



Juno Emergency Services Solution v3.1

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<https://junohealth.com/certifications>

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1 Introduction

1.1 Purpose

The purpose of this ONC test plan is to document the overall testing processes for DSS Juno Emergency Services Solution v3.1 ONC Certification. This test plan describes the test strategy, testing activities and methods to determine DSS Juno Emergency Services Solution v3.1 meets the “Real World Testing” ONC cures technology for interoperability requirements.

1.2 Test Objective

This ONC Test plan supports:

- Meeting the regulatory test coverage of the 2015 Edition ONC requirements per DSS marketed environments.
- Execution of 100% of the test cases for each certified 2015 Edition ONC test component for Juno Emergency Services Solution.
- Identification of the functional components and ONC requirements that should be targeted by tests.
- Provision of time estimates for the testing efforts.
- Description of test data and environments per DSS target marketing environments.
- Listing of deliverable elements that are certified within Juno Emergency Services Solution v3.1 and included in the CHPL listing.

1.3 Process and References

The processes and procedures that guide the implementation of this test plan are:

- 2015 Edition Test Methods, [Test Procedures](#) and Conformance Method
- 2015 Edition Cures Real World [Testing Regulations](#)

The references that support the implementation of this test plans are:

- Health IT Standards References and Resource Documents are listed within each criteria test case.

2 Criteria to be Tested from ONC 2015 Certification

2.1 Test Inclusion

DSS Juno Emergency Services Solution Test plan includes test scenarios for Ambulatory settings. All data exchange and communications are secured and follow both HIPAA Privacy and compliance rules. ONC Technical standards have been carefully reviewed and implemented for testing.

Test cases have been created for the following criteria:



Care Coordination criteria

[§170.315\(b\)\(1\) - Transitions of Care](#)

[§170.315\(b\)\(2\) - Clinical Information Reconciliation and Incorporation](#)

Public Health criteria

[§ 170.315\(f\)\(2\) - Transmission to Public Health Agencies — Syndromic Surveillance](#)

[§ 170.315\(f\)\(3\) - Transmission to Public Health Agencies — Reportable Laboratory Tests and Value/Results](#)

2.2 Test Methodology

To demonstrate Interoperability and conformance compliance during the Real World Testing the user, following previously written scripts that are based on application workflow, conducts System Testing and Integration Testing.

- Data is sent and/or received properly between systems.
- Interfaces between applications move data correctly and completely. Test both sending and receiving when interfaces are bi-directional.
- Connectivity with external organizations is accurate and complete as authorized (e.g., portal access to/from hospital/clinic, continuity of care record to referrals, personal health records for patients, disease management to/from health plan).
- System access is appropriate per assigned privileges.
- Data are processed accurately.
- Data are correctly populated in the user interfaces, reports, and clinical documents.
- All system components that share data or depend on other components work together properly.
- The workflows reflect actual new processes and workflows.
- Usage is defined in and follows policies and procedures. Reinforce training as applicable.

3 General Information for All Measures

Product and CHPL ID	Juno Emergency Services Solution v3.1 - CHPL ID 15.04.04.2925.JESS.03.01.0.210308
Care Setting	Hospital Emergency Department/Urgent Care <ul style="list-style-type: none"> Ambulatory
Test Environment	Customer TEST environment that mirrors the organization’s production environment.
Justification/Approach	The current certified version of Juno Emergency Services Solution v3.1 is in use at one of our customer sites, however that site has not attested to any of the criteria that utilize all the features/functions of the certified measures included in this test plan. Therefore, test data has been provided for each criteria to be used in order to complete testing. See Appendices for details.
Real-world networks /tools	Customer partner network <ul style="list-style-type: none"> Surescripts Admin Console-for the data exchange for §170.315(b)(1) if the testing is being done in a TEST environment; not needed if testing is being done in PRD environment and transmission is being done to/from other providers <p>Results will be captured through a variant of screenshots and extracts.</p>
Standards Update	Standards updated to USCDI (Y/N): Not Applicable

4 Measures used in Overall Approach

4.1 §170.315(b)(1) Transitions of Care

Use Case	<p>To ensure the continuity of care for any given patient, Juno Emergency Services Solution is able to receive transition of care documents from other providers for care prior to the patient’s admission for review/reference. Likewise, Juno Emergency Services Solution is able to generate the transition of care documents to be transmitted to other providers in the ambulatory setting post discharge or to other inpatient care settings upon patient discharge.</p> <p>Based on the standards for interoperability, this ensures that care can be provided based on clinical documentation that provides a complete picture and that the results of testing previously completed is available and does not necessarily need to be repeated.</p>
Certification Criteria	<p>§ 170.315 (b)(1) <i>Transition of care</i>—</p> <p>(i) <i>Send and receive via edge protocol</i>—</p>

	<ul style="list-style-type: none">(A) 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(B) 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).(C) 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. <p>(ii) <i>Validate and display</i> —</p> <ul style="list-style-type: none">(A) <i>Validate C-CDA conformance – system performance.</i> 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:<ul style="list-style-type: none">(1) Parse each of the document types.(2) 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).(3) 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).(4) Correctly interpret empty sections and null combinations.(5) Record errors encountered and allow a user through at least one of the following ways to:<ul style="list-style-type: none">(i) Be notified of the errors produced.(ii) Review the errors produced.(B) <i>Display.</i> 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).(C) <i>Display section views.</i> 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:<ul style="list-style-type: none">(1) Directly display only the data within a particular section(2) Set a preference for the display order of specific sections; and
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	<p>(3) Set the initial quantity of sections to be displayed.</p> <p>(iii) <i>Create</i>. 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:</p> <p>(A)</p> <ol style="list-style-type: none"> (1) 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 (2) 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 (3) The following data classes: <ol style="list-style-type: none"> (i) <i>Assessment and plan of treatment</i>. 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). (ii) <i>Goals</i>. In accordance with the “Goals Section” of the standard specified in § 170.205(a)(4). (iii) <i>Health concerns</i>. In accordance with the “Health Concerns Section” of the standard specified in § 170.205(a)(4). (iv) <i>Unique device identifier(s) for a patient’s implantable device(s)</i>. In accordance with the “Product Instance” in the “Procedure Activity Procedure Section” of the standard specified in § 170.205(a)(4). <p>(B) Encounter diagnoses. Formatted according to at least one of the following standards:</p> <ol style="list-style-type: none"> (1) The standard specified in § 170.207(i). (2) At a minimum, the version of the standard specified in § 170.207(a)(4). <p>(C) Cognitive status.</p> <p>(D) Functional status.</p> <p>(E) Ambulatory setting only. The reason for referral; and referring or transitioning provider’s name and office contact information.</p> <p>(F) Inpatient setting only. Discharge instructions.</p> <p>(G) 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:</p> <ol style="list-style-type: none"> (1) <i>Date of birth constraint</i>. <ol style="list-style-type: none"> (i) 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. (ii) 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. (2) <i>Phone number constraint</i>. 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.
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	<p>(3) Sex constraint. Represent sex in accordance with the standard adopted in § 170.207(n)(1).</p> <p>References:</p> <ul style="list-style-type: none"> • 170.202(a)(2) Applicability Statement for Secure Health Transport, Version 1.2, August 2015 (Direct) <p>File: Applicability Statement for Secure Health Transport v1.2.pdf - Direct Project</p> <ul style="list-style-type: none"> • 170.202(d) ONC Implementation Guide for Direct Edge Protocols, Version 1.1, June 25, 2014 <p>Implementation Guide for Direct Edge Protocols, Version 1.1, June 25, 2014 (healthit.gov)</p> <ul style="list-style-type: none"> • 170.202(e)(1) Interoperability Standards Advisory (ISA) (healthit.gov) <p>170.202(e)(1) Interoperability Standards Advisory (ISA) (healthit.gov)</p> <ul style="list-style-type: none"> • § 170.205(a)(4) HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015
<p>Justification</p>	<p>Each type of Transition of Care document has its own specific content requirements. For the Ambulatory care setting, the C-CDA types to be tested include:</p> <ul style="list-style-type: none"> • Continuity of Care • Referral Note <p>Using 4 scenarios, all of the components of the §170.315(b)(1) Transitions of Care will be tested i.e.,</p> <ul style="list-style-type: none"> • Receive health information in accordance with the standard specified in §170.202(a)(2) in the form of a transition of care/referral summary for a given patient that was sent in accordance with a method that conforms to the standard specified in § 170.202(d) and process it such that it is viewable within the patient’s EHR. <i>(Note: The incorporation of some of the data elements will be tested separately as part of 170.315(b)(2).)</i> • Display the transition of care/referral summary received in a manner in accordance with 170.315(b)(1)(ii)(C) which allows the user to view a specific section, set the # of sections to display and rearrange the order of display. • Create a transition of care/referral summary that can be displayed in human readable format using the appropriate template that includes at a minimum: <ul style="list-style-type: none"> ➤ Patient matching data, i.e., First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex ➤ Common Clinical Data Set items (see the Test Data section for details) ➤ Assessment and plan of treatment sections, either together or separately ➤ Goals ➤ Health Concerns ➤ Unique device identifier(s) for a patient’s implantable device(s)

	<ul style="list-style-type: none"> ➤ Encounter diagnosis ➤ Cognitive status ➤ Functional status ➤ Discharge instructions • Transmit the transition of care/discharge summary in accordance with the standard specified in §170.202(a)(2) to an 'address' provided for use for the specific patient at a time to be specified. <i>(Note: The address would allow the C-CDA to be transmitted to other providers in the ambulatory setting post discharge or to an inpatient care setting upon patient discharge.)</i>
<p>Test Methodology</p>	<p>The content of transition of care documents that will be received from other EHRs will vary as the data will be unique to the specific patient. Customer site is not currently utilizing the Transition of Care functionality, so may be required to use test data. Two xml files provided by the vendor may be required to be utilized for Scenarios #1 and #2 for importing the specific C-CDA template, i.e., Continuity of Care and Referral Note.</p> <p>For Scenarios #3 and #4 that involve creation and transmission of the transition of care documents to be transmitted to other providers or other facilities where the patient might be transferred, a single patient will be utilized. This patient will have all the required data as detailed in the Test Data section.</p>
<p>Test Data</p>	<p>For testing the receipt of transition of care documents from other providers in Scenarios #1 and #2, xml files provided by the vendor for import and processing if they are required since the functionality is not currently in use by the site.</p> <p>For testing of creation and transmission of the transition of care documents in Scenarios #3 and #4, data will be entered into Juno Emergency Services Solution for use in the generation of the transition of care documents. At a minimum, this data will include:</p> <ul style="list-style-type: none"> ➤ Common Clinical Data Set items <ul style="list-style-type: none"> ❖ Patient Name ❖ Sex ❖ Date of Birth ❖ Race and Ethnicity ❖ Preferred Language ❖ Smoking Status ❖ Medication Allergies ❖ Medications ❖ Problems ❖ Procedures ❖ Immunizations ❖ Vital Signs ❖ Laboratory Tests and Results ❖ Care Team Members ❖ Unique Device Identifiers ❖ Assessment and plan of treatment sections, either together or separately ❖ Goals

