FORTE HOLDINGS INC. CHIRO8000 REAL WORLD TESTING PLAN

GENERAL INFORMATION

Plan Report ID Number: [For ONC-Authorized Certification Body use only]

Developer Name: Forte Holdings Inc.

Product Name(s): Chiro8000

Version Number(s): v17

Certified Health IT: ONC Certified HIT 2015 Edition Modular Certification

Product List (CHPL) ID(s): 15.04.04.2986.Chir.16.00.0.190627

Developer Real World Testing Page URL: http://www.chiro8000.com/certifications/

JUSTIFICATION FOR REAL WORLD TESTING APPROACH

Provide an explanation for the overall approach to Real World Testing, including an outline of the approach and how data will be used to demonstrate successful Real-World Testing[i].

All measures should reasonably align with the elements within a Real-World Testing plan, the scope of the certification, the types of settings in which the certified health IT is marketed, and other factors relevant to the implementation of the certified Health IT Module(s). The justification should reflect how each element within the plan is relevant to the developer's overall strategy for meeting the Real-World Testing Condition and Maintenance of Certification requirements.

Note: A single Real World Testing plan may address multiple products and certification criteria for multiple care settings.

The overall approach we are taking is to develop a testing process that will demonstrate interoperability and functionality of our Certified Health IT, Chiro8000. The testing has been designed around real chiropractic office settings and scenarios. We have ensured that all measures being tested reasonably align with the elements within a real-world testing plan rather than in a controlled test environment with an ONC authorized testing lab. Testing was created and performed to ensure they align with the chiropractic industry as that is the type of setting our program is used for and how Chiro8000 is marketed. The testing will be used as a measure to verify that Chiro8000 continues to perform as intended by conducting and measuring observations of interoperability and data exchange.

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

Both required and voluntary standards updates must be addressed in the Real-World Testing plan. Real World Testing plans must include all certified health IT updated to newer versions of standards prior to August 31 of the year in which the updates were made.

Describe approach(es) for demonstrating conformance to all certification requirements using each standard to which the health IT is certified. List each version of a given standard separately. For each version of a standard submit the following:

- ✓ *Identify standard versions*
- ✓ *Indicate what certification criteria in which product(s) has been updated*
- ✓ *If reporting for multiple products, identify the certification criteria that were affected by the update for each of the associated products*
- ✓ *CHPL ID for each Health IT Module*
- ✓ *Method used for standard update (e.g., SVAP)*
- ✓ *Date notification sent to ONC-ACB*
- ✓ *If SVAP, date notification sent to customers*
- ✓ *Measure used to demonstrate conformance with updated standard(s)*
- ✓ *Which certification criteria were updated to USCDI and/or to which version of USCDI was the certification criteria updated?*

Standard (and version)	N/A
Updated certification criteria and associated product	N/A
Health IT Module CHPL ID	15.04.04.2986.Chir.16.00.0.190627
Method used for standard update	N/A
Date of ONC-ACB notification	06/27/2019
Date of customer notification (SVAP only)	
Conformance measure	170.315.b.1 Transitions of Care 170.315.b.2 Clinical Information Reconciliation 170.315.b.6 Data Export 170.315.c.1 CQM-Report and Export 170.315.g.7 API-Patient Selection 170.315.g.8 API-Data Category Request 170.315.g.9 API-All Data Request 170.315.h.1 Direct Project
USCDI-updated certification criteria (and USCDI version)	

MEASURES USED IN OVERALL APPROACH

Each plan must include at least one measurement/metric that addresses each applicable certification criterion in the Health IT Module's scope of certification. Describe the method for measuring how the approach(es) chosen meet the intent and purpose of Real-World Testing.

For each measurement/metric, describe the elements below:

- ✓ Description of the measurement/metric
- ✓ Associated certification criteria
- ✓ Justification for selected measurement/metric
- ✓ Care setting(s) that is addressed
- ✓ Expected outcomes

DESCRIPTION OF MEASUREMENT/METRIC

Describe the measure(s) that will be used to support the overall approach to Real World Testing.

Measurement/Metric	Description
170.315.b.1 Transitions of Care	Chiro8000 will demonstrate how to produce a properly formatted transition of care summary/referral summary using Consolidated-Clinical Documents Architecture (C-CDA) to create summary of care and referral documents which can be imported into other Health IT 2015 certified products that adhere to this standard. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.b.2 Clinical Information Reconciliation	Chiro8000 will demonstrate how to digest a properly formatted transition of care summary/referral summary using Consolidated-Clinical Documents Architecture (C-CDA) and correctly match to a patient in Chiro8000 to reconcile summary of care and referral documents. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.b.6 Data Export	Chiro8000 will demonstrate how to successfully create and export a proper Continuity of Care (CCD) document based on selected criteria and export. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.c.1 CQM-Report and Export	Chiro8000 will demonstrate how a user can export a file at any time the user chooses and without subsequent developer assistance. Based upon the patient records updated in paragraph (c)(1)(i), a user exports a data file formatted in accordance with the standard specified at § 170.205(h)(2) HL7 CDA® Release 2 Implementation Guide for: Quality Reporting Document Architecture – Category I (QRDA I); Release 1, DSTU Release 3, Volume 1 for a single patient and for multiple patients for each eCQM per certified criteria. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.g.7 API-Patient Selection	Ensure that Chiro8000 can create a properly formatted CCD document and be sent by the documented API which adheres to the standards set for in this measure for API syntax, function names, required parameters, and their data types, return variables in the proper type/structure. In addition, the API

	should handle all exceptions and exception handling methods and their returns. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.g.8 API-Data Category Request	Ensure that Chiro8000 can create a properly formatted CCD document and be sent by the documented API which adheres to the standards set for in this measure for API syntax, function names, required parameters, and their data types, return variables in the proper type/structure. In addition, the API should handle all exceptions and exception handling methods and their returns. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.g.9 API-All Data Request	Ensure that Chiro8000 can create a properly formatted CCD document and be sent by the documented API which adheres to the standards set for in this measure for API syntax, function names, required parameters, and their data types, return variables in the proper type/structure. In addition, the API should handle all exceptions and exception handling methods and their returns. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.
170.315.h.1 Direct Project	Ensure that Chiro8000 can electronically transmit (including sending and receiving) health information to/from a third party which must be secure and properly packaged as defined in the direct project measure. This will be tested using encounters on different dates and also to confirm not only that the measure properly increments but also cannot be improperly incremented by means of using criteria that does not adhere to the required scope of this measure.

