Real World Testing Scripts 2021

b(1) Transitions of care & b(3) Electronic prescribing

METRIC b1

1. Over two weeks' time, observe the capture in the audit log of the number of messages with CCDAs attached successfully sent

METRIC b3:

1. Observe the number of messages and success rate of RX messages over two-week timeframe

SCRIPT:

1. Log into TenEleven eCR software using username realworldtest and password Re@lWorldTest1
2. Open Day to Day-> Patient Details, search for a patient Hensley, Grant.
3. Go to e-Prescribe tab,
4. Set patient default pharmacy.
    a. Click warning to set patient default pharmacy.
    b. Type CVS in Name field
    c. Select CVS Pharmacy #2775
5. Navigate to allergies section.
6. Add allergy.
    a. Click Add Allergen (plus sign icon)
    b. Fill out allergy section (Allergen=strawberry, reaction=hives, severity=mild to moderate, Onset Date=12/1/2001)
    c. Click Save
7. Navigate to "Create New Prescription" button
8. Prescribe medication
    a. Click "Create New Prescription"
    b. Search for Tylenol tablet
    c. Click 325mg otc
    d. Fill out add Medication section (Action=take, Dose=1, Dose unit=tablet, Route=by mouth, Frequency=once a day, Other=as needed, Days Supply 30 days, Start Date=current date)
    e. Click Review
    f. Review Clinical Alerts, Click Prescribe Anyway
9. Navigate in eCR to Allergies and Medications tabs to confirm allergy and medication.
10. Click "Chart List" tool strip and open a patient chart (create new chart if necessary)
11. Open a form with a diagnosis control and add a diagnosis of "F10.26 Alcohol Dependence with alcohol-induced persisting amnestic disorder" Check primary Check Box. Then add a diagnosis of I48.2 Chronic atrial fibrillation.
12. Generate CCDA.
    a. Return to "Patient Details", Go to "Additional Demographic Info (cont.)" tab

b. Click “Create CCDA” button
c. Click “Queue Care Referral”

13. Navigate to the “Patient Portal Admin” tab of “Patient Details”.
14. Click the “Consolidated CDA” button
15. Scroll down to the Care/Referral Summaries section and Click the link for the first document
16. Click the first “Health Summary” link in the list
17. Click the Send Via Direct link (4 arrows icon)
18. Scroll down to the list of direct addresses and click the “Send” button in the CCDA XML column for the Procentive Provider.
19. Navigate to Direct-> Direct Incoming->Incoming Document Center
20. Locate the message from Dr Hart
21. Open and view message, along with status line, “subject” line, “from” line, and viewing the attached C-CDA.
22. Download the attached C-CDA

b(2) Clinical Information Reconciliation and Incorporation

METRIC:

1. Count number of times reconciliation of medications, allergies and problems is performed over a two-week time frame

SCRIPT:

1. Log into TenEleven eCR software using username realworldtest and password Re@lWorldTest1
2. Open Day to Day->Clinical Information Reconciliation
3. Search for patient Hensley, Grant
4. Select Diagnosis
5. Review diagnoses in both grids. Check the “Select” check box in both grids for the diagnoses you wish to keep/import.
6. Click Save
7. Repeat the same steps for Medications and Medication Allergies
8. Navigate to patient chart and Patient Details to confirm Reconciliation has occurred.

b(6) Data Export

METRIC:

1. Count the number of times data export is performed over a two-week time frame

SCRIPT:

1. Log into TenEleven eCR Admin Portal using username and password to be given
2. Navigate to Administration->Data Exports.
3. Select proper Practice.
4. Test 1: Real-time summary
   a. Select “Export all patients”

b. Click “Schedule report”
c. Confirm report was generated, accessing files in the File Portal

