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Psychosocial Factors Predict Patient Ratings of Care Transition Quality: Results from Transitions, Risks, and Actions in Coronary Events – Center for Outcomes Research and Education (TRACE-CORE)

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Background: Short hospital stays and fragmented care make the transition following hospitalization a high-risk period for ACS patients. Identified risks for rehospitalization and complications associated with transitions include demographic (e.g., older age), clinical (e.g., co-morbidities), and psychosocial (e.g., depression) factors. Thus, one might expect high-risk patients to receive better quality transitional care to minimize negative outcomes; alternatively, the quality of care may be yet another outcome influenced by the same risk factors. Little is known about the predictors of quality of care transitions from the patients' perspective.

Methods: We studied 1,545 TRACE-CORE patients (mean age = 62, 34% female, 78% non-Hispanic white) admitted with an ACS who completed in-hospital interviews and the Care Transition Measure (CTM) at 1 month after discharge. High quality transitions were indicated by a CTM-15 score >74. Using logistic regression models we examined the association between in-hospital demographic, clinical, and psychosocial characteristics, generic and disease specific quality of life, health literacy and numeracy, and cognitive status with high quality transitions.

Results: Over one-third (36%) of participants (n=552) reported high quality transitions after an ACS. Most variables of interest were associated (p < .20) with care transition quality in bivariate analyses. After adjustment, in-hospital cognitive impairment (Odds Ratio (OR) 0.68; 95% CI 0.46, 0.98) and older age (OR 0.99; CI 0.98, 1.00) were negatively associated with reporting high care transition quality, while high levels of social support (OR 1.06; CI 1.03, 1.10) and patient activation (OR 1.46; CI 1.02, 2.09) increased the chance of reporting high care transition quality in a multivariable model.

Conclusions: Older patients, those with cognitive impairment, low social support, or lower patient activation may be at risk for lower-quality transitions following hospitalization for ACS, and may benefit from extra attention and support during the transition from hospital to home.