

Coordination of Care Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is a patient-centered medical home (PCMH) and its relevance to care coordination?**
 - A. A care delivery model emphasizing coordinated, team-based primary care that improves access, quality, and patient experience through comprehensive care coordination.**
 - B. A hospital-centric model focusing on inpatient services.**
 - C. A model that excludes primary care.**
 - D. A system that replaces clinician decision-making with automated scheduling.**

- 2. Which condition is targeted by HRRP's 30-day readmission measures?**
 - A. Colorectal cancer**
 - B. Stroke**
 - C. Acute myocardial infarction (AMI)**
 - D. Asthma**

- 3. Which of the following is NOT a recommended health literacy practice?**
 - A. Prioritize plain language**
 - B. Use 'tummy' instead of 'abdomen'**
 - C. Limit content**
 - D. Use medical jargon when possible**

- 4. What is the purpose of a care coordination "hotline" or central contact point?**
 - A. To facilitate rapid communication, triage issues, and ensure consistent point of contact for the patient and providers.**
 - B. To replace all in-person visits.**
 - C. To document billing disputes.**
 - D. To provide patient entertainment while waiting.**

- 5. Which member of the care team typically leads the care coordination process for high-risk patients and coordinates services across settings?**
 - A. A social worker.**
 - B. A care manager or nurse care coordinator.**
 - C. A physician only.**
 - D. A patient.**

- 6. Which practice during discharge reduces readmission risk?**
- A. Providing medication reconciliation and a clear follow-up plan.**
 - B. Leaving follow-up details to the patient to arrange.**
 - C. Relying only on in-hospital care without post-discharge plans.**
 - D. Skipping patient education to save time.**
- 7. In chronic disease management, what is disease-specific care planning?**
- A. Creating a generic plan that fits all diseases.**
 - B. Creating a tailored plan that includes goals, self-management support, monitoring, and timely action when readings are out of range.**
 - C. A plan focusing only on medication optimization.**
 - D. A plan that excludes patient input.**
- 8. Which statement reflects one of the three questions encouraged by the Ask Me 3 framework?**
- A. What is my main problem? What do I need to do? Why is it important for me to do this?**
 - B. What is my diagnosis? How will this medication help? When can I leave?**
 - C. Who will manage my care? Where can I get more services? How much time will this take?**
 - D. What are the side effects of every medication? How long is my hospital stay?**
- 9. In I PASS the BATON, what information belongs in the 'Background'?**
- A. Comorbidities, previous episodes, current medications, family history**
 - B. Current complaints and symptoms**
 - C. Insurance information**
 - D. Physical exam findings**

10. Limited health literacy is associated with what outcomes?

- A. Better understanding of medications**
- B. Higher mortality, lower knowledge, greater inpatient/ED use, poor adherence**
- C. Decreased use of hospital services**
- D. No effect**

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Answers

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1. A
2. C
3. D
4. A
5. B
6. A
7. B
8. A
9. A
10. B

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Explanations

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1. What is a patient-centered medical home (PCMH) and its relevance to care coordination?

- A. A care delivery model emphasizing coordinated, team-based primary care that improves access, quality, and patient experience through comprehensive care coordination.**
- B. A hospital-centric model focusing on inpatient services.**
- C. A model that excludes primary care.**
- D. A system that replaces clinician decision-making with automated scheduling.**

The patient-centered medical home is a care delivery model that organizes primary care as a coordinated, team-based hub designed to improve access, quality, and patient experience through comprehensive care coordination. It centralizes responsibility for coordinating a patient's care across the health care system—managing preventive services, chronic disease care, referrals to specialists, tests, transitions from hospital to home, and follow-up—using a dedicated care team and health information technology to share information, track plans, and ensure timely communication. This approach emphasizes accessible, continuous relationships with a consistent clinician team, proactive care planning, and ongoing quality improvement. In contrast, a hospital-centric inpatient focus, a model that excludes primary care, or a system that replaces clinician decision-making with automated scheduling do not capture the essence of PCMH, which relies on coordinated, patient-focused primary care and team-based collaboration to align care with the patient's needs and preferences.

