

F7CFD!BYcbUH`5VghbYbWY`GmbXfca Y`=

## **Grantee Directory**

### **2023 Cohort**

**Developed by JBS International, Inc.**

**October 2023**

## Table of Contents

Adagio Health, Inc.....	3
Arizona Youth Partnership.....	6
Arukah Institute of Healing, Inc.....	8
Augusta University Research Institute, Inc.....	11
Baptist Health Deaconess Madisonville, Inc.....	14
Bethany Christian Services of Georgia, Inc.....	16
Bighorn Valley Health Center, Inc.....	19
Children’s Dental Services.....	21
Citizens Memorial Hospital District of Polk County.....	24
Community Care of West Virginia, Inc.....	26
Cornerstone Whole Healthcare Organization, Inc.....	28
Counseling Management Services, Inc.....	31
Fairview Health Services.....	33
Fairview Park LP.....	36
Family Health Center of Marshfield, Inc.....	38
Gaston Family Health Services, Inc.....	41
Genesee Council on Alcoholism and Substance Abuse, Inc.....	43
Great Plains Tribal Leaders Health Board.....	45
Hamot Health Foundation.....	47
Hopewell Health Centers, Inc.....	49
Illuminate Colorado, Inc.....	52
Kentucky River Comm Care, Inc.....	54
Logan County Commission.....	56
Luce Mackinac Health Department.....	58
MaineHealth.....	60
Mary Hitchcock Memorial Hospital.....	62
Menominee Indian Tribe of Wisconsin.....	65
Open Door Community Health Centers.....	67
Robeson Health Care Corporation.....	69
Saint Elizabeth Medical Center, Inc.....	73
SMA Healthcare, Inc.....	76
South Central Missouri Community Health Center.....	78
Southern Healthcare Collaboration, Inc.....	80
Southern Highlands Community Mental Health Center, Inc.....	83

<b>St. Johns River Rural Health Network, Inc.....</b>	<b>85</b>
<b>Texas A&amp;M University System Health Science Center.....</b>	<b>87</b>
<b>United Way of Rutherford County.....</b>	<b>90</b>
<b>Volunteers of America, OK, Inc.....</b>	<b>92</b>
<b>West Virginia University Research Corporation.....</b>	<b>94</b>
<b>The Wright Center Medical Group.....</b>	<b>96</b>
<b>WV Perinatal Partnership, Inc.....</b>	<b>98</b>

**Organizational Information:**

<b>Project Title:</b>	Adagio Health, Inc. HRSA RCORP-NAS Project
<b>State:</b>	Pennsylvania
<b>Organization Type:</b>	Health Care Provider
<b>Website:</b>	www.adagiohealth.org
<b>Address:</b>	603 Stanwix Street Suite 500 Pittsburgh, PA 15601

**Grantee Points of Contact:**

<b>Project Director:</b>	Sandra Soloski, ssoloski@adagiohealth.org
--------------------------	---

**Target Service Area(s):**

County, State	
Armstrong County, PA	Lawrence County, PA
Butler County, PA	Venango County, PA
Indiana County, PA	

**Partner Organization(s):**

Organization Name	City, State
Adagio Health	Pittsburgh, PA
Armstrong/ Indiana/ Clarion Drug & Alcohol Commission	Shelocta, PA
Butler County Human Services/ Butler County SCA	Butler, PA
Carlow University	Pittsburgh, PA
Discovery House	New Castle, PA
Lawrence County Drug & Alcohol Commission	New Castle, PA
UPMC Insurance Services Division	Pittsburgh, PA
Venango County Human Services	Oil City, PA

**Project Information:**

**Project Summary**

The need for integrated and coordinated care among pregnant people, parents, and people of childbearing age who have a history of or who are at risk for SUD/ODU in Armstrong, Indiana, and Butler, Venango, and Lawrence counties of Pennsylvania is urgent. To meet this growing need deeper interventions are required that can effectively reduce the incidence of Neonatal Abstinence Disorder (NAS) in this 5-county rural service area, which includes 2 of the 5 counties in the state that have the highest incidence of NAS, Venango and Lawrence.

Goals of the RCORP NAS consortium include:

1. Increase access to contraception and STI testing to individuals of childbearing age who are at risk for SUD/ODU.
2. Educate key groups on best practice to improve engagement of individuals of childbearing age with treatment and recovery.
3. Improve engagement with the target population with behavioral health services through cross sectoral collaborative programs designed to increase points of service entry.
4. Increase the number of OB/GYN and other health and social service professionals who can screen diagnose and treat pregnant women with SUD/ODU and other mental health conditions through recruitment and training initiatives.
5. Increase the number of providers who are trained and waived to prescribe buprenorphine-containing products for the purpose of MAT.
6. Reduce physical and social barriers for pregnant individuals with SUD/ODU to enter and engage with behavioral health treatment, including MAT, to individuals in the earliest stages of pregnancy.
7. Improve behavioral health financial systems in order to sustain the maternal behavioral health work force.
8. Increase the number of providers who can screen, diagnose, and treat NAS.
9. Ensure infants with NAS receive a discharge plan that facilitates proper care.
10. Ensure mothers receive adequate post partem psychosocial support including access to behavioral health services including treatment for SUD/ OUD and access to mental health services.

**Focus Areas**

- Integration of Services
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women’s Health

**Areas Where We Would Like to Serve as a Peer Mentor**

- Improving access to sexual and reproductive health
- Integrated services model

**Intended Audience(s)**

<b>Age:</b>	Adolescents (13-17), Young Adult (18-24), Adult (25-64)
<b>Health Status:</b>	People with/at risk for OUD or SUD, people in recovery from SUD/ODU

<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Special Populations:</b>	Pregnant and Parenting People, Veterans, LGBTQ+ Populations

**Organizational Information:**

<b>Project Title:</b>	AZYP Linking Actions for Healthy Mothers and Babies (LAHMB)
<b>State:</b>	Arizona
<b>Organization Type:</b>	Community based organization, Nonprofit 501(3)(c)
<b>Website:</b>	azyp.org
<b>Address:</b>	7575 W Twin Peaks Rd. #165 Tucson, AZ 85743

**Grantee Points of Contact:**

<b>Project Director:</b>	Sara Sherman, saras@azyp.org
<b>Data Coordinator:</b>	Charlene Becker, charlene@azyp.org
<b>Learning Collaborative Point of Contact:</b>	Julie Craig, julie@azyp.org
<b>Health Care Navigator:</b>	Darien Mathews, darien@azyp.org

**Target Service Area(s):**

<b>County, State</b>
Gila County, AZ

**Partner Organization(s):**

<b>Organization Name</b>	<b>City, State</b>
Amistades, Inc.	Tucson, AZ
Cobre Valley Regional Medical Center	Globe, AZ
Community Bridges	Mesa, AZ
Copper Hills Family Advocacy Center	Globe, AZ
Gila County Sheriff's Office	Globe, AZ
Gila House, Inc.	Globe, AZ
HCC Consultants	Mesa, AZ
Hope Family Care Center	Globe, AZ
San Carlos Apache Tribe / Healthcare	San Carlos, AZ

Organization Name	City, State
San Carlos Apache Tribe / Nnee Bich'o Nii Department	Peridot, AZ
Individual: Monica Flores	Mimi, AZ

**Project Information:**

Project Summary	
<p>LAHMB will serve rural communities within Gila County in Arizona, specifically addressing the target tribal population living in the San Carlos Apache Reservation. The LAHMB Consortium will focus on the prevalence of opioid and other substance use disorders and their consequences on children and families. Through the LAHMB Consortium, members plan to substantially reduce the incidence and impact of neonatal abstinence syndrome with a multi-dimensional approach across the preconception, prenatal, and post-partum stages for women and birthing people who are of childbearing age and pregnant and/or pregnant with substance use disorder. This will consist of prevention education within local schools, intervention education (motivational interviewing, ACEs screening, and SBIRT) for regional healthcare providers, behavioral health facilities, and local law enforcement, and establishing a trauma-informed, culturally appropriate structure and system of care to increase accessibility to services for women and birthing people experiencing SUD/OD.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>Community Behavioral Health</li> <li>Health Literacy</li> <li>MOUD/MAT Implementation</li> </ul>	<ul style="list-style-type: none"> <li>Maternal and Obstetric Care</li> <li>Neonatal Abstinence Syndrome</li> <li>Tribal Populations</li> </ul>
Areas Where We Would Like to Serve as a Peer Mentor	
<p>ACEs screening, motivational interviewing, trauma-informed care/strategies, culturally responsive approaches to healthcare</p>	
Areas Where We Would Welcome Technical Assistance	
<p>Case management guidelines, medical coding/billing best practices, data evaluation components</p>	
Intended Audience(s)	
<b>Age:</b>	Adolescents (13-17), Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OD, Substance-exposed children and infants
<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Special Populations:</b>	Pregnant and Parenting People



**Organizational Information:**

<b>Project Title:</b>	Innovative, Community-based Care to Reduce Neonatal Abstinence Syndrome in Vulnerable, Rural Populations in Northcentral Illinois
<b>State:</b>	Illinois
<b>Organization Type:</b>	Behavioral Health Provider, Certified Community Behavioral Health Organization, Community based organization, Substance Use Disorder Provider
<b>Website:</b>	arukahinstitute.org
<b>Address:</b>	1916 N Main St., STE 3, Princeton, IL 61356

**Grantee Points of Contact:**

<b>Project Director:</b>	Sarah B. Scruggs, PhD, sarah.scruggs@arukahinstitute.org
<b>Data Coordinator:</b>	Ethan M. Smith, ethan.smith@arukahinstitute.org
<b>Health Care Navigator:</b>	Sherry Mullins, sherry.mullins@arukahinstitute.org

**Target Service Area(s):**

County, State	
Bureau County, IL	Marshall County, IL
LaSalle County, IL	Putnam County, IL

**Partner Organization(s):**

Organization Name	City, State
Catching Joy Midwifery	Princeton, IL
Second Story Teen Center	Princeton, IL
YMCA	Peru, IL
Youth Services Bureau of Illinois Valley	Ottawa, IL

**Project Information:**

**Project Summary**

We propose an innovative, collaborative strategy for reducing morbidity and mortality of SUD, including opioid use disorder (OUD), for women of childbearing age, pregnant women, and their families in Bureau, LaSalle, Marshall, and Putnam Counties in Illinois. This region is enduring a women's healthcare crisis with the closing of a major hospital that provided the majority of obstetric, labor, and delivery services. This has caused a scarcity of services and for moms that are socioeconomically disadvantaged or face other health disparities, which has been catastrophic for access to care. Not only is transportation a major issue in our 2,500 sq. mi. region, but vulnerable women face other barriers, including stigma, lack of primary care, lack of consistent prenatal care, language barriers, and lack of social/family supports. This sequence of events has ignited the pivoting and collaboration of consortium members, who leverage tremendous successes of the RCORP NAS-I funding and respond to these new challenges and barriers. The proposed project uses the momentum of the past 3 years to strengthen and expand the capacity of women's health services by investing in a local women's health practice to become the sustainable "one-stop shop" provider of comprehensive care for vulnerable NAS populations. This project will ignite and propel outreach, education, and treatment efforts across the harder-to-reach communities for at-risk teens and pregnant or postpartum moms by investing in education and engagement approaches. This project will enhance cross-sectoral linkages within the community to ensure any NAS participant, anywhere, anytime can access the needed care across the continuum of preconception to postpartum. There are 5 key consortium members collaborating on this project. All are located within the rural service area.

**Focus Areas**

- Adolescent Health
- Co-occurring Disorders
- Community Behavioral Health
- Integration of Services
- MOUD/MAT Implementation
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Peer Recovery Supports
- Women's Health

**Areas Where We Would Like to Serve as a Peer Mentor**

Recovery Support Services, Mobile Crisis Response Services, Living Rooms for Crisis Stabilization and Harm Reduction

**Areas Where We Would Welcome Technical Assistance**

Forming tighter linkages with the State Office of Women's Health and State Office of Rural Health. Assistance with sustainability methods for women's health services through the FQHC model. Technical assistance with billing and reimbursement of psychiatric and MAT services as a Community Mental Health Center in Dept. Human Services (not as a hospital through Dept. Public Health). These are different credentialing for Medicaid billing in our state.

**Intended Audience(s)**

<b>Age:</b>	Adolescents (13-17), Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	White, Hispanic/Latino/Latinx

<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g. cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, Special Populations - People Experiencing Homelessness, Pregnant and Parenting People, People Who Use Drugs

**Organizational Information:**

<b>Project Title:</b>	Access to Services for Pregnant and Postpartum Persons in Northeast Georgia (ASPIriNG)
<b>State:</b>	Georgia
<b>Organization Type:</b>	Institution of Higher Education
<b>Website:</b>	www.augusta.edu
<b>Address:</b>	1120 15th St. Augusta, GA 30912

**Grantee Points of Contact:**

<b>Project Director:</b>	Vahé Heboyan, vheboyan@augusta.edu
<b>Data Coordinator:</b>	Katherine Hatcher, khatcher@augusta.edu
<b>Learning Collaborative Point of Contact:</b>	Marlo Vernon, mvernon@augusta.edu

**Target Service Area(s):**

County, State	
Banks County, GA	Rabun County, GA
Elbert County, GA	Stephens County, GA
Franklin County, GA	Towns County, GA
Habersham County, GA	Union County, GA
Hart County, GA	Walton County, GA
Jackson County, GA	White County, GA

**Partner Organization(s):**

Organization Name	City, State
Georgia Council for Recovery	Atlanta, GA
Georgia Department of Public Health District 2 Office	Gainesville, GA
Habersham Medical Center	Demorest, GA
MedLink Georgia FQHC	Colbert, GA

Organization Name	City, State
Mountain Judicial Circuit Accountability Court	Clarksville, GA
Northeast Georgia Health System	Gainesville, GA
Piedmont Judicial Circuit Accountability Court	Jefferson, GA
Reboot Jackson RCO	Jefferson, GA
Self-Discovery 24 RCO	Toccoa, GA
Union General Hospital	Blairsville, GA

**Project Information:**

**Project Summary**

The Access to Services for Pregnant and Postpartum Persons in Northeast Georgia (ASPIriNG) project provides a comprehensive family-oriented approach to reduce the incidence and impact of neonatal abstinence syndrome (NAS) in 12 rural counties in Northeast Georgia by improving preventive services for persons of childbearing age with or at risk of SUD/ODU and providing comprehensive family-oriented ongoing behavioral healthcare needs and support services for rural pregnant and post-partum persons and their families. These 12 counties are among the most underserved in the state in terms of access to healthcare services, particularly access to primary care and behavioral health services. The rate of NAS in our target service area is almost three times the state's overall rate. Compared to the state average, the majority of target counties have higher rates of fatal and nonfatal overdose rates among women of childbearing age and opioid-related emergency room inpatient visits.

Our consortium includes Augusta University's (AU) Department of Population Health Sciences, AU's Georgia Cancer Center, AU's Institute of Public and Preventive Health, MedLink Georgia FQHC, the Georgia Council for Recovery, Northeast Georgia Medical Center, Reboot Jackson RCO, Self-Discovery 24 RCO, Mountain Judicial and Piedmont Judicial Circuit Accountability Courts, the Georgia Department of Public Health District 2, Habersham Medical Center, and Union General Hospital. We address the program objectives and specific service needs through provider and community-based education/training, improvement of linkages between systems of care, reducing barriers to treatment, and expansion of services within the target service area to include medication-assisted treatment and peer/recovery support services.

