Real World Test Plan for 2022

Contents

General Information

Plan Report ID Number : [For ONC-Authorized Certification Body use only]
Developer Name : WRS Health
Product Name(s) : WRS Health Web EHR and Practice Management System
Version Number(s) : 7.0
Certified Health IT Product List (CHPL) ID(s) : CHPL Product Number: 15.02.05.2527.WRSH.01.01.1.211214
ONC-ACB Certification ID:15.02.05.2527.WRSH.01.01.1.211214

Developer Real World Testing Page URL : https://www.wrshealth.com/certified-ehr-what-to-look-for

Justification for Real World Testing approach

WRS Health is a certified EHR and Practice Management software solutions provider for medical practice settings. This test plan aims to demonstrate continued compliance of WRS solutions and services to the criteria standards outlined in ONC Health Certification program. The test plan includes the utilization of methodology to gather and produce relevant information for verifying interoperability capability and functionalities conforming to health IT's certification.

Generally, WRS Health RWT plan focuses on the following methodology:

1. Standard Based Evaluation - includes review and re-assessment of various event and transaction logs generated by the system. This approach includes manual data audit, report generation and gathering of transactional logs in the system.

2. Performance Measurement - evaluate the conformance of the system in each of the applicable criteria set via measurable outcomes of relevant system functions. This method primarily is presenting statistics and measures through dashboard reporting. Outcome evaluation will also be part of the test plan to recommend functionalities or changes that will further the progress of compliance.

3. Performance Outcome Indicators - the result of the evaluation will be reported and the indicators derived from this activity will be monitored to check unexpected occurrences, or assess results and scenarios with a predetermined reporting period. Periodic evaluation is scheduled to generate and check reports, transactional logs, data sources for alignment and compliance of the system's operations and services.

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Standard Updates (SVAP and USCDI) -

Standard (and version)	All standard versions are as specified in 2015 Edition Cures Update
Updated certification criteria and associated product	(b)(1), (b)(2), (e)(1), (g)(9)
Health IT Module CHPL ID	CHPL Product Number: 15.02.05.2527.WRSH.01.01.1.211214 ONC-ACB Certification ID: 15.02.05.2527.WRSH.01.01.1.211214
Method used for standard update	2015 Edition Cures Update Test Procedure
Date of ONC ACB notification	September 30, 2022
Date of customer notification (SVAP only)	N/A
Conformance measure	(b)(1) - Use Case 1, Measures 1, 2, 3 (b)(2) - Use Case 2 (e)(1) - Use Case 1, Measure 4 (g)(9) - Use Case 7
USCDI updated certification criteria	(b)(1), (b)(2), (e)(1),(g)(9) - Version 1

Standard (and version)	§170.315(c)(3) – CQMs – Report ● CMS Implementation Guide for Quality Reporting Document Architecture: Category III; Eligible Clinicians and Eligible Professionals Programs; Implementation Guide for 2022 (December 2021) ● 170.205(h)(3) 2022 CMS Implementation Guide for Quality Reporting Document Architecture: Category I; Hospital Quality Reporting; Implementation Guide for 2022 (November 2021)
Updated certification criteria and associated product	§170.315(c)(3)
CHPL Product Number	15.02.05.2527.WRSH.01.01.1.211214
Method used for standard update	SVAP
Date of ONC ACB notification	September 30, 2022
Date of customer notification (SVAP only)	December 6, 2022
Conformance measure	c3 - Use Case 5, Measures 3 and 5
USCDI updated certification criteria	N/A

Care Setting(s)

Care Setting	Justification
Primary/specialty care	Not all clients are using direct messaging and public registry modules. For the modules that are being used, the above metrics would apply.
Urgent care	For the modules that are being used, the above metrics would apply.
Nursing home	Our nursing home clients are not using erx and public registry modules, but for the modules that are being used, the above metrics would apply

Birth center	Not all clients are using direct messaging and public registry modules. For the modules that are being used, the above metrics would apply.
Orthopedic and other rehabilitation centers	Not all clients are using direct messaging and public registry modules. For the modules that are being used, the above metrics would apply.

Schedule of Key Milestones

Key Milestones	Care Settings	Date / Time Frame
Communicating with our customers how we intend to conduct the Real-World Testing.	All	January 2023
Start collection of necessary data, transaction reports, submission statistics, relevant documents as laid out in the test plan.	All	January 2023 (Throughout the year)
End of Real World Testing period data collection/analysis	All	December 2023
Submit Real World Testing report to ACB	All	January 15, 2024

Measure(s) Used

USE CASE 1:

Providers or patients may create, access, download and transmit patient records (CCDAs) over secure networks. Practices use direct messages when they need to communicate with patients' primary care providers or specialists, and receive CCDA sent via direct messages for new patients that were referred by other providers.

