WRSHealth

Real World Test Plan for 2024

Contents

General Information

Plan Report ID Number : 20231107wrs
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 our ongoing commitment to ensuring that WRS Health solutions and services adhere to the criteria and standards set forth by the ONC Health Certification program. The test plan includes the utilization of methodology to gather and generate relevant information for verifying interoperability capability and functionalities conforming to health IT's certification.

Generally, this RWT plan employs the following methodology:

1. Standard Based Evaluation - involves 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 evaluation's outcomes will be reported, and the metrics obtained from this process will be monitored to detect unforeseen incidents and assess results and scenarios within a pre-established reporting timeframe. Regular assessments are planned to generate and verify reports, transactional logs, and data sources, ensuring alignment and compliance with the system's operations and services.

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Standard Updates (SVAP and USCDI)

there are no standards updates to report. All relevant standards were comprehensively addressed in the previous year's RWT Plan.

Care Setting(s)

WRS Health is an ONC-certified product designed for various ambulatory care settings. The care settings that will be used to test the certification criteria are representative of all care settings.

- Primary/Specialty care
- Urgent Care
- Birth Center
- Orthopedic and other rehabilitation centers

Measure(s) Used

USE CASE 1:

Healthcare providers and patients may create, access, download and transmit patient records (CCDAs) over secure networks. When healthcare practices need to contact a patient's primary care provider or a specialist, they utilize direct messages. Additionally, they receive CCDAs via direct messages for new patients 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 displaying the total imports of CCDA documents. This testing process aims to validate compliance with §170.315(b)(1) - Transition of Care, particularly assessing the capability to send and receive CCDA documents effectively.

- **Justification:** The metrics will verify that the application complies to the prescribed standards and methods under §170.315(b)(1) criterion. This metric will provide information on the types of transmissions and the frequency with which end users in EHR systems import CCDA documents.

- **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 to assess the system's performance in facilitating information exchange, ensuring interoperability and confirming compliance with the necessary 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 exceed 99% successful validation, with <1% error rate.

Measure 2: Metrics on the generated CCDA documents

The measure will use dashboard showing the aggregated number of CCDA documents generated by healthcare practices over time, including Continuity of Care Document, Referral Note and Care Plan, both automated scheduled jobs or initiated manually upon request.

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 review of the activity logs including continuity of care documents, referral notes and care plan both systematically or manually generated. originating 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 healthcare 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:** Metrics obtained from historical logs, which monitor the views and downloads of CCDA documents, will serve as proof of the system's accessibility and seamless functionality for both viewing and downloading a variety of CCDA documents. The recorded activities will provide evidence of the system's capability to validate received transition of care and referral summaries. The log files will confirm the system's alignment with the standard implementations of the specified criteria.

- **Test Methodology:** We will examine the patient's activity and history logs. The test will include assessment of the metrics related to patients' access and the identification of activities pertinent to downloading and transmitting CCDA documents. The measure will determine the frequency of downloads and the method employed by patients to transmit transition of care data 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 demonstrate that end users access CCDA documents through the WCAG 2.0-compliant patient portal. The activity logs will serve as an indicator of the proper application of credentials and security measures as outlined 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 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 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 specified time frame will fall within a 1% margin of error.

Measure 5: Metrics on the transaction reports of direct messages

This measure will utilize a dashboard displaying a comprehensive set 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, along with the final transmission status of all messages.

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 transaction report will show metrics for CCDA documents sent via direct messages, particularly pertaining to patients with outgoing referrals.

- **Test Methodology:** We will conduct an examination of logs from various transaction reports related to direct messages to assess the frequency and the transport methods used by providers for sending and receiving transitions of care. The primary aim of this approach is to confirm the implementation's compliance.

- **Expected Outcome:** It is expected that some practices will regularly engage in sending and receiving CCDA documents through direct messages. For practices who routinely utilize this feature, there is a consistent pattern of data usage over time. Low usage rate of this feature is expected for healthcare practices that infrequently send or receive referrals or when their counterparts do not have support for direct messages.

