U.S. Department of Health and Human Services

Fiscal Year 2022
Report on the Public Health Service Act Section 760 Training Demonstration Program

EXECUTIVE SUMMARY

This report to Congress is required by Section 760(f)(2) of the Public Health Service (PHS) Act, which states:[1]

> *REPORT TO CONGRESS.—Not later than 1 year after receipt of the data described in paragraph (1)(B), the Secretary shall submit to Congress a report that includes—*
> *(A) an analysis of the effect of the demonstration program under this section on the quality, quantity, and distribution of mental health and substance use disorder services;*
> *(B) an analysis of the effect of the demonstration program on the prevalence of untreated mental health and substance use disorders in the surrounding communities of health centers participating in the demonstration; and*
> *(C) recommendations on whether the demonstration program should be expanded.*

This is the Fiscal Year (FY) 2022 Report to Congress on the PHS Act Section 760 Training Demonstration Program, administered by the Health Resources and Services Administration (HRSA). This report serves as the annual report for FY 2022, describes funding and activities authorized under the PHS Act Section 760 for FY 2022, and highlights activities conducted by grantees of the Addiction Medicine Fellowship (AMF) Program and Integrated Substance Use Disorder Training Program (ISTP). Both programs serve to bolster the nation's response to substance use by enhancing the quantity of clinicians capable of effectively treating mental health and substance use disorders and enhancing the quality of clinical training undertaken to prepare them for their work.

In FY 2020, HRSA awarded 44 grants under the AMF Program to Accreditation Council for Graduate Medical Education-accredited training programs for physicians in AMFs and in Addiction Psychiatry Fellowships.

In FY 2021, HRSA awarded 43 AMF Program continuation awards. In addition, HRSA awarded five ISTP grants to projects providing analogous training for one or more of these provider types: nurse practitioners, physician assistants, clinical social workers, and health service psychologists.

In FY 2022, HRSA awarded 43 AMF Program continuation awards and awarded three additional grants through the ISTP for a total of eight ISTP grantees. One of the five ISTP grantees partially funded in FY 2021 received additional funds to fully fund their proposal in FY 2022.[2]

[1] Training Demonstration Program, 42 U.S.C. § 294k. Retrieved on March 5, 2024, from https://www.govinfo.gov/content/pkg/COMPS-8778/uslm/COMPS-8778.xml.
[2] Performance data presented within this report covers academic year 2022 to 2023.

Fiscal Year 2022 Report on the Public Health Service Act Section 760 Training Demonstration Program

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ACRONYM LIST

AMF	Addiction Medicine Fellowship
APF	Addiction Psychiatry Fellowship
AY	academic year
COVID-19	Coronavirus Disease 2019
FY	fiscal year
HRSA	Health Resources and Services Administration
HSP	health service psychologist
ISTP	Integrated Substance Use Disorder Training Program
MOUD	Medications for Opioid Use Disorder (formerly Medication Assisted Treatment)
NP	nurse practitioner
OUD	opioid use disorder
PA	physician assistant
PHS Act	Public Health Service Act
SUD	substance use disorder

I. Introduction

On October 26, 2017, the Acting Secretary of Health and Human Services declared the opioid crisis a public health emergency under Section 319 of the Public Health Service Act; since then, subsequent Secretaries have renewed this declaration, most recently in June 2024.[3]

In 2019, prior to the Coronavirus Disease 2019 (COVID-19) pandemic, 70,630 drug overdose deaths occurred in the United States.[4] In 2022, the Centers for Disease Control and Prevention reported 107,941 overdose deaths,[5] showing a small increase over the number of deaths reported in 2021 and no evidence of a return to pre-pandemic levels.[6] While fentanyl, a synthetic opioid, remains the single most common cause of overdose deaths, polysubstance use-related overdoses have become increasingly common in recent years with drugs that include xylazine, a non-opioid sedative,[7] and methamphetamine, a stimulant,[8] complicating the medical and public health responses. These two drugs have serious and at times fatal effects distinct from opioids, and naloxone is not effective in reversing their effects.[9] Non-fatal overdoses have also increased at a rate of about 4 percent quarterly since 2018.[10]