**Focus Areas**

- Neonatal Abstinence Syndrome

**Areas Where We Would Like to Serve as a Peer Mentor**

NAS, MAT, Program evaluation, Child and Maternal Health

<b>Intended Audience(s)</b>	
<b>Age:</b>	Children (0-12)
<b>Race/Ethnicity:</b>	White, Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients Health access – Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, People Experiencing Homelessness, Pregnant and Parenting People, Veterans, Justice-Involved/Incarcerated Persons, LGBTQ+ Populations, People Experiencing Food Insecurity, People Who Use Drugs
<b>Other:</b>	Families and Caretakers of People With SUD/OUD

**Organizational Information:**

<b>Project Title:</b>	Baptist Health Deaconess Madisonville FY23 RCORP NAS Integrated Care Consortium
<b>State:</b>	Kentucky
<b>Organization Type:</b>	Health Care Provider
<b>Website:</b>	<a href="https://www.baptisthealthdeaconess.com/">https://www.baptisthealthdeaconess.com/</a>
<b>Address:</b>	900 Hospital Drive Madisonville, KY 42431

**Grantee Points of Contact:**

<b>Project Director:</b>	Julia Kays, <a href="mailto:julia.kays@baptistdeaconess.com">julia.kays@baptistdeaconess.com</a>
--------------------------	--

**Target Service Area(s):**

County, State	
Hopkins, KY	Muhlenberg, KY
Webster, KY	

**Partner Organization(s):**

Organization Name	City, State
Baptist Health Deaconess Madisonville Medical Group	Madisonville, KY
Baptist Health Deaconess Madisonville, Inc.	Madisonville, KY
BrightView	Madisonville, KY
Hopkins County Health Department	Madisonville, KY

**Project Information:**

Project Summary
<p>Baptist Health Deaconess Madisonville Integrated Care Consortium will improve systems of care by collaborating and maximizing resources, thereby making positive impacts on the rural communities we serve. The project service area includes three counties in Western Kentucky. These counties are medically underserved areas in which there is a Mental Health Professionals Shortage Area.</p> <p>We will use an integrated care approach by adding behavioral health staff, creating a strong referral process, and collaborating with partners for targeted case management and peer support for persons impacted by SUD/ODU.</p>

This project will allow us to provide education, health screening, and improved access to medical services. Key deliverables will include an increase in the number of health professionals and other social service professionals who can screen, diagnose, and treat individuals who are at risk of becoming pregnant, are currently pregnant, and/or have recently given birth, and their families; stronger referral processes for MAT/SUD services, and addressing social determinants of health.

We anticipate that the program will positively impact the community by 1) enhancing care for NAS babies, 2) expanding access to comprehensive SUD/ODU care, 3) expanding coordinated care by integrating behavioral health care with primary care and obstetrics and gynecology, 4) addressing social determinants of health and disparities that serve as barriers for accessing treatment services, and 5) providing education and prevention services which will reduce the impact of the opioid crisis in our service area.

**Focus Areas**

- Co-occurring Disorders
- Infant & Child Health
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women’s Health
- Rural Healthcare Provider offering Multiple Services

**Intended Audience(s)**

General population



## Organizational Information:

<b>Project Title:</b>	ReNewed HOPE (Healing, Opportunity, Preservation, Education)
<b>State:</b>	Georgia
<b>Organization Type:</b>	Community based organization, Social Service Provider
<b>Website:</b>	bethany.org/atlanta
<b>Address:</b>	6645 Peachtree Dunwoody Road Atlanta, GA 30328

## Grantee Points of Contact:

<b>Project Director:</b>	Nonyem Nwabuoku-Drayton, ndrayton@bethany.org
<b>Data Coordinator:</b>	Carla Smith, csmith@bethany.org
<b>Learning Collaborative Point of Contact:</b>	Andrea Gibbs Brooks, agibbsbrooks@bethany.org

## Target Service Area(s):

County, State	
Heard County, GA	Troup County, GA
Meriwether County, GA	Upson County, GA

## Partner Organization(s):

Organization Name	City, State
Calumet Center for Healing and Attachment	LaGrange, GA
Children's Clinic of LaGrange, LLC	LaGrange, GA
District 4, Georgia Department of Public Health	LaGrange, GA
First Choice Women's Center	LaGrange, GA
Georgia Department of Human Services, Family & Children Services	Atlanta, GA
Troup Cares, Inc.	LaGrange, GA
Troup County Juvenile Court	LaGrange, GA
Troup Family Connection Authority	LaGrange, GA

Organization Name	City, State
Twin Cedars Youth and Family Services, Inc.	LaGrange, GA
Way Maker Women's Center	Marietta, GA
Wellstar Medical Group, Obstetrics & Gynecology	LaGrange, GA
Wellstar West Georgia Medical Center	LaGrange, GA

**Project Information:**

**Project Summary**

ReNewed HOPE (Healing, Opportunity, Preservation, Education)

Bethany Christian Services has served pregnant women for over 65 years. Through the ReNewed HOPE program, Bethany Christian Services of Georgia (BCSGA) seeks to serve 110 women of childbearing age, pregnant mothers, and infants in rural counties who have been underserved in Troup County as well as residents from adjacent counties of Heard, Meriwether, and Upson who travel to LaGrange (the capital of Troup County) and its surrounding towns to seek SUD/ODU and NAS services not readily available in their local communities.

Recognizing the importance of integrated multi-system service delivery, BCSGA has set out to create a community-driven collaborative to ensure ongoing monitoring, engagement, and improvement of "ReNewed HOPE" stakeholders in Troup County. The ReNewed HOPE Consortium incorporates a planning team of representatives across systems of child welfare; substance abuse treatment & recovery; medicine; behavioral health; and criminal justice who will provide a diverse array of coordinated wraparound services for this target population.

Service on the client or micro level includes a holistic model that utilizes the Treatment Alternatives for Safe Communities (TASC) Specialized Case Management model that encompasses but is not limited to:

- identifying and screening for critical needs and strengths; leveraging science-based tools for assessment; coordinating timely referral/placement into treatment; monitoring; motivating through ongoing specialized case management; utilizing evidence-based programs including Motivational Interviewing and Trust-Based Relational Intervention; and recovery support utilizing a Certified Peer Support Specialist.

On the macro level, the consortium positively impacts community outcomes at large where individuals in need of SUD/ODU services have to access them and are supported in their recovery journey by a community of service providers working together in a COHESIVE manner.

**Focus Areas**

- Infant & Child Health
- Integration of Services
- MOUD/MAT Implementation
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Peer Recovery Supports
- Women’s Health

**Areas Where We Would Welcome Technical Assistance**

Recruitment and Intake, Continuous Quality Improvement, Data Collection, Surveys/Assessments, Community Partnerships

**Intended Audience (s)**

<b>Age:</b>	Children (0-12), Adolescents (13-17), Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	White, Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, People Experiencing Homelessness, Pregnant and Parenting People, Veterans, Justice-Involved/Incarcerated Persons, LGBTQ+ Populations, People Who Use Drugs
<b>Other:</b>	Families and Caretakers of People With SUD/OUD, People With Low Health Literacy, Non-English Speakers

**Organizational Information:**

<b>Project Title:</b>	Rural Health Outreach and Rural Network Development Program
<b>State:</b>	Montana
<b>Organization Type:</b>	FQHC
<b>Website:</b>	www.onechc.org
<b>Address:</b>	10 4th St W, Ste B Hardin, MT 50934-1804

**Grantee Points of Contact:**

<b>Project Director:</b>	Shawnalea Chief Goes Out, shawnalea.chiefgoesout@onechc.org
<b>Data Coordinator:</b>	Sloane Real Bird, sloane.realbird@onechc.org
<b>Learning Collaborative Point of Contact:</b>	Shawnalea Chief Goes Out, shawnalea.chiefgoesout@onechc.org
<b>Health Care Navigator:</b>	Tiffany Klein, tiffany.klein@onechc.org

**Target Service Area(s):**

County, State	
Bighorn County, MT	Judith Basin County, MT
Blaine County, MT	Musselshell County, MT
Custer County, MT	Petroleum County, MT
Fergus County, MT	Rosebud County, MT
Golden Valley County, MT	Wheatland County, MT

**Partner Organization(s):**

Organization Name	City, State
ACCTOUT Psychotherapy and Consultation	Helena, MT
Intermountain Health	Billings, MT
Montana Department of Health and Human Services (DPHHS), Child and Family Services, Region 1	Miles City, MT

Organization Name	City, State
Montana Department of Health and Human Services (DPHHS), Medicaid Office	Helena, MT
Mountain Shadow Associate	Lodge Grass, MT
One Health	Hardin, MT
University of Montana, Rural Institute for Inclusive Communities	Missoula, MT

**Project Information:**

Project Summary	
<p>In light of the demonstrated need and gaps in available services, we propose the following goals for our RCORP-NAS project. Goal #1: Reduce structural- and systems-level barriers (e.g., transportation challenges, limited workforce, reimbursement issues) to (a) increase access to behavioral health care, especially substance use disorders, including opioid use disorder (SUD/OD), services for rural pregnant and postpartum persons and their families; and (b) address community risk factors and social determinants of health. Goal #2: Strengthen the quality and sustainability of behavioral health care services for rural pregnant and postpartum persons and their families by implementing coordinated, evidence-based, trauma-informed, family-centered SUD/OD and other services. Methods for providing behavioral health care services throughout the preconception, prenatal, labor and delivery, and postpartum stages are detailed with these goals in mind.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>• Co-occurring Disorders</li> <li>• Community Health Workers</li> <li>• Infant &amp; Child Health</li> <li>• Integration of Services</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal and Obstetric Care</li> <li>• Neonatal Abstinence Syndrome</li> <li>• Peer Recovery Supports</li> <li>• Women’s Health</li> </ul>
Areas Where We Would Like to Serve as a Peer Mentor	
Recovery Doulas	
Areas Where We Would Welcome Technical Assistance	
Billing	
Intended Audience(s)	
<b>Race/Ethnicity:</b>	Tribal populations/Native Americans/American Indian/Alaska Native
<b>Special Populations:</b>	Pregnant and Parenting People

## Organizational Information:

<b>Project Title:</b>	Rural Communities Opioid Response-Neonatal Abstinence Syndrome Pregnant Lives Un-use Support (RCORP-NAS PLUS)
<b>State:</b>	Minnesota
<b>Organization Type:</b>	Public Health Dental Clinic
<b>Website:</b>	<a href="https://childrensdentalservices.org">https://childrensdentalservices.org</a>
<b>Address:</b>	636 Broadway St NE Minneapolis, MN 55413

## Grantee Points of Contact:

<b>Project Director:</b>	Sarah Wovcha, <a href="mailto:swovcha@childrensdentalservices.org">swovcha@childrensdentalservices.org</a>
<b>Data Coordinator:</b>	Erianna Reyelts, <a href="mailto:ereyelts2@childrensdentalservices.org">ereyelts2@childrensdentalservices.org</a>
<b>Learning Collaborative Point of Contact:</b>	Samantha Cotellessa, <a href="mailto:scotellessa@childrensdentalservices.org">scotellessa@childrensdentalservices.org</a>
<b>Health Care Navigator:</b>	Samantha Cotellessa, <a href="mailto:scotellessa@childrensdentalservices.org">scotellessa@childrensdentalservices.org</a>

## Target Service Area(s):

County, State	
Itasca County, MN	Noles County, MN
Lyon County, MN	Wilkin County, MN

## Partner Organization(s):

Organization Name	City, State
Children's Dental Services	Minneapolis, MN
Ross Resources	Grand Rapids, MN
Southwestern Minnesota Opportunity Council	Worthington, MN
Wilkin County Public Health	Breckenridge, MN

## Project Information:

### Project Summary

Opioids are the leading cause of Minnesota's overdose deaths increasing 17-fold over the past 20 years. Five rural, underserved counties collectively had a more than 10 percent increase in nonfatal opioid overdoses in 2020 compared to 2019. Native Americans experienced a 27 percent increase in that 1-year period and are 10 times more likely to die than White Minnesotans. The target counties experienced higher rates of poverty and unemployment, worse health outcomes, and higher Health Professional Shortage Area designations. Between 2019 and 2020, the diagnoses of NAS at birth increased over 12 percent. RCORP-NAS PLUS will expand services to address preconception and prenatal and labor/delivery needs for individuals at risk of SUD/OD misuse, short- and long-term reduction of harm related to SUD/OD-related illness for postpartum target populations in five fully rural, low-income counties: Itasca, Lyon, Nobles, Redwood, and Wilkin. Additionally, a Native American Liaison & Opioid Use Disorder Prevention Taskforce will engage regional tribal communities and create adapted services. Applying a community-based approach building on successes of past and current RCORP work, NAS PLUS will engage target communities using evidence-based approaches to expand access to NAS services developed by four partners: CDS, Ross Resources, SMOC, Inc. and Wilkin County Public Health. Access to NAS services will be expanded by at least 25 percent across the region, making NAS resources accessible for a target rural population of 114,143. NAS PLUS will involve practitioners, teen parents, immigrant, Tribal, and other BIPOC community groups in implementing innovative, evidence-based approaches to expanding access to NAS services. Results, measured by assessing short- and long-term objectives, will guide continuous quality improvement in improving systems of care, family supports, and social determinants of health for pregnant and postpartum mothers and their families suffering from or at risk of opioid use disorder.

### Focus Areas

- Hub & Spoke Model
- Infant & Child Health
- MOUD/MAT Implementation
- Mobile Healthcare Delivery
- Neonatal Abstinence Syndrome
- Peer Recovery Supports
- Tribal Populations
- Women's Health
- Workforce Development

### Areas Where We Would Like to Serve as a Peer Mentor

Interrelationship between dental care and NAS services

### Intended Audience(s)

<b>Race/Ethnicity:</b>	White, Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People in recovery from SUD/OD, Substance-exposed children and infants
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients
<b>Economic:</b>	Socioeconomically Disadvantaged Population

<b>Special Populations:</b>	Racial and Ethnic Minorities, Pregnant and Parenting People, People Who Use Drugs
-----------------------------	---



**Organizational Information:**

<b>Project Title:</b>	Southwest Missouri Rural Health Network Project to Provide Women's Support and Treatment Access
<b>State:</b>	Missouri
<b>Organization Type:</b>	Rural Local Hospital
<b>Website:</b>	www.citizensmemorial.com
<b>Address:</b>	1500 N. Oakland Ave. Bolivar, MO 65613

**Grantee Points of Contact:**

<b>Project Director:</b>	Christina Bravata, christina.bravata@citizensmemorial.com
--------------------------	---

**Target Service Area(s):**

County, State	
Benton County, MO	Hickory County, MO
Dade County, MO	Polk County, MO
Dallas County, MO	St. Clair County, MO

**Partner Organization(s):**

Organization Name	City, State
30th Children's Circuit	Bolivar, MO
Begin Again Ministries	Bolivar, MO
Bolivar Police Department	Bolivar, MO
CMH EMS Services	Bolivar, MO
CMH OB/GYN Clinic	Bolivar, MO
Polk County Health Department	Bolivar, MO
Thrive Ministries	Bolivar, MO

**Project Information:**

**Project Summary**

The Southwest Missouri Rural Health Services network will collaborate to provide resources and services to vulnerable women and their families who may be at risk for SUD and its impact within their homes. Each network member is committed to supporting at-risk community members impacted by social determinants of health, lack of resources, and other barriers to treatment access. Services and resources supported through the consortium will be accessible to all community members to benefit the health and wellness of the rural population through partnerships and accessible services.

Each network member is committed to coordinating services to make treatment for SUD accessible, manageable, and sustainable. This includes prenatal care, MAT, daycare access, family support services, counseling, cognitive behavioral therapy, and peer support.

Coordinating services that support the physical, mental, and emotional well-being of individuals in the rural communities served through the Network will directly impact overall health and wellness of this generation and generations to come.

**Focus Areas**

- MOUD/MAT Implementation

**Areas Where We Would Like to Serve as a Peer Mentor**

MAT Access in a Rural Setting

**Areas Where We Would Welcome Technical Assistance**

Coordination with Jail/Prison Systems

**Intended Audience(s)**

<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g. cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Special Populations:</b>	Pregnant and Parenting People, People Who Use Drugs
<b>Other:</b>	Families and Caretakers of People With SUD/OUD

**Organizational Information:**

<b>Project Title:</b>	Community Care of West Virginia, Inc.
<b>State:</b>	West Virginia
<b>Organization Type:</b>	FQHC
<b>Website:</b>	www.ccwv.org
<b>Address:</b>	78 Queens Alley Road Rock Cave, WV 26234

**Grantee Points of Contact:**

<b>Project Director:</b>	Laura Meadows, laura.meadows@ccwv.org
<b>Data Coordinator:</b>	Genevieve Dunn, genevieve.dunn@ccwv.org
<b>Learning Collaborative Point of Contact:</b>	Laura Meadows, laura.meadows@ccwv.org

**Target Service Area(s):**

County, State	
Lewis County, WV	Upshur County, WV

**Partner Organization(s):**

Organization Name	City, State
Lewis County Schools	Weston, WV
Mountain CAP of West Virginia	Buckhannon, WV
Saint Joseph's Hospital, WVU Medicine	Buckhannon, WV
Upshur County Development Authority	Buckhannon, WV
Upshur County Schools	Upshur, WV
Upshur County Sheriff	Buckhannon, WV
WV Prevention Solutions	Clarksburg, WV

**Project Information:**

**Project Summary**

Together with its Consortium of providers and other key stakeholders, Community Care of West Virginia will provide services to people with SUD/ODU in the target rural service area who are at risk of becoming pregnant, are currently pregnant, or have recently given birth, as well as their families.

