



Executive Summary

This is the real-world test plan for CY 2025 for iSalus Healthcare's OfficeEMR certified EHR solution. We have one version certified, and we will be testing on the most current version, 2021, which is deployed to our provider partner community. As ONC has said in its rule, "The objective of real-world testing is to verify the extent to which certified health IT deployed in operational production settings is demonstrating continued compliance to certification criteria and functioning with the intended use cases as part of the overall maintenance of a health IT's certification." We have worked toward this objective in designing our test plan and its subsequent real world testing measurements and metrics.

This document builds toward the final testing measurements and metrics we will use to evaluate our product's interoperability within production settings. Within each use case, we document our planned testing methodology, associated ONC criteria, justification for measurement, expected outcomes from the testing, care settings applied for the respective measure, and if applicable the number of clients to use our real-world testing approach, including how our test cases were created, our selected methodology, the number of client/practice sites to use, and our general approach and justification for decisions.

We have included our timeline and milestones for completing the real-world testing in CY 2025, and information about compliance with the Standards Version Advancement Process updates.



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General Information

Plan Report ID Number: OfficeEMR.RWTP.2025

Developer Name: iSALUS Healthcare

Product Name(s): OfficeEMR

Version Number(s): 2021

Certified Health IT Product List (CHPL) ID(s): 15.04.04.2629.Offi.21.02.1.220606

Developer Real World Testing Page URL: <https://officeemr.knowledgeowl.com/help/officeemr-real-world-testing>



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: Tara Cox

Authorized Representative Email: tcx@everhealthsoftware.com

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Signed by:

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Tara Cox
VP Product Management, EverHealth

Authorized Representative Signature:

10/31/2024
Date: _____



Timeline and Milestones for Real-World Testing CY 2025

- **1Q-2025 - Communication:** Begin communication with clients to ask for their support and participation in real-world testing. The goal is to have enough clients committed to real world testing by the end of 1Q-2025.
- **2Q-3Q 2025 - Testing:** During the 2nd and 3rd quarter of CY 2025, the real-world testing with clients will be scheduled and performed. It is expected that a preparatory call will be done with clients to prepare them for testing activities. Results will be documented in the test results section of the test methods and ultimately used to build the test report. If any non-compliances are observed, we will notify the ONC-ACB of the findings and make the necessary changes required.
- **4Q-2025 – January 2026 Real World Test Plan:** During the 4th quarter of CY2025, the CY 2025 real-world test plan will be completed according to ONC and ONC-ACB requirements and expectations. The test plan will be prepared for submission before the end of the year.
- **February 2026 Real World Test Plan Results:** iSalus will document CY 2025 test results into our Real-World Test Report and submit to our ONC-ACB.



Standards Version Advancement Process (SVAP)

For CY 2025, iSalus Healthcare is not planning to make any version updates on approved standards through the SVAP process. This applies to all test scenarios described within.

- **Standard (and version):** None
- **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 version):**
N/A



Justification for the Real-World Testing Approach

iSalus Healthcare's real-world testing is focused on meeting the ever-changing demands of our provider partners and the industry. This focus will be centered around ensuring scenarios that independent ambulatory physician practices expect to encounter in a changing landscape are captured. Our approach will be to generate a test plan that satisfies key workflows (i.e., submitting an electronic prescription, submitting immunizations to a health registry). We will use objective measurements including data log reviews, API log inspection, surveys, and manual verification using third-party tools to ensure data is correctly retrieved or updated according to industry standards. We will set thresholds on acceptable success rates to ensure our partners have confidence in the data exchanges.



Real World Testing Measurements

The measurements for iSalus Healthcare's real-world testing plan are described below.

Each measure contains the following elements:

- Associated ONC criteria
- Testing Methodology used
- Description of the measurement/metric
- Justification for the measurement/metric
- Expected outcomes in testing for the measurement/metric
- Number of client sites to use in testing (if applicable)
- Care settings which are targeted with the measurement/metric

In each measure evaluated, we elaborate specifically on our justification for choosing this measure and the expected outcomes. All measurements were chosen to evaluate compliance with the certification criteria and interoperability of exchanging electronic health information (EHI) within the certified EHR.

