



Real World Test Plan -Enable Healthcare, Inc -2023

Background

This document, Real World Test Plan (RWT) pertains to CY 2023 on behalf of Enable Healthcare Inc (EHI). EHI's MDNET, a certified EHR solution, under the ONC Health IT Certification program will be testing on the most current version (v10) of MDNet, which is deployed to our user community.

Our objective of RWT plan is aligned with ONC's objective which is stated in its rule, "The objective of real-world testing is to verify the extent to which certified health IT deployed in operational production settings is demonstrating continued compliance to certification criteria and functioning with the intended use cases as part of the overall maintenance of a health IT's certification."

EHI Inc Product portfolio include CEHRT-EHR, Practice Management, Revenue Cycle Management, Remote Patient Monitoring, Chronic Care Management, and Patient Portal. EHI Inc, products comply with ONC Standards and Certifications, as well as Interoperability specifications, in addition to complying with state and federal requirements.

RWT Plan document is part of the final testing measurements and metrics which we will utilize to test our product interoperability within the production environment. Within each use case, we document planned testing methodology, associated ONC criteria, justification for measurement, expected outcomes from the testing, care settings applied for the respective measure, and if applicable the number of clients to use our RWT approach, including how our test cases were created, test methodology, the number of client/practice sites to use, and our general approach and justification for decisions.

We have included our timeline and milestones for completing the real-world testing in Current Year- 2023, and information about compliance with the Standards Version Advancement Process updates.



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Justification of Real World Testing Approach

EHI Inc-MDNet is a certified EHR technology, and it has established a plan to comply with interoperability and functionality in a real world setting and scenario within ambulatory care settings. Our MDNet EHR has adopted updated vocabularies and content standards for capture and exchange of health information. Our RWT test plan and testing will include using live practices, structured patient data, and clinic environment to ensure accuracy and transparency in the Real World Testing process and outcomes.

General Information

- Plan Report ID #: (For ONC authorized certification body use only)
- Developer Name: Enable Healthcare Inc, <https://ehiconnect.com>
- Product Name (s): MDNet
- Version No (s): V10
- Certified Health IT Product List (CHPL) IDs: 15.04.04.2719.MDne.10.01.1.191231
- Certification Status: Active
- Developer Real World Testing Page (URL):

Schedule of Key Milestones

Key milestone	Care settings	Date/Timeframe
Submission of RWT plan documentation to ONC authorized representative-Drummond Group	Ambulatory	December 10, 2022
RWT Plan publicly made available on CHPL	Ambulatory	December 12, 2022
Begin communication with clients for RWT participation and sign up clients for participation	Ambulatory	Q1,2023
Create and perform test schedules. Document results	Ambulatory	Q2-2023
Create and perform test schedules. Document results	Ambulatory	Q3-2023
Make changes if non-compliance is observed	Ambulatory	4Q-2023
Submit RWT Test Report to ONC-ACB.	Ambulatory	Q1-2024

Standards Version Advancement Process (SVAP) Updates For CY 2023

(No version updates are planned on approved standards through the SVAP process).

Standard (and version)	
Updated certification criteria and associated product	
Health IT Module CHPL ID	15.04.04.2719.MDne.10.01.1.191231
Method used for standard update	
Date of ONC-ACB notification	
Date of customer notification (SVAP only)	
Conformance measure	
USCDI-updated certification criteria (and USCDI version)	



Real World Testing Measurements

The measurements for our real-world testing plan are described below. Each measurement contains:

- Description of the measurement/metric
- Associated ONC criteria/s
- Justification for the measurement/metric
- EHR Test Plan/plan
- Expected outcomes

All measurements were chosen to best evaluate compliance with the certification criteria and interoperability of exchanging electronic health information (EHI) within the certified EHR.

Testing Methodologies

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

Reporting/Logging: This methodology will be using the logging or reporting capabilities of the EHR to examine functionality performed in the system. This methodology often provides historical measurement reports which can be accessed at different times of the year and evaluate interoperability of EHR functionality, and it can serve as a benchmark for evaluating real world testing over multiple time intervals.

No of Client Sites: For each certification criteria, no of client sites used are **(3)** to test the measurements/metrics. The sample size varies depending on the methodology as well as overall used of associated EHR Module criteria by our users.

Care and Practice Settings

All mentioned certification criterias are applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing such functions which are directly associated with the Real World Testing criteria and scenarios for RWT testing.