Certification Criteria	Requirement	Relied Upon Software
§170.315 (b)(1): Transitions of Care	(i) Send and receive via edge protocol. (ii) Validate and display (iii) Create	n/a
§170.315 (b)(9): Care Plan	Enable a user to record, change, access, create, and receive care plan information in accordance with the Care Plan document template	n/a
§170.315 (e)(1): View, download, and transmit to 3rd party	(i)(A) View (i)(B) Download (i)(C) Transmit to third party	n/a
§170.315 (h)(1): Direct Project	(i) Applicability Statement for Secure Health Transport (ii) Delivery Notification in Direct	EMR Direct phiMail

Measure 1 : Metrics on number of CCDA imports - This measure will use the dashboard metrics showing the total imports of CCDA documents. This will be tested to prove compliance to §170.315(b)(1) - Transition of Care**,** specifically the ability to send and receive CCDA.

- **Justification:** The metrics will prove the conformance of the application to the prescribed standards and methods under §170.315(b)(1) criterion. This metric will provide information on the types of transmissions and the regularity of importing CCDA documents by end users in the EHR systems.
- **Test Methodology:** The activity logs of users and providers in different practices will determine how often the system was used for CCDA import. The metrics will be used for review of the performance capability of the system for exchange of information, interoperability conformance and the compliance to the required standards for the transition of care.
- **Expected Outcome:** It is expected that some but not all will regularly import CCDA. The log files will verify the frequency of imports made by users over a period of time. Errors related to this activity will be tracked and analyzed. To demonstrate interoperability, we expect to meet and exceed 99% successful validation, with <1% error rate.

Measure 2: Metrics on the generated CCDA documents - The measure will use dashboard showing the total number of CCDA documents generated by practices over time, including Continuity of Care Document, Referral Note and Care Plan, both systematically (scheduled jobs) or manually (on demand).

This will be tested to prove compliance to

- ✓ §170.315(b)(1) - Transition of Care, the ability for user to a user to create a transition of care/referral summary document

- ✓ §170.315 (b)(9): Care Plan, the ability for user to a user to create a Care Plan document

- **Justification:** The metrics abstracted from log files will illustrate that various CCDA documents are being generated regularly through automated events and manual operations. The generated documents will show compliance with the prescribed standards in §170.315(b)(1) and §170.315 (b)(9).

- **Test Methodology:** The logs of the generated CCDA documents will be validated and analyzed to test whether the system generates these documents following the proper standards required in §170.315 (b)(9). Specifically, the test will include the assessment of the activity logs including continuity of care documents, referral notes and care plan both systematically or manually generated from Patient portal and EHR.

- **Expected Outcome:** It is expected that a large number of CCDA documents would be generated daily by automated scripts; and a smaller number of CCDA documents would be manually generated on demand. The expectation is to meet and exceed a 99% success rate for generating CCDA documents both manual and automated.

Measure 3: Metrics on the views and downloads of CCDA by practice users - This measure will use a dashboard of metrics showing the number of views and download activities of imported and generated CCDA by practices over time.

This will be tested to prove compliance to

- ✓ §170.315(b)(1) - Transition of Care, the ability to validate and display
- ✓ §170.315 (b)(9) - Care Plan, the ability to validate and display

- **Justification:** The metrics derived from history logs of the views and downloads of CCDA will provide proof that the system is accessible and that functions are working properly for viewing and downloading of various CCDA documents. The details of the activity included will illustrate that the system can validate transition of care/referral summaries received. The log files will show that the system is in compliance with the standard implementations of the specified criteria.

- **Test Methodology:** Patient's activity and history logs will be examined. The test will include assessment of the metrics of patient's access and identification of activities relevant to the download and transmit operations of CCDA documents. The measure will determine the frequency of downloads and the transport mechanism used by the patient in transmitting transition of care to external parties.

- **Expected Outcome:** It is expected that practices who routinely receive and send CCDA documents to other entities, would generate regular CCDA views and downloads. We expect that an authorized user can view and download CCDA with a success rate of 99% or more.