Testing Methodologies

For each measurement, a testing methodology is used. For our test plan, we use the following methodologies.

- **Audit Trail/ Reporting:** This methodology uses the audit logging or various reporting capabilities of the application to examine tasks performed in the system. This methodology often provides historical measurement reports which can be accessed at different times of the year to evaluate interoperability. It can serve as a benchmark for evaluating real world testing over multiple time intervals.
- **Third Party Software Confirmation or Attestation:** This methodology leverages industry standards or industry required technology and services to evaluate data sharing. By way of example, when submitting an electronic prescription in the 20170701 SCRIPT standard to Surescripts, it may be necessary to review logs stored in the Surescripts Admin Console to verify receipt and accuracy of data provided. Other third-party software may be used as well to simulate or confirm activities when another option is not available. It may also be necessary to receive an attestation report from third-party applications to verify the receipt and accuracy of data when access to the third-party system is unavailable or prohibited.



- **Manual Chart Review:** This methodology leverages human intervention to visually review and confirm changes to data as expected. When data is shared to the application that may cause a change to a patient's medical chart, it may be necessary for a human to review the expected change and sign-off that the update occurred as expected.
- **User Survey:** This methodology evaluates interoperability and compliance of EHR Module capabilities through feedback from users. This methodology can provide insight into how clinicians employ and use a feature which reveals actual value and impact of interoperability of the EHR Module.

Number of Clients Sites

For each measure, we denote the minimum number of practice partners we plan to use for the evaluation. The numbers vary depending on the methodology as well as overall use of the associated EHR Module criteria by our users. For criteria that are not widely used by our customer base, we may test the respective measure in our own production-sandbox environment given lack of customer experience with the criteria functionality.

Practice Settings Targeted

iSalus Healthcare's OfficeEMR application focuses on serving the needs of intentent ambulatory medical practices across the United States. We have a heavy focus on Urologists and Nephrologists due to the unique software offerings that we provide. Our Real-World Test Plan is designed with these practice settings in mind. In each measure, we do also address the care settings targeted and note any necessary adjustment or specific factor to consider with this specific measure.



Real World Test Case: Comprehensive Care Coordination

Measurement Overview

One of the most critical steps for users of our application is to facilitate the seamless flow of data that is captured during an encounter and then sharing that data, when necessary, with those interested in the patient's care. It is our opinion that the exchange of data is both multi-faceted and interconnected and creates the best outcome for those interested in comprehensive care coordination. A routine medical visit should result in data sharing events across the medical industry to key stakeholders with limited burden on the provider/practice entering the data.

This comprehensive test case will cover the workflow in which a patient is seen at a medical practice for a routine visit then referred to another provider for additional care. We will start with the assumption that the provider treating the patient receives a clinical summary document. This document will be reviewed and incorporated into the medical record. The provider will also retrieve an updated immunization history from a connected immunization registry. During the visit, new immunizations and medications will be documented. Following the visit, data will flow to third party data registries based on data captured. The data will also flow to the patient via the patient portal. Key phases are covered as follows:



Phase 1: Records received and reviewed for a patient prior to a medical visit.

Scenario 1.A - Receive a clinical summary for an upcoming visit from an alternate provider via DIRECT Email (170.315(h)(1) Direct Project)

- **Description:** Receive a clinical summary for an upcoming visit from an alternate provider via DIRECT Email
- **Associated Certification Criteria:** 170.315(h)(1) Direct Project
- **Justification:** The use case will describe the case in which a provider transitions a patient to the care of a provider/practice using OfficeEMR. The provider transitioning the patient will be able to send a DIRECT e-mail containing a CCDA document to the provider using OfficeEMR. We will use audit logs and manual verification to confirm successful receipt of the DIRECT Email. Providers will be able to confirm the validity of the CCDA via the CCDA Validation tool built within OfficeEMR.
- **Testing Method:** Manual Verification and Audit Trail Review
- **Relied Upon Software:** Secure Exchange Solutions
- **Expected Outcomes:**
 - Audit trail verification of a new DIRECT E-Mail received for desired user. The audit trail should accurately reflect the count of records to increase by 1 following a successful transmission.
 - Manual verification of a DIRECT E-Mail received in OfficeEMR Communications Inbox should review 1 new record in the inbox.
 - Successful validation of the CCDA via CCDA Validation in OfficeEMR with an error rate of less than 10%.
- **Care Settings and Number of Clients Site to Test:** We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.

