance use conditions. Oregon's application for this waiver noted that peer-run organizations would expand the network of available providers and more effectively engage individuals who may be reluctant to access care in clinical settings.

PRSS and Medicaid Benefits

The Medicaid and CHIP Payment and Access Commission (MACPAC) issued a report entitled *Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder* (2019). They note that, historically, Medicaid payments for RSS were mainly limited to beneficiaries with mental health conditions and less common for states to pay for these services for beneficiaries with an SUD. This has changed due to two factors: the opioid epidemic, which has disproportionately impacted Medicaid beneficiaries, and the Patient Protection and Affordable Care Act (ACA). The ACA established SUD and mental health services, as well as rehabilitative services, as essential health benefits for individuals purchasing coverage in the individual insurance market and those newly covered by Medicaid.

This report notes that recovery support services are not defined in federal Medicaid statutes, regulations, or in policy guidance. As a result, there is wide variation in how states define and pay for these services in Medicaid, as noted above. Several states reported that they use the SAMHSA description of recovery as having four dimensions: home, health, community, and purpose.

MACPAC found that this lack of definition presented a challenge to even being able to conduct a survey of the 50 states to determine what is provided across the nation. As a result, MACPAC developed a framework consisting of five distinct service categories of RSS:

- Comprehensive Community Supports
- Peer Support Services
- Skills Training and Development
- Supported Employment
- Supportive Housing

The survey of 50 states and the District of Columbia showed that these services are offered to varying degrees across the states for beneficiaries with a SUD:

- 27 states cover some form of Comprehensive Community Supports
- 37 states cover some type of Peer Support Services
- 11 states cover some form of Skill Training and Development
- 11 states cover Supported Employment
- 4 states cover some form of Supportive Housing

Peer Support Service Roles and Medicaid

The findings of the GAO (2020) report are also confirmed by an earlier March 2018 report from OPEN MINDS, entitled *State Medicaid Reimbursement for Peer Support Services* (OPEN MINDS, 2018). The OPEN MINDS report found that peer support services vary widely by program and state. The service roles played by peer specialists include the following:

1. Recovery Coaches
2. Whole Health and Wellness Coaches
3. Community Treatment Teams
4. Transition Team - bridge consumers from hospitals to the community
5. System Navigators
6. Insurance Navigators
7. Data Collection
8. Supported Employment
9. Supportive Housing

These roles are also reflected in the five distinct service categories outlined in the MACPAC 2019 report.

The responsibilities of peer workers may overlap with those of a case manager in a typical implementation (Blash et al., 2015; Gaiser et al., 2021). This can lead to confusion within care teams about the role differentiation between peer workers and case managers, especially if both roles exist within care teams, or can lead to the creation of a “consumer case manager” role (Blash et al., 2015). Added confusion may also arise from certifications being confused with job titles. For example, Pennsylvania has a Certified Recovery Specialist (CRS) state certification, CRS job positions, and job positions for CRS that are not entitled CRS.

Role definition and a clear differentiation of job responsibilities are important to ensure that the operationalization of PRSS is consistent and done with fidelity to the model. It is also important to keep peer workers within their scope of practice and maintain a reasonable workload. Having a reasonable workload may lead to better retention of peer workers because of its association with

job satisfaction. One study of mental health peer workers found that peer workers who had significantly higher workloads (Black/African American peer workers) also had significantly lower job satisfaction compared with white peer workers (O. Mowbray et al., 2021). While differentiating the peer worker role from the role of a 12-Step sponsor and from a clinical therapist has been the focus of previous efforts (W. L. White, 2006), differentiation from a case manager and other important behavioral health roles is a key future direction. While there may be elements of these services in PRSS, case managers and care coordinators do not bring lived experience to the table. These clinical roles are not based on building trust, being vulnerable, or communicating authentically.

MACPAC (2018) found that Case Management is an important component of building a continuum of care for an individual's continued recovery. They concluded that in order to support continued recovery, individuals need progressive clinical treatment, such as outpatient services and medication assisted treatment, as well as non-clinical supports such as recovery services. MACPAC's survey of 50 states found the following.

- Ten states covered some form of recovery management for certain beneficiaries with SUD.
- Seventeen states covered transitional case management for a patient following discharge from a hospital or a facility-based care.
- Forty-one states covered targeted case management for certain Medicaid SUD beneficiaries, giving them access to needed medical, social, educational, and other services.

Several states, including California, Illinois, Indiana, Rhode Island, and West Virginia, use Section 1115 to provide comprehensive, clinically appropriate SUD care.

PRSS and Medicaid Codes

Medicaid reimbursement is primarily made to the organization employing a certified peer specialist rather than to the individual peer worker, as can be done by Medicaid clinical professionals. The billing Codes used are as follows:

- For general services:
 - H0038: Self-help/peer services for 15 minutes
 - H3008 HQ group, per 15 minutes
- For specific services:
 - H0039: Assertive community treatment, face-to-face, per 15 minutes
 - H0040: Assertive community treatment, per diem
 - H0025: Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)

PRSS and Medicaid Rates

The 2018 OPEN MINDS report found that RSS rates ranged from \$1.94 for 15 minutes of group therapy to \$24.36 for code H0038. According to data from ADP supplemented with statistics from ZIPRecruiter, the cities with the highest average salaries have hourly wages ranging from \$19.50 to \$21.84. Given an average fringe rate of 30% (based on data from the Bureau of Labour and Statistics), this would be equivalent to \$25.25 to \$28.39. This suggests that MCD rates would not be capable of compensating for just the wages of PRSS in these cities, and that is just for the services. These costs exclude time outside of consultation or administrative costs. Reimbursement rates this low make it impossible for RCOs to serve Medicaid clients without incurring substantial losses. Even states with rates above these very low rates do not cover the direct or indirect costs for delivering peer recovery support services.

The low rate of reimbursement for these services continues to be problematic and does not support the sustainable development of recovery community organizations or similar non-profits offering PRSS, much less support building the capacity as states face the opioid epidemic and the rising use of alcohol and drugs in the face of the COVID pandemic. An August 2020 publication in Health Services Research, *The Effects of State Regulations and Medicaid Plans on the Peer Support Specialist Workforce* (Page et al., 2020), examined national directory data from the 2018 National Survey on Substance Abuse Treatment Services (N-SSATS) and the 2018 National Mental Health Services Survey (N-MHSS). The authors then pulled all the state regulations of peer provider licensing/certification, service authorization, and Medicaid reimbursement. Their statistical analysis suggests that increasing the Medicaid reimbursement rate for peers and creating a state-regulated peer credential (license or certification) could improve the rate at which MHTX and SUDTX facilities offer services within states. Since recovery community organizations were not included in the N-SSATS or N-MHSS directories, no data related to RCOs was included. However, it is clear that increasing Medicaid rates would also result in an increase in services at recovery community organizations in states where RCOs can bill Medicaid.

PRSS and Medicaid Providers

The MACPAC (2019) survey also found a wide range of providers paid by state Medicaid programs to deliver RSS from peers to physicians. In most states, paraprofessionals provide RSS and bill Medicaid. Peer workers provide recovery management services as well as one-on-one peer support and employment support. They engage in a wide array of activities including advocating for people in recovery, leading recovery groups, mentoring, and setting goals.

The types of providers include the following:

- Certified Recovery Support Specialists
- Certified Family Support Specialists or Family Support Peer Advocates
- Certified Peer Recovery Coaches
- Youth Peer Support Specialists

Most often, peers are individuals who are in recovery themselves from a behavioral health condition and have obtained specific training and met certification requirements defined by the state. Peer workers' training, education, certification, and practice requirements vary significantly from state to state. There are no national standards at this time, and the quality of the training, key content, and required length of the training vary. RCOs that employ peer workers can evaluate what additional training would be beneficial beyond state requirements as a part of staff development. As research provides additional information on what the key elements are and what makes PRSS effective, training and education need to be updated.

In addition, MACPAC found that professionals, including social workers, psychologists, and addiction counselors, can typically bill for RSS, including skills training and development, and comprehensive community support services. In some states, physicians, nurse practitioners and physician assistants can also bill Medicaid for RSS. As discussed, having clinicians deliver peer recovery support and services is problematic, at the very least, and likely to be ineffective, as unique elements will be missing. In order to ensure peer support is delivered in the way that people in recovery desire, delivery of PRSS should be restricted to peers.