Measure 4: Metrics on the access and activity log for viewing, downloading, and transmitting of CCDA by patients

This will be tested to prove compliance to § 170.315(e)(1) View, download, and transmit to 3rd party,

- ✓ the ability to access WCAG 2.0 Levels A or AA patient portal
- ✓ the ability to view, generate, and download CCDA
- ✓ the ability to view access and activity logs

- **Justification:** This metric will show that the CCDA documents are accessed by the end users via the WCAG 2.0 patient portal. The activity logs will indicate that proper credentials and security measures are applied as specified in the standards. The metrics will provide statistics on the number of views of CCDA documents in both raw format

and human readable format, generate CCDA with time range options, download CCDA individually, and prove that the system can transmit the CCDA securely.

- **Test Methodology:** This measure will use a dashboard of metrics from activity logs showing patients access/authentication activity to WCAG 2.0 compliant patient portal, and the activities for viewing, generating and transmitting of CCDA.

- **Expected Outcome:** It is expected that when patients do access the patient portal they can successfully view and generate CCDA. We expect that the number of failed attempts to view, download, or share CCDA, compared to the number of successful attempts within the given time period, are within the 1% error margin.

Measure 5: Metrics on the transaction reports of direct messages - This measure will use a dashboard of metrics showing transactions of all direct messages: messages sent and received by practices with or without CCDA attachments, messages sent by patient from patient portal to transmit CCDA documents, and all messages' final transmission status.

This will be tested to prove compliance to

- ✓ §170.315 (b)(1): Transitions of Care, the ability for practice users to transmit CCDA via Direct message
- ✓ §170.315 (b)(9): Care Plan, the ability for practice users to transmit CCDA via Direct message
- ✓ §170.315 (e)(1) View, download, and transmit to 3rd party, the ability for patients to transmit CCDA via Direct message
- ✓ §170.315 (h)(1) Direct Project, the ability of sending and reviewing Direct messages, with or without attachments, the ability of showing errors and final transmission status.

- **Justification:** This test method will demonstrate that both practice and patients can safely transmit CCDA documents via direct messages to other entities. The analyzed transaction report will also include the metrics of the sent CCDA documents using direct messages for patients with outgoing referrals.

- **Test Methodology:** Analysis of the logs of the various transaction reports pertaining to direct messages will be reviewed to determine the frequency and the transport mechanism used by providers for sending/receiving transitions of care. This methodology will primarily test the conformance of the implementation.

- **Expected Outcome:** It is expected that some practices would be receiving and sending CCDA using direct messages. For practices who routinely utilize this feature we expect to see the data hold steady over time. Some practices will only use this feature rarely if they generally do not send or receive referrals, or when their counterparts do not support direct messages. It is expected that transmitting CCDA via direct messaging may only be used infrequently. We recognize that possible errors may occur outside the system's environment and might prevent a direct message to be sent or received, but within an acceptable error rate of <10%. We expect to meet or exceed the 90% success rate of CCDA transmissions.

USE CASE 2:

Using the EHR system, providers have the ability to create a single list of medications, medication allergies and problems by reconciling key clinical data elements from two sources.

Certification Criteria	Requirement
§170.315 (b)(2): Clinical Information Reconciliation and Incorporation	(i) General requirements (ii) Reconciliation

Measure: Metrics on number of Clinical Information Reconciliation performed - This measure will use the dashboard metrics showing clinical information reconciliation performed. The associated log files will be checked and reviewed also for the accuracy of data.

- **Justification:** The metrics used will prove that the system provides the functionality for the reconciliation of clinical data from two sources. These metrics will prove that the reconciliation is an administrative function and is only available to credentialed users.
- **Test Methodology:** The activity logs related to the Clinical Information reconciliation will be reviewed to test the performance of the system for the proper operations of reconciliation as specified in §170.315 (b)(2) and that the associated implementation guides, including validation and verification of all required data elements are supported.
- **Expected Outcome**: Since clinical information reconciliation is performed under certain circumstances, it is expected that the feature would be infrequently utilized by a small number of practices. Even with a small number of reconciliations performed, we expect to exceed 99% success rate to prove that the functionality is available and that the system is able to demonstrate interoperability as specified in §170.315(b)(2).

USE CASE 3:

The EHR system allows health care providers to prescribe medications electronically.

Certification Criteria	Requirement	Relied Upon Software
§170.315 (b)(3): Electronic Prescribing	(ii)(A) Enable a user to perform the following prescription-related electronic transactions in accordance with the standard specified in § 170.205(b)(1) and, at a minimum, the version of the standard specified in § 170.207(d)(3).	MDToolbox v5.0

Measure: transaction reports from Surescripts - This measure will use transaction logs from Surescripts indicating the number of Erx messages transmitted through Surescripts network, to prove compliance to § 170.315 (b)(3).