Scenario 1.B - Review clinical care summary and incorporate medication/problem/allergy changes from the CCDA (170.315(b)(2) Clinical Information reconciliation and incorporation)

- **Description:** Review clinical care summary and incorporate medication/allergy/problem changes from the CCDA
- **Associated Certification Criteria:** 170.315(b)(2) Clinical Information reconciliation and incorporation.
- **Justification:** The use case will describe the case in which a provider receives a transition of care summary (CCDA) from a referring provider then subsequently associates the CCDA with



a patient record in OfficeEMR. When the provider loads the chart that the CCDA was linked to, the user should be prompted to reconcile medications, problems, and allergies from the CCDA with the medications, problems, and allergies on files in the patient chart. Users will be able to manually see the comparison of medications, problems, and allergies along with suggested changes. Once reconciled, we can use audit trails and manual verification to ensure the patient chart is correctly updated with the reconciled information.

- Testing Method: Manual Verification and Audit Trail Review
- Expected Outcomes:
 - Audit trail verification of a new DIRECT E-Mail received for desired user. The count of audit records should increase by 1 follow the successful receipt.
 - Manual verification of the CCDA Reconciliation Process should reveal medications, problems and allergies supplied in the CCDA and medication, problems and allergies stored on the patient record. For each new record merged into the chart, the count of rows in the audit table should increase by 1.
 - Following the successful reconciliation of data, the audit trail and manual chart review should show the addition of added medications, problems or allergies or the status change of a medication, problem, or allergy.
- Care Settings and Number of Clients Site to Test: We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.

Scenario 1.C – Request and reconcile immunization history records from a state immunization registry (170.315(f)(1) Transmission to immunization registries)

- Description: Request, review, and reconcile immunizations for a patient from an immunization registry
- Associated Certification Criteria: 170.315(f)(1) Enable a user to request, access, and display a patient's evaluated immunization history and the immunization forecast from an immunization registry.
- Justification: The use case will describe the scenario in which a provider electronically requests immunization history data from a state immunization registry using the CDC SOAP-Based webservice transmission protocol. The end user should be able to view the immunization history records and compare those records to those that are already on file. The end user will also be able to reconcile these immunization history records in such a way that the patient's medical record is correctly updated with these new entries.
- Testing Method: Audit Trail Review, Manual Verification and Third-Party Application Attestation



- Expected Outcomes:
 - Audit trail records and a manual chart review should reveal new immunizations being added to the patient chart following reconciliation. For each new record added, the count of audit trail records should increase accordingly.
 - Manual review of the immunization history response should reveal a successful request to the registry by displaying the immunization history records within the OfficeEMR application.
 - Third-Party Attestation from the state registry would need to be obtained confirming the successful receipt of the request and verification that the data displayed matches the data sent.
- Care Settings and Number of Clients Site to Test: We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.



Phase 2: Complete a routine medical visit with a patient

Scenario 2.A - Capture and electronically prescribe medications (170.315(b)(3) Electronic Prescribing)

- **Description:** Capture and electronically prescribe medications
- **Associated Certification Criteria:** 170.315(b)(3) Electronic Prescribing
- **Justification:** The use case will describe the scenario in which a provider electronically creates and subsequently transmits a NewRx request from OfficeEMR to a pharmacy via the Surescripts network in the 20170701 format. Users will be able to manually confirm the transmission via the prescription history in the OfficeEMR application. iSalus staff will be able to login to the Surescripts Admin Console to verify the successful receipt of the message by Surescripts and the successful delivery of that NewRx message to the pharmacy.
- **Testing Method:** Manual Verification and Third-Party Application Verification
- **Expected Outcomes:**
 - Audit trail should reveal a new medication successfully saved to the patient record. The audit trail count should increase by 1 for each new record sent electronically.
 - Audit trail should reveal a NewRx transmission to Surescripts and 0 errors should be reported.
 - Manual review of the patient chart should reveal the new medication successfully added and displayed in the medication history.
 - Audit trail should reveal the NewRx being generated in the 20170701 SCRIPT version.
 - Third-Party Application (Surescripts Admin Console) should display the receipt of a NewRx message from OfficeEMR in the 20170701 SCRIPT version with 0 errors.
- **Care Settings and Number of Clients Site to Test:** We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.

