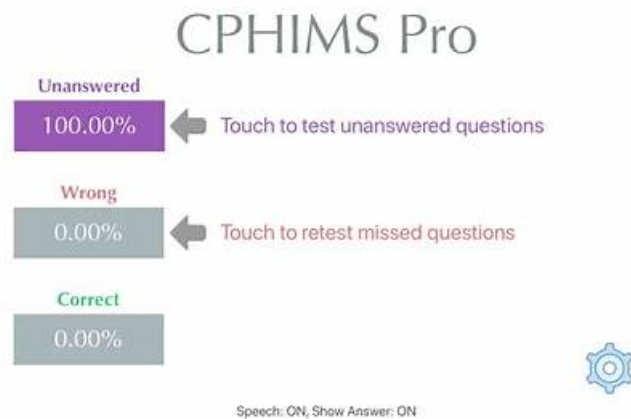


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HIMSS Certified Professional in Healthcare Information and Management Systems CPHIMS Prüfungsfragen mit Lösungen (Q54-Q59):

54. Frage

Strategic plans include

- A. budget requests.
- B. financial projections.
- C. policies and procedures.
- D. operational plans.

Antwort: D

Begründung:

A strategic plan defines an organization's long-term direction, priorities, and high-level goals, typically over a multi-year horizon. While it articulates mission alignment, competitive positioning, and major initiatives, it must also be translated into actionable steps. For this reason, strategic plans include or are supported by operational plans, which outline how the strategy will be executed in practice. Operational plans define timelines, responsibilities, resource allocation, performance metrics, and specific initiatives that move the organization toward its strategic objectives. In healthcare leadership and information systems governance, operational

planning ensures that broad goals-such as digital transformation, quality improvement, or cost reduction-are implemented through concrete projects and workflows.

In contrast, budget requests and financial projections may support strategic planning but are financial management tools rather than core structural components of the strategic plan itself. Policies and procedures are detailed governance documents that guide daily operations; they support compliance and consistency but are not defining elements of a strategic plan.

Thus, operational plans are the key component that connects high-level strategy to day-to-day execution, making option A the correct answer.

55. Frage

To improve patient safety and reduce the rate of medication administration errors, implementation of which of the following types of clinical systems or modules should have the GREATEST immediate impact?

- A. EMR.
- **B. BCMA.**
- C. CDSS.
- D. CPOE.

Antwort: B

Begründung:

Bar coded medication administration (BCMA) has the greatest immediate impact on reducing medication administration errors because it places an electronic safety check directly at the point where the medication is given to the patient. BCMA requires scanning the patient identifier (e.g., wristband) and the medication barcode, then automatically verifying the match against the active medication order and the scheduled administration time. This creates a real-time "stop-and-check" mechanism that prevents or interrupts common administration errors such as wrong patient, wrong drug, wrong dose, wrong time, and in many implementations, wrong route. Because the control is applied at bedside (or point of administration), improvements are often seen quickly once workflows and scanning compliance stabilize.

An EMR is a broad record platform that can contain many tools, but by itself it does not guarantee bedside verification. CPOE primarily reduces prescribing and transcription errors earlier in the medication-use process; its benefits are substantial but are not as directly tied to administration errors as BCMA. CDSS can reduce errors via alerts and guidance, yet its effectiveness depends heavily on rule design and can be limited by alert fatigue; it also does not inherently verify the medication in-hand at the bedside. Therefore, BCMA is the best choice for the greatest immediate reduction in medication administration errors.

56. Frage

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.

Antwort: B

Begründung:

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.

57. Frage

Which of the following is a standard for clinical healthcare terminology for electronic health records (EHR)?

- A. SSAE 16.
- B. HL7.
- **C. SNOMED.**
- D. DICOM.

Antwort: C

Begründung:

SNOMED (commonly implemented as SNOMED CT) is a widely adopted standard clinical terminology used in EHRs to represent patient problems, diagnoses, findings, procedures, organisms, substances, and other clinical concepts in a consistent, computable way. In clinical informatics, terminology standards are essential because they allow clinicians to document care using structured concepts that support clinical decision support, quality measurement, analytics, population health reporting, and interoperability. When different clinicians or organizations use the same standardized clinical terms, the meaning is preserved and can be accurately interpreted by receiving systems, reducing ambiguity that often occurs with free-text documentation.

The other options are not clinical terminology standards. SSAE 16 relates to service organization controls reporting (an assurance/audit framework). DICOM is a standard for medical imaging data and related information exchange

58. Frage

A balanced scorecard is used to provide visual representation of

- A. organizational perception and values.
- B. monitoring and assessment.
- **C. goals and performance.**
- D. opportunities and limitations.

Antwort: C

Begründung:

A balanced scorecard is a strategic management and performance measurement framework that visually represents an organization's goals and performance across multiple perspectives. Traditionally, it includes four domains: financial, customer (or patient), internal processes, and learning and growth. Rather than focusing solely on financial results, the balanced scorecard links strategic objectives to measurable indicators, allowing leaders to track whether operational activities align with long-term strategy.

In healthcare organizations, this might include measures such as patient satisfaction scores, clinical quality indicators, operational efficiency metrics, workforce development benchmarks, and financial sustainability targets. The balanced scorecard translates mission and vision into specific, quantifiable objectives and displays them in dashboards or scorecards that allow executives and managers to monitor progress at a glance.

Option A (monitoring and assessment) is partially true but too narrow; the balanced scorecard is broader than simple monitoring-it connects strategy to measurable outcomes. Option B resembles SWOT analysis (strengths, weaknesses, opportunities, threats). Option C relates more to organizational culture and values statements.

Therefore, the balanced scorecard's primary purpose is to provide a structured, visual representation of strategic goals and organizational performance, making D the correct answer.

59. Frage

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