DSS Juno Emergency Services Solution v3.2 Test Plan

CHPL # 15.04.04.2925.JESS.03.02.1.220304

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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 v3.2 ONC Certification. This test plan describes the test strategy, testing activities and methods to determine DSS Juno Emergency Services Solution v3.2 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 v3.2.
- 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 v3.2 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
§170.315(b)(10) – Electronic Health Information Export

Clinical Quality Measures criteria
§ 170.315(c)(1) - Clinical Quality Measures (CQMs) — Record and Export
§ 170.315(c)(2) - Clinical Quality Measures (CQMs) — Import and Calculate
§170.315(c)(3) - Clinical Quality Measure (CQMs) – Report

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 Values/Results

Application Programming Interfaces
§170.315(g)(10) – Standardized API for Patient and Population Services

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 v3.2 - 15.04.04.2925.JESS.03.02.1.220304
Care Setting	Hospital Emergency Department/Urgent Care • Ambulatory
Test Environment	Customer TEST environment that mirrors the organization's production environment.
Justification/Approach	The current certified version of Juno Emergency Services Solution v3.2 is not in use at any of our customer sites; 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 • DHIT CQMsolution® - for the generation of measure specific data for review, generation of the QRDA I files for consumption by CMS systems using the QualityNet Secure Portal for Hospital Quality Reporting (HQR) • 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 Results will be captured through a variant of screenshots and extracts.
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	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. 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.
Certification Criteria	§ 170.315 (b)(1) *Transition of care—* (i) *Send and receive via edge protocol—* (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. (ii) *Validate and display —* (A) Validate C-CDA conformance – system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in § 170.205(a)(3), (4),

	and (5) for the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to: (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: (i) Be notified of the errors produced. (ii) Review the errors produced. (B) *Display*. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in § 170.205(a)(3), (4), and (5). (C) *Display section views*. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in § 170.205(a)(3), (4), and (5) in a manner that enables the user to: (1) Directly display only the data within a particular section (2) Set a preference for the display order of specific sections; and (3) Set the initial quantity of sections to be displayed. (iii) *Create.* Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in § 170.205(a)(3), (4), and (5) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum: *(A)* (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: (i) *Assessment and plan of treatment*. In accordance with the "Assessment and Plan Section (V2)" of the standard specified in § 170.205(a)(4); or in accordance with the "Assessment Section (V2)"

	and "Plan of Treatment Section (V2)" of the standard specified in § 170.205(a)(4). (ii) *Goals*. In accordance with the "Goals Section" of the standard specified in § 170.205(a)(4). (iii) *Health concerns*. In accordance with the "Health Concerns Section" of the standard specified in § 170.205(a)(4). (iv) *Unique device identifier(s) for a patient's implantable device(s)*. In accordance with the "Product Instance" in the "Procedure Activity Procedure Section" of the standard specified in § 170.205(a)(4). (B) Encounter diagnoses. Formatted according to at least one of the following standards: (1) The standard specified in § 170.207(i). (2) At a minimum, the version of the standard specified in § 170.207(a)(4). (C) Cognitive status. (D) Functional status. (E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. (F) Inpatient setting only. Discharge instructions. (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: (1) *Date of birth constraint*. (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) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in § 170.207(q)(1). All phone numbers must be included when multiple phone numbers are present. (3) Sex constraint. Represent sex in accordance with the standard adopted in § 170.207(n)(1). **References:** • 170.202(a)(2) Applicability Statement for Secure Health Transport, Version 1.2, August 2015 (Direct) File: Applicability Statement for Secure Health Transport v1.2.pdf - Direct Project • 170.202(d) ONC Implementation Guide for Direct Edge Protocols, Version 1.1, June 25, 2014 Implementation Guide for Direct Edge Protocols, Version 1.1, June 25, 2014 (healthit.gov) • 170.202(e)(1) | Interoperability Standards Advisory (ISA) (healthit.gov) 170.202(e)(1) | Interoperability Standards Advisory (ISA) (healthit.gov)

	• §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
Justification	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: • Continuity of Care • Referral Note • Using 4 scenarios, all of the components of the §170.315(b)(1) Transitions of Care will be tested i.e., • 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. (Note: The incorporation of some of the data elements will be tested separately as part of 170.315(b)(2).) • 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: ➢ 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) ➢ 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. *(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.)*
Test Methodology	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. If Customer site is not currently utilizing the Transition of Care functionality, Real World Testing 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. 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.
Test Data	For testing the receipt of transition of care documents from other providers in Scenarios #1 and #2, xml files may be provided by the vendor for import and processing if they are required since the functionality is not currently in use by the site. 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: ➢ Common Clinical Data Set items ❖ 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 See attached Appendix A for the script for Test Data Entry
Expected Outcomes	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. 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., • 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 See attached Appendix A for the step-by-step details and Expected Outcomes
Measure	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. The measure includes two parts, i.e., • % 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 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. *Numerator= # scenarios with expected results* *Denominator = # scenarios tested with C-CDAs received (Scenarios 1-2 included in test plan)* • % 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 processed by a service that has implemented the standard specified in § 170.202(a) *Numerator= # of correct data elements in outgoing C-CDA's* *Denominator = # data elements expected in C-CDAs created and transmitted (Scenarios #3-4) included in test plan)*

4.2 §170.315(b)(2) Clinical Information Reconciliation and Incorporation

Use Case	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. 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.
Certification Criteria	*§170.315 (b)(2) Clinical information reconciliation and incorporation—*

	(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. *(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.* *(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:* *(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.* *(B) Enable a user to create a single reconciled list of each of the following: Medications; medication allergies; and problems.* *(C) Enable a user to review and validate the accuracy of a final set of data.* *(D) Upon a user's confirmation, automatically 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); and* *(3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4).* *(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.* **References:** § 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 § 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)
Justification	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., • 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	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 may be 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).
Test Data	Data entered at a minimum will include: ➢ Common Clinical Data Set items ❖ 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 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. See attached Appendix B for the script for Test Data Entry
Expected Outcomes	A total of 2 scenarios will be utilized: • 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. See attached Appendix B for the step-by-step details and Expected Outcomes
Measure	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). *Numerator= # scenarios with correctly reconciled Allergies, Medications, and Problems* *Denominator = # scenarios tested for import and reconciliation of Allergies, Medications, and Problems*

4.3 §170.315(b)(10) Electronic Health Information Export

Use Case	To ensure the continuity of care for any given patient, Juno Emergency Services Solution can create export files with single patient or patient population electronic health information in a computable format. Specific JESS users with required permissions can generate an export of a folder with a series of files containing patient specific data that can then be saved to a designated folder accessible to specified users. As part of the folder contents, there is a publicly accessible hyperlink 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.
Certification Criteria	§ 170.315 (b)(10) *Electronic Health Information export-* 1. *Single patient electronic health information export.* 1. Enable a user to timely create an export file(s) with all of a single patient's electronic health information that can be stored at the time of certification by the product, of which the Health IT Module is a part.

	2. A user must be able to execute this capability at any time the user chooses and without subsequent developer assistance to operate. 3. Limit the ability of users who can create such export file(s) in at least one of these two ways: 1. To a specific set of identified users 2. As system administrator function. 4. The export file(s) created must be electronic and in a computable format. 5. The publicly accessible hyperlink of the export's format must be included with the exported file(s). 2. *Patient population electronic health information export*. Create an export of all the electronic health information that can be stored at the time of certification by the product, of which the Health IT Module is a part. 1. The export created must be electronic and in a computable format. 2. The publicly accessible hyperlink of the export's format must be included with the exported file(s). 3. *Documentation*. The export format(s) used to support paragraphs (b)(10)(i) and (ii) of this section must be kept up-to-date.
Justification	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 a scenario that is organized in accordance with the clinical workflow, the required components of the §170.315(b)(10) Electronic Health Information Export criteria will be tested. Once testing for the §170.315(b)(10) has been completed, the exported folder with the data files will be available in the specified location. The format of the file will be in a computable format.
Test Methodology	Must do required configuration in advance-both users and file location. Permissions for the EHR (b)(10) Export functionality are assigned to a specific role in Configuration. The specific role with the required permission is then assigned to the users as deemed appropriate. One or more "Single Patient Export Directory Locations" can be configured for use. Once configured, choices will be viewable once the patient has been selected. The content of the patient specific data in the exported folder will vary as the data/files will depend on the specific data on the specific patient.
Test Data	Data will be entered into Juno EHR as part of ongoing clinical workflow. At a minimum, this data will include the following (if entered on a given patient): ➢ Common Clinical Data Set items ❖ 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
Expected Outcomes	A total of 1 scenario will be utilized: • Scenario 1 will be utilized for the export of single patient file in electronic computable format. See attached Appendix C for the step-by-step details and Expected Outcomes
Measure	Successful export of single patient file in electronic computable format. *Numerator= # scenarios with successful patient file export in proper format with correct data elements confirmed by visual inspection.* *Denominator = # scenarios tested for export of patient file in proper format with correct data elements. Files reviewed should include (at a minimum): Problems, Meds, Allergies, Diagnoses*

4.4 §170.315(c)(1) Clinical Quality Measures (CQMs) — Record and Export and §170.315(c)(3) Clinical Quality Measures (CQMs) — Report

Use Case	In order to ensure the capture of data in real time, configuration of the clinical documentation data is done in a manner that allows the association of codes with the data at the time of the data storage for the various data elements. This includes the demographic data as well as the data entered in the various modules within Juno Emergency Services Solution including Physician Documentation, Nursing Documentation, Orders, and Laboratory Results. Data required for CQM exclusions or exceptions must also be codified entries, which may include specific terms as defined by each CQM, or may include codified expressions of "patient reason," "system reason," or "medical reason." In general, the clinical documentation is done by physicians and nursing staff in their representative modules.
Certification Criteria	§170.315(c)(1) *Clinical quality measures—record and export—*

	(i) *Record.* For each and every CQM for which the technology is presented for certification, the technology must be able to record all of the data that would be necessary to calculate each CQM. Data required for CQM exclusions or exceptions must be codified entries, which may include specific terms as defined by each CQM, or may include codified expressions of "patient reason," "system reason," or "medical reason." (ii) Export. A user must be able to export a data file at any time the user chooses and without subsequent developer assistance to operate: (A) Formatted in accordance with the standard specified in §170.205(h)(2); (B) Ranging from one to multiple patients; and (C) That includes all of the data captured for each and every CQM to which technology was certified under paragraph (c)(1)(i) of this section. §170.315(c)(3) *Clinical quality measures—report—* Enable a user to electronically create a data file for transmission of clinical quality measurement data: (i) In accordance with the applicable implementation specifications specified by the CMS implementation guides for Quality Reporting Document Architecture (QRDA), category I, for inpatient measures in §170.205(h)(3) and CMS implementation guide for QRDA, category III for ambulatory measures in §170.205(k)(3); or (ii) In accordance with the standards specified in §170.205(h)(2) and § 170.205(k)(1) and (2) for the period until December 31, 2022. **References:** • §170.205(h)(3) CMS Implementation Guide for Quality Reporting Document Architecture: Category I; Hospital Quality Reporting Implementation Guide for 2020 CMS QRDA HQR IG (healthit.gov) • §170.205(k)(3) CMS Implementation Guide for Quality Reporting Document Architecture: Category III; Eligible Clinicians and Eligible Professional Programs Implementation Guide for 2020
Justification	Electronic Clinical Quality Measures (eCQMs) are specific to either the inpatient care setting or the ambulatory setting; however, the approach to data capture and calculations is the same. Juno Emergency Services Solution functionality supports clinical documentation for ambulatory setting associated with the inpatient facility, thus eCQM testing will be limited to EP measures and will not include any EH measures. Through the use of 20 scenarios for the emergency department in accordance with the clinical workflow for the data capture functionality, all of the components of the

