Appendix 3. Full additional representative quotes by domain and theme

Domain	Theme	Representative Quotes
Information Exchange and Communication in IHT (Domain 1)	Information exchanged is missing, inaccurate, untimely and/or extraneous (Theme 1.1)	"...when you're not seeing the patient, and you're not able to look in the chart and look through the records, it's hard to even know what you're missing… which is part of what makes doing the [transfer request] calls so difficult." Interview 18, Physician
		"...another issue is, we're not trained to [take transfer acceptance calls] at all, no one is formally trained to do this. So, you kind of learn on the fly, by trial and error." Interview 5, Physician
		"I wonder if it would be helpful through [our call center] to have a phone number for [the transferring] person in case if there's any questions about this patient. I bet people would give you their cell phones which would be really helpful." Interview 30, Physician
	Information Fragmentation (Theme 1.2)	"You hope somebody wrote a good note, The note that the accepting physician writes and puts in the chart can be super helpful... there's a wide variety of how much is documented there. Your next step is you hope that we can see the outside hospital records, so you can actually look up their [discharge] summary, their progress notes, and then the worst-case scenario is that you go through the packet of information that comes with the patient, inevitably, that packet is bloated with information that is unhelpful... your last ditch is to actually just ask the patient themselves, they do actually know a lot about their care, but I think, in the new Epic era, we try and do as much as we can in the chart before seeing them." Interview 2, Physician
		"… the packets are either just huge and burdensome or disorganized, or both. They're missing things that have been done [and] that just results in repetitive testing and care." Interview 29, APP
		"...a discharge summary is for me far and away the most valuable... like a good synthesis of their admission, then having some progress notes to sift through that might have a little bit more details on some of the individual things that are going on with them.... I think having a clear picture of why they came into the outside hospital, in the beginning - what was their initial complaint, their biggest problem, and then some kind of chronologic description of what treatments they've had already, just a brief timeline of what they've had done procedure-wise, is helpful." Interview 11, APP

Responsibilities During IHT (Domain 2)	Pressures on clinicians at time of IHT acceptance (Theme 2.1)	"I also think you're accepting some level of liability and more importantly, for me professionally, responsibility for another person. Because moving them from one place to another is not without potential harm, as is the case with any transition of care. And then, ... [as the admitting] provider, it's unpleasant and frustrating to have someone or their family who feels like something was promised to them, which they then don't receive. And they went through all of the hassle, including potentially now having to travel way farther to see their loved one." Interview 15, Physician
	Uncertainty around who is responsible for IHT patients upon arrival (Theme 2.2)	"Generally, [as] the [triage clinicians], we have the systems knowledge to try to help people figure it out. I've had contact with nurses that are like, "I've called three people or four people or five people, and I just don't know what to do." And so I think that we have that knowledge and the time on triage to ... help out. So, if it's really busy, I'll say, "Hey, let me call you back after I do a little research here, if things are stable." Or I'll try to do a little chart digging while I'm on the phone with them. If I have a couple minutes, and they have a couple minutes, then say, "Hey, it looks like this is who I would recommend calling as the next step." And usually, they're pretty grateful." Interview 25, APP
		"It's just kind of nerve-wracking when you get a patient who arrives to the floor and [is] not painted as what you thought you were walking into based on the summary note." Interview 10, APP
		[When things go well], the first step is that the floor nursing staff and administrative staff know who to reach out to. That's clear that they can notify us right away. I can pass it on right away. The nurses don't feel sort of scared in a timeframe where they don't have a provider contact or they don't have orders... I mean, I think that's probably one of the most important things is that [the nurses] know who to call and how to do it quickly." Interview 25, APP
Expectations Management During IHT (Domain 3)	Nursing expectations of hospital medicine clinicians (Theme 3.1)	"When nursing gets these patients, I think they have the assumption that the way that patient is going to show up is the same way a patient presents from the emergency room, which is usually some basic orders and things have already been done for the patient. They expect that stuff right away. And they expect you to know that patient, like you got sign out from an emergency room doctor and not that you just read some note and didn't think that patient was coming for three days. So, I think management of expectation there is really hard." Interview 21, Physician