  Overall, 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:

Healthcare providers can utilize the EHR system 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 1: Metrics on number of Clinical Information Reconciliation performed

This measure will use the dashboard metrics to display the total number of reconciliation performed on clinical information. The associated log files will be checked and reviewed to verify the accuracy of the data used in the reconciliation process.

- **Justification:** The metrics used will prove that the system provides the functionality for the reconciliation of clinical data from two sources. These metrics will confirm that the reconciliation process is an administrative function exclusively accessible by authorized and credentialed users.
- **Test Methodology:** The activity logs related to the Clinical Information reconciliation will be evaluated to confirm the system's performance in executing the proper reconciliation operations as specified in §170.315(b)(2) and check whether 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 confirm the availability of this functionality and to demonstrate the system's capacity for interoperability, in accordance with the requirements 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 1: transaction reports from Surescripts

To demonstrate compliance with §170.315(b)(3), we will utilize transaction logs provided by Surescripts; these logs display the quantity of eRx messages transmitted via the Surescripts network.

- **Justification:** Transaction logs from Surescripts are highly relevant for confirming compliance with §170.315(b)(3) because they directly capture Electronic Prescribing (eRx) transactions. This aligns with the requirement to demonstrate the capability of transmitting electronic prescriptions electronically to pharmacies.

- **Test Methodology:** We will examine the logs to determine the quantity of eRx messages transmitted over a defined period of time. We will also analyze the logs to understand the frequency of eRx transactions and calculate how often prescriptions are electronically transmitted. Logs will be reviewed for any error or rejection of data related to eRx transactions.

- **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. Some transactions may produce errors due to data validation measures that are implemented to ensure compliance with network standards. This test plan will assess the provider's capability to send or modify electronic prescriptions with a success rate of 95% or higher.

USE CASE 4:

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 results obtained through the selected test approach will show the precise count of users who utilize the EHR system to capture data points for their clinical data reporting. The metrics will prove the system's performance in validating the clinical data captured is compliant to the prescribed standard of CMS implementation guide and the required data elements are also supported.

- **Test Methodology:** This test will use a dashboard of metrics showing the aggregated number of recorded clinical data entries recorded by practices over time. These clinical data entries will include various elements 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 necessary standards and that the additional required data elements are adequately supported.

- **Expected Outcome:** It is expected that practices will consistently capture clinical data points throughout the year. The metrics derived from usage trends within the system are expected to provide insights to improve accessibility and functional performance for recording clinical records. The expectation is to achieve a success rate of 99% or higher compared to failures, with an acceptable margin of error of less than 10%. The system's ability to query the total numbers of recorded clinical data will confirm the availability of the functionality.

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 obtained from the system logs will demonstrate that end users of the EHR system can consistently utilize the reporting function to calculate and report on their CQMs. The test will verify the system's accuracy in calculating each clinical data measure for reporting purposes. Additionally, this process will serve to validate and identify any issues related to generating CQM reports.

- **Test Methodology:** The measure will use the dashboard of metrics showing the total number of CQMs generated by practices throughout the year..

- **Expected Outcome:** It is expected that all practices will generate at least one report per provider annually, with the majority running monthly and/or quarterly reports consistently throughout the year. Our expectation is that over 95% of uploaded files will be successfully imported, with less than a 5% failure rate attributed 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 outlined in the CMS guides for QRDAs. The metrics will assess the accessibility of the export functions and likewise will show the frequency of QRDAs being exported.

- **Test Methodology:** This measure will rely on a dashboard displaying metrics for the total count of users requesting QRDA Category I data files, the number of systems-generated QRDA Category I data files for registry submission, and the tally of downloaded QRDA Category III files.

- **Expected Outcome:** It is expected for the first quarter of the year, the CQM report submission window, will include manual downloads of QRDA Category I and QRDA Category III data files. Additionally, system-generated QRDA Category I data files are expected to occur monthly for clients opting for monthly data submissions to registries. Our expectation is that the system will successfully generate at least 95% of the submitted files.