5. Test 2: Relative date and time
   a. Select “Schedule this report”
   b. Select Monthly
   c. Select the current date for “Scheduled Start date” and a date 4 days in the future for “Scheduled End Date”
   d. Enter the current day of the month in “Day of the Month”
   e. Select a time 3 minutes in the future as the “Scheduled Execution Time”
   f. Click “Schedule Report”
   g. Confirm report was generated, accessing files in the File Portal
6. Test 3: Specific Date and Time
   a. Select “Schedule this report”
   b. Select Run Once
   c. Pick a Scheduled start date of today and a start time of 5 minutes from the current time
   d. Click Schedule Report
   e. Confirm report was generated, accessing files in the File Portal
7. Enable user to set storage location
   a. Navigate to Administration->Practice Management->Bulk Practice Configuration
   b. Select proper Practice in the “Practices” list
   c. Fill in location name into “Data Export Location”
   d. Scroll to bottom and click Save

b(7) Data segmentation for privacy – send & b(8) Data segmentation for privacy – receive -

METRIC b7:

1. Count the number of times C-CDA document is generated in restricted mode

SCRIPT:

1. Log into eCR
2. Open Day to Day->Patient Details
3. Search for Patient Willy Carson
4. Navigate to tab “Additional Demographic info (cont.)”
5. Click the “Create CCDA” Button
6. Check the check box “Check this box to create a restricted CCDA”
7. Click “Queue Referral Note” button
8. Verify regular user cannot see document
   a. Navigate to Setup->Meaningful Use Portal.
   b. Click Patient Search, if not there already
   c. Search for Willy Carson

d. Click the “Consolidated CDA” button at the bottom of the screen

9. TenEleven to confirm that the CCDA is visible by an admin user

METRIC b8:

1. Count the number of times C-CDAs are received and identified as restricted over a two-week timeframe

SCRIPT:

1. Navigate to Patient Search
2. Search for Patient Jacob Schmidt
3. Click View External Documents
4. Confirm Documents shows in Restricted External Documents section and not accessible to a regular user.

b(9) Care Plan

METRIC:

1. Count the number of times Care Plans are generated over a two-week time frame.

SCRIPT:

1. Log into software
2. Go to My Client List, locate chart for Willy Carson, open chart
3. Open TGI MU3 Comprehensive Assessment (TGI_MUCA)
4. Navigate to the “Needs” tab
5. Enter needs
    1. In first row of grid: Priority = “1”, Prioritized Assessed Need="Needs to reduce smoking in effort to quit”, Status= “Active”, SNOMED Code= “(110483000) Tobacco use”
    2. In second row of grid: Priority = “2”, Prioritized Assessed Need="Needs to stop binge drinking”, Status= “Active”, SNOMED Code= “(266890009) Alcoholism in family”
6. Open TGI MU Health Concerns (TGI_MUHC)
7. Enter first health concern
    1. In first row of grid (Type=”HealthstatusObsrevation”, Description= “Alive and Well”, Problem/Need= ”(266890009) Alcoholism in family”)
    2. In first row of grid (Type=”HealthConcernAct”, Description= “In remission”, Problem/Need= ”(110483000) Tobacco use”)
    3. In first row of grid (Type= ”Narrative”, Description= “Alive and Well”, Problem/Need=” (266890009) Alcoholism in family”)
8. Open the TGI MU Treatment Plan (TGI_MUTP)
9. Add a goal with an objective.
    1. On the goals tab fill out a goal (Goal # = “1”, Goal Keyword=” Stop binge drinking”, Check “New” radio button, Start Date=current date, Target Completion Date=1 year from start date, Need=select alcoholism need entered at assessment, Desired Outcome=”To be a more responsible drinker”, Individual Strengths=” Strong family support system”, Supports,

Resources=" Family, AA hotline", Summary of Progress="Client given information pamphlets and AA hotline number"

2. Click Add/Update
3. Go to Objectives tab
4. Select Goal 1 in Grid
5. Fill out Objective Objective=" A", Objective Description=" Remove self from bad situations", Check New radio button, Start Date=todays date, Target completion date=1 year from start date, Intervention/Method/Action="", Services Description/Modality=" Individual Counseling sessions", Frequency= "Once Per Week", Responsible (Type of Provider)= "Counselor"
6. Click Add/Update