PRSS and Medicaid Funded Settings

Medicaid reimburses PRSS in clinical settings, such as outpatient behavioral health providers, as well as in community settings, such as beneficiaries' homes or workplaces. A few states restrict the delivery of RSS to behavioral health treatment facilities, which means that recovery community organizations are underutilized. Many of the individuals interviewed stated that they prefer that RSS be made available across the continuum of care, rather than being limited to specific treatment settings, such as residential treatment, including once treatment is complete.

The availability of where individuals can access peer recovery support services is a limiting factor and has a structural impact on the development of a robust recovery-oriented system of care and recovery-based community solutions. This system issue needs to be addressed. The current Medicaid system supports a medically based model in which recovery is based within a clinical treatment model and is available post-treatment. In medical settings, treatment is administered to achieve stability/normal range of functioning with minimum follow-up (e.g., 3 months, 6 months, or 1 year). Treatment plans are developed by clinical staff and are not person-centered, strength-based, or generated by the recipient of the plan, as is a recovery plan. In addition, clinical and medical language often does not translate well to peer and SUD services. The Medicaid system does not reflect current research on addiction as a chronic illness, where three to five years of long-term engagement is required for successful recovery.

Federal Grant Funding

SAMHSA Funding

The MACPAC report *Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder* (2019) also details the use of Non-Medicaid Funding for RSS. SAMHSA has made funding available for these services through numerous programs, including:

- Access to Recovery Grants
- State Targeted Response to the Opioid Crisis Grants
- Substance Abuse Prevention and Treatment Block Grants

Importantly, the MACPAC report notes that there is a need to identify a long-term source of funding for RSS. Stakeholders must use multiple funding streams to provide comprehensive RSS to Medicaid beneficiaries. Grant funding is often used as a way to compensate for restrictions imposed by Medicaid on payment for certain services needed by the population being served, such as housing and food. This again points to the discussion in Section 1 on the social determinants of health and the need to meet basic wellness requirements.

The Substance Abuse and Mental Health Services Administration has paid for peer recovery support services through Building Communities of Recovery (BCOR) funding opportunities, among other mechanisms. Rather than reimbursing PRSS in a fee-for-service payment system, BCOR and other similar grants would support all or a portion of a peer worker's salary, delivering PRSS more flexibly than fee-for-service models may allow. Leaders of mental health peer-run organizations were surveyed in 2012 about their willingness to accept Medicaid reimbursement for mental health peer services and indicated concerns about the compatibility of a recovery orientation of services with fee-for-service reimbursement as well as concerns about the lack of sufficient staff to manage billing (Ostrow et al., 2017). Funding mechanisms such as BCOR allow recovery community organizations and other organizations where PRSS are delivered to structure budgets and pay for PRSS in ways that are compatible with the mission and capacity of the organization.

It should be noted that Federal grants are often used to provide funding for the salaries of the SUD peer workers, the result of which is that the salary is set by the organization submitting the grant. According to a June 2022 aggregation of reported certified peer workers, the average hourly rate is \$16.33 (Annual salary of \$38,061 with a range of about \$13.00 to \$21.00 (Indeed.com, 2022). This is particularly important during the substantial increases in cost of living across many US regions since the COVID-19 pandemic. Medicaid reimbursement rates set by each state may not be able to keep pace with cost-of-living increases, whereas grants that allow organizations to set their own employee salaries may offer more flexibility to address these concerns. Furthermore, multiple funding streams can create disparities in the delivery and reporting of PRSS and reimbursement rates within the same organization. For example, grant funding streams may allow for more flexibility in delivering PRSS and a higher wage/

salary for the peer providing those services under the grant funding stream, whereas the delivery of PRSS under Medicaid may result in a lower wage/ salary and more restrictive delivery of PRSS. Differing funding streams may also create additional barriers to the delivery of PRSS through the burdensome documentation of the PRSS. This is evident in organizations that have diverse funding streams with PRSS delivered through grants, contracts, and Medicaid.

Block grant funds are received by each state from the federal government to support behavioral health services. Each state has discretion regarding how these funds are spent. Funds are provided by SAMHSA for Community Mental Health Services (MHBG) and Substance Abuse, Prevention, and Treatment (National Association of State Alcohol and Drug Abuse Directors, 2021; Substance Abuse and Mental Health Services Administration, 2017). Block grants are non-competitive grants used to supplement Medicaid, Medicare, and private insurance services. Specifically, they fund:

- Priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time
- Priority treatment and support services that demonstrate success in improving outcomes and/ or supporting recovery that are not covered by Medicaid, Medicare, or private insurance

SAMHSA requires states to “set aside” a percentage of the appropriated amount to cover its costs for data collection, technical assistance, and program evaluation, as well as a baseline allotment. The baseline allotment is calculated based on the relative shares of the Population-at-Risk, Cost-of-Services and Fiscal Capacity Indexes. Some states have made substantial investments in recovery support services, including peer support services, RCOs, recovery housing, and recovery workforce development, using SAPT Block Grant funds. Recovery stakeholders are currently advocating for SAMHSA to require each state to “set aside” ten percent of the SAPTBG specifically for RCOs and PRSS. This would be an important step in providing stable, sustainable funding for PRSS and RCOs.

In addition to funds received by the federal government through Block Grants and other grant funding, states also use general revenue funds, as well as dedicated funds from the governor’s missions or task forces. Funds from lawsuits brought against pharmaceutical companies implicated in unethical practices during the opioid public health emergency may also provide important, if temporary, funds for some states. Lessons learned from the tobacco industry lawsuit settlement funds may provide important guidance on how these funds are allocated (Sharfstein & Olsen, 2020).

Health Resources & Services Administration Funding

The Health Resources and Services Administration (HRSA) offers multi-year funding for rural communities to address barriers to the treatment of opioid use disorders and other substance use disorders that the community may consider a priority. The grants are available to communities in HRSA-designated rural areas with a demonstrated need to address substance use. The Rural Communities Opioid Response Program (RCORP) provides funding and technical

assistance for communities to develop and convene a regional coalition of multisector stakeholders (e.g., behavioral health providers, residents with lived experience, homeless/housing sectors, criminal justice system, communities of faith) to conduct an assessment and prepare an action plan to address use of opioids and other substances. Additional grant funding is available for the plan implementation. Since 2018, HRSA has invested over \$400 million across 1,500 counties (Health Resources Services Administration, 2022). RCORP initiatives offer the opportunity to reduce silos and work at community and system levels to address barriers to SUD prevention, treatment, and recovery.

The Health Resources & Services Administration (HRSA) has relatively recently begun to fund the training and development of the substance use disorder peer workforce. One recently concluded funding opportunity entitled the Opioid Workforce Expansion Program (OWEP) for paraprofessionals provided up to \$3,000 in scholarships per trainee in addition to supporting some administrative costs of training programs (Health Resources and Services Administration [HRSA], 2021). A recent expansion of HRSA's Behavioral Workforce Education and Training funding opportunity to include paraprofessionals further expands OWEP by providing both the \$3,000 in scholarships, and an additional stipend of \$5,000 per trainee to offset the financial burden of experiential training required by many states for peer worker certification (HRSA, 2021). Although HRSA workforce development grants do not fund the provision of peer recovery support services, they are an important and relatively recent mechanism by which the expansion of the peer workforce can be promoted.

State, County, and City Funding

The University of Massachusetts Medical School (UMASS) conducted a December 2018 study, *Recovery Coaches in Opioid Use Disorder Care*, prepared for the RIZE Foundation (London et al., 2018). The study conducted interviews with ten programs and found that state and county entities frequently administer federally funded grants or use other public grants to fund recovery coach programs.

For example, Communities for Recovery (CforR), an RCO in Austin, TX, has a number of grant-funded contracts. CforR currently receives funding from Travis County as a sub-recipient of a SAMHSA grant to serve the Family Drug Treatment Court. CforR also has a contract with the county's local Mental Health Authority, Integral Care. In addition, they have contracts with the City of Austin for the Downtown Community Court and the Office of Public Health. A third subrecipient contract with the city is through a partnership with the Texas Harm Reduction Alliance. All these contracts serve individuals below 200% of the poverty rate; many are also either unhoused or formerly unhoused. Furthermore, CforR is in the process of developing additional contracts through the county, including a community-based Federally Qualified Health Center (FQHC).

Sobering centers may also employ peer workers and are often funded by local governments at the city or county level (Warren et al., 2016). Sobering centers are alternatives to jail or emergency departments for individuals who are

publicly intoxicated, but not otherwise suffering from a medical emergency due to that intoxication (Warren et al., 2016). For example, the Sobering Center in Houston, Texas receives a budget of \$1.64 million from the City of Houston, and the primary staff on site are state-certified SUD peer workers who work in concert with psychiatric technicians to serve acutely intoxicated individuals and connect them to appropriate services prior to discharge (Jarvis et al., 2019).

