The University of Texas at Austin
PhARM Program

TXOTI Podcast Packet

Podcast Episode

Expanding an Addiction Medicine Rotation in Internal Medicine Residency Training

Host / Moderator

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Guests

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Learning Objectives

- Explain the rationale for integrating addiction medicine training into internal medicine residency education.
- Describe how an addiction medicine elective rotation was developed and expanded within an internal medicine residency program, including key drivers and decision points.
- Discuss how interdisciplinary exposure shapes residents' understanding of substance use disorder care.

The Big Three questions this episode will address for the listener (note: target listeners are academic instructors of addiction medicine/substance use disorders)

1. Why does addiction medicine training belong in every internal medicine residency, and what was the gap this selective rotation was designed to fill?
2. What does it actually take to build and scale a selective rotation from a small pilot to a larger offering?
3. What do residents gain from learning alongside peer support specialists and other professionals that they cannot get from traditional clinical training alone?

Moderator Questions

Panelist Answer Key

(BK) Eugene Brooks Keener, MD
(DS) Daniel Sledge, BA, LP

Addiction medicine education for future health professionals

Briefly describe addiction medicine to a health professional or faculty member with little to no experience in this space

- (BK) Addiction Medicine is a subspecialty dedicated to the care of patients with substance use disorders, typically using a combination of medications, counseling, and other supports. It is based on principles of risk reduction and treating substance use disorders as chronic diseases.
- (DS) Addiction medicine is medicine that helps address or treat substance use and issues related to substance use.

Explain why addiction medicine and substance use disorder should be part of foundational training of all health professionals, not just those specializing in this practice area.

- (BK) Substance use disorders impact patients in every field of medicine and at all levels of care that a health professional might encounter a patient. Developing a shared understanding of substance use disorders as chronic diseases that can be treated and managed like any other health condition allows all healthcare professionals to meet patients wherever they are, treat them with dignity and respect, make them feel safe, and provide the best possible care for the whole person in front of them.
- (DS) If a provider is treating humans (i.e. they are not just doing research without interacting with patients) then they are coming into contact with people living with opioid use disorder (OUD) or other SUDs. All providers are – even if they are not aware yet. They may not be aware because they are not having real discussions with patients that are needed to make the patient feel safe enough to disclose a SUD. But addiction is encountered in all facets of medicine, and in terms of making treatment more accessible, there should be no wrong door in healthcare.

How the internal medicine residency selective came together

Provide a brief history of how this selective rotation was created for internal medicine residents Where did the idea come from, and what did the early version look like?

- (BK) There have been efforts to develop an addiction medicine curriculum for internal medicine (IM) residents at Dell Medical School going back to at least 2020. Initially, this looked like incorporating addiction medicine didactic lectures and experiences into the general internal medicine curriculum that all IM residents would be exposed to during their training. Additionally, there were residents over the years, including myself, who arranged elective experiences in the addiction medicine clinic with Dr. John Embers, Matt Hunt, and Dr. Anu Kapadia. However, in 2023, the ACGME, the accrediting body for residency programs, updated their guidelines and recommended that all internal medicine residents have an experience in addiction medicine. Prior to my chief resident year, I had the opportunity to attend the Chief Resident Immersion Training in Addiction Medicine, which gave me the foundation and tools I needed to develop the 1-week selective course, which we piloted in 2024-2025 academic year, before rolling out to all third year residents this past year.

Describe any push back, barriers, or challenges you encountered when creating the pilot selective rotation.

- (BK) Fortunately, for the most part, we experienced nothing but support and encouragement as we put together this rotation. That said, one of the challenges we faced was finding the time to fit this into the existing residency curriculum. Three years of residency training might seem like a long time, but the reality is there is a lot to learn over the course of a residency program, and dedicating a full week rotation was not easy. We had great support from leaders within our program, and from our healthcare professionals that residents get to work with during the rotation. Another challenge has been sustainability. The goal is for this rotation to continue to be a permanent part of the residency curriculum so that all internal medicine residents can graduate with a foundational experience in addiction medicine.
- (BK) The main challenge has been scheduling. With that said, we were able to have over 18 residents complete the rotation this year.

The pilot reached eight residents in its first offering, and there is now interest in extending the rotation to all third year residents. What has that conversation looked like?