	§170.315(c)(1) Clinical quality measures (CQMs)-record and export will be tested as well as §170.315(c)(3) Clinical quality measures (CQMs)-report, i.e., • record encounter data that includes the Taxpayer Identification Number (TIN) and National Provider Identifier (NPI), Provider Type and Practice Site Address for the provider as well as the Insurance, Age, Sex, Race and Ethnicity and Problem List for the patient; • record codified clinical data as defined for the specific measure utilizing the core functionality of the various modules within Juno Emergency Services Solution including Physician Documentation, Nursing Documentation, Orders, and Laboratory Results; • utilize the DHIT CQMsolution® software to generate measure specific data for review; and • generate data files and successfully export the QRDA I data file(s) for one or more patients and one or more measures on demand or for consumption by CMS systems using the QualityNet Secure Portal for submissions for Hospital Quality Reporting (HQR);
Test Methodology	At least 2 providers need to be tested in order to confirm the display of the appropriate NPIs associated with each provider. DHIT CQMsolution® is utilized for (1) calculation of the measures, (2) viewing the data in a Dashboard format or a patient drill-down screen, and (3) generation of the QRDA I files needed for submission to Joint Commission, CMS or other regulatory bodies.
Test Data	Data will be entered into Juno Emergency Services Solution as part of ongoing clinical workflow; however, in order to ensure that the data required for the measures is captured in a manner that it will be included in the abstract for subsequent analysis/compilation, it must be entered using specific defined processes. See Appendix D for the details for Test Data Entry. NOTES: • The details included in Appendix C provides an example of data based on the scenarios. If the organization chooses, different data can be utilized for the testing as long as all of the required steps are included. • The data entry scripts include the minimum required data based on the CNT design, so some data has been included that does not otherwise contribute to the data utilized for the measure.
Expected Outcomes	A total of 20 scenarios will be utilized. This includes 3 scenarios each for the EP Measures: • CMS 68v10 Documentation of Current Medications in the Medical Record

	• CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan • CMS 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention • CMS 146v6 Appropriate Testing for Pharyngitis • CMS 147v10 Preventive Care and Screening: Influenza Immunization 2 scenarios each for: • CMS 127v9 Pneumococcal Vaccination Status for Older Adults CMS 146v9 • CMS 349v3 HIV Screening plus an additional 1 scenario for the generation and download of the reports. • Scenario 1 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 68v10 Documentation of Current Medications in the Medical Record; • Scenario 2 will be utilized for the items with negation rationale where a specific action was refused by the patient or was medically not indicated for eCQM CMS 68v10 Documentation of Current Medications in the Medical Record; • Scenario 3 will be utilized for exclusions/exceptions where the patient was included in the denominator but not the numerator based on the predefined rationale documented for that specific measure for eCQM CMS 68v10 Documentation of Current Medications in the Medical Record; • Scenario 4 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan; • Scenario 5 will be utilized for the items with negation rationale where a specific treatment was refused by the patient or was medically not indicated for eCQM CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan; • Scenario 6 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan; • Scenario 7 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 127v9 Pneumococcal Vaccination Status for Older Adults; • Scenario 8 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 127v9 Pneumococcal Vaccination Status for Older Adults; • Scenario 9 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention;

	• Scenario 10 will be utilized for the items with negation rationale where a specific treatment was refused by the patient or was medically not indicated for eCQM 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention; • Scenario 11 will be utilized for exclusions/exceptions where the patient was included in the denominator but not the numerator based on the predefined rationale documented for that specific measure for eCQM CMS 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention; • Scenario 12 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 146v9 Appropriate Testing for Pharyngitis; • Scenario 13 will be utilized for exclusions/exceptions where the patient was included in the denominator but not the numerator based on the predefined rationale documented for that specific measure for eCQM CMS 146v9 Appropriate Testing for Pharyngitis; • Scenario 14 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on predefined rationale for that specific measure for eCQM CMS 146v9 • Scenario 15 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 147v10 Preventive Care and Screening: Influenza Immunization; • Scenario 16 will be utilized for the items with negation rationale where a specific treatment was refused by the patient or was medically not indicated for eCQM CMS 147v10 Preventive Care and Screening: Influenza Immunization; • Scenario 17 will be utilized for exclusions/exceptions where the patient was included in the initial patient population but not in the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 147v10 Preventive Care and Screening: Influenza Immunization; • Scenario 18 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 349v3 HIV Screening; • Scenario 19 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 349v3 HIV Screening; • Scenario 20 will be utilized for generation and download of the measure specific data for review in CQMsolution® . For Scenarios #1-#19, the following QDM Data Elements will be captured as part of the patient registration and admitting process: ✓ Encounter, Performed ✓ Patient Characteristic: Ethnicity ✓ Patient Characteristic: Payer ✓ Patient Characteristic: Race ✓ Patient Characteristic: Sex ✓ Patient Characteristic: Birthdate ✓ Discharge Disposition

	In addition, the following QDM Elements will be captured as part of the clinical documentation process for measure specific scenarios: CMS 68v10 ✓ Documentation of Current Medications ✓ Documentation of Current Medications Negation, Procedure Contraindicated CMS 69v9 ✓ Physical Exam Performed, Body Mass Index ✓ Physical Exam Performed, Body Mass Index Negation, Patient Refusal ✓ Intervention Performed, Follow-Up for Above Normal BMI ✓ Intervention Performed, Follow-Up for Above Normal BMI Negation, Procedure Contraindicated CMS 127v9 ✓ Pneumococcal Vaccine Administered ✓ Intervention Performed, Hospice Care CMS 138v9 ✓ Tobacco Use Screening ✓ Tobacco Use Screening Negation, Procedure Contraindicated CMS 146v9 ✓ Group A Streptococcus Test ✓ Diagnosis: Pharyngitis ✓ Antibiotic Medications for Pharyngitis ✓ Intervention Performed, Hospice Care CMS 147v10 ✓ Influenza Vaccination Administered ✓ Influenza Vaccination Administered Negation, Patient Refusal CMS 349v3 ✓ Human Immunodeficiency Virus Laboratory Test ✓ Diagnosis – Indicators of HIV See attached Appendix D for the step-by-step details and Expected Outcomes.
Measure	Successful compilation of the data for the selected EP eCQMs compiled by DHIT in CQMSolution® in a format that can be utilized for subsequent transmission to the designated site (Joint Commission or CMS). The measure includes:

	• % reports viewed that include the accurate data for the measure and for each of the patients on the report Numerator= # reports (either aggregated or patient specific) with expected results for (1) Initial Patient Population, (2) Numerator, (3) Denominator, (4) Denominator Exception and (5) Denominator Exclusion, based on data entry for the patient Denominator = # reports reviewed prior to transmission/uploading (either aggregated or patient specific)

4.5 §170.315(c)(2) Clinical Quality Measures (CQMs) — Import and Calculate

Use Case	Although it is appropriate for organizations to receive and import C-CDA documents and reconcile/integrate specific data for patients (active medications, allergies and intolerances, and problems) to be used in providing appropriate clinical care, no scenario exists where a provider would be receiving a QRDA file and incorporating data into the patient's EHR and then subsequently utilize that data documenting care provided elsewhere for the calculation of the clinical quality measures. Only clinical documentation for care provided at the organization should be included. In the event that clinical data for care or testing provided at other facilities is appropriate for inclusion, it would be manually entered through the usual clinical documentation workflow after review by the appropriate provider and not imported from a QRDA file.
Certification Criteria	§170.315(c)(2) Clinical quality measures—import and calculate— (i) Import. Enable a user to import a data file in accordance with the standard specified in §170.205(h)(2) for one or multiple patients and use such data to perform the capability specified in paragraph (c)(2)(ii) of this section. A user must be able to execute this capability at any time the user chooses and without subsequent developer assistance to operate. (ii) Calculate each and every clinical quality measure for which it is presented for certification. **References:** • Clinical quality measures (CQMs) — import and calculate | HealthIT.gov • 170.205(h)(2) HL7 CDA Release 2 Implementation Guide for: Quality Reporting Document Architecture-Category 1 (QRDA I); Release 1, DTSU Release 3 (US Realm), Volume 1
Justification	QRDA I files that are utilized during certification of Juno Emergency Services Solution contain data for patients not under the care of the organization executing the Real World Testing Plan. No use case exists for this functionality.
Test Methodology	Import QRDA I into DHIT CQMsolution which can utilize that data for generation of measure specific data for review, generation of the QRDA I files for: (1) calculation of

	the measures, (2) viewing the data in a Dashboard format or a patient drill-down screen, and (3) generation of the QRDA I files needed for submission to regulatory bodies.
Test Data	QRDA files obtained from a vendor supplied xml file provided for use during testing, i.e. "170.315c2_QRDA_Andre_Sullivan.xml."
Expected Outcomes	Successful ingestion of the data from the QRDA I file such that it is included in the calculation of the selected measure.
Measure	• **Measure c2:** % reports viewed that include the accurate data calculated for the measure and for each of the patients imported via the QRDA I file. *Numerator= # patients with expected results based on import from the QRDA I file for the specific patient* *(1) Initial Patient Population,* *(2) Numerator* *(3) Denominator,* *(4) Denominator Exception (None for this measure) and* *(5) Denominator Exclusion,* *Denominator = # patients imported from QRDA I files*

4.6 §170.315(f)(2) Transmission to Public Health Agencies — Syndromic Surveillance

Use Case	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. 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.
Certification Criteria	*§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).* 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. • 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. Design and Performance: The following design and performance certification criteria (adopted in §170.315(g)) must also be certified for the product to be certified. • 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: • 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 F for the script for Test Data Entry
Expected Outcomes	A total of 3 scenarios will be utilized. • 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 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. See attached Appendix F for the step by step details and Expected Outcomes
Measure	Successful creation, transmission, and receipt of the A04, A03, A08, and A01 messages in the format that conforms to the standard specified in • 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 with no errors detected during the validation process. *Numerator= # of correct data elements in HL7 messages for each scenario* *Denominator = # of data elements expected in HL7 messages for each scenario tested*

4.7 §170.315(f)(3) Transmission to Public Health Agencies — Reportable Laboratory Tests and Values/Results

Use Case	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. Based on the standards for interoperability, this process can improve timeliness, reduce manual data entry errors, and provide reports that are more complete.
Certification Criteria	*§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).* **References:** • *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*

	• *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*
Justification	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
Test Methodology	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.
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 G for the script for Test Data Entry
Expected Outcomes	One maximally populated scenario will be utilized. • 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 G 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. *Numerator= # of correct data elements in HL7 message for scenarios with expected results* *Denominator = # of expected data elements in HL7 message for scenario tested*

4.8 §170.315(g)(10) Standardized API for patient and population services

Use Case	Third party applications allow patients to connect their medical information to an app using an API that allows data access to the patient specific data in Juno Emergency Services Solution.