ASSOCIATED CERTIFICATION CRITERIA

List certification criteria associated with the measure and if updated to the 2015 Edition Cures Update criteria.

Measurement/Metric	Associated Certification Criteria
170.315.b.1 Transitions of Care	§ 170.315 (b)(1) Transition of care— Send and receive via edge protocol— Send transition of care/referral summaries through a method that conforms to the standard specified in § 170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in § 170.202(a); and Receive transition of care/referral summaries through a method that conforms to the standard specified in § 170.202(d) from a service that has implemented the standard specified in § 170.202(a)(2). XDM processing. Receive and make available the contents of a XDM package formatted in accordance with the standard adopted in §

	170.205(p)(1) when the technology is also being certified using an SMTP-based edge protocol. Validate and display — Validate C-CDA conformance – system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in § 170.205(a)(3), (4), and (5) for the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to: Parse each of the document types. Detect errors in corresponding "document-templates," "section-templates," and "entry-templates," including invalid vocabulary standards and codes not specified in the standards adopted in § 170.205(a)(3), (4), and (5). Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in § 170.205(a)(3), (4), and (5). Correctly interpret empty sections and null combinations. Record errors encountered and allow a user through at least one of the following ways to: Be notified of the errors produced. Review the errors produced. Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in § 170.205(a)(3), (4), and (5). Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in § 170.205(a)(3), (4), and (5) in a manner that enables the user to: Directly display only the data within a particular section; Set a preference for the display order of specific sections; and Set the initial quantity of sections to be displayed. Create. Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in § 170.205(a)(3), (4), and (5) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum: The data classes expressed in the standard in § 170.213 and in accordance with § 170.205(a)(4), (a)(5), and paragraphs (b)(1)(iii)(A)(3)(i) through (iii) of this section, or The Common Clinical Data Set in accordance with §170.205(a)(4) and paragraph (b)(1)(iii)(A)(3)(i) through (iv) of this section for the period until December 31, 2022, and The following data classes: Assessment and plan of treatment. In accordance with the "Assessment and Plan Section (V2)" of the standard specified in § 170.205(a)(4); or in accordance with the "Assessment Section (V2)" and "Plan of Treatment Section (V2)" of the standard specified in § 170.205(a)(4).

	Goals. In accordance with the "Goals Section" of the standard specified in § 170.205(a)(4). Health concerns. In accordance with the "Health Concerns Section" of the standard specified in § 170.205(a)(4). Unique device identifier(s) for a patient's implantable device(s). In accordance with the "Product Instance" in the "Procedure Activity Procedure Section" of the standard specified in § 170.205(a)(4). Encounter diagnoses. Formatted according to at least one of the following standards: The standard specified in § 170.207(i). At a minimum, the version of the standard specified in § 170.207(a)(4). Cognitive status. Functional status. Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. Inpatient setting only. Discharge instructions. Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply: Date of birth constraint. The year, month and day of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown. Optional. When the hour, minute, and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included. Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in § 170.207(q)(1). All phone numbers must be included when multiple phone numbers are present. Sex constraint. Represent sex in accordance with the standard adopted in § 170.207(n)(1).
170.315.b.2 Clinical Information Reconciliation	§ 170.315 (b)(2) Clinical information and reconciliation and incorporation— General requirements. Paragraphs (b)(2)(ii) and (iii) of this section must be completed based on the receipt of a transition of care/referral summary formatted in accordance with the standards adopted in § 170.205(a)(3) through (5) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates on and after December 31, 2022. Correct patient. Upon receipt of a transition of care/referral summary formatted according to the standards adopted § 170.205(a)(3) through (5), technology must be able to demonstrate that the transition of care/referral summary received can be properly matched to the correct patient. Reconciliation. Enable a user to reconcile the data that represent a patient's active medication list, allergies and intolerance list, and problem list as follows. For each list type: Simultaneously display (i.e., in a single view) the data from at least two sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. Enable a user to create a single reconciled list of each of the following: Medications; Allergies and Intolerances; and problems.

	Enable a user to review and validate the accuracy of a final set of data. Upon a user's confirmation, automatically update the list, and incorporate the following data expressed according to the specified standard(s) on and after December 31, 2022: Medications. At a minimum, the version of the standard specified in § 170.213; Allergies and intolerance. At a minimum, the version of the standard specified in § 170.213; and Problems. At a minimum, the version of the standard specified in § 170.213. System verification. Based on the data reconciled and incorporated, the technology must be able to create a file formatted according to the standard specified in § 170.205(a)(4) using the Continuity of Care Document template and the standard specified in § 170.205(a)(5) on and after December 31, 2022.
170.315.b.6 Data Export	§170.315(b)(6) Data export— General requirements for export summary configuration. Enable a user to set the configuration options specified in paragraphs (b)(6)(iii) and (iv) of this section when creating an export summary as well as a set of export summaries for patients whose information is stored in the technology. A user must be able to execute these capabilities at any time the user chooses and without subsequent developer assistance to operate. Limit the ability of users who can create export summaries in at least one of these two ways: To a specific set of identified users. As a system administrative function. Creation. Enable a user to create export summaries formatted in accordance with the standard specified in §170.205(a)(4) using the Continuity of Care Document template that includes, at a minimum: The Common Clinical Data Set. Encounter diagnoses. Formatted according to at least one of the following standards: The standard specified in §170.207(i). At a minimum, the version of the standard specified in §170.207(a)(4). Cognitive status. Functional status. Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. Inpatient setting only. Discharge instructions. Timeframe configuration. Enable a user to set the date and time period within which data would be used to create the export summaries. This must include the ability to enter in a start and end date and time range. Consistent with the date and time period specified in paragraph (b)(6)(iii)(A) of this section, enable a user to do each of the following: Create export summaries in real-time; Create export summaries based on a relative date and time (e.g., the first of every month at 1:00 a.m.); and

