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NEW QUESTION: 1
Clinical guidelines, data flow sheets, documentation templates, alerts, and reminders can be found in a
A. Clinical Decision Support System.
B. Health Information Exchange System.
C. Clinical Data Repository System.
D. Uniform Data System.
Answer: A (LEAVE A REPLY)
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: 2
Digital health apps and fitness tracking devices can add patients' health data to their Electronic Health Records (EHR) by using a(n):
A. Controlled Unclassified Information (CUI).
B. Application Programming Interface (API).
C. Electronic Data Interchange (EDI).
D. Virtual Desktop Machine (VDM).
Answer: (SHOW ANSWER)
An Application Programming Interface (API) is the standard technology mechanism that allows digital health apps and consumer fitness devices to exchange data with an EHR in a controlled, automated way.
APIs define the rules for how one software system can request data from, or send data to, another system- typically using secure authentication, authorization, and standardized data formats. In modern healthcare interoperability, APIs enable patient-generated health data (PGHD) such as heart rate, activity, sleep, glucose readings, and blood pressure measurements to flow into clinical systems where it can be reviewed, trended, and incorporated into care plans. This approach supports patient engagement and more continuous monitoring beyond traditional clinical visits.
The other options do not fit this function. CUI is a U.S. government information classification concept and is not a data exchange method for EHR integration. EDI is primarily used for structured business transactions (such as eligibility checks and claims submissions) rather than streaming wellness-device metrics into clinical records. VDM (virtual desktop) is a way to deliver a desktop computing environment remotely; it does not provide a standardized pathway for device/app data ingestion into an EHR. Therefore, the best answer is API .

NEW QUESTION: 3
A system selection committee devised a methodology for assigning priorities to requirements as follows:
* Priority requirements: 5 points
* Desired requirements: 3 points
* Optional requirements: 1 point
Four vendor responses to the request for proposal are summarized in the table. Which vendor should be selected?
A. Vendor 1.
B. Vendor 2.
C. Vendor 3.

D. Vendor 4.

Answer: A (LEAVE A REPLY)

To determine the correct vendor, a weighted scoring methodology must be applied based on the assigned point values. The requirements and vendor responses can be calculated as follows:

* Requirement 1 (Optional - 1 point): Vendor 1 = Present (1), Vendor 2 = 0, Vendor 3 = 1, Vendor 4 =
1
* Requirement 2 (Optional - 1 point): Vendor 1 = 0, Vendor 2 = 1, Vendor 3 = 0, Vendor 4 = 1
* Requirement 3 (Priority - 5 points): Vendor 1 = 5, Vendor 2 = 0, Vendor 3 = 0, Vendor 4 = 0
* Requirement 4 (Desired - 3 points): Vendor 1 = 0, Vendor 2 = 3, Vendor 3 = 3, Vendor 4 = 3 Now summing totals:
* Vendor 1: 1 + 0 + 5 + 0 = 6 points
* Vendor 2: 0 + 1 + 0 + 3 = 4 points
* Vendor 3: 1 + 0 + 0 + 3 = 4 points
* Vendor 4: 1 + 1 + 0 + 3 = 5 points

Vendor 1 receives the highest total score. Importantly, Vendor 1 is the only vendor meeting the priority requirement , which carries the greatest weight (5 points). In structured healthcare IT procurement and system selection processes, weighted scoring models ensure that critical requirements drive objective vendor evaluation. Therefore, based on the defined scoring methodology, Vendor 1 should be selected.

NEW QUESTION: 4

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

A. Big Bang Approach.

B. Phased Approach.

C. Pilot Group Approach.

D. Routine Operations Approach.

Answer: A (LEAVE A REPLY)

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: 5
Which of the following technologies directly reduces adverse medication events through the use of additional checks and balances in the clinical information system?
A. Bar coded medication administration (BCMA).
B. Wearable devices.
C. Medication diversion management.
D. Electronic Medical Record (EMR).
Answer: (SHOW ANSWER)
Bar coded medication administration (BCMA) is specifically designed to reduce medication administration errors by adding real-time, system-enforced verification steps at the point of care. In a typical BCMA workflow, clinicians scan the patient's identification band and the medication barcode; the clinical information system then confirms whether the medication aligns with the active order and key safety checks (commonly framed as the "five rights": right patient, drug, dose, route, and time). If there is a mismatch- wrong patient, wrong medication, wrong dose, or wrong timing-the system can generate an alert and block or discourage administration until the discrepancy is resolved. This creates the "additional checks and balances" referenced in the question and is a hallmark of closed-loop medication administration processes.
By contrast, wearable devices primarily support monitoring and patient-generated data, medication diversion management focuses on controlled-substance oversight and security, and an EMR is a broad platform that may enable safety tools but does not inherently provide bedside barcode verification unless paired with BCMA functionality. HIMSS informatics guidance explicitly describes BCMA as hardware/software used to electronically verify these "five rights," directly supporting reduction of medication-related errors at administration.

