Real World Testing Plan

General Information

Plan Report ID Number: 20221020adv01

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)(6)), (§ 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(g)(7), (§170.315(g)(9)), (§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)	N/A
Method used for standard update	N/A
Date of ONC-ACB notification	N/A
Date of customer notification (SVAP only)	N/A
USCDI-updated criteria	N/A
Conformance measure	N/A
Updated certification criteria and associated product	N/A
Health IT Module CHPL ID	N/A

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

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 Referral summary screen. From the Patient dashboard provider	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. MedicsDocAssistant users can receive a C-CDA patient summary record electronically using	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 the success/failure rate of this measure. MedicsDocAssistant is compliant to the C-CDA standard

	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.	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.	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 01/01/2023 to 12/31/2023 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:-

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 01/01/2023 to 12/31/2023 performance period.

Measure 3:- Bulk Patient Export Summaries in C-CDA format

Measure Description:-

The purpose of this measure is tracking and counting the total number of summary of care records exported in C-CCDA format through bulk export from the EHR over a course of a time interval/reporting period.

Associated Certification Criteria:-

(§ 170.315(b)(6)) Data Export

Justification for Selected measurement/Metric:-

Requirement	**EHR Test Plan**	**Justification**	**Expected Outcome/Metrics**
Create Bulk patient export summaries in CCDA format.	Privileged users access 'Bulk Patient Data Portability' option from Tools Menu and generate the bulk C-CDA for selected patients using Export option. Privileged user login to admin and configure the Relative Date/Specific Date and location for generating C-CDAs in bulk.	MedicsDocAssistant users can generate C-CDAs in bulk and can configure batch export of C-CDAs. The goal of this test approach is how a user can generate summary of care records for multiple patients with manual and bulk export configuration as per the specified standards.	Providers/Users can generate summary of care records(C-CDAs) in Bulk by a timeframe configuration. Metrics:- We can demonstrate the batch export of CCDAs based on Relative Date Range/Specified Date Range in EMR and can verify audit logs when the batch CCDAs are generated and view reports to determine the total number of CCDAs exported 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. 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 01/01/2023 to 12/31/2023 performance period.

Measure 4:- 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.	MedicsDocAssistant Users can use Care Plan template to Record, Change, Access and can	Providers/Users can capture Care Plan information in EMR and can create /receive the care plan information in

	Provider can Record required data in encounter as per the template Goals, Health Concerns, Interventions and Health Status 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.	create and receive care plan template. The goal of this test approach is to demonstrate how a provider can capture Care Plan information as per the patient chronic conditions and can create/receive care plan information as per the standards.	C-CDA format as per the standards. Metrics:- We can demonstrate the Care plan 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 01/01/2023 to 12/31/2023 performance period.

Measure 5:- 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 01/01/2023 to 12/31/2023 performance period.

Measure 6:- 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

Meinberg NTP Daemon for NTP

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	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

	to 3rd party through regular email address and through secure email address.		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 01/01/2023 to 12/31/2023 performance period.

Measure 7:- 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	Provider Opens patient encounter.	MedicsDocAssistant supports the transmission of	Providers/authorized users can send vaccination

Record to state registry. 2. Request, Access and display a patients evaluated Immunization registry and forecast it from an Immunization registry	Provider Navigates to Immunization section and documents the vaccination information and save it. Provider Navigates to Tools Menu and selects '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.	Immunization information to State registries as per the state registry requirements standards. Users can query the evaluated vaccination information of the patient from state registries and can forecast it to the user.	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 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 01/01/2023 to 12/31/2023 performance period.

Measure 8:- 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 01/01/2023 to 12/31/2023 performance period.

Measure 9:- 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	Provider open patient encounter and capture the	MedicsDocAssistant users can create cancer case CCDA file	Practices that register with Cancer registry for data

transmission in CCDA file format from EHR as per the standards.	required clinical information. 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.	and transmit it electronically to cancer registry. 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.	exchange can create and submit the cancer case CCDA 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 01/01/2023 to 12/31/2023 performance period.

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 provided for requested categories.	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 with proper authentication from 3rd party application or systems as per the specified standards.	3rd party applications/systems can access complete patient data 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 01/01/2023 to 12/31/2023 performance period.

Schedule of Key Milestones

Key Milestone	Care Setting	Date/Timeframe
Release the Real-World Testing Document	Internal Medicine	December 1, 2022
Collection of information as laid out by the plan for the period.	Internal Medicine	01/01/2023 to 12/31/2023
Planned System updates to allow for collection of data after a SVAP update.	Internal Medicine	March 1, 2023
Follow-up with providers and authorized representatives on a regular basis to understand any issues arising with the data collection.	Internal Medicine	Quarterly, 2023
End of Real-World Testing period/final collection of all data for analysis.	Internal Medicine	January 1, 2024
Analysis and report creation.	Internal Medicine	January 15, 2024
Submit Real World Testing report to ACB (per their instructions)	Internal Medicine	January 15, 2024

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.

Authorized Representative Name: Surya Kuchimanchi

Authorized Representative Email: surya@adsc.com

Authorized Representative Phone: 800-899-4237

Authorized Representative Signature:

Date: 10/20/2022