Associated Certification Criteria

- 170.315 (b)(1): Transitions of Care
- 170.315 (b)(2): Clinical Information Reconciliation and Incorporation
- 170.315 (b)(3): Electronic Prescribing
- 170.315 (b)(6): Data Export
- 170.315 (c)(1): Clinical Quality Measures - Record and Export
- 170.315 (c)(2): Clinical Quality Measures - Import and Calculate
- 170.315 (c)(3): Clinical Quality Measures – Report
- 170.315 (e)(1): View, Download, and Transmit to 3rd Party
- 170.315 (f)(1): Transmission to Immunization Registries
- 170.315 (f)(2): Transmission to Public Health Agencies - Syndromic Surveillance
- 170.315 (g)(7): Application Access - Patient Selection
- 170.315 (g)(8): Application Access - Data Category Request
- 170.315 (g)(9): Application Access - All Data Request
- 170.315 (h)(1): Direct Project



Use case 1: Real world testing requirement for Certification Criteria Measurement under care coordination-

- § 170.315(b)(1) Transition of care
- § 170.315(b)(2) Clinical information reconciliation and incorporation
- § 170.315(b)(6) Data export
- § 170.315(b)(3) Electronic prescribing.

MDNet will apply the following scope for the usability and testing plan

§ 170.315(b)(1) Transition of care

Description of Measure/s used to support the overall approach of Real-World Testing

Measurement/Metric	Description
Send and Receive Transition of Care/Referral Summaries	Provider can send and receive TOC/Referral Summaries to the external providers/ health IT vendors using Direct Edge Protocols.

Justification for Real World Testing Approach

Measurement/Metric	Justification
Send and Receive Transition of Care/Referral Summaries	MDNet application supports Transition of care (send/receive) from other external CEHRT. This will be achieved through the scenarios included in the EHR Test Plan.

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Send and Receive Transition of Care/Referral Summaries	§ 170.315(b)(1) Transition of care

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(b)(1) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.

EHR Test Plan

- Provider can select patient and send transition of care/referral summaries as a C–CDA document from **Encounter /Orders and Requisitions>Refer this patient and submit in EHR**
- **Provider can add referral reason, referral to and specialty.**
- **Provider can send to referring physician as direct message.**
- Provider can receive transition of care/referral summaries as a C–CDA document
- Display, and incorporate transition of care/referral summaries in the **selected patient chart through Direct transportation tracker/Received CCDA/Select Patient/View and Add in Chart in EHR**



- System supports **Send and Receive Referral Tracking, Status, Error and Verify transactions in HER**

Surescripts Clinical Direct Message will be tested in the above steps to comply with § 170.315(b)(1)

Transition of care

Expected Outcomes:

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count. During the year, we will examine the log information for a minimum period of three (3) months to determine an appropriate sample of this measurement. A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can create the C-CDA patient summary record, including record required clinical data elements. In sending the C-CDA patient summary record, the EHR will demonstrate ability to confirm successful interoperability of an exchanged patient record with a 3rd party, including support for Direct Edge protocol in connecting to a HISP. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Measurement Metrics	Expected Outcomes
Send and Receive Transition of Care/Referral Summaries	<ul style="list-style-type: none"> • Provider can send and receive transition of care/referral summaries as CCDA to/from external providers

Care Settings and Number of Clients Site Tested:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have tested this measure to be applicable to all settings. We tested a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

§ 170.315(b)(2) Clinical information reconciliation and incorporation

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Accept and Match CCDA	User case here is that provider is able to accept CCDA and System can match to the correct patient
Reconcile and incorporate	Provider can display, validate, incorporate a patient’s active data and the data elements from minimum two sources-Medication list, medication allergy list and problem list which includes the source and the last modification date.
Create a CCDA document	Provider can create a CCDA document using reconciled and incorporated patient data



Justification for Real World Testing Approach

Measurement/Metric	Justification
<ul style="list-style-type: none"> Accept and Match CCDA Reconcile and incorporate Create a CCDA document 	MDNet application supports Clinical information reconciliation and incorporation of Transition of Care/Referral summaries from other external CEHRT. This will be achieved through the scenarios included in the EHR Test Plan.

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Accept, Match, Reconcile, Incorporate and Create CCDA	§ 170.315(b)(2) Clinical information reconciliation and incorporation

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(b)(2) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.

