



REALWORLDTESTINGRESULTSREPORT TEMPLATE

BACKGROUND&INSTRUCTIONS

Under the ONC HealthIT Certification Program (Certification Program), healthIT developers are required to conduct Real World Testing of their certified health IT (45 CFR 170.405). The Office of the National Coordinator for Health Information Technology (ONC) issues Real World Testing resources to clarify health IT developers' responsibilities for conducting Real World Testing, to identify topics and specific elements of Real World Testing that ONC considers a priority, and to assist health IT developers in developing their Real-World Testing plans and results reports.

[A RealWorld Testing plan template](#) was created to assist health IT developers in organizing the required information that must be submitted for each element in their Real World Testing plan. To accompany the plan template, ONC has also provided this results report template.

While the use of this template is voluntary, health IT developers may find it useful in preparing their Real World Testing results report(s). HealthIT developers must submit one year of results to address the Real World Testing of eligible products as outlined in their previous year's Real World Testing plan(s). If adjustments to approaches are made throughout Real World Testing, the health IT developer should reflect these adjustments in their Real World Testing results report. ONC expects that the results report will include a list of these changes, the reasons for them, and how intended outcomes were more efficiently met as a result.

While every effort has been made to ensure the accuracy of the statements of 45 CFR Part 170, this template is not a legal document. The official program requirements are contained in the relevant laws and regulations. This resource should be read and understood in conjunction with the following companion resources, which describe in detail many of the Certification Program requirements referenced in this resource.

- [RealWorldTesting–WhatItMeansforHealthITDevelopers–FactSheet](#)
- [RealWorldTestingResourceGuide](#)
- [RealWorldTestingCertificationCompanionGuide](#)

HealthIT developers should also review the following regulatory materials, which establish the core requirements and responsibilities for Real World Testing under the Certification Program.

- 21st Century Cures Act: Interoperability, Information Blocking, and the ONC HealthIT Certification Program final rule, [85 FR 25642](#) (May 1, 2020) (**ONC Cures Act Final Rule**)
 - [Section VII.B.5](#)—“RealWorldTesting”



TEMPLATEINSTRUCTIONS

The following template is organized by elements required to be submitted in the Real World Testing results report. Each section provides a field for submitting responses and/or explanations for how the healthIT developer addressed each required element in their Real World Testing approach. These fields serve as a foundation of information required for developing a Real World Testing results report and can be expanded with additional rows or columns to address the specific needs of the Real World Testing results being submitted.

INTRODUCTION

This document contains a list of the steps taken to conduct the annual Real World Testing requirements for ONC certification. The Results within this document were reviewed as Screenshots and spreadsheets for their compliance with the criteria defined in the test plan. These artifacts will be maintained by the health IT developer for audit purposes or further requests.

GENERAL INFORMATION

PlanReportIDNumber:[For ONC-Authorized Certification Body use only] Developer

Name: Enable Healthcare Inc

Product Name: MDnet

VersionNumber(s):V10

CertifiedHealthITProductList(CHPL) ProductNumber(s):15.04.04.2719.MDne.10.01.1.191231 Developer

Real World Testing Plan Page URL: <https://ehiehr.com/rwt>

DeveloperRealWorldTestingResultsReportPageURL[if different from above]:

[OPTIONAL]CHANGESTOORIGINALPLAN

If a developer has made any changes to their approach for Real World Testing that differs from what was outlined in their plan, note these changes here.

Summary of Change [Summarize each element that changed between the plan and actual execution of Real World Testing]	Reason [Describe the reason this change occurred]	Impact [Describe what impact this change had on the execution of your Real World Testing activities]
N/A		

[OPTIONAL]WITHDRAWNPRODUCTS

If a developer withdrew any products within the past year that were previously included in their Real World Testing plan, please provide the following information.

ProductName(s):	N/A
VersionNumber(s):	
CHPLProductNumber(s):	
Date(s)Withdrawn:	
InclusionofDatainResults Report: [Provide a statement as to whether any data was captured on the withdrawn products. If so, this data should be identified in the results report.]	

SUMMARY OF TESTING METHODS AND KEY FINDINGS

Provide a summary of the Real World Testing methods deployed to demonstrate real-world interoperability, including any challenges or lessons learned from the chosen approach. Summarize how the results that will be shared in this report demonstrate real-world interoperability.