Measure 4: Metrics on the QRDA Category I import performed

This will be tested to demonstrate 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:** This measure will confirm that end users can access and import QRDA Category I data files into their actual practice using the system. The frequency of imports carried out by end users will demonstrate the availability of the import function, even though it may be rarely utilized in practice.
- **Test Methodology:** The test will include assessment of the total numbers of QRDA imports performed to demonstrate that users are capable of data imports within the system. The use of import functions will be offered as part of 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 in file uploads, with less than a 5% failure rate attributed to data validations.

Measure 5: Metrics on CMS and specialty registry submissions

This measure will use a 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 utilized by CMS submission tools. Furthermore, this will also confirm the system's capability of generating valid QRDA Category I data files that can be consumed by specialty registries for calculation and reporting. In summary, the derived metrics will indicate the system's operational compliance with CQM reporting standards.
- **Test Methodology:** The test method will evaluate 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 export of QRDA Category I files.
- **Expected Outcome:** It is expected that we would be able to collect CMS data submission confirmations from a portion of our clients during the CMS submission window (January 2024 – March 2024). 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. Our expectation is that the system will successfully generate 99% of the submitted files.

USE CASE 5:

The EHR system can efficiently handle the transmission of electronic data to pertinent public health authorities.

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: Immunization message success

This measure will utilize the dashboard metrics that display the total number of conformant transactions shared with state immunization registries. This will be tested to verify compliance to § 170.315 (f)(1) and HL7 specifications.

- **Justification:** The metrics derived from immunization message transaction reports provided by Iron Bridge will demonstrate that WRS is both capable and compliant in electronically transmitting data to immunization registries, and it conforms to the prescribed standards in these criteria.
- **Test Methodology:** We will review the immunization message transaction reports received from Iron Bridge, which provide detailed information about the transactions exchanged with state immunization registries.
- **Expected Outcome:** It is expected that we would see a higher volume of outbound messages from WRS to state registries compared to bi-directional messages, since the majority of the practices have only outbound connections. Additionally, we expect that a portion of these messages would contain errors due to incomplete submission data. We expect to meet 90% or higher for data transmissions, with <10% error rate attributed to validation and data format requirements imposed by the 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 quantity of syndromic surveillance messages successfully generated by the system will prove the capability of transmitting syndromic surveillance data in compliance with the implementation guidelines required by the standard.
- **Test Methodology:** The reports showing the total number of syndromic surveillance will be analyzed to confirm the system's adherence to the creation of 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 demonstrate the system's capability to facilitate electronic submission of cancer case information in accordance with § 170.315 (f)(4), we will utilize log files that record the number of cancer registry messages successfully generated by the system in order to create dashboard metrics.

- **Justification:** The metrics will provide evidence that WRS EHR system includes a functional module capable of capturing vital 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 the reports that are generated, we expect a success rate of over 95%, with a transmission failure rate of less than 5%.

USE CASE 6:

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 access and request patient data 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
§170.315 (g)(10): Standardized API for patient and population services	(i) Functional Requirements (ii) Documentation

Measure: metrics on API access and activity

This measure will evaluate the successful use of all certified APIs under (g)(7), (g)(9) and (g)(10) certification criteria (https://api.fhir.wrs.cloud/docs) through the lens of individual transaction requests by request, API Information Source and API Users.

- **Justification:** This criterion requires the ability of WRS Health to respond to requests for patient data thru FHIR standards from authorized/registered applications.
- **Test Methodology:** We intend to record the frequency that data is requested thru FHIR applications to demonstrate that the certified capability is available and effective, regardless of the frequency it is used. System logs will be reviewed to determine the success rates for the following:
    - API Requests Served

- API Information Sources with at least one successful response -- validates successful API use
- API Users with at least one successful response - validates successful API use spanning current API Users

- **Expected Outcome:** We expect that all the authorized queries will return the requested clinical records of patients, 100% of the time when the data is present.

Schedule of Key Milestones

Key Milestones	Care Settings	Date / Time Frame
Client Communication for support and participation	All	January 2024
Collection of information as laid out by the plan	All	January 2024 (Throughout the year)
End of Real World Testing period data collection/analysis	All	December 2024
Submission of Real World Testing report to ONC-ACB	All	January 15, 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.

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