

**Improving Utilization of Pharmacotherapy for the Treatment of Alcohol Use Disorder in
Primary Care**

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Submitted to: Dr. Issa Sturm, DNP Chair

This paper is submitted in partial fulfillment of the requirements for the Doctor of Nursing
Practice degree.

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Problem Description

Alcohol use disorder (AUD) is one of the most common psychiatric disorders in the United States, affecting nearly one-third of adults at least once in their lifetime (Ehrie et al., 2020). As a result, alcohol is a large contributor to global disease and a leading cause of death in the United States. Not only does AUD carry high costs in terms of disability-adjusted life years, but the societal cost is also high with totals estimated at more than \$249 billion annually. Although it's estimated that more than 30 million people in the United States meet the criteria for AUD, it is believed that fewer than nine percent of individuals receive the appropriate pharmacotherapy (Ehrie et al., 2020).

Pharmaceutical and behavioral treatments have proven effective at reducing alcohol use and facilitating abstinence. Studies support outpatient treatment with medications like naltrexone, disulfiram, and acamprosate since most individuals with AUD do not require inpatient medical treatment for detoxification. These medications remain underutilized, however, due to lack of provider training and confidence, coupled with the belief that medications cannot replace specialty addiction treatment (Hagedorn et al., 2019; McNeely et al., 2018). Although most evidence supporting the use of outpatient medication therapy for AUD originates from specialty or addiction treatment settings, medications to treat AUD can be appropriately prescribed and managed in primary care (Ashford et al., 2018). Training healthcare providers to appropriately diagnose and treat individuals with AUD using evidence-based guidelines is a proposed solution to increase provider self-efficacy and reduce patient barriers to outpatient addiction treatment (Williams et al., 2018)

This project takes place in rural Oregon where specialty addiction medicine services are limited. As a result, individuals with AUD face barriers to accessing treatment. Primary care providers (PCPs) are in an opportune position to identify patients with AUD who are appropriate candidates for outpatient pharmacologic management. Yet to provide these lifesaving medications in the outpatient primary care setting, we must first address provider barriers.

Available Knowledge

An electronic search of PubMed was conducted using the keywords *provider barriers*, *alcohol*, and *pharmacotherapy* which yielded 925 results. Once publication dates were narrowed to articles published in the last five years, 382 studies remained. All study designs discussing provider barriers and implementation strategies for prescribing pharmacotherapy to treat AUD in the primary care setting were eligible for inclusion.

Screening, brief intervention and referral to treatment (SBIRT) is an evidence-based approach utilized in both acute and primary care settings to identify individuals with substance use disorders and trigger a referral to specialty addiction care (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). However, among identified patients who meet the criteria for AUD, only a small number will ever receive any type of formal treatment (Hagedorn et al., 2022). PCPs can increase access to life-saving medications for AUD, especially for individuals in rural areas, or for those who are unable or unwilling to engage in specialty treatment. Studies have identified numerous tangible and perceived barriers to prescribing pharmacotherapy for AUD in primary care settings, including lack of knowledge, concerns about medication efficacy, and time constraints. Although providers receive training on addressing behavioral health conditions such as smoking cessation, many feel they are less prepared to address substance use due to limited training and experience prescribing medications for AUD

(Gregory et al., 2021; Williams et al., 2018). The level of knowledge regarding these medications is universally described as low. Providers report that they did not receive training during school nor continuing education about AUD pharmacotherapy (Hagedorn et al, 2019). Furthermore, many providers cite concerns about the efficacy of outpatient medication management for AUD (Gregory et al., 2021; Hagedorn et al., 2019; Williams et al., 2018). Many providers expressed beliefs that pharmacologic management of AUD is not within the scope of the PCP. Others felt that for medication therapy to be effective, patients would need to be engaged with clinicians who are able to address the psychosocial elements of addiction (Williams et al., 2018). Time constraints, coupled with the complexity of AUD contributes to PCP barriers to prescribing medication for AUD treatment (Williams et al., 2018; Gregory et al., 2021).

