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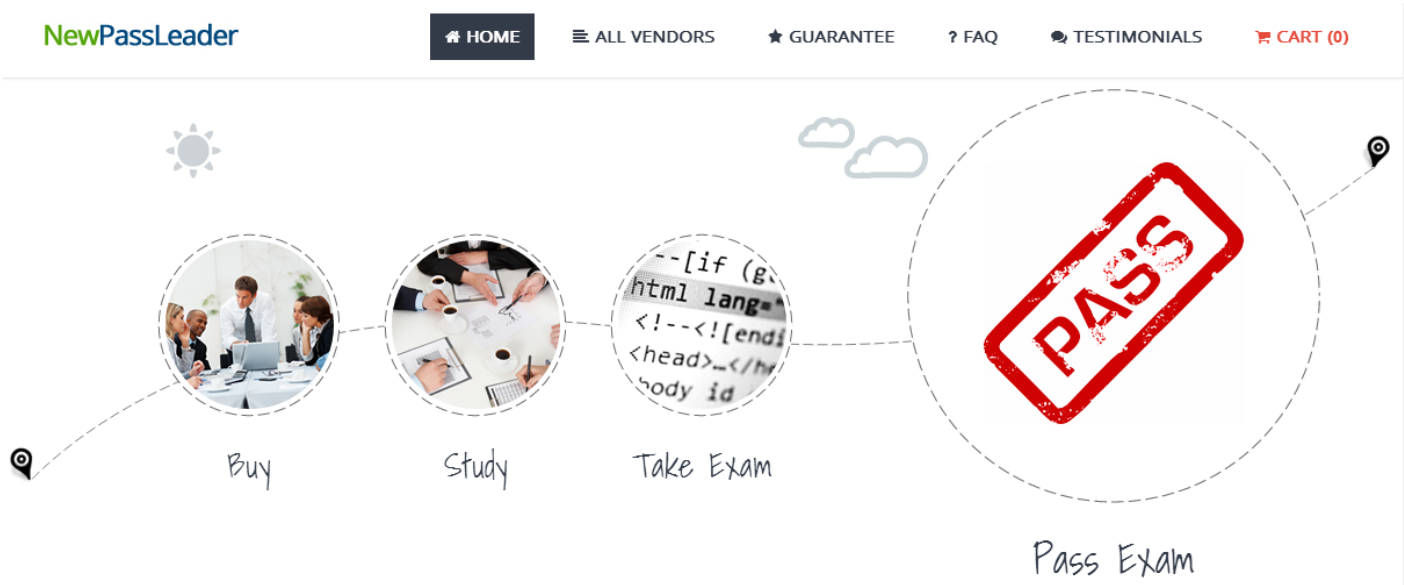

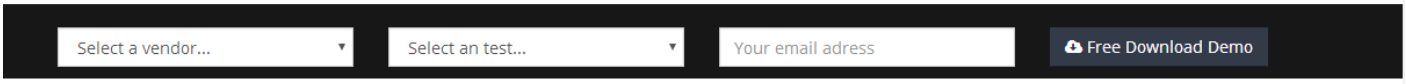

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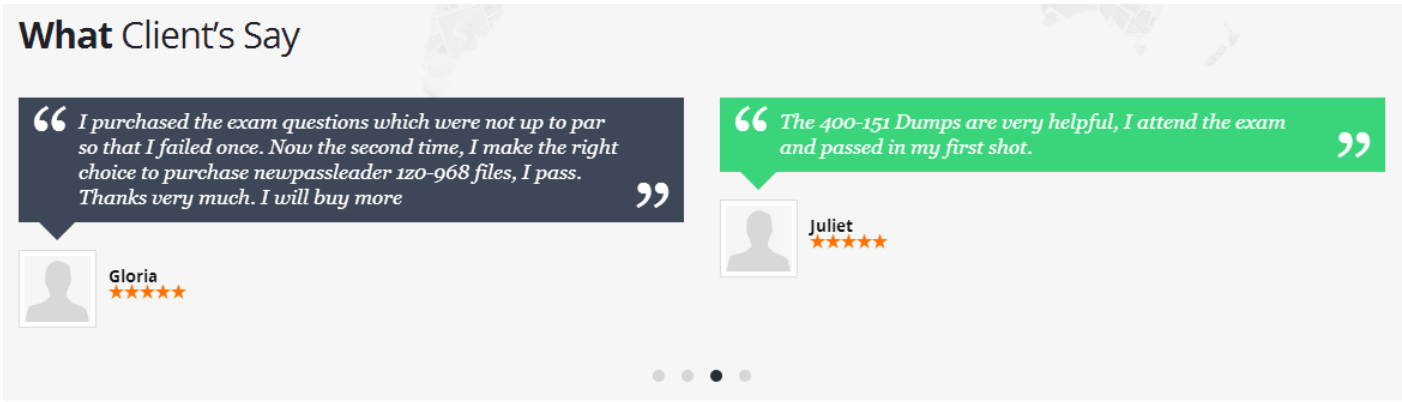