10. Close the treatment plan
11. Re-open the Treatment Plan
12. Add a new goal with an objective
    1. Click New Button to start a new goal
    2. On the goals tab fill out a goal (Goal # = "2", Goal Keyword= "Reduce Smoking", Check "New" radio button, Start Date=current date, Target Completion Date=1 year from start date, Need=select tobacco need entered at assessment, Desired Outcome= "Reduce amount of smoking by half", Individual Strengths=" Strong family support system", Supports, Resources=" Family", Summary of Progress= "Client given information pamphlets about smoking cessation"
    3. Click Add/Update
    4. Go to Objectives tab
    5. Select Goal 2 in Grid
    6. Fill out Objective Objective= "A", Objective Description= "Reduce Smoking", Check New radio button, Start Date=today's date, Target completion date=1 year from start date, Intervention/Method/Action= "Start Zyban", Services Description/Modality=" Individual Smoking Cessation sessions", Frequency= "Once Per Week", Responsible (Type of Provider)= "Smoking Cessation Counselor"
    7. Click Add/Update
13. Close treatment plan
14. Open, confirm access and changes are present.

SCRIPT:

1. Open Patient Details and search for Willy Carson
2. Generate CCDA.
    1. Go to "Additional Demographic Info (cont.)" tab
    2. Click "Create CCDA" button.
    3. Click "Queue Care Plan"
3. Go to the Patient Portal Admin tab
4. Click the consolidated CDA button at the bottom of the page.
5. Click the Care Plan generated at the bottom of the page.
6. Verify Care Plan was created and contains data in health concerns, goals and objectives section.

SCRIPT:

1. Open Setup->Meaningful Use Portal
2. Navigate to Direct -> Direct Incoming -> Incoming Document Center
3. Locate the message from Dr. Hart
4. Open and view message, along with status line, “subject” line, “from” line, and viewing the attached C-CDA.
5. Download the attached C-CDA

c(1) Record and Export & c(3) Report

c(1) METRIC:

1. Count of unique customers that have exported at least one QRDA I document in Q1 at all sites.

(c)3 METRIC:

1. Count number of QRDA are exported with correct CQM calculation

SCRIPT:

CQM 137

1. Log into eCR
2. Open Chart for patient Negative CQM137 and open form “Diagnosis”
3. Give Patient Diagnosis of “F10.26 Alcohol dependence with alcohol-induced persisting amnestic disorder” and Save form
4. Open Chart for patient Positive CQM137 and open form Diagnosis
5. Give Patient diagnosis of “F10.26 Alcohol dependence with alcohol-induced persisting amnestic disorder” and Save form
6. Fill out a progress note for Positive CQM137
    1. Use a Date of Service within desired reporting period
    2. Select a visit type of Alcohol Counseling
7. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
8. Click Create Report at the top of the screen
9. Enter “RWT CQL 137 Test” in Description box
10. Select date range of the current year
11. Select 2019 for CQM Update Year
12. Under the section “Select Measures” select “CMS 137v7/NQF 0004/MIPS 305 – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment”
13. Click Queue Report
14. Open the report and confirm the correct patient is in numerator and denominator.

CQM 138

1. Open chart for patient Negative CQM138
2. Fill out a progress note
    1. Use Date of Service within desired reporting period
    2. Use visit type Tobacco Screening

3. Open Chart for patient Positive CQM138
4. Fill out a progress note
    1. Use Date of Service within desired reporting period
    2. Use visit type Tobacco Screening
5. Go back to chart for patient Positive CQM138
6. Fill out another progress note
    1. Use a Date of Service a couple days after the Date of Service of the previously filled out note
    2. Use a visit type of Tobacco Counseling
7. Process those notes in My Billing
8. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
9. Click Create Report at the top of the screen
10. Enter “RWT CQM 138 Test” in Description box
11. Select date range of the current year
12. Select 2019 for CQM Update Year
13. Under the section “Select Measures” select “CMS 138v7/NQF 0028/MIPS 226 Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention”
14. Click Queue Report
15. Open the report and confirm the correct patient is in numerator and denominator

