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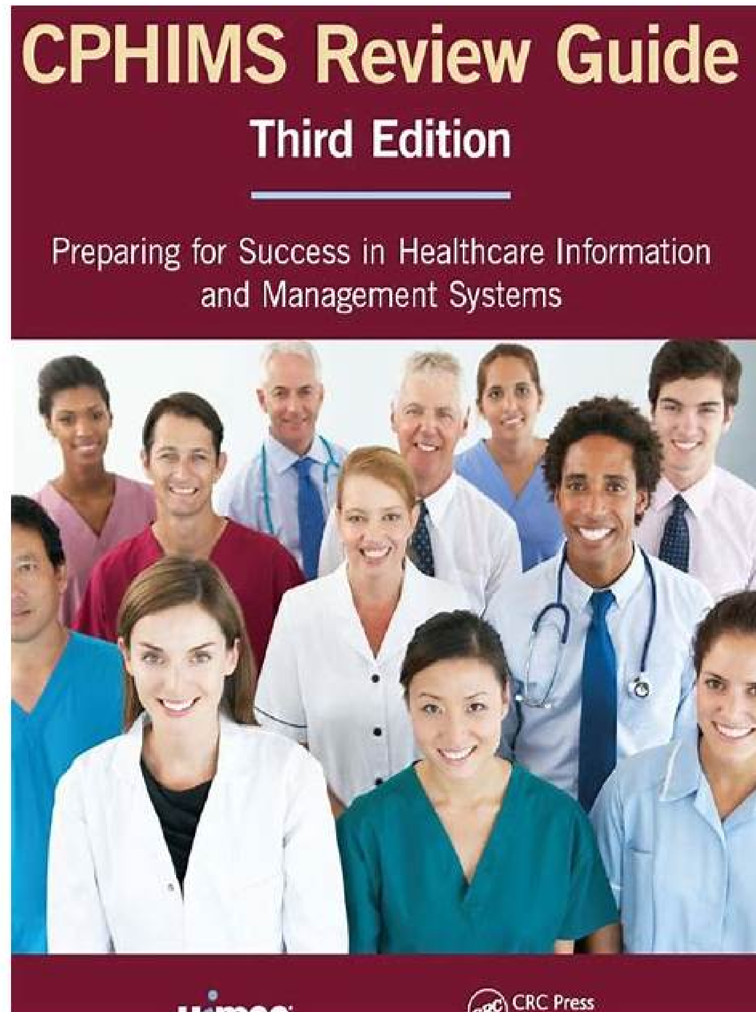

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HIMSS Certified Professional in Healthcare Information and Management Systems Sample Questions (Q80-Q85):

NEW QUESTION # 80
Which of the following is a standard for clinical healthcare terminology for electronic health records (EHR)?

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

Answer: A

Explanation:
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

NEW QUESTION # 81
A survey of the client community, sponsored by the IT department, reported a significant decline in overall satisfaction with the IT service provided. Which of the following is the FIRST step the Chief Information Officer should take?

- A. Evaluate the survey results to better understand the reported decline.
- B. Convene an all-staff meeting to discuss the results with the IT department.
- C. Send out a follow-up survey to the client community to get more detail.
- D. Engage an external consultant for a departmental effectiveness review.

Answer: A

Explanation:
The CIO's first step should be to evaluate the survey results to understand what is actually driving the decline and how credible and actionable the findings are. In IT service management and leadership practice, survey outcomes are an initial signal-not a diagnosis.
The CIO should review response rates, sampling (which departments responded), trends by service line, and segmentation (e.g., clinical vs. administrative users, inpatient vs. ambulatory). They should also analyze which dimensions dropped (incident response time, communication, downtime experience, training, EHR support, project delivery) and whether the decline correlates with recent events such as system outages, major upgrades, staffing changes, or backlog increases.
This assessment establishes a fact base and prevents premature actions that may miss the real issues.
A follow-up survey (B) may be useful later, but only after determining what gaps already exist in the data and what additional detail is needed. Convening an all-staff meeting (C) is also premature without a clear problem statement; it risks turning into speculation rather than focused improvement planning. Hiring an external consultant (D) can be appropriate for complex or persistent issues, but it is not the first move when internal data has not yet been analyzed.

NEW QUESTION # 82
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 # 83
A community-based healthcare organization has implemented a new electronic drug prescribing system that allows prescribers to access the complete current drug profile of their patients. From a quality of care perspective, which indicator will MOST likely be used to measure the success of the implementation?

- A. Reduction in adverse events and drug abuse.
- B. System adoption by care providers.
- C. Productivity improvements and reduced drug costs.
- D. Patient and provider satisfaction.

Answer: A

Explanation:
From a quality-of-care perspective, the most meaningful measure of success for an electronic prescribing (e- prescribing) system that provides access to a complete current medication profile is the reduction in adverse events and drug abuse . The primary clinical purpose of such systems is to improve medication safety by enabling prescribers to review allergies, drug-drug interactions, duplicate therapies, contraindications, and controlled substance histories before issuing prescriptions.
Clinical informatics principles emphasize outcome-based evaluation when assessing health IT effectiveness.
While satisfaction (Option A), productivity and cost reduction (Option B), and adoption rates (Option C) are important operational or implementation metrics, they do not directly measure improvements in patient safety or quality of care. True quality indicators focus on measurable clinical outcomes-such as decreased adverse drug events (ADEs), fewer medication errors, reduced inappropriate prescribing, and better monitoring of controlled substances.
By giving prescribers comprehensive medication visibility, the system helps prevent harmful interactions, overprescribing, and misuse. Therefore, the strongest quality-focused indicator of success would be a demonstrated reduction in adverse drug events and drug abuse , aligning with healthcare informatics goals of improving patient safety and clinical outcomes.

NEW QUESTION # 84
When routing transition of care information between the systems of different care providers, which of the following interoperability challenges must be overcome to ensure the right care for the right patient?

- A. Patient demographic data.
- B. Unique patient identifier.
- C. Patient identity integrity.

- D. Enterprise master patient index.

Answer: C

Explanation:
The central interoperability challenge in transitions of care across different organizations is patient matching -ensuring that incoming clinical information is accurately linked to the correct individual. This is best captured by patient identity integrity , which refers to the correctness, completeness, and consistency of a patient's identity data across systems so records are not mismatched (overlay) or split/duplicated. When identity integrity is weak, care teams may receive incomplete histories, allergies, medications, or problem lists-or, worse, information for the wrong person-creating direct patient-safety risk and undermining continuity of care.
While patient demographic data (name, DOB, address, phone) is used as input for matching, demographics alone are not the "challenge"-the challenge is maintaining integrity and reliably matching across systems with variations, missing fields, typos, name changes, and differing registration workflows. A unique patient identifier could help, but in real-world cross-provider exchange it is often not universally available or consistently used across all participants. An enterprise master patient index (EMPI) is a tool that supports matching within an enterprise or network, but the broader interoperability problem remains the integrity and accuracy of identity across boundaries. Therefore, overcoming patient identity integrity issues is essential to ensure the right patient receives the right care.

NEW QUESTION # 85
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