

Western Governors University (WGU) HLTH 2012 D391 Pre-Assessment Healthcare Ecosystems Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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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. Which healthcare regulation prohibits discrimination by health insurance companies based on clients' genetics?**
 - A. The Health Insurance Portability and Accountability Act (HIPAA)**
 - B. The Occupational Safety and Health Administration (OSHA)**
 - C. The Health Information Technology for Economic and Clinical Health Act (HITECH)**
 - D. The Patient Protection and Affordable Care Act (ACA)**

- 2. In Medicare, value-based purchasing primarily rewards providers based on which?**
 - A. Performance on quality and outcomes measures.**
 - B. Number of patients seen per day.**
 - C. Time of day services are delivered.**
 - D. Appointment scheduling efficiency only.**

- 3. Which combination of technologies best supports patient engagement in care management?**
 - A. Paper-based messaging and mail-only reminders**
 - B. Physician-only outreach without patient portals**
 - C. In-person visits exclusively**
 - D. Portals, mobile apps, and remote monitoring**

- 4. Within the DECIDE framework, which step involves selecting the best alternative after evaluating options?**
 - A. Identify the best alternative**
 - B. Define the problem**
 - C. Establish the criteria**
 - D. Develop and implement a plan of action**

- 5. Which technologies are part of patient engagement technologies used in care management?**
 - A. Portals**
 - B. Mobile apps**
 - C. Remote monitoring**
 - D. All of the above**

- 6. What is the role of analytics in identifying at-risk populations and allocating resources accordingly?**
- A. Predictive modeling identifies high-risk individuals for targeted outreach and proactive interventions to prevent hospitalization and complications**
 - B. Takes patient preference into account only**
 - C. Only tracks billing data**
 - D. Ignores patient outcomes**
- 7. Which description best captures the essence of an Accountable Care Organization (ACO) as a payment and care model?**
- A. A CO maximizes fee-for-service revenue without data sharing.**
 - B. An ACO consists of a network that coordinates care for a defined patient population, with a goal to improve quality and reduce costs and share savings with payers.**
 - C. An ACO is a government agency that sets healthcare standards.**
 - D. An ACO pays clinicians a fixed salary with no performance incentives.**
- 8. Which level of care involves specialized services after referral from primary care, such as specialty clinics or surgeons?**
- A. Primary care**
 - B. Secondary care**
 - C. Tertiary care**
 - D. Hospice care**
- 9. Which savings mechanism pairs with a high-deductible plan to give individuals tax-advantaged funds for medical expenses?**
- A. Health Reimbursement Arrangement (HRA)**
 - B. Health Insurance Marketplace**
 - C. Health Savings Account (HSA)**
 - D. Flexible Spending Account (FSA)**

10. How do care transitions contribute to patient safety and cost containment?

- A. Proper handoffs reduce adverse events and readmissions; streamlined transitions cut duplicative testing and fragmentation costs**
- B. They have no impact on safety or costs**
- C. They increase length of stay**
- D. They delay medications**

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Answers

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

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Explanations

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1. Which healthcare regulation prohibits discrimination by health insurance companies based on clients' genetics?

- A. The Health Insurance Portability and Accountability Act (HIPAA)**
- B. The Occupational Safety and Health Administration (OSHA)**
- C. The Health Information Technology for Economic and Clinical Health Act (HITECH)**

D. The Patient Protection and Affordable Care Act (ACA)

The main idea here is that broad protections in health insurance come from the ACA, which makes it harder for plans to discriminate based on a person's health status, including genetic information, when underwriting or setting conditions of coverage. The ACA extends guarantees like not denying coverage for preexisting conditions and limits practices that could lead to higher premiums due to health concerns, which covers genetic risk as part of health status. HIPAA mainly protects privacy and security of health information, not insurer discrimination in underwriting. OSHA deals with workplace safety. HITECH focuses on health IT and privacy related to electronic records, not insurance underwriting practices. Note: a separate law, the Genetic Information Nondiscrimination Act (GINA), specifically prohibits using genetic information for underwriting by health insurers, but it isn't among the given options.