As of 2022, the United States continues to have high rates of both substance use and substance use disorders (SUD) among people over 12 years of age. Results of the 2022 National Survey of Drug Use and Health show that more than 61 million people reported binge drinking in the past month, and an estimated 29.5 million have an alcohol use disorder.[11] An estimated 27.2 million people have a SUD involving a substance other than alcohol or tobacco, while 8 million people reported having both a SUD involving a substance other than alcohol or tobacco and an alcohol

[3] U.S. Department of Health and Human Services. (June 25, 2024). Renewal of determination that a public health emergency exists. Retrieved on October 7, 2024, from https://aspr.hhs.gov/legal/PHE/Pages/Opioid-25June2024.aspx.
[4] Centers for Disease Control and Prevention. (December 2021). Drug overdose deaths in the United States, 1999-2020. Retrieved on March 5, 2024, from https://www.cdc.gov/nchs/data/databriefs/db428.pdf.
[5] Spencer MR, Garnett MF, Miniño AM. (2024). Drug overdose deaths in the United States, 2002–2022. NCHS Data Brief, no 491. Hyattsville, MD: National Center for Health Statistics. Retrieved on October 7, 2024, from https://stacks.cdc.gov/view/cdc/135849.
[6] National Center for Health Statistics. (December 2022). Drug overdose deaths in the United States, 2001–2021. NCHS Data Brief No. 457. Retrieved on March 5, 2024, from https://www.cdc.gov/nchs/products/databriefs/db457.htm#print.
[7] Kariisa M, et.al. (2023). Illicitly manufactured fentanyl–involved overdose deaths with detected xylazine — United States, January 2019–June 2022. *MMWR Morb Mortal Wkly Rep 2023*(72), 721–727. Retrieved March 5, 2024, from https://www.cdc.gov/mmwr/volumes/72/wr/mm7226a4.htm#:~:text=In%202022%2C%20provisional%20data%20indicated,(IMFs)%20(1).
[8] Ciccarone, D. (July 2021). The rise of illicit fentanyl, stimulants and the fourth wave of the opioid overdose crisis. *Current Opinion in Psychiatry 34*(4), 344-350. doi: 10.1097/YCO.000000000000071. Retrieved March 13, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8154745/.
[9] Op. cit. Ciccarone.
[10] Casillas SM, et al. (2022). Patient-level and county-level trends in nonfatal opioid-involved overdose emergency medical services encounters — 491 counties, United States, January 2018–March 2022. *MMWR Morb Mortal Wkly Rep 2022*(71), 1073–1080. doi: 10.15585/mmwr.mm7134a1. Retrieved on March 5, 2024, from http://dx.doi.org/10.15585/mmwr.mm7134a1.
[11] Ibid.

use disorder.[12] Almost 9 million people are thought to have misused opioids in the past year, with 7.5 million people misusing prescription pain relievers, 461,000 using heroin, and 587,000 reporting use of both.[13] Over 70 million people reported any illicit drug use in the past year; an estimated 1 million used heroin, 5.3 million used cocaine, and 2.7 million used methamphetamine.[14] While SUD impacts all communities in the United States, there is some variation across demographic groups. Overall rates of SUD are lower among people of Asian descent, while White individuals have higher rates of alcohol use disorder, and multiracial and Black individuals have higher rates of illicit substance use.[15] Low socioeconomic status is a risk factor for SUD, particularly amongst White individuals.[16]

SUDs can be treated with either medications, counseling, or both. Medications for opioid use disorder (MOUD), which include buprenorphine, oral and injectable naltrexone, and methadone, are the most effective treatment approach for opioid use disorders (OUD).[17] Although the quality of evidence is less strong, most experts recommend that these medications be given in combination with other methods of treatment including psychotherapy, medical care, addiction counseling, and other recovery support services. [18,19] Medications are also used to treat alcohol use disorder and are often combined with psychosocial interventions such as counseling and cognitive behavioral therapy, as well as self-help groups.[20,21] With the exception of treatment for nicotine use disorder, there are currently no Food and Drug Administration-approved medications to treat other SUDs, but the rapidly increasing understanding of the neurobiology of addiction holds promise that other treatments will become available in the coming decade.[22]

The federal government has taken steps to increase access to substance use treatment services during and after the COVID-19 pandemic. In March 2020, in response to the COVID-19 public