EHR Test Plan

- Provider can approve incoming CCDA file for a patient from **Data transportation tracker/Received CCDAs/View and Import into chart**
- Provider can complete the reconcile and incorporate process of a patient’s clinical information from patient chart under the chart/clinical reconciliation section (**Medications/Allergies/Problem List**).
- Review and capture audit logs in **Data Transportation tracker**

Expected Outcomes

This use case has two measures:

Measure #1: C-CDA Incorporation. The first measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count. During the year, we will examine the log information for a minimum period of three (3) months to determine an appropriate sample of this measurement.

A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can create the EHR can receive a C-CDA patient summary record. In incorporating the C-CDA patient summary record, the EHR will demonstrate successful interoperability of problems, medications, and medication allergies of patient record with a 3rd party, including support for Direct Edge protocol in connecting to a HISP. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. EHI CY 2023 Real World Test Plan



will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Measure #2: C-CDA Error Detection. EHI has an internal tool for tracking the errors from C-CDA received. The user will import in, either through upload or inbound messages, C-CDAs with different known errors. The user will use the EHR functions to parse the C-CDA document and perform errors detection which will be reviewed by the user. We will confirm the process and steps done by the user meet the criteria requirements of the EHR Module and works as expected in production-type environment.

Measurement Metrics	Expected Outcomes
Accept, Match, Reconcile, Incorporate and Create CCDA	<ul style="list-style-type: none"> System can match patient with the received transfer of summaries/referral summary Provider can Reconcile clinical information for the patient in patient chart-data from multiple sources can be simultaneously displayed in a single view for medications, allergies and intolerances, and problems, including both the source and last modification date. Provider can create a C-CDA document (using the CCD template in C-CDA Release 2.1) that includes the reconciled and incorporated data.

Care Settings and Number of Clients Site to Tested:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

§ 170.315(b)(6) Data export

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Send Export File	Use case here is that this functionality allows authorized users to automatically schedule export of data for all patients that represents the most current clinical information in the specified date and time range.

Justification for Real World Testing Approach

Measurement/Metric	Justification
Send Export File	MDNet application supports a successful generation and transmission of export file CCDA of single/multiple patients which indicates support and compliance to the underlying ONC criteria. This will be



	achieved through the scenarios included in the EHR Test Plan.
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Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Send an Export File	§ 170.315(b)(6) Data export

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(b)(6) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.

EHR Test Plan

- Authorized Provider/user can configure options for data elements, real time, date and time range, and storage location using **CCDA Export tracker/Add new Export Summary in EHR**
- System can transmit all required data (specific sections) for a specific date range specified
- Review and capture logs and audit events in the **EHR/CCDA Export tracker**

Expected Outcomes

Measurement Expected Outcome:

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs to determine our measure count. During the year, we will examine the log information for a minimum period of three (3) months to determine an appropriate sample of this measurement. A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can create a batch export of multiple C-CDA patient summary records, which can be used in means of health IT interoperability. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Measurement Metrics	Expected Outcomes
Send Export File	<ul style="list-style-type: none"> • Authorized user can send all required data for a specific date range specified. • Limited Users authorized to execute data export functionality • Send export summaries using the Continuity of Care Document template

Care Settings and Number of Clients Site to Test:



Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

§ 170.315(b)(3) Electronic prescribing

Description of Measure/s used to support the overall approach of Real-World Testing

Measurement/Metric	Description
<ul style="list-style-type: none"> • Create and transmit electronic prescription • Track Status (Transmitted, Delivered, Failed) of Count of Eprescription for a given period. 	Use case here is create and transmit with track count of New-Rx e-prescriptions to surescripts and pharmacy using EHR over the course of time.

Justification for Real World Testing Approach

Measurement/Metric	Justification
<ul style="list-style-type: none"> • Create and transmit electronic prescription • Track Status (Transmitted, Delivered, Failed) of Count of Eprescription for a given period. 	MDNet application supports Erx transmission to external pharmacies via Surescripts certified Health IT system. A successful Erx transmission to pharmacy indicates compliance to the underlying ONC criteria.

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Associated Certification Criteria
<ul style="list-style-type: none"> • Create and transmit electronic prescription • Track Status (Transmitted, Delivered, Failed) of Count of Eprescription for a given period. 	§ 170.315(b)(3) Electronic prescribing

Care Setting	Justification
Ambulatory Practice	Certification criteria -§ 170.315(b)(3) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.