CQM 161

1. Open chart for patient Negative CQM161
2. Open form “Diagnosis”
3. Select a diagnosis of " F32.9 Major depressive disorder, single episode, unspecified”
4. Select a date diagnosed within the reporting period
5. Open chart for patient Positive CQM161
6. Open form “Diagnosis”
7. Select a diagnosis of " F32.9 Major depressive disorder, single episode, unspecified”
8. Select a date diagnosed within the reporting period
9. Fill out a progress note for patient Positive CQM161
    1. Use a Date of Service of the same day as diagnosed
    2. Use a Visit Type of Psychoanalysis
10. Process that note through My Billing
11. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
12. Click Create Report at the top of the screen
13. Enter “RWT CQM 161 Test” in Description box
14. Select date range of the current year
15. Select 2019 for CQM Update Year
16. Under the section “Select Measures” select “CMS 161v7/NQF 0104/MIPS 107 – Adult Major Depressive Disorder (MDD): Suicide Risk Assessment”
17. Click Queue Report
18. Open the report and confirm the correct patient is in numerator and denominator

CQM 68

1. Open chart for patient Positive CQM68
2. Open form “Diagnosis”
3. Fill out a progress note for patient Positive CQM68
    1. Use a Date of Service within the reporting date range

    2. Use a Visit Type of Medication Evaluation
    3. Fill out any other required fields
4. Process that note through My Billing
5. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
6. Click Create Report at the top of the screen
7. Enter “RWT CQM 68 Test” in Description box
8. Select date range of the current year
9. Select 2019 for CQM Update Year
10. Under the section “Select Measures” select “CMS 68v8/NQF 04/MIPS 130 – Document of Current Medications in the Medical Record”
11. Click Queue Report
12. Open the report and confirm the correct patient is in numerator and denominator

CQM 159

1. Open chart for patient Negative CQM159
2. Open form “Diagnosis”
3. Select a diagnosis of " F32.9 Major depressive disorder, single episode, unspecified”
4. Select a date diagnosed within the reporting period
5. Open chart for patient Positive CQM159
6. Open form “Diagnosis”
7. Select a diagnosis of " F32.9 Major depressive disorder, single episode, unspecified”
8. Select a date diagnosed within the reporting period
9. Fill out a progress note for patient Positive CQM159
    1. Use a Date of Service of the same day as diagnosed
    2. Use a Visit Type of Psychoanalysis
10. Process that note through My Billing
11. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
12. Click Create Report at the top of the screen
13. Enter “RWT CQM 159 Test” in Description box
14. Select date range of the current year
15. Select 2019 for CQM Update Year
16. Under the section “Select Measures” select “CMS 159v7/NQF 0710/MIPS 370 – Depression Remission at Twelve Months”
17. Click Queue Report
18. Open the report and confirm the correct patient is in numerator and denominator

CQM 177

1. Open chart for patient Negative CQM177
2. Open form “Diagnosis”
3. Select a diagnosis of " F32.9 Major depressive disorder, single episode, unspecified”
4. Select a date diagnosed within the reporting period
5. Open chart for patient Positive CQM177
6. Open form “Diagnosis”
7. Select a diagnosis of " F32.9 Major depressive disorder, single episode, unspecified”
8. Select a date diagnosed within the reporting period
9. Fill out a Suicide Risk Assessment form.