2. In Medicare, value-based purchasing primarily rewards providers based on which?

- A. Performance on quality and outcomes measures.**
- B. Number of patients seen per day.**
- C. Time of day services are delivered.**
- D. Appointment scheduling efficiency only.**

Value-based purchasing in Medicare focuses on how well care is actually delivered, not how much care is delivered. It ties payments to performance on standardized quality and outcomes measures—things like patient safety, effectiveness of treatment, and patient experience. When providers meet or exceed these quality benchmarks and achieve better outcomes, they earn higher payments; if they lag on these measures, payments can be adjusted downward. This shifts the incentive from quantity (how many patients are seen) to quality and results. The other options don't fit because simply seeing more patients, delivering services at a certain time of day, or prioritizing scheduling efficiency doesn't directly measure the care quality or patient outcomes that Medicare uses to determine value-based rewards.

3. Which combination of technologies best supports patient engagement in care management?

- A. Paper-based messaging and mail-only reminders**
- B. Physician-only outreach without patient portals**
- C. In-person visits exclusively**
- D. Portals, mobile apps, and remote monitoring**

Engaging patients in care management requires tools that provide access, feedback, and data outside of the clinic. Portals give secure access to test results, messages, and treatment plans so patients can review information anytime. Mobile apps extend engagement with education, reminders, and self-management tasks that patients can use on the go. Remote monitoring gathers vital signs or activity data between visits, allowing clinicians to adjust care promptly and keep patients involved. This combination enables two-way communication, continuous support, and data-driven decisions, all of which boost adherence and proactive management. In contrast, paper-based messaging and mail-only reminders are slow and often fail to drive timely engagement. Physician outreach without patient portals limits patient access to information and participation. In-person visits alone can be costly and can't sustain ongoing engagement between visits.

4. Within the DECIDE framework, which step involves selecting the best alternative after evaluating options?

- A. Identify the best alternative**
- B. Define the problem**
- C. Establish the criteria**
- D. Develop and implement a plan of action**

In the DECIDE process, after you've evaluated the different options against your criteria, the next move is to pick which option best meets those standards. This is the moment of selecting the best alternative to pursue, which is described as identifying the best option to move forward with. Defining the problem is the initial framing step, establishing criteria sets the standards you'll use to judge options, and developing and implementing a plan of action happens after you've chosen an option to carry out.

5. Which technologies are part of patient engagement technologies used in care management?

- A. Portals**
- B. Mobile apps**
- C. Remote monitoring**
- D. All of the above**

In care management, patient engagement technologies are tools that help patients participate in and manage their health. Portals give patients secure access to their health information—records, test results, appointment details—and a way to message the care team, which keeps them informed and involved in decisions. Mobile apps bring engagement into daily life with features like medication reminders, symptom tracking, goal setting, education, and easy contact with providers, making self-management more convenient and ongoing. Remote monitoring uses home devices to collect health data (like blood pressure, glucose, or weight) and transmit it to clinicians, enabling real-time monitoring, trend analysis, and timely interventions before problems escalate. Together, these technologies cover access to information, everyday self-management, and remote data-driven care, which is why the comprehensive option—encompassing all of them—is the best choice.

6. What is the role of analytics in identifying at-risk populations and allocating resources accordingly?

- A. Predictive modeling identifies high-risk individuals for targeted outreach and proactive interventions to prevent hospitalization and complications**
- B. Takes patient preference into account only**
- C. Only tracks billing data**
- D. Ignores patient outcomes**

Analytics helps healthcare systems identify at-risk populations by turning diverse data into actionable risk signals that guide where to focus care. Predictive modeling uses information from clinical histories, prior utilization, lab results, diagnoses, medications, and even social determinants of health to estimate each patient's chance of hospitalization, complications, or adverse events in a given period. With these risk estimates, providers can target outreach and deploy proactive interventions—such as care management, home visits, remote monitoring, or tailored care plans—to prevent crises before they happen. This approach supports allocating resources where they will have the greatest impact, improving patient outcomes while using limited resources more efficiently. Options that focus only on patient preferences, rely solely on billing data, or ignore outcomes don't capture how analytics actually identifies risk and informs resource distribution.

