Real World Testing Plan

General Information

Plan Report ID Number: 20231108adv01

Developer Name: **Advanced Data Systems Corporation**

Product Name(s): MedicsDocAssistant

Version Number(s): 8.0

Certified Health IT: (§170.315(b)(1)-(b)(3)), (§ 170.315(b)(9)), (§ 170.315(c)(1)-(c)(3)), (§ 170.315(e)(1)), (§ 170.315(f)(1)), (§ 170.315(f)(2), (§ 170.315(f)(4)), (§ 170.315(f)(5)), (§170.315(g)(7), (§170.315(g)(9)), (§170.315(g)(10)), (§170.315(h)(1))

Product List (CHPL) ID(s): 15.02.05.1044.AVDD.01.01.1.220111.

Developer Real World Testing Page URL: https://www.adsc.com/2015-certified

Justification for Real World Testing approach

In order to comply this Real-world test plan requirements ADSC is geared towards achieving the Real World test Results every year and will be publishing the results on CHPL portal for public on or before March 15th of the subsequent year.

ADSC has established a Real World test Plan for the EHR product (MedicsDocAssistant) with real world customers to demonstrate the interoperability and functionality of its certified requirements in all ambulatory care clinics and public health. ADSC will be using real customer's data to ensure functional accuracy and transparencies. All functional criteria further referenced in the test plan is predicted on customer usability in real world environments such as practices and the users will include practice staff members providers, Nurse and users etc.

Standards Updates (SVAP and USCDI)

Standard (and version)	USCDI v1
Updated certification criteria and associated product	b1, b2, e1, f5, g9
Health IT Module CHPL ID	15.02.05.1044.AVDD.01.01.1.220111
Method Used for standard update	Cures Update
Date of ONC ACB notification	12/23/2022
Date of customer notification(SVAP only)	N/A
Conformance measure	Measure 1 for b1,b2 Measure 5 for e1 Measure 9 for f5 Measure 10 for g9
USCDI updated certification criteria (and USCDI version)	b1, b2, e1, f5, g9 – USCDI v1

Measure 1:- Health Information Exchange electronically Using C-CCDAs and incorporating the clinical data to patient chart.

Measure Description:-

The purpose of this measure is tracking and counting how many transitions of care/CCDAs are created and successfully sent electronically to 3rd party using direct messaging. And also tracking and displaying the transition of care/CCDA received electronically from a 3rd party during a transition of care event and successful reconciliation of clinical summary data in to patient chart in an EHR over a course of a time interval/reporting period.

Associated Certification Criteria:-

(§170.315(b)(1))- Transitions of care

(170.315(b)(2))- Clinical information reconciliation and incorporation

§170.315(h)(1) Direct Project

Relied Upon Software:-

Surescripts N2N Direct Messaging for (§170.315(b)(1)) and §170.315(h)(1)

Justification for Selected measurement/Metric:-

Requirement	EHR Test Plan	Justification	Expected Outcome/Metrics
1. Send Transition of care or Referral Summaries 2. Receive Transition of care or referral summaries. 3. From the imported referral summary, Providers incorporated the Medications, Medication Allergies and Problem list data by incorporating the clinical summary file.	Provider selects the patient from patient search screen and then click on Export button. Provider selects Referrals section from patient Dashboard and can send the transition of care using Send Care Document option. Provider navigates to N2N inbox and download the referral summary or transition of care received. Provider Import the CCDA using Import patient Referral Summary option from Tools menu. Provider selects the patient and view the CCDA file as per his preference for	The goal of this test approach is to demonstrate the capabilities of Sending and Receiving a Transition of care summaries and reconciliation of clinical information data like problems, Medications and Allergies section data to EHR as per the specified standards. MedicsDocAssistant user can create a C-CDA patient summary record including all required clinical data set elements and by sending electronically, EHR can successfully demonstrate the exchange of patient record with 3rd party providers/Practices.	Providers/Authorized Users can send or Receive the transition of care or Referral summaries in CCDA standard to external providers or practices and Providers can reconcile the clinical data from imported C-CDA file to the patient chart. **Metrics: -** We will use audit logs and can extract a report from Reports Menu for total number of C-CDAs exported and Total number of C-CDA imported and reconciled clinical data in to MedicsDocAssistant as per the specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify

	Referral summary screen. From the Patient dashboard provider selects the Referral summary tab and view the patient data from imported referral summary. Provider navigates to reconciliation screen in encounter and then selects the data from both the sources that is from patient chart and Referral summary file for Medications, Problem List and Medication Allergies section and reconcile the data to patient chart. Provider reviews the incorporated data in patient chart.	MedicsDocAssistant users can receive a C-CDA patient summary record electronically using direct messaging and can incorporate the summary of care record in EHR to display it in human readable format and then reconcile the available clinical information data Problems, Medications and Allergies to EHR.	the success/failure rate of this measure. MedicsDocAssistant is compliant to the C-CDA standard architecture and meets the compliance requirement for EHR data exchange, So a 100% success rate on this measure is expected.

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 2:- Number of Prescriptions created and sent electronically.

Measure Description:-

The purpose of this measure is tracking and counting how many NewRx, Renew, Refill, ChangeRx and Cancel electronic prescriptions generated and successfully sent to pharmacy from EHR over a course of a time interval/reporting period.

Associated Certification Criteria:-

(§ 170.315(b)(3)) e-prescription

Relied Upon Software:-

NewCrop Rx

Justification for Selected measurement/Metric:-

Requirement	EHR Test Plan	Justification	Expected Outcome/Metrics
Electronic Prescription sent by the provider	Provider opens patient encounter. Provider navigates to Medications Tab and click on 'RX Medication' section. Provider search for Drug Name by selecting the appropriate 'Drug Formulary' Provider selects the drug and complete the SIG, quantity etc for medication. Provider selects the patient preferred pharmacy and then transmit the medication to pharmacy electronically.	MedicsDocAssistant supports transmission of eRx to external pharmacy via NewCrop certified Health IT System. The goal of this test approach is to demonstrate that the electronic prescription can be transmitted between certified Health IT and external pharmacies in conformance capabilities and requirements of 170.315 (b)(3).	Provides can create an electronic prescription request to patient preferred pharmacy through NewCrop and can respond to the requests from pharmacies as per the standards. Metrics: - We will use audit logs for verifying the prescription related transactions and can extract a report from Reports Menu to identify the total number of prescriptions sent to pharmacy electronically in a specified time interval. We will test this measure at least

			once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. A 100% success rate on this measure is expected.

Care Settings:-

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Measure 3:- Care Coordination

Measure Description:-

The purpose of this measure is tracking how a provider can spend more time with complex, chronic care patients by creating a care plan in EHR.

Associated Certification Criteria:-

(§ 170.315(b)(9)) Care Plan

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
Record, Change, Access, Create and receive care plan information as per the care plan document template.	Provider logs in to MedicsDocAssistant and opens the patient encounter. Provider can Record required data in encounter as per the template Goals, Health Concerns, Interventions and Health Status	MedicsDocAssistant Users can use Care Plan template to Record, Change, Access and can create and receive care plan template. The goal of this test approach is to demonstrate how a provider can capture	Providers/Users can capture Care Plan information in EMR and can create /receive the care plan information in C-CDA format as per the standards. Metrics:- We can demonstrate the Care plan

	Evaluation and Outcomes. Provider can Access the encounter care plan and Change the data as per the update. Providers can create/receive Care plan in C-CDA format.	Care Plan information as per the patient chronic conditions and can create/receive care plan information as per the standards.	documentation, Create and Receive in C-CDA format and will use audit logs to identify the Care plan capture information, Create and receive information and can generate a report for total number of care plan documented in a specified time frame. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. A 100% success rate on this measure is expected.

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 4:- Clinical Quality Measures Reporting

Measure Description:-

The purpose of this measure is tracking and counting the total number of Clinical quality measures that reported across various reporting programs like MIPS, CPC+ etc., as per the requirement during the reporting period.

