Real World Testing Plan

GENERAL INFORMATION

Plan Report ID Number: [For ONC-Authorized Certification Body use only]

Developer Name: **Vision Infonet Inc**

Product Name(s): **MDCare EHR/PMS**

Version Number(s): **6.0**

Certified Health IT Product List (CHPL) ID(s): **15.04.04.2872.MDCa.06.02.1.250604**

Developer Real World Testing Page URL: https://www.mdcare.com/pdf/MDCARERWTPLAN2027.pdf

JUSTIFICATION FOR REAL WORLD TESTING APPROACH

In order to comply with the Real-World Testing Condition and Maintenance of Certification requirements, Real World Testing plans would be made publicly available on the Certified Health IT Product List (CHPL) by December 15th. Vision Infonet is prepared towards achieving Real-World Testing results which will subsequently be publicly available on the CHPL by March 15th of the subsequent year.

MDCare EHR/PMS is a browser based application. MDCare has an established plan to demonstrate interoperability and functionality of its certified modules in a real world setting and scenario within Primary care and Internal Medicine settings. MDCare will be using real customer settings to ensure functional accuracy and transparencies. All functional criteria further referenced in the document are predicated on customer usability in real world environments such as ambulatory clinics. The use cases will include actions by varying user types to capture the required data and workflows.

Vision Infonet's overall approach to Real World Testing, will use data to demonstrate interoperability criterion by measuring relevant tasks and successful collection of specific auditable data associated with each certification requirement.

Measures will align with the elements within a Real World Testing plan including certification requirements and clinical settings.

SVAP

The Standards Version Advancement Program (SVAP) is Not Applicable

MEASURES USED IN OVERALL APPROACH

Each plan includes at least one measurement/metric that addresses each applicable certification criterion in the Health IT Module's scope of certification. Describe the method for measuring how the approach(es) chosen meet the intent and purpose of Real World Testing.

For each measurement/metric, following elements are described:

- □ Description of the measurement/metric
- □ Associated certification criteria and Relied Upon Software
- □ Justification for selected measurement/metric
- □ Care setting(s) addressed
- □ Expected outcomes

Description of Measurement/Metric Associated Certification Criteria/ Justification for Selected Measurement/Metric

Measure(s) that will be used to support the overall approach to Real World Testing are:

Associated Certification Criteria and Relied Upon Software(s)	Measurement/Metric	Description	Justification
170.315(b)(1) Transitions of care and 170.315(h)(1) Direct Project.	1. 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.	The user will be sending and receiving C-CDA's to demonstrate that the system successfully exchanges the certified C-CDA with another outside provider via HISP.	1. To demonstrate the ability to send C-CDAs to the next provider of care through Direct Messaging via HISP after the visit.
Relied upon Software: MaxMD Direct API and MaxMD Direct mdEmail	2. Demonstration of the ability to receive a C-CDA through Direct messaging into the Inbound Documents Queue and save it into the EHR.		2. To demonstrate the ability to receive C- CDAs from other sources through Direct Messaging via HISP at the time of patient visit.
	3. Total number of successfully transmitted C- CDAs (CCD, and Referral Note) based on receipt of ACK messages.		
	4. Total number failed C- CDA (CCD, and Referral Note) transmissions based on receipt of ACK messages.		
	5. Total number of received C- CDAs via inbound Direct messaging		
170.315(b)(2) Clinical information reconciliation and incorporation	1. Demonstration of correctly matching an incoming C-CDA document to the appropriate patient record.	The certified Health IT Module will be tested to demonstrate its ability to receive a C-CDA document and correctly match it to the corresponding patient record. Testing will use applicable C-CDA documents and USCDI data elements.	1. To demonstrate the ability to correctly identify patients and associate incoming clinical information with the appropriate patient record.
	2. Demonstration of reconciling medication information received from an external C-CDA document with the existing medication list.	Testing will evaluate the ability to display medication information from multiple sources, support reconciliation, and incorporate the user's confirmed reconciled medication list into the patient record.	2. To demonstrate the ability to reconcile and maintain accurate medication information in accordance with the applicable certification requirements.
	3. Demonstration of reconciling allergy and intolerance information received from an external C-CDA document with the existing allergy list.	Testing will evaluate the ability to reconcile incoming allergy and intolerance information with existing patient information and incorporate the confirmed reconciled list.	3. To demonstrate the ability to reconcile allergy and intolerance information and support patient safety.
	4. Demonstration of reconciling problem information received from an external C-CDA document with the existing problem list.	Testing will evaluate the ability to reconcile incoming problem information with existing patient information and incorporate the confirmed reconciled problem list.	4. To demonstrate the ability to maintain accurate problem information and support continuity of care.
	5. Demonstration of generating a C-CDA Continuity of Care Document (CCD) containing the reconciled and incorporated clinical information.	Testing will evaluate the ability to generate a CCD based on the reconciled information, using the applicable C-CDA standard and USCDI requirements.	5. To demonstrate that reconciled clinical information can be incorporated into the patient's record and used to generate a compliant CCD, supporting the exchange of accurate clinical information.

