Real World Test Plan

GENERAL INFORMATION

Plan Report ID Number: rwt_plan_2023

Developer Name: Metasolutions Inc

Product Name(s): ZoomMD

Version Number(s): 4.1

Certified Health IT: 15.04.04.1979.Zoom.41.01.1.221230

Product List (CHPL) ID(s): 15.04.04.1979.Zoom.41.01.1.221230

Developer Real World Testing Page URL: https://www.zoommd.com/company-certifications-awards/

JUSTIFICATION FOR REAL WORLD TESTING APPROACH

Currently the Certified Health IT module, ZoomMD is sold by Metasolutions Inc as an Ambulatory Care Electronic Health Record (EHR) Software application. It is used in Ambulatory Provider Offices of all sizes, and multiple specialties, throughout the US. The applicable 2015 Edition Cures Update criteria that we will include in our Real World Test (RWT) plan are:

Table 1

§170.315 (b)(1)	§170.315 (c)(2)
§170.315 (b)(2)	§170.315 (c)(3)
§170.315 (b)(3)	§170.315 (e)(1)
§170.315 (b)(10)	§170.315 (f)(1)
§170.315 (c)(1)	§170.315 (f)(2)
§170.315 (f)(5)	§170.315 (g)(9)
§170.315 (f)(7)	
§170.315 (g)(7)	

These criteria were tested individually during the ONC certification process. However, in the real world these certified modules provide one seamless approach to accomplish the clinical and administrative documentation requirements and incorporate the features and functions of all of the criteria mentioned in Table 1. To that end, the Real World Test plan will be designed to demonstrate how these combined certified criteria perform in the production environment. Since this certified product is deployed in multiple settings and specialties within the marketplace, we will design our Real World Test plan to reinforce the capabilities that we encounter in these production environments. The ZoomMD application does allow providers to fully satisfy their reporting requirements for the MIPS program.

STANDARDS UPDATES (INCLUDING STANDARDS VERSION ADVANCEMENT PROCESS (SVAP) AND UNITED STATES CORE DATA FOR INTEROPERABILITY (USCDI v1 Data Set)

Standard (and version)	USCDI v1 Data Set
Updated certification criteria and associated product	N/A
Health IT Module CHPL ID	N/A
Method used for standard update	N/A
Date of ONC-ACB notification	N/A
Date of customer notification (SVAP only)	N/A
Conformance measure	N/A
USCDI-updated certification criteria (and USCDI V version)	N/A

MEASURES USED IN OVERALL APPROACH

DESCRIPTION OF MEASUREMENT/METRIC

The Measure/Metrics and the Descriptions listed below will apply to the simultaneous and seamless use of the functionality of the applicable certified measures mentioned in Table 1. The RWT will be witnessed via Web sessions with the participants (current customers) using a mirrored production environment and real patient data. Upon completion we will observe and report the successful conformance of our customers using the certified technology as it was designed, to be able to complete the applicable 2015 Edition Cures Update certified criteria listed in Table 1 above.

The Measure/Metrics and Descriptions for Measures 1 - 9 listed below will apply to multiple criteria simultaneously to demonstrate the functionality of these certified measures: § 170.315(b)(1) Transitions of care

(Receive), § 170.315(b)(2) Clinical Information Reconciliation and Incorporation, § 170.315(b)(3) Electronic Prescribing, § 170.315(c)(1) Record and Export, § 170.315(c)(2) Import and Calculate, § 170.315(c)(3) Report, § 170.315(b)(1) Transitions of care (Send), § 170.315 (e)(1) View, Download and Transmit to 3rd party, §170.315(g)(7,9) API. The Measure/Metrics and Descriptions for Measures 10 - 12 will apply to § 170.315(b)(10) Electronic Health Information export. The Measure/Metrics and Descriptions for Measures 13 and 14 will apply to § 170.315(f)(1) Transmission to Immunization Registries and Measure 15 will apply to the § 170.315(f)(2) Transmission to Public Health Agencies – Syndromic Surveillance, and Measure 16 will apply to the § 170.315(f)(5) Transmission to Public Health Agencies – Electronic Case Reporting, and Measure 17 will apply to § 170.315(f)(7) Transmission to Public Health Agencies – Health Care Surveys.