NEW QUESTION: 6
A healthcare organization's Chief Information Officer (CIO) can ensure that computer systems adhere to regulatory standards by
A. relying on end-user departments to inform the CIO of regulatory changes.
B. requesting that the compliance officer review regulatory upgrades.

C. auditing systems against industry compliance standards.
D. modifying vendor-supplied software with standards-based program changes.
Answer: C (LEAVE A REPLY)
The most effective way for a CIO to ensure computer systems adhere to regulatory standards is auditing systems against industry compliance standards . Auditing provides a formal, repeatable mechanism to confirm that required controls are not only designed but also implemented and operating effectively . In healthcare IT, this includes assessing access controls, authentication practices, audit logging, data retention, encryption, backup/recovery, change management, and incident response-controls that map to regulatory obligations and accepted frameworks. Regular audits also produce documentation and evidence (policies, configurations, logs, test results) needed for governance and external scrutiny, and they reveal gaps early so corrective actions can be prioritized and tracked.
Option A is weak governance because it depends on informal communication from departments rather than a structured compliance monitoring program. Option B helps, but delegating review to a compliance officer alone does not ensure technical controls are actually configured and functioning across systems-CIO accountability requires verification. Option D is risky because modifying vendor-supplied software can violate support agreements, complicate validation, and introduce new defects; compliance is typically achieved through configuration, controls, and vendor-managed updates , not custom code changes. Therefore, systematic auditing is the strongest CIO-led method to ensure adherence.

NEW QUESTION: 7
A CIO is challenged with project requests exceeding the IT department's capability to execute. Which of the following approaches would BEST help stakeholders understand opportunities and limitations?
A. Implement customer-led governance and prioritization processes.
B. Provide monthly briefings on high priority projects.
C. Prepare monthly technology briefings on emerging technologies.
D. Initiate new charge-back cost allocation models.
Answer: A (LEAVE A REPLY)
When demand exceeds delivery capacity, the most effective leadership response is to create a transparent, stakeholder-driven governance and prioritization process . Implementing customer-led governance (e.g., an executive steering committee with clinical, operational, financial, and IT representation) establishes a shared method to evaluate requests against agreed criteria such as patient safety, regulatory need, strategic alignment, ROI/value, risk reduction, operational impact, and resource requirements. This helps stakeholders clearly see why some projects proceed while others are deferred, and it makes IT constraints (staffing, budget, vendor dependencies, change windows) visible and understood.

Monthly briefings on high-priority projects (B) improve communication but do not resolve the root problem- too many competing requests and no agreed mechanism to choose among them. Technology briefings (C) can educate leaders, yet they don't address capacity management or tradeoffs. Charge-back models (D) may influence demand by making costs explicit, but without governance they can create conflict, incentivize siloed decision-making, and still fail to align the portfolio with enterprise strategy and safety priorities.
Customer-led governance is therefore the best approach because it institutionalizes decision rights, prioritization discipline, and accountability , enabling stakeholders to understand both opportunities and limitations in a fair and consistent way.

NEW QUESTION: 8
To improve accountability, the directors of materials and information management have decided to consolidate asset management. Which of the following should be done FIRST?
A. Assess inventory par levels.
B. Merge both inventory systems.
C. Evaluate inventory turns.
D. Validate current inventory.
Answer: D (LEAVE A REPLY)
When consolidating asset (or inventory) management to improve accountability, the first priority is establishing a trustworthy baseline of what assets and stock actually exist, where they are located, and how they are recorded. That is why validating current inventory should be done first. If item masters, quantities on hand, serial/lot information, locations, and ownership/custody data are inaccurate, any later step-such as setting par levels or calculating inventory turns-will be built on incorrect inputs and can worsen shortages, expirations, and uncontrolled spend. Validation typically includes physical counts or cycle counts, reconciliation against system records, resolving duplicates in item catalogs, confirming units of measure, and aligning location and department assignments.
Only after the current state is validated does it make sense to assess par levels (which depend on accurate usage and replenishment data) and evaluate inventory turns (which require reliable on-hand values and consumption history). Similarly, merging inventory systems before cleansing and validation risks carrying forward bad data into the consolidated environment, making accountability harder rather than easier. In healthcare settings-where supplies and equipment affect patient care, charge capture, and compliance- inventory validation is the foundation step that enables effective consolidation and measurable accountability.