While specialty addiction medicine is an effective, evidence-based treatment for AUD, data substantiates that most patients will not engage in specialty addiction care. Offering pharmacotherapy in a primary care setting is a patient-centered approach that increases access to AUD treatment for qualifying individuals. Current evidence supports improving prescriber self-efficacy through offering continuing education with an emphasis on diagnosis and pharmacologic management of AUD.

Rationale

A significant number of individuals in Jackson County are estimated to suffer from a substance use disorder, approximately 35,211. Of these individuals, 34,940 are estimated to have had a need for treatment within the last year but did not receive care in a specialty addiction medicine facility (Henahan et al., 2023). In 2022, researchers from OHSU-PSU School of Public Health collaborated with the Oregon Health Authority to analyze gaps in substance use disorder

services. The study utilized the Calculating for Adequate System Tool (CAST) to quantify estimated gaps in services. Jackson County's CAST risk of hospitalization for alcohol or drug diagnosis score was 23, which makes individuals in the county 69-92% more likely than the national average to be hospitalized for a substance use-related diagnosis (Henahan et al., 2023). The CAST methodology is a framework for the assessment of the substance abuse care system, as well as a strategy for evaluating limitations in a care continuum by looking at components of health promotion, prevention, referral, treatment, and recovery (Green et al., 2016). The primary care provider is placed in a unique position to address all components evaluated by the CAST framework.

To reduce the county's CAST risk, this project utilized the Theory of Constraints (TOC) model to evaluate provider barriers regarding utilization of pharmacotherapy for patients with AUD. The TOC was first developed by Dr. Eliyahu Goldratt in the 1980s and utilizes five repeatable steps to improve organizational constraints. The TOC first identifies the biggest factor within an organization that prevents goal achievement (the constraint), and proceeds by deciding how to exploit the constraint, alleviate the constraint, and then repeats the process as needed (Goldratt & Cox, 2004). The literature has identified numerous provider barriers regarding the utilization of pharmacotherapy for AUD, including lack of knowledge and concerns about medication efficacy. There is limited available research thus far that aims to overcome the identified barriers. This project aims to increase the prescribing rates of naltrexone, acamprosate and/or disulfiram within The Organization to alleviate the constraint: low utilization of pharmacologic agents for the treatment of AUD in primary care.

Specific Aims

Between the dates of October 3rd, 2023, and November 7th, 2023, 100% of primary care providers at The Health Center who see patients with an active diagnosis of Alcohol Use Disorder will report a 20% increase in the number of patients with AUD to whom they recommend pharmacotherapy. To accomplish the primary aim, 100% of participating providers must respond to both the initial and follow up Provider Survey on Alcohol Use Disorder Treatment.

Methods

Context

This project was implemented across multiple Federally Qualified Health Centers located in Jackson County, Oregon, which will hereby be referred to as The Health Centers. The Health Centers operate within a larger organization (hereby referred to as The Organization), that provides comprehensive medical care to more than 30,000 patients in Jackson County. In 2022, 65% of patients who were cared for by the organization were below 200% of the Federal Poverty Level. Most patients are Medicaid insured (65%), while 14% have no insurance, 21% are privately insured, and 9% are insured through Medicare. The providers that make up the Organization include family medicine physicians, family nurse practitioners, physician assistants, and psychiatric mental health nurse practitioners. Most patients with substance use disorder are seen at one of the eight neighborhood health centers. Prescribing rates of pharmacotherapy for AUD is perceived as low at the other seven health centers, likely due to lack of education and familiarity regarding their use. This DNP project examined the reasons behind prescribing discrepancies among clinics within The Organization while simultaneously

attempting to increase utilization of these pharmacologic agents through a brief educational presentation to clinic providers.