Measurement/Metric	Description
Measure 1: Clinician logs into ZoomMD and receives a C-CDA from a referring provider via Direct Protocol with no Tech Support and no errors. C-CDA has demographic information adjusted so PHI is not visible. Successful receipt of C-CDA is achieved and observed.	Clinician begins a new patient encounter in the ZoomMD certified software with a patient referred by another clinician. With a Direct Address and unique Surescripts credentials the clinician is able to have a seamless login and secure receipt of C-CDA from the referring clinician using the Direct Protocol. The USCDI v1 Data Set standard will be demonstrated in these transactions through screenshots collected. Log files are also captured. These will all show the successful receipt of the CCDA with all fields completed and arranged per provider preference. This will meet § 170.315(b)(1) (Receive).
Measure 2: The C-CDA is validated, and Clinical Information Reconciliation is performed. No errors are expected.	After successful receipt of the C-CDA, the clinician validates the CCDA within ZoomMD. Clinical information reconciliation for medication, medication allergy, and current problem list is performed using ZoomMD software. USCDI v1 Data Set standard will be demonstrated in these transactions through screenshots collected. Log files demonstrate the reconciliation. This will meet § 170.315(b)(2).
Measure 3: The ability to review and approve a prescription refill requests and to create and transmit a new e-Prescriptions. No errors are expected.	The clinician easily completes the review and renewal of a refill request and to create and transmit a new prescription electronically within appropriate location in the ZoomMD software to meet § 170.315(b)(3) by completing the appropriate fields in ZoomMD software.

Measure 4: Documentation of Medications (CQM68) is done without assistance. No errors are expected.	The clinician easily completes Documentation of Medications (CQM68) within appropriate location in the ZoomMD software to meet § 170.315(c)(1) by completing the appropriate fields as they document the patient's medications on the date of the encounter in ZoomMD software. It will be later reflected in the numerator and denominator of this MIPS CQM Dashboard with the generation of a QRDA file format.
Measure 5: The ability to for ZoomMD to use the imported	The clinician completes the necessary steps to work with the generated QRDA file format to confirm not duplicate data exists

and de-duplicated CQM data to calculate the aggregate reports for eCQM68 will be demonstrated.	and the proper patients will be attributed to the eCQM under review. Numerators, denominators, exceptions and excludes will be available. Measure 5 will satisfy the §170.315 (c)(2) criteria.
Measure 6: The results of the documentation of the eCQM68 is presented on a CQM Dashboard.	The clinician can review the CQM Dashboard, without the need of EHR developer assistance, with the ability to select the: • CQM • Reporting Period □ Provider(s) The Dashboard will have everything organized for easy review of progress throughout the year. The patients that contribute to each section can be identified. data The QRDA file format can be exported to a Registry or to the QPP portal for MIPS submission. Measure 6 will satisfy the §170.315 (c)(3) criteria.
Measure 7: Updated C-CDA is sent back to referring partner. Successful sending of CCDA is achieved and observed.	Clinician sends updated C-CDA with minimal delay back to referring clinician via Direct Protocol. Updated C-CDA is also sent to the patient portal. Confirmation of sent C-CDA is captured along with log files. This will meet § 170.315(b)(1) (Send).
Measure 8: Access via patient portal - Observation of the View, Download & Transmit functions is performed. This will demonstrate the portal as a key tool for the clinician to share the patient's most current health information with the patient.	Real-time patient data will be adjusted to protect PHI before Measure 5 is completed. A patient will have access to patient portal to view encounter summaries of their choice as human readable C-CDAs and download the C-CDA without assistance. Transmission of patient data will be sent to a provider (Edge Protocol) and a standard email address. This will meet § 170.315 (e)(1).

Measure 9: Additionally, the patient will have the ability to access (by authentication) full encounter summaries by way of an API call from a 3rd-party application running on a patient-owned device to the API of the EHR.	This same patient will be enabled to present their authenticated credentials to use a 3rd-party application running on a patient owned device to access full encounter summary. They will have the ability to view and or transmit their information as they see fit. This will meet § 170.315 (g)(7,9).
Measure 10: A selected practice staff member is observed successfully exporting bulk patient data files on demand.	Authorized office practice staff member will perform an export of data from the production server in real-time (on demand) with a specific start & end date immediately. This will be done without delay and sent to a specific file location decided by the staff member. This will be accomplished efficiently and with no error and the file will be inspected when received to ensure it is the file requested. Real world data will be used but demographic information will be changed to protect patient health information.

