Addiction Medicine Fellowship Program Evaluation

Academic Years 2020-2023

The Health Resources and Services Administration (HRSA) is the primary federal agency for improving health care to people who are geographically isolated or economically or medically vulnerable. HRSA programs help those in need of high-quality primary health care by supporting the training of health professionals – focusing on the geographical distribution of providers to areas where they are needed most.

The Addiction Medicine Fellowship (AMF) program was established in Fiscal Year (FY) 2020 to increase the number of addiction medicine specialists who work in underserved, community-based settings that integrate primary care with mental health and substance use disorder (SUD) prevention and treatment services. To accomplish this, AMF provides stipends to fill new addiction medicine and addition psychiatry fellowship slots at accredited addiction medicine fellowship programs. The AMF program enhances training by establishing close collaborations with community-based partners to provide experiential training opportunities in underserved areas and in community-based settings.

This report summarizes the results of a retrospective evaluation of the first three years of the AMF program, Academic Years (AY) 2020-2023.

Key Findings

- The AMF program substantially increased the number of new addiction medicine physicians by 158% and addiction psychiatry physicians by 11% compared with the two years prior to the beginning of the program.
- AMF now trains nearly 60% of all addiction medicine specialists and addiction psychiatry specialists in the United States.
- 57% of fellows who graduated now work in a medically underserved community, 37% work in a primary care setting, and 10% work in a rural area.
- During their training AMF fellows provided over 318,000 hours of patient care in medically underserved communities, almost 44,000 hours of patient care in rural areas, over 81,000 hours of patient care in primary care settings, and over 103,000 hours of patient care through telehealth.
- AMF fellows who trained in primary care settings were almost three times more likely to work in that setting after graduating than fellows who did not. Similarly, fellows who trained in rural areas were four and a half times more likely to work in a rural area after graduating.

Who did the AMF program support and train?

During its first year, AMF filled 98 new fellowship slots, increased the number of slots to 169 in AY 2021-2022, and filled 159 slots in AY 2022-2023 (Table 1). The largest number of incoming fellows had completed residencies in family medicine, internal medicine, or psychiatry. Fellows were trained to provide SUD prevention, treatment, and recovery services at various settings across health care sectors with the goal of providing addiction-related care at the first place a patient seeks it.

Table 1. Subspecialties of Incoming AMF Fellows by Year

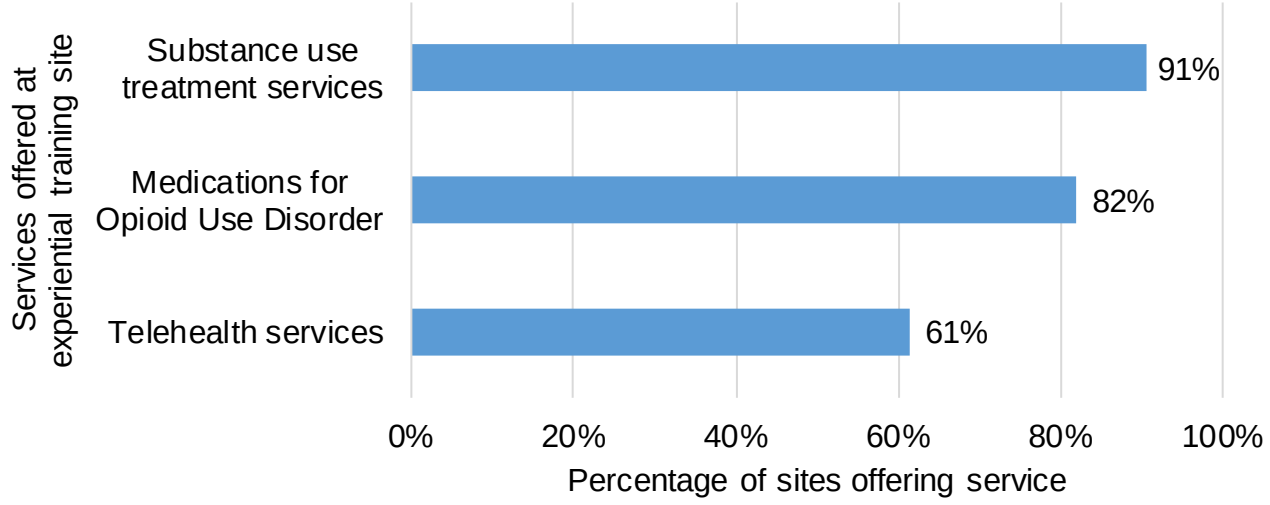
Fellowship Subspecialty	AY 2020-2021	AY 2021-2022	AY 2022-2023
Addiction Medicine Fellows	84	140	130
Addiction Psychiatry Fellows	14	29	29
Total	98	169	159