- **Justification:** The metric will indicate the frequency of usage of the Electronic Prescribing functionality in the system. This test will provide proof that the system is capable and compliant to the required standards by assessing the performance of the functionality against the required operational standards. The test will also prove that the system is accessible by end users to perform prescription-related transactions according to the prescribed standards.
- **Test Methodology:** The Erx transaction logs from Surescripts will be reviewed and analyzed to ensure that the Electronic Prescribing functions properly and meet the required standards of its operations. The log files that

include the number of Erx messages transmitted through Surescripts network will be tested of its conformance to the implementations of §170.315 (b)(3): Electronic Prescribing standards.

- **Expected Outcome**: It is expected that we would see the volumes of Erx transactions across Surescripts network hold steady throughout the year, with a low error rate. There will be some transactions resulting in errors as part of data validation implemented to ensure prescriptions are compliant with the network standards. This test plan will indicate the provider's ability to send or change electronic prescriptions with 95% or more success rate.

USE CASE 4:

The EHR system allows practices to perform export enabled-permissions of patient's clinical data.

Certification Criteria	Requirement
§170.315 (b)(6): Data Export	(i) General requirements for export summary configuration (ii) Creation (iii) Timeframe configuration (iv) Location configuration

Measure: dashboard for export reports - This measure will use the dashboard metrics showing total number of users given permissions to the function, number of export reports generated by practices over time, report filter and configuration options, and number of patients included in the reports, number of CCDA generated.

- **Justification:** The metrics will illustrate that the end users can grant access to selected users of the export report function. The method will also be used to demonstrate that end users can generate reports with various configurations and filtering options, and can review patients included in the export as well as download CCDA in bulk. This measure will look at the performance of the system to manage export configurations according to defined preferences. Additionally, credentialing requirements will be tested as only authorized users will have the capability to perform export functions.

- **Test Methodology:** The test approach will use performance analysis of the functionalities of the system to allow practices to perform export enabled-permissions of patient's clinical data. The export logs will be used to assess proper credentialing and validation of the required export operations.

- **Expected Outcome:** It is expected that the export functions according to the required operational standards. Since the ability to perform export depends on access permission granted to some practice users, it is expected that export function is used sparsely/infrequently by some practices. We expect a 99% or more success rate for all transactions performed by authorized users.

USE CASE 5:

The EHR system allows users to generate QRDA files according to prescribed standards for submission to CMS and other quality reporting needs.

Certification Criteria	Requirement
§170.315 (c)(1): Clinical Quality Measures - Record and Export	(i) Record (ii) Export
§170.315 (c)(2): Clinical Quality Measures - Import and Calculate	(i) Import (ii) Calculate each and every clinical quality measure
§170.315 (c)(3): Clinical Quality Measures – Report	Enable a user to electronically create a data file for transmission

Measure 1: Metrics on number of recorded clinical data - This measure will use the dashboard metrics showing numbers of recorded clinical data to verify conformance to §170.315 (c)(1) criteria. The associated log files will be checked and reviewed also for the accuracy of data.

- **Justification:** The measurement outcome of the selected test method will show the actual numbers of users accessing EHR to capture data points for their clinical data reporting. The metrics will prove the performance of the system to validate clinical data captured is conformant to the prescribed standard of CMS implementation guide and that the required data elements are also supported.
- **Test Methodology:** Test will use a dashboard of metrics showing the number of recorded clinical data entries recorded over time by practices. Clinical data entries will include but not limited to ICD, CPT, SNOMED, LOINC, allergies, medications, immunizations, vitals. The data metrics will be assessed to validate that CQMs are designed according to required standards and that the additional required data elements are supported.
- **Expected Outcome:** It is expected that practices will be able to capture clinical data points throughout the year in a consistent pattern. It is expected that the metrics abstracted from the trends on the usage of the system will give an insight to the developers to enhance accessibility and functional performance in capturing clinical records. It is expected to have 99% or more attempts that are successful against failures, with an acceptable <10% margin of error. The numbers queried by the system will prove that this functionality is highly available.

Measure 2: Metrics on the generated CQM reports - This will be tested to prove compliance to § 170.315 (c)(2): Clinical Quality Measures - Import and Calculate, the ability to calculate the aggregated report.