	<ul style="list-style-type: none"> ❖ Health Concerns <ul style="list-style-type: none"> ➤ Encounter diagnosis ➤ Cognitive status ➤ Functional status ➤ Discharge instructions <p>See attached Appendix A for the script for Test Data Entry</p>
<p>Expected Outcomes</p>	<p>Testing is organized according to the clinical workflow with the criteria being tested grouped according to the specific scenario. The specific criteria is referenced for each scenario. The steps for the testing and the Expected Outcome for each step are detailed in the Appendix section of this document for each scenario included below. In general, the Interoperability and electronic health information exchanged is accomplished successfully without errors or message failures during the exchange.</p> <p>A total of 4 scenarios will be utilized. This includes two (2) scenarios for the Receive criteria and two (2) scenarios for the Create, Validate and Send criteria, i.e.,</p> <ul style="list-style-type: none"> • Scenario 1 will be utilized for the receipt and validation of the Continuity of Care C-CDA; • Scenario 2 will be utilized for the receipt and validation of the Referral Note C-CDA; and. • Scenario 3 will be utilized for the creation, validation and transmission of the Continuity of Care C-CDA in real time; and • Scenario 4 will be utilized for the creation, validation and transmission of the Referral Note in real time <p>See attached Appendix A for the step by step details and Expected Outcomes</p>
<p>Measure</p>	<p>Successful creation, display, and transmission of the C-CDA for transition of care/referral summaries, i.e., Continuity of Care Document and Referral Note, in the format that conforms to the standard specified in § 170.202(d) with no errors detected during the validation process.</p> <p>The measure includes two parts, i.e.,</p> <ul style="list-style-type: none"> • % scenarios that include receipt of C-CDAs and a display of C-CDAs received in human readable format the required data as detailed in § 170.205(a)(3), (4), and (5) using the using the Continuity of Care Document and Referral Note document templates that allow the user to view a specific section, set the # of sections to display and rearrange the order of the display. <p><i>Numerator= # scenarios with expected results</i></p> <p><i>Denominator = # scenarios tested with C-CDAs received (Scenarios 1-2 included in test plan)</i></p> <ul style="list-style-type: none"> • % scenarios that include creation and successful transmission of the data for Continuity of Care Document and Referral Note document types through SMTP protocol to an appropriate direct address in accordance with § 170.202(d) based on the date/time specified and that leads to such summaries being

	<p>processed by a service that has implemented the standard specified in § 170.202(a)</p> <p><i>Numerator= # of correct data elements in outgoing C-CDA's</i></p> <p><i>Denominator = # data elements expected in C-CDAs created and transmitted (Scenarios #3-4) included in test plan)</i></p>
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4.2 §170.315(b)(2) Clinical Information Reconciliation and Incorporation

Use Case	<p>To ensure the continuity of care for any given patient, Juno Emergency Services Solution can receive transition of care documents from other providers for care prior to the patient's admission for review/reference. It is essential that the data included in these documents be reconciled and incorporated into the patient's active record.</p> <p>Based on the standards for interoperability, this ensures that care can be provided using clinical documentation that provides a complete picture, accounting for any changes in the patient's medical history, medication list, or allergy status.</p>
Certification Criteria	<p><i>§170.315 (b)(2) Clinical information reconciliation and incorporation—</i></p> <p><i>(i) General requirements. These requirements 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) and §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates.</i></p> <p><i>(ii) Correct patient. Upon receipt of a transition of care/referral summary formatted according to the standards adopted §170.205(a)(3) and §170.205(a)(4), technology must be able to demonstrate that the transition of care/referral summary received can be properly matched to the correct patient.</i></p> <p><i>(iii) Reconciliation. Enable a user to reconcile the data that represent a patient's active medication list, medication allergy list, and problem list as follows. For each list type:</i></p> <p><i>(A) 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.</i></p> <p><i>(B) Enable a user to create a single reconciled list of each of the following: Medications; medication allergies; and problems.</i></p> <p><i>(C) Enable a user to review and validate the accuracy of a final set of data.</i></p> <p><i>(D) Upon a user's confirmation, automatically update the list, and incorporate the following data expressed according to the specified standard(s):</i></p> <p><i>(1) Medications. At a minimum, the version of the standard specified in §170.207(d)(3);</i></p>

	<p>(2) Medication allergies. At a minimum, the version of the standard specified in §170.207(d); and</p> <p>(3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4).</p> <p>(iv) 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.</p> <p>References:</p> <p>§ 170.205(a)(3) Health Level 7 (HL7®) Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012</p> <p>§ 170.205(a)(4) HL7® Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1 August 2015, June 2019 (with Errata)</p>
<p>Justification</p>	<p>For the clinician to deliver appropriate care, it is essential that information regarding a patient’s past medical history, medications, and allergies be accurate and up to date. Using two scenarios that are organized in accordance with the clinical workflow, all the required components of the §170.315(b)(2) Clinical Information Reconciliation and Incorporation criteria will be tested, i.e.,</p> <ul style="list-style-type: none"> • Demonstrate that the received transition of CCA formatted according to the standards adopted §170.205(a)(3) and §170.205(a)(4), technology can be properly matched to the correct patient. • Display 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. • Create a single reconciled list of each of the following: Medications; medication allergies; and problems. • Demonstrate that the user can review and validate the accuracy of a final set of data. • Demonstrate that the user can confirm, update the list, and incorporate the following data expressed according to the specified standard(s): (1) Medications. At a minimum, the version of the standard specified in §170.207(d)(3); (2) Medication allergies. At a minimum, the version of the standard specified in §170.207(d) (3); and (3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4). • Based on the data reconciled and incorporated, create a file formatted according to the standard specified in §170.205(a)(4) using the Continuity of Care Document template.

Test Methodology	<p>The content of transition of care documents that will be received from other EHRs will vary as the data will be unique to the specific patient. Two xml files are provided by the vendor to be utilized for Scenarios #1-2 for import, reconciliation, and incorporation of the specific C-CDA template, i.e., Continuity of Care and Referral Note in accordance with Paragraph (b)(2)(i) and (ii), (b)(2)(iii)(B)-(D), and (b)(2)(iv).</p>
Test Data	<p>Data entered at a minimum will include:</p> <ul style="list-style-type: none"> ➤ Common Clinical Data Set items <ul style="list-style-type: none"> ❖ Patient Name ❖ Sex ❖ Date of Birth ❖ Race and Ethnicity ❖ Preferred Language ❖ Smoking Status ❖ Medication Allergies ❖ Medications ❖ Problems ❖ Procedures ❖ Immunizations ❖ Vital Signs ❖ Laboratory Tests and Results ❖ Care Team Members ❖ Unique Device Identifiers ❖ Assessment and plan of treatment sections, either together or separately ❖ Goals ❖ Health Concerns ➤ Encounter diagnosis ➤ Cognitive status ➤ Functional status ➤ Discharge instructions <p>For testing the receipt and reconciliation of transition of care documents from other providers, two xml files will be provided by the vendor for import, reconciliation, and incorporation.</p> <p>See attached Appendix B for the script for Test Data Entry</p>
Expected Outcomes	<p>A total of 2 scenarios will be utilized:</p> <ul style="list-style-type: none"> • Scenario 1 will be utilized for the import, reconciliation, and incorporation of the Continuity of Care C-CDA; • Scenario 2 will be utilized for the import, reconciliation, and incorporation and reconciliation of the Referral Note C-CDA. <p>See attached Appendix B for the step by step details and Expected Outcomes</p>
Measure	<p>Successful import, reconciliation and incorporation of the data in accordance with Paragraph (b)(2)(i) and (ii), (b)(2)(iii)(B) -(D), and (b)(2)(iv).</p> <p><i>Numerator= # scenarios with correctly reconciled Allergies, Medications, and Problems</i></p>

	<i>Denominator = # scenarios tested for import and reconciliation of Allergies, Medications, and Problems</i>
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4.3 §170.315(f)(2) Transmission to Public Health Agencies - Syndromic Surveillance

Use Case	<p>The objective of Syndromic Surveillance is the early detection of disease outbreaks and the monitoring of disease trends. To this purpose, Juno Emergency Services Solution can generate messaging regarding disease indicators and transmit that data to monitoring agencies. This is done in an automated fashion without the need for user intervention.</p> <p>Based on the standards for interoperability, this process can facilitate the mobilization of a rapid disease response with the goal of reducing overall morbidity and mortality.</p>
Certification Criteria	<p><i>§170.315 (f)(2) Transmission to public health agencies – syndromic surveillance— Create syndrome-based public health surveillance information for electronic transmission in accordance with the standard (and applicable implementation specifications) specified in §170.205(d)(4).</i></p> <p>This certification criterion was adopted at § 170.315(f)(2). As a result, an ONC-ACB must ensure that a product presented for certification to a § 170.315(f) “paragraph (f)” criterion includes the privacy and security criteria (adopted in § 170.315(d)) within the overall scope of the certificate issued to the product.</p> <ul style="list-style-type: none"> • The privacy and security criteria (adopted in § 170.315(d)) do not need to be explicitly tested with this specific paragraph (f) criterion unless it is the only criterion for which certification is requested. • As a general rule, a product presented for certification only needs to be tested once to each applicable privacy and security criterion (adopted in § 170.315(d)) so long as the health IT developer attests that such privacy and security capabilities apply to the full scope of capabilities included in the requested certification. However, exceptions exist for § 170.315(e)(1) “VDT” and (e)(2) “secure messaging,” which are explicitly stated. • § 170.315(d)(2)(i)(C) is not required if the scope of the Health IT Module does not have end-user device encryption features. <p><u>Design and Performance:</u> The following design and performance certification criteria (adopted in § 170.315(g)) must also be certified for the product to be certified.</p> <ul style="list-style-type: none"> • When a single quality management system (QMS) is used, the QMS only needs to be identified once. Otherwise, the QMS’ need to be identified for every capability to which it was applied. • When a single accessibility-centered design standard is used, the standard only needs to be identified once. Otherwise, the accessibility-centered

	design standards need to be identified for every capability to which they were applied; or, alternatively the developer must state that no accessibility-centered design was used.
Justification	Using three scenarios that are organized in accordance with the clinical workflow, all of the required components of the §170.315(f)(2) Transmission to Public Health Agencies – Syndromic Surveillance criteria will be tested. This will include generation and transmission of the following ADT message types: <ul style="list-style-type: none"> • ADT^A01 Admit / Visit Notification • ADT^A03 Discharge / End Visit • ADT^A04 Register a Patient • ADT^A08 Update Patient Information
Test Methodology	Data for test scenarios are provided by the vendor to be utilized for Scenarios #1-3. Data will be entered by client tester, and outgoing ADT messages will be sent to the customer State Public Health Agency and verification of receipt will be obtained.
Test Data	For testing of creation and transmission in Scenarios #1-3, data will be supplied by vendor and entered into Juno Emergency Services Solution by the client tester. See attached Appendix C for the script for Test Data Entry
Expected Outcomes	A total of 3 scenarios will be utilized. <ul style="list-style-type: none"> • Scenario 1 will be utilized for the creation, transmission, and receipt validation of A04 and A03 ADT messages • Scenario 2 will be utilized for the creation, transmission, and receipt validation of A04, A03, and A08 ADT messages • Scenario 3 will be utilized for the creation, transmission, and receipt validation of A04, A03, A08, and A01 ADT messages <p>A04 messages will be sent upon completion of Triage A08 message will be sent upon completion of an update to Patient Demographics A03 and A01 messages will be sent upon locking of physician and nurse charts for the patient.</p> <p>See attached Appendix C for the step by step details and Expected Outcomes</p>
Measure	Successful creation, transmission, and receipt of the A04, A03, A08, and A01 messages in the format that conforms to the standard specified in <ul style="list-style-type: none"> • The HL7 Version 2.5.1 PHIN Messaging Guide for Syndromic Surveillance: Emergency Department, Urgent Care, Inpatient, and Ambulatory Care Settings, Release 2.0, April 21, 2015 https://knowledgerepository.syndromicsurveillance.org/hl7-version-251-phin-messaging-guide-syndromic-surveillance-emergency-department-urgent-care-and • The Erratum to the CDC PHIN 2.0 Implementation Guide, August 20, 2015 https://online.fliphtml5.com/ajfm/nvhk/#p=1