Associated Certification Criteria:-

§ 170.315(c)(1)—record and export

§ 170.315(c)(2)—import and calculate

§ 170.315(c)(3)—report

Justification for Selected measurement/Metric:-

Requirement	EHR Test Plan	Justification	Expected Outcome/Metrics
Generate MIPS/MU/CPC+ Quality Reports Data.	Capture required data for the selected quality measures in patient encounters. Navigate to Reports Menu and then generate CQM report by selecting the provider and with a time interval. Select the individual quality measure and export the report in QRDA 1 format. Using import QRDA 1 file option users can import the patient's data in to the EMR and calculate the CQM measures data. Export the QRDA III report from reports screen.	MedicsDocAssistant users can generate quality measures report data for MIPS, Meaningful Use, CPC+ reporting programs. The goal of this test approach is how a user can generate QRDA1, QRDA III and quality reports data in an excel format as per the standards for multiple reporting programs.	Providers/Users can generate quality measures data as per the standards. Metrics:- We will demonstrate the quality measures data through reports in csv/excel, pdf, QRDA 1/QRDA III formats in a specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. Most of our clients are not using all the certified quality measures we can demonstrate the measures used in live environment and we can expect a 100% success rate on this measure.

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 5:- Provider Patient Engagement through Patient portal

Measure Description:-

The purpose of this measure is tracking and counting the total number of C-CCDA files were exported to portal and out of those information how many patients/patient authorized users viewed, Downloaded and transmitted that health information to 3rd party providers/practices.

Associated Certification Criteria:-

§ 170.315(e)(1)—View, Download, and Transmit to 3rd party.

§170.315(h)(1) Direct Project

Relied Upon Software:-

Surescripts N2N for §170.315(h)(1)

Meinberg NTP Daemon for NTP for § 170.315(e)(1)

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
Patient/Patient authorized representative can login to patient portal and view, download and transmit the Clinical summary information to 3rd party.	Patient/Patient authorized user logs in to patient portal. From Health summary section in patient portal Users can View, Download in both C-CDA xml and readable format and then can export to 3rd party through regular email address and through secure email address.	The goal of this test approach is to demonstrate how a patient/patient authorized users can view, download and transmit the C-CDA to 3rd party that are available for patients in patient portal.	Patients/patient authorized users can access the health summary available in patient portal. Metrics:- We will use audit logs for verifying the Clinical Summary activity on view, download and transmit by patients and can generate a report from Promoting interoperability category to identify the total number of C-CDAs view, downloaded and transmitted in a specified time frame. We will test this measure at least once a quarter and can evaluate the

			audit log to identify the success/failure rate of this measure. A 100% success rate on this measure is expected.

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 6:- Exporting Immunization Data to State Registries

Measure Description:-

The purpose of this measure is tracking how a user can export/ query (bi-directional) communication the vaccination data to State registries from EHR.

Associated Certification Criteria:-

(§ 170.315(f)(1)) Transmission to Immunization Registries

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
1. Send Immunization Record to state registry. 2. Request, Access and display a patients evaluated Immunization registry and forecast it from an	Provider Opens patient encounter. Provider Navigates to Immunization section and documents the vaccination information and save it. Provider Navigates to Tools Menu and selects	MedicsDocAssistant supports the transmission of Immunization information to State registries as per the state registry requirements standards. Users can query the evaluated vaccination	Providers/authorized users can send vaccination information to state registries and can query the evaluated history vaccination information of the patient and forecast it to the user as per the standards. Metrics:- We will use

Immunization registry	'Immunization Registry' option. Providers selects the date range to load the vaccination information and then transmit the data to state registry. Provider saves the ACK received after transmitting data to state registry. Provider Navigates to Tools Menu and selects 'Immunization Registry' option. Provider selects the patient and then click on query button. Provider receive the Response from state registry and forecast the historical information to user.	information of the patient from state registries and can forecast it to the user.	audit logs for verifying the send and query immunization information and we can use ACK response from state registries regarding the status of sent and query immunization information during the specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. A 100% success rate on this measure is expected.