10. Fill out a progress note for patient Positive CQM177
    1. Use a Date of Service of the same day as diagnosed
    2. Use a Visit Type of Suicide Risk Assessment
11. Process that note through My Billing
12. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
13. Click Create Report at the top of the screen
14. Enter "RWT CQM 177 Test" in Description box
15. Select date range of the current year
16. Select 2019 for CQM Update Year
17. Under the section "Select Measures" select "CMS 177v7/NQF 1365/MIPS 382 – Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment"
18. Click Queue Report
19. Open the report and confirm the correct patient is in numerator and denominator

Export QRDA

1. Click Home
2. Click "View Results" for the test labelled "RWT CQM 137 Test"
3. Click the Details tab
4. Click the Download Button
5. Click Download QRDA 3
6. Repeat steps 3 through 6 for the remaining reports ("RWT CQM 138 Test", "RWT CQM 161 Test", "RWT CQM 68 Test", "RWT CQM 159 Test", "RWT CQM 177 Test")

c(2) Import and Calculate

METRIC c(2):

1. Count number of imported QRDAs which demonstrates successful calculation of CQM's based on imported file

SCRIPT:

1. Open screen Day to Day->Clinical Quality Measures-> Clinical Quality Measures Stage II
2. Click "Create Report"
3. Enter "RWT Import Test" into Description field
4. Enter "Begin Date" of 1/1/2015 and "End Date" of '12-31-2015'
5. Select 2019 for CQM update year
6. Check the Use Zip Folder check box
7. Click "Choose file"
8. Select file RWT_TestQRDA.qrda.
9. In the "Select Measures" list check CMS137v7 only
10. Click Queue Report
11. Click View Results
12. Confirm expected patients are in results
13. Repeat steps 2 through 12 for each of the following clinical quality measures (CMS138, CMS161, CMS68, CMS159, CMS177)
14. Repeat steps 2 through 13 using a QRDA Cat-1 file in step 8.

e(1) View, download, and transmit to 3rd party

METRICS:

1. Count number of instances a C-CDA View, C-CDA Download, and C-CDA Transmit for the user with date and time stamps

SCRIPT:

1. Open a web browser and go to patient portal url
2. Log in using username and password
3. Click on “Patient Medical information” in the tool strip and then select “All Documents”
4. Scroll down to the “Care/Referral Summaries” and click the link for the first document
5. Inspect the page, confirm data for each section of the CCDS
6. Click the “Download PDF” button
7. Open the pdf downloaded, inspect all necessary sections of the CCDS
8. Click on “Send to Your Doctor Via Direct”
9. Enter a direct email address “testclinician@directmsg.10e11messaging.com“ and nick name "Test Clinician”
10. Click “Send XML”
11. Confirm the physician receiving the Direct email with attached CCDA.

f(1) Transmission to immunization registries

METRICS:

1. Count of user organizations live with this interface. For immunizations, all immunization fields (Start of Vaccine Date, Start of Vaccine Time, Ordering Provider, Administering Provider, Administered Test Code, Administered Test Code System, Procedure (name of vaccine), Amount, Units, Lot Number, Manufacturer Name, Manufacturer Code, Date Time Expiration, Route, Body Site, Order ID, Substance/treatment Refusal, Administration Notes, and Status) are tracked as “add” in the audit log
2. Count of interface transactions

SCRIPTS:

1. Log into TenEleven eCR software
2. Open chart for Willy Carson
3. Open form "Immunization Administration Note”
4. Enter details of note "Immunization Administration Note”
    a. (Date of service= Today’s Date, Duration=15 minutes)
    b. Select Procedure = DTaP Vaccine in Procedure grid
    c. Fill out Immunization section (Immunization=11111-DTaP Immunization, Manufacturer=”Medline Vaccine”, Dose Amount=.5ml, Route

Administered=" Intramuscular", Body Site Administered="Left Arm", Immunization Type="Active", VFC Eligibility="Not VFC eligible", Immunization Date=Yesterday's date, Lot#=54345, Expiration Date=12/31/2021, VIS Sheet Given=Yes, VIS Date=Yesterday's Date)

d. Click "Add" to add record to grid
e. Sign and complete the form.