	<p>with no errors detected during the validation process.</p> <p><i>Numerator= # of correct data elements in HL7 messages for each scenario</i></p> <p><i>Denominator = # of data elements expected in HL7 messages for each scenario tested</i></p>
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4.4 §170.315(f)(3) Transmission to Public Health Agencies — Reportable Laboratory Tests and Values/Results

Use Case	<p>Reporting to registries is an important part of improving population and public health. To this purpose, Juno Emergency Services Solution can create reportable laboratory tests and values/results for electronic transmission and transmit that data to monitoring agencies.</p> <p>Based on the standards for interoperability, this process can improve timeliness, reduce manual data entry errors, and provide reports that are more complete.</p>
Certification Criteria	<p><i>§170.315 (f)(3) Transmission to public health agencies – reportable laboratory tests and value/results—Create reportable laboratory tests and values/results for electronic transmission in accordance with:(i) The standard (and applicable implementation specifications) specified in §170.205(g).(ii)At a minimum, the versions of the standards specified in §170.207(a)(3) and (c)(2).</i></p> <p>References:</p> <ul style="list-style-type: none"> • <i>HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) with Errata, and ELR 2.5.1 Clarification Document for EHR Technology Certification</i> • <i>IHTSDO SNOMED CT® International Release July 2012 and US Extension to SNOMED CT® March 2012 Release; and the Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.40</i>
Justification	<p>Using one scenario that is organized in accordance with the clinical workflow, all of the required components of the §170.315(f)(3) Transmission to Public Health Agencies – Reportable Laboratory Tests and Value/Results criteria will be tested. This will include capability to create HL7 v2 laboratory results messages for transmission to public health agencies that are conformant to HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) with Errata, and ELR 2.5.1 Clarification Document for EHR Technology Certification and use the IHTSDO SNOMED CT® International Release July 2012 and US Extension to SNOMED CT® March 2012 Release; and the Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.40</p>
Test Methodology	<p>Using a test patient created in maximally populated Scenario #1, the vendor will import laboratory values/results to patient record. Client tester will select outgoing HL7 ELR v2 messages and send to customer State Public Health Agency. Verification of receipt will be obtained.</p>

Test Data	Using patient record created in Scenarios #1, laboratory results/values data will be imported to patient record by the vendor. See attached Appendix D for the script for Test Data Entry
Expected Outcomes	One maximally populated scenario will be utilized. <ul style="list-style-type: none"> Scenario 1 (Blood Lead Level) HL7 ELR v2 message will be successfully sent by client tester to the customer Public Health Agency. See attached Appendix D for the step by step details and Expected Outcomes
Measure	Successful creation, transmission, and receipt of the ORU messages in the format that conforms to HL7 Version 2.5.1 and IHTSDO SNOMED CT® International Release July 2012. <i>Numerator= # of correct data elements in HL7 message for scenarios with expected results</i> <i>Denominator = # of expected data elements in HL7 message for scenario tested</i>

5 Schedule of Key Milestones

Key Milestone	Date/Timeframe
Release of documentation for the Real World Testing to be provided to authorized representatives and providers running Juno Emergency Services Solution v3.1. This includes surveys, specific instructions on what to look for, how to record issues encountered, and Customer Agreements.	December 1, 2021
Begin collection of information as laid out by the plan.	January 1, 2022
Meet with previously identified providers and authorized representatives to ensure that Real World Testing protocols are effective.	March 1, 2022
Follow-up with providers and authorized representatives to understand any issues arising with the data collection.	Quarterly, 2022
Data collection and review.	Quarterly, 2022
End of Real World Testing period/final collection of all data for analysis.	January 2023
Analysis and report creation.	January 15, 2023
Submit Real World Testing report to ACB (per their instructions).	February 1, 2023



6 Attestation

This Real World Test 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 and Title:	Jeffrey Smith, Senior Manager PMO & Professional Services	Authorized Representative Phone:	561-215-7049
Authorized Representative Signature:	<i>Jeffrey Smith</i>	Date Signed:	11/12/2021

7 Appendices

7.1 Appendix A §170.315(b)(1) Transitions of Care

7.1.1 Criteria

- §170.315(b)(1) Transitions of Care

7.1.2 Test Data Prerequisites

- Patient required to exist in the system prior to receipt of the C-CDA.
- Scenario 1 will be utilized for the receipt and validation of the Continuity of Care C-CDA. If test data needs to be utilized since functionality is not currently in use by the site, data for Katherine Madison below will be entered in advance.

Patient:	Katherine Madison		Alias:	
DOB:	6/1/1970			
Gender:	Female			
Race:	White (2106-3)		Ethnicity:	Not Hispanic or Latino (2186-5)
Address:	1001 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)-111-1234		Mobile Phone:	
Height:	177 cm		Weight:	88 kg
BP:	145/88		Heart Rate:	80 bpm
O2% BldC Oximetry:	95%		Inhaled o2 concentration	
Body Temp:	100.4 F		Respiratory Rate:	18 /min
Active Medication Allergies:	Penicillin G benzathine	RxNorm 7980 (IN)	Moderate Hives (247472004)	
	Ampicillin	RxNorm 733	Moderate Hives (247472004)	



Medications:	Ceftriaxone 100MG/ML	BID	RxNorm 309090	Start: Current date	
	Tylenol 500mg	PRN	RxNorm 209459	Start: Current date	
	Darbepoetin Alfa 0.5 MG/ML	One a week	RxNorm 731184	Start: Current date	
Problems:	Essential Hypertension	SNOMED CT 59621000		Status: Active	
	Severe Hypothyroidism	SNOMED CT 83986005		Status: Active	
	Chronic Rejection of Renal Transplant	SNOMED CT 236578006		Status: Active	
	Fever	SNOMED CT 386661006		Status: Active	
	Overweight	SNOMED CT 238131007		Status: Completed	
	Encounter Diagnosis:	Fever	SNOMED CT 386661006	Date: Current date	
	Immunizations	Influenza virus vaccine		Date: 5/10/2014	Status: Completed
	Tetanus and diphtheria toxoids		Date: 1/04/2012	Status: Completed	
	Influenza, intradermal, quadrivalent, preservative free		Date: Current date	Status: refused by patient	
Social History	Smoking Status	Heavy Tobacco Smoker	Dates: 5/1/2005 – 2/27/2011		
	Current Smoking Status	Current Every Day Smoker	Date: Current date		
Procedures:	Nebulizer Therapy			Date: 6/22/2015	
	Introduction of cardiac pacemaker system via vein			Date: 10/5/2011	
Implants: UDI	Cardiac Pacemaker		Subclavian Vein	(01)00643169007222(17)160128(21)BLC20 0461H	
Results:	Color of Urine	Yellow	Normal	Date: Current date	
	Appearance of Urine	Clear	Normal	Date: Current date	



	Specific Gravity	1.015	Normal	Date: Current date
	pH of Urine	5.0	Normal	Date: Current date
	Glucose in Urine	50 mg/dL		Date: Current date
	Ketones in Urine	Negative		Date: Current date
	Protein in Urine	Negative		Date: Current date
Functional Status:	Dependence on Cane	SNOMED CT: 105504002		Date: 5/1/2005
Assessment:	The patient was found to have fever and Dr Davis is suspecting Anemia based on the patient history. So, Dr Davis asked the patient to closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.			
Treatment Plan:	i. Urinalysis macro dipstick panel 6/29/2015 ii. Get an EKG done on 6/23/2015. iii. Get a Chest X-ray done on 6/23/2015 showing the Lower Respiratory Tract Structure. iv. Take Clindamycin 300mg three times a day as needed if pain does not subside/ v. Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2015.			
Goals:	Get rid of intermittent fever that is occurring every few weeks			Date: Current date
	Need to gain more energy to do regular activities			Date: Current date
Health Concerns	Chronic sickness exhibited by patient	Status: Active		Date: Current date
	Documented Hypertension problem	Status: Active		Date: Current date
	Documented Hypothyroidism problem	Status: Active		Date: Current date
	Watch weight of patient	Status: Active		Date: Current date
Reason for Referral	Ms. Kathy Madison is being referred to Community Health Hospitals Inpatient Facility because of high fever noticed and suspected anemia			
Mental Status:	Amnesia			Date: 5/5/2005

Step	Steps to Enter Data	Expected Outcome
Step 1	As a nurse user, click on the "New Patient" button to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	<ul style="list-style-type: none"> In the Name Type dropdown, select "Legal Name". Enter Last Name: Madison; First Name: Katherine DOB: 06/01/1990 Sex: Female Gender Identity: Female Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: White – declined to specify 	Initial patient demographic data is entered



	<ul style="list-style-type: none"> Preferred Language: English EDP: select ED physician Tax ID: select Tax ID if not pre-populated Prior to clicking the "OK" button, select the "Address and Phone" tab at the upper aspect of the Presentation window 	
Step 3	<ul style="list-style-type: none"> In the Address Type dropdown, select "Home". Then enter home address: 1001 Amber Dr., Beaverton OR 97006 In the Phone Type dropdown, select "Primary Residence Number". In the Device Type dropdown, select "Telephone" then enter phone number: (555)-111-1234 	Address and Phone data is entered
Step 4	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Offline account number"). Continue in nursing documentation.	Registration is completed
Step 5	In Triage, select Chief Complaint #1: FEVER (ADULT). Click "Save" to bypass the supplemental questions, then click the Status Board icon to exit the patient chart.	Chief Complaint is entered and user exits Nurse Chart

- Scenario 2 will be utilized for the receipt and validation of the Referral Note C-CDA. If test data needs to be utilized since functionality is not currently in use by the site, data for Myra Banks below will be entered in advance.

Patient:	Myra Banks		Alias:	
DOB:	6/1/1970			
Gender:	Female			
Race:	White (2106-3)		Ethnicity:	Not Hispanic or Latino (2186-5)
Address:	1003 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)-115-1234		Mobile Phone:	
Height:	177 cm		Weight:	88 kg
BP:	145/88		Heart Rate:	80 bpm
O2% BldC Oximetry:	95%		Inhaled o2 concentration	
Body Temp:	100.4 F		Respiratory Rate:	18 /min
Active Medication Allergies:	Penicillin G benzathine	RxNorm 7980 (IN)	Moderate Hives (247472004)	
	Ampicillin	RxNorm 733	Moderate Hives (247472004)	
Medications:	Ceftriaxone 100MG/ML	BID	RxNorm 309090	Start: Current date
	Tylenol 500mg	PRN	RxNorm 209459	Start: Current date
	Darbepoetin Alfa 0.5 MG/ML	One a week	RxNorm 731184	Start: Current date
Problems:	Essential Hypertension	SNOMED CT 59621000		Status: Active

	Severe Hypothyroidism	SNOMED CT 83986005		Status: Active
	Chronic Rejection of Renal Transplant	SNOMED CT 236578006		Status: Active
	Fever	SNOMED CT 386661006		Status: Active
	Overweight	SNOMED CT 238131007		Status: Completed
Encounter Diagnosis:	Fever	SNOMED CT 386661006	Date: Current date	
Immunizations:	Influenza virus vaccine		Date: 5/10/2014	Status: Completed
	Tetanus and diphtheria toxoids		Date: 1/04/2012	Status: Completed
	Influenza, intradermal, quadrivalent, preservative free		Date: Current date	Status: refused by patient
Social History	Smoking Status	Heavy Tobacco Smoker	Date: 5/1/2005 – 2/27/2011	
	Current Smoking Status	Current Every Day Smoker	Date: Current date	
Procedures:	Nebulizer Therapy			Date: Current date
	Introduction of cardiac pacemaker system via vein			Date: 10/5/2011
Implants:	Cardiac Pacemaker		Subclavian Vein	(01)00643169007222(17)160128(21)BLC20046 1H
Results:	Color of Urine	Yellow	Normal	Date: Current date
	Appearance of Urine	Clear	Normal	Date: Current date
	Specific Gravity	1.015	Normal	Date: Current date
	pH of Urine	5.0	Normal	Date: Current date
	Glucose in Urine	50 mg/dL		Date: Current date
	Ketones in Urine	Negative		Date: Current date
	Protein in Urine	Negative		Date: Current date



