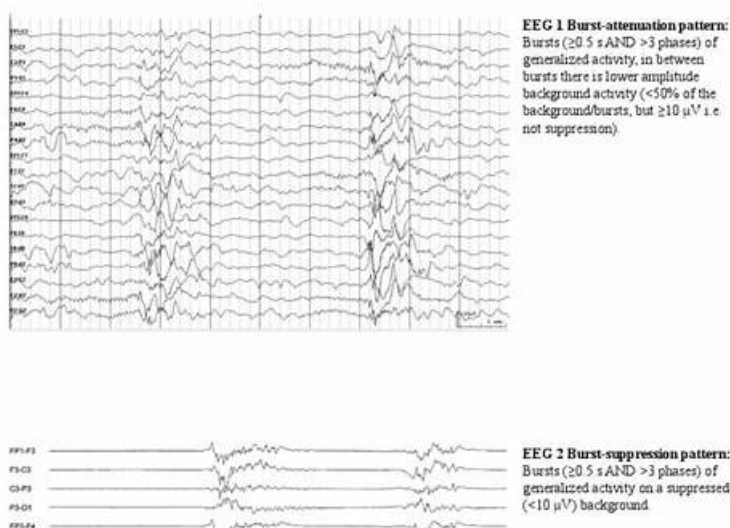


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## Nursing ANCC Adult Health Clinical Nurse Specialist Certification (ACNS) Sample Questions (Q43-Q48):

### NEW QUESTION # 43

Which of the following is the major complication of aortic regurgitation?

- A. Myocardial infarction.
- **B. Congestive heart failure.**
- C. Aortic rupture.
- D. Aortic dissection.

**Answer: B**

Explanation:

Congestive heart failure (CHF) is recognized as the primary major complication associated with aortic regurgitation. Aortic regurgitation involves the leaking of the aortic valve, which allows blood to flow back from the aorta into the left ventricle during diastole, the heart's relaxation phase. This backflow forces the left ventricle to work harder to pump sufficient blood to meet the body's needs, leading to progressive heart enlargement and eventually heart muscle weakness.

Over time, as the left ventricle dilates, it loses elasticity and efficiency in pumping blood. This inefficiency can culminate in left ventricular failure. The increased volume load on the left ventricle also increases the pressure in the left atrium and subsequently in the pulmonary veins and capillaries. This elevated pulmonary pressure can result in pulmonary congestion, one of the hallmarks of congestive heart failure.

Patients with aortic regurgitation might remain asymptomatic for years, even while their heart function is declining. Symptoms such as shortness of breath, fatigue, and edema (swelling due to fluid retention), which are indicative of CHF, may eventually manifest. These symptoms often first appear during exertion but can become present at rest as the condition progresses.

Congestive heart failure from aortic regurgitation is distinct from other acute complications such as aortic dissection or myocardial infarction, which involve different pathophysiological mechanisms. While aortic dissection involves a tear in the aorta's wall and myocardial infarction relates to the obstruction of coronary blood flow, congestive heart failure due to aortic regurgitation is a chronic condition resulting from the volumetric overload of the left ventricle and ensuing cardiac remodeling and dysfunction.

Management of aortic regurgitation aims to delay the progression of heart failure with medications like diuretics, ACE inhibitors, or beta-blockers, which help reduce the workload on the heart and control blood pressure. In severe cases or when symptomatic heart failure develops, surgical intervention such as valve repair or replacement may be necessary to restore normal heart function and prevent further complications. Regular monitoring and early detection through echocardiography and other diagnostic measures are crucial for preventing the onset of congestive heart failure in patients with aortic regurgitation.

### NEW QUESTION # 44

You have agreed to participate in the Medicare health insurance program and work for a small privately owned physician office. Medicare paid 80% of the charges billed for a clinic visit when the patient was seen by the Adult Clinical Nurse Specialist. What could your employer do about the remaining 20% that is owed to the facility?

- **A. The facility can bill the patient for a percentage of the remainder on behalf of the Adult Clinical Nurse Specialist.**
- B. The facility is prohibited from billing the patient in this case.
- C. The facility can resubmit the bill for additional payment on behalf of the Family Clinical Nurse Specialist.
- D. The facility, on behalf of the Adult Clinical Nurse Specialist, can collect 100% if billed incident to the supervision Medical Doctor.

