The Case Manager's Handbook 6th Edition
Home Study Course Questions

Chapter 1: The Case Manager as Catalyst, Problem Solver, Educator

1. It is the case manager's responsibility to make assessments and recommendations based upon:
   a. The client's ability to pay for the services.
   b. The organization's relationship with the providers.
   c. The provider's recommendations from other patients.
   d. An objective assessment of the client's medical, motivational and psychosocial needs.

2. Case management is a collaborative process that includes:
   a. Assessment, precertification of services, planning and coordination of essential services.
   b. Precertification and utilization management, benefit determination, two-midnight rule determination and appeal/denial management of services being requested.
   c. Assessment, planning, implementing, coordination, monitoring and evaluating the options and services required to meet a client's health and human service needs.
   d. Meeting with families, documenting requests that have been denied, incident reports and holistic management.

3. The focal point of case management in all of its roles is to:
   a. Empower patients with knowledge and resources which will allow them to be active participants in their care.
   b. Reduce fraud and abuse in all of its forms.
   c. Elevate the position of case managers within the organization.
   d. Assist the providers of care and services to understand the needs of their patients.

4. The proliferation of titles and the fragmentation of the various roles and functions incase management:
   a. Allows organizations to hire one person for several roles.
   b. Demonstrates the flexibility of case managers to multi-task.
   c. Creates confusion among patients, their families and other providers and erodes the full extent and value of case managers.
   d. Is a response to a trend toward the merger of responsibilities and functions.

5. Select the correct statement:
   a. Licensure and Certification are the same.
   b. Standards of Practice are only for certified case managers.
   c. Accreditation is granted to organizations; certification is granted to individuals.
   d. Case managers must be registered nurses.

Chapter 2. The Case Manager's Universe

1. Hospitalists are physicians who:
    a. Manage the Intensive Care Units of Hospitals.
    b. Manage the majority of a patient's care when patients are hospitalized.
    c. Manage hospice organizations.
    d. Are licensed to work in hospitals rather than office-based practices.

2. A local healthcare organization and a related set of providers that are responsible forthe cost and quality of care delivered to a defined population is called:
    a. Managed Care Organization (MCO)
    b. Point of Service (POS)
    c. Accountable Care Organization (ACO)
    d. Affordable Care Association (ACA)

3. A Patient Centered Medical Home (PCMH):
    a. Seeks to bring other professionals e.g. social workers, pharmacists and others into a collaborative team on behalf of patients, especially those deemed at most risk.
    b. Is a capitated fee agreement between patients and teams of physicians.
    c. Controlled and licensed by counties and municipalities.
    d. Designated by providers and payers as a solution to increasing costs and complexity of medical conditions.

4. The organization that accredits rehabilitation facilities is:
    a. Association for Rehabilitation Providers (ARP)
    b. Commission for Rehabilitation Organizations (CRO)
    c. Commission for Accreditation of Rehabilitation Facilities (CARF)
    d. National Rehabilitation Association (NRA)

5. The organization that provides evidence-based medicine and guidelines for care is:
    a. World Health Organization (WHO)
    b. National Practice Guidelines Organization (NPGO)
    c. Agency for Healthcare Research and Quality (AHRQ)
    d. National Clearinghouse for Care (NCC)

6. The characteristics of a patient-centered medical home include all of the following <u>except:</u>
    a. Physician-directed medical practice and whole person orientation.
    b. Coordinated and integrated care.
    c. Enhanced access to care and improved quality and safety.
    d. Reduction in medical errors and lawsuits.

7. At the microsystem level or point of care, case managers evaluate clinical, satisfaction,functional, selected financial and other quality outcomes for:
    a. Hospitals
    b. Insurance Carriers
    c. Individual patients
    d. Group medical practices

8. The organizational analysis of outcomes from case management has its focus onaggregate data for an entire population. This outcome level is also called:
    a. Macrosystem
    b. Strategic methodology
    c. Risk Allocation
    d. Variance

Chapter 3: The Case Manager's Work Format and Process

1. The accuracy of the entire case management process depends on the informationgathered. The process of collecting information might include all but which one?
    a. Scheduling a conversation with the referral source.
    b. Determining policy limits and coverage.
    c. Interviewing the patient's accountant.
    d. Interviewing the patient and family.

2. In the interview process, RIP stands for:
    a. Rapport, Information, Plan
    b. Review, Inform, Process
    c. Report, Infer, Protect
    d. Report, Interview, Proceed

3. In order to determine eligibility for case management, both a screening and riskstratification should take place. Three assessment tools include:
    a. The SF 36 (Short Form 36), the PAM (Patient Activation Measure) and BMI.
    b. The BMR, CMA, and SF 36.
    c. The SF 36, the PAM (Patient Activation Measure) and Health Risk Assessment (HRA).
    d. RST (Risk Stratification Tool), SF 36 and Health Risk Assessment (HRA).

4. The primary purpose of the case management process is to:
    a. Prevent excessive use of precious health resources.
    b. Ensure appropriate, high-quality care for at-risk individuals in a timely and cost-effective manner.
    c. Avoid costly legal action by safeguarding PHI.
    d. Position the case manager as a patient advocate.

5. A case management plan should be:
    a. As concise as possible because no one actually reads them.
    b. Useful to the payer in order to control costs.
    c. Focused, action-oriented, measurable, attainable and fiscally responsible.
    d. Aligned with those services covered by the funding source.

6. Sometimes individuals are most appropriately identified for case management through:
    a. Predictive modeling, health risk assessments, flags in a claims payment system.
    b. Utilization review, auditors spotting high-cost cases, community organizers.
    c. Specific medical conditions, failure to refill prescriptions, applications for food stamps.
    d. Rejections by family care providers, housing shortages for the homeless, increase in emergency room visits.

7. Typically, case management should be targeted for those with complex conditions and who present significant risks to themselves and to the payers of care and services. In an employer-sponsored health plan the following may be considered "red-flags":
    a. Repeat back injuries, multiple absences from work, frequent workplace accidents.
    b. Extended hospital confinement, multiple hospital admissions, multiple medical conditions and providers.
    c. Post-operative infection, history of drug abuse, unauthorized leave of absence.
    d. Application for FMLA, repeat requests for therapy, non-adherence to diabetic diet.

8. In developing a case management plan, specific activities would include all but:
    a. Contacting the patient in the hospital.
    b. Meeting with the family.
    c. Reviewing the patient's financial statements.
    d. Consulting with the primary care physician and other providers.

9. In CMSA's Standards of Practice, the case managers will seek to identify opportunities for intervention when there is:
    a. Compromised patient safety, poor pain control, high-cost injuries or conditions.
    b. Sufficient benefit coverage, normal health literacy levels, psycho-social support.
    c. Physician respect for the case manager's role.
    d. Policies that pay for case management intervention.

10. In the screening process of potential candidates for case management in an employer-sponsored health plan, these aspects are important consideration:
    a. Likelihood of a successful outcome and ease of management.
    b. Knowledge of the claims adjudication process and that case management services will be reimbursed.
    c. Eligibility of the patient for coverage and the identification of high-cost or high-risk clients.
    d. Actively employed with a compensable injury.

11. In the planning phase of the case management process the following is determined:
    a. Problems are identified and prioritized; goals are identified and the plan of care is documented.
    b. Willingness of the providers to accept charity patients.
    c. Ability of the case managers to accept own knowledge deficits.
    d. Ease of transition to out-of-network provider.

12. The Commission for Case Manager Certification (CCMC) has identified seven knowledge domains for case managers. These include:
    a. Case management concepts, healthcare reimbursement, principles of practice, healthcare management and delivery, centers of excellence, legislative issues and rehabilitation.
    b. Healthcare innovation, evidence-based practice guidelines, Affordable Care Act, principles of practice, risk management, advocacy, and utilization management.
    c. Case management concepts, principles of practice, healthcare management and delivery, healthcare reimbursement, psychosocial aspects of care, rehabilitation, and professional development and advancement.
    d. Case management outcomes, legal issues, health and public policy, evidence-based practice guidelines, certification and accreditation principles, communication skills and negotiating principles.