Certification Criteria	§ 170.315(g)(10) *Standardized API for patient and population services—*
	
	The following technical outcomes and conditions must be met through the demonstration of application programming interface technology.
	
	1. *Data response*.
	  1. Respond to requests for a single patient's data according to the standard adopted in § 170.215(a)(1) and implementation specifications adopted in § 170.215(a) and in § 170.215(b)(1), including the mandatory capabilities described in "US Core Server CapabilityStatement," for each of the data included in the standards adopted in § 170.213. All data elements indicated as "mandatory" and "must support" by the standards and implementation specifications must be supported.
	  2. Respond to requests for multiple patients' data as a group according to the standards and implementation specifications adopted in § 170.215(a), (b)(1), and (d), for each of the data included in the standards adopted in § 170.213. All data elements indicated as "mandatory" and "must support" by the standards and implementation specifications must be supported.
	2. *Supported search operations*.
	  1. Respond to search requests for a single patient's data consistent with the search criteria included in the implementation specifications adopted in § 170.215(b)(1), specifically the mandatory capabilities described in "US Core Server CapabilityStatement."
	  2. Respond to search requests for multiple patients' data consistent with the search criteria included in the implementation specification adopted in § 170.215(d).
	3. *Application registration*. Enable an application to register with the Health IT Module's "authorization server."
	4. *Secure connection*.
	  1. Establish a secure and trusted connection with an application that requests data for patient and user scopes in accordance with the implementation specifications adopted in § 170.215(b)(1) and (c).
	  2. Establish a secure and trusted connection with an application that requests data for system scopes in accordance with the implementation specification adopted in § 170.215(d).
	5. *Authentication and authorization.*
	  1. *Authentication and authorization for patient and user scopes.*
	  1. *First time connections.*
	  1. Authentication and authorization must occur during the process of granting access to patient data in accordance with the implementation

	specification adopted in § 170.215(c) and standard adopted in § 170.215(e). 2. A Health IT Module's authorization server must issue a refresh token valid for a period of no less than three months to applications using the "confidential app" profile according to an implementation specification adopted in § 170.215(c). 3. A Health IT Module's authorization server must issue a refresh token for a period of no less than three months to native applications capable of securing a refresh token. 2. *Subsequent connections*. 1. Access must be granted to patient data in accordance with the implementation specification adopted in § 170.215(c) without requiring re-authorization and re-authentication when a valid refresh token is supplied by the application. 2. A Health IT Module's authorization server must issue a refresh token valid for a new period of no less than three months to applications using the "confidential app" profile according to an implementation specification adopted in § 170.215(c). 2. *Authentication and authorization for system scopes.* Authentication and authorization must occur during the process of granting an application access to patient data in accordance with the "SMART Backend Services: Authorization Guide" section of the implementation specification adopted in § 170.215(d) and the application must be issued a valid access token. 6. *Patient authorization revocation.* A Health IT Module's authorization server must be able to revoke and must revoke an authorized application's access at a patient's direction within 1 hour of the request. 7. *Token introspection.* A Health IT Module's authorization server must be able to receive and validate tokens it has issued in accordance with an implementation specification in § 170.215(c). 8. *Documentation*. 1. The API(s) must include complete accompanying documentation that contains, at a minimum: 1. API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns. 2. The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).

	3. All applicable technical requirements and attributes necessary for an application to be registered with a Health IT Module's authorization server. 2. The documentation used to meet paragraph (g)(10)(viii)(A) of this section must be available via a publicly accessible hyperlink without any preconditions or additional steps. References: § 170.215(a)(1) Health Level 7 (HL7®) Version 4.0.1 Fast Healthcare Interoperability Resources Specification (FHIR®) Release 4, October 30, 2019 § 170.215(b)(1)(i) HL7®FHIR® US Core Implementation Guide STU V3.1.1 (Adoption of this standard expires on January 1, 2026) § 170.213(a) United States Core Data for Interoperability (USCDI), Version 1 (Adoption of this standard expires on January 1, 2026) § 170.215(d)(1) HL7® FHIR® Bulk Data Access (Flat FHIR®) (V1.0.0:STU 1) § 170.215(c)(1) HL7® SMART Application Launch Framework Implementation Guide Release 1.0.0 (Adoption of this standard expires on January 1, 2026) § 170.215(c)(2) HL7® SMART App Launch Implementation Guide Release 2.0.0, including mandatory support for the "Capability Sets" of "Patient Access for Standalone Apps" and "Clinician Access for EHR Launch"; all "Capabilities" as defined in "8.1.2 Capabilities," excepting the "permission-online" capability; "Token Introspection" as defined in "7 Token Introspection" (This standard is required by December 31, 2025)
Justification	Using a single scenario that is organized in accordance with the clinical workflow, the required components of the §170.315(g)(10) Standardized API for patient and population services will be tested.
Test Methodology	Must do required configuration in advance for the external application configuration, e.g. Apple Health® or Inferno®. The content of the patient specific data that appears in the external application will vary based on both the functionality of the specific application and the specific data on the specific patient.
Test Data	No data entry is routinely needed if the necessary configuration exists for utilization of an app. Data entered in the EHR will vary by patient. At a minimum, this data will include the following (if entered on a given patient): ➢ Common Clinical Data Set items ❖ 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 Test data entry would apply ONLY to the event the facility is not utilizing any external applications such as Apple Health®. If the Inferno test tool is to be used, the data for the 2 patients required is detailed below. • Happy Always Kid • Jolly Always Kid
Expected Outcomes	Storage of data with the required codes in Juno Emergency Services Solution for retrieval by the standardized API used by external applications, including but not limited to the Inferno test tool. See Appendix H for the details for Test Data Entry.
Measure	*Numerator= # patients evaluated using the Inferno test tool/external application that passed validation/did not generate any errors* *Denominator = # patients evaluated using the Inferno test tool/external application*

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 v3.2. This includes surveys, specific instructions on what to look for, how to record issues encountered, and Customer Agreements.	December 1, 2024
Begin collection of information as laid out by the plan.	March 1, 2025
Meet with previously identified providers and authorized representatives to ensure that Real World Testing protocols are effective.	March 31, 2025
Follow-up with providers and authorized representatives to understand any issues arising with the data collection.	Quarterly, 2025
Data collection and review.	Quarterly, 2025
End of Real World Testing period/final collection of all data for analysis.	January 2026
Analysis and report creation.	January 15, 2026
Submit Real World Testing report to ACB (per their instructions).	February 1, 2026

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:	Hilary Kloska, Director of Clinical Content	Authorized Representative Phone: 561-402-9621
Authorized Representative Signature:	*Hilary Kloska*	Date Signed: 10/31/2024

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

- **Prerequisite**: 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. Note: The first table for Scenario 1 displays the data that will be contained in the incoming C-CDA and will not be manually entered into JESS.

Patient:	Katherine Madison		**Alias:**	
DOB:	6/1/1970			
Gender:	Female			
Race:	White (2106-3)			
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
02% BldC Oximetry:	95%		**Inhaled o2 concentration**	
Body Temp:	100.4 F		**Respiratory Rate:**	18 /min
Active Medication Allergies:	Penicillin G	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)BLC200461H
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	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: Madison; First Name: Katherine • DOB: 06/01/1970 • Sex: Female • Gender Identity: Female • Sexual Orientation: Do not know • 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	Initial patient demographic data is entered
Step 3	• 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. Note: The first table for Scenario 2 displays the data that will be contained in the incoming Referral Note and will not be manually entered into JESS.

Patient:	Myra Banks		**Alias:**	
DOB:	6/1/1970			
Gender:	Female			
Race:	White (2106-3)			
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
02% BldC Oximetry:	95%		**Inhaled o2 concentration**	
Body Temp:	100.4 F		**Respiratory Rate:**	18 /min
Active Medication Allergies:	Penicillin G	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)BLC200461H
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. Myra Banks 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	• In the Name Type dropdown, select "Legal Name". Then enter Last Name: Banks First Name: Myra • DOB: 06/01/1970 • Sex: Female • Gender Identity: Female • Sexual Orientation: Do not know • 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	• 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.

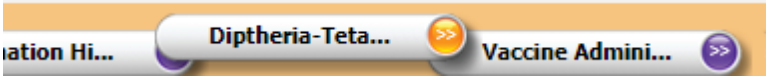
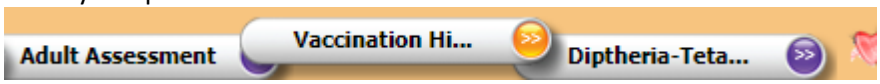
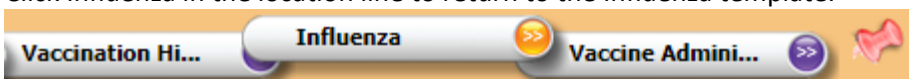
Patient:	Alice Jones Newman	**Birth Name:**	Alicia	
DOB:	5/1/1970			
Gender:	Female			
Race:	White (2106-3) White European (2108-9)	**Ethnicity**:	Not Hispanic or Latino (2186-5)	
Address:	1357 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)-723-1544	**Mobile Phone:**	(555)-777-1234	
Height:	177 cm	**Weight:**	88 kg	
BP:	145/88	**Heart Rate:**	80 bpm	
02% 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 500 mg injectable Recon Soln	BID	RxNorm 1665005	Start: Current Date End: in 10 days
	Tylenol 500mg	PRN	RxNorm 209459	Start: Current Date End: Current Date
	Aranesp 200 mcg/mL injectable solution	One a week	RxNorm 1654955	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,	CVX: 166	Date: Current Date	Status: Cancelled

	quadrivalent, preservative free			
	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 300 mg 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	• In the Name Type dropdown, select "Legal Name". Then enter Last Name: Newman First Name: Alice Middle Name: Jones • DOB: 05/01/1970 • Sex: Female • Gender Identity: Female • Sexual Orientation: Do not know • Race: White –> European White European – declined to specify • Preferred Language: English • EDP: select DIRECT, JESS P • 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	• In the Address Type dropdown, select "Home". Then enter home address: 1357 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)-723-1544	Address and Phone data is entered
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	In Triage, select "Vital Signs" and enter: • 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	In Triage, select "Allergies" to open Allergies Table: • 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	In Triage, select "Current Medications" to open Medications Table: • Enter Ceftriaxone in search line then click to move to the Current Medications List. Enter: Route – injectable. Dosage – 500 mg Recon Soln. Frequency – every 12 hours. 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. Dosage - 500 mg tablet. 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. Dosage – 200 mcg/mL solution. Frequency - 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	In Triage, select "Problems" to open the Problems Table: • 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 • 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	Problems are entered
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	Go to Assessment -> Adult Assessment -> Vaccination History. ○ Select Diphtheria – Tetanus, then enter:	Immunizations are entered