		The nurses... don't understand the flow of triage most of the time, except for very experienced nurses. A lot of times, they are like, “Okay, I have the patient in 615.” And I'm, “...that means nothing to me, I need an MRN.” When a nurse calls me and says, “Hi triage, this person got accepted to medicine, their MRN is blank. This person accepted them. And here are their current vitals” – that would be the most ideal situation because then I can go on, look at their MRN, make sure they got accepted by an actual medicine MD... and call them out to admitting...” Interview 16, APP
	Patient expectations of care at the accepting hospital (Theme 3.2)	"Patients always have the expectation that there's going to be no loss of voltage in terms of information when that patient comes to this place. We're going to have all the information and know exactly what happened at the previous facility, and that they're coming to this place that has the latest and greatest stuff, and that's why they're here. Those expectations are rarely managed on the sending side. Sometimes they get sent and we don't have anything to offer - and they shouldn't have been sent to begin with. And that leads to massive disappointment [for] the patient." Interview 21, Physician
		"I think people get frustrated with the fact that all those things don't start happening the moment they walk in the door. I think they get annoyed sometimes that you're asking them questions about their medical history or what the hospital has already done before they came over, and they've already been told, I'm coming here for this, why aren't we doing this, why am I seeing you and not seeing this specialist... I think a lot of times they get… if they get transferred for a specific reason, or specific test or specific consult, the expectation is that that's going to happen, like the moment they walk in." Interview 11, APP
		“…I empathize with them [patients and families] a lot, because we're also stuck in the middle, right? Because they're on our service, but perhaps they’re being transferred for a procedure that I don't actually do. And I would gladly help them, but I also have to be respectful of the team that I'm consulting and be respectful of their reservations, but you're also stuck in the middle and your hands are tied a lot because you can't make consultants do things, but sometimes it feels like a pointless transfer if you're like why were they transferred if nobody's going to do anything?” Interview 27, APP

		"I guess when people get transferred they always think that they're going to come in and get all these studies. It's always hard [when] they think something is going to happen, and it actually doesn't happen. Those are always really hard conversations to have. ... it just puts you in a bad place because you also feel horrible." Interview 30, Physician
		"Always better communication with other members of the care team makes anything about our jobs easier and more effective." Interview 29, APP
	Unrealistic expectations of what can be achieved on a floor-level unit (Theme 3.3)	"Even if all the communication has been perfect, sometimes patient status changes, and it really creates a lot of risk to patients when they are transferred to floor status, and then immediately require escalation of care." Interview 7, Physician
		"I think the scariest is when they show up and they're on the floor, and they're totally unstable or they're bleeding and you don't know where they're bleeding from... or there's something that's really acute, that's really difficult to handle on the floor in the middle of the night - that is always very stressful." Interview 18, Physician
		"Oftentimes there can be a good amount of time that elapses in between that conversation and actually having the patient show up on your door. And that may not be something that we have any control over, particularly if beds are tight. I think that delays from that initial communication can be a big problem. I think there's probably a missed opportunity for EMS, when they're transporting a patient because they may have been with the patient for hours, they may have a good amount of information about their vitals, their pain medicine requirement, are they clinically worsening? I think that information may be communicated to the nurses, but it's not. There are so many breaks in the information chain that we're potentially missing some clinically relevant changes that were observed by somebody, but we just don't have a way to get that information. And then all of a sudden we just have to respond to what we're seeing in the moment. I think that's another missed opportunity to have providers meet outside hospital transfers at the bedside." Interview 25, APP
		"It would be really nice if [an IHT patient] decompensated before they hit the ambulance that a provider would have called us said, "Hey, they don't look so great, they're tachycardic now, what would you like me to do?" and [the patient] could have gotten life flighted here or went to the right place immediately. If it happened enroute, it would have

		been helpful if the ambulance crew intervened or told us right away or went through the ED instead of coming directly to the floor." Interview 30, Physician