

FELLOW OF THE AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES (FACHE) PRACTICE EXAM (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

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- 1. What is the role of a Chief Information Officer (CIO) in a healthcare organization?**
 - A. To manage financial budgets
 - B. To oversee information technology systems and strategies
 - C. To conduct patient satisfaction surveys
 - D. To lead clinical operation activities
- 2. Which of the following best describes a "value proposition" in healthcare?**
 - A. A strategy to enhance financial performance
 - B. A communication tool outlining the unique benefits of services offered
 - C. A report detailing compliance with healthcare regulations
 - D. An assessment of patient satisfaction levels
- 3. What is the primary regulatory authority for healthcare facilities in the United States?**
 - A. Food and Drug Administration (FDA)
 - B. Centers for Disease Control and Prevention (CDC)
 - C. Centers for Medicare and Medicaid Services (CMS)
 - D. National Institutes of Health (NIH)
- 4. The Joint Commission's accreditation is necessary for healthcare organizations to receive funds from which program?**
 - A. Medicaid
 - B. Medicare
 - C. Veterans Affairs Healthcare
 - D. Private Insurance
- 5. Which term describes the formal structure composed of representatives prioritizing opportunities for improvement in healthcare?**
 - A. Performance Improvement Council (PIC)
 - B. Quality Control Board
 - C. Healthcare Advisory Board
 - D. Management Committee

- 6. What is the significance of revenue cycle management in healthcare?**
- A. It ensures timely and accurate billing and collection
 - B. It regulates healthcare quality standards
 - C. It improves patient satisfaction scores
 - D. It minimizes employee turnover rates
- 7. What is the definition of "clinical governance" in healthcare?**
- A. A systematic approach to maintaining and improving the quality of patient care within a healthcare system
 - B. A method for patient satisfaction surveys and feedback analysis
 - C. A regulatory framework for ensuring medical compliance and legality
 - D. A protocol for emergency response and patient safety
- 8. What is defined as a corporate structure that includes hospitals and often other healthcare services?**
- A. Healthcare Network
 - B. Healthcare Systems
 - C. Health Organizations
 - D. Community Health Services
- 9. What role does a board of directors play in a healthcare organization?**
- A. They manage daily operations
 - B. They provide governance and oversight of the organization's activities and ensure accountability
 - C. They are responsible for financial auditing
 - D. They handle patient care decisions
- 10. What is the importance of quality improvement processes in healthcare settings?**
- A. They primarily focus on financial returns.
 - B. They are essential for enhancing patient care and operational efficiency.
 - C. They only benefit top management.
 - D. They are optional in most healthcare organizations.

Answers

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

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Explanations

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1. What is the role of a Chief Information Officer (CIO) in a healthcare organization?

- A. To manage financial budgets
- B. To oversee information technology systems and strategies**
- C. To conduct patient satisfaction surveys
- D. To lead clinical operation activities

The role of a Chief Information Officer (CIO) in a healthcare organization primarily focuses on overseeing information technology systems and strategies. In this capacity, the CIO is responsible for establishing and implementing the IT infrastructure that supports the organization's healthcare delivery model. This includes managing electronic health records (EHRs), health information exchanges, data analytics, cybersecurity initiatives, and ensuring compliance with regulations related to patient data. The CIO also plays a critical role in leveraging technology to improve patient outcomes, enhance operational efficiency, and facilitate better decision-making within the organization. As technology becomes increasingly integral to healthcare, the CIO is expected to align IT strategies with the overall goals of the organization, ensuring that the technological resources effectively support clinical and administrative functions. In contrast, managing financial budgets typically falls under the purview of the Chief Financial Officer (CFO), while conducting patient satisfaction surveys is usually handled by departments focused on quality improvement or patient experience. Leading clinical operation activities is generally the responsibility of clinical executives or operational leaders rather than the CIO. Therefore, the position of CIO is distinctly centered on information technology management, making that the correct choice.

2. Which of the following best describes a "value proposition" in healthcare?

- A. A strategy to enhance financial performance
- B. A communication tool outlining the unique benefits of services offered**
- C. A report detailing compliance with healthcare regulations
- D. An assessment of patient satisfaction levels

The best description of a "value proposition" in healthcare is a communication tool outlining the unique benefits of services offered. A value proposition articulates what sets a healthcare organization apart from its competitors, emphasizing the unique advantages and benefits that patients can expect to receive. It is critical for healthcare providers to clearly present their value proposition to attract and retain patients, as it helps to convey the organizational mission, quality of care, and any distinctive services or features offered. In the broader context of healthcare, a well-defined value proposition assists in fostering trust and engagement with patients, encouraging them to choose one provider over another based on the specific benefits and services highlighted. This may include aspects such as superior clinical outcomes, specialized services, personalized care experiences, or other factors that provide value to patients. While the other options touch on important components of healthcare management, they do not align as directly with the definition of a value proposition. A strategy to enhance financial performance focuses on the financial aspects rather than on communicating benefits to patients. A report detailing compliance with healthcare regulations primarily addresses regulatory requirements and governance, while an assessment of patient satisfaction levels is concerned with feedback on experiences rather than the proactive communication of benefits.