2. Which condition is targeted by HRRP's 30-day readmission measures?

- A. Colorectal cancer**
- B. Stroke**
- C. Acute myocardial infarction (AMI)**
- D. Asthma**

The key idea is that HRRP uses 30-day readmission measures to push hospitals to improve care transitions after certain acute conditions, with the goal of preventing avoidable returns to the hospital. Acute myocardial infarction is one of the main conditions included in this 30-day readmission set. After an AMI, patients face complex post-discharge needs—medication management, timely follow-up, and clear discharge instructions—that, if not well coordinated, can lead to a readmission within 30 days. By monitoring and financially penalizing higher-than-expected 30-day readmission rates for AMI, the program encourages hospitals to strengthen discharge planning, ensure early outpatient follow-up, and improve care coordination. The other options—colorectal cancer, stroke, and asthma—are not part of the standard 30-day readmission measures under HRRP.

3. Which of the following is NOT a recommended health literacy practice?

- A. Prioritize plain language**
- B. Use 'tummy' instead of 'abdomen'**
- C. Limit content**
- D. Use medical jargon when possible**

Clear health communication relies on making information easy to understand and act on. The best practice is to use plain language, present only essential information, and use terms that people are likely to know and relate to. Using familiar words like tummy or belly instead of more formal terms helps people grasp instructions, remember details, and make informed decisions. Medical jargon, on the other hand, creates barriers. When complex terms are used by themselves, people may not understand what is being asked or advised, which can lead to mistakes or unsafe decisions. If specialized terms must be used, they should be clearly defined in plain language. So, the statement that using medical jargon when possible is not a recommended health literacy practice is the one that best fits these principles.

4. What is the purpose of a care coordination "hotline" or central contact point?

- A. To facilitate rapid communication, triage issues, and ensure consistent point of contact for the patient and providers.**
- B. To replace all in-person visits.**
- C. To document billing disputes.**
- D. To provide patient entertainment while waiting.**

A care coordination hotline provides a single, reliable access point that enables rapid communication between patients and the care team, allows real-time triage of issues, and maintains a consistent point of contact for both the patient and all providers involved. This centralized channel helps prevent fragmented information and delays by ensuring questions, concerns, and urgent needs are routed to the right clinician promptly, decisions are documented in the care plan, and follow-up steps are clearly communicated. It supports timely escalation for urgent problems, coordinates referrals or appointments, and strengthens continuity of care across settings and disciplines. This isn't intended to replace in-person visits, which are still necessary when a physical evaluation or procedures are required. It isn't a venue for documenting billing disputes, which fall under administrative processes, nor is it for entertainment while waiting. The hotline's value lies in streamlining communication, triaging appropriately, and providing a dependable, consistent touchpoint that keeps the care team aligned and the patient's needs addressed quickly.

5. Which member of the care team typically leads the care coordination process for high-risk patients and coordinates services across settings?

A. A social worker.

B. A care manager or nurse care coordinator.

C. A physician only.

D. A patient.

The main idea here is that keeping high-risk patients connected across hospital, clinic, home, and community services requires a dedicated coordinator who can manage the whole care plan. A care manager or nurse care coordinator is best suited for this role because they are trained to create and oversee integrated care plans, track risk factors, and organize services from multiple settings. They act as the central point of contact, ensuring timely communication among hospitals, primary care, specialists, social services, and community resources. They handle transitions of care—such as discharge planning, medication reconciliation, follow-up appointments, and arranging home health or community supports—and they address barriers like transportation or caregiver needs. While a social worker often handles discharge planning and resource connections, and a physician leads medical decisions, neither typically carries the day-to-day cross-setting coordination responsibility for high-risk patients. The patient is essential to the process, but the care manager or nurse care coordinator is the one who orchestrates the coordination.

