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HIMSS Certified Professional in Healthcare Information and Management

Systems Sample Questions (Q94-Q99):

NEW QUESTION # 94

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. Enterprise master patient index.
- B. Unique patient identifier.
- C. Patient identity integrity.
- D. Patient demographic data.

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 # 95

A consultant has been tasked to evaluate the intake process of the emergency department. Which of the following should the consultant do FIRST?

- A. Workflow analysis.
- B. Time study.
- C. Simulation.
- D. Benchmarking.

Answer: A

Explanation:

The first step in evaluating an emergency department (ED) intake process is to understand how the work is currently performed, end-to-end, across people, tasks, information, and enabling technologies. Workflow analysis comes first because it establishes the "current state" process map: who performs each step (registration, triage, bed assignment), what information is collected, where delays occur, how handoffs happen, what systems are used (EHR, tracking board), and where rework or duplication exists. This aligns with health IT and process-improvement best practices emphasized in healthcare information and management contexts: you cannot accurately measure, simulate, or compare a process until you have clearly defined it.

A time study (measuring durations and wait times) is valuable, but it should be guided by the workflow map so the consultant measures the right segments and interprets delays correctly (e.g., delay due to staffing vs. documentation bottlenecks). Simulation is typically performed after workflow and data collection to test "what-if" changes (staffing models, fast-track pathways). Benchmarking is also later-stage because comparing to peers is only meaningful when the organization's process boundaries and definitions are consistent and well understood. Therefore, workflow analysis is the correct first action.

NEW QUESTION # 96

How can training staff's effectiveness be best improved?

- A. Empower trainers to participate in design and user acceptance testing and develop the curriculum in the process.
- B. Provide the design and solution documents to the training team immediately after the contract is executed.
- C. Provide training before go-live, once testing is completed and the product is ready to ship.

- D. Train the trainers on the system functions.

Answer: A

Explanation:
Training staff are most effective when they are integrated early into the implementation lifecycle- particularly during design and user acceptance testing (UAT) -because this gives them deep, practical understanding of the new workflows, decisions, and real-world usability issues that end users will face. By participating in design sessions, trainers learn the intended future-state processes, policy choices (e.g., documentation standards, order set governance), and role-based responsibilities. Through UAT involvement, trainers observe where users struggle, what steps are error-prone, which screens are confusing, and which workflow workarounds emerge. That insight allows trainers to build targeted curriculum, scenarios, and tip sheets that directly address high-risk tasks and common points of failure-improving adoption, reducing errors, and shortening the productivity dip at go-live.
Option B delays trainer readiness until late, limiting time to develop scenario-based training and incorporate UAT lessons learned. Option C (receiving documents) helps but is insufficient because documents rarely capture the nuanced, operational "how work really happens" details. Option D (training trainers on functions) is necessary but not sufficient; effective healthcare IT training must be workflow- and role-based , not only feature-based. Hence, early empowerment and participation (A) best improves training effectiveness.

NEW QUESTION # 97
When initiating clinical practice guidelines into an EHR, which of the following has the LEAST impact on patient care?

- A. Frequently occurring health conditions.
- B. Randomized clinical trials.
- C. Variations in care compared to evidence-based practices.
- D. Infrequent but high-risk health conditions.

Answer: B

Explanation:
The correct answer is D. Randomized clinical trials because, while they are foundational sources of clinical evidence, they do not directly represent a patient care condition or operational factor within the EHR environment. When initiating clinical practice guidelines into an EHR-often through clinical decision support (CDS) tools-prioritization is based on conditions or care processes that will most directly influence patient outcomes.
Frequently occurring health conditions affect large patient populations; embedding guidelines for these conditions (such as diabetes or hypertension) can significantly improve quality metrics and standardize care delivery. Infrequent but high-risk conditions (e.g., sepsis or stroke) may affect fewer patients but have substantial morbidity and mortality impact, making CDS interventions highly valuable. Variations in care compared to evidence-based practices directly indicate quality gaps; addressing these variations through standardized guidelines can markedly improve safety, consistency, and outcomes.
Randomized clinical trials, however, are research methodologies used to generate evidence. While their findings inform guidelines, the trials themselves are not operational targets within the EHR. Therefore, compared to direct clinical conditions or practice variations, randomized clinical trials have the least immediate impact on patient care when prioritizing EHR-based guideline implementation.

NEW QUESTION # 98
A healthcare entity provides care on an at-risk basis. Which of the following is an appropriate use of quality-related data?

- A. Develop a research study for a new clinical compound.
- B. Determine reimbursement opportunities.
- C. Identify opportunities for clinical care improvement.
- D. Target network security weakness.

Answer: C

Explanation:
In an at-risk (value-based) care environment, the organization assumes financial accountability for outcomes and total cost of care, so quality-related data is primarily used to improve clinical performance and patient outcomes . Quality data (e.g., readmissions, infection rates, care gap closure, guideline adherence, patient experience, mortality/complications, and equity stratifications) enables leaders and frontline teams to identify unwarranted variation, pinpoint high-impact process failures, and prioritize interventions such as care pathways, clinical decision support refinements, medication safety workflows, and population health outreach. HIMSS

emphasizes that meaningful quality measures and access to performance data should "drive improvements in patient care delivery and outcomes," which directly aligns with using quality data to find and act on clinical improvement opportunities.

Option A is tempting in at-risk contracts because quality can affect payment, but "determine reimbursement opportunities" is a financial optimization framing rather than the best use of quality data; reimbursement effects are typically downstream of improved outcomes and performance. Option B is research and development, not operational quality management. Option D is cybersecurity risk management, which relies on security telemetry rather than clinical quality indicators. Therefore, the appropriate use is to identify opportunities for clinical care improvement .

NEW QUESTION # 99

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