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Additionally, students can take multiple ASHRM CPHRM exam questions, helping them to check and improve their performance. Three formats are prepared in such a way that by using them, candidates will feel confident and crack the Certified Professional in Health Care Risk Management (CPHRM) (CPHRM) actual exam. These three formats suit different preparation styles of CPHRM test takers.

ASHRM Certified Professional in Health Care Risk Management (CPHRM) Sample Questions (Q57-Q62):

NEW QUESTION # 57

An intervention between parties to promote reconciliation, settlement, or compromise is

- A. a judge trial.
- B. an arbitration.
- C. a mediation.
- D. a jury trial.

Answer: C

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification

Center, mediation is a form of alternative dispute resolution designed to facilitate voluntary settlement between parties. In mediation, a neutral third party assists disputing parties in communicating, clarifying issues, and exploring mutually acceptable resolutions. The mediator does not impose a binding decision but guides negotiation toward compromise and reconciliation. Arbitration differs in that the neutral arbitrator typically renders a decision that may be binding, depending on the agreement between parties. Jury trials and bench trials involve formal court proceedings where a judge or jury determines liability and damages based on legal standards and evidence. These processes are adversarial and result in judicial determinations rather than negotiated compromise. Claims and litigation objectives emphasize cost containment, early resolution, and reduction of adversarial conflict when appropriate. Mediation can reduce defense expenses, shorten case duration, and preserve professional relationships. It also provides greater confidentiality and flexibility than courtroom litigation. Therefore, the intervention specifically intended to promote reconciliation, settlement, or compromise between parties is mediation.

NEW QUESTION # 58

An unstable patient in the emergency department needs transfer to another hospital. Which of the following statements is true regarding the refusal of an on-call physician to treat this patient?

- A. The on-call physician may refuse to participate in the care of a patient, as long as that refusal is not based on insurance status or other financial concerns.
- **B. The on-call physician is relieved of duty only if unavailable because of caring for another patient, or because of other circumstances outside the physician's control.**
- C. The on-call physician is never relieved of duty to accept a patient needing specialized services.
- D. The on-call physician may refuse to participate in the care of any patient, for any reason.

Answer: B

Explanation:

Under Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, obligations under the Emergency Medical Treatment and Labor Act EMTALA govern on-call physician responsibilities. When a hospital maintains an on-call roster to provide specialty services for emergency department patients, physicians listed on call are required to respond and participate in the evaluation and stabilization of patients with emergency medical conditions. An on-call physician may only be relieved of duty if legitimately unavailable due to circumstances beyond their control, such as actively caring for another patient or being otherwise unable to respond in accordance with hospital policy. Refusal to treat for convenience or non-clinical reasons may constitute an EMTALA violation and expose both the hospital and physician to regulatory penalties. A blanket right to refuse care is inconsistent with EMTALA requirements. While financial discrimination is prohibited, refusal for other non-justifiable reasons may still violate federal law. Conversely, stating that a physician is never relieved of duty is inaccurate, as legitimate unavailability may excuse performance under specific circumstances. Legal and regulatory objectives emphasize compliance with EMTALA, proper on-call coverage policies, and documentation of availability. Therefore, the correct statement is that relief occurs only when the physician is unavailable due to circumstances outside their control.

NEW QUESTION # 59

The following is a table of expense and indemnity figures for an organization's last 6 years.

Year	Expense Reserves	Expense Paid	Indemnity Reserves	Indemnity Paid
1	\$15,000	\$10,000	\$125,000	\$100,000
2	\$35,000	\$35,000	\$175,000	\$125,000
3	\$10,000	\$45,000	\$100,000	\$80,000
4	\$25,000	\$15,000	\$150,000	\$75,000
5	\$32,000	\$12,000	\$200,000	\$19,000
6	\$50,000	\$15,000	\$250,000	\$15,000

What is the ratio of total incurred expense to total incurred indemnity for Year 4?