Scenario 2.B- Capture and electronically transmit immunization to an immunization registry (170.315(f)(1) Transmission to immunization registries)

- **Description:** Capture and electronically transmit immunization to an immunization registry
- **Associated Certification Criteria:** 170.315(f)(1) Transmission to immunization registries.
- **Justification:** The use case will describe the scenario in which a provider electronically captures and subsequently transmits an Immunization record in the HL7 2.5.1 format via the CDC SOAP-Based webservice transmission method from OfficeEMR to a state's



immunization registry. Users will be able to manually confirm the transmission via the Immunization Export History in OfficeEMR. Users will need to receive an attestation from the state registry that the file was received and accepted into the registry application.

- Testing Method: Audit Trail Review, Manual Verification and Third-Party Application Attestation
- Expected Outcomes:
 - Audit trail should reveal a new immunization successfully saved to the patient record. For each new immunization added, the audit trail record count should increase by 1.
 - Manual review of the immunization export history should show a successful transmission to a connected state registry with 0 errors.
 - Third-Party Attestation from the state registry would need to be obtained confirming the successful receipt of the immunization record into their application.
- Care Settings and Number of Clients Site to Test: We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.

Scenario 2.C - Refer a patient to a different provider for additional care (§170.315(b)(1)

Transitions of care)

- Description: Refer a patient to a different provider for additional care
- Associated Certification Criteria: §170.315(b)(1) Transitions of care.
- Justification: The use case will describe the scenario in which a provider decides to refer the patient that they are seeing to another provider for additional care. The provider will place a referral order, then send a transition of care clinical summary via DIRECT Email. It will provide a numeric value to indicate both how often this interoperability feature is being used as well as its compliance to the requirement. An increment to this measure indicates that the EHR can create a C-CDA patient summary record, including ability to record all clinical data elements, and by sending the C-CDA patient summary record, the EHR demonstrates successful interoperability of an exchanged patient record with a 3rd party. This measurement shows support for Direct Edge protocol in connecting to a HISP for successful transmission which reveals compliance to the associated criteria listed above.
- Testing Method: Audit Trail Review, Third-Party Application Attestation
- Relied Upon Software: Secure Exchange Solutions
- Expected Outcomes:



- Audit trail should reveal a new transition of care summary being sent via DIRECT Email. For each new record sent, the audit trail record count should increase by 1.
 - Third-Party Attestation from the provider that the DIRECT Email was sent to should be obtained with 0 errors.
- Care Settings and Number of Clients Site to Test: We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.



Phase 3: Patient provided access to their clinical information post-visit

Scenario 3.A - Patient obtains access to their clinical summary following a medical visit (170.315(e)(1) View, download, and transmit to 3rd party)

- **Description:** Patient obtains access to their clinical summary following a medical visit
Associated Certification Criteria: 170.315(e)(1) View, download, and transmit to 3rd party
- **Justification:** The use case will describe the scenario in which a provider practice completes a routine medical visit and supplies patients with access to their clinical summary via the patient portal. The measure will evaluate the ability to successfully create a new patient portal account for a new patient and the ability to track if the patient viewed, downloaded, or transmitted their clinical care summary (CCDA).
- **Testing Method:** Audit Trail Review
- **Relied Upon Software:** MyMedicalLocker
- **Expected Outcomes:**
 - Audit trail should reveal a new summary of care documents being generated for a patient upon completion of the visit. For each new CCDA generated, the audit trail should increase by 1.
 - Audit trail should reveal a successful connection by the patient to the Patient Portal.
 - Audit trail should reveal a successful view or download of the CCDA by the patient via the patient portal. Each time the record is accessed, the audit trail records should increase by a count of 1.
- **Care Settings and Number of Clients Site to Test:** We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.