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[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Vilsaint CL, NeMoyer A, Fillbrunn M, Sadikova E, Kessler RC, Sampson NA, Alvarez K, Green JG, McLaughlin KA, Chen R, Williams DR, Jackson JS, Alegría M. (February 20219). Racial/ethnic differences in 12-month prevalence and persistence of mood, anxiety, and substance use disorders: Variation by nativity and socioeconomic status. *Compr Psychiatry 89*, 52-60. Retrieved on October 7, 2024, from https://www.sciencedirect.com/science/article/pii/S0010440X18302104?via%3Dihub.
[17] Connery, HS. (March/April 2015). Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. *Harvard Review of Psychiatry*, *23*(2), 63-75. doi: 10.1097/HRP.0000000000000075. Retrieved on March 5, 2024, from https://pubmed.ncbi.nlm.nih.gov/25747920/.
[18] Watan Pal A, Aziz Z, Kamarulzaman A. (December 2021). Methodological quality of guidelines for the management of opioid use disorder: a systematic review. *J Clin Pharm Ther*. *46*(6), 1531-1548. Retrieved on March 5, 2024, from https://onlinelibrary.wiley.com/doi/10.1111/jcpt.13449.
[19] Substance Abuse and Mental Health Services Administration. (2021). Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series. 63 Publication No. PEP21-02-01-002. Retrieved on October 7, 2024, from https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf.
[20] Fairbanks J, et al. (September 2020). Evidence-Based Pharmacotherapies for Alcohol Use Disorder: clinical pearls. *Mayo Clin Proc*. *95*(9), 1964-1977. Retrieved on March 5, 2024, from https://www.mayoclinicproceedings.org/article/S0025-6196(20)30088-4/fulltext.
[21] Op. cit. Watan Pal A., et al. (2021).
[22] Volkow ND, Boyle M. (August 2018). Neuroscience of Addiction: Relevance to Prevention and Treatment. *Am J Psychiatry*, *175*(8), 729-740. Retrieved March 5, 2024, from https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.17101174?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.

health emergency declaration, the Drug Enforcement Administration granted temporary exceptions that allowed prescribing controlled substances (e.g., buprenorphine) via telehealth, with or without an in-person evaluation.[23] Notably, telehealth was extensively used during the COVID-19 pandemic with no measurable decrease in quality of care.[24] Also in 2020, in cooperation with states, the federal government provided flexibility to opioid treatment programs, allowing them to provide up to 28 days of take-home methadone for stable patients and up to 14 days of medications for less stable patients.[25] In February 2024, the federal government issued a final rule, amending 42 C.F.R. part 8, that made these flexibilities permanent and removed provisions pertaining to the Drug Addiction and Treatment Act of 2000, which was repealed by the Consolidated Appropriations Act, 2023.[26]

Despite this progress, access to treatment remains a challenge, as the Substance Abuse and Mental Health Services Administration estimates that only 24 percent of people who needed SUD treatment in 2022 received it, leaving more than 40 million people without needed care.[27] While many individuals living with SUD are unable to access SUD treatment, the vast majority of persons living with SUD who need treatment do not seek it.[28] The reasons why persons living with SUD do not seek treatment are complex and incompletely understood. Some reasons include denial, perceptions that treatment does not work, internalized stigma that suggests substance use is a matter of willpower and not a treatable disease, fear of discrimination, and concurrent challenges the person is experiencing (e.g., housing instability) that take precedence over a perceived need for treatment.[29,30]

Policy changes in recent years, such as state laws allowing nurse practitioners (NP) and physician assistants (PA) to prescribe buprenorphine and greater flexibility at the federal level in what can be prescribed via telehealth, have made it possible for primary care providers, including physicians, NPs, and PAs, to provide substance use treatment.[31] Policy alone does not guarantee

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[23] 88 FR 69879-69883 (October 10, 2023). Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications. Retrieved March 13, 2024, from https://www.federalregister.gov/documents/2023/10/10/2023-22406/second-temporary-extension-of-covid-19-telemedicine-flexibilities-for-prescription-of-controlled.

[24] Op. cit. Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health.

[25] Substance Abuse and Mental Health Services Administration. (No date). Methadone Take-Home Flexibilities Extension Guidance. Retrieved March 11, 2024 from https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance.