If any non-conformities were discovered and reported to the ONC-ACB during testing, outline these incidences and how they were addressed.

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

Consistent with the ONC's recommendation that "Real World Testing verify that deployed Certified Health IT continues to **perform as intended by conducting and measuring observations of interoperability and data exchange**", our original test plan focused on capturing and documenting the number of instances that certified capability was successfully utilized in the real world. In instances where no evidence exists due to low or zero adoption of a certified capability or the inability to capture evidence of successful use for other reasons, we tested and demonstrated the required certified capability in a semi-controlled setting as close to a "real world" implementation as possible.

As per the test plan, we leveraged a 3-fold approach to demonstrate successful real-world implementations.

- Adoption Rate
- Summative Testing
- Interactive Testing

Adoption rate was used to determine if/when certified capability is being used in the real world and to help identify differences in care settings. Evidence of high rates of implementation and usage indicate (but don't by themselves prove) a certified capability's usefulness and practical value. Evidence of low rates of implementation and usage might be accounted for by patient volume, location or provider preference among other reasons. Note, it is not the goal of this exercise to identify the individual causes of why a given certified capability may have a high or low adoption rate, but rather to identify the users and care settings for which a given test is relevant.

Summative assessments were used to measure which certified actions were performed at the conclusion of a given time period where the minimum time period was 90 days and longer where possible. These results are typically obtained by generating reports and examining audit logs from within the certified health IT module to help demonstrate the frequency of actions within the given time frame, and where possible, whether those actions were successful or unsuccessful. High success rates should be an indicator of a successful implementation of a given certified capability in a real-world setting.

Interactive testing was used to demonstrate conformance to requirements where the adoption rate of a given certified capability is zero and to demonstrate ongoing compliance with updated standards and code sets (SVAP). Interactive tests were live tested as opposed to examining historical usage statistics. The goal being to demonstrate the certified Health IT module being used in a way consistent within a practice or care setting.

This approach allowed for the successful testing and obtaining results for each criterion. Detailed below in the **Metrics and Outcomes** section the reader will find evidential data in the form of a Summative result(s) or Interactive test outcome for each certified criteria for the Enable Healthcare EHR.

STANDARDSUPDATES(INCLUDINGSTANDARDSVERSIONADVANCEMENT PROCESS (SVAP)AND UNITED STATES CORE DATA FOR INTEROPERABILITY (USCDI))

Bothrequiredand voluntary standardsupdatesmustbeaddressedintheRealWorldTestingplan.Real World Testing plans must include all certified health IT updated to newer versions of standards prior to August 31 of the year in which the updates were made.

Indicateastowhetheroptionalstandards,viaSVAPand/orUSCDI,areleveragedaspartofthe certification of your health IT product(s).

☐ Yes, I have products certified with voluntary SVAP or USCDI standards. (If yes, please complete the table below.

☒ No, none of my products include these voluntary standards.

Standard (and version)	Updated certification criteria and associated product	CHPL Product Number	Conformance Measure
N/A	N/A	N/A	N/A

Care Setting(s)

The expectation is that a developer's RealWorld Testing is conducted with in each type of clinical setting in which their certified health IT is marketed. Health IT developers are not required to test their certified health IT in every setting in which it is marketed for use.

List each care setting that was tested.

- Doctor's Office—Ambulatory Care Setting

Metrics and Outcomes

Within this section is a list of the results collected from the Enable Health care resolution Real World Testing measures as defined in their Real World Test plan. Outcomes are listed as Pass, Pass with Exception, or Fail determined by the success of obtaining testing results. This determination was based on a thorough review by the Enable Health care team. A link is included within the **Outcomes** column in the table below to a subsequent **Outcomes Details** table. This second table matches each outcome with additional detailed information such as supporting resources and descriptions of the tests that were performed.

Key components include:

- Customer created a comprehensive Test Results Report which details customer environment, patient data utilized for tests, locations of testing
- Customer attempted Summative and/or Interactive Testing
- Customer collected audit logs to support spreadsheets and as necessary, screen shots that demonstrate proof of Interactive Testing for each criteria with "0" values in Summative Testing. These files are referenced and remain on file with Enable Health care.