Scenario 3.B – Patient obtains an export of their electronic health information following a medical visit (170.315 (b)(10) Electronic Health Information Export)

- **Description:** Patient obtains an electronic copy of their electronic health information following a medical visit
- **Associated Certification Criteria:** 170.315 (b)(10) Electronic Health Information Export
- **Justification:** The use case will describe the scenario in which a provider completes a routine medical visit and supplies a patient with an electronic export of their health information. The measure will evaluate the ability to successfully create a new single patient electronic health information export.
- **Testing Method:** Manual Verification and Audit Trail Review



- Expected Outcomes:
 - Audit trail should reveal a new electronic health information export being generated for a patient upon request by the provider. For each new single-patient export generated, the audit trail should increase by 1.
 - Audit trail should reveal a successful export by the user. For each new single-patient export exported, the audit trail should increase by 1.
 - Manual verification confirms the data export file contents matches the data populated in the patient's chart and is in conformance to the documented file structure: <https://officeemr.knowledgeowl.com/help/ehi-export>.
- Care Settings and Number of Clients Site to Test: We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.



Real World Test Case: Third Party Application Data Access

Measurement Description

As the medical industry evolves and medical data becomes more commercialized, third-party application developers or other EMR/PM companies will likely build tools that can be used by patient's to securely access and manage key aspects of their health record.

This test case will cover the workflow in which a third-party developer chooses to build an application that would leverage iSalus Healthcare's public API's to securely retrieve data for a patient to display in their application. iSalus Healthcare's public API documentation can be found on our website at <https://docs.isalushealthcare.com/> and <https://isalus-fhirpresentation.everhealthsoftware.com/isalus/basepractice/r4/Home/ApiDocumentation>.

Scenario 4.A: Application access - patient selection (170.315(g)(7))

- Description: Application access - patient selection
- Associated Certification Criteria: 170.315(g)(7)
- Justification: The use case will describe the scenario in which a third-party application developer builds an application to retrieve patient data from OfficeEMR. The first step in utilizing the public API's is to allow a patient to retrieve a patient-specific API token. Patients can access these patient-specific tokens securely via our patient portal. The third-party application will be required to receive and store the token provided by the patient along with the patient first name, patient last name, and patient date of birth. Then, the application must call the public endpoint `ONC.FindPatient` to retrieve an API Token. This endpoint requires the API token, patient first name, patient last name, and patient date of birth to be supplied and match data in our application that meets these parameters. If a successful patient match is found, an API token will be returned. This API token is used in all subsequent application access calls to retrieve patient specific data. If any of the required elements do not match the data stored in OfficeEMR, an appropriate error message will be returned.
- Testing Method: Third-Party Application (MyLinks / Webservice Test Suite)
- Relied Upon Software: MyMedicalLocker
- Expected Outcomes:
 - Manual verification that a patient can successfully retrieve a patient-specific webservice token.
 - Third Party Application (Web service Test Suite) is able to make a call to our production endpoint (<https://www.officemd.net/officemobile/screens/webservices.htm>)



utilizing the ONC.FindPatient method. When passing in a matching patient-specific token, first name, last name, and date of birth, an API token should be returned. 0 errors should be returned when a valid call is executed.

- Third Party Application (Web service Test Suite) is able to make a call to our production endpoint (<https://www.officemd.net/officemobile/screens/webservices.htm>) utilizing the ONC.FindPatient method. When passing in a mis-matched patient-specific token, first name, last name, or date of birth, an appropriate error message should be returned. 1 error should be returned when an invalid call is executed.
- Client Sites Tested: At the time of this writing, no third-party application developers have chosen to utilize the public API endpoints provided. We are looking to partner with MyLinks personal health record application to help us with this testing. Real world testing will either be conducted in partnership with MyLinks or by utilizing a webservice testing suite to simulate making live API calls. We will utilize a third party webservice test suite to follow the test plan and ensure appropriate responses and error messages are returned according to the API documentation provided on our website: <https://docs.isalushealthcare.com/>.