[26] 89 FR 7528-7563 (February 2, 2024). Medications for the Treatment of Opioid Use Disorder. Retrieved October 7, 2024, from https://www.federalregister.gov/d/2024-01693.

[27] Op. cit. Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health.

[28] Ibid.

[29] Rogers SM, et al. (2019). "I don't feel like I have a problem because I can still go to work and function": Problem recognition among persons with substance use disorders. *Subst Use Misuse*. *54*(13), 2108-2116. Retrieved March 6, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032932/.

[30] Strach P, Zuber K, Pérez-Chiqués E. (2020). Why policies fail: the illusion of services in the opioid epidemic. *J Health Polit Policy Law 45*(2), 341-364. Retrieved March 6, 2024, from https://read.dukeupress.edu/jhppl/article/45/2/341/143968/Why-Policies-Fail-The-Illusion-of-Services-in-the.

[31] Varghese R, et al. (2019). Final research report: Buprenorphine Prescribing by Nurse Practitioners, Physician Assistants, and Physicians after CARA 2016. IMPAQ International. Retrieved on March 5, 2024, from https://www.macpac.gov/publication/buprenorphine-prescribing-by-nurse-practitioners-physician-assistants-and-physicians-after-cara-2016/.

that these services will be provided however, and clinicians express many concerns about providing substance use treatment, including the limited availability of addiction specialists to consult when necessary, potential diversion of treatment medications, and lack of sufficient training in managing patients with SUDs.[32,33]

Addiction Medicine Fellowships (AMF) and Addiction Psychiatry Fellowships (APF) prepare physicians for board certification by the American Board of Medical Specialties through advanced training pathways for both psychiatrists through APF and for other board certified physicians through AMF.[34] Public Health Service Act Section 760 provides authority for grants to such training programs to expand and enhance training capacity under the AMF Program.[35] Expansions in AMFs and APFs hold promise for greater dissemination of evidence-based SUD treatment, including MOUD.

Several features of the SUD epidemic and the challenges in providing treatment to those who need it highlight the importance of AMF-trained physicians. Primary care providers including physicians, PAs, and NPs often cite a lack of addiction-related expertise as a challenge in their ability to provide care for SUD.[36,37,38] Consultation and support by specialists, including those trained via AMFs and APFs, as part of the "hubs" in a "hub and spoke" model greatly increase the likelihood that these primary care providers and other specialists will offer SUD treatment, including MOUD, to their patients.[39] Therefore, a relatively modest increase in the number of AMFs and APFs can significantly bolster the overall availability of SUD treatment. The high rates of polysubstance use and related overdoses, as well as the absence of Food and Drug Administration-approved treatment medications for drugs other than opioids, alcohol, and nicotine, require specialized clinical care and clinical research efforts of AMF- and APF-trained physicians.[40,41,42]

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[32] Andrilla CHA, Jones KC, Patterson DG. (March 2020). Prescribing Practices of Rural Physicians Waivered to Prescribe Buprenorphine. *J Rural Health 36*(2), 187-195. Retrieved March 11, 2024, from https://www.ajpmonline.org/article/S0749-3797(18)31548-4/fulltext.

[33] Lanham H, et al. (March 2022). Survey of Barriers and Facilitators to Prescribing Buprenorphine and Clinician Perceptions on the Drug Addiction Treatment Act of 2000 Waiver. *JAMA Network Open 5*(5), e2212419. Retrieved on March 11, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9099423/.

[34] Nunes, EV, et al. (2020). Addiction Psychiatry and Addiction Medicine: The Evolution of Addiction Physician Specialists. *Am J Addict*., 390-400. Retrieved on March 5, 2024, from https://doi.org/10.1111/ajad.13068.

[35] Public Health Service Act, Section 760, 42 USC 294k. Retrieved on March 5, 2024, from https://www.govregs.com/uscode/title42_chapter6A_subchapterV_partD_section294k.

[36] Op. cit. Lanaham H, et al. (2022).

[37] Op. cit. Chaple MJ, et al. (2018).

[38] Op. cit. Kawasaki S, et al. (2019).

[39] Op. cit. Chaple MJ, et al. (2018).

[40] Schottenfeld JR, et al. Pain and addiction in specialty and primary care: The bookends of a crisis. (2018). The Journal of Law, Medicine & Ethics, 46(2), 220-237. Retrieved on May 6, 2024, from https://www.proquest.com/docview/2730845780/fulltext/6261942272194DC6PQ/1?accountid=12786&sourcetype=Scholarly%20Journals.

