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ORIGINAL ARTICLE

Best Practices for Creating an Addiction Curriculum Within Family Medicine Residency Programs: A Qualitative Analysis of Expert Opinion

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ABSTRACT

Background and Objectives: Primary care physicians are well-positioned to be at the forefront of screening for and treating substance use disorders (SUDs). In addition, the Accreditation Council for Graduate Medical Education has deemed addiction training a common program requirement for all residency programs. With less than one-third of family medicine residency programs providing addiction training, understanding best practices for addiction training is important.

Methods: We interviewed 12 faculty at family medicine residency programs across the country who have a strong reputation for addiction training. We analyzed interview transcripts thematically to identify best practices for creating and providing addiction curricula.

Results: Creating an addiction curriculum originates with an addiction champion who garners the support of clinical leadership and provides faculty development that is augmented by a multidisciplinary team of providers, often grant-supported. Coupling didactic learning with a wide array of experiential opportunities is important, particularly allowing residents to care for patients with SUDs longitudinally in their primary care clinics. Residency programs should anticipate stigma and associated resistance from clinic staff and providers and should work collaboratively to mitigate these.

Conclusions: Comprehensive and robust addiction training in family medicine residency training should include didactic and experiential learning opportunities with a well-supported and philosophically aligned clinical and educational culture that values caring for patients with SUDs.

BACKGROUND

Substance use disorders (SUDs) rank among the leading causes of death and disability in the United States, with approximately one-quarter of all deaths directly or indirectly related to SUDs. The COVID-19 pandemic further exacerbated the SUD crisis, resulting in a 30% rise in drug overdose deaths.[1] Unfortunately, among the 54.5 million people aged 12 or older in the United States in 2022 who had an SUD and were deemed to need treatment, only 24% of them received treatment.[2]

For decades, SUD treatment was offered primarily by psychiatrists and addiction specialists; however, these providers comprise less than 1% of the US physician workforce, and access has been severely limited, especially in rural areas.[3] A clear need exists to further expand the workforce providing SUD treatment. Because primary care providers comprise 33% of the physician workforce, the largest proportion of the clinical workforce in the United States, they are well-positioned to fill the gap in SUD treatment.[4] In addition to providing lifesaving medication for addiction, primary care providers also can attend to the primary care needs of this population as well as provide care for sequelae of and risks associated with substance use.[5–10] These combined interventions are estimated to result in a total mortality reduction by 33% if medication for opioid use disorder and harm reduction kits are prescribed by a primary care provider.[3] Additionally, seeking care at a primary care office rather than an addiction clinic allows patients to feel less stigmatized and more comfortable with a provider with whom they are familiar.[5]

To grow a primary care workforce capable of providing frontline addiction care, implementing addiction as a core component of primary care residency training is crucial so that graduating residents can further disseminate these skills and influence the culture where they practice after graduating. The Accreditation Council for Graduate Medical Education (ACGME)

has deemed addiction training a common program requirement for all residency programs.[11] Despite this requirement, only 28.6% of family medicine residency programs have an addiction medicine curriculum.[12] Additionally, only 20% of the current primary care providers feel very prepared to screen for SUDs, and only 6% frequently prescribe medications for SUDs.[13]

Programs without an addiction curriculum or those that are in the early stages of development might find implementing a new SUD curriculum challenging, especially if their faculty have minimal SUD expertise. As family medicine residency programs continue to develop and grow their SUD curricula, understanding key didactic, experiential, and other systemic educational factors that promote effective addiction training will be important. Thus, we identified family medicine residency programs across the country that provide robust SUD training and interviewed their faculty to learn about best practices.

METHODS

We obtained exempt approval from both the Cambridge Health Alliance (CHA) and Jefferson University Institutional Review Boards. We used the Consolidated Criteria for Reporting Qualitative Research checklist[14] to ensure rigor in our methodology.

Participant Recruitment

The principal investigator (G.J., a male family medicine and addiction medicine physician at Jefferson University) recruited faculty from family medicine residencies that were deemed to have a strong addiction medicine curriculum—those who prioritized addiction training, had an addiction curriculum in place for several years, had presented their curriculum at national conferences, and/or had a large percentage of graduates entering addiction medicine fellowships. These faculty members were identified through a national program director's listserv, a national family medicine education conference, and ongoing referrals made by previously identified programs. Prospective participants were contacted via phone and email to discuss the study, explain the risks and benefits of participating, determine their interest, and address their concerns. Interested participants then were sent an informed consent and scheduled for an interview. In total, 12 faculty were invited and all agreed to participate. Table 1 provides descriptions of the participants and their associated programs.