Functional Status:	Dependence on Cane	SNOMED CT: 105504002	Date: 5/1/2005
Assessment:	The patient was found to have fever and Dr Davis is suspecting Anemia based on the patient history. So, Dr Davis asked the patient to closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.		
Treatment Plan:	i. Urinalysis macro dipstick panel 6/29/2015 ii. Get an EKG done on 6/23/2015. iii. Get a Chest X-ray done on 6/23/2015 showing the Lower Respiratory Tract Structure. iv. Take Clindamycin 300mg three times a day as needed if pain does not subside/ v. Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2015.		
Goals:	Get rid of intermittent fever that is occurring every few weeks		Date: Current date
	Need to gain more energy to do regular activities		Date: Current date
Health Concerns	Chronic sickness exhibited by patient	Status: Active	Date: Current date
	Documented Hypertension problem	Status: Active	Date: Current date
	Documented Hypothyroidism problem	Status: Active	Date: Current date
	Watch weight of patient	Status: Active	Date: Current date
Reason for Referral	Ms. Kathy Madison is being referred to Community Health Hospitals Inpatient Facility because of high fever noticed and suspected anemia		
Mental Status:	Amnesia		Date: 5/5/2005

Step	Steps to Enter Data	Expected Outcome
Step 1	As a nurse user, click on the "New Patient" button to open the Presentation data entry fields.	Open Presentation data entry fields
Step 2	<ul style="list-style-type: none"> In the Name Type dropdown, select "Legal Name". Then enter Last Name: Banks First Name: Myra DOB: 06/01/1990 Sex: Female Gender Identity: Female Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: White – declined to specify Preferred Language: English EDP: select ED physician Tax ID: select Tax ID if not pre-populated Prior to clicking the "OK" button, select the "Address and Phone" tab at the upper aspect of the Presentation window 	Create new patient and add initial demographic data

Step 3	<ul style="list-style-type: none"> In the Address Type dropdown, select "Home". Then enter home address: 1003 Amber Dr., Beaverton OR 97006 In the Phone Type dropdown, select "Primary Residence Number". In the Device Type dropdown, select "Telephone" then enter phone number: (555)-115-1234 	Add Address and Phone data
Step 4	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Offline account number"). Continue with Nursing Documentation.	Complete registration
Step 5	In Triage, select Chief Complaint #1: FEVER (ADULT). Click "Save" to bypass the supplemental questions, then click the Status Board icon to exit the patient chart.	Enter Chief Complaint and exit patient chart

- Scenario 3 and 4 will be utilized for the creation, validation and transmission of the Continuity of Care C-CDA and Referral Note in real time.
- If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Patient:	Alice Jones Newman	Birth Name:	Alicia	
DOB:	5/1/1970			
Gender:	Female			
Race:	White (2106-3) White European (2108-9)	Ethnicity:	Not Hispanic or Latino (2186-5)	
Address:	1357 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)-723-1544	Mobile Phone:	(555)-777-1234	
Height:	177 cm	Weight:	88 kg	
BP:	145/88	Heart Rate:	80 bpm	
O2% BldC Oximetry:	95%	Inhaled o2 concentration:	36%	
Body Temp:	100.4 F	Respiratory Rate:	18 per min	
Provider	Physician user of choice	Nurse		
Active Medication Allergies:	Penicillin G	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 5/01/1980
	Ampicillin	RxNorm 733	Moderate Hives (247472004)	Start: 5/01/1980
Medications:	Ceftriaxone 100MG/ML	BID	RxNorm 309090	Start: Current Date End: in 10 days
	Tylenol 500mg	PRN	RxNorm 209459	Start: Current Date End: Current Date
	Aranesp 0.5 MG/ML	One a week	RxNorm 731241	Start: Current Date No end date
Problems:	Essential Hypertension	SNOMED CT 59621000	Start Date: 10/5/2011	Status: Active
	Severe Hypothyroidism	SNOMED CT 83986005	Start Date: 12/31/2006	Status: Active
	Chronic Rejection of Renal Transplant	SNOMED CT 236578006	Start Date: 12/31/2011	Status: Active



	Fever	SNOMED CT 386661006	Start Date: Current Date	Status: Active
	Overweight	SNOMED CT 238131007	Start Date: 12/31/2006 End Date: 6/1/2007	Status: Completed
Clinical Impression	Fever	SNOMED CT 386661006	Date: Current Date	
Immunizations:	Tetanus and diphtheria toxoids	CVX: 106	Date: 01/04/2012	Status: Completed
	Lot Number: 2	Manufacturer: Immuno Inc.	Additional Comments: N/A	
	Influenza, intradermal, quadrivalent, preservative free	CVX: 166	Date: Current Date	Status: Cancelled
	Lot Number: unknown	Manufacturer: Immuno Inc.	Additional Comments: Immunization was not given – Patient rejected immunization	
Smoking Status	Current Every Day Smoker	SNOMED CT 449868002	Date: Current Date	
Procedures:	Nebulizer Therapy	SNOMED CT 56251003	Date: Current date	Status: Completed
	Introduction of cardiac pacemaker via vein	SNOMED CT 175135009	Date: 10/5/2011	Status: Completed
Laboratory Tests:	Urinalysis macro	LOINC 24357-6	Date: Current Date	
	Urinalysis macro	LOINC 24357-6	Date: Current Date	Future test to be entered in Discharge Plan
Laboratory Results	Color of Urine	LOINC 5778-6	Date: Current Date	Result: Yellow
	Appearance of Urine	LOINC 5767-9	Date: Current Date	Result: Clear
	Specific Gravity of Urine by Test strip	LOINC 5811-5	Date: Current Date	Result: 1.015
	pH of Urine by Test strip	LOINC 5803-2	Date: Current Date	Result: 5.0
	Glucose in Urine by Test strip	LOINC 5792-7	Date: Current Date	Result: Neg
	Ketones in Urine by Test strip	LOINC 5797-6	Date: Current Date	Result: Negative



	Protein in Urine by Test strip	LOINC 5804-0	Date: Current Date	Result: Negative
Unique Device Identifier (UDI):	(01)00643169007222(17)160128(21)BLC200461H			
Assessment:	The patient was found to have fever and Dr Davis is suspecting Anemia based on the patient history. So, Dr Davis asked the patient to closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.			
Plan of Treatment:	i. Get an EKG done on 6/23/2015. ii. Get a Chest X-ray done on 6/23/2015 showing the Lower Respiratory Tract Structure. iii. Take Clindamycin 300mg three times a day as needed if pain does not subside/ iv. Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2015.			
Goals:	a. Get rid of intermittent fever that is occurring every few weeks. b. Need to gain more energy to do regular activities			
Health Concerns:	a. Chronic Sickness exhibited by patient b. HealthCare Concerns refer to underlying clinical facts i. Documented Hypertension problem ii. Documented Hypothyroidism problem iii. Watch Weight of patient			
Reason for Referral:	Ms Alice Newman is being referred to Community Health Hospitals Inpatient facility because of the high fever noticed and suspected Anemia.			
Functional Status:	Dependence on Cane	SNOMED CT: 105504002	Date: 5/1/2005	
Cognitive Status:	Amnesia	SNOMED CT: 48167000	Date: 5/1/2005	

Step	Steps to Enter Data	Expected Outcome
Step 1	As a nurse user, click on the "New Patient" button to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	<ul style="list-style-type: none"> In the Name Type dropdown, select "Legal Name". Then enter Last Name: Newman First Name: Alice Middle Name: Jones DOB: 05/01/1990 Sex: Female Gender Identity: Female Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: White – declined to specify White European – declined to specify Preferred Language: English EDP: select ED physician Tax ID: select Tax ID if not pre-populated Prior to clicking the "OK" button, select the "Address and Phone" tab at the upper aspect of the Presentation window 	Initial patient demographic data is entered
Step 3	<ul style="list-style-type: none"> In the Address Type dropdown, select "Home". Then enter home address: 1357 Amber Dr., Beaverton OR 97006 	Address and Phone data is entered

	<ul style="list-style-type: none"> In the Phone Type dropdown, select "Primary Residence Number" in the Device Type dropdown, select "Telephone" then enter phone number: (555)-723-1544 	
Step 4	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Offline account number") and continue in nursing documentation.	Registration is completed
Step 5	In Triage, select Chief Complaint #1: FEVER (ADULT). Click "Save" to bypass the supplemental questions	Chief Complaint is entered
Step 6	<p>In Triage, select "Vital Signs" and enter:</p> <ul style="list-style-type: none"> T - 100.4 F P – 88 R - 18 BP - 145/88 O2 Amount – 36 O2 Sat – 95 Click "Save" to close Vital Signs entry window 	Vital Signs are entered
Step 7	In Triage, select "Triage Level" and enter Triage Level 2	Triage Level is entered
Step 8	<p>In Triage, select "Allergies" to open Allergies Table:</p> <ul style="list-style-type: none"> Enter Penicillin G in search line then click to move to the Current Allergies List. Double click the "Symptoms" field and select "Hives" from the dropdown. Double click the "Severity" field and select "Moderate". Double click the "Onset" field and enter 05/01/1980 Enter Ampicillin in search line then click to move to the Current Allergies List. Double click the "Symptoms" field and select "Hives" from the dropdown. Double click the "Severity" field and select "Moderate". Double click the "Onset" field and enter 05/01/1980. Click "OK" to close the Allergies table 	Allergies are entered
Step 9	<p>In Triage, select "Current Medications" to open Medications Table:</p> <ul style="list-style-type: none"> Enter Ceftriaxone in search line then click to move to the Current Medications List. Enter: Route – injectable Frequency – every 12 hours. Double click in the "Dosage" field and enter 100 mg/mL. Double click in the "Start Date" field and enter the current date Enter Tylenol in search line then click to move to the Current Medications List. Enter: Route – oral. Double click in the "Dosage" field and enter 500 mg. Double click in the "Frequency" field and enter "prn". Double click in the "Start Date" field and enter the current date Enter Aranesp in search line then click to move to the Current Medications List. Enter: Route – injectable. Double click in the "Dosage" field and enter 0.5 mg/mL. Double click in the "Frequency" field and enter "once a week". Double click in the "Start Date" field and enter the current date. Click "OK" to close the Medications table 	Current Medications are entered
Step 10	<p>In Triage, select "Problems" to open the Problems Table:</p> <ul style="list-style-type: none"> Enter Essential Hypertension in search line then click to move to the Current Problem List- Double click in the "Onset Date" field and enter 10/05/2011 	Problems are entered