	Create export summaries based on a specific date and time (e.g., on 10/24/2015 at 1:00 a.m.). Location configuration. Enable a user to set the storage location to which the export summary or export summaries are intended to be saved.
170.315.c.1 CQM-Report and Export	§ 170.315(c)(1) Clinical quality measures—record and export— Record. For each and every CQM for which the technology is presented for certification, the technology must be able to record all of the data that would be necessary to calculate each CQM. Data required for CQM exclusions or exceptions must be codified entries, which may include specific terms as defined by each CQM, or may include codified expressions of "patient reason," "system reason," or "medical reason." Export. A user must be able to export a data file at any time the user chooses and without subsequent developer assistance to operate: Formatted in accordance with the standard specified in §170.205(h)(2); Ranging from one to multiple patients; and That includes all of the data captured for each and every CQM to which technology was certified under paragraph (c)(1)(i) of this section.
170.315.g.7 API-Patient Selection	§170.315 (g)(7) Application access – patient selection— The following technical outcome and conditions must be met through the demonstration of an application programming interface (API). Functional requirement. The technology must be able to receive a request with sufficient information to uniquely identify a patient and return an ID or other token that can be used by an application to subsequently execute requests for that patient's data. Documentation— The API must include accompanying documentation that contains, at a minimum: API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns. The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s). Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements. The documentation used to meet paragraph (g)(7)(ii)(A) of this section must be available via a publicly accessible hyperlink.
170.315.g.8 API-Data Category Request	§170.315 (g)(8) Application access – data category request— The following technical outcome and conditions must be met through the demonstration of an application programming interface. Functional requirements. Respond to requests for patient data (based on an ID or other token) for each of the individual data categories specified in the Common Clinical Data

	Set and return the full set of data for that data category (according to the specified standards, where applicable) in a computable format. Respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range. Documentation— The API must include accompanying documentation that contains, at a minimum: API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns. The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s). Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements. The documentation used to meet paragraph (g)(8)(ii)(A) of this section must be available via a publicly accessible hyperlink.
170.315.g.9 API-All Data Request	§ 170.315 (g)(9) Application access – all data request— The following technical outcome and conditions must be met through the demonstration of an application programming interface. Functional requirements. (1) Respond to requests for patient data (based on an ID or other token) for all of the data classes expressed in the standards in § 170.213 at one time and return such data (according to the specified standards, where applicable) in a summary record formatted in accordance with § 170.205(a)(4) and (5) following the CCD document template, and as specified in paragraphs (g)(9)(i)(A)(3)(i) through (iii) of this section, or The Common Clinical Data Set in accordance with paragraphs (g)(9)(i)(A)(3)(i) through (iv) of this section for the period until December 31, 2022, and The following data classes: Assessment and plan of treatment. In accordance with the "Assessment and Plan Section (V2)" of the standards specified in § 170.205(a)(4); or in accordance with the "Assessment Section (V2)" and "Plan of Treatment Section (V2)" of the standards specified in § 170.205(a)(4). Goals. In accordance with the "Goals Section" of the standard specified in § 170.205(a)(4). Health concerns. In accordance with the "Health Concerns Section" of the standard specified in § 170.205(a)(4). Unique device identifier(s) for a patient's implantable device(s). In accordance with the "Product Instance" in the "Procedure Activity Procedure Section" of the standard specified in § 170.205(a)(4). Respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range. Documentation— The API must include accompanying documentation that contains, at a minimum:

	API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns. The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s). Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements. The documentation used to meet paragraph (g)(9)(ii)(A) of this section must be available via a publicly accessible hyperlink.
170.315.h.1 Direct Project	§170.315 (h)(1) Direct Project— Applicability Statement for Secure Health Transport. Able to send and receive health information in accordance with the standard specified in §170.202(a)(2), including formatted only as a "wrapped" message. Delivery Notification in Direct. Able to send and receive health information in accordance with the standard specified in §170.202(e)(1).

JUSTIFICATION FOR SELECTED MEASUREMENT/METRIC

Provide an explanation for the measurement/metric selected to conduct Real World Testing.

Measurement/Metric	Justification
170.315.b.1 Transitions of Care	*This measure was selected to conduct real world testing because Chiropractors will, on occasion, have patients that transition to another care team and will need to support creating and submitting the patient's health information using current, electronic standards to be imported into the other care team's certified Health IT.*
170.315.b.2 Clinical Information Reconciliation	This measure was selected to conduct real world testing because Chiropractic profession requires the ability to import and reconcile patient information.
170.315.b.6 Data Export	This measure was selected to conduct real world testing because Chiropractors need to have the ability to export patient data in accordance with current standards.
170.315.c.1 CQM-Report and Export	This measure was selected to conduct real world testing to ensure the implemented CQM's selected are functioning correctly.
170.315.g.7 API-Patient Selection	This measure was selected to conduct real world testing to ensure Chiropractic offices utilizing Chiro8000 have the ability to export and transmit data as needed with an emphasis on selecting specific patients.
170.315.g.8 API-Data Category Request	This measure was selected to conduct real world testing to ensure Chiropractic offices utilizing Chiro8000 have the ability to export and transmit data as needed with an emphasis of pulling selected data from categories.
170.315.g.9 API-All Data Request	This measure was selected to conduct real world testing to ensure Chiropractic offices utilizing Chiro8000 have the ability to export and transmit data as needed.
170.315.h.1 Direct Project	This measure was selected to conduct real world testing to ensure the office can successfully utilize direct messaging between associated providers.

CARE SETTING(S)

The expectation is that a developer's Real World Testing plan will address each type of clinical setting in which their certified health IT is marketed. Health IT developers are not required to test their certified health IT in every setting in which it is marketed for use. Developers should address their choice of care and/or practice settings to test and provide a justification for the chosen approach.

Note: Health IT developers may bundle products by care setting, criteria, etc. and design one plan to address each, or they may submit any combination of multiple plans that collectively address their products and the care settings in which they are marketed

List each care setting which is covered by the measure and an explanation for why it is included.

Care Setting	Justification
Chiropractic	Chiro8000 is exclusively marketed and sold to Chiropractors for use in the Chiropractic care setting.

EXPECTED OUTCOMES

Health IT developers should detail how the approaches chosen will successfully demonstrate that the certified health IT:

(1) is compliant with the certification criteria, including the required technical standards and vocabulary codes sets;

(2) is exchanging electronic health information (EHI) in the care and practice settings for which it is marketed for use; and/or,

(3) EHI is received by and used in the certified health IT.

(from 85 FR 25766)

Not all of the expected outcomes listed above will be applicable to every certified Health IT Module, and health IT developers may add an additional description of how their measurement approach best addresses the ongoing interoperability functionality of their product(s). Health IT developers could also detail outcomes that should <u>not</u> result from their measurement approach if that better describes their efforts.

Within this section, health IT developers should also describe how the specific data collected from their Real-World Testing measures demonstrate expected results. Expected outcomes and specific measures do not necessarily have to include performance targets or benchmarks, but health IT developers should provide context for why specific measures were selected and how the metrics demonstrate individual criterion functionality, EHI exchange, and/or use of EHI within certified health IT, as appropriate.

