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Question: 1

When communicating patterns and trends, it is important to _____.

- A. Be factual.
- B. Be firm.
- C. Be emotional.
- D. Be creative.

Answer: A

Explanation:

Be factual. The primary focus when conveying patterns and trends, particularly in data-sensitive environments like healthcare or business, should be on the accuracy and reliability of the information. Patterns and trends are often used to make critical decisions; therefore, the information must be objective and supported by data. Presenting factual information ensures that the audience, such as doctors and leaders, can trust and utilize the insights provided to make informed decisions. The tone of the presentation should be professional and respectful, aiming to inform rather than persuade through emotion or bias.

Be firm. While it is crucial to be factual, being firm in your presentation of patterns and trends also plays a significant role. Being firm means being confident and clear in the delivery of information. It involves sticking to the facts and resisting the urge to downplay or exaggerate the data to fit personal biases or expectations. This approach reinforces the credibility of the communicator and helps the audience understand the importance and reliability of the information being presented.

Be emotional. Although the primary approach should be factual, incorporating a measured degree of emotional appeal can be effective, especially if the data impacts human lives. For example, when addressing patterns in patient recovery rates, a touch of empathy in discussing patient outcomes could make the presentation more relatable and compelling. However, it is crucial to balance emotional content with factual data to maintain professionalism and credibility.

Be creative. Creativity in presenting patterns and trends can also enhance the effectiveness of the communication. This does not mean altering facts but rather involves using innovative ways to present the data. Creative data visualization techniques, such as infographics, charts, and interactive presentations, can make complex data more accessible and engaging for the audience. Creativity can help highlight key trends and patterns in a memorable way, ensuring the audience grasps the essential insights without getting lost in the details.

Question: 2

A care plan for which condition will MOST likely end with the patient's death?

- A. Hip replacement.
- B. Diabetes.

- C. Unknown.
- D. Pancreatic cancer.

Answer: D

Explanation:

The question asks which medical condition from the list provided is most likely to end with the patient's death as part of the care plan. The options given are hip replacement, pancreatic cancer, diabetes, and an unknown condition. The correct answer is pancreatic cancer.

Pancreatic cancer is known for its particularly aggressive nature and poor prognosis. It is one of the deadliest forms of cancer due to its tendency to be diagnosed at a later stage, where symptoms become more apparent and the cancer may have already metastasized. According to various health sources, the five-year survival rate for pancreatic cancer is significantly low compared to many other cancers. This low survival rate is due to several factors including the difficulty in detecting the cancer early, the rapid progression of the disease, and the limited effectiveness of current treatments in more advanced stages. In contrast, the other conditions listed—hip replacement and diabetes—typically have much better prognoses. A hip replacement is a surgical procedure where a damaged hip joint is replaced with an artificial one. This procedure is generally performed to relieve pain and improve mobility, and it is not usually associated with a high risk of mortality. Diabetes, while a serious chronic condition that requires ongoing management, can often be controlled with medication, diet, and lifestyle changes. With proper management, many individuals with diabetes can lead long and productive lives.

The inclusion of an "unknown" condition does not provide enough information to determine the likelihood of death, making pancreatic cancer the clear answer when considering the severity and the usual outcomes of the listed conditions.

Therefore, in planning care for a patient with pancreatic cancer, medical professionals often have to consider end-of-life care as a significant component of the care plan. This might involve managing symptoms, providing palliative care, and supporting the patient and their family emotionally and psychologically as they navigate this challenging time. This is why a care plan for a patient with pancreatic cancer is more likely to end with the patient's death compared to the other conditions listed.

Question: 3

A patient has come into the ER after having excessive bleeding from the wrists. The nurse also noticed several cut marks on the wrist. The nurse likely recommended to the case manager to assess for what?

- A. Neglect.
- B. Alcohol abuse.
- C. Sexual abuse.
- D. Self-injury.

Answer: D

Explanation:

When a patient presents in the emergency room (ER) with excessive bleeding from the wrists accompanied by visible cut marks, it is crucial for medical professionals, including nurses and case managers, to consider self-injury as a potential cause. Self-injury, also known as self-harm or self-

mutilation, is the act of deliberately inflicting harm upon oneself without suicidal intent. The primary aim is typically to manage or relieve emotional pain or distress.