NEW QUESTION: 9
Which is an example of scope creep in an EHR implementation?
A. The hospital administration requests that additional facilities be included in the system.
B. The IT team has found that additional servers are required for the system to operate.

C. The respiratory therapists require additional training.
D. The pharmacy system fails to print medication labels when ordered from the Operating Room.
Answer: (SHOW ANSWER)
Scope creep is the uncontrolled expansion of a project's scope after the scope baseline has been approved- typically through adding new requirements, sites, departments, features, or deliverables without corresponding adjustments to time, budget, resources, and formal change control. In an EHR implementation, the original scope usually defines which entities (hospitals, clinics, departments), which modules (CPOE, eMAR, results review), and which interfaces or conversions will be delivered by a target go-live date. Option A is a classic example of scope creep because adding additional facilities expands the project boundaries and increases complexity (build, training, workflow alignment, data conversion, integration testing, support staffing, and cutover planning). If this addition is requested midstream and not handled through a structured governance and change management process, it can derail timelines, increase costs, and introduce risk to patient care operations at go-live.
By contrast, option B is a technical capacity discovery (resource planning), option C is a training/readiness need, and option D is a defect or integration issue that must be fixed to meet existing requirements-none of which inherently expands scope. Therefore, A is the best example of scope creep.

NEW QUESTION: 10
The BEST format for reporting overall enterprise performance, grouped in major dimensions, to hospital leadership is a:
A. Pareto analysis.
B. Gantt chart.
C. Balanced scorecard.
D. Pie chart.
Answer: C (LEAVE A REPLY)
A Balanced Scorecard is the best format for reporting overall enterprise performance to hospital leadership because it organizes performance metrics into major strategic dimensions , typically including financial performance, customer/patient perspective, internal processes, and learning and growth (workforce and innovation). This structured framework aligns operational performance with strategic objectives and provides a comprehensive view rather than focusing on a single metric or short-term result.
Hospital executives require visibility into multiple domains simultaneously-quality and safety indicators, patient satisfaction, operational efficiency, financial stability, workforce engagement, and regulatory compliance. The balanced scorecard allows leadership to see how improvements (or declines) in one domain affect others, supporting strategic decision-making and accountability. It also promotes goal alignment across departments by linking metrics to enterprise strategy.

In contrast, a Pareto analysis identifies the most significant contributing factors to a problem but does not provide a comprehensive performance overview. A Gantt chart is used for project timeline tracking. A pie chart shows proportional distribution but lacks multidimensional strategic context. Therefore, the balanced scorecard is the most appropriate tool for summarizing enterprise-level performance in healthcare organizations.

NEW QUESTION: 11
Which of the following is MOST important to ensure successful data integration between two systems?
A. Data entry process.
B. Secure data transmission.
C. Verification of data calculations.
D. Common data dictionary.
Answer: D (LEAVE A REPLY)
Successful data integration depends first on shared meaning of the data being exchanged. A common data dictionary provides the agreed-upon definitions, formats, permissible values, units of measure, and identifiers for data elements (for example: patient identifiers, encounter numbers, provider IDs, lab test codes, medication codes, and timestamps). Without this shared semantic foundation, two systems may exchange data correctly from a technical standpoint yet still fail operationally because the receiving system interprets data differently (e.g., mismatched code sets, different units such as mg vs. mcg, inconsistent field lengths, or different meanings for "discharge date" vs. "discharge time").
While secure transmission is essential for protecting PHI (e.g., encryption in transit, authentication), it does not ensure that integrated data is accurate, comparable, or usable. The data entry process affects upstream data quality but does not resolve mapping and semantic alignment across systems. Verification of calculations is important for analytics and reporting validation, but it occurs after the underlying data elements have been defined and mapped consistently.
In healthcare information systems management, integration success is measured by correctness and usability across workflows-achieved by standardizing data definitions and mappings through a common data dictionary (often aligned with standards and code sets) before interface build and testing.

NEW QUESTION: 12
After a new pharmacy dispensing system is implemented, issues are reported regarding pharmacies not being able to process prescriptions that were received before the cutover to the new system. Which testing phase could have identified this issue?
A. Regression testing.
B. Unit testing.
C. Acceptance testing.
D. System integration testing.

Answer: (SHOW ANSWER)

Acceptance testing (User Acceptance Testing/UAT) is the testing phase most likely to identify an inability to process prescriptions that existed before cutover , because UAT validates that the solution supports real operational workflows and business requirements under conditions that mirror production use. A key go-live risk in pharmacy system replacement is data conversion and continuity of care : prescriptions entered in the legacy system prior to cutover must be accessible and actionable in the new environment (e.g., visible in work queues, eligible for verification, dispensing, labeling, adjudication, and documentation). In well-designed acceptance testing, users execute scripted scenarios that include "pre-cutover" items-converted orders, historical prescriptions, and in-flight work-specifically to confirm that the new system can safely continue processing without interruption.

