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Cover Page Footnote

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Research

Going from an academic medical center to a community hospital: Patient experiences with transfers

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Abstract
Academic medical centers (AMCs) often operate at or near full capacity, which leads to delays in care while smaller community hospitals may have excess capacity. To address this issue and to match patient needs to care acuity, patients may be transferred from an AMC emergency department for direct admission to a community hospital. We aimed to explore the experiences and perspectives of patients who were transferred. We randomly selected patients transferred between February 2019 and February 2020. We conducted structured thirty-minute interviews containing fixed response and open-ended questions focusing on the transfer rationale and experience, care quality, and patient financial outcomes. We used descriptive statistics to summarize questions with fixed responses and thematic analysis for open-ended questions. We interviewed a total of 40 patients. While most (88%) understood the rationale for transfer, many (60%) did not feel they had agency in the decision despite the voluntary nature of the program. Patients generally had a positive experience with the transfer (65%) and valued the expedited admission. However, some highlighted issues with transfer-related billing and the mismatch between the expectations of presenting to an academic hospital and the reality of being admitted to a community one. We conclude that patients are amenable to transfers for an expedited admission and understand the rationale for such transfers. However, participants should receive a clear explanation of benefits to them, guidance that the program is voluntary, and protection from financial risk

Keywords
Patient experience, patient-centered care, hospital transfers, communication, patient engagement

Background

Patients presenting to an emergency department (ED) of a tertiary/quaternary hospital who require admission typically get admitted to the same tertiary/quaternary hospital. Outbound transfers usually occur from a smaller hospital to a larger one due to need for specialty or higher levels of care.[1] However, larger hospitals typically operate at higher capacity[2] than smaller ones. As a result, patients may face longer boarding times,[3] physically remaining in the ED while officially admitted to the hospital. Longer ED boarding negatively impacts patient outcomes[4,5] and is association with poor communication and patient frustration.[6] Meanwhile, smaller community hospitals often have excess capacity and may struggle to fill beds. One way to balance out this discrepancy in hospital censuses is increased collaboration and transfers between academic medical centers and community hospitals, a trend growing in the United States.[7] Full mergers allow for collaboration, but affiliations and partnerships provide many of the same benefits without the cost and challenges of acquisition and comprehensive integration.[8] Our institution developed a voluntary/opt-in program to transfer lower acuity patients who require admission from an academic medical center ED to a community hospital for direct admission. Patients transferring benefit from shorter wait times (2½ hours rather than 6 hours from disposition to admission), get a private room, and have similar clinical outcomes (no difference in mortality or readmission rates).[9] There are limited data on patient experiences with transfers though one small survey (n=42) of patients in a similar program showed that 85% had a positive experience and 95% found the transfer to be easy.[10] However, patients may have concerns about transferring to different sites of care not highlighted in a single quantitative survey. We sought to interview patients to gather descriptive and qualitative data about their perceptions, experiences, and the financial impact of transfers on participants.

Methods

Setting

University of California, San Francisco (UCSF) Helen Diller Medical Center at Parnassus Heights is an academic medical center with 475 inpatient beds. St. Mary's Medical Center (SMMC) is a community hospital with 275 inpatient beds and part of CommonSpirit Health, a nonprofit hospital system. SMMC is located one mile away from UCSF and the general wards are staffed by the UCSF hospitalist group.

Transfer Program

Patients presenting to UCSF emergency department are assessed, stabilized, and triaged. If they warrant admission but do not require critical or advanced subspecialty care, they are given the option of transferring to SMMC if open staffed beds are available. Patients who agree are transferred by ambulance to SMMC for direct admission. The program has been in operation since 2018 with an interruption early in the COVID-19 pandemic.

Participants

For our study, we used a random number generator to select patients from a database of 492 patients who were transferred from the UCSF ED to the inpatient medicine service at SMMC between February 2019 and February 2020. We attempted to reach each patient twice using all phone numbers listed in the medical record before moving on to the next patient. Participants were excluded if English was not their preferred language (as listed in the medical record), if they were unable to consent to the study (e.g., due to cognitive impairment), if they did not recall the transfer experience, or if they died. Family members and caregivers present in the background on some of the calls could share their perspectives, but the primary participant needed to be able to participate and consent. We continued to interview until responses and topics identified were similar to prior ones, suggesting thematic saturation.

Interview guide development

We developed a study specific interview guide that explored patient experiences with the transfer process. Specifically, we asked about the transfer process and rationale, experience and quality of care following the transfer, and costs borne by patients (see supplement 1 for interview guide). Questions were largely open-ended, allowing respondents to describe their experiences in their own words. The remaining questions required fixed responses that were either binary (yes/no) or a 5-point Likert Scale ("1" being "strongly disagree" to "5" being "strongly agree" with an option for "unsure/don't remember"). Interviews were approximately thirty minutes long and participants could discontinue at any time.

