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NEW QUESTION: 1
In a failure mode and effects analysis, the risk priority number is calculated by
A. adding the severity and occurrence scores.
B. multiplying the severity and detection scores.
C. adding the severity, occurrence, and detection scores.
D. multiplying the severity, occurrence, and detection scores.
Answer: D (LEAVE A REPLY)
According to Health Care Risk Management standards endorsed by ASHRM and the American Hospital Association Certification Center, Failure Mode and Effects Analysis FMEA is a proactive patient safety tool used to identify and prioritize potential process failures before harm occurs. Within FMEA methodology, each potential failure mode is evaluated using three separate scoring components: severity, occurrence, and detection. Severity measures the potential impact of the failure if it occurs. Occurrence assesses the likelihood that the failure will happen. Detection evaluates the probability that the failure will be identified before causing harm.
Each component is typically assigned a numerical value based on predefined criteria. The Risk Priority Number RPN is calculated by multiplying the three scores: severity multiplied by occurrence multiplied by detection. This multiplication approach produces a composite score that reflects both the seriousness of potential harm and the likelihood that the event will occur and escape detection. Higher RPN values indicate higher-priority risks requiring mitigation.
Clinical and patient safety objectives emphasize systematic risk prioritization to allocate resources effectively and reduce preventable adverse events. Therefore, the RPN is calculated by multiplying severity, occurrence, and detection scores.

NEW QUESTION: 2
What in particular is the process chain in a laboratory subject to?
A. Standardization only
B. Variability across pre-analytical, analytical, and post-analytical phases
C. Zero human factors influence
D. Exclusively equipment failure
Answer: (SHOW ANSWER)
Laboratory testing is best understood as atotal testing process(from test ordering through specimen collection, analysis, and result reporting). Across this chain, error risk is heavily influenced byvariability- especially inpre-analytical steps(patient identification, tube labeling, specimen handling, transport conditions) andpost-analytical steps(timely reporting, critical value communication, interpretation). Risk management objectives emphasize controlling variation through standard work, barcoding, competency training, environmental controls, and quality indicators for each phase. Importantly, many lab failures arise outside the analyzer itself; focusing only on the analytical instrument misses major sources of harm. Reducing variability improves reliability, reduces redraws and diagnostic delay, and supports defensible performance in accreditation and event review. In short: the lab process chain is a high-volume, multi-step clinical production system- variation is inevitable, but unmanaged variation increases patient safety risk.

NEW QUESTION: 3
In enterprise risk management, which of the following are external factors that may affect risk?

	physician shortage	resolution of claims	new regulations	soft insurance market trends
A.	yes	yes	yes	no
B.	yes	yes	no	yes
C.	yes	no	yes	yes
D.	no	yes	yes	yes

A. Option A
B. Option B
C. Option C
D. Option D
Answer: C (LEAVE A REPLY)
According to Health Care Risk Management standards supported by ASHRM and enterprise risk management ERM principles, external factors include conditions outside the direct control of the organization that influence strategic, operational, financial, and regulatory risk exposures.
A physician shortage is an external workforce market condition that can affect staffing stability, access to care, and malpractice exposure. New regulations are also external factors, as legislative or regulatory changes may alter compliance requirements,

reimbursement structures, or reporting obligations. Similarly, soft insurance market trends reflect external economic and underwriting environments that influence premium pricing, availability of coverage, and risk financing strategy.
Resolution of claims, however, is generally an internal operational or claims management outcome. While influenced by external legal environments, the resolution process itself is primarily part of internal risk management and litigation strategy rather than a broad external environmental factor.
ERM objectives emphasize analysis of external environmental drivers, including regulatory, workforce, economic, and market conditions. Therefore, physician shortages, new regulations, and soft insurance market trends are external factors affecting risk, while resolution of claims is not primarily classified as external.

NEW QUESTION: 4
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 (LEAVE A REPLY)
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.

NEW QUESTION: 5
An HMO advertises it is "the best" and its physicians can manage any illness/injury. A patient relies on this and is injured. The patient might sue the HMO for:
A. Apparent agency / negligent misrepresentation / vicarious liability (depending on facts and jurisdiction)
B. Only weather damage
C. Only EMTALA penalties
D. Only OSHA violations
Answer: (SHOW ANSWER)
Marketing claims can create liability exposure when they reasonably induce reliance and the patient suffers harm. Depending on jurisdiction and facts, plaintiffs may allegeapparent agency(belief that physicians acted as the HMO's agents),vicarious liability, negligent credentialing, or negligent misrepresentation/consumer protection claims if statements are misleading. Risk management objectives include reviewing public claims for accuracy, ensuring marketing does not overpromise clinical capability, and aligning network adequacy and credentialing with representations. Clear disclosures about independent contractors may help but do not always defeat apparent agency claims. Controls include legal review of advertising, credentialing rigor, quality oversight, and complaint surveillance to detect mismatches between marketing and actual service capability.