By comparison, unit testing focuses on individual components and would not validate end-to-end prescription processing across converted legacy data. System integration testing emphasizes interfaces between systems (e.

g., EHR-to-pharmacy, claims, automation) but may not adequately validate business readiness with converted pre-cutover prescriptions unless explicitly included. Regression testing checks that changes did not break previously working functions, but it is not the primary phase for validating cutover continuity. Therefore, acceptance testing is the best answer.

NEW QUESTION: 13

A CEO asks the CIO to show the return on investment (ROI) for mobile technology. Equipment maintenance costs have decreased 30%, personnel costs have increased 2%, and communication costs have increased 5%.

Which of the following BEST illustrates the economic impact of the technology?

A. Spider diagram.

B. Scatter plot.

C. Bar chart.

D. Pareto chart.

Answer: C (LEAVE A REPLY)

A bar chart is the best choice because the CEO needs a clear, direct comparison of discrete cost categories and their percentage changes after implementing mobile technology. In ROI and economic-impact reporting for health IT, leaders typically want to see how different cost components move in opposite directions (e.g., maintenance down while personnel and communication rise). A bar chart makes these contrasts immediately visible by placing each category on the same scale and displaying positive and negative changes side-by-side, supporting fast executive interpretation and decision-making.

A spider (radar) diagram is better suited for comparing multiple performance dimensions across a common scale (often used in capability or maturity comparisons), but it is less intuitive for conveying simple cost deltas. A scatter plot is used to show relationships or

correlation between two variables (e.g., staffing levels vs. throughput), not categorical ROI components. A Pareto chart ranks causes by frequency or magnitude to highlight the "vital few" contributors to a problem; it is most appropriate when analyzing defect types or drivers of cost, not when simply communicating pre/post percentage changes across several budget lines.

NEW QUESTION: 14
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. Enterprise master patient index.
D. Patient identity integrity.
Answer: (SHOW ANSWER)
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: 15
The infection control report indicates that the number of bloodstream infections this month has decreased.
This information is best displayed using a
A. Control chart.
B. PERT chart.
C. Spider chart.

D. Flow chart.

Answer: A (LEAVE A REPLY)

A control chart is the best display for showing that bloodstream infections have decreased because it is designed to track a measure over time and distinguish normal process variation from meaningful change. In infection prevention and quality management, bloodstream infection counts or rates are monitored monthly to determine whether improvement interventions (e.g., central-line bundles, hand hygiene reinforcement, standardized insertion checklists) are producing a sustained effect. A control chart plots the data sequentially and adds a center line (process average) along with statistically derived upper and lower control limits. This structure helps leaders and clinical teams see whether the observed decrease represents special-cause variation (a real shift in performance) versus random fluctuation that can occur in any process.

A PERT chart is used for project scheduling and task dependencies, not for outcome trends. A spider (radar) chart compares multiple dimensions at one time point and is not optimal for time-series infection surveillance.

A flow chart maps process steps (e.g., line insertion workflow) and is useful for understanding how work occurs, but it does not display performance trends. Therefore, when the goal is to communicate a reduction in infections and assess whether the change is stable and significant, the control chart is the most appropriate tool.

NEW QUESTION: 16

Vendor A provides a major clinical system for an organization. Vendor B has an interface from the clinical system to a billing system. Over the weekend, vendor A upgraded the clinical system and vendor B upgraded the interface to the billing system. On Monday morning, the billing system has errors. After failing to adequately resolve the issue in-house, the IT manager should contact

A. vendors A and B.

B. vendor B.

C. vendor A.

D. legal and contracting.

Answer: (SHOW ANSWER)

Because two interdependent components changed at the same time -the core clinical system (Vendor A) and the interface engine/interface build (Vendor B)-the most appropriate escalation is to engage both vendors .

Interface failures after concurrent upgrades commonly stem from version compatibility issues (e.g., updated message formats, changed field mappings, new code sets, modified API endpoints, altered authentication, or stricter validation rules). Even if the error appears "in billing," the root cause may originate upstream in the clinical system's outbound messages or in the interface transformation logic that sits between systems.

Best practice in healthcare systems management is coordinated vendor triage: confirm upgrade versions, review release notes for breaking changes, validate interface

specifications, and compare pre-/post-upgrade message samples. Involving both vendors speeds resolution because each controls different layers of the transaction path-Vendor A for source data creation/export and Vendor B for interface routing, translation, acknowledgments, and delivery to billing. Contacting only one vendor risks slow back-and-forth and "fault isolation" disputes. Legal/contracting is typically reserved for unresolved service-level or contractual disputes, not initial technical remediation. By escalating to both vendors, the IT manager enables joint troubleshooting, faster restoration of revenue-cycle workflows, and reduced operational risk.

