Real World Testing Plan

Pertexa IQ EHR v 5.4.0

Date of Test Plan November 18, 2021

Report Prepared By Pertexa Healthcare Technologies Inc.
900 North Heritage Drive, Building, Suite E

Table of Contents

Executive Summary

This Real World Test (RWT) plan is intended to verify the adoption of Pertexa-IQ V5.4.0 (Clinical) certified functionality. The plan outlines the process for conducting and measuring observations of interoperability and data exchange.

The RWT plan will focus on certification criteria, represented as individual user stories, in a single Ambulatory setting of care:

User Story: Care Coordination

§ 170.315(b)(1) Transition of Care
§ 170.315(b)(2) Clinical information reconciliation and incorporation
§ 170.315(b)(6) Data export
§ 170.315(h)(1) Direct Project
§ 170.315(c)(1) Clinical quality measures (CQMs) — record and export
§ 170.315(c)(2) Clinical quality measures (CQMs) — import and calculate
§ 170.315(c)(3) Clinical quality measures (CQMs) — report
§ 170.315(e)(1) View, Download, and Transmit to 3rd Party
§ 170.315(f) (5) Transmission to public health agencies — electronic case reporting
§ 170.315(g)(7) Application access— patient selection
§ 170.315(g)(8) Application access— data category request
§ 170.315(g)(9) Application access— all data request

General Information

Plan Report ID Number	V1.0
Developer Name	Pertexa
Product Name(s)	Pertexa-IQ EHR
Version Number(s)	Pertexa-IQ V5.4.0
Certified Health IT	2015 Edition
Product List (CHPL) ID(s)	15.04.04.2962.Pert.05.00.1.200213
Developer Real World Testing Page URL	https://pertexahealthtech.com/wp-content/uploads/2021/11/RWT.pdf

Pre Test Background

The following elements are addressed for each User Story (listed above). Ambulatory is the only setting of care where Pertexa-IQ V5.4.0 is used

- Testing methodology:
  - demonstrate real world interoperability and conformance to the the criterion requirements
  - include scenario and use case-focused testing
- Description:
  - of how the test is performed
  - of how conformance is demonstrated
- Schedule :
  - of key Real World Testing milestones;
- Expected Outcomes:
  - based on feature adoption in current year
- Measurement/ metric:
  - all measures used to validate criteria
- Justification for the Health IT Developer's Real World Testing approach
  - description of how the measurements/metrics selected reflect the adoption rate of each required Real World Testing element

Introduction

The EHR analyzed in this Real World Test is Pertexa-IQ V5.4.0, an EHR designed to present medical information to healthcare providers in Ambulatory healthcare settings. The workflows in Pertexa-IQ help users view and create outpatient tests and medication orders. Clinical Decision Support is provided at critical decision points within specific workflows. Users are also able to merge client records via the Clinical modules.

The purpose of this test is to validate the adoption of the current user interface and EHR capabilities and to provide evidence of usability within Pertexa-IQ. To this end, measures of real world utilization of interoperability features and functionality are captured during the test.