- **Justification:** The metrics derived from the system logs will prove that end users of the WRS system can use the reporting function to regularly calculate and report on their CQM. The test will prove the performance of the system for accuracy to calculate each clinical data measure for reporting. This will also be used to validate and identify issues related to generating CQM reports.
- **Test Methodology:** The measure will use the dashboard of metrics showing total number of CQM generated by practices over the course of year.

- **Expected Outcome:** It is expected that all practices will run at least 1 report per provider per year, and most practices will run monthly and/or quarterly reports throughout the year. We expect that more than 95% of uploaded files will be successfully imported with <5% unsuccessful rate due to formatting issues and validations.

Measure 3: Metrics on QRDA Category I and QRDA Category III activities - This will be tested to prove compliance to

- ✓ § 170.315 (c)(1): Clinical Quality Measures - Record and Export, the ability of generating QRDA Category I data files
- ✓ § 170.315 (c)(3): Clinical Quality Measures - Report, the ability of generating QRDA Category I and QRDA Category III data files

- **Justification:** This test method will prove that the EHR system met the applicable implementation specifications of the CMS guides for QRDAs. The metrics will identify the accessibility capability of the export functions and likewise will show the frequency of usage in exporting QRDAs.
- **Test Methodology:** This measure will use a dashboard of metrics showing number of users requested for QRDA Category I data files, number of systems generated QRDA Category I data files for registry submission, and number of downloaded QRDA Category III files.
- **Expected Outcome:** It is expected that there would be QRDA Category I data file and QRDA Category III data file manual download activities during the 1st quarter of 2022 which is CQM report submission window. It is also expected that system generated QRDA Category I data files should take place each month for clients who choose to have their data submitted to registries monthly. We expect that at least 95% of submitted files are successfully generated using the system .

Measure 4: Metrics on the QRDA Category I import performed - This will be tested to prove compliance to § 170.315 (c)(2): Clinical Quality Measures - Import and Calculate**,** the ability to import patient data from QRDA Category I data files.

- **Justification:** The measure will prove that end users can access and import QRDA Category I data files via the system into their real practice. The frequency of imports performed by end users will prove the availability of the import function amidst its rare use in the practice.
- **Test Methodology:** The test will include assessment of the numbers of QRDA imports performed to prove that users are capable of data imports in the system. The use of import functions will be offered as part of the clinical training to have it tested by users in real practice. The metrics from this log will be examined to verify that the system is able to correctly calculate each of the imported clinical quality data measures.
- **Expected Outcome:** As this is a function that is not commonly used by clients as part of their regular workflow, it is expected that infrequent imports were performed as part of clinical training effort. We expect to have more than 95% success rate of uploading files with <5% unsuccessful rate due to data validations.

Measure 5: Metrics on CMS and specialty registry submissions - This measure will use dashboard of metrics showing number of practices/providers that have successfully downloaded QRDA Category III data files from EHR, uploaded to and accepted by CMS, and clinical quality measures performance scorecards from specialty registries reflecting successful generation and exporting of QRDA Category I data files.

This will be tested to prove compliance to:

- ✓ § 170.315 (c)(1): Clinical Quality Measures - Record and Export, the ability of generating QRDA Category I data files
- ✓ § 170.315 (c)(2): Clinical Quality Measures - Import and Calculate, the ability to calculate the aggregated report.
- ✓ § 170.315 (c)(3): Clinical Quality Measures - Report, the ability of generating QRDA Category III data files

- **Justification:** The metrics will illustrate the system's capability of generating valid QRDA Category III data files which can be consumed by CMS submission tools. Additionally, this will also prove the system's capability of generating valid QRDA Category I data files that can be consumed by specialty registries for calculation and reporting. Overall, the metrics derived will indicate the operational compliance of the system to CQM reporting.
- **Test Methodology:** The test method will analyze and interpret the number of practices/providers that have successfully downloaded QRDA Category III files from EHR, uploaded to and accepted by CMS. Likewise, the test will include analysis of clinical data report cards from specialty registries reflecting providers CQM performance based on QRDA Category I file export.
- **Expected Outcome:** It is expected that we would be able to collect CMS data submission confirmation for a number of clients during the CMS submission open period (January 2023 – March 2023). It is also expected that we would be able to collect submission score cards for clients who submit data to FigMD for their specialty registries. We expect that 99% of submitted files are successfully generated using the system .

USE CASE 6:

The EHR system is capable of processing electronic transmission to relevant public health agencies.