[41] Hiebler-Ragger M, Unterrainer HF. (August 2019). The Role of Attachment in Poly-Drug Use Disorder: An Overview of the Literature, Recent Findings and Clinical Implications. *Front Psychiatry* 10, 579. Retrieved on March 11, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6720034/.

[42] Hazani HM, et al. (April 2022). Goofballing of Opioid and Methamphetamine: the Science Behind the Deadly Cocktail. *Front Pharmacol*. 13, 859563. Retrieved on March 24, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9021401/.

Each AMF- or APF-trained physician provides direct clinical care and resources that increase overall community capacity to care for persons living with SUD.[43,44] They provide consultation to other clinicians and conduct clinical research that improves treatment strategies and outcomes. Current AMF Program grantees are working to increase the recruitment of future addiction medicine and addiction psychiatry specialists, provide training and support for other physicians and health professionals, and reduce stigma both among health care providers and in the community. Treatments for SUD have significantly improved in recent years with the addition of new FDA-approved medications to treat alcohol use disorder and OUD, reduction of stigma within the treatment community, and increased understanding of the neurobiology of addiction.[45,46] As AMF- and APF-trained physicians promote and support access to these improved, evidence-based treatments, health outcomes have improved and stigma associated with SUD has decreased in the surrounding community and among health care providers.[47,48] Decreased stigma leads to more people seeking care, as stigma no longer discourages persons with SUD from seeking it, and leads to more providers offering treatment, as providers feel less stigmatized in giving it and more motivated to provide it as their own stigmatizing views of the disease diminish.[49,50]

Providing treatment, care, and services to persons living with SUD requires a broad, team-based approach that includes other health care professionals. The demonstration program discussed below thus includes a separate training program for NPs, PAs, clinical social workers, and health service psychologists (HSP) under the Integrated Substance Use Disorder Training Program (ISTP). ISTP prepares trainees to provide mental health and SUD services in underserved community-based settings that integrate primary care with mental health and SUD services.[51] These providers also serve as part of the "hubs" of the "hub and spoke" model and allow evidence-based addiction care to reach into community-based, primary care sites across the nation.

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[43] Ibid.
[44] Ibid.
[45] Op. cit. Connery HS.
[46] Substance Abuse and Mental Health Services Administration. Low barrier models of care for substance use disorders. *Advisory*. Publication No. PEP23-02-00-005. Rockville, MD: Substance Abuse and Mental Health Services Administration (2023). Retrieved on May 6, 2024 from https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf.
[47] Op. cit. Smart R, et al. (2022).
[48] Mackey K, et al. (December 2020). Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review. *J Gen Intern Med*. *35*(Suppl 3), 954-963. Retrieved on March 6, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7728943/.
[49] Ellick KL, et al. (January 2024). Increasing access to quality care for pregnant and postpartum people with opioid use disorder: Coordination of services, provider awareness and training, extended postpartum coverage, and perinatal quality collaboratives. *J Subst Use Addict Treat*. 156, 209208. Retrieved on March 6, 2024, from https://www.sciencedirect.com/science/article/pii/S294987592300259X.
[50] Madden EF, et al. (2021). Intervention Stigma toward Medications for Opioid Use Disorder: A Systematic Review. *Subst Use Misuse* *56*(14), 2181-2201. Retrieved on March 6, 2024, from https://www.tandfonline.com/doi/full/10.1080/10826084.2021.1975749.
[51] Ibid.

II. Demonstration Program Grants

In carrying out physician fellowship training, the Health Resources and Services Administration (HRSA) published Notice of Funding Opportunity HRSA-20-013 for the AMF Program. The purpose of the AMF Program is to expand the number of fellows at accredited AMF and APF programs trained as addiction medicine specialists who work in underserved, community-based settings that integrate primary care with mental health disorder and SUD prevention and treatment services. In fiscal year (FY) 2022, HRSA awarded 43 grants for a total of $22,690,653. Thirty-three AMF, four APF, and six dual (AMF and APF) training programs received funding. Project performance started July 1, 2020, for a 5-year project period. FY 2022 awardees are listed in Table 1.

