AURORAEHR REAL WORLD TESTING PLAN - CY 2023

GENERAL INFORMATION

Plan Report ID Number:

Developer Name: **Practice Alternatives, Inc.**

Product Name(s): **AuroraEHR**

Version Number(s): **2.0**

Certified Health IT: **315(b)(1),(2),(6); (c)(1)-(c)(3); (g)(7),(9); (h)(1)**

Product List (CHPL) ID(s): **15.05.04.2186.Auro.02.00.1.171221**

Developer Real World Testing Page URL: https://www.practice-alt.com/AuroraEHR_RWT_Plan_CY2023.pdf

REAL WORLD TESTING APPROACH

AuroraEHR's Real World Testing plan applies to the ambulatory care setting. The measurements and metrics detailed within this plan will be used to assess our product's compliance with respective criteria as well as its interoperability within production environments. AuroraEHR is integrated with MD Toolbox-Direct for Direct Message functionality.

Criteria and testing has been grouped together based on primary focus and user workflow:

- Care Coordination - sending/receiving CCDA documents
  - § 170.315(b)(1) Transitions of Care
  - § 170.315(b)(2) Clinical information reconciliation and incorporation
  - § 170.315(h)(1) Direct Project
- Care Coordination - clinical data export via CCD
  - § 170.315(b)(6) Data export
- Clinical Quality Measures
  - § 170.315(c)(1) CQMs — record and export
  - § 170.315(c)(2) CQMs — import and calculate
  - § 170.315(c)(3) CQMs — report
- Application Programming Interfaces
  - § 170.315(g)(7) Application access — patient selection
  - § 170.315(g)(9) Application access — all data request
  - § 170.315(g)(10) Application access — standardized API for patient and population services

Standards Version Advancement Process (SVAP) and United States Core Data for Interoperability (USCDI) Updates

For CY 2023, we are not planning to make any version updates on approved standards through the SVAP process.

Standard (and version)	USCDI v1
Updated certification criteria and associated product	Not applicable
Method used for standard update	Not applicable
Date of ONC-ACB notification	Not applicable
USCDI-updated certification criteria (and USCDI version)	USCDI Version 1: § 170.315(b)(1) Transitions of Care § 170.315(b)(2) Clinical information reconciliation and incorporation § 170.315(g)(9) Application access — all data request

Schedule of Key Milestones

Key Milestone	Date/Timeframe
Begin collecting data elements specified in Real World Testing measures	01/01/2023
Collection of data pertaining to each Real World Testing measure	Quarterly throughout 2023
Final day of data collection for analysis	12/31/2023
Begin analysis of data and creation of report detailing real world testing results	01/02/2024
Deadline to submit real world testing report(s) to ACB	02/01/2024

Care Setting(s)

AuroraEHR is marketed to and utilized by physicians, nurses and other healthcare professionals providing care in an office and/or ambulatory surgical center. For this reason, the Real World Testing plan and each of its measurements are geared toward the workflows of providers and medical staff in ambulatory settings.

PAI
Practice Alternatives, Inc.

REAL WORLD TESTING MEASUREMENTS

The measurements used for our real world testing plan can be found below. Each measurement contains details surrounding the following:

- ✓ Description of the measure
- ✓ Associated certification criteria
- ✓ Test methodology used
- ✓ Justification for selected measurement/metric
- ✓ Expected outcomes

RWT MEASURE #1 – SEND/RECEIVE/RECONCILE C-CDA

This measure will confirm that users are successfully able to create properly formatted transition of care/referral summaries, send/receive them via Direct Message, and upon receipt reconcile the medications, allergies, and problems with patient data already in the chart. The Transition of Care and Referral Note CCDs attached to these Direct Messages are USCDI v1 compliant.

Associated certification criteria:

§ 170.315(b)(1) Transitions of Care	(i)(A) Send transition of care/referral summaries
	(i)(B) Receive transition of care/referral summaries
	(ii) Validate and display
	(iii) Create transition of care/referral summary
§ 170.315(b)(2) Clinical information reconciliation and incorporation	(ii) Correct patient
	(iii) Reconciliation
	(iv) System verification
§ 170.315(h)(1) Direct Project	(i) Applicability Statement for Secure Health Transport
	(ii) Delivery Notification in Direct

Test Methodology:

System log entries will be created throughout the process of a user sending or receiving a transition of care/referral summary via Direct Message. As well, logging will be created during the reconciliation process.

While sending a Direct Message, logging records the following:

- When the user attempts to send a Direct Message.
- When the Direct Message is sent. This includes any errors with sending the Direct Message in general.
- If there are any errors with the C-CDA attachment.

While receiving a Direct Message, logging records the following:

- When a Direct Message is received.
- If there are any errors with the C-CDA attachment.

Logs will be reviewed to determine the frequency of send/receive events, as well as the number of errors found during C-CDA validation. While reviewing logs, errors will be classified into user error

(those that can be fixed by the user) and those that will require developer assistance. When reconciling and incorporating clinical information, user actions will be logged when the user has reconciled Medications, Allergies and intolerance, or Problems. These logs indicate the clinical data being reconciled, as well as for which CCD and which patient.