	<ul style="list-style-type: none"> • Enter Severe Hypothyroidism in search line then click to move to the Current Problem List - Double click in the "Onset Date" field and enter 12/31/2006 • Enter Chronic Rejection of Renal Transplant in search line then click to move to the Current Problem List - Double click in the "Onset Date" field and enter 12/31/2011 • Enter Fever in search line then click to move to the Current Problem List - Double click in the "Onset Date" field and enter the current date • Enter Overweight in search line then click to move to the Current Problem List – Double click the "Status" and select "completed". Double click in the "Onset Date" field and enter 12/31/2006. Double click in the "Resolved" field and enter 06/01/2007. Click "OK" to close the Problems table 	
Step 11	In Triage, select "Height and Weight" to open the Height and Weight Table and enter height 177 cm and weight 88 kg	Height and Weight are entered
Step 12	In Triage, select "Arrival Mode" and enter AMB-POV	Arrival Mode is entered
Step 13	In Triage, select "PCP" and enter PCP of choice	PCP is entered
Step 14	In Triage, select "Treating Physician". EDP is preselected – click "OK"	Treating Physician is entered
Step 15	Click the "Done" button to complete triage. Bypass the triage orders by clicking "Done" on the orders page, then assign the patient to a room	Triage is completed
Step 16	<p>Go to Assessment -> Adult Assessment -> Vaccination History.</p> <ul style="list-style-type: none"> • Select Diphtheria – Tetanus, then enter: <ul style="list-style-type: none"> ○ Vaccine Administered - Tdap ○ Date of Administration – 01/04/2012 ○ Manufacturer – click the "Text" icon and enter "Immuno Inc." ○ Lot Number – 2 ○ Status – completed • Select Influenza, then enter: <ul style="list-style-type: none"> ○ Vaccine Administered - Influenza, intradermal, quadrivalent, preservative free ○ Date of Administration – enter current date ○ Manufacturer – click the "Text" icon and enter "Immuno Inc." ○ Lot Number – enter "unknown" ○ Status – cancelled ○ Additional Comments – "immunization not given – Patient rejected immunization" 	Immunizations are entered
Step 17	Go to Nursing Dx/Care Plan -> Goals -> Custom Entry, then enter in free text: "a. Get rid of intermittent fever that is occurring every few weeks b. Need to gain more energy to do regular activities".	Goals are entered
Step 18	Go to Nursing Dx/Care Plan -> General Health Concerns -> Custom Entry, then enter in free text: " a. Chronic sickness exhibited by patient b. Healthcare concerns refer to underlying clinical facts c. Documented Hypertension problem d. Documented Hypothyroidism problem e. Watch weight of patient".	Health Concerns are entered

Step 19	Go to Assessment -> Adult Assessment -> Psychosocial -> Ability to Ambulate ->Requires Assistance ->dependence on a cane, and enter Start Date 05/01/2005	Functional Status is entered
Step 20	Go to Assessment -> Adult Assessment -> Neurological ->Mental Status -> Altered Mental Status ->Amnesia, and enter Start Date 05/01/2005	Cognitive Status is entered
Step 21	Go to Assessment -> Adult Assessment -> Psychosocial -> Smoking Status -> Current Every Day Smoker and enter the current date	Smoking Status is entered
Step 22	Go to Assessment -> Adult Assessment -> Implantable Devices. In the Implantable Devices Table, click the “New” button to open the device data entry fields. Copy and paste the UDI (01)00643169007222(17)160128(21)BLC200461H into the UDI field. Click the “Parse” button to display the parsing of the UDI, then “Accept”. Click the “Lookup” button to display the lookup data, then “Accept”. Click “Save” to close the UDI Table	Unique Device Identifier data is entered
Step 23	This completes the nursing data entry. Go to the Status Board.	Exit Nurse Chart
Step 24	Log in to Alice Newman as a physician user	User logs in to Alice Newman Physician Chart
Step 25	Click “History of Present Illness” and “FH SH Allergies Meds” buttons to auto-populate nursing data	nurse data for Allergies, Medications, and Problems is auto-populated
Step 26	Go to PMH and PSH -> Procedures and select: <ul style="list-style-type: none"> • Cardiac Pacemaker via Vein <ul style="list-style-type: none"> ○ Status – completed ○ Date of Procedure: 10/05/2011 • Nebulizer Therapy <ul style="list-style-type: none"> ○ Status - Completed ○ Date of Procedure: current date 	Procedures are entered
Step 27	Select the “Orders” tab. Go to Diagnostic -> Laboratory -> Urinalysis to place the order in “Pending Orders”. Click the “Submit” button and enter user password to send the order to “Completed Orders”. Select the “Completed Orders” tab and click the “clock” icon under Host Time associated with the order. Enter the current date and time.	Laboratory Tests are ordered
Step 28	Go to Test Results -> Labs -> Abnormal Lab Results (Manual Enter) -> Urinalysis and enter: <ul style="list-style-type: none"> • Appearance – Clear • Color – Yellow • pH – 5.0 • Ketones – Negative • Specific Gravity – 1.015 • Glucose – Neg • Protein – Negative 	Test Results are entered
Step 29	Click the “Clinical Impression” button and select “Fever (Adult)”	Clinical Impression is entered
Step 30	Go to Disposition -> Narrative Assessment -> Narrative Typed and enter in free text “The patient was found to have fever and Dr Davis is suspecting Anemia based on the patient history. So, Dr Davis asked the patient to	Assessment is entered

	closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.”	
Step 31	Go to Instructions -> Discharge Plan. Click the “Text” icon to open free text entry window. Enter “i) Get an EKG done on 6/23/2015 ii) Get a Chest X-ray done on 6/23/2015 showing the Lower Respiratory Tract Structure iii) Take Clindamycin 300mg three times a day as needed if pain does not subside iv). Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2015” Also add “Urinalysis (macro) Panel LOINC 24357-6 in 7 days”	Plan of Treatment is entered
Step 32	Go to Consultation, DDx -> Consults -> Chief Consultant (Called prior to disposition) -> Reason for Referral and paste into the search line “Ms Alice Newman is being referred to Community Health Hospitals Inpatient facility because of the high fever noticed and suspected Anemia”	Reason for Referral is entered
Step 33	This completes the physician data entry. Go to the Status Board.	Exit Physician chart

7.1.3 Test Script

Prerequisites:

- (1)** Juno Emergency Services Solution user registers a patient and adds all the necessary data. The patient demographic data for these patients must match the data included in the two (2) xml files if test data is required.

Manual data entry for Scenarios #1-2:

- Katherine Madison or selected patient
- Myra Banks or selected patient

Manual data entry for Scenarios #3-4:

- Alice Newman or selected patient

- Scenario 1 will be utilized for the receipt via Direct message and validation of the Continuity of Care C-CDA for selected patient or Katherine Madison. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps to View, Parse and Import incoming C-CDA	Expected Outcome
Step 1	In JESS, log into patient Katherine Madison as a nurse user and click Import/Export tab.	“Current and Exported Documents” opens with focus on the Export
Step 2	Click the Import tab and select the message that contains Katherine Madison r2.1 CCD.XML	Katherine Madison r2.1 CCD.XML is selected
Step 3	Click the “Validate” button to display the document validation. Review the validation.	Validation for the Katherine Madison r2.1 CCD.XML is displayed
Step 4	Close the document validation, then click “Import” button to import the Katherine Madison r2.1 CCD.XML document into Katherine Madison’s chart.	Imported CCD for Katherine Madison is listed in the Imported Documents section



Step 5	Select the green ball to parse and display all sections of the imported document	Parse and display all sections of the first imported document
Step 6	In the Table of Contents uncheck one or more of the sections.	The sections that were selected no longer display on the page
Step 7	In the Table of Contents add the check box on one of the sections that is currently not visible on the page.	The page refreshes and the section that was selected is now in view.
Step 8	Use the “Up” and “Down” arrows to change the display order of the section display.	The display order of the sections is changed
Step 9	Select the “Save Order Preference” icon to save the display order	Display order is saved
Step 10	Click the green ball to close the imported CCD. Click the Status Board icon to exit the patient chart.	Imported CCD is closed

- Scenario 2 will be utilized for the receipt via Direct message and validation of the Referral Note for Myra Banks or selected patient. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps to View, Parse and Import incoming Referral Note	Expected Outcome
Step 1	In JESS, log into patient Myra Banks as a nurse user and click Import/Export tab.	“Current and Exported Documents” opens with focus on the Export
Step 2	Click the Import tab and select the message that contains Susan Myra Banks RN.XML	Myra Banks r2.1 RN.XML is selected
Step 3	Click the “Validate” button to display the document validation. Review the validation.	Validation for the Myra Banks r2.1 RN.XML is displayed
Step 4	Close the document validation, then click “Import” button to import the Myra Banks r2.1 RN.XML document into Myra Banks’ chart.	Imported RN for Myra Banks is listed in the Imported Documents section
Step 5	Select the green ball to parse and display all sections of the imported document.	Parse and display all sections of the imported RN document
Step 6	In the Table of Contents uncheck one or more of the sections.	The sections that were selected no longer display on the page



Step 7	In the Table of Contents add the check box on one of the sections that is currently not visible on the page.	The page refreshes and the section that was selected is now in view.
Step 8	Use the “Up” and “Down” arrows to change the display order of the section display.	The display order of the sections is changed
Step 9	Select the “Save Order Preference” icon to save the display order	Display order is saved
Step 10	Click the green ball to close the imported Referral Note. Click the Status Board icon to exit the patient chart.	Imported Referral Note is closed

- Scenario 3 will be utilized for the creation, validation and transmission of the Continuity of Care C-CDA for Alice Newman or selected patient in real time. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps for Creation and Transmission of C-CDA	Expected Outcome
Step 1	In JESS, log into patient Alice Newman as physician user with “Send” privileges and click Import/Export tab.	“Current and Exported Documents” opens with focus on the Export
Step 2	Select the CCD radio button	CCD for Alice Newman is displayed
Step 3	Click the “Export Document” icon to open the “Select Document Export Target” window	“Select Document Export Target” window is opened
Step 4	Scroll to select addressee “JESS partner (TTT)”. Enter “AN CCD” in the “Subject” line and “Body” dialog box	Addressee for the CCD is selected. “Subject” and “Body” fields completed
Step 5	Click “OK” to send the message. Enter user password.	Message and CCD attachment is sent
Step 6	Validate with “JESS partner (TTT)” the receipt of the message with CCD attachment. Click the Status Board icon to exit the patient chart.	Message and CCD attachment is successfully received by addressee

- Scenario 4 will be utilized for the creation, validation and transmission of the Referral Note for Alice Newman or selected patient in real time. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps for Creation and Transmission of the Referral Note	Expected Outcome
Step 1	In JESS, log into patient Alice Newman as physician user with “Send” privileges and click Import/Export tab.	“Current and Exported Documents” opens with focus on the Export
Step 2	Select the “Referral Note” radio button	Referral Note for Alice Newman is displayed
Step 3	Click the “Export Document” icon to open the “Select Document Export Target” window	“Select Document Export Target” window is opened



Step 4	Scroll to select addressee "JESS partner (TTT)". Enter "AN Referral Note" in the "Subject" line and "Body" dialog box	Addressee for the Referral Note is selected. "Subject" and "Body" fields completed
Step 5	Click "OK" to send the message. Enter user password.	Message and Referral Note attachment is sent
Step 6	Validate with "JESS partner (TTT)" the receipt of the message with Referral Note attachment. Click the Status Board icon to exit the patient chart.	Message and Referral Note attachment is successfully received by addressee

7.2 Appendix B §170.315(b)(2) Clinical Information Reconciliation and Incorporation

7.2.1 Criteria

- §170.315(b)(2) Clinical information and Reconciliation and Incorporation

7.2.2 Test Data

- Scenario 1 will be utilized for the import, reconciliation, and incorporation of the Continuity of Care C-CDA. If functionality is in use, site is to use actual patient. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. Data in BLUE is in JESS prior to receiving the reconciliation xml from the partner site. Data in the incoming reconciliation xml is shown below in RED.