Table 1: AMF Program Awards, FY 2022

INSTITUTION	STATE	FY 2022 AWARD	AMF TRAINING	APF TRAINING
University of Arizona	AZ	$296,199	Yes	N/A
University of California Los Angeles	CA	$784,298	Yes	N/A
University of California San Francisco	CA	$800,000	Yes	N/A
Loma Linda University	CA	$746,504	Yes	N/A
Stanford University	CA	$357,524	Yes	N/A
University of California San Diego	CA	$460,104	N/A	Yes
Yale University	CT	$532,093	Yes	Yes
Rushford Center Inc.	CT	$366,999	Yes	N/A
Howard University	DC	$493,265	Yes	N/A
University of Florida	FL	$552,000	Yes	N/A
Augusta University	GA	$528,510	Yes	N/A
University of Iowa	IA	$250,805	Yes	N/A
Family Medicine Residency of Idaho/Full Circle Health Inc.	ID	$161,620	Yes	N/A
Indiana University	IN	$799,848	N/A	Yes
Tulane University	LA	$607,726	Yes	N/A
Louisiana State University	LA	$325,663	Yes	N/A
Boston Medical Center	MA	$785,601	Yes	N/A
Massachusetts General Hospital	MA	$799,850	Yes	Yes
Children's Hospital (Boston)	MA	$777,017	Yes	N/A

INSTITUTION	STATE	FY 2022 AWARD	AMF TRAINING	APF TRAINING
Mountain Area Health Education Center	NC	$362,296	Yes	N/A
University of North Carolina Chapel Hill	NC	$728,137	Yes	N/A
Cooper Health System	NY	$709,979	Yes	N/A
Montefiore Medical Center	NY	$799,981	Yes	N/A
New York University	NY	$600,000	Yes	N/A
OhioHealth Research Institute	OH	$546,216	Yes	N/A
Ohio State University	OH	$799,200	Yes	N/A
University Hospitals of Cleveland	OH	$512,577	Yes	Yes
Summa Health	OH	$220,520	Yes	N/A
Oklahoma State University	OK	$274,295	Yes	N/A
Oregon Health & Science University	OR	$449,310	Yes	N/A
Pennsylvania State University	PA	$577,675	Yes	N/A
Geisinger Clinic	PA	$398,732	Yes	N/A
Thomas Jefferson University	PA	$409,081	Yes	Yes
Universidad Central del Caribe	PR	$486,612	Yes	N/A
Baptist Memorial Health Care	TN	$799,974	Yes	N/A
University of Texas – Austin	TX	$599,608	N/A	Yes
Baylor College of Medicine	TX	$160,000	N/A	Yes
University of Utah	UT	$773,966	Yes	Yes
University of Virginia	VA	$158,624	Yes	N/A
Virginia Commonwealth University	VA	$646,274	Yes	N/A
University of Washington	WA	$268,614	Yes	N/A
Swedish Health Services	WA	$600,583	Yes	N/A
West Virginia University	WV	$382,773	Yes	Yes
Total		**$22,690,653**		

In carrying out advanced training for NPs, PAs, clinical social workers, and HSPs, HRSA published Notice of Funding Opportunity HRSA-21-087 for the ISTP.[52] HRSA awarded five grants for a 5-year period of performance from HRSA 21-087 in FY 2021. Of these grants, four were fully funded for the 5-year period of performance and one was partially funded. The grantee partially funded in FY 2021 received additional funds in FY 2022 to fully fund their proposal. The period of performance for these grants began on July 1, 2021. HRSA awarded three additional grants for the 5-year period of performance from HRSA 21-087 in FY 2022. Their period of performance began on July 1, 2022. Awardees are listed in Table 2. ISTP awards in this table reflect total amounts for the periods of performance.

Table 2: ISTP Awards, FY 2021 and FY 2022

INSTITUTION	STATE	FY 2021 AWARD*	FY 2022 AWARD	PROFESSIONS TO BE TRAINED
Cahaba Medical Care	AL	$0	$2,074,240	NP, PA, clinical social worker
Western University of Health Sciences	CA	$2,570,500	$0	NP, PA
Denver Health and Hospital Authority	CO	$2,060,964	$0	PA
University of Iowa	IA	$0	$2,258,032	NP, PA
University of Illinois	IL	$1,822,862	$752,138	NP
Massachusetts General Hospital	MA	$2,567,825	$0	NP, clinical social worker, HSP
Rutgers, The State University of New Jersey	NJ	$2,575,000	$0	NP, PA, clinical social worker, HSP
Osteopathic Medical Education Consortium of Oklahoma	OK	$0	$2,115,807	HSP
Total		**$11,597,151**	**$7,200,217**	

* Grantees fully funded in FY 2021 continued to conduct grant activities in FY 2022.