EHR Test Plan

- Provider w/ Prescriber status can select drug/s and create electronic prescription from patient chart>encounter>Rx writer module in EHR.
- Provider saves electronic prescription in patient chart> encounter>Rx writer module in EHR.



- Provider can send electronic prescription to a patient’s **preferred list of pharmacy from EHR.**
- Provider/authorized user can view **Eprescription Tracker for count and details of Transmitted newRx, Delivered NewRx, Failed NewRx etc.**
- System supports Erx transmission Status, Error and Verify transactions via Erx Tracker in EHR

Expected Outcomes:

Measurement Expected Outcome:

This use case will have two different measurement metrics, and both measurements will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count. During the year, we will examine the log information for a minimum period of three (3) months to determine an appropriate sample of this measurement. Measure #1 will show that the EHR can create the NewRx message and send over a production network, like the Surescripts Network, to a pharmacy.

Measure #2 will count the number of CancelRx message sent over the same time period. Successfully completing these measure use cases also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. We will use the measure counts to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Measurement /Metrics	Expected Outcomes
<ul style="list-style-type: none"> • Create and transmit electronic prescription • Track Status (Transmitted, Delivered, Failed) of Count of Eprescription for a given period. 	<ul style="list-style-type: none"> • Create and transmit NewRx over a production network (Surescript, pharmacy) using EHR

Care Settings and Number of Clients Site to Test:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

Use Case 3: Real world testing requirement for Certification Criteria Measurement under Patient

Engagement: § 170.315(e)(1) View, download, and transmit to 3rd party

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Publish CCDA to patient portal	Use case here is that this functionality allows providers to publish CCDA to patients who are registered with MDNet patient portal
View, Download and Transmit	Use case here is that this functionality allows Patient and their authorized representatives can access their patient portal and view, download and transmit Common Clinical



	Data Set to a 3 rd party.
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Justification for Real World Testing Approach

Measurement/Metric	Justification
Publish CCDA to patient portal View, Download and Transmit	MDNet application supports Patient CCDA is published in the patient portal using CEHRT for purposes of the measurement under the Health Information Exchange objective. A successful viewing, downloading and transmission of CCDA file from patient portal indicates compliance to the underlying ONC criteria. This will be achieved through the scenarios included in the EHR Test Plan.

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Publish CCDA to patient portal	§ 170.315(e)(1) View, download, and transmit to 3rd party
View, Download and Transmit	§ 170.315(e)(1) View, download, and transmit to 3rd party

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(e)(1) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.

EHR Test Plan

- Provider/Authorized user can register a patient for PHR from EHR
- Patient can login in PHR and access the Clinical Summary or Summary of Care Record and system marks the CCD Export Summary Document status as Viewed or Downloaded or transmitted based on patient actions.
- System can track no of patients registered in PHR via **PHR Activity Tracker in EHR**
- System supports Status, Error and Verify transactions via **Data transportation tracker/Available in PHR.**
- **Surescripts Clinical Direct Message will be tested in the above steps to comply with § 170.315(e)(1) View, download, and transmit to 3rd party**

Expected Outcomes:

Measurement Expected Outcome:

The measurements will produce numeric results over a given time interval of a minimum of three (3) months. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count. For all three measures, a successful increment indicates compliance to the underlying ONC criteria. It will show that patients can log into their patient portal



to access their patient data and transmitting their health data to a 3rd party. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. We will use the measure counts to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Measurement Metrics	Expected Outcomes
Publish CCDA to patient portal	<ul style="list-style-type: none"> A provider can publish necessary data (Common Clinical Data set) in patient portal.
View, Download and Transmit	<ul style="list-style-type: none"> Patient or authorized representative is able to register, view, download and transmit CCDA through patient portal using internet technology.

Care Settings and Number of Clients Site to Test :

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

Use Case 4: Real world testing requirement for Certification Criteria Measurement under CQM:

- § 170.315(c)(1)—record and export
- § 170.315(c)(2)—import and calculate
- § 170.315(c)(3)—report

MDNet will apply the following scope for the usability and testing plan.

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Record and Export CQM Measure/s	Use case here is that this functionality allows users to record necessary numerator data points automatically or manually for eligible measures related to patient and patient population and export QRDA 1 for identified clinical quality measures for the practice/provider
Import and calculate CQM Measure/s	Use case here is that this functionality allows system to calculate and depict Total Patient Denominator Count, Numerator Count, Numerator Percentage, and Decile Value of each measure reported in accordance with MIPS CQM Specifications as per CMS guidelines, demonstrating successful interoperability and functionality in production environment.



