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HRSA Rural Communities Opioid Response Program Award Recipients Generally Met All Core Activities and Benchmarks

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Why OIG Did This Audit

- The opioid crisis has impacted rural communities where barriers to treatment services limit access to care. The Rural Communities Opioid Response Program (RCORP) is a multiyear initiative that works toward meeting HHS's goal of ending the opioid epidemic by addressing the barriers to treatment for substance and opioid use disorder.
- In 2019, the Health Resources and Services Administration (HRSA) awarded $8.3 million to 12 eligible rural hospitals, clinics, and Tribal organizations through its RCORP Medication-Assisted Treatment (MAT) Expansion award to support establishing or expanding MAT programs in rural communities.
- This audit assessed whether the RCORP MAT Expansion award recipients met the five required core activities and three proposed benchmarks within the grant period.

What OIG Found

- Ten of the 12 award recipients implemented all 5 required core activities, and 2 award recipients implemented 4 of the 5 required core activities.
- Ten award recipients met two of the three proposed benchmarks, and two award recipients met only one of the three proposed benchmarks. We were unable to determine whether any of the award recipients met the proposed benchmark to increase the number of unique patients.
- Award recipients reported challenges in establishing or expanding their MAT programs in rural communities, including lack of transportation, hiring and retaining staff, the COVID-19 pandemic, and lack of recovery housing.

What OIG Recommends

This report does not contain recommendations.

HRSA informed us that it did not have comments on our draft report.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2017, the Department of Health and Human Services (HHS) declared the opioid epidemic in the United States a public health emergency. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. In 2022 alone, there were approximately 82,000 opioid-related overdose deaths in the United States.[1, 2]

The opioid crisis has impacted rural communities where barriers to treatment services limit access to care. In 2020, the rate of deaths involving psychostimulants with abuse potential was 31 percent higher in rural counties (9.4 per 100,000 standard population) than in urban counties (7.2 per 100,000), and the rate of deaths involving natural and semisynthetic opioids was nearly 13 percent higher in rural counties (4.5 per 100,000) than in urban counties (4.0 per 100,000).[3] As a part of the Office of Inspector General's oversight of efforts to combat the opioid crisis, we audited the Health Resources and Services Administration's (HRSA's) Rural Communities Opioid Response Program (RCORP) Medication-Assisted Treatment (MAT) Expansion award recipients.

OBJECTIVE

Our objective was to determine whether the RCORP MAT Expansion award recipients met the required core activities and proposed benchmarks within the grant period.

BACKGROUND

Health Resources and Services Administration

HRSA is an operating division within HHS that has programs, including RCORP, that provide health care to people who are geographically isolated and economically or medically vulnerable.[4] These include programs that deliver health services to people with HIV, pregnant women, mothers and their families, those with low incomes, residents of rural areas,

[1] Centers for Disease Control and Prevention (CDC), "Understanding the Opioid Overdose Epidemic." Accessed on Apr. 16, 2025.

[2] According to CDC, overdose deaths involving opioids decreased from an estimated 83,140 in 2023 to 54,743 in 2024.

[3] CDC, "Urban-Rural Differences in Drug Overdose Death Rates, 2020;" National Center for Health Statistics Data Brief No. 440, July 2022. Accessed on Apr. 16, 2025.

[4] On March 27, 2025, HHS announced a plan to consolidate its current 28 divisions into 15 new divisions. Under the announced plan, HRSA would be combined with multiple agencies under the new Administration for a Healthy America.

American Indians and Alaska Natives, and those otherwise unable to access high-quality health care. HRSA's mission is to improve health outcomes through access to quality services, a skilled health workforce, and innovative, high-value programs.