CCWV will take the lead in addressing the need for contraception, prevention, and treatment access to individuals of childbearing age who have, or are at risk for, SUD/ODU. Clearly, the in-utero exposure of infants to substances is rising along with the substance use rates in this region, putting more women and infants at risk for potentially long-term negative consequences. A united partnership with Saint Joseph’s Hospital, WVU Medicine’s OB-GYN department will expand this project’s impact. This project will also extend efforts to improve NAS affected infants by engaging mothers and families with additional supportive services to aid in early childhood development.

This Consortium will also spearhead efforts to educate key groups on best practices that improve the engagement and/or early intervention of individuals of childbearing age into treatment. Evidence-based information will be disseminated to engage those in need of treatment services. In addition, expanding education and decreasing stigma throughout the target rural service area will be addressed through a series of monthly educational seminars and trainings.

**Focus Areas**

- Community Behavioral Health
- Integration of Services
- MOUD/MAT Implementation
- Neonatal Abstinence Syndrome
- Peer Recovery Supports
- School-Based Care

**Areas Where We Would Like to Serve as a Peer Mentor**

Implementing a MAT program in a rural area.

**Areas Where We Would Welcome Technical Assistance**

Leading a community-based effort focused on pregnant mothers, infants and their families affected by SUD/ODU.

**Intended Audience(s)**

<b>Health Status:</b>	People with/at risk for OUD or SUD, Substance-exposed children and infants
<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Other:</b>	Families and Caretakers of People With SUD/ODU

**Organizational Information:**

<b>Project Title:</b>	Idaho Pregnant and Parenting Opioid Support System
<b>State:</b>	Idaho
<b>Organization Type:</b>	Behavioral Health Provider, Community based organization, Health Care Provider, Public Health Organization
<b>Website:</b>	C-who.org
<b>Address:</b>	11485 Payette Heights Rd. Payette, ID 836551

**Grantee Points of Contact:**

<b>Project Director:</b>	Rachel Blanton, Rachelbh@c-who.org
<b>Data Coordinator:</b>	I-Ting Wu, ItingW@c-who.org
<b>Learning Collaborative Point of Contact:</b>	Elise Winbrock, EliseW@c-who.org
<b>Health Care Navigator:</b>	Sam Tackitt, Stackitt@efsps.org

**Target Service Area(s):**

County, State	
Bingham County, ID	Gem County, ID
Cassia County, ID	Lincoln County, ID
Gooding County, ID	Twin Falls County, ID

**Partner Organization(s):**

Organization Name	City, State
Bingham Memorial	Blackfoot, ID
Cornerstone Whole Healthcare Organization	Payette, ID
Family Health Services	Twin Falls, ID
Idaho Department of Health and Welfare	Boise, ID
Marimn Health	Plummet, ID
Valor Health	Emmett, ID

**Project Information:**

**Project Summary**

The purpose of the I-PPOSS project is to initiate a systematic response to the crisis of perinatal SUD in Idaho by addressing partnership, rural clinical care capacity, housing stability, availability of referral and consultation pathways, and data collection/monitoring.

The I-PPOSS Program will target the following goals:

1. Develop a nursing and peer support consultation service for rural and frontier primary care teams and patients at sites across the state.
2. Create a rural primary care/critical access learning collaborative focused on perinatal OUD.
3. Coordinate with Idaho Department of Health and Welfare to conduct a feasibility study on collection of NAS data.
4. Pilot care coordination huddle for perinatal OUD cases between clinical providers, social services, and local law enforcement agencies.
5. Pilot a housing voucher program for women who screen positive for SUD and housing insecurity.
6. Evaluate program impact in areas of implementation to promote sustainability and scaling.

As a result of the aforementioned goals, I-PPOSS Project Team and partners anticipate the following outcomes: solidified state-wide strategy to collect and share NAS data; support and non-stigmatizing education for pregnant and parenting patients struggling with OUD; promote increased MOUD treatment and adherence among target population; increased confidence and implementation of standards of care for pregnant patients with MOUD; reduced adverse birth outcomes among women served; increased housing stability among the target population; reduced ACEs among children of women with OUD.

**Focus Areas**

- Co-occurring Disorders
- Community Behavioral Health
- Hub & Spoke Model
- Infant & Child Health
- MOUD/MAT Implementation
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Peer Recovery Supports
- Unhoused Populations
- Women’s Health

**Areas Where We Would Like to Serve as a Peer Mentor**

Behavioral health integration; rural primary care; data analysis

**Areas Where We Would Welcome Technical Assistance**

Housing; maternal mental health; care of substance exposed newborn

**Intended Audience(s)**

**Age:** Children (0-12), Young Adult (18-24), Adult (25-64)

<b>Race/Ethnicity:</b>	Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, People living with disabilities, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, People Experiencing Homelessness, Pregnant and Parenting People, Justice-Involved/Incarcerated Persons, LGBTQ+ Populations, People Experiencing Food Insecurity, People Who Use Drugs
<b>Other:</b>	Families and Caretakers of People With SUD/OUD, Healthcare Workers and Providers, Law Enforcement and First Responders, People With Low Health Literacy, Non-English Speakers

**Organizational Information:**

<b>Project Title:</b>	Schuylkill County Pregnant and Postpartum NAS Prevention & Support Services
<b>State:</b>	Pennsylvania
<b>Organization Type:</b>	Behavioral Health Provider, Substance Use Disorder Provider
<b>Address:</b>	200 N 7th St. Lebanon, PA 17046

**Grantee Points of Contact:**

<b>Project Director:</b>	Kendell Jones, kejjones@pacounseling.com
--------------------------	--

**Target Service Area(s):**

County, State
Schuylkill County, PA

**Partner Organization(s):**

Organization Name	City, State
Gaudenzia Addiction Treatment & Recovery Services	Lebanon, PA
Ilene K. Weizer, MD	Pottsville, PA
Nurse Family Partnership	Pottsville, PA
Pennsylvania Counseling Services	Lebanon, PA
Schuylkill County Adult Probation & Parole Department	Pottsville, PA
Schuylkill County Child and Adolescent Service System Program	Lebanon, PA
Schuylkill County MH/DS/DA Department	Pottsville, PA
Services Access and Management, Inc.	Pottsville, PA
Silver Pines Treatment Center	Lebanon, PA



**Project Information:**

Project Summary	
<p>Counseling Management Services and consortium partners will address health equity within the target rural service area of Schuylkill County, Pennsylvania, through professional development and training opportunities, community engagement, and stigma reduction campaigns. The consortium partners will work collaboratively to provide holistic care across physical and behavioral health sectors, and in conjunction with social services, community supervision to pregnant women, or women of childbearing age, with SUD or who are at-risk of SUD. Additional wraparound services and community referrals will ensure a continuity of care for families with NAS affected infants, while decreasing barriers and increasing access and engagement to treatment.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>• Adolescent Health</li> <li>• Co-occurring Disorders</li> <li>• Community Behavioral Health</li> <li>• MOUD/MAT Implementation</li> <li>• Neonatal Abstinence Syndrome</li> <li>• Peer Recovery Supports</li> </ul>	
Intended Audience (s)	
<b>Age:</b>	Young Adult (18-24), Adult (25-64)
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Special Populations:</b>	Pregnant and Parenting People
<b>Other:</b>	Families and Caretakers of People With SUD/OUD

**Organizational Information:**

<b>Project Title:</b>	Fairview Health Services
<b>State:</b>	Minnesota
<b>Organization Type:</b>	Rural Local Hospital
<b>Website:</b>	www.granditasca.org
<b>Address:</b>	1601 Golf Course Road Grand Rapids, MN 55744

**Grantee Points of Contact:**

<b>Project Director:</b>	Andrea Carter, Andrea.Major@Fairview.org
--------------------------	--

**Target Service Area(s):**

County, State	
Itasca County, MN	Cass County, MN
Beltrami County, MN	Koochiching County, MN

**Partner Organization(s):**

Organization Name	City, State
Grand Itasca Clinic & Hospital - OB/GYN Dept	Grand Rapids, MN
Grand Itasca Clinic & Hospital - Pediatric & Family Medicine Depts	Grand Rapids, MN
IMCare	Grand Rapids, MN
Itasca County Attorney's Office	Grand Rapids, MN
Itasca County HHS	Grand Rapids, MN
Itasca County Public Health	Grand Rapids, MN
Itasca County Sheriff's Office	Grand Rapids, MN
Leech Lake Band of Ojibwe	Cass Lake, MN
Ross Resources	Grand Rapids, MN

**Project Information:**

**Project Summary**

The project will facilitate no less than quarterly lunch-and-learn for GICH providers on topics related to SUD/ODU access and treatment and best practices for women, birthing, and their families through training related to screening and referral tools, motivational interviewing, trauma-informed care, care coordination, stigma reduction, managing medical complications in children with NAS, and harm reduction programs. Second, three key clinical leaders will work with the consortium to help meet the goals. The providers will help give health education resources to community members on healthy pregnancy, prenatal care access, risks to mom and baby of substance use during pregnancy. The Cultural Broker will work with the criminal justice system, social services, ED, and community action sites, to provide community-based, individually tailored services to clients. The members represent criminal justice, child welfare, and social services. The RN Care Coordinator role will be critical to this coordination, serving as a key trainer and supportive leader throughout this process. The proposed project goal is to reduce the incidence and impact of neonatal abstinence syndrome in the target rural service area by improving clinical and social services systems of care, and cultural and family supports. Over the three-year period of performance, the Grand Rapids RCORP project will

- (1) Reduce structural- and systems-level barriers within the rural target service area to
  - (a) Increase access to behavioral health care, specifically SUD/ODU, services for rural pregnant and postpartum persons and their families; and
  - (b) Address community risk factors and social determinants of health.
- (2) Strengthen the quality and sustainability of behavioral health care services for rural pregnant and postpartum persons and their families in the service area by implementing coordinated, evidence-based, family-centered SUD/ODU and other services.

**Focus Areas**

- Infant & Child Health
- MOUD/MAT Implementation
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Tribal Populations
- Women’s Health

**Areas Where We Would Welcome Technical Assistance**

Keeping consortium engaged, How to align MAT with NAS but keep the focus on NAS, Getting providers interested in MAT

**Intended Audience(s)**

<b>Age:</b>	Children (0-12)
<b>Race/Ethnicity:</b>	White, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, Substance-exposed children and infants
<b>Health Access:</b>	Medicaid or Medicare recipients

<b>Special Populations:</b>	Pregnant and Parenting People
<b>Other:</b>	Families and Caretakers of People With SUD/OD, Healthcare Workers and Providers

**Organizational Information:**

<b>Project Title:</b>	Fairview Park LP
<b>State:</b>	Georgia
<b>Organization Type:</b>	Rural Regional Hospital
<b>Website:</b>	<a href="https://fairviewparkhospital.com/">https://fairviewparkhospital.com/</a>
<b>Address:</b>	200 Industrial Blvd. Dublin, GA 31021-2981

**Grantee Points of Contact:**

<b>Project Director:</b>	Candace Murbach, <a href="mailto:candace.murbach@hcahealthcare.com">candace.murbach@hcahealthcare.com</a>
<b>Data Coordinator:</b>	Brad Lian, PhD, <a href="mailto:blian_be@mercer.edu">blian_be@mercer.edu</a>
<b>Learning Collaborative Point of Contact:</b>	Candace Murbach, DO, <a href="mailto:candace.murbach@hcahealthcare.com">candace.murbach@hcahealthcare.com</a>
<b>Health Care Navigator:</b>	Kenneth Howell, <a href="mailto:Kenneth.howell@hcahealthcare.com">Kenneth.howell@hcahealthcare.com</a>

**Target Service Area(s):**

County, State	
Bleckley County, GA	Treutlen County, GA
Dodge County, GA	Twiggs County, GA
Johnson County, GA	Wheeler County, GA
Laurens County, GA	Wilkinson County, GA

**Partner Organization(s):**

Organization Name	City, State
Babies Can't Wait	Dublin, GA
Community Health Care Systems, Inc.	Dublin, GA
Fairview Park Hospital	Dublin, GA
Gateway Community Service Board	Savannah, GA
Georgia State Office of Rural Health	Atlanta, GA
Mercer University School of Medicine	Macon, GA

**Project Information:**

**Project Summary**

Rural Georgia counties experience disproportionately poor outcomes compared to the rest of the state as well as the country. Behavioral health outcomes, SUD/ODU rates, including instances of Neonatal Abstinence Syndrome (NAS), and maternal health outcomes are no exception to this disparity. Without proper treatment and monitoring, NAS has the potential to result in poor health outcomes for generations of children and their families. With these vital outcomes at stake, it is clear there is an urgent need for intensive NAS intervention that takes a whole-patient approach to prevention, treatment, and recovery. In an effort to pursue this solution, Fairview Park Hospital proposes to form a multisectoral consortium of experts in behavioral health, primary care, rural health, women's health, early childhood education, and medical education to provide a solution that is tailored to the unique needs of the counties involved in this grant. The target population of this effort are at risk of becoming pregnant and are living with addiction. Each of the consortium members has committed their support to actively participating in creating a program that will continue to grow and serve the target population long after the grant period of performance has concluded. The diversity of expertise provided by each consortium member will lend itself to a program that is well-rounded and inclusive of the unique challenges facing the population of these counties most affected by NAS. Each consortium member is well established in the community based on their achievements not only as individuals but also as collaborators with others in the community. Through strategic planning efforts and continuous collaboration, the proposed consortium plans to create an NAS intervention program that is specifically tailored to our community and that is set up to grow and adapt to the changing needs of the target population.