Report CQM Measure/s	Use case here is that this functionality allows providers a count and list of electronic-Clinical Quality Measures (eCQMs) which are calculated and submitted to CMS for CMS Quality Reporting and Value-Based Programs.
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Justification for Real World Testing Approach

Measurement/Metric	Justification
Record and Export CQM Measure/s Import and calculate CQM Measure/s Report CQM Measure/s	<p>MDNet application supports providers to record and export the CQM Measures for multiple patients and all user scenarios.</p> <p>MDNet application supports providers to import and Calculate the CQM Measures for multiple patients and all user scenarios.</p> <p>MDNet application supports providers to report CQM Measures for multiple patients and all user scenarios.</p> <p>Additionally, we educate our customers on how to achieve the desired percentile benchmark and the metrics associated with each eCQM for successful reporting to CMS which translates to compliance to the associated criteria as per MIPS CQM Specifications, ensuring that they have a general understanding of the EHR functionalities and use of EHR in a meaningful use manger.</p> <p>Clinical quality measures applicable for the practice is recorded, exported, imported, calculated, and reported using CEHRT for purposes of the CQMs under the Health Information Exchange objective. A successful reporting of CQMs indicates compliance to the underlying ONC criteria. This will be achieved through the scenarios included in the EHR Test Plan.</p>

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Record and Export	§ 170.315(c)(1)—record and export
Import and calculate	§ 170.315(c)(2)—import and calculate
Report	§ 170.315(c)(3)—report

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(c)(1), (c)(2),(3) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users



	performing and fulfilling RWT functions for RWT testing.
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EHR Test Plan

- System can display eligible eCQM measures for a patient/patient population **in Patient’s compliance console section in patient dashboard in EHR**
- Provider can record numerator for the displayed measures for a patient/patient population in EHR.
- System calculates the scores for numerator, denominator automatically based on current year decile scoring criteria in **MIPS Dashboard in EHR**.
- MIPS Dashboard provides a count and list of electronic-Clinical Quality Measures (eCQMs) which are calculated and submitted to CMS for CMS Quality Reporting and Value-Based Programs.
- System can calculate and depict Total Patient Denominator Count, Numerator Count, Numerator Percentage, and Decile Value of each measure reported in accordance with MIPS CQM Specifications as per CMS guidelines, demonstrating successful interoperability and functionality in production environment.
- System can export selected measures by the provider and practice.
- Provider can import QRDA received from an external system and calculate the measure. (HL7 QRDA Category 1 Release 3 for one or multiple patients to perform calculations on the CQMs that providers are attesting.
- Provider can export QRDA 3 for reportable selected measures for the applicable year.
- Providers can create a data file for transmission of CQM Data in QRDA category 1 (for individual level reports) and Category III (For aggregate reports) as per specified standards
- Created data file to be electronically accepted by CMS
- Review and capture audit events

Expected Outcomes

Measurement Metrics	Expected Outcomes
Record and Export	<ul style="list-style-type: none"> • A user is able to record and export for selected measure as identified by the provider and the practice
Import and calculate	<ul style="list-style-type: none"> • A user is able to import and calculate the QRDA III for selected measure as identified by the provider and the practice
Report	<ul style="list-style-type: none"> • Generate CQM files (QRDA category III for ambulatory measures in § 170.205 (k)(3) and report for the applicable measure that was selected by the provider/practice.

Care Settings and Number of Clients Site to Test:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.



Use Case 5: Real world testing requirement for Certification Criteria Measurement under Electronic Exchange

- § 170.315(h)(1) Direct Project

MDNet will apply the following scope for the usability and testing plan

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Send and Receive EHI to and from a third party	Use case here is that this functionality allows providers to Transmit (send and receive) health information to and from a third party. Technology used- Secure Health Transport, Version 1.2

Justification for Real World Testing Approach

Measurement/Metric	Justification
Send and Receive EHI to and from a third party	MDNet application supports providers to send and receive CCDAs to/from external providers which is exchanged using CEHRT Direct Messaging module for purposes of the measurement under the Health Information Exchange objective. A successful secure transmission using Direct Messaging Specification indicates compliance to the underlying ONC criteria. This will be achieved through the scenarios included in the EHR Test Plan.