Measurement/Metric	Expected Outcomes

Program Preparation	**The Following Are Expectations of Real-World Clients in real setup and use case of our program.**
Install and register Chiro8000 version 17 to a C8K3 licensed account	Chiro8000 v17 will be successfully licensed with the 'C8K3' service level
Click on Chiro8000 to open login screen	The login screen will launch
Log into Chiro8000 using your credentials	Enter your username and password
Click on 'View' in menu toolbar	The 'view' menu and all sub-menu items will be displayed
Select 'Doctor's List' from the sub-menu	The 'Doctor's list edit screen will display
Ensure your doctor is properly configured with: Name (first/last); Display Name; Phone; Email; Individual/Group NPI; Federal ID No; Taxonomy code	The purpose of this step is to ensure correct, real-world data for the provider has been entered
Close the doctor's list	The doctor's list screen will close
Navigate to the 'Home' tab	You will be situated on the 'Home' tab of Chiro8000 v17
Navigate to the 'Message Center'	You will have moved to the 'Message Center' area located within the home tab
Click on 'Email Settings' within the 'Actions' area	The email setting screen will display which will allow you to enter proper email settings in the next step
If required, please confirm your email settings for your chosen email provider. Ensure you have entered corresponding information in the main email settings screen in all fields.	All available email settings will be populated.
Click on the 'Advanced' button within email settings	The advanced email settings screen will display
Ensure you have entered corresponding information in the advanced email settings screen in all fields	This is the second, and final email screen and will be populated with all email settings as provided from your email provider
Close the email settings	The email settings screen will close and you will be returned to the Chiro8000 home screen
Click on 'Tools'	The 'Tools' menu and sub-menu options will display
Select 'EMR Options' from the sub-menu	The 'EMR Options' menu will display on-screen
Ensure you have filled out ever filled in the 'Info' tab with correct corresponding, relevant information	All fields will be completed in the 'Info' tab of the EMR settings
Close the EMR options window	The 'EMR Options' window will close and you will be returned to the Chiro8000 v17 home screen
As this is a real-world test, the expectation is that you have more than twenty-five (25) real world patients entered into your system. Your patients will be properly entered with full demographics, medical history, medications, allergies, complaints, treatments, visits/exams, etc... as	The end goal will yield at minimum 25 real world patients that have completed full demographics, medical history, medications, allergies, complaints, treatments, visits and exams all as related to your Chiropractic environment.

encountered in the Chiropractic environment.	
Open one patient file from your group of 25 patients listed in previous testing step.	The selected patient file will launch and display
Select the 'Compliance' option	The 'Compliance' screen will display
In the menu bar select 'CCD"	The 'CCD' menu will display
Select 'Configuration' within the sub-menu	The CCD configuration menu will display
Ensure you have setup configuration in accordance with the information provided from your vendor	All CCD configuration fields will be populated
Close CCD Configuration window	The CCD configuration menu will close and you will be returned to the 'Compliance' screen
In the menu bar select 'CCD'	The 'CCD' menu will display
Select 'FTP Configuration' with the sub-menu	The FTP Configuration menu will display
Ensure you have setup FTP configuration in accordance with the information provided from your vendor	All FTP configuration fields will be populated
Close FTP configuration window	The FTP configuration window will close and you will return to the 'Compliance' screen
In the menu select 'Tools'	The tools menu will display including sub-menu items
Select 'Direct Setup' in the sub-menu	The direct setup screen will display
Ensure you have properly filled out all fields in the direct setup screen in accordance with your vendor guidance.	All direct setup fields will be populated
While still in the direct setup screen, click manage certificates	The sub-area 'manage certificates' screen will display
Ensure all proper certificates have been added in accordance with your vendor's recommendations	All certificates will have been added and ready for use
Close the direct setup window	The direct setup window will close and return you to the compliance screen
While still in the 'Compliance' screen navigate to the patient education section and select the area for viewing	The patient education screen will display
Ensure that all patients to be used in your real-world testing have information, as applicable to each individual patient's real-world health information, in all patient education sections including: educational links; Med Reconciliation; Med Allergies; Labs; Medications; Immunization; Implantable Devices; Other	Your patient base is real-world, each populated with real-world data associated with your patient base.
Close the compliance window	The compliance window will close

Close the patient file currently open	The currently selected patient file will close and you will be returned to the Chiro8000 v17 home screen
Standard Chiro8000 v17 installation and setup is complete	You now have installed and completed the initial setup required for standard use.
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.b.1 Transitions of Care	**Chiro8000 will demonstrate how to produce a properly formatted transition of care summary/referral summary using Consolidated-Clinical Documents Architecture (C-CDA) to create summary of care and referral documents which can be imported into other Health IT 2015 certified products that adhere to this standard.**
Open a patient file	The patient file will successfully open
Click on 'Compliance'	The 'Compliance' screen will display
Select 'CCD' from the menu bar	The CCD screen will display
Select 'Configuration' within the sub-menu	The configuration options screen will display
Review available options	You will read all options to ensure understanding
Ensure there are options to limit the set of users who can create export summaries	Verification that options exist to limit which of your office staff can create export summaries and you will have set some who can along with some who cannot
Ensure there are options to configure the data export by timeframe and save locations	You will have adjusted the options for when you want the export to occur and where you would like it to save
First, verify that the access to this screen corresponds with a level your user login has been assigned to allow proper access	You have now proven ability to log in with given permissions
Next, log out of the program and back in as someone with a security level who has not been given CCD access	You have no proven ability that you do not have CCD access without permissions
Open a patient file	The patient file will successfully open
Click on 'Compliance'	The compliance screen will display
Select 'CCD' from the menu bar	The CCD screen will display
Select 'Configuration' within the sub-menu	The CCD configuration will display
Attempt to export a file by clicking 'Export CCD' and confirm you CANNOT export the file due to the security level to which the user you are logged in has access	This proves a negative case that you are unable to access and use without proper permissions
Log out of the program and back in as a user with a security level who has been given CCD access	You are now logged in as the new user
Open a patient file	The patient file will open