3. What is the primary regulatory authority for healthcare facilities in the United States?

- A. Food and Drug Administration (FDA)
- B. Centers for Disease Control and Prevention (CDC)
- C. Centers for Medicare and Medicaid Services (CMS)**
- D. National Institutes of Health (NIH)

The primary regulatory authority for healthcare facilities in the United States is the Centers for Medicare and Medicaid Services (CMS). CMS plays a critical role in overseeing the quality and standards of care provided in healthcare facilities that receive federal funding, particularly those that participate in Medicare and Medicaid programs. This oversight includes establishing and enforcing health and safety standards, which ensure that facilities themselves operate effectively and provide high-quality care to patients. CMS also conducts inspections and provides guidance on compliance with federal regulations, thus influencing the operational protocols of healthcare facilities across the nation. The organization's regulatory framework is essential to maintaining the integrity and safety of healthcare services provided to the public, thereby reinforcing the commitment to patient-centered care. The other organizations listed have important roles in the healthcare ecosystem but focus on different aspects. For example, the FDA is primarily responsible for regulating food, drugs, and medical devices, while the CDC concentrates on public health and disease prevention. The NIH focuses on medical research and does not have a regulatory role regarding healthcare facilities.

4. The Joint Commission's accreditation is necessary for healthcare organizations to receive funds from which program?

- A. Medicaid
- B. Medicare**
- C. Veterans Affairs Healthcare
- D. Private Insurance

The Joint Commission's accreditation is essential for healthcare organizations to qualify for Medicare funds. This accreditation indicates that a healthcare facility meets specific performance standards related to safety, quality, and efficiency in patient care. Medicare, as a federal program, heavily relies on this accreditation to ensure that the facilities providing services are held to a high standard of care. The need for accreditation is particularly important in the context of Medicare, as it appears to emphasize compliance with regulations that protect patients and ensure they receive necessary and effective healthcare services. Without this accreditation, a healthcare organization would not be eligible to receive reimbursements from Medicare, which can significantly impact its financial viability and ability to provide care. While Medicaid also requires certain standards for reimbursement, the connection between Joint Commission accreditation and Medicare funding is more direct and established. Similarly, the Veterans Affairs Healthcare system and private insurance may have their own accreditation requirements or performance standards but do not specifically rely on Joint Commission accreditation as a prerequisite for funding.

5. Which term describes the formal structure composed of representatives prioritizing opportunities for improvement in healthcare?

A. Performance Improvement Council (PIC)

B. Quality Control Board

C. Healthcare Advisory Board

D. Management Committee

The term that accurately describes a formal structure composed of representatives prioritizing opportunities for improvement in healthcare is the Performance Improvement Council (PIC). This council is specifically designed to focus on enhancing the quality and efficiency of healthcare services. It typically comprises a diverse group of stakeholders from various levels and functions within the healthcare organization, including clinical and administrative staff. The role of the PIC is to identify areas that need improvement, implement strategies for enhancing performance, and evaluate the outcomes of these strategies. By having a dedicated council, organizations can foster a systematic approach to quality improvement, ensuring that efforts are aligned with organizational goals and best practices in healthcare. Other options, such as a Quality Control Board, may also deal with aspects of quality but are often more focused on compliance and standards rather than ongoing performance improvement initiatives. The Healthcare Advisory Board usually provides guidance and recommendations but might not be dedicated exclusively to performance improvement activities. The Management Committee often has a broader mandate, overseeing general operations rather than specifically prioritizing quality improvement issues.

6. What is the significance of revenue cycle management in healthcare?

A. It ensures timely and accurate billing and collection

B. It regulates healthcare quality standards

C. It improves patient satisfaction scores

D. It minimizes employee turnover rates

Revenue cycle management (RCM) is crucial in healthcare as it encompasses all the processes related to patient care revenue, from patient registration and appointment scheduling to coding and claims processing, as well as Billing and Accounts Receivable (AR) management. Ensuring timely and accurate billing and collection is fundamental for the financial health of healthcare organizations. It directly impacts cash flow, revenue generation, and overall efficiency. Timely billing ensures that healthcare facilities can quickly receive payment for the services provided, which is critical for maintaining operations and fulfilling other financial obligations. Accuracy in billing reduces the incidence of claim denials and payment delays, which can strain resources and disrupt services. Additionally, effective revenue cycle management optimizes reimbursements from payers and minimizes the time between providing services and collecting payments. In contrast, while other aspects such as healthcare quality standards, patient satisfaction, and employee turnover are important in their own right, they do not directly pertain to the specific functions of revenue cycle management. RCM primarily focuses on the financial aspects of healthcare delivery, making the accurate and timely handling of billing and collections its central significance.