The following metrics were measured by viewing audit logs in the client's live production system for October 1–December 29, 2025 for Interactive tests. For each test, a screenshot was taken of the audit report criteria screen showing the auditing information being reported. The resultant report was then saved to show the usage (or lack thereof) of the criterion.

Associated Criterion(a)	Measurement/Metric	Relied Upon Software (if applicable)	Outcomes	Challenges Encountered (if applicable)
170.315(b)(1) Transition of care	Over a 90-day period: 1) Number of CCDAs created 2) Number of CCDAs sent 3) Number of CCDAs received	Surescripts-Direct Message Interface API	Pass 1) 806 2) 806 3) 1	
170.315(b)(2) Clinical information reconciliation and incorporation	Over a 90-day period: 1) Number of times a user reconciled medication list data from a received CCDA 2) Number of times a user reconciled allergies and intolerance list data from a received CCDA 3) Number of times a user reconciled problem list data from a received CCDA	CCDA are received using Surescripts-Direct Message Interface	Pass 1) 7 2) 7 3) 7	

170.315(b)(3) Electronic prescribing	Over a 90-day period: 1) Number of prescriptions created 2) Number of prescriptions changed 3) Number of prescriptions canceled 4) Number of prescriptions renewed		Pass 1) 2180 2) 0 3) 0 4) 1296	
170.315(b)(10) EHI export	Over a 90-day period: 1) Number of times a data export was performed for a patient 2) Number of times a data export was performed for multiple patients		Pass 1) 4612 2) 3	
170.315(c)(1-3) Clinical quality measures (CQMs)	Over a 90-day period: 1) Number of measures recorded during the period 2) Number of QRDA Category 3 aggregate report(s) created over the period		Pass 1) 10 2) 1	
170.315(e)(1) View, download, and transmit to 3rd party	Over a 90-day period: 1) Number of views of health information by a patient or authorized representative 2) Number of downloads of health information by a patient or authorized representative 3) Number of transmissions of health information by a patient or authorized representative		Pass 1) 46 6 2) 46 3) 46	

170.315(f)(1) Transmission to immunization registries	Over a 90-day period: 1) Number (or percentage) of immunization records submitted to the immunization record		Pass 1) 104	
170.315(f)(2) Transmission to public health agencies— Syndromic surveillance	Over 3 separate unique 10-day periods within a 90-day window: 1) Total number of Syndromic surveillance events created and submitted		Pass 1) 0	
170.315(g)(7) Application access —patient selection	1) Number of requests for a patient ID or token 2) Number of requests that provided sufficient information to provide a valid response 3) Number of follow-up requests made using the provided patient ID or token		Pass 1) 4612 2) 4612 3) 4612	
170.315(g)(9) Application access —all data request	1) Number of requests for a patient's Summary Record made by an application via an all data category request using a valid patient ID or token 2) Number of requests for a patient's Summary Record made by an application via an all data category request using a valid patient ID or token for a specific date range		Pass 1) 4612 2) 4612	

170.315(g)(10) Application access —Electronic Health Information Export	<ol style="list-style-type: none"> 1) Number of requests for a patient's Summary Record made by an application – Single Patient export request using a valid patient ID or token 2) Number of requests for a patient's Summary Record made by an application – Patient Population EHI Export Functionality request using a valid patient ID or token for a specific date range 		Pass 1) 4612 2) 3	
170.315(h)(1) Direct Project	<ol style="list-style-type: none"> 1) Number of Direct Messages sent 2) Number of Delivery Notifications received 3) Number of Direct Messages received 4) Number of Delivery Notifications sent 	SureScripts-Direct Message Interface	Pass 1) 806 2) 806 3) 1 4) 1	

Outcome Details

The following sections contain additional descriptions and test results supporting documentation to provide more context for the testing outcomes defined in the [Metrics and Outcomes](#) table above.

