AuroraEHR Real World Testing Plan - CY 2024

General Information

Plan Report ID Number: **AuroraEHR_RWT_Plan_CY2024**

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

Product Name(s): **AuroraEHR**

Version Number(s): **2.1**

Certified Health IT: **315(b)(1),(2),(6); (c)(1)-(c)(3); (g)(7),(9),(10); (h)(1)**

Product List (CHPL) ID(s): **15.99.04.2186.Auro.02.01.1.221227**

Developer Real World Testing Page URL: https://www.practice-alt.com/AuroraEHR_RWT_Plan_CY2024.pdf

Real World Testing Approach

The Real World Testing plan for AuroraEHR is designed for the ambulatory care setting. The measurements and metrics outlined in this plan are intended to evaluate our product's adherence to specific criteria and its interoperability in real-world production environments. AuroraEHR is seamlessly integrated with MD Toolbox-Direct to enable 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 2024, 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 § 170.315(g)(10) Standardized API for Patient and Population Services

Schedule of Key Milestones

Key Milestone	Date/Timeframe
Begin collecting data elements specified in Real World Testing measures	01/01/2024
Collection of data pertaining to each Real World Testing measure	Quarterly throughout 2024
Final day of data collection for analysis	12/31/2024
Begin analysis of data and creation of report detailing real world testing results	01/02/2025
Deadline to submit real world testing report(s) to ACB	02/01/2025

Care Setting(s)

AuroraEHR is marketed to and used by physicians, nurses, and other healthcare professionals who deliver care in office and ambulatory surgical center settings. As a result, the Real World Testing plan and its measurements are tailored to the workflows of providers and medical staff in ambulatory settings.

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 validates that users can effectively create properly formatted transition of care/referral summaries, send and receive them via Direct Message, and, upon receipt, reconcile medications, allergies, and patient problems with existing chart data. The Transition of Care and Referral Note CCDs included in these Direct Messages adhere to the USCDI v1 compliance standards.

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:

Throughout the process of a user sending or receiving a transition of care/referral summary via Direct Message, system log entries will be generated. Additionally, logging will occur during the reconciliation process.

Logging during Direct Message Sending:

- Logging will record when the user attempts to send a Direct Message.
- Logging will record when the Direct Message is successfully sent, including any errors encountered during the sending process.
- Logging will capture any errors related to the C-CDA attachment.

Logging during Direct Message Receiving:

- Logging will document when a Direct Message is received.
- Logging will capture any errors related to the C-CDA attachment.

Logs will be reviewed to assess the frequency of send/receive events and to count the number of errors found during C-CDA validation. When reviewing the logs, errors will be categorized into two groups: user errors (those that can be resolved by the user) and errors requiring developer assistance.

For the reconciliation and incorporation of clinical information, user actions will be logged when they reconcile Medications, Allergies and intolerance, or Problems. These logs will include details about the clinical data being reconciled, the associated CCD, and the patient involved.

Measure Justification:

The measure data will assess the system's ability to facilitate a smooth exchange of electronic health information and workflow. Logging will provide insights into the frequency of providers sending Direct Messages, along with details about attachments and their specific contents. The examination of the CCD will verify the transmission of a transition of care or referral note, as well as validation results, demonstrating the user's capability to send a Direct Message with a CCD attachment.

Additionally, the logging will capture the user's receipt of a Direct Message, including the attachment and any validation errors encountered.

User action logs will reveal whether the user successfully reconciled the data in the CCD with the existing patient chart data.

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)(9)	Application access — all data request
§ 170.315(g)(10)	Application access — standardized API for patient and population services

Test Methodology:

When an API request for patient data is submitted, the logging system records both the request attempt and its successful completion. These logs contain information about the requester's identity, the specific API accessed, and the parameters provided with the request. Furthermore, the results of the API request are logged.

The logs will undergo review to determine the frequency of API requests, verify that only authorized users can request data, and confirm that the correct data corresponding to the accessed API is returned. This test methodology primarily assesses the conformance of the implementation.

Measure Justification:

The measure data will demonstrate the ability of authorized applications to request patient data using an ID or token and AuroraEHR's capacity to provide complete and timely responses according to the request.

Logs capture the timing of request submissions and their success status. These logs encompass all three API request types: patient selection, data category(ies), and all data. By analyzing these logs in combination with the identity of the requestor and the timing of their requests, it can be shown that only authorized applications have the privilege to make requests and that the responses are delivered promptly. Furthermore, examining the logs alongside the request results will confirm the accuracy of the response data.

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.

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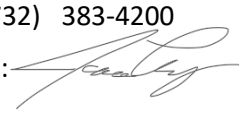
Authorized Representative Signature: 

Date: 10/31/2023