	This measure allows the capture of report data selected by and on demand without assistance from development staff. The ability to independently create reports is vital to office practices and integral to a certified EHR. Metasolutions Inc staff will verify the reports have been created successfully with requested data and sent to specific location through screenshots.
Measure 11: a selected practice staff member is successfully exporting a file at a single delayed time - with a specific start and end date in the future.	An authorized office staff member will perform a EHI export data in the future - 5 minutes from current time - from the production server with a scheduled specific start & end date -such as November 1 - November 2, 2023.This will be accomplished efficiently and with no error and the file will be inspected when received to ensure it is the file requested. This measure allows the staff member to select a time in the future without assistance from development staff. The ability to independently create reports is vital to office practices and integral to a certified EHR. Metasolutions Inc staff will verify the reports have been created successfully and sent to a specific file location with requested data through screenshots.

Measure 12: A selected practice staff member sets an export for a delayed future time during hours after the practice is closed and is able to run successfully. This scheduled event will repeat as scheduled.	An authorized staff member sets up a specific EHI export to run after the practice is closed. This measure allows the capture of report data selected by and on demand without assistance from development staff. The ability to independently create reports is vital to office practices and integral to a certified EHR. Metasolutions Inc staff will verify the reports have been created successfully with requested data and sent to specific location with screenshots that capture the activity. At the finish of Measure 12 § 170.315(b)(10) Electronic Health Information export will be satisfied.
Measure 13: The practice staff will demonstrate the ability to create immunization messages that can be transmitted to the Immunization Registry and properly respond to the Immunization Registries return messages.	An office staff member will be able to enter in the typical immunization administration data into the patient's record and generates HL7 v2.5.1 Z22 VXU immunization information messages to an on boarded Immunization Registry, with the proper response of acceptance.
Measure 14: The practice staff will query Immunization Registry to demonstrate the ability to support receipt of immunization messages from an on boarded Immunization Registry and properly receives the patient's Immunization history and forecasted dates.	An office staff member can receive the patient's immunization history and forecast response in accordance with the standard at §170.205(e)(4) HL7 v2.5.1 Immunization Guide. The staff visualizes the display of the history and forecast information. Measures 13 and 14 will satisfy the §170.315 (f)(1) criteria.
Measure 15: The practice staff demonstrates the ability to create and report Syndromic Surveillance messages that can be transmitted to a public health system (compliant to the Urgent Care setting).	An office staff member will aggregate the required information and generates the syndromic surveillance messages for a patient for the Urgent Care setting type. They will generate the messages to an on boarded public health entity. Measure 15 will satisfy the §170.315 (f)(2) criteria.

Measure 16: The practice staff can create and maintain a table of trigger codes to determine which encounters should initiate and initial case report being sent to a public health agency.	The certified EHR technology will demonstrate how it can work with and maintain a table of trigger codes that will determine the encounters that will initiate, and initial case report being sent to a public health agency. We will demonstrate that when a trigger is matched it creates an initial case report that includes the following data: • USCDI v1 Data Set – 2015 Edition Cures Update • Encounter diagnoses (using SNOMED CT®) • Provider name • Office contact information Reason for visit Measure 16 will satisfy the §170.315 (f)(5) criteria.
Measure 17: The practice staff will be able to produce Healthcare Surveys compliant to the NHCS IG Release 1.2. ZoomMD will produce Ambulatory surveys.	The office staff will be able to create the appropriate Healthcare Survey for the Ambulatory/Outpatient care setting. Additionally, ZoomMD is enabled to create visit records to allow for the correct number of outpatient visits to be submitted within the last 12 months. Measure 17 will satisfy the §170.315 (f)(7) criteria.