170.315(b)(1) Transition of care

Summary Description
<p>Pass Method: Interactive Testing</p> <p>The purpose of this test was to show that providers can send and receive transition of care/referral summaries as C-CDAs to/from external providers. During the year, examination of the log information will be performed for a minimum period of three (3) months to determine an appropriate sample for the 170.315(b)(1) criterion. Due to low or zero adoption of this criteria, Enable Healthcare demonstrated the module function in their system as an interactive test demonstrating a compliant result.</p>
Justification
<p>This criterion necessitates that a certified Health IT module be able to generate C-CDAs in accordance with predetermined standards and vocabulary code sets as well as transmit and receive C-CDAs. Moreover, 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. Obtaining copies of C-CDAs records from outside providers who have no incentive to take part in this activity is not practical. As the certified capability must be available and effective regardless of how frequently it is utilized, we plan to demonstrate the necessary certified capabilities by showing how frequently C-CDAs are generated and exchanged with other systems. We anticipate that there will be a high success rate.</p>
Results Supporting Documents

Please Contact Enable Healthcare for any Results spreadsheets and screenshots if needed.

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

Summary Description	
Pass	Method: Interactive Testing <p>This test was designed to demonstrate the importability of C-CDA documents, their compatibility with patient charts, their ability to be reconciled, as well as the ability to create and export new C-CDA documents.</p> <p>During the year, examination of the log information will be performed for a minimum period of three (3) months to determine an appropriate sample for the 170.315(b)(2) criterion. Due to low or zero adoption of this criteria, Enable Healthcare demonstrated the module function in their system as an interactive test demonstrating a compliant result.</p>
Justification	
<p>According to this criterion, a certified Health IT module must be able to match a C-CDA received from an external system to the appropriate patient, reconcile and incorporate clinical information from the patient's chart under the section "Medications", "Allergies," and "Problem Lists," and then incorporate the lists into the patient records. Each of these stages should ideally be completed electronically within a certified Health IT module. The majority of providers in the actual world often chose to carry out these processes manually and choose to save any externally received C-CDAs as attachments to the patient record, even though this certified capability is provided to our users. In order to prove the certified capability is available and useful, independent of the frequency it is used, we plan to track the frequency that providers are electronically reconciling and incorporating C-CDAs that were received from outside providers. We anticipate that providers will use their resources wisely and with a high success rate.</p>	
Results Supporting Documents	
Please Contact Enable Healthcare for any Results spreadsheets and screenshots if needed.	

170.315(b)(3) Electronic Prescribing

Summary Description	
Pass	Method: Summative Testing <p>The purpose of this test was to show that providers have been given a functionality to create and transmit with track count of New-Rxe-prescription to Surescripts and pharmacy using EHR over the course of time. During the year, examination of the log information will be performed for a minimum period of three (3) months to determine an appropriate sample for the 170.315(b)(3) criterion.</p>
Justification	
<p>This criterion requires the ability of a certified Health IT module to perform prescription-related electronic transactions (eRx) using required standards. MDNet applications support eRx transmission to external pharmacies via Surescripts certified Health IT system. A successful eRx transmission to pharmacy indicates compliance to the underlying ONC criteria. Provider/authorized user can view Eprescription Tracker for count and details of Transmitted New Rx, Delivered New Rx, Failed New Rx. This will indicate that the eRx transactions are delivered from the certified Health IT module and that the eRx clearinghouse successfully receives them. 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 RW T functions for RW T testing.</p>	
Results Supporting Documents	
Please Contact Enable Healthcare for any Results spreadsheets and screenshots if needed.	

170.315(b)(10) EHI Export

SummaryDescription	
Pass	Method: InteractiveTesting
<p>The purpose of this test was to show that authorized users have been given a functionality to automatically schedule export of data for all patients that represents the most current clinical information in the specified date and time range.</p> <p>During the year, examination of the log information will be performed for a minimum period of three (3) months to determine an appropriate sample for the 170.315(b)(3) criterion. Due to low or zero adoption of this criteria, Enable Healthcare demonstrated the module function in their system as an interactive test demonstrating a compliant result.</p>	
Justification	
<p>This criterion requires the ability of a certified Health IT module to export a summary of a patient's record in C-CDA format according to specified standards and vocabulary code sets. MDNet application supports a successful generation and transmission of export file C-CDA of single/multiple patients which indicates support and compliance to the underlying ONC criteria. Authorized Provider/user can configure options for data elements, real time, date and time range, and storage location using C-CDA Export tracker/Add new Export Summary in EHR. Certification criteria 170.315(b)(10) 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>	
ResultsSupportingDocuments	
Please Contact Enable Healthcare for any Results spreadsheets and screenshots if needed.	

