M_CCMPQ (1400+ Questions) - Quiz Questions with Answers

1.

When choosing a community vendor to supply durable medical equipment (DME) to a client, the most important factor is:

Reliability.

Proximity.

Quality.

Cost.

Explanation:

While all of these factors are important, reliability is especially important because a reliable vendor usually provides both quality and timely service. Costs may vary somewhat, but the least expensive may not be the best option if equipment is faulty or service is poor. Some community vendors cover a wide area, but this usually poses no problem if they have adequate delivery. Quality is always important, but high quality can sometimes be associated with high costs, so the case manager must determine the level of quality needed. For example, an inexpensive commode chair may be adequate.

2.

Under the CMS Quality Framework for Home and Community Based Services, participant safeguards include:

Licensure and certification of staff.

Right to make decisions.

Incident reporting.

Surveys of outcomes.

Explanation:

The CMS Quality Framework for Home and Community Based Services (HCBS) participant safeguards include a process for incident reporting. Other safeguards include risk assessments (taking into consideration a client's right to choose), monitoring of interventions (behavioral/pharmacological), emergency/disaster preparedness, administration of medications, and monitoring of general health condition. Other areas covered by the framework include participation access, client-centered service planning/delivery, capacity of provider, rights and responsibilities, outcomes and client satisfaction, and system preferences.

3.

A prevention strategy that encourages physicians, nurses, and other healthcare providers to discuss smoking cessation with all adolescents is an example of:

Secondary prevention.

Universal primary prevention.

Indicated primary prevention.

Targeted primary prevention.

Explanation:

Targeted. Primary prevention strategies include:

- *Targeted: Aimed at a select group or subgroup with perceived risk. Strategies may include encouraging physicians to intervene with brief advice, such as advising all adolescents about the dangers of substance abuse.*
- *Universal: Aimed at the entire population, nonspecific. These strategies may include mass-marketing procedures, such as multimedia antidrug campaigns aimed at the general public.*
- *Indicated: Aimed at individuals at high risk, such as adolescents in environments with heavy drug use.*
- *Secondary prevention: Includes efforts to prevent further drug abuse, such as Narcotics Anonymous.*

4.

The method used to determine monetary savings resulting from planned interventions is:

Cost/benefit analysis.

Cost-effective analysis.

Efficacy study.

Cost/utility analysis.

Explanation:

A cost/benefit analysis uses the average cost of an event and the cost of intervention to demonstrate savings. A cost-effective analysis measures the effectiveness of an intervention rather than the monetary savings. Efficacy studies may compare a series of cost/benefit analyses to determine the intervention with the best cost/benefit. They may also be used for

process or product evaluation. Cost/utility analysis (CUA) is essentially a subtype of cost-effective analysis, but it is more complex and the results are more difficult to quantify and use to justify expense because cost/utility analysis measures the benefit to society in general, such as decreasing teen pregnancy.

5.

For quality/performance improvement, the best tool to determine methods to streamline processes is:

Root cause analysis.

Tracer methodology.

Family survey.

Staff survey.

Explanation:

Tracer methodology looks at the continuum of care a client receives from admission to post discharge. A client is selected to be "traced," and the medical record serves as a guide. Tracer methodology uses the experience of this client to evaluate the processes in place through documents and interviews. Root cause analysis (RCA) is a retrospective attempt to determine the cause of an event, often a sentinel event such as an unexpected death or a cluster of events. Root cause analysis involves interviews, observations, and review of medical records. Family and staff surveys can be helpful but may contain less detailed information.

6.

A violation of professional boundaries on the part of the case manager is:

Accepting a box of chocolates to be shared by all unit staff from a client's daughter.

Confiding to the client that he, like the client, is getting a divorce, so he understands the client's stress.

Assisting a client in placing a call to his landlord so the client can explain that he cannot pay the rent on time.

Noticing that a client is crying and placing his hand on the client's shoulder.

Explanation:

The case managers should not disclose personal information, such as impending divorce, because this establishes a social relationship that interferes with their professional role. Small tokens of appreciation that can be shared with other staff, such as a box of chocolates, are usually acceptable (depending upon the policy of the institution), but almost any other gifts (jewelry, money, clothes) should be declined. Assisting a client to place a phone call is not a boundary issue. Touching should be used with care, such as touching a hand or shoulder. Hugging may be misconstrued.

7.

The most critical skill for a case manager collaborating in an interdisciplinary team is:

Patience.

Assertiveness.

Empathy with others.

Willingness to compromise.

Explanation:

While all of these characteristics are important for team members, central to collaboration is the willingness to compromise. In addition, members must be able to communicate clearly, which encompasses assertiveness, patience, and empathy. Teams should identify specific challenges and problems and then focus on the task of reaching a solution. Collaboration is needed in order to pursue the goal of continual improvement. It is essential to actively gather data for evidence-based practice to support roles in health care and share this information with other health professionals.

8.

If a 24-year-old Asian client states a treatment preference but plans to leave the decision to her family members, the case manager should:

Try to convince the client to assert herself.

Recognize that cultural values regarding individualism vary, and respect the client's right to be guided by family.

Tell the family that the client should be the one to make the decision.

Ask the ethics committee to intervene.

Explanation:

Autonomy and self-determination should be viewed within the broad context of diverse cultures. The idea of individualism is less important in some cultures, so the case manager must respect and appreciate the client's right to be guided by her family. Trying to convince the client to assert herself may just lead to emotional conflict. This is not an appropriate concern for the

ethics committee, as the woman is not being forced to comply with family decisions but chooses to do so.

9.

The following act prevents transfer of a client from the ED until the client stabilizes:

The Health Insurance Portability and Accountability Act (HIPAA).

The Emergency Medical Treatment and Active Labor Act (EMTALA).

Americans with Disabilities Act (ADA).

Older Americans Act (OAA).

Explanation:

EMTALA prohibits client dumping from EDs. Stabilization of emergent conditions or active labor must be done prior to transfer, and the client's condition should not deteriorate during transfer. HIPAA addresses the rights of the individual related to privacy of health information. ADA is civil rights legislation that provides the disabled, including those with mental impairment, access to employment and the community. OAA provides improved access to services for older adults and Native Americans, including community services (meals, transportation, home health care, adult day care, legal assistance, and home repair).

10.

An example of documentation that is currently on The Joint Commission's "Do Not Use" list is:

5 mg.

0.5 mg.

15 U.

@.

Explanation:

The abbreviation of U for units is on the "Do Not Use" list. Other prohibited abbreviations/symbols include IU; QD; QOD; MS, MSO, and MgSO4 for morphine or magnesium sulfate; and trailing zeros (4.0 mg) and lack of a leading zero (.4 mg). Additional abbreviations/symbols are allowed but under consideration for future prohibition. These include <, >, @, cc, μg, and abbreviations of drug names (such as TCN for tetracycline). Using the correct word or term is always better than using an abbreviation, which may be misunderstood, especially if the handwriting is not clear.

11.

If all clients who develop urinary infections with urinary catheters are evaluated per urine culture and sensitivities for microbial resistance, but only those clients with clinically evident infections are included, this is an example of:

Information bias.

Selection bias.

Compliance bias.

Admission bias.

Explanation:

This is an example of selection bias because those with catheters without clinically evident infections are excluded. The results are skewed because many clients may have subclinical infections. Information bias occurs when there are errors in classification, so an estimate of association is incorrect. Information bias may be nondifferential or differential. Compliance bias occurs when adherence to protocol is inconsistent. Admission bias occurs when some groups, such as spinal cord injury clients, are omitted from the study.

12.

The National Patient Safety Goals communication requirements related to telephone orders or reports include:

The receiver "reading back" the orders or report.

The receiver repeating each part of an order or report as it's given.

The individual giving orders or reports asks if information is understood.

The individual giving orders or reports repeats each item twice.

Explanation:

The NPSG's requirement for telephone orders or reporting requires that after the information is received and documented, the receiver "read back" the information to ensure that it was heard and documented correctly. Other communication requirements include using a list of approved abbreviations and avoiding unclear or ambiguous abbreviations, acronyms, symbols, or dose designations. Reporting should be done in a timely manner, and the organization should have a standardized manner of hands-off communication that allows for a time to ask/answer questions.

13.

The most significant challenge to community-based case managers is:

The acutely ill.

Pediatric clients.

Mothers and infants.

The chronically ill.

Explanation:

The most significant challenge for community-based case managers is the chronically ill because clients with chronic illnesses may have multiple needs, and needs often continue to evolve and increase as the disease progresses. Insurance and Medicare/Medicaid coverage is often inadequate, even though the chronically ill often utilize healthcare resources at a rate higher than others because of their inability to self-manage their conditions. In some cases, the chronically ill may become dependent on healthcare providers, so educating and supporting clients to remain independent are critically important.

14.

A necessary component of informed consent prior to a procedure is:

Names of assisting staff members.

Beginning and ending times.

Risks and benefits of the procedure.

Facility statistics regarding the procedure.

Explanation:

Clients and family should be apprised of all reasonable risks and any complications that might be life-threatening or increase morbidity as well as benefits. The American Medical Association has established the following guidelines for informed consent:

- *Explanation of diagnosis*
- *Nature and reason for treatment or procedure*
- *Risks and benefits*
- *Alternative options (regardless of cost or insurance coverage)*
- *Risks and benefits of alternative options*
- *Risks and benefits of not having a treatment or procedure*
- *Providing informed consent is a requirement of all states*

15.

When instituting a plan for risk management, the primary concern in the statement of purpose should be:

Reduction in financial risk.

Client safety.

Decreased liability.

Scope of program.

Explanation:

Client safety should always be the primary concern for risk management. Reduction of financial risks and liability relate directly to client safety. A risk management plan should include:

- *Goals: Specific and measurable*
- *Program scope: Should include linkage with other programs*
- *Line of authority: Beginning with the governing board and ending with employees*
- *Policies: This should include confidentiality and conflict of interest*
- *Data sources and referrals: Types of measures*

- *Documentation/reporting: The responsibility for reporting should be clarified and the frequency of reports*
- *Activities integration*
- *Evaluation of program: The method and frequency of evaluation*
- *Charts/diagrams: Flow charts, organizational charts, and diagrams*

16.

The Mini-Cog Test to assess for dementia includes:

Counting backward from 100 by 7s.

Copying a picture of interlocking shapes.

Following simple three-part directions.

Drawing the face of a clock with the hands indicating a specified time.

Explanation:

The Mini-Cog Test to assess for dementia has two components:

- *Drawing the face of a clock with all 12 numbers and the hands indicating the time specified by the examiner*
- *Remembering and later repeating the names of three common objects*

The Mini-Mental State Exam includes:

- *Remembering and later repeating the names of three common objects*
- *Counting backward from 100 by 7s or spelling "world" backward*
- *Naming items*
- *Providing the address and location of the examiner*
- *Repeating common phrases*
- *Copying a picture of interlocking shapes*
- *Following simple three-part instructions*

17.

Outcomes are derived from:

Client, nurse, and system.

Client only.

Clients, physicians, and nurses.

Nurse only.

Explanation:

Outcomes are derived from client, nurse, and system:

- *Client: Trust in the healthcare provider based on perceived caring and competency is an essential outcome and links with the functional ability of the client and the quality of life.*
- *Nurse: Measurable outcomes are associated with nursing and include physiological changes, occurrence or prevention of infection, and effectiveness of nursing care and treatments.*
- *System: Outcomes relate to the delivery of care that is consistently both high quality and cost-effective. This includes data regarding rates of rehospitalization, length of hospitalization, and optimal utilization of resources linked to cost data.*

18.

A community resource that can provide nursing and personal care in the home is:

Public health department.

Home health agency.

Social services.

Senior citizens' organization.

Explanation:

The home health agency provides medical and personal care to clients who are homebound and unable to care for themselves. Public health departments offer vaccinations and various clinics. Nurses may visit people with communicable diseases, such as tuberculosis, but they do not provide general medical or personal care. Social services agencies have social workers who can evaluate people's ability to remain independent, determine if abuse is occurring, and help provide financial support for the needy. Senior citizens' organizations vary widely but usually offer social services, such as classes and activities.

19.

The primary focus of a risk mitigation program is:

To decrease adverse patient outcomes and reduce liability.

To improve processes of care.

To improve patient outcomes.

To adhere to professional standards.

Explanation:

The primary focus of a risk mitigation program is to decrease adverse patient outcomes and reduce liability, so it involves identifying potential risks, such as patient safety issues, and resolving these before they result in litigation or excess costs. Risk mitigation programs usually derive from adverse effects identified retrospectively by risk management. Examples of risk mitigation programs include deep vein thrombosis (DVT) prophylaxis, infection control

surveillance, review of patient flow activities, hand hygiene, methicillin-resistant Staphylococcus aureus (MRSA) screening, and pressure ulcer prevention programs.

20.

The governmental agency responsible for bloodborne pathogens standards in medical institutions is:

CDC.

OSHA.

EPA.

FDA.

Explanation:

The Occupational Safety and Health Administration (OSHA), under the Department of Labor, is responsible for bloodborne pathogens standards as well as other workplace standards and inspection of workplaces to ensure safety standards are met. The Centers for Disease Control and Prevention (CDC) provides treatment guidelines and recommendations and monitors public health, compiling statistics regarding reportable disease. The Environmental Protection Agency (EPA) is not a statutory agency but provides information about the environment to other governmental agencies. The Food and Drug Administration (FDA) is a consumer protection agency ensuring safety of medications, biological products, medical devices, and food.

21.

With the continuous quality improvement (CQI) model, the focus of improvement is on:

Processes.

Staff.

Administrative personnel.

Clients.

Explanation:

CQI emphasizes the organization, systems, and processes within that organization rather than individuals. It recognizes internal customers (staff) and external customers (clients) and utilizes data to improve processes, recognizing that most processes can be improved. CQI uses the scientific method of experimentation to meet needs and improve services and utilizes various tools, such as brainstorming, multivoting, various charts and diagrams, storyboarding, and meetings. Core concepts include:

- *Quality and success are defined by meeting or exceeding internal and external customers' needs and expectations.*
- *Problems relate to processes, and variations in process lead to variations in results.*
- *Change can be incremental.*

22.

When developing guidelines for evidence-based practice, the weakest justification for establishing a procedure is:

Evidence review.

Staff preference.

Policy considerations.

Expert judgment.

Explanation:

Staff preference is subjective and is the weakest justification for establishing a procedure. Evidence review includes review of literature, critical analysis of studies, and summarizing of results, including pooled meta-analysis. Expert judgment, recommendations based on personal experience from a number of experts, may be utilized, especially if there is inadequate evidence based on review, but this subjective evidence should be explicitly acknowledged. Policy considerations include cost-effectiveness, access to care, insurance coverage, availability of qualified staff, and legal implications.

23.

Viatical settlements primarily benefit:

Beneficiaries.

Healthcare providers.

Insurance companies.

Policyholders.

Explanation:

Viatical settlements benefit the policyholders of life insurance policies. A policyholder essentially sells the policy to a third party so the policyholder can obtain cash to use for care. Beneficiaries must sign a release. HIPAA waives taxes if the policyholder's life expectancy is <24 months but there may be state or local taxes. Added income may interfere with Medicaid benefits. Up to 6 weeks may be necessary before settlements are completed, so those with a very short life expectancy may not benefit.

24.

The primary purpose of negotiation in case management practice is to:

Control costs and provide medically necessary services.

Avoid conflict and promote cooperation.

Educate participants.

Represent the payor’s interests.

Explanation:

While all of these factors are important to varying degrees, the primary purpose of negotiation in case management practice is to control costs and provide medically necessary services. Cost control was an important factor in developing the case management model, but this must be balanced with providing medically necessary care at the appropriate level. Negotiation can avoid the problems that arise if care is denied. Additionally, negotiation allows participants, including the case manager, to learn new information or learn reasons for decisions or requests.

25.

The model for managed care that provides services at discounted rates to those enrolled is:

Health maintenance organization (HMO).

Point of service plan (POS).

Preferred provider organization (PPO).

Exclusive provider organization (EPO).

Explanation:

An EPO provides services at discounted rates to those enrolled. An HMO provides a prepaid contract between healthcare providers, payors, and enrollees for specified services in a specified time period, provided by a list of providers. A POS is a combination of HMO and PPO structures such that people can receive service in the network but can opt to seek treatment outside the network in some situations. PPOs involve healthcare providers who have agreed to be part of a network that provides services to an enrolled group at reduced rates of reimbursement. Care received outside the network is usually only partially paid for.

26.

The model for health maintenance organizations in which the HMO hires physicians to work in clinic-type settings is:

Group model.

Network model.

Staff model.

Direct contact model.

Explanation:

HMO models:

- *Staff: The HMO hires physicians to work in clinic-type settings. This cost-effective method limits access.*
- *Group: The HMO contracts with multispecialty physician groups, allowing the client more choices.*
- *IPA: The HMO contracts with an independent practice association (IPA) to provide physicians in various specialties. These physicians may see non-HMO clients as well.*

- *Network: The HMO contracts with different physicians and groups in various locations to improve access.*
- *Direct contact: The HMO contracts directly with physicians to provide services rather than through an IPA.*

27.

Medicare B benefits include:

Hospitalization (acute care).

Skilled nursing facility care.

Clinical laboratory services.

Hospice care.

Explanation:

Medicare B benefits include:

- *Clinical laboratory services*
- *Medical expenses, including doctor, surgical, and medical services/supplies including durable medical equipment and various therapies (speech, physical, occupational)*
- *Home health care*
- *Outpatient hospital treatment, including diagnostic tests and treatment, ambulatory surgery, mental health services, ambulance services, and administration of blood products*

Medicare A benefits include hospitalization (acute care) with all necessary hospital services and supplies, skilled nursing facility care, hospice care, and administration of blood products.

28.

The healthcare insurance reimbursement system that involves an advanced fixed monthly payment to a provider is:

Per-diem reimbursement.

Fee-for-service.

Pay-for-performance.

Capitation.

Explanation:

Capitation is a healthcare reimbursement system in which providers receive fixed monthly payments in advance of services, based on a negotiated rate. Capitation rates may vary widely. Pay-for-performance reimbursement is a system in which providers receive cash incentives to meet specific outcomes (such as reduced infections). Per-diem reimbursement provides a fixed daily dollar amount for services, regardless of actual costs. Different types of services may receive different per-diem rates. Fee-for-service reimbursement is the traditional system in which providers bill for series provided. This is the most costly type of reimbursement.

29.

The Agency for Healthcare Research and Quality (AHRQ)'s Quality Indicators (QIs) that measure the quality of care for disorders sensitive to outpatient care (with good care reducing the need for hospitalization) are:

Prevention QIs.

Inpatient QIs.

Patient safety indicators (PSIs).

Pediatric QIs.

Explanation:

Prevention QIs measure the quality of care for disorders (such as diabetes and heart disease) sensitive to outpatient care, with good care reducing the risk of complications and the need for hospitalization. Inpatient QIs measure the quality of care within a hospital and include morbidity and mortality rates for different disorders, utilization of procedures, and volumes of procedures. PSIs measure complications and adverse events in hospitals related to surgery, procedures, and labor and delivery. Pediatric QIs measure adverse effects of healthcare exposure in the pediatric population.

30.

Core measures for Centers for Medicare & Medicaid Services (CMS) include measures related to:

Cancer.

Brain injuries.

Asthma care for children.

Alzheimer's disease.

Explanation:

CMS core measures include three measures concerning asthma care for children (not adults): relievers (age related), corticosteroids (age related), and plan of care for home management. Additional core measures include eight measures to utilize for care of heart attacks, four measures to care for heart failure, seven measures to care for pneumonia, and five measures to prevent surgical infections. Core measures include standardized procedures to improve the

quality of care in hospitals by focusing on outcomes. Hospitals are evaluated based on the percentage rate of compliance.

31.

URAC case management accreditation standards require healthcare organizations, such as managed care programs, to establish processes to:

Assess, plan, and implement case management interventions.

Evaluate outcomes of case management interventions.

Conduct peer reviews of case management interventions.

Cut costs of case management interventions.

Explanation:

URAC (formerly Utilization Review Accreditation Commission) in conjunction with the Case Management Society of America (CMSA) developed case management accreditation standards that require healthcare organizations, such as managed care programs, to establish processes to assess, plan, and implement case management interventions. Categories for assessment include staff structure and organization, staff management/development, quality improvement processes, case management processes, delegation oversight, ethics, and complaint procedures. Policies must be in place to protect the rights of the clients, such as policies for informed consent, conflict resolution, and confidentiality.

32.

The healthcare accreditation agency that assists purchasers of health plans and consumers to evaluate the performance of health plans is:

Centers for Medicare & Medicaid Services (CMS).

The Joint Commission (formerly JCAHO).

URAC.

National Committee for Quality Assurance (NCQA).

Explanation:

The NCQA administers the Healthcare Effectiveness Data and Information Set (HEDIS) to measure performance of healthcare plans and to help identify plans that provide competent care. NCAQ collects data to demonstrate comparability and consistency in various health plans. Accreditation categories include quality improvement, physician credentials, members' rights/responsibilities, preventive services, utilization management, and medical records. HEDIS categories include effectiveness of care, accessibility and availability of care, satisfaction, cost of care, informed decision-making, use of services, plan description, and health plan stability.

33.

The government agency that regulates protection of human subjects involved in research projects for experimental treatments is:

FDA.

OSHA.

CMS.

CDC.

Explanation:

The Food and Drug Administration, Code of Federal Regulations, Title 21, Volume 1, regulates protection of human subjects and states that any researcher involving clients in research must obtain informed consent, in language understandable to the client or the client's agent. The elements of this informed consent must include an explanation of the research, the purpose, and the expected duration as well as a description of any potential risks. Potential benefits must be described and possible alternative treatments. The client must be informed that participation is voluntary and that he/she can discontinue participation at any time without penalty.

34.

Eligibility criteria for Supplemental Security Income (SSI) for those with low income and few resources include:

Deafness.

Age 55 or older.

Chronic pain.

Blindness.

Explanation:

Supplemental Security Income (SSI) is additional money paid each month to those who are over 65, blind, or disabled with low incomes and few resources. Recipients are allowed only to own their homes and a car, have $1500 in funds set aside for burial and $2000 (single) or $3000 (couple) in savings. While chronic pain may be associated with a disability, pain alone does not

qualify a person for SSI unless it results in a disability that severely impairs function, may result in death, and has persisted, or is expected to persist, for 12 months or more.

35.

A requirement for participation in a pharmacy assistance program usually includes:

Prescription insurance coverage or Medicare D.

Generic prescriptions only.

U.S. residency.

Income of less than 200% of federal poverty level.

Explanation:

While pharmacy assistance plans may vary somewhat from one drug company to another, most set an income limit of less than 200% of the federal poverty level. Many drug companies preclude those with prescription insurance coverage or Medicare D, but some will consider these applicants. Programs usually cover brand name prescription drugs. In most cases, U.S. residency alone is not sufficient; people must be citizens or legal immigrants. Pharmacy assistance programs offer people free drugs or low-cost drugs if the drugs are medically necessary and people cannot afford to purchase them.

36.

Guidelines for eligibility and reimbursement in Medicaid programs are established by:

The Social Security Administration.

Individual counties.

State consortia.

Individual states.

Explanation:

Medicaid programs are administered by individual states, which establish eligibility and reimbursement guidelines, so benefits vary considerably from one state to another. Medicaid is a combined federal and state welfare program authorized by Title XIX of the Social Security Act to assist people with low income with payment for medical care. This program provides assistance for all ages, including children. Older adults receiving SSI are eligible as are others who meet state eligibility requirements.

37.

Under the chronic care model, the primary purpose of utilizing community resources is to:

Identify client needs.

Improve client's self-management skills.

Reduce the need for rehospitalization.

Reduce costs.

Explanation:

In the chronic care model, community resources promote the essential element of self-management in conjunction with health systems and organizations, which provide a system of

delivery, decision support, and clinical information systems. These work together to allow interactions between an informed client and a proactive team to improve client outcomes. Improved outcomes may include reducing the need for rehospitalization, identifying and anticipating client needs, and reducing costs.

38.

If a client has only Medicare and no supplementary insurance and her physician accepts Medicare, the client's out-of-pocket cost for care will be:

Nothing.

10%.

20%.

80%.

Explanation:

Out-of-pocket costs are 20%. Medicare, a federal health insurance program for those who have Social Security or bought into Medicare, provides payment to private healthcare providers, such as physicians and hospitals, but limits reimbursement. Physicians receive 80% of usual customary and reasonable (UCR) fees if they accept Medicare assignment. If they do not, they can charge up to 115% of what Medicare allows. Clients are responsible for the remaining 20% or up to 115% if their physicians do not accept Medicare.

39.

A client with both Tricare and Medicare may avoid hospitalization in a Veterans' Affairs medical facility because:

Tricare and Medicare combined reimburse for only 80% of costs.

The VA can bill neither Tricare nor Medicare.

The VA cannot bill Tricare.

The VA cannot bill Medicare.

Explanation:

Those eligible for both Tricare and Veterans' Affairs (VA) programs may receive care at VA medical facilities if the service is covered under Tricare and the facility is part of the Tricare network, but the VA cannot bill Medicare, so costs not covered by Tricare must be paid by the client. For those with Medicare, Tricare becomes the secondary insurer. If clients opt out of Medicare, Tricare pays the amount equivalent to a secondary insurer (20% of allowable), and the client is responsible for the rest. By law, all other insurances must pay before Tricare.

40.

Criteria for Social Security Disability Insurance (SSDI) include a physical/mental disability as well as:

Restriction in employment ability.

Age >65.

Limited income.

Expectation of permanent disability.

Explanation:

Criteria for Social Security Disability Insurance (SSDI) include a physical/mental disability, which may be temporary (at least 12 months) or permanent (until death) but restricts the person's ability to be gainfully employed. SSDI is available for people under age 65. While SSI has income requirements, SSDI does not. People younger than age 22 may receive SSDI based on parent's work credits, but most people must have accumulated at least 20 Social Security credits over the preceding 10 years for those up to age 42 for eligibility. Those older than age 42 must have one additional Social Security credit for each year of age.

41.

A specified dollar amount that a client must pay at the time of receiving healthcare services is a:

Premium.

Copayment.

Deductible.

Coinsurance.

Explanation:

Out-of-pocket expenses include a copayment, which is a specified dollar amount a client must pay at the time of receiving healthcare services, such as a fee of $20 for each physician visit. A premium is the monthly cost of an insurance plan. Coinsurance is a secondary insurance policy to cover expenses not covered by the primary insurance, such as supplementary insurance plans used in addition to Medicare. A deductible is a specified dollar amount that must be paid each year before the insurance plan covers costs, such as a $150 annual deduction.

42.

If a child has been hospitalized three times in 12 months with acute asthma because of noncompliance with the treatment regimen, the best initial action of the case manager is:

Make a referral to child protective services (CPS).

Reprimand the parents.

Suggest a change in treatment regimen.

Question the reasons for noncompliance.

Explanation:

The case manager should begin by questioning the reasons for noncompliance to determine the most effective course of action. If the parents are clearly negligent, then a referral to CPS may be indicated, but often noncompliance relates to lack of education about the disease or treatments or lack of adequate financial resources. If caregivers work and the child is expected to do treatments independently, or the child is left with a sitter unfamiliar with the treatment regimen or necessity of maintaining the regimen, then these factors may result in unintentional noncompliance.

43.

An affidavit of merit is usually filed to:

Support a lawsuit for malpractice.

Refute a lawsuit for malpractice.

Reward excellence in service.

Confer accreditation.

Explanation:

An affidavit of merit is usually filed to support a lawsuit for malpractice. In most states, it must be filed at the time the lawsuit is filed or shortly afterward. A person in the same profession as the defendant swears under oath that there is reasonable cause to proceed and that the evidence suggests that the lawsuit will be successful. This professional may or may not be the same person who provides expert witness testimony during the trial.

44.

The most appropriate rehabilitation placement for a 72-year-old woman who lives alone and had a hip replacement five days earlier is:

Rehabilitation in an acute hospital.

Rehabilitation in the provider's office.

Rehabilitation in her home.

Rehabilitation in a skilled nursing/rehabilitation facility.

Explanation:

A skilled nursing/rehabilitation facility is the most appropriate placement. Unless the client develops complications, continued therapy in the acute care hospital is costly and unnecessary. Home rehabilitation is not appropriate at this stage of recovery because the client lives alone and will still need help with ADLs and exercises. Rehabilitation in a provider office is not appropriate because the client should not yet be alone and has probably not learned to transfer in and out of a vehicle at this early date and would need transportation assistance.

45.

For a client with peripheral arterial disease (PAD), an ankle-brachial index (ABI) score of 0.37 indicates:

A limb-threatening condition, with pain at rest.

Mild narrowing of one or more blood vessels.

A normal reading, likely asymptomatic.

Possible calcification of vessel walls.

Explanation:

An ABI score of 0.37 (<0.4) indicates a limb-threatening condition, with pain at rest:

Ankle-brachial index score

>1.3	*Abnormally high; may indicate calcification of vessel wall*
0.9-1.3	*Normal reading; asymptomatic*
0.4-0.9	*Mild to moderate PAD (narrowing of one or more leg blood vessels)* *<0.8 is often associated with intermittent claudication during exercise*
<0.4	*Severe disease and ischemia; pain is present even at rest; limb threatened*
<0.25	*Critical limb-threatening condition*

46.

Under InterQual's ISD criteria of severity of illness (SI) reflecting the need for acute hospitalization, onset of symptoms within one week is categorized as:

Acute/sudden onset.

Recently or newly discovered.

Recent onset.

Newly discovered.

Explanation:

Recent onset under ISD criteria of SI is onset of symptoms within one week. Other criteria include:

- *Acute or sudden onset meaning symptoms occurred within 24 hours.*
- *Recently discovered meaning symptoms occurred after one week.*
- *Newly discovered meaning symptoms occurred during the current episode of sickness.*

InterQual's ISD criteria refer to intensity of service (IS), severity of sickness (SS), and discharge screening (DS) regarding the client's stability for discharge. InterQual criteria are used for utilization review and management of clients receiving Medicare and Medicaid benefits.

47.

For a client with a chronic mental health disorder, recovery means:

Absence of symptoms.

Discontinuation of mental health service.

Coping with symptoms and problems.

Independence in meeting individual needs.

Explanation:

Recovery for a person with a chronic mental health disorder means that the client is able to cope with symptoms and problems. In most cases, some symptoms will persist, and clients may still need the intervention of mental health services and may never achieve complete independence in meeting individual needs. The goal of recovery is to allow the client to function to the best of his/her ability with the least amount of supervision and intervention.

48.

Client empowerment primarily requires:

Options, authority, and action.

Time and effort.

Intellectual capacity.

Institutional support.

Explanation:

Client empowerment requires that the client have options, so whenever possible, the case manager should present more than one choice when decisions must be made. The second requirement is the authority to make decisions. In many cases, clients may assume that the authority lies with others in the healthcare system and don't realize that they have the ultimate

authority. The last requirement is action. The case manager should support clients in making decisions about their own care.

49.

Threatening to injure and withhold food and clothes from a person who is uncooperative is an example of:

Physical abuse.

Psychological abuse.

Neglect.

Financial abuse.

Explanation:

Psychological abuse includes threats and intimidations. Caregivers may make frequent threats to hit the person, sometimes brandishing a weapon if the person doesn't cooperate. Ongoing intimidation may make the person terrified and anxious. Sometimes, caregivers threaten to injure pets or family members, increasing the person's fear. Physical abuse includes various types of assaults related to hitting, biting, kicking, pulling hair, shoving, and pushing. Financial abuse can include fraud, outright stealing, and forcing people to sign away property. Neglect, failure to provide basic needs, may be active/intentional or passive/unintentional.

50.

Medication reconciliation should be completed:

Prior to admission.

During the admission assessment.

On discharge.

During all phases of care.

Explanation:

Medication reconciliation should be an ongoing process during all phases of care. Medication reconciliation includes making a list of all current medications (dose and frequency), including herbs and OTC drugs and vitamins, as well as drug allergies or intolerances. This list should be posted prominently in the patient's chart so physicians can check the list whenever ordering medications. The patient must receive a new/revised list on discharge with thorough explanation of any changes and access to drug information and the advice of a pharmacist.

51.

If the case manager observes an elderly patient in an assisted living facility is unkempt, dehydrated, and fearful, and has a number of unexplained bruises, the case manager's most appropriate response is to:

Notify the owner of the facility.

Reprimand caregivers.

Notify appropriate state authorities, such as adult protective services.

Arrange for transfer to another facility.

Explanation:

As a mandatory reporter, the case manager should notify appropriate state authorities, such as adult protective services, of the probability of elder abuse. Additional steps, such as notifying the physician or facility owner or even transferring the client, may be necessary to ensure the health and safety of the client, depending on the extent of abuse or neglect. Reprimanding the caregivers may result in their "punishing" the client and may be directed at the wrong caregivers unless the case manager has directly observed abuse.

52.

According to InterQual's ISD discharge reviews, the appropriate discharge documentation of a client admitted with a WBC of 15,000 and temperature of 39.8 °C is:

"Client stable."

"Infection cleared."

"Client's laboratory findings and temperature within normal limits."

"WBC 7,000 and temperature 37 °C."

Explanation:

Discharge documentation should note improvements related to symptoms or findings present on admission, so "WBC 7,000 and temperature 37 °C" provides the most specific information regarding the change in condition. General statements, such as "stable" and "within normal limits" should be avoided. Discharge documentation is especially important if clients need to be readmitted, as this may become an issue for risk management as it may reflect poor quality of care or too early discharge for status.

53.

An important purpose of a critical pathway is to:

Allow flexibility.

Focus on one discipline.

Establish accountability.

Reduce/prevent variations in care.

Explanation:

Critical pathways provide a tool for patient management that reduces variations in care. Critical pathways are diagnosis-, procedure-, or condition-specific care plans developed for multiple disciplines, outlining steps in care and expected outcomes. The pathways outline goals in patient care as well as the sequence and time of interventions to achieve those goals. They may be developed for physician care or nursing care. Increasingly, critical pathways are being developed as a method to improve and standardize care and decrease hospital stays.

54.

The first step in negotiation for a case manager should be:

Statement of problem.

Discussion.

Research.

Statement of financial limits.

Explanation:

The first step in negotiation for a case manager should be research to determine current market values and utilization. The case manager must go to negotiations prepared with facts and figures. Aggressively starting with financial limits or demands about costs is counterproductive, especially if they are unrealistic. Once research is completed, then the case manager can give a statement of the problem and the elements needed to solve the problem (such as the need for physical therapy at a skilled nursing facility). Clear, honest, open communication is essential. After an agreement is attained, the resolution should be placed in writing and signed by all participants.

55.

A case manager who is contracted by an individual or family to manage healthcare needs and services is a(n):

Private case manager.

Independent case manager.

Community-based case manager.

Internal case manager.

Explanation:

A private case manager is contracted by an individual, family, or insurance company to manage healthcare needs and services. Private case managers represent the company or individual that hires them and try to meet those needs within an ethical framework. When representing an individual, the case manager may assist the transition along the continuum of care and monitor services and outcomes. Private case managing is a form of external (non-hospital-based) management. Independent case managers work for independent case management firms rather than individuals or companies directly.

56.

The Milliman care guidelines that can be used for clients with very complex medical situations that do not easily fit into other guidelines are:

General recovery guidelines.

Inpatient and surgical care guidelines.

Chronic care guidelines.

Ambulatory care guidelines.

Explanation:

General recovery guidelines can be used with clients with very complex medical situations that do not fit into other guidelines. Milliman guides cover a wide range of topics for different levels of care. The guidelines provide specific information needed by case managers to determine if care is appropriate. For example, the coronary artery bypass graft (CABG) guideline provides detailed information about needs: preoperative, acute, recovery facility, home, and risk factor reduction as well as lists of interventions and equipment needed on days one to four.

57.

With mandatory beneficiary ownership of capped rental durable medical equipment (DME), once ownership has passed to the beneficiary, Medicare will pay for:

Routine service and maintenance.

Only repairs necessary to make the DME serviceable.

All routine service and repairs.

No service or repairs.

Explanation:

Once DME ownership is transferred to a beneficiary, Medicare will pay only for repairs necessary to make the DME serviceable. Medicare no longer pays for routine service or maintenance of DME and now requires that ownership be transferred after specified periods of rental (13 months for most capped DMEs and 36 months for oxygen equipment), after which the cost of rental exceeds the cost of purchase. During the rental period, Medicare also no longer pays for routine service or maintenance, as these are considered covered by the rental fee.

58.

According to Tuckman's group developmental stages, the stage in which members express positive feelings toward each other is:

Forming.

Storming.

Norming.

Performing.

Explanation:

Norming. Tuckman's group development stages:

- *Forming: Leader lists the goals and rules and encourages communication among the members.*

- *Storming: This stage involves a divergence of opinions regarding management, power, and authority. Storming may involve increased stress and resistance as shown by absence, shared silence, and subgroup formation.*
- *Norming: Members express positive feelings toward each other and feel deeply attached to the group.*
- *Performing: The leader's input and direction decreases and mainly consists of keeping the group on course.*
- *Mourning: This is common in closed groups when discontinuation nears and in open groups when the leader or other members leave.*

59.

If a client recently discharged from rehabilitation for substance abuse calls the case manager crying and states she is going to kill herself, the best response is to:

Advise the client to hang up and call the suicide prevention line.

Conclude the call and call 9-1-1.

Keep the client on the line and ask another individual to call 9-1-1.

Put the client on hold and call 9-1-1.

Explanation:

If a client recently discharged from rehabilitation for substance abuse calls the case manager crying and states she is going to kill herself, the best response is to keep the client on the line and ask another individual to call 9-1-1. It's important to keep the client talking and to encourage the client to talk about her distress and the reasons she is feeling suicidal. Engaging the client can help to defuse the situation until first responders can arrive.

60.

If a mental health client must attend court-ordered Alcoholics Anonymous® (AA) meetings but tells the case manager that it's a waste of his time and that he is only going because he is forced to because he doesn't have a drinking problem, the most appropriate response is:

"You should try to benefit from the meetings."

"It's good that you are attending regularly."

"AA can help you accept that you have a drinking problem."

"You were driving drunk, so you do have a problem."

> ***Explanation:***
>
> *If a mental health client must attend court-ordered Alcoholics Anonymous® (AA) meetings but tells the case manager that it's a waste of his time and that he is only going because he is forced to because he doesn't have a drinking problem, the most appropriate response is, "It's good that you are attending regularly." This provides positive feedback for what the client is actually doing without challenging the client's insistence that he has no drinking problem.*

61.

If the case manager is evaluating the facility's assessments and policies for fall risks in response to a suit against the facility for a client injury, the type of indicator the case manager is researching is a:

Clinical indicator.

Financial indicator.

Productivity indicator.

Quality indicator.

Explanation:

If the case manager is evaluating the facility's assessments and polices for fall risks in response to a suit against the facility for a client injury, this type of indicator the case manager is researching is a clinical indicator because it relates to nursing practices and client care. A clinical indicator is a measure to evaluate the quality of client care and to determine if modifications in practice are needed to ensure quality care and client safety.

62.

A factor that is not generally part of caseload calculation is:

Client acuity.

Practice setting.

Risk stratification.

Client gender.

Explanation:

Client gender is a factor that is not generally part of caseload calculation although, in some instances, the case manager may be serving a population of only one gender (such as pregnant women). A number of different software programs are available to help to calculate caseload. Factors often considered include client acuity, risk stratifications, practice setting, type of record keeping required, type of supervision, and type of care management in addition to any other responsibilities that the case manager may have.

63.

When considering the cost effectiveness of case management, soft savings can include:

A client who transferred from an acute care hospital to a skilled nursing facility.

A client who loses weight and controls diabetes, resulting in fewer emergency room visits.

A client who switches from brand name medications to generic.

A client who stops curative treatments and enters hospice care.

Explanation:

When considering the cost effectiveness of case management, soft savings can include a client who loses weight and controls diabetes, resulting in fewer emergency room visits. With soft savings, it's not possible to calculate a specific dollar amount of savings because it's impossible to know exactly how many emergency department visits the client would have made if the client had not made changes. However, a review of past records can give some indication of savings. Hard savings are those in which a dollar amount can be calculated, such as with a transfer from an acute care hospital to a skilled nursing facility.

64.

If a client is transferred from an acute care hospital to an inpatient rehabilitation center, the client must be able to participate in therapy for a minimum of:

1 hour daily.

3 hours daily.

5 hours daily.

6 hours daily.

Explanation:

If a client is transferred from an acute care hospital to an inpatient rehabilitation center, the client must be able to participate in therapy for a minimum of 3 hours daily. The type of therapy may vary but may include speech therapy, occupational therapy, and physical therapy. Clients may also have access to counselors, nutritionists, and social workers. Length of stay varies but is usually 10 to 14 days although some clients will need a longer stay.

65.

If a 56-year-old client has recovered well from a heart attack and is to undergo cardiac rehabilitation, the best option for the client is likely:

Outpatient rehabilitation program.

Inpatient rehabilitation center.

Subacute care facility.

Skilled nursing facility.

Explanation:

If a 56-year-old client has recovered well from a heart attack and is to undergo cardiac rehabilitation, the best option for the client is likely an outpatient rehabilitation program. The goal of cardiac rehabilitation is preventive, to lower the risk of further cardiac problems. In addition to physical exercise to increase aerobic capacity, increase strength, and improve

flexibility, the client may receive additional services, such as nutritional guidance and smoking cessation.

66.

If a 46-year-old client with cerebral palsy receiving SSDI and Medicare has not worked for pay for 8 years but is interested in doing computer work from home using assistive devices, the case manager should advise the client that:

He would lose all of his government benefits if he is employed.

He should apply to the Ticket to Work program.

Reapplying is a difficult process if he can no longer work.

There are few jobs that involve working from home.

Explanation:

If a 46-year-old client with cerebral palsy receiving SSDI and Medicare has not worked for pay for 8 years but is interested in doing computer work from home using assistive devices, the case manager should advise the client that he should apply to the Ticket to Work program. This is a government program that provides vocational rehabilitation to clients ages 18 to 64 who are receiving Social Security disability payments. Clients can retain Medicare for up to 93 months, and expedited reinstatement is available for up to 5 years.

67.

Under the Affordable Care Act, a benefit that is not part of the 10 essential benefits that must be covered each year by insurance companies without a dollar cap is:

Prescription drugs.

Laboratory services.

Dental care (Adult).

Maternity and newborn care.

Explanation:

Adult dental care is not one of the 10 essential benefits that must be covered each year by insurance companies without a dollar cap, although dental care must be provided for pediatric clients. The 10 essential benefits include ambulatory patient/outpatient services, emergency services, hospitalization, maternity and newborn care, prescriptions drugs, laboratory services, mental health and substance abuse services, rehabilitation and habilitative services/equipment, preventive and wellness/chronic disease services, pediatric services, including oral and vision care.

68.

The best placement for a 47-year-old male with an IQ of 68 who cannot live alone is probably a:

Group home.

Skilled nursing facility.

Assisted living facility.

Mental health facility.

Explanation:

While there are many factors to consider, the best placement for a 47-year-old male with an IQ of 68 is probably a group home because this is a mild level of intellectual disability, so the client can usually manage self-care with minimal supervision. Group homes are licensed facilities that usually house four to eight clients with similar conditions. Staff members may live in the facility or work in shifts. The quality of group homes may vary widely, so the case manager should be familiar with group homes used for referrals.

69.

If a laptop computer with FIPS 140-2 encryption was stolen from the case manager's car and contained PHI regarding clients, the case manager should:

Gather documents proving encryption.

Notify HHS of a breach of unsecured PHI.

Notify clients of a violation of privacy.

Place a media notice regarding the breach.

Explanation:

If the case manager's laptop computer with FIPS 140-2 encryption was stolen and contained PHI regarding clients, the case manager should gather documents proving encryption. FIPS 140-2 is HIPAA compliant encryption and renders the PHI inaccessible, so the loss of the computer does not require a notification of breach; however, the organization should conduct a risk assessment, including reviewing documentation regarding encryption and policies regarding storage of laptops, which should generally be stored in a locked trunk out of the line of sight.

70.

The situation that is not covered by the Family and Medical Leave Act is:

The client's spouse wants family leave to care for the client during a short-term illness.

The client wants medical leave because of a high-risk pregnancy.

The client wants medical leave because of cancer treatment.

A sibling wants family leave to care for the client during a serious illness.

Explanation:

The situation that is not covered by the Family and Medical Leave Act is a sibling who wants family leave to care for the client during a serious illness. FMLA does not extend benefits to extended family, such as grandparents, in-laws, and siblings, only close family members, such as parents, children, and spouse. FMLA provides those who are eligible up to 12 work weeks of unpaid leave each year, during which time group health benefits must be maintained. The individual must be able to return to the same or an equivalent position after leave. If caring for a service member with serious illness or injury, 26 weeks are allowed in a single year.

71.

If the client chooses to forego transfer to an inpatient rehabilitation center and have home health care instead against the advice of the physician and the case manager, and the case manager alters the plan of care to correspond with the client's wishes, the case manager is exhibiting the ethical principle of:

Beneficence.

Autonomy.

Nonmaleficence.

Justice.

Explanation:

If the client chooses to forego transfer to an inpatient rehabilitation center and have home health care instead against the advice of the physician and the case manager, and the case manager alters the plan of care to correspond with the client's wishes, the case manager is exhibiting the ethical principle of autonomy. The case manager is respecting the client's wishes and doing what the client feels is best while respecting the right of the client to exercise autonomy.

72.

If a deaf client who prefers to use sign language but can read and type is in a rehabilitation center away from family and friends, the best way for them to communicate is via:

Teletypewriter (TTY).

Messaging.

Video chat (Facetime, Skype).

E-mail.

Explanation:

If a deaf client who prefers to use sign language but can read and type is in a rehabilitation center away from family and friends, the best way for them to communicate is via video chat (Facetime, Skype) because it allows for more natural exchange of ideas. The teletypewriter is another option as are email and messaging, but these choices slow communication and require more effort than video chatting, which is now readily available if the client has access to a smart phone, tablet, or computer.

73.

A verbal exchange with a client should be documented as:

"Client angry and uncooperative."

"Client states treatment is not working and, therefore, refused to take medications."

"Client refusing treatment, including medications."

"Client appears upset with the medical care received."

> ***Explanation:***
>
> *When documenting a verbal exchange with a client, the case manager must avoid subjective opinions and provide an objective report: "Client states treatment is not working and, therefore, refused to take medications." Whenever possible, the reason for the client's action should be included, not just that the client is refusing treatment, because the information that the client believes the treatment is ineffective is important for healthcare workers to address with the client.*

74.

When considering whether the Americans with Disabilities Act will provide protections for a client, the case manager recognizes that a condition that is not considered a disability is:

Muscular dystrophy.

HIV/AIDS.

Transsexualism.

Blindness.

Explanation:

When considering whether the Americans with Disabilities Act will provide protections for a client, the case manager recognizes that a condition that is not considered a disability is transsexualism. While the ADA does not provide an exclusive list of covered conditions, generally, conditions related to addictions (drugs, gambling) are not covered, nor are conditions related to sexual preferences or differences, such as homosexuality, transsexualism, and transvestism. However, transsexuals are protected in the workplace by the Civil Rights Act.

75.

The case manager uses Interqual®, an evidence-based tool, in order to determine:

The client’s level of acuity and level of care needed.

The client’s long-term risk factors.

The estimated costs of client care.

The client’s eligibility for assistance programs.

Explanation:

The case manager uses Interqual®, an evidence-based tool, in order to determine the client’s level of acuity and level of care needed. Interqual® offers a number of products: Levels of care criteria, care planning criteria, behavioral health criteria, coordinated care content, and evidence-based development. The goals of Interqual® include preventing over- and under-utilization, reducing risks, facilitating communication, improving data collection, supporting consistency of care in alignment with CMS guidelines, reducing costs, identifying areas in which improvement can be made, facilitating payments, and identifying trends.

76.

The assessment that must be included in the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for CMS to determine the rate of payment for fee-for-service clients is:

Mini-Mental State Exam (MMSE).

Instrumental Activities of Daily Living (IADL).

Index of Independence of Activities of Daily Living (Katz Index).

Functional Independence Measure™ (FIM™).

Explanation:

The assessment that must be included in the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for CMS to determine the rate of payment for fee-for-service clients is the Functional Independence Measure™ (FIM™). This tool evaluates the client's level of disability. Admission scores are obtained during the first three days of rehabilitation hospitalization based on observations over the entire 3-day period. FIM™ items include eating, grooming, bathing, upper dressing, lower dressing, toileting, bladder, bowel, transfers (bed, chair, wheelchair), transfers (toilet), transfers (tub/shower), walk/wheelchair, stairs, comprehension, expression, social interaction, problem solving, and memory.

77.

If the case manager is utilizing the strengths model of case management, the case manager must assist the client to:

Take responsibility for his/her own recovery.

Identify family and friends who can serve as resources for recovery.

Learn to manage self-care independently and decrease dependence on others.

Identify abilities, skills, and environmental factors that may promote recovery.

Explanation:

If the case manager is utilizing the strengths model of case management, the case manager must assist the client to identify abilities, skills, and environmental factors that may promote recovery. The strengths model of case management focuses on client's strengths rather than deficits in planning interventions based on the belief that people have inner resources that can help them to cope. The relationship between the case manager and the client is considered essential. Clients' problems are viewed in the context of goals, and methods are developed to overcome the problems rather than viewing them as barriers to recovery.

78.

If the case manager wants to make a change in procedures but concedes to another team member who opposes the changes, the approach to negotiation that the case manager is using is:

Competition.

Avoidance.

Accommodation.

Compromise.

Explanation:

Accommodation. Approaches to negotiation include:

Competition	*One party wins and the other loses*

Accommodation	*One party concedes to the other; the losing side may gain little or nothing*
Avoidance	*Negotiation is avoided and nothing is resolved; likely when both parties dislike conflict*
Compromise	*Both parties make concessions in order to reach a consensus; this can result in decisions that satisfy no one*
Collaboration	*The parties work together to arrive at a solution that provides everyone with a satisfactory result; a win-win solution and often a creative one*

79.

Denial or noncertification of services may result from:

Extended hospitalization because of postoperative myocardial infarction.

Extended hospitalization because PT is not available on weekends.

Change in policy after services rendered.

Client's death.

Explanation:

Denial or noncertification may result from extended hospitalization because PT or other services are not available on the weekend. Extended hospitalizations with cause, such as a myocardial infarction, are covered but may require concurrent authorization to notify the payor of changes in condition. A change in policy that takes place after services are rendered should not affect a case, as the effective policy is the one in place at the time of authorization. A client's death should result in termination of benefits rather than denial.

80.

If an Inpatient Prospective Patient System hospital is in the Hospital Readmissions Reduction Program, the hospital is penalized if a client has an unplanned readmission for a condition included in the program within:

10 days.

15 days.

20 days.

30 days.

Explanation:

If an Inpatient Prospective Patient System hospital is in the Hospital Readmissions Reduction Program, the hospital is penalized by being reimbursed at a lower rate if a client has an unplanned readmission for a condition included in the program within 30 days or for a client who is admitted to the same or any acute care hospital for any reason with 30 days. Planned readmissions are not counted against the facility. A payment adjustment factor is calculated for each eligible hospital.

81.

If a client with repeated emergency department visits for migraine headaches has received relief from a new treatment, but the client's insurance does not yet cover the cost of the very expensive medication and denied an appeal, the case manager should advise the client to:

Pay privately for the medication.

Apply to the pharmaceutical company's patient assistance program.

Set up a Go-Fund-Me page for assistance.

Try other medications and treatments.

Explanation:

If a client with repeated emergency department visits for migraine headaches has received relief from a new treatment, but the client's insurance does not yet cover the cost of the very expensive medication and denied an appeal, the case manager should advise the client to apply to the pharmaceutical company's patient assistance program. Such programs often supply the drug at lowered cost or free for up to a year. New treatments are often denied by insurance companies until more data are available.

82.

If the case manager is utilizing video calls with clients rather than in-person visits, the HIPAA regulations regarding privacy and security:

Must apply.

Are less stringent.

Can be waived.

Do not apply.

Explanation:

If the case manager is utilizing video calls with clients rather than in-person visits, the HIPAA regulations regarding privacy and security must apply. Therefore, the video calls must be encrypted so that the calls cannot be accessed by others. The Privacy Rule protects any information in the medical record, billing information, conversations between the client and

case manager, and other health information. The security rule requires that electronic health information be secure and protected and safeguards be in place.

83.

With the disease management model of case management, the case manager focuses on:

Evidence-based practice to improve outcomes of acute care.

Guiding the client from acute care to post-acute care.

Post-acute services for chronic illness to reduce readmission.

Both caregiving and case management for the client.

Explanation:

With the disease management model of case management, the case manager focuses on post-acute services for chronic illness to reduce readmissions. Typical clients include those with COPD, heart disease, liver disease, renal disease, and diabetes. Case management may include educating clients about their disease, and proving guidance in making lifestyle changes (weight loss, increased exercise, smoking cessation), and in better managing of disease. Additionally, the case manager may assist the client to access community resources, such as Meals-on-Wheels and low-cost transportation services.

84.

If the case manager is part of an interdisciplinary team in which two members of the team have a disagreement regarding client care, the first step to resolving the conflict is to:

Determine which person has the most reasonable argument.

Encourage the individuals to cooperate.

Remind the individuals that their argument is negatively impacting the team.

Allow both individuals to present their side of the issue.

Explanation:

If the case manager is part of an interdisciplinary team in which two members of the team have a disagreement regarding client care, the first step to resolving the conflict is to allow both individuals to present their side of the disagreement without bias, keeping the focus on the opinions rather than the individuals. Often, individuals just want to feel that they are heard and their views are appreciated. Then, the case manager should encourage the individual to cooperate with negotiation and compromise.

85.

The case manager's primary role in transitions of care is to ensure that:

The client receives the appropriate level of care and services.

The costs of client care and services don't exceed expectations.

The client is informed about all aspects of client care.

The client understands the need for stepdown or discharge.

Explanation:

The case manager's primary role in transitions of care is to ensure that the client receives the appropriate level of care and services. The client's status should be assessed on a daily basis to

determine if stepdown (such as from ICU to a medical-surgical unit) or transfer to another facility (such as a skilled nursing facility) is indicated because overutilization can result in decreased pay for services. Even though there are financial incentives to appropriate transitions of care, this should not be the primary factor for case management.

86.

In terms of utilization management, an example of underutilization is:

The average length of stay in the ICU is 8 to 10 days, which is longer than the average.

The hospital lacks an MRI and must transfer clients needing an MRI to another hospital.

A client received an overdose of narcotic and required an extra day of hospitalization.

Routine CBC and urinalysis tests are ordered for all clients in the emergency department.

Explanation:

In terms of utilization management, an example of underutilization is if the hospital lacks an MRI and must transfer clients needing an MRI to another hospital. Trends that are analyzed as part of utilization management include:

- *Overutilization: This may relate to inappropriate admissions, levels of care, length of stay, or undocumented rationale for resource use (such as lab tests).*
- *Underutilization: Level of care or resources may be inadequate for medical necessity (failure to admit, inadequate testing).*
- *Misutilization: This includes errors in treatment or other inefficiencies, such as scheduling.*

87.

According to Lewin's force field analysis of change, a driving force would be:

Hostility.

Lack of equipment.

Insufficient funds.

Competition.

Explanation:

According to Lewin's force field analysis of change, a driving force would be competition. Force field analysis includes:

- *Driving forces: These are forces responsible for instigating and promoting change, such as leaders, incentives, and competition.*
- *Restraining forces: These are forces that resist change, such as poor attitudes, hostility, inadequate equipment, or insufficient funds.*

Force field analysis is used when considering changes and begins by listing a proposed change and creating two subgroups below: driving and restraining forces. In order to bring about change, a plan must be developed to diminish or eliminate the restraining forces.