13. In implementing a plan of care for a client, some activities might include:
    a. Arranging the services; designating tasks and coordinating the services; and maintaining communication with members of the healthcare team and stakeholders.
    b. Determining the easiest tasks and doing them first; rejecting alternate suggestions for more time-intensive plans.
    c. Delaying discussion of the details of the plan from the family who might object to the demands on their time. that the plan might involve.
    d. Refusing to any discharge plan that would occur over a weekend.

14. In assessing a patient, it's important for the case manager to first:
    a. Determine the patient's insurance benefits for care that might be recommended.
    b. Determine the patient's comprehension of his/her medical condition.
    c. Determine the patient's support system.
    d. Ensure the insurance provider will accept the involvement of the case manager.

15. In order to obtain the most accurate and objective picture of a patient's condition, it's helpful to speak with:
    a. The patient, family and treating professionals.
    b. Only the patient due to HIPAA regulations.
    c. Those designated as the patient's healthcare proxy.
    d. The patient and the insurance company who will have the claims history.

16. As defined in the Case Management Body of Knowledge (CMBOK TM) the first step in the case management process is:
    a. Assessment
    b. Screening/identification
    c. Goal-setting
    d. Communication

17. Case management intervention would be beneficial for the following problems:
    a. Lack of a clear plan of care with established goals and indication of substantial savings.
    b. Patient non-adherence to a plan of care and lack of a support system.
    c. Excessive use of services and denial of payment by insurance carrier.
    d. Confusion about complementary medicine for the treatment of back and muscle pain.

Chapter 4: Communication and Patient Engagement

1. In 1988, the Picker Institute coined the term “patient-centered care”. The characteristics of this include:
    a. Physical comfort, coordination and integration of care, access to care.
    b. Avoidance of unnecessary procedures and timely appointments.
    c. Involvement of eastern medicine for treatment.
    d. Stress-free offices and inclusion in clinical trials.

2. Communication with members of the patient’s care team is necessary in case management in order to achieve all but the following:
    a. Create an effective care plan.
    b. Establish goals.
    c. Demand their cooperation.
    d. Improve outcomes and enhance patient satisfaction.

3. Ineffective communication by case managers with patients can result in:
    a. Confusion, anger, errors and an increase in costs.
    b. Poor results for the informatics staff.
    c. Decrease in staff satisfaction.
    d. Decrease in referrals to that organization.

4. Barriers to effective communication include all but the following:
    a. Socioeconomic class, religion and language.
    b. Culture and sexual orientation.
    c. Membership on Facebook and use of twitter.
    d. Depression, pain and anxiety.

5. The Center for Advancing Health defines “patient engagement” as:
    a. An individual who selects a provider based upon credentials and outcomes.
    b. Actions individuals must take to obtain the greatest benefits from the health care services offered to them.
    c. Those patients who are compliant with treatment plans.
    d. An effective tool in motivational interviewing.

6. A strategy that incorporates talking and listening with a focus of determining a patient’s ability to be adherent to treatment is called:
    a. Interactive communication
    b. Effective communication
    c. Motivational interviewing
    d. Reflection

7. Understanding the physician’s perspective about case managers is important because:
    a. The case manager must maintain control of the patient.
    b. The physician and the case manager share the same goals of wanting the best outcome for the patient.
    c. Unless there is a positive relationship, great harm to the patient will result.
    d. Case managers can influence payment decisions to physician practices.

8. To create collaboration, case managers should do all the following except the following:
    a. Have insight into the patient’s needs.
    b. Make it clear to the physician that the patient is their first concern.
    c. Create an atmosphere of cooperation.
    d. Skip introductions because they are time-consuming.

9. To enhance physician-case manager relationships you should do all except:
    a. Develop an understanding of the physician practice.
    b. Go in as a knowledgeable professional.
    c. Drop in any time to visit the physician…the chances are good he/she will see you.
    d. Let the physician know you appreciate his time.

Chapter 5: Hospital Case Management: Changing Roles and Transition of Care

1. In the 1990’s, several models of case management were used by hospitals. Two of these were:
    a. Coordinated and evolving
    b. Utilization review and discharge planning
    c. Consolidated and integrated
    d. Unit based and social work

2. A complicated formula that will review or penalize hospitals for how well they perform is called:
    a. Reimbursement Audit Compensation (RAC)
    b. Hospital Value-Based Purchasing Program (HVBP)
    c. Level of Care Determination and Reimbursement (LOCR)
    d. Milliman & Roberts Guidelines (MRG)

3. A landmark study in 2009 that eventually resulted in a decision by CMS (Centers for Medicare and Medicaid) to impose financial penalties on hospitals found that:
    a. Almost 20% of patients were readmitted in less than 30 days after a discharge.
    b. Nosocomial infections were increasing.
    c. Staff turnover was responsible for medical error.
    d. Community, non-profit hospitals performed better than for-profit ones.

4. In 2013, CMS introduced new regulations to control situations where patients were classified as inpatients without meeting the criteria of the "two-midnight" rule. This is also known as:
    a. Alternate Site Placement (ASP)
    b. Room and Care Audit (RCA)
    c. Observation Status
    d. Level of Care Determination (LOCD)

5. The National Transitions of Care Coalition (NTOCC) recommends seven essential interventions to reduce readmission incidents. These include all but:
    a. Transition planning
    b. Follow-up care
    c. Patient and family engagement
    d. Monetary incentives to at-risk patients to encourage adherence to treatment plans

6. Ensuring the safe use of medications by patients based on their plan of care is called:
    a. MedCheck
    b. Medication Management
    c. Pharmaceutical Restoration
    d. Physician-Patient-Pharmacist Plan – the 4 P's

Chapter 6: ACOs, PCMHs, and State Health Exchanges

1. The following is a healthcare model introduced by the Patient Protection Affordable Care Act:
    a. Disease Management Programs
    b. Transition Care Initiatives
    c. Accountable Care Organizations
    d. Health Savings Accounts

2. An issue that has received much attention following the enactment of the Patient Protection Affordable Care Act is:
    a. Decreased reimbursement for avoidable readmissions that occur in less than 30 days after discharge.
    b. Introduction of new ICD-10 and CPT codes.
    c. Overpayment to home care agencies.
    d. Overutilization of inpatient hospitalizations.

3. CMS expects Accountable Care Organizations (ACOs) to:
    a. Generate more profits than HMOs (Health Maintenance Organizations).
    b. Deliver seamless, high-quality care for medical beneficiaries.
    c. Reduce the use of the Emergency Room by 20% within 3 years.
    d. Increase the use of generic drugs.

4. When healthcare systems provide case managers to physician practice groups the term used is:
    a. Coordinated care managers (CCMs)
    b. Physician practice navigators (PPNs)
    c. Embedded case managers
    d. Clinical transformation specialists

5. In order for the patient-centered medical home (PCMH) to be successful, case managers will need to:
    a. Focus on those patients with the most complex conditions and highest costs.
    b. Obtain specialized certification for this newest practice setting.
    c. Purchase additional malpractice insurance.
    d. Only use evidence-based guidelines.

Chapter 7: Independent Case Management

1. In determining if you have what it takes to enter the practice as an independent case manager, which of the following should not be a consideration?
    a. Can I imagine myself to be my own boss?
    b. Am I self-disciplined and can I make effective decisions?
    c. Can I be an effective patient advocate without the support of other staff and colleagues?
    d. Is my current position paying me what I deserve?

2. Independent case managers should have:
    a. Experience in case management and marketing expertise.
    b. Business contact in their community and negotiated contracts with providers.
    c. Advanced case management experience; CCM certification or working toward that and demonstrated ability to work independently.
    d. A business office in a prestigious location to attract wealthy clients.

3. Community-based case managers must:
    a. Be willing to reduce their fees 20 percent than their competitors in order to gain a market advantage.
    b. Be willing to develop new skills in order to establish and expand their practice.
    c. Purchase new wardrobes, and locate their offices in upscale communities in order to impress prospective clients.
    d. Refuse to negotiate their fees in order to demonstrate strength and success.

Chapter 8: Home Care Case Management, Long-Term Care and Healthcare Reform

1. Before transfer home the patient's condition should be:
    a. Evaluated for palliative and hospice care benefits.
    b. Stable and safe for transition.
    c. Monitored for appropriate placement in a community-based program.
    d. Free from any infectious diseases.