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NEW QUESTION: 17
Which of the following scenarios is MOST likely to violate the business ethics of a not-for-profit healthcare organization?
A. A software vendor pays the travel expenses of the Chief Information Officer to speak at a users' conference.
B. A vendor pays for the Chief Information Officer to fly to a premier sporting event. The vendor is a corporate sponsor of the event.
C. A collection firm, with whom the organization does business, sends a holiday gift basket valued at USD
1,000. The gift basket is shared among 200 business office staff.
D. An employee's sibling owns a software firm that has submitted a proposal. The employee is not directly involved in the decision to award the contract.
Answer: B (LEAVE A REPLY)
Option B is most likely to violate business ethics because it represents a personal benefit provided by a vendor that is unrelated to legitimate business or educational purposes . Paying for a CIO to attend a premier sporting event creates the appearance of undue influence, conflict of interest, or inducement in vendor selection or contract management decisions. Not-for-profit healthcare organizations are held to high standards of fiduciary responsibility, transparency, and stewardship of public trust. Accepting entertainment or luxury travel from a vendor can compromise-or appear to compromise-objective decision-making.
Option A may be permissible if the travel is directly related to professional speaking engagement and complies with organizational conflict-of-interest policies and disclosure

requirements. Option C involves a shared nominal-value gift distributed broadly, which may fall within allowable gift policy thresholds depending on institutional rules. Option D describes a potential conflict of interest; however, if the employee is fully disclosed and recused from the decision-making process, governance controls can mitigate ethical risk. In healthcare leadership and information systems management, maintaining vendor neutrality, transparency, and strict adherence to conflict-of-interest policies is essential to uphold ethical standards and organizational integrity

NEW QUESTION: 18
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 (LEAVE A REPLY)
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: 19
What key management practice BEST ensures the ongoing value of an IT project?
A. Organizational change management.
B. Alignment of project purpose with the organization's strategy.
C. Attention to costs and project completion timeframes.
D. Identification of investment risks.

Answer: A (LEAVE A REPLY)
Organizational change management (OCM) best ensures the ongoing value of an IT project because value in healthcare IT is realized only when the solution is adopted, used correctly, and sustained in daily operations. Even if a project is strategically aligned, delivered on time, and within budget, it can fail to produce lasting benefits if clinicians and staff do not change workflows, follow standardized processes, and consistently use the system as intended. OCM addresses the human and operational side of transformation: stakeholder engagement, communication, role-based training, readiness assessment, super-user networks, leadership sponsorship, workflow redesign, and reinforcement after go-live. These elements reduce resistance, improve competency, and support stabilization and optimization-where many long-term benefits (quality, safety, efficiency, data integrity) are actually achieved.
Option B (strategic alignment) is essential for selecting the right project, but it does not guarantee continued performance once implemented. Option C focuses on project management constraints (time/cost) and is necessary for delivery, not sustained value. Option D strengthens governance by anticipating risks, but risk identification alone does not drive adoption or behavior change. OCM is therefore the most direct practice for ensuring that an IT investment delivers and maintains measurable benefits over time.

NEW QUESTION: 20
A CIO is hearing from staff members that the team needs additional resources to be successful with maintaining all of the organization's current systems. The MOST appropriate first step for the CIO would be to:
A. poll each member to understand their thoughts on what skill sets and abilities are needed from the new hires.
B. review performance indicators and service metrics along with organizational perception of the team's effectiveness.
C. adjust the departmental budget to allow for the hiring of additional staff members.
D. review process improvement opportunities and develop a plan to implement the changes.
Answer: B (LEAVE A REPLY)
The most appropriate first step is to establish an objective, evidence-based baseline of operational performance and customer experience. In health IT management practice, staffing assertions must be validated against measurable service performance (e.g., ticket volumes, backlog aging, mean time to resolve, change success rate, system uptime/availability, on-call burden, cybersecurity response times) and against how well IT services are meeting clinical and business expectations (e.g., clinician satisfaction, recurring downtime complaints, escalation frequency). This aligns with foundational governance and service management principles emphasized in healthcare information systems leadership: decisions about resourcing should be driven by data, risk, and service obligations to patient care-not by anecdote alone.

Option A (polling) can be useful later, but it is subjective and may reflect local pain points rather than enterprise priorities. Option C (budget adjustment) presumes the solution (more headcount) before diagnosing whether the issue is demand, process, tooling, skill mix, or governance. Option D (process improvement) also jumps to intervention without first confirming where performance gaps exist and how severe they are. By starting with metrics and stakeholder perception, the CIO can perform a defensible gap analysis and then determine whether the right remedy is additional FTEs, reallocation, automation, vendor support, training, or process redesign.