Health Insurers

The UMASS study (London et al., 2018) notes that private insurers are beginning to cover recovery coach services on a limited basis. In Massachusetts, Aetna Insurance agreed to fund recovery coach services for individuals enrolled in its programs and several private health plans employed their own recovery coaches.

The UMASS paper also notes that a strong recovery coach workforce needs sustainable financing that can be relied upon year after year. The study found that most recovery coach programs reviewed were funded through grants that required annual renewal. Although grant funding provided much appreciated flexibility, it did not provide sustainability. Some programs were working on developing the infrastructure needed to bill third parties, particularly Medicaid. In addition, some RSS providers were concerned that trying to utilize a medically oriented system, such as Medicaid for revenue, would have a negative impact on the peer-driven model.

Health Care Plans and Private Providers

There has been an explosion of national interest and investment in peer recovery support substance-use services, including recovery services. Middle Market Growth notes that as the demand for drug and alcohol rehabilitation facilities continues to rise, private equity firms see an opportunity to help patients receive care. According to an analysis conducted by Provident, a leading investment banking firm specializing in mergers and acquisitions, strategic planning, and capital formation, addiction treatment has rapidly become one of the sought-after subsectors of healthcare services for investment. They identify a multitude of key factors at both macroeconomic and microeconomic levels that have promoted the flow of private equity dollars into the sector.

“Given the varied treatment settings for addiction treatment services, private equity firms are attracted to the multitude of options available for growing a portfolio investment within the sector across a number of services, payors, and geographical segments.”

For example, in 2019, Austin, Texas-based MAP Health Management (MAP), a leading national provider of peer recovery support services, announced an investment by Triton Pacific Capital Partners, LLC. This investment is in addition to the \$25 million capital round MAP announced closing in March 2019, which was headed by Aetna, a CVS Health Business.

Joseph Davis, Managing Partner at Triton Pacific, said, “MAP’s important mission of providing ongoing care for the chronic disease of addiction through leveraging peer services is filling a very substantial gap in the addiction treatment space. We’re thrilled to invest in MAP and help power the company’s national expansion of treatment providers and health plans.”

Ophelia, a New York-based provider of virtual opioid disorder treatment services, landed \$15 million in Series A Funding. They raised another \$50 million in a Series B funding round. RCap Equity, a Philadelphia private equity firm, made a growth investment in Ascension Recovery Services in 2020 (Coward, 2021; Larson, 2021). The addiction treatment market is estimated to be worth \$42 billion and has grown alongside the nationwide rise in substance use disorders (Albinus, 2021).

This is part of the overall growth trend for private equity investments in the US healthcare industry. According to Bruch et al., (2020), private equity investments in US Healthcare grew from \$23.1 billion to \$78.9 billion from 2015 to 2019. Private equity investment in the addiction treatment industry is likely to lead to increasing concentration with larger providers operating facilities across multiple states. Equity investment offers investors the potential for greater returns through innovation or improved efficiency. It is unclear how private equity would impact peer workers. On the one hand, equity investors may be willing to support peer worker interventions depending on how the intervention impacts the organization’s bottom line—which depends on the reimbursement practices of the organization’s payors. Value-based care arrangements that incentivize maintenance of recovery would provide support for peer worker programs. On the other hand, the desire for efficiencies may incentivize lower wage offers and higher caseloads for peer workers. Notwithstanding these opportunities and threats, the recovery community should be prepared for the competition that a more consolidated addiction treatment industry would entail. Additionally, private equity investors may be willing to fund innovative models that involve peer workers to demonstrate proof of concept. Such opportunities may involve more local-level enterprises at municipal and regional levels.

What is clear from this review of both federal and non-federal funding sources is that the current funding system falls short of providing sustainable funding for peer recovery support services, recovery community organizations or other organizations delivering authentic PRSS in peer-led settings. It also appears that, as PRSS increases in popularity as an effective approach to addressing substance use and addiction, for-profit companies and health insurance providers are adding these services to their health care programs and plans. However, in doing so, they may overlook the very organizational elements that lead to PRSS being an effective intervention. Without the presence of a strong organizational recovery culture built on recovery principles and values, PRSS outcomes may vary in their effectiveness.



SECTION 3: Cultivating the Value of Peer Recovery Support

Introduction

As discussed in Section 1, peer workers emerged as a profession during a period of health reform and a rise in diseases of despair. These trends influence how the behavioral health system delivers care to people struggling with substance use, which, in turn, shapes the employment and professional development of peer workers. From these trends, we sense an emerging future that develops peer recovery support services as a critical component of a science-based approach to recovery, liberated from the structural constraints that inhibit transformative systems change.

This chapter provides a summary of the trends that have shaped the current opportunity structures for transformative systems change. We identify two leverage points at which RCOs and other recovery advocates can intervene to produce larger shifts in complex systems that shape substance misuse and recovery. Based on an underlying theory of change, we expect that these shifts will uplift the peer recovery support services profession, greatly reduce relapse through peer and other recovery supports, and foster the development of recovery-ready communities across the US.

Emerging Innovations Offering Leverage for Transformative Change

Because substance misuse has historically been viewed as a moral or criminal justice issue, rather than a treatable medical condition, resources for prevention and treatment have often been limited. This social/cultural lens has revealed significant disparities and inequities, and transformative changes must include efforts to address these issues. Developing culturally informed PRSS systems, increasing Black, Indigenous and People of Color (BIPOC) PRSS providers and BIPOC-led organizations that provide PRSS, and creating space for BIPOC recovery leaders to emerge and receive recognition are all needed in a system that supports harm reduction, recovery, and wellness for BIPOC community members.

The greater recognition of SUD as a treatable disease and the desire to increase resources for treatment has accelerated efforts to integrate behavioral health with medical care. As noted in Section 1, the Institute for Healthcare Improvement's Triple Aim framework has recently influenced thinking about how behavioral health services should be delivered to people with SUD.

Section 1115 waivers allow states flexibility to implement innovative delivery system reforms to reduce costs and improve Medicaid efficiency. The Center for Medicare and Medicaid Services (CMS) has expressed interest in working with states to provide a continuum of care for people struggling with addiction. A letter to state Medicaid directors, CMS (2017), offered guidance

on applying for waivers to address the opioid epidemic. This included a set of goals and milestones for the proposed 5-year demonstrations. The proposed demonstrations utilizing peer support can support several of the six recommended milestones, particularly for improved coordination and transitions between levels of care and comprehensive treatment and prevention strategies.

This is an example of how the Affordable Care Act (ACA) accelerated innovative approaches to achieving the Triple Aim. The CMS's value-based programs involve several innovative financing methods to ensure that providers are paid for quality rather than volume. The CMS Innovation Center nurtured delivery systems and payment innovations for both Medicare and Medicaid. For example, the Patient Centered Medical Home (PCMH) is a model designed to provide comprehensive, coordinated, patient-centered primary care. Over 500 PCMHs have been implemented across the country (Appold, 2021). CMS offers the Medicaid Medical Home Plan option to develop similar models as an option for Medicaid managed care organizations (MCO).¹ In response to ACA, MCOs in a number of states, particularly those that expanded Medicaid, have integrated substance abuse benefits with physical health and mental health benefits, and many states have explored ways to integrate social services for beneficiaries with SUD (Centers for Medicare & Medicaid Services, 2019).

Recent innovations go beyond meeting an individual patient's social needs to actively engage in community transformation through cross-sectoral collaboration. For example, FQHCs implementing the Community Centered Health Homes model (Cantor et al., 2011) go beyond screening and matching patients with services. Rather, the model involves FQHC leadership taking an active role in addressing the social determinants of health in their communities. By improving the environments in which patients, their families, and neighbors live, learn, work, play, pray, and transport, community stakeholders can address the root causes that determine how patients present in the clinic. These efforts can be seen as a continuation of the movement to build healthy communities and reduce health inequities through policy, systems, and environmental change. A common approach is to convene local or regional stakeholders from multiple sectors to assess, plan, and implement the plans (Cantor et al., 2011; Woulfe et al., 2010).