Table of Contents	**Associated Certification Criteria:** **§ 170.315(b)(1) Transition of Care** **§ 170.315(b)(2) Clinical information reconciliation and incorporation** **§ 170.315(h)(1) Direct Project**					
	Measure Description: **Send and receive Transition of Care (TOC) messages with other providers to close the referral loop. The patient's ePHI will be exchanged using a C-CDA 2.1 Care Referral or Referral Note and DIRECT secure messaging for data transport. Patient data from incoming TOCs will be reconciled with existing data in the EHR including, at minimum, the patient's problems, medications, and medication allergies.**	**Justification:** **We chose to concentrate on the aspects of this criteria that would:** **1) Demonstrate a streamlined provider-to-provider patient referrals and transitions of care with the ultimate goal being higher quality patient care** **2) Eliminate as much risk of data entry errors as possible by transmitting patient data securely and electronically rather than relying on manual data entry for referrals** **3) Reduce the overall time burden of manual data entry** **4) Ensure private and secure transmission of patient's PHI** **5) Result in increased interoperability between disparate HIT systems.**				
	Metric Description: **1) 90 percent of outbound TOC's successfully received by HISP** **2) Average C-CDA grade from scorecard for C-CDAs generated is a "C" or better** **3) 75 percent of trading partner's TOC C-CDAs successfully received by system under test.** **4) Average score between 1 and 3 (1=Easy to use, 5=Unable to access) for reconciliation of patient problems, medications, and medication allergies from incoming TOCs**		**Standards Implemented:** **• CCDS (Common Clinical Data Set)** **• § 170.202(a)(2) Direct Project: ONC Applicability Statement for Secure Health Transport, Version 1.2 August 2015** **• § 170.202(d) ONC Implementation Guide for Direct Edge Protocols, Version 1.1, June 25, 2014** **• § 170.205(p)(1) IHE IT Infrastructure Technical Framework Volume 2b (ITI TF- 2b)** **• § 170.205(a)(3) HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012** **• § 170.205(a)(4) HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015** **• § 170.207(a)(4) International Health Terminology Standards Development Organisation (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2015 Release** **• § 170.207(i) Encounter diagnoses: The code set specified at 45 CFR 162.1002(c)(2)** **• § 170.205(a)(4) HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015** **• § 170.207(n)(1) Birth sex must be coded in accordance with HL7 Version 3 Standard, Value Sets for AdministrativeGender and NullFlavor attributed** **• § 170.207(q)(1) International Telecommunication Union E.123: Notation for national and international telephone numbers, e-mail addresses and web addresses and International Telecommunication Union E.164: The international public telecommunication numbering plan** **• § 170.207(a)(3) International Health Terminology Standards Development Organisation (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) International Release July 31, 2012 and US Extension to SNOMED CT® March 2012** **• § 170.207(d)(3) RxNorm, September 8, 2015 Full Release Update** **• § 170.207(d)(2) RxNorm, August 6, 2012 Full Release Update** **• § 170.202(e)(1) Delivery Notification - Implementation Guide for Delivery Notification in Direct v1.0**			
	Developer Info: **Pertexa Healthcare Technologies Inc.** **900 North Heritage Drive, Building E, Suite 201** **City: Ridgecrest State: CA Zip Code: 93555, Country: USA** **Care Setting:** **Ambulatory Care Setting:** **The ambulatory care setting is the most common one for Pertexa Healthcare Technologies users. Many belong to specialties such as Primary care, Assisted Livingand Skilled Nursing Facilities . This test plan generically applies to these ambulatory care settings.**	**Product Info:** **Product Name: Pertexa-IQ** **Product Version: 5.4.0** **CHPL ID:** **15.04.04.2962.Pert.05.00.1.200213**	**Methods Use to Demonstrate Interoperability:** **1) HISP via Direct Protocol (SMTP)** **2) HTTPS via secure provider portal** **3) HIE exchange**			
Test Step:	**Testing Procedure:**	**Expected Outcomes:**	**Key Milestone Date:**	**Key Milestone:**	**Outcomes:**	**Comments:**

