**Appendix 1. Interview Guide**

 I’d like to ask you a few questions about your feelings regarding opioid prescribing at the time of hospital discharge. Please think about factors which may influence whether or not you would prescribe an opioid medication at hospital discharge. Please tell me about you experiences with both acute and chronic pain.

First off, please tell me how you go about **assessing pain in your patients**.

Are you more comfortable treating acute or chronic pain, or is there no difference in your comfort level of treating either of these conditions?

**(PATIENT FACTORS)**

How well do you think you subjectively determine a patient’s risk of opioid misuse?

Tell me what factors play into your subjective determination of a patient having risky behavior.

Can you identify any patient related factors would make you more inclined to prescribe an opioid medication at hospital discharge? Please tell me more about that.

What about these patient factors make you feel more inclined to prescribe opioid therapy at discharge?

\*\*If the interviewee wants clarification, here are some examples:

1. Documented pain related health condition which has not responded to NSAIDS or physical therapy
2. Acute pain, i.e. post-operative, fracture, procedure
3. Reliable primary care physician follow up – ability to access ongoing care
4. Prior substance or alcohol use or abuse

What patient related factors would make you less inclined to prescribe an opioid medication at hospital discharge? Please tell me more about that.

Can you describe why these patient factors make you feel less inclined to prescribe opioid therapy at discharge?

Would these factors increase your likelihood of doing a more indepth chart review, i.e. PDMP search or a checking a UTOX prior to prescribing opioids?

\*\*If the interviewee needs prompts, consider history of, or current, substance abuse/use, history of, or current, alcohol abuse/ heavy use.

Are there any situations when you would absolutely **not** prescribe an opioid medication at hospital discharge? If so, can you describe some of those situations? Please tell me more about that.

In your opinion, what percentage of patients request opioids at discharge?

Do these patients have common characteristics?

Do you have any experience with a patient requesting opioids after you have completed their discharge and you were not expecting that request?

Tell me about that experience. How did it make you feel?

What are the most challenging aspects of this situation?

Are there demographic characteristics you hypothesize to be relevant when prescribing opioids?

Please elaborate on that.

\*\*If the interviewee wants clarification, here are some examples: **educational level, homelessness, age, gender, race**

Can you tell me about a time when prescribing opioids at discharge was uncomfortable for you? Why do you thinking it was uncomfortable? How could it have been made into a positive experience?

**(INSTITUTIONAL/SYSTEMS FACTORS)**

What institutional (or systems) factors would make you more inclined prescribe an opioid medication at discharge?

\*\*If the interviewee wants clarification, here are some examples:

1. Increasing role of auxiliary staff in completing patient discharge paperwork
2. Ease of communication between yourself and the patient’s primary care physician
3. Availability of time for communication (email, phone, fax) to the patient’s primary care physician or accessibility of state run prescription monitoring system

Can you describe why these system factors make you more inclined to prescribe opioid therapy at discharge? That is very interesting; please tell me more about that.

What systems factors would make you less inclined to prescribe opioid therapy at discharge?

Can you describe why these system factors make you feel less inclined to prescribe opioid therapy at discharge?

Does your patient load affect whether or not you would consider prescribing opioids at the time of discharge?

How does patient satisfaction influence your behavior? What about measuring and accountability toward this metric?

How does patient hand-offs complicate opioid prescribing in house and/or at discharge? Please tell me about your thoughts.

How do you feel opioid prescribing is difference on different services, i.e. surgery vs. orthopedics? Please tell me about your thoughts.

Tell me about your impression of attending oversight on opioid prescribing.

What examples drive this impression?

Where do you see room for improvement, if any?

Are there any areas where change is warranted?

Are you aware that the CDC has described three key roles for providers to acknowledge when prescribing opioids?

The three key roles are the following:

* Have adequate training in opioid therapy
* Know the content of the most current opioid drug labels
* Educate patients about the appropriate use of opioids, their potential risks and proper disposal techniques.

Do you feel like it is feasible to discuss these key roles with each patient in the busy hospital setting?

Do you have this conversation with your patients when you prescribe opioids?

**(PHYSICIAN RELATED FACTORS)**

What do you think of having a standing PRN order for an opioid on patients? How does it affect patient care?

How do you thinking calls from nursing staff regarding patients’ complaints about pain affect your ordering of opioid prn pain meds?

Do you think hospitalists or admitting physician order opioids on their patients to reduce calls from nursing staff? If so, please tell me about why this may or may not happen?

Do you think hospitalist physicians play a role in prescribing chronic pain medications to patients who receive opioids from a primary care physician??

What do you see your colleagues doing when prescribing opioids? Do you feel that there are many opioid prescribing styles among your colleagues? Tell me about how that makes you feel or your thoughts about it.

What professional or personal factors make you more inclined to prescribe opioid therapy at discharge? (i.e. training in residency, experience of bad outcome with a patient, overall work experience with opioids)

What professional or personal factors make you less inclined to prescribe opioid therapy at discharge?

Can you describe why these factors make you feel less inclined to prescribe opioid therapy at discharge?

Please tell me about your experiences with opioid prescribing at hospital discharge when working with **resident** physicians.

 Can you think of a time when a resident was very informed or misinformed about opioid prescribing that led to a good or bad outcome?

Do you feel that they generally do a good job in prescribing opioids at discharge?

In your opinion, do residents utilize non narcotic pain control methods well? For example, do you think NSAIDs, scheduled acetaminophen, ice packs, heating blankets are used to their full extent?

If no, why not?

Do you feel that residents have a uniform knowledge about how to manage pain in the hospital and prescribe opioids at discharge?

Are there areas for improving opioid prescribing at discharge with residents? What are your thoughts on that?

Have you had any specific experiences with your peers or with residents around opioid prescribing at hospital discharge that felt uncomfortable? How could that experience have been improved upon?

Do you think providing physicians with an algorithm for opioid prescribing would be useful? I envision this as a flow chart that would incorporate patient factors, opioid doses received in house, pain scores, direct access to the PDMP, and any narcotic contracts into the ordering schema [may be possible with epic])

**Overall factors**

What do you think are the primary factors influencing your opioid prescribing behavior beyond pain?

Patients, peers, experiences, etc? For example, how do your patients influence your opioid prescribing behaviors?

**Next, let’s talk about your personal opinions regarding opioid training.**

Was there a specific activity in medical school, residency, or during your time as an attending when you were trained to know when a non-opioid is more appropriate than an opioid for pain control (for example, if there is a history of illicit substance use or excessive alcohol use)? Can you describe this specific activity?

What about opioid titration? Do you feel that you have had adequate training?

Looking back, is there any training that you feel would have better prepared you to prescribe opioids?

Are there any institutional policies that help guide opioid prescribing you are aware of?

**Okay, great. I have just a few more questions before we finish. These questions are about** **Colorado’s Prescription Drug Monitoring Program (PDMP)**

Are you aware of the Colorado prescription drug monitoring program? Please tell me what you know about it.

Are you aware that you can access patient’s prescription history online?

What functionalities of PDMP have you used, if any?

Please tell me about that.

Do you have a login and password to the program?

If so, how often do you access Colorado’s PDMP before prescribing opioids to patients at the time of discharge?

What are some reasons why you would or would not access the prescription drug monitoring program?

Please elaborate on that.

Lastly, do you have any suggestions about regarding or improving opioid prescribing at discharge?

Is there anything that I should have asked you but I didn’t? Is there anything else you think I should add?

Thank you—this information is very helpful.