**Supplementary Document 3: Commonly submitted questions identified from thematic analysis of survey responses\***

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| Question | Coding categories associated with question  |
|  | A priori (Theory-driven/deductive) codes | Data-driven (inductive) code |
| 1. Are patients and caregivers adequately prepared for discharge?
 |  | Care transitions discharge  |
| 1. As a patient or family member, how do I know if everything has been communicated to me about the hospitalization and post-discharge care?
 | Communication (Care team – patient/caregiver) |  |
| 1. Can hospital staff be more transparent about hospital practices (e.g. parking, cafeteria, rules about protocol for entering patient rooms, rounds, sleep interruptions).
 |  | Transparency |
| 1. Can hospital staff be more transparent about the care that is available at the hospital at admission?
 |  | Transparency |
| 1. Can my care team explain what new medications they are giving me and why?
 | Patient education | Medications |
| 1. Can my care team tell me the side effects of new medications?
 | Patient education | Medications |
| 1. Can you give me a narrative of what to expect in recovery including how long recovery will take?
 | Patient education | What to expect? |
| 1. Did your health-care providers explain to you what your problem or diagnosis is, what steps were done to further explore that condition, what treatment was undertaken, and what will still need to be done after discharge?
 | Patient education | Making sense of the hospitalization |
| 1. Do patients and caregivers understand about follow up appointments, test results, worrisome symptoms and their care management?
 | Post-acute care | What to expect? |
| 1. Do you work with your patients to set realistic discharge and recovery goals?
 |  | -Patient understanding-What to expect |
| 1. For a patient being discharged from the hospital with pain medications (e.g. opioids) who will the manage this post discharge?
 | Post-acute care | -Medications-Pain management |
| 1. How can education on medications, medical conditions, hospital care and discharge be better coordinated by the care team, and not so confusing and overwhelming to patients?
 | -Patient education - Communication (between care teams/health care providers) | - Patient education |
| 1. How can patients, family members, other caregivers and heath care teams work together to create effective discharge experiences that allow patients to feel empowered to manage their health once they get home?
 |  | -Shared decision-making-Care transitions discharge  |
| 1. How can the hospital discharge hand off to other care facilities (e.g. SNFs), primary care providers and specialists be made smoother?
 | Communication (inpatient and outpatient providers) | Care transitions discharge  |
| 1. How can we ensure shared decision-making and that patients and families are included in treatment decision-making and goals of care discussion?
 |  | -Shared decision-making- Goals of care |
| 1. How can we ensure that the care team provide consistent education and messaging about medications?
 | -Patient education -Communication (between care teams/health care providers) | -Medications |
| 1. How can we expand the idea of pharmacist-to-pharmacist handoff of patient care from hospital-based pharmacists and community pharmacists (chain or independent)?
 | Communication (between care teams/health care providers) | Medications |
| 1. How can we use telemedicine technology to improve transitions of care and reduce re-hospitalization?
 | -Care transitions-Models of care |  |
| 1. How do changes in my medication effect what I am already taking and have in my medicine cabinet at home?  In other words, what should I throw away that is replaced by something new I am going home on, what doses of my medicines at home have changed, and what has been discontinued during my stay in the hospital that I should stop taking when I return home?
 |  | -Patient education - Medications |
| 1. How do I treat patients with pain / chronic pain effectively?
 |  | Pain management |
| 1. How do we ensure that information provided by the care team during hospitalization and at discharge was clearly understood and clearly communicated by patients and caregivers?
 | Communication (Care team – patient/cargiver) | Patient understanding |
| 1. How is patient centered care truly defined and why isn't it the standard of care everywhere?
 | Models of care | Patient centeredness |
| 1. How often are patients discharged from the hospital given clear, understandable instructions about their treatment and follow-up?
 |  | - Care transitions discharge -Patient understanding |
| 1. How to determine what medications are covered by insurance so discharged patients can access and afford prescribed medications?
 |  | -Financial matters/Insurance-Medications |
| 1. Was our institution able to successfully notify the patient's PCP or relevant specialist of any medication changes?
 | Communication (inpatient and outpatient providers) | Medications |
| 1. What are my post discharge from hospital care arrangements and plans?
 | Post-acute care | -Patient understanding -What do I do? |
| 1. What are patient expectations related to the treatment of pain/chronic pain?
 |  | -Pain management-What to expect |
| 1. What can I do as caregiver to better care for my family member when we get home?
 |  | -Caregiver experience-What do I do? |
| 1. What is the best timing for patient and caregiver discharge education during hospitalization?
 |  | -Care transitons discharge -Patient education |
| 1. What is the best way to reconcile medications between home hospital and primary care?
 |  | Medications |
| 1. What is the most effective method for patient education during hospitalization?
 | Patient education |  |
| 1. What is the training and evaluation given to the people who are responsible for instructing patients?
 | Workforce |  |
| 1. What problems or symptoms should I call you about if they happen after I get home?
 | Post-acute care | What should I do?Who should I call? |
| 1. What transitions of care communications are provided to my primary care provider/team?
 | Communication (inpatient and outpatient providers) |  |
| 1. Which interventions improve medication reconciliation at key time points of the care trajectory (hospital/home, admission/discharge) and what are each intervention’s outcomes?
 | Models of care | Medications |
| 1. Who do I call if I have any questions after I have been discharged?
 |  | Who do I call? |

\*Questions are not prioritized and not rank ordered in order of perceived importance