1	Identify Trading Partner (TP) and coordinate with TP for sending/receiving clinical documents using production data as described in this RWT plan.	• Confirm Trading Partner • Confirm ability to send and receive clinical documents • Confirm with TP that production data will be used, whether in an actual live environment or a copy of a live environment	June, 2022			
*	Next 2 steps are for Ambulatory setting only					
2a	Patient A has encounter with care provider and data is captured in EHR	• CCDS data elements captured in EHR (system under test)				
3a	Care provider initiates TOC to TP EHR in EHR	• Care provider selects recipient from directory of Direct addresses and initiates sending of Clinical Document. The user is able to create a C-CDA Release 2.1 that also includes the reason for referral, and the referring or transitioning provider's name and office contact information. • C-CDA Care Referral or Referral Note is triggered to send via Direct Protocol	June, 2022			
*	Next steps take place in trading partner's EHR.					
4	Validate that C-CDA for Patient A contains CCDS data elements.	• Recipient uses scorecard to grade C-CDA	June, 2022			
5	Trading partner refers Patient B from TP EHR to system under test by generating C-CDA Clinical Document or Referral Note.	• Care provider selects recipient from directory of Direct addresses and initiates sending of Clinical Document. • Clinical document is sent to system under test.				
6	In system under test, tester acknowledges receipt of valid Clinical Document.	• Care provider in system under test locates clinical document in provider's Tasks Queue or on patient record. • Provider confirms that the document is filed on the correct patient or refers it to an HIM queue for review if it is on the wrong patient	July, 2022			
7	In system under test, the incoming data is incorporated via reconciliation into Patient B's existing medical record.	• The care provider reviews the record, and the patient's problems, medications, and medication allergies are merged into the system under test with no duplicates.	July, 2022			
8	Calculate and compile metrics		August, 2022			

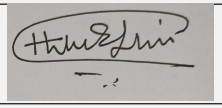
	Attestation: **This Real World Testing plan is complete with all required elements, including measures that address all certification criteria and care settings.** **All information in this plan is up to date and fully addresses the Health IT Developer's Real World Testing requirements.**
	Authorized Representative Name: **Harshil Thakkar**
	Authorized Representative Email: **harshil@fanestra.net**
	Authorized Representative Phone: **844-327-2199**
	Authorized Representative Signature: 
	Date: **18th November 2021**

Table of Contents	Associated Certification Criteria: § 170.315(c)(1) - Clinical quality measures (CQMs) — record and export § 170.315(c)(2) - Clinical quality measures (CQMs) — import and calculate § 170.315(c)(3) - Clinical quality measures (CQMs) — report					
	Measure Description: • Capture and record electronic clinical quality measure (eCQM) data in EHR (or trading partner's EHR) for calculating eCQMs.	Justification: We chose to concentrate on the aspects of this criterion that would closely follow the actual activities of Pertexa Healthcare Technologies users with respect to eCQM calculation and output: 1) Run quality measure reports and display results on Dashboard to compare with industry-standard benchmarks and with prior/expected performance. 2a) Generate eCQM output for PI/IQR (universal eCQM reporting program for hospitals). 2b) Generate eCQM output for MIPS (the most widely-used eCQM reporting program for ambulatory) . 3a) Verify that CQMsolution is a product that can support hospital quality reporting needs. 3b) Verify that CQMsolution is a product that can support MIPS participants in achieving an end-to-end reporting bonus.				
	Metric Description: 1) 100 percent matching data elements in CQMsolution vs EHR. . This will be confirmed by visual validation of the following data: • Demographics • Problems • Medications • Allergies 2) 100 percent matching calculation results in CQMsolution vs submission environment 3) 0 percent of files uploaded to submission environment result in errors		Standards Implemented: (SVAP) • HL7 CDA® R2 Implementation Guide: Quality Reporting Document Architecture - Category I (QRDA I); Release 1, DSTU Release 3 (US Realm), Volume 1 - Introductory Material, June 2015 • HL7 CDA R2 Implementation Guide: Quality Reporting Document Architecture - Category I (QRDA I); Release 1, DSTU Release 3 (US Realm), Volume 2 - Templates and Supporting Material, June 2015			
	Developer Info: Pertexa Healthcare Technologies Inc. 900 North Heritage Drive, Building E, Suite 201 City:Ridgecrest,, State:CA Zipcode:93555, Country:USA Care Setting: CQMsolution is used for eCQM submission in ambulatory environments,. Primary Care, Assisted Living and Nursing Home settings, thus this test plan accounts for care settings.	Product Info: Product Name: Pertexa-IQ Product Version: 5.4.0 CHPL ID: 15.04.04.2962.Pert.05.00.1.200213	Methods Use to Demonstrate Interoperability: • Visual inspection and matching of QRDA I data to EHR data • Matching of calculation results from CQMsolution to CMS • API Sandbox testing with CMS for file acceptance			