Rural Communities Opioid Response Program Medication-Assisted Treatment Expansion

RCORP is a multiyear initiative that is working toward meeting HHS's goal of ending the opioid epidemic by addressing barriers to treatment in high-risk rural communities. RCORP funds a variety of award programs, each aimed to prevent or treat opioid use disorder (OUD) for people in rural areas. As part of its efforts to combat the opioid crisis, in 2019, HRSA awarded a total of $8.3 million to 12 award recipients to support the establishment or expansion of MAT in eligible rural hospitals, clinics, and Tribal organizations through RCORP MAT Expansion awards.[5] This 3-year award provided award recipients in Iowa, Illinois, Indiana, Kentucky, Louisiana, Michigan, New Hampshire, Pennsylvania, South Dakota, Texas, Utah, and Washington with up to $725,000 to cover the initial fixed and operating costs to develop a MAT program.

Over the course of the 3-year period of performance, award recipients were expected to build the requisite staffing levels, patient volumes, and revenues to sustain MAT services after Federal funding ended by implementing five core activities and meeting three proposed benchmarks.

The core activities were:

1. recruiting, training, and mentoring interdisciplinary teams of providers who can provide MAT;
2. building new, or enhancing existing, clinical workflows and supply chain services to support the delivery of MAT;
3. providing staff with training to optimize insurance reimbursements;
4. organizing medical and social services to help patients achieve and maintain recovery; and
5. strengthening partnerships to improve the use of community resources and streamline referrals between clinical and community organizations for substance use disorder (SUD) /OUD and mental health services.

The benchmarks expected the award recipients to:

1. increase staffing by at least 1.0 full-time equivalent (FTE) to implement SUD/OUD and MAT services on-site;
2. increase the number of unduplicated (i.e., unique) patients receiving MAT; and
3. have MAT costs fully covered by third-party reimbursements or non-federal funding or both.

[5] See Appendix B for a list of the 12 award recipients and awards. The MAT Expansion award program ended August 31, 2022, and is no longer active.

Award recipients were required to participate in monthly progress calls with a HRSA Project Officer and a HRSA-funded technical assistance provider. Additionally, award recipients were required to submit progress reports to HRSA quarterly.[6]

HOW WE CONDUCTED THIS AUDIT

Our audit covered RCORP MAT Expansion award recipients. We reviewed all 12 of the MAT Expansion award recipients, located in rural areas in 12 States, that received award funds between $449,335 and $725,000 from September 1, 2019, through August 31, 2022.[7] See Appendix B for award recipient locations and the amount of funds awarded to each recipient.

Our audit included site visits to the 12 award recipients to determine whether their MAT programs were operational. Our site visits occurred approximately 1 year after the end of the award's period of performance.[8] At the time of our visits, all 12 award recipients were still operating their MAT program with the intention of continuing the program. Our evaluation of the 12 award recipients included determining whether they implemented the five required core activities and three proposed benchmarks outlined in the Notice of Funding Opportunity (NOFO).

In our interviews with the award recipients, they shared challenges and barriers to providing MAT and the practices that helped mitigate these issues. Based on the interview responses, we have highlighted both the challenges and barriers as well as the top practices shared by the award recipients in Appendix C of the report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology.

FINDINGS

The 12 award recipients implemented at least 4 of the 5 required core activities and met 1 of the 3 proposed benchmarks. Two award recipients did not fully implement the core activity to strengthen partnerships. One award recipient did not meet the proposed benchmark to increase staffing. We were unable to determine if another award recipient met this benchmark. Due to our inability to verify some of the data provided, we were unable to

[6] Progress reports were submitted biannually at the start of the third year of the award period.

[7] Five award recipients received a no-cost extension to their budget and project period in 2023. Of these, one had an extension date of May 31, two had an extension date of June 30, and two had an extension date of August 31.

[8] Site visits occurred from August through November 2023.

determine whether any award recipients met the benchmark to increase the number of unduplicated patients.