Data collection

We obtained demographic and clinical data for patients from UCSF's Epic-based electronic health record platform (Epic 2017; Epic Systems Corporation, Verona, WI) that was implemented on June 1, 2012. All study data elements were obtained from Clarity, the relational database that stores Epic's inpatient data. Data extracted included age, gender, race/ethnicity, insurance provider, and whether patients were admitted directly from the emergency room or transferred from observation status.

Data analysis

We used descriptive statistics to summarize questions with binary or Likert responses. For open-ended questions we used thematic analysis to summarize the data.[11] Two trained reviewers coded the data independently and then reconciled with a third independent reviewer in place as the tiebreaker. Representative quotes reflective of general themes were also collected and recorded verbatim.

Oversight

This study was approved by the CommonSpirit Health CA/NV Institutional Review Board (IRB) (#00006573) with reciprocal approval by the University of California San Francisco IRB. If participants had concerns regarding financial questions or billing, we provided them with telephone numbers for patient financial services at SMMC and UCSF.

Results

Study participants

We reached out to 325 participants and interviewed 40 (12% interview rate) before similar responses/topics suggested thematic saturation. Of those, 43% (n=17) were over 65 years old and 45% (n=18) were women. Race and insurance status were representative of the broader patient population at our institution (see Table 1 for demographic details).

Transfer rationale and perspectives

Most people understood the reasons for the transfer (n=35, 88%) with patients citing bed availability (n=23, 58%) and better wait times to leave the emergency department (n=15, 38%) as primary benefits. Although participation in the program was voluntary (opt-in), many (n=24, 60%) felt that the decision to transfer was not their own (replying "disagree" or "strongly disagree" with "the decision to transfer is my own"). Patients reported not having a choice ("they told me [the hospital] was full and I had to go") or struggling to make an informed decision when ill ("It was a very confusing experience. You know, you just do what the doctor tells you"). However, patients who understood reasons for transfer and felt that they had agency were glad to have the option to transfer ("it was an

Table 1. Baseline Participant Characteristics

Age	**Number (Percent)**
Under 65	23 (58%)
65 and over	17 (43%)
Average	59.6
Gender	
Female	18 (45%)
Male	22 (55%)
Race	
Asian	4 (10%)
Black/African America	11 (28%)
White/Caucasian	19 (48%)
Other/Unknown	6 (15%)
Ethnicity	
Hispanic or Latino	6 (15%)
Not Hispanic or Latino	33 (83%)
Unknown	1 (3%)
Insurance	
Medicare	18 (45%)
Medi-Cal	8 (20%)
Private	14 (35%)
Admission Type	
Emergency	36 (90%)
Observation	4 (10%)

unexpected opportunity to make a terrible situation a little bit better") and to be admitted faster ("I would have a room much quicker"). See Table 2 for details and additional information.

Care quality

Once patients agreed to the transfer, most (n=31, 78%) felt that the transfer process itself was seamless ("agree" or "strongly agree"). Most (n=26, 65%) had a positive experience at the receiving hospital, particularly highlighting excellent nursing and ancillary staff care (n=29, 73% of respondents mentioning high quality nursing or ancillary care without prompts). However, while some (n=17, 43%) patients felt care at the two hospitals was similar, a minority (n=8, 20%) felt that care could not be compared between the two institutions. A significant minority (n=14, 35%) said they would not agree to the transfer again, citing financial challenges and hospital size/expectations as key reasons. See Table 3 for further details.

Financial implications

Finally, with respect to financial implications of transfer, most patients (n=33, 82%) felt that hospital bills had limited or no impact on their experience with the transfer ("I did not see any bill, my insurance took care of everything"). Most either did not remember paying (n=15, 38%) or recall no issues with paying for care (n=10, 25%). However, some (n=7, 18%) were negatively impacted by billing challenges. They highlighted duplicate billing for ambulance transfers (which should have been covered by the program) and challenges disputing bills across insurance providers and multiple healthcare systems. Although a quarter (n=10, 25%) of participants interviewed successfully negotiated bills, others (n=7, 18%) are still involved in disputes or were unsuccessful. Several participants (n=6, 15%) mentioned that financial concerns were a major contributor to their negative perception of the transfer – "if I knew about the ambulance bill…I would drive to St Mary's [myself]". See Table 4 for additional information.

Discussion

Hospital transfers represent an opportunity to expedite patient care, increase capacity for complex specialty patients at tertiary hospitals and increase patient volumes at smaller community hospitals. We interviewed patients at one transfer program and learned that most people understand the reasons for transferring and had a positive experience. The transfer process was generally described as smooth, and patients were satisfied with their care. Our interviews were conducted for patients who had been hospitalized before the COVID-19 pandemic but programs such as this are particularly relevant in today's environment where hospitals operate at full capacity facing staffing challenges and may divert lower acuity admissions to other sites.

