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## **Real World Testing Plan**

**Developer Name: Dexter Solutions Inc**

**Product Name: eZDocs EHR**

**Version Number: 5.5**

**CHPL ID: 15.02.04.2708.eZDo.05.02.1.240102**

**Testing Page URL: <https://dexter-solutions.com/certification>**

**USCDI Version: USCDI Version 1.0**

**Relied upon Software: NewCropRx & EMRDirect**

No current standards have been updated under the standards version advancement process.

**Assumptions:**

Execution of the test plan is dependent on customer participation and availability. Dexter Solutions Inc will try its best to engage the customer throughout CY 2025 to complete the testing.

## Justification of RWT Approach

### Description of Testing Plan:

This test plan is to demonstrate the different use cases in the real world to give the end users (clients) a better understanding of the features and different functions of the EHR in order to satisfy each requirement required by certification criteria.

The testing will be performed in an ambulatory setting and will be using live data (in some cases) to demonstrate each use case. E.g. transition of care criteria direct email addresses will be of real providers. NO PHI of real patients will be used during the testing.

The end users will be notified in advance to prepare for the data (if any) before the actual testing is done.

The testing will have to be conducted in different settings in order to capture the complete workflow.

*Example A referral order generated at the primary care's office and transmitted to the specialist. The specialist will import and reconcile the medications, allergies and problem list and eventually generate and transmit the consultation note back to the primary care provider.*

### Testing Methods / methodologies

One or more methods will be used to accomplish complete testing of use cases for one or more certification criteria's.

- Manual data entry
- Screenshots of manually entered data
- Evidence of data entry supported by log files and time stamps.
- Analysing of Audit log files

### Applicable Care Setting:

Internal Medicine  
Specialty Medicine

### Expected Outcomes

Clients will be able to successfully demonstrate all interoperability elements related to the certification

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## **MEASURES USED IN OVERALL APPROACH**

### **Certification Criteria:**

170.315(b)(1) Transitions of care  
170.315(h)(1) Direct Project

### **Description of Measurement / Metric**

Demonstration of creation of a C-CDA at the end of an ambulatory encounter with transmission to the next provider of care via Direct Messaging with a confirmation of receipt in a client production environment

### **Justification of selected Measurement / Metric**

To demonstrate the ability to generate and send C-CDA documents to the next provider of care via Direct Messaging.

To demonstrate the ability to receive C-CDA documents from external sources (referrals or discharge summaries) via Direct Messaging before or at the time of patient visit.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

### **Expected Outcomes**

Documentation and screen shots evidencing the receipt of the C-CDA document in the EHR from an external source.

### **Ongoing Reporting Metrics:**

- Total number of failed C-CDAs (Referral Notes and Consultation notes) via Direct Messaging.
- Total number of received C-CDAs (Referral Notes, Discharge Summaries and Consultation notes) via Direct Messaging that could not be processed.

### **Expected Outcomes:**

- Total number of failed C-CDA transmission
- Total number of receipt C-CDA transmission

### **Certification Criteria:**

170.315(b)(2) Clinical Information reconciliation and incorporation

### **Description of Measurement / Metric**

Demonstration of incorporation and reconciliation of problem list, medications and allergies from received C-CDA data file with the data present in the HER (if Any)

### **Justification of selected Measurement / Metric**

To demonstrate the ability import and reconcile problem list, medications and allergies when received from external setting into the EHR.

Reconciliation is a process of combining the data from external sources and existing EHR data.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

### **Expected Outcomes**

Documentation and screen shots evidencing the parsing of discrete problems, medications, and medication allergies from an inbound C-CDA with reconciliation of that data into the EHR problem list, medication list and allergy list.

### **Ongoing Reporting Metrics:**

- Total number of Failed problem list reconciliation.
- Total number of Failed Medication list reconciliation.
- Total number of Failed allergies reconciliation.
- Total number of Failed problems, medications and allergies reconciled.

### **Expected Outcomes:**

- Total number of problem list reconciliation against total files received.
- Total number of Medication list reconciliation against total files received.
- Total number of allergies reconciliation against total files received.
- Total number of problems, medications and allergies reconciled against total files received.

**Certification Criteria:**

170.315(b)(3) Electronic Prescribing

**Description of Measurement / Metric**

Demonstrate creation and transmission of an electronic prescription in a client production environment.

**Justification of selected Measurement / Metric**

To demonstrate the ability to create and transmit electronic prescriptions successfully in a real-world environment.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

**Expected Outcomes**

Documentation and screen shots evidencing the ability to create and transmit electronic prescriptions as well as validate successful transmission of real-world prescriptions.