6. Which practice during discharge reduces readmission risk?

A. Providing medication reconciliation and a clear follow-up plan.

B. Leaving follow-up details to the patient to arrange.

C. Relying only on in-hospital care without post-discharge plans.

D. Skipping patient education to save time.

Discharge planning that ensures medications are correct and a concrete follow-up plan is in place reduces readmission risk. Medication reconciliation aligns the hospital-prescribed medicines with what the patient should take at home, catching omissions, duplications, dosing errors, or interactions. When patients leave with a clear, accurate med list and instructions, adverse events are less likely and adherence improves. A well-defined follow-up plan gives a specific next step—an appointment, a phone check, or a point of contact—so problems are addressed early rather than spiraling into a preventable return to the hospital. These elements together create a safer and smoother transition from hospital to home, which is directly linked to fewer readmissions. Gaps arise when follow-up is left to the patient, when post-discharge plans are missing, or when patient education is skipped, leading to confusion, missed symptoms, and delayed care.

7. In chronic disease management, what is disease-specific care planning?

- A. Creating a generic plan that fits all diseases.**
- B. Creating a tailored plan that includes goals, self-management support, monitoring, and timely action when readings are out of range.**
- C. A plan focusing only on medication optimization.**
- D. A plan that excludes patient input.**

Disease-specific care planning means a tailored plan for a particular chronic condition that includes goals, self-management support, regular monitoring, and timely actions when readings are out of range. This approach makes care practical and patient-centered by involving the person in setting targets and deciding how to reach them. Ongoing monitoring provides data to adjust treatment promptly and prevent complications, with predefined action steps when values rise or fall beyond target. It's not a generic or one-size-fits-all plan, it isn't limited to medications alone, and it includes the patient's input to ensure relevance and adherence.

8. Which statement reflects one of the three questions encouraged by the Ask Me 3 framework?

- A. What is my main problem? What do I need to do? Why is it important for me to do this?**
- B. What is my diagnosis? How will this medication help? When can I leave?**
- C. Who will manage my care? Where can I get more services? How much time will this take?**
- D. What are the side effects of every medication? How long is my hospital stay?**

The main idea being tested is how patient education frameworks encourage clear, active patient participation in care. Ask Me 3 prompts patients to focus on three essential points: What is my main problem? What do I need to do? Why is it important for me to do this? This combination targets understanding the issue, the specific actions the patient should take, and the rationale behind those actions, which supports safer, more engaged care. The statement that fits this framework directly asks about the problem, the required steps, and the importance of taking those steps. Other options center on diagnosing, medication details, or logistics like length of stay, which are not the three questions promoted by Ask Me 3.

9. In I PASS the BATON, what information belongs in the 'Background'?

- A. Comorbidities, previous episodes, current medications, family history**
- B. Current complaints and symptoms
- C. Insurance information
- D. Physical exam findings

In a handoff, Background provides historical context about the patient that helps the team understand who they are and what factors influence care. This includes chronic conditions (comorbidities), prior episodes or illnesses, current medications, and family history. These pieces of information are stable over a single encounter and set the stage for interpreting the current situation and planning the next steps. Current complaints and symptoms describe what brought the patient in today and belong in the Illness portion or Patient Summary, not Background. Insurance information is administrative, and physical exam findings are objective data from the current encounter that belong in the assessment/plan or objective sections, not the Background. Therefore, the list of comorbidities, prior episodes, current medications, and family history best fits the Background category.

10. Limited health literacy is associated with what outcomes?

- A. Better understanding of medications
- B. Higher mortality, lower knowledge, greater inpatient/ED use, poor adherence**
- C. Decreased use of hospital services
- D. No effect

Limited health literacy means patients struggle to understand health information and navigate care. That struggle translates into misreading medication instructions, dosing errors, missed follow-ups, and not recognizing when to seek care. Because of this, knowledge about conditions and treatments tends to be lower, adherence to treatment plans is poorer, and problems often escalate. Those factors contribute to higher mortality in some groups and markedly more use of inpatient services and emergency department care. In short, limited health literacy is linked to worse outcomes and greater healthcare utilization, not to better understanding, reduced use of services, or no effect.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://coordinationofcare.examzify.com>

We wish you the very best on your exam journey. You've got this!

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