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HIMSS Certified Professional in Healthcare Information and Management Systems Sample Questions (Q88-Q93):

NEW QUESTION # 88
An MPI system assigns each patient a

- A. master population index.
- B. medical provider identifier.
- C. unique person identifier.
- D. unique prescription number.

Answer: C

Explanation:
A Master Patient Index (MPI) is a core health information management function that supports accurate patient identity matching across an organization's clinical and administrative systems. Its central purpose is to ensure that each patient's records-encounters, lab results, imaging, medications, allergies, and billing information- are correctly linked to the right individual, even when the patient receives care at multiple locations or has multiple registrations. To accomplish this, an MPI assigns (and maintains) a unique person identifier for each patient. This identifier serves as the consistent "key" used to connect records from different systems and prevent duplicate charts or overlay errors (where one patient's information is mistakenly filed under another's record).
The other choices do not align with what an MPI does. A prescription number relates to a medication order /dispense transaction, not a person. "Master population index" is not something that is "assigned" to the patient; it is the system/process itself (sometimes called an enterprise master patient index). A medical provider identifier applies to clinicians, not patients. In practice, MPI integrity is supported by demographic attributes (name, DOB, address, phone), matching algorithms, and governance processes for duplicate resolution-built around the patient's unique person identifier .

NEW QUESTION # 89
A consulting firm was hired to discover causes of medication errors for a healthcare facility. Data was collected and analyzed within a 3-month period. Which of the following is the BEST way to display the results of the analysis?

- A. Pareto chart.
- B. Flowchart.
- C. Histogram.
- D. Control chart.

Answer: A

Explanation:
A Pareto chart is the best way to display results when the goal is to communicate the most common causes of medication errors and prioritize improvement actions. In medication safety and quality management, error causes are usually categorized (e.g., wrong dose, wrong patient, transcription issues, look-alike/sound-alike drugs, override of alerts, labeling problems). A Pareto chart sorts these categories from highest to lowest frequency and typically includes a cumulative percentage line, making it easy to see which "vital few" causes account for the majority of errors. This aligns with the Pareto principle (often described as 80/20), supporting leadership decisions about where interventions will yield the greatest impact (training, workflow redesign, decision support tuning, barcode scanning compliance, etc.).
A control chart is designed to monitor a process over time and distinguish common-cause from special- cause variation; it is excellent for tracking monthly error rates but not for ranking causes. A flowchart maps steps in a process and helps identify where errors might occur, but it does not summarize analyzed frequency results. A histogram shows the distribution of numeric data (e.g., time-to-administer), not categorical root- cause frequencies. Therefore, the Pareto chart best displays the analysis of error causes.

NEW QUESTION # 90
To enhance patient safety, which of the following abbreviations should be eliminated when introducing or upgrading an Electronic Health Record (EHR)?

- A. npo.

- B. qd.
- C. hs.
- D. prn.

Answer: B

Explanation:
The abbreviation "qd" (intended to mean "every day") should be eliminated because it is well known to be error-prone and has been repeatedly associated with misinterpretation and serious medication dosing errors. In handwritten or poorly rendered text, "qd" can be mistaken for "q.i.d." (four times daily), which can lead to a fourfold dosing frequency error -a high-risk patient safety event. Because EHR implementations often standardize order sets, medication dictionaries, and clinical documentation templates, this is a key opportunity to remove unsafe abbreviations and replace them with fully spelled-out, unambiguous instructions (e.g., "daily").
In contrast, NPO ("nothing by mouth"), PRN ("as needed"), and HS ("at bedtime") are common clinical abbreviations that are generally understood and are not typically singled out in major "do-not-use" abbreviation lists in the same way "qd" is. Safety-focused informatics practice emphasizes embedding these standards directly into computerized provider order entry (CPOE) and order sentences so clinicians select clear, standardized terms instead of typing free-text abbreviations. Eliminating "qd" supports safer prescribing, reduces ambiguity across care teams, and strengthens medication safety during EHR go-lives and upgrades.

NEW QUESTION # 91
Clinical guidelines, data flow sheets, documentation templates, alerts, and reminders can be found in a

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

Answer: D

Explanation:
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 .

NEW QUESTION # 92
During which of the following system development life cycle stages should security FIRST be addressed?

- A. Requirements development.
- B. Unit testing.
- C. Design specification.
- D. Integration testing.

Answer: A

Explanation:
Security should be addressed first during requirements development because that is the earliest point in the system development life cycle (SDLC) where the organization defines what the system must do , including essential safeguards for confidentiality, integrity, and availability of health information. In healthcare environments, requirements must explicitly capture privacy and security needs such as role-based access control, authentication strength, audit logging, encryption expectations, downtime/backup requirements,

and regulatory obligations for protected health information. If these controls are not defined up front, downstream phases may produce designs and builds that cannot feasibly support required protections without expensive rework.
While design specification is where requirements are translated into architecture and technical controls, design can only be correct if it is driven by complete and validated security requirements. Unit testing and integration testing occur much later and focus on verifying that code modules and system interfaces function properly; security testing at those stages is important, but it is not the first opportunity to ensure the system is built to meet security needs. Addressing security early supports "security by design," reduces vulnerabilities introduced by poor assumptions, and helps ensure the final solution aligns with patient safety, clinical operations, and compliance expectations.

NEW QUESTION # 93
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