**Focus Areas**

- Neonatal Abstinence Syndrome

**Areas Where We Would Welcome Technical Assistance**

All areas

**Intended Audience (s)**

<b>Age:</b>	Children (0-12)
<b>Health Status:</b>	People with/at risk for OUD or SUD, People in recovery from SUD/ODU, Substance-exposed children and infants
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Special Populations:</b>	Pregnant and Parenting People
<b>Other:</b>	People With Low Health Literacy

**Organizational Information:**

<b>Project Title:</b>	HOPE Consortium Perinatal Support Project
<b>State:</b>	Wisconsin
<b>Organization Type:</b>	FQHC
<b>Website:</b>	hopeconsortium.org
<b>Address:</b>	1000 N. Oak Ave. Marshfield, WI 54449

**Grantee Points of Contact:**

<b>Project Director:</b>	Danielle Luther, luther.danielle@marshfieldclinic.org
<b>Data Coordinator:</b>	Rachel Stankowski, stankowski.rachel@marshfieldclinic.org
<b>Learning Collaborative Point of Contact:</b>	Wayne Sorenson, yeater.jean@marshfieldclinic.org
<b>Health Care Navigator:</b>	Jean Yeater, yeater.jean@marshfieldclinic.org

**Target Service Area(s):**

County, State	
Barron County, WI	Polk County, WI
Clark County, WI	Portage County, WI
Forest County, WI	Price County, WI
Iron County, WI	Rusk County, WI
Jackson County, WI	Vilas County, WI
Oneida County, WI	Wood County, WI

**Partner Organization(s):**

Organization Name	City, State
Children's Service Society of Wisconsin	Rhineland, WI
Family Health Center of Marshfield, Inc.	Marshfield, WI
Marshfield Clinic Health System – Minocqua, Women's Health & Pediatrics	Minocqua, WI

Organization Name	City, State
Oneida County Department of Social Services	Rhineland, WI
Peter Christianson Health Center	Lac du Flambeau, WI
Wisconsin Association for Perinatal Care	Madison, WI
Wisconsin Department of Corrections, Division of Community Corrections	Oconto, WI
Wisconsin Department of Health Services, Division of Medicaid Services	Madison, WI
Wisconsin Northern Highland Area Health Education Center, Inc.	Rhineland, WI

**Project Information:**

**Project Summary**

Family Health Center of Marshfield, Inc. plans to use the HRSA RCORP-NAS grant to reduce the incidence and impact of NAS in rural central, northern, and western Wisconsin through the HOPE Consortium partnership. Initiatives will support individuals affected by substance use disorder (SUD) who are at risk of becoming pregnant, are currently pregnant, and/or have recently given birth, as well as their families, who reside in: Barron, Clark, Forest, Iron, Jackson, Oneida, Polk, Portage, Price, Rusk, Vilas, and Wood Counties and the Forest County Potawatomi, Ho-Chunk, Lac du Flambeau Chippewa, and Sokaogon Chippewa Tribal Nations. With a total population of 397,943, the rural service area is characterized by a higher proportion of residents who are Native American, over 65 years of age, disabled, or military veterans than in the state of Wisconsin overall. Pregnant persons represent a sub-population with an especially high prevalence of SUD. Rates of NAS in the service area have increased since 2018, ranging from 4.1–10.9/1,000 births in 2021, even as statewide rates decreased (6.1/1,000 birth). Recognizing that Indigenous people and those making 200–400 percent of the federal poverty level are at elevated risk for inequity relevant to accessing SUD treatment, strategies will be rooted in the concept of cultural safety while providing access to experts in financial trauma and perinatal care. The following activities will be completed by August 31, 2026: 1) Support regional HOPE Consortium Perinatal Workgroups and infrastructure to encourage collaborative service delivery to help prevent, treat, and care for opioid-exposed infants; 2) Provide education such as lactation certification and doula trainings for service area care providers; 3) Increase opportunities for access to contraceptives, infectious disease testing, perinatal nursing support, and resource connections; and 4) Address immediate needs such as transportation, safe and sober housing, and peer support.

**Focus Areas**

- Neonatal Abstinence Syndrome
- Tribal Populations



**Areas Where We Would Like to Serve as a Peer Mentor**

Family Health Center is willing to serve as a peer mentor for consortium capacity building and infrastructure as well as coordinating trainings and implementing the novel RentReady housing program.

**Areas Where We Would Welcome Technical Assistance**

Family Health Center would like technical assistance on funding for doula programs, training primary care providers on NAS recognition and support, and best practices for universal screening.

**Intended Audience(s)**

<b>Race/Ethnicity:</b>	Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, Substance-exposed children, and infants
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Special Populations:</b>	People Experiencing Homelessness, Pregnant and Parenting People

**Organizational Information:**

<b>Project Title:</b>	Gaston Family Health Services, Inc.
<b>State:</b>	North Carolina
<b>Organization Type:</b>	FQHC
<b>Address:</b>	200 E Second Ave. Gastonia, NC 28052

**Grantee Points of Contact:**

<b>Project Director:</b>	Anna Diggs, adiggs@kintegra.org
<b>Data Coordinator:</b>	Daniel Whitmore, dwhitmore@kintegra.org

**Target Service Area(s):**

County, State
Cleveland County, NC

**Partner Organization(s):**

Organization Name	City, State
Atrium Shelby Women's Care	Shelby, NC
Cleveland County Department of Social Services	Shelby, NC
Cleveland County Health Department	Shelby, NC
Olive Branch Ministry	Shelby, NC

**Project Information:**

Project Summary
<p>The objective of this collaboration is to create a consortium in which all entities are working to improve NAS incident and impact through SUD/ODU prevention, treatment, and recovery efforts for individuals and families within Cleveland County.</p> <p>The consortium will support the delivery of health- and human-related services for individuals of Cleveland County, especially focused on vulnerable citizens – children, elderly, disabled, and low-income families. Working to assure, enhance, and protect with a mission of creating a healthy and safe community to live. Further, provide guidance and technical assistance to agencies that provide direct services that address issues of poverty, family violence and exploitation. Focus on promoting self-reliance and work to prevent abuse, neglect, dependency and exploitation of vulnerable individuals, children, and families of Cleveland County. Atrium Health is an integrated, nonprofit healthcare system, nationally recognized as a</p>

leader in shaping health outcomes, delivering services at 40 hospitals and more than 1,400 locations.

Atrium Health was recognized by Newsweek in 2022 as one of America’s best Maternal Hospitals. Atrium Health Cleveland hospital provides maternity services, specifically focused on highest risk patients in the region.

**Focus Areas**

- Community Behavioral Health
- MOUD/MAT Implementation
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women’s Health

**Areas Where We Would Welcome Technical Assistance**

Creative ways to integrate prevention of NAS/ODU in schools.

**Intended Audience(s)**

<b>Age:</b>	Adolescents (13-17), Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/ODU, People living with disabilities, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, People Experiencing Homelessness, Pregnant and Parenting People, Veterans, Justice-Involved/Incarcerated Persons, LGBTQ+ Populations, People Experiencing Food Insecurity, People Who Use Drugs
<b>Other:</b>	Families and Caretakers of People With SUD/ODU, Healthcare Workers and Providers, Law Enforcement and First Responders, Non-English Speakers

# Genesee Council on Alcoholism and Substance Abuse, Inc.

## Organizational Information:

<b>Project Title:</b>	Genesee Council On Alcoholism And Substance Abuse, Inc.
<b>State:</b>	New York
<b>Organization Type:</b>	Substance Use Disorder Provider
<b>Website:</b>	<a href="https://oasas.ny.gov/location/genesee-council-alcoholism-and-substance-abuse-inc-gcasa">https://oasas.ny.gov/location/genesee-council-alcoholism-and-substance-abuse-inc-gcasa</a>
<b>Address:</b>	430 East Main Street Batavia, NY 14020

## Grantee Points of Contact:

<b>Project Director:</b>	Amy Kabel, <a href="mailto:akabel@uconnectcare.org">akabel@uconnectcare.org</a>
<b>Data Coordinator:</b>	Jessica Budzinack, <a href="mailto:jbudzinack@uconnectcare.org">jbudzinack@uconnectcare.org</a>

## Target Service Area(s):

County, State
Orleans County, NY

## Partner Organization(s):

Organization Name	City, State
Finger Lakes Independent Provider Association	Ithaca, NY
Genesee County Mental Health Department	Batavia, NY
Genesee County Public Health Department	Batavia, NY
Lake Plains Community Care Network	Batavia, NY
Oak Orchard Health	Hornell, NY
Oak Orchard WIC Program	Batavia, NY
Orleans County Public Health Department	Albion, NY
Rochester Regional Health/UMM MOMS Program	Rochester, NY

**Project Information:**

<b>Project Summary</b>
<p>To reduce (1) the morbidity and mortality of substance use disorder (SUD) (including opioid use disorder (OUD)) and (2) the incidence and impact of Neonatal Abstinence Syndrome (NAS) in Genesee and Orleans Counties by improving systems of care, family supports, and social determinants of health. NAS is a group of conditions that can occur when newborns withdraw from certain substances, including opioids, that they were exposed to before birth.</p> <p>Our project goals are to:</p> <ol style="list-style-type: none"> <li>1. Reduce structural- and systems-level barriers (e.g., transportation challenges, limited workforce, reimbursement issues, etc.) to:             <ol style="list-style-type: none"> <li>a. Increase access to behavioral health care, especially SUD/OUD, services for rural pregnant and postpartum persons and their families; and</li> <li>b. Address community risk factors and social determinants of health.</li> </ol> </li> <li>2. Strengthen the quality and sustainability of behavioral health care services for rural pregnant and postpartum persons and their families by implementing coordinated, evidence-based, trauma-informed, family-centered SUD/OUD and other services.</li> </ol>
<b>Focus Areas</b>
<ul style="list-style-type: none"> <li>• Neonatal Abstinence Syndrome</li> </ul>
<b>Intended Audience(s)</b>
<p>General population</p>

**Organizational Information:**

<b>Project Title:</b>	Crow Creek Sioux Tribe RCORP NAS Project
<b>State:</b>	South Dakota
<b>Organization Type:</b>	Tribal Government
<b>Website:</b>	www.hunkpatioyate.org
<b>Address:</b>	225 Sam Boy Dr. Fort Thompson, SD 57339

**Grantee Points of Contact:**

<b>Project Director:</b>	Jean Nahomni Mani, jean.nahomni.mani@gptchb.org
<b>Data Coordinator:</b>	Jean Nahomni Mani, jean.nahomni.mani@gptchb.org

**Target Service Area(s):**

County, State	
Buffalo County, SD	Hughes County, SD
Hyde County, SD	

**Partner Organization(s):**

Organization Name	City, State
Crow Creek Sioux Tribe	Fort Thompson, SD
Diamond Willow Ministries	Fort Thompson, SD
Family Enrichment - Lower Brule Community College	Fort Thompson, SD
Great Plains Tribal Leaders Health Board	Rapid City, SD
HorizonHealth Care Clinic	Fort Thompson, SD

**Project Information:**

Project Summary
The Great Plains Tribal Leaders Health Board staff are located on the Crow Creek Sioux reservation; the office is located in Fort Thompson, South Dakota. The goals are: Promote the prevention of OUD, SUD, and NAS, access to treatment, and recovery support, and use Dakota culture and language to support the goals of the RCORP-NAS Project and the efforts to develop Dakota cultural knowledge and traditions as evidence-based prevention and healing efforts for OUD, NAS and SUD.

Focus Areas	
<ul style="list-style-type: none"> <li>Neonatal Abstinence Syndrome</li> </ul>	
Areas Where We Would Like to Serve as a Peer Mentor	
Promote Prevention of OUD, SUD, and NAS, Access to Treatment, Recovery support and use Dakota culture and language to support goals of RCORP NAS Project.	
Areas Where We Would Welcome Technical Assistance	
Native American support to incorporate traditional ceremonies and teachings that promote sobriety and recovery from OUD, SUD, and prevention of NAS.	
Intended Audience(s)	
<b>Age:</b>	Adolescents (13-17), Young Adult (18-24), Adult (25-64), Older Adult (65+)
<b>Race/Ethnicity:</b>	Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, People living with disabilities, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, People Experiencing Homelessness, Pregnant and Parenting People, Veterans, Justice-Involved/Incarcerated Persons, LGBTQ+ Populations, People Experiencing Food Insecurity, People Who Use Drugs
<b>Other:</b>	Families and Caretakers of People With SUD/OUD, Healthcare Workers and Providers, Law Enforcement and First Responders, People With Low Health Literacy

**Organizational Information:**

<b>Project Title:</b>	Reducing the Impact of Neonatal Abstinence Syndrome in Northwest Pennsylvania
<b>State:</b>	Pennsylvania
<b>Organization Type:</b>	Community based organization
<b>Website:</b>	www.hamothhealthfoundation.org
<b>Address:</b>	201 State Street Erie, PA 16550

**Grantee Points of Contact:**

<b>Project Director:</b>	Michelle Wright, DO, wrigml@upmc.edu
<b>Data Coordinator:</b>	Annmarie Kutz, kutza@upmc.edu
<b>Learning Collaborative Point of Contact:</b>	Elizabeth Krans, MD, MSc, kransee@upmc.edu
<b>Health Care Navigator:</b>	Samantha Hartle, hartles3@upmc.edu Elizabeth

**Target Service Area(s):**

County, State	
Clarion County, PA	Venango County, PA
Crawford County, PA	

**Partner Organization(s):**

Organization Name	City, State
Hamot Health Foundation	Erie, PA
Pennsylvania Department of Human Services	Pittsburgh, PA
Primary Health Network	Clarion, PA
UPMC Magee-Womens Hospital	Pittsburgh, PA
UPMC Magee-Womens Specialty Service at UPMC Northwest	Clarion, PA
UPMC Northwest	Seneca, PA
UPMC Pediatric Service at UPMC Northwest	Seneca, PA



Organization Name	City, State
UPMC Western Behavioral Health at Safe Harbor	Franklin, PA
UPMC Western Psychiatric Hospital	Pittsburgh, PA
Venango County Human Services	Franklin, PA

**Project Information:**

**Project Summary**

Our goal is to reduce the incidence and impact of NAS by improving systems of care, coordinating services across clinical settings, and expanding family supports for rural pregnant and postpartum individuals and their families. Our innovative program will facilitate the adoption of evidence-based practices in our target service area designed in response to unmet needs and gaps in care that contribute to adverse outcomes among individuals and their families in NWP. These include (a) a lack of trained providers to deliver "point of care" addiction medicine services including the initiation of medications for OUD (MOUD) for pregnant individuals, (b) a lack of dedicated personnel to support neonatal interventions to decrease NAS severity, (c) a lack case management services (e.g., Plans of Safe Care) to bridge the gaps between inpatient and outpatient clinical care settings, service systems, and recovery supports, and (d) a lack of outpatient services to address social determinants of health (SDOH) and physical health needs (e.g., HCV/HIV). Initiatives will address these gaps by developing, implementing, and sustaining programs and services across community and clinical settings including:

- a. a Parent Partnership Unit, a rooming-in unit that will utilize Eat, Sleep, and Console
- b. a PPU Nurse Navigator providing case management , Plans of Safe Care and who will work with the Nurse Health Navigator to integrate inpatient with outpatient services
- c. a Peer Recovery Specialist
- d. a peer-to-peer addiction medicine education, mentoring, and consultation program
- e. the development of clinical pathways for SUD, HCV/HIV, intimate partner violence (IPV), and SDOH screening across clinical settings.
- f. remotely delivered telehealth HCV consultations designed specifically for pregnant and postpartum individuals with SUD
- g. outpatient SUD treatment services to seamlessly bridge care transitions that between inpatient and outpatient clinical settings

**Focus Areas**

- Integration of Services
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women’s Health

**Intended Audience(s)**

<b>Special Populations:</b>	Justice-Involved/Incarcerated Persons
-----------------------------	---------------------------------------

**Organizational Information:**

<b>Project Title:</b>	Partnerships to Reduce NAS in Southeast Ohio
<b>State:</b>	Ohio
<b>Organization Type:</b>	FQHC
<b>Website:</b>	www.hopewellhealth.org
<b>Address:</b>	215 Columbus Road Athens, OH 45701

**Grantee Points of Contact:**

<b>Project Director:</b>	Sherry Shamblin, sherry.shamblin@hopewellhealth.org
<b>Data Coordinator:</b>	Richard Wittberg, Richard.Wittberg@hopewellhealth.org
<b>Learning Collaborative Point of Contact:</b>	Tammy Hogsett, Tammy.Hogsett@Hopewellhealth.org

**Target Service Area(s):**

County, State	
Athens County, OH	Meigs County, OH
Gallia County, OH	Perry County, OH
Hocking County, OH	Vinton County, OH
Jackson County, OH	Washington County, OH

**Partner Organization(s):**

Organization Name	City, State
Alexander Local Schools	Athens, OH
Christian Life Academy	Jackson, OH
COAD	Athens, OH
Hopewell Health Centers	Athens, OH
Life and Purpose Community Resource Center	Marietta, OH
Marietta Memorial Health Systems	Marietta, OH
PACS Network/Membership	Athens, OH

Organization Name	City, State
The Athens Photographic Project	Athens, OH
Washington County Jobs and Family Services	Marietta, OH