The current environment is fertile ground for introducing a greater focus on treatment, prevention, and recovery. Peer specialists already link clients in recovery with tangible assistance such as housing and transportation, which are two important social determinants of health. Recovery community organizations already foster connections with social service agencies, to whom peer workers refer to their clients. They are ideal conveners for recovery-related assessment and planning. The recovery-ready ecosystem model (Ashford, Brown, et al., 2019) provides a systematic framework for building a recovery-ready community that prevents substance abuse, promotes harm reduction, and ensures that people in recovery have needed supports to prevent re-occurrence of use.

¹ This and other options involve waivers that facilitate delivery system improvements. For example, by law, federal Medicaid dollars can only be allocated to medical care. However, certain waivers provide support for home- and community-based services to facilitate long-term care.

This suggests that the seeds are already sown for new and more efficacious approaches to recovery. However, a clear understanding of the lay of the land is required before cultivating the field. In the next section, we discuss the potential value of peer recovery support and the factors that limit this potential.

The Unrealized Potential of Peer Recovery Support

As discussed in Section 1 on the Value of PRSS, research has shown that the risk level of SUD among individuals in recovery takes approximately 4-5 years to decrease the risk level to that of the general population (Dennis et al., 2007; Dennis & Scott, 2007). During this time frame, higher-than-average stress hormones render these individuals more prone to return to stress-induced substance use (Kelly & Hoepfner, 2015; Stephens & Wand, 2012). Stress hormones also impair the cultivation of new skills, which can make it challenging for people in recovery to learn to cope with stressors involving place, people, and mood states.

By design, peer workers are poised to play a leading role in reducing re-occurrence of use by supporting those that are most challenged by these stressors. Peer workers help people draw upon recovery capital to sustain recovery over the long term. They build an individual's recovery capital by offering four sources of support: (1) tangible support (e.g., linkages to jobs and housing), (2) informational support (e.g., advice), (3) emotional support (e.g., compassion, empathy), and (3) social support (e.g., sense of belonging). This supports the building of resilience and buffers stress during the recovery period. Evidence indicates that recovery capital is associated with reduced serum CRH/ cortisol levels, which can support continued remission (Kelly & Hoepfner, 2015).

Research suggests that a large segment of the recovery population could benefit from PRSS. Although many in this population will recover from alcohol and other drug problems after several quit attempts, a significant number struggles with chronic re-occurrence of use. For example, the distribution of quit attempts among those with alcohol and other drug problems is highly skewed, with an average of 5.4 quit attempts (with a standard deviation of ± 13.4). This suggests that a very large population with severe SUD continues to struggle with relapse (Kelly et al., 2019) over multiple years. Many of these individuals are likely to be exposed to multiple social stressors and could substantially benefit from a trustworthy partner who can help them build the recovery capital needed to prevent re-occurrence of use. In a systematic review of the scientific findings on peer-based recovery services, Kelly (2017, p.9) confirms: "Taken together, results from the emerging P-BRSS [peer-based recovery support services] literature suggest P-BRSS may have potential to reduce substance use and increase treatment engagement and adherence."

Unlocking Potential at Multiple Levels

The current behavioral health delivery system is focused primarily on acute-care medical stabilization and has insufficient funding for long-term recovery management and support services. Waivers required to incorporate wraparound and other community support involve transaction costs that can constrain

the spread of innovations. These factors result in a system that fails people in recovery at unnecessarily higher costs for taxpayers. The research points to a solution: an extended recovery period combined with peer recovery support services. Systems changes that could bring about this can improve a number of population health outcomes, including lower rates of re-occurrence of use and associated societal and health system cost savings. However, PRSS has the potential to affect changes beyond the walls of the healthcare system as well as the walls of the criminal justice system.

Peer workers hold the promise of a trustworthy companion, helping to unlock potential and transform the lives of people on their journeys to full recovery (Simpson et al., 2014). As members of a community at large, these peer workers, with the support of recovery care organizations, can also transform communities by strengthening social cohesion. In the process of supporting individual clients, peer workers help build networks of trust within the recovery community and beyond. Social cohesion, the strength of relationships, and a sense of solidarity in the community are key components of Healthy People 2030's Social and Community Context Domain (Pronk et al., 2021). Greater social cohesion is associated with greater physical and psychosocial well-being at the individual level (Thoits, 2011). Social cohesion can also help foster action at the community level, which further improves access to tangible support often lacking in many communities.

There is incidental evidence that peer workers and RCOs are helping to produce social cohesion at the community level, a positive externality for which, by definition, they are not compensated. Cultivation of a trusting relationship is a core part of developing a sense of belonging. Developing a sense of belonging is one way in which peer support specialists provide social support. However, such a relationship by nature cannot be fully transactional, and some would consider it to be inherently priceless.

RCOs and peer workers are best positioned to play major roles in improving community cohesion and community-level recovery capital. For example, RCOs can leverage their networks to advocate for changes in policies and practices at a local level. They could be conveners of regional cross-sector collaboratives to foster joint action among sectors that are impacted by addictions but often do not work together, including housing, healthcare, and criminal justice. In fact, we recommend that new behavioral health delivery system innovations consider incorporating an explicit role for recovery care organizations to improve the social and community contexts in which people in recovery live. This could potentially strengthen the impact of the model by operating across multiple levels of the socio-ecological model.

The socioecological model is a framework that recognizes the relationship between individual, relational, community, and societal factors in shaping health. Peer workers impact health at the individual level by helping their peers avoid re-occurrence of use or offering support in the event of a re-occurrence of use. However, they also impact health at the relational level by providing a trusted companion on a peer's recovery journey. This type of social support has an impact beyond individual health. By developing recovery-ready communities,

RCOs can have an impact on health at the community level, as more resources for building recovery capital are available to people in recovery. Finally, supporting the peer worker profession can have an impact on health at the societal level by supporting the well-being of peer workers and their families through a living wage.

Notwithstanding the existing evidence on the benefits of peer recovery support services, we wonder whether observational or experimental studies can capture the full potential of this evolving profession. Current market dynamics suggest that peer recovery services operate below their optimal level of impact on the society. Peer recovery support services, which were originally recommended by people in recovery themselves and not by medical experts, exist in a market environment that currently underutilizes and undervalues the services provided by peer workers. Estimates of the impact of peer workers, for example, are conditioned on a market that does not enable coaches to provide as much as they can potentially offer. In a world where peer workers flourish as a profession and are fully integrated into the recovery process, it is quite likely that they would demonstrate even better outcomes.

Ending The Failure to Value Peer Workers

To gain insight into how peer workers are valued in the market, we compared observed hourly wages with the livability wage for one state.² Texas, a middling state in terms of annual salaries (see Table 2), is below the national average for hourly wages. At \$15.44 per hour, the mean observed wage comes within 11 cents of a living wage for a single adult with zero children (see Table 3). However, the mean observed wage for peer workers in Texas was well below the living wage for a family of two working adults with one child. If both adults are working, they would both need to earn at least \$21.24 to afford the basic necessities of life; otherwise, a peer recovery specialist could still earn the average wage of \$15.44, but their partner would need to earn \$26.93 to achieve a combined livable wage.

² The living wage is a market-based approach that draws upon geographically specific expenditure data related to a family's likely minimum costs for food, childcare, health insurance, housing, transportation, cell phone and broadband services, funds for civic engagement and other necessities (Glasmeier, 2020).

TABLE 2

*Estimated Peer Recovery Specialist (Peer Worker) Average Salary:
National and Select States, March 2022*

STATE	ANNUAL SALARY	HOURLY WAGE
National	\$36,869	\$17.73
TOP 5		
Massachusetts	\$42,961	\$20.65
Washington	\$39,333	\$18.91
Maryland	\$38,305	\$18.42
New York	\$38,101	\$18.32
Nebraska	\$37,558	\$18.06
MIDDLE RANGE		
Delaware	\$35,842	\$17.23
Vermont	\$34,690	\$16.68
Connecticut	\$33,689	\$16.20
West Virginia	\$33,115	\$15.92
Alaska	\$33,108	\$15.92
Pennsylvania	\$32,555	\$15.65
Texas	\$32,121	\$15.44
Minnesota	\$31,853	\$15.31
Oregon	\$31,346	\$15.07
North Carolina	\$30,907	\$14.86
Kansas	\$30,861	\$14.84
BOTTOM		
Iowa	\$30,459	\$14.64
Alabama	\$30,213	\$14.53
New Mexico	\$30,039	\$14.44
Florida	\$29,158	\$14.02
Mississippi	\$28,909	\$13.90

Source: ZipRecruiter estimations based on ADP data, March 2022 Note: Estimated salaries are based on a sample of 20 percent of the US labor force and track closely with estimates from the US Bureau of Labor Statistics.