NEW QUESTION: 6
Per The Joint Commission and CMS patient visitation standards, a hospital may restrict an individual's ability to visit a patient if the visitor
A. is not the patient's immediate family member.
B. is known to be a drug seeker in the community.
C. administered the patient an unknown drug via IV.
D. is not the patient's designated healthcare surrogate.
Answer: C (LEAVE A REPLY)
According to Health Care Risk Management standards supported by ASHRM, CMS Conditions of Participation, and The Joint Commission patient visitation standards, hospitals must have written visitation policies that respect patient rights. Patients generally have the right to designate visitors of their choosing, including individuals who are not immediate family members. Visitation cannot be restricted based on non- clinical factors such as relationship status or surrogate designation.
However, facilities may impose clinically reasonable or safety-based restrictions. If a visitor administers an unknown drug intravenously to a patient, this presents a clear and immediate threat to patient safety. Such conduct justifies restricting visitation to protect the patient from harm, maintain clinical control of treatment, and prevent unsafe interference with care.
Being known as a drug seeker in the community, without evidence of disruptive or harmful behavior during the visit, does not alone justify restriction under patient rights standards.

Similarly, visitation cannot be denied solely because the individual is not the designated healthcare surrogate.
Legal and regulatory objectives emphasize balancing patient rights with safety and security. Therefore, a hospital may restrict visitation when a visitor's actions pose a direct threat to patient safety.

NEW QUESTION: 7
People make fewer errors when:
A. Staff work as a coordinated team with shared communication tools
B. Individuals work alone to avoid distraction
C. Speed is prioritized over verification
D. Errors are hidden to protect reputations
Answer: (SHOW ANSWER)
Team-based care reduces errors by improving communication, cross-monitoring, workload distribution, and escalation when risk increases. TeamSTEPPS and related patient safety evidence show teamwork training can improve safety culture and reduce clinical error rates by creating predictable behaviors-briefs, huddles, check-backs, and mutual support. From a risk management standpoint, teamwork is a high-leverage control because many serious adverse events involve coordination failures (handoffs, unclear ownership, missed deterioration). Effective teams also reduce "single-point-of-failure" risk; when one clinician misses something, another can catch it. Organizations operationalize this through standardized communication (SBAR), structured handoffs, simulation, and leadership support for psychological safety so staff speak up.
Team functioning is therefore not "soft skill"-it is a measurable safety barrier that reduces preventable harm and strengthens reliability in complex, high-acuity environments.

NEW QUESTION: 8
An organization has recently changed insurance. The risk manager receives a claim from a former patient on July 3, 2004, claiming injury and alleging negligence by the surgery staff on September 5, 2003. Which of the following would apply to this claim?
* a claims-made policy for the period 1/1/03 to 1/1/04 with a retro date of 1/1/02
* an occurrence policy for the period 1/1/03 to 1/1/04
* a claims-made policy for the period 1/1/03 to 1/1/04 with a 1-year tail coverage
* an occurrence policy for the period 1/1/04 to 1/1/05
A. 1 and 2 only
B. 1 and 4 only
C. 2 and 3 only
D. 3 and 4 only
Answer: (SHOW ANSWER)
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, coverage determination depends on

both the policy trigger and relevant dates. The alleged negligence occurred on September 5, 2003. Under an occurrence policy in effect from 1/1
/03 to 1/1/04, coverage applies because the event occurred during that policy period, regardless of when the claim was filed. Therefore, option 2 applies.
For a claims-made policy covering 1/1/03 to 1/1/04, coverage would require that the claim be made and reported during the policy period unless tail coverage is in place. Because the claim was received on July 3,
2004, after expiration of the 1/1/03 to 1/1/04 claims-made policy, coverage would apply only if a 1-year tail was purchased. Thus, option 3 applies.
Option 1 would not apply because the claim was made after the claims-made policy period ended, and no tail is specified. Option 4 would not apply because occurrence coverage from 1/1/04 to 1/1/05 would not cover an event that occurred in 2003.
Risk financing objectives emphasize understanding policy triggers, reporting requirements, and tail coverage.
Therefore, the applicable coverage scenarios are the occurrence policy for 2003 and the claims-made policy with tail coverage.

NEW QUESTION: 9
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: (SHOW ANSWER)
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.

NEW QUESTION: 10
A hospital has opted to open an anticoagulation clinic. As this is a high-risk medication, a risk manager wants to conduct a risk assessment before opening the clinic. The BEST tool to use would be a
A. root cause analysis RCA.
B. failure mode and effects analysis FMEA.
C. cause and effect diagram.
D. scatter diagram.
Answer: B (LEAVE A REPLY)
Failure Mode and Effects Analysis FMEA is the most appropriate tool in this scenario because it is a proactive risk assessment methodology designed to identify and mitigate potential failures before harm occurs. According to Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, FMEA is specifically used when introducing new processes, services, or high-risk clinical operations, such as an anticoagulation clinic involving medications with narrow therapeutic indices and significant bleeding risks.
FMEA systematically evaluates each step in a proposed process, identifies possible failure modes, analyzes their causes and effects, and prioritizes risks using severity, occurrence, and detectability scoring. This structured approach aligns with patient safety objectives by reducing preventable adverse events before implementation.
In contrast, Root Cause Analysis RCA is a retrospective tool used after an adverse event has occurred. A cause and effect diagram is a component often used within RCA or FMEA but is not a comprehensive risk assessment tool on its own. A scatter diagram is primarily used for statistical correlation analysis and does not evaluate process failures.
Therefore, for proactive risk identification and mitigation prior to clinic opening, FMEA is the best and most appropriate tool.

