

COORDINATION OF CARE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

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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. Which limitation is commonly associated with telehealth in care coordination?**
 - A. Telehealth has no privacy concerns and is always reimbursed.
 - B. Telehealth reduces privacy concerns.
 - C. Common limitations include technology access, privacy concerns, and reimbursement challenges.
 - D. Telehealth is not useful for care coordination.
- 2. What is the electronic medical record (EMR)?**
 - A. A paper-based record kept in the clinic
 - B. Information collected electronically in a digital format that includes standard clinical and medical data gathered by a healthcare provider
 - C. A data system used only for billing
 - D. A patient-owned personal medical diary
- 3. How is HCAHPS data used at a high level?**
 - A. Data is confidential and used only internally
 - B. Data is publicly reported and published quarterly on CMS platforms
 - C. Data is publicly reported and published annually
 - D. Data is publicly reported and based on four consecutive quarters of results
- 4. Describe the impact of caregiver burden on care coordination outcomes.**
 - A. High caregiver burden can hinder adherence and follow-through; addressing caregiver needs improves outcomes
 - B. Caregiver burden has no effect
 - C. Addressing caregiver needs worsens outcomes
 - D. Only reduces caregiver satisfaction
- 5. Which data element is least essential for meaningful risk stratification in care management?**
 - A. Clinical data (diagnoses, labs, medications)
 - B. Utilization data (hospitalizations/ED visits)
 - C. Social determinants of health data
 - D. Patient-reported outcome measures

- 6. Which statement best describes the role of a care dashboard or registry in care coordination?**
- A. It tracks completion of outstanding care needs (screenings, vaccines, follow-ups)
 - B. It schedules staff shifts
 - C. It stores financial records
 - D. It tracks only patient satisfaction
- 7. Why is HRRP significant in the shift toward value-based care?**
- A. It aligns payment with value-based care and reduces avoidable readmissions
 - B. It supports fee-for-service only
 - C. It eliminates penalties for readmissions
 - D. It increases payments for high readmission hospitals
- 8. Which statement about limited health literacy is supported by available data?**
- A. Higher mortality rates
 - B. Better medicine adherence
 - C. Shorter ED visits
 - D. Lower hospital admissions
- 9. What does the SBAR framework stand for in clinical communication?**
- A. Structure-Background-Analysis-Report.
 - B. Situation-Background-Assessment-Recommendation.
 - C. Status-Bridge-Action-Review.
 - D. Scenario-Basis-Alerts-Response.
- 10. Which element is not typically part of a Transition of Care protocol?**
- A. Timely follow-up
 - B. Medication reconciliation
 - C. Scheduling elective procedures prior to discharge
 - D. Patient education

Answers

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

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Explanations

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1. Which limitation is commonly associated with telehealth in care coordination?

- A. Telehealth has no privacy concerns and is always reimbursed.
- B. Telehealth reduces privacy concerns.
- C. Common limitations include technology access, privacy concerns, and reimbursement challenges.**
- D. Telehealth is not useful for care coordination.

Telehealth in care coordination can greatly improve connection and access, but real-world constraints often limit its effectiveness. The most common limitations are technology access, privacy concerns, and reimbursement challenges. Not everyone has reliable internet, appropriate devices, or the digital literacy to use telehealth smoothly, which creates a gap in who can be reached and how often care can be coordinated. Privacy and confidentiality are also important, since health information travels over networks and must be protected by secure, compliant platforms and careful handling in home environments. Reimbursement adds another layer of complexity, with varying coverage, payment rules, and documentation requirements across payers and programs. These intertwined barriers explain why telehealth, while valuable, faces practical limits in care coordination.

