# WESTERN GOVERNORS UNIVERSITY (WGU) HLTH 2012 D391 PRE-ASSESSMENT HEALTHCARE ECOSYSTEMS PRACTICE TEST (SAMPLE)

## STUDY GUIDE

## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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https://wgu-hlth-2012d391preassessment.examzify.com

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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. What is a primary incentive for providers to participate in value-based purchasing?**

A. Administrative simplicity and reduced paperwork

B. Higher patient volumes guaranteed regardless of outcomes

C. Better reimbursement tied to outcomes

D. Reduced regulatory oversight

**2. Which approach helps test a change that is implemented?**

A. Seek, Help, Assess, Reach, Evaluate (SHARE)

B. DECIDE

C. STEEP

D. Plan-Do-Study-Act (PDSA)

**3. Which statement accurately reflects MACRA/MIPS performance areas?**

A. Reimbursement is tied to performance on quality, cost, interoperability, and improvement activities.

B. Payment is based only on patient satisfaction scores.

C. There is no link between reimbursement and performance.

D. Performance is assessed only by the number of procedures performed.

**4. What is value-based purchasing and how does it affect provider behavior?**

A. Payment is based on service volume

B. Payment tied to quality and outcomes

C. Payment is determined by patient satisfaction alone

D. Payment is fixed regardless of performance

**5. Which statement best defines value-based care in contrast to fee-for-service models?**

A. Value-based care links payment to quality outcomes and total costs; fee-for-service pays for each service regardless of outcomes.

B. Value-based care pays for every service; fee-for-service rewards holistic outcomes.

C. Value-based care only improves access; fee-for-service only focuses on outcomes.

D. Value-based care eliminates reimbursements entirely; fee-for-service doubles payments.

**6. What is the main purpose of mental health organizations?**

A. To improve the mental health of people

B. To promote inpatient services in mental health institutions

C. To advocate for patients in skilled nursing facilities

D. To encourage the use of public health resources

**7. How is risk stratification used in population health?**

A. Classifies patients by disease name only.

B. Allocates resources based on random assignment.

C. Evaluates hospital profitability.

D. Classifies patients by likelihood of adverse events to target interventions and allocate resources.

**8. Which stakeholder is primarily responsible for cost control and risk management in a healthcare ecosystem?**

A. Patients

B. Payers

C. Providers

D. Policymakers

**9. A 40-year-old client thinks that the pharmacy made a mistake with the instructions for their medication. Which resource should the client consult to verify the instructions for their medication?**

A. Google

B. A medical journal

C. The pharmacy

D. Their electronic medical records

**10. Which option grants patients the ability to review their medical records and request amendments?**

A. The Health Information Technology for Economic and Clinical Health Act (HITECH)

B. The Patient bill of rights

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

D. Health Reimbursement Arrangements

# Answers

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

# Explanations

## 1. What is a primary incentive for providers to participate in value-based purchasing?

A. Administrative simplicity and reduced paperwork

B. Higher patient volumes guaranteed regardless of outcomes

C. Better reimbursement tied to outcomes

D. Reduced regulatory oversight

*Value-based purchasing ties reimbursement to patient outcomes, so providers are financially rewarded for delivering real improvements in care. When outcomes are strong—better quality, fewer complications, lower readmissions, and efficient use of resources—their payment increases or they earn bonuses. This aligns money with the goal of better health results, motivating investments in care coordination, preventive services, and evidence-based practices. Other options don't capture the core driver: VBP typically adds reporting and metrics rather than simplifying paperwork; it doesn't guarantee higher volumes regardless of outcomes; and it usually involves more, not less, regulatory oversight to track performance.*

## 2. Which approach helps test a change that is implemented?

A. Seek, Help, Assess, Reach, Evaluate (SHARE)

B. DECIDE

C. STEEP

D. Plan-Do-Study-Act (PDSA)

*In quality improvement, testing a change uses an iterative learning loop that lets you learn and adjust before broader rollout. Plan-Do-Study-Act provides this clear framework. Plan what change you will try and what you expect to happen. Do the change on a small, controlled scale. Study the results by collecting and analyzing data to see if the prediction held. Act based on what you learned—adopt, modify, or abandon the change—and then repeat the cycle as needed. This approach helps ensure the change actually leads to improvement without disrupting care on a large scale. The other options are more about broad planning or decision-making rather than a structured, repeated testing process, so they don't fit as well for testing a change before full implementation.*

## 3. Which statement accurately reflects MACRA/MIPS performance areas?

A. Reimbursement is tied to performance on quality, cost, interoperability, and improvement activities.

B. Payment is based only on patient satisfaction scores.

C. There is no link between reimbursement and performance.

D. Performance is assessed only by the number of procedures performed.

*MACRA underpins how Medicare rewards clinicians by tying reimbursement to performance across four areas: quality of care, cost (resource use), interoperability and meaningful use of certified health IT, and improvement activities that promote care coordination and patient engagement. This framework means payments depend on a clinician's overall performance in these domains, not on a single factor. So reimbursement isn't based only on patient satisfaction, nor is there no link to performance, nor is it limited to the number of procedures performed. The four areas together drive the payment adjustment through a composite score that reflects both outcomes and efficiency as well as data sharing and continuous improvement.*

## 4. What is value-based purchasing and how does it affect provider behavior?

A. Payment is based on service volume

B. Payment tied to quality and outcomes

C. Payment is determined by patient satisfaction alone

D. Payment is fixed regardless of performance

*Value-based purchasing is a reimbursement approach that ties payment to the quality of care and patient outcomes rather than the amount of services provided. It rewards providers who achieve better health results, higher safety, and more efficient care, and may penalize for poor outcomes or excessive costs. This shift encourages care teams to adopt evidence-based practices, improve care coordination, and continually seek quality improvements. Providers become more focused on preventing complications, reducing avoidable admissions or tests, and enhancing patient experience, since these factors influence reimbursement. The other descriptions describe models where payment is based on volume, or on satisfaction alone, or is fixed regardless of performance, which do not align with the value-based focus on outcomes and quality.*

## 5. Which statement best defines value-based care in contrast to fee-for-service models?

A. Value-based care links payment to quality outcomes and total costs; fee-for-service pays for each service regardless of outcomes.