	○ Vaccine Administered - Select Tdap. Immunization NDC Codes table opens. Select NDC Code 49281-0286-58 DTaP 5 pertussis antigens DAPTACEL and click SAVE. ○ Click Diptheria – Tetanus in the location line to return to the Diptheria – Tetanus template.  ○ Date of Administration – 01/04/2012 ○ Manufacturer – click the "Text" icon and enter "Immuno Inc." ○ Lot Number – 2 ○ Status – completed ○ Click Vaccination History in the location line to return to the Vaccination History template.  ○ Select Influenza, then enter: ○ Vaccine Administered - Influenza, intradermal, quadrivalent, preservative free. Immunization NDC Codes table opens. Select NDC Code 49281-0710-48 influenza, intradermal, quadrivalent, preservative free Fluzone… and click SAVE ○ Click Influenza in the location line to return to the Influenza template.  ○ 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"	
Step 17	Go to Nursing Dx/Care Plan/Case Management -> Goals -> Custom Entry -> Custom Goal, 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". Status -> Active Due Date -> enter current date.	Goals are entered
Step 18	Go to Nursing Dx/Care Plan/Case Management -> Health Concerns -> 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. Manually enter the UDI (01)00643169007222(17)160128(21)BLC200461H into the UDI field. Click	Unique Device Identifier data is entered

	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	
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: ○ Cardiac Pacemaker via Vein ○ Status – completed ○ Date of Procedure: 10/05/2011 ○ Select the UDI button, then click “Save”. ○ Nebulizer Therapy ○ Status - Completed ○ Date of Procedure: current date	Procedures are entered
Step 27	Select the “Orders” tab. Go to Diagnostic -> Laboratory -> Urinalysis Macro (dipstick) panel 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. Select the "Pending Orders" tab. Again go to Diagnostic -> Laboratory -> Urinalysis Macro (dipstick) panel and add the order to "Pending Orders". In the Order Time field, click the date to open "Timing for Future Orders" window. Select the "is future order" check box, then adjust the date to the desired post-discharge date. 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: ○ 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 closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.”	Assessment is entered

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 300 mg 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

- **Prerequisite**: 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 (used for both Scenario 3 and Scenario 4)
- Scenario 1 will be utilized for the receipt via Direct message and validation of the Continuity of Care C-CDA for **Katherine Madison** 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 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 Myra Banks r2.1 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. (physician user DIRECT, JESS (jess_direct/jess1?direct!)	"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 "A 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. (physician user DIRECT, JESS (jess_direct/jess1?direct!)	"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 "A 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)			
Address:	1011 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)-336-1544	**Mobile Phone:**	(555)-335-1234	
Active Medication Allergies:	Penicillin G	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 5/01/1980
	Penicillin G	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 2/22/2015
	Ampicillin	RxNorm 733	Moderate Hives (247472004)	Start: 2/22/2015
Medications:	Ceftriaxone 100 gram Recon Soln	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	• 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 • 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	In Triage, select "Allergies" to open Allergies Table: • 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	In Triage, select "Current Medications" to open Medications Table: • 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 gram Recon Soln. 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"	Current Medications are entered

	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	In Triage, select "Problems" to open the Problems Table: • 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)			
Address:	1014 Amber Dr., Beaverton OR 97006			
Home Phone:	(555)340-1544	**Mobile Phone:**	(555)339-1234	
Active Medication Allergies:	Penicillin G	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 5/01/1980
	Penicillin G	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: 2/22/2015
	Ampicillin	RxNorm 733	Moderate Hives (247472004)	Start: 2/22/2015
Medications:	Ceftriaxone 100 gram Recon Soln	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	• 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 • 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	In Triage, select "Allergies" to open Allergies Table: • 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	In Triage, select "Current Medications" to open Medications Table: • 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 gram Recon Soln. 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: • 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

7.2.3 Test Script

- **Prerequisite**: 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_reconcilation.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_reconcilation.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	Initial allergy list is reconciled with the imported source to create the

	bottom of the “Allergies” table, select “Allergies reconciled with Supplemental Records” then close the “Allergies” table	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(b)(10) Electronic Health Information Export

7.3.1 Criteria

- §170.315(b)(10) Electronic Health Information Export

7.3.2 Test Data

- Scenario 1 will be utilized for the single patient Electronic Health Information export.
- 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:	Amber Jo Green			
DOB:	07/01/1970			
Gender:	Female			
Race:	White (2106-3) White European (2108-9)			
Active Medication Allergies:	Penicillin G	RxNorm 7980 (IN)	Moderate Hives (247472004)	Start: current date
Medications	Aranesp 200 mcg/ml	Once a week	RxNorm 1654955	Current date
	Tylenol 500mg	Every 6 hours	RxNorm 209459	Current date
Problems:	Essential Hypertension	SNOMED-CT 59621000		Current date
	Severe Hypothyroidism	SNOMED-CT 83986005		Current date
Diagnosis:	Fever (Acute Pyrexia)	SNOMED-CT 386661006		Current date

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	• In the Name Type dropdown, select "Legal Name". Then enter Last Name: Green First Name: Amber Middle Name: Jo • DOB: 05/01/1970 • Sex: Female • Gender Identity: Female • Sexual Orientation: Do not know • Race and Ethnicity: White –> European White European – declined to specify • Preferred Language: English • EDP: select Seven, Henry • 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 completed
Step 4	In Triage, select Chief Complaint #1: FEVER (ADULT). Click "Save" to bypass the supplemental questions	Chief Complaint is entered
Step 5	In Triage, select "Triage Level" and enter Triage Level 2	Triage Level is entered
Step 6	In Triage, select "Allergies" to open Allergies Table: • Enter Penicillin G in search line then click to move to the Current Allergies List. From the **Select Symptom** list choose "**hives**". From the **Select Severity** list choose "**Moderate**". Double click the "Onset" field and use the calendar icon to enter the current date. Click "OK" to close the Allergy Table.	Allergies are entered
Step 7	In Triage, select "Current Medications" to open Medications Table: • Enter Tylenol in search line then click to move to the Current Medications List. Select: Route – oral. Dosage - 500 mg tablet. Frequency – every 6 hours. Double click in the "Start Date" field and use the calendar icon to enter the current date. • Enter Aranesp in search line then click to move to the Current Medications List. Enter: Route – injectable. Dosage – 200 mcg/mL solution. Frequency - once a week. Double click in the "Start Date" field and use the calendar icon to enter the current date. Click "OK" to close the Medications table.	Current Medications are entered
Step 8	In Triage, select "Problems" to open the Problems Table: • Enter Essential Hypertension in search line then click to move to the Current Problem List- Double click in the "Onset Date" field and use the calendar icon to enter the current date. • Enter Severe Hypothyroidism in search line then click to move to the Current Problem List - Double click in the "Onset Date" field and use the calendar icon to enter the current date. Click "OK" to close the Problems table	Problems are entered
Step 9	In Triage, select "Arrival Mode" and enter AMB-POV	Arrival Mode is entered
Step 10	In Triage, select "PCP" and select **Albert Davis** from the dropdown.	PCP is entered
Step 11	In Triage, select "Treating Physician". EDP is preselected – click "OK"	Treating Physician is entered
Step 12	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 and click the red "**Continue Documentation**" button.	Triage is completed
Step 13	Click the Status Board icon  to exit the nurse chart	User exits Nurse Chart
Step 14	From the Status Board, log in to Amber Green as a physician user.	User logs in to physician chart
Step 15	Click the **Hx of Present Illness**, **PMH and PSH**, and **FH Allergies/Intolerances, Meds** buttons to pull the triage data into physician chart.	Triage Allergies, Medication, and Problems are pulled into physician chart
Step 16	Select **Clinical Impression** -> **Fever (Adult)**	Diagnosis is entered
Step 17	This completes data entry. Go to the Status Board	User exits Physician Chart

7.3.3 Test Script

- **Prerequisite**: If test data needs to be utilized since functionality is not currently in use by the site, data below will need to be entered.
- Scenario 1 will be utilized for the single patient Electronic Health Information export.

Step	Steps to export single patient file	Expected Outcome
Step 1	In JESS, log in to Configuration (Maintenance) as the HIM user - user id: him01 pwd: him01$	HIM user logs in to Configuration. User has access to perform single patient export.
Step 2	From the left menu, select the **Data Import/Export** button.	QRDA Import/Export is selected
Step 3	Select the **ONC(b)(10) Single Patient Export** button.	(b)(10) Single Patient Export modal window is opened.
Step 4	Click the dropdown menu for Single Patient Export Location, then select: **SinglePatientLocation1**	Single Patient Export location is selected.
Step 5	In the **Patient Search** field, enter **First Name**: Amber, **Last Name**: Green, **Date of Service**: current date, then click the **Search** button.	Patient is selected for export.
Step 6	Click the check box to select patient Amber Green identified in the search, then click the "**Run Export**" button.	Patient file export is initiated.
Step 7	Note the **Export Job Status** field to the right. When the status has reached "Completed", select the "**Acknowledge Job**" button	Completed export is acknowledged
Step 8	Close the **b)(10) Single Patient Export** window then click the Status Board icon to exit Configuration.	Exit Configuration
Step 9	Vendor will access database to verify patient export with specified data and publicly accessible hyperlink.	Export and publicly accessible hyperlink are confirmed

7.4 Appendix D §170.315(c)(1) Clinical Quality Measures (CQMs) — Record and Export and §170.315(c)(3) Clinical Quality Measures (CQMs) — Report

7.4.1 Criteria

- §170.315(c)(1) Clinical Quality Measures (CQMs) — Record and Export and §170.315(c)(3) Clinical Quality Measures (CQMs) — Report

7.4.2 Test Data and Script

- Scenario 1 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 68v10 Documentation of Current Medications in the Medical Record.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 68NUM • DOB: 05/05/1951 • Sex: Female • Gender Identity: Female • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 68Harrison, Shane • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions • Click the Status Board icon to return to the Status Board	Chief Complaint is entered and user exits Nurse chart
Step 5	From the Presentation Board, select patient CMS, 68NUM then click the "Physician" tab • Log in as provider Shane 68Harrison. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint • Select FH SH Allergies, Meds -> Medications -> Meds Reviewed.	Current Medications Reviewed is entered
Step 6	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 7	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 8	This completes data entry for Scenario 1. Go to the Status Board	User exits Chart

- Scenario 2 will be utilized for the items with negation rationale where a specific action was refused by the patient or was medically not indicated for eCQM CMS 68v10 Documentation of Current Medications in the Medical Record.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 68DENEXC • DOB: 05/05/1951 • Sex: Female • Gender Identity: Female • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 68Harrison, Shane • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Current Medications. In the "Medications" entry window, select "Unable to Obtain Med History" then "procedure contraindicated" from the dropdown. Click "OK" • Select the Status Board icon to return to the Status Board	"Unable to Obtain Med History" is entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 68DENEXC then click the "Physician" tab • Log in as provider Shane 68Harrison. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 2. Go to the Status Board	User exits Chart

- Scenario 3 will be utilized for exclusions/exceptions where the patient was included in the denominator but not the numerator based on the predefined rationale documented for that specific measure for eCQM CMS 68v10 Documentation of Current Medications in the Medical Record.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened

Step 2	• In the Name Type dropdown, select “Legal Name”. • Enter Last Name: CMS First Name: 68DEN • DOB: 05/05/1951 • Sex: Female • Gender Identity: Female • Sexual Orientation: Chose not to disclose • Race: White – select “Declined to Specify” then “Save” • Preferred Language: English • EDP: select ED physician 68Harrison, Shane • Tax ID: select Tax ID “Team A”	Initial patient information is entered
Step 3	Click the “OK” button. Complete registration (If hospital system is unavailable, select “Assign Offline Account”) and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click “Select” • Select “Save” for the Screening Questions • Select the Status Board icon to return to the Status Board	Chief Complaint is entered and user exits Nurse chart
Step 5	From the Presentation Board, select patient CMS, 68DEN then click the “Physician” tab • Log in as provider Shane 68Harrison. (Vendor will provide current login credentials) • Select the “Hx of Present Illness” button to load the Chief Complaint	Physician documentation is started
Step 6	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click “OK”	Disposition “Home” is entered along with Disposition Date and Time
Step 7	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 8	This completes data entry for Scenario 3. Go to the Status Board	User exits Chart

- Scenario 4 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the “New Patient” button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select “Legal Name”. • Enter Last Name: CMS First Name: 69NUM • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select “Declined to Specify” then “Save” • Preferred Language: English • EDP: select ED physician 69Owens, Jacob • Tax ID: select Tax ID “Team A”	Initial patient information is entered

Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Height and Weight • Enter Height 69 inches • Enter Weight 250 lbs • Select "OK" • Click the Status Board icon to return to the Status Board	Height and Weight are entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 69NUM then click the "Physician" tab • Log in as provider Jacob 69Owens. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 8	Select Instructions -> Discharge Plan -> Abnormal BMI -> Intervention Performed for Abnormal BMI -> Dietary education for elevated BMI -> Reason -> BMI = or > 30	Abnormal BMI intervention is entered along with reason for intervention
Step 9	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 10	This completes data entry for Scenario 4. Go to the Status Board	User exits Chart

- Scenario 5 will be utilized for the items with negation rationale where a specific treatment was refused by the patient or was medically not indicated for eCQM CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 69DENEXC • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 69Owens, Jacob • Tax ID: select Tax ID "Team A"	Initial patient information is entered

Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Height and Weight • Enter Height 69 inches • Enter Weight 250 lbs • Select "OK" • Click the Status Board icon to return to the Status Board	Height and Weight are entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 69DENEXC then click the "Physician" tab • Log in as provider Jacob 69Owens. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 8	Select Instructions -> Discharge Plan -> Abnormal BMI -> Intervention Performed for Abnormal BMI -> Reason intervention not done for elevated BMI -> procedure contraindicated	Negation reason for Abnormal BMI intervention is entered
Step 9	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 10	This completes data entry for Scenario 5. Go to the Status Board	User exits Chart

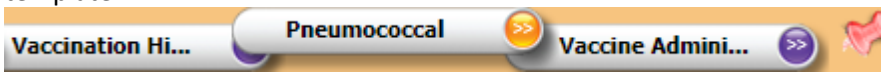
- Scenario 6 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 69v9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 69DENEXCLUSION • DOB: 05/05/1951 • Sex: Female • Gender Identity: female • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 69Owens, Jacob • Tax ID: select Tax ID "Team A"	Initial patient information is entered

Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Problems • Problems dialog box displays • Search and select "Planned Pregnancy" (left panel) • Select Onset Date field (right panel) and enter current date • Select "OK" Click the Status Board icon to return to the Status Board	Planned Pregnancy is added to the Problems list
Step 6	From the Presentation Board, select patient CMS, 69DENEXCLUSION then click the "Physician" tab • Log in as provider Jacob 69Owens. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 6. Go to the Status Board	User exits Chart

- Scenario 7 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 127v9 Pneumococcal Vaccination Status for Older Adults.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 127NUM • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 127Ortiz, Henry • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered

Step 5	Select Assessment -> Adult Assessment -> Vaccination History -> Pneumococcal -> Vaccine Administered -> Polysaccharide PPV 23. Immunization NDC Codes table opens. Select NDC Code 00006-4837-01 pneumococcal polysaccharide PPV 23 PNEUMOVAX 23 and click SAVE • Click Pneumococcal in the location line to return to the Pneumococcal template  • Select Date of Administration and enter current date • Select the Status Board icon to return to the Status Board	Pneumococcal vaccine administration is entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 127NUM then click the "Physician" tab • Log in as provider Henry 127Ortiz. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 7. Go to the Status Board	User exits Chart

- Scenario 8 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 127v9 Pneumococcal Vaccination Status for Older Adults.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 127DENEXCLUSION • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 127Ortiz, Henry • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered

Step 5	Select Disposition -> Discharged -> Special Needs Present -> Referral to hospice care • Select Disposition -> Discharged -> Time of Disposition (add 1 hour to current time – this time must be **after** the physician disposition time) • Select Special Needs Present -> referral to hospice care • Select the Status Board icon to return to the Status Board	Hospice care referral is entered along with Disposition information. User exits Nurse chart.
Step 6	From the Presentation Board, select patient CMS, 127DENEXCLUSION then click the "Physician" tab • Log in as provider Henry 127Ortiz. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 8. Go to the Status Board	User exits Chart

- Scenario 9 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 138POP1NUM • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 138Torres, Connie • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Assessment -> Adult Assessment -> Psychosocial -> Smoking Status -> never smoker • Enter the current date • Select the Status Board icon to return to the Status Board	Smoking Status is entered and user exits Nurse chart

Step 6	From the Presentation Board, select patient CMS, 138POP1NUM then click the "Physician" tab • Log in as provider Connie 138Torres. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Preventative -> CPT 99386	Encounter Type is entered
Step 9	This completes data entry for Scenario 9. Go to the Status Board	User exits Chart

- Scenario 10 will be utilized for the items with negation rationale where a specific treatment was refused by the patient or was medically not indicated for eCQM 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 138POP2DENEXC • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 138Torres, Connie • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Assessment -> Adult Assessment -> Psychosocial -> Smoking Status -> tobacco user • Enter the current date • Select the Status Board icon to return to the Status Board	Smoking Status is entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 138POP2DENEXC then click the "Physician" tab • Log in as provider Connie 138Torres. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started

Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Instructions -> Discharge Plan -> Tobacco Cessation -> Medication -> Reason intervention not done -> Procedure contraindicated	Negation reason for smoking intervention is entered
Step 9	Select Disposition -> Encounter Type -> Other -> Preventative -> CPT 99386	Encounter Type is entered
Step 10	This completes data entry for Scenario 10. Go to the Status Board	User exits Chart

- Scenario 11 will be utilized for exclusions/exceptions where the patient was included in the denominator but not the numerator based on the predefined rationale documented for that specific measure for eCQM CMS 138v9 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 138POP1DEN • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 138Torres, Connie • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	• Select the Status Board icon to return to the Status Board	User exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 138POP1DEN then click the "Physician" tab • Log in as provider Connie 138Torres. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office visit -> CPT 99386	Encounter Type is entered

Step 9	This completes data entry for Scenario 11. Go to the Status Board	User exits Chart

- Scenario 12 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 146v9 Appropriate Testing for Pharyngitis.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 146NUM • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 146Nunez, Rafael • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Problems • Problems dialog box displays • Search and select "Streptococcal Pharyngitis" (left panel) • Select Onset Date field (right panel) and enter current date and time • Select "OK" • Click the Status Board icon to return to the Status Board	Problem Streptococcal Pharyngitis is entered along with onset date and time, and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 146NUM then click the "Physician" tab • Log in as provider Rafael 146Nunez. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Orders tab • Select Diagnostic -> Laboratory -> Microbiology -> Culture -> Throat • Select the "Submit" button • Enter user password	Throat Culture order is submitted
Step 8	On the "Completed Orders" tab click the "Host Time" icon and enter the current date and time	Host time is entered

Step 9	At this time, vendor will import results of the Throat Culture into the patient chart.	Throat culture results are imported into chart
Step 10	Still on the Physician tab. Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 11	Select Instructions -> Discharge Plan -> Pharyngitis -> Medications -> Cephalexin 500 mg Oral Tablet -> tid	Intervention for Pharyngitis is entered
Step 12	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 13	This completes data entry for Scenario 12. Go to the Status Board	User exits Chart

- Scenario 13 will be utilized for exclusions/exceptions where the patient was included in the denominator but not the numerator based on the predefined rationale documented for that specific measure for eCQM CMS 146v9 Appropriate Testing for Pharyngitis.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 146DEN • DOB: 05051951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 146Nunez, Rafael • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Problems • Problems dialog box displays • Search and select "Streptococcal Pharyngitis" (left panel) • Select Onset Date field (right panel) and enter current date and time. • Select "OK"	Problem Streptococcal Pharyngitis is entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 146DEN then click the "Physician" tab • Log in as provider Rafael 146Nunez. (Vendor will provide current login credentials)	Physician documentation is started

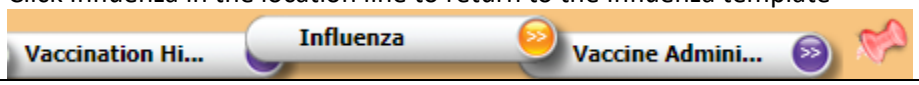
	• Select the "Hx of Present Illness" button to load the Chief Complaint	
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 8	Select Instructions -> Discharge Plan -> Pharyngitis -> Medications -> Cephalexin 500 mg Oral Tablet -> tid	Intervention for Pharyngitis is entered
Step 9	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 10	This completes data entry for Scenario 13. Go to the Status Board	User exits Chart

- Scenario 14 will be utilized for exclusions/exceptions where the patient was excluded from the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 146v9 Appropriate Testing for Pharyngitis.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 146DENEXCLUSION • DOB: 05051951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 146Nunez, Rafael • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Problems • Problems dialog box displays • Search and select "Streptococcal Pharyngitis" (left panel) • Select Onset Date field (right panel) and enter current date and time. • Select "OK"	Problem Streptococcal Pharyngitis is entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 146DENEXCLUSION then click the "Physician" tab • Log in as provider Rafael 146Nunez. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started

Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 8	Select Instructions -> Discharge Plan -> Pharyngitis -> Medications -> Cephalexin 500 mg Oral Tablet -> tid	Intervention for Pharyngitis is entered
Step 9	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 10	Select Instructions -> Discharge Plan -> refer for hospice care	Patient referred for hospice care
Step 11	This completes data entry for Scenario 13. Go to the Status Board	User exits Chart

- Scenario 15 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 147v10 Preventive Care and Screening: Influenza Immunization.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name:147NUM • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • Presentation date must be during the previous flu season. (October 1 thru Dec 31 of the previous year or January 1 thru March 31 of current year) • EDP: select ED physician 147Dunn, Oscar • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions • If the Presentation date has be edited, click on the Patient Name  to open the Edit Demographic window • Edit the Triage date to match the Presentation date	Chief Complaint is entered
Step 5	Select Assessment -> Adult Assessment -> Vaccination History -> Influenza -> Vaccine Administered -> Seasonal Injectable. Immunization NDC Codes table opens. Select NDC Code 33332-0118-11 Influenza, seasonal injectable AFLURIA and click SAVE. Click Influenza in the location line to return to the Influenza template 	Influenza vaccine administration is entered along with date of administration during prior flu season. User exits Nurse chart