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Exam : **CPHRM**

Title : Certified Professional in Health Care Risk Management (CPHRM)

Vendor : ASHRM

Version : DEMO

NO.1 A claims manager needs to open a loss reserve and perform an investigation of an event. They review the patient demographics, the nature and extent of the injury, and other liability factors. Which of the following would be helpful to the claims manager in determining a loss reserve?

A. comparable verdicts in the county

B. the surgery center's claims history

C. the patient's total medical bills

D. amount of insurance allowed per occurrence

Answer: A

Explanation:

Within Health Care Risk Management practice as outlined by ASHRM and the American Hospital Association Certification Center, establishing an accurate loss reserve requires an estimation of the probable financial exposure associated with a claim. A loss reserve represents the anticipated cost to resolve a claim, including indemnity payments and defense expenses.

Comparable verdicts in the county are particularly useful because they reflect jurisdiction-specific jury tendencies, local legal climate, and historical award patterns. Venue significantly influences claim valuation, as jury awards can vary substantially between counties and states. Reviewing similar case outcomes allows the claims manager to benchmark potential settlement or verdict ranges based on injury severity and liability factors.

The surgery center's claims history may inform overall risk trends but does not directly determine the value of a specific claim. The patient's total medical bills are relevant but represent only one component of damages and do not account for non-economic damages such as pain and suffering. The insurance limit per occurrence defines maximum exposure but does not guide the realistic reserve estimate unless damages approach policy limits.

Therefore, analysis of comparable local verdicts is most helpful in establishing an appropriate and defensible loss reserve.

NO.2 Which of the following should prompt a risk manager to give notice to a malpractice carrier?

A. written medical record request from an attorney

B. demand letter from a patient

C. internal incident report

D. disclosure to a patient

Answer: B

Explanation:

Under Health Care Risk Management principles established by ASHRM and the American Hospital Association Certification Center, timely notice to a malpractice carrier is a critical obligation, particularly under claims-made policies. A demand letter from a patient constitutes a clear assertion of liability and a request for compensation, which typically meets the definition of a claim under most malpractice insurance policies. Failure to notify the carrier promptly may jeopardize coverage.

A written medical record request from an attorney may signal potential litigation, but it does not necessarily constitute a claim unless accompanied by an allegation of wrongdoing or a demand for damages. An internal incident report is a risk management tool used for quality and safety improvement and does not itself trigger insurance notification requirements. Similarly, disclosure to a patient regarding an adverse event aligns with transparency practices but does not automatically represent a formal claim.

Risk management objectives emphasize understanding policy language, particularly definitions of

claim and reporting requirements. Because a demand letter explicitly alleges harm and seeks compensation, it most clearly triggers the duty to notify the malpractice carrier to preserve coverage and initiate appropriate claims handling procedures.

NO.3 For a risk management program to be effective, it needs:

A. Organizational commitment, visibility/access, and physician engagement

B. Only a policy manual

C. Only insurance coverage

D. Only incident reporting software

Answer: A

Explanation:

Effective risk management requires more than tools-it needs organizational commitment (tone at the top), operational visibility (access to events, leaders, data), and physician engagement because many high-severity risks involve medical decision-making and clinical leadership. Risk management objectives include preventing harm (patient safety), reducing financial loss (claims and insurance costs), ensuring compliance, and building a learning culture. Without executive and board support, corrective actions stall; without visibility, emerging risks are missed; without physician buy-in, clinical process redesign fails. Successful programs integrate with quality, patient safety, compliance, legal, and operations, and they use structured methods (RCA/FMEA, audits, claims trend analysis) to drive measurable improvement. This also strengthens defensibility: it shows governance, action, and continuous improvement-key elements in regulatory review and litigation.