NEW QUESTION: 11
All of the following are valid reasons for performing risk management review of policies and procedures EXCEPT
A. ensuring consistency between practice and policy.
B. identifying potential risk exposures.
C. monitoring compliance with standards.
D. maintaining staff competency.
Answer: D (LEAVE A REPLY)
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, periodic review of policies and procedures is essential to ensure alignment with current laws, regulatory standards, accreditation requirements, and best practices. Reviewing policies helps ensure

consistency between written procedures and actual clinical practice, thereby reducing liability exposure.
Policy review also supports identification of potential risk exposures by detecting outdated language, conflicting guidance, or gaps in processes that could lead to adverse events. Additionally, monitoring compliance with standards-such as federal regulations, state statutes, and accreditation requirements-is a central purpose of policy review, ensuring that organizational practices meet required benchmarks.
Maintaining staff competency, however, is primarily addressed through education, training programs, credentialing, and performance evaluation processes. While policies provide guidance for staff conduct, competency assessment is not the primary objective of policy review itself.
Health Care Operations objectives emphasize governance oversight, regulatory compliance, and risk mitigation through clear, current policies. Therefore, maintaining staff competency is not a direct reason for performing risk management review of policies and procedures, making it the correct exception.

NEW QUESTION: 12
Which of the following should a risk manager consider when evaluating the effectiveness of a claims management program?
* indemnity-to-expense ratios
* total number of cases reported
* percentage of cases resolved within reserves
* percentage of cases identified prior to claim
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 (LEAVE A REPLY)
According to Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, evaluation of a claims management program focuses on efficiency, financial accuracy, and proactive identification of risk exposures.
Indemnity-to-expense ratios are important performance indicators that measure the proportion of funds spent on compensation versus defense costs. A balanced ratio reflects efficient claim handling and appropriate litigation management. The percentage of cases resolved within reserves evaluates the accuracy of initial reserve setting and ongoing claims assessment, demonstrating financial forecasting effectiveness.
Additionally, the percentage of cases identified prior to formal claim filing reflects proactive risk identification and early intervention practices, which may reduce litigation costs and improve resolution outcomes.

In contrast, the total number of cases reported alone does not measure program effectiveness, as volume may be influenced by patient population, service lines, or reporting culture rather than management quality.
Claims and litigation objectives emphasize accurate reserving, early case identification, and cost-effective resolution strategies. Therefore, indemnity-to-expense ratios, resolution within reserves, and early case identification are appropriate metrics for evaluating the effectiveness of a claims management program.

NEW QUESTION: 13
The enterprise risk management process extends beyond clinical risk management by
A. ensuring its strategic priority at the senior leadership and governance levels.
B. maintaining risks in silos as the best risk management approach.
C. comparing the organization's internal and external environment for efficacy.
D. analyzing the organization's medication administration program.
Answer: A (LEAVE A REPLY)
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, enterprise risk management ERM expands traditional clinical risk management to include strategic, financial, operational, regulatory, and reputational risks across the entire organization. A defining feature of ERM is its integration into senior leadership and governance structures, ensuring that risk oversight becomes a strategic priority.
ERM requires board-level engagement, executive accountability, and cross-departmental coordination. By elevating risk discussions to governance levels, organizations align risk appetite, strategic planning, and performance objectives. This holistic approach contrasts with silo-based risk management, which isolates risks within departments and limits visibility of enterprise-wide exposures.
Maintaining risks in silos contradicts ERM principles. Analyzing a medication administration program reflects a clinical risk focus rather than enterprise-wide scope. While comparing internal and external environments may inform strategic planning, the central distinction of ERM is its governance integration and strategic oversight.
Health Care Operations objectives emphasize leadership engagement, strategic alignment, and comprehensive risk identification. Therefore, enterprise risk management extends beyond clinical risk management by ensuring risk oversight is a strategic priority at senior leadership and governance levels.

NEW QUESTION: 14
Which of the following is the most reliable measure of the effectiveness of an educational program?
A. analysis of written evaluations
B. observable changes in human behavior
C. reduced frequency of claims or suits

D. reduced severity of claims or suits

Answer: B (LEAVE A REPLY)

According to Health Care Risk Management principles endorsed by ASHRM and the American Hospital Association Certification Center, the effectiveness of an educational program is best measured by demonstrated changes in behavior rather than by subjective or indirect outcomes. Educational initiatives in healthcare risk management aim to improve compliance, enhance patient safety practices, and modify unsafe behaviors.

Analysis of written evaluations primarily reflects participant satisfaction and perceived value of the program, but does not confirm that learning objectives were achieved or that behaviors changed. Reductions in claim frequency or severity are important organizational outcomes; however, these are influenced by multiple variables beyond education alone, including patient volume, case complexity, legal climate, and system-level interventions. Therefore, claims data are indirect and delayed measures.