**Project Information:**

Project Summary	
<p>Hopewell Health Centers (HHC) is the grantee on behalf of the PACS (Partnering to Achieve Compliance and Savings) Consortium in rural Appalachian Ohio. The PACS was formed in 2019 and brings together the regional FQHC, local health departments, managed care plans, Ohio University, and other stakeholders interested in implementing and sustaining community health workers (CHWs) to address health disparities. One success was the implementation the Pathways HUB model, whereby managed care plans contract with the HUB to complete care pathways, many focused on maternal and child health. In this new project, PACS will work with partners to increase the network's capacity to reduce the incidence and impact of NAS by (1) Creating a NAS subcommittee to the PACS Network that will bring expertise and equip the consortium to address NAS; (2) Better addressing preconception needs of individuals impacted by SUD/ODU by hiring and sustaining a RN Health Navigator to screen, identify, link, and coordinate the care of individuals served by Marietta Health Systems in the ER and/or are being served by the OB/GYN; (3) Better addressing the prenatal and delivery needs of individuals impacted by SUD/ODU through training efforts to OB/GYN providers, increasing providers who are able to provide MAT services to this population, reducing barriers to care through implementation of the healthcare navigator, peer recovery support in the community resource center, and stigma reduction aimed at the population through Athens Photographic project – all while leveraging the Pathways HUB/Medicaid managed care relationships to sustain these efforts post grant; and (4) Better addressing postpartum needs of caregivers and children impacted by NAS by leveraging HHC's early intervention team and trauma-informed teams to provide supports in school districts which act as community hubs and the community resource center.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>Community Health Workers</li> <li>Maternal and Obstetric Care</li> <li>Neonatal Abstinence Syndrome</li> </ul>	<ul style="list-style-type: none"> <li>Peer Recovery Supports</li> <li>Workforce Development</li> </ul>
Areas Where We Would Like to Serve as a Peer Mentor	
<p>Infant/Early Childhood Consultation; School-based prevention; Use of Community Health Workers/overlap with Peer Support</p>	
Areas Where We Would Welcome Technical Assistance	
<p>Maternal Child Health</p>	
Intended Audience(s)	
<p><b>Health Status:</b></p>	<p>People with/at risk for OUD or SUD, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/ODU, Substance-exposed children and infants,</p>

	People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Special Populations:</b>	Pregnant and Parenting People
<b>Other:</b>	Rural Appalachian Families

**Organizational Information:**

<b>Project Title:</b>	Increasing Responsive Support through the San Luis Valley Neonatal Task Force (SaVaNT)
<b>State:</b>	Colorado
<b>Organization Type:</b>	Community based organization
<b>Website:</b>	www.illuminatecolorado.org
<b>Address:</b>	951 20th Street #1860 Denver, CO 80201

**Grantee Points of Contact:**

<b>Project Director:</b>	Jillian Fabricius, jfabricius@illuminatecolorado.org
<b>Data Coordinator:</b>	Anna Van Slyke, avanslyke@illuminatecolorado.org
<b>Learning Collaborative Point of Contact:</b>	Ruth Horn, ruth@slvahec.org
<b>Health Care Navigator:</b>	Cherise Minnick, cherise.minnick@slvrmc.org

**Target Service Area(s):**

County, State	
Alamosa County, CO	Mineral County, CO
Conejos County, CO	Rio Grande County, CO
Costilla County, CO	Saguache County, CO

**Partner Organization(s):**

Organization Name	City, State
Illuminate Colorado	Denver, CO
San Luis Interagency Oversight Group	Alamosa, CO
San Luis Valley AHEC	Alamosa, CO
San Luis Valley American Indian Center	Center, CO
San Luis Valley Behavioral Health Group	Alamosa, CO
San Luis Valley Health	Alamosa, CO

Organization Name	City, State
Valley Wide Health Systems	Alamosa, CO

**Project Information:**

Project Summary	
<p>Pregnant &amp; parenting people and women of childbearing age in the San Luis Valley (SLV) are not receiving the integrated care, care coordination, and responsive support they need. We will achieve our overall project goal and consequently reduce NAS cases in SLV by focusing on our three primary drivers: 1) increasing access to coordinated preconception services, 2) increasing access to coordinated prenatal, labor &amp; delivery, and behavioral health care, and 3) increasing access to coordinated postpartum support services for our target population. The required approaches from HRSA serve as the secondary drivers, and each of our 18 identified strategies (or change concepts) bolster the secondary drivers that then contribute to the progress on each primary driver. Inspired by the systemic, cultural, and language barriers that lead to poor outcomes in our region, health equity is a concerted focus of our grant. It is for this reason that we have chosen to focus on strategies that build capacity and foster coordination and collaboration between existing programs and that offer culturally and linguistically appropriate support to navigate care.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>• Community Health Workers</li> <li>• Infant &amp; Child Health</li> <li>• Integration of Services</li> <li>• Maternal and Obstetric Care</li> </ul>	<ul style="list-style-type: none"> <li>• Neonatal Abstinence Syndrome</li> <li>• Peer Recovery Supports</li> <li>• Women’s Health</li> </ul>
Areas Where We Would Like to Serve as a Peer Mentor	
<p>Addressing childcare as a barrier to treatment and leveraging public awareness campaigns to address stigma for pregnant and parenting people</p>	
Areas Where We Would Welcome Technical Assistance	
<p>Anything that supports our focus on strategies related to health equity and plans of safe care</p>	
Intended Audience(s)	
<b>Age:</b>	Children (0-12), Adult (25-64)
<b>Health Status:</b>	Substance-exposed children and infants
<b>Special Populations:</b>	Racial and Ethnic Minorities, Pregnant and Parenting People
<b>Other:</b>	Non-English Speakers

**Organizational Information:**

<b>Project Title:</b>	Kentucky River Comm Care, Inc.
<b>State:</b>	Kentucky
<b>Organization Type:</b>	Community Mental Health Center
<b>Website:</b>	www.krcnet.com
<b>Address:</b>	115 Rockwood Lane Hazard, KY 41701

**Grantee Points of Contact:**

<b>Project Director:</b>	Judy Cattoi, judy.cattoi@krcnet.com
--------------------------	-------------------------------------

**Target Service Area(s):**

County, State	
Breathitt County, KY	Letcher County, KY
Knott County, KY	Owsley County, KY
Lee County, KY	Perry County, KY
Leslie County, KY	Wolfe County, KY

**Partner Organization(s):**

Organization Name	City, State
Daniel Boone Community Action Council, Inc.	Beattyville, KY
Kentucky River Community Care, Inc.	Hazard, KY
Kentucky River District Health Department	Hazard, KY
Moore Care Clinic, LLC	Beattyville, KY
UK Center of Excellence in Rural Health	Hazard, KY

**Project Information:**

Project Summary
Kentucky River Communities United for Restoring Resilience and Empowerment (KyR-CURRE) is a subgroup of a larger Consortium known as the Kentucky River Health Consortium. This sub-group, chaired by Kentucky River Community Care (lead agency), recognized a need in the Kentucky River Region of rural Appalachia for funding to strengthen collaboration between maternal child health providers, prevention resources, courts, and child

welfare to better manage referral supports between providers to combine sober housing, intensive outpatient, MOUD-assisted withdrawal, social withdrawal, and monitored withdrawal treatment options, 1-3 weeks in length. The Rural Communities Opioid Response Program – Neonatal Abstinence Syndrome grant project will focus on meeting this need.

HRSA funds will be used to train local providers in the use of NAS screeners, support credentialing for MOUD prescribers, increase referral options for assessment, treatment, and parent education, and offer supports for pregnant and parenting women with opioid use disorder and comorbid substance use and mental health disorders with emphasis on children who range in age from infant to 5 years old.

CURRE partnering agencies include MOUD clinic, OB/Women's Health Clinic, Health Dept, Community Mental Health Center, and Community Action Agency, all with a history of collaboration and dedication to a region-wide consortium that has been functional since 2017.

In year 1, KRCC projects serving 15 women in home and 15 women in a housing unit. By year 2, we project the addition of two MOUD prescribers to the county, and to have a protocol in place for MOUD withdrawal management, and maintenance during pregnancy and post-delivery. KRCC is licensed as a Community Mental Health Center, and Program staff are trauma informed and trained in evidence-based interventions. The implementation team will include licensed therapists, peer support, case management, MOUD prescriber, primary care/OB/GYN and pediatrician.

**Focus Areas**

- Co-occurring Disorders
- Integration of Services
- MOUD/MAT Implementation
- Neonatal Abstinence Syndrome
- Recovery for pregnant and parenting women, access to services, and community outreach

**Areas Where We Would Like to Serve as a Peer Mentor**

Substance use disorder treatment and recovery housing

**Areas Where We Would Welcome Technical Assistance**

Evidence-based treatment for pregnant and parenting women and strategies for providing education to community providers

**Intended Audience(s)**

<b>Health Status:</b>	People with/at risk for OUD or SUD, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Special Populations:</b>	People Experiencing Homelessness, Pregnant and Parenting People, People Experiencing Food Insecurity, People Who Use Drugs



**Organizational Information:**

<b>Project Title:</b>	Project Empower
<b>State:</b>	West Virginia
<b>Organization Type:</b>	County Government
<b>Address:</b>	100 Washington Avenue Suite 300 Logan, WV 25601

**Grantee Points of Contact:**

<b>Project Director:</b>	Michelle Akers, makers@lccwv.us
<b>Data Coordinator:</b>	Erica O'Briant, eobriant@lccwv.us
<b>Learning Collaborative Point of Contact:</b>	Jeannie Curry, jcurry@lccwv.us
<b>Health Care Navigator:</b>	Lucy Adkins, ladkins@lccwv.us

**Target Service Area(s):**

<b>County, State</b>
Logan County, WV

**Partner Organization(s):**

Organization Name	City, State
Coalfield Health Center	Chapmanville, WV
Logan County Family Treatment Court	Logan, WV
Logan Regional Medical Center	Logan, WV
Logan County Commission	Logan, WV

**Project Information:**

<b>Project Summary</b>
<p>Project Empower (PE) is a collaborative program in Logan County, West Virginia, dedicated to reducing the incidence of NAS and increasing access to SUD/ODU treatment and recovery support services for pregnant individuals and individuals of childbearing age. The Project Empower Consortium works together to address the needs of the target population throughout preconception, prenatal and labor/delivery, and postpartum stages in a high-risk, rural community.</p> <p>PE participants have access to a variety of treatment opportunities including: evidence-based outpatient SUD/ODU treatment through mental health assessments, psychological</p>

evaluations, treatment planning, individual therapy from a master’s level therapist, manualized evidence-based professional group counseling, case management, supportive group counseling, rehabilitative psychoeducational programming, peer recovery support services, psychiatric care and MAT treatment via telehealth, and opportunities for educational and career development.

Logan County, a rural Appalachian County in Southwestern West Virginia, has been plagued for decades by the opioid epidemic, resulting in high overdose rates and low health outcomes. Children and families continue to bear the burden of the county’s high poverty rate, lack of employment opportunities, significant environmental health and infectious/chronic disease concerns, lack of general and behavioral health treatment, and overcrowded child welfare and foster care systems.

By offering collaborative, wrap-around primary and behavioral healthcare services, the PE consortium will work to empower the target population to make decisions about their own healthcare, decrease rates of SUD/ODU and overdose, improve the health of individuals and their young children, support families impacted by substance use, and prevent further cycles of trauma.

**Focus Areas**

- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women’s Health

**Areas Where We Would Like to Serve as a Peer Mentor**

Working with pregnant individuals or individuals of childbearing age with SUD/ODU

**Areas Where We Would Welcome Technical Assistance**

Collaboration with Family Treatment Court

**Intended Audience (s)**

<b>Health Status:</b>	People with/at risk for OUD or SUD, People in recovery from SUD/ODU
<b>Special Populations:</b>	Pregnant and Parenting People

**Organizational Information:**

<b>Project Title:</b>	UP MOMS Model Expansion
<b>State:</b>	Michigan
<b>Organization Type:</b>	Public Health Organization
<b>Website:</b>	<a href="http://www.lmasdhd.org">www.lmasdhd.org</a>
<b>Address:</b>	14150 Hamilton Lake Rd Newberry, MI 49868

**Grantee Points of Contact:**

<b>Project Director:</b>	Leann Espinoza, lespinoza@lmasdhd.org
<b>Learning Collaborative Point of Contact:</b>	Leann Espinoza, lespinoza@lmasdhd.org

**Target Service Area(s):**

County, State	
Alger County, MI	Mackinac County, MI
Dickinson County, MI	Menominee County, MI
Iron County, MI	Schoolcraft County, MI
Luce County, MI	

**Partner Organization(s):**

Organization Name	City, State
92 <sup>nd</sup> Judicial District Community Court	Newberry, MI
Michigan Center for Rural Health	East Lansing, MI
Michigan Department of Health and Human Services (MDHHS) Child Protection Services in the Upper Peninsula	Marquette, MI
Upper Peninsula Health Care Solutions (UPHCS)	Marquette, MI
Upper Peninsula Health Plan	Marquette, MI
Upper Peninsula Maternal Opioid Misues (UP MOM)	Sault Ste. Marie, MI

**Project Information:**

Project Summary	
<p>The goal of the UP MOM Model Expansion Program is to improve the quality of care for pregnant and postpartum Medicaid beneficiaries with opioid use disorder residing in Luce, Mackinac, Alger, Schoolcraft, Menominee, Dickinson and Iron Counties, by implementing Community Health Worker (CHW)-centered care coordination strategies that focus on cross-system collaboration and improved health outcomes over the course of the three year performance period.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>• Community Health Workers</li> <li>• Infant &amp; Child Health</li> <li>• Maternal and Obstetric Care</li> <li>• Neonatal Abstinence Syndrome</li> <li>• Peer Recovery Supports</li> <li>• Women’s Health</li> </ul>	
Areas Where We Would Like to Serve as a Peer Mentor	
<p>Care coordination and local community resource logistics.</p>	
Areas Where We Would Welcome Technical Assistance	
<p>Billable Medicaid Services for CHWs. Policies and Procedures for CHWs who work with substance use clients.</p>	
Intended Audience(s)	
<b>Health Status:</b>	People in recovery from SUD/ODU, Substance-exposed children and infants, Medicaid or Medicare recipients
<b>Special Populations:</b>	Pregnant and Parenting People, People Who Use Drugs

**Organizational Information:**

<b>Project Title:</b>	MaineHealth
<b>State:</b>	Maine
<b>Organization Type:</b>	Rural Health Network
<b>Website:</b>	<a href="https://www.mainehealth.org/">https://www.mainehealth.org/</a>
<b>Address:</b>	105 Mt Blue Circle Suite 1, Farmington, ME 04938

**Grantee Points of Contact:**

<b>Project Director:</b>	Lorri Brown, <a href="mailto:lorri.brown@mainehealth.org">lorri.brown@mainehealth.org</a>
<b>Data Coordinator:</b>	Erica Swan, <a href="mailto:erica.swan@mainehealth.org">erica.swan@mainehealth.org</a>

**Target Service Area(s):**

County, State	
Carroll County, NH	Oxford County, ME
Franklin County, ME	

**Partner Organization(s):**

Organization Name	City, State
Franklin Community Health Network	Farmington, ME
Franklin County Children's Task Force	Farmington, ME
Franklin County Sherriffs Office	Farmington, ME
Maine Behavioral Health	Portland, ME
Office of MaineCare	Augusta, ME

**Project Information:**

Project Summary
<p>This project aims to reduce the incidence and impact of NAS in MaineHealth's Mountain Service Region by supporting access to critical care and resources for pregnant and post-partum persons with SUD/ODU and their families. HCC will work with area healthcare providers and community partners to establish an evidence-based, trauma-informed, family-centered comprehensive care model that addresses the unique needs of pregnant individuals with SUD/ODU. This care model will align with the work being done through the Maine RMOMS Network, a MaineHealth initiative that enhances the work of local government initiatives and programs designed to strengthen the state's perinatal system of care.</p>

Focus Areas	
<ul style="list-style-type: none"> <li>Maternal and Obstetric Care</li> </ul>	
Areas Where We Would Like to Serve as a Peer Mentor	
Peer Recovery Centers, Community Health Worker Model	
Areas Where We Would Welcome Technical Assistance	
Reimbursable models of care for mobile health services and telehealth	
Intended Audience(s)	
<b>Health Status:</b>	People with/at risk for OUD or SUD
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Special Populations:</b>	Pregnant and Parenting People

**Organizational Information:**

<b>Project Title:</b>	Peer Outreach to Enhance Care and Improve Prenatal, Postpartum, and NAS Outcomes for Rural Families affected by Substance Use
<b>State:</b>	New Hampshire
<b>Organization Type:</b>	Rural Regional Hospital
<b>Website:</b>	www.dartmouth-hitchcock.org
<b>Address:</b>	Department of Ob/Gyn, 1 Medical Center Drive Lebanon, NH 03756

**Grantee Points of Contact:**

<b>Project Director:</b>	Daisy Goodman, daisy.j.goodman@hitchcock.org
<b>Data Coordinator:</b>	Katherine Stokes, katherine.olivia.p.stokes@hitchcock.org
<b>Learning Collaborative Point of Contact:</b>	Daisy Goodman, daisy.j.goodman@hitchcock.org
<b>Health Care Navigator:</b>	Meagan Adams, Meagan.M.Adams@hitchcock.org

**Target Service Area(s):**

County, State	
Grafton County, NH	Sullivan County, NH
Orange County, VT	Windsor County, VT

**Partner Organization(s):**

Organization Name	City, State
Families Flourish	Lebanon, NH
HIV Hepatitis C Resource Center	Lebanon, NH
NH Medicaid	Concord, NH
The Haven	Wilder, VT
TLC	Claremont, NH

**Project Information:**

**Project Summary**

Early access to compassionate SUD/ODU care for pregnant people, adequate prenatal care, and continuation of SUD treatment postpartum are essential to decrease the severity and impact of NAS. Our program centers on the needs of childbearing people for a safe entry to care and a smooth transition from one level of care to another, supported by people in long-term recovery from SUD/ODU as healthcare navigators, equipping navigators with the knowledge and skills to support postpartum mothers and infants with NAS, and bringing together people with lived experience, healthcare professionals, and community-based service providers to make sure that programs for families with SUD/ODU are responsive to the needs of the community.