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 7:- Exporting Syndromic surveillance Data to State Registries

Measure Description:-

The purpose of this measure is tracking how a user can create syndromic surveillance message and can sent that message to Syndromic Surveillance registries from EHR.

Associated Certification Criteria:-

(§ 170.315(f)(2)) Transmission to Public Health Agencies – Syndromic surveillance

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
Create Syndromic Surveillance information from EHR and sent it through electronic transmission to Syndromic Surveillance Registry.	Provider open patient encounter and capture the required clinical information. Provider/Authorized user navigates to Past Encounters menu and then selects required patient encounter. Provider then generate the Register Patient message and before closing the patient chart, provider/user can submit Discharge patient message to state registry.	MedicsDocAssistant users can create and transmit electronically to syndromic surveillance registry. The goal of this test approach is demonstrate how a user can create syndromic surveillance data and submit it through electronically to syndromic surveillance registry.	Practices that register for syndromic surveillance registry for data exchange can create and submit the messages electronically to syndromic surveillance registries. Metrics:- We will use audit logs for verifying the created and sent messages to syndromic surveillance and we can use ACK response from state registries regarding the status of sent message to syndromic surveillance registry during the specified time interval. We will test this measure at least once a quarter and can evaluate the

			audit log to identify the success/failure rate of this measure. As we have 0 clients using this measure in live environment, we can collect the measure results in our local environment and can expect a 100% success rate on this measure

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 8:- Exporting Cancer Cases patient information Data to State Registries

Measure Description:-

The purpose of this measure is tracking how a user can capture and generate cancer case CCDA documents data and submit it electronically from EHR.

Associated Certification Criteria:-

(§ 170.315(f)(4)) Transmission to Cancer Registries

Justification for Selected measurement/Metric:-

Requirement	EHR Test Plan	Justification	Expected Outcome/Metrics
Create cancer case information for electronic transmission in CCDA file format from EHR as per the standards.	Provider open patient encounter and capture the required clinical information.	MedicsDocAssistant users can create cancer case CCDA file and transmit it electronically to cancer registry.	Practices that register with Cancer registry for data exchange can create and submit the cancer case CCDA

	Provider/Authorized user navigates to Patient search and selects patient then click on Export button. Provider then selects the Cancer registry option and submit cancer case CCDA file by clicking the Export button for electronic transmission.	The goal of this test approach is demonstrate how a user can capture required data for creating a cancer case CCDA file and submit it through electronically to Cancer registry as per the specified standards.	files electronically to cancer registries. Metrics:- We will use audit logs for verifying the created and sent messages to cancer registry and we can use ACK response from state registries regarding the status of sent message to cancer registry during the specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. As we have 0 clients using this measure in live environment, we can collect the measure results in our local environment and can expect a 100% success rate on this measure

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Measure 9:- Electronic Case Reporting to State Registries

Measure Description:-

The purpose of this measure is tracking how a user can submit case reporting of reportable conditions to public health agencies in CCDA format from EHR.

Associated Certification Criteria:-

170.315(f)(5): Transmission to public health agencies - Electronic Case Reporting

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
Create an electronic case file transmission in CCDA file format from EHR as per trigger requirement.	User can verify the trigger codes available for generating an electronic case file format in CCDA. Provider open patient encounter and capture the required clinical information. Provider/Authorized user navigates to Tools menu and then selects Electronic Case Reporting option. Provider/Authorized user then select the date range and generate a CCDA file by clicking the Report button for electronic transmission.	MedicsDocAssistant users can generate the electronic case CCDA file based on the trigger codes and transmit it to public health agencies. The goal of this test approach is demonstrate how a user can identify the encounters based on The specified trigger codes and then generate a CCDA file and submit it to electronic case reporting registries as per the specified standards.	Practices that register with Electronic case registries/public health agencies for data exchange can create and submit the electronic case CCDA files to transmit the data to registries. Metrics:- We will use audit logs to verify the generated CCDA's from Electronic case reporting option during the specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. As we have 0 clients using this measure in

			live environment, we can collect the measure results in our local environment and can expect a 100% success rate on this measure.