2. In a home visit by a case manager which of the following is not a consideration?
    a. Is the home in rural or city setting?
    b. Is there access to emergency services and transportation to that setting?
    c. Are there recreational activities for agency care providers?
    d. Is there room for the required equipment?

3. When a patient is discharged to home care, the case manager should:
    a. Assess care needs and coordinate with providers.
    b. Work quickly to expedite the discharge before the Friday afternoon rush?
    c. Hand off responsibilities that are clerical.
    d. Be relieved that her job is done.

4. In the elderly, potential complications from hospitalization include all of the following except:
    a. Prolonged immobilization, nutritional wasting, and hallucinations.
    b. Decubiti, muscular degeneration, and insomnia.
    c. Falls, fractures, and medication errors.
    d. Elevated plasma volume, decrease in infections, and increased socialization.

5. While home care is often an attractive and cost-effective option for some patients there are others who may object. Their reasons may include all but the following:
    a. Loss of feeling of security that patients feel, fear of managing care by themselves.
    b. Anxiety about a sudden emergency.
    c. Lack of trust in new providers.
    d. Preference for attention from visitors while in the hospital, rather than home.

6. Case managers need to be able to evaluate which patients are not appropriate for home care. Those case managers who are involved telephonically need to:
    a. Gather information for additional malpractice insurance.
    b. Understand when an onsite assessment of the patient's home is necessary in order to evaluate safety and appropriateness.
    c. Only arrange for services that will be reimbursed by insurance.
    d. Ensure that all of the providers are in the patient's network.

7. When a patient requires long-term care at home:
    a. There is always dissatisfaction with provider choices and costs.
    b. Families often require respite from 24/7 responsibilities.
    c. Case managers can terminate their involvement as soon as the necessary services are in place.
    d. The ROI from a less costly setting is always realized.

8. Which of the following are not indicators that a case could be a long-term one:
    a. Diagnosis of a terminal illness
    b. Catastrophic injury
    c. Lack of improvement or multiple complications
    d. Lack of insurance

9. The type and level of involvement on a long-term case depends on which of the following?
    a. Diagnosis, age, prior medical history, and current situation.
    b. Existence of malpractice litigation.
    c. Concerns raised by the patient and family about costs.
    d. Existence of medical error.

10. Financial resources for long term care are:
    a. Never a concern
    b. Occasionally a concern
    c. Always a concern
    d. Never available for patients with dementia

11. An important factor for an independent case manager to be aware of in a long term case is:
    a. The existence of sufficient funds to pay for the case manager's services.
    b. The ability to make weekly visits.
    c. To remain as an advocate and professionally objective.
    d. Remaining emotionally detached from family members.

12. According to the Institute of Medicine (IOM) report "To Err is Human", the following issue may be responsible for more than 98,000 deaths annually:
    a. Diabetes
    b. Medical errors
    c. Aging
    d. Obesity

13. Helping families through long term cases is an extremely valuable contribution that case managers provide. Examples of recommendations that might be helpful include all but the following:
    a. Suggesting family counseling.
    b. Suggesting the primary care giver join a support group.
    c. Telling the family that the insurance carrier will provide reimbursement for respite care.
    d. Reminding family members about the importance of taking care of themselves i.e. keeping medical appointments, getting exercise etc.

Chapter 9: Pediatric Case Management

1. Children are often our most vulnerable patients due to a variety of factors. These include all but the following:
    a. They may not have speech.
    b. Be unable to express symptoms or what he is actually experiencing.
    c. Be afraid of medical procedures.
    d. Are more interested in play activities.

2. There is a higher incidence in medication errors and hospital admissions in children due to:
    a. Inability of children to communicate any adverse effects that their medications may be causing.
    b. Reluctance of providers to prescribe for children.
    c. The concern parents have that their child will become addicted.
    d. Direct to consumer advertising.

3. Regardless of the level of care coordination and case management provided, pediatric case management must be:
    a. Less expensive than that provided for adults.
    b. Patient and family centered.
    c. Restricted to those with an intact family support system.
    d. Focused on meeting all of the child's needs.

4. One of the major challenges facing healthcare professionals, including case managers, is parents' refusal to immunize their children. Among the top reasons given for this refusal are all but the following:
    a. The autism debate.
    b. That a gluten-free diet provides the best immunity.
    c. Belief that the vaccines aren't effective or safe.
    d. Distrust of the pharmaceutical and healthcare industry.

5. An estimated 10 percent of pediatric hospitalizations are for a primary mental health diagnosis. Parents need to be educated regarding potential behaviors that could signal a serious mental health problem in their child. These include:
    a. Changes in appetite, social withdrawal, self-destructive behavior or a focus on death.
    b. Wanting to join multiple sports activities without practicing.
    c. Preferring video games to school work.
    d. Disrespectful attitude toward teachers and other adults.

Chapter 10: Workers' Compensation Case Management Overview

1. Workers' Compensation insurance is:
    a. Only for fully insured employer organizations.
    b. Controlled by the federal government in order to reduce costs to the states.
    c. Is mandated for all employers on behalf of their employees except for domestic service employees, agricultural employees and employees at small companies.
    d. Guarantees replacement of lost wages until the employee is fully recovered.

2. The costs for workers' compensation insurance is based upon:
    a. The costs of litigation related to lost-time injuries.
    b. The number of employees in the organization who have been injured previously.
    c. The employer groups' actual experience and the costs associated with both medical costs and wage replacement.
    d. The age and gender of the employees in the organization.

3. Case management in workers' compensation cases should be considered for all but the following:
    a. Those who have sustained catastrophic injuries e.g. spinal cord injury, amputation.
    b. For cases where the claims examiner requests a non-scheduled visit by the case manager to check on the claimant's ability to return to work.
    c. For those who have repeat injuries or failed back surgeries.
    d. For medical issues and associated disabilities that are not resolving in a timely manner.

4. The role of the case manager in workers' compensation case management includes all but the following:
    a. Coordinating medical care and treatment.
    b. Assisting with a timely return to work for the employee.
    c. Investigation of the claim to assist with establishing causality.
    d. Advocating for the most effective treatment for the claimant while monitoring the efficient use of dollars for care and services.

5. When an employee has a diagnosis or injury that is complicated by a mental health condition there are challenges because:
    a. Employers don't want to take someone back who may be more at risk in the workplace.
    b. The stigma of a mental health problem prevents appropriate treatment.
    c. Increased concern for drug dependency.
    d. There is no objective tool that can accurately determine a continuing need for treatment or ability to return to work.

6. In workers' compensation case managers need to do all but the following:
    a. Educate the worker about his/her injury and the rehabilitation and return to work (RTW) process.
    b. Assess the worker's motivation and provide continuing encouragement for adhering to the recommended treatment plan.
    c. Agree to serve as an expert witness if there is a lawsuit.
    d. Keep all parties fully informed at all times regarding progress, developments and/or setbacks.

Chapter 11: Legal Responsibilities of the Case Manager

1. Which of the following statements is not true?
    a. A case manager should have the patient's consent to engage in case management services.
    b. The employer paying for case management services has the right of access to the patient's medical records.
    c. It is the case manager's responsibility to protect the rights of the patients with whom she is working.
    d. With authorization from the employer, the case manager can share confidential medical information with the injured worker's coworkers.

2. The failure to meet a standard of care or failure to deliver care that a reasonably prudent case manager would deliver in a similar circumstance is:
    a. Malpractice
    b. Criminally irresponsible
    c. Violation of risk management principles
    d. Quality of care metric

3. Potential issues for case manager liability include:
    a. Premature discharge and RAC audits.
    b. Failure to communicate, failing to adhere to standards of care, failure to document and failure to assess and monitor.
    c. Exaggeration of expertise and incorrect documentation.
    d. Failure to report incident, failure to provide diagnostic study reports, failure to warn about potential lawsuits.

4. The concept that allows nurses to practice across state lines or in participating states is called:
    a. National Council State Boards of Nursing (NCSBN)
    b. Nurse Licensure Compact (NLC)
    c. Multi-State Practice Agreement (MSPA)
    d. National Board of Nursing Agreement

5. The document created by the Case Management Society of America that provides guidance, direction and the scope of practice for case managers is the:
    a. Case Management Model Act
    b. Standards of Practice for Case Management
    c. Consent Authorization Form
    d. Principles of Case Management Competency

6. There are four elements of a malpractice lawsuit. To prove malpractice, an attorney must prove all but the following:
    a. The case manager had a duty to the patient. The duty is established by the standard of care.
    b. The patient suffered an injury or damage.
    c. The case manager failed to carry malpractice insurance.
    d. The case manager breached of the duty is the cause of the patient's injury.