Self-injurious behavior can manifest in various forms, including but not limited to cutting, burning, picking at the skin, pulling out hair, and even more extreme behaviors such as bone breaking or hitting oneself. These actions often result in visible marks or damage to the skin, which can sometimes lead to serious medical complications if not adequately treated.

Individuals who engage in self-injury are often experiencing intense emotions that they find difficult to express or manage in healthier ways. This behavior is more prevalent among certain demographic groups, such as adolescents and young adults, particularly females. Additionally, individuals who have a history of trauma, abuse, or mental health disorders such as borderline personality disorder, depression, or anxiety are at a higher risk of self-injuring.

In the clinical setting, when a healthcare provider observes signs of self-injury, it is essential to approach the situation with sensitivity and care. The initial medical focus should be on treating any immediate physical injuries. Concurrently, a psychological assessment is critical to address the underlying emotional distress and to initiate appropriate mental health interventions.

The assessment may involve questions about the patient's emotional state, reasons for self-injury, frequency and methods of self-harm, and any previous attempts at seeking help. It is also important to evaluate the patient's support system and to provide resources or referrals for therapy and counseling. Effective communication and a non-judgmental approach are key in encouraging the patient to engage in more constructive coping mechanisms and in reducing the risk of future self-injury.

Overall, recognizing and addressing self-injury in clinical practice requires a multifaceted approach that includes immediate medical care, psychological support, and ongoing management strategies to help the patient develop healthier coping skills. By understanding and addressing both the physical and emotional aspects of self-injury, healthcare providers can significantly impact the recovery and well-being of affected individuals.

Question: 4

Which of the following is a high-risk diagnosis?

- A. Renal failure.
- B. HIV.
- C. Gestational diabetes.
- D. Bone marrow transplant.

Answer: C

Explanation:

A high-risk diagnosis refers to a medical condition that carries significant potential for serious health complications, which can lead to increased healthcare costs and intensive medical management. However, these conditions are typically less complex compared to catastrophic diagnoses, which involve extremely severe and often life-threatening conditions requiring extensive and costly treatment options. High-risk diagnoses are serious and require careful monitoring and management but are generally more manageable than catastrophic conditions.

Among the options given, Gestational diabetes is classified as a high-risk diagnosis. Gestational diabetes develops during pregnancy and can cause complications for both the mother and the baby if not adequately controlled. These complications might include high birth weight, premature delivery, and

increased risk of developing type 2 diabetes later in life for the mother. Although serious, with proper monitoring and management, gestational diabetes can often be controlled effectively, reducing the risk of complications.

On the other hand, the other conditions listed—Renal failure, HIV, and undergoing a Bone marrow transplant—are considered catastrophic diagnoses. These conditions are characterized by their severe impact on the individual's health, high treatment complexity, and significantly higher healthcare costs. Renal failure and HIV are chronic conditions that can severely impair the quality of life and require long-term, intensive treatment strategies. A bone marrow transplant is a complex procedure typically reserved for severe or life-threatening diseases like leukemia or other severe blood disorders, involving high risks and requiring extensive post-transplant care.

Therefore, among the options provided, Gestational diabetes is the correct answer to the question of which condition is a high-risk diagnosis. It is crucial to distinguish between high-risk and catastrophic diagnoses in clinical practice to plan effectively for the level of care and resources required.

Understanding these distinctions helps healthcare providers prioritize interventions and allocate healthcare resources appropriately.

Question: 5

DME coverage stands for:

- A. Durable Medical Equipment coverage.
- B. Direct Medical Elimination coverage.
- C. Durable Medical Elite coverage.
- D. Direct Medicine Equipped coverage.

Answer: A

Explanation:

DME coverage stands for Durable Medical Equipment coverage. This type of coverage is crucial for many individuals who require medical equipment to manage their health conditions in their own homes. Durable Medical Equipment (DME) includes a range of items such as wheelchairs, walkers, hospital beds, and other medical appliances that are prescribed by a healthcare provider to aid in a patient's quality of life. The primary criterion for an item to be classified as DME is that it must be able to withstand repeated use; it is not disposable. It must serve a medical purpose, be used in the patient's home, and generally not be useful to someone who isn't sick or injured.