5. Open Day to Day-> My Billing, click Refresh, Select and process the progress note you just created.
6. TenEleven will verify the HL7 message was generated.
    a. Locate the file in the designated location, verify it exists and is complete.
    b. Visually inspect the file for details on patient and vaccine provided

Immunization Query

1. Open Patient Details search for Patient
2. Navigate to the "Additional Demographic Info (Cont)" tab
3. Click the "Immunization Query" button
4. Select Act="Query" Sending Organization="RWT Immunization Facility", Receiving Organization="St Jonathan's Hospital"
5. Click "Queue" button
6. TenEleven will verify the HL7 message was generated.
    a. Locate the file in the designated location, verify it exists and is complete.
    b. Visually inspect the file for details on patient and vaccine provided

f(2) Transmission to public health agencies – Syndromic Surveillance

METRIC:

1. Count of user organizations live with this interface and 90% all observation fields (Date Taken, Observation Type, Observation Value, Coding System, Code, Alt Code, Alt Value, Units Type, Notes, Observation Result, and Status) contain all expected data elements
2. Count of interface transactions

SCRIPT:

1. Log into TenEleven eCR software
2. Open Day to Day->Patient Details
3. Search for Patient William Carson
4. Navigate to the "Additional Demographic Info (Cont)" tab
5. Click the "Syndromic Surveillance" Button
6. Fill out the form
    a. Select Pseudonym
    b. Select "Admit" in the "ADT Event Type" drop down
    c. Enter a Date/Time of Service

d. Enter “ABC Clinic” in the “Clinic Name” field
e. Select “20 – Expired” from the “Discharge Disposition” drop down
f. Enter “123456789” in the Clinic NPI text box
g. Select “Urgent Care” in the “Facility/Visit type”
h. Enter “Medical cardiac critical care unit” in the Patient Location
i. Select “year” in the “Age Unit Identifier” drop down
j. Enter today in “Date/Time of Location”
k. Select “Influenza” in the “Chief Complaint Identifier”
l. Select “ICD10” in the Admit Reason and select F16.220 Hallucinogen dependence with intoxication, uncomplicated in the ICD10 field

7. Click the Add button and then click the “Queue” button in the tool strip
8. TenEleven will verify the message was generated
    a. Locate the file in the designated location, verify it exists and is complete.
    b. Visually inspect the file.

f(3) Transmission to public health agencies — reportable laboratory tests and value/results

METRIC:

1. Count of user organizations live with this interface for reportable laboratory results
2. Count of interface transactions

SCRIPT:

1. Log into eCR
2. Open the screen Day to Day -> Lab Results Entry
3. Search for patient William Carson
4. Click the “New” button in the tool strip
5. Fill out the lab result
    a. Click New button
    b. Select provider
    c. Select Organization “Real World Organization”
    d. On “MSH & PID” Tab enter the following
        i. Sending Application -> Namespace ID : eLab Software
        ii. Sending Facility -> Namespace ID: RWT Laboratories
        iii. Software Organization -> Name: eLab Inc
        iv. Software Organization -> Product Name: eLab Communicator
        v. Software Organization -> Certified Version: 2.0
        vi. Receiving Facility -> Namespace ID: Healthy Life Clinic
    e. On OBR tab enter the following:
        i. Placer Order Number Entity Identifier: PN-P20120325-1
        ii. Filler Order number Entity Identifier: FN-F20120325-1
        iii. Ordering Facility Name: Healthy Life Clinic
        iv. Ordering Facility Address: 311 Clinic Circle
        v. Ordering Facility City: Pittsburgh
        vi. Ordering Facility State: PA

vii. Ordering Facility Zip Code: 15202
viii. Universal Service ID: 5671-3
ix. Universal Service Text: Lead [Mass/volume] in Blood
x. Universal Service Coding System: LN
xi. Universal Serice Coding System Version: 2.40
xii. Enter Observation Date Time
xiii. Enter Observation End Date Time