III. Demonstration Program Performance

AMF and ISTP awardees submit annual performance reports to HRSA at the end of each academic year (AY) in July to comply with statutory and programmatic requirements for performance measurement and evaluation.

[52] Health Resources and Services Administration. ISTP funding opportunity number: HRSA-21-087. (2021). Retrieved on March 12, 2024 from https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/istp-modification-1-11-21.pdf.

Pursuant to the Paperwork Reduction Act, HRSA completes the Office of Management and Budget information collection review process for the annual performance report, which includes making all proposed performance metrics available for public comment and receiving formal approval to collect these data. Specific performance measurement reporting requirements are available on the HRSA website at https://bhw.hrsa.gov/grants/reportonyourgrant. These metrics provide HRSA with important data and allow grantees and HRSA to show progress in meeting program objectives and demonstrate compliance with applicable statutory requirements.

In the annual performance report, awardees report on the prior AY training and graduation counts associated with their training grant. In this report, awardees presented outputs and outcomes for AY 2022-2023, the most recent year for which data are available. Given the AMF Program's July 1, 2020, start date and ISTP's July 1, 2021, start date, the data needed for HRSA to assess the programs' overall impact on the quality, quantity, and distribution of behavioral health workforce members are not yet available. Similarly, HRSA cannot yet assess the prevalence of untreated mental health disorders and SUDs in the communities surrounding the clinical care settings participating in the demonstration programs.

In AY 2022-2023, the AMF Program trained 159 fellows, which included 130 AMF fellows and 29 APF fellows. The 159 fellows had previously completed residencies in the following medical specialties: family medicine (47), internal medicine (46), psychiatry (37), preventive medicine (7), internal medicine/family medicine (3), and other medical specialties (19). By the end of the AY, 134 physicians completed their fellowship, which included 112 in addiction medicine and 22 in addiction psychiatry. AMF and APF fellows increased access to behavioral health services in areas of need through nearly 255,000 patient encounters. These included more than 126,000 hours of patient care in medically underserved communities and more than 31,000 hours through telehealth. AMF fellows and APF fellows received training on topics such as MOUD and medications for other SUDs (90 percent), health equity (76 percent), and integrating behavioral health into primary care (72 percent). Fifty-five percent of program completers with follow-up data were working in medically underserved communities 1-year after completing their fellowship program, and 36 percent were working in primary care settings.

In AY 2022-2023, AMF Program awardees supported 296 training sites where fellow trainees provided direct supervised care. Seventy-one percent of experiential training sites were located in medically underserved communities and/or rural settings, and 30 percent were in primary care settings.[53] Eighty-eight percent of sites provided interprofessional education and 62 percent offered telehealth services. AMF Program awardees developed or enhanced 325 courses on topics such as SUDs, which they delivered to 3,733 trainees. In addition, the AMF Program offered 120 faculty development training programs and activities to 1,746 faculty members.

[53] Sites may be in more than one type of setting, and therefore the total may add up to greater than 100%.

Several AMF Program grantees struggled to recruit fellows in AY 2022-2023. Reasons for limited interest in comparison to slots available are multiple and include: the relative newness of the specialty, stigma, lack of adequate exposure to the specialty in medical school and residency, and regulatory constraints on practice.[54] Lower than average salaries for addiction medicine and addiction psychiatry may also play a role, with addiction medicine salaries averaging $201,441[55] and addiction psychiatrists earning $135,000 to $250,000[56] compared to physicians' average salary of $352,000.[57] Yet interest in addiction medicine is growing among medical students,[58] and in some schools, students are demanding curricular changes to prepare them to care for patients living with SUD.[59,60] These students will eventually be eligible for fellowships in addiction medicine or addiction psychiatry following completion of their residencies. This growing interest, while promising for the future, has not kept pace with the rising need driven by the current SUD epidemic.[61]