Observable changes in human behavior, such as improved adherence to safety protocols, increased incident reporting, or consistent compliance with documentation standards, provide direct evidence that learning has translated into practice. Risk management objectives emphasize measurable performance improvement, competency validation, and alignment with patient safety goals.

Thus, observable behavioral change is the most reliable and immediate indicator that an educational program has achieved its intended effect.

NEW QUESTION: 15

Root Cause Analyses most often reveal that mistakes are a result of:

A. A series of small events and system flaws aligning

B. A single reckless person in most cases

C. Random chance with no patterns

D. Only equipment malfunction

Answer: A (LEAVE A REPLY)

RCA and systems safety models (e.g., Swiss Cheese) emphasize that adverse events typically requiremultiple contributing factors-small process breakdowns, latent conditions, and active failures-to align. This is why focusing only on the last person who touched the patient ("sharp end blame") rarely prevents recurrence. Risk management objectives are to identify and strengthen defenses: policies, training, equipment design, staffing models, communication standards, and redundancy where needed. A series-of-events understanding enables targeted corrective actions (forcing functions, standardization, automation with safeguards, independent double checks for high-alert processes). It also supports just culture: accountability is preserved for reckless behavior, but most improvement comes from redesigning systems that make errors more likely. This approach improves reliability, reduces repeat harm, and provides defensible evidence of organizational learning and corrective action.

NEW QUESTION: 16
A root cause analysis of inpatient suicides would be most likely to discover problems with:
A. The physical environment (e.g., ligature points, visibility)
B. Billing documentation
C. Dietary preferences
D. Parking access
Answer: A (LEAVE A REPLY)
Inpatient suicide prevention is a high-stakes patient safety domain where RCAs frequently identify environmental hazards-particularly ligature risks, blind spots, and unit design that limits observation. Joint Commission-style reviews and published analyses note that thephysical environmentis commonly
"incriminated" in inpatient suicides, emphasizing design/engineering controls alongside clinical monitoring.
Risk management objectives prioritize layered defenses: ligature-resistant fixtures, environmental rounding, safe room standards, removal control for risky items, and observation policies matched to patient risk.
Environmental mitigation is especially powerful because it reduces reliance on perfect human vigilance (which is not realistic). By treating suicide prevention as a systems problem-not an individual failure- organizations improve reliability and reduce recurrence. Environmental corrections also strengthen regulatory readiness and demonstrate that the facility addressed known hazards with sustainable controls.

NEW QUESTION: 17
When considering the proper insurance to purchase for an organization and its practitioners, a risk manager should understand which of the following about specific types of coverage?
A. Occurrence coverage provides coverage for incidents that occur prior to initiation date of the policy as long as the event is reported to the insurer before signing.
B. Occurrence coverage provides coverage for incidents that occur while the policy is in effect.
C. With claims-made coverage, the retroactive date does not impact the coverage of the insured.

D. With claims-made coverage, the nose period has no significance to the coverage of the insured.

Answer: B (LEAVE A REPLY)

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, occurrence coverage provides protection for incidents that occur during the policy period, regardless of when the claim is reported. The triggering event is the date of the occurrence. As long as the alleged act or omission took place while the policy was in force, coverage applies even if the claim is filed years later.

Option A is incorrect because occurrence coverage does not extend to incidents that occur prior to the policy's effective date. Coverage is strictly tied to the policy period.

Option C is incorrect because in claims-made coverage, the retroactive date is critical. Coverage applies only to claims made during the policy period for incidents that occurred on or after the retroactive date.

Option D is incorrect because the "nose" period, also known as prior acts coverage, is highly significant in claims-made policies. It determines whether earlier acts are covered when switching carriers.

Risk financing objectives emphasize understanding policy triggers, retroactive dates, and reporting requirements. Therefore, occurrence coverage applies to incidents that occur while the policy is in effect.

NEW QUESTION: 18

When CPOE is implemented, there is almost always a decline in:

A. Medication errors related to prescribing/transcription

B. Nurse staffing requirements

C. Patient acuity

D. The need for clinical decision-making

Answer: A (LEAVE A REPLY)

Computerized Provider Order Entry (CPOE) reduces medication errors primarily by eliminating illegible handwriting, standardizing order fields, and enabling decision support (allergy checks, dosing ranges, interactions). Evidence indicates CPOE can significantly reduce prescribing errors and improve patient safety, though it can also introduce new error types (selection errors, alert fatigue), requiring careful design and monitoring. From a risk management perspective, CPOE is a high-impact control that strengthens medication safety defenses at the "front end" of the medication-use process. Risk objectives include governance for order sets, usability testing, monitoring override patterns, and continuous training to prevent workarounds. Properly implemented, CPOE supports safer, more reliable care and reduces preventable adverse drug events, aligning with enterprise safety goals and regulatory expectations for medication management.

NEW QUESTION: 19

A doctor fails to administer an indicated test, and the patient deteriorates and must be admitted. This is an example of:
A. Diagnostic error (delay/omission in diagnostic process)
B. Risk financing error
C. Contracting breach
D. Facility security event
Answer: (SHOW ANSWER)
Failing to order or perform an indicated test can represent a diagnostic process failure-an omission that delays recognition of deterioration, leading to harm and escalation of care. Risk management objectives treat diagnostic safety as a systems issue: access to decision support, timely follow-up of abnormal results, clear responsibility for test ordering and review, effective handoffs, and adequate staffing/workload conditions to avoid missed steps. Such errors are often linked to underuse in the IOM quality framework (failure to provide beneficial service) and can drive claims due to preventable worsening. Preventive strategies include standardized pathways, trigger tools for abnormal labs, closed-loop test result management, and teamwork practices that encourage escalation when clinical concern persists despite uncertainty.