Key elements include:

- Community outreach by Recovery Support Workers to increase access to contraception and infectious disease testing for people of childbearing age with SUD/ODU.
- Increasing the number of Ob/Gyn professionals who can screen, diagnose, and prescribe buprenorphine to treat OUD.
- Training Recovery Support Workers as Healthcare Navigators to reach out to pregnant people with SUD/ODU, assist them in enrolling in Medicaid if needed, and help them access prenatal care and treatment.
- Train Recovery Support Workers to serve as Doulas to support postpartum mothers and infants, including trauma-informed breastfeeding support
- Develop a dedicated hospital-based program to ensure pregnant people have immediate access to research-based care for SUD/ODU, including initiation of MOUD and detoxification from other substances as early as possible during pregnancy.
- Work with Consortium members providing housing, family support, outpatient, and SUD/ODU treatment to build a system of care that is non-stigmatizing and meets the needs of families most severely impacted by SUD/ODU.
- Work with state Medicaid programs to improve the sustainability of comprehensive services for families impacted by SUD/ODU.

**Focus Areas**

- |                               |                                |
|-------------------------------|--------------------------------|
| • Community Health Workers    | • Neonatal Abstinence Syndrome |
| • Health Literacy             | • Peer Recovery Supports       |
| • Integration of Services     | • Women’s Health               |
| • Maternal and Obstetric Care | • Doula care                   |

**Areas Where We Would Welcome Technical Assistance**

Perinatal detoxification and stabilization



<b>Intended Audience(s)</b>	
<b>Age:</b>	Adolescents (13-17), Young Adult (18-24), Adult (25-64)
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Racial and Ethnic Minorities, People Experiencing Homelessness, Pregnant and Parenting People, Justice-Involved/Incarcerated Persons, LGBTQ+ Populations, People Who Use Drugs
<b>Other:</b>	Healthcare Workers and Providers

### Organizational Information:

<b>Project Title:</b>	Menominee Indian Tribe of Wisconsin
<b>State:</b>	Wisconsin
<b>Organization Type:</b>	Health Care Provider
<b>Website:</b>	mtclinic.org
<b>Address:</b>	PO Box 970 W3275 Wolf River Drive Keshena, WI 54166

### Grantee Points of Contact:

<b>Project Director:</b>	Diane Hietpas, dianec@mtclinic.net
<b>Data Coordinator:</b>	Brandon Waupekenay, brandonw@mtclinic.net
<b>Learning Collaborative Point of Contact:</b>	Davey Boyd, daveyb@mtclinic.net
<b>Health Care Navigator:</b>	Sue Boldgett, sbldgett@mitw.org

### Target Service Area(s):

County, State	
Menominee County, WI	Shawano County, WI

### Partner Organization(s):

Organization Name	City, State
Community Resource Center	Keshena, WI
Menominee Tribal Clinic	Keshena, WI
Theda Care Medical Center	Shawano, WI
Theda Care Physicians	Shawano, WI

### Project Information:

Project Summary
The Menominee Indian Tribe of Wisconsin has the goal to strengthen and sustain access to appropriate substance use, behavioral, and maternal health services for rural pregnant and postpartum patients and their families. We will partner with our local hospital, ThedaCare Shawano, and its health clinic to expand services for all pregnant patients in need of substance use services. We would also like to support women of childbearing years and

families with children to improve outcomes. The end goal is better outcomes for infants, mothers, and families.

**Focus Areas**

- Neonatal Abstinence Syndrome

**Areas Where We Would Like to Serve as a Peer Mentor**

We have experience in delivering T-SBIRT services to pregnant mothers. We have worked with University of Wisconsin-Milwaukee and have developed an evidence-based protocol. We have worked with several pregnant patients with an OUD, prescribing Subutex. Our local hospital also offers Eat, Sleep and Console, a validated strategy to help NAS babies. Finally, our physicians have worked with the local rural hospital to advocate for local deliveries for pregnant patients that have regular pre-natal care with no further complications. We would be happy to offer other sites that may be looking at similar strategies any help we could.

**Areas Where We Would Welcome Technical Assistance**

This is the first project that we will be working in tandem with our neighboring clinic, ThedaCare Shawano. We would look for any suggestions others have that would help us strengthen our relationship.

**Intended Audience(s)**

<b>Race/Ethnicity:</b>	Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	Substance-exposed children and infants
<b>Special Populations:</b>	Pregnant and Parenting People

## Organizational Information:

<b>Project Title:</b>	Humboldt County Neonatal Opioid Prevention & Response Project
<b>State:</b>	California
<b>Organization Type:</b>	FQHC
<b>Website:</b>	<a href="https://opendoorhealth.com/">https://opendoorhealth.com/</a>
<b>Address:</b>	1275 8th Street Arcata, CA 95521

## Grantee Points of Contact:

<b>Project Director:</b>	Aila Gilbride-Read, <a href="mailto:agilbride-read@opendoorhealth.com">agilbride-read@opendoorhealth.com</a>
<b>Data Coordinator:</b>	Valerie Padilla, <a href="mailto:vpadilla@opendoorhealth.com">vpadilla@opendoorhealth.com</a>

## Target Service Area(s):

County, State
Humboldt County, CA

## Partner Organization(s):

Organization Name	City, State
CalPoly Humboldt: Social Work Program	Arcata, CA
CalPoly Humboldt: Student Health & Wellbeing Services	Arcata, CA
First 5 Humboldt	Eureka, CA
McKinleyville Family Resource Center	McKinleyville
St. Joseph Hospital/Open Door Community Health Centers: Family Medicine Residency Program	Eureka, CA

## Project Information:

Project Summary
<p>Our project will leverage the resources of core community institutions to reduce the incidence and impact of Neonatal Abstinence Syndrome (NAS) on the rural Northern California coast. Humboldt County's reported NAS rate of 13.5 per 1,000 is over five times as high as the state's (2.5 per 1,000), and the county has the highest number of adults reporting adverse childhood experiences (ACEs). Additionally, the reported rate of perinatal SUD in Humboldt County is 3.7 times the state average.</p> <p>With our community partners we will take a multifaceted approach emphasizing education, prevention, and support. We plan to educate current (our internal &amp; community providers) and</p>

future service providers, working with our local junior college, university & family medicine residency program. We will emphasize prevention by making birth control easily available in our MAT programs. Through increased training of current service providers, we will enhance support for prenatal patients experiencing SUD, families effected by SUD, and infants experiencing neonatal abstinence syndrome.

### Focus Areas

- Infant & Child Health
- Integration of Services
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women’s Health

### Areas Where We Would Like to Serve as a Peer Mentor

MAT Program Development, Group OB practice

### Areas Where We Would Welcome Technical Assistance

Reimbursement for OB services in CA, OCHIN/EPIC reporting for OB Measures

### Intended Audience(s)

<b>Health Status:</b>	People with/at risk for OUD or SUD, People in recovery from SUD/OUD, Substance-exposed children and infants
<b>Special Populations:</b>	Pregnant and Parenting People, People Who Use Drugs

### Organizational Information:

<b>Project Title:</b>	Robeson Health Care Corporation
<b>State:</b>	North Carolina
<b>Organization Type:</b>	Certified Community Behavioral Health Organization
<b>Website:</b>	<a href="https://www.rhcchealth.org/">https://www.rhcchealth.org/</a>
<b>Address:</b>	60 Commerce Plaza Circle, Pembroke, NC 28372

### Grantee Points of Contact:

<b>Project Director:</b>	Bart Grimes, bart_grimes@rhcc1.com
<b>Data Coordinator:</b>	Mary Breedlove-McGinnis, Mary_Breedlove@RHCC1.com
<b>Learning Collaborative Point of Contact:</b>	Latasha Murray, Latasha_Murray@RHCC1.com
<b>Health Care Navigator:</b>	Valerie Comrie, Valerie_Comrie@RHCC1.com

### Target Service Area(s):

County, State
Robeson County, NC

### Partner Organization(s):

Organization Name	City, State
Community Organized Relief Effort (CORE)	Los Angeles, CA
Christian Recovery Center Inc.,	Ash, NC
North Carolina Rural Forward	Durham, NC
Skyler Brunson (SMILE) Foundation	Fairmont, NC
Monarch	Lumberton, NC
Robeson Substance-Use Coalition	Lumberton, NC
Lumbee Tribe of North Carolina	Lumberton, NC
Robeson County Department of Social Services	Lumberton, NC

Organization Name	City, State
Robeson County Department of Public Health	Lumberton, NC
Lumberton Treatment Center	Lumberton, NC
Robeson Community College	Lumberton, NC
Eastpointe	Lumberton, NC
Robeson County Guardian ad litem	Lumberton, NC
Robeson County Family Treatment Court	Lumberton, NC
Robeson County DWI Court	Lumberton, NC
Robeson County Adult Treatment Court	Lumberton, NC
North Carolina Harm Reduction	Lumberton, NC
Robeson County District Attorney's Office	Lumberton, NC
Robeson County Distric Court	Lumberton, NC
Southeastern Integrated Care	Lumberton, NC
UNC Southeastern Health	Lumberton, NC
National Pan Hellenic Council of Lumberton	Lumberton, NC
Life Net Services, LLC	Lumberton, NC
Life Bridge	Lumberton, NC
Colors of Life	Lumberton, NC
CONNECT Community, Inc.	Lumberton, NC
MS Contracting, Inc.	Lumberton, NC
Robeson County Housing Authority	Lumberton, NC
Seed Harvest Development Enterprise (SHADE)	Lumberton, NC
Robeson County African American Cultural Center	Lumberton, NC
Lumberton Alumnae Chapter-Delta Sigma Theta Inc.,	Lumberton, NC

Organization Name	City, State
Hope Alive	Lumberton, NC
Palmer Prevention, Inc	Lumberton, NC
Public Schools of Robeson County (SCORE)	Lumberton, NC
Lambda Eta Zeta Chapter Zeta Phi Beta Sorority, Inc.,	Lumberton, NC
Tae's Pathway	Lumberton, NC
Offender Resource Center	Lumberton, NC
Zeta Amicae of Lumberton North Carolina	Lumberton, NC
Strength Wisdom and Achievement (SWA)	Lumberton, NC
Better AM	Lumberton, NC
Robeson County Sheriff's Office	Lumberton, NC
Breeches Buoy Addiction Medicine Service	Lumberton, NC
The Carter Clinic	Lumberton, NC
Lumberton Housing Authority	Lumberton, NC
From the Heart by Truly Treasure	Lumberton, NC
Robeson Health Care Corporation	Pembroke, NC
Stop The Pain	Pembroke, NC
University of North Carolina at Pembroke	Pembroke, NC
PAWSS Inc.	Pembroke, NC
Towne of Pembroke	Pembroke, NC
Lumbee Regional Development Association, Inc.	Pembroke, NC
Borderbelt Behavioral Healthcare, LLC	Raeford, NC
Red Springs Police Department	Red Springs, NC
The Church Gathering Place	Red Springs, NC



Organization Name	City, State
Hope Health Family Practice	Rowland, NC
Carolina Youth Action Association	Rowland, NC

**Project Information:**

**Project Summary**

The project will address the needs of pregnant women, mothers, and women of childbearing age who have a history of, or who are at risk for, substance use disorder (SUD), including opioid use disorder (OUD) and accompanying co-occurring disorders (CODs), and their children, families, and caregivers in the identified service area. The initiative will also build capacity in reaching underserved populations who lack advocacy at the systems level.

The project initiative, along with our consortium (The Consortium), will aim to reduce the incidence and impact of Neonatal Abstinence Syndrome (NAS) in rural Robeson County, North Carolina, by improving systems of care, family supports, and social determinants of health.

**Focus Areas**

- Neonatal Abstinence Syndrome

**Intended Audience(s)**

<b>Special Populations:</b>	Pregnant and Parenting People
-----------------------------	-------------------------------

**Organizational Information:**

<b>Project Title:</b>	Saint Elizabeth Medical Center, Inc.
<b>State:</b>	Kentucky
<b>Organization Type:</b>	Hospital System
<b>Website:</b>	www.stelizabeth.com
<b>Address:</b>	1 Medical Village Drive, Edgewood, KY 41017

**Grantee Points of Contact:**

<b>Project Director:</b>	Angela Scroggins, angela.scroggins@stelizabeth.com
<b>Data Coordinator:</b>	Azelin Gutierrez, azelin.gutierrez@stelizabeth.com
<b>Learning Collaborative Point of Contact:</b>	Maggie Lynott, Margaret.lynott@stelizabeth.com

**Target Service Area(s):**

County, State	
Dearborn County, IN	Ripley County, IN
Franklin County, IN	Switzerland County, IN
Ohio County, IN	

**Partner Organization(s):**

Organization Name	City, State
Cincinnati Children's Hospital Medical Center	Cincinnati, OH
Dearborn County Health Department	Lawrenceburg, IN
One Community One Family	Batesville, IN
Pregnancy Care Center Southeastern Indiana	Lawrenceburg, IN
St. Elizabeth Physicians	Erlanger, KY

**Project Information:**

**Project Summary**

Pregnant and parenting women with SUD/ODU face tremendous challenges including access to treatment. This is especially true in rural counties. Therefore, treatment services must be readily available regardless of where one lives. With this funding, St. Elizabeth is proposing to convene a consortium of community members to address NAS occurrence in Southeastern Indiana including the expansion of the St. Elizabeth Baby Steps Program and Shuttle Service to Southeastern Indiana and convening of a regional Pregnancy Collaborative for key groups tackling this problem.

Since 2016, the St. Elizabeth Baby Steps Program has addressed the need for comprehensive service coordination for pregnant and parenting mothers with SUD/ODU in Northern Kentucky. Pregnant and parenting women are identified through the health system and referred by community partners to receive the support and compassion needed to enter treatment and achieve recovery. This program has connected over 1,500 women to recovery support and services. Services provided by Baby Steps, along with early induction onto MAT, have led to the 56 percent decrease in infants born with NAS/NOWS in Northern Kentucky.

The proposed program will provide individualized treatment plans and service coordination with a Nurse Clinical Liaison/NOWS Educator and Peer Support Specialist and remove transportation barriers with a Shuttle Service. These positions will be augmented by a Consortium of community partners (Dearborn County Health Department, One Community One Family, St. Elizabeth Physicians, Pregnancy Care Southeast Indiana, Cincinnati Children's Hospital & Medical Center) representing a variety of sectors relevant to behavioral and maternal health care. Together this team will engage pregnant and parenting mothers with SUD/ODU in Southeastern Indiana, connecting them to treatment and a myriad of ongoing support services in their own communities.