170.315(c)(1-3) Clinical Quality Measures (CQMs)

SummaryDescription	
Pass	Method: InteractiveTesting
<p>The purpose of this test is to show that users are allowed to record and export for selected measure, import and calculate the QRDA III for selected measure and 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.</p> <p>During the year, examination of the log information will be performed for a minimum period of three (3) months to determine an appropriate sample for the 170.315(c)(1-3) criterion.</p>	
Justification	
<p>170.315(c)(1) requires a certified Health IT module 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. 170.315(c)(2) requires a certified Health IT module must be 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. 170.315(c)(3) count and list of electronic-Clinical Quality Measures (eCQMs) which are calculated and submitted to CMS for CMS Quality Reporting and Value-Based Program. 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. 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. MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.</p>	
ResultsSupportingDocuments	
Please Contact Enable Healthcare for any Results spreadsheets and screenshots if needed.	

170.315(e)(1)View,Download,andTransmitto3rdParty

SummaryDescription	
Pass	Method: InteractiveTesting
<p>ThepurposeofthistestistoshowthatthisfunctionalityallowsPatientandtheirauthorizedrepresentativescan access their patient portal and view, download and transmit Common Clinical Data set to a 3rd party.</p> <p>Duringtheyear,examinationoftheloginformationwillbeperformedforaminimumperiodofthree(3)monthsto determine an appropriate sample for the 170.315(e)(1) criterion.</p>	
Justification	
<p>According to this criterion, a certified health IT module must be able to offer patients and their authorised representativesaccesstotheirpatientportalswheretheycanview,download,andsendCommonClinicalDatasets in C-CDA format to a third party using either encrypted or unencrypted transmission methods. According to the patient's activities, thesystem updates thestatus of theCCDEExport Summary Documentas Seen, Downloaded, or SentaftertheylogintotheirPHRaccountandaccesses theClinicalSummaryorSummaryofCareRecord.WithPHR Activity Tracker in EHR, the system keeps track of the number of patients registered in PHRs and supports Status, Error,andVerifytransactionsthroughDataTransportationTrackeravailable inPHR.Thus, MDNetCEHRTforsuch settings include eligible providers and other authorized users performing and fulfilling RWTfunctions for RWT testing.</p>	
ResultsSupportingDocuments	
PleaseContactEnableHealthcareforanyResultsspreadsheetsandscreenshotsifneeded.	

170.315(f)(1)TransmissiontoImmunizationRegistries

SummaryDescription	
Pass	Method: Summative Testing
<p>The purpose of this test was to show that the EHR allows providers to create and transmit immunization information(historicalandnewlyadministeredvaccines)toImmunizationregistryusingCVXandNDCcodes.</p> <p>Duringtheyear,examinationoftheloginformationwillbeperformedforaminimumperiodofthree(3)monthsto determine an appropriate sample for the 170.315(f)(1) criterion.</p>	
Justification	
<p>MDNetapplicationsupportsausertorequest,accessanddisplaytheevaluatedimmunizationhistoryandforecast 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. A successful secure transmission to immunizationregistryandpublicagenciesindicatescompliancetotheunderlyingONCcriteria.Provider/Authorizer usercancreateimmunizationinformationforapatientinimmunizationhistorymoduleinpatientchartinEHR.Thus, MDNetCEHRTforsuchsettingsincludeeligibleprovidersandotherauthorizedusersperformingandfulfillingRWT functions for RW T testing.</p>	
ResultsSupportingDocuments	
PleaseContactEnableHealthcareforanyResultsspreadsheetsandscreenshotsifneeded.	

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

Summary Description

Pass

Method: Interactive Testing

The purpose of this test was to show that the EHR 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.

During the year, examination of the login information will be performed for a minimum period of three (3) months to determine an appropriate sample for the 170.315(f)(2) criterion. Due to low or zero adoption of this criteria, Enable Healthcare demonstrated the module function in their system as an interactive test demonstrating a compliant result.

