

# CPHIMS Prüfungsaufgaben - CPHIMS Dumps

## CPHIMS Exam with Complete Questions and Answers 100% Correct

Which of the following functions are typically performed by a health information management professional?

1. diagnosis and procedure coding
2. system implementation
3. content retention
4. record administration - ANSWER 1, 3, and 4 only

Item #3, system implementation, typically involves hardware, software, network and training. This would not be performed by a health information management professional.

A CIO is hearing from staff members that the team needs additional resources to be successful with maintaining all of the organization's current systems. The MOST appropriate first step for the CIO would be to:

- A. poll each member to understand their thoughts on what skill sets and abilities are needed from the new hires.
- B. review performance indicators and service metrics along with organizational perception of the team's effectiveness.
- C. adjust the departmental budget to allow for the hiring of additional staff members.
- D. review process improvement opportunities and develop a plan to implement the changes. - ANSWER B. review performance indicators and service metrics along with organizational perception of the team's effectiveness.

The review of performance indicators, service metrics, and customer satisfaction validates the staff's concerns.

At which of the following care settings should a large, orthopedic healthcare organization anticipate the highest volume of postoperative patient services?

1. urgent care
  2. rehabilitation
  3. assisted-living
  4. home health
- A. 1 and 3 only
  - B. 1 and 4 only
  - C. 2 and 3 only
  - D. 2 and 4 only - ANSWER D. 2 and 4 only

A rehabilitation center's (#2) primary service is therapies designed to restore functioning to patients following orthopedic surgery which means a large number of

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# HIMSS Certified Professional in Healthcare Information and Management Systems CPHIMS Prüfungsfragen mit Lösungen (Q75-Q80):

## 75. Frage

A risk response plan includes swapping desktops for laptops for physicians to eliminate the risk of physicians failing to adopt a new Electronic Health Record (EHR). This is an example of

- A. risk transference.
- B. risk mitigation.
- **C. risk avoidance.**
- D. risk acceptance.

**Antwort: C**

Begründung:

Risk avoidance involves changing a project plan to eliminate a threat entirely, rather than merely reducing its probability or impact. In this scenario, leadership identifies the risk that physicians may resist or fail to adopt the new EHR system due to workflow inconvenience or lack of mobility. By replacing desktop computers with laptops, the organization alters the work environment to remove a key barrier to adoption—thereby eliminating the root cause of the identified risk. This proactive adjustment represents risk avoidance because it restructures the approach so that the risk condition no longer exists in its original form.

Risk mitigation, by contrast, would reduce the likelihood or impact of non-adoption (for example, through training or support programs) but would not fully remove the underlying barrier. Risk transference shifts responsibility to another party (such as through insurance or outsourcing). Risk acceptance acknowledges the risk without taking preventive action.

Within healthcare IT governance and project management frameworks aligned with HIMSS principles, risk avoidance is appropriate when the organization can feasibly change scope, technology, or workflow to eliminate a significant adoption threat. Ensuring clinician engagement and usability is critical for EHR success, and structural changes that remove adoption barriers exemplify risk avoidance.

## 76. Frage

Digital health apps and fitness tracking devices can add patients' health data to their Electronic Health Records (EHR) by using a(n):

- A. Controlled Unclassified Information (CUI).
- **B. Application Programming Interface (API).**
- C. Virtual Desktop Machine (VDM).
- D. Electronic Data Interchange (EDI).

**Antwort: B**

## 77. Frage

Which of the following is a disadvantage to fully customizing a system to current organizational workflow?

- A. Increases the time and cost of the implementation process.
- **B. Prevents implementing future system upgrades.**
- C. Minimizes end-user training requirements.
- D. Makes regulatory compliance more challenging.

**Antwort: B**

Begründung:

Fully customizing a healthcare information system to match an organization's current workflow can create long-term operational risk because extensive customization often becomes tightly coupled to a specific vendor version and technical architecture. As vendors release upgrades, patches, and new features (often driven by patient-safety improvements, interoperability requirements, cybersecurity fixes, and regulatory updates), heavily customized environments typically require significant rework, retesting, and validation to ensure the custom components still function correctly. This can delay or effectively block timely upgrades, leaving the organization on older versions that may lack critical security patches or updated functionality.

While customization may reduce training needs in the short term by preserving familiar workflows (making option A an advantage), the upgrade burden is a classic downside: custom code, custom interfaces, and non-standard configurations increase maintenance complexity and can break during version changes. Over time, this can raise total cost of ownership and reduce agility, especially

when the organization needs to adopt new standards, integrate additional systems, or support new care models. Therefore, the most direct and strategically significant disadvantage listed is the inability (or practical difficulty) of implementing future system upgrades, captured best by option C .

### 78. Frage

Clinical guidelines, data flow sheets, documentation templates, alerts, and reminders can be found in a

- A. Uniform Data System.
- B. Health Information Exchange System.
- C. Clinical Data Repository System.
- **D. Clinical Decision Support System.**

**Antwort: D**

Begründung:

A Clinical Decision Support System (CDSS) is designed to deliver knowledge and patient-specific information to clinicians and staff at appropriate times to enhance decision-making and standardize care. The items listed- clinical guidelines, data flow sheets, documentation templates, alerts, and reminders -are hallmark CDSS capabilities because they operationalize evidence-based practice and workflow support directly within clinical processes. Guidelines and protocols can be embedded as order sets, pathways, and standardized documentation tools. Flow sheets and templates structure data capture so clinicians document consistently and can trend key measures over time (e.g., vitals, intake/output, pain scores, ventilator settings).

Alerts and reminders provide real-time prompts for safety and quality (e.g., allergy checking, drug-drug interactions, overdue preventive screenings, abnormal results follow-up).

By contrast, a Health Information Exchange (HIE) focuses on sharing data across organizations, not generating point-of-care guidance and alerts. A Clinical Data Repository (CDR) stores and aggregates clinical data for reporting and analytics; it may feed CDSS logic but is not where end-user alerts/templates are

"found" as a functional toolset. "Uniform Data System" is not the standard system used for these bedside clinical guidance functions. Therefore, the correct answer is Clinical Decision Support System .

### 79. Frage

A clinician is looking to retrieve a CT image from the patient's current visit. In which system does it reside?

- A. Health information exchange.
- B. HL7.
- **C. PACS.**
- D. Data warehouse.

**Antwort: C**

Begründung:

Computed Tomography (CT) images are diagnostic imaging objects that are stored, indexed, and retrieved through a Picture Archiving and Communication System (PACS) . PACS is purpose-built to manage medical images and related metadata for radiology and other imaging departments, enabling clinicians to view studies from the current encounter as well as historical imaging. In a typical healthcare architecture, the imaging modality (CT scanner) produces images in the DICOM format and transmits them to PACS, where they are archived and made available to viewing applications (often via an enterprise viewer integrated into the EHR). The other options do not primarily "house" the image data. A Health Information Exchange (HIE) facilitates sharing clinical information across organizations, and while it may enable access to imaging results or links, it is not the authoritative repository for the original CT images in most workflows. A data warehouse is optimized for analytics and reporting; it may store imaging-derived metadata or summarized results but not serve as the operational imaging system of record. HL7 is a messaging standard for exchanging clinical and administrative data (orders, results, ADT messages), not an image storage system. Therefore, PACS is the correct system where the CT image resides.

### 80. Frage

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