f. In the Specimen Section enter the following:
i. Type identifier: 122554006
ii. Type Test: Capillary Blood Specimen
iii. Type Coding System: SCT
iv. Type Coding System Version ID: v2.3
v. Received Date Time: 2015-5-11 16:30

g. On the OBX Tab enter the following:
i. Observation Identifier ID: 5671-3
ii. Observation Identifier Text: Lead [Mass/volume] in Blood
iii. Observation Identifier Coding System: LN
iv. Value Type: SN
v. Units ID: ug/dL
vi. Unite Text: microgram per deciliter
vii. Units Coding System: UCUM
viii. Reference Ranges: <10 ug/dL
ix. Result Status: F
x. Observation Date Time: 2015-5-11 16:30
xi. Date Time of Analysis 2015-5-12 12:00
xii. Performing Organization: RWT Diagnostics

h. In the Observation Details Values-SN section enter the following
i. Num1: 24

i. In the Observation Details Abnormal Flags Section enter:
i. Abnormal Flag/Susceptibility: Above high normal
ii. Name of coding System: HL70078

6. Click Save
7. Click Queue Reportable Labs
8. TenEleven to retrieve generated lab file from file location and inspect for accuracy

f(5) Transmission to public health agencies — electronic case reporting

METRIC:

1. For electronic case reporting count of user organizations live with this interface
2. Count of interface transactions

SCRIPT:

1. Log into eCR using username realworldtest and password Re@lWorldTest1

2. Open Setup->Case Reporting Trigger Codes
3. Enter new values in Diagnosis Trigger Code grid: F15.23 Other stimulant dependence with withdrawal and F16.220 Hallucinogen dependence with intoxication, uncomplicated
4. Click Save
5. Open chart for patient William Carson in program Outpatient Substance Abuse
6. Open form “Diagnosis”
7. Select diagnosis F15.23 Other stimulant dependence with withdrawal
8. Click Save
9. TenEleven will retrieve message generated and visually inspect for
    a. The Common Clinical Data Set.
    b. Encounter diagnoses.
    c. The provider's name, office contact information, and reason for visit
    d. An identifier representing the row and version of the trigger table that triggered the case report.

g(7) Application access — patient selection, g(8) Application access — data category request, g(9) Application access — all data request

METRIC:

1. For Application Access – Patient Selection, a connection can be established to the API for the specified patient over a two-week time frame
2. For Application Access – Data Category Request, a request is made for a single data category over a two-week time frame (a single date or a date range) and the category of data that was requested.
3. For Application Access – All Data Request, a request is made for the specified patient over all time for all data over a two-week time frame

SCRIPT:

1. Establish external application used to connect to API
2. Execute request from external application with specific patient (TBD) information identified.
3. Confirm established connection for the specified patient
4. Execute a request for the specified patient for a single data category in the CCDS starting with patient name.
5. Verify results return match the specified patient and contains the full set of data for that category
6. Repeat Steps 3 &4 for each of the other categories listed in the CCDS
    1. Sex
    2. Date of Birth
    3. Race
    4. Ethnicity
    5. Preferred Language
    6. Smoking Status
    7. Problems

8. Medications
9. Medication Allergies
10. Laboratory Tests
11. Laboratory Values(s)/Result(s)
12. Vital Signs
13. Procedures
14. Care Team Member(s)
15. Immunizations
16. Unique Device Identifier(s) for a Patient's Implantable Device(s)
17. Assessment and Plan of Treatment
18. Goals
19. Health Concerns

7. Execute a request for the patient for a single data category starting with patient name for a specific date
8. Verify results return match the specified patient and contains the data set for the patient for the specified date
9. Repeat steps 7 & 8 for the remaining categories of the CCDS
10. Execute a request for the individual for a single data category patient name for a specified date range
11. Verify results return match the specified patient and contains the data set for the individual for the specified date range
12. Repeat steps 9 & 10 for the remaining categories of the CCDS
13. Execute a request for the individual for all categories of the CCDS
14. Verify results return match the specified patient and contains the following data element