ASSOCIATED CERTIFICATION CRITERIA

Measurement/Metric	Associated Certification Criteria	Relied Upon Software
Measures 1 - 9 will be completed in one session.		
Measure 1	§ 170.315(b)(1) Transitions of care - Receive	Surescripts Clinical Direct Messaging
Measure 2	§ 170.315(b)(2) Clinical Information Reconciliation and Incorporation	Surescripts Clinical Direct Messaging
Measure 3	§ 170.315(b)(3) e-Prescribing	NewCropRx
Measure 4	§ 170.315(c)(1) Record and Export	
Measure 5	§ 170.315(c)(2) Import and Calculate	
Measure 6	§ 170.315(c)(3) Report	
Measures 7	§ 170.315(b)(1) Transitions of care - Send	Surescripts Clinical Direct Messaging
Measure 8	§ 170.315 (e)(1) View, Download and Transmit to 3rd party	Surescripts Clinical Direct Messaging
Measure 9	§ 170.315 (g)(7, 9) API	
Measure 10 - 12	§ 170.315(b)(10) Electronic Health Information export	

Measure 13	§ 170.315(f)(1) Transmission to Immunization Registries - Send	
Measure 14	§ 170.315(f)(1) Transmission to Immunization Registries – History and Forecast	
Measure 15	§ 170.315(f)(2) Transmission to Public Health Agencies – Syndromic Surveillance	
Measure 16	§ 170.315(f)(5) Transmission to Public Health Agencies – Electronic Case Reporting	
Measure 17	§ 170.315(f)(7) Transmission to Public Health Agencies – Health Care Surveys	

JUSTIFICATION FOR SELECTED MEASUREMENT/METRIC

Measurement/Metric	Justification
Measure 1: Clinician logs into ZoomMD and receives a C-CDA from a referring provider via Direct Protocol with no Tech Support and no errors. C-CDA has demographic information adjusted so PHI is not visible. Successful receipt of C-CDA is achieved and observed.	The ability to electronically receive a C-CDA, without developer assistance, from another provider and or point of service by using the Edge Protocol is integral to the exchange of data and interoperability and inherent in a certified EHR. The C-CDA will use the USCDI v1 Data Set standard.
Measure 2: The C-CDA is validated, and Clinical Information Reconciliation is performed. No errors are expected.	A clinician must be able to perform clinical information reconciliation and incorporation for medication, medication allergy and the problems effectively, without developer assistance. As a result, a revised C-CDA using the USCDI v1 Data Set standard will be created which can then be shared with additional clinicians and be sent to the patient portal for patient access. The ability to do this as part of the test plan will show how clinicians can complete this task efficiently and without error. The most current information will be available to both clinicians and the patient as required by a certified EHR.

Measure 3: The ability to review and approve a prescription refill requests and to create and transmit a new e-Prescriptions. No errors are expected.	An important part of certified EHR technology is the ability to review, create and electronically send patient prescriptions. Included in this functionality are the ability to refill prescriptions, review drug formularies, receive drug-drug and drug-allergy alerts as well and to easily send the prescriptions to the pharmacy of the patient's choice.

Measure 4: Documentation of Medications (CQM68) is done without assistance. No errors are expected.	A clinician must be able to perform medication reconciliation and enter proper documentation into the record without developer assistance. The clinician's actions will be captures and logged to indicate that the requirement for a given eCQM (CMS68) has been satisfied. Additionally, the ZoomMD EHR will be able to generate a QRDA format of the eCQM for export purposes. The ability to do this as part of the test plan will show how clinicians can complete this task efficiently and without error.
Measure 5: The ability to for ZoomMD to use the imported and de-duplicated CQM data to calculate the aggregate reports for eCQM68 will be demonstrated.	The certified EHR technology must be able to: • Electronically import a data file formatted compliant to the QRDA Category I standard specified at §170.205(h)(2); • De-duplicate imported test data • Calculate aggregate reports based on the imported and deduplicated test data; and generate an aggregate report for each of the CQMs to be certified.
Measure 6: The results of the documentation of the eCQM68 is presented on a CQM Dashboard.	The certified EHR technology must be able to: • Generate a CQM Dashboard, on demand, without EHR developer assistance • View the patients that make up the numerators, denominators, exceptions, and exclusions • Review by reporting period and providers • Allow for submission of the QRDA formatted file to a Registry and or the CMS QPP portal for submission.
Measure 7: Updated C-CDA is sent back to referring provider. Successful sending of the C-CDA is achieved and observed.	To complete the ability to bi-directionally participate in the interoperability of patient information the certified EHR technology must be able to allow providers to send a C-CDA using the Edge Protocol, and the USCDI v1 Data Set standard.

