Care Transitions Curriculum Pretest and Self-Efficacy Survey for Trainees

Domain 1: Patient-centered medical record

1. Adverse events related to hospitalization in older adults may include:
   A. Delirium
   B. Medication errors
   C. Deconditioning
   D. Pressure ulcers
   E. All of the above

2. A risk factor for a poor care transitions outcome is:
   A. Any medical subspecialist visit in the past 30 days
   B. Any outpatient visit in the past 30 days
   C. Any hospitalization in the past 30 days
   D. Any new prescription filled in the past 30 days
   E. All of the above

3. An advance directive:
   A. May be modified at any time
   B. Requires a lawyer or a notary in order to complete
   C. Means that the patient gives up his or her right to make medical decisions
   D. Means “do not resuscitate”
   E. Must be completed in a physician’s office

4. Approximately what percentage of hospital discharge summaries never make it to the primary care physician?
   A. 20 – 30%
   B. 30 – 40%
   C. 0 – 50%
   D. 50 – 60%
   E. 60 – 70%

5. Essential elements of a hospital discharge summary include:
   A. Assessment of cognitive and functional status at the time of discharge
   B. List of tests with pending results and follow-up appointments
   C. Name of hospital physician
   D. Updated medication list
   E. All of the above
Domain 2: Medication management

6. Which of the following medication(s) has been most often associated with delirium, falls and urinary retention in older adults?
   A. Diphenhydramine
   B. Loratadine
   C. Guaifenesin
   D. Fluticasone
   E. Acetaminophen

7. Medication reconciliation should be done:
   A. Upon hospital admission
   B. Upon hospital discharge
   C. During the first post-hospitalization visit
   D. During all primary care and specialist visits
   E. All of the above

8. Which of the following is recommended when prescribing medications for older adults?
   A. “Start low and go slow.”
   B. “Start low and go high.”
   C. “Start fast and go low.”
   D. “Start fast and go high.”
   E. “Stop everything, then restart.”

9. A widely accepted list of medications that may potentially be harmful for older adults is called the:
   A. Malt criteria
   B. Beers criteria
   C. Hops criteria
   D. Barley criteria
   E. Rye criteria
10. The “brown bag” approach, as used by physicians and pharmacists, refers to:
A. Asking the patient to empty her pill boxes into a brown bag
B. Asking the patient to discard all of her unused medications in a brown bag
C. Asking the patient to bring all of her medications to the office visit
D. Asking the patient to carry her medications in a bag for privacy reasons
E. None of the above

**Domain 3: Identification of red flags**

11. The most significant barrier to an effective care transitions is likely to be:
A. Tenth-grade reading level
B. Cognitive impairment
C. A caregiver who is not related to the patient
D. Telephone instead of Internet access
E. All of the above

12. An example of a “red flag” that might signal an avoidable care transition in a patient with heart failure is:
A. Weight gain of ≥ 2 lb. per day
B. Weight gain of ≥ 2 lb. per week
C. Weight gain of ≥ 2 lb. per month
D. Weight gain of ≥ 2 lb. per year
E. None of the above

13. “Index conditions” associated with frequent rehospitalizations include:
A. CHF, COPD, stroke, hip fracture
B. CHF, cellulitis, stroke, osteoporosis
C. CHF, COPD, UTI, osteoporosis
D. CHF, cellulitis, UTI, hip fracture
E. CHF, COPD, stroke, osteoporosis

14. The best available evidence supports care transitions interventions in which the target of the intervention is:
A. The primary care physician
B. The clinic support staff
C. The patient and/or caregiver
D. The medical subspecialist
E. The hospitalist
15. The teach-back method:
A. Involves the physician restating the follow-up plan to the patient
B. Involves the patient restating the follow-up plan to the physician
C. Involves the physician restating the follow-up plan to the nurse
D. Involves the nurse restating the follow-up plan to the physician
E. Involves the patient restating the follow-up plan to the nurse

Domain 4: Primary care and specialist follow-up:

16. The following is required for insurance payment for admission of a patient with Medicare Part A to a skilled nursing facility:
A. An emergency department evaluation
B. A 24-hour hospital observation period
C. A hospitalization that includes 2 nights
D. A hospitalization that includes inpatient rehabilitation services
E. A hospitalization that includes 3 nights

17. Most long-term nursing home care is paid for by:
A. Medicare
B. Medicaid
C. Medicare Advantage plans
D. Private insurance
E. Veterans Administration

18. Ten-fold increased hospital readmission rates have been shown if the following is not done within 4 weeks of discharge:
A. Follow-up with a physical therapist
B. Follow-up with a medical subspecialist
C. Follow-up with a primary care physician
D. Follow-up with a social worker
E. Follow-up with a home care nurse

19. Assisted living type 1 facilities differ from assisted living type 2 facilities in that:
A. Type I facilities require dependence in 2 or fewer ADL
B. Type I facilities require dependence in 2 or fewer IADL
C. Type I facilities exclude patients with tuberculosis.
D. Type I facilities administer medications to residents.
E. Type I facilities arrange for transportation to medical appointments
20. Hospice eligibility under the Medicare benefit is determined by:
A. Two physicians’ certification of a life expectancy of 6 hours or less
B. Two physicians’ certification of a life expectancy of 6 days or less
C. Two physicians’ certification of a life expectancy of 6 weeks or less
D. Two physicians’ certification of a life expectancy of 6 months or less
E. Two physicians’ certification of life expectancy of 6 years or less

Please rate YOUR level of COMFORT in the following areas:

1. Identifying the essential elements that should be documented during care transitions:
   Not very 1 2 3 4 5 Very

2. Reconciling medications during each new care transition:
   Not very 1 2 3 4 5 Very

3. Identifying “red flags” (such as weight gain in patients with heart failure) that may increase risk of hospital readmission during care transitions:
   Not very 1 2 3 4 5 Very

4. Formulating an appropriate follow-up plan for patients who have recently undergone a care transition:
   Not very 1 2 3 4 5 Very

5. Identifying functional status as a barrier that may prevent an effective care transition:
   Not very 1 2 3 4 5 Very

6. In carrying out the role of team leader:
   Not very 1 2 3 4 5 Very
Please rate YOUR PREFERENCE for question 7:
7. Delivering patient care as an individual versus as a member of a team:

Prefer individual 1 2 3 4 5 Prefer team

8. Additional education in my training program about transitions of care would be:

Not at all useful 1 2 3 4 5 Very beneficial

9. Please rate your satisfaction with how you provide care for patients undergoing transitions of care.

Not satisfied 1 2 3 4 5 Completely satisfied

Comments:
ANSWER KEY:

1. E
2. C
3. A
4. A
5. E
6. A
7. E
8. A
9. B
10. C
11. B
12. A
13. A
14. C
15. B
16. E
17. B
18. C
19. A
20. D