2. What is the electronic medical record (EMR)?

- A. A paper-based record kept in the clinic
- B. Information collected electronically in a digital format that includes standard clinical and medical data gathered by a healthcare provider**
- C. A data system used only for billing
- D. A patient-owned personal medical diary

Digital documentation of a patient's care created and maintained by clinicians within a single health care organization is what an EMR is. It stores information electronically in a standardized digital format, including clinical data gathered during visits—history, diagnoses, medications, allergies, immunizations, lab results, imaging reports, and encounter notes. EMRs are designed to support ongoing clinical care and decision-making, making it easier for providers within the same system to view and update the chart, track care, and order tests or prescriptions. This is different from a paper chart, which is not electronic; from billing-focused systems, which are primarily for financial transactions rather than clinical documentation; and from a patient-owned personal diary, which is outside the clinician's chart. Note that EMR data are typically used within a single organization, whereas an EHR is more focused on sharing data across multiple care settings.

3. How is HCAHPS data used at a high level?

- A. Data is confidential and used only internally
- B. Data is publicly reported and published quarterly on CMS platforms
- C. Data is publicly reported and published annually
- D. Data is publicly reported and based on four consecutive quarters of results**

HCAHPS data are shared publicly to let patients and others compare how hospitals perform on patient experience. To keep the measurements reliable and fair, the scores are calculated from four consecutive quarters of survey results, using a rolling four-quarter window. This approach smooths out short-term swings and seasonal variation, providing a stable basis for comparisons while still updating over time.

4. Describe the impact of caregiver burden on care coordination outcomes.

- A. High caregiver burden can hinder adherence and follow-through; addressing caregiver needs improves outcomes
- B. Caregiver burden has no effect
- C. Addressing caregiver needs worsens outcomes
- D. Only reduces caregiver satisfaction

The key idea here is that caregiver burden directly affects how well care is coordinated and carried out. When caregivers are overwhelmed—emotionally, physically, or financially—they may struggle to manage medications, keep up with follow-up appointments, and relay important changes to the care team. This can lead to missed doses, missed visits, delayed communication during transitions between settings, and overall poorer execution of the care plan, all of which disrupt coordination and worsen outcomes. On the other hand, addressing caregiver needs—through education about the plan, clearer instructions, access to respite or home support, and help with navigating resources—empowers the caregiver. That support improves adherence to the care plan and follow-through on actions, which makes transitions smoother, reduces avoidable problems, and tends to improve health outcomes for the patient. So, recognizing and mitigating caregiver burden is a crucial part of effective care coordination; ignoring it tends to undermine adherence and timely care, while supporting caregivers strengthens the entire coordination process.

5. Which data element is least essential for meaningful risk stratification in care management?

- A. Clinical data (diagnoses, labs, medications)
- B. Utilization data (hospitalizations/ED visits)
- C. Social determinants of health data
- D. Patient-reported outcome measures

Risk stratification in care management relies on data that predict future events and resource needs. Clinical data—Diagnoses, lab results, and medications—quantify disease burden and current treatment intensity, making them strong predictors of adverse outcomes. Utilization data showing prior hospitalizations or emergency visits signal patterns of instability and are among the strongest indicators of future high resource use. Social determinants of health data add essential context by highlighting barriers to care, access, and adherence that can elevate risk. Patient-reported outcome measures reveal how patients feel and function, which is valuable for tailoring care, but they are more subjective and vary across individuals, so they are less consistently predictive of near-term risk. They can still enrich care planning, but for identifying who needs the next level of intervention, PROMs are the least essential among these data elements.

6. Which statement best describes the role of a care dashboard or registry in care coordination?

- A. It tracks completion of outstanding care needs (screenings, vaccines, follow-ups)**
- B. It schedules staff shifts
- C. It stores financial records
- D. It tracks only patient satisfaction

The main idea here is that care dashboards or registries keep a clear, centralized view of what each patient still needs in their care plan. They track overdue or upcoming items like preventive screenings, vaccinations, follow-up appointments, tests, and referrals, so the care team can act promptly. This visibility supports proactive outreach, helps prevent gaps in care, and enables coordination across clinicians and settings. Scheduling staff shifts, storing financial records, or tracking only patient satisfaction don't address the clinical tasks that need to be completed for each patient. Those functions belong to workforce management, financial administration, or patient experience metrics, respectively. So the best description is that the dashboard/registry tracks completion of outstanding care needs and coordinates timely delivery of care.