Interventions

A survey named The Provider Survey on Alcohol Use Disorder Treatment (Appendix B) was created and modeled based on the *Survey of Additional Specialists' Use of Medications to Treat Alcohol Use Disorder*, which was developed to investigate prescribing patterns amongst addiction specialists treating AUD (Ehrie et al., 2020). The Provider Survey on Alcohol Use Disorder Treatment was created to evaluate primary care provider's attitudes, beliefs, and barriers to the utilization of pharmacotherapy for AUD within The Organization. In order to participate in the survey, providers were required to not only see patients with AUD, but to also have prescribing privileges. The Provider Survey on Alcohol Use Disorder Treatment asked participants to estimate the percentage of patients with AUD to whom they offered pharmacotherapy to in the last year and rate their experience and comfort with this process. Providers were also queried about whether they offer pharmacotherapy to all patients diagnosed with AUD and the rationale behind their clinical decision making. The survey utilized a Likert scale, having providers rate their comfort, experience, and opinions about prescribing naltrexone, acamprosate, and disulfiram in the primary care setting. The surveys were administered during a monthly provider meeting via an anonymous Zoom poll.

Following receipt of the initial survey responses, a presentation about the treatment of alcohol use disorder in the primary care setting was given during a scheduled meeting. The presentation described the implications of AUD within the local community and provided information about pharmacologic treatment options for AUD. One month after the presentation, providers were asked to answer a follow up survey at their scheduled meeting via another Zoom

poll. The Follow Up Provider Survey on Alcohol Use Disorder Treatment was adjusted to include one additional answer option for providers who do not see any patients with AUD. Following completion of the final survey, provider responses were compiled for analysis and interpretation. The project aimed to investigate emerging themes and whether prescribing rates increased.

Measures

The primary outcome measure of the project was to evaluate whether providers reported offering pharmacotherapy to 20% more patients with AUD following the intervention.

Secondary measures include compliance in completing the Provider Survey on Alcohol Use Disorder Treatment before and after the intervention. Provider survey responses also assess knowledge and opinions about pharmacotherapies for AUD, as well as provider use of these interventions.

Process measures for this project include the number of patients with an active diagnosis of AUD that were seen by each provider, time allotted for each visit and administration of the survey by the site contact and DNP student. To assess for accuracy and thoroughness of data, the DNP student was responsible for facilitation of the survey and for monitoring provider compliance. The site contact assisted with administering the poll and downloading data before returning it to the DNP student.

The increased burden that was placed on providers by requiring survey participation was a balancing measure that may influence project outcomes. Providers may also feel that the medication options included in the presentation do not compose an exhaustive list of available medications and approaches to treat AUD. While there are numerous approaches and

medications used to treat alcohol use disorder, the presentation focused on the three FDA approved oral medications: naltrexone, disulfiram, and acamprosate.

Analysis

Survey response data was gathered by the DNP student with the assistance of the site contact. Providers were asked to estimate patient characteristics, including approximately how many patients they care for with AUD to establish baseline information on patient characteristics. Quantitative data gathered from Likert scale and multiple-choice survey responses were uploaded electronically from the Zoom polling platform for analysis and theme identification. The primary outcome measure of the project was to evaluate whether providers reported offering pharmacotherapy to 20% more patients with AUD following the intervention. The survey also gathered qualitative data on perceived provider barriers regarding utilization of pharmacotherapy for AUD. Themes identified included provider knowledge, opinions, and comfort prescribing medications for AUD in the primary care setting.

Ethical Considerations

The main ethical consideration for this project was maintaining the anonymity of survey respondents to allow respondents to answer survey questions without inhibition (Geur et al., 2020). Provider anonymity was achieved through settings on the Zoom poll. Providers were not required to provide identifying information, such as title nor highest level of education. This study did not require disclosure of HIPPA-protected information.