Measure 8: Access via patient portal - Observation of the View, Download & Transmit functions is performed. This will demonstrate the portal as a key tool for the clinician to share the patient's most current health information with the patient. The amount of time should be no more than 3 minutes total for 3 tasks and there should be no errors.	The patient portal is vital to all patients. Patients will be able to login at any time and view their most current information as well as share it with any other clinicians they might choose to visit. This allows the exchange of information by the patients themselves which is key to giving control of their health information. This is an essential part of certified EHR technology.

Measure 9: Additionally, the patient will have the ability to access (by authentication) full encounter summaries by way of an API call from a 3rd-party application running on a patient-owned device to the API of the EHR.	The certified EHR technology must provide the patient with an additional ability to obtain their medical information via a request from an application of their own, outside of the domain of an EHR. This functionality will supplement the capabilities that are achieved with a patient portal.
Measure 10: Practice staff member is observed successfully exporting data files on demand.	Exporting data on demand is an essential requirement for a clinical practice with a certified EHR. A selective member of the office staff needs the capability of doing this immediately and successfully without developer assistance.
Measure 11: Practice staff member is successfully exporting a file at a delayed time - with a specific start and end date.	Exporting data at a relative time is a requirement for a clinical practice with a certified EHR. A selective member of the office staff needs the capability of doing this successfully without developer assistance.
Measure 12: Practice staff member sets an export for a delayed time during hours after the practice is closed and is able to run successfully.	Exporting a specific report with large amount of data after hours is an essential requirement for a clinical practice with a certified EHR. A selective member of the office staff needs the capability of doing this successfully without developer assistance. The certified EHR requires this capability to avoid placing undue load on the technology during regular business hours and allows the staff member to place the files in a location of their choice.

Measure 13: The practice staff will demonstrate the ability to create immunization messages that can be transmitted to the Immunization Registry and properly respond to the Immunization Registries return messages.	The creation of immunization information for electronic transmission to an appropriate Registry is an important part of the information sharing of the patient's immunization status. The EHR must use HL7 immunization messages that can be transmitted to an Immunization Registry. The full range of immunizations that can be administered are supported.
Measure 14: The practice staff will query Immunization Registry to demonstrate the ability to support receipt of immunization messages from an on boarded Immunization Registry and properly receives the patient's Immunization history and forecasted dates.	The certified EHR technology needs to complete the immunization process by providing a message response and to display a patient's evaluated immunization history and immunization forecast from an immunization registry.
Measure 15: The practice staff demonstrates the ability to create and report Syndromic Surveillance messages that can be transmitted to a public health system (compliant to the Urgent Care setting).	The certified EHR technology must demonstrate the ability to create syndromic surveillance messages that can be transmitted to a public health system. The minimum method will correspond to the within the Urgent Care point of service. This group of tests are for the creation of syndromic surveillance information for electronic transmission.
Measure 16: The practice staff can create and maintain a table of trigger codes to determine which encounters should initiate and initial case report being sent to a public health agency.	The certified EHR technology will demonstrate that it can consume and maintain a table of trigger codes to determine which encounters should initiate and initial case report being sent to a public health agency. Demonstrate that when a trigger is matched, create an initial case report that includes the following data: • USCDI v1 Data Set – 2015 Edition Cures Update • Encounter diagnoses (SNOMED CT®) • Provider name • Office contact information • Reason for visit • Identifier representing the row and version of the trigger table that triggered the case report

Measure 17: The practice staff will be able to produce Ambulatory Healthcare Surveys compliant to the NHCS IG Release 1.2.	The certified EHR technology will support the creation of Healthcare Survey CDA documents. The certified EHR must be able to create CDA healthcare survey documents for the care setting that it is used (Outpatient). In addition, there are additional visit records to be loaded to allow for the correct number of outpatient visits within the last 12 months.