Click on 'Compliance'	The compliance screen will display
Select 'CCD' from the menu bar	The CCD menu will display
Select 'Configuration' within the sub-menu	The CCD configuration menu will display
Select a unique and custom timeframe configuration within the automatic export area. As you will be testing successful functionality, it is recommended you set to a date and time relative to the date/time you are testing to easily verify the results are created.	You successfully adjust the settings
Navigate to the 'CCD Data-Date Range'	The CCD Data-Date Range area will be reviewed
Ensure you have selected a date range that will include one or more patient encounters (visit/exam)	You have successfully setup a date range and selected the patient encounters desired
Select CCD Export Location to your preference	You have setup the export location
Click 'Export CCD'	Test Case will Complete Successfully
Observe the CCD document will be created at the correct date/time you scheduled and sent to the save location of your choosing.	The CCD document has been created using your selected parameters
Return to CCD configuration	The CCD configuration screen will display
Turn off auto export	You have now disabled the auto CCD export so it will no longer occur
Navigate to the 'CCD Data-Date Range'	The CCD Data-date range area will be reviewed
Ensure you have selected a date range that will include one or more patient encounters (visit/exam)	You have set the desired date range for the chosen patients
Select CCD Export Location to your preference	You have now selected your CCD save or export location
Click 'Export CCD'	You will have initiated a send of the CDD file
Observe the CCD document will be created immediately and sent to the save location of your choosing.	You have successfully submitted a CCD document
Close the CCD screen	The CCD screen will close
Close the compliance window	The compliance window will be closed
Close the selected patient file	The patient file will be closed
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.b.2 Clinical Information Reconciliation	**Chiro8000 will demonstrate how to digest a properly formatted transition of care summary/referral summary using Consolidated-Clinical Documents Architecture (C-CDA) and**

	correctly match to a patient in Chiro8000 to reconcile summary of care and referral documents.
Open a patient file	The patient file will open
Click on 'Compliance'	The compliance screen will display
Select 'CCD' from the menu bar	The CCD sub-menu will display
Select 'Import' from the sub-menu bar	The CCD will import if properly format or if an invalid CCD will display the invalid messaging
Verify the CCD correctly matches with the select patient	All data will be verified
Using file explorer, navigate to the location of the CCD file you wish to incorporate for this patient and select it.	You will select the desired CCD
Observe the screens for reconciliation and incorporation presented	Reconciliation and incorporation screens will both display
Verify the information is relevant to the selected patient and is in human readable format	The information will match that of the selected patient (for identification purposes)
Using available on-screen reconciliation options, select desired actions	The action you take will be executed
Observe the data incorporated matches the CCD import data within the patient record.	You will have completed confirmation the data incorporated matches the data from the CCD
Close the current patient	The patient file will close
Open a different patient file	The new patient file will open and display
Click on 'Compliance'	The compliance menu will be displayed
Select 'CCD' from the menu bar	The CCD sub-menu and options will be presented
Select 'Import' from the sub-menu bar	The import screen will be displayed
Select the CCD file previously used on the last patient	This is to test a negative example
Attempt to finalize the import	You have attempted import but will be prevented
Observe messaging stating the action cannot be completed as the patient file does not match and the process will be aborted.	Messaging as to why you are unable to import are presented visually on screen with specific details
Close the CCD screen	The CCD screen will close
Close the compliance window	The compliance screen will close and you will be returned to the patient file
Close the selected patient file	The patient file will close
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.b.6 Data Export	
Open a patient file	The patient will open and display

Click on 'Compliance'	The client menu will display
Select 'CCD' from the menu bar	The CCD and sub-menu options will open and display
Select 'Configuration' within the sub-menu	The CCD configuration options will display
Review available options	You have familiarized yourself will all available options
Ensure there are options to limit the set of users who can create export summaries	You have confirmed ability to authorize and limit users
Ensure there are options to configure the data export by timeframe and save locations	You have confirmed the configuration options for both location and time frame
First, verify that the access to this screen corresponds with a level your user login has been assigned to allow proper access	You have confirmed the program authorization is working as intended
Next, log out of the program and back in as someone with a security level who has not been given CCD access	You successfully login as a different user to test the access for someone who does not have authorization
Open a patient file	The patient will open and display
Click on 'Compliance'	The compliance menu will open
Select 'CCD' from the menu bar	The CCD menu and options will display
Select 'Configuration' within the sub-menu	The CCD configuration sub-menu and options will display
Attempt to export a file by clicking 'Export CCD' and confirm you CANNOT export the file due to the security level to which the user you are logged in has access	You will not be able to export the CCD with the user you are currently logged in with
Log out of the program and back in as a user with a security level who has been given CCD access	You are now logged back in as a user with CCD access
Open a patient file	The patient file will open and display
Click on 'Compliance'	The compliance menu will display
Select 'CCD' from the menu bar	The CCD menu will display
Select 'Configuration' within the sub-menu	The CCD configuration sub-menu and options will display
Select a unique and custom timeframe configuration within the automatic export area. As you will be testing successful functionality, it is recommended you set to a date and time relative to the date/time you are testing to easily verify the results are created.	You will have set the time frame and export to selections of your own personal choice
Navigate to the 'CCD Data-Date Range'	You will be located into the area to adjust the data/date range
Ensure you have selected a date range that will include one or more patient encounters (visit/exam)	You have selected a date range encompassing encounters of your real-world patient base

Select CCD Export Location to your preference	You have successfully selected an export location
Click 'Export CCD'	You will execute the CCD export process
Observe the CCD document will be created at the correct date/time you scheduled and sent to the save location of your choosing.	The CCD will have created at the time you set, for the time frame you provided to the save location you decided upon
Return to CCD configuration	The CCD configuration sub-menu and options page will be displayed
Turn off auto export	You have disabled the auto-export
Navigate to the 'CCD Data-Date Range'	You are present in the field to set data location and data range for the CCD
Ensure you have selected a date range that will include one or more patient encounters (visit/exam)	You have selected a date range encompassing encounters of your real-world patient base
Select CCD Export Location to your preference	You have successfully selected an export location
Click 'Export CCD'	You will execute the CCD export process
Observe the CCD document will be created immediately and sent to the save location of your choosing.	The CCD will have created at the time you set, for the time frame you provided to the save location you decided upon
Close the CCD screen	The CCD screen will close
Close the compliance window	The compliance screen will close and you will be returned to the patient file
Close the selected patient file	The patient file will be closed and you will be returned to the home screen of Chiro8000 v17
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.c.1 CQM-Report and Export	**Chiro8000 will demonstrate how a user can export a file at any time the user chooses and without subsequent developer assistance. Based upon the patient records updated in paragraph (c)(1)(i), a user exports a data file formatted in accordance with the standard specified at § 170.205(h)(2) HL7 CDA® Release 2 Implementation Guide for: Quality Reporting Document Architecture – Category I (QRDA I); Release 1, DSTU Release 3, Volume 1 for a single patient and for multiple patients for each eCQM per certified criteria.**
Log into Chiro8000 v17	You will be successfully logged into Chiro8000 v17
Open any patient file	The selected patient file will open and display
Select 'Compliance'	The compliance screen will launch and display
Select 'MIPS' in the menu toolbar	The MIPS menu will display
Select 'Patient Lists' from the sub-menu	The patient list options within the MIPS menu will be selected
Select 'MIPS Estimates' from the Lists drop-down menu	MIPS estimates are selected