Coverage for DME is provided under Medicare Part B, which covers outpatient care, preventive services, ambulance services, and certain other medical services that Part A does not cover. When a doctor prescribes DME, Medicare Part B typically covers 80% of the Medicare-approved amount for the equipment, after the patient meets the deductible. The patient is responsible for the remaining 20%. However, if the patient has supplementary insurance, such as Medigap, it may cover this remaining cost. To access DME coverage, the equipment must be prescribed by a doctor, and the prescription should indicate that the equipment is essential for the patient's quality of life. Additionally, the equipment must be sourced from a supplier that is enrolled in the Medicare program to ensure that the equipment meets the required medical standards and is cost-effective.

It is important for patients and caregivers to understand the specifics of DME coverage, including which items are covered and how to navigate the approval process to ensure they receive the benefits to

which they are entitled. Proper knowledge and management of DME can significantly enhance an individual's ability to manage health issues and maintain independence at home.

Question: 6

A case manager is reviewing a care plan before it goes into effect. The case manager believes an area that does not belong in the care plan was placed there. Which of the following does not belong in the care plan?

- A. Suggested outcomes.
- B. Costs of each nursing action.
- C. Nursing orders.
- D. Evaluations.

Answer: B

Explanation:

Creating a comprehensive and effective care plan is a crucial part of managing patient health in any healthcare setting. A care plan is typically structured to address several key components that focus on the patient's specific health needs and the strategies to meet those needs. These components generally include diagnoses or problems, goals or expected outcomes, nursing orders, and evaluations. Each of these areas plays a vital role in ensuring that the care provided is both appropriate and effective.

Diagnoses or problems are identified based on a thorough assessment of the patient. These are issues that the healthcare team needs to address and can include medical conditions, as well as psychosocial, cultural, or spiritual issues.

Goals or expected outcomes define what the healthcare team hopes to achieve through their interventions. These should be specific, measurable, achievable, relevant, and time-bound (SMART).

Nursing orders are the specific interventions that the nursing staff will undertake to achieve the set goals. These can include medication administration, therapies, patient education, and other nursing activities tailored to address the diagnosed problems.

Evaluations involve assessing the effectiveness of the care plan and determining whether the goals have been achieved. This component is crucial as it informs necessary adjustments to the care plan to better meet the patient's needs.

One aspect that typically does not belong directly in a care plan is the "costs of each nursing action." While budget considerations are undeniably important in healthcare management, the primary focus of a care plan should be on patient care quality and effectiveness, rather than the cost associated with each action. Costs are generally handled at different administrative or managerial levels to ensure that while care remains patient-centered and effective, it is also cost-efficient. Including direct costs in a care plan could shift the focus away from patient needs and towards financial considerations, potentially compromising the quality of care.

Therefore, in reviewing a care plan, a case manager would rightly question the inclusion of detailed costs for each nursing action. The main objective of a care plan is to outline a clear, actionable path for patient care based on clinical needs and best practices. Financial aspects, while important, should be managed separately to ensure that financial constraints do not hinder the provision of necessary healthcare services.

Question: 7

You are the case manager at a general hospital in a large city. A 62-year-old male patient is admitted from a physician's office with Parkinson's Disease. The patient lives with his wife, adult daughter, and two grandchildren. The patient's family is healthy, and helps the patient with his condition.

Simulation History

Current medication: Levodopa

Past medication: None

Non-medication/Surgery Treatments: Exercise routine, special diet

Symptoms shown: Slowed voluntary movements, unsteady balance, swallowing problems, lightheadedness

Education level: High school graduate

Current height and weight: 6'2", 203 pounds

Pain management: Pain management therapy

Additional therapy: Occupational therapy

Living situation: Wife, daughter, grandchildren

Family history: None

Which of the following data that was collected should be reviewed and used for this patient?