NEW QUESTION: 21
Patient safety is best promoted when
A. traditional standards are implemented.
B. vendor agreements are in place.
C. physician input is sought after workflows are designed, built, and tested.
D. prescriptions for scheduled medications are written electronically.
Answer: A (LEAVE A REPLY)
Patient safety is best promoted when traditional standards are implemented because standards create consistent, evidence-based expectations for how care and supporting information systems should function. In clinical informatics, "standards" include established clinical and safety practices (e.g., medication safety processes, verification steps, standardized order sets), as well as consistent documentation and workflow rules that reduce unwanted variation. When standards are embedded into clinical operations and health IT (such as standardized clinical protocols, medication administration safeguards, and consistent data definitions), they reduce preventable errors, improve reliability of care, and support measurable quality improvement.
Option B (vendor agreements) is important for governance and accountability, but contractual arrangements do not inherently improve bedside safety unless translated into operational controls and effective system design. Option C is explicitly late involvement of physicians; engaging clinicians only after workflows are designed and built is a common cause of poor usability and workarounds, which can increase safety risk.
Option D (electronic prescribing for scheduled medications) can improve security and reduce certain prescribing errors, but it is a narrower intervention than implementing broad safety standards across clinical practice and system workflows. Therefore, implementing traditional standards is the most comprehensive and foundational approach to promoting patient safety.

NEW QUESTION: 22
A healthcare organization is scheduled to decommission 400 computers. An employee committee suggests the computers should be donated to a local charity. Which of the following is the MOST relevant IT policy?
A. Conflict of interest policy.

B. Release of information policy.
C. Media disposal policy.
D. Charitable contribution policy.
Answer: C (LEAVE A REPLY)
The most relevant IT policy is the media disposal policy because donating decommissioned computers creates a high-risk pathway for unintentional disclosure of sensitive data , including ePHI. Even if the organization's intent is charitable, any storage media inside those computers (hard drives, SSDs, removable media) may contain patient information, employee data, cached credentials, configuration files, audit logs, or locally stored documents. A media disposal policy defines the required processes to prevent data leakage when equipment leaves organizational control, including asset inventory and tracking, approved sanitization methods, verification/validation of data destruction, documentation, and chain-of-custody controls .
In healthcare, secure disposal (or re-use/donation) typically requires sanitization aligned to organizational standards-such as cryptographic wiping, secure erase procedures, degaussing where appropriate, or physical destruction-plus records showing which assets were sanitized, by whom, when, and using what method. This ensures compliance with privacy and security obligations and reduces breach risk.
Conflict of interest and charitable contribution policies may apply to governance and ethics, but they do not address the core IT control required before donation: ensuring all data is irretrievably removed. Release of information policies focus on authorized disclosure of patient records, not device-level data sanitization.
Therefore, media disposal policy is the correct choice.

NEW QUESTION: 23
Effective health information exchange requires:
A. Remote patient monitoring.
B. Transcription software efficiency.
C. Clinical decision support.
D. Master Patient Index accuracy.
Answer: (SHOW ANSWER)
Effective health information exchange (HIE) fundamentally depends on accurate patient identification , which is achieved through a reliable Master Patient Index (MPI) . An MPI is a core component of interoperability infrastructure that maintains unique identifiers for patients across different systems and organizations. When health data is exchanged between hospitals, clinics, laboratories, and other entities, the receiving system must correctly match the incoming data to the appropriate patient record. Without accurate patient matching, there is significant risk of duplicate records, overlay errors (information assigned to the wrong patient), incomplete clinical histories, and potential patient safety events.

Remote patient monitoring and clinical decision support are valuable digital health capabilities, but they are not foundational requirements for HIE functionality. Transcription software efficiency relates to documentation workflow and does not directly impact cross-organizational data exchange. In contrast, MPI accuracy ensures that demographic data elements-such as name, date of birth, address, and other identifiers-are properly reconciled to support safe and reliable interoperability.
Within healthcare information systems management, strong MPI governance, standardized demographic data capture, and ongoing data quality monitoring are essential best practices. Therefore, Master Patient Index accuracy is the critical requirement for effective health information exchange.

NEW QUESTION: 24
Which of the following ensures enhanced health care for the individual, improved health for the community population, and reduced per-capita cost?
A. Triple aim.
B. Population health.
C. Home health care.
D. Tertiary care.
Answer: A (LEAVE A REPLY)
The Triple Aim is the recognized strategic framework that explicitly targets three linked goals: (1) improving the individual experience of care (quality, safety, and satisfaction), (2) improving the health of populations , and (3) reducing the per-capita cost of healthcare . These three aims are designed to be pursued together because progress in one area can be undermined if the others are ignored-for example, improving patient experience without controlling cost may be unsustainable, while cost cutting that harms outcomes or experience fails the overall purpose of healthcare.
"Population health" (option B) is one component of the Triple Aim, but by itself it does not inherently ensure the other two aims (experience and per-capita cost). "Home health care" (option C) is a care setting/service model that may contribute to better outcomes and lower cost for certain groups, but it is not a comprehensive system-wide framework.
"Tertiary care" (option D) refers to specialized, high-complexity services and likewise does not define a three-part improvement strategy.
Therefore, the option that best matches the combined goals in the question is Triple Aim .

NEW QUESTION: 25
Which of the following BEST describes the purpose of the domain name system (DNS)?
A. Ensure data network security across a public access network.
B. Provide user authentication across domains.
C. Route information securely across the internet.
D. Enable internet applications to uniquely identify resources.
Answer: D (LEAVE A REPLY)

The Domain Name System (DNS) is the internet's distributed "naming service" that translates human- readable names (like server or website names) into machine-usable network identifiers , primarily IP addresses. This capability allows internet applications to uniquely locate and connect to resources such as web servers, email servers, application endpoints, and other network services without requiring users or systems to memorize numeric IP addresses. In practical terms, when a clinician launches a web-based EHR, a patient portal, or a secure messaging service, DNS helps the workstation or mobile device resolve the service name to the correct destination so the connection can be made.
Option A is incorrect because DNS is not a security mechanism by default; while there are security enhancements (e.g., DNSSEC), DNS itself is about naming and resolution. Option B describes identity services (like Active Directory, LDAP, Kerberos, SSO), not DNS.
Option C refers to secure routing or transport protections (e.g., TLS, VPNs, secure network protocols); DNS does not "route" traffic, it only helps determine where traffic should go.
Therefore, the best description of DNS is that it enables applications to reliably identify and reach network resources.
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NEW QUESTION: 26
The MOST significant outcome of achieving interoperability of medical devices is
A. optimal workflow.
B. reduced data errors.
C. regulatory compliance.
D. patient safety.
Answer: D (LEAVE A REPLY)
The most significant outcome of achieving interoperability of medical devices is patient safety . When devices such as infusion pumps, ventilators, cardiac monitors, and anesthesia machines are interoperable with clinical information systems (e.g., EHRs), data flows automatically and accurately between systems. This reduces the need for manual transcription of vital signs, medication rates, and device settings-thereby minimizing transcription errors, omissions, and delays in documentation.
While reduced data errors (option B) is a direct and measurable benefit, it ultimately supports the broader and more critical goal of protecting patients from harm. For example, real-time device integration allows clinicians to see accurate, up-to-date physiologic data, supports clinical decision support alerts (e.g., unsafe infusion parameters), and improves alarm management. These capabilities directly influence timely interventions and prevention of adverse events.
Optimal workflow (option A) is also improved through automation, and regulatory compliance (option C) may be facilitated through accurate documentation and audit trails; however, these are secondary benefits. In healthcare technology strategy and informatics practice, improvements are evaluated primarily by their impact on safety and quality of

care. Therefore, patient safety is the most significant outcome of medical device interoperability.

NEW QUESTION: 27
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. CPOE.
D. CDSS.
Answer: B (LEAVE A REPLY)
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.

NEW QUESTION: 28
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. Simulation.
C. Time study.
D. Benchmarking.
Answer: (SHOW ANSWER)
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: 29
What type of diagram illustrates how artifacts in a database are associated with one another?
A. Pareto.
B. Data flow.
C. Fishbone.
D. Entity relationship.
Answer: D (LEAVE A REPLY)
An Entity Relationship (ER) diagram illustrates how data elements (entities) within a database relate to one another. In healthcare information and management systems, ER diagrams are foundational tools used during system design, data modeling, and database development. They visually represent entities (such as Patient, Encounter, Provider, Order, or Medication), their attributes (e.g., patient ID, date of birth), and the relationships between them (such as one-to-many or many-to-many relationships).
For example, a Patient entity may have a one-to-many relationship with Encounters, and an Encounter may have a one-to-many relationship with Orders. These structured relationships ensure data integrity, minimize redundancy, and support accurate reporting and interoperability across healthcare systems. ER diagrams are critical when designing EHR databases, analytics repositories, and integration architectures because they clarify how information is logically structured and linked.
The other options serve different purposes. A Pareto diagram is used in quality improvement to prioritize issues based on frequency or impact. A data flow diagram (DFD) illustrates how data moves between processes and systems, not how data is relationally structured in a database. A fishbone diagram (Ishikawa) supports root cause analysis.

Therefore, the correct answer is Entity relationship , as it specifically describes associations between database artifacts.

NEW QUESTION: 30
A department has provided a list of suggested enhancements to its primary system. Which of the following is the BEST method to prioritize these enhancements?
A. Organize the list of enhancements based on IT resource requirements.
B. Identify frequency of problems from a service desk log review.
C. Group enhancements into major categories.
D. Conduct a cost/benefit analysis of enhancement options.
Answer: D (LEAVE A REPLY)
The best method to prioritize enhancement requests is to conduct a cost/benefit analysis because it provides an objective, decision-oriented way to compare competing options using consistent criteria. In healthcare information systems management, enhancements compete for limited analyst time, testing capacity, training bandwidth, and change windows-so prioritization must consider not only effort but also measurable value .
A cost/benefit analysis evaluates expected benefits such as improved patient safety, reduced clinical risk, compliance impact, productivity gains, reduced turnaround time, better charge capture, lower support burden, and improved user satisfaction, then weighs them against costs such as implementation effort, licensing, interface work, workflow redesign, training time, downtime risk, and ongoing maintenance. This approach supports governance transparency and aligns investment with organizational strategy and outcomes.
The other options can inform prioritization but are not sufficient alone. Organizing by IT resource requirements (A) risks prioritizing what is easiest rather than what delivers the greatest value or risk reduction. Service desk frequency (B) highlights pain points, but high-frequency issues may be low impact, while low-frequency issues can be high severity (e.g., safety or regulatory). Grouping into categories (C) helps organize discussion but does not rank options. Therefore, cost/benefit analysis is the strongest method for rational, defensible prioritization.

NEW QUESTION: 31
Strategic plans include
A. budget requests.
B. financial projections.
C. operational plans.
D. policies and procedures.
Answer: C (LEAVE A REPLY)

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NEW QUESTION: 32
What coding system is used to identify a patient's diagnosis in an electronic health record?
A. LOINC.
B. ICD.
C. CPT.
D. DRG.
Answer: B (LEAVE A REPLY)
The International Classification of Diseases (ICD) is the standardized coding system used to identify and classify patient diagnoses in an electronic health record (EHR). ICD codes are applied to document diseases, conditions, signs, symptoms, abnormal findings, and external causes of injury or illness. Within healthcare information systems, ICD coding ensures uniform clinical documentation, supports data analytics, enables population health reporting, and drives reimbursement processes.
By contrast, LOINC (Logical Observation Identifiers Names and Codes) is used to standardize laboratory tests and clinical observations, not diagnoses. CPT (Current Procedural Terminology) codes describe medical, surgical, and diagnostic procedures performed by providers. DRGs (Diagnosis-Related Groups) are reimbursement categories used primarily for inpatient hospital payment classification, grouping cases based on diagnoses and procedures rather than serving as the primary diagnosis coding system itself.
In healthcare information and systems management, accurate ICD coding is critical for regulatory reporting, quality measurement, epidemiological tracking, and claims submission. It also supports interoperability by allowing consistent diagnostic data exchange between organizations. Therefore, ICD is the correct system specifically designed to identify and classify patient diagnoses within the electronic health record environment.

NEW QUESTION: 33
A healthcare facility needs to connect with an external agency to send financial billing information from the electronic health record (EHR) system. Which of the following protocols would BEST facilitate this?
A. VPN and RDP.
B. HTTPS and SSL.

C. VPN and HL7.
D. HTTPS and DICOM.
Answer: C (LEAVE A REPLY)
The best choice is VPN and HL7 because it combines a secure transport method with a healthcare messaging standard suited to exchanging administrative and financial transactions. A VPN (Virtual Private Network) creates an encrypted tunnel between organizations, supporting secure connectivity over public networks and helping protect sensitive data (including billing-related patient information) during transmission. HL7 - commonly HL7 v2 in many environments-provides standardized message structures used by hospitals to exchange patient demographics (ADT), charges, billing events, and related administrative data with external systems such as clearinghouses, payers, or revenue-cycle partners. Using HL7 reduces interface ambiguity by defining consistent fields and event triggers, which is critical for accurate billing and reconciliation.
Option A (VPN and RDP) is not ideal because RDP is for remote screen access, not structured data interchange; it also introduces operational and security risks when used as a substitute for interfaces. Option B (HTTPS and SSL) focuses on transport security, but does not specify a healthcare data format for billing;
"SSL" is also a legacy term often replaced by TLS, and HTTPS alone doesn't ensure standardized billing content. Option D (HTTPS and DICOM) is incorrect because DICOM is primarily for medical imaging, not financial billing transactions.

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