Data Collection

The principal investigator performed 1-hour-long semistructured interviews with participants on the Zoom virtual meeting platform to learn about best practices in training learners in addiction medicine. The interviews were audio-recorded and transcribed by a professional transcription service. Two members of the research team (B.M., a female research coordinator, and M.S., a female medical student, both at Thomas Jefferson University) manually removed identifying information. The transcripts were not returned to the participants for their feedback before analysis.

Data Analysis

A second group of six researchers from a separate institution—composed of two CHA faculty members (R.S., a female family medicine and addiction medicine physician, and B.B., a female family medicine and addiction medicine physician); two CHA family medicine residents (C.P., female, and J.B., male); a CHA addiction medicine fellow (P.R., male); and a Jefferson medical student (M.S., female)—used Dedoose version 9.2.12 8 software (SocioCultural Research Consultants) to thematically code the transcripts. The six researchers initially met as one large team to code the transcripts until saturation was reached, identifying 28 distinct parent codes defined in a consensually agreed upon codebook. The team then broke into pairs to code the remaining transcripts. During this process, seven additional parent codes were identified, four parent codes were merged down to two, and two child codes were reparented; additional identified codes were shared with other paired coders to incorporate into their coding schema. Team members met to reconcile differences, and then the lead coder (R.S.) reviewed all transcripts for final reconciliation. The coding team then reconvened to discuss and group the 35 identified codes into six broad themes. The team pulled excerpts from each theme to illustrate our findings. In identifying both codes and themes, the research team took a qualitative approach with the goal of identifying those that held both distinct and significant meaning in describing curriculum and its implementation. Some codes were described by only a few participants, while other codes were described by a majority. Participants did not necessarily describe all codes; but they did describe all six themes, though in differing depths. A complete codebook is available upon request.

RESULTS

We identified six overall themes from the interviews in which participants described best practices for creating and providing a robust addiction curriculum within their family medicine residency programs. Major themes included the following.

1. The origins of addiction curricula usually started with an addiction champion who sought extra training and mentorship and then spread their passion and knowledge to residents and faculty and gained support from clinical leadership early on; the impetus for such change often was spurred by the surrounding cultural climate of the opioid epidemic that affected both patients and providers. Through grant funding, programs then grew their capacity to provide addiction care by creating multidisciplinary teams, including nurses, social workers, and recovery coaches.
2. Programs created a breadth of experiential learning opportunities for residents in a variety of settings and prioritized incorporating addiction into primary care, finding continuity crucial to supporting optimal patient care and breeding provider satisfaction.
3. These experiential opportunities were coupled with a didactic curriculum, which included bread-and-butter

TABLE 1. Demographics of Participants and Their Associated Family Medicine Residency Programs

Participant characteristics	Program characteristics	
Role in family medicine residency program	**Total # residents**	
PD or APD: 2 Core faculty: 10 (Includes 2 addiction fellowship PDs)	<20: 2 20–29:1 30–39: 4 >40: 5	
Gender	**Location**	
Female: 7 Male: 5	West Coast: 4 (3 from CA, 1 from WA) Northeast: 7 (2 from MA, 3 from NY, 2 from PA) South: 1 (from NC)	
Ethnicity	**Setting**	**No. of core faculty**
White/European: 7 Asian American: 4 Chicana/Latinx: 1	Suburban: 3 Urban: 7 Rural: 2 Community: 7 Academic: 4 Hybrid: 1	<10: 3 10–15: 9
Years in practice	**Addiction experience**	
<5 years: 0 5–10 years: 6 >10 years:6	No. with associated addiction fellowships: 5 No. with majority of faculty comfortable with SUDs: 11	

Abbreviations:PD, program director; APD, associate program director; SUD, substance usedisorder

addiction topics as well as other more innovative topics that learners found particularly interesting.

