COMMUNITY HEALTH EXAM II PRACTICE (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. A relative risk of 2.0 for disease in exposed versus unexposed groups indicates what?

A. Exposed have half the risk

B. Exposed have twice the risk

C. No difference in risk

D. The risk cannot be determined

2. Which statement describes a test with high sensitivity and low specificity?

A. It will have few false negatives.

B. It will have few false positives.

C. It will have both high positive predictive value and high negative predictive value.

D. It will correctly identify most diseased individuals but produce many false positives.

3. In a case-control study, why is the odds ratio used, and when does it approximate relative risk?

A. Because incidence cannot be measured; OR approximates RR when disease is rare.

B. Because incidence can be measured; OR approximates RR when exposure is rare.

C. OR and RR are always equal.

D. Case-control studies measure prevalence.

4. What core public health functions were identified in the 1988 report titled The Core of Public Health?

A. Assessment, Policy Development, and Service Assurances

B. Prevention, Cure, and Education

C. Surveillance, Vaccination, and Quarantine

D. Research, Policy, and Administration

5. In outbreak settings, which entity is often responsible for mass immunization?

A. Public Health Department

B. Hospitals

C. Private clinics

D. Insurance companies

6. Which statement correctly describes how disease prevalence affects positive predictive value (PV+)?

A. PV+ is not influenced by prevalence.

B. PV+ increases with higher disease prevalence.

C. PV+ equals sensitivity.

D. PV+ decreases with higher prevalence.

7. DALYs and QALYs are used in public health decision making primarily to do what?

A. To compare interventions

B. To calculate hospital billing

C. To measure provider productivity

D. To estimate vaccine efficacy in trials

8. In the LOGIC model, the step describing addressing the problem by listing the activities to undertake?

A. Input

B. Activities

C. Outputs

D. Outcomes

9. What causes nonresponse bias and how can it be mitigated?

A. Measurement error from instruments; mitigation: calibration

B. Confounding from baseline differences; mitigation: randomization

C. Data entry errors; mitigation: double data entry

D. Differences between respondents and nonrespondents; mitigation: follow-up, incentives, weighting adjustments

10. Which sequence outlines the steps of an outbreak investigation?

A. Prepare, verify case definition, identify cases, describe by time/place/person, develop hypotheses, test hypotheses, implement control measures, communicate findings, evaluate

B. Randomly sample population; declare outbreak; treat cases

C. Wait for official orders; collect data; publish

D. None of the above

Answers

1. B
2. D
3. A
4. A
5. A
6. B
7. A
8. B
9. D
10. A

Explanations

1. A relative risk of 2.0 for disease in exposed versus unexposed groups indicates what?

A. Exposed have half the risk

B. Exposed have twice the risk

C. No difference in risk

D. The risk cannot be determined

Relative risk is the ratio of disease risk in those exposed to the risk in those not exposed. A value of 2.0 means the exposed have twice the risk compared with the unexposed. For example, if the unexposed risk is 5%, the exposed risk would be about 10%. Values above 1 indicate higher risk in the exposed, while values below 1 indicate lower risk, and a value of 1 means no difference. So the interpretation that the exposed have twice the risk is the correct one.

2. Which statement describes a test with high sensitivity and low specificity?

A. It will have few false negatives.

B. It will have few false positives.

C. It will have both high positive predictive value and high negative predictive value.

D. It will correctly identify most diseased individuals but produce many false positives.

High sensitivity means a test catches most people who have the disease, resulting in few false negatives. Low specificity means the test also flags many people without the disease as positive, producing many false positives. So a test described as correctly identifying most diseased individuals but producing many false positives fits a high-sensitivity, low-specificity profile. The other statements don't capture that trade-off: focusing only on few false negatives describes sensitivity without acknowledging the many false positives, claiming few false positives points to high specificity, and asserting very high predictive values implies good performance in both sensitivity and specificity.

3. In a case-control study, why is the odds ratio used, and when does it approximate relative risk?

A. Because incidence cannot be measured; OR approximates RR when disease is rare.

B. Because incidence can be measured; OR approximates RR when exposure is rare.

C. OR and RR are always equal.

D. Case-control studies measure prevalence.

In case-control studies, the measure of association used is the odds ratio because the study design fixes the number of cases and controls, so you can't measure incidence or risk directly from the data. The odds ratio compares the odds of exposure among cases to the odds of exposure among controls, providing a useful estimate of the association between exposure and disease. This odds ratio is a good approximation of relative risk when the disease is rare in the source population. When the outcome is rare, the probability of disease in both exposed and unexposed groups is small, so the odds of disease closely track the actual risks, making OR ≈ RR. If the disease is common, the odds ratio can overstate the relative risk, so they diverge. Also, case-control studies do not measure prevalence or incidence directly, since participants are selected based on disease status rather than followed over time to observe new cases.

4. What core public health functions were identified in the 1988 report titled The Core of Public Health?

A. Assessment, Policy Development, and Service Assurances

B. Prevention, Cure, and Education

C. Surveillance, Vaccination, and Quarantine

D. Research, Policy, and Administration

Three fundamental public health functions were identified in the 1988 IOM report The Core Functions of Public Health: assessment, policy development, and assurance. Assessment means gathering and analyzing information about the community's health status and needs—doing surveillance, monitoring trends, and identifying problems so decisions are evidence-based. Policy development involves using that information to formulate policies and plans in collaboration with the community to address health issues and guide resource allocation. Assurance is about making sure the essential public health services are available and performed—enforcing laws and regulations, linking people to needed services, ensuring a competent workforce, and evaluating programs for accountability and improvement. The option listing these three functions aligns with this established framework. Other choices describe specific activities or mix different concepts instead of the overarching triad of assessment, policy development, and assurance.

5. In outbreak settings, which entity is often responsible for mass immunization?

A. Public Health Department

B. Hospitals

C. Private clinics

D. Insurance companies

Mass immunization during an outbreak is typically led by the public health department because they have the authority and the systemic reach to mobilize vaccination across an entire community. They can rapidly set up accessible vaccination sites—such as in schools, community centers, and mobile clinics—coordinate vaccine supply and cold-chain logistics, train and direct volunteers, and monitor safety and coverage while ensuring equitable access. Hospitals and private clinics can administer vaccines and support the effort, but they alone don't provide the population-wide, organized response needed for a rapid outbreak campaign. Insurance companies don't lead these initiatives; their role is mainly financing care rather than coordinating large-scale immunization.

6. Which statement correctly describes how disease prevalence affects positive predictive value (PV+)?

A. PV+ is not influenced by prevalence.

B. PV+ increases with higher disease prevalence.

C. PV+ equals sensitivity.

D. PV+ decreases with higher prevalence.

The main idea is that positive predictive value (PV+) depends on how common the disease is in the population. When disease prevalence is higher, a positive test result is more likely to be a true positive, so PV+ goes up. With the test's sensitivity and specificity held constant, PV+ can be described by the formula PV+ = [sensitivity × prevalence] / [sensitivity × prevalence + (1 − specificity) × (1 − prevalence)]. As prevalence increases, the numerator grows and the balance of the denominator shifts in a way that raises PV+. For a concrete sense, imagine a test with 90% sensitivity and 95% specificity: at 1% prevalence, PV+ is relatively low; at 10% prevalence, PV+ becomes much higher. This reflects why a positive result is more trustworthy when disease is common. The other statements don't fit because PV+ is not independent of prevalence, so it isn't constant regardless of how common the disease is. PV+ is not simply the same as sensitivity, since PV+ is the probability of disease given a positive test, whereas sensitivity is the probability of a positive test given disease. And PV+ does not decrease as prevalence rises; it increases with higher prevalence.

7. DALYs and QALYs are used in public health decision making primarily to do what?

A. To compare interventions

B. To calculate hospital billing

C. To measure provider productivity

D. To estimate vaccine efficacy in trials

DALYs and QALYs are health outcome measures that combine how long people live with the quality of that life. They're used in public health decision making to compare the overall health benefits of different interventions, often within a cost-effectiveness framework. By putting health gains into a common unit, these measures help policymakers see which interventions provide more years of healthy life for the cost, guiding resource allocation when choices are limited. They aren't meant for hospital billing, measuring provider productivity, or estimating vaccine efficacy in trials, which rely on other methods and endpoints.

8. In the LOGIC model, the step describing addressing the problem by listing the activities to undertake?

A. Input

B. Activities

C. Outputs

D. Outcomes

The main concept being tested is identifying the part of the Logic Model that outlines the actions to address the problem. The step that lists what will be done—the concrete actions, activities, and tasks—is the Activities component. It translates the available resources into implementing actions: what will be done, by whom, and when. This sits after inputs (the resources) and before outputs (the direct products of those actions). By laying out the activities, you show how the program converts resources into deliverables, which then lead to outputs and ultimately to outcomes (changes in participants or conditions) and long-term impact. Inputs are the resources used, outputs are the tangible products of those actions, and outcomes are the changes resulting from them.

9. What causes nonresponse bias and how can it be mitigated?

A. Measurement error from instruments; mitigation: calibration

B. Confounding from baseline differences; mitigation: randomization

C. Data entry errors; mitigation: double data entry

D. Differences between respondents and nonrespondents; mitigation: follow-up, incentives, weighting adjustments

Nonresponse bias happens when the people who respond to a survey differ in important ways from those who don't respond, and those differences are related to what you're measuring. If the characteristics that distinguish respondents from nonrespondents also influence the outcomes of interest, the results won't accurately reflect the target population. To mitigate this, start by boosting how often people respond: follow up with nonrespondents, use multiple modes of data collection (phone, mail, online), and offer incentives to participate. If some nonresponse persists, apply weighting adjustments so the respondent sample better matches the population on known characteristics (for example, age, gender, race/ethnicity) through post-stratification or raking. This helps correct the estimates by giving more weight to underrepresented groups. In contrast, the other issues describe problems like measurement error from instruments, confounding from baseline differences, or data entry mistakes—different sources of error not tied to who chose to respond.

10. Which sequence outlines the steps of an outbreak investigation?

A. Prepare, verify case definition, identify cases, describe by time/place/person, develop hypotheses, test hypotheses, implement control measures, communicate findings, evaluate

B. Randomly sample population; declare outbreak; treat cases

C. Wait for official orders; collect data; publish

D. None of the above

Outbreak investigations follow a deliberate, stepwise process that moves from preparation to action and assessment. Starting with preparation ensures responders have the resources, roles, and plan in place. Verifying the case definition is essential so everyone is counting the same illness consistently, not mixing unrelated cases. Identifying cases and describing them by time, place, and person reveals patterns—when cases began, where they're occurring, and who is affected—which helps point to possible sources or exposure events. Developing hypotheses based on that descriptive view guides targeted testing rather than guessing. Testing hypotheses through analytic methods helps confirm or refute potential sources or transmission routes. Implementing control measures comes next to stop transmission, followed by communicating findings to stakeholders so the response is coordinated. Finally, evaluating the outcome shows whether the actions worked and what might need adjustment. The other sequences miss key steps or rely on waiting and broad actions instead of the systematic flow that drives effective outbreak response.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!