Training AMF Fellows in Underserved Areas and Community-based Settings

The AMF program provides experiential training in underserved areas and in community-based settings to increase the number of fellows working in these locations after graduation. During the evaluation period, fellows trained at 345 clinical training sites, of which 20% were hospitals, 15% were specialty clinics treating mental health and SUD, and 13% were Federally Qualified Health Centers. Over 70% of these sites were in medically underserved communities and/or rural areas and 30% were in primary care settings.

Eighty-eight percent of training sites provided interprofessional training, allowing AMF fellows to train alongside 6,346 health professionals from disciplines such as clinical psychology, social work, and nursing. Most sites offered services such as SUD treatment, medications for opioid use disorder, and telehealth ensuring fellows received training across modalities. These services helped meet the needs of patients in hard-to-reach locations who otherwise may not have received treatment (Figure 1).

Figure 1. Types of Services Offered at Experiential Training Sites, AY 2020-2023 (N=345)



How much additional care was provided to patients from underserved and rural areas because of the AMF program?

The expansion of fellows trained by the AMF program enabled hundreds of thousands of hours of patient care across settings and through telehealth (Table 2). This fellowship training significantly enhanced access to care for patients that may not have been treated had the AMF program not existed.

Table 2. Patient Contact Hours and Encounters by Setting, AY 2020-2023 (N = 426)

	Medically Underserved Communities	Rural Areas	Primary Care Setting	Telehealth
Contact Hours	318,453	43,910	81,622	103,130
Patient Encounters	400,912	16,648	96,704	122,783

Note: These settings are not mutually exclusive.

What percent of the nation's new addiction medicine and addiction psychiatry specialists did the AMF program produce?

The AMF program substantially expanded the number of new physician specialists entering the health care workforce. This expansion is a 158% increase in addiction medicine specialists and an 11% increase in addiction psychiatry specialists trained due to the AMF program during the evaluation period when compared with the two academic years just prior to its start (AY 2018-2020).[1]

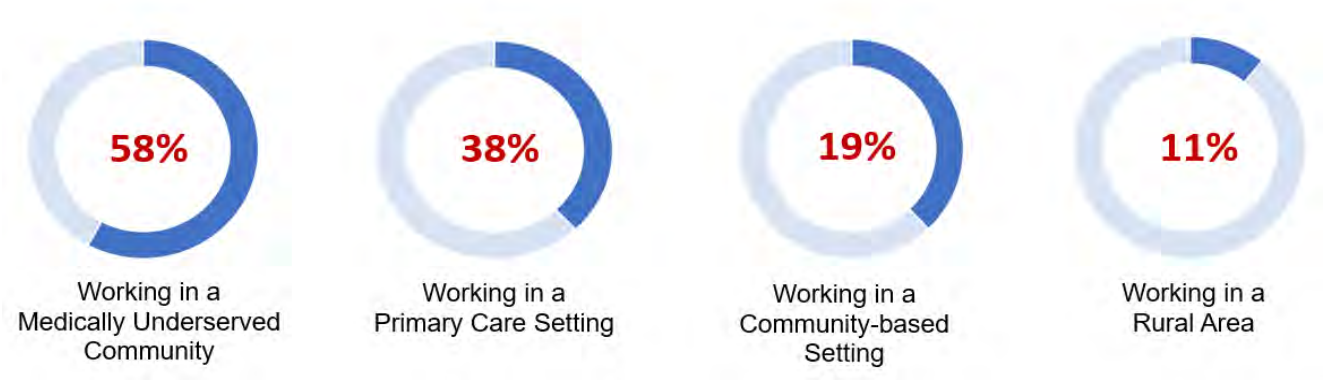
The AMF program now trains nearly 60% of all addiction medicine specialists and addiction psychiatry specialists in the United States.

Are AMF physicians working in underserved areas at program graduation?