NEW QUESTION: 20
A 78-year-old patient in the ICU is unable to speak or swallow. The physician states that she is terminally ill and believes she lacks decision-making capacity. As such, he has deferred to her properly executed advance directive that clearly outlines her wishes for no life-prolonging treatment. The patient's three sons know of the directive, but insist that a PEG tube be placed to assist with feeding. The physician is opposed to placing the tube. The nurse calls the risk manager for advice. Which of the following should the risk manager advise?
A. The patient has the right to autonomy, and the advance directive is proper; support the physician.
B. The family will outlive the patient, and they have the right to sue; support the family.
C. More facts are needed; decision making capacity must be determined before moving forward.
D. More facts are needed; request an ethics consultation.
Answer: A (LEAVE A REPLY)
Under Health Care Risk Management principles recognized by ASHRM and the American Hospital Association Certification Center, a properly executed advance directive carries legal authority when a patient lacks decision-making capacity. The physician has assessed that the patient is terminally ill and lacks capacity, triggering activation of the advance directive. If the directive clearly states refusal of life-prolonging treatment, including artificial nutrition and hydration, those wishes must be honored in accordance with state law and the Patient Self-Determination Act framework.

Patient autonomy is a foundational ethical and legal principle in health care. Once capacity is lost, previously expressed wishes through a valid advance directive govern care decisions. Family members do not have authority to override a valid directive unless legal defects or ambiguity exist. Their disagreement does not negate the patient's documented preferences.
Although ethics consultation can be helpful in managing conflict, the directive here is described as properly executed and clear. Additional determination of capacity is unnecessary because the physician has already made that assessment.
Risk management objectives emphasize compliance with advance directive statutes, respect for patient autonomy, and reduction of liability through adherence to documented patient wishes. Therefore, the appropriate advice is to support the physician in honoring the advance directive.

NEW QUESTION: 21
According to The Joint Commission, which of the following should be done to patient-owned electrical devices entering the facility?
A. sequester the electrical device
B. tag by biomedical engineering
C. inventory with patient belongings
D. conduct an electrical safety inspection
Answer: (SHOW ANSWER)

NEW QUESTION: 22
A hospital's Ethics Committee is seeking advice on a case involving the elective sterilization of an adolescent patient who is developmentally disabled. One of the parents is refusing consent. The risk manager should evaluate which of the following?
* who has consent authority
* competency level of the patient
* diagnosis of the patient
* state statutes and laws
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: (SHOW ANSWER)
Under Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, cases involving sterilization of minors, particularly those who are developmentally disabled, raise significant legal and regulatory concerns. The risk manager's primary responsibility is to ensure compliance with applicable consent laws and protect patient rights while minimizing organizational liability.

First, determining who has legal consent authority is essential. When parents disagree, state law typically governs whether both parents must consent, whether one parent's consent is sufficient, or whether court involvement is required. Second, evaluating the competency level of the patient is critical because decision- making capacity influences whether the patient can participate in consent or assent processes. Capacity assessments may require clinical and legal evaluation.
Third, state statutes and laws are highly relevant, as many jurisdictions impose strict legal requirements or court approval for sterilization of minors or individuals with developmental disabilities. These laws are designed to protect vulnerable populations.
The patient's diagnosis alone is not the determining legal factor; rather, decision-making capacity and statutory requirements are central. Therefore, the risk manager must evaluate consent authority, competency, and applicable state laws to ensure regulatory compliance and ethical integrity.

NEW QUESTION: 23
Which condition must be met for a patient to no longer be protected by EMTALA obligations of the hospital?
A. The patient provides a caregiver contact for discharge
B. The patient is admittedin good faithas an inpatient (or is stabilized/appropriately transferred as applicable)
C. The patient signs a satisfaction survey
D. The patient receives a diagnosis code
Answer: B (LEAVE A REPLY)
EMTALA creates federal obligations for emergency screening and stabilization/appropriate transfer when an individual presents for emergency care. CMS interpretive guidance states a hospital's EMTALA obligation ends when the individual is admitted in good faith for inpatient services(even if not stabilized), shifting responsibility to inpatient Conditions of Participation and standard malpractice frameworks. EMTALA obligations also end followingstabilizationor anappropriate transfer(with required documentation /acceptance). Risk management objectives include tight ED documentation, clear decision points (screening complete, EMC identified, stabilization initiated, transfer accepted), and policy training to prevent EMTALA violations (which can carry major regulatory and financial consequences). The incorrect notion that EMTALA ends when contact information is provided is not supported; discharge planning is important, but it does not terminate EMTALA duties.

