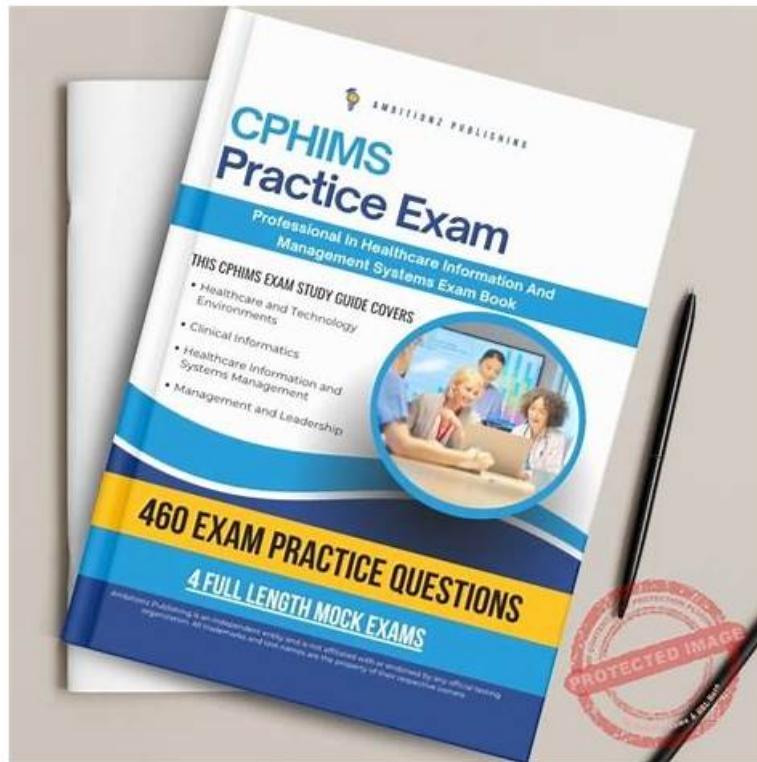


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## HIMSS Certified Professional in Healthcare Information and Management Systems Sample Questions (Q63-Q68):

### NEW QUESTION # 63

Which of the following is the primary function of a project steering committee?

- A. Meet according to the project plan.
- B. Provide oversight of the project.

- C. Execute specific project milestones.
- D. Troubleshoot project barriers.

**Answer: B**

Explanation:

A project steering committee's primary function is to provide oversight of the project. In healthcare information systems initiatives, the steering committee serves as the governance body that ensures the project remains aligned with organizational strategy, clinical priorities, patient safety, regulatory needs, and available resources. Oversight includes setting or approving major direction, validating scope and success criteria, reviewing progress against milestones, monitoring risk, and making high-impact decisions when tradeoffs are required (e.g., timeline vs. scope, workflow standardization vs. local variation). It also establishes accountability across stakeholders-clinical, operational, financial, and IT-and provides executive sponsorship and escalation pathways.

While steering committees often help remove barriers, troubleshooting (A) is a secondary outcome of oversight and escalation rather than the core purpose. Executing milestones (B) is the responsibility of the project team-project manager, analysts, builders, trainers, and operational owners-who perform the day-to- day work. "Meet according to the project plan" (C) describes a procedural detail, not a primary function.

Effective oversight is especially critical in health IT projects because decisions can affect care delivery, clinician workload, data integrity, privacy/security, and operational continuity. Therefore, the best answer is Provide oversight of the project .

#### NEW QUESTION # 64

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

**Answer: A**

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 # 65

What does Logical Observation Identifiers Names and Codes (LOINC) represent?

- A. The universal standard for identifying radiology test orders for the exchange of clinical health information.
- B. The universal standard for clinical information exchange authorization.
- C. The universal standard to display lab results on the patient portal.
- D. The universal standard for laboratory and clinical observations in the exchange of clinical health information.

**Answer: D**

Explanation:

LOINC (Logical Observation Identifiers Names and Codes) is a standardized terminology used to identify laboratory tests, clinical measurements, and other observations in a consistent, interoperable way. Its primary purpose is to ensure that when clinical data is exchanged between systems-such as hospitals, laboratories, public health agencies, and EHRs-the receiving system can correctly understand what observation was performed (e.g., hemoglobin in blood, SARS-CoV-2 PCR result, blood pressure, vital signs,

survey instruments). This makes option C correct because LOINC is widely used to code laboratory and clinical observations for health information exchange, analytics, and longitudinal patient records.

Option A is too narrow: while LOINC-coded results can be displayed on portals, LOINC is not a "display standard"; it is an observation identification vocabulary. Option B is incorrect because authorization is handled by security/access control frameworks, not clinical terminologies. Option D is also not the best match: radiology uses multiple standards; orders and imaging procedures are often represented with other vocabularies (and imaging content uses standards like DICOM). LOINC may represent some imaging-related observations (e.g., certain reportable results), but its core identity is coding observations and results to support semantic interoperability.

#### NEW QUESTION # 66

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

- A. Clinical Data Repository System
- B. Uniform Data System
- C. Health Information Exchange 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 # 67

Which of the following management activities is used to increase revenue, reduce days in accounts receivable, and reduce denied claims?

- A. Revenue optimization.
- B. Revenue accounting.
- **C. Revenue cycle management.**
- D. Expense management.

**Answer: C**

Explanation:

Revenue cycle management (RCM) is the end-to-end set of administrative and financial processes that manage patient service revenue from pre-registration and eligibility through coding, billing, claims submission, payment posting, denial management, and collections. Because RCM spans the full lifecycle, it directly targets the three outcomes named in the question. First, it increases revenue by improving charge capture, ensuring accurate clinical documentation and coding, and preventing underbilling. Second, it reduces days in accounts receivable (A/R) by streamlining claim submission, improving first-pass claim acceptance, accelerating payment posting, and prioritizing follow-up on unpaid claims. Third, it reduces denied claims by strengthening front-end verification (coverage, authorization), enforcing coding and medical necessity rules, and implementing denial analytics and appeal workflows to fix root causes.

"Revenue optimization" is a broader, less standardized term that may describe strategic improvement efforts but does not specifically represent the operational discipline that controls A/R and denials across the full cycle. "Revenue accounting" focuses on financial reporting and recognition rather than operational claim performance. "Expense management" targets cost reduction, not revenue realization. Therefore, RCM is the management activity that best fits all elements of the prompt.

## NEW QUESTION # 68

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