Measure Justification:

Measure data will indicate whether the system's functionality and workflow allow for a seamless exchange of electronic health information. Logging will show the frequency at which providers are sending Direct Messages. This log will also show what was attached and specific contents of the attachment. The CCD will be examined to confirm a transition of care or referral note was sent as well as what the validation results. This will show that the user was able to send a Direct Message with a CCD attachment.

Logging will also show that the user received a Direct Message, including the attachment itself, and any errors found during validation.

Logging of user actions will show if the user reconciled the data in the CCD with the data already in the patient's chart.

Expected Outcomes:

- CCDAs created, sent and received will meet the standards set forth in 170.315(b)(1), with less than a 1% error rate.
- Upon receipt of a transition of care/referral summary, user can match patient and reconcile medications, allergies, and problems with data already in the patient's chart.

RWT MEASURE #2 – DATA EXPORT

This measure will confirm that a specific set of system users can successfully create export summaries, formatted according to the C-CDA R2.1 standard, for as many patients as they choose. These export summaries can be created at the time of the user's choosing.

Associated certification criteria:

§ 170.315(b)(6) Data export	(i)(B) Limit the ability of users who can create export summaries
	(ii) Creation
	(iii) Timeframe configuration

Test Methodology:

When initiating an export (whether for a single patient, set of patients, or all patients), logging records the following:

- Any errors found during C-CDA validation
- Number of export summaries requested and created.

When scheduling an export (either a single run export, or a recurring export), logging records the following:

- The export took place at the specified date/time.
- Any errors found during C-CDA validation.
- Number of export summaries created.

The system limits the ability to create export summaries based on user groups. The system user groups that have access are the managers in the billing, clinical, and provider groups.

Measure Justification:

Logging shows conformance to the requirements of 170.315(b)(6):

- The export summaries that were created, and whether the CCD had any validation errors.
- When the export took place. Cross-referencing this with when the user wanted the export to take place.

Expected Outcomes:

- Only authorized users successfully create export summaries
- The user is able to specify the time at which the export takes place: either immediately, or at a date/time of their choosing.
- The user is able to create export summaries formatted according to the C-CDA R2.1 standard.

Our expectation is that the above actions will occur with less than a 1% error rate.

RWT MEASURE #3 – CALCULATION AND CREATION OF CQMS

This measure will confirm that users are able to successfully create accurately formatted and calculated QRDA category 3 files.

Associated certification criteria:

§ 170.315(c)(1) CQMs — record and export	(i) Record
	(ii) Export
§ 170.315(c)(2) CQMs — import and calculate	(ii) Calculate
§ 170.315(c)(3) CQMs — report	(i) Create data file in accordance with §170.205(h)(3) and §170.205(k)(3).

Test Methodology:

Actions are logged whenever a user performs tasks for entering data to be used when calculating CQMs. Exporting data files for one or more patients formatted according to 170.205(h)(3) is not in the scope of features utilized by the care setting in which our product is used.

Logging indicates when a user requests the CQMs be calculated as well as when the process has finished. A request will include at least one CQM. The QRDA category 3 file is generated at the same time. The logging includes the name of the QRDA category 3 file.

Measure Justification:

Logging shows when the user uses the product to enter clinical data, record notes, or otherwise perform tasks as part of their usual workflow. That recorded data is used when calculating the CQMs. Those calculations are then included in the QRDA files that are generated. Logging shows when the user requests the CQM data be calculated and a report generated.

Expected Outcomes:

Log files obtained will show the EHR's ability to:

- Record quality measure data for measure(s) identified by the provider and practice.
- Generate QRDA category 3 files and report for the applicable measure(s).

RWT MEASURE #4 – API REQUESTS

This measure will determine the frequency of read-only clinical data requests made by authorized health IT applications. Additionally, the measure will confirm that AuroraEHR provides a complete, accurate and timely response to each request.

Associated certification criteria:

§ 170.315(g)(7)	Application access — patient selection
§ 170.315(g)(8)	Application access — data category request (inactive as of 12/31/22)
§ 170.315(g)(9)	Application access — all data request
§ 170.315(g)(10)	Application access — standardized API for patient and population services

Test Methodology:

Upon submission of an API request for patient data, logging records both the attempt, and the success when the request has finished. The logs indicate who made the request, the specific API accessed, as well as the parameters that were passed in. The results of the API request are also logged.

Logs will be reviewed to determine the frequency of API requests, ensure that only authorized users are able to request data, and that the correct data for the API accessed is returned. This test methodology will above all test the conformance of the implementation.

Measure Justification:

Measure data will show that authorized applications are able to request patient data based on an ID or token, and that AuroraEHR provides a complete and timely response based on the request made.

Logs show when a request was made and if it was successful. These logs are recorded for all three API requests: patient selection, data category(ies), and all data. The combination of these logs by who made the requests and when they were made will show that only authorized applications can make requests, and that the responses are timely. Finally, the logs combined with the results of the request will show that the request results are correct.

Expected Outcomes:

Log files obtained will be analyzed to determine the frequency and proper operation of API requests. Our expectation is that there will be less than a 1% error rate associated with API requests.

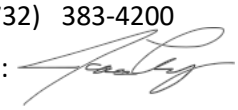
DEVELOPER ATTESTATION

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: Joe Thomasey

Authorized Representative Email: jthomasey@practice-alt.com

Authorized Representative Phone: (732) 383-4200

Authorized Representative Signature: 

Date: 10/31/2022