	• Select Date of Administration. Enter 09/21/ of the previous calendar year. • Select Status ->completed • Select the Status Board icon to return to the Status Board	
Step 6	From the Presentation Board, select patient CMS, 147NUM then click the "Physician" tab • Log in as provider Oscar 147Dunn. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time or match the modified date of service then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 14. Go to the Status Board	User exits Chart

- Scenario 16 will be utilized for the items with negation rationale where a specific treatment was refused by the patient or was medically not indicated for eCQM CMS 147v10 Preventive Care and Screening: Influenza Immunization.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name:147DENEXC • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • Presentation date must be during the previous flu season. (October 1 thru Dec 31 of the previous year or January 1 thru March 31 of current year) • EDP: select ED physician 147Dunn, Oscar • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions • If the Presentation date has be edited, click on the Patient Name  to open the Edit Demographic window • Edit the Triage date to match the Presentation date	Chief Complaint is entered

Step 5	Select Assessment -> Adult Assessment -> Vaccination History -> Influenza -> Reason not given -> refused • Select the Status Board icon to return to the Status Board	Reason for not administering Influenza vaccine is entered and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 147DENEXC then click the "Physician" tab • Log in as provider Oscar 147Dunn. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time or match the modified date of service then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 15. Go to the Status Board	User exits Chart

- Scenario 17 will be utilized for situations where the patient was in the initial patient population but not included in the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 147v10 Preventive Care and Screening: Influenza Immunization.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name:147IPP • DOB: 05/05/1951 • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • Presentation date **must not** be from October 1 thru December 31 of prior year or January 1 thru March 31 of current year. • EDP: select ED physician 147Dunn, Oscar • Tax ID: select Tax ID "Team A"	Initial patient information is entered. If necessary, the Presentation date is edited to be between April 1 thru September 30.
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions • If the Presentation date has be edited, click on the Patient Name to open the Edit Demographic window. • Edit the Triage date to match the Presentation date	Chief Complaint is entered. If necessary, the Triage date is edited to match the Presentation date
Step 5	Select the Status Board icon to return to the Status Board	User exits Nurse chart

Step 6	From the Presentation Board, select patient CMS, 147IPP then click the "Physician" tab • Log in as provider Oscar 147Dunn. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time or match the modified Presentation date then click "OK"	Disposition "Home" is entered along with Disposition Date and Time
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 16. Go to the Status Board	User exits Chart

- Scenario 18 will be utilized for the codified data where expected actions were taken/treatments were provided for eCQM CMS 349v3 HIV Screening.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 349NUM • DOB: 05/05/**1981** • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 349Delgado, Seth • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions • Click the Status Board icon to return to the Status Board	Chief Complaint is entered and user exits Nurse chart
Step 5	From the Presentation Board, select patient CMS, 349NUM then click the "Physician" tab • Log in as provider Seth 349Delgado. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started
Step 6	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 7	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered

Step 8	Select the "Orders" tab • Select Diagnostic -> Laboratory -> Microbiology -> HIV 1 Ag in Serum • Click the "Submit" button • Enter user password • On the "Completed Orders" tab click the "Host Time" icon and enter the current date and time	HIV 1 Ag in Serum is submitted and host time is entered
Step 9	This completes data entry for Scenario 17. Go to the Status Board	User exits Chart

- Scenario 19 will be utilized for exclusions/exceptions where the patient was not included in the denominator based on the predefined rationale documented for that specific measure for eCQM CMS 349v3 HIV Screening.

Step	Steps to Enter Data	Expected Outcome
Step 1	Click on the "New Patient" button and log in as a nurse user to open the Presentation data entry fields.	Presentation data entry fields are opened
Step 2	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: CMS First Name: 349DENEXCLUSION • DOB: 05/05/**1981** • Sex: Male • Gender Identity: Male • Sexual Orientation: Chose not to disclose • Race: White – select "Declined to Specify" then "Save" • Preferred Language: English • EDP: select ED physician 349Delgado, Seth • Tax ID: select Tax ID "Team A"	Initial patient information is entered
Step 3	Click the "OK" button. Complete registration (If hospital system is unavailable, select "Assign Offline Account") and continue in nursing documentation.	Registration is completed
Step 4	In Triage, select CC#1 -> ABRASION – SIMPLE and click "Select" • Select "Save" for the Screening Questions	Chief Complaint is entered
Step 5	Select Triage -> Problems • Problems dialog box displays • Search and select "HIV 1 Infection" (left panel) • Select Onset Date field (right panel) • **Select a date prior to the measurement period** (in previous year) • Select "OK" • Click the Status Board icon to return to the Status Board	Problem HIV 1 Infection is entered with date in a prior year and user exits Nurse chart
Step 6	From the Presentation Board, select patient CMS, 349DENEXCLUSOIN then click the "Physician" tab • Log in as provider Seth 349Delgado. (Vendor will provide current login credentials) • Select the "Hx of Present Illness" button to load the Chief Complaint	Physician documentation is started

Step 7	Select Disposition -> Disposition -> Discharge -> Home • Select Disposition -> Disposition Date and Time. Enter current date and time then click "OK"	Disposition "Home" is entered along with Disposition Date and Time.
Step 8	Select Disposition -> Encounter Type -> Other -> Office Visit -> CPT 99203	Encounter Type is entered
Step 9	This completes data entry for Scenario 18. Go to the Status Board	User exits Chart

- Scenario 20 will be utilized for exporting the patient data from JESS then generating the necessary CQM reports in CQM Solutions.

Step	Steps to Enter Data	Expected Outcome
Step 1	From the Status Board, select the "Maintenance" icon. Login as Administrator username and password.	User accesses JESS Maintenance
Step 2	Select QRDA Import/Export -> eCQM Data Export • Enter From: 10/01/previous year • Enter To: 12/31/current year • Select "OK". The export process is completed and "OK" button is then disabled. • Select "Cancel" to close the Data Export dialog box then click the Status Board icon to exit JESS Maintenance	Data export is completed and user exits JESS Maintenance
Step 3	Open the CQM Solutions application. Log in as Administrator username and password.	User accesses CQM Solutions application
Step 4	"Queued Reports" form displays. Select "Create Report"	Begin report creation
Step 5	"Queue A Report" form displays. Enter the appropriate report details • Description: CMS 68 • Select Provider check box: Shane Harrison (68) • Begin Date: 01/01/current year • Click the "Add" dropdown and choose "12 months". The End Date auto-populates 12 months after the Begin Date • Select CQM Update Year: 2021 • The "Use Zip Folder" check box is left unchecked • Select the "Queue Report" button to generate the report • Information dialog box displays. Select "OK"	Report details are entered and CMS 68 report is generated
Step 6	Repeat steps 4 and 5 for each report using the following Report Descriptions and Providers • CMS 69 Provider: Jacob Owens (69) • CMS 127 Provider: Henry Ortiz (127) • CMS 138 Provider: Connie Torres (138) • CMS 146 Provider: Rafael Nunez (146) • CMS 147 Provider: Oscar Dunn (147) • CMS 349 Provider: Seth Delgado (349)	CMS 69, CMS 127, CMS 138, CMS 146, CMS 147, and CMS 349 reports are generated
Step 7	Still in CQM Solutions, select "Home" menu to display Queued Reports form	Queued Reports form displays

Step 8	For the CMS 68 report, select the "View Results" button to open the CMS 68 report Dashboard. • Select "Detail" tab • Select the Downloads button and choose "Download QRDA-I" to download the report to the default Downloads folder • After download is complete, select the "Home" menu	CMS 68v10 report QRDA-I is downloaded
Step 9	Repeat step 8 for each report to download the remaining QRDA I reports	Remaining QRDA I reports are downloaded
Step 10	Again for the CMS 68 report, select the "View Results" button to open the CMS 68 report Dashboard • Select "Detail" tab • Select the Downloads button and choose "Download QRDA III" • The xml file is downloaded to the default Downloads folder • After download is complete, select the "Home" menu	CMS 68v10 report QRDA III is downloaded
Step 11	Repeat Step 10 for each report to download the remaining QRDA III	Remaining QRDA III are downloaded

Expected Report Outcomes:

	Measure 68v10				
Patient Name	**IPP**	**Den**	**Excl**	**Num**	**Excp**
CMS, 68NUM	✓	✓		✓	
CMS, 68DENEXC	✓	✓			✓
CMS, 68DEN	✓	✓			

	Measure 69v9				
Patient Name	**IPP**	**Den**	**Excl**	**Num**	**Excp**
CMS, 69NUM	✓	✓		✓	
CMS, 69DENEXC	✓	✓			✓
CMS, 69DENEXCLUSION	✓	✓	✓		

	Measure 127v9				
Patient Name	**IPP**	**Den**	**Excl**	**Num**	**Excp**
CMS, 127NUM	✓	✓		✓	
CMS, 127DENEXCLUSION	✓	✓	✓		

Measure 138v9

Patient Name	IPP	Den	Excl	Num	Excp
CMS, 138POP1NUM (Population 1 report)	✓	✓		✓	
CMS, 138POP2DENEXC (Population 2 report)	✓	✓			✓
CMS, 138DEN (Population 1 report)	✓	✓			

	Measure 146v9				
Patient Name	**IPP**	**Den**	**Excl**	**Num**	**Excp**
CMS, 146NUM	✓	✓		✓	
CMS, 146DEN	✓	✓			
CMS, 146DENEXCLUSION	✓	✓	✓		

	Measure 147v10				
Patient Name	**IPP**	**Den**	**Excl**	**Num**	**Excp**
CMS, 147NUM	✓	✓		✓	
CMS, 147DENEXC	✓	✓			✓
CMS, 147IPP	✓				

	Measure 349v3				
Patient Name	**IPP**	**Den**	**Excl**	**Num**	**Excp**
CMS, 349NUM	✓	✓		✓	
CMS, 349DENEXCLUSION	✓	✓	✓		

7.5 Appendix E §170.315(c)(2) Clinical Quality Measures (CQMs) — Import and Calculate

7.5.1 Criteria

- §170.315(c)(2) Clinical Quality Measures (CQMs) — Import and Calculate

7.5.2 Test Data Entry

QRDA files obtained from Cypress Test Tool.

7.5.3 Test Script Prerequisites

Configuration of DHIT CQMsolution® to generate the report.

7.5.4 Measure Data

The measure includes three parts, i.e.,
Measure c2: % reports viewed that include the accurate data calculated for the measure and for each of the patients imported via the QRDA I file.

Numerator= # patients with expected results based on import from the QRDA I file for the specific patient
(1) Initial Patient Population,
(2) Numerator
(3) Denominator,
(4) Denominator Exception (None for this measure) and
(5) Denominator Exclusion,
Denominator = # patients imported from QRDA I files

7.6 Appendix F §170.315(f)(2) Transmission to Public Health Agencies — Syndromic Surveillance

7.6.1 Criteria

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

7.6.2 Test Data

- **Prerequisite**: 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)		
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)		
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		
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		

7.6.3 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.