**Focus Areas**

- MOUD/MAT Implementation
- Neonatal Abstinence Syndrome
- Maternal and Obstetric Care
- Peer Recovery Supports

**Areas Where We Would Like to Serve as a Peer Mentor**

Our program goals are to help women have a healthy pregnancy and delivery, reduce the incidence of NAS in newborns, gain and sustain recovery and have the opportunity to be discharged with their baby and parent. We have a program in Kentucky that has met these goals and can assist and mentor in these areas.

**Areas Where We Would Welcome Technical Assistance**

Community data gathering and referral sources

**Intended Audience(s)**

<b>Health Status:</b>	People with/at risk for OUD or SUD, Substance-exposed children and infants
<b>Health Access:</b>	Medicaid or Medicare recipients, Medically underserved

<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Special Populations:</b>	Pregnant and Parenting People

**Organizational Information:**

<b>Project Title:</b>	HRSA RCORP- Neonatal Abstinence Syndrome
<b>State:</b>	Florida
<b>Organization Type:</b>	Behavioral Health Provider
<b>Website:</b>	<a href="https://smahealthcare.org/">https://smahealthcare.org/</a>
<b>Address:</b>	330 Kay Larkin Dr. Palatka, FL 32177

**Grantee Points of Contact:**

<b>Project Director:</b>	Bari Johnson, <a href="mailto:bjohnson@smahealthcare.org">bjohnson@smahealthcare.org</a>
--------------------------	--

**Target Service Area(s):**

County, State
Putnam County, FL

**Partner Organization(s):**

Organization Name	City, State
Community Partnership for Children (CPC)	Daytona Beach, FL
Putnam County Sheriff's Office	Palatka, FL
Lucien-Max Tchuisse, M.D.	Palatka, FL
Dwight P. Tiu, M.D.	Palatka, FL
SMA Healthcare, Inc. (SMA)	Daytona Beach, FL
AZA Health	Daytona Beach, FL
Healthy Start of North Central Florida	Tallahassee, FL
Florida Agency for Healthcare Administration	Daytona Beach, FL

**Project Information:**

Project Summary
SMA will provide assistance to population of focus in connecting to Putnam County Health Department for contraception and testing for infectious diseases; provide transportation for population of focus to access behavioral health and medical appointments; use SBIRT for early intervention for those at risk of substance use; assist women released from jail; and assist in accessing detoxification, outpatient, and residential substance use treatment programs, including medication-assisted treatment services. The position will also enroll

eligible individuals into health insurance; provide transportation to behavioral health, medical, and other community appointments to meet the needs of the population of focus. SMA will participate in community outreach events; provide prevention/educational training to consortium member agencies and high school/college students utilizing curriculum based on Council of Patient Safety in Women's Healthcare's "Obstetric Care for Women with Opioid Use Disorder." SMA will work with Healthy Start to provide an in-home nurse to work with families with NAS babies. Increase access to contraceptives by adding contraceptives to Narcan vending machines

**Focus Areas**

- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women's Health

**Intended Audience(s)**

<b>Special Populations:</b>	Pregnant and Parenting People
-----------------------------	-------------------------------

**Organizational Information:**

<b>Project Title:</b>	Four Rivers - RCORP NAS Project
<b>State:</b>	Missouri
<b>Organization Type:</b>	FQHC
<b>Website:</b>	<a href="https://www.smchc.org/">https://www.smchc.org/</a>
<b>Address:</b>	1081 E. 18th St. Rolla, MO 65401

**Grantee Points of Contact:**

<b>Project Director:</b>	Laura Soldan, <a href="mailto:Isoldan@fourrivers.org">Isoldan@fourrivers.org</a>
--------------------------	--

**Target Service Area(s):**

County, State	
Dent County, MO	Phelps County, MO

**Partner Organization(s):**

Organization Name	City, State
Compass Health Network	Jefferson City, MO
Dent County Health Department	Salem, MO
Hope Alliance of Missouri	Rolla, MO
Invent Yourself, LLC	Cuba, MO
Phelps Health	Rolla, MO
Prevention Consultants	Rolla, MO
SEMO Behavioral Health	Bluff, MO
St. James Chamber of Commerce	St. James, MO
The Rolla Mission	Rolla, MO

**Project Information:**

**Project Summary**

Four Rivers will increase the availability of providers, including OB/GYN and behavioral health, to address the needs of the rural community. Four Rivers will also lead a consortium of community partners to streamline referrals and increase MAT and behavioral services, particularly for prenatal and patients of child-bearing age. Four Rivers will work with healthcare partners in and out of the consortium to improve care to those most in need throughout the service area, providing resources and referrals for MAT, behavioral health, and resources that improve the social determinants of health.

**Focus Areas**

- Community Health Workers
- Infant & Child Health
- Peer Recovery Supports

**Intended Audience(s)**

General population



**Organizational Information:**

<b>Project Title:</b>	Southern Healthcare Collaboration, Inc. NAS 2023
<b>State:</b>	Georgia
<b>Organization Type:</b>	Behavioral Health Provider, Health Care Provider, Substance Use Disorder Provider
<b>Address:</b>	821 S. Main Street Baxley, GA 31513

**Grantee Points of Contact:**

<b>Project Director:</b>	Knicole Lee, knicole.shc@gmail.com
<b>Data Coordinator:</b>	Amanda Sheple, amandas.shc@gmail.com
<b>Learning Collaborative Point of Contact:</b>	Knicole Lee, knicole.shc@gmail.com
<b>Health Care Navigator:</b>	Megan Thornton, LPN, megant.shc@gmail.com

**Target Service Area(s):**

County, State	
Appling County, GA	Evans County, GA
Bacon County, GA	Jeff Davis County, GA
Charlton County, GA	Pierce County, GA
Clinch County, GA	Tattnall County, GA

**Partner Organization(s):**

Organization Name	City, State
Bacon County Department of Family & Children's Services	Alma, GA
Bacon County Hospital System	Alma, GA
Bacon County Sheriff's Department	Alma, GA
Clinch County Sheriff's Department	Homerville, GA
HealthIE Community Center of Baxley	Baxley, GA

Organization Name	City, State
Pineland Community Service Board	Statesboro
Southern Healthcare Collaboration, Inc.	Baxley, GA

**Project Information:**

**Project Summary**

Southern Healthcare Collaboration will mobilize Consortium efforts, strategically increasing awareness of, and access to, SUD screening and treatment for women of childbearing age. Individuals served across the healthcare and law enforcement sectors will be screened for substance use and pregnancy and connected to appropriate services in a "warm handoff" strategy. SHC's HealthIE Community Center of Baxley is already an MAT site that offers physical and behavioral healthcare. The continuum of care will be strengthened through the addition of on-site OB/GYN services, as well as family medical practice physician services and pediatric services delivered by traveling professionals from Bacon County Health System. Providers across the eight-county region will be offered new opportunities to be certified as a buprenorphine MAT provider, with grant funds covering expenses related to certification. Recovery services will be supported by Pineland Community Service Board through available Transitional Mother Baby Housing. Transportation will be available to support expectant mothers and new mothers as they attend appointments.

Goal #1: Reduce structural- and systems-level barriers (transportation challenges, limited workforce, reimbursement issues) to increase access to behavioral healthcare, especially for SUD/ODD disorders, for rural pregnant and postpartum persons and their families, and address community risk factors and social determinants of health.

Goal #2: Strengthen the quality and sustainability of behavioral health care services for rural pregnant and postpartum persons and their families by implementing coordinated, evidence-based, trauma-informed, family-centered SUD/ODD and other services.

**Focus Areas**

- Infant & Child Health
- MOUD/MAT Implementation
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women's Health

**Areas Where We Would Like to Serve as a Peer Mentor**

Southern Healthcare Collaboration, Inc. is experienced at building partnerships to maximize the reach of limited resources.

**Areas Where We Would Welcome Technical Assistance**

SHC will welcome technical assistance and peer support in any area!

Intended Audience(s)	
<b>Health Status:</b>	People with/at risk for OUD or SUD, People in recovery from SUD/OUD
<b>Special Populations:</b>	Pregnant and Parenting People, People Who Use Drugs

### Organizational Information:

<b>Project Title:</b>	Perinatal Postpartum Partnership Access and Community Integration (PACI)
<b>State:</b>	West Virginia
<b>Organization Type:</b>	Substance Use Disorder Provider
<b>Website:</b>	www.shcmhc.com
<b>Address:</b>	1345 Mercer Street Princeton, WV 24740

### Grantee Points of Contact:

<b>Project Director:</b>	Staci Lafferty, stacilafferty@shcmhc.com
<b>Data Coordinator:</b>	Lucy Pack, lucypack@shcmhc.com
<b>Learning Collaborative Point of Contact:</b>	Staci Lafferty, stacilafferty@shcmhc.com

### Target Service Area(s):

County, State	
Mcdowell County, WV	Mercer County, WV
Wyoming County, WV	

### Partner Organization(s):

Organization Name	City, State
Community Connections	Princeton, WV
Dr. Lingenfelter	Princeton, WV
McDowell SAFE	Welch, WV
Medicaid	Charleston, WV
Tug River	Welch, WV

**Project Information:**

<b>Project Summary</b>
PACI will address health equity in the target rural service area by reducing disparities in African American and housing instable individuals who are pregnant/postpartum. Community Connections will identify referral partners in the African American community & initiate culturally competent outreach with the goal of increasing program referrals. Case Managers & Maternal Support Workers will visit client homes and assess housing stability, work with clients to find stable housing & fast track high-need clients to residential SUD programs.
<b>Focus Areas</b>
<ul style="list-style-type: none"> <li>• MOUD/MAT Implementation</li> <li>• Peer Recovery Supports</li> </ul>
<b>Areas Where We Would Like to Serve as a Peer Mentor</b>
Expand a successful comprehensive MAT model for pregnant & postpartum people which integrates behavioral, physical, obstetric, OUD & case management services to rural McDowell and Wyoming counties in southern West Virginia
<b>Areas Where We Would Welcome Technical Assistance</b>
<ul style="list-style-type: none"> <li>• Assisting the Project Director in ensuring compliance with HRSA reporting requirements.</li> <li>• Assisting with finalizing plan for tracking/collection of aggregate data/other info from Consortium to fulfill HRSA reporting requirements.</li> <li>• Tracking, collecting, aggregating, and reporting on quantitative and qualitative data and information to fulfill HRSA's reporting requirements.</li> <li>• Supporting and enabling consortium members to collect accurate data in response to HRSA reporting requirements by coordinating data collection/reporting process across Consortium members.</li> <li>• Working with a HRSA-funded evaluator to take part in a larger RCORP-wide evaluation.</li> <li>• Participating in regular project calls with Project Director, Consortium Meetings &amp; HRSA/Technical Assistance team calls.</li> </ul>
<b>Intended Audience(s)</b>
General population

**Organizational Information:**

<b>Project Title:</b>	HRSA RCORP-NAS: Nassau County, FL
<b>State:</b>	Florida
<b>Organization Type:</b>	Rural Health Network
<b>Website:</b>	<a href="http://www.stjohnsruralhealthnetwork.org">www.stjohnsruralhealthnetwork.org</a>
<b>Address:</b>	4201 Baymeadows Road, Suite 2, Jacksonville, FL 32217

**Grantee Points of Contact:**

<b>Project Director:</b>	Susan Grich, <a href="mailto:Susan_Grich@hpcnef.org">Susan_Grich@hpcnef.org</a>
<b>Data Coordinator:</b>	Julia Deangelo, <a href="mailto:jdeangelo@hpcnef.org">jdeangelo@hpcnef.org</a>
<b>Learning Collaborative Point of Contact:</b>	Flora Davis, <a href="mailto:Flora_Davis@hpcnef.org">Flora_Davis@hpcnef.org</a>
<b>Health Care Navigator:</b>	Erin Patrick, <a href="mailto:Erin_Patrick@hpcnef.org">Erin_Patrick@hpcnef.org</a>

**Target Service Area(s):**

County, State
Nassau County, FL

**Partner Organization(s):**

Organization Name	City, State
Baptist Medical Center Nassau	Fernandina Beach, FL
Health Planning Council of Northeast Florida, Inc.	Jacksonville, FL
Starting Point Behavioral Healthcare, Inc.	Yulee, FL

**Project Information:**

Project Summary
The St. Johns River Rural Health Network, Inc.'s, RCORP-NAS project proposes to increase access to SUD/OD behavioral health care services by addressing the social determinants of health needs for rural Nassau County, Florida, pregnant and postpartum persons and their families. Network partners will increase access to care through health-related payment resources and address workforce shortages for the target service population.

<b>Focus Areas</b>	
<ul style="list-style-type: none"> <li>• Community Behavioral Health</li> <li>• Health Literacy</li> <li>• Maternal and Obstetric Care</li> </ul>	<ul style="list-style-type: none"> <li>• Neonatal Abstinence Syndrome</li> <li>• Women’s Health</li> </ul>
<b>Areas Where We Would Like to Serve as a Peer Mentor</b>	
Health literacy, Cultural competency	
<b>Areas Where We Would Welcome Technical Assistance</b>	
Payment optimization, Integration of behavioral health services with primary care.	
<b>Intended Audience(s)</b>	
General population	

**Organizational Information:**

<b>Project Title:</b>	Golden Crescent - Management of Opioid Risk in Mothers (GC-MOMs)
<b>State:</b>	Texas
<b>Organization Type:</b>	Institution of Higher Education
<b>Website:</b>	<a href="https://nursing.tamu.edu/research/cpp/poemcf/index.html">https://nursing.tamu.edu/research/cpp/poemcf/index.html</a>
<b>Address:</b>	School of Nursing, 8447 Riverside Parkway, Bryan, TX 77807

**Grantee Points of Contact:**

<b>Project Director:</b>	Robin Page, rpage@tamu.edu
<b>Data Coordinator:</b>	Tasha Johnson, nyjohnson@tamu.edu

**Target Service Area(s):**

County, State	
Calhoun County, TX	Jackson County, TX
DeWitt County, TX	Lavaca County, TX

**Partner Organization(s):**

Organization Name	City, State
Billy T Cattan Recovery and Outreach	Victoria, TX
Cuero Regional Hospital	Cuero, TX
Driscoll Health Plan	Corpus Christi, TX
Memorial Medical Center	Lavaca, TX
Pregnancy Help Center of the Crossroads Area	Port Lavaca, TX
Southeast Texas Health System (SETHS)	Weimer, TX
Texas A&M University Health Science Center	Bryan, TX
Texas HHSC Medicaid	Austin, TX



**Project Information:**

**Project Summary**

Golden Crescent Management of Opioid Risk in Mothers (GC-MOMS) aims to reduce morbidity and mortality related to substance use disorder (SUD) and opioid use disorder (OUD) in high-risk rural communities. The purpose of GC-MOMS is to improve systems of care, family supports, and social determinants of health in a rural area of southeastern Texas known as the Golden Crescent.

Project goals are to 1) Increase access to behavioral health care, especially SUD; and 2) Address community risk factors to improve social determinants of health.

Proposed services: We will implement coordinated, evidence-based, trauma-informed and family-centered behavioral health care services for our target population. We propose an innovative home-visiting program (CHAMPions) for high-risk pregnant women and women who have given birth in the past year to provide 12 months of structured support to prevent and identify substance misuse, refer to treatment and recovery services, and support social determinants of health (SDOH) to build recovery capital. With GC-MOMS, we will bring innovative technology guided by Community Health Workers serving as healthcare navigators, to improve outcomes by enabling families to find and access what they need in ways that have not existed heretofore. GC-MOMS will enhance awareness of existing healthcare and socioeconomic resources by leveraging the most advanced technology in collaboration with a groundbreaking user-friendly interface our team created – the Olivia Ecosystem, encompassing OliviaHealth.org and IntelligentCHILD.org (CHILD is an acronym for 'Community Health Information Local Database).

Population group to be served: GC-MOMS will serve rural individuals susceptible to SUD/OUD who are at-risk for or are currently pregnant or have given birth in the past year, as well as their families. We will prioritize those who are socioeconomically disadvantaged and racial and ethnic minorities.