7. When there is a question of a patient's mental competency or capacity, the case manager should:
    a. Avoid obtaining a consent for case management because it wouldn't be valid.
    b. Decline the referral because it would place the case manager at significant risk.
    c. Involve family members in the case management plan and recommend that they seek legal help to establish power of attorney.
    d. Obtain additional malpractice insurance.

8. The process utilized by professionals, including case managers, to explain the risks and benefits for each treatment being proposed is called:
    a. Informed consent
    b. Fiduciary responsibility
    c. Due diligence
    d. Professional courtesy

9. In its Accreditation Manual for Hospitals, the Joint Commission identified privacy and confidentiality as two patient rights that entitle a patient to all the following except:
    a. To be interviewed and examined in surroundings designated to ensure reasonable visual and auditory privacy.
    b. To expect all communications and other records pertaining to the patient's care, including the source of payment for treatment, to be treated as confidential.
    c. To be placed in protective privacy when considered necessary for personal safety.
    d. Access to information about malpractice claims that might be in existence for providers treating them.

10. Case managers can decrease the legal liability associated with patient discharges through:
    a. Decreasing the average length of stay of their clients.
    b. Confirming the appropriateness of the discharge plan, the safety of the home and the consensus of the stakeholders.
    c. Ensuring that the providers are in-network.
    d. Ensuring prompt payment of claims.

11. When considering a practitioner or a facility for referral, a case manager should do all of the following except:
    a. Examine current licensure and accreditation.
    b. The outcomes of cases similar to the one under consideration.
    c. The insurance benefits or coverage available for the recommended service.
    d. Limit the choice of providers which might cause a delay in discharge.

12. In Medicare's "Conditions of Participation", hospitals and managed care organizations are responsible:
    a. To advise patients just how they are to cooperate with treatment plans.
    b. To disclose direct or indirect financial relationships with agencies to whom they refer.
    c. To share the pricing and contractual arrangements obtained with employer health plans.
    d. To disclose which providers achieve the best return on investment, so appropriate decisions can be made.

13. The process of informed consent for case management services includes all of the following except:
    a. Giving the information verbally and in writing.
    b. Offer an opportunity for questions and answers to clarify the patient's understanding.
    c. Advising the patient which providers will waive copayments for services they provide.
    d. Witness the signing of the consent form and retain that in case management records.

Chapter 12: Ethical Responsibilities of the Case Manager

1. Which principle is not considered a moral or ethical principle or value?
    a. Capacity
    b. Autonomy
    c. Beneficence
    d. Veracity

2. When case management is done well, it pursues two moral goods. One moral good is patient advocacy. The other is:
    a. Agreeing with the client
    b. Getting advance directives to relatives
    c. Proper use of resources
    d. Always directing the client to the best course of action

3. The Principles of the Code of Professional Conduct for Case Managers include all but the following:
    a. Certificants will place the public interest above their own.
    b. Certificants will obey all laws and regulations relevant to case management practice.
    c. Certificants will maintain sufficient continuing education credits.
    d. Certificants will respect the rights and inherent dignity of all of their clients.

4. As a case manager for a client with a chronic illness, the health care team strongly recommends continuing treatment, but the patient and family are opposed. The most appropriate initial step to take is:
    a. Immediately consult with the ethics committee.
    b. Carefully review the treatment plan with the patient to ensure complete understanding.
    c. Arrange for an Independent Medical Examination (IME).
    d. Attempt to persuade the patient and family to cooperate with the treatment plan being proposed.

5. The primary role of the case manager, regardless of practice setting or funding source is to act as a:
    a. Negotiator
    b. Utilization reviewer
    c. Patient advocate
    d. Care coordinator

6. A managed care plan may have a contract provision that prohibits physicians from discussing treatment options that would not be covered by the plan and might adversely affect the financial reimbursement to the medical group. This provision is called:
    a. Gag clause
    b. Confidentiality agreement
    c. A financial ethical dilemma
    d. Non-participating provider clause

7. Advocacy versus Paternalism occurs:
    a. When the case manager overrides a benefit decision in order to promote a better outcome.
    b. When the case manager makes a decision that she believes to be in the patient's best interest without involving the patient.
    c. When cost containment issues result in underutilization of services.
    d. When treatment decisions are made by administrators in organizations in order to decrease costs.

8. Case managers should refrain from accepting finder's fees from head injury programs, theatre tickets or bonuses based upon saving obtained because:
    a. It's against the law.
    b. Disrupts the objectivity of the relationship that case managers need to maintain.
    c. Creates a barrier for professional relationships with colleagues.
    d. Corrupts the decision-making process and damages the reputation of case managers.

Chapter 13: Evidence Based Practice for Case Managers: Data-Driven Decision Making

1. All of the following are benefits to evidence-based case management except:
    a. The ability to create an individualized program based on other patients with similar situations.
    b. Increasing possibility of patient success.
    c. Greater recognition of consumers and legislators.
    d. Higher overall success rates help ease the demands of the system.

2. The reasons case managers may be reluctant to utilize evidence-based practice includes all but the following:
    a. Lack of understanding of the various data bases.
    b. Lack of computer skills.
    c. Unwillingness to change.
    d. Difficulty understanding and then incorporating the findings into practice.

3. Two types of evidence that can impact case management are:
    a. Utilization evidence and experiential evidence.
    b. Disease-based evidence and case management evidence.
    c. Return on investment and anecdotal opinions.
    d. Qualitative evidence and Macrosystem evidence.

4. Examples of credible disease-based evidence resources for case managers includes all of the following except:
    a. Medline-Plus (www.nlm.nih.gov/medlineplus/)
    b. Agency for Health Research and Quality (www.ahrq.gov)
    c. National Guideline Clearinghouse (www.guideline.gov)
    d. GoogleMed (www.googlemed.com)

5. Of the following, which should not be a consideration when looking at evidence-based case management information:
    a. Be peer reviewed and researched.
    b. Be applicable across all practice settings.
    c. Increases return on investment for case management services.
    d. The recommended intervention can be applied to a broad population.

6. Of the following which would not be an appropriate step in the application of evidence- based case management?
    a. Immediately implement solutions in order to obtain savings.
    b. Identify the problem or issue.
    c. Search for evidence that might be related to that problem.
    d. Analyze the evidence and the strength of the literature.

Chapter 14: Case Manager Credentialing

1. Which credential is not related to case management:
    a. CCM
    b. CDMS
    c. CCRN
    d. CRRN

2. Which statement is not true about the CCM exam?
    a. It is developed by academicians in order to raise the standards of the services being provided.
    b. To take the CCM exam one must have documented experience in case management.
    c. Many different position titles may be deemed eligible to apply for and take the exam.
    d. CCM is the only recognized credential for case managers.

3. The American Nurses Credentialing Center has a case management credential which is:
    a. RC CCM
    b. RN-BC
    c. ANCC-CM
    d. CMC

4. The process by which an impartial organization reviews a company's operations in order to insure that its business is in keeping with national standards is:
    a. Audit review
    b. Critical Assessment Analysis
    c. Accreditation
    d. Certification

5. An organization that provides accreditation for organizations providing case management services is:
    a. Interqual
    b. CMS
    c. HEDIS
    d. URAC

6. The only accreditation program that focuses on ensuring that the organization has processes to ensure safe transitions for patients across the continuum of care is:
    a. NCQA
    b. NTOCC
    c. CMSA
    d. CCMC

Chapter 15: Reimbursement Resources and Challenges

1. Which of the following statements is not true?
    a. The role of the case manager becomes more complex the larger the company that is insuring and the larger the group that is being insured.
    b. Insurance companies vary in how they work with case managers.
    c. In the majority of cases, the case manager is employed by the insurers or hospitals.
    d. The insurer's operations must be contained within one state.