TEN AWARD RECIPIENTS IMPLEMENTED ALL FIVE CORE ACTIVITIES AND TWO IMPLEMENTED FOUR OF THE FIVE CORE ACTIVITIES

To provide or coordinate complementary services for MAT patients who may have other clinical and social service needs, the MAT Expansion award required recipients to implement five core activities. (See Table 1 on the following page.) Ten award recipients implemented all five required core activities, but two award recipients implemented four of the five core activities and did not implement the core activity to strengthen partnerships.

Table 1: Required Core Activities

Core Activity	Description	Number of Award Recipients That Implemented the Core Activity
1	Recruit, train, and mentor interdisciplinary teams of providers who can provide MAT.	12
2	Build new or enhance existing clinical workflows* and supply chain systems to support the delivery of MAT and other SUD/OUD and mental health services.	12
3	Train clinical, social service, and administrative staff to optimize insurance reimbursements through effective coding and billing, ensuring the long-term financial stability of services.	12
4	Coordinate medical and social services, such as transportation and referrals, to help patients achieve and maintain recovery.	12
5	Strengthen partnerships to improve the use of community resources and streamline referrals between clinical and community organizations for SUD/OUD and mental health services.	10

* A clinical workflow refers to the sequence of tasks, activities, and processes that healthcare providers follow to deliver patient care.

Core Activity 1

All 12 award recipients implemented this core activity. The award recipients recruited an interdisciplinary team of SUD/OUD providers, and in some cases, the grant funding made it possible for them to hire mental health professionals or care coordinators. Award recipients advertised vacancies on their own websites as well as on commercial and profession-based

websites. However, most award recipients reported that it was difficult to recruit and retain qualified medical providers because, for example, they had to compete with larger cities that could offer higher pay. To overcome the challenges of recruiting and retaining counselors or mental health professionals, award recipients partnered with other mental health organizations and providers to provide those services.

Most award recipients relied on in-house training or shadowing to train and mentor staff, including providers. They provided in-house training to their staff on various topics, including the types of stigma related to SUD/OUD, working with MAT patients, recovery support and paired more experienced providers with new providers to mentor and shadow. Some award recipients used awarded funds to provide outsourced training to staff.

Core Activity 2

All 12 award recipients implemented this core activity. Award recipients found various ways to build new clinical workflows or enhance their existing ones. Some award recipients achieved this by integrating referrals from emergency rooms or other clinical partners. Other award recipients adjusted when or how they treated MAT patients. For example, they saw patients virtually, scheduled medical and behavioral appointments on the same day, or integrated patients into their primary care practice. For some award recipients, enhancing their workflow meant learning how to deal with the stigma associated with treating MAT patients in their community and providing additional training for their staff.[9] In addition, award recipients were able to build new supply chains or enhance their existing ones by working with a local pharmacy to ensure the prescribed medication was available for their MAT patients.

Core Activity 3

All 12 award recipients implemented this requirement by utilizing the technical assistance provided by HRSA in training their clinical, social services, and administrative staff on effective coding and billing of reimbursement claims.

Core Activity 4

All 12 award recipients implemented this core activity. Referrals played an important part in providing patients with access to these services and achieving and maintaining recovery. Award recipients received referrals for patients needing MAT services from emergency rooms, inpatient hospitals, and other health facilities, as well as from correctional facilities and probation officers. Award recipients that did not have the resources to provide counseling, peer support groups, or inpatient hospital stays referred patients to other providers for these services.

[9] See Appendix C for more information on the stigma that award recipients faced.

Achieving and sustaining recovery is difficult when patients lack resources to access clinical and social services. Most award recipients reported transportation as a barrier for their MAT patients. Some award recipients were able to mitigate this problem by providing transportation assistance, using gas cards as an incentive to return for services, or providing transportation vouchers.

Telehealth also helped patients overcome transportation barriers and maintain access to medical and social services. To help patients maintain recovery, award recipients coordinated social services to patients by providing them referrals to other community services, such as food banks, dentists, housing, and clothing for job interviews as well as help signing up for insurance programs.