- (BK) Again, there has been great support from everyone involved to help expand this experience to all third year residents during this academic year. The program leadership at Dell Medical School, including Dr. Parker Hudson, Dr. Brandon Altillo, and the chief residents have been key to creating a sustainable selective rotation. We have also gotten great support from everyone the residents work with during the rotation, which includes addiction medicine physicians, nurse practitioners, counselors, social workers, case managers. In particular, Dr. John Embers, Dr. Matt Levasseur, Dr. Kaci Thomas, Rachel Holliman, Frances Ibarra, and Daniel Sledge have been awesome educators for the residents.
- (DS) We received some feedback and perspectives directly from residents saying everyone should have to take the rotation (not just Internal Medicine). I wish they could have taken during 2nd year, because I think it would have given them greater perspective on opioid and substance use disorders before they begin interacting with patients. Residents are often so busy they don't have time to complete a rotation evaluation, but their feedback is crucial to making the experience meaningful, practical and applicable to practice. May need to think of more accessible ideas for providing rotation feedback, like maybe texting could work better then email for feedback.

Making it more applicable to practice

Discuss the rotation structure and how it gives residents a sense of how addiction medicine care actually happens across different settings and roles.

- (BK) The reality of addiction medicine is that it doesn't just happen in a hospital or a clinic between a doctor and a patient. It is a multidisciplinary team effort and happens across the spectrum of healthcare and the community. We designed the rotation to try to expose the residents to as much of the entire multidisciplinary process as possible, while also creating space for them to engage with other learning materials throughout the week including online modules, journal articles, and podcasts. The residents spend a few half days in the Wellness and Holistic Addiction Medicine clinic at CommunityCare, attend an open mutual support group meeting, spend a day in the Integral Care Opioid Treatment Program (methadone clinic), spend a half day with substance use navigators at Dell Seton hospital, and spend time with Daniel Sledge for a one-on-one academic detailing session about OUD treatment as well. While we can't capture the full scope of addiction care in a one week rotation, these experiences do give the residents a taste of what it looks like to provide whole-person care for people living with substance use disorders, and a foundation of knowledge they can build off of as they go into independent practice after residency

Describe how exposure to practitioners of varying backgrounds helped learners understand the multiple perspectives in addiction medicine care.

- (BK) I think getting exposed to practitioners from the different backgrounds of the multidisciplinary team helps the residents learn that addiction medicine, at its best, is focused on the care of the whole person, and that it can't be done in isolation. So much of medical care now is siloed, with each specialty focusing on specific problems within their individual sphere. But to provide high quality, effective care for people with substance use disorders, it truly requires a team and a community, to meet a patient wherever they are on their journey with substance use, and provide the care they need. Hopefully, the selective experience is giving the residents a sense of how important the multidisciplinary approach is.

- (DS) Learning about/from all the different perspectives allows residents to appreciate what the other health professions are contributing to the patient care process and this creates greater understanding and openness to collaborate when they practice. Also, the divers experiences creates greater awareness for what patients are experiencing in the treatment process (how it feels to be in hospital, social stuff, communication, community referrals, etc.)
- (DS) My component requires residents to view recorded interviews with patients with opioid use disorder to learn first-hand what they have experienced when seeking healthcare. These patient testimonial videos have been very impactful, with feedback from residents about how 'powerful' and beneficial it was for them to learn about what patients experience (both positive and negative experiences).

Key Tips and Takeaway Points

What key tips would you provide to another residency program director or faculty member who wants to build something like this but doesn't know where to start?

- (BK) I think the most important element at the beginning is to identify the people within your program or community that are excited about caring for people with substance use disorders, and utilize their skills, expertise, and passion. Developing and executing this curriculum was by no means something I did on my own. I've already mentioned a handful of folks, but there have been so many people who have been key to getting this started and keeping it going. They are people who really care about this and want to share it with learners. Another key for me was engaging with leadership and the administrative team for our program. One of the main barriers to adding learning experiences to a healthcare professions curriculum is time, and having the support of the folks who can help to carve out some space for a new learning experience is key. Lastly, so much of the care of people living with substance use disorders happens outside of traditional healthcare settings, so reach out to programs within your community who are already doing awesome work and see if there are ways incorporate learners into those spaces.
- (DS) Involve people with lived experience to a great extent because residents appreciate learning about that perspective.
- (DS) Keep reviewing feedback received for continuous areas of improvement or new ideas, keep evolving, and be prepared to pivot sometimes.
- (DS) As a guest instructor, I can say having a good partnership with Brooks strengthens the experience and makes it much easier to make it all happen. Brooks and I collaborate on lots of other projects regarding opioid use disorder in the Austin area.
- (DS) Find the champions in healthcare and in the community and involve them whenever possible in these types of collaborations, to further the reach of important information.

References

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