**Ongoing Reporting Metrics:**

- Total number of new prescriptions transmitted electronically
- Total number of changed prescriptions transmitted electronically
- Total number of cancelled prescriptions transmitted electronically
- Total number of refill prescriptions transmitted electronically

**Expected Outcomes:**

- Total number of new prescriptions transmitted electronically against generated prescriptions.
- Total number of changed prescriptions transmitted electronically
- Total number of cancelled prescriptions transmitted electronically
- Total number of refill prescriptions transmitted electronically against requested refills

**Relied Upon Software:** NweCropRx

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**Certification Criteria:**

170.315(b)(10) EHI export

**Description of Measurement / Metric**

Demonstrate the ability to generate complete data export of one or all patients in the database. Generated data file will be in C-CDA format and will be stored in a file location at the client site which can be downloaded at any time.

**Justification of selected Measurement / Metric**

To demonstrate the ability to successfully generate a set of C-CDAs on demand based upon a list of patients in a real-world environment. Provision to export data is restricted to specific users.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

**Expected Outcomes**

Documentation and screen shots evidencing the ability to export data in C-CDA format for one or all patients with all relevant health information.

**Ongoing Reporting Metrics:**

- Total number of patients exported via the EHI export functionality.

**Expected Outcomes:**

- Total number of patients exported via the EHI export functionality

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**Certification Criteria:**

170.315(c)(1) Clinical quality measures – record and export

**Description of Measurement / Metric**

Demonstrate of the ability to capture data elements for specific clinical quality measures that the client intends to report data on.

Demonstrate the ability to export CQM data recorded in the EHR in QRDA 1 and QRDA 3 format and import that into the Cypress Test Tool for calculation of specified quality measures that will match the results obtained in the testing for 170.315(c)(2).

**Justification of selected Measurement / Metric**

To demonstrate the ability to capture all data elements for each certified clinical quality measure (CQM) and export the data in QRDA-1 and QRDA-2 report format which can be imported into other systems (CYPRESS for testing) for submission to CMS.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

**Expected Outcomes**

Documentation and screen shots evidencing the ability to capture data elements and export the clinical quality measures in QRDA 1 and 3 formats

**Ongoing Reporting Metrics:**

- Total number of QRDA files generated and submitted.

**Expected Outcomes:**

- Total data exports performed.

**Ongoing Reporting Metrics:**

- Total number of quality measures recorded and exported in each quarter.
- Total number of QRDA -1 files submitted or uploaded.

**Expected Outcomes:**

- Identify and fix defects related to successful submission of QRDA files.

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**Certification Criteria:**

170.315(c)(2) Clinical quality measures – import and calculate

**Description of Measurement / Metric**

Demonstration of the ability to calculate quality measures for the patient population and measures specified in the demonstration for 170.315(c)(1) and match to the quality measure results obtained from the Cypress Test Tool.

**Justification of selected Measurement / Metric**

Demonstrate ability to import the QRDA 1 files generated in 170.315(c)(1) criteria in CYPRES Test Tool which calculates and verifies the initial population, denominators, numerators, exclusions and exceptions for each quality measure

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

**Expected Outcomes**

Documentation and screen shots evidencing successful import and measure calculations out of the Cypress Test Tool.

**Ongoing Reporting Metrics:**

- Total number of QRDA files generated from Cypress.
- Total number of QRDA files imported into EHR

**Expected Outcomes:**

- Identify and fix defects related to import of QRDA files.



**Certification Criteria:**

170.315(c)(3) Clinical quality measures – Report

**Description of Measurement / Metric**

Demonstration of the ability of the EHR to generate a report to quantify the initial population, denominator, numerator, exclusions and exceptions for each measure as configured by the client.

**Justification of selected Measurement / Metric**

To demonstrate ability to generate a human readable report for eCQM metrics and generate the QRDA 1 and 3 files acceptable for submission to CMS sponsored quality reporting programs.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

**Expected Outcomes**

Documentation and screen shots evidencing successful validation of the QRDA 1 & 3 files using standard testing tools.

**Ongoing Reporting Metrics:**

- Generate report for a given time frame from the EHR for the criteria metrics.

**Expected Outcomes:**

- Report displaying initial population, denominator, numerator, exclusions and exceptions for each measure for which the data is recorded.

**Certification Criteria:**

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

**Description of Measurement / Metric**

Demonstrate the ability of the EHRs patient portal to generate a valid C-CDA clinical summary document for patient review.