B. Value-based care pays for every service; fee-for-service rewards holistic outcomes.

C. Value-based care only improves access; fee-for-service only focuses on outcomes.

D. Value-based care eliminates reimbursements entirely; fee-for-service doubles payments.

*Value-based care ties reimbursement to quality outcomes and total costs, rather than paying for each service delivered. This means providers are rewarded when patients achieve better health results while keeping overall care costs in check. In contrast, fee-for-service pays for each service rendered, regardless of the patient's outcomes, which can incentivize more tests or procedures even if they don't improve health. The other options misstate the relationship—value-based care isn't about paying for every service or focusing only on access, and fee-for-service doesn't reward holistic outcomes.*

## 6. What is the main purpose of mental health organizations?

A. To improve the mental health of people

B. To promote inpatient services in mental health institutions

C. To advocate for patients in skilled nursing facilities

D. To encourage the use of public health resources

*Mental health organizations exist to improve the mental health of people and communities. They work to raise awareness, reduce stigma, provide education and resources, advocate for better policies and funding, and support research and services that help individuals live healthier, more stable lives. That broad aim—strengthening overall mental health and well-being—guides their activities, outreach, and programs. The other options miss this overarching purpose. Promoting inpatient services focuses on a specific type of care rather than the wider goal of improving mental health for all. Advocating for patients in skilled nursing facilities targets a narrow setting rather than the general aim of mental health improvement. Encouraging the use of public health resources may be a tactic they support, but it is not the fundamental purpose; the core mission is the health and well-being of people's mental health.*

## 7. How is risk stratification used in population health?

A. Classifies patients by disease name only.

B. Allocates resources based on random assignment.

C. Evaluates hospital profitability.

D. Classifies patients by likelihood of adverse events to target interventions and allocate resources.

*In population health, risk stratification uses patient data to estimate how likely someone is to experience an adverse health event, such as hospitalization or deterioration of a condition. This helps health teams identify who is at higher risk and tailor care accordingly. By knowing who is most at risk, resources and interventions can be directed where they'll have the greatest impact—for example, more intensive care management, proactive outreach, home visits, or added monitoring for high-risk patients. This approach improves outcomes and makes resource use more efficient by preventing problems before they escalate. It's not simply grouping patients by disease name, which doesn't address risk, nor is it about random resource allocation. It also isn't about measuring profitability of a hospital.*

## 8. Which stakeholder is primarily responsible for cost control and risk management in a healthcare ecosystem?

A. Patients

B. Payers

C. Providers

D. Policymakers

*The main idea is that the entity that designs how care is paid for and how financial risk is shared is the payer. Payers control costs and manage risk by shaping coverage and payment structures, negotiating rates with providers, and implementing tools that influence how care is used. They use utilization management, prior authorizations, and formulary decisions to steer care toward cost-effective options. Through value-based payment models, such as bundled payments, shared savings, and capitation, they align incentives for providers to deliver high-quality care efficiently, which helps contain costs and spread financial risk across the system. While patients and providers play critical roles in care delivery, and policymakers influence the environment, the payer is the primary driver of cost control and risk management because they bear and arrange the financial risk and determine how services are paid for.*

## 9. A 40-year-old client thinks that the pharmacy made a mistake with the instructions for their medication. Which resource should the client consult to verify the instructions for their medication?

A. Google

B. A medical journal

C. The pharmacy

D. Their electronic medical records

*When you want to verify how a medication should be taken, the most reliable source is the official record from your healthcare system. Your electronic medical records contain the exact prescribed instructions—current active medications, the dose, how often to take it, how long to continue, and any special directions. These records are kept up to date and can be accessed through a patient portal, so you can compare what the provider ordered with what you're seeing on the label. If you notice a mismatch between the EMR and what the pharmacy provided, contact your clinician or the pharmacy to clarify before continuing. External sources like Google or medical journals aren't tailored to your specific prescription, and while the pharmacy can dispense the medication, the EMR is the authoritative reference for the physician's ordered instructions.*

**10. Which option grants patients the ability to review their medical records and request amendments?**

A. The Health Information Technology for Economic and Clinical Health Act (HITECH)

B. The Patient bill of rights

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

D. Health Reimbursement Arrangements

*Access to medical records and the ability to request amendments are patient rights described in materials that spell out what patients can expect. The Patient Bill of Rights explicitly includes the right to review records and request corrections or amendments. The other options address different topics: the HITECH Act strengthens privacy protections and enforcement around health information; the ACA focuses on health coverage and access; Health Reimbursement Arrangements are a type of employee benefit plan. Because this question is about patients reviewing their records and making changes, the Patient Bill of Rights best fits that right.*

# 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!