Enter a valid start and end date for which your patients have data	You have successfully entered a date range for which you are wanting to pull data
Click 'Execute' to generate the numbers (denominator/numerator/exclusions) on all patients within the search parameters for all CQMs and tracked metrics	The query will execute and visually display all metric data
Click 'Export' to export a copy of your current CQM statistics and totals	The executed query data will export to the location of your choosing
Retain the export for future comparison	You now have a control set of data before making data positive/negative adjustments in subsequent test steps
CMS138v2-Preventive Care and Screening: Tobacco Use	
Log into Chiro8000 v17	You will be logged into Chiro8000 v17
Open a patient file who you have not yet filled out any CQM data. If needed for practice, you can add a new patient to the system.	The selected patient file will open
Select 'Compliance'	The compliance menu will display
In the Patient Education area, navigate to the 'Demographics' tab	The demographics area will display
Select 'Smoking Status' field	The smoking status field is selected
Note your patients smoking status as appropriate	Enter a smoking status that pertains to your real-world patient
In the Patient Education area, navigate to the 'Labs' tab	The labs area will display
Select 'New Lab Test'	The option to enter information for a new lab opens
Select facility where the tobacco cessation is related	The facility has been entered
Under 'Test' enter 'Tobacco Cessation Education'	This will denote that tobacco cessation education has occurred
Under 'Instructions' enter 'Tobacco Cessation Education'	This ensures the program will tabulate the entry for tobacco cessation
Click 'Save' to save your entry	The entry has been saved
CMS68 Documentation of Current Medications in the Medical Record	
Using the same patient as before, Select 'Compliance' if not already in the screen	The compliance tab is displayed
In the Patient education area, navigate to the 'Medications' tab	The medications tab will display
Enter the order date, set if active, medication name, dispense information, patient instructions	The medication entry is present and complete
Click 'Save' to save your entry	The medication entry has been saved
As an alternate, you can perform the same entry of a medication for the purpose of documentation, history, or	This completes an alternate method of medication entry from within the exam or visit

allergy in the EHR patient history section of any note or exam using the same data entry methods	
Ensure you have noted all medications and/or allergies relative to the patient you are entering data for	The patient now has completed medication and medication allergy entries
CMS69 Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	
Using the same patient as before	The patient used in the previous entries is still open and displayed
Select 'Visits'	The visits area will display
Click 'Create Note' to create a new exam or visit or double-click into an existing if wanting to amend an existing entry	The new exam/visit screen will display
Navigate to 'Vital Signs' section of visit or exam	The vital signs section is displayed
Ensure you have entered the patient's height and weight in the corresponding available fields	Height and weight for the patient has been successfully entered
Navigate to 'Plan' section of visit or exam	The plan section is displayed
Click + to add a new follow-up plan	The follow-up plan screen is displayed
Enter 'Body Mass Index and Screening Follow-up'	The body mass index and screening follow-up has been filled out
Save your follow-up plan with next follow-up date entered	The follow-up plan is now successfully saved
CMS155 Population 1 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	
Select a new patient who is under the age of 18 at the time of testing whom you have not filled out CQM data for yet	The selected patient file will display
Select 'Visits'	The visits tab is opened and displayed
Click 'Create Note' to create a new exam or visit or double-click into an existing if wanting to amend an existing entry	A new exam/visit window has opened
Navigate to 'Vital Signs' section of visit or exam	The vital signs area is now open and displayed
Ensure you have entered the patient's height and weight in the corresponding available fields	The selected patient now has height and weight entered
CMS146 Appropriate Testing for Children with Pharyngitis	
Select a new patient who is under the age of 18 at the time of testing whom you have not filled out CQM data for yet	The selected patient file is now open and displayed
Select 'Compliance'	The compliance screen is displayed

In the Patient Education area, navigate to the 'Demographics' tab	The demographic screen is displayed
Select 'Smoking Status' field	The smoking status available selections are presented
Note your patients smoking status as appropriate	The selected patient file now has a recorded smoking status value
In the Patient Education area, navigate to the 'Labs' tab	The labs area will open and be displayed
Select 'New Lab Test'	The new lab data entry window is displayed and available for use
Select the date of the Pharyngitis test	The testing date will be set
Select if the test is ordered or has already been completed	The status of testing has been recorded
Select facility where the Pharyngitis testing was performed	The facility is now present
Under 'Test' enter 'Pharyngitis'	This denotes the type of test
Under 'Instructions' enter 'Pharyngitis'	This ensures the metric is properly tabulated
Click 'Save' to save your entry	The entry is saved and the window has been closed automatically
CMS165 Controlling High Blood Pressure	
Open a patient file who you have not yet filled out any CQM data. If needed for practice, you can add a new patient to the system.	The new patient file has been opened
Select 'Visits'	The visits area is open and available for use
Click 'Create Note' to create a new exam or visit or double-click into an existing if wanting to amend an existing entry	The new visit/exam is available and displayed
Navigate to 'Vital Signs' section of visit or exam	The vital signs area has been opened
Ensure you have entered the patients' blood pressure in the corresponding available fields	The patient has applicable blood pressure information recorded
Close patient file	The data is saved and the patient file has been closed
Open any patient file	The selected patient file is open
Select 'Compliance'	The compliance area is displayed
Select 'MIPS' in the menu toolbar	The MIPs menu will display all sub-menu items
Select 'Patient Lists' from the sub-menu	The patient lists area will display and present further sub-menu items
Select 'MIPS Estimates' from the Lists drop-down menu	The MIPs estimates summary screen is displayed
Enter a valid start and end date for which your patients have data	You have successfully entered the date range
Click 'Execute' to generate the numbers (denominator/numerator/exclusions) on	The denominator/numerator and any exclusions for all CQMs are displayed on screen for review