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Send and Receive EHI to and from a third party	§ 170.315(h)(1) Direct Project

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(h)(1) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.

EHR Test Plan

- Provider or authorized user can create and send **Direct message in EHR** to external provider/third party over a production **network (via Superscript) with orig-date as per RFC 5322 and message ID as per RFC 5322.**
- Provider or authorized user can receive **direct messages in EHR** for a patient from other providers or third party (example Walgreens, CVS Pharmacy, Healthix)



- Direct messages may include clinical data, consultation notes, medication information and other healthcare related information.

Surescripts Clinical Direct Message is used and tested as per Measure § 170.315(h)(1) Direct Project

- System supports Statuses of direct messages, Errors and Verify transactions in **Direct Message Module in EHR.**

Expected Outcomes

Measurement Metrics	Expected Outcomes
Send and Receive EHI to and from a third party	<ul style="list-style-type: none"> • Authorized user can send Patient’s health information through direct message module to external providers or third party • Authorized user can receive Patient’s health information through direct message module from external providers or third party

Care Settings and Number of Clients Site to Test:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

Use Case 6: Real world testing requirement for Certification Criteria Measurement under Public Health:

- § 170.315(f)(1) Transmission to immunization registries
- § 170.315(f)(2) Transmission to Public Health Agencies - Syndromic Surveillance

MDNet will apply the following scope for the usability and testing plan

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Create and Transmit Immunization record/messages	Use case here is that this functionality allows providers to create and transmit immunization information (historical and newly administered vaccines) to Immunization registry using CVX and NDC codes.
Create and Transmit Syndromic surveillance data and message (count of messages)	Use case here is that this functionality allows providers to send real-time, electronic syndromic surveillance data to a state syndromic surveillance system using data standards SNOMED CT and ICD 10 codes.

Justification for Real World Testing Approach

Measurement/Metric	Justification
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<p>Create and Transmit Immunization record/messages</p>	<p>MDNet application supports a user to request, access and display the evaluated immunization history and forecast from an immunization registry for a patient in accordance with the HL7 2.5.1 standard, the HL7 2.5.1. IG for Immunization Messaging, Release 1.5, and July 2015 Addendum.</p> <p>A successful secure transmission to immunization registry and public agencies indicates compliance to the underlying ONC criteria.</p>
<p>Create and Transmit Syndromic surveillance data and message (count of messages)</p>	<p>The Syndromic Surveillance use case sets forth requirements for providers to send real-time, electronic syndromic surveillance data to a state syndromic surveillance system. The Health IT Module enables a user to record, select and transmit the syndromic surveillance data elements for a patient in accordance with the HL7 2.5.1 standard.</p> <p>A successful secure transmission to HIN and public health registry and public agencies indicates meaningful use and compliance to the underlying ONC criteria.</p>

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Associated Certification Criteria
<p>Create and Transmit Immunization record</p>	<p>§170.315(f)(1) Transmission to immunization registries</p>
<p>Create and Transmit Syndromic surveillance data and message (count of messages)</p>	<p>§ 170.315(f)(2) Transmission to Public Health Agencies - Syndromic Surveillance</p>

Care Setting	Justification
<p>Ambulatory Practice</p>	<p>Ambulatory practices and providers participation and ability to transmit immunization information and syndromic surveillance messages provides real-time patient care and situational awareness of potential public health threats and emergencies. Certification criteria § 170.315(f)(1),(2) is applicable for ambulatory care settings -Private Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.</p>

EHR Test Plan



- Provider/Authorizer user can create immunization information for a patient in **immunization history module in patient chart in EHR**
- System can transmit patient’s immunization information to state immunization registries electronically (example NJIIS, CIR) and track in **Interface/Immunization tracker in EHR**.
- Provider can request for immunization record from immunization registries
- Review and capture information logs and messages in **immunization tracker in EHR**.
- Provider/authorized user can record chief complaint, diagnoses and select such data elements from patient record using tool/validator function.
- System can transmit patient’s syndromic surveillance data information to HIN and public health registries electronically using HL7 data standards as syndromic messages
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Expected Outcomes

Measurement/Metrics	Expected Outcomes
Create and Transmit Immunization record	RWT demonstrates that authorized user is able to create and transmit immunization information to state immunization registry (example NJIIS, CIR) using CVX and NDC Codes.
Transmission of Syndromic surveillance data	RWT demonstrates that the providers’ EHR systems can send messages to the HIN so the syndromic data can be forwarded to the state.