Core Activity 5

Award recipients were required to partner with at least two separately owned entities, supported by Letters of Commitment, which would state the organization's role and responsibilities to the award recipient's MAT program. Supporting documentation depicting a referral relationship between the two organizations could also be submitted to HRSA.

Ten award recipients implemented this core activity but two did not. The two award recipients each had only one partnership that was verifiable with supporting documentation. The award recipients had entities listed as partners on quarterly progress reports that were different from their award applications. According to the award recipients, the partnerships in their applications were not established. However, there was no supporting documentation that the award recipients had established a partnership with the other entities listed on their progress reports. While the change in partners was documented on progress reports to HRSA, without supporting documentation, we were unable to (1) determine the roles and responsibilities of the partnership, including how SUD/OUD and mental health resources would be better leveraged, and (2) verify the referral relationship between partners.

We determined that the core activity was not implemented because the award recipients lacked supporting documentation and because the two-partnership requirement was not met and maintained for the entire period of performance.

MOST AWARD RECIPIENTS MET TWO OF THE THREE PROPOSED BENCHMARKS

The award recipients were expected to meet three benchmarks: building requisite staffing levels, patient volumes, and revenues to sustain MAT services beyond the award period. (See Table 2 on the following page.) However, two award recipients either did not meet the increase in staffing level benchmark or we were unable to determine whether it had met it. In addition, due to our inability to verify some of the data provided, we were unable to determine whether any award recipients met the benchmark to increase unduplicated patients receiving MAT over Year 1 of the award. The award recipients met the third benchmark to be able to sustain the program beyond Year 3 of the award.

Table 2: Benchmarks			
Benchmark	**Time Period**	**Description**	**Number of Award Recipients That Met the Benchmark**
1	One Year Post-Award	Increase personnel by at least 1.0 FTE to implement SUD/OUD and MAT services on-site.	10
2	Two-and Three Years Post-Award	Increase the number of unduplicated patients receiving MAT over Year 1.	Undetermined
3	Three Years Post-Award	MAT costs are fully covered by third-party reimbursements and/or non-federal funding.	12

Benchmark 1

The benchmark for the first year, post-award, was to achieve a minimum 1.0 FTE increase in personnel who would implement SUD/OUD services, including MAT, onsite. Award recipients could achieve this benchmark by hiring new staff or by reassigning and training existing staff to provide these services. Additionally, award recipients were required to report in their application the baseline numbers for the number of FTEs providing SUD/OUD services in the year prior to the date of their submitted application, either directly or through contract(s), at their organization. The breakdown was to be reported as FTE by provider type.

Ten award recipients met the first-year benchmark. One award recipient did not meet the FTE benchmark after the first year of the award, and stated that it was difficult to hire and retain qualified medical personnel in rural areas. For the remaining recipient, we were unable to determine whether the benchmark was met. The award recipient had several MAT providers prior to the award period. However, we were unable to determine a baseline for the FTE count prior to the first year of the award because the award recipient's application did not include FTEs associated with personnel implementing SUD/OUD services. We noted that, by the end of the award period, both of these award recipients increased their FTEs by more than 1 FTE.

Benchmark 2

For the second and third year of the award period, award recipients were expected to increase the number of unduplicated patients who received MAT over the first year of the award. We did not assess whether the award recipients met this benchmark because we could not verify

the reliability of data provided to support this benchmark. The award recipients were not consistent in how they identified the population of individuals that were screened for SUD or the data that they collected on patients. As such, the request to support the unduplicated patient count posed a challenge. Further, award recipients had difficulty providing the patient data we requested to assess whether unduplicated patient counts increased.