Employment data were available for 290 AMF fellows at the time of graduation. More than half of the graduates reported working in medically underserved communities, over one third in a primary care setting, nearly one fifth in a community-based setting,[2] and one out of ten in a rural area (Figure 2). Employing AMF graduates in primary care settings and in underserved areas is vital to removing barriers for access to care for addiction.[3]

[1] Adapted from the *Data Resource Book, Academic Year 2022-2023*, by the Accreditation Council for Graduate Medical Education, 2023 (https://www.acgme.org/globalassets/pfassets/publicationsbooks/2022-2023_acgme_databook_document.pdf).
[2] Community-based settings included: Certified Community Behavioral Health Clinics, Community Behavioral Health/Mental Health Centers, Community Health Centers, Community Mental Health Centers, Critical Access Hospitals, Federally Qualified Health Centers or look alike, Other Community-Based Organizations, and Rural Health Clinics
[3] 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.

Figure 2. Addiction Medicine Fellows' Employment Setting at Program Graduation, AY 2020-2023 (N=290)



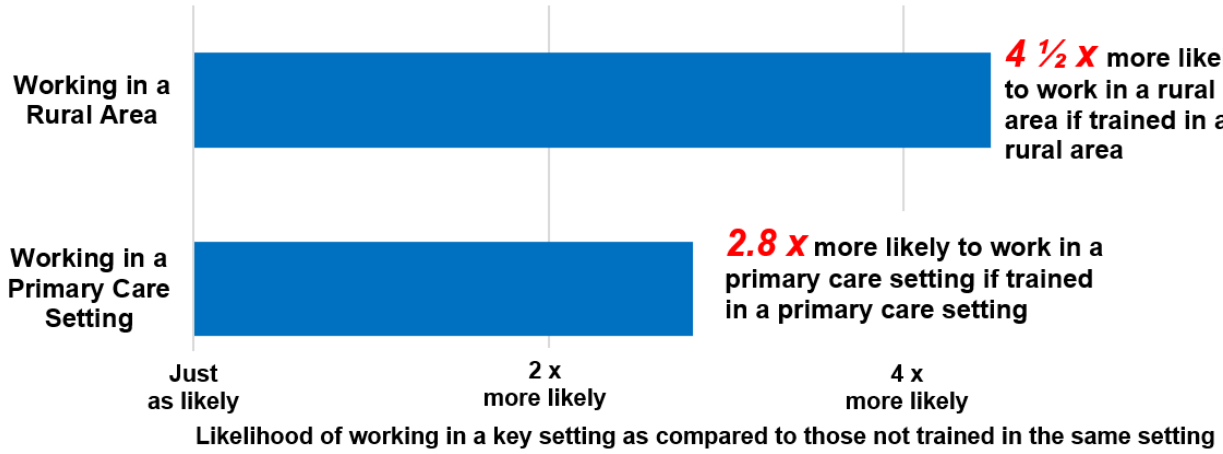
Note: Employment settings are not mutually exclusive and may sum to greater than 100%.

How Training Related to Employment at Graduation

A closer examination of how training settings related to the eventual employment location of the 290 program graduates suggests where physicians train is related to where they work.[4] See Figure 3.

- AMF fellows who trained in primary care settings were almost three times more likely to work in primary care settings after graduation than fellows who did not train in primary care settings.[5]
- AMF fellows who trained in rural areas were four and a half times more likely to work in a rural area after graduation than those who did not train in a rural area.[6]

Figure 3. Where AMF Fellows Train Relates to Employment Setting at Time of Graduation, AY 2020-2023 (N=290)



Note: Employment settings are not mutually exclusive.

[4] Figueiredo, A. M., Labry Lima, A. O., Figueiredo, D. C. M. M., Neto, A. J. M., Rocha, E. M. S., & Azevedo, G. D. (2023). Educational strategies to reduce physician shortages in underserved areas: A systematic review. *International Journal of Environmental Research and Public Health*, *20*(11), 5983. https://doi.org/10.3390/ijerph20115983
[5] Odds ratio = 2.81, 95% CI 1.58-5.02, p <.01
[6] Odds ratio = 4.49, 95% CI 2.01-10.01, p < .01

Conclusion

During its first three years, the AMF program expanded the addiction medicine workforce while increasing access to evidence-based prevention, treatment, and recovery services. The AMF program provided fellows with training in several addiction treatment modalities such as SUD prevention, medications for opioid use disorder, and telehealth services. Fellows also received experiential training in medically underserved communities, rural areas, and primary care settings. These training experiences were directly related to AMF graduates gaining employment in primary care settings and rural areas. The program's emphasis on training in medically underserved communities led to over half of graduates working in those areas upon program completion.

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