7. Why is HRRP significant in the shift toward value-based care?

- A. It aligns payment with value-based care and reduces avoidable readmissions**
- B. It supports fee-for-service only
- C. It eliminates penalties for readmissions
- D. It increases payments for high readmission hospitals

The main idea here is that HRRP ties Medicare payments to the quality of care by penalizing hospitals with higher than expected 30-day readmission rates, encouraging better care transitions and post-discharge support. This aligns reimbursement with value because it rewards efforts that prevent avoidable readmissions—improving outcomes while controlling costs—rather than paying based solely on volume. HRRP motivates hospitals to invest in discharge planning, follow-up care, and coordination with primary care and community resources, all key elements of value-based care. It doesn't support fee-for-service only, since the program reduces payments for higher readmission rates rather than increasing or maintaining payments based on volume alone. It doesn't eliminate penalties, as penalties are a core part of the program. It also doesn't increase payments for high readmission hospitals; the opposite happens, rewards go to those that keep readmissions down.

8. Which statement about limited health literacy is supported by available data?

- A. Higher mortality rates**
- B. Better medicine adherence
- C. Shorter ED visits
- D. Lower hospital admissions

Limited health literacy means difficulty understanding health information and instructions needed to manage care. Available data show this is linked to higher mortality rates, because misunderstandings and gaps in following treatment plans can lead to poorer disease control and worse outcomes over time. It is not associated with better medicine adherence; in fact, adherence tends to be poorer among individuals with limited health literacy. It also leads to greater use of emergency services and higher hospital admissions, rather than shorter ED visits or fewer admissions.

9. What does the SBAR framework stand for in clinical communication?

- A. Structure-Background-Analysis-Report.
- B. Situation-Background-Assessment-Recommendation.**
- C. Status-Bridge-Action-Review.
- D. Scenario-Basis-Alerts-Response.

SBAR is a concise, structured way to communicate about a patient to improve clarity and safety. It breaks the message into four parts: Situation, Background, Assessment, and Recommendation. The Situation states the immediate issue or reason for the communication. Background provides relevant context such as diagnosis, recent treatments, and pertinent history. Assessment is the clinician's interpretation of the situation, including seriousness and possible causes. Recommendation specifies the proposed next steps and who should act, with any urgency clearly noted. This exact four-part format is what makes SBAR effective in fast-paced or handoff scenarios, helping ensure that critical information is conveyed in a predictable, efficient order. Other wordings mix in different terms (for example, using Analysis instead of Assessment or Report instead of Recommendation) and don't align with the standard SBAR structure. Example: Situation: patient in room 210 with chest pain. Background: history of CAD, currently on nitrates. Assessment: possible ACS, vitals show mild instability. Recommendation: obtain ECG now, draw troponin, start appropriate therapy, and notify on-call cardiology.

10. Which element is not typically part of a Transition of Care protocol?

- A. Timely follow-up
- B. Medication reconciliation
- C. Scheduling elective procedures prior to discharge**
- D. Patient education

This item examines what components belong to a Transition of Care protocol to support safe handoffs across care settings. The goal of transitions is to ensure continuity, safety, and clear responsibility as a patient moves from one setting to another, such as from hospital to home. Timely follow-up is essential because a post-discharge check-in helps catch new or evolving issues early, reassess the treatment plan, and prevent avoidable readmissions. It anchors the patient in ongoing care after leaving the hospital. Medication reconciliation is critical to safety. By comparing and aligning medications across the inpatient stay, discharge prescriptions, and the patient's home regimen, it prevents omissions, duplications, and harmful interactions during the transition. Patient education is a core piece because informed patients and caregivers know how to take medications correctly, follow activity or diet instructions, recognize warning signs, and know when to seek help. This empowers them to manage care effectively outside the hospital. Scheduling elective procedures prior to discharge is not a standard element of a Transition of Care protocol. While planning and coordination occur in care more broadly, the transition protocol focuses on ensuring safe handoffs, clear follow-up plans, and medication safety. Scheduling elective procedures tends to belong to overarching treatment planning or outpatient scheduling rather than the fundamental handoff elements that define a transition of care.

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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