It is important to note that a significant share of peer workers in Texas earn a wage well above the mean.³ If they lack health insurance, however, the wage in Texas is too high for Medicaid, and the peer workers would need to purchase a plan on the individual insurance market. Notwithstanding compensation, more than a third (See Table 4) of peer workers in Texas earn above the livable wage for a single individual, while *none of them earn a livable wage for a single-parent adult*, at least among those that appear in the ADP database.

TABLE 3

Peer Recovery Specialist (Peer Worker) Hourly Actual with Living Wage: Texas, March 2022

WAGE GROUP	MARCH 2022 AVERAGE
Hourly Wage: Peer Recovery Specialist, Texas, 2022	\$15.44
Living Hourly Wage: One Adult, No Children, Texas, 2022	\$15.41
Living Hourly Wage: One Adult, One Child, Texas, 2022	\$31.55
Living Hourly Wage: Two Adults (both working), No Children, Texas, 2022	\$21.43

Source: MIT Wage Calculator, 2020. Note: Living wages were inflated from 2020-2022 dollars using the Consumer Price Index to enable comparisons in comparable years.

³ Some might suggest that higher salary ranges indicate the potential for career advancement; however, the geographic distribution of jobs in a state as large as Texas makes this highly unlikely. Furthermore, peer workers are more effective when they come from the same communities and backgrounds as those they serve.

TABLE 4

Observed Peer Recovery Specialist (Peer Worker) Wage Distribution: Texas, March 2022

ANNUAL SALARY RANGE	MIDPOINT HOURLY WAGE	JOBS WITHIN RANGE
\$17,721 - \$21,264	\$9.37	3%
\$21,265 - \$24,808	\$11.06	14%
\$24,809 - \$28,352	\$12.75	24%
\$28,353 - \$31,897	\$14.49	23%
\$31,898 - \$35,441	\$16.19	13%
\$35,442 - \$38,985	\$17.89	6%
\$38,986 - \$42,529	\$19.60	8%
\$42,529 - \$46,071	\$21.30	2%
\$46,074 - \$56,708	\$24.71	<1%

Source: ZipRecruiter estimations based on ADP data, March 2022 *Note:* Observed salaries are based on a sample of 20 percent of the US labor force and track closely with estimates from the US Bureau of Labor Statistics. The Jobs Within Range distribution does not add to 100 because it excludes observations for which salary information was unavailable.

As a product, the peer recovery support service industry can be characterized as a market failure. If the current prices offered for these services are insufficient to incentivize for-profit firms to enter the market, services will not be provided at the optimal level for society. One consequence of this is that peer workers fail to grow into a mature profession. One observed outcome demonstrating market failure in the peer worker market is the predominance of mission-based non-profits, such as recovery community organizations that offer support services. Despite the risk, such organizations may deliver services at margins far narrower than for-profit firms because of the desire for social impact. As a result, they may hire, train, and offer services under financial constraints that limit both organizational capacity building and peer worker workforce development. Similar phenomena (Budd, 2011) have been observed in other “caring professions” such as those in the childcare and long-term care industries, where occupations are considered “low status,” “women’s work,” or “not real work” (Folbre, 1995; Greener, 2015; Harbach, 2015).

Notwithstanding this risk, some enterprising private firms may enter a recovery market. However, for-profit firms would enter the market only with a business strategy that would assure sufficient profit margins. On one hand, they may implement business models that compete based on improved cost efficiency. This may involve leaner staff with lower salaries, which may conflict with efforts to elevate the compensation levels of peer workers, or stinting on quality. They may enter the market through mergers and acquisitions, thereby creating a more concentrated market that allows them to negotiate higher prices owing to greater market power. However, private investments in the recovery market

need not be predatory and may play an important role in developing recovery-ready communities. Non-profit RCOs may develop and control for-profit entities that could partner with investors to market goods and services to supplement peer recovery support service product lines.

Like many jobs in the US, peer workers' wages do not reflect their dignity as individuals. For peer workers, low wages are compounded by the stigma associated with SUD, regardless of the number of years of successful recovery. Peer workers demonstrated successful navigation during their own recovery journeys. Their employment as peer workers ought to support the continued success of their journey. However, low wages are a social determinant of health that can affect one's ability to maintain recovery. Thus, peer workers' wages ought to represent more than what the market offers, especially if the employer is genuinely interested in recovery.

We find that the concept of market value is problematic when applied to peer workers and their compensation levels. Cultivation of a trusting relationship is a necessary condition for the positive reception of informational and social support. Some forms of social support, such as empathy, love, trust, and caring, are inherently non-transactional. Some would consider a relationship based on trust and understanding to be priceless. However, it is clear that recovery community organizations based on the values and principles of recovery are delivering these priceless services.

Peer recovery support occurs within a community and builds a greater community. The relationships formed are likely to endure. Over time, peer workers can build a powerful network of people in recovery who can not only support others individually, but also take leadership roles in advocating for systems change. This provides an untapped and unappreciated resource for building recovery-ready communities and nurturing broad systems change.

Uplifting the Peer Support Labor Force

A signal that transformative systems change has arrived is when peer workers are adequately compensated and valued for their services. We can reduce the gap between this aspiration and current reality by actively promoting the peer recovery support service labor force during the implementation of innovative care models. For example, behavioral health delivery reforms that utilize peer workers should support the workforce development of the profession, as follows:

- Prioritizing the lived experience of recovery coaches in hiring practices
- Incorporating self-care into organizational structure to reduce burnout
- Providing a living wage and financial support that aligns the payment of services to meet client needs
- Offering opportunities for training and professional development to improve coaches' potential impact (London et al., 2018)
- Embedding PRSS as a comprehensive service using a bundled case rate where the peer support is naturally a part of the system of care, not something that can be "picked apart"

The best way to make this happen is for advocates of peer recovery support services to be active in developing, promoting, and implementing models with the most promising impact that (1) are consistent with the fidelity standards of peer support, (2) incorporate the workforce development features described above, and (3) address the need for diversity in the workforce and make recovery spaces more diverse.

As these innovative models are implemented and evaluated, positive outcomes will demonstrate the economic value of peer workers. If you pay them fairly and utilize them optimally, there will be an economic return that will, post facto, evidence the monetary value of peer recovery support. Our theory of change is that these workforce features will become the norm when their use is associated with cutting edge, impactful approaches to recovery.

The next two sections identify two kinds of innovative approaches to improving health that recovery advocates can leverage for change. The idea is that we can foster new labor market behaviors by incorporating the value of recovery support in organizational forms that are most likely to proliferate in the future. We discuss these forms and identify strategies to help nurture changes that bring us closer to our vision of recovery.

Leveraging Delivery System and Payment Innovations

We reviewed the literature for delivery systems and payment reform models with the greatest potential for reducing relapse and for wider dissemination across the country. We zeroed in on those with all three criteria:

1. Science-based: Recovery period of up to five years
2. Fidelity: Peer recovery support services in fidelity with recovery support standards
3. Fair Value: Potential to garner resources to ensure a living wage, employment stability, self-care time, and professional development opportunities among the peer workers they employ

Among the models that met these criteria, the Addiction Recovery Medical Home-Alternative Payment Model (ARMH-APM) emerged at the top (see Table 5). We describe the key features of this model and its implications for peer recovery support. We identify actions to further benefit patients, their communities, and the peer worker profession. These actions can leverage the ARMH-APM to support transformative systems change (Foster-Fishman et al., 2007).

The Addiction Recovery Medical Home was designed to treat addiction, similar to other chronic diseases. Services are delivered in three care transition phases, where bundles of services are delivered to stabilize, treat, and ensure full recovery. An alternative payment model is presented to ensure adequate compensation for bundles of services for treatment, with additional payments to achieve quality metrics. None of these features is particularly novel, except for their application to SUD. (See Figure 1: Components of Value-Based Care.)

The most innovative and impactful component of the model was the time allotted for treatment and recovery. After an initial 1-month Pre-Recovery and Stabilization phase, patients enrolled in the ARMH undergo a Recovery Initiation and Active Treatment episode of up to 12 months and a Community-Based Recovery Phase from 12 months to 60 months. Consistent with science, the model provides the opportunity for the development of recovery capital and the provision of support needed to prevent relapse during the sensitive period in which the brain is still healing. Although not everyone will require all 60 months, the fact that the model structures the episode of care based on science is an advancement.