4. During implementation of the curriculum, programs encountered various barriers that required intentional navigation, including stigma across all providers, faculty with minimal addiction training, and management of a challenging and often emotionally draining patient population.
5. Underlying attitudinal philosophies that helped shape programs' success included recognizing that primary care is best suited to provide addiction care, assuming a just do it mentality, and understanding that residents are seeking this type of training.
6. Some residents graduating from programs that provide this quality of addiction training go on to provide addiction care in their future careers, even when addiction was not necessarily their "thing," because they developed the confidence and competence to provide such care.

In Appendix Table A, we outline these six overall themes, describe them in more depth using identified subthemes (the parent codes, italicized), and provide illustrative quotes for many of these.

DISCUSSION

In this study, 12 faculty at family medicine residency programs across the country shared their expertise in starting and growing addiction curricula, which we hope will provide helpful guidance for programs looking to implement or expand addiction training. Key themes identified included the importance of identifying an addiction champion to launch and maintain the program; gaining residency and clinic leadership buy-in; and training and supporting faculty and staff—all of which are consistent with implementation science literature[15–17] and highlight the need to create a clinical and residency culture that supports addiction care.

Another prominent theme that emerged was the value of providing a breath of experiential learning opportunities that complement didactic teaching. Many programs have a few designated faculty who teach these topics, many invite behavioral health faculty to coteach, and many make use of premade online addiction modules (such as those provided by the Society of Teachers of Family Medicine, Providers Clinical Support System, and American Society of Addiction Medicine)[18–20] and modify them to their own clinical and residency setting. Topics that seem to be particularly instructive go beyond the common use disorder topics and encourage learners to reflect on their own philosophical conceptions about addiction, such as stigma and bias, harm reduction, and how to develop therapeutic relationships among patients with SUDs.

As part of the experiential learning curriculum, prioritizing embedding addiction care longitudinally into primary care clinics will be important for programs. Repeat exposure to patients with SUDs helps grow faculty's and residents' comfort and skills;[21,22] it provides the opportunity to witness patient success stories; and it models comprehensive care for patients with SUDs—all of which shape a clinic culture that values this work as integral to primary care.

Effectively embedding SUD work into primary care requires buy-in from all office personnel who interact with patients, including front desk and clinical staff, as well as clinical providers. Though addressing stigma is beyond the scope of this paper, programs launching addiction curricula should anticipate this potential barrier and have a plan for addressing

it. While attitudes toward treating addiction continue to evolve, residents are becoming an increasing driving force for change. As more medical schools are incorporating training on SUDs, medical students are entering residency with a high level of knowledge about addiction and are driving faculty—who might have little addiction training—to provide SUD care and teach SUD-related topics, as described by several faculty in our study.

Spurring educational change around addiction training thus requires not only the top-down ACGME requirement, but also a bottom-up approach in which medical schools and residency programs prioritize addiction training for all learners. Additionally, training in SUDs should not be limited to primary care or psychiatry, but democratized to all specialties, especially ones with high prevalence of patients with addiction, such as obstetrics and gynecology, emergency medicine, surgery, pediatrics, and physical medicine and rehabilitation. Because SUDs affect all other health conditions, caring for patients struggling with SUDs will require a well-trained workforce collaborating to provide optimal patient care.

Limitations

Data was collected only from residency programs that already have a well-established addiction curriculum, not from those who are in early stages or are struggling to launch addiction curricula. Likely, many other residency programs that offer robust training in addiction exist that we did not interview. Thus, interviewing more residency programs and programs that are at various stages of addiction curricula development might uncover additional themes, and these could be tailored to programs' stage of development. We also interviewed only faculty members; interviewing other team members providing addiction care, such as residents, social workers, nurses, and front desk staff might uncover additional themes. The themes captured also represent best practices that faculty were able to identify. Likely, other best practices exist that faculty were not aware of or did not have the chance to identify during their interviews. Additionally, faculty-identified best practices is a supposition not rooted in outcomes data around knowledge, skills, and attitudes as reflected in Miller's pyramid, such as residents providing addiction care in their current or future practice.[23]

Areas of Future Research

More rigorous evaluation of addiction curricula (beyond expert opinion) should describe what curricular components lead graduating residents to practice addiction care in their subsequent practices. Future studies also should seek to uncover curricular components that could further physicians' confidence and competence that might not currently be provided by residency programs. Asking graduates who practice addiction medicine after they graduate about their experiences in residency that were most helpful and impactful or that they wish they would have learned could be rich. Asking other providers (besides faculty) who provide addiction care about key elements of training also should be assessed. Additionally, future studies should seek to identify barriers and limitations for programs that are struggling to start addiction curricula and provide associated implementation guidance to support programs in early stages of curricula development.