Test Step:	Testing Procedure:	Expected Outcomes:	Key Milestone Date:	Key Milestone:	Outcome:	Comment(s)
	* Ambulatory Setting					
1a	Identify Trading Partner (TP) and coordinate with TP for calculating and reporting electronic clinical quality measures (eCQMs) using production data as described in this RWT plan.	• Confirm Trading Partner • Confirm ability to calculate and report eCQMs • Confirm with TP that production data will be used, whether in an actual live environment or a copy of a live environment	Apr 2022			
2a	Identify six EP (Eligible Professional) eCQMs for RWT.	Based on historical data, select the most popular eCQMs.	Apr 2022			
3a	Identify a one calendar year reporting period with adequate patient data for reporting.	Admins with sufficient familiarity with the physician practice's clinical activities should be able to choose a period with an appropriate amount of quality data.				
4a	Capture and record clinical quality measure (CQM) data in Trading Partner's (TP) EHR. Since manual data entry for an adequate quantity of data would be onerous, we will use actual patient data. a. If TP is integrated with CQMsolution, CQMsolution will capture data through a SQL query, so that when a user runs a CQM report, CQMsolution pulls data directly from the TP's database. b. Alternative approach: Pull in data through QRDA I files in a .zip folder	Data ready for report generation.	April, 2022			
5a	Correctly calculate numerator, denominator, exclusion and exception values for selected eCQMs.	The CQMsolution report should complete with no errors.				

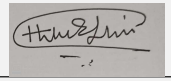
6a	Spot-check 10 patients for each measure, ensuring that some are in the denominator only, some are in the numerator and denominator and, if possible, some are exclusions or exceptions.	Use Patient List to check which categories Initial Patient Population (IPP), Denominator (Den), Exclusions (Excl), Numerator (Num) or Exceptions (Excp) each patient falls into. For each spot-check patient, use the drill-down to confirm that the patient data in CQMsolution (encounters, codes, demographics) matches the patient data in the EHR and that the patient is correctly categorized in CQMsolution.				
7a	Upload the generated MIPS QRDA III file to QPP.	The file should upload and be accepted by the environment without error.	July, 2022			
8	Check the submission environment's measure calculation results and compare them to CQMsolution's calculation results. *Both settings*	All populations of all measures should match.	July, 2022			
9	Calculate and compile metrics		August, 2022			
	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: **Harshil Thakkar**					
	Authorized Representative Email: **harshil@fanestra.net**					
	Authorized Representative Phone: **844-327-2199**					
	Authorized Representative Signature: 					
	Date: **18th November 2021**					