7. What is the definition of “clinical governance” in healthcare?

- A. A systematic approach to maintaining and improving the quality of patient care within a healthcare system**
- B. A method for patient satisfaction surveys and feedback analysis
- C. A regulatory framework for ensuring medical compliance and legality
- D. A protocol for emergency response and patient safety

“Clinical governance” refers to a systematic approach to maintaining and improving the quality of patient care within a healthcare system. This concept encompasses various practices and frameworks designed to ensure that healthcare organizations deliver safe, effective, and high-quality care. It emphasizes accountability, transparency, and continuous quality improvement, involving healthcare professionals at all levels in the process of assessing and enhancing the services provided to patients. In a broader context, clinical governance includes elements like clinical effectiveness, risk management, patient safety, and the audit of clinical practices. It enables healthcare organizations to implement policies and procedures that foster an environment where quality improvement is prioritized, and patient outcomes are continually monitored and enhanced. The other choices focus on narrower aspects of healthcare. While patient satisfaction surveys and feedback analysis are important for understanding patient experiences, they do not encompass the overarching systematic approach that clinical governance represents. Similarly, a regulatory framework for ensuring medical compliance and legality pertains to adherence to laws and guidelines rather than the holistic quality framework defined by clinical governance. Lastly, protocols for emergency response and patient safety are vital components of healthcare operations but are specific procedures rather than a broad governance strategy aimed at quality improvement across the spectrum of care.

8. What is defined as a corporate structure that includes hospitals and often other healthcare services?

- A. Healthcare Network
- B. Healthcare Systems**
- C. Health Organizations
- D. Community Health Services

The correct answer is that a corporate structure defined as including hospitals and often other healthcare services is referred to as a healthcare system. Healthcare systems are comprehensive entities that integrate multiple facets of healthcare delivery, such as hospitals, outpatient facilities, skilled nursing facilities, and ancillary services, under a unified management structure. This integration allows for improved coordination of care, resource allocation, and has the potential for economies of scale. Healthcare systems aim to provide a continuum of care, where patients can receive related services ranging from primary care to specialized treatments. This structure is designed to create efficiencies and improve outcomes by ensuring that all components of care are aligned and working together. In contrast, while a healthcare network may encompass a collection of providers and services, it does not necessarily denote the same level of structural integration or management similarity as a healthcare system. Health organizations is a broader term that can include various entities within the healthcare field and lacks specific emphasis on the integrated model. Community health services generally focus on public health initiatives and community-based resources, which may not include hospitals or be as comprehensive in scope as a healthcare system.

9. What role does a board of directors play in a healthcare organization?

- A. They manage daily operations
- B. They provide governance and oversight of the organization's activities and ensure accountability**
- C. They are responsible for financial auditing
- D. They handle patient care decisions

A board of directors in a healthcare organization serves a vital role in governance and oversight. Their primary responsibilities involve setting the strategic direction of the organization, ensuring compliance with laws and regulations, and holding management accountable for the organization's performance. By providing oversight, the board ensures that the organization operates efficiently and aligns with its mission and values while delivering quality care to patients. Additionally, the board is tasked with fiduciary responsibilities, which means they must act in the best interest of the organization and its stakeholders. This includes overseeing the financial health of the organization and ensuring that resources are used effectively. Their governance work involves regularly assessing risks, evaluating the organization's strategic plans, and ensuring that there are systems in place for proper oversight and accountability. While the board is not involved in the day-to-day management or operational decisions – such as financial auditing or handling patient care decisions – their role is to establish policies that guide these activities and ensure that competent management is in place to carry out those policies. Thus, option B accurately captures the essence of the board's responsibilities in a healthcare setting.

10. What is the importance of quality improvement processes in healthcare settings?

- A. They primarily focus on financial returns.
- B. They are essential for enhancing patient care and operational efficiency.**
- C. They only benefit top management.
- D. They are optional in most healthcare organizations.

Quality improvement processes are fundamental in healthcare settings because they serve to enhance patient care and operational efficiency. These processes involve systematic efforts to improve the quality of services delivered, ensuring that patients receive the highest standard of care possible. By implementing quality improvement initiatives, healthcare organizations can identify areas for enhancement, reduce medical errors, and improve patient outcomes. Moreover, focusing on operational efficiency helps mitigate waste and optimize resource use, which is crucial in the ever-evolving healthcare landscape where demand for services is high and resources can be limited. Quality improvement fosters a culture of continuous learning and improvement, allowing healthcare providers to adapt to new challenges and innovate processes that enhance the patient experience and streamline operations. In contrast, the other options do not accurately reflect the broader purpose of quality improvement processes. While financial considerations are important, quality improvement's primary objective is to elevate patient care rather than merely focusing on financial returns. Additionally, the benefits of quality improvement extend beyond top management; they impact all levels of staff and contribute to a more effective healthcare delivery system. Lastly, these processes are not optional; they are increasingly becoming essential for compliance with regulations and accreditation standards, as well as for the sustainability of healthcare organizations.

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:

<https://fache.examzify.com>

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

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