CARE SETTING(S)

Care Setting	Justification
Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	The ZoomMD is currently used by providers in multiple points of service and multiple specialties. This test plan will demonstrate that the overall functionality is the same regardless of the facility or specialty. We will get feedback from Internal Medicine, Cardiology, Behavioral Health, and Dermatology. Additionally, we will document that the EHR performs the same in different facilities. The overall process will be the same in all specialties. However, we will confirm that the EHR accommodates the specific workflow of each specialty.
	We will be conducted the Real World Testing with clinicians from the listed care settings with between 1-5 clinicians, these are the Metasolutions Inc's target audience. Real patient data will be deidentified and the testing will be using a mirrored production environment. The ability to complete all measures successfully with these practices will be documented through observation of the completed tasks. Deviations from the designed process, if any, will be noted and addressed.

EXPECTED OUTCOMES

Measurement / Metric	Expected Outcomes
§ 170.315(b)(1) Transitions of care (Receive)	The Real World Testing will demonstrate that the clinician can receive C-CDA R2.1 C-CDA Document payload type in the designated setting. Using the Edge Protocol SMTP protocol, both Referral Notes and Discharge Summaries will be evaluated. The received document will be evaluated for the ability to: • Receive and validate and display any recorded errors if not a valid C-CDA documents. • Parse and present a pre-configured human readable display of all USCDI v1 Data Set from the relevant C-CDA. ZoomMD is compliant with standards for these criteria and vocabulary code sets in all of these measures. A 0% error rate is expected.
§ 170.315(b)(2) Clinical Information Reconciliation and Incorporation	The Real World Testing will demonstrate that the receiving clinician will be able to validate the C-CDA, compliant to the USCDI v1 Data Set, perform reconciliation successfully for medication, medication allergy and problems at any time without delay and create an updated C-CDA, compliant to the USCDI v1 Data Set, as required to demonstrate EHR exchange of information and interoperability. A 0% error rate is expected.
170.315(b)(3) Electronic Prescribing	The Real World Testing will demonstrate that the clinician can perform the following prescription-related transactions in accordance with established required standard as follows: • Create new prescription with full sig • Change prescriptions
	• Transmit to pharmacy of choice and receive notification of success. A 0% error rate is expected.
§ 170.315(b)(1) Transitions of care (Send)	The Real World Testing will demonstrate that the clinician can send R2.1 C-CDA Referral Notes and Discharge Summaries compliant to the USCDI v1 Data Set using the SMTP Edge Protocol. We will successfully validate the receipt of the sent documents. A 0% error rate is expected.

§ 170.315 (e)(1) View, Download and Transmit to 3rd party	The Real World Testing will demonstrate that the clinician can enable patients (and their authorized representatives) to view, at a minimum, the USCDI v1 Data Set; laboratory test report(s); and diagnostic image reports. Enable patient (and their authorized representative) to view for health information filtered by a specific date and date range. Enable patient (and their authorized representatives) to download an ambulatory or inpatient summary (as applicable to setting) in the following formats: • Human readable format • Format C-CDA document summary will include, at a minimum, the USCDI v1 Data Set; laboratory test report(s); diagnostic image reports. For all settings, patients (and their authorized representatives) will be able to transmit the C-CDA summary through both: o Email transmission to any email address o The Edge protocol of electronic transmission • When transmitted, the ambulatory or inpatient summary will be compliant to the USCDI v1 Data Set; laboratory test report(s); diagnostic image reports; and: • Enable patient (and their authorized representative) to download for health information filtered by a specific date and date range. For all view, download, and transmit capabilities, the following information will be recorded and made accessible to the patient (and authorized representative): o The action that occurred o The date and time each action occurred o The user who took the action; and the addressee to whom the summary was transmitted A 0% error rate is expected.
	The Real World Testing will demonstrate that the clinician has the functionality within ZoomMD to receive a request with sufficient information to uniquely identify a patient and return an ID or other token that can be used by an application to subsequently execute requests for that patient's data.