Benchmark 3

By the end of the third year of the award period, award recipients were expected to have MAT costs fully covered by third-party reimbursements, other non-Federal funding, or both, and for the MAT program to be self-sustaining by the end of the award period. The 12 award recipients were able to meet this benchmark. Two of the twelve award recipients stated their MAT program is self-sustaining through third-party reimbursement and a patient volume sufficient to cover the cost of the MAT program. Ten of the twelve award recipients stated that their MAT program was not self-sustaining based solely on third-party reimbursement for MAT services. However, to help cover the cost of MAT, award recipients integrated their MAT services into their primary care practice or used hospital or clinic revenue, or a combination.

CONCLUSION

The MAT Expansion program was generally successful among the 12 award recipients. Each of the award recipients implemented at least four of the five required core activities and met one of the three benchmarks. We verified that FTEs eventually increased during the award period for the two award recipients who did not meet the deadline for the first benchmark. In addition, while we did not assess whether the award recipients met the second benchmark, award recipients were still treating MAT patients at their facilities at the time of our site visits. The program has since ended and is no longer being funded, therefore we are not making formal recommendations to HRSA that would improve its ability to determine if grant recipients implemented all core activities and met benchmarks.

HRSA informed us that it did not have comments on our draft report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed all 12 award recipients located in 12 States. The award recipients were awarded funds from HRSA's RCORP to expand MAT services. Each award recipient received between $449,335 and $725,000 from September 1, 2019, through August 31, 2022. HRSA awarded $8.3 million in total.

We did not conduct a comprehensive assessment of HRSA's internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective. Specifically, we (1) interviewed HRSA officials to obtain an understanding of controls related to the MAT Expansion award and the requirements for supporting documentation and (2) reviewed HRSA's NOFO to obtain an understanding of the requirements of the MAT Expansion program.

We conducted our audit work from June 2023 through July 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and policies;
- reviewed the NOFO to understand the requirements, including the 5 required core activities and 3 proposed benchmarks that award recipients were expected to meet throughout the period of performance;
- interviewed HRSA officials to gain an understanding of the oversight and assistance HRSA provided to award recipients in implementing their MAT programs;
- reviewed and analyzed award recipient applications, notices of award, and quarterly progress reports provided by HRSA;
- administered an online questionnaire, prior to the start of fieldwork, to contact the award recipients and make initial assessments of the status of the award recipients' MAT programs;
- visited each of the 12 award recipient locations;
- interviewed the award recipients to determine how MAT programs were being implemented;

- reviewed and analyzed documentation provided by award recipients to verify their compliance with the NOFO criteria;

- obtained deidentified (i.e., anonymized) patient data to determine the number of unduplicated patients receiving MAT each award year;

- identified top practices, challenges, and barriers faced by award recipients while establishing or expanding MAT services; and

- discussed the results of our audit with HRSA officials.

We shared our draft report with HRSA, and it informed us that it did not have comments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B: MAT Expansion Award Recipients' Location and Amount Awarded

Award Recipient Location	Amount Awarded
Emmetsburg, Iowa	$724,895
Jerseyville, Illinois	725,000
Huntington, Indiana	724,656
Morehead, Kentucky	725,000
Cottonport, Louisiana	722,325
Sandusky, Michigan	725,000
Lancaster, New Hampshire	449,335
Susquehanna, Pennsylvania	725,000
Sisseton, South Dakota	581,554
Mount Vernon, Texas	711,406
Skull Valley, Utah	712,372
Elma, Washington	724,860
Total	**$8,251,403**