- A. Current medication and non-medication/surgery treatments.
- B. Non-medication/surgery treatments, symptoms shown, education level.
- C. Current medication, non-medication/surgery treatments, symptoms shown, education level, current height and weight, pain management, additional therapy, and living situation.
- D. Height and weight, pain management, additional therapy, and living situation.

Answer: C

Explanation:

In this scenario, it is essential to review and use a comprehensive set of data for the 62-year-old male patient with Parkinson's Disease to provide optimal management and care planning. Each piece of information collected plays a crucial role in understanding the patient's overall health, needs, and the best approaches to treatment. Here's why each data point is significant:

Current Medication: Levodopa - Levodopa is a primary treatment for Parkinson's Disease and helps to manage symptoms by compensating for the decreased production of dopamine in the brain.

Monitoring the effects and dosage of Levodopa is critical as it directly impacts the patient's motor symptoms and quality of life.

Non-Medication/Surgery Treatments: Exercise routine, special diet - These are vital for managing Parkinson's Disease as they help improve mobility, balance, and overall health. A special diet can address specific nutritional needs or deficiencies that might arise with Parkinson's and its treatments.

Symptoms Shown: Slowed voluntary movements, unsteady balance, swallowing problems, lightheadedness - Understanding the symptoms helps in assessing the progression of the disease and the effectiveness of the current treatment plan. It also aids in anticipating and managing complications or needs for additional interventions.

Education Level: High school graduate - Education level can influence a patient's ability to understand and comply with medical instructions and treatment plans. It may also impact

communication styles and educational approaches needed to ensure the patient fully understands their condition and management strategies.

****Current Height and Weight: 6'2", 203 pounds**** - This data helps in calculating body mass index (BMI) which is important for medication dosages, nutritional needs, and evaluating the patient's general physical health.

****Pain Management: Pain management therapy**** - Addressing pain is crucial for improving quality of life. Pain management strategies can include medications, physical therapy, or other modalities that need to be tailored to the patient's specific situations and effectiveness of current treatments.

****Additional Therapy: Occupational therapy**** - Occupational therapy is essential for maintaining independence and safety in performing daily activities. It helps in adapting the living environment and routines to the patient's abilities and needs.

****Living Situation: Wife, daughter, grandchildren**** - The patient's living situation can significantly affect his support system. Understanding family dynamics and the physical environment at home helps in planning both immediate treatment and long-term management strategies, including any necessary home modifications or in-home support services.

In conclusion, all the listed data points are interconnected and critical for holistic care and management of a patient with Parkinson's Disease. Each aspect, from medical treatments to personal and environmental factors, contributes to tailored care planning that aims to enhance the patient's health, safety, and quality of life.

Question: 8

It is important for covered entities to put safeguards in place. A specific covered entity is working on placing up-to-date safeguards under the Security Rule. The case management team is investigating to ensure that the safeguards are implemented correctly and are the required safeguards. The team found:

-An audit control safeguard has been implemented

With the given information, what type of safeguard does the covered entity have in place currently?

- A. Physical safeguard.
- B. Administrative safeguard.
- C. Marketing safeguard.
- D. Technical safeguard.

Answer: D

Explanation:

The Security Standards for the Protection of Electronic Protected Health Information, commonly known as the Security Rule, outlines various types of safeguards that covered entities are required to implement to ensure the confidentiality, integrity, and security of electronic protected health information (ePHI). These safeguards are broadly categorized into three groups: administrative safeguards, physical safeguards, and technical safeguards.

Technical safeguards specifically refer to the technology and the policies and procedures for its use that protect electronic health information and control access to it. Since the information provided mentions that an audit control safeguard has been implemented, this falls under the category of technical safeguards. Audit controls are mechanisms that record and examine activity in information systems that contain or use ePHI. They are essential for ensuring that proper access and security measures are maintained and for providing a trail that can be analyzed should a security breach occur.

Therefore, with the implementation of an audit control safeguard, the covered entity has a technical safeguard in place. This aligns with the requirements of the Security Rule to protect ePHI from unauthorized access and to ensure the integrity and security of the patient data it handles.

