## Supplement I. Initial CAP-POD Draft Items

1. Patients who are addicted to opioids should not be prescribed opioids
2. Patients who are addicted to opioids should be prescribed buprenorphine
3. I know when it is time to transition a patient to buprenorphine.
4. I want to work with patients who have chronic pain
5. I want to work with patients who have opioid use disorders.
6. I have adequate training in the treatment of addiction
7. I have adequate training in the treatment of chronic pain.
8. I check the prescription drug monitoring system for each of my patients being prescribed opioids.
9. I have the ability to assess risk for opioid use disorder in my chronic pain patients.
10. I assess risk for opioid use disorder in my chronic pain patients.
11. When choosing a treatment for chronic pain, I weigh the risks and benefits.
12. I have adequate avenues of information to assess what is going on with my chronic pain patients
13. I have the ability to track my patients' behaviors related to their chronic pain.
14. I believe in empirical evidence
15. I trust research evidence related to chronic pain.
16. I trust research evidence related to opioid use disorder.
17. I have access to nonpharmacologic treatments for chronic pain
18. There are sufficient evidence-based treatments available for chronic pain.
19. There are sufficient evidence-based treatments available for opioid use disorder.
20. I am afraid to prescribe opioids for chronic pain.
21. I have expertise in managing co-occurring chronic pain and opioid use disorder.
22. Monitoring patients' medications takes too much time.
23. Opioid dose reduction results in a reduced risk of addiction.
24. When a patient on long term opioids begins to exhibit aberrant behaviors related to their medication, I fire them from my practice.
25. When a patient on long term opioids begins to exhibit aberrant behaviors related to their medication, I discontinue opioid therapy.
26. My patients can afford the recommended therapies for chronic pain.
27. My patients can afford the recommended treatments for opioid use disorder.
28. It is difficult to prioritize patients' clinical needs when treating comorbidities.
29. Reliance on patient self-report is a barrier to treating pain.
30. My team wants to work with patients with chronic pain.
31. My team wants to work with patients with opioid use disorders.

32. I collaborate with pharmacists when prescribing opioids
33. I communicate with other health care providers that are treating my chronic pain patients.
34. I have a buprenorphine provider I can refer my patients to if necessary
35. Interdisciplinary pain management services are challenging to assemble.
36. I work with a team when treating chronic pain.
37. I work with a team when treating opioid use disorder
38. It is easy to acquire a buprenorphine waiver
39. Research participants in chronic pain studies are representative of my patients.
40. Research participants in opioid use disorder studies are representative of my patients.
41. My organization makes it difficult to treat patients with chronic pain.
42. My organization makes it difficult to treat opioid use disorder.
43. Regulations make it difficult to treat patients with chronic pain
44. Regulations make it difficult to treat patients with opioid use disorder