Scenario 4.B: Application access – all data request 170.315(g)(9)

- Description: Application access – all data request
- Associated Certification Criteria: 170.315(g)(9)
- Justification: The use case will describe the scenario in which a third-party application developer builds an application to retrieve patient data from OfficeEMR. To complete this test case, the steps in Scenario 1.A must first be followed to obtain an API Key that will be used in this test case. With a successful API Token in hand, an application should be able to make a call to the public endpoint ONC.GetCCD. This endpoint requires the API token, start date, end date, or a timeframe for the CCDA that the application would like to retrieve. If a successful API token is used, the API should return the requested CCDA in XML format (as described in the API documentation). If any of the required elements do not match the data stored in OfficeEMR, an appropriate error message will be returned.
- Testing Method: Third-Party Application (MyLinks / Webservice Test Suite)
- Relied Upon Software: MyMedicalLocker
- Expected Outcomes:
 - Third Party Application (MyLinks / Webservice Test Suite) is able to make a call to our production endpoint (<https://www.officemd.net/officemobile/screens/webservices.htm>) utilizing the ONC.GetCCD method. When passing in a valid API token the API should return



the complete CCDA document for the patient. The response from the API call should match the API documentation. 0 errors should be returned when a valid call is executed.

- Manual verification of the data elements in the patient chart should match the data returned in the API response.
- Third Party Application (MyLinks / Webservice Test Suite) is able to make a call to our production endpoint (<https://www.officemd.net/officemobile/screens/webservices.htm>) utilizing the ONC.GetCCD method. When passing in a mis-matched API token an appropriate error message should be returned. 1 error should be returned when an invalid call is executed.
- Client Sites Tested: At the time of this writing, no third-party application developers have chosen to utilize the public API endpoints provided. We are looking to partner with MyLinks personal health record application to help us with this testing. Real world testing will either be conducted in partnership with MyLinks or by utilizing a webservice testing suite to simulate making live API calls. We will utilize a third party webservice test suite to follow the test plan and ensure appropriate responses and error messages are returned according to the API documentation provided on our website: <https://docs.isalushealthcare.com/>.

Scenario 4.C: Standardized API for patient and population services 170.315(g)(10)

- Description: Standardized API for patient and population services
- Associated Certification Criteria: 170.315(g)(10)
- Justification: The use case will describe the scenario in which a third-party application developer builds an application to retrieve patient data from OfficeEMR. To complete this test case, the third-party would need to register with iSalus Healthcare as an API Client and obtain a client ID, client secret, client scopes, R4 endpoints and access token endpoint which will be used to pull patient data from OfficeEMR via FHIR APIs. With the successful API configurations in hand, an application should be able to authenticate with our Identity Provider and can then call any of the R4 resources they have been given access to for an authorized patient. If a successful API token is used, the API should return the requested FHIR resource with the patient's data (as described in the API documentation). If any of the required elements do not match the data stored in OfficeEMR, an appropriate error message will be returned.
- Testing Method: Third-Party Application (Inferno / Apple Health)
- Relied Upon Software: ConnectEHR
- Expected Outcomes:



- Third Party Application (Inferno / Apple Health) can make a call to our provided production API endpoint for a single patient. When passing in a valid API token and valid R4 resource (Demographics, Social History, Problems, Allergies, Medications, Diagnostic Results, Vital Signs, Procedures, Care Team Members, Immunizations, Unique Device Identifiers, Assessment and Plan of Treatment, Goals, or Health Concerns), the API should return the various sections and the individual data elements for those sections. The response from the API call should match the API documentation. 0 errors should be returned when a valid call is executed.
- Third Party Application (Inferno / Apple Health) can make a call to our provided production API endpoint for multiple patients. When passing in a valid API token and valid R4 resource (Demographics, Social History, Problems, Allergies, Medications, Diagnostic Results, Vital Signs, Procedures, Care Team Members, Immunizations, Unique Device Identifiers, Assessment and Plan of Treatment, Goals, or Health Concerns), the API should return the various sections and the individual data elements for those sections. The response from the API call should match the API documentation. 0 errors should be returned when a valid call is executed.
- Manual verification of the data elements in the patient chart should match the data returned in the API response.
- Third Party Application (Inferno / Apple Health) can make a call to our production endpoint to query for valid R4 resources. When passing in a mis-matched API token and resource name, an appropriate error message should be returned. At least 1 error should be returned when an invalid call is executed.
- Client Sites Tested: At the time of this writing, no third-party application developers have chosen to utilize the public API endpoints provided. We are looking to partner with Apple Health personal health record application to help us with this testing. Real world testing will either be conducted in partnership with Apple Health or by utilizing a webservice testing suite Inferno to simulate making live API calls. We will utilize a third party webservice test suite to follow the test plan and ensure appropriate responses and error messages are returned according to the API documentation provided on our website: <https://isalus-fhirpresentation.everhealthsoftware.com/isalus/basepractice/r4/Home/ApiDocumentation>.