88.

As part of a wellness program, clients with average risk should begin colorectal screening at age:

40.

50.

60.

65.

Explanation:

As part of a wellness program, clients with average risk should begin colorectal screening at age 50. Those with increased risk, should begin screening at age 40. Increased risk factors include:

- *Family history of colorectal cancer in first or second-degree relatives*
- *Family history of genetic syndrome (FAP, HNLPCC)*
- *Adenomatous polyps in first-degree relatives before age 60*
- *History of polyps or colorectal cancer*
- *History of inflammatory bowel disease*

Screening may include fecal occult blood, flexible sigmoidoscopy, colonoscopy, capsule colonoscopy, and/or double contrast barium enema.

89.

According to the transtheoretical model of change, a client who indicates readiness to change and begins making plans is in the stage of:

Contemplation.

Action.

Precontemplation.

Preparation.

Explanation:

Preparation. Transtheoretical stages:

- *Precontemplation: Client informed about consequences of problem behavior and has no intention of changing behavior in the next 6 months.*

- *Contemplation: Client aware of costs and benefits of changing behavior and intends to change in the next 6 months but is procrastinating.*
- *Preparation: Client has a plan to instigate change in the near future (≤1 month) and is ready for action plans.*
- *Action: Client modifies behavior. Change occurs only if behavior meets a set criterion (such as complete abstinence from drinking).*
- *Maintenance: Client works to maintain changes and gains confidence that he/she will not relapse.*

90.

If a client in an acute care hospital has comorbidities of prostate cancer, type 1 diabetes, hypertension, and pneumonia, the priority in treatment is:

Prostate cancer.

Type 1 diabetes.

Hypertension.

Pneumonia.

Explanation:

When a client has comorbidities, the priority in care must be to the condition that is most acute or may be life threatening. While both prostate cancer and pneumonia may be life threatening, pneumonia is the more acute condition and should receive priority. However, this does not mean that other conditions are left untreated, although in some cases aggressive treatment may be delayed. For example, treatment for prostate cancer may be delayed until the pneumonia resolves. Routine treatment for hypertension and type 1 diabetes may continue, but educating the client about disease management may be postponed.

91.

If a 35-year-old client with rheumatoid arthritis has become increasingly withdrawn and socially isolated and states her family and friends don't understand what she is going through, an appropriate intervention is referral to a:

Support group.

Psychiatrist.

Yoga program.

Holistic practitioner.

Explanation:

If a 35-year-old client with rheumatoid arthritis has become increasingly withdrawn and socially isolated and states that her family and friends don't understand what she is going through, an appropriate intervention is referral to a support group. Clients with chronic illnesses often benefit from participating in a support group with others with the same disease because clients often find that they can express what they are feeling and the challenges they face more freely and gain insight from the group regarding coping strategies.

92.

The average length of stay (LOS) in an acute care hospital for a complete knee replacement is approximately:

3 days.

4 days.

7 days.

10 days.

Explanation:

According to the Agency for Healthcare Research and Quality (AHRQ) data, the average length of stay in a hospital after a complete knee replacement is about 4 days (3.9), after which most clients transfer to a skilled nursing facility or rehabilitation center for continued therapy. Reducing LOS is a major factor in reducing costs and complications, as prolonged hospitalization is more likely to result in infection. Stays beyond the average for a particular condition may result in denial of services or increased scrutiny to determine the cause.

93.

When conducting a survey for program evaluation, the easiest questions to quantify are:

Descriptive informational questions (who, what, when, where, how, how much, and why).

Yes/no questions.

Multiple-choice questions.

Rating scale.

Explanation:

Yes/no questions are the easiest questions to quantify since this type of survey requires only simple addition of two categories, but they provide limited information. Descriptive/information questions often provide the most information, but results are difficult to quantify because each individual may answer questions differently. Multiple-choice questions must be designed carefully or clients may not find choices that reflect their opinions. These questions are also easy to quantify. Rating scales are used primarily to rate satisfaction or to indicate the level of agreement with a statement and—like multiple-choice questions—are easy to quantify.

94.

If a client has outpatient surgery in the morning and stays overnight for extended observation, the client becomes an inpatient:

At midnight.

After 8 hours.

When the physician orders inpatient services.

After 24 hours.

Explanation:

A client becomes an inpatient only after the doctor changes the order to have the client admitted as an inpatient. People receiving outpatient/ambulatory surgery may in some cases stay overnight, especially if their surgery was performed late in the day or if they prolonged observation. Even with an overnight stay, people are still considered outpatients. The distinction is important because the basis for payment differs for inpatient services and outpatient services.

95.

A case manager in the emergency department (ED) must consider national indicators for ED crowding, such as:

Need for follow-up appointments.

Acute care hospital admission.

Diversions.

Unsafe discharges.

Explanation:

National indicators for emergency department crowding include:

- *Diversions: Number of hours the ED is unable to accept clients because it has reached capacity, requiring diversion of clients to other facilities.*
- *Boarding: Number of clients who must remain in the ED awaiting admission because the hospital has no beds available or no staff available to prepare rooms or facilitate transfer.*
- *Clients are leaving the ED after triage: If there is a substantial delay in time between triage and evaluation, some clients leave the ED for various reasons, such as impatience, transportation needs, or family responsibilities. Some seek medical care elsewhere.*

96.

The case manager in the admitting department serves essentially as a:

Gatekeeper.

Negotiator.

Communicator.

Supervisor.

Explanation:

The case manager in an admitting department serves essentially as a gatekeeper to determine if admission to acute care is necessary or if a lower level of care is indicated. The case manager is responsible for acquiring preauthorization of care or certifications as needed. Additionally,

the case manager communicates information about the client and client's condition to the insurance company/payor to support a request for authorization or to discuss the need for other care.

97.

When a client is receiving occupational therapy in the home, documentation must include:

Costs.

Client preferences.

Realistic and measurable goals.

Indirect supervision of unlicensed staff.

Explanation:

Because of perceived excess costs associated with occupational, physical, and speech therapy, careful documentation must include realistic and measurable goals as well as a physician's order for therapy and evidence that therapy was provided by or supervised by a licensed therapist who conducted a thorough evaluation and developed a plan of care that included frequency and duration of treatment. Documentation must also indicate that the therapy was medically necessary. The same documentation requirements apply to skilled nursing facilities.

98.

The best initial method of ensuring correct medication dosage for a home client who wants to remain independent but sometimes forgets to take her morning medications or takes a double dose is:

Hiring an aide to come in daily to give medications.

Providing an electronic alarmed medication delivery device.

Placing the client in an assisted living facility.

Arranging for someone to telephone daily.

Explanation:

An electronic alarmed medication delivery device can hold up to 30 days' supply of medications and can be set to deliver the medications at a particular time or times each day, with an alarm sounding when the medication cup is full. While someone may need to fill the device one or two times monthly, this is more cost effective than hiring someone daily to give medications and allows the client to remain more independent in care.

99.

The Older Americans Act provides:

Hospital services.

Pharmacy assistance programs.

Home and community services.

Financial assistance to older adults.

Explanation:

The Older Americans Act (OAA) provides a wide range of home and community services for older adults as well as respite services for family caregivers for older adults and children with special needs. OAA programs include support of senior centers, nutrition services, respite

programs, and long-term care planning. The OAA also supports health, prevention, and wellness programs that include Alzheimer's disease, diabetes, HIV/AIDS, and self-management of chronic disease as well as the Healthy People 2030 initiative. The OAA is also involved with protection of elder rights through legal assistance, pension counseling and information services, and ombudsman programs.

100.

Initial symptom management of shortness of breath in a palliative care client usually includes:

Elevating the head and using a fan aimed toward the person's face.

Corticosteroids.

Oxygen by nasal cannula.

Bronchodilators.

Explanation:

Initial symptom management of shortness of breath in a palliative care client includes elevating the head and aiming a fan toward the person's face to circulate air. Up to 80% of palliative care clients may experience some degree of dyspnea, which can usually be managed conservatively. If dyspnea is severe, as may occur with lung disease, an opioid (usually morphine) or sedative (benzodiazepines) may be indicated. Corticosteroids are used for specific cases, such as those with superior vena cava syndrome. Oxygen by facemask may relieve dyspnea for some patients. Bronchodilators are indicated if shortness of breath is associated with bronchospasm.

101.

In Kurt Lewin's change theory, the first stage, motivation to change, is also referred to as:

Freezing.

Unfreezing.

Unfrozen.

Refreezing.

Explanation:

Change theory:

- *Motivation to change (unfreezing): Dissatisfaction occurs when goals are not met, but as previous beliefs are brought into question, survival anxiety occurs. Sometimes learning anxiety about having to learn different strategies causes resistance that can lead to denial, blaming others, and trying to maneuver or bargain without real change.*
- *Desire to change (unfrozen): Dissatisfaction is strong enough to override defensive actions, and desire to change is strong but must be coupled with identification of needed changes.*
- *Development of permanent change (refreezing): New behavior becomes habitual, often requiring a change in perceptions of self and establishment of new relationships.*

102.

A person who is resistive to seeing a psychologist for severe emotional problems because of a personal belief that prayer will heal may benefit most from:

Pastoral counseling.

Personal meditation.

Medications.

Spiritual instructions.

Explanation:

Pastoral counseling provides a bridge between religion and therapy, with members of the clergy trained as mental health professionals, usually with a master's degree or doctorate. A client who may be reluctant to see a psychologist may be more receptive to one that engages spirituality and prayer as part of therapy. Pastoral counselors serve those with mental health disorders and substance abuse disorders as well as providing family and couples therapy. They may also promote wellness/spirituality programs.

103.

For a trauma patient who will need long-term care and has no coverage and no financial resources beyond Social Security income, the acute care case manager should explore:

Charity organizations.

Extended acute care.

Home health agency care.

State long-term care programs.

Explanation:

While state programs for long-term care may vary, in general, all states provide for those with low income requiring long-term care because of complex illnesses that need extensive care or multiple physical or mental problems that preclude clients' caring for themselves. Most state programs have strict financial guidelines and limit the amount of savings and/or property a

person can own, and the application process can take up to three months, so the case manager should explore this option early.

104.

The primary purpose of the Caseload Matrix in caseload calculations is to:

Differentiate activities and interventions.

Measure specific outcomes.

Determine accuracy of caseload calculations.

Identify variables in various settings affecting caseloads.

Explanation:

The primary purpose of the Caseload Matrix in caseload calculations is to identify variables in various settings affecting caseloads. Elements of the Caseload Matrix that impact the caseload include

- *Initial elements: Business environment, market segment, regulatory and legal requirement, clinical practice setting, factors related to individual CM, types/characteristics of CM services, and CM tools, including technology support.*
- *Comprehensive needs assessment: Clinical factors and client, family, and environmental psychosocial factors.*
- *CM interventions: CM plan.*
- *Outcomes: Intermediate, CM, and long term.*

105.

To facilitate the continuum of care after a client is discharged from an acute hospital, the most important relationship for a case manager to develop is with:

Physician's staff.

HMO clinicians.

Skilled nursing facilities and home health agencies.

Acute care hospital administrators.