Care Settings and Number of Clients Site to Test:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.

Use Case 7: Real world testing requirement for Certification Criteria Measurement under Application Programming Interface:

- § 170.315(g)(7) Application access— patient selection
- § 170.315(g)(8) Application access— data category request
- § 170.315(g)(9) Application access— all data request

MDNet will apply the following scope for the usability and testing plan

Description of measure/s used to support the overall approach of Real World Testing

Measurement/Metric	Description
Request for patient record	<ul style="list-style-type: none"> • User case here is that external vendor can query the patient using MDNet API and retrieves the patient record. System can receive a request with sufficient information to uniquely identify a patient and return an ID or token that can be used by an application to subsequently execute requests for that patient’s data using FHIR specifications.



	<ul style="list-style-type: none"> MDNet queries a patient using the third party vendor (example Healthix) and retrieves the patient record
Requests for a specific data category	<ul style="list-style-type: none"> User case here is that Third party requests for a specific data category from MDNet (e.g. immunization/demographics/problem list) and system responds to requests for patient data token for each of the individual data categories specified in the CCDAs and return the full set of data for that data category. MDNet requests a specific data category from the third party API
Requests for complete CCDAs	<ul style="list-style-type: none"> User case here is that Third party requests for complete Common clinical dataset from MDNet and system responds to requests for patient data token for all the data categories specified in the Common clinical dataset and return such data in a summary record according to CCD document template. MDNet requests a complete CCDAs from the third party API

Justification for Real World Testing Approach

Measurement/Metric	Justification
Request for patient record Requests for a specific data category Requests for complete CCDAs	MDNET supports providers are able to retrieve patient information of single and multiple patients using standard API service for patient information exchange for purposes of the measurement under the Health Information Exchange objective. A successful secure and trusted API transaction between MDNet and external application indicates compliance to the underlying ONC criteria. This will be achieved through the scenarios included in the EHR Test Plan.

Certification criteria associated with the list of measures stated above.

Measurement/Metric	Certification Criteria
Request for patient record	§ 170.315(g)(7) Application access— patient selection
Third party requests for a specific data category	§ 170.315(g)(8) Application access— data category request
Third party requests for complete CCDAs	§ 170.315(g)(9) Application access— all data request

Care Setting	Justification
Ambulatory Practice	Certification criteria § 170.315(g)(7), (g)(8), (g)(9) is applicable for ambulatory care settings -Private



	Practice. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.
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EHR Test Plan

- Provider can add a new request as “Patient Request” from Data Transportation Tracker/Add New Request Button.
- Search and select patient (last name, First Name) and requests for patient record
- Select specific data from external provider/third-party vendor (example Healthix) or through secure messaging in EHR.
- CCDAs from external provider/third party vendor is received and available to review and incorporate in patient chart
- System can receive request from external providers through secure messaging in EHR in CCDAs standard.
- System responds to patient request, specific data requests through secure messaging in EHR in CCDAs standard.
- Review statuses in Data Transportation tracker.

Expected Outcomes

Measurement Metrics	Expected Outcomes
Request for patient record	Provider will be able to Add a new request/query a patient from a third-party system using FHIR mechanism.
Third party requests for a specific data category	Provider will additionally have the capability to request/query a patient specific data.
Third party requests for complete CCDAs	Provider will additionally have the capability to request/query a patient’s complete CCDAs Provider will be able to receive the data and verify/approve the incoming CCDAs with clinical reconciliation.

Care Settings and Number of Clients Site to Test:

Our EHR is targeted to a variety of care settings including family practice, internal medicine, general practice, pediatrics, and some other settings in ambulatory care. We have designed this measure to be applicable to all settings. We will test a minimum of three (3) client practice(s). This number covers a sufficient percentage of existing practices to provide a viable sample of users of the certified EHRs.



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Relied Upon Software: *Surescripts Direct Clinical Messaging* is used for criteria (b.1), (e.1), and (h.1) and same will be tested as part our Test Plan mentioned above.

Developer Attestation

This Real-World Testing plan is complete with all required elements, including measurements/metrics that address all certification criteria and ambulatory care settings. All information in this plan is up-to-date and fully addresses the health IT developer’s Real World Testing requirements.

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A handwritten signature in black ink, appearing to read 'J. Kumar', is written over the signature line.

Date: 12//12/2022