NO.4 The ultimate goal of Enterprise Risk Management (ERM) is to:

A. Optimize risk mitigation and risk financing aligned to organizational objectives

B. Eliminate all risk permanently

C. Transfer all risk to patients

D. Replace clinical governance

Answer: A

Explanation:

ERM integrates clinical, operational, financial, legal, and strategic risks into a single governance approach so leadership can prioritize resources based on enterprise objectives-patient safety, quality, financial sustainability, and regulatory compliance. The goal is not "zero risk," butoptimized risk response: reduce likelihood and severity where feasible, and alignrisk financing(insurance, reserves, captives, contractual transfer) to the organization's risk appetite and volatility. Risk management objectives in healthcare ERM include strengthening high-reliability clinical systems, improving compliance, preventing reputational harm, and ensuring continuity of operations during crises. ERM also improves board oversight by providing a transparent risk register, consistent scoring, and accountability for mitigation plans. Ultimately, ERM is a decision system that helps leaders invest where risk reduction and value are highest.

NO.5 An original contract could contain:

A. Effective date, insurance requirements, and contract terms

B. Only a logo and slogan

C. Only verbal promises

D. Only a price estimate without scope

Answer: A
Explanation:
Healthcare contracting is a risk control tool. Core terms include effective date, scope, responsibilities, performance standards, indemnification, andinsurance requirements(limits, additional insured, notice of cancellation). Clear terms reduce disputes, clarify liability allocation, and strengthen compliance (HIPAA BAAs, data security, subcontractor controls). Risk management objectives focus on preventing uninsured exposures and ensuring vendors meet safety, credentialing, and regulatory requirements-especially for clinical services, technology, and facility operations.

NO.6 Which of the following should be included in a risk management plan?
* purpose of the program
* budget for the department
* process of risk management activities
* structure of the program
A. 1, 2, and 3 only
B. 1, 2, and 4 only
C. 1, 3, and 4 only
D. 2, 3, and 4 only
Answer: C
Explanation:
According to Health Care Risk Management standards defined by ASHRM and the American Hospital Association Certification Center, a formal risk management plan is a governance document that outlines the framework, scope, and operational processes of the program. It is intended to define how risk management activities support organizational objectives and regulatory compliance.
The plan should clearly state the purpose of the program, establishing its mission, goals, and alignment with patient safety and enterprise risk management strategies. It must also describe the structure of the program, including reporting relationships, committee oversight, leadership roles, and accountability mechanisms.
Additionally, the process of risk management activities should be detailed, including event reporting, investigation procedures, claims management, education initiatives, and performance evaluation methods.
While financial planning is important for departmental operations, the budget for the department is typically addressed in administrative or financial planning documents rather than the risk management plan itself. The plan focuses on governance, structure, and operational processes rather than line-item budgeting.
Therefore, inclusion of the program's purpose, structural framework, and operational processes appropriately defines a comprehensive risk management plan.

NO.7 The source of many medication errors is:
A. Verbal/telephone orders (when avoidable and not properly verified)
B. Patient wristbands
C. Elevator delays
D. Radiology scheduling
Answer: A
Explanation:

Verbal/telephone orders are widely recognized aserror-pronebecause they can be misheard, misunderstood, or transcribed incorrectly-especially with sound-alike drug names, confusing numerals (15 vs 50), background noise, accents, and interruptions. ISMP and patient safety advisories recommend minimizing verbal orders whenever possible and using safeguards such as read-back/confirm-back, spelling drug names, stating digits individually, and documenting promptly. Risk management objectives include reducing reliance on memory and imperfect communication by prioritizing written or electronic orders (CPOE), standardizing when verbal orders are permitted (true emergencies), and auditing compliance to prevent unsafe normalization. Because medication errors can cause severe harm, controlling verbal order risk is a high-yield safety intervention and improves legal defensibility by aligning practice with recognized safety recommendations.

NO.8 Which of the following documents will an insurance underwriter use to provide an insurance quote?

A. certificate of insurance

B. declaration page

C. certificate of need

D. application

Answer: D

Explanation:

Under Health Care Risk Management principles supported by ASHRM and the American Hospital Association Certification Center, the insurance application is the primary document used by an underwriter to evaluate risk and generate a premium quote. The application provides detailed information about the organization's operations, services, patient volume, claims history, risk control measures, governance structure, and prior insurance coverage. This information enables the underwriter to assess exposure, determine eligibility, and calculate appropriate pricing and coverage terms.

A certificate of insurance is issued after a policy is in force to verify coverage to third parties and does not serve as a quoting document. The declaration page is part of an existing insurance policy and summarizes coverage limits, deductibles, and endorsements; it reflects finalized terms rather than information used to generate a quote. A certificate of need is a regulatory document related to state approval of healthcare facilities or services and is unrelated to underwriting.