APPENDIX C: AWARD RECIPIENTS' CHALLENGES AND BARRIERS AND TOP SHARED PRACTICES

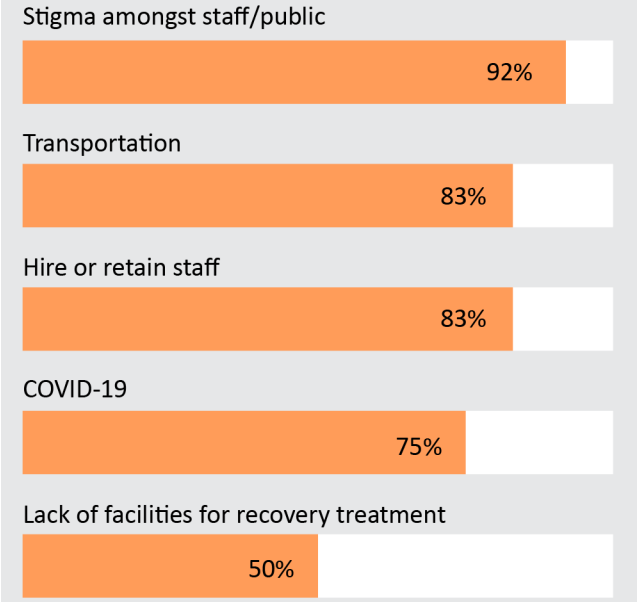
CHALLENGES AND BARRIERS

We asked award recipients about the challenges and barriers they faced while establishing or expanding their MAT program. We have highlighted the top challenges experienced by the award recipients in the chart below.

Stigma

Stigma was the most common challenge award recipients faced in trying to establish or expand their MAT program. The stigma came from the award recipient's own staff, other health providers in the area, and from within the community. Some health providers feared their facilities would develop a negative reputation or were fearful of violent patients. In addition, members of the local community did not believe there was an opioid addiction problem in their community. They saw OUD as a lifestyle choice rather than a disease or did not believe MAT was an acceptable treatment. Also, they saw MAT as substituting dependence on one drug for another. However, proponents of the MAT program continued educating the community and health providers on the benefits of MAT.

Figure 1: Top Challenges and Barriers that Most Award Recipients Experienced



Award recipients said that it was important that they earn their patients' trust and establish low-barrier access for MAT patients. In rural areas, a lack of anonymity is common, and individuals with OUD may not seek needed treatment or might seek treatment outside their community due to stigma. Many award recipients incorporated MAT into their primary health care practice, which helped mitigate stigma. By doing so, MAT patients could be seen at their facility with other primary care patients, rather than on a set day or at a facility designated for MAT services. The low-barrier, primary care model ensured that the other patients in the waiting room would not know who was being seen for MAT services and that MAT patients were treated the same as other patients.

Transportation

Award recipients said that they found the lack of reliable transportation to be a major barrier for the ongoing recovery needs of their MAT patients. A common disadvantage of being in a rural area is the lack of public transportation or ride-sharing options. According to the award recipients, MAT patients were willing to continue their treatment but did not have reliable transportation, which could prevent them from returning for their ongoing treatments. Award recipients stated that even when transportation options were available, such as nonemergency medical transportation or other contracted transportation providers, patients had difficulty scheduling rides or found that there were restrictions to using the service. While telehealth has helped remedy some transportation problems, some elements of treatment (e.g., drug screenings) require a patient to come into a medical facility. Some award recipients were able to reduce the transportation barrier by offering gas cards to patients to assist in their return for services, or by providing transportation vouchers.

Hiring and Retaining Staff

While award funding was helpful in hiring and paying staff, award recipients said that they still found it difficult to recruit and retain staff in rural areas. According to one award recipient, attracting qualified individuals was difficult when competing with larger cities that may provide better pay and fringe benefits. Hiring behavioral health professionals proved to be the biggest challenge for most award recipients.

COVID-19

The COVID-19 pandemic coincided with the first year of the award's period of performance. As a result, many award recipients felt the challenge of trying to start the program while still offering primary care to patients. Some award recipients said that their resources were constrained because providers had COVID or were seeing an influx of patients during this time while trying to provide MAT. Award recipients that pivoted to telemedicine were able to ameliorate this problem. Other award recipients said that they experienced a delay in implementing their programs because they were unable to go out into the community, talk to other medical providers, or get referrals to gain new patients. Additionally, they said the pandemic compounded the hiring problem.