Explanation:

To facilitate the continuum of care after a client is discharged from an acute hospital, the case manager should establish ongoing relationships with staff and administrators of skilled nursing facilities, home health agencies, subacute and rehabilitation facilities, as well as assisted living facilities because the services they provide may be critical to allow the client to safely be discharged. Establishing relationships with physician's staff, hospital administrators, and HMO clinicians is usually more important for preadmission issues.

106.

A tool that provides a client's self-assessment of functional health and quality-of-life issues is the:

Health Status Survey (SF-36).

Patient Health Questionnaire (PHQ).

Post Deployment Clinical Assessment Tool (PDCAT).

Barthel Index.

Explanation:

Health Status Survey (SF-36 or SF-12) is a tool that provides a client's self-assessment of functional health and quality-of-life issues. The Patient Health Questionnaire (PHQ) is used to screen patients and monitor conditions related to mental health disorders, such as depression and anxiety and substance abuse. The Post Deployment Clinical Assessment Tool (PDCAT) is used to screen returning military for mental health and substance abuse problems related to deployment, including PTSD, depression, anxiety, and alcoholism. The Barthel Index assesses the functional ability of older adults in relation to activities of daily living.

107.

The type of group therapy that aims to help members who share a common problem learn to cope is:

Education group.

Self-help group.

Psychotherapy group.

Support group.

Explanation:

Support groups help members who share a common problem, such as the stress of caregiving, learn to cope. Education groups provide information to group members about specific issues, such as managing medication or disease. Self-help groups are usually informal groups without professional leaders intended for members who share a common experience, such as Alcoholics Anonymous. Psychotherapy groups teach members about their behavior and methods to change by interacting with others.

108.

The national organization that may provide the best information for the family of a young man who suffered a third concussion as a football injury is:

American College of Sports Medicine.

American Association of Physical Medicine and Rehabilitation.

Brain Trauma Foundation.

Orthopedic Research Society.

Explanation:

The Brain Trauma Foundation (BTF) has taken an active role in preventing concussions and provides checklists and videos and other information. The BTF also provides information about comas and guidelines for care of traumatic brain injury (TBI). The American College of Sports Medicine is intended for professionals and students involved in sports medicine and exercise, providing research and information about effective techniques. The American Association of Physical Medicine and Rehabilitation is a medical society for physicians engaged in physical medicine and rehabilitation. The Orthopedic Research Society promotes multidisciplinary collaborations in orthopedic care and dissemination of current research.

109.

The primary purpose of a health coach is to:

Prescribe treatment.

Guide clients to discuss concerns regarding recovery.

Counsel clients.

Ensure treatment compliance.

Explanation:

The primary purpose of a health coach is to guide clients to discuss concerns regarding recovery, including obstacles and the need for support. The health coach specifically avoids prescribing treatment, advising, and counseling because the focus remains on the client and helping the client develop the motivation to change and reach goals. Health coaching was initially used to help people recover from substance abuse, but it is now also used to help people cope with chronic illnesses and adopt a healthier lifestyle.

110.

The best intervention for a 68-year-old male with COPD who lives alone and manages his own care but has been eating only candy and snack foods is:

Nutritional counseling.

Admission to assisted-living facility.

Home delivery of meals (Meals On Wheels).

Referral to an occupational therapist.

Explanation:

Clients who resort to eating only candy and snack foods usually do so because these foods are easy to obtain and require no preparation, so the best intervention is home delivery of meals, such as Meals on Wheels programs. While an occupational therapist may help the man learn ways to prepare meals with less exertion and nutritional counseling may help the client understand the need to eat better meals, home delivery of meals is the most direct and simple intervention. Since the man is managing other aspects of care, he does not yet require assisted living.

111.

The first step in crisis intervention is:

Devising a plan.

Assessing the problem and the triggering event.

Teaching coping mechanisms.

Evaluating resources.

Explanation:

The first step in crisis intervention is a thorough evaluation and assessment of the problem and the triggering event as well as assessment of risks, such as suicide. A plan should be devised in collaboration with the individual, taking resources into consideration. Steps in intervention include:

- *Helping the individual to gain understanding about the cause of the crisis*
- *Encouraging the individual to freely express thoughts and feelings*
- *Teaching the individual different coping mechanisms and adaptive behaviors*
- *Encouraging social interaction*

112.

Older adults with chronic illnesses that result in pain and/or physical limitations should often be evaluated for:

Dementia.

Depression.

Drug abuse.

Alcoholism.

Explanation:

Depression often goes undiagnosed, so screening for at-risk individuals should be done routinely. Depression is associated with conditions that decrease quality of life, such as heart disease, neuromuscular diseases, arthritis, cancer, diabetes, Huntington's disease, stroke, and diabetes. Some drugs may also precipitate depression: diuretics, Parkinson's drugs, estrogen, corticosteroids, cimetidine, hydralazine, propranolol, digitalis, and indomethacin. Patients experience changes in mood, sadness, loss of interest in usual activities, increased fatigues, changes in appetite and fluctuations in weight, anxiety, and sleep disturbance.

113.

The coping mechanism that involves actively searching for a way to reduce stress and cope is:

Problem solving.

Avoidance.

Physical activity.

Spirituality.

Explanation:

Problem solving *involves actively searching for a way to reduce stress and cope.* ***Avoidance*** *means to avoid stressors or reduce their impact if possible.* ***Physical activity*** *can often increase feelings of well-being and allow people to cope more effectively.* ***Spirituality*** *can involve attending religious services or engaging in religious or spiritual endeavors to provide emotional support and a positive outlook. Those with ineffective coping skills may express anxiety, anger,*

and agitation (which may interfere with decision making) and may develop depression and physical ailments, such as anorexia, weight loss, nausea, urinary and bowel problems, and sleep disturbance.

114.

The best response to a dying Hmong patient who states that a shaman is coming to heal her is:

"That is not realistic in your condition."

"If you believe, then a cure is possible."

"You will need your doctor's permission."

"What can I do to help?"

Explanation:

According to the Dying Person's Bill of Rights, every patient has a right to hope and to participate in religious/spiritual experiences, so the correct response is "What can I do to help?" The case manager should not state that the healing is unrealistic or put the burden on the patient with "If you believe . . ." Patients have a right to seek spiritual guidance and/or healing without a doctor's permission. Traditional Hmong families may shun Western medicine and rely solely on healers, while Christian Hmong may rely only on Western medicine. However, many Hmong people straddle both the traditional and Western worlds.

115.

Using the four-point Likert scale to assess clients with low self-care, a client with severe risk of failing to adhere to medical regimens/treatments is classified as:

Level 1.

Level 2.

Level 3.

Level 4.

Explanation:

Level 3. The four-point Likert scale is used to assess clients who are at risk of low self-care. The Likert scale has four levels:

- *Level 1: A client who is able to attend to normal activities of daily living (ADLs), hygiene, and the environment and has a low risk of failing to adhere to medical regimens/treatments.*
- *Level 2: A client who has a moderate risk of failing to adhere to medical regimens/treatments and making poor choices.*
- *Level 3: A client with severe risk of failing to adhere to medical regimens/treatments and making poor choices.*
- *Level 4: A client whose lack of self-care is extreme and results in self-abuse and neglect.*

116.

For a person with a dual diagnosis, the initial treatment usually focuses on:

Detoxification.

Rehabilitation.

Mental health treatment.

Coping strategies.

Explanation:

Dual diagnosis is a combined substance abuse and a mental health disorder. The initial treatment usually involves detoxification to stop the use of drugs so that the mental health condition can be more accurately evaluated. This is followed by rehabilitation, such as a drug recovery program, and mental health treatment, which can include medications [such as selective serotonin reuptake inhibitors (SSRIs) or psychotropics] or therapy, including group and cognitive-behavioral therapy. In some cases, people abuse drugs to self-treat mental illnesses, but in other cases, the mental illnesses result from drug abuse.

117.

Health literacy primarily requires:

Basic reading, numerical, comprehension, and communications skills.

A thorough understanding of disease and appropriate treatments.

An above-average intellectual capacity.

Motivation to learn about health.

Explanation:

Health literacy primarily requires basic reading, numerical, comprehension, and communication skills. Clients should be able to read and understand prescription labels and warnings, insurance forms, and consent forms. They should be able to do basic math to calculate doses when necessary, and they should be able to comprehend basic information about disease and self-management. They need the ability to communicate their concerns and needs and to comprehend instructions and health information. Motivation alone is not enough, but an above-average intellectual ability is not necessary.

118.

Bereavement is:

A normal response to loss.

The public expression of grief.

Change of mood and feeling of sadness.

The time period of mourning.

Explanation:

Bereavement is the time period of mourning. This time period varies but may extend to a year or even longer. Grief is a normal response to loss while mourning is the public expression of grief. There are three types of grief: acute, anticipatory, and chronic. Chronic grief poses a serious risk to people and should be treated as depression, with antidepressants, psychological evaluation, and counseling. Depression is characterized by changes in mood and feelings of sadness.

119.

An alert elderly home care patient who complains that items have begun disappearing from her home is most likely the victim of:

Elder abuse.

Psychological abuse.

Financial abuse.

Physical abuse.

Explanation:

One indication of financial abuse is the disappearance of items from the home. Family, friends, or caregivers may begin taking one or two items at a time, assuming the person will not notice. Other types of financial abuse include:

- *Outright stealing of property or persuading patients to give away possessions*
- *Forcing patients to sign away property*
- *Emptying bank and savings accounts*
- *Using stolen credit cards*
- *Convincing the person to invest money in fraudulent schemes*
- *Taking money for home renovations that are not done*

Indications of financial abuse may be unpaid bills, unusual activity at ATMs, and inadequate funds to meet needs.

120.

Before making a telephone call to a client to review status, the case manager should:

Prepare a script.

Outline the objectives of the call.

Send a mail notification.

Notify the physician.

Explanation:

The case manager should outline objectives of a call prior to telephoning a client to review status. This helps to maintain focus and ensures that all necessary topics are covered. Preparing a script in advance is not necessary and may seem "faked" to the client. The case

manager should be prepared to guide the conversation and answer potential questions the client may have. It is not necessary to mail a notification, but the case manager should, if possible, advise the client that follow-up may be done by phone as clients may be reluctant to divulge personal information over the phone.

121.

Under the Case Management Society of America (CMSA) Standards of Practice, the standard of Facilitation, Coordination, and Collaboration can be demonstrated by:

Documentation of termination of care.

Documentation of ongoing efforts at collaboration with the client.

Use of screening for high-risk individuals.

Use of mediation/negotiation.

Explanation:

The CMSA standard of Facilitation, Coordination, and Collaboration can be demonstrated by the use of mediation and/or negotiation to facilitate communication. The CMSA Standards of Practice (2016) comprise 15 standards: client selection (includes use of screening for high-risk clients); client assessment; problem/opportunity identification; planning; outcomes; monitoring (includes documentation of ongoing efforts at collaboration); termination of CM services (includes documentation of termination of care); facilitation, coordination, and collaboration; qualifications; legal; ethics, advocacy, cultural competency, resource management/stewardship; and research/research utilization.

122.

If all shelters are full and an indigent uninsured client with planned discharge in three days is placed on a waiting list for a preferred shelter, then the case manager's next action should be to:

Call daily to determine where the client is on the list.

Place the client on a second waiting list.

Plan transfer to a skilled nursing facility until shelter placement is possible.

Refer the problem to social services.