- **A. 0.20**
- B. 3.23
- C. 0.15
- D. 0.18

Answer: A

Explanation:

According to Health Care Risk Management principles supported by ASHRM and the American Hospital Association Certification

Center, total incurred amounts include both paid amounts and reserves. Incurred expense equals expense paid plus expense reserves. Incurred indemnity equals indemnity paid plus indemnity reserves.

For Year 4:

Total incurred expense = \$25,000 reserves + \$15,000 paid = \$40,000.

Total incurred indemnity = \$150,000 reserves + \$75,000 paid = \$225,000.

The ratio of total incurred expense to total incurred indemnity is calculated as:

$\$40,000 \div \$225,000 = 0.1778$, which rounds to approximately 0.18.

However, among the answer options provided, the closest value is 0.20 only if rounded broadly. Since precise calculation yields approximately 0.18, the mathematically correct ratio is approximately 0.18.

In risk financing analysis, expense-to-indemnity ratios help evaluate claims handling efficiency and cost allocation. Monitoring this ratio assists in forecasting defense costs, evaluating litigation management strategies, and supporting actuarial review. Accurate calculation of incurred values is essential for financial planning and reserve adequacy assessment.

NEW QUESTION # 60

Which of the following are common techniques used to include patients and families in programs to educate patients about their safety?

- * lay persons on select committees
 - * patient education opportunities
 - * patient events referred for peer review
 - * event reporting by patients and families
-
- A. 2, 3, and 4 only
 - B. 1, 2, and 4 only
 - C. 1, 2, and 3 only
 - D. 1, 3, and 4 only

Answer: B

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, patient and family engagement is a critical element of patient safety programs. Including lay persons on select committees, such as patient safety or quality committees, allows patients and families to contribute perspectives that enhance transparency and system improvement.

Structured patient education opportunities empower individuals to understand their care, ask questions, and actively participate in safety practices, such as medication verification and infection prevention.

Event reporting by patients and families is another proactive strategy that promotes open communication and early identification of safety concerns. Encouraging patients to report perceived errors or near misses supports a culture of safety and partnership.

Referring patient events for peer review is an internal professional evaluation process focused on provider performance and quality improvement. While important for clinical oversight, it is not a technique designed to directly include patients and families in educational safety programs.

Clinical and patient safety objectives emphasize collaboration, transparency, and patient-centered care.

Therefore, inclusion of lay persons on committees, patient education initiatives, and patient or family event reporting are appropriate techniques for involving patients in safety programs.

NEW QUESTION # 61

Which of the following concerns meets the CMS Hospital Conditions of Participation 42 CFR §482.12 classification as a grievance?

- A. a patient calling regarding a billing issue requesting for adjustment to the charges
- B. post-hospital verbal communication regarding a care issue that could have been handled by the staff during visit but was not reported
- C. a verbal complaint that cannot be solved by current staff, and the resolution of which is postponed for later
- D. information obtained with a patient satisfaction survey

Answer: C

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, the CMS Hospital Conditions of Participation define a grievance as a formal or informal written or verbal complaint made by a patient or representative regarding care, abuse, neglect, compliance with regulations, or patient rights that is not resolved at the

time of the complaint by staff present.

A verbal complaint that cannot be resolved immediately by current staff and whose resolution is postponed qualifies as a grievance under 42 CFR §482.12. Such grievances require formal investigation, documentation, and written response within established timeframes.

Billing issues generally fall outside the grievance definition unless they involve quality of care or patient rights concerns. Information from patient satisfaction surveys is not automatically classified as a grievance unless the patient specifically requests investigation or follow-up. Post-discharge verbal concerns may constitute grievances depending on context, but the key CMS criterion is whether the complaint could not be resolved at the time it was expressed.

Legal and regulatory objectives emphasize proper classification, timely response, documentation, and board oversight of grievance processes. Therefore, a verbal complaint that cannot be resolved immediately and is deferred meets CMS grievance criteria.

NEW QUESTION # 62

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