Lack of Recovery Housing

Half of the award recipients stated that a lack of recovery housing in their area created a challenge for the ongoing recovery of their MAT patients.[10] According to one award recipient, a patient's chance of recovery is lessened when there is not a recovery environment promoting a

[10] Recovery houses are safe, healthy, family-like, substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support connection to services that promote long-term recovery.

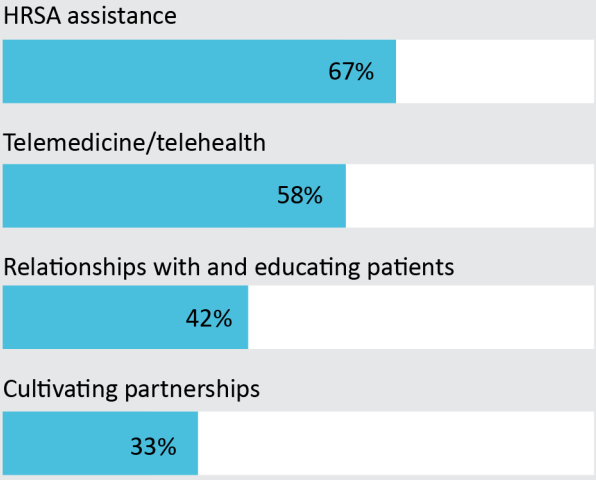
healthy lifestyle for the patient. Award recipients said they want to provide patients with additional resources to continue their recovery; however, recovery houses are located outside award recipients' service areas.

SHARED PRACTICES

We asked the award recipients to share practices that helped them establish or expand their MAT program. We have highlighted the top practices in Figure 2 below.

HRSA Assistance

Figure 2: Top Shared Practices that Most Award Recipients Experienced



Award recipients described the assistance provided by HRSA as helpful, supportive, and effective. HRSA offered essential guidance throughout the award period; HRSA project officers held monthly phone calls with award recipients, providing them the opportunity to ask questions, receive feedback, and obtain additional information as needed. Award recipients participated in an in-person RCORP conference in Washington, DC, in March 2020 and virtual meetings each subsequent year due to COVID-19. These meetings allowed award recipients to learn from each other and share best practices for addressing common challenges. Award recipients also found HRSA to be understanding of their unique situations, such as when dealing with provider turnover.

HRSA used a technical assistance (TA) provider to deliver additional hands-on support and practical resources. Monthly calls with award recipients often involved both HRSA and the TA provider. Award recipients said they found the calls with the TA provider to be very beneficial. The TA provider also provided guidance on contingency management and addressed award recipients' concerns and challenges with the program. Award recipients were able to contact HRSA or the TA provider when they needed assistance.

Telehealth

Telehealth was implemented during the COVID-19 pandemic, transitioning patient care from in-person services to remote care. It contributed to a reduction in no-show rates for therapy sessions and helped reduce the transportation barrier. Additionally, due to limited resources in rural areas, telehealth allowed award recipients to provide additional services, such as behavioral health to their MAT patients. While telehealth was a key component in supporting MAT patients, face-to-face interactions remained essential for vital checks, drug screenings, and relationship-building, which were critical to recovery.

Patient Relationships and Education

Award recipients believed that the success of the MAT program was largely dependent on establishing strong relationships with patients. Creating connections, maintaining continual communication, and educating patients were the keys to success for many award recipients. Additionally, award recipients developed strong relationships between their case managers and patients as they strived to address patients' daily needs, such as housing and food security. Furthermore, award recipients focused on increasing community awareness of the MAT program by giving presentations in local settings. This included celebrating patient success stories that highlighted the positive impacts of MAT and expanded its reach within the community.

Cultivating Partnerships

Most award recipients were members of consortiums that included other hospitals and clinics, health care centers, and law enforcement agencies with the purpose of referring patients for SUD/OUD services. Other award recipients formed partnerships with SUD/OUD and mental health providers to provide services not available at their facilities.

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