CONCLUSIONS

Comprehensive and robust addiction training in family medicine residency training requires coupling a breadth of didactic and experiential learning opportunities with a well-supported and philosophically aligned clinical and educational culture that values caring for patients with substance use disorders.

REFERENCES

1. Provisional drug overdose death counts. *Centers for Disease Control and Prevention.* 2023. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.
2. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: results from the 2021 National Survey on Drug Use and Health. *Center for Behavioral Health Statistics and Quality.* 2022.
3. Jawa R, Tin Y, Nall S. Estimated clinical outcomes and cost-effectiveness associated with provision of addiction treatment in US primary care clinics. *JAMA Netw Open.* 2023;6(4):237888.
4. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. *US Department of Health and Human Services.* 2013. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/projecting-primary-care.pdf.
5. Lipari RN, Park-Lee E, Van Horn, S. American's need for and receipt of substance use treatment in 2015. *The CBHSQ Report. Center for Behavioral Health Statistics and Quality.* 2016.
6. Bernell S, Howard SW. Use your words carefully: what is a chronic disease? . *Front Public Health.* 2016;4:159.
7. Wakeman SE, Barnett ML. Primary care and the opioid-overdose crisis-buprenorphine myths and realities. *N Engl J Med.* 2018;379(1):1-4.
8. Rosenblatt RA, Andrilla CH, Catlin M, Larson EH. Geographic and specialty distribution of US physicians trained to treat opioid use disorder. *Ann Fam Med.* 2015;13(1):23-26.
9. Rowe TA, Jacapraro JS, Rastegar DA. Entry into primary care-based buprenorphine treatment is associated with identification and treatment of other chronic medical problems. *Addict Sci Clin Pract.* 2012;7(1):22.
10. Russell HA, Sanders M, Meyer J, Loomis E, Mullaney T, Fiscella K. Increasing access to medications for opioid use disorder in primary care: removing the training requirement may not be enough. *J Am Board Fam Med.* 2021;34(6):212-213.
11. *Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education. ACGME.* 2023. .
12. Tong S, Sabo R, Aycock R. Assessment of addiction medicine training in family medicine residency programs: a CERA study. *Fam Med.* 2017;49(7):537-543.
13. Wakeman SE, Pham-Kanter G, Donelan K. Attitudes, practices, and preparedness to care for patients with substance use disorder: results from a survey of general internists. *Subst Abus.* 2016;37(4):635-641.

14. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care.* 2007;19(6):349-357.
15. Hutchinson E, Catlin M, Andrilla CH, Baldwin LM, Rosenblatt RA. Barriers to primary care physicians prescribing buprenorphine. *Ann Fam Med.* 2014;12(2):128-133.
16. Wood K, Giannopoulos V, Louie E. The role of clinical champions in facilitating the use of evidence-based practice in drug and alcohol and mental health settings: a systematic review. *Implement Res Pract.* 2020;1:26334895209590 72.
17. Gordon AJ, Kavanagh G, Krumm M. Facilitators and barriers in implementing buprenorphine in the Veterans Health Administration. *Psychol Addict Behav.* 2011;25(2):215-224.
18. Sokol R, Ahern J, Pleman B. An evaluation of STFM's national addiction curriculum. *Fam Med.* 2023;55(6):362-366.
19. Providers Clinical Support System [website]. . https://pcssnow.org.
20. American Society of Addiction Medicine [website]. 2025. https://www.asam.org/.
21. Klimo MCV, Nolan L, Corbin M. Physician reluctance to intervene in addiction: a systematic review. *JAMA Netw Open.* 2024;7(7):2420837.
22. Deflavio JR, Rolin SA, Nordstrom BR, Kazal LA. Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. *Rural Remote Health.* 2015;15:3019.
23. Cate OT, Carraccio C, Damodaran A. Entrustment decision making: extending Miller's pyramid. *Acad Med.* 2021;96(2):199-204.