all patients within the search parameters for all CQMs and tracked metrics	
Click 'Export' to export a copy of your current CQM statistics and totals	The totals are now exported to the location of your choosing
Compare your denominator and numerator with the original CQM report you had exported at the start of the CQM test and observe each measure has been appropriately incremented	Using the export at the start, you can now every measure has totaled and has incremented per your additions
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.g.7 API-Patient Selection	**Ensure that Chiro8000 can create a properly formatted CCD document and be sent by the documented API which adheres to the standards set for in this measure for API syntax, function names, required parameters, and their data types, return variables in the proper type/structure. In addition, the API should handle all exceptions and exception handling methods and their returns.**
Open a preferred internet web browser	The internet browser will launch and be available for use
Navigate to the following web address: http://www.chiro8000.com/certifications/	The chiro8000.com web page will be displayed
Click on section titled 'API DOCUMENTATION'	The API documentation area will display
Click and review API Documentation link below to verify the API information is available for review in public environment	You have now confirmed and verified that the API documentation is present and available for the public to review
Click and review Developer policy below to verify the API developer policy is available for review in public environment	You have now confirmed the developer policy is present and available for the public to review
Client and review API terms of use below to verify the API terms are available for review in public environment	You have now confirmed the API terms of use is present and available for the public to review
Close your internet browser and return to the Chiro8000 v17 application	The internet browser will be closed and you have successfully logged into Chiro8000
Open a patient file	The selected patient will open and is available for use
Click on 'Compliance'	The compliance tab is displayed
Select 'API' from the menu toolbar	The API menu is open
Click 'Start Service' to start the API service	The API service has now been started
Click 'Get Security Token' to obtain proper security token, Retain for subsequent queries	The security token is now present available to be used in the subsequent queries
Enter the security token in the text string to the left of 'Get Patient Token'	The security token is entered in the ‘Get patient Token’ area as directed
Click 'Get Patient token' to obtain individualized patient token for the	The patient token has been obtained as directed

patient you have open, Retain this token for use in subsequent API queries	
Pull patient data for the selected patient by entering the correct security and patient tokens in the string to the left of 'Get Patient Data'	You are now prepared to pull patient information for the selected patient
Execute the process by clicking 'Get Patient Data' to display the requested information below for the selected patient	The process is complete and the data requested is displayed
Pull patient data by date for the selected patient by entering the correct security, patient tokens, and enter the desired start and end date in the string to the left of 'Get Patient Data by Date'	You are prepared to pull patient data by date range as directed
Execute the process by clicking 'Get Patient Data by Date' to display the requested information below for the selected patient	The patient data for the date range selected is now displayed
The information displayed in any successfully executed API will match the corresponding data within the patient chart	For verification, you can compare the information presented through the API command with the information found in the patient's chart
Close the API screen	The API screen will close
Close the compliance window	The compliance window is closed and you are returned to the patient file
Close the selected patient file	The patient file is closed and you have been returned to the Chiro8000 v17 home screen
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.g.8 API-Data Category Request	**Ensure that Chiro8000 can create a properly formatted CCD document and be sent by the documented API which adheres to the standards set for in this measure for API syntax, function names, required parameters, and their data types, return variables in the proper type/structure. In addition, the API should handle all exceptions and exception handling methods and their returns**.
Open a preferred internet web browser	The internet browser will launch and be available for use
Navigate to the following web address: http://www.chiro8000.com/certifications/	The chiro8000.com web page will be displayed
Click on section titled 'API DOCUMENTATION'	The API documentation area will display
Click and review API Documentation link below to verify the API information is available for review in public environment	You have now confirmed and verified that the API documentation is present and available for the public to review
Click and review Developer policy below to verify the API developer policy is available for review in public environment	You have now confirmed the developer policy is present and available for the public to review

Client and review API terms of use below to verify the API terms are available for review in public environment	You have now confirmed the API terms of use is present and available for the public to review
Close your internet browser and return to the Chiro8000 v17 application	The internet browser will be closed and you have successfully logged into Chiro8000
Open a patient file	The selected patient will open and is available for use
Click on 'Compliance'	The compliance tab is displayed
Select 'API' from the menu toolbar	The API menu is open
Click 'Start Service' to start the API service	The API service has now been started
Click 'Get Security Token' to obtain proper security token, Retain for subsequent queries	The security token is now present available to be used in the subsequent queries
Enter the security token in the text string to the left of 'Get Patient Token'	The security token is entered in the 'Get patient Token' area as directed
Click 'Get Patient token' to obtain individualized patient token for the patient you have open, Retain this token for use in subsequent API queries	You now have a patient token for the selected patient as directed
Pull patient data by category for the selected patient by entering the correct security and patient tokens in the string to the left of 'Data by Category' and finally entering the category code as found in the lower left category code legend corresponding with the data request you wish to execute	You have now entered the data needed to pull data by the chosen category
Execute the process by clicking 'Data by Category' to display the requested information below for the selected patient	The data is presented for the selected patient and the category chosen
Pull patient data by category for the selected patient by entering the correct security and patient tokens in the string to the left of 'Data by Category' and finally entering the date range (started and end date) and category code as found in the lower left category code legend corresponding with the data request you wish to execute	The information needed to pull patient data by category has been entered
Execute the process by clicking 'Data by Category & Date' to display the requested information below for the selected patient	The patient data for the category and dates entered are now displayed
The information displayed in any successfully executed API will match the corresponding data within the patient chart	If wanting further verification, you can compare the API data presented with the information found on the patient's chart

Close the CCD screen	The CCD screen has been closed and you have been returned to the compliance area
Close the compliance window	The compliance screen has been closed and you have been returned to the patient file
Close the selected patient file	The patient file has been closed and you have returned to the home screen
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
170.315.g.9 API-All Data Request	**Ensure that Chiro8000 can create a properly formatted CCD document and be sent by the documented API which adheres to the standards set for in this measure for API syntax, function names, required parameters, and their data types, return variables in the proper type/structure. In addition, the API should handle all exceptions and exception handling methods and their returns.**
Open a preferred internet web browser	The internet browser will launch and be available for use
Navigate to the following web address: http://www.chiro8000.com/certifications/	The chiro8000.com web page will be displayed
Click on section titled 'API DOCUMENTATION'	The API documentation area will display
Click and review API Documentation link below to verify the API information is available for review in public environment	You have now confirmed and verified that the API documentation is present and available for the public to review
Click and review Developer policy below to verify the API developer policy is available for review in public environment	You have now confirmed the developer policy is present and available for the public to review
Client and review API terms of use below to verify the API terms are available for review in public environment	You have now confirmed the API terms of use is present and available for the public to review
Close your internet browser and return to the Chiro8000 v17 application	The internet browser will be closed and you have successfully logged into Chiro8000
Open a patient file	The selected patient will open and is available for use
Click on 'Compliance'	The compliance tab is displayed
Select 'API' from the menu toolbar	The API menu is open
Click 'Start Service' to start the API service	The API service has now been started
Click 'Get Security Token' to obtain proper security token, Retain for subsequent queries	The security token is now present available to be used in the subsequent queries
Enter the security token in the text string to the left of 'Get Patient Token'	The security token is entered in the 'Get patient Token' area as directed
Click 'Get Patient token' to obtain individualized patient token for the patient you have open, Retain this token for use in subsequent API queries	You now have a patient token for the selected patient as directed
Pull all patient data for the selected patient by entering the correct security	You have now entered the data needed to pull data

