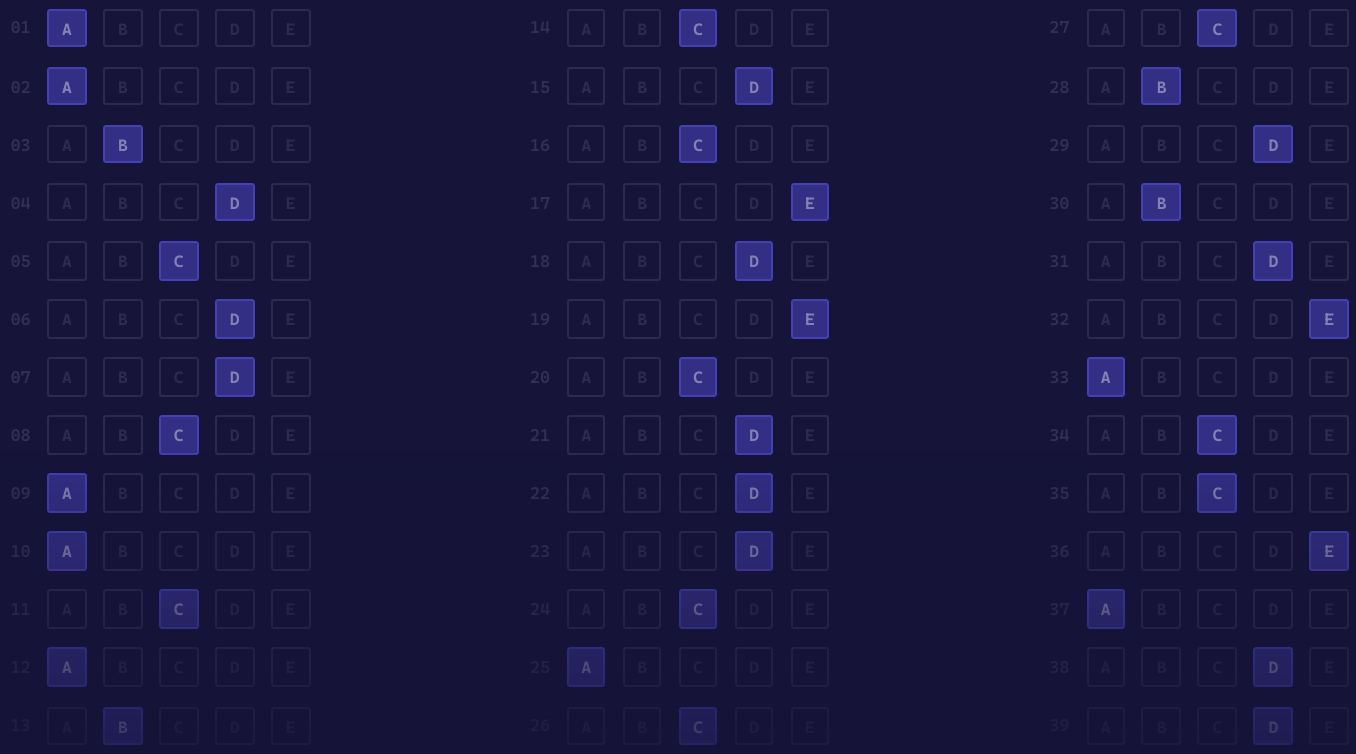
MOMETRIX
SMARTER PREP. BETTER RESULTS.



PRACTICE QUESTIONS

American Nurses Credentialing Center (ANCC)

30FT

Nursing Case Management - Field Test

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

WEB www.mometrix.net

SUPPORT support@mometrix.net

Before you begin

What this is

9 practice questions for American Nurses Credentialing Center (ANCC) `30FT`, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, `30FT`
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

mometrix.net

QUESTION 1 MULTIPLE CHOICE

A nurse case manager is preparing a patient for discharge following a total hip arthroplasty. Which of the following are essential components of the discharge transition plan? (Choose two.)

A **Medication reconciliation including new anticoagulant therapy**

B Scheduling the patient's follow-up appointment with the orthopedic surgeon

C Documentation of the surgeon's intraoperative findings in the operative note

D **Review of the patient's home environment for fall hazards**

ANSWER **A · D**

WHY Correct: A and D. Medication reconciliation is a core case management function at transitions of care to prevent errors, and a post-hip-replacement home safety assessment for fall hazards directly supports recovery and prevents readmission. B (scheduling follow-up) is typically the responsibility of scheduling staff/surgeon's office, not the case manager's core discharge role, though it may be supported. C (operative note documentation) is the surgeon's responsibility, not a discharge planning activity.

mometrix.net

QUESTION 2 MULTIPLE CHOICE

Which of the following actions by the nurse case manager best reflect appropriate utilization management of healthcare resources? (Choose two.)

