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HIMSS Certified Professional in Healthcare Information and Management Systems Sample Questions (Q13-Q18):

NEW QUESTION # 13

How can training staff's effectiveness be best improved?

- A. Train the trainers on the system functions.
- **B. Empower trainers to participate in design and user acceptance testing and develop the curriculum in the process.**
- C. Provide training before go-live, once testing is completed and the product is ready to ship.
- D. Provide the design and solution documents to the training team immediately after the contract is executed.

Answer: B

Explanation:

Training staff are most effective when they are integrated early into the implementation lifecycle- particularly during design and user acceptance testing (UAT) -because this gives them deep, practical understanding of the new workflows, decisions, and real-world usability issues that end users will face. By participating in design sessions, trainers learn the intended future-state processes, policy choices (e.g., documentation standards, order set governance), and role-based responsibilities. Through UAT involvement, trainers

observe where users struggle, what steps are error-prone, which screens are confusing, and which workflow workarounds emerge. That insight allows trainers to build targeted curriculum, scenarios, and tip sheets that directly address high-risk tasks and common points of failure-improving adoption, reducing errors, and shortening the productivity dip at go-live.

Option B delays trainer readiness until late, limiting time to develop scenario-based training and incorporate UAT lessons learned. Option C (receiving documents) helps but is insufficient because documents rarely capture the nuanced, operational "how work really happens" details. Option D (training trainers on functions) is necessary but not sufficient; effective healthcare IT training must be workflow- and role-based, not only feature-based. Hence, early empowerment and participation (A) best improves training effectiveness.

NEW QUESTION # 14

Which is NOT a type of waste, according to Lean experts?

- A. Transportation.
- **B. Planning.**
- C. Waiting.
- D. Inventory.

Answer: B

Explanation:

In Lean management, "waste" (often called *muda*) refers to activities that consume resources but do not add value from the customer's perspective-within healthcare, that "customer" is commonly the patient and the care team relying on timely, safe services. Classic Lean frameworks identify specific categories of waste, commonly remembered as TIMWOODS: Transportation, Inventory, Motion, Waiting, Overproduction, Overprocessing, Defects, and Skills (unused talent). In that list, Waiting, Inventory, and Transportation are all explicitly recognized waste types because they create delays, tie up capital and space, and add risk without improving care. For example, waiting can increase length of stay and frustrate patients; excess inventory can lead to expired supplies; and unnecessary transportation can raise labor cost and increase the chance of loss or error.

Planning, however, is not categorized as a Lean waste type. In fact, effective planning-especially when aligned with standardized work, clear value-stream goals, and stakeholder communication-supports Lean by preventing rework, reducing variation, and improving flow. While "over-planning" could be viewed as overprocessing in some contexts, planning itself is not one of the defined Lean waste categories. Therefore, the correct choice for what is not a Lean waste type is Planning.

NEW QUESTION # 15

In reviewing audit logs an analyst finds that a charge nurse, not assigned to a celebrity patient, is reviewing that patient's medical record. Which of the following should the analyst do first?

- A. Notify the risk manager.
- B. Continue monitoring the situation.
- C. Delete the security logs.
- **D. Archive the security logs.**

Answer: D

Explanation:

When an audit log review suggests potential inappropriate access to a patient's record, the first priority is to preserve evidence and maintain an accurate chain of custody. Archiving the security logs ensures the organization retains an immutable snapshot of the access event details-who accessed the chart, timestamps, workstation/device identifiers, actions performed, and any related system context. This preservation step is essential because logs can rotate, be overwritten, or be altered through routine system processes. Without secured logs, a later investigation may be unable to confirm what happened, determine scope, or support corrective and disciplinary actions.

Continuing to monitor (option B) delays response and increases risk of additional improper access. Notifying the risk manager (option C) is an important escalation step, but it should occur after the analyst has ensured the evidence is protected so the investigation can proceed effectively and defensibly. Deleting the logs (option D) is never appropriate; it destroys evidence, undermines compliance obligations, and can create significant legal and regulatory exposure.

In healthcare privacy and security management, suspected inappropriate access is handled through incident response procedures that begin with evidence preservation, then escalation to privacy, compliance, risk management, and HR as required.

NEW QUESTION # 16

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

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

Answer: C

Explanation:

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.

NEW QUESTION # 17

Which of the following is an example of EHR training that integrates workflow?

- A. Radiologist reviewing error messages received when viewing x-rays.
- B. Privacy Officer determining appropriate access related to patient confidentiality.
- C. Intensive Care Unit nurse reviewing Emergency Department patient handover reports.
- D. Pharmacist evaluating medication errors.

Answer: C

Explanation:

EHR training that integrates workflow is role-based and scenario-driven, meaning it teaches end users how to perform their real clinical tasks in the system in the same sequence, context, and timing they experience in practice. This approach emphasizes end-to-end processes (handoffs, ordering, documentation, medication administration, discharge) rather than isolated features or generic navigation. The example that best reflects workflow-integrated training is the ICU nurse reviewing Emergency Department patient handover reports, because it mirrors a common, time-sensitive clinical transition of care. In this scenario, the nurse must locate the correct patient, review ED documentation, reconcile current status and interventions, confirm orders, and prepare for ongoing ICU management-steps that directly match actual bedside workflow and support safe continuity of care.

Option A focuses on troubleshooting system error messages, which is more technical than workflow training.

Option B relates to governance and access control decision-making, not frontline EHR workflow use. Option D (evaluating medication errors) is primarily a quality/safety analysis activity; while important, it does not clearly represent a hands-on EHR workflow task sequence for routine care delivery. Workflow-integrated training improves adoption, efficiency, and patient safety because users practice exactly how the EHR supports their daily work.

NEW QUESTION # 18

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