Table of Contents	Associated Certification Criteria: 170.315(e)(1) View, Download, and Transmit to 3rd Party					
	Measure Description: Provide patient (and their authorized representatives) user friendly, secure Portal access to their PHI in C-CDA 2.1 HL7 Standard format. Allowing patient to download a summary in both a human readable format and using the CCD document template of the Consolidated CDA Release 2.1 containing: • The USCDI Data Elements • The provider's name and office contact information • Laboratory test report(s) • Diagnostic image report(s)	Justification: We chose to concentrate on the aspects of this criterion that would empower patients with timely electronic access to comprehensive, useful ePHI.				
	Metric Description: 1) 90 percent of unique patient with encounters in the review period are provided timely access (within 24 hours of their encounter) to health information to view online, download, and transmit to a third party. 2) Average score between 1 and 2 (1=Easy to use, 5=Unable to access) for patients or Authorized Representatives who tried to access the patient portal and responded to survey questions. 3) Average score between 1 and 2 (1=Easy to download/transmit, 5=Unable to download/transmit) for patients or Authorized Representatives who accessed the patient portal and tried to download or transmit a C-CDA.		Standards Implemented: (SVAP) • USCDIv1 July 2020 Errata • Web Content Accessibility Guidelines (WCAG) 2.0, December 11, 2008 • Web Content Accessibility Guidelines (WCAG) 2.1, June 05, 2018 (Available 3/12/2021) • HL7 C-CDA R2.1 Implementation Guide, October 2019. CDAR2_IG_C-CDAA_CLINNOTES_R1_DSTU2.1_2015AUG_2019JUNwith_errata • HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1 - Introductory Material, Release 2.1, August 2015 • HL7® CDA R2 Implementation Guide: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 2-US Realm, October 2019		
	Developer Info: Pertexa Healthcare Technologies Inc. 900 North Heritage Drive, Building E, Suite 201 City:Ridgecrest,, State:CA Zipcode:93555, Country:USA Care Setting: Ambulatory, The functionality for the criteria is the same regardless of the primery care setting.	Product Info: Product Name: Pertexa-IQ Product Version: 5.4.0 CHPL ID: 15.04.04.2962.Pert.05.00.1.200213	Methods Use to Demonstrate Interoperability: 1) Direct Protocol Send Functionality 2) SMTP Email Send Functionality 3) HTTPS via secure portal Access for patient from any browser 4) Ability for Portal to be accessed via a Smartphone or Tablet			

Test Step:	Testing Procedure:	Expected Outcomes:	Key Milestone Date:	Key Milestone:	Outcomes:	Comment(s)
1	Identify Trading Partner (TP) and coordinate with TP for providing patients timely access to their ePHI using production data as described in this RWT plan.	• Confirm Trading Partner • Confirm ability to provide patients timely access to their ePHI • Confirm with TP that production data will be used, whether in an actual live environment or a copy of a live environment	May, 2022			
2	For a period of time (1 month?), monitor the system as the below steps (3-12) take place continuously.	Many patient visits will occur during the period of time, generating a sufficient amount of data for calculating the metrics at the end of testing.	May, 2022			

3	Patient arrives for a visit	Patient demographics are captured in the EHR				
4	Provider Charts on the Patients health status	USCDIv1 data elements are recorded in EHR				
5	Provider Signs note or patient checks out	Trigger is provided to create C-CDA or C-CDA is dropped to ConnectEHR				
6	EHR system generates CCD including all provided USCDIv1 data	• Validate that a C-CDA has been triggered. • Ensure patient is mapped to the right provider and practice. • Visually verify USCDIv1 data sections exist with accurate information • Validate code systems and format with ScoreCard or ETT tool for schema validation.				
7	Patient activates Portal	• Ensure patient received activation email or • provide patient with Username and Password	June, 2022			
8	Patient or authorized representative logs into Portal	• URL is provided to patient in an email or • the Patient is provided the URL while in the physician's office. • Record validation in the audit log that URL is functional				
9	Patient or authorized representative views C-CDA or choses a date range of CCDs to view	• Record validation in the audit log that patient has viewed C-CDA • Validate NTP by comparing Portal timestamp with ConnectEHR timestamp				
10	Patient or authorized representative downloads C-CDA their choice of xml or pdf	Record validation in the audit log that patient has downloaded C-CDA				
11	Patient or authorized representative transmits:	Record validation in the audit log that patient has transmitted the C-CDA via DIRECT or email	June, 2022			
a	C-CDA via Direct Protocol to a provider					
b	C-CDA via email to others					

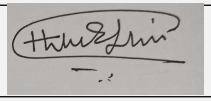
12	Request survey response on Patient Portal ease of use and accessibility.	Patient or authorized representative provides a score from 1 (easy) to 5 (unable) on the following criteria: • accessing the portal • downloading and/or transmitting ePHI				
13	Calculate and compile metrics	• Run Timely Access report in ConnectEHR and compare to patient visit report from EHR to determine percentage of patients who had access within 24 hours. • Calculate average of survey responses.	August, 2022			
	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: **Harshil Thakkar**					
	Authorized Representative Email: **harshil@fanestra.net**					
	Authorized Representative Phone: **844-327-2199**					
	Authorized Representative Signature: 					
	Date: **18th November 2021**					