Table 2. Rationale and Perceptions for Transfer

I understood reasons for transfer	**Number (Percent)**
Yes	35 (88%)
No	5 (13%)
Elicited reasons for transfer	
No bed availability at UCSF	23 (58%)
Better wait time at SMMC	15 (38%)
Unsure/confused/too sick to know	6 (15%)
Other	3 (8%)
Benefit - Privacy	2 (5%)
Benefit - Same providers	1 (3%)
The decision to transfer was my own	
Strongly Agree	11 (28%)
Agree	4 (10%)
Neutral or Unsure	1 (3%)
Disagree	15 (38%)
Strongly Disagree	9 (23%)
Overall perception about transfer	
Positive/Neutral	27 (68%)
Good care experience at SMMC	6 (15%)
Wanted to get care quickly	6 (15%)
Unspecified	16 (40%)
Negative	13 (33%)
Concern for SMMC quality of care	2 (5%)
Wanted care at UCSF	2 (5%)
Financial concerns	6 (15%)
Unspecified	4 (10%)

However, our patient interviews also identified significant challenges with transfers. One issue is that of agency – many patients did not feel the choice to transfer was theirs despite the voluntary nature of the program and consent obtained prior to transfer. This may have been driven by the inherent power differential in the patient-doctor relationship,[12] by patient's clinical acuity, or by the hectic nature of the emergency department. Participants also worried about quality of care at the smaller hospital even though acute care can be delivered efficiently at smaller institutions with high quality and high patient satisfaction[13, 14] without sacrificing quality. Both issues – agency and expectation setting – can be addressed through better communication about transfers and a more detailed consent discussion.

While most participants were not significantly impacted financially by the transfer, a minority had a negative experience because financial aspects of the transfer. Patients had poor experiences with erroneous ambulance

Table 3. Care Quality at SMMC

Overall Care Experience	**Number (Percent)**
Positive	26 (65%)
Mixed	5 (13%)
Negative	9 (23%)
Compared to UCSF, how does SMMC compare?	
Better	4 (10%)
Same	17 (43%)
Worse	10 (25%)
Can't Compare	8 (20%)
If offered to transfer, would you do it again?	
Strongly agree	11 (28%)
Agree	12 (30%)
Neutral	2 (5%)
Disagree	3 (8%)
Strongly disagree	11 (28%)

Table 4. Financial Implications of SMMC Transfer

Impact of financial bills	**Number (Percent)**
Significant impact	7 (18%)
No impact or minor impact	33 (83%)
Detail	
Don't remember bills	15 (38%)
Remember, no issues paying them	10 (25%)
Successfully disputed or negotiated bills	10 (25%)
Ambulance Bill	6 (15%)
Hospital Bills	5 (13%)
Ongoing or unsuccessful action to dispute or resolve bills	7 (18%)
Ambulance Bill	6 (15%)
Hospital Bills	2 (5%)

billing and difficulties navigating financial services across two separate systems. While the specific details are unique to our program, logistical and billing infrastructure challenges commonly arise in complex systems and lead to an erosion of patient trust. The participants facing financial complications reported significant stress and not wanting future transfers. This negative experience highlights the notion of financial toxicity of medical care: similar to medication side effects, healthcare comes with expenses which have a negative impact on patients' health and wellbeing.[15, 16] While some costs are expected, those that are inappropriate or surprising (such as ambulance bills for this program) are particularly pernicious, akin to medical errors or unexpected adverse surgical outcomes. Transfers programs need to be at least cost-neutral to the patient, have simplified billing flows to minimize errors, and have a clear way of escalating problems so that patients are not stuck navigating medical bills across two healthcare systems.

Our study was limited in participant number and generalizability. Only 12% of people we called agreed to an interview driven by participant concern about picking up calls from an unknown number, recent acute illness, and the time commitment of the interview. Retrospective telephone surveys such as ours have biases including participant self-selection (particularly given the low response rate), desirability (especially for recently hospitalized patients talking to a healthcare researcher) and recall bias. Future research could target patients during or immediately after their hospitalization and use a mix of interviews and anonymous surveys. We surveyed only forty patients limited to English speakers at a single institution in one geography although interview responses suggested thematic saturation and the participants were broadly representative of demographics at our institution. We also did not have direct access to billing data from both the transferring and receiving institution and thus could not quantify the financial impact of the program on co-pays, deductibles, and out of pocket costs beyond what the participants themselves could remember. Finally, given the acuity of illness, some participants had limited recall of the transfer process and could not answer all questions fully, though this is a general challenge of patient surveys about acute care experiences. Transfer programs will continue as they come with benefits for both the healthcare systems and patients. Transferring from a full hospital to a smaller one with excess capacity is a promising way to streamline care but should be done with clear communication of risks/benefits and informed consent from patients. Healthcare systems setting up similar arrangements should also integrate direct patient feedback into program design to improve patient experience, quality, and value.

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