Patient:	Susan Jones Turner	Alias:	Susy Turner	
DOB:	8/1/1970			
Gender:	Female			
Race:	White (2106-3) White European (2108-9)	Ethnicity:	Not Hispanic or Latino (2186-5)	
Address:	1011 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)-336-1544	Mobile Phone:	(555)-335-1234	
Active Medication Allergies:	Penicillin G benzathine	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 5/01/1980
	Penicillin G benzathine	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 2/22/2015
	Ampicillin	RxNorm 733	Moderate Hives (247472004)	Start: 2/22/2015
Medications:	Ceftriaxone 100MG/ML	BID	RxNorm 309090	Current date
	Tylenol 500mg	PRN	RxNorm 209459	Current date

	Aranesp 0.5 mg/ml	Once a week	RxNorm 731241	2/22/2015
	Tylenol 500mg	For 10 days as needed	RxNorm 209459	2/22/2015
Problems:	Fever	SNOMED-CT 386661006		Current date
	Essential Hypertension	SNOMED-CT 59621000		10/05/2011
	Severe Hypothyroidism	SNOMED-CT 83986005		12/31/2006
	Chronic rejection of renal transplant	SNOMED-CT 236578006		12/31/2011
	Fever	SNOMED-CT 386661006		02/22/2015

Step	Steps to Enter Data	Expected Outcome
Step 1	As a nurse user, click on the “New Patient” button to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	<ul style="list-style-type: none"> In the Name Type dropdown, select “Legal Name”. Enter Last Name: Turner First Name: Susan Middle Name: Jones DOB: 08/01/1970 Sex: Female Gender Identity: Female Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: White – declined to specify White European – declined to specify Preferred Language: English EDP: select ED physician Tax ID: select Tax ID if not pre-populated 	Initial patient information is entered
Step 3	Click the “OK” button. Complete registration (If hospital system is unavailable, select “Offline account number”) and continue in nursing documentation.	Registration is completed
Step 4	<p>In Triage, select “Allergies” to open Allergies Table:</p> <ul style="list-style-type: none"> Enter Penicillin G in search line then click to move to the Current Allergies List. Double click the “Symptoms” field and select “Hives” from the dropdown. Double click the “Severity” field and select “Moderate”. Double click the “Onset” field and enter 05/01/1980 Click “OK” to close the Allergies table. 	Allergies are entered
Step 5	<p>In Triage, select “Current Medications” to open Medications Table:</p> <ul style="list-style-type: none"> Enter Ceftriaxone in search line then click to move to the Current Medications List. Enter: Route – injectable Frequency – every 12 hours. Double click in the “Dosage” field and enter 100 mg/mL. Double click in the “Start Date” field and enter the current date 	Current Medications are entered



	<ul style="list-style-type: none"> Enter Tylenol in search line then click to move to the Current Medications List. Enter: Route – oral. Double click in the “Dosage” field and enter 500 mg. Double click in the “Frequency” field and enter “prn”. Double click in the “Start Date” field and enter the current date Click “OK” to close the Medications table. 	
Step 6	<p>In Triage, select “Problems” to open the Problems Table:</p> <ul style="list-style-type: none"> Enter Fever in search line then click to move to the Current Problem List. - Double click in the “Onset Date” field and enter the current date 	Problems are entered
Step 7	This completes data entry. Go to the Status Board	User exits Nurse Chart

- Scenario 2 will be utilized for the import, reconciliation, and incorporation and reconciliation of the Referral Note C-CDA. If functionality is being utilized, site is to use actual patient. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. Data in **BLUE** is in JESS prior to receiving the reconciliation xml from the partner site. Data in the incoming reconciliation xml is shown below in **RED**.

Patient:	Cecilia Franklin Cummings	Alias:	Cecil Cummings
DOB:	07/01/1970		
Gender:	Female		
Race:	White (2106-3) White European (2108-9)	Ethnicity:	Not Hispanic or Latino (2186-5)
Address:	1014 Amber Dr., Beaverton OR 97006		
Home Phone:	(555)340-1544	Mobile Phone:	(555)339-1234
Active Medication Allergies:	Penicillin G benzathine	RxNorm 7980 (IN)	Moderate Hives (247472004) Start: 5/01/1980
	Penicillin G benzathine	RxNorm 7980 (IN)	Moderate Hives (247472004) Start: 2/22/2015
	Ampicillin	RxNorm 733	Moderate Hives (247472004) Start: 2/22/2015
Medications:	Ceftriaxone 100MG/ML	BID	RxNorm 309090 Current date
	Tylenol 500mg	PRN	RxNorm 209459 Current date
	Aranesp 0.5 mg/ml	Once a week	RxNorm 731241 2/22/2015
	Tylenol 500mg	For 10 days as needed	RxNorm 209459 2/22/2015
Problems:	Fever	SNOMED-CT 386661006	Current date



	Essential Hypertension	SNOMED-CT 59621000		10/05/2011
	Severe Hypothyroidism	SNOMED-CT 83986005		12/31/2006
	Chronic rejection of renal transplant	SNOMED-CT 236578006		12/31/2011
	Fever	SNOMED-CT 386661006		02/22/2015

Step	Steps to Enter Data	Expected Outcome
Step 1	As a nurse user, click on the “New Patient” button to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	<ul style="list-style-type: none"> In the Name Type dropdown, select “Legal Name”. Enter Last Name: Cummings First Name: Cecilia Middle Name: Franklin DOB: 07/01/1970 Sex: Female Gender Identity: Female Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: White – declined to specify White European – declined to specify Preferred Language: English EDP: select ED physician Tax ID: select Tax ID if not pre-populated 	Initial patient demographic data is entered
Step 3	Click the “OK” button. Complete registration (If hospital system is unavailable, select “Offline account number”) and continue in nursing documentation.	Registration is complete
Step 4	<p>In Triage, select “Allergies” to open Allergies Table:</p> <ul style="list-style-type: none"> Enter Penicillin G in search line then click to move to the Current Allergies List. Double click the “Symptoms” field and select “Hives” from the dropdown. Double click the “Severity” field and select “Moderate”. Double click the “Onset” field and enter 05/01/1980 Click “OK” to close the Allergies table. 	Allergies are entered
Step 5	<p>In Triage, select “Current Medications” to open Medications Table:</p> <ul style="list-style-type: none"> Enter Ceftriaxone in search line then click to move to the Current Medications List. Enter: Route – injectable Frequency – every 12 hours. Double click in the “Dosage” field and enter 100 mg/mL. Double click in the “Start Date” field and enter the current date Enter Tylenol in search line then click to move to the Current Medications List. Enter: Route – oral. Double click in the “Dosage” field and enter 500 mg. Double click in the “Frequency” field and enter “prn”. Double click in the “Start Date” field and enter the current date Click “OK” to close the Medications table. 	Current Medications are entered
Step 6	In Triage, select “Problems” to open the Problems Table:	Problems are entered

	<ul style="list-style-type: none"> Enter Fever in search line then click to move to the Current Problem List. - Double click in the "Onset Date" field and enter the current date 	
Step 7	This completes data entry. Go to the Status Board	User exits Nurse Chart

7.2.3 Test Script

Prerequisites:

(1) If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. The patient demographic data for these patients must match the data included in the two (2) xml files. Patient must exist in system prior to reconciliation.

- Scenario 1 will be utilized for the receipt and reconciliation of the Continuity of Care C-CDA. If functionality is in use, site is to use actual patient. If functionality is not being utilized, use Susan Turner.

Step	Steps to Receive, Import and Reconcile	Expected Outcome
Step 1	In JESS, log into patient Susan Turner as a nurse user and click Import/Export tab.	"Current and Exported Documents" opens with focus on the Export.
Step 2	Click the Import tab and select the message that contains Susan Turner CCD_reconciliation.XML	The CCD reconciliation document for Susan Turner is selected
Step 3	Click the "Preview" button. Review the CCD then click "OK" to close the preview	The CCD reconciliation document for Susan Turner is parsed and displayed
Step 4	Click the "Validate" button to display the document validation. Review the validation then click "OK" to close	Validation for the CCD reconciliation document for Susan Turner is displayed
Step 5	Click "Import" button to import the Susan Turner CCD reconciliation document into Susan Turner's chart.	CCD reconciliation document for Susan Turner is listed in the Imported Documents section
Step 6	Go to the Nurse tab to open nursing documentation. Select the "Allergies" button to open the "Allergies" table	"Allergies" table is opened
Step 7	Click the History tab to display the allergies from the imported CCD for Susan Turner. Compare the imported list to the initial allergy list	Allergies from the imported CCD for Susan Turner are displayed along with the initial allergy list
Step 8	Click on any allergies from the imported list not already included on the initial allergies list to add them to the current list. At the bottom of the "Allergies" table, select "Allergies reconciled with Supplemental Records" then close the "Allergies" table	Initial allergy list is reconciled with the imported source to create the consolidated allergy list. "Allergies" table is closed
Step 9	Select the "Current Medications" button to open the "Medications" table	"Medications" table is opened
Step 10	Click the History tab to display the medication list from the imported CCD for Susan Turner. Compare the imported med list with the initial medications list	Med list from the imported CCD for Susan Turner is displayed along with the initial medication list

Step 11	Click on any medications from the imported list not already included on the initial medications list to add them to the current list. At the bottom of the “Medications” table, select “Medications reconciled with Supplemental Records” then close the “Medications” table	Initial medication list is reconciled with the imported source to create the current medication list. “Medications” table is closed
Step 12	Select the “Problems” button to open the “Problems” table	“Problems” table is opened
Step 13	Click the History tab to display the problem list from the imported CCD for Susan Turner. Compare the imported problem list with the initial problem list	Problem list from the imported CCD for Susan Turner is displayed along with the initial problem list
Step 14	Click on any problems from the imported list not already included on the initial problem list to add them to the current list. At the bottom of the “Problems” table, select “Problems reconciled with Supplemental Records” and close the Problems table	Initial problem list is reconciled with the imported source to create the current problem list. “Problems” table is closed
Step 15	Go back to the Import/Export tab, then select “Export” to display continuity of care documents. Click the CCD radio button to display the updated CCD with consolidated Allergies, Medications, and Problems	Updated CCD is displayed with reconciled Allergies, Medications, and Problems

- Scenario 2 will be utilized for the receipt and reconciliation of the Referral Note C-CDA. If functionality is being utilized, site is to use actual patient. If functionality is not being utilized, use Cecilia Cummings.

Step	Steps to Receive, Import and Reconcile	Expected Outcome
Step 1	In JESS, log into patient Cecilia Cummings as a nurse user and click Import/Export tab.	“Current and Exported Documents” opens with focus on the Export
Step 2	Click the Import tab and select the message that contains Cecilia Cummings Referral Note_reconciliation.XML.	The referral note reconciliation document for Cecilia Cummings is selected
Step 3	Click the “Preview” button. Review the Referral Note, then click “OK” to close the preview.	The Referral Note reconciliation document for Susan Turner is parsed and displayed
Step 4	Click the “Validate” button to display the document validation. Review the validation then click “OK” to close.	Validation for the CCD reconciliation document for Cecilia Cummings is displayed.
Step 5	Click “Import” button to import the Cecilia Cummings Referral Note reconciliation document into Cecilia Cumming’s chart.	Referral Note reconciliation document for Cecilia Cummings is listed in the Imported Documents section
Step 6	Go to the Nurse tab to open nursing documentation. Select the Allergies button to open the “Allergies” table.	“Allergies” table is opened.