Table of Contents	Associated Certification Criteria: § 170.315(f)(5) Transmission to public health agencies — electronic case reporting					
	Measure Description: **Create Electronic Case Reports (eCR) for transmission to public health agency based on a specific LOINC, ICD-10 and SNOMED codes entered in a patient's encounter. eCR functionality looks up the patient's codes in the table and, if appropriate, sends an eCR message to the health agency.**	**Justification:** **We chose to focus on aspects of this criterion that would provide the most patient care value in an actual setting. Public health registries can be very helpful to patient care, epidemiologists and government for identifying disease outbreaks, epidemics and even pandemics.**				
	Metric Description: **1) 100 percent of eCR messages successfully received and processed by public health agency based on either:** **a) Logging into agency web site and validating, or** **b) Using a report provided by agency**		**Standards Implemented: (SVAP)** **• HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1 - Introductory Material, Release 2.1, August 2015** **• HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2 - Templates and Supporting Material, Release 2.1, August 2015** **• United States Core Data for Interoperability (USCDI), Version 1, July 2020 Errata**			
	Developer Info: **Pertexa Healthcare Technologies Inc.** **900 North Heritage Drive, Building E, Suite 201** **City:Ridgecrest,, State:CA Zipcode:93555, Country:USA** **Care Setting:** **The ambulatory care setting is the most common one for Pertexa-IQ users. Many belong to specialties such as Primary Care clinics, Assisted Living and Skilled Nursing Facilities. This test plan generically applies to these ambulatory care settings.**	**Product Info:** **Product Name: Pertexa-IQ** **Product Version: 5.4.0** **CHPL ID:** **15.04.04.2962.Pert.05.00.1.200213**	**Methods Use to Demonstrate Interoperability:** **1) Table of Trigger Events based on LOINC, ICD-10 and SNOMED codes.** **2) Use of USCDI**			

Test Step:	Testing Procedure:	Expected Outcomes:	Key Milestone Date:	Key Milestone:	Outcomes:	Comment(s)
1	Identify Pertexa IQ Client who either: • Has a public health agency that can receive eCR data • Already has a functional eCR interface or would like to implement one to their public health agency and the agency willing to share metrics of eCR messages successfully received.	eCR messages are successfully received and processed by public health agency.	May, 2022			
2	Implement send-only public health interface (if interface not already in place). • Determine whether test or production interface will be used • If production, determine whether an actual patient or a test patient will be used	Functioning eCR interface to public health agency	June, 2022			
3	Create a patient encounters. • Register patients or create new patients in Client EHR and create a current patient encounter • Enter one or more SNOMED Codes or ICD-10 diagnosis codes present in the Trigger Events table that lists reportable eCR diagnoses	Patient registered and queued for interface				
4	Enter Lab results through EHR or Lab interface. Make sure LOINC codes correspond to codes present in the Trigger Events table that lists reportable LOINC codes.	Patient queued for interface				
5	Run eCR process to send to public health agency (assuming process is batch, rather than real-time).	Messages sent to public health agency				

6	Query agency to verify that public health data was received for patients from steps 3 and 4.	Public health successfully processed by agency				
7	Calculate and compile metrics		August, 2022			

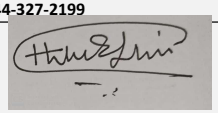
	Attestation: **This Real World Testing plan is complete with all required elements, including measures that address all certification criteria and care settings.** **All information in this plan is up to date and fully addresses the Health IT Developer's Real World Testing requirements.**
	Authorized Representative Name: **Harshil Thakkar**
	Authorized Representative Email: **harshil@fanestra.net**
	Authorized Representative Phone: **844-327-2199**
	Authorized Representative Signature: 
	Date: **18th November 2021**