**Answer: A**

Explanation:

When a Medicare beneficiary visits a healthcare provider, such as an Adult Clinical Nurse Specialist (CNS) in a small privately owned physician's office, Medicare usually covers a part of the total service cost, typically 80%. This payment model leaves a balance, often referred to as the 20% co-insurance, which is the patient's responsibility to pay. In this specific scenario, the CNS has agreed to participate in the Medicare program by accepting assignment.

Accepting assignment means that the provider agrees to accept the Medicare Approved Amount (MAA) as the total payment for their services. The MAA is a pre-determined rate that Medicare considers reasonable for a specific medical service within a specific geographical area. For participating providers, this agreement also stipulates that they cannot charge the patient more than the Medicare deductible and the 20% co-insurance. Therefore, the CNS, by agreeing to accept assignment, is bound to this pricing

structure.

Since the CNS has accepted Medicare's terms, after Medicare pays its share of 80%, the facility where the CNS practices has the right and the ability to bill the patient for the remaining 20%. This is a standard practice in the healthcare industry where the patient pays a portion of the cost, ensuring that Medicare's payments and the patient's contributions together cover the total approved charge for the service.

It's important to note that if the CNS had not accepted assignment, the billing dynamics would be different. A non-participating provider can choose to accept assignment on a case-by-case basis. If they do not accept assignment, they can charge the patient more than the Medicare approved amount, up to the limiting charge, which is typically 15% over the Medicare approved amount in most states. However, in this scenario, because the CNS is a participating provider, they must adhere to the terms of assignment, thus limiting the charge to the patient to no more than the deductible and 20% co-insurance.

In summary, the facility where the Adult Clinical Nurse Specialist works, under the obligations of Medicare assignment, can and should bill the patient for the remaining 20% of the Medicare approved charge after Medicare has paid its 80% share. This process ensures that the provider is compensated for the total approved amount for their services, while also adhering to the legal and ethical standards set forth by Medicare.

#### NEW QUESTION # 45

The U.S. Food and Drug Administration (FDA) and the Department of Health and Human Services (DHHS) have regulations governing research activities on human subjects. The CNS understands that the principle investigator is responsible for:

- A. Going before the Institutional Review Board to present the study and gain approval to proceed with subject recruitment.
- B. Reporting to the Institutional Review Board if a subject is injured during the course of the study.
- C. All of the above.
- D. Securing a signed consent form allowing the research.

**Answer: C**

Explanation:

The U.S. Food and Drug Administration (FDA) and the Department of Health and Human Services (DHHS) have established stringent regulations to ensure the ethical and safe conduct of research involving human subjects. These guidelines are designed to protect the rights and welfare of participants and to ensure that the research is conducted in a scientifically appropriate manner. One of the key responsibilities of a principal investigator (PI) in a research study involving human subjects is securing a signed consent form. This document must clearly outline the purpose of the research, the procedures involved, any potential risks and benefits, and the rights of the participants, including the right to withdraw from the study at any time without penalty. The informed consent process is crucial as it ensures that participants are voluntarily participating in the research with a full understanding of what it involves.

Another major responsibility of the PI is to gain approval from the Institutional Review Board (IRB) before beginning the study. The IRB is an independent committee that reviews and monitors biomedical and behavioral research involving humans. Its role is to ensure that the study is ethical and that the risks posed to participants are minimized and justified by the potential benefits. The PI must present detailed study protocols to the IRB, explaining how the study will be conducted, how participants will be recruited and protected, and how data will be collected and analyzed.

Furthermore, the PI must report any adverse events or unexpected problems to the IRB, especially if they involve harm to study participants. This not only includes physical injuries but also psychological or emotional distress. Timely reporting is critical to ensure the continued safety of participants and may lead to modifications in the study protocol or, in some cases, termination of the study if it is deemed too risky.

Hence, when the question presents options such as securing a signed consent form, gaining IRB approval, and reporting to the IRB in the case of an injury, the correct answer is "All of the above." Each of these tasks is a fundamental requirement for conducting research involving human subjects. Adhering to these responsibilities ensures that the research complies with federal regulations and ethical standards, thereby protecting the integrity of the research and the safety and rights of the participants.