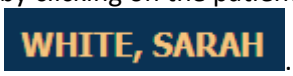
Step	Steps to Trigger ADT Messages	Expected Outcome
Step 1	Click "New Patient" and log in as nurse user to open the "Presentation" data entry window	"Presentation" data entry window opens.
Step 2	In the Name Type field, click the dropdown and select "Coded Pseudo Name…" Enter Last Name "Black" and First Name "Chris"	Name fields are completed
Step 3	Enter: Birth Date: 07/25/2020 Sex: Male Gender Identity: Male Sexual Orientation: Do not know 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.

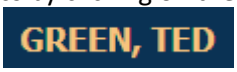
Step	Steps to Trigger ADT Messages	Expected Outcome
Step 1	Click "New Patient" and log in as nurse user to open the "Presentation" data entry window.	"Presentation" data entry window opens.
Step 2	In the Name Type field, click the dropdown and select "Unspecified". Enter Last Name "White" and First Name "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 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  .	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 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	Address is entered and "Presentation" is closed. Registration is completed.

	County: Pottawatomie Zip Code: 74852 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 	Demographics is opened
Step 10	Add Name Suffix “JR” and click “OK” to close Demographics	Demographics is updated and closed. AO8 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

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

7.7.1 Criteria

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

7.7.2 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)		
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 102nd 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

7.7.3 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 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” ion 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

7.8 Appendix H §170.315(g)(10) Standardized API for Patient and Population Services

7.8.1 Criteria

- §170.315(g)(10) Standardized API for Patient and Population Services

7.8.2 Test Data

- Test data entry would apply ONLY to the event the facility is not utilizing any external applications such as Apple Health®. If the Inferno test tool is to be used, the data for the 2 patients required is detailed below
- No data entry is routinely needed if the necessary configuration exists for utilization of an app.
- Patient #1 Happy Kid

Patient:	Happy Kid		**Alias:**	
DOB:	6/1/2022			
Gender:	Female			
Race:	White (2106-3)			
Address:	1357 Amber Dr., Beaverton OR 97006			
Previous Address:	1402 Dairy Dr, Beaverton OR 97006			
Home Phone:	(555)-723-1544		**Mobile Phone:**	555-777-1234
Email Address	happykid@gmail.com			
Height:	85 cm		**Weight:**	12 kg
BMI Percentile	56%			
Head OFC percentile	46.24 cm		**18%**	
Weight for Length Percentile	51%			
BP:	145/88		**Heart Rate:**	80 bpm
02% BldC Oximetry:	95%		**Inhaled o2 concentration**	36%
Body Temp:	100.4 F		**Respiratory Rate:**	18 /min
Head OFC percentile	46.24 cm		**18%**	
Weight for Length Percentile	51%			
Active Medication Allergies:	Products containing benzodiazepine	SNOMED CT 16047007 (IN)	Moderate Hives (247472004)	Start: 12/1/2022
	Ampicillin-Sulbactam	RxNorm 1009148	Moderate Hives (247472004)	
Medications:	Ceftriaxone 100 gram Recon Sol	BID	RxNorm 309090	Start: 6/22/2022 End : 6/30/2022

	Tylenol 500mg	PRN	RxNorm 209459	Start: 6/22/2022 for 10 days
	Aranesp 500 mcg/ML	One a week	RxNorm 731241	Start: 6/22/2022
Problems:	Hypoplastic Left Heart Syndrome	SNOMED CT 62067003		Status: Active
Encounter Diagnosis:	Fever	SNOMED CT 386661006	Date: Current date	
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. Get an EKG done on 6/23/2020. ii. Get a Chest X-ray done on 6/23/2020 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 7/1/2025.			
Goals:	i.Get rid of intermittent fever that is occurring every few weeks ii. Need to gain more energy to do regular activities			Date: Current date
	Need to gain more energy to do regular activities			Date: Current date
Health Concerns	a. Chronic sickness exhibited by patient	Status: Active		Date: Current date
	b. Healthcare Concerns refer to underlying clinical facts i. Documented Hypertension problem	Status: Active		Date: Current date
Consultation Note	Dr. Albert Davis diagnosed Ms. Happy Kid to be suffering from Fever and suspected Pneumonia and recommended admission to the Community Health Hospitals. The note was captured on (current date) at 11:00 am ET.			

Step	Steps to Enter Data for Patient #1 Happy Kid	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	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: Kid; First Name: Happy; Middle Name: Always • DOB: 06/01/2022 • Sex: Female • Gender Identity: Female • Sexual Orientation: Do not know • Race: 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	• In the Address Type dropdown, select "Home". Then enter home address: 1357 Amber Dr., Beaverton OR 97006 • Click the ➕ icon to add Additional Address. In the dropdown, select "Birth". Then enter previous address: 1402 Dairy Dr., Beaverton, OR 97006. In the Status dropdown to "Previous". • In the Email dropdown, select "Personal". Then enter happykid@gmail.com. • In the Phone Type dropdown, select "Primary Residence Number". In the Device Type dropdown, select "Telephone" then enter phone number: (555)-723-1544. • Click the ➕ icon to add Additional Phone. In the dropdown, select Mobile Phone. In the Device Type dropdown, select "Cellular Phone" then enter 555-777-1234.	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 - DIARRHEA. 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
Step 6	In Triage, select "Vital Signs" and enter: • T - 100.4 F • P – 88 • R - 18 • BP - 145/88 • O2 Amount – 36 • O2 Sat – 95 • O2 Concentration – 36% 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	In Triage, select "Allergies" to open Allergies Table: • Enter Ampicillin in search line then click Ampicillin-Sulbactam to move to the Current Allergies List. In the "Symptoms" field select "Hives" from the dropdown. In the "Severity" field and select "Moderate". Double click the "Onset" field and enter 12/01/2022. • Enter "Product" in the search line, then click "Products containing benzodiazepine". In the "Symptoms" field select "Allergic Headache" from the dropdown. In the "Severity" field and select "Mild". Double click the "Onset" field and enter 12/01/2022. Click "OK" to close the Allergies table	Allergies are entered
Step 9	In Triage, select "Current Medications" to open Medications Table: • Enter Ceftriaxone in search line then click to move to the Current Medications List. Enter: Route – injectable. Dosage – 100 gram Recon Soln. Frequency – every 12 hours. Double click in the "Start Date" field and enter 06/22/2022 then in the End Date field enter 06/30/2022. • Enter Tylenol in search line then click to move to the Current Medications List. Enter: Route – oral. Dosage - 500 mg tablet. Double click in the	Current Medications are entered

	"Frequency" field and enter " for 10 days prn". Double click in the "Start Date" field and enter current date. • Enter Aranesp in search line then click to move to the Current Medications List. Enter: Route – injectable. Dosage – 500 mcg/mL solution. Frequency - once a week. Double click in the "Start Date" field and enter the current date. Click "OK" to close the Medications table	
Step 10	In Triage, select "Problems" to open the Problems Table: • Enter Hypoplastic Left Heart Syndrome in search line then click to move to the Current Problem List- Double click in the "Onset Date" field and enter 06/01/2022	Problems are entered
Step 11	In Triage, select "Height and Weight" to open the Height and Weight Table and enter height 85 cm and weight 12 kg	Height and Weight are entered
Step 12	In Triage, select Pediatric Assessment -> Head Circumference then enter a measurement of 46.24 cm and Tab to calculate the Percentile	
Step 13	In Triage, select "Arrival Mode" and enter AMB-POV	Arrival Mode is entered
Step 14	In Triage, select "PCP" and enter PCP of choice	PCP is entered
Step 15	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 and click the red "Continue Documentation" button.	Triage is completed
Step 16	Go to Nursing Dx/Care Plan/Case Management -> Goals -> Custom Entry -> Custom Goal, 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". Status -> Active Due Date -> enter current date.	Goals are entered
Step 17	Go to Nursing Dx/Care Plan/Case Management -> Health Concerns -> General Health Concerns – custom entry, then enter in free text: " a. Chronic sickness exhibited by patient b. Healthcare concerns refer to underlying clinical facts i. Documented Hypertension problem	Health concerns are entered
Step 18	This completes the nursing data entry. Go to the Status Board.	Exit Nurse Chart
Step 19	Log in to Happy Kid as a physician user	User logs in to Happy Kid Physician Chart
Step 20	Click "History of Present Illness, "PMH and PSH", and "FH SH Allergies Meds" buttons to auto-populate nursing data	nurse data for Allergies, Medications, and Problems is auto-populated
Step 21	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 closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day."	Assessment is entered
Step 22	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 300 mg three times a day as needed if pain does not subside iv). Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2025	Plan of Treatment is entered

Step 23	Select Consultation and Medical Decision Making ->Consults -> Consultant Note and enter "Dr. Albert Davis diagnosed Ms. Happy Kid to be suffering from Fever and suspected Pneumonia and recommended admission to the Community Health Hospitals. The note was captured on (current date) at 11:00 am ET."	Consultant Note is entered
Step 34	This completes the physician data entry. Go to the Status Board.	Exit Physician chart

- Patient #2 Jolly Kiddy

Patient:	Jolly Kiddy		**Alias:**	
DOB:	6/1/2022			
Gender:	Female			
Race:	White (2106-3)			
Address:	1357 Amber Dr., Beaverton OR 97006			
Previous Address:	1402 Dairy Dr, Beaverton OR 97006			
Home Phone:	(555)-723-1544		**Mobile Phone:**	555-777-1234
Email Address	jollykid@gmail.com			
Height:	85 cm		**Weight:**	12 kg
BMI Percentile	56%			
Head OFC percentile	46.24 cm		**18%**	
Weight for Length Percentile	51%			
BP:	145/88		**Heart Rate:**	80 bpm
02% BldC Oximetry:	95%		**Inhaled o2 concentration**	36%
Body Temp:	100.4 F		**Respiratory Rate:**	18 /min
Head OFC percentile	46.24 cm		**18%**	
Weight for Length Percentile	51%			
Active Medication Allergies:	Products containing benzodiazepine	SNOMED CT 16047007 (IN)	Moderate Hives (247472004)	Start: 12/1/2022
	Ampicillin-Sulbactam	RxNorm 1009148	Moderate Hives (247472004)	
Medications:	Ceftriaxone 100 gram Recon Sol	BID	RxNorm 309090	Start: 6/22/2022 End : 6/30/2022
	Tylenol 500mg	PRN	RxNorm 209459	Start: 6/22/2022 for 10 days

	Aranesp 500 mcg/ML	One a week	RxNorm 731241	Start: 6/22/2022
Problems:	Hypoplastic Left Heart Syndrome	SNOMED CT 62067003		Status: Active
Encounter Diagnosis:	Fever	SNOMED CT 386661006	Date: Current date	
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. Get an EKG done on 6/23/2020. ii. Get a Chest X-ray done on 6/23/2020 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 7/1/2025.			
Goals:	i.Get rid of intermittent fever that is occurring every few weeks ii. Need to gain more energy to do regular activities			Date: Current date
	Need to gain more energy to do regular activities			Date: Current date
Health Concerns	a. Chronic sickness exhibited by patient	Status: Active		Date: Current date
	b. Healthcare Concerns refer to underlying clinical facts i. Documented Hypertension problem	Status: Active		Date: Current date
Consultation Note	Dr. Albert Davis diagnosed Ms. Happy Kid to be suffering from Fever and suspected Pneumonia and recommended admission to the Community Health Hospitals. The note was captured on (current date) at 11:00 am ET.			