Results

Results

The intent of this project was to increase prescribing rates of naltrexone, acamprosate, and disulfiram throughout The Organization, while simultaneously analyzing providers beliefs

and barriers to prescribing pharmacotherapy for patients with AUD. Twenty-nine providers responded to the initial survey. Respondents included physicians, physician assistants, nurse practitioners, and nurse midwives. The majority of providers (76%) identified 0-25% of their panel had an active diagnosis of AUD. Approximately one quarter of providers reported that 26-50% of their patients had an active diagnosis of AUD. Amongst the 29 providers, the majority (58%) discussed or offered pharmacotherapy to only 0-25% of patients with AUD, and 7% of providers discussed it with 26-50% of patients. Yet notably, 21% of providers discussed or offered pharmacotherapy to 80-100% of their patients with AUD and 14% had the conversation with 51-79% of patients. Only 7% of providers discussed it with 26-50% of their patients. The most cited reason for not prescribing pharmacologic agents was patient noncompliance or declination to initiate treatment (14 providers: 48%). Twenty-four percent cited “other” as the reason behind their decision making, 10.5% of providers reported lack of time, another 10.5% were uncomfortable or unfamiliar with the available medications, and 7% were hesitant to prescribe because the patient was not in a formal treatment program or receiving addition counseling. In terms of self-reported knowledge, 45% of providers reported they were knowledgeable about the available pharmacotherapeutic agents, 34% said they were slightly knowledgeable, 10.5% were slightly unknowledgeable, and 10.5% felt they were unknowledgeable about the pharmacologic treatment options. When asked if they felt comfortable prescribing medications for AUD, 41% of providers agreed with this statement, 28% slightly agreed, 17% slightly disagreed, and 14% disagreed.

Only 18 out of 29 providers participated in the follow up survey. Of these providers, results similarly show that the majority (78% in this case) reported that 0-25% of patients seen in the last month had an active diagnosis of AUD, while the other 22% reported that 26-50% of

patients seen in the last month met criteria for AUD. Again, the majority (56%) discussed or offered pharmacotherapy to only 0-25% of patients and 11% discussed it with 26-50% of patients. Just over 33% of providers discussed or offered pharmacotherapy to 51-100% of patients compared to 35% in the initial survey. However, the results differ in that only 16.5% discussed treatment with 80-100% of patients post intervention compared to 21% preintervention. This difference could be attributed to a lower sample size at follow up. Compared to the 14% of providers that offered pharmacotherapy to 51-79% of patients in the initial survey, there was a 2% increase to 16% of providers offering pharmacotherapy. The most cited reason why pharmacotherapy was not offered was other (34%), followed by the patient declining treatment (33%). Twenty two percent of providers cited discomfort or unfamiliarity with medication as their rationale while the final 11% cited time constraints. Self-rated knowledge varied post-intervention. Thirty-three percent of providers reported they felt knowledgeable about the available pharmacotherapeutic agents which was lower than the 45% of providers who rated their prior knowledge highly pre-intervention. Fifty percent said they were slightly knowledgeable which improved from 34%, 11% were slightly unknowledgeable which was consistent with initial survey results, and 6% felt they were unknowledgeable about the drugs. The percentage of providers who rated themselves as unknowledgeable about AUD pharmacotherapy decreased by nearly 4% after the intervention. When asked if they felt comfortable prescribing medications for AUD, more providers agreed with this statement (44%) compared to pre-survey responses (41%). Twenty-two percent slightly agreed (4% fewer than initial), 22% slightly disagreed (an increase of 5%), and 12% disagreed compared to the initial 14%.

Discussion

Summary

The majority of providers (76%) reported that up to 25% of their patient panel included patients with AUD, which is consistent with state and national statistics (Ehrie et al., 2020; Oregon Statewide Strategic Plan, 2023). Only 21% of providers who completed the initial survey reported offering or discussing pharmacotherapy with 80% or more patients prior to the intervention. One-month post-intervention, 16.5% of providers reported having these conversations with patients. Pre-intervention, 79% of providers rated themselves as slightly knowledgeable or knowledgeable about the medications used to treat AUD, compared to 83% post intervention.