NEW QUESTION: 24
What is responsible for many HIPAA privacy violations in practice?
A. Impermissible access/disclosure (including "snooping" without a job-related need)
B. Correctly authorized disclosures
C. Proper encryption practices

D. De-identification

Answer: A (LEAVE A REPLY)

A frequent HIPAA Privacy Rule violation isimpermissible access or disclosureof protected health information-commonly including employee "snooping" (accessing records of family, friends, coworkers, or celebrities without a work-related need) and other unauthorized disclosures. Risk management objectives focus on preventing these events through role-based access, audit logs with active monitoring, sanctions policies consistently enforced, workforce training, and a culture that treats privacy as patient safety. Even when disclosures are not malicious, "minimum necessary" failures, misdirected faxes/emails, and unsecured devices can create reportable breaches. Effective prevention is layered: technical controls (access restrictions), administrative controls (policies, training), and detection/response (auditing, rapid mitigation). Privacy violations are high-risk because they harm patients, trigger regulatory action, and damage trust and reputation.

NEW QUESTION: 25

Which of the following is the BEST reason for the selection of defense counsel?

A. proximity to the facility

B. percentage of defense verdicts

C. area of expertise

D. fee schedule

Answer: C (LEAVE A REPLY)

According to Health Care Risk Management standards outlined by ASHRM and the American Hospital Association Certification Center, the selection of defense counsel should be based primarily on demonstrated expertise in the relevant area of law. Medical malpractice litigation involves complex clinical issues, evolving standards of care, expert witness coordination, and familiarity with healthcare regulations. Counsel with specialized experience in healthcare liability defense is better equipped to manage case strategy, assess exposure, and navigate jurisdiction-specific procedural rules.

Proximity to the facility may offer logistical convenience but does not ensure competency in complex medical litigation. Percentage of defense verdicts can be misleading, as case mix, settlement strategy, and jurisdictional tendencies influence outcomes. A high defense verdict rate does not necessarily reflect effective risk management or cost control. Fee schedule is an important financial consideration; however, cost alone should not override qualifications and experience.

Claims and litigation objectives emphasize effective case management, accurate evaluation of liability exposure, and protection of organizational reputation. Selecting counsel based on specialized expertise supports stronger legal defense, strategic settlement evaluation, and improved coordination with clinical experts. Therefore, area of expertise is the best reason for selecting defense counsel.

NEW QUESTION: 26

The reporting requirements of the Safe Medical Devices Act SMDA apply to which of the following?
* nursing homes
* physician offices
* ambulatory surgery
* hospitals
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 (LEAVE A REPLY)
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, the Safe Medical Devices Act SMDA establishes mandatory reporting requirements for certain healthcare facilities when a medical device has or may have caused or contributed to a patient death or serious injury. These requirements apply to device user facilities, which include hospitals, nursing homes, and ambulatory surgical facilities.
Hospitals are explicitly required to report device-related deaths to both the FDA and the manufacturer, and serious injuries to the manufacturer or the FDA if the manufacturer is unknown. Nursing homes and ambulatory surgery centers are also considered device user facilities under the Act and must comply with similar reporting obligations.
Physician offices, however, are generally not classified as device user facilities under SMDA reporting rules and therefore are not subject to the same mandatory reporting requirements, although voluntary reporting is encouraged.
Legal and regulatory objectives emphasize timely compliance with FDA reporting mandates, maintenance of documentation, and coordination with manufacturers and regulatory authorities to mitigate risk and enhance patient safety. Therefore, the SMDA reporting requirements apply to nursing homes, ambulatory surgery facilities, and hospitals.

NEW QUESTION: 27
An emergency department physician has evaluated and stabilized a patient who needs a sign language interpreter. The on-call physician is consulted for admission. Which of the following regulatory laws are most relevant?
A. ADA and EMTALA/COBRA
B. HCQIA and ADA
C. EMTALA/COBRA and HIPAA
D. HIPAA and HCQIA
Answer: A (LEAVE A REPLY)
Under Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, two federal laws are most directly implicated in

this scenario: the Americans with Disabilities Act ADA and the Emergency Medical Treatment and Labor Act EMTALA, formerly enacted under COBRA.
EMTALA requires hospitals with emergency departments to provide an appropriate medical screening examination, stabilization of emergency medical conditions, and appropriate transfer or admission regardless of ability to pay. Since the emergency physician has evaluated and stabilized the patient and the on-call physician is being consulted for admission, EMTALA obligations remain central to ensuring compliant continuation of care.
The ADA is also directly relevant because it mandates that health care organizations provide reasonable accommodations to individuals with disabilities, including effective communication. For a patient requiring a sign language interpreter, the hospital must provide appropriate auxiliary aids and services to ensure meaningful access to care.
HIPAA relates primarily to privacy and protected health information, while HCQIA addresses peer review immunity and credentialing matters. Therefore, ADA and EMTALA are the most relevant regulatory frameworks in this case.