Step	Steps to Enter Data for Patient #2 Jolly Kiddy	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	• In the Name Type dropdown, select "Legal Name". • Enter Last Name: Kiddy; First Name: Jolly; Middle Name: Always • DOB: 06/01/2022 • Sex: Female • Gender Identity: Female • Sexual Orientation: Do not know • Race: 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	• In the Address Type dropdown, select "Home". Then enter home address: 1357 Amber Dr., Beaverton OR 97006	Address and Phone data is entered

	• Click the ➕ icon to add Additional Address. In the dropdown, select "Birth". Then enter previous address: 1402 Dairy Dr., Beaverton, OR 97006. In the Status dropdown to "Previous". • In the Email dropdown, select "Personal". Then enter happykid@gmail.com. • In the Phone Type dropdown, select "Primary Residence Number". In the Device Type dropdown, select "Telephone" then enter phone number: (555)-723-1544. • Click the ➕ icon to add Additional Phone. In the dropdown, select Mobile Phone. In the Device Type dropdown, select "Cellular Phone" then enter 555-777-1234.	
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 - DIARRHEA. 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
Step 6	In Triage, select "Vital Signs" and enter: • T - 100.4 F • P – 88 • R - 18 • BP - 145/88 • O2 Amount – 36 • O2 Sat – 95 • O2 Concentration – 36% 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	In Triage, select "Allergies" to open Allergies Table: • Enter Ampicillin in search line then click Ampicillin-Sulbactam to move to the Current Allergies List. In the "Symptoms" field select "Hives" from the dropdown. In the "Severity" field and select "Moderate". Double click the "Onset" field and enter 12/01/2022. • Enter "Product" in the search line, then click "Products containing benzodiazepine". In the "Symptoms" field select "Allergic Headache" from the dropdown. In the "Severity" field and select "Mild". Double click the "Onset" field and enter 12/01/2022. Click "OK" to close the Allergies table	Allergies are entered
Step 9	In Triage, select "Current Medications" to open Medications Table: • Enter Ceftriaxone in search line then click to move to the Current Medications List. Enter: Route – injectable. Dosage – 100 gram Recon Soln. Frequency – every 12 hours. Double click in the "Start Date" field and enter 06/22/2022 then in the End Date field enter 06/30/2022. • Enter Tylenol in search line then click to move to the Current Medications List. Enter: Route – oral. Dosage - 500 mg tablet. Double click in the "Frequency" field and enter " for 10 days prn". Double click in the "Start Date" field and enter current date.	Current Medications are entered

	• Enter Aranesp in search line then click to move to the Current Medications List. Enter: Route – injectable. Dosage – 500 mcg/mL solution. Frequency - once a week. Double click in the "Start Date" field and enter the current date. Click "OK" to close the Medications table	
Step 10	In Triage, select "Problems" to open the Problems Table: • Enter Hypoplastic Left Heart Syndrome in search line then click to move to the Current Problem List- Double click in the "Onset Date" field and enter 06/01/2022	Problems are entered
Step 11	In Triage, select "Height and Weight" to open the Height and Weight Table and enter height 85 cm and weight 12 kg	Height and Weight are entered
Step 12	In Triage, select Pediatric Assessment -> Head Circumference then enter a measurement of 46.24 cm and Tab to calculate the Percentile	
Step 13	In Triage, select "Arrival Mode" and enter AMB-POV	Arrival Mode is entered
Step 14	In Triage, select "PCP" and enter PCP of choice	PCP is entered
Step 15	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 and click the red "Continue Documentation" button.	Triage is completed
Step 16	Go to Nursing Dx/Care Plan/Case Management -> Goals -> Custom Entry -> Custom Goal, 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". Status -> Active Due Date -> enter current date.	Goals are entered
Step 17	Go to Nursing Dx/Care Plan/Case Management -> Health Concerns -> General Health Concerns – custom entry, then enter in free text: " a. Chronic sickness exhibited by patient b. Healthcare concerns refer to underlying clinical facts i. Documented Hypertension problem	Health concerns are entered
Step 18	This completes the nursing data entry. Go to the Status Board.	Exit Nurse Chart
Step 19	Log in to Jolly Kiddy as a physician user	User logs in to Jolly Kid Physician Chart
Step 20	Click "History of Present Illness, "PMH and PSH", and "FH SH Allergies Meds" buttons to auto-populate nursing data	nurse data for Allergies, Medications, and Problems is auto-populated
Step 21	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 closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day."	Assessment is entered
Step 22	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 300 mg three times a day as needed if pain does not subside iv). Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2025	Plan of Treatment is entered
Step 23	Select Consultation and Medical Decision Making ->Consults -> Consultant Note and enter "Dr. Albert Davis diagnosed Ms. Jolly Kiddy to be suffering from Fever and suspected Pneumonia and recommended admission to the	Consultant Note is entered

	Community Health Hospitals. The note was captured on (current date) at 11:00 am ET."	
Step 34	This completes the physician data entry. Go to the Status Board.	Exit Physician chart

7.8.3 Test Script Prerequisites

- Configuration of external application such as Apple Health® or the Inferno test tool if no external applications are configured/utilized

Step	Steps to Validate Inferno Test Tool	Expected Outcome
Step 1	• Navigate to Inferno at (g)(10) Standardized API Options (healthit.gov) • Radio buttons selected on main Inferno screen will be what is used for the test, no need to change. • Select the orange **Start Testing** button.	https://inferno.healthit.gov/test-kits/g10-certification/
Step 2	**Inferno test 1**: Choose option 1 **Standalone Patient App**, click **Run Tests** and fill in required fields.	Inferno Tool Runs
Step 3	Click Submit for Test Case 1. **Follow this link to authorize with SMART server.**	Inferno Tool brings up patient login screen.
Step 4	Login as patient, select patient and click **Yes, Allow** at bottom of screen.	Inferno Runs test and receive all green check marks.
Step 5	**Inferno test 2**: Choose option 2 **Limited Access App** and click Run Tests and then Submit.	Inferno Tool brings up pop up.
Step 6	Click the **Follow this link to authorize with SMART server** and then select your patient. **Deselect** all except: • FHIR User Scope • Offline Access • Patient • Condition • Observation • SMART on FHIR launch Patient Context Click the **Yes, Allow** button and review results	Inferno Tool runs test and receive all green check marks.
Step 7	**Inferno test 3**: Choose option **EHR Practitioner App,** click **Run Tests** and fill in required fields. Click the **Submit** button.	Inferno Tool brings up a pop-up EHR Practitioner App.

Step 8	• Navigate to JESS at http://10.70.6.42:6092/StatusBoard/#5 • Select the **Patient Listing** tab on the JESS dashboard as a physician user. • **Search** for a patient by **last name: KID** • Click on the **Find** button. • **Left click** on the patient once to highlight. • **Right click** on the patient and select **External Applications** to display the newly created apps. • Choose app **LiveCert_2of4_EHRLaunch** • Return to Status Board	Juno EHR brings you back to the ConnectEHR server to select patient.
Step 9	• Return to Inferno Test Tool • Click the **Follow this link to authorize with SMART server.** • Select **Yes, Allow** button. • Review results	Inferno runs test and receive all green check marks.
Step 10	**Inferno test 4**: Choose option **4 Single Patient API** and click Run Tests. Click the Submit button and review results.	Inferno runs all tests and receive all green check marks.
Step 11	**Inferno test 7**: Choose option **7 Multi-Patient API**, click **Run Tests** and fill in required fields.	All fields are filled in properly .
Step 12	Click Submit and review results.	Inferno runs test and receive all green check marks.
Step 13	**Inferno test 9.1**: Choose option **9.1 SMART Public Client Launch** , click **Run Tests**, and fill in required fields and click Submit.	Inferno will run test and you will receive a pop-up.
Step 14	Click **Follow this link to authorize with SMART server** and login to the patient, select patient and click **Yes, Allow** at bottom of the screen. View results.	Inferno will run test and receive all green check marks.
Step 15	**Inferno test 9.3**: Chose **9.3 Token Revocation**. Click the **Run Tests** button. Copy Bearer **Token** and provide to developer.	All required fields are populated.
Step 16	Developer will Access Postman and enter the bearer token into Postman and select Send.	Receive an active status in Postman.
Step 17	In new browser, navigate to https://dssjess-dev-web.dssinc.com/dhit/practiceone/r4 Login to ConnectEHR as patient and Choose **Revoke Access** button from **Test 1 of 4 Patient Standalone.** Select **Revoke Access**. Navigate back to the Inferno application. Select **YES** radio button in the Token Revocation window.	Access has been revoked for the patient.

Step 18	Click Submit for test 9.3.	Inferno will run test and receive all green check marks.
Step 19	**Inferno test 9.4**: choose **9.4 SMART Invalid AUD Launch,** select **Run Tests**, and click Submit.	Inferno brings up a pop-up.
Step 20	Select the "perform invalid launch" link.	Directed to ConnectEHR Identity Server and receive an error.
Step 21	Select the back button and click "Attest Launch Failed".	Inferno runs test and receive all green check marks.
Step 22	**Inferno test 9.5**: Chose **9.5 SMART Invalid Token Request, click Run Tests**, and click submit.	Inferno brings up a pop-up.
Step 23	Select the "follow this link to authorize the SMART server".	Directed to the ConnectEHR Identity Server.
Step 24	Select patient and confirm scopes and select **Yes, Allow** at bottom of the screen.	Inferno runs test and receive all green check marks.
Step 25	**Inferno test 9.8**: Choose **9.8 EHR Launch with Patient Scopes**, select **Run Tests**, and fill in required fields. Click Submit.	Inferno Tool brings up a pop-up EHR Practitioner App.
Step 26	• **Go to JESS** and select the **Patient Listing tab** • Log in as a Physician user • Search for patient by Last Name "Kid" • Left click once to highlight the patient, then right click to view menu • Choose **External Applications** > **LiveCert_2of4_EHRLaunch** • Select **Ok** • Return to the **Inferno application**	Juno EHR brings you back to the ConnectEHR server to select patient.
Step 27	**Select Follow this link to authorize with SMART server** and click the **Select** button. Click **Yes, Allow** at bottom of screen and review results.	Inferno runs test and receive all green check marks.
Step 28	**Inferno test 9.10**: **Choose 9.10 Visual Inspection**, select **Run Tests**, and fill in required fields. After reviewing all 9.10 Attestation Questions scroll to top of page and select **Run Test**.	All fields are filled in properly.
Step 29	Select **"Yes"** for all questions and then select **Submit**.	Inferno runs test and receive all green check marks.

Step 30	**Save Final Report** • Select the **Report** option (located below the 9.10 Visual Inspection) • **Toggle** to **Show Details** • **Print** to PDF	Report is exported and available.