§ 170.315(g)(7,9) API	The EHR will demonstrate the functionality to respond to requests for patient data for partial or all of the data categories specified in the USCDI v1 Data Set at one time and return such data (according to the specified standards, where applicable) in a summary record formatted according to the standard adopted C-CDS standard. The requests will respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range. A 0% error rate is expected.
§ 170.315(b)(10) Electronic Health Information export	The Real World Testing will demonstrate that a limited clinician group are enabled to set the configuration options when creating an export summary as well as a set of export summaries for patients whose information is stored in ZoomMD. A clinician within the limited group is able to execute these capabilities at any time the user chooses and without subsequent developer assistance to operate. The limited set of clinicians are enabled to create export summaries formatted in accordance with the standard specified using the C-CDA that is compliant to the USCDI v1 Data Set. The limited set of clinicians are enabled to set the date and time period (Start and End Dates) within which data would be used to create the export summaries. They can: o Create export summaries in real-time o Create export summaries based on a relative date and time (e.g., the first of every month at 1:00am) o Create export summaries based on a specific date and time (e.g., on 10/24/2024 at 1:00am) The limited set of clinicians are enabled to set the storage location to which the export summary or export summaries are intended to be saved. A 0% error rate is expected.

§ 170.315(f)(1) Transmission to Immunization Registries - Send	The Real World Testing will demonstrate that the clinician can Health IT module must: • Record immunization content and generate the HL7 v2.5.1 Z22 VXU immunization information messages • Consume the associated acknowledgement (ACK) messages according to the §170.205(e)(4) HL7 v2.5.1 Immunization Guide • Generate evaluated immunization history and forecast query messages • Receive and display HL7 evaluated immunization history and forecast response • Support §170.207(e)(3) CVX codes for historical vaccines • Support §170.207(e)(4) National Drug Code Directory – vaccine codes for administered vaccines • Compliance to the CDC-defined NIP003-Immunization Information Source value set specified in §170.205(e)(4) HL7 v2.5.1 Immunization Guide Additional value set from the §170.205(e)(4) HL7 v2.5.1 Immunization Guide to be selected and inspected by Proctor to verify compliance. A 0% error rate is expected.
§ 170.315(f)(1) Transmission to Immunization Registries – History and Forecast	The Real World Testing will demonstrate that the clinician can record immunization content and generate the HL7 v2.5.1 Z22 VXU immunization information messages. Additionally, they will receive and display HL7 evaluated immunization history and forecast responses. A 0% error rate is expected.
§ 170.315(f)(2) Transmission to Public Health Agencies – Syndromic Surveillance	The Real World Testing will demonstrate that the clinician can record syndromic surveillance content and generate the HL7 v2.5.1 ADT according to the §170.205(d)(4) HL7 v2.5.1 PHIN Messaging Guide. A 0% error rate is expected.
§ 170.315(f)(5) Transmission to Public Health Agencies – Electronic Case Reporting	The certified EHR technology must demonstrate that it can consume and maintain a table of trigger codes to determine which encounters should initiate and initial case report being sent to a public health agency. Demonstrate that when a trigger is matched, create an initial case report that includes the following data: • USCDI v1 Data Set – 2015 Edition Cures Update • Encounter diagnoses (using SNOMED CT®) • Provider name • Office contact information Reason for visit Identifier representing the row and version of the trigger table that triggered the case report. A 0% error rate is expected.

§ 170.315(f)(7) Transmission to Public Health Agencies – Healthcare Surveys	The certified EHR technology must support the creation of Healthcare Survey CDA documents. The certified EHR must be able to create CDA healthcare survey documents for the care setting that it is used (Outpatient). In addition, there are additional visit records to be loaded to allow for the correct number of outpatient visits within the last 12 months. A 0% error rate is expected.

SCHEDULE OF KEY MILESTONES

Key Milestone	Care Setting	Date/Timeframe
Prepare the ZoomMD application for use in collecting data to support the RWT plan.	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	January 2024
Identify the users and practices that will participate in the test plan	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	April 2023
Confirm that the Real World Test Plan participants are able to log into their accounts and are ready to start the RWT plan documentation	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	April 2023
Conduct the series of Real World Testing with the participants to obtain feedback on their progress and or if there are any issues to address.	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	Yearly 2023

End the Real World Test to coincide with the end of the Year.	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	December 2024
Real World Test analysis and generation of the report	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	January 2025
Submit Real World Test Report to ACB before established deadline	Facilities: • Ambulatory Specialties: • Internal Medicine • Pediatrician	February 2025

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: P. S. L. Narasimha Rao

Authorized Representative Email: spaluri@metasolutionsinc.com

Authorized Representative Phone: 562-309-4312

Authorized Representative Signature:

Date: 11-20-2023

P.S.L. Narasimha Rao