Low utilization of AUD pharmacotherapy is established by pre and post survey responses; however, the statistical significance of fewer providers offering pharmacotherapy and whether provider rated knowledge increased post intervention cannot be definitively determined because of poor study retention, which will be discussed below.

Limitations

This project faced numerous limitations, the most significant being that only 62% of providers completed the follow up survey thus making it impossible to completely assess whether the intervention was successful. Additionally, the sample included providers, nurse midwives, who do not see patients with AUD at The Organization. Surveys were originally planned to be printed and distributed to qualifying providers with the assistance of the site contact. Administrative burnout/fatigue was referenced as a reason to change the modality of survey administration to a Zoom poll at a monthly provider meeting. Verbal instructions advised that only PCPs should complete the survey, however due to the manner of survey distribution it

was not possible to control which providers were included in the sample. Limitations of this project were assumed to be related to a disruption in the survey distribution, which likely resulted in non-eligible providers being included in the initial sample. Another contributing factor was the limited time allotted for the educational intervention. While the intent was to provide an educational presentation which thoroughly reviewed evidence-based treatment guidelines, providers were ultimately delivered a condensed 5-minute-long presentation.

This project considered the challenges that providers face at Federally Qualified Health Centers, such as high patient volumes and limited resources yet was unable to address these issues. Bettering support of primary care providers to address substance use disorders may broaden the impact of screening for AUD to allow for more discussion about treatment (McNeely et al., 2023).

Conclusions

Although the intervention did not achieve the intended aim, the results of the study support the need for better education for healthcare providers regarding the prevalence and treatment of AUD in primary care. Continuing education and provider support may mitigate barriers to prescribing pharmacologic agents for AUD by focusing on provider knowledge, confidence, and self-efficacy (Hagedorn et al., 2019).

Primary care remains a valuable setting to screen, identify, and treat patients with AUD who are unable or unwilling to seek specialty addiction care. Providers reported better initial rates of knowledge and comfort about prescribing medication for AUD than anticipated. These findings question the etiology of the low perceived rates of medication utilization within The Organization. Results of this study support the need for further research focused on the significant percentage of providers (24% pre-intervention and 34% post-intervention) who cited

“other” as their reason for not prescribing. Identifying these barriers would guide targeted interventions to support providers and improve the capacity of The Organization to provide addiction care. Organizational capacity is critical to successfully treat AUD in primary care settings (Rombouts et al., 2019). This study cannot discern whether The Organization has the infrastructure to support the management of AUD on an outpatient basis.