#### NEW QUESTION # 46

When counseling a patient with allergic rhinitis, you prescribe Cromolyn. The ACNS understands that its mechanism of action is as a/an:

- A. leukotriene modifier
- B. anti-immunoglobulin E antibody
- C. vasoconstrictor
- D. mast cell stabilizer

**Answer: D**

Explanation:

When counseling a patient with allergic rhinitis and considering the use of Cromolyn, it is crucial to understand its mechanism of action and how it fits into the treatment regimen. Cromolyn is classified as a mast cell stabilizer. Here's an expanded explanation of how Cromolyn works and why it is used for allergic rhinitis:

Mast cells are a type of white blood cell that play a significant role in the body's allergic response. During an allergic reaction, allergens trigger the release of histamine and other chemicals from these mast cells, leading to symptoms such as sneezing, itching, and runny nose. Cromolyn works by stabilizing the mast cell membranes, thereby preventing them from releasing these inflammatory mediators when they encounter an allergen. This action helps in reducing the severity of the symptoms associated with allergic reactions.

Unlike some other treatments for allergic rhinitis, such as antihistamines or corticosteroids, Cromolyn does not work immediately after administration. It is not effective at treating acute symptoms. Instead, Cromolyn is used as a preventive measure. Patients typically need to use the Cromolyn nasal spray regularly, starting it before the allergy season begins or before coming into contact with known allergens. It may take about a week or more of consistent usage before significant symptom relief is achieved. Because of its mechanism of action and its preventive nature, Cromolyn is an excellent choice for patients who have predictable seasonal allergies or who can anticipate exposure to specific allergens. It is particularly useful for those who prefer to use a medication with fewer side effects compared to systemic medications like corticosteroids. Cromolyn is generally well-tolerated, and side effects are rare, making it suitable for long-term use in managing allergic rhinitis.

In summary, when prescribing Cromolyn for allergic rhinitis, it is important to educate patients about its role as a mast cell stabilizer. Patients should understand that they need to begin treatment before their allergy season starts and that consistent daily use is crucial for the medication to be effective. Additionally, they should be informed that Cromolyn is used for the prevention of symptoms rather than for immediate relief. This understanding will help ensure patient compliance and satisfaction with this treatment approach.

#### NEW QUESTION # 47

Which of the following managed care organizations has the LEAST control of managed care?

- A. Staff/group Health Maintenance Organization (HMO).
- B. Network Independent Practice Association (IPA).
- C. Preferred provider organization.
- D. Fee-for-service.

**Answer: D**

Explanation:

In the context of healthcare, the term "managed care" refers to a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care. It is characterized by arrangements with healthcare providers to provide care to members at reduced costs. These healthcare systems contrast significantly in terms of how much control they exert over services, costs, and the management of care.

Among the options provided—Network Independent Practice Association (IPA), Fee-for-service, Preferred Provider Organization (PPO), and Staff/Group Health Maintenance Organization (HMO)—the Fee-for-service (FFS) model has the least control over managed care. This is because the Fee-for-service model compensates providers for each service, such as tests and procedures, rather than providing care under a fixed fee or capitation system, which is common in other forms of managed care systems.

In a Fee-for-service system, healthcare providers are paid individually for each service they perform. This can lead to increased usage of healthcare services since providers are incentivized to perform more treatments and procedures as they will receive more payments. Consequently, there is less control over the overall use and cost of medical care, which contrasts with managed care models that seek to control costs and manage care more effectively through structured provider networks and set payment arrangements.

On the other hand, models like HMOs, PPOs, and IPAs have more structured systems. HMOs usually employ or partner closely with a network of providers to provide care for members at a fixed annual or monthly fee, thus controlling costs and managing care more tightly. PPOs, while allowing for more provider flexibility, still negotiate rates with providers and may offer incentives for members to use network providers. IPAs manage member care by contracting with independent physicians who continue to operate their own offices but must meet the IPA's standards and cost controls.

Thus, when comparing these models, the Fee-for-service system stands out as having the least control over managed care, focusing primarily on the volume of services rather than the coordination and overall management of patient care. This lack of control can lead to higher healthcare costs and less efficient care management.

#### NEW QUESTION # 48

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