Real World Test Case: Syndromic Surveillance

Scenario 5.A: Transmission to public health agencies - syndromic surveillance (170.315(f)(2))

- Description: Transmission to public health agencies - syndromic surveillance
- Associated Certification Criteria: 170.315(f)(2) Transmission to public health agencies - syndromic surveillance
- Justification: The use case will describe the scenario in which a practice has configured an integration with a public health agency to submit syndromic surveillance data. iSalus supports the ability to have a Syndromic Surveillance file generated as a patient is admitted and discharged within the application. Following successful registration and discharge, the appropriate syndrome surveillance file will be generated and available for export by the practice.
- Testing Method: Manual Verification
- Expected Outcomes:
 - Manual verification of the syndromic surveillance file being downloaded upon request. A screenshot of the download location should reveal 1 new file added to the directory.
- Client Sites Tested: At the time of this writing, no iSalus customers have chosen to utilize the syndromic surveillance data file. Therefore, real world testing must be conducted by utilizing a simulated workflow. Our findings will be documented relative to the workflow to ensure standards are met and the application behaves as intended.

Real World Test Case: Electronic Case Reporting

Scenario 6.A- Capture and electronically transmit electronic case information to a public health agency (170.315(f)(5) Transmission to public health agencies – electronic case reporting)

- Description: Capture and electronically transmit electronic case reporting information to a public health agency
- Associated Certification Criteria: 170.315(f)(5) Transmission to public health agencies – electronic case reporting
- Justification: The use case will describe the scenario in which a practice has configured an integration with a public health agency to submit electronic case reporting data via DIRECT secure mail. iSalus supports the ability to have an electronic case reporting CCDa file generated upon completion of a patient visit within OfficeEMR for case reportable triggered events. Following a successful sign-off of a clinician's note, the appropriate electronic case



report CCDAs will be generated and sent via DIRECT mail to a practice configured recipient (public health agency).

- Testing Method: Manual Verification
- Expected Outcomes:
 - Manual verification of the receipt of the electronic case report files via DIRECT mail.
 - Audit trail should reveal a new electronic case report document being generated for a patient upon completion of a visit with a “trigger code” event. For each new electronic case report generated, the audit trail should increase by 1.
- Client Sites Tested: At the time of this writing, no iSalus customers have chosen to utilize the electronic case reporting data file. Therefore, real world testing must be conducted by utilizing a simulated workflow. Our findings will be documented relative to the workflow to ensure standards are met and the application behaves as intended.

Real World Test Case: Electronic Health Information Export

Scenario 7.A: All Data Electronic Health Information Export (170.315 (b)(10) Electronic Health Information Export)

- Description: Practice Level Electronic Health Information Export (All Data)
- Associated Certification Criteria: 170.315 (b)(10) Electronic Health Information Export
- Justification: The use case will describe the scenario in which a practice is migrating to another EHR platform or closing their practice and requests a practice/all data electronic health information export. The measure will evaluate the ability to successfully create and export a practice/all data electronic health information export.
- Testing Method: Manual Verification and Audit Trail Review
- Expected Outcomes:
 - Audit trail should reveal a new electronic health information export being generated for the practice upon request by the provider. For each new single-patient export generated, the audit trail should increase by 1.
 - Manual verification confirms the data export file contents matches the data populated in the patient’s chart and is in conformance to the documented file structure: <https://officeemr.knowledgeowl.com/help/ehi-export>.
- Care Settings and Number of Clients Site to Test: We designed this measure to test general ambulatory sites that we support and target. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHR.