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HIMSS Certified Professional in Healthcare Information and Management Systems Sample Questions (Q53-Q58):

NEW QUESTION # 53
The quickest approach to activating a new Electronic Health Record (EHR) system across a healthcare organization is the

- A. Routine Operations Approach.
- B. Big Bang Approach.
- C. Pilot Group Approach.
- D. Phased Approach.

Answer: B

Explanation:
The Big Bang approach is the quickest method to activate a new EHR across an organization because it involves a single, organization-wide go-live at one point in time . Rather than deploying the system unit-by- unit or site-by-site, the organization switches from the legacy environment to the new EHR simultaneously.
From a healthcare information systems management perspective, this compresses the implementation timeline and eliminates prolonged periods of dual workflows (old and new systems running in parallel across different areas). It can also simplify integration planning because all departments move to the same platform and standardized processes at once.
However, "quickest" does not mean "lowest risk." Big Bang go-lives demand intensive readiness work:
enterprise training completion, workflow redesign, data conversion validation, downtime/contingency planning, command center staffing, and rapid issue escalation. In contrast, a phased approach spreads activation over time to reduce disruption but is slower overall. A pilot group approach limits initial activation to a controlled area first (also slower than Big Bang for enterprise completion).
"Routine operations" is not a standard EHR activation strategy and implies normal running rather than conversion. Therefore, the fastest activation approach is Big Bang .

NEW QUESTION # 54
An MPI system assigns each patient a

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

Answer: A

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 # 55
Healthcare organization executives can be held accountable for losses that result from computer system breaches if the healthcare organization fails to

- A. follow due process to prosecute the intruder.

- B. rapidly identify the unauthorized user.
- C. exercise due care protecting computing resources.
- D. insure computing resources against loss.

Answer: C

Explanation:
Executives can be held accountable for breach-related losses if the organization fails to exercise due care in protecting computing resources. "Due care" refers to the legal and managerial obligation to take reasonable and appropriate steps to safeguard information assets from foreseeable harm. In healthcare environments, this includes implementing administrative, technical, and physical safeguards such as risk assessments, access controls, encryption, audit logging, workforce training, incident response planning, and ongoing monitoring.
Leadership is responsible for ensuring that these controls are established, maintained, and periodically evaluated.
If an organization cannot demonstrate that it exercised due care-meaning it failed to act responsibly or ignored known risks-executives may face regulatory penalties, civil liability, reputational damage, or contractual consequences. Accountability is not dependent on whether the organization purchased insurance (A), successfully prosecuted the intruder (B), or immediately identified the unauthorized user (C). While those actions may mitigate impact, they do not substitute for proactive governance and risk management.
In healthcare information management, exercising due care reflects executive-level responsibility for security oversight, policy enforcement, compliance monitoring, and continuous improvement of cybersecurity posture.

NEW QUESTION # 56
Which of the following is an example of EHR training that integrates workflow?

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

Answer: D

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 # 57
To enhance patient safety, which of the following abbreviations should be eliminated when introducing or upgrading an Electronic Health Record (EHR)?

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

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 # 58
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