2. In response to rising costs, many businesses have pursued alternative financing methods for their employee benefit plans such as:
    a. Bank loans
    b. Increased profits
    c. Self-Insurance
    d. Grant funding

3. Which statement is not correct?
    a. TPAs are Tools for Physician Administrators.
    b. ASOs are firms offering only administrative services for employer health plans.
    c. PPOs are preferred provider organizations.
    d. POSs are Point of Service Plans.

4. A case manager needs to know all but the following:
    a. The relationship of the referring party to the claimant.
    b. Vocational services that might be available for a claimant who needs them.
    c. Legal services that would assist a claimant with a malpractice suit.
    d. Medical management services.

Chapter 16: Healthcare Reimbursement: Private Sector or Employer Sector

1. Which statement about Auto Insurance is always true?
    a. Auto Insurance varies from state to state.
    b. Auto Insurance only pays for the physical damage to the automobile.
    c. Auto Insurance is always surrounded by litigation.
    d. Auto Insurance only pays for the at-fault driver's vehicular damage.

2. Knowing Group Medical Plan Benefits for a specific client is important because:
    a. It will determine what can be paid by the plan and which will be paid by the State Insurance Fund.
    b. COBRA benefits will be primary as soon as the client is disabled.
    c. The extent of medical benefits, is subject to the determination of the employer group or union contract, rather than the name of the insurance carrier.
    d. The employer can make exceptions for VIPs that other employees may not receive.

3. The legislation that requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events is:
    a. FMLA
    b. COBRA
    c. ACA
    d. TEFRA

4. The model of health care that was created following the growing dissatisfaction of employees about limited choices of physicians and providers is:
    a. HMO
    b. POS
    c. PPO
    d. PCMH

5. Medigap Plans can only be accessed by:
    a. Those individuals on Medicaid.
    b. Those who have served in the Military.
    c. Those individuals on Medicare.
    d. Those individuals who are frail and elderly.

6. The plans that provide for wage replacement when an employee is unable to work are called:
    a. Social Security Disability and ERISA
    b. STD and LTD
    c. COBRA and Medigap
    d. Supplemental Income and Provisional Benefits

7. The type of plan that allows individuals to personalize their coverage by selecting benefits, deductibles, premiums and copayments to suit their individual needs while assuming their own financial risk is:
    a. Consumer Directed Health Plan (CDHP)
    b. Point of Service Plan (POS)
    c. Health Savings Account (HSA)
    d. Voluntary Employee Benefit Assignment (VEBA)

8. Health insurance plans, insurance companies and others purchase reinsurance policies to reduce their risks when paying the healthcare claims of an individual or group. This type of insurance is also called:
    a. Term insurance
    b. Threshold protection insurance
    c. Triple indemnity insurance
    d. Stop-Loss insurance

9. When there are two or more coverages on a claim, there are rules governing which of the plans is primary and pays first, and which pays second. This provision is:
    a. Often arbitrary and capricious.
    b. The coordination of benefits process.
    c. Always favors the individual with better coverage.
    d. Negated in a contested claim.

Chapter 17: Healthcare Reimbursement: Public Sector

1. “Dual Eligibles” is a term used to define individuals who receive benefits from:
    a. Food Stamps and Housing
    b. Medicare and Medicaid
    c. Veterans Health Administration and TRICARE
    d. TRICARE and SSDI

2. Examples of public sector healthcare benefits include:
    a. Medicare, Children's Health Insurance Program (CHIP), Medicaid, and Health Insurance Plan (HIP).
    b. CHAMPUS, Medicare, Veterans Health Care and Viatical Settlements.
    c. Medicaid, TRICARE, Medicare and Veteran's Health.
    d. America Health, Medicare, TRICARE, CHAMPUS.

3. The name of the Department of Defense (DOD) healthcare plan for active and retired military personnel and their dependents is:
    a. Patriot Plan Organization (PPO)
    b. Government Allied Health (GAH)
    c. United States Health Services (USHS)
    d. TRICARE

4. The Children's Health Insurance Program (CHIP) was enacted by Congress in 1997:
    a. To provide coverage for children who are already receiving food stamps.
    b. To provide health benefits for infants and pre-school age children.
    c. To subsidize premium costs for employers who want to cover dependents of employees.
    d. To increase health insurance coverage for low-income children.

5. Medicare is an entitlement program created in 1965 for:
    a. People age 65 or older; those younger than 55 with certain disabilities and qualified for Social Security Disability (SSD) at least 24 months and those with end-stage Alzheimer's Disease.
    b. People over 65; those younger than 65 with certain disabilities and those with end-stage renal disease.
    c. For retirees of the federal government; those who are younger than 65 with certain disabilities and those providing documentation of immigration status.
    d. People born in the United States employed for more than 10 years and contributing to Social Security; those younger than 65 with certain disabilities; those with a wrap-around plan.

6. Medicare benefits under the Part A program include which of the following:
    a. Outpatient hospital services
    b. Ambulatory services
    c. Hemodialysis
    d. Inpatient hospital service

7. Medicare Part B helps pay for the cost of all except which of the following services?
    a. Physician services
    b. Medical equipment and supplies
    c. Outpatient services
    d. Prescription drugs

Chapter 18: Working Effectively with Claims Departments

1. Claims office titles may include all but the following:
    a. Processor
    b. Examiner
    c. Money manager
    d. Adjuster

2. Generally speaking, claims adjusters have all but the following:
    a. Only on the job training.
    b. Little knowledge of medical terminology.
    c. A focus on paying claims.
    d. Very few claims or cases at any given time.

3. Indicators for case management should include all of the following except:
    a. The most expensive cases.
    b. Frequent hospital admissions.
    c. Any cancer diagnosis.
    d. A prolonged hospital stay.

4. A plan administrator's responsibilities include all of the following except:
    a. Acting as the medical administrator for contested claim.
    b. Oversight of accurate and timely payment of claims.
    c. Appeals and denials.
    d. Adherence to the plan contract.

Chapter 19: Outcomes Management with Analysis of Financial and Quality Assurance Reporting

1. Which of the following is an example of hard savings?
    a. Avoidance of ED visits
    b. Avoidance of complications
    c. Avoidance of potential hospital readmission
    d. Change to a lower level of care

2. The case manager should:
    a. Stay away from the financial issues so medical judgment will not be compromised.
    b. Seek to understand the cost of claims and negotiate when appropriate for best cost and quality.
    c. Ask for legal counsel if approached to negotiate health care costs.
    d. Advise a supervisor if the client's health finances are mentioned.

3. Negotiating fees requires that case managers understand the existence of roadblocks. These include all but the following:
    a. Difference in educational backgrounds.
    b. Female to male communication styles.
    c. Lack of knowledge about the product or service.
    d. Previous success in negotiating.

4. To document a negotiated agreement you should:
    a. Confirm the agreement in writing.
    b. Not share it with others in order to protect the terms.
    c. Realize that negotiated agreements are not intended to be documented.
    d. Advise the competitors about this arrangement so they would offer the same.

5. Which of the following is not considered necessary in most negotiations involving case managers:
    a. Respect between the parties.
    b. Permission from senior management to enter into a negotiation.
    c. Trust and trustworthiness.
    d. The goal of a win-win outcome.

6. Cost benefit analysis reports should include all but the following:
    a. Document savings from case management intervention.
    b. Dollars spent vs. dollars saved.
    c. Detailed clinical patient information.
    d. Negotiated services that were used.

7. Cost benefit analysis reports are considered as:
    a. Quality Assurance Programs.
    b. Proof in a court of law that case managers are objective.
    c. Legal documents for risk management.
    d. Marketing tools for corporations.

8. The term that describes the results and consequences from the care that was received is:
    a. Intervention
    b. Quality improvement
    c. Outcomes
    d. Management by Objectives

9. The analysis of care at the point of care is said to be at the:
    a. Microsystem level
    b. Integrated level
    c. Macrosystem level
    d. Measurement Evaluation level

10. Tools used to capture outcomes and patient satisfaction include:
    a. Economic Research, Score Cards, and Customer Surveys
    b. Picker/Commonwealth Patient Satisfaction, the Agency for Health Research and Quality; and Hospital Consumer Assessment of Healthcare Providers and Systems
    c. Press-Ganey Survey, Health Grades, and AARP Reports
    d. HEDIS, Interqual and AHRQ Outcomes Analysis

Chapter 20: New Strategies for Leading a Case Management Department: Today and into the Future

1. Characteristics of good leaders and managers include all but following:
    a. Honesty and integrity
    b. Inspiration
    c. Ability to challenge
    d. Need to maintain strong control of subordinates

2. Complex skills for case management administrators, as defined by the Credentialing Advisory Board for Case Management Administrators should include all but the following competencies:
    a. Ability to identify at-risk populations.
    b. Negotiate for salary increases and benefits with unions.
    c. Development of strategies to manage populations.
    d. Human resources management.