**Focus Areas**

- Community Behavioral Health
- Maternal and Obstetric Care
- Community Health Workers

**Areas Where We Would Like to Serve as a Peer Mentor**

Home Visiting models, Community Health Worker training, Rural health

**Areas Where We Would Welcome Technical Assistance**

Enrolling eligible families, healthcare provider champions, family retention in program

**Intended Audience(s)**

<b>Age:</b>	Young Adult (18-24), Age - Adult (25-64)
<b>Health Status:</b>	People with/at risk for OUD or SUD
<b>Health Access:</b>	Medicaid or Medicare recipients, Medically underserved

<b>Economic:</b>	Socioeconomically Disadvantaged Population
<b>Special Populations:</b>	Racial and Ethnic Minorities, Pregnant and Parenting People

**Organizational Information:**

<b>Project Title:</b>	Addressing Neonatal Abstinence Syndrome in Rutherford County, NC
<b>State:</b>	North Carolina
<b>Organization Type:</b>	Community based organization
<b>Website:</b>	<a href="https://unitedwayofrutherford.org/">https://unitedwayofrutherford.org/</a>
<b>Address:</b>	668 Withrow Road Forest City, NC 28043

**Grantee Points of Contact:**

<b>Project Director:</b>	Suzanne Porter, s.porter@uwrinc.org
--------------------------	-------------------------------------

**Target Service Area(s):**

County, State
Rutherford County, NC

**Partner Organization (s):**

Organization Name	City, State
Blue Ridge Community Health Services	Spindale, NC
Community Health Council of Rutherford County	Rutherfordton, NC
Family Preservation Services, Inc.	Rutherfordton, NC
Family Resources of Rutherford County	Forest City, NC
Isothermal Community College	Spindale, NC
NC Department of Public Safety Division of Adult Correction and Juveniles Justice	Rutherfordton, NC
NC DHHS Vocational Rehabilitation Services- Forest City	Forest City, NC
NCWorks Career Center	Rutherfordton, NC
Partners Health Management	Gastonia, NC
Rutherford County Department of Social Services	Spindale, NC
Rutherford County Government	Rutherfordton, NC
Rutherford County Public Defender's Office	Rutherfordton, NC

Organization Name	City, State
Rutherford County Sheriff's Office	Rutherfordton, NC
Rutherford Regional Health Systems	Rutherfordton, NC
Rutherford/McDowell District Attorney's Office	Rutherfordton, NC
United Way of Rutherford County	Rutherfordton, NC

**Project Information:**

**Project Summary**

Our project will reduce the incidence of and impact of NAS in Rutherford County, NC by implementing a multi-faceted, trauma informed array of supports and services across the continuum of care. The applicant agency and its consortium members have a long history of successfully collaborating to serve our community. We will expand and enhance services provided by the Rutherford Mobile Harm Reduction Team and Syringe Services Program. Mobile HRT is staffed by a peer support specialist and medical assistant to provide overdose prevention, harm reduction, minor health care, and rapid testing in the field. The expanded outreach will serve target population of pregnant and parenting women, women of childbearing age and their families. Increasing access to contraceptives and MAT will reduce incidence of NAS. Opening a fixed site to provide MAT telehealth services for the target population in addition to Mobile MAT services will remove barriers to care. We will embed peer support specialists in areas of frequent rates of contact with the target population in medical and justice system settings. We will provide community and provider education, create multidisciplinary teams to serve the target population, and address stigma regarding MAT. We will partner with consortium members to continue expanding supports at our newly launched Community Healing, Recovery, and Thriving Center (HRT Center), which integrates a variety of trauma informed, culturally linguistic wrap-around support services provided by consortium members and other community partners.

**Organizational Information:**

<b>Project Title:</b>	Partnership for Family Health and Recovery Program
<b>State:</b>	Oklahoma
<b>Organization Type:</b>	Behavioral Health Provider
<b>Website:</b>	www.voak.org
<b>Address:</b>	502 NW Sheridan Rd., Suite 4, Lawton, OK 73501

**Grantee Points of Contact:**

<b>Project Director:</b>	Christina Erman, cerman@voak.org
<b>Learning Collaborative Point of Contact:</b>	Christina Erman, cerman@voak.org

**Target Service Area(s):**

County, State	
Caddo County, OK	Kiowa County, OK
Cotton County, OK	Stephens County, OK

**Partner Organization(s):**

Organization Name	City, State
District Attorney/Drug Court	Lawton, OK
Lawton Community Health Center	Lawton, OK
OK State Dept. of Health District 5	Anadarko, OK
OK State Dept. of Health District 8	Duncan, OK
Wichita and Affiliated Tribe	Anadarko, OK

**Project Information:**

Project Summary
VOAOK with a consortium of partners, proposes to reduce the incidence and impact of neonatal abstinence syndrome in rural areas of Southwest Oklahoma. Consortium will apply the concept of multifaceted care to the individuals at greatest risk of NAS in rural Oklahoma. Program will implement activities in support of women of childbearing ages who are SUD/OD. Program will improve systems of care, family supports, and social determinants of

health, in order to improve health care of women at risk and prevent prenatal exposure as well as child removal and family disruption. Over the three-year period of performance, the program will build on the combined experience of a multi-sectoral consortium to design a culturally responsive program to advance health equity by adapting treatment services to the target population.

**Focus Areas**

- Community Behavioral Health
- Hub & Spoke Model
- Neonatal Abstinence Syndrome
- Peer Recovery Supports

**Areas Where We Would Like to Serve as a Peer Mentor**

Behavioral Health

**Areas Where We Would Welcome Technical Assistance**

Strategic planning with the consortium members

**Intended Audience(s)**

<b>Age:</b>	Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People in recovery from SUD/OUD, Substance-exposed children and infants
<b>Special Populations:</b>	Pregnant and Parenting People

**Organizational Information:**

<b>Project Title:</b>	Rural Health Care Program for Neonatal Abstinence Syndrome and Exposed Infants and Families
<b>State:</b>	West Virginia
<b>Organization Type:</b>	Institution of Higher Education
<b>Website:</b>	<a href="https://osp.research.wvu.edu/">https://osp.research.wvu.edu/</a>
<b>Address:</b>	886 Chestnut Ridge Road, Morgantown, WV 26506-6845

**Grantee Points of Contact:**

<b>Project Director:</b>	Lesley Cottrell, lcottrell@hsc.wvu.edu
<b>Learning Collaborative Point of Contact:</b>	Charlotte (Sue) Workman, Charlotte.workman@hsc.wvu.edu

**Target Service Area(s):**

County, State	
Harrison County, WV	Tyler County, WV
Marshall County, WV	Ohio County, WV
Marion County, WV	Preston County, WV
Monongalia County, WV	Wetzel County, WV
Taylor County, WV	

**Partner Organization(s):**

Organization Name	City, State
Burlington United Family Services	Keyser, WV
CASA, Inc	Wheeling, WV
Northern Panhandle Head Start	Wheeling, WV
Taylor County Family Resource Network	Taylor, WV
WVU Medicine Children's Hospital	Morgantown, WV

**Project Information:**

**Project Summary**

The long-term goals of these proposed efforts are to: 1) establish and evaluate a comprehensive team model for infants with NAS and their families; 2) expand and sustain communication among a collection of service providers; and 3) coordinate services that address family need. Target Population: The opioid epidemic is associated with poor health outcomes, chronic stress from abuse and neglect, and poverty and is presently higher than the national average in West Virginia. This proposal focuses on 9 northern WV counties with the highest NAS prevalence rates and most impacted by the physical, economic, and social effects of maternal substance use. Services developed to increase resiliency against hardships and poor health outcomes must incorporate attention to social determinants of health and take a two-generation approach. There is also a vital need to coordinate care such that an exposed child and family has a complete medical home team available to them to identify, and connect to, needed services. Training, technical assistance, and referral mechanisms within this system of care will be provided to strengthen resources for these teams as well as lessons learned to the regional and national audiences. The consortium's postpartum follow-up care for infants and their families will utilize evidence-based weaning and transition techniques noted in Pediatric and Neonatology literature. Home visiting curricula such as Right From the Start and Parents As Teachers are also evidence based and will be provided. Successful implementation of our consortium activities is expected to provide: direct services that include service providers in a comprehensive way, increase communication among providers, improve direct services as a result and health outcomes for the infant and family, and provide needed programming, training, and referral points to fill service gaps.

**Focus Areas**

- Community Behavioral Health
- Neonatal Abstinence Syndrome
- MOUD/MAT Implementation

**Areas Where We Would Like to Serve as a Peer Mentor**

Rural service coordination, Family and provider training, Family-centered approach

**Areas Where We Would Welcome Technical Assistance**

Substance use coordination in interconceptual care, Medical provider networks

**Intended Audience(s)**

<b>Age:</b>	Children (0-12), Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	White, Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People in recovery from SUD/OUD, People living with disabilities, Substance-exposed children and infants



### Organizational Information:

<b>Project Title:</b>	Healthy Moms Empowered in Recovery
<b>State:</b>	Pennsylvania
<b>Organization Type:</b>	FQHC
<b>Website:</b>	<a href="https://www.healthymoms.org/">https://www.healthymoms.org/</a>
<b>Address:</b>	501 South Washington Avenue, Suite 1000, Scranton, PA 18505

### Grantee Points of Contact:

<b>Project Director:</b>	Maria Kolcharno LSW, kolcharnom@thewrightcenter.org
<b>Data Coordinator:</b>	Lauren Nardelli, nardellil@thewrightcenter.org
<b>Learning Collaborative Point of Contact:</b>	Maria Kolcharno LSW, kolcharnom@thewrightcenter.org

### Target Service Area(s):

County, State	
Carbon County, PA	Schuylkill County, PA
Monroe County, PA	Susquehanna County, PA
Pike County, PA	Wayne County, PA

### Partner Organization(s):

Organization Name	City, State
Justice Works	Greentown, PA
Lackawanna County SCA	Scranton, PA
Maternal Family Health Services/ Nurse Family Partnership	Scranton, PA
Moses Taylor Hospital	Scranton, PA
Outreach	Scranton, PA
PA Chapter American Academy of Pediatrics/ First Food	Luzerne, PA
Pike County Children and Youth	Hawley, PA

Organization Name	City, State
St. Josephs Maternal Services	Scranton, PA
United Neighborhood Centers	Scranton, PA
Wayne County Hospital New Beginnings	Honesdale, PA
Wayne County SCA Office of Drug and Alcohol	Honesdale, PA

**Project Information:**

Project Summary	
<p>The Healthy MOMS Program is designed to assist expectant mothers struggling with substance use disorder to enhance their and their baby's health, ensure family stability, and minimize neonatal abstinence syndrome-related expenses. The program provides case management services and helps individuals access community resources. The program utilizes the Maternity Care Home model and operates in nine counties in Northeast Pennsylvania. We are grateful for the support from the HRSA RCORP-NAS grant, which enables us to offer these critical services.</p>	
Focus Areas	
<ul style="list-style-type: none"> <li>• Co-occurring Disorders</li> <li>• Infant &amp; Child Health</li> <li>• MOUD/MAT Implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal and Obstetric Care</li> <li>• Neonatal Abstinence Syndrome</li> <li>• Other - Write In: SUD/ODD Addiction</li> </ul>
Areas Where We Would Like to Serve as a Peer Mentor	
<p>The Healthy Moms team started the program in September 2018. We are happy to share any of the lessons learned in the infancy of the program.</p>	
Areas Where We Would Welcome Technical Assistance	
<p>Any information for like programs would be welcomed.</p>	
Intended Audience(s)	
<b>Health Status:</b>	People who inject drugs, People in recovery from SUD/ODD, Substance-exposed children and infants
<b>Health Access:</b>	Medically underserved
<b>Special Populations:</b>	Pregnant and Parenting People
<b>Other:</b>	Families and Caretakers of People With SUD/ODD

**Organizational Information:**

<b>Project Title:</b>	Healthy Moms and Babies
<b>State:</b>	West Virginia
<b>Organization Type:</b>	Perinatal Quality Collaborative (non-profit)
<b>Website:</b>	wvperinatal.org
<b>Address:</b>	1018 Kanawha Blvd. E. Suite 1100 Charleston, WV 25301

**Grantee Points of Contact:**

<b>Project Director:</b>	Janine Breyel, jbreysel@wvperinatal.org
<b>Learning Collaborative Point of Contact:</b>	Molly McMillion, mmcmlion@osteo.wvsom.edu

**Target Service Area(s):**

County, State	
Barbour County, WV	Pocahontas County, WV
Greenbrier County, WV	Randolph County, WV
Nicholas County, WV	Webster County, WV

**Partner Organization(s):**

Organization Name	City, State
Bureau for Social Services, Division of Children and Adult Services (Child Protective Services)	Charleston, WV
Camden Family Health	Charleston, WV
Davis Health System	Charleston, WV
Greenbrier Physicians	Charleston, WV
New River Health Association	Charleston, WV
Robert C Byrd Clinic	Charleston, WV
West Virginia Perinatal Partnership	Charleston, WV
West Virginia School of Osteopathic Medicine's Center for Rural and Community Health	Charleston, WV

Organization Name	City, State
WV Department of Health and Human Resources Bureau for Medical Services (WV Medicaid)	Charleston, WV

**Project Information:**

**Project Summary**

Through our consortium, the West Virginia Perinatal Partnership will focus on ensuring integrated care and care coordination to improve systems of care, family supports, and social determinants of health in Barbour, Greenbrier, Nicholas, Pocahontas, Randolph, and Webster counties. The Consortium includes:

- WV Perinatal Partnership
- Davis Health System
- Greenbrier Physicians
- Robert C Byrd Clinic
- New River Health Association
- Camden Family Health
- West Virginia School of Osteopathic Medicine, Center for Rural and Community Health
- WV Department of Health and Human Resources Bureau for Medical Services
- Bureau for Social Services, Division of Children and Adult Services

Consortium members have worked together to improve outcomes of mothers and babies since WVPP's inception in 2006.

Project activities include increasing access to family-planning services to women of childbearing age who have, or are at risk for, SUD/ODU through the Love Your Birth Control! shared decision-making educational campaign. The consortium will work to keep women engaged in the postpartum period by supporting pediatricians with patient coordinators in office to conduct mood disorder screenings, follow up on SUD treatment, connect moms to wrap around services, in order to prevent subsequent NAS births and high-risk SUD pregnancies.

Specific additional activities include decreasing social barriers to treatment among pregnant women and mothers through the expansion of DFMB programs into new clinics that provide prenatal and postpartum care, the implementation of a hospital-based quality improvement project focused on a health and safety bundle for the mother-baby dyad with substance exposure, and an anti-stigma campaign. To increase the number of providers and other health and social service professionals who are able to diagnose and treat pregnant women, the Consortium will pilot NAS prevention and postpartum support options through a mobile unit in rural communities.

**Focus Areas**

- Infant & Child Health
- Integration of Services
- Maternal and Obstetric Care
- Neonatal Abstinence Syndrome
- Women's Health

**Areas Where We Would Like to Serve as a Peer Mentor**

Integration of care for pregnant persons with SUD

**Areas Where We Would Welcome Technical Assistance**

Integration of services for pediatric providers serving families with SUD. Access to mobile units and telehealth services.

**Intended Audience(s)**

<b>Age:</b>	Children (0-12), Young Adult (18-24), Adult (25-64)
<b>Race/Ethnicity:</b>	White, Hispanic/Latino/Latinx, Black/African-American, Asian or Pacific Islander, Tribal populations/Native Americans/American Indian/Alaska Native
<b>Health Status:</b>	People with/at risk for OUD or SUD, People who inject drugs, People with/at risk for co-occurring conditions as a result of SUD (e.g., cirrhosis, HIV, hepatitis), People in recovery from SUD/OUD, Substance-exposed children and infants, People with/at risk for co-occurring conditions (mental illness, eating disorders, etc.)
<b>Health Access:</b>	Uninsured or underinsured, Medicaid or Medicare recipients, Medically underserved
<b>Economic:</b>	Socioeconomically Disadvantaged Population, Unemployed Persons
<b>Special Populations:</b>	Pregnant and Parenting People, Justice-Involved/Incarcerated Persons, People Experiencing Food Insecurity
<b>Other:</b>	Families and Caretakers of People With SUD/OUD, Healthcare Workers and Providers