**Justification of selected Measurement / Metric**

To demonstrate ability to provide patients with the ability to access their health information via the patient portal.

**Applicable Care Settings** Primary Care / Internal Medicine

**Expected Outcomes**

Documentation and screen shots evidencing successful registration and access to the patient portal.

**Ongoing Reporting Metrics:**

- Total number of C-CDA documents available to the patients via patient portal.
- Total number of patient portal registrations
- Total number of patient portal access.

**Expected Outcomes:**

Generate metrics for

- Total number of C-CDA documents available to the patients via patient portal.
- Total number of patient portal registrations
- Total number of patient portal access.

Against total patients seen for a given period

**Certification Criteria:**

170.315(f)(1) Transmission to public health agencies—immunization registry

**Description of Measurement / Metric**

Demonstrate the ability of the EHR to generate a VXU message for administered immunization and transmit to immunization registries.

Demonstrate the ability to pull the historical immunization information for a patient from the registry.

**Justification of selected Measurement / Metric**

To demonstrate ability to generate and submit immunization information to the state immunization registries. Submission of immunization is mandated in many states.

**Applicable Care Settings** Primary Care / Internal Medicine

**Expected Outcomes**

Documentation and screen shots evidencing successful submission of immunization to the registries.

**Ongoing Reporting Metrics:**

- Total number immunizations transmitted to the registries.

**Expected Outcomes:**

Generate metrics for

- Total number immunizations transmitted to the registries.

Against total immunizations administered for a given period

### **Certification Criteria:**

- 170.315(g)(7) Application access – Patient selection.
- 170.315(g)(9) Application access – All data request.
- 170.315(g)(10) Standardized API for patient and population services.

### **Description of Measurement / Metric**

Demonstrate the ability to request and make a single or multiple patient selection based on patient name and date of birth via a 3rd party application that is connected to EHR's patient-facing API following authentication.

Demonstrate the ability to make a data category request for one or more data elements from the Common Clinical Data Set (USCDI v1) via a 3rd party application that is connected to EHR's patient-facing API following authentication.

Demonstrate the ability to fulfill the data request made based on the selected data category and generate the data file in C-CDA (USCDI v1) format which can be received and incorporated into the 3<sup>rd</sup> part application.

EHR must be able to receive a request with sufficient information to uniquely identify a patient and return an ID or other token that can be used by an application to subsequently execute requests for that patient's data

### **Justification of selected Measurement / Metric**

To demonstrate ability to request, validate and share PHI across different EHR and Reporting platforms.

**Applicable Care Settings** Primary Care / Internal Medicine / Speciality Medicine

### **Expected Outcomes**

Documentation and screen shots evidencing end to end functionality of requesting, identifying and selecting data elements to be exported.

### **Limitations**

We are not aware of any 3<sup>rd</sup> party applications which are trying to consolidate the PHI acquired from different sources. The testing will be conducted using the testing tools provided by our partner EMR Direct.

**Ongoing Reporting Metrics:**

- Total number of patient API authentication events.
- Total number of data category request received
- Total number of all data request (C-CDA's) received.

**Expected Outcomes:**

Generate metrics for

- Total number of successful and Failed patient API authentication events.
- Total number of data category request received
- Total number of all data request (C-CDA's) received.

Against a given period

## Schedule of Key Milestones

<u>Key Milestone</u>	<u>Date</u>
Identify providers based on care setting for referenced criteria and set expectations to meet RWT Requirements	12/01/2025 – 01/31/2025
Scheduling of Testing process with providers and office managers.	02/01/2025 – 02/28/2025
Establish time lines, procedures and collection of data	
Conduct RWT activities for each selected provider	03-01-2025 – 06-30-2025
Ongoing follow up with providers and office managers for review of processed followed and corrective actions (if required)	03-01-2025 – 06-30-2025
Data Collection and Review	03-01-2025 – 06/30/2025
Follow up and Retesting if required	07/01/2025 – 08/31/2025
Review and analysis of output from individual client RWT outputs concurrently with client testing activities	
Aggregation of all client RWT outputs into a final RWT Report section for Point-in-Time Testing	09-01-2025 – 11/30/2025
Analysis of Report Creation	12/01/2025 – 12/31/2025
Submit Real World Testing report to ACB	01/10/2026

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## Attestation

This real world testing plan is complete with all required elements, including measures that address all certification criteria's 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 email: [rakeshv@dexter-solutions.com](mailto:rakeshv@dexter-solutions.com)

Authorized representative Phone: 630-219-1919

Date: Dec 15<sup>th</sup> 2024



Rakesh Vedavyas