3. In evaluating a case management department, the following is perhaps the most important consideration:
    a. Is there flexibility with the “red flags” for case management?
    b. Which staff members are poor performers?
    c. Have you established goals?
    d. Has the department been considered for accreditation?

4. A good business plan needs to consider the following:
    a. Type of company, structure, financial resources, and goals.
    b. Liability issues, management style of leaders, and target markets.
    c. Risk management strategy, competition, and location.
    d. Caseload, diseases to be managed, and staff competencies.

5. When staffing a case management department, some important considerations and characteristics for a potential staff member include all but:
    a. Professional background, education, and clinical experience.
    b. Flexibility, life experience, and demonstrated ability to overcome challenges.
    c. Number and age of children.
    d. Energy, creativity and commitment to professionalism.

6. Reviewing aggregate clinical, financial, quality, functional and satisfaction outcomes for entire populations in case management administration is considered to be:
    a. At the point of intervention by the case manager and after the case is closed.
    b. At the macrosystem level.
    c. Throughout the care continuum.
    d. For optimum resource management.

7. The purpose of outcomes management in case management is:
    a. To determine trends, to participate in clinical resource management decisions, and monitor return on investment.
    b. To analyze and justify staff resources; report findings to senior management.
    c. To provide justification for increase in staff and training resources; reward outstanding staff members.

Chapter 21: Predictive Modeling

1. A set of tools to stratify a population according to risk of adverse outcomes and cost is called:
    a. Case Management Identification
    b. A “Red-Flag” List
    c. Predictive Modeling
    d. Acuity Score Card

2. Predictive modeling can answer all of the following questions except:
    a. Is current care provided according to clinical guidelines?
    b. Are patients following self-care programs and refilling prescriptions?
    c. Which medical conditions are most costly?
    d. Which providers have incurred malpractice claims?

3. A goal of predictive modeling in healthcare settings is:
    a. To guarantee best use of resources.
    b. To tailor a disease management program to prevent costly complications for at-risk patients.
    c. To increase staff satisfaction by selecting only those patients that will adhere to recommended treatment.
    d. To avoid overcrowding of emergency rooms.

4. A benefit for case management departments using predictive modeling is:
    a. Resources can be focused on patients who need and want assistance.
    b. Elimination of RAC audits.
    c. Ensures comprehensive HIPAA compliance.
    d. Promotes referrals to in-network providers.

5. Positive benefits associated with predictive modeling include all but:
    a. Identification of individuals for specific types of programs.
    b. Established process to track clinical and financial outcomes.
    c. Increased focus on changing patient behavior once risks are identified.
    d. Guarantee of reduced costs.

Chapter 22: New Characteristics of Today's Healthcare System

1. The new healthcare delivery models such as the PCMH, and ACO are intended to improve the quality of patient care but in particular it has:
    a. A desire to restrict the use of providers outside the designated network.
    b. A mandate from the government to enforce adherence to treatment plans or risk financial penalties.
    c. A strong focus on accountability and a transition to a value-based healthcare delivery system.
    d. Financial incentives to reduce medical costs.

2. Three key factors that are driving new characteristics in today's healthcare systems and affecting the role of case managers are: the continuing trend of hospital consolidation, new models of care and:
    a. The increased competition for ancillary healthcare professionals.
    b. The growing shortage of physicians.
    c. Immigration.
    d. An increase in clinical trials.

3. The growing shortage of primary care physicians can be attributed to the expanded health insurance coverage ushered in by the ACA along with:
    a. An increase in the number of baby boomers who are aging.
    b. Growing dissatisfaction by physicians to achieve a work-life balance.
    c. Closure of medical schools.
    d. An increased concern about contracting disease from patients from other countries.

4. In response to the growing complexities in today's healthcare systems case managers may serve individuals in new roles. These new roles may include:
    a. Arbitrator, Mediator, and Consultant.
    b. Health Coach, Value Coach, and Wealth Coach.
    c. RAC Auditor, Appeals/Denial Director, and Documentation Coder.
    d. Informatics Professional, Ombudsman, and Health Blogger.

Chapter 23: Case Manager's Role in Value-Based Care

1. Three goals of the Triple Aim quality system are:
    a. Reduce medical errors, eliminate malpractice suits, improve staff performance.
    b. Enhance productivity, monitor the hospital's through-put, improve informatics.
    c. Improve the individual experience of care, improving the health of populations, reduce the per capita costs of care for populations.
    d. Reduce readmissions, improve patient adherence to treatment, reduce staff-burnout.

2. Healthcare providers, including case managers must prove that the concept of value also includes the value derived by the patient, as stated by the patient and documented by the provider. This metric is called:
    a. INTERQUAL
    b. Patient Reported Outcomes Measures (PROMs)
    c. HEDIS Score
    d. The HER

3. Examples of value-based models of healthcare include all but:
    a. Pay for performance model, PPO, Bundled Payment
    b. PCMH, Bundled Payment, Shared Savings Model
    c. HMO, Alternate Fee Arrangement, Capitation full-risk model
    d. Bundled Payment, IPA, PPO

4. The model in which providers share in the savings that accrue when spending on a defined population is less than the targeted amount is:
    a. Pay for Performance model
    b. Bundled Payment model
    c. Shared-savings model
    d. Capitation full-risk model

5. The Case Management Model Act supports the objectives of:
    a. Value-based healthcare
    b. Cost control measures
    c. A fully integrated model of care
    d. Single-payer healthcare system

Chapter 24: New Case Management and Healthcare Provider Approaches for Managing the High-Risk, High-Cost Patient

1. The process that can be utilized to create a predictive risk score for patients is:
    a. Analytic scoring
    b. Stratification
    c. Capitation
    d. Comorbid analysis

2. The strategy whose primary goal is to help improve the delivery of care, contain health costs and improve the health of a given community is known as:
    a. Integrated Health
    b. Value Based Care
    c. Population Health Management
    d. Health Promotion

3. Complex Care Management (CCM) programs used by larger practices with a higher number of complex patients may rely upon:
    a. Information systems and patient education videos
    b. Embedded case managers
    c. Home visits by physicians
    d. Families to update them on patient conditions

4. Conditions that are responsible for many hospital readmissions involving high-risk patients in the Medicare population include all of the following except:
    a. Congestive heart failure
    b. Chronic Obstructive Pulmonary Disease (COPD)
    c. Pneumonia
    d. Dementia

5. The benefits of Complex Care Management (CCM) programs include all but:
    a. Decrease in emergency department visits and reduced readmissions
    b. Lower costs and a decrease in mortality rates
    c. Reduced staff turnover and increased job satisfaction
    d. Improved quality of care outcomes and healthier lifestyles

Chapter 25: The Aging Population, Medical Advancements and New Case Management Considerations

1. Those case managers working with older adults and their families are typically called:
    a. Senior Placement Specialists
    b. Geriatric Care Managers
    c. Elder Navigators
    d. Placement Coordinators

2. Challenges in living longer include:
    a. Elderly growing in numbers; increase in racial and ethnic diversity; changes in living arrangements; health care needs and financial challenges.
    b. Increase in divorce rates, social isolation; decreased mobility.
    c. Death of significant other; home repairs; malnutrition.
    d. Dementia; Medicare Part D challenges; inflation and recreational problems.

3. Strategies that can be utilized to prevent or reduce the risk of disease in older adults include all but the following:
    a. Promote healthy lifestyle behavior; identify barriers for access to care.
    b. Increase the use of clinical preventative services; address cognitive impairment.
    c. Address issues related to mental health; provide education on planning for serious illness.
    d. Explore recreational activities to increase happiness with aging; estate planning.