Table of Contents	Associated Certification Criteria: § 170.315(g)(7) Application access— patient selection § 170.315(g)(8) Application access— data category request § 170.315(g)(9) Application access— all data request		
	Measure Description: Enable a patient's to access their electronic health data through a Personal Health Record (PHR) app on their smartphone. They have had a healthcare encounter with a provider using an EHR that is integrated with the Dynamic FHIR API and Patient Portal modules of ConnectEHR. They would like to view the results from that encounter along with the rest of their electronic health record.	Justification: CMS has a focus on empowering patients by providing them with an electronic copy of their health record. We agree that this is very important for patient satisfaction and improving population health in general.	
	Metric Description: 1) Patient is able to retrieve FHIR API data from PHR app for 100 percent of encounters. 2) In 100 percent of encounters from Step #1, PHR data matches data from EHR. This will be confirmed by visual validation of the following FHIR resources: • Demographics • Problems • Medications • Allergies		Standards Implemented: (SVAP) • HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1 - Introductory Material, Release 2.1, August 2015 • HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2 - Templates and Supporting Material, Release 2.1, August 2015 • FHIR STU3 • FHIR R4
	Developer Info: Pertexa Healthcare Technologies Inc. 900 North Heritage Drive, Building E, Suite 201 City:Ridgecrest,, State:CA Zipcode:93555, Country:USA Care Setting: Ambulatory, The functionality for the criteria is the same regardless of the care setting.	Product Info: Product Name: Pertexa-IQ Product Version: 5.4.0 CHPL ID: 15.04.04.2962.Pert.05.00.1.200213	Methods Use to Demonstrate Interoperability: 1) HTTPS via secure portal 2) FHIR

Test Step:	Testing Procedure:	Expected Outcomes:	Key Milestone Date:	Key Milestone:	Outcomes:	Comment(s)
1	Identify Trading Partner (TP) and coordinate with TP for providing patients timely access to their ePHI using production data as described in this RWT plan.	• Partner with PHR or identify existing PHR that can receive patient clinical data as described in this RWT plan. • Ensure that PHR has functionality to access the Dynamic FHIR API, as described here. • Partner with EHR that is integrated with the Dynamic FHIR API and Patient Portal modules of ConnectEHR.	May, 2022			
2	Patient A has encounter with care provider who uses EHR described above.	Encounter is created and visually confirmed	June, 2022			
3	Provider captures USCDIv1 data elements in EHR	USCDIv1 data elements are validated in the system				
4	Provider manually generates Care/Referral Summary C-CDA post-visit or ensures that the EHR generates one automatically.	C-CDA is confirmed for the specified patient				

5	Patient A uses Dynamic Patient Portal login to view clinical information	• Patient Portal automatically sends email reminder that Patient A has a new clinical document available. • Email reminder has a URL/hyperlink to the patient portal. • If patient hasn't already activated their portal account, portal account can be activated via Welcome Email or by an Administrator user				
6	Patient A uses portal login credentials to log into PHR app	Specific patient ID and token are returned for authentication and data requests				
7	PHR app displays full set of data for all data categories	• Dynamic FHIR API has transformed C-CDA into FHIR resources. • PHR app consumes FHIR resources to populate EHR data	July, 2022			
8	PHR app returns full set of data for a given category	PHR app will display and all data to be displayed for each data category				
9	PHR app returns data in a computable format using specified standards.	Data is confirmed to be in XML or JSON format				
10	PHR app returns full and accurate data for a specific date and specific date range	• Step 10 is optional, if PHR app has the capability to filter by date range • Filtering data by a specific date returns data accurately and as expected • Filtering data by a specific date range returns data accurately and as expected				
11	Via visual inspection of PHR app, the data is verified to include Assessment, Plan of Treatment and Health concerns are specified as narrative text	Visually validate Assessment, Plan of Treatment and Health Concerns narrative text	July, 2022			
12	Calculate and compile metrics		August, 2022			

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.