Certification Criteria	Requirement
§170.315 (f)(1): Transmission to Immunization Registries	(i) Create immunization information for electronic transmission in accordance to standards (ii) Enable a user to request, access, and display a patient's evaluated immunization history and the immunization forecast from an immunization registry in accordance to standards
§170.315 (f)(2): Transmission to Public Health Agencies - Syndromic Surveillance	Create syndrome-based public health surveillance information for electronic transmission in accordance to standards
§170.315 (f)(4): Transmission to Cancer Registries	Create cancer case information for electronic transmission in accordance…

Measure 1: transaction reports from Iron Bridge - This measure will use the dashboard metrics showing numbers of transactions exchanged with state immunization registries. This will be tested to demonstrate compliance to § 170.315 (f)(1) and HL7 specifications.

- **Justification:** The metrics derived from immunization message transaction reports from Iron Bridge will prove that WRS is capable and compliant to electronic transmission to immunization registries and is conformant to the prescribed standards in these criteria.

- **Test Methodology:** WRS will review the immunization message transaction reports from Iron Bridge showing details of transactions exchanged with state immunization registries.

- **Expected Outcome:** It is expected that we would see a larger volume of outbound messages from WRS to state registries than bi-directional messages, as the majority of the practices only have outbound connections. It is also expected that a portion of the messages would contain errors due to incomplete submission data. We expect to meet 90% or more successful data transmissions with <10% transmission errors due to validations and data formats required by registries.

Measure 2: metrics on generated syndromic surveillance messages - This measure will use the dashboard metrics showing numbers of generated syndromic surveillance messages to prove compliance to § 170.315 (f)(2).

- **Justification:** The indicator of the number of syndromic surveillance messages successfully generated by the system will prove the capability of transmitting syndromic surveillance data in accordance with the implementation guidelines required by the standard.

- **Test Methodology:** The reports showing the number of syndromic surveillance will be analyzed to provide proof on conformance of the system to create syndrome-based public health surveillance information for electronic transmission.

- **Expected Outcome:** It is expected that for all eligible events, syndromic surveillance messages will be correctly generated by the system according to the standard. We expect to meet 90% or more successful data transmissions with <10% transmission errors due to validations and data formats required by the public health agencies.

Measure 3: metrics on generated cancer registry messages - To prove that the system supports the electronic submission of cancer case information, § 170.315 (f)(4) - the log files that show the number of cancer registry messages successfully generated by the system will be used to generate dashboard metrics.

- **Justification:** The metrics will provide evidence that WRS EHR system has a functional module which is capable of capturing essential cancer diagnosis data, and generating registry reporting messages.

- **Test Methodology:** Log files showing the number of cancer registries generated by the system will be used for Dashboard reporting.

- **Expected Outcome:** It's expected that a very small number of activities would take place during the reporting period, as none of our clients are treating cancer patients and would not be using this function during daily interactions with patients. For reports generated, we expect more than 95% success rate with only <5% unsuccessful transmissions rate.

USE CASE 7:

WRS - EHR system uses certified APIs for both patient and provider-oriented use cases. WRS published FHIR format APIs and maintained its supporting documentation that enabled external applications to request patient data by category from the certified Health IT module.

Certification Criteria	Requirement
§170.315 (g)(7): Application Access - Patient	(i) Functional Requirements (ii) Documentation

§170.315 (g)(9): Application Access - All Data Request	(i) Functional Requirements (ii) Documentation

Measure: metrics on API access and activity – The test approach includes the examination and assessment of the activity logs and review of API documentations to ensure that the API services of WRS is compliant and conforms to the operational standards as described in each criterion. The summary will be reflected using Dashboard metrics for analysis.

- **Justification:** The test method performed in these criteria will illustrate that authorized requests can search and retrieve patient identifiers after providing valid identification criteria, that the API endpoints support requesting of categories of data and full data, and proper response would be returned by the API. Additionally, the method will ensure that there is a proper technical documentation of the APIs and is accessible via public URL.
- **Test Methodology:** Patient's activity logs will be used to determine the number of patient's accessing the system, the capability of the API to search and uniquely identify authorized patients. The activity logs will also be used to examine the details of the API responses as patients made data category requests in the system. The API documentation will be examined for adherence to the required standards specified under these criteria.
- **Expected Outcome:** It is expected that unauthorized requests would be rejected, and authorized requests would be granted and recorded; requests with correct patient search criteria should successfully retrieve patient identifiers, whereas insufficient search criteria would result in no match. It is also expected that API endpoints would handle both categories data request and full data requests, and respond with appropriate data. We expect that all the authorized queries shall return the requested categories of data for the selected patient 100% of the time when the data is present.

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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