4. Assistance with financial planning for older adults can best be addressed by any of the following except:
    a. Estate planner
    b. Elder Law Attorney
    c. Financial Counselor
    d. Funeral Director

5. In addressing the needs of older adults, case managers need to first:
    a. Assess their physical ability to function independently.
    b. Recommend relocating to home of a family member for those living alone.
    c. Only recommend services that are covered by Medicare.
    d. Discourage the use of pain medication in order to protect seniors from falls.

Chapter 26: Dying in America

1. CMSA's Dying in America Survey found all of the following challenges except:
    a. Patient's DNR requests are overridden by physicians.
    b. Patients are admitted to hospitals while actively dying with rehab orders.
    c. Doctors are unwilling to refer to hospice.
    d. Patients who are admitted to hospice spend 2-3 months.

2. According to the Pain Care Bill of Rights, the following applies:
    a. The right to report your pain and the right to have your pain assessed.
    b. The right to pain medicines as soon as you request them.
    c. The right to search for doctors who will meet you pain medication needs.
    d. The right to demand stronger medications or more frequent dosing.

3. Hospice care can be delivered: (select all that apply)
    a. In homes
    b. In the hospital
    c. In long term facilities
    d. Only in hospice facilities

4. The legislation that indirectly encourages individuals to make decisions now about the type and scope of medical care they will want when they are no longer able to make that decision themselves because of incapacitation is:
    a. Patient Self-Determination Act
    b. Affordable Care Act
    c. Advanced Directives
    d. Living Will

5. Appropriate items to discuss in Advanced Directive conversations are:
    a. The family trust and sale of property.
    b. The distribution of financial assets.
    c. The patient's wishes and designation of the healthcare proxy.
    d. The executor of the will.

6. In the Vietnamese culture, end of life care:
    a. Family has a central role.
    b. Family argues a lot about inheritance matters.
    c. There is little respect for elders.
    d. Is rarely discussed.

Chapter 27: Medication Management: A Case Management Call to Action

1. Polypharmacy incidence is defined simply as:
    a. The use of multiple and potentially addictive medications.
    b. The filling of prescriptions in multiple pharmacies.
    c. Taking more than five medications.
    d. The interaction and adverse reactions from medications.

2. The incidence of polypharmacy is increasing as:
    a. Our population ages, as the pharmaceutical industry continues research and development and as marketing continues to prescribers and consumers.
    b. Medicare Part D allows more liberal amounts of medications on its formularies.
    c. State and community programs fund for those uninsured or underinsured for pharmaceutical benefits.
    d. Access to care, services and benefits have expanded under the ACA.

3. When taking multiple medications, there is an increased risk of drug-related problems, including all of the following except:
    a. Over or under-dosage of medication
    b. Nausea and dementia
    c. Drug-drug interaction
    d. Adverse drug reactions

4. When clients have a polypharmacy situation case managers should:
    a. Report offending individuals to their managed care organization and pharmacist.
    b. Have them keep a list of all of their medications; appoint a lead physician to become the primary and only prescriber; enlist the assistance of a pharmacist.
    c. Avoid making any statements about their potential drug abuse in order to avoid litigation.
    d. Only become involved if they go to a different care setting.

5. In addition to taking more than five medications, polypharmacy can also include all but:
    a. The use of prescription or non-prescription medications that have no legitimate use.
    b. The use of multiple medications to treat the same condition.
    c. Borrowing medications from several sources.
    d. The use of medications to counteract the side effects of another medication.

6. "The standard of care that ensures that each patient's medications are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe, given the comorbidities and other medications being taken and able to be taken by the patient as directed" is the definition of:
    a. Medication Adherence
    b. Case Management Adherence Guidelines (CMAG)
    c. Council for Patient Safety to Promote Adherence
    d. Comprehensive Medication Management

7. The medication reconciliation process includes five steps:
    a. Develop list of the medications; develop a list of the medications to be prescribed; compare the medications on the two lists; make clinical decisions based on the comparison; communicate the new list to the patient and the caregivers.
    b. Develop a list of the medications; review those that are most costly; determine generic substitutions; obtain authorization from physician for alternate medications; provide new list to patient and caregivers.
    c. Request list of current medications from patient; obtain coverage provisions from funding source; make clinical decision based upon coverage provisions; refer patient for financial assistance; advise physician.
    d. Determine patient's diagnosis; review prescribed medications for those conditions; advise physician of any non-coverage issues after reviewing benefit coverage; arrange for substitutes for those medications that won't be covered; advise physician and patient.

Chapter 28: Pain Management

1. More than 40 years ago, noted nurse and researcher, Margo McCaffrey defined _____ as: "…whatever the experiencing person says it is, existing whenever the existing person says it does…"
   a. Depression
   b. Anxiety
   c. Pain
   d. Fear

2. _____ is a disorder that often lasts for months or years, cannot be fully relieved by standard medication or treatments, and may be a life-altering condition.
   a. Phantom limb pain
   b. Neurogenic pain
   c. Sympathetic dystrophy
   d. Chronic pain

3. The kind of pain which results from an injury, surgery, or trauma and is usually time-limited frequently decreasing as healing occurs is:
   a. Post-traumatic hypersensitivity
   b. Acute pain
   c. Acute neuralgia
   d. Intermittent dysalgia

4. Pain management programs are most likely to be successful when:
   a. They include non-narcotic medications and biofeedback.
   b. Are realistic and covered by insurance.
   c. Incorporate both the physical and emotional components of pain.
   d. They include medication, acupuncture, massage and occupational therapy.

5. In the management of patients with pain issues, which of the following should case managers not pursue:
   a. Their own feelings about pain management especially those surrounding addiction.
   b. The preferences of the patient.
   c. Discouraging the use of potentially addictive medications in patients with metastatic bone disease.
   d. That safeguards are in place to ensure safe treatment and protections from harm.

Chapter 29: Multiculturalism

1. The United States has at least _____ different ethnic cultures.
   a. 50
   b. 75
   c. 100
   d. 150

2. The process by which some ethnic cultures adopt the culture, values and norms of the dominant population is called:
   a. Racial bias
   b. Acculturation
   c. Ethnocentric preference
   d. Assimilation

3. When immigrants feel that in order to succeed they abandon their native culture, beliefs, norms and traditions and replace them with those of the dominant group this process is called:
   a. Racial identification
   b. Cultural awareness
   c. Cultural metamorphosis
   d. Assimilation

4. Cultural competency includes all of the following except:
   a. Understanding one's own cultural heritage; cross cultural skills.
   b. A belief that one's own heritage is the most worthwhile.
   c. Obtaining knowledge about cultural preferences of other groups.
   d. A multi-cultural workforce that is committed to ongoing education in order to meet the needs of a changing population.

5. A case manager's steps toward cultural competency include all of the following except:
   a. Participating in a cultural competency training program.
   b. Asking a family member to serve as an interpreter.
   c. Reading articles about cultural preferences.
   d. Not assuming sameness about members of a specific ethnic group.

6. The national Association of Social Workers has identified multiple aspects of cultural competence which include:
   a. Ethics and values; self-awareness; cross cultural knowledge; cross cultural skills.
   b. Organizational awareness; multicultural staff; willingness to adopt.
   c. Linguistically diverse staff; staff which mirrors the population being served; signage reflecting the cultures being served.
   d. Mandatory cultural competency for new staff; adherence to JCAHO standards for culturally competent care; certification for all care providers.

Chapter 30: Health Literacy and Adherence Issues

1. Recommended resources for case managers on health literacy include:
    a. Google, Wikipedia and HCFA.
    b. American Medical Society Foundation, Ask Me 3, National Patient Safety Foundation.
    c. National Institutes for Health and Washington Business Group on Health.
    d. Foundation for Wellness, Literacy for America, American Foundation for Health Literacy.

2. A case manager can improve communication with patients by all of the following except:
    a. Using plain non-medical language.
    b. Drawing pictures or showing colorful illustrations.
    c. Limiting the amount of information given.
    d. Speaking loudly and avoiding hand gestures which might be distracting.

3. Certain groups may be more vulnerable to a deficiency in health literacy than others and may include:
    a. Older adults; minority populations; immigrant populations.
    b. Patients with diabetes and hypertension.
    c. Adults living alone; individuals who receive government assistance.
    d. Adults in rural areas; children of immigrant parents.