A **Advocating for an inpatient rehabilitation stay when the patient meets acute rehabilitation criteria**

B Continuing daily acute care hospitalization for a patient awaiting placement in a long-term care facility

C **Facilitating early discharge planning on day one of admission for a patient with a chronic obstructive pulmonary disease exacerbation**

D Ordering additional diagnostic tests not requested by the attending physician

ANSWER **A · C**

WHY Correct: A and C. Advocating for the appropriate level of care based on documented criteria (A) and initiating early discharge planning to prevent unnecessary acute care days (C) are both appropriate utilization management activities. B is inappropriate—acute hospital days are not justified while waiting for long-term care placement, indicating a need for transition planning, not continued acute stay. D is outside the nurse case manager's scope; ordering tests is a prescriptive provider function.

mometrix.net

QUESTION 3 SINGLE CHOICE

Which core concept of case management practice is defined as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources?

A Disease management

B Care coordination

C Utilization review

D Case finding

ANSWER B

WHY Care coordination is the collaborative, patient-centered process of assessing, planning, implementing, coordinating, monitoring, and evaluating services and resources to meet the individual's health needs. It is a foundational competency for nurse case managers. Disease management focuses on specific chronic conditions; utilization review evaluates necessity of services; case finding identifies individuals who may benefit from case management services.

QUESTION 4 SINGLE CHOICE

A nurse case manager is reviewing readmission data for patients discharged with heart failure. Which quality indicator is most appropriate to track for this population?

A 30-day all-cause heart failure readmission rate

B Number of cardiology consults obtained during the index admission

C Average length of stay for the heart failure diagnosis-related group

D Patient satisfaction scores for the nursing unit

ANSWER A

WHY 30-day all-cause readmission rates for heart failure are a widely tracked, evidence-based quality and outcomes measure used by hospitals, payers, and accrediting bodies to evaluate care transitions and case management effectiveness. The other options measure different dimensions (consultation use, efficiency, patient experience) but not the specific transition-of-care outcome relevant to heart failure discharge.

QUESTION 5 SINGLE CHOICE

A patient with decision-making capacity refuses a recommended post-acute rehabilitation stay. The nurse case manager's most appropriate action is to:

A Contact the patient's family to encourage them to override the patient's decision

B Document the patient's informed refusal and discuss safe discharge alternatives

C Request a psychiatric evaluation to determine competency

D Report the patient to adult protective services for self-neglect

ANSWER B

WHY Adult patients with decision-making capacity have the right to refuse treatment, including post-acute placement. The case manager must respect autonomy, document the informed refusal, and work with the patient on safer alternatives. Overriding a capacitated patient's decision violates autonomy (A); capacity is presumed absent contrary evidence (C); refusing recommended care is not self-neglect when capacity exists (D).

QUESTION 6 SINGLE CHOICE

A Medicare beneficiary requires continued intravenous antibiotics for two weeks following hospitalization. The nurse case manager should anticipate that this care is most likely to be covered under which Medicare benefit?

A Medicare Part A skilled nursing facility benefit

B Medicare Part B home health benefit

C Medicare Part D prescription drug benefit

D Medicare Part C hospice benefit

ANSWER B

WHY Medicare Part B covers home health services, including intermittent skilled nursing visits for services such as IV antibiotic administration when the patient is homebound and meets eligibility criteria. Part A covers inpatient/SNF stays; Part D covers outpatient self-administered prescriptions; Part C is an alternative to Original Medicare and does not specifically cover hospice (which falls under Part A).

QUESTION 7 SINGLE CHOICE

During a transition of care from hospital to home, which activity by the nurse case manager best reduces the risk of medication errors?

A Providing the patient with a copy of the discharge medication list at the time of discharge

B Performing medication reconciliation at the time of discharge

C Calling the patient's pharmacy to refill existing prescriptions

D Instructing the patient to continue all pre-admission medications

ANSWER B

WHY Medication reconciliation at transitions of care is the evidence-based intervention shown to reduce medication discrepancies and errors. It involves comparing pre-admission, inpatient, and post-discharge medication regimens. A (handing over a list) is necessary but is a step within reconciliation, not the full risk-reduction activity. C and D do not ensure accuracy and may perpetuate errors.

QUESTION 8 SINGLE CHOICE

A nurse case manager is participating in an interdisciplinary team meeting. Which communication skill is most essential for the case manager to facilitate effective team function?

A Advocating exclusively for the patient's stated preferences regardless of clinical feasibility

B Synthesizing input from multiple disciplines and identifying shared goals

C Documenting only the medical aspects of the patient's plan of care

D Presenting information using discipline-specific clinical terminology only

ANSWER B

WHY Effective case management communication across disciplines requires synthesizing diverse professional perspectives into a coherent plan and aligning shared goals. Advocacy must be balanced with clinical realities (A); documentation must reflect the full plan including psychosocial and functional concerns (C); terminology should be understandable to all team members (D).

mometrix.net

QUESTION 9 SINGLE CHOICE

When developing a care plan for a patient from a culture with collectivist decision-making norms, the nurse case manager should first:

A Document that the patient is non-adherent to Western medical decision-making

B Exclude the patient from decision-making discussions

C Assess the patient's preferences regarding family involvement in healthcare decisions

D C. Request a medical interpreter regardless of the patient's primary language

E D. Require the patient to designate a single legal decision-maker

ANSWER C

WHY Cultural competence begins with assessment of the individual patient's preferences rather than assumptions based on group identity. The case manager should ask the patient how they wish family to be involved. Labeling the patient (A), excluding them (B), or unilaterally imposing structures (D, E) violates individualized, culturally responsive practice.

mometrix.net