More importantly, peer workers (coaches in the model) are core members of a Care Recovery Team. The model is most consistent with the fidelity of the recovery support standards. A peer worker is involved in all three care transition phases; however, they have the greatest impact in the last phase, where recovery capital has the greatest opportunity to reduce the risk of re-occurrence of use.

Implications for Peer Recovery Support

The model appears to be consistent with the fidelity standards for recovery support. The peer worker is part of the care team. There is a clear distinction between the roles of care coordinator and peer recovery specialist. Peer workers meet with patients early on to cultivate trust-based relationships. The model clearly defines the nature and role of a peer recovery coach (peer worker) and the types of support they would provide as part of the intervention.

Less clear, however, is how peer workers will be compensated in the model. The model includes a procedure code for reimbursement of peer services (CT18384), but the peer worker in the model performs more than individual consultations. How would they be compensated for time during meetings?

TABLE 5*Structural Elements of ARMH-APM and Implications for Recovery Support*

STRUCTURE	STRUCTURE DESCRIPTION	IMPLICATIONS FOR RECOVERY SUPPORT
Recovery Care Team	The recovery care team includes providers, a care coordinator, and the peer recovery coach. They help ensure coordination of both medical care and community supports.	Peer worker is an important member of the care team. The role is distinct from the coordinator and is focused on building recovery capital.
Treatment & Recovery Plan	The patient develops a treatment and recovery plan at intake with necessary revisions across episodes of care.	The peer worker supports patients in developing care plans, provides ongoing recovery support, and connects patients with community resources to improve recovery capital. Early introduction strengthens potential for relationship-building.
Network	A network of medical and behavioral providers and specialists are linked, presumably through a common Electronic Health Record, to provide integrated medical and behavioral care.	RCOs could be integrated into the network to place peer workers, foster linkages with the community, and help build community-level recovery capital where they are lacking.
Quality Metrics	Quality metrics are used to monitor outcomes and the basis for performance-based payments.	One quality metric in this model includes degree of engagement with peer workers, which makes receipt of recovery support a performance indicator. Engagement levels and quality of engagement may be shaped by caseloads, case mix, and community-level recovery capital.
Payment Model	An alternative payment model incorporates value-based reimbursement over an extended recovery period. A blended financing model involves fee-for-service reimbursement during Pre-Recovery and Stabilization, capitated payments across two episodes of care, and additional quality achievement and bonus payments.	The peer relationship is extended for up to five years, maximizing the potential to prevent re-occurrence of use. However, the peer compensation levels and methods are unspecified. It is unclear how discontinuities in coverage during the community-based recovery and management period will impact the peer relationship and the ability of peer specialists to support recovery.

More than any other model, the ARMH-APM model elevates peer workers as valued professionals. They are part of a care team and are given the opportunity to offer support for as many as five years. This is something that recovery community organizations and other recovery advocates can wholeheartedly support, especially if the fair value criterion is met.

Indeed, recovery community organizations can actively promote and support the model as partners. RCOs can potentially be included in the integrated network as providers of trained peer workers. They can ensure supervision and continual training, provide professional development activities, and offer programs for self-care. They could potentially play the role of an ombudsman or mediator when human resource issues arise. They could become a platform for peer workers to provide support to each other and function as regional hubs to support PRSS regionally.

The model includes a quality measure of engagement with peer workers. It is unclear how bonuses associated with meeting this quality measure will be distributed to peer workers. The outcomes of peer recovery support depend on community-level factors, which cannot be controlled by peer workers. Individuals from low-resource communities may lack access to the community-level recovery support available to individuals from high-resource communities. As a result, performance measures across different peer workers may be the result not only of individual-level differences in caseloads but also the characteristics of the communities in which participants live. This could potentially disincentivize the uptake of individuals from low-resource communities or incentivize cherry picking from higher-resource communities. Some thought may be required to develop a risk-adjusted caseload to ensure equality among peer workers. This might be a role for recovery community organizations; they could potentially advocate on behalf of peer workers who may be unable to negotiate with a larger organization when their cases become unfairly allocated.

Without considering community-level differences, the ARMH-APM model could potentially magnify the existing disparities. Although caseloads could be risk-adjusted with more time allocated to building individual recovery capital, the model does not address some of the structural factors that might be associated with substance misuse, re-occurrence of use, and associated disparities in a community. Again, the RCOs can play a role. If included as part of the network implementing the ARMH-APM, they could work to help build community-level recovery capital in collaboration with other organizations in low-resourced communities. Thus, RCOs can help to reduce health inequities across communities. Funding sources could examine how to effectively address these differences between neighborhoods and communities.

Action Strategies for Broader Systems Change

In reviewing the implications of the ARMH-APM model, we identified different ways in which the model could be enriched and bring about broader systems change. The first involves being explicit about a model that demonstrates the value of peer workers as a profession. All systems have a purpose, often unstated, that shapes the rules of the game. By being explicit that the model

demonstrates the value of the profession and identifying ways to do so at the outset, the ARMH-APM will be “pre-programmed” to ensure that the profession is continually valued. As the model spreads, fair compensation and workforce recommendations will become the norm.

The second activity involves the role of recovery community organizations as partners in the implementation of the model. They play a role in supporting the provision and maintaining the value of peer workers. More importantly, their participation as partners can help strengthen linkages with the community and provide a foundation for building recovery-ready communities.

In doing so, they will further improve the outcomes of the ARMH-APR model.

Leveraging Emerging Collaborative Approaches to Complexity

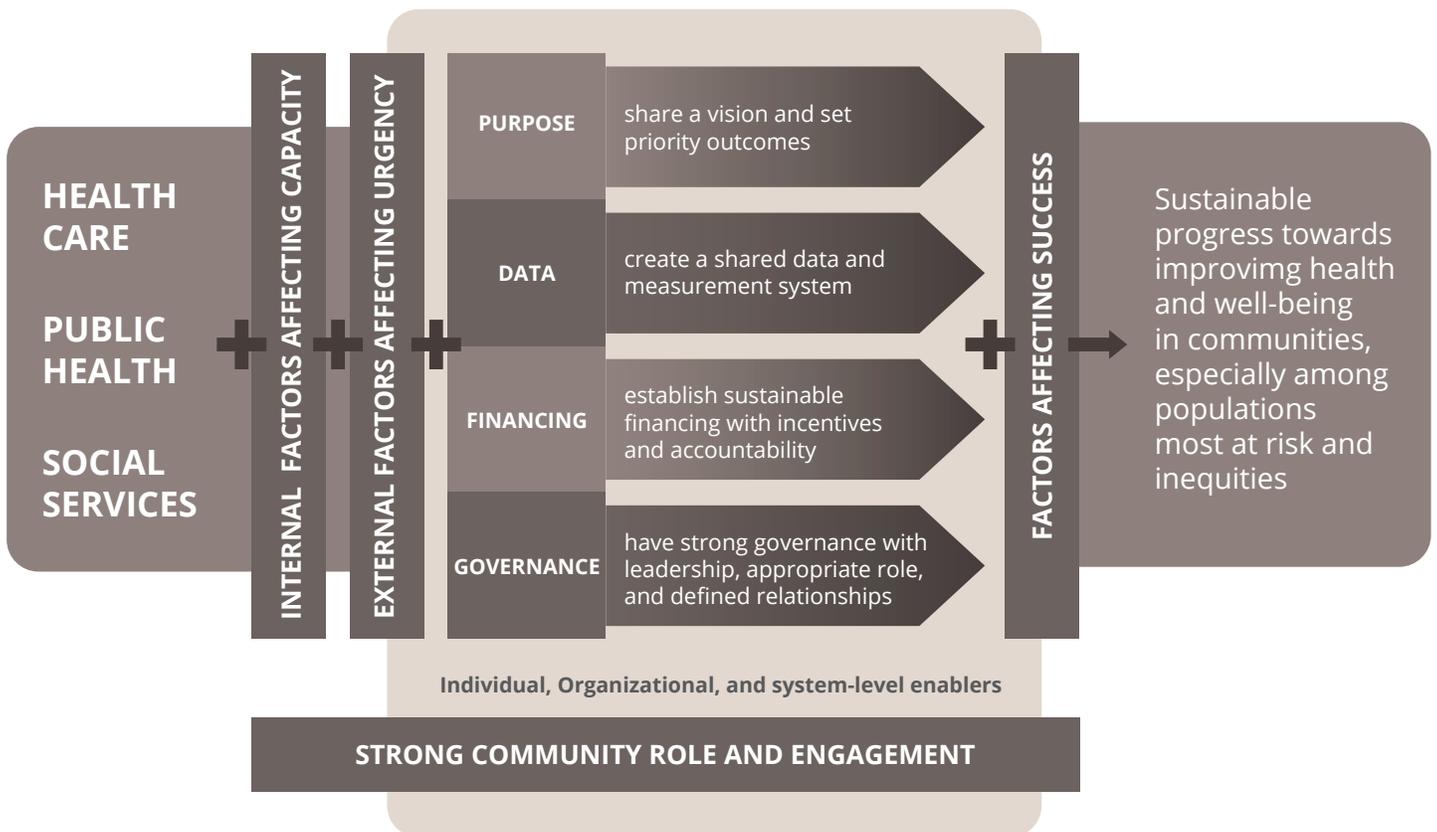
Substance use is a complex problem that affects a wide variety of sectors that often do not communicate, let alone collaborate, to address an issue that significantly impacts each sector. This results in a system in which the most vulnerable find themselves trapped in a vicious cycle. Consider an individual with substance abuse and a mental health diagnosis who is arrested. While substance use is a significant risk factor for incarceration, prior imprisonment causes housing instability. In turn, unstable housing and homelessness were correlated with substance use and recidivism. The result is that the most vulnerable individuals with SUD fall through the cracks as they move across systems (criminal justice, social services, housing, behavioral health, etc.) that often fail to communicate across siloed sectors.