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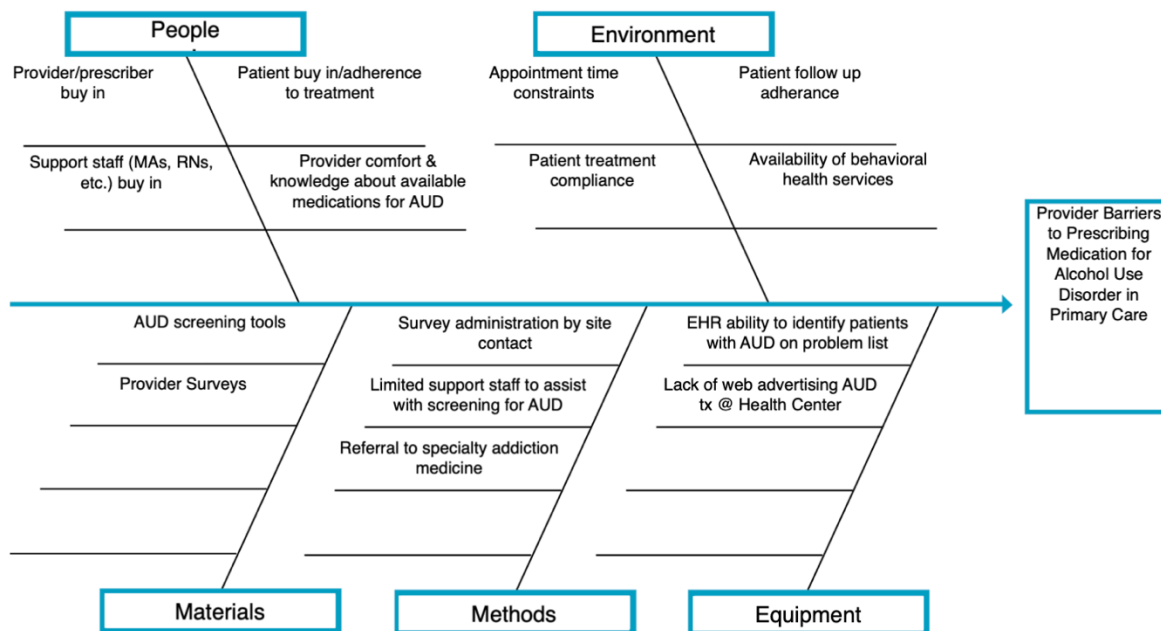
Appendix A

Template: Cause and Effect Diagram

Team: Bobbi Bertsch

Project: PCP Barriers to Prescribing Medication for AUD

- 1) Input the effect you'd like to influence.
- 2) Input categories of causes for the effect (or keep the classic five).
- 3) Input causes within each category.



Appendix B

The Provider Survey on Alcohol Use Disorder Treatment, Initial

Out of the patients you treated in the last year, approximately what percentage had a diagnosis of alcohol use disorder?

- A. 0 - 25 %
- B. 26 - 50 %
- C. 51 - 79 %
- D. 80 - 100 %

Of the patients you saw in the last year who met the criteria for alcohol use disorder, approximately what percentage did you discuss or offer pharmacotherapy to?

- E. 0 - 25 %
- F. 26 - 50 %
- G. 51 - 79 %
- H. 80 - 100 %

If you did not prescribe medication to a patient with alcohol use disorder, which selection listed below best reflects the reason behind your decision?

- A. Discomfort/unfamiliarity with medication
- B. Patient declined or would not comply with treatment
- C. Patient wasn't in a formal treatment program or receiving addiction counseling
- D. Lack of time to counsel the patient and monitor response to treatment
- E. Other

I am knowledgeable about the medications used to treat alcohol use disorder.

- A. Agree
- B. Slightly Agree
- C. Slightly Disagree
- D. Disagree

I feel comfortable prescribing medications for alcohol use disorder for most patients.

- A. Agree
- B. Slightly Agree
- C. Slightly Disagree

D. Disagree

Appendix C

The Follow Up Provider Survey on Alcohol Use Disorder Treatment

Of the patients you saw in the last month who met the criteria for alcohol use disorder, approximately what percentage did you discuss or offer pharmacotherapy to?

- A. 0 - 25 %
- B. 26 - 50 %
- C. 51 - 79 %
- D. 80 - 100 %
- E. I don't see patients with AUD

If you did not prescribe medication to a patient with alcohol use disorder, which selection listed below best reflects the reason behind your decision?

- A. Discomfort/unfamiliarity with medication
- B. Patient declined or would not comply with treatment
- C. Patient wasn't in a formal treatment program or receiving addiction counseling
- D. Lack of time to counsel the patient and monitor response to treatment
- E. Other

I am knowledgeable about the medications used to treat alcohol use disorder.

- A. Agree
- B. Slightly Agree
- C. Slightly Disagree
- D. Disagree

I feel comfortable prescribing medications for alcohol use disorder for most patients.

- A. Agree
- B. Slightly Agree
- C. Slightly Disagree
- D. Disagree