4. Other factors contributing to low health literacy are which of the following?
    a. Stress; stigma associated with certain diseases; time; trust and communication.
    b. Misinformation from direct-to-consumer advertising; medical dramas on TV.
    c. Perceptions and values regarding non-invasive treatment.
    d. Preference for spiritual healing and meditation.

5. The levels of health literacy have been divided into 4 levels and include:
    a. Average, informed, proficient, superior
    b. Proficient, intermediate, basic and below basic
    c. Average, mediocre, below par, substandard
    d. Informed, intelligent, inquisitive, standard

Chapter 31: Obesity: The New Epidemic

1. Secondary issues arising from obesity include all but the following:
    a. Hypertension
    b. Diabetes
    c. Multiple sclerosis
    d. Joint and spine disorders

2. Obesity increases the risk of:
    a. Coronary artery disease, dyslipidemia, stroke
    b. Dementia, decubiti, vascular insufficiency
    c. AIDS, COPD, Lupus
    d. Arthritis, polycystic fibrosis, celiac disease

3. Approximately what percent of American are overweight or obese?
    a. 25%
    b. 50%
    c. 66%
    d. 75%

4. Normal BMI is:
    a. 35
    b. 25
    c. 45
    d. 15

5. Treatment strategies for obesity include:
    a. Acceptance by medical professionals, and improved guidelines.
    b. Diet, behavioral therapy, pharmaceuticals, and as appropriate, surgical intervention.
    c. Avoidance therapy, hypnosis, and acupuncture.
    d. Herbal treatment, shock therapy, behavioral counseling.

6. _____ is a set of negative attitudes directed toward people with obesity simply and solely based simply on their weight.
    a. Stigma
    b. Ethical bias
    c. Aversion
    d. Prejudicial judgment

7. Opportunities for case managers working with patients with obesity may include all but:
    a. Acting as coordinator bringing multiple providers and the patient together.
    b. Providing encouragement and reinforcement of goals.
    c. Identifying replacements for the addiction to food.
    d. Communicating in a trusting and caring manner.

Chapter 32: Behavioral Health with Primary Care: An Integrated Model of Care

1. In the United States, psychiatric disorders affect approximately what percent of the population?
    a. 10%
    b. 25%
    c. 50%
    d. 75%

2. Patients with chronic illnesses have up to what percent of concurrent psychiatric diagnoses?
   a. 20%
   b. 17%
   c. 50%
   d. 65%

3. One-half of all chronic mental illness begins by the age of ____, three quarters of these illnesses begin by age ____.
   a. 20, 45
   b. 14, 24
   c. 10, 30
   d. 2, 15

4. Treatment modalities for behavioral and mental health conditions can include all but the following:
   a. Pharmacotherapy, cognitive behavioral therapy
   b. Biofeedback, electroconvulsive therapy
   c. Counseling, hypnosis
   d. Fasting, detoxification

5. Evidence-based guidelines are important resources for case managers working with patients with behavioral, mental health and substance abuse disorders. Two resources for these are:
   a. AL- ANON and AA
   b. AHRQ and SAMHSA
   c. FDA and NIH
   d. JCAHO and AMA

6. Actions that case managers can take in order to improve outcomes in patients with complex behavioral health or mental health conditions include all but the following:
   a. Updating one's knowledge about the diagnosis, current treatments and medications.
   b. Speaking with the patient's family in order to obtain information about the patient's long-term psychological history and behavior.
   c. Immediately refer the patient to a case manager with more experience in order to avoid any potential liability.
   d. Despite the existence of disruptive or embarrassing actions by the patient, maintain respect for the individual as a human being.

7. The models which are best suited to address and treat patients' mental health and medical conditions are:
   a. Specialized mental health centers; outpatient clinics.
   b. Integrated case management models, patient-centered medical homes (PCMH).
   c. Accountable Care Organizations (ACOs), urgent care centers.
   d. Detox Programs, residential treatment programs.

Chapter 33: Healthcare Technology and Trends: Implications for Case Managers

1. A system for compiling and sharing relevant patient information in real time is:
    a. Quickly replacing person-to-person communication.
    b. Called Electronic Health Record (EHR).
    c. Called Protected Health Information (PHI).
    d. Shared with AHRQ to develop evidence-based guidelines.

2. Some of the technology improving care coordination and communication between providers and patients include:
    a. Text messaging, mobile health, remote patient monitoring and twitter.
    b. Mobile health, Pinterest, Google Health and Facebook.
    c. Mobile health, telemedicine, telehealth and remote patient monitoring.
    d. Insulin pumps, telemedicine, mobile health and skype.

3. "The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care" is:
    a. Telemedicine
    b. Remote patient monitoring
    c. Medical Analytics
    d. Informatics

4. Skills necessary for case managers in the future include all but the following:
    a. Data management
    b. Implementing evidence-based guidelines
    c. Creating websites
    d. Clinical and business analytics

5. Recommendations to secure EHR systems and protecting the PHI of patients include all of the following except:
    a. Use of encryption and authentication technologies; physical access controls.
    b. Limiting use of computers in public spaces; mandating security clearance for employees.
    c. Establishing written protocols regarding access to PHI; implementing robust password policies.
    d. Data integrity checks to detect corrupt files; diligent management of archived data.

6. Allowing patients to obtain an appointment with their personal physician or another member of the physician's office on the day that they call is known as:
    a. Open-access scheduling
    b. On-demand services
    c. Same-day visit
    d. Urgent care

Chapter 34: Transformative Healthcare Approaches for the Millennial Generation

1. Millennials are the first generation who:
    a. Were born into the digital era.
    b. Will live longer than the preceding generation.
    c. Will have a negative impression of healthcare providers.
    d. Will demand immediate access to healthcare.

2. When considering their choice of physicians, millennials find value in:
    a. Physician practices that promote their services on Facebook.
    b. Online physician reviews offered by other patients.
    c. Discounts to community pools and health food stores.
    d. Those physicians that their parents use.

3. According to research, millennials do have expectations of healthcare providers and these include:
    a. Ability to contact them for phone consults in order to avoid time-consuming office visits and to save money.
    b. Access to their medical records and multiple digital ways to engage with healthcare professionals.
    c. Access in the waiting rooms to wi-fi and interactive games.
    d. Adherence to on-time appointments which demonstrates respect and understanding of the many demands on the millennials time.

4. When working with millennials, case managers will often function as:
    a. Mediators in dysfunctional family situations.
    b. Surrogate parents for those living far away from home.
    c. A health coach providing encouragement and direction to maintain healthy lifestyles.
    d. Career and marriage counselors.

5. A model of medicine that empowers individuals to set and attain their own wellness goals with the one-on-one support and coaching of primary care physicians is:
    a. Health Maintenance Organization (HMO)
    b. Primary Care
    c. Community Based Care
    d. Concierge Medicine

Chapter 35: The Affordable Care Act of 2010: Implications for Case Managers

1. Some basic provisions of the Affordable Care Act (ACA) include all of the following except:
   a. Guaranteed coverage, no annual or lifetime limits.
   b. All individuals not covered by employer, Medicare or Medicaid must obtain a policy or face a financial penalty.
   c. Unlimited number of in-vitro procedures.
   d. Provisions for health exchanges in each state.

2. The Affordable Care Act provides an expansion of mental health and substance abuse services:
   a. Greater than those provided in 1965.
   b. At parity with medical and surgical benefits.
   c. Only if provided at government approved sites.
   d. In order to decrease overall disability related costs.

3. In order to address the issues of linguistic and health literacy, the ACA has several initiatives. Its primary goal is to:
   a. Insure fair and equal treatment for all communities and populations.
   b. Train providers in speaking more than one language.
   c. Mandate that all interpreters be certified by 2018.
   d. Eliminate all discrimination in agencies funded by CMS.

4. The Case Management Model Act of 2009 states that part of a case manager's responsibility is to:
   a. Report instances of malpractice.
   b. Cooperate with fraud investigations.
   c. Promote optimal consumer/patient safety.
   d. Always consider cost before implementing services for uninsured patients.

5. Competitive marketplaces for individuals and employers to purchase health insurance are called:
   a. Cooperative benefit systems
   b. Health care exchanges
   c. Subsidiary insurance cooperatives
   d. Stratified risk exchange