Step 7	Click the History tab to display the allergies from the imported Referral Note for Cecilia Cummings. Compare the imported list to the initial allergy list.	Allergies from the imported Referral Note for Cecilia Cummings are displayed along with the initial allergy list
Step 8	Click on any allergies from the imported list not already included on the initial allergies list to add them to the current list. At the bottom of the "Allergies" table, select "Allergies reconciled with Supplemental Records" then close the "Allergies" table	Initial allergy list is reconciled with the imported source to create the consolidated allergy list. "Allergies" table is closed.
Step 9	Select the "Current Medications" button to open the "Medications" table.	"Medications" table is opened
Step 10	Click the History tab to display the medication list from the imported Referral Note for Cecilia Cummings. Compare the imported med list with the initial medications list.	Med list from the imported Referral Note for Cecilia Cummings is displayed along with the initial medication list
Step 11	Click on any medications from the imported list not already included on the initial medications list to add them to the current list. At the bottom of the "Medications" table, select "Medications reconciled with Supplemental Records" then close the "Medications" table.	Initial medication list is reconciled with the imported source to create the current medication list. "Medications" table is closed
Step 12	Select the "Problems" button to open the "Problems" table.	"Problems" table is opened
Step 13	Click the History tab to display the problem list from the imported Referral Note for Cecilia Cummings. Compare the imported problem list with the initial problem list.	Problem list from the imported Referral Note for Cecilia Cummings is displayed along with the initial problem list
Step 14	Click on any problems from the imported list not already included on the initial problem list to add them to the current list. At the bottom of the "Problems" table, select "Problems reconciled with Supplemental Records" and close the Problems table.	Initial problem list is reconciled with the imported source to create the current problem list. "Problems" table is closed
Step 15	Go back to the Import/Export tab, then select "Export" to display continuity of care documents. Select the "Referral Note" radio button to display the updated Referral Note with consolidated Allergies, Medications, and Problems.	Updated Referral Note is displayed with reconciled Allergies, Medications, and Problems

7.3 Appendix C §170.315(f)(2) Transmission to Public Health Agencies - Syndromic Surveillance

7.3.1 Criteria

- §170.315(f)(2) Transmission to Public Health Agencies-Syndromic Surveillance

7.3.2 Test Data

- Prior to the first transmission, the organization must register their intent to submit data to the appropriate surveillance system.



- Scenario 1: Urgent Care – A04 and A03 ADT Messages. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.
- Note: Patient must be registered as: Enterprise.Facility.Setting – UrgentCare
Enterprise.HostInterface.PatientClass – O

Patient:		Pseudo – Name: S	Chris Black
DOB:	7/25/2020		
Gender:	Male		
Race:	White (2106-3) Asian (2028-9) Native Hawaiian (2076-8)	Ethnicity:	Not Hispanic or Latino (2186-5)
Address:	Jamaica Plain, Massachusetts 02130 County: Suffolk		
Chief Complaint #1	FEVER 100.5 – 102.2 (3 – 24 MONTHS OLD	Chief Complaint #2	EARACHE.
Admit Reason	fever, cough, earache		
Working Diagnosis #1	Influenza J11.1	Working Diagnosis #2	Acquired stenosis of external ear canal due to inflammation and infection, unspecified ear H61.329
Smoking Status	Never Smoker	Patient stated chief complaint	Mother states patient has fever, cough, and earache
Height:	177 cm	Weight:	88 kg
Clinical Impression #1	Influenza J11.1	Clinical Impression #2	Acquired stenosis of external ear canal due to inflammation and infection, unspecified ear H61.329

- Scenario 2: Emergency Department – A04, A08, and A03 ADT Messages. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.
- Note: Patient must be registered as: Enterprise.Facility.Setting – EmergencyDepartment
Enterprise.HostInterface.PatientClass – E

Patient:	Sarah White (U)	Alias:	
DOB:	01/24/1986 (estimated)		
Gender:	Female		
Race:	White (2106-3)	Ethnicity:	Declined to Specify
Address:			
Chief Complaint #1	HEAD INJURY – (MOD – SEVERE).		
Admit Reason	Pedal cycle driver injured in collision with car, pick-up truck or van		



	in traffic accident V13.4XXA		
Smoking Status	Unknown if ever smoked		
Height:	65 in	Weight:	128 lbs
Working Diagnosis #1	Type III Occipital Condyle Fracture	Working Diagnosis #2	Unspecified intracranial injury with loss of consciousness of 1 hour to 5h 59min, initial encounter S06.9X3A
Address:	Chicago	IL	60601
Disposition	Expired		
Clinical Impression #1	Concussion with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter S06.0X7A	Clinical Impression #2	Type III Occipital Condyle Fracture

- Scenario 3: Emergency Department – A04, A08, A03, and A01 ADT Messages. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.
- Note: Patient must be registered as: Enterprise.Facility.Setting – EmergencyDepartment
Enterprise.HostInterface.PatientClass – E

Patient:	Ted Green (S)	Alias:	
DOB:	01/24/1951		
Gender:	Male		
Race:	White (2106-3) American Indian Other	Ethnicity:	Declined to Specify
Address:	Oklahoma City, Oklahoma 74852 County: Pottawatomie		
Smoking Status	Current light smoker	Patient stated chief complaint	A headache, nausea, and dizziness
Chief Complaint #1	ALTERED MENTAL STATUS		
Height:	65 in	Weight:	170 lbs
Working Diagnosis #1	CO Exposure - Accidental		
Admit Reason:	toxic effect of carbon monoxide from other source, accidental T58.8X1A		
Clinical Impression	CO Exposure – Accidental		
Disposition	Admit		

7.3.3 Test Script

- Scenario 1: Urgent Care – A04 and A03 ADT Messages. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps to Trigger ADT Messages	Expected Outcome
Step 1	Click “New Patient” and log in as nurse user to open the “Presentation” data entry window	“Presentation” data entry window opens.
Step 2	In the Name Type field, click the dropdown and select “Coded Pseudo Name...” Enter Last Name “Black” and First Name “Chris”	Name fields are completed
Step 3	Enter: Birth Date: 07/25/2020 Sex: Male Gender Identity: Male Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: Asian, Native Hawaiian, White Preferred Language: English EDP: EDP of choice Tax ID: Team A Prior to clicking the “OK” button, click the “Address and Phone” tab.	Demographic data is entered then Address and Phone tab is opened
Step 4	Enter: City: Jamaica Plain State: Massachusetts County: Suffolk Zip Code: 02130 Click “OK” to close the “Presentation” window. Complete registration. (If hospital system is unavailable, select “Offline account number”) and continue in nursing documentation.	Address is entered and “Presentation” is closed. Registration is completed.
Step 5	In Triage enter: JESS Chief Complaint #1 – FEVER 100.5 – 102.2 (3 – 24 MONTHS OLD Click “Save” on the Screening Questions window JESS Chief Complaint #2 – EARACHE. Click “Save” on the Screening Questions window	Chief Complaints are entered
Step 6	Prior to the completion of triage, go back to the Status Board. Click the “Presentation” tab and select Chris Black. Log into Chris Black as physician user. Click “No” to the Rapid Chart prompt	Prior to completion of triage, user enters physician documentation. Rapid Chart prompt declined
Step 7	In the physician chart, go to History of Present Illness -> Context -> Encounter Reason -> Narrative Typed and enter the Admit Reason: “fever, cough, earache”. Skip the ICD 10 Search Tool.	Admit Reason is entered

Step 8	Go to Consultation, DDx -> DDx. Enter the Working Diagnosis "Influenza". In the ICD 10 Search Tool select J11.1 "Influenza due to unidentified influenza virus with other respiratory manifestations" and click "OK"	First Working Diagnosis is entered
Step 9	To enter the second Working Diagnosis, select "Stenosis of ear canal". In the ICD 10 Search Tool, select "[H61.329] – Acquired stenosis of external ear canal due to inflammation and infection, unspecified ear" and click "OK."	Second Working Diagnosis is entered
Step 10	Return to the Status Board and select the "Presentation" tab	Return to patient Presentation
Step 11	Select Chris Black and click the "Triage" button to the left of the Status Board. Log in as nurse user to resume the triage for Chris Black	Re- enter nursing chart for Chris Black
Step 12	Select Assessment -> Pediatric Assessment -> Psychosocial -> Smoking Status and enter "Never Smoker"	Smoking Status is entered
Step 13	Return to Triage. Go to "Notes" and enter the patient stated chief complaint "Mother states patient has fever, cough, and earache"	Patient stated Chief Complaint is entered
Step 14	Enter: Triage Level: 2 Height: 27 inches Weight: 17 lbs Arrival Mode: Carried PCP: Black, Ben J Treating Physician: preselected EDP Click "Done" to complete triage Click "Done" on the Orders page to bypass Orders, assign the patient to a room, and continue in nursing documentation.	Triage is completed and room is assigned. A04 Registration message is sent.
Step 15	Go back to the Status Board. Log in to Chris Black as physician user. Go to Disposition -> Disposition -> Discharge -> Home followed by disposition date and time.	Physician Disposition is entered
Step 16	Go to Clinical Impression and select "Influenza". In the ICD 10 Search Tool select "[J11.1] – Influenza due to unidentified influenza virus with other respiratory manifestations" and click "OK". Then select "Stenosis of Ear Canal". In the ICD 10 Search Tool, select "[H61.329] – Acquired stenosis of external ear canal due to inflammation and infection, unspecified ear" and click "OK".	Clinical Impressions are entered
Step 17	Print and e-sign as physician user to lock the physician chart. Go back to the Status Board.	Physician chart is locked



Step 18	Log in to Chris Black as nurse user. Select Disposition → Discharged and enter date/time of disposition followed by “Discharged to” – DC option 1.	Nurse disposition and date/time is entered
Step 19	Print and e-sign as nurse user to lock the nurse chart. Go back to the Status Board.	Nurse chart is locked and A03 Discharge message is sent

- Scenario 2: Emergency Department – A04, A08, and A03 ADT Messages. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps to Trigger ADT Messages	Expected Outcome
Step 1	Click “New Patient” and log in as nurse user to open the “Presentation” data entry window.	“Presentation” data entry window opens.
Step 2	In the Name Type field, click the dropdown and select “Unspecified”. Enter Last Name “White” and First Name “Sarah”	Name fields are completed
Step 3	Enter: Birth Date: 01/24/1986 – Select the “Estimated” box Sex: Female Gender Identity: Female Sexual Orientation: Do not know Ethnicity: Declined to specify Race: White Preferred Language: English EDP: EDP of choice Tax ID: Team A Click “OK” to close the “Presentation” window. Complete registration. (If hospital system is unavailable, select “Offline account number”) and continue in nursing documentation.	Demographic data is entered and “Presentation” is closed. Registration is completed
Step 4	In Triage enter: JESS Chief Complaint #1 – HEAD INJURY – (MOD – SEVERE). Click “Save” on the Screening Questions window. Before completing triage return to the Status Board.	JESS Chief Complaint is entered
Step 5	Go to the “Presentation” tab and select Sarah White. Log in to physician chart.	Prior to completion of triage, user enters physician documentation.
Step 6	In the physician chart, go to History of Present Illness -> Nature of Injury -> Encounter Reason -> Narrative Typed and enter the Admit Reason: “Pedal cycle driver injured in collision with car, pick-up truck or van in traffic accident”.	Admit Reason is entered
Step 7	In the ICD 10 Search Tool, select V13.4XXA “Pedal cycle driver injured in collision with car, pick-up truck or van in traffic accident, initial encounter” and click “OK”.	ICD 10 code is selected