Justification

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. A successful secure transmission to HIN and public health registry and public agencies indicates meaningful use and compliance to the underlying ONC criteria. System can transmit patient's immunization information to state immunization registries electronically (example NJIS, CIR) and track in Interface/Immunization tracker in EHR. System can transmit patient's syndromic surveillance data information to HIN and public health registries electronically using HL7 data standards as syndromic messages. Thus, MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing

Results Supporting Documents

Please Contact Enable Healthcare for any Results spreadsheets and screenshots if needed.

170.315(g)(7)ApplicationAccess—PatientSelection

SummaryDescription	
Pass	<p>Method: InteractiveTesting</p> <p>The purpose of this test is to show thatwhen external vendor querythe patient using MDNetAPIand retrieves the patient record, system can receive a request with sufficient information to uniquely identify a patient and return an ID ortoken that canbe used byan application tosubsequently executerequests for thatpatient's datausing FHIR specifications.</p> <p>During the year, examination of the log information will be performed for a minimum period of three (3) months to determine an appropriatesamplefor the170.315(g)(7)criterion. Due to low or zeroadoptionof thiscriteria,Enable Healthcaredemonstratedthefunctionintheirsystemasaninteractivetestdemonstratingacompliantresult.</p>
Justification	
<p>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. Provider can add a new request as "Patient Request" from DataTransportationTracker/AddNewRequestButton,andsearchandselectpatient (last name,FirstName)and requests for patient record. Provider will be able to Add a new request/query a patient from a third-party system using FHIR mechanism. Thus, MDNet CEHRT for such settings include eligible providers and other authorized users performing and fulfilling RWT functions for RWT testing.</p>	
ResultsSupportingDocuments	
<p>PleaseContactEnableHealthcareforanyResultsspreadsheetsandscreenshotsifneeded.</p>	

170.315(g)(9)ApplicationAccess—AllDataRequest

SummaryDescription	
Pass	Method: InteractiveTesting <p>ThepurposeofthistestistoshowthatThirdpartyrequestsforcompleteCommonclinicaldatasetfromMDNetand 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 C-CDA from the third party API.</p> <p>During the year, examinationof the log informationwill be performed for aminimum period of three (3) months to determinean appropriatesampleforthe170.315(g)(9)criterion.Duetoloworzeroadoptionofthiscriteria,Enable Healthcaredemonstratedthemodulefunctionintheirsystemasaninteractivetestdemonstratingacompliantresult.</p>
Justification	
<p>MDNETsupportsprovidersareabletoretrievepatientinformationofsingleandmultiplepatientsusingstandardAPI 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 compliancetotheunderlyingONCcriteria.C-CDAfromexternalprovider/thirdpartyvendorisreceivedandavailable to review and incorporate in patient chart. System can receive request from external providers through secure messaging in EHR in C-CDA standard. Furthermore, system responds to patient request, specific data requests through securemessaging in EHRinC-CDA standard. Thus, MDNet CEHRTforsuchsettings includeeligible providers and other authorized users performing and fulfilling RWT functions for RWTtesting.</p>	
ResultsSupportingDocuments	
<p>PleaseContactEnableHealthcareforanyResultsspreadsheetsandscreenshotsifneeded.</p>	

170.315(g)(10)ApplicationAccess—ElectronicHealthInformationExport

SummaryDescription	
Pass	Method: InteractiveTesting
<p>ThepurposeofthistestistoshowthatThirdpartyrequests forcompleteCommonclinical datasetfrom MDNetand systemrespondstorequests thesinglepatientEHIaccess.HealthITdeveloperssupportaclinician'sentirepatient population export. And return such data in a summary record according to CCD document template. MDNet requests a complete C-CDA from the third party API.</p> <p>During the year, examinationof the log informationwill be performed for aminimum period of three (3) months to determinean appropriatesampleforthe170.315(g)(10)criterion.Duetoloworzeroadoptionofthiscriteria,Enable Healthcaredemonstratedthemodulefunctionintheirsystem asaninteractivetestdemonstratingacompliantresult.</p>	
Justification	
<p>MDNETsupports providers are able to retrieve patient information of single andPatient population EHI Export functionalityusingstandardAPIServiceforpatientinformationexchangeofthepurposeofthemeasurementunderthe Health Information Exchange objective. A successful secure and trusted API transaction between MDNet and external application indicates compliancetothelunderlyingONCcriteria.C-CDA from external provider/third party vendorisreceivedandavailabletoreviewandincorporateinpatientchart.Systemcanreceiverequestfromexternal providers through secure messaging in EHR in C-CDA standard. Furthermore, system responds to patient request, specificdatarequeststhroughsecuremessaginginEHRinC-CDASTANDARD.Thus,MDNetCEHRTforsuchsettings include eligible providers and other authorized users performing and fulfilling RWT functions for RWTtesting.</p>	
ResultsSupportingDocuments	
PleaseContactEnableHealthcareforanyResultsspreadsheetsandscreenshotsifneeded.	