Care Settings:-

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Measure 10:- Application Programming Interfaces

Measure Description:-

The purpose of this measure is to provide patient data access from EHR to 3rd party applications with proper authentication through API request.

Associated Certification Criteria:-

(§170.315(g)(7)) Application access — patient selection

(§170.315(g)(9)) Application access — all data request

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
Provide patient data access as per the request from 3rd party applications or systems through API access as per the standards.	Patients/3rd party users can access a API request through 3rd party application. For successful validation of API request data is	The goal of this test approach is to measure the adoption of accessing the patient complete data request with a specified time period through API request	3rd party applications/systems can access complete patient data as per the request through API access. Metrics:- We will use

	provided for requested categories.	with proper authentication from 3rd party application or systems as per the specified standards.	audit logs to identify the API request access and can generate a report from reports menu for API access request with in the specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. As we have 0 clients using this measure in live environment, we can collect the measure results in our local environment and can expect a 100% success rate on this measure

Care Settings:-

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Measure 11:- Standardized API for patient and population services

Measure Description:-

The purpose of this measure is to provide patient data access from EHR to 3rd party applications with proper authentication through API request.

Associated Certification Criteria:-

170.315(g)(10) Standardized API for patient and population services

Justification for Selected measurement/Metric:-

Requirement	EHR Test Plan	Justification	Expected Outcome/Metrics
Provide patient data access as per the API request.	Patients/3rd party users can access API request through 3rd party application by establishing a secure and trusted connection. Perform search operation on USCDI data elements provided. For successful validation of API request data is provided for requested categories.	The goal of this test approach is to measure the access of patient data request for all USCDI data elements through API request with proper authentication from single patient or multiple patients as per the specified standards.	Patients can access there complete EHR data for all USCDI data elements provided as per the request through API access. Metrics: - We will use audit logs to identify the API request access and can generate a report from reports menu for API access request with in the specified time interval. We will test this measure at least once a quarter and can evaluate the audit log to identify the success/failure rate of this measure. As we have 0 clients using this measure in live environment, we can collect the measure results in our local environment and can expect a 100% success rate on this measure

Care Settings:-

Our MedicsDocAssistant EHR markets it EHR modules to a variety of specialties like Family Medicine, Urology, Pain, Cardiovascular and Internal Medicine in ambulatory care. All the certified measures are common in every care setting addressed here, so we can report the metrics from any of these care settings during 01/01/2024 to 12/31/2024 performance period.

Schedule of Key Milestones

Key Milestone	Care Setting	Date/Timeframe
Release the Real-World Testing Document	Internal Medicine	December 1, 2023
Collection of information as laid out by the plan for the period.	Internal Medicine	01/01/2024 to 12/31/2024
Planned System updates to allow for collection of data after a SVAP update.	Internal Medicine	March 1, 2024
Follow-up with providers and authorized representatives on a regular basis to understand any issues arising with the data collection.	Internal Medicine	Quarterly, 2024
End of Real-World Testing period/final collection of all data for analysis.	Internal Medicine	January 1, 2025
Analysis and report creation.	Internal Medicine	January 15, 2025
Submit Real World Testing report to ACB (per their instructions)	Internal Medicine	January 15, 2025

This Real World Testing plan is complete with all required elements, including measures that address all certification criteria and care settings. All information in this plan is up to date and fully addresses the health IT developer's Real World Testing requirements.

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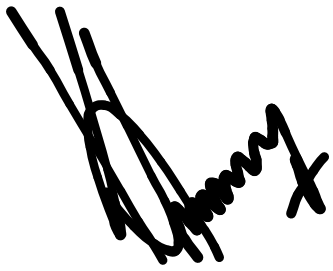

Date: 11-10-2023