Risk financing objectives emphasize accurate disclosure and thorough completion of insurance applications, as misrepresentation or omission may affect coverage validity. Therefore, the application is the document used by an underwriter to provide an insurance quote.

NO.9 Supervisors who conduct job interviews may ask which of the following questions?

A. Are you currently taking a prescription medication?

B. Do you plan to have children?

C. Can you meet the organization's attendance requirement?

D. Are you a citizen of the United States?

Answer: C

Explanation:

Under Health Care Risk Management standards aligned with ASHRM and the American Hospital Association Certification Center, employment interview questions must comply with federal and state anti-discrimination laws, including the Americans with Disabilities Act ADA, Title VII of the Civil Rights

Act, the Pregnancy Discrimination Act, and the Immigration Reform and Control Act.
Questions about prescription medications may violate ADA provisions by eliciting information about potential disabilities prior to a conditional offer of employment. Asking whether a candidate plans to have children may constitute unlawful discrimination based on sex or family status. Inquiring directly about citizenship may violate federal employment eligibility standards; employers may instead ask whether the applicant is legally authorized to work in the United States.
In contrast, asking whether a candidate can meet the organization's attendance requirements is permissible because it relates directly to essential job functions and business necessity. Employers may inquire about the ability to perform job-related duties, provided questions are applied consistently to all applicants and are not designed to screen out protected classes.
Legal and regulatory objectives emphasize nondiscriminatory hiring practices and adherence to equal employment laws. Therefore, questions regarding attendance requirements are appropriate in a job interview setting.

NO.10 Documentation that assists with defense of a malpractice claim

A. contains subjective comments about the patient.

B. describes the provider's clinical decision-making process.

C. is not important if the claim happened in prior years.

D. does not need to be complete or timely.

Answer: B

Explanation:
According to Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, high-quality clinical documentation is critical in defending malpractice claims. The medical record serves as the primary evidence of care provided and reflects whether the standard of care was met.
Documentation that clearly describes the provider's clinical decision-making process is particularly valuable in litigation. It demonstrates assessment findings, differential diagnoses, rationale for chosen interventions, informed consent discussions, and follow-up plans. Thorough documentation provides objective support for clinical judgments and establishes a defensible narrative of care.
Subjective or disparaging comments about the patient can undermine credibility and may be harmful in court.
Complete and timely documentation is essential; delayed or incomplete entries may suggest negligence or alteration. Additionally, documentation remains important regardless of when a claim arises, as statutes of limitation may allow claims to be filed years after the event, especially in cases involving minors or discovery rules.
Claims and litigation objectives emphasize accurate, objective, and contemporaneous recordkeeping to reduce liability exposure. Therefore, documentation that clearly outlines the provider's clinical reasoning best assists in defending a malpractice claim.

NO.11 What group reports information (historically HIPDB content; now within NPDB) related to fraud/abuse oversight?

A. Peer review organizations (for certain state/federal reporting categories)

B. Any patient advocacy blog

C. Restaurant inspectors

D. School boards

Answer: A
Explanation:
The Healthcare Integrity and Protection Data Bank (HIPDB) was created to combat healthcare fraud and abuse; it isno longer operational as a separate bank, and its content was merged into the NPDB. Reporting and querying are governed by HRSA rules defining authorized entities, including certain peer review and oversight organizations in specific reporting frameworks. Risk management objectives include ensuring organizations understand which actions must be reported, ensure due process, and comply with data handling rules. Proper reporting supports system integrity by preventing practitioners or entities with serious adverse actions from moving undetected across organizations. For hospitals and health plans, this strengthens credentialing and contracting decisions, reducing organizational exposure to negligent credentialing and improper network participation risks.

NO.12 Whenever possible, medication orders should be by:
A. Verbal shorthand
B. Color coding
C. Brand name
D. Dose (explicit numeric dose and units)
Answer: D
Explanation:
Ordering by cleardose(with units, route, frequency, and indication when needed) reduces ambiguity and prevents common medication errors such as wrong concentration, wrong formulation, or misunderstood shorthand. Risk management objectives emphasize "closed-loop" medication communication: standardized ordering, read-back for limited verbal orders, and minimizing abbreviations that cause confusion (sound-alike drug names, numeric mishearing like 15 vs 50). Patient safety frameworks consistently identify unclear orders as a high-frequency contributor to adverse drug events; therefore, explicit dosing is a core reliability practice.
When dose is specified precisely and entered via CPOE (preferred), organizations reduce transcription errors, improve pharmacy verification, and enable automated safety checks. Clear dosing also supports legal defensibility by documenting rational prescribing aligned with standards of care.