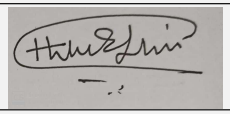
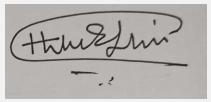
Authorized Representative Name: **Harshil Thakkar**
Authorized Representative Email: **harshil@fanestra.net**
Authorized Representative Phone: **844-327-2199**
Authorized Representative Signature: 
Date: **18th November 2021**

Table of Contents	Associated Certification Criteria: § 170.315(b)(6) - Data export					
	Measure Description: **Export all available data elements from the Common Clinical Dataset (CCDS) for a population of patients for use in a different health information technology product or a third party system. This export can be used for many purposes, including data portability when a physician practice switches to a new EHR platform.**	Justification: **We chose to concentrate on the aspects of this criterion that would: 1) We are using third party which name is "ConnectEHR" for this criteria. 2) demonstrate ConnectEHR's ability to export batches of patient data in a straightforward fashion 3) facilitate interoperability by providing the exported data in the form of valid CCD files that conform to the HL7 standards as described in the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm).**				
	Metric Description: **1) 100 Percent of Exports ran at the correct time. 2) C-CDA count matches actual patient count for requested date range. 3) Spot-checked C-CDAs pass scorecard with average overall grade of "C" or better.**		Standards Implemented: (SVAP) **• HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1 - Introductory Material, Release 2.1, August 2015 •HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2 - Templates and Supporting Material, Release 2.1, August 2015**			
	Developer Info: **Pertexa Healthcare Technologies Inc. 900 North Heritage Drive, Building E, Suite 201 City:Ridgecrest,, State:CA Zipcode:93555, Country:USA** Care Setting: **Ambulatory The functionality for the criteria is the same regardless of the care setting.**	Product Info: **Product Name: Pertexa-IQ Product Version: 5.4.0** CHPL ID: **15.04.04.2962.Pert.05.00.1.200213**	Methods Use to Demonstrate Interoperability: **1) Visual validation/counting 2) Test output file with C-CDA scorecard to ensure correct format/contents.**			
Test Step:	Testing Procedure:	Expected Outcomes:	Key Milestone Date:	Key Milestone:	Outcomes:	Comment(s):
1	Using production data in an actual live environment or copy of live environment, demonstrate the ability to configure data export configurations for Timeframe and Location	• Date and time ranges can be configurable via the UI • Targeted Practices can be configurable via the UI • Patients exported can be configurable via the UI	Start test plan execution: May, 2022			
2	Demonstrate the ability to limit the set of users who can create export summaries	Logging in as a VendorAdmin will allow access to the export functionality				
3	Confirm users roles that have been denied export summary access cannot create export summaries	Logging in as a non-VendorAdmin will not allow access to the export functionality				
4	Create and validate an export for a single patient	Use the Edge Test Tool to check validity of output file	June, 2022			
5	Create an export summary for data within a entered date and time range	• Data was available for the entered date and time range • The export summary contained data only within that date and time range				
6	Create an export summary in real time	Export summary was created and completed successfully	July, 2022			
7	Create an export summary based on a relative date and time.	The scheduled export summary would be display and be visually validated				
8	Create an export summary for a specific date/time.	• The scheduled export summary was created successfully • The specific date/time would be in the near future so the export could be confirmed				
9	Save the export summary to a preferred location at the time of export.	• Saving to a preferred location is allowed • Visually confirming the export after save is performed and successful				
10	Calculate and compile metrics		Complete test execution: August, 2022			
	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: **Harshil Thakkar**					
	Authorized Representative Email: **harshil@fanestra.net**					
	Authorized Representative Phone: **844-327-2199**					
	Authorized Representative Signature: 					
	Date: **18th November 2021**					