Question: 9

A patient has come into the hospital with problems with blood pressure. The patient was diagnosed with hypertension. A care plan was set to be created for this diagnosis. The care plan was reviewed by the case manager, and found to treat the wrong symptoms. The case manager investigated and found:

- The symptoms were related to high blood pressure
- The care plan was based on symptoms of low blood pressure

What likely occurred?

- A. The patient changed his file information.
- B. A general staff member diagnosed the patient instead of the physician.
- C. The information was correctly documented.
- D. The information was incorrectly documented.

Answer: D

Explanation:

In the scenario described, a patient diagnosed with hypertension (high blood pressure) was subject to a care plan that erroneously addressed symptoms of hypotension (low blood pressure). This misalignment between the patient's actual condition and the treatment plan suggests a lapse in the medical documentation or information handling processes. The case manager's review and subsequent investigation revealed that the care plan was incorrect due to it being based on symptoms not exhibited by the patient.

The most likely explanation for this error is that the information about the patient's condition was incorrectly documented at some point in the process. This could have occurred during the initial intake and diagnosis, where the patient's symptoms were perhaps recorded inaccurately, or during the transcription of medical notes into the patient's health record. It is also possible that there was a miscommunication or misunderstanding between the medical staff members who assessed the patient and those who developed the care plan.

Proper documentation is critical in the healthcare setting as it ensures continuity and accuracy in patient care. Errors in documentation can lead to inappropriate treatment plans, as seen in this case, which can jeopardize patient safety. Therefore, it is essential that all patient information is accurately recorded and clearly communicated among the healthcare team. Regular audits and reviews by case managers or similar oversight roles are crucial in identifying and correcting such errors to prevent potential harm to patients.

In conclusion, the likely cause of the error in the care plan for the hypertensive patient was incorrect documentation of the patient's symptoms. This incident underscores the importance of meticulous documentation and the need for systematic checks to ensure the accuracy and appropriateness of patient care plans.

Question: 10

A patient has come into the ER several times for different ailments related to drug abuse. He is screened each time. Each time personal information is collected, it is different. The case management team has been asked to investigate, to find out what information is factual. The team found:

- No information given matches the patient's driver's license.
- The patient gives false reasons for ailments

Given the information, what likely occurred?

- A. The patient is trying to get free services.
- B. The administration is inputting data incorrectly.
- C. The patient is trying to cover his drug abuse.
- D. The patient's information constantly changes.

Answer: C

Explanation:

Based on the details provided, it appears the patient is engaging in deceptive behavior by providing inconsistent personal information and falsifying reasons for ailments during multiple emergency room visits. This pattern of behavior suggests a few potential underlying motives or issues:

****The patient is trying to cover his drug abuse.**** By giving different personal details and false reasons for visitations, the patient might be attempting to avoid detection and documentation of a drug abuse problem. Drug users often fear judgment, legal consequences, or being barred from obtaining certain medications, which might lead them to disguise their true reasons for hospital visits.

****The patient is trying to get free services.**** Another possibility is that the patient is manipulating information to exploit the hospital's resources, possibly to receive medication or care without proper accountability or charges. This is often seen in individuals who lack insurance or adequate funds to cover medical expenses.

****The administration is inputting data incorrectly.**** While the behavior predominantly suggests patient deception, there is also a possibility, albeit smaller, that there might be errors in how hospital staff are recording data. This would be less about the patient's intentions and more about administrative errors; however, given the pattern of false ailments reported, this seems less likely.

****Recommendations for Hospital Staff:**** To address such issues, it is crucial that patients are thoroughly assessed and screened. Documentation during every visit should be meticulous, and efforts should be made to verify all provided information against reliable identification documents.

Implementing stricter verification processes can help in identifying discrepancies and preventing abuse of services.

****Conclusion:**** The most plausible explanation for the observed behavior is that the patient is trying to cover up his drug abuse, possibly combined with an attempt to receive care or medication without proper attribution. While administrative errors can occur, the consistent pattern of deceitful behavior points strongly towards the patient's actions rather than data entry mistakes. Proper verification and consistent documentation practices are essential in mitigating such issues and ensuring that all patients receive appropriate and accountable care.

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