170.315(b)(10) Electronic Health Information-Export	This measure indicates that an authorized user can only export a single patient's electronic health information (EHI) or that of a patient population.	Exporting patient EHI is necessary for patients to have a comprehensive view of their health information. This measure will provide a numeric values include both success and errors, to indicate how often this interoperability feature is being used as well as its compliance to the requirement, namely that the EHR can create an export of patient EHI in a computable format.	This measure is tracking and counting how many patients requested and received EHI exports of their health information by the EHR Module over the course of a given interval.
170.315(b)(11) Decision Support Interventions	1. Total number of unique patient encounters by the provider. 2. The number of times that DSI was utilized over the course of the year.	Enable intervention interaction to a user when user is interacting with technology, using evidence based interventions.	To help users follow best practice methods based on help with decisions based and evidence based support.
170.315(c)(1) Clinical quality measures – record and export	Record and generate the CQM export file QRDA-1 for selected measures as identified by the provider and practice system counts the total number of successful submissions as reported by clients	1. Provider completes the patient encounters for the selected measures. 2. Provider navigates to CQMs page and selects the quality measures and generates the report and then "Export to QRDA 1" to export CQM in QRDA 1 format.	1. Application enables the providers to record and generate the CQM measures for the multiple patients and all user scenarios are specific to the certified criterion. 2. The goal of this approach is to demonstrate that both the interoperability and conformance capabilities of the certified Health It are consistent with the requirement of the 170.315 (c) (1) certification criteria.
170.315(c)(3) Clinical quality measures-- report.	1. Generate CQM QRDA I & III files and export for the applicable measures that was selected by the provider. 2. System counts the total number of successful submissions as reported by clients.	Demonstration of the ability to generate QRDA I and QRDA III files which comply with the CMS QRDA Implementation Guide.	To demonstrate that the EHR can produce QRDA files and the system performs as expected
170.315(f)(1) — Transmission to Immunization Registries	1. Demonstration of generating an HL7 v2.5.1 VXU immunization message containing the required patient and vaccination information. 2. Demonstration of generating immunization messages using CVX codes for historical vaccines and National Drug Code (NDC) codes for newly administered vaccines, as applicable. 3. Demonstration of transmitting immunization messages and processing the corresponding acknowledgment messages. 4. Demonstration of enabling a user to request, receive, access, and display a patient's evaluated immunization history and forecast from an immunization registry.	The certified Health IT Module will be tested to evaluate its ability to generate and transmit immunization messages using the applicable HL7 v2.5.1 messaging standards and vaccine code sets. Testing will assess the transmission of historical and newly administered vaccine information, processing of acknowledgment messages, and handling of transmission errors. Where applicable, testing will also verify the ability to request, receive, and display a patient's evaluated immunization history and forecast from an immunization registry.	1. To demonstrate the ability to generate immunization messages in accordance with the applicable certification requirements and messaging standards. 2. To demonstrate the appropriate representation of vaccine information for immunization registry reporting. 3. To demonstrate reliable immunization information exchange and support the identification of transmission issues. 4. To demonstrate the ability to retrieve and display immunization history and forecast information from an immunization registry to support clinical decision-making.
170.315(g)(7) Application access – patient selection	1. For Application Access – Patient Selection, a connection can be established to the API for the specified patient. 2. Total number patient API authentication events	For Application Access – Patient Selection a connection can be established to the API and a token is returned that uniquely identifies a single patient.	The token returned match the specified patient, verifying that the system performs as expected and meets the ONC criteria.
170.315(g)(9) Application access – all data request	1. For Application Access – All Data Request, a request is made for the specified patient over all time for all data. 2. Total number of all data requests (C-CDAs) received	For Application Access – All Data Request, a response is received that contains all relevant data over all time.	An API response with all data requested for the specified patient over all time verifies that the system performs as expected and meets the ONC criteria.

Care Setting(s):

Care Setting	Justification
Internal Medicine	This type of care setting encompasses nearly 30% of Vision Infonet user base. Including this care setting will demonstrate that the system works in the real world for many of our users.
Primary Care practice	This type of care setting encompasses nearly 30% of Vision Infonet user base. Including this care setting will demonstrate that the system works in the real world for many of our users.
Other Specialties	These types of care settings encompass nearly 40% of Vision Infonet user base. Including these care settings will demonstrate