NEW QUESTION: 28
What significantly impacts whether incident reports are discoverable?
A. State statutes, federal statutes, and case law
B. The color of the incident form
C. The patient's insurance plan
D. Staff seniority
Answer: A (LEAVE A REPLY)
Discoverability of incident reports varies substantially by jurisdiction and depends on how state and federal laws define peer review privilege, quality improvement protections, and confidentiality-plus how courts interpret those protections. Risk management objectives include structuring reporting and investigation workflows to maximize protected quality review where legally available: routing analyses through designated committees, labeling and handling documents per policy, limiting distribution, and avoiding mixing risk/peer review materials with ordinary business records. However, privilege is not automatic; mishandling (broad email distribution, using reports for disciplinary actions outside protected structures, inconsistent committee practices) can weaken protections. A defensible program uses legal counsel guidance, staff training, and clear documentation rules so the organization learns from events while reducing unnecessary legal exposure.

NEW QUESTION: 29
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 (LEAVE A REPLY)
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.

NEW QUESTION: 30
What is the voluntary relinquishment by the insurer or self-insurer of the right to recover from a third party?
A. Waiver of subrogation
B. Coinsurance
C. Underwriting
D. Experience rating
Answer: A (LEAVE A REPLY)
Subrogation is the insurer's right to seek recovery from a responsible third party after paying a loss. Awaiver of subrogationclause means the insurer (or self-insured entity) gives up that recovery right, usually to support business relationships and reduce litigation between contracting parties. Risk financing objectives include understanding when waivers are acceptable (balanced against increased retained loss), ensuring the waiver aligns with insurance policy endorsements, and preventing unintended coverage gaps. Poorly managed waivers can shift costs back onto the organization and complicate recovery efforts. Contracts should be reviewed to ensure the waiver is mutual when appropriate and consistent with the organization's risk appetite and insurance program.

NEW QUESTION: 31
Which of the following can be considered evidence in a malpractice claim?

* photographs of injuries
* thank you note from the patient to the physician
* patient journal of the hospital stay
* gift from the patient to a volunteer

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: A (LEAVE A REPLY)
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, evidence in a malpractice claim includes any relevant material that may help establish facts related to duty, breach, causation, or damages. Photographs of injuries are routinely admissible as demonstrative or documentary evidence to illustrate the nature and extent of harm. A thank you note from a patient to a physician may be introduced to reflect the patient's contemporaneous perception of care, credibility, or satisfaction at a particular time, depending on context. A patient's personal journal documenting experiences during hospitalization may also be considered evidence, particularly if it describes symptoms, interactions, or emotional distress relevant to damages.
A gift from a patient to a volunteer, however, is generally not probative of negligence or injury unless directly tied to issues of undue influence or misconduct. In typical malpractice litigation, such a gift does not establish standard of care, breach, or damages and would not ordinarily be considered relevant evidence.
Claims and litigation objectives emphasize careful documentation, preservation of relevant materials, and coordination with counsel regarding evidentiary matters. Therefore, photographs, written communications, and patient journals may be considered evidence in a malpractice claim.

NEW QUESTION: 32
Which of the following are essential elements of a standard loss run?
A. date, frequency, and severity
B. common law, case law, and analysis

C. date, expense, and indemnity
D. date, location, and root cause analysis
Answer: (SHOW ANSWER)
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, a standard loss run is a report generated by an insurer or third-party administrator summarizing claims activity for a specific period. Loss runs are critical tools in risk financing, underwriting review, actuarial analysis, and budgeting for self-insured retentions.
Essential elements of a standard loss run include the date of loss, indemnity payments, and expense payments.
Indemnity reflects amounts paid or reserved for compensation to claimants, while expense represents allocated loss adjustment expenses such as defense costs, expert witness fees, and investigation costs. These data elements allow the organization to evaluate financial exposure, trends in claim development, and adequacy of reserves.
While frequency and severity are important analytical concepts derived from loss data, they are not typically listed as standalone fields within the basic loss run report. Legal analysis, case law references, and root cause analyses are not standard components of loss run documentation.
Risk financing objectives emphasize accurate tracking of financial exposure and informed forecasting.
Therefore, date, expense, and indemnity are essential elements of a standard loss run report.

NEW QUESTION: 33
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. 1, 2, and 3 only
B. 1, 2, and 4 only
C. 1, 3, and 4 only
D. 2, 3, and 4 only
Answer: B (LEAVE A REPLY)
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: 34
The set of values, norms, guiding beliefs, and understandings that is shared by members of a healthcare organization and is taught to new members is
A. organizational culture.
B. corporate vision.
C. managerial ethics.
D. strategic mission.
Answer: (SHOW ANSWER)
Within Health Care Risk Management frameworks identified by ASHRM and the American Hospital Association Certification Center, organizational culture refers to the collective values, shared norms, guiding beliefs, and behavioral expectations that shape how members of a healthcare organization function. It influences decision-making, communication patterns, leadership styles, and responses to risk and safety concerns. Culture is transmitted formally through policies and training, and informally through leadership behavior, peer interactions, and organizational traditions.
Organizational culture plays a critical role in patient safety, compliance, and ethical conduct. A strong culture of safety encourages reporting of adverse events, supports transparency, and promotes continuous improvement. Conversely, a punitive or hierarchical culture may suppress reporting and increase liability exposure.
Corporate vision describes the aspirational future state of the organization. A strategic mission outlines the organization's purpose and objectives. Managerial ethics refers to principles guiding leadership conduct.
While these elements contribute to the broader organizational framework, they do not encompass the shared and socially transmitted system of norms and beliefs that define culture.