170.315(h)(1)DirectProject

SummaryDescription	
Pass	Method: InteractiveTesting
<p>ThepurposeofthistestwastoshowthatprovidershavebeengivenafunctionalitycalledDirectMessagingto Transmit (send and receive) health information to and from a third party technology used- Secure Health Transport, Version 1.2.</p> <p>Duringtheyear,examinationoftheloginformationwillbeperformedforaminimumperiodofthree(3)monthsto determine an appropriate sample for the 170.315(h)(1) criterion.</p>	
Justification	
<p>MDNetapplicationsupportsproviderstosendandreceiveC-CDATo/fromexternalproviderswhichisexchanged using CEHRT Direct Messaging module for purposes of the measurement under the Health Information Exchangeobjective.AsuccessfullsecuretransmissionusingDirectMessagingSpecificationindicatescompliance to the underlying ONC criteria. Provider or authorized user can create and send Direct message in EHRto external provider/third party over a production network (via Superscript) with orig-date as per RFC 5322 and messageIDas perRFC5322.ProviderorauthorizedusercanreceivedirectmessagesinEHRforapatientfrom other providers or third party (example Walgreens, CVS Pharmacy, Healthix). Thus, MDNet CEHRT for such settings includeeligible providers and other authorized users performing andfulfilling RWTfunctions for RWT testing.</p>	
ResultsSupportingDocuments	
PleaseContactEnableHealthcareforanyResultsspreadsheetsandscreenshotsifneeded.	

KEY MILESTONES

Includes a list of key milestones that were met during the Real World Testing process. Includes detail on how and when Enable Healthcare implemented measures and collected data.

Key Milestone	Care Setting	Date/Timeframe
Scheduling and logistics	Doctor's Office – Ambulatory Care Setting	Q3 2025
Data collection	Doctor's Office – Ambulatory Care Setting	Q3 2025
Review and Collect Data	Doctor's Office – Ambulatory Care Setting	Q3 2025
Writing Report	Doctor's Office – Ambulatory Care Setting	Q3 2025
Enable Healthcare executed summative testing to show that the criteria are functional. The following metrics were pulled from transaction logs as detailed in the outcomes section above: <ul style="list-style-type: none"> 170.315(b)(3) Electronic Prescribing 170.315(f)(1) Transmission to immunization registries 	Doctor's Office – Ambulatory Care Setting	Q3 2025 e-prescribing Immunizations
Enable Healthcare executed interactive testing to show that the criteria are functional. The following metrics were retested interactively as detailed in the outcomes section above: <ul style="list-style-type: none"> 170.315(b)(1) Transition of care 170.315(b)(2) Clinical Information Reconciliation and Incorporation 170.315(b)(10) EHI Export 170.315(c)(1-3) Clinical Quality Measures (CQMs) 170.315(e)(1) View, Download, and Transmit to 3rd Party 170.315(g)(7) Application access—patient selection 170.315(g)(9) Application access—all data request 170.315(g)(10) Application access—Electronic Health Information Export 170.315(h)(1) Direct Project 	Doctor's Office – Ambulatory Care Setting	Q3 2025



ATTESTATION

The Real World Testing Results Template must include the following attestations signed by the Health IT Developer Authorized representative.

Note: The Results must be approved by a Health IT Developer authorized representative capable of binding the Health IT Developer for execution of the plan and include the representative's contact information.^[1]

This Real World Testing Results Report 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: Rohini Vignesh

Authorized Representative Email: rohini@ehiehr.com

Authorized Representative Phone: 973-200-6566

Authorized Representative Signature:  4B4A0F3E63494AE...

Date: 01/23/2026

^[1]<https://www.federalregister.gov/d/2020-07419/p-3582>