and patient tokens in the string to the left of 'Get Patient Data'	
Execute the process by clicking 'Get Patient Data' to display all of the requested information below for the selected patient	The data is presented for the selected patient
The information displayed in any successfully executed API will match the corresponding data within the patient chart	If further verification is needed, you can compare data presented from the API with the information found in the patient chart
Close the CCD screen	The CCD screen will close and you will return to the compliance window
Close the compliance window	The compliance screen has been closed and you have been returned to the patient file
Close the selected patient file	The patient file has been closed and you have returned to the home screen
170.315.h.1 Direct Project	
Prior to testing this measure, you will be sending/receiving direct messages with other certified Health Its. As both data and HIPAA security are paramount, you must always ensure the facility you are communicating with is certified, verified, and has been properly vetted by your organization	You confirm that you have read and acknowledge this statement
Open a patient file	The patient file is open and available for use
Click on 'Compliance'	The compliance tab is open
Select 'Tools' from the menu bar	The tools menu is opened and all available sub-menu items are displayed
Select 'Direct Setup' in the sub-menu	The direct setup menu is open
Ensure you have properly filled out all fields in the direct setup screen in accordance with your vendor guidance and any facilities to which you will communicating with.	The direct setup configuration options are filled out
While still in the direct setup screen, click manage certificates	The certificate management screen opens and is available for use
Ensure all proper certificates have been added in accordance with your vendor's recommendations	All certificates to be used have been selected
Click 'Save' to save all entered settings	Both the settings and the certificates have been saved and the direct message feature is available for use
Close the direct setup window	The direct setup menu closes and you have been returned to the compliance screen
Select 'Tools' from the menu bar	The tools menu is open
Select 'Direct Messages' in the sub-menu	The direct message windows will be displayed

Click 'Send Message' to open the send message screen	The message screen will load and display
Enter the desired message	You have entered your desired message
Select the recipient (which will be available once the proper certificates were entered)	You have chosen a recipient from the available list
Click 'Send' to execute sending the message	The message is sent
Confirm receipt and that the facility was able to properly decrypt the message. The message will match as sent.	The receiving facility can verify message was received and content was human readable and matches the message sent
Have the facility send a message in reply	The facility sends a message to you
Confirm receipt by clicking 'Get Messages'	The message will be received
The message sent from the other facility will be displayed	The message will be displayed
Verify the message was decrypted and is human readable. The message will match as sent from the other facility.	The message, if properly sent will display and is readable. If the sending facility is not sending in accordance with the required scope of the direct message you will receive messaging alerting you to this
Close the direct message window	The direct message window will close and you are returned to the compliance window
Close the compliance window	The compliance window has closed and you are returned to the patient file
Measurement	*Record number of pass test steps for this test cycle:* *Record number of failed test steps for this test cycle:* *Record % success rate:*
Final Measurement	***Record number of pass test steps for the full test:*** ***Record number of failed test steps for the full test:*** ***Record % success rate for the total test:***

SCHEDULE OF KEY MILESTONES

Include steps within the Real-World Testing plan that establish milestones within the process. Include details on how and when the developer will implement measures and collect data. Key milestones should be relevant and directly related to expected outcomes discussed in the next section.

For each key milestone, describe when Real World Testing will begin in specific care settings and the date/timeframe during which data will be collected.

Key Milestone	Care Setting	Date/Timeframe
Successfully test and record testing data for 170.315.b.1 Transitions of Care	Chiropractic	10/20/2022

Successfully test and record testing data for 170.315.b.2 Clinical Information Reconciliation	Chiropractic	10/22/2022
Successfully test and record testing data for 170.315.b.6 Data Export	Chiropractic	10/24/2022
Successfully test and record testing data for 170.315.c.1 CQM-Report and Export	Chiropractic	10/26/2022
Successfully test and record testing data for 170.315.g.7 API-Patient Selection	Chiropractic	10/28/2022
Successfully test and record testing data for 170.315.g.8 API-Data Category Request	Chiropractic	10/30/2022
Successfully test and record testing data for 170.315.g.9 API-All Data Request	Chiropractic	11/02/2022
Successfully test and record testing data for 170.315.h.1 Direct Project	Chiropractic	11/04/2022
Save Results from Testing Cycle 1	**Chiropractic**	**11/4/2022**
Successfully retest and record testing data for 170.315.b.1 Transitions of Care	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.b.2 Clinical Information Reconciliation	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.b.6 Data Export	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.c.1 CQM-Report and Export	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.g.7 API-Patient Selection	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.g.8 API-Data Category Request	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.g.9 API-All Data Request	Chiropractic	05/01/2023
Successfully retest and record testing data for 170.315.h.1 Direct Project	Chiropractic	05/01/2023
Save Results from Testing Cycle 1	**Chiropractic**	**05/01/2023**
Gather and incorporate results	Chiropractic	05/02/2023

ATTESTATION

The Real-World Testing plan must include the following attestation signed by the health IT developer authorized representative.

Note: The plan must be approved by a health IT developer authorized representative capable of binding the health IT developer for execution of the plan and include the representative's contact information.[ii]

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: Josh Nation

Authorized Representative Email: jnation@forteholdings.com

Authorized Representative Phone: (800) 456-2622 ext. 2070

Authorized Representative Signature: 

Date:10/25/2022

[i] Certified health IT continues to be compliant with the certification criteria, including the required technical standards and vocabulary codes sets; certified health IT is exchanging EHI in the care and practice settings for which it is marketed for use; and EHI is received by and used in the certified health IT. (85 FR 25766)

[ii] https://www.federalregister.gov/d/2020-07419/p-3582