Therefore, the correct term describing shared and taught values and norms within a healthcare organization is organizational culture.

NEW QUESTION: 35
Which of the following is an essential component of a risk management policy and procedure manual?
A. department organizational chart
B. medical staff bylaws
C. actuarial report
D. loss run report
Answer: A (LEAVE A REPLY)
According to Health Care Risk Management standards outlined by ASHRM and the American Hospital Association Certification Center, a risk management policy and procedure manual should clearly define the structure, authority, and operational framework of the risk management program. An organizational chart is an essential component because it identifies reporting relationships, lines of authority, and accountability within the department and in relation to executive leadership and governing bodies.
A clearly documented organizational structure supports regulatory compliance, facilitates communication, and ensures that responsibilities for event reporting, claims management, patient safety initiatives, and regulatory oversight are properly assigned. It also demonstrates governance alignment and helps accrediting bodies evaluate program effectiveness.
Medical staff bylaws are separate governance documents that outline credentialing, peer review, and clinical governance standards. Actuarial reports are financial analyses used in risk financing decisions but are not part of a policy and procedure manual. Loss run reports summarize historical claims activity and support financial review but do not define program structure.
Health Care Operations objectives emphasize formal documentation of authority, processes, and accountability within the risk management framework. Therefore, inclusion of the department organizational chart is an essential element of a comprehensive risk management policy and procedure manual.

NEW QUESTION: 36
An appropriate way to complete the verification read-back of a complete order, as required by The Joint Commission National Patient Safety Goals, is to have the person receiving the order
A. write the information down before reading it back.
B. immediately repeat the information.
C. have a witness verify that the information is repeated back correctly.
D. document the date and time the order was received.
Answer: A (LEAVE A REPLY)

According to Health Care Risk Management standards supported by ASHRM and The Joint Commission National Patient Safety Goals, the read-back process is designed to ensure accurate communication of verbal or telephone orders. The correct process requires the person receiving the order to first write down the complete order and then read it back to the prescribing practitioner for verification.
Writing the order down before reading it back reduces reliance on memory and decreases the risk of omission or transcription errors. The practitioner who gave the order must then confirm that the read-back is accurate.
This closed-loop communication process enhances patient safety and reduces medication and treatment errors associated with miscommunication.
Immediately repeating the information without documenting it does not meet the full verification requirement, as the written record must be confirmed. A witness is not required under the standard. Documenting the date and time is necessary for proper charting but does not constitute completion of the read-back verification itself.
Clinical and patient safety objectives emphasize clear, structured communication processes. Therefore, writing the information down before reading it back is the appropriate method to complete the verification process.

NEW QUESTION: 37
An intervention between parties to promote reconciliation, settlement, or compromise is
A. an arbitration.
B. a mediation.
C. a jury trial.
D. a judge trial.
Answer: (SHOW ANSWER)
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: 38
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 any patient, for any reason.
B. 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.
C. 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.
D. The on-call physician is never relieved of duty to accept a patient needing specialized services.
Answer: (SHOW ANSWER)
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: 39
Information from the Data Bank (NPDB; includes former HIPDB content) can be requested by:
A. Any member of the public
B. Professional societies with formal peer review (as permitted)

C. Social media investigators
D. Patients requesting a clinician's full file
Answer: B (LEAVE A REPLY)
Access to NPDB information is restricted to authorized entities for credentialing, privileging, and oversight- not public browsing. HRSA's NPDB rules identify who can query and report;professional societies with formal peer revieware listed among entities that may query under certain circumstances. This limited-access model supports patient safety objectives by enabling credentialing bodies to identify adverse licensure actions, certain negative clinical privilege actions, and other reportable events, while protecting due process and confidentiality. From a risk management perspective, proper querying supports defensible credentialing and reduces negligent credentialing exposure. Equally important: organizations must maintain secure handling of NPDB responses and follow permitted-use rules to avoid compliance violations.

NEW QUESTION: 40
For a liability claim to succeed, the claimant must establish duty owed, duty breached, proximate cause, and
A. contributory negligence.
B. injury sustained.
C. punitive damages.
D. gross negligence.
Answer: B (LEAVE A REPLY)
Under Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, a successful negligence claim requires proof of four essential legal elements: duty, breach of duty, causation, and damages. Duty refers to the legal obligation owed by the healthcare provider to the patient. Breach occurs when the provider fails to meet the applicable standard of care. Proximate cause establishes the direct link between the breach and the harm suffered.
The final required element is actual injury or damages sustained by the claimant. Without demonstrable harm, a negligence claim cannot succeed, even if duty and breach are proven. The injury may include physical harm, emotional distress, or financial loss, but it must be measurable and attributable to the breach.
Contributory negligence is a defense that may reduce or bar recovery but is not an element the claimant must prove. Punitive damages are awarded in exceptional cases involving egregious misconduct and are not required to establish liability. Gross negligence represents a higher degree of negligence but is not a required element in standard malpractice claims.
Therefore, proof of injury sustained is essential for a liability claim to succeed.

NEW QUESTION: 41
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 (LEAVE A REPLY)
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.