7. Which description best captures the essence of an Accountable Care Organization (ACO) as a payment and care model?

- A. A CO maximizes fee-for-service revenue without data sharing.**
- B. An ACO consists of a network that coordinates care for a defined patient population, with a goal to improve quality and reduce costs and share savings with payers.**
- C. An ACO is a government agency that sets healthcare standards.**
- D. An ACO pays clinicians a fixed salary with no performance incentives.**

ACOs bring together providers to manage the care of a defined patient group, tying reimbursement to both quality and cost. They coordinate care across the full spectrum—primary care, specialists, hospitals, and other services—with the goal of improving outcomes while lowering overall spending. When cost and quality benchmarks are met, the organization shares some of the savings with payers, aligning financial incentives with better patient care. This description matches the idea of a network that coordinates care for a defined population, aims to improve quality and reduce costs, and distributes savings to payers. Other options conflict with this approach: maximizing fee-for-service revenue focuses on volume rather than value and typically lacks collaboration and data sharing; a government agency setting standards is not an ACO; a fixed salary with no performance incentives misses the accountability for outcomes and shared savings that define an ACO.

8. Which level of care involves specialized services after referral from primary care, such as specialty clinics or surgeons?

- A. Primary care**
- B. Secondary care**
- C. Tertiary care**
- D. Hospice care**

Understanding levels of care in health systems helps explain why specialized services after a primary care referral fit secondary care. Primary care is the generalist, first-contact stage that handles routine illnesses and coordinates overall health needs. When more specialized evaluation or treatment is needed, a referral is made to secondary care, which includes specialty clinics and surgeons who provide targeted expertise and services not typically available in primary care. This is exactly what the scenario describes: specialized services accessed after a primary care referral. Tertiary care goes even further, offering highly complex and advanced interventions at specialized centers, often for rare or highly intricate conditions. Hospice care focuses on comfort and palliative support at the end of life, not on delivering specialized medical procedures through a referral from primary care.

9. Which savings mechanism pairs with a high-deductible plan to give individuals tax-advantaged funds for medical expenses?

- A. Health Reimbursement Arrangement (HRA)**
- B. Health Insurance Marketplace**
- C. Health Savings Account (HSA)**
- D. Flexible Spending Account (FSA)**

Pairing a high-deductible plan with an HSA lets individuals set aside money specifically for medical costs with favorable taxes. An HSA is designed to work with HDHPs: you contribute funds (typically on a pre-tax basis or tax-deductible), the money grows tax-free, and withdrawals are tax-free when used for qualified medical expenses. The funds stay in the account year after year and are owned by you, so they aren't tied to a job and can roll over indefinitely. This triple tax advantage—tax-deductible contributions, tax-free growth, and tax-free withdrawals for eligible medical costs—makes the combination the best match for an HDHP. Other options don't fit as well: a Health Insurance Marketplace is where you purchase coverage, not a savings vehicle; a Flexible Spending Account is often tied to a non-HDHP and may have use-it-or-lose-it rules; a Health Reimbursement Arrangement is typically employer-funded and less portable, with funds that aren't owned by you.

10. How do care transitions contribute to patient safety and cost containment?

- A. Proper handoffs reduce adverse events and readmissions; streamlined transitions cut duplicative testing and fragmentation costs**
- B. They have no impact on safety or costs**
- C. They increase length of stay**
- D. They delay medications**

Effective care transitions ensure that when a patient moves between care settings or providers, responsibility, information, and the care plan move with them. This relies on thorough handoffs, standardized communication, medication reconciliation, and timely follow-up. When transitions are well managed, safety improves because the next care team has complete, accurate information about medications, allergies, test results, and planned treatments, reducing the risk of adverse events and readmissions. At the same time, streamlined transitions cut duplicate or unnecessary testing and help prevent fragmented care, which lowers avoidable costs. Conversely, poorly handled transitions introduce safety risks and extra costs through miscommunication, missed follow-ups, medication errors, and duplicated tests. Statements that transitions have no impact, always lengthen stays, or delay medications don't reflect how essential good handoffs and coordination are to both patient safety and cost containment.

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://wgu-hlth2012d391preassessment.examzify.com>

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

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