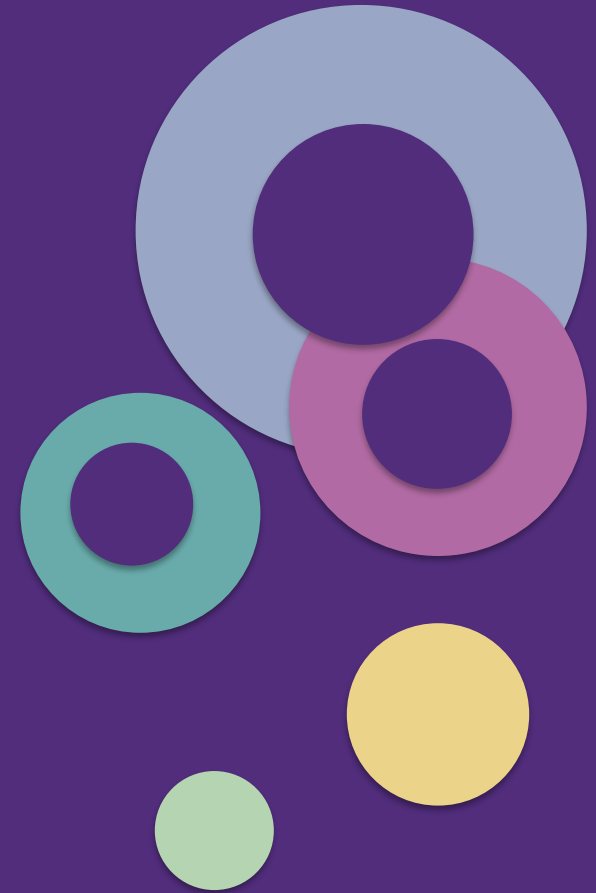




A family-centered path to treatment,
recovery, and stability

Who we are • How we began • Where we are • What comes next

Bethany Cottrell | Executive Director



Who we are

Families Flourish Northeast is a New Hampshire nonprofit building a family-centered residential treatment program for pregnant and parenting women and their children.

Our distinction is access and continuity across the family's recovery journey.

OUR ROLE IN THE CARE CONTINUUM

- Reduce barriers to entering intensive treatment
- Keep mothers and children together when clinically appropriate and safe
- Connect clinical care with parenting, child development, and family stability
- Coordinate support before admission and after discharge

How the idea began

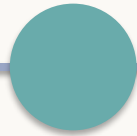
2013



Moms in Recovery

Dartmouth Health clinicians created outpatient support for pregnant and parenting women.

A gap became clear



Higher level of care

Some women needed residential treatment where they could remain with their children.

2020



FFNE formed

A nonprofit began organizing partners and resources to build that missing option.

The starting point was a clinical need: families needed intensive treatment without losing the support of one another.

The barrier is often access -

A mother may be ready for help and still be unable to enter the right level of care.

 Distance

Rural travel, transportation, and limited local options

 Family separation

Childcare and placement concerns can delay treatment

 Fragmented support

Health, behavioral health, housing, and parenting needs cross systems

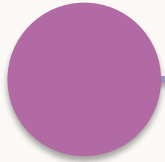
 Transition risk

Without a warm handoff, gains in treatment can be hard to sustain

FFNE treats recovery and family stability as connected parts of care.

One connected continuum of care

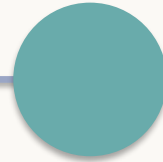
BEFORE



Care navigation

Referral coordination
Stabilization planning
Health and family connections

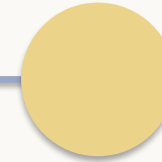
DURING



Residential care

ASAM 3.5 treatment
Parenting and child supports
Peer and family services

AFTER



Community transition

Continuing care
Housing and service links
Recovery support

Residential care is the center of the model.
Coordination starts before admission and continues after discharge.

The facility will support the care model

PLANNED CAPACITY

12

Families Onsite

Mount Support Road
Dartmouth Health land lease



Family units

Living space designed for mothers and children



Child development

Age-responsive supports and child-focused programming



Clinical and parenting space

Treatment, therapy, and parenting education



Outdoor areas

Safe space for family connection and regulation

Where we are right now

CAPITAL CAMPAIGN

\$9.16M

secured / committed / awarded



\$13.3M goal

About \$3.79M remains to goal

PROJECT READINESS



Regional partnerships are established and growing



Program and facility planning continue with Dartmouth Health



Interim care coordination can begin while construction proceeds



Operating, referral, and reimbursement pathways need continued design

Construction is one workstream

FACILITY PATH

Build the permanent residential program

- Advance capital and construction planning
- Prepare the 12-family ASAM 3.5 program
- Plan staffing, policies, and operational readiness

AND

INTERIM PATH

Strengthen connections now

- Offer case management and care navigation
- Develop referral and warm-handoff practices
- Coordinate medical, behavioral health, and community supports

The interim work can build the partner relationships and routines the residential program will need.

What comes next:

- 1 Launch interim coordination**
Define who can be referred, how families enter, and how providers communicate. Hire Director of Clinical Integration.
- 2 Build the referral network**
Agree on warm handoffs, shared expectations, and follow-up across systems.
- 3 Prepare the residential program**
Advance facility plans, staffing, policies, clinical partnerships, and launch readiness.
- 4 Secure a sustainable operating model**
Develop payer relationships, reimbursement workflows, and diversified support.

Where PQC can help shape the work

WE WOULD VALUE PQC INPUT ON

- How families move from prenatal and postpartum care into substance use treatment
- Warm handoffs between obstetric, behavioral health, and recovery providers
- Care coordination when child welfare, housing, or transportation needs are present
- Measures that show whether access and continuity improve

A useful next step -

Identify one or two referral pathways to map together, then test them with partners and families.

PQC's perinatal perspective can help make the continuum work across real care settings.

How we will know the work is helping

ACCESS

Families can reach the level of care they need.

ENGAGEMENT

Mothers and children stay connected to support.

STABILITY

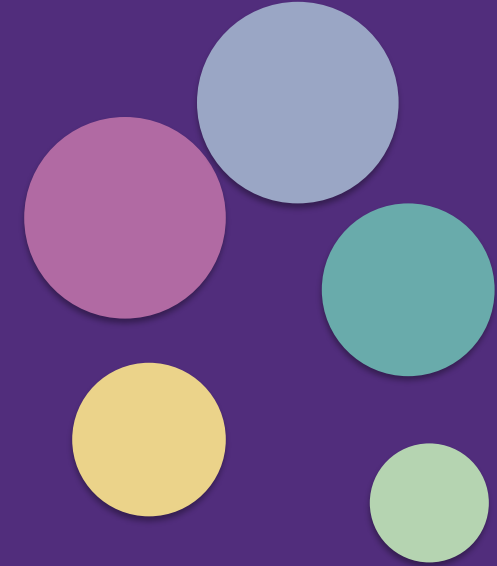
Families leave with stronger health, housing, and recovery links.

SYSTEM CONNECTION

Providers can make and receive warm handoffs.

Measures will follow access, retention, family stability, and continuity of care, with input from families and partners.

**Families should not have to choose
between healing and staying together.**



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Families Flourish
NORTHEAST