In AY 2022-2023, the second year ISTP awardees reported performance data, the ISTP trained 48 health care professionals, which included 22 NPs, 13 PAs, 12 clinical social workers, and one HSP. By the end of AY 2022-2023, 29 health care professionals completed the program. ISTP health professionals increased access to behavioral health services in areas of need through nearly 30,000 patient encounters. These included more than 36,000 hours of patient care in medically underserved communities and more than 5,000 hours through telehealth. ISTP trainees received training on topics such as MOUD and medications for other SUDs (92 percent), SUD treatment (90 percent), health equity (71 percent), integrating behavioral health into primary care (65 percent), and telehealth (40 percent). Seventy-four percent of AY 2021-2022 program completers with follow-up data were working in medically underserved communities 1-year after completing their ISTP training, and 32 percent were working in primary care settings.

In AY 2022-2023, ISTP awardees also supported 33 experiential training sites. Sixty-seven percent of experiential training sites were located in medically underserved communities and 55 percent were in primary care settings. All sites provided interprofessional education and 70 percent of sites offered telehealth services. ISTP awardees developed or enhanced 70 courses,

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[54] McNeely J, et al. How physician workforce shortages are hampering the response to the opioid crisis. *Psychiatric Serv.* (2022 May). Retrieved on May 6, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8920951/.

[55] Salary.com. Addiction Medicine Physician Salary in the United States. Retrieved October 7, 2024, from https://www.salary.com/research/salary/posting/addiction-medicine-physician-salary.

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[57] Medical School Insiders. How Much Do Doctors Make in 2024? Retrieved October 7, 2024, from https://medschoolinsiders.com/pre-med/how-much-do-doctors-make/.

[58] Moses TEH, et al. (July 2023). Optimizing buprenorphine training during undergraduate medical education: Medical student feedback and attitudes. *Am J Addict*. *32*(4), 376-384. Retrieved March 13, 2024, from https://onlinelibrary.wiley.com/doi/full/10.1111/ajad.13395.

[59] Nagle LE, et al. (April - June 2023). Building a strong foundation from the ground up: the impact of a medical student substance use disorder organization on curriculum and community. *J Addict Dis*. *41*(2), 156-166. Retrieved March 11, 2024, from https://pubmed.ncbi.nlm.nih.gov/35470767/.

[60] Waskel EN, et al. (July – September 2020). The impact of medical school education on the opioid overdose crisis with concurrent training in naloxone administration and MAT. *J Addict Dis*. *38*(3), 380-383. Retrieved March 11, 2024, from https://pubmed.ncbi.nlm.nih.gov/32449488/.

[61] Op. cit. McNeely J., et al. (2022).

including 30 clinical rotations, on topics such as integrating behavioral health into primary care. In addition, the ISTP trained more than 180 faculty members.

IV. Conclusion

The demonstration program described here represents important progress in the federal response to the opioid epidemic, addiction treatment, and mental health in general. The two components of the effort (AMF Program and ISTP) together train a range of health care professionals to address the needs of current and future patients in medical management of SUD and to serve as effective "hubs" within the aforementioned "hub and spoke" model of care. Through these programs, psychiatrists, other physicians, PAs, NPs, clinical social workers, and HSPs are being trained to provide addiction-related care in holistic, team-oriented approaches. Notably, HRSA is the sole source of federal funding for AMFs, and in the absence of such funding these fellowships would rely entirely on hospital budgets or philanthropy to sustain these critical programs. Interest in SUD treatment is increasing, and evidence suggests recruitment rates into the field are improving and will continue to do so over time. Both programs contributed to and, in the case of ISTP, increased these efforts in FY 2022. The AMF Program and ISTP are building a health workforce increasingly prepared to address the epidemic of substance use disorders.

V. Recommendations

Given the persistence and the rapidly changing nature of the opioid public health emergency, it is critical to continue support to train clinical professionals to provide medical care and services to persons living with OUD and other SUDs in a variety of clinical settings. Grantees have achieved meaningful impact related to the training and overall goals of the demonstration program. Additionally, grant applicants and recipients have expressed strong interest in establishing and expanding relevant grant projects. HRSA will continue to monitor grantee performance and modify the program as needed to support a behavioral health workforce to meet the needs of communities.