Step 8	Return to the Status Board and select the “Presentation” tab	Return to patient Presentation
Step 9	Select Sarah White and click the “Triage” button to the left of the Status Board. Log in as nurse user to resume the triage for Sarah White	Re- enter nursing chart for Sarah White
Step 10	Select Assessment -> Adult Assessment -> Psychosocial -> Smoking Status and enter “Unknown if ever smoked”	Smoking Status is entered.
Step 11	Return to Triage. Enter: Triage Level: 1 Height: 65 inches Weight: 128 lbs Arrival Mode: STR - EMS PCP: Black, Ben J Treating Physician: preselected EDP Select “Done” to complete triage. Click “Done” on the Orders page to bypass Orders, assign the patient to a room, and continue in nursing documentation.	Triage is completed and room is assigned. A04 Registration message is sent.
Step 12	Go back to the Status Board. Log in to physician chart as user (DIRECT, JESS). Go to Consultation, DDx -> DDx -> Head Injury -> Skull Fracture. Enter the Working Diagnosis Type III Occipital Condyle Fracture	First Working Diagnosis is entered
Step 13	Then select Closed -> Concussion -> Severe with LOC. In the ICD 10 Search Tool, select “[S06.0X3A] Unspecified intracranial injury with loss of consciousness of 1 hour to 5h 59min, initial encounter” and click “OK”.	Second Working Diagnosis is entered
Step 14	Click the “Save” icon.	Document content is saved to the database
Step 15	Open Demographics by clicking on the patient name at the top of the view template WHITE, SARAH .	Demographics is opened
Step 16	In Demographics: 1. Change the Name Type Code to “S”- Coded Pseudo-name ... 2. Age – remove the check from the “Estimated” box 3. Prior to clicking the “OK” button , select the “Address and Phone” tab. Add City: Chicago State: IL Zip code: 60601 Then click “OK” to close Demographics	Demographics is updated and closed. AO8 Update message is sent
Step 17	Go back to the Status Board. Log in to Sarah White as physician user (DIRECT, JESS). Go to Disposition -> Disposition -> Expired -> Time of Death and enter disposition date and time	Disposition “Expired” and date/time are entered



Step 18	Go to Clinical Impression -> Head Injury -> Closed ->Concussion and select "Severe with Death". In ICD 10 Search Tool, select S06.0X7A Concussion with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter" and click "OK".	First Clinical Impression is entered
Step 19	Then go to select Clinical Impression -> Head Injury -> Skull Fx-> Type III Occipital Condyle Fracture.	Second Clinical Impression is entered
Step 20	Print and e-sign as physician user to lock the physician chart. Go back to the Status Board.	Physician chart is locked
Step 21	Log in to Sarah White as nurse user. Select Disposition -> Expired/DOA ->Expired/DOA. Click "Expired". Then select "Time of Disposition" and enter disposition date/time	Nurse disposition and date/time is entered
Step 22	Print and e-sign as nurse user to lock the nurse chart. Go back to the Status Board.	Nurse chart is locked and A03 Discharge message is sent

- Scenario 3: Emergency Department – A04, A08, A03, and A01 ADT Messages. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps to Trigger ADT Messages	Expected Outcome
Step 1	Click "New Patient" and log in as nurse user to open the "Presentation" data entry window.	"Presentation" data entry window opens.
Step 2	In the Name Type field, click the dropdown and select "Coded Pseudo Name...". Enter Last Name "Green" and First Name "Ted"	Name fields are completed.
Step 3	Enter: Birth Date: 01/24/1951 Sex: Male Gender Identity: Male Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: American Indian, White, Other Preferred Language: English EDP: EDP of choice Tax ID: Team A Prior to clicking the "OK" button, click the "Address and Phone" tab.	Demographic data is entered and "Presentation" is closed. Registration is completed
Step 4	Enter City: Oklahoma City State: Oklahoma County: Pottawatomie Zip Code: 74852	Address is entered and "Presentation" is closed. Registration is completed.

	Click "OK" to close the "Presentation" window. Complete registration. (If hospital system is unavailable, select "Offline account number") and continue in nursing documentation.	
Step 5	In the nurse chart, select Assessment -> Adult Assessment -> Psychosocial -> Smoking Status and enter "Current light smoker"	Smoking Status is entered.
Step 6	Go to Triage. Enter: JESS Chief Complaint #1: ALTERED MENTAL STATUS. Click "Save" on the Screening Questions window Notes: "A headache, nausea, and dizziness" Triage Level: 1 Height: 65 inches Weight: 170 lbs Arrival Mode: AMB - POV PCP: Black, Ben J Treating Physician: preselected EDP Click "Done" to complete triage Click "Done" on the Orders page to bypass Orders, assign the patient to a room, and continue in nursing documentation.	Triage is completed and room is assigned. A04 Registration message is sent
Step 7	Go to the Status Board. Select Ted Green. Log in to physician chart as DIRECT, JESS	User enters physician documentation
Step 8	Go to Consultation, Ddx -> Ddx -> CO Exposure - Accidental.	Working Diagnosis is entered
Step 9	Open Demographics by clicking on the patient name at the top of the view template GREEN, TED	Demographics is opened
Step 10	Add Name Suffix "JR" and click "OK" to close Demographics	Demographics is updated and closed. A08 Update message is sent
Step 11	Go to History of Present Illness ->Context ->Encounter Reason ->Narrative Typed. Enter "toxic effect of carbon monoxide from other source, accidental" in Free Text entry window, then in the ICD 10 Search Tool select T58.8X1A "toxic effect of carbon monoxide from other source, accidental (unintentional), initial encounter" and click "OK".	Admit Reason is entered
Step 12	Go to Clinical Impression and select "CO Exposure – Accidental"	Clinical Impression is entered
Step 13	Go to Disposition -> Disposition -> Admit -> Medical and enter the disposition date and time.	Disposition and disposition date/time are entered



Step 14	Print and e-sign as DIRECT, JESS to lock the physician chart. Go back to the Status Board.	Physician chart is locked
Step 15	Log in to Ted Green as nurse user. Select Disposition → Admit → Admit to and select “Admit Area - 1. Then select “Time of Disposition” and enter disposition date/time	Nurse disposition and date/time is entered
Step 16	Print and e-sign as nurse user to lock the nurse chart. Go back to the Status Board.	Nurse chart is locked. A03 Discharge and A01 Admit messages are sent

7.4 Appendix D §170.315(f)(3) Transmission to Public Health Agencies — Reportable Laboratory Tests and Values/Results

7.4.1 Criteria

- §170.315(f)(3) Transmission to Public Health Agencies — Reportable Laboratory Tests and Values/Results

7.4.2 Test Data

- Scenario 1 (Blood Lead Level) maximally populated message will be utilized. If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Patient:	Todd G. Lerr Jr	Legal Name:	Theodore F. Gwinn Jr
Mother's maiden name	Ramona G Doolittle Jr PhD		
DOB:	6/7/2018		
Gender:	Male		
Race:	White (2106-3)	Ethnicity:	Not Hispanic or Latino (2186-5)
Address:	123 N 102 St, Apt 4D, Harrisburg, PA. 17102 USA		
Alternate Address:	111 South, Apt 14, Harrisburg, PA. 17102 USA		
Patient email	smithb@yahoo.com		
Home Phone:	(555)-725-9890 Ext 4 Call before 8 PM	Business Phone:	(555)-725-9890 Ext 4 Call before 8 PM
Emergency Contact:	Dr. Bea G Smith Jr PhD	Emergency Contact Address:	123 N 102 nd St, Apt 4D, Harrisburg, PA. 17102, USA
Emergency Contact email:	smithb@yahoo.com	Emergency Contact Phone	(555)-725-9890 Ext 4 Call before 8 PM



7.4.3 Test Script

- If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered. If functionality is being utilized, site is to use actual patient.

Step	Steps to Enter Data to populate HL7 messages	Expected Outcome
Step 1	In JESS, Click the "New Patient" button and log in as nurse user	"New Patient" data entry fields are opened.
Step 2	In Name Type dropdown, select "Unspecified. Enter Todd G. Lerr Jr	Patient name is entered
Step 3	Enter: Date of Birth: 6/7/2018 Sex: Male Gender Identity: Male Sexual Orientation: Do not know Ethnicity: Not Hispanic or Latino Race: White Preferred Language: English EDP: JESS, DIRECT Tax ID: Team A Do not select "OK"	Patient's Date of Birth, Sex, Ethnicity, Race, Preferred Language, EDP, and Tax ID are entered
Step 4	Select the "Other Names" tab. In the first Name Type dropdown, select "Legal Name". Enter "Theodore F Gwinn Jr". Under "Mother's Maiden Name", in the Name Type dropdown, select "Unspecified". Then enter "Ramona G Doolittle Jr PhD". Do not select "OK"	Patient's Legal Name and Mother's Maiden Name are entered
Step 5	Select the "Address and Phone" tab. In the Address Type dropdown select "Home", then enter "123 N 102 St., Apt 4D, Harrisburg, PA. 17102 USA"	Patient home address is entered
Step 6	Click the "+" icon under Address to open the "Alternate Address" entry fields. In the Address Type dropdown select "Current or Temporary". Enter "111 South, Apt 14, Harrisburg, PA. 17102 USA". Click "Save" to return to the "Address and Phone" tab.	Patient Alternate Address is entered
Step 7	In the Email Type dropdown, select "Personal". Enter "smithb@yahoo.com".	Patient email is entered
Step 8	In the Phone Type dropdown, select "Primary Residence Number". In the Device Type dropdown, select "Telephone". Enter "(555)-725-9890 Ext 4". Enter Comment "call before 8 PM"	Patient primary phone number is entered
Step 9	Click the "+" icon to open the "Additional Phone" data entry fields. In the Phone Type dropdown select "Work Phone". Enter "(555)-725-9890 Ext 4". Enter Comment "call before 8 PM". Click "Save" to return to the "Address and Phone" tab Do not select "OK"	"Additional Phone" entry fields are opened, and Business phone number is entered.
Step 10	Select the "Emergency Contact" tab. In the "Relationship" dropdown select "Guardian". In the Name Type dropdown select "Unspecified". Enter "Dr. Bea G Smith Jr PhD".	Emergency Contact name is entered.



Step 11	Click on "Contact Information" to open the Contact Information data entry fields. For Address, click the "Same as Patient" check box.	Emergency Contact address is entered.
Step 12	In the Email Type dropdown select "Personal". Enter smithb@yahoo.com For Phone, select the "Same as Patient" check box. Click "Save" to return to the "Emergency Contact" tab. Select "OK" to exit demographics. Complete patient registration. (If hospital system is unavailable, select "Offline account number") and continue in nursing documentation.	Emergency Contact email phone number are entered.
Step 13	Go to the Orders tab. Select Diagnostic -> Laboratory ->Drug Levels/Toxicology -> Lead to order a Lead Level. Select Order Entry Source "Verbal" and click "OK". Then click the green "Submit" button and enter comment "screening". Click the "Send" button to move the order to the "Completed Orders" tab.	Lead Level is ordered
Step 14	Receive verification from the JESS vendor that lab results have been imported into Todd Lerr's chart. Go to the "Results" tab and select the "Green Ball" icon for Laboratory Results to view the imported lab results	Lab results are displayed
Step 15	Go to the Status Board. Select the "Patient Listing" tab and log in as nurse user.	Log in to Patient Listing
Step 16	Select patient Todd Lerr. Right click on the patient and select "Transmit to Public Health Agency". In the "Transmission of Results to Public Agencies Manager" select the Blood Lead test results check box and click the "Send Selected" button.	Lead test results are selected and sent to Public Health Agency.
Step 17	Verify receipt of message	Receipt of message is verified