Explanation:

The case manager should immediately place the client on a second shelter waiting list to increase the chance for placement, even though the client may prefer a different shelter. Discharging a client into the streets poses an ethical dilemma, and if no placement can be found, then Social Services may be able to provide some alternatives. The decision about calling daily depends on the individual shelter and the relationship the case manager has with the shelter administration. Transferring to a level of care that is higher than needed is not a viable option even with Medicaid, and the client is indigent and uninsured.

123.

Bloodshot eyes, sniffing repeatedly, altered sleeping habits, and marked weight loss are indications of:

Excess smoking.

Cocaine abuse.

Alcoholism.

Marijuana abuse.

Explanation:

Bloodshot eyes, sniffing repeatedly, altered sleeping habits, and marked weight loss are typical signs of cocaine use. Cocaine depresses the appetite, so a sudden drop in weight may be one of the first signs. Because cocaine is often snorted, it can damage the septum and mucous membranes of the nose, causing the nose to run constantly. Clients may go without sleep for long periods followed by long periods of sleeping. Eyes become bloodshot from irritation.

124.

For a patient recovering from a brain injury, the Glasgow coma score that indicates potential for rehabilitation is:

3.

5.

8.

10.

Explanation:

A Glasgow coma score of 10 (more than 8) suggests the potential for rehabilitation. A score of 3 to 8 indicates coma, while a score of 9 to 12 indicates severe head injury and 13 to 15 indicates mild head injury. The Glasgow Coma Scale (GCS) measures the depth and duration of coma or impaired consciousness and is used for postoperative assessment. The GCS measures three parameters: best eye response, best verbal response, and best motor response, with a total possible score that ranges from 3 to 15.

125.

Upon discharge from an acute care hospital, the most appropriate placement for a client who has slight dementia and requires a simple daily dry dressing change but is medically stable and ambulates independently with a cane is:

Subacute/rehabilitation facility.

Skilled nursing facility.

Intermediate care facility.

Assisted living/custodial care facility.

Explanation:

An assisted living/custodial care facility is the appropriate placement for a client who has slight dementia but is otherwise medically stable and can ambulate and toilet independently. Unlicensed staff may assist patients to take routine medications and perform simple dry dressing changes, although a home health nurse may be necessary if care is more complex. Clients may have home oxygen but should not require tracheal suctioning. Assisted living facilities are not usually appropriate for clients in need of rehabilitation or those who are more confused or disoriented because of safety concerns.

126.

A young adult in the emergency department for attempted suicide with three previous attempts should be:

Referred to outpatient mental health services.

Treated and discharged to family.

Asked to sign a “no-suicide contract” before discharge.

Admitted to the hospital.

Explanation:

People who attempt suicide must be evaluated carefully. Those with a history of previous attempts are especially at risk for suicide. Patients who actually attempt suicide should be hospitalized and assessed for suicide risk after initial treatment. High-risk findings include:

- *Violent suicide attempt (knives, gunshots).*
- *Suicide attempt with low chance of rescue.*
- *Ongoing psychosis or disordered thinking.*
- *Ongoing severe depression and feeling of helplessness.*
- *History of previous suicide attempts.*
- *Lack of social support system.*

127.

An example of unskilled care is:

Administering sliding scale insulin.

Instructing a client on a low-sodium diet.

Instructions in the use of assistive devices.

Taking and reporting routine vital signs.

Explanation:

Unskilled care includes taking and reporting routine vital signs, assisting clients to take medications, assisting with personal care (bathing, applying lotions and creams, changing

simple dressings), preparing meals, assisting with feeding, emptying drainage bags and measuring drainage, assisting with colostomy and ileostomy care, administering medical gases (after client has stabilized), providing chest physiotherapy, assisting with stable tracheostomy care, and supervising exercises prescribed by a therapist as well as performing simple range-of-motion (active and passive) exercises, and utilizing or helping clients use assistive devices.

128.

A client's or parent's refusal of care may be overridden if:

The physician orders the care provided despite client objections.

The client is mentally incompetent.

The patient is elderly.

The client is a minor child.

Explanation:

A client or parent's refusal of care may be overridden in only a few instances, including when the client is mentally incompetent to make decisions, although advance directives completed prior to onset of dementia may remain valid. Other factors that may result in overriding refusal of care include life-threatening conditions for minor children and conditions that put the general public at risk, such as with those who refuse treatment for resistive forms of tuberculosis or other highly communicable diseases.

129.

A risk factor for malnutrition is:

Poverty.

Recent weight loss of five pounds.

Recent weight gain of five to eight pounds.

Dentures.

Explanation:

Poverty is a risk factor for malnutrition as people may be unable to purchase nutritious foods. Other risk factors include recent weight gain or loss of 10 pounds or more and ill-fitting dentures, lack of teeth, tooth abscesses, and dental caries. Those with a history of eating disorders (bulimia, anorexia) are at risk as well as those with acute or chronic illnesses. People who live alone or are socially isolated may experience loss of appetite. Disabilities may interfere with the ability to purchase and/or prepare foods.

130.

A psychosocial evaluation is indicated for a client with:

Chronic heart disease.

Homelessness.

Unintentional overdose.

Limited financial resources.

Explanation:

Clients who experience an unintentional overdose should be referred for a psychosocial evaluation because the overdose may result from lack of knowledge, inability to read

instructions, or polydrug use. Other indications include intentional overdoses, substance abuse (illegal or prescription drugs, alcohol), eating disorders (anorexia, bulimia), chronic mental illness, and dementia. In some cases, referrals are indicated based on behavior, such as repeated hospitalizations, noncompliance with treatment regimen, and aggressive or uncooperative behavior. Homelessness, heart disease, and limited financial sources do not necessarily indicate a need for psychosocial evaluation.

131.

The legal element of negligence that refers to a failure to carry out duties in accordance with accepted and usual standards of practice is:

Duty.

Breach.

Causation.

Harm.

Explanation:

Breach is the legal element of negligence that refers to a failure to carry out duties in accordance with accepted and usual standards of practice. Duty is a legal responsibility or obligation that relates to a relationship (such as parent to protect his/her child) or statute (such as the requirement for a case manager to report child abuse). Causation is the direct proof that a breach of duty resulted in harm. Harm is the injury that results from a breach of duty.

132.

Job accommodations for an office worker with fine motor impairment might include:

Providing speech recognition program for computer access.

Modifying the workstation to increase accessibility.

Providing stand/lean stools.

Providing rolling safety ladders.

Explanation:

Because fine motor impairment interferes with a person's ability to use the hands, a job accommodation might include a speech recognition program for computer access as well as alternative methods to answer the phone and adaptive writing materials, ergonomic tools, page turners, grip devices, book holders, arm supports, and modified keyboards. Those with gross motor impairment may require modification in the workstation, stand/lean stools, rolling safety ladders, desktop Lazy Susans, and carts to transport materials.

133.

During case selection, the client that is most likely to need and benefit from case management services is:

12-year-old child having a tonsillectomy.

67-year-old man having a transurethral resection of the prostate (TURP).

47-year-old Type 2 diabetic with severe insulin reaction after a bout of food poisoning with vomiting and diarrhea.

72-year-old woman with a postoperative wound infection after hip replacement.

Explanation:

The client most likely to need and benefit from case management is the 72-year-old woman with a postoperative wound infection after hip replacement because the infection may result in both an extended stay in the acute care hospital as well as in a skilled nursing facility and increased need for medications and other treatments. If osteomyelitis develops, then chronic care may be necessary. People with uncomplicated procedures, such as appendectomy and TURP, usually do not need case management. The diabetic's insulin reaction probably resulted from the vomiting and diarrhea and will resolve with treatment.

134.

When a facility is converting to the interoperable electronic healthcare delivery system, the most important aspect to consider is:

Equipment choice.

Time needed for conversion.

Staff training.

Staff preference.

Explanation:

When converting to an interoperable healthcare delivery system, the most important aspect to consider is the need for extensive training for all staff at all levels because all procedures that are currently paper related must be modified and converted to a digital format. Standard terminology may need to be established or modified. Staff must be trained to input information in the electronic system as well as to retrieve information, and safeguards must be built into the

system to prevent violations of confidentiality. Information retrievable over the Internet must be encrypted.

135.

The client-centered model of care in which a primary care physician manages, facilitates, and coordinates all levels of client care, including care provided by specialists, is:

Chronic care model.

Medical home model.

Planned care model.

Expanded care model.

Explanation:

The medical home model is a client-centered model of care in which a primary care physician manages, facilitates, and coordinates all levels of client care, including care provided by specialists. The leader (physician) usually receives some type of additional payment for providing the service. Clients may be assigned to a medical home or may, in some cases, choose one. The goal is to decrease the fragmented and uncoordinated care that many clients receive in order to improve client outcomes.

136.

Using real tasks or simulated work-related tasks and progressive exercises to strengthen and condition a person to return to work is an example of:

Job coaching.

Work adjustment.

Transitional employment.

Work hardening.

Explanation:

Work hardening is using real tasks or simulated work-related tasks and progressive exercises to strengthen and condition a person to return to the workplace. Work adjustment is assessing work behavior to determine behaviors that are appropriate and inappropriate and then providing support to increase appropriate behaviors and improve job skills. Transitional employment is the noncompetitive employment placement utilized with job coaching. Job coaching is placing a person in a position and using a job specialist to train the employee to do specific job-related tasks and to learn the necessary interpersonal skills needed for the job.

137.

The three-midnight rule for extended Medicare benefit applies to clients transferring to:

Skilled nursing facilities.

Home health agency services.

Long-term care facilities for rehabilitation.

Assisted living facilities.

Explanation:

The three-midnight rule for extended Medicare benefit applies to clients transferring to skilled nursing facilities (SNFs). Clients must be under inpatient care for three days (three midnights), but time spent in extended observation in an ED or treatment as an outpatient does not apply. The three-day stay must be justified by care needs. Hospitalization alone does not qualify the client for the extended benefit, as the client must also require daily care at a level appropriate to an SNF.

138.

A client being discharged from an acute care hospital with an infusion pump for multiple intravenous medications can be transferred to:

Subacute and rehabilitation facilities.

Skilled nursing facility.

Subacute and skilled nursing facilities.

Intermediate care facility.

Explanation:

Subacute and rehabilitation facilities usually provide IV care that can include infusion pumps and multiple IV medications. These facilities also provide ongoing monitoring by RNs and manage complex drug regimens. They may also care for people on respirations or those requiring tracheal suctions and can provide tube care for gastrostomy and jejunostomy, T-tubes, and catheters as well as colostomy and ileostomy care. Complex wound care is available as well as at least two types of rehabilitation therapy (speech, physical therapy, occupational therapy).

139.

During assessment and problem identification for a client with multiple physicians, if inconsistencies in medical data are found, the case manager should first:

Consult with the client.

Accept the latest information as most accurate.

Consult with the source of inconsistent data.

Ask for a medical review of client care.

Explanation:

Inconsistencies in social, medical, and functional data are not uncommon, so the case manager should first consult with the source of inconsistent data to try to determine the reason for the inconsistency. In some cases, the inconsistency may result from error or misstatements. In other cases, the client's condition may have changed from one assessment to another. The client usually serves as the primary source of information, but other sources can include family, friends, employers, physicians, other healthcare providers (such as home health nurses and physical therapists), and medical records.

140.

The level of care that provides people with moderate assistance in activities of daily living and periodic nursing supervision for some activities is:

Custodial care.

Intermediate care.

Skilled nursing.