Collective impact (Kania & Kramer, 2011, 2013) and other collaboration models have emerged as tools to address complex and seemingly intractable social problems. In this section, we summarize some of the emerging work on collaboration in health. As in the previous section, we zero in on a model of collaboration that has the greatest prospect of addressing substance abuse and could be retrofitted to improve recovery support at the individual and community levels. We conclude with actions to leverage the model to build community recovery, while advocating for opportunities to value peer recovery support.

Addressing Complex Social Problems Through Collaboration

Over the past two decades, the U.S. experienced growth in a wide variety of cross-sector collaborative approaches to address complex social problems, including substance use. In 2011, FSG Consulting Group researchers John Kania and Mark Kramer described what became known as the Collective Impact Model. The model is based on the theory that stakeholders, through shared information and coordinated action, can collaborate to intentionally solve complex social problems. Kania and Kramer (2013) described the five key components required to successfully coordinate joint actions to effect changes in complex systems. Despite their varying perspectives, stakeholders from different sectors must develop a common agenda for change. Stakeholders must develop a set of mutually reinforcing activities consistent with their agendas and track progress using a common set of progress measures. This requires a communication infrastructure not only for collecting and sharing data but also for facilitating dialogue among the various stakeholders. The final component is a backbone organization that maintains the administrative infrastructure to sustain the enterprise in the long run.

Figure 1
Robert Wood Johnson Foundation: Cross-Sector Alignment Theory of Change



Source: Petiwala et al., 2021.

The Collective Impact Forum is an associative organization that supports coalitions in building effective collective impact models. The forum recognized collective impact models as having all five key components, with a focus on three complex social issues. For example, Prosper Waco, a collective impact coalition in Texas, focused on education, health, and financial opportunities in the city. Many multi-sector coalitions describe themselves as a collective impact model, but often lack a three-issue focus. For example, the Marathon AOD Partnership in Wisconsin focuses on alcohol and other drug abuse issues. The Collective Impact Model has been criticized for its lack of transparency and accountability to populations affected by the targeted social problem. However, the promoters of the model suggest that health equity and involvement with affected populations are core values of genuine collective impact.

The Robert Wood Johnson Foundation developed a cross-sector collaboration theory of change that incorporates transparency and accountability structures more explicitly (Lanford et al., 2022). The theory of change was developed to better understand the capacities required to align the medical, public health, and social service sectors to improve population health and health equity through collaboration. The theory of change identifies four individual-, organizational-, and systems-level enablers of success: (1) shared purpose, vision, and outcomes; (2) shared data and measurements; (3) sustainable financing with suitable accountability structures; and (4) strong, transparent government structures (see Figure 1). Currently, this model is being tested nationally. For example, The Texas Health Institute evaluates whether the theory of change is consistent with over a dozen multisector partnerships for health equity in Texas. Two of these, the Panhandle Behavioral Health Alliance and El Paso Behavioral Health Consortium, focus on substance misuse.

Table 6
Core Elements of an Accountable Community for Health

1. Mission
2. Multi-Sectoral Partnership
3. Integrator Organization
4. Governance
5. Data and Indicators
6. Strategy and Implementation
7. Community Member Engagement
8. Communications
9. Financing

Source: Prevention Institute 2015

The Accountable Community for Health Model

We assessed a wide variety of collaborative approaches for their potential to integrate a focus on recovery and wide dissemination across the country. Among these approaches, the Accountable Community for Health (ACH) model appears most promising. ACHs incorporate many of the features of the multi-sector collaboration approaches discussed above, but are focused on improving population health and health equity. Rather than focusing on population health activities in the delivery system, where the focus is on holding providers accountable for managing patient health, the ACH model provides a framework for stakeholders across sectors to develop systems to improve health and health equity in their community (see Table 6).

Key ACH elements include convening diverse stakeholders with active participation in planning on joint priorities; developing a shared vision, mission, and priorities; building adequate structure and support such as staff, governance, and analytic capacity; developing and implementing action plans with metrics to track progress; and leading the enterprise in ways that foster trust, open communication, and collaboration.

The number of ACHs has grown rapidly over the past 10 years as a result of CMS's State Innovation Model Initiative. Implemented through the Innovation Center, the initiative provides states with financial and technical support to advance new service delivery models and multi-payer health care payment reforms. According to the Funders Forum on Accountable Health, there are currently 154 ACHs in the country. This number is likely to increase with additional philanthropic funding, supporting further demonstration of this model. For example, the Episcopal Health Foundation of Texas funded six new ACHs in a recently launched demonstration initiative.

Implications For Peer Recovery Support

ACH leaders have recognized the potential of leveraging ACHs to address SUD. The Funders Forum on Accountable Health (FFAH) convened a meeting of experts and stakeholders regarding the use of ACHs and similar models to address SUD. In a summary of their meeting (2018), they identified supportive policies and technical assistance to support the ACH adoption of initiatives to address SUD. Currently, 62 ACHs across 18 states have a behavioral health focus on their mission. It is unclear whether and to what extent these 62 ACHs incorporated recovery support. However, the Funders Forum acknowledges that genuine community engagement for ACHs in tackling SUD is paramount. This acknowledgement provides an opportunity for RCOs and advocates for ACHs in these 18 states. However, RCOs would require education on the ACH model before engaging with leaders in ACHs. However, there is great promise that ACHs and RCOs can collaboratively develop recovery-ready communities. It also offers a platform to advocate for the peer recovery profession.

Action Strategies for Broader Systems Change

RCO leadership and other recovery advocates have the opportunity to engage with ACHs and other cross-sectoral coalitions to determine the potential for collaboration to build recovery-ready communities and advance peer recovery support in fidelity with recovery support standards. These engagement activities are strengthened by an engagement plan and additional resources. This can include a service area profile of ACHs and other coalitions working in the area, and messaging to support communication and engagement.

The Need for Leadership

Systems thinker and famed environmentalist Donella Meadows notes, “The most powerful place to intervene in a system is the paradigm out of which it arises.” This is because systems are often driven by unconscious mindsets and mental models that limit what is conceivable. Our approach involves nurturing the rise of new systems that incorporate mindsets associated with recovery principles and heartfelt appreciation for the value that peer workers bring to communities. Leaders who already have that mindset are a necessary condition for this to occur, and many of them can be found leading state and local RCOs. Thus, RCOs and other recovery advocates play a key role in leading the emerging future.

Our vision of developing recovery-ready communities that value peer recovery support is possible. The components of this vision are already emerging. However, for leadership to nurture what appears to be the initial stages of its manifestation, assistance and capacity building are needed. In the next section, we discuss in more detail some of the recommendations to help build the leadership capacity necessary to nurture transformative systems change.



SECTION 4: Recommendations

Our call for broad systems change will require the recovery community to work with allies across sectors to effect changes in laws and regulations, organizational capacity-building and community development, workforce development, and leadership. We detail the specific recommendations for each of these four areas below, and encourage allies in the recovery advocacy movement to join forces to translate these recommendations into action.

1. Laws and Regulations

Our first recommendation is to develop a common understanding of PRSS by codifying a definition in federal and state statutes based on the SAMHSA definition or a variant developed with peer input. We need national uniformity in our definition, which must distinguish PRSS from case management. In addition, it must ensure that we are talking about “peer-based,” and that these services are delivered by individuals who are in recovery. We also need to leverage 1115(a) demonstration waivers and other authorizations to develop state innovations that incorporate the continuum of recovery support, including peer recovery.

Our second recommendation involves payment reforms that adequately compensate for the full costs associated with employing and supporting peer workers to provide recovery services. In order for RCOs to be sustainable, peer workers need to be paid a living wage, and Medicare and Medicaid reimbursement levels must also be increased. Furthermore, fee-for-service rates also need to be increased to adequately account for administrative costs of providing quality supervision, offering training and professional development, and time for self-care.

Third, the recovery advocacy community must be involved in ongoing conversations regarding payment reforms. Alternatives to the fee-for-services model need to include discussions on the design of capitated payment methods. For example, will capitated payments incentivize stinting on recovery services in ways that ultimately limit the effectiveness of peer-worker outcomes? If so, could carve-outs be one way to neutralize that incentive?

Similarly, in designing value-based care reimbursement approaches, we recommend greater consideration of how to ensure that the optimal use of peer workers is recognized as a quality performance measure. While we highly recommend the Alliance for Addiction Payment Reform’s alternative payment model, we would also recommend additional consideration of bonuses to be allocated to peer workers for successful recovery outcomes, and that peer worker caseloads be reimbursed based on the characteristics of the cases and the cases’ communities.

Fourth, we recommend that the National Institute for Mental Health or another federal agency study the impact of various financing models (i.e., embedded PRSS in comprehensive bundled package vs. FFS rate) in terms of access, engagement, long-term outcomes, and overall cost reductions compared to the costs of care without PRSS. Various financing models can be studied in the context of demonstration models, such as the Addiction Recovery Medical Home Model or Accountable Communities for Health. In both cases, the differences in reimbursement approaches could be an element of the model design, which in turn can be evaluated for its impact on outcomes. We recommend considering the structure of peer worker compensation as a design element and peer worker satisfaction and compensation adequacy as key evaluation outcomes.

Finally, we recommend and encourage comprehensive and bundled rate approaches that incorporate all aspects of PRSS: services, peer support, housing, and medical.

2. Organizational Capacity Building and Community Development

We recommend that RCOs receive support to better understand their roles as players in the public health arena. RCOs need to be educated about public health systems and the role that they can play in building community health from a broader perspective. They will need to build capacity to implement the strategies presented in this report.

Recovery community leadership can develop webinars to educate RCOs about the role they can play in public health, addressing SDOH, and community health transformation. They will need assistance in identifying and collaborating with public health partners in their communities, and they will need training on policy, systems, and environmental change strategies. RCOs can engage with and lead local and regional coalitions that address the social determinants of health, and support new or existing cross-sector coalitions.

Recovery organizations generally play a strong role in community transformation efforts. For example, Recovery Cafés provide a strong sense of community for all people who have been traumatized by substance use and mental health issues. They and other recovery organizations should be encouraged to participate in cross-sector partnership initiatives, such as the Build Health Challenge, which encourages non-profits to work collaboratively to develop infrastructure solutions that elevate the quality and accessibility of healthcare.

We also see the need to develop a national social marketing campaign to address the stigma associated with substance use and improve the perception of the value of peer support services. Research has shown that stigma persists in relation to substance use. It also impacts how the public values peer recovery support services as a credible and effective means of receiving help with recovery.

Funding from philanthropy and government agencies will be needed to help build the capacity for RCOs to lead in the development of recovery-ready community initiatives. It would also be useful to provide training for RCOs, where they might look locally for public health funding at the state, regional, and local levels. Funders and policymakers can promote the value of consciously building recovery-ready communities as key components of a healthy community. We recommend prioritizing support for building systems and regional initiatives, and the capacity building needed for RCOs to lead those efforts.

And last, but not least, we recommend that there be ongoing support for the implementation of CAPRSS standards that focus on recovery values and principles. As the PRSS workforce grows and develops, there must be a focus on peers with lived experience, the unique elements of PRSS, and fidelity to the model so that key elements are not lost.

3. Workforce Development

We recommend that recovery community stakeholders and policymakers actively monitor compensation levels and the development of PRSS as a profession. We need to prioritize the issues of peer workers earning a living wage, having time for self-care, and providing opportunities for training and professional development. RCOs can play an assurance role by becoming hubs for contracting to expand PRSS in the community. Contracts for PRSS could be designed to ensure adequate compensation, fair caseloads, time for self-care, and so on. It could also include services that increase recovery capital in the community, which may lead to new civic engagement opportunities for peer workers.

Career advancement paths should be fostered within the recovery-support profession. Having a regional RCO hub structure for delivering PRSS would be extremely helpful in providing a variety of career paths for PRSS as PRSS moves into judicial, educational, and medical settings, to name a few. Building an experienced workforce to move into supervisory, management, and leadership positions as programs expand is critical to building a recovery-ready community. Workplace environments also need to be built with a recovery orientation to deliver services and a supportive organizational peer culture. Labor force development must be promoted at the organizational, community, regional, state, and national levels. RCO hubs will also contribute to ensuring that PRSS is practiced with sufficient support for peer workers, with supervision provided by individuals who themselves are in recovery and who have experience providing PRSS, and with management provided by organizations that understand the key elements of PRSS.

Because the diversity of the peer workforce is linked to its ability to support diverse communities in recovery, we recommend that all recovery organizations strengthen their efforts to hire, train, maintain, and develop a diverse workforce. We recommend that RCOs monitor and report their efforts to promote a diverse workforce, including annual training to support the cultural competence and humility of all staff.

4. Leadership Development

We recommend that recovery community leaders develop partnerships with the Alliance for Addiction Payment Reform to support and further enrich their model by addressing community-level support. We need to build cross-sector collaborative partnerships within service areas where ARMH and similar models can be implemented using PRSS. We need to provide support to RCOs to engage and partner with Accountable Communities for Health (ACH). Webinars for RCOs on strategies to connect with ACHs must be provided.

We recommend that recovery leaders convene groups of major players to discuss ways to coordinate and collaborate to build a stronger movement for PRSS. This should include the following:

- Peer workers
- Individuals in recovery who have used PRSS
- Individuals from communities who have been disproportionately impacted by SUD and/or historically under-served by recovery-related services
- RCO leaders at state and local levels
- Private, public, and non-profit sectors
- Behavioral health and other providers
- Insurers: Medicaid, Managed Care Organizations, leaders of new delivery system models
- Substance Abuse and Mental Health Services Administration (SAMHSA); National Institute of Mental Health (NIMH), Health Resource Services Administration (HRSA)
- Faces & Voices of Recovery
- Philanthropic Funders/Foundations: Robert Wood Johnson Foundation, Hogg Foundation for Mental Health, Meadows Foundation, Dell Foundation
- Alliance for Payment Reform leadership
- Representatives from Accountable Communities for Health
- Funders Forum on Accountable Health

We offer this report and make recommendations not only as a call to action, but also as a call to courage. We truly believe that our greatest strength as a movement is our values, and by effecting change in these four areas, we have the opportunity to promote those values throughout society.

“Courage is a heart word. The root of the word courage is cor—the Latin word for heart. In one of its earliest forms, the word courage meant ‘To speak one’s mind by telling all one’s heart.’ Over time, this definition has changed, and today, we typically associate courage with heroic and brave deeds. But in my opinion, this definition fails to recognize the inner strength and level of commitment required for us to actually speak honestly and openly about who we are and about our experiences—good and bad. Speaking from our hearts is what I think of as ordinary courage.”

— Brené Brown

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Acknowledgements

We would like to acknowledge the following individuals for taking the time to read our draft paper and provide us with valuable feedback and comments:

Carol Clayton, private behavioral healthcare consultant and retired happy person

Dr. Kyle Grazier, DrPH, University of Michigan; Richard Carl Jelinek Professor of Health Services Management, Health Management and Policy, School of Public Health; Professor, Department of Psychiatry; Director, Behavioral Health Workforce Research Center

Dr. Octavio Martinez Jr., Executive Director, Hogg Foundation for Mental Health

Marianna Reid, Program Manager, Faces & Voices of Recovery

Sheila Savannah, Managing Director, Prevention Institute.

William White, Emeritus Senior Research Consultant at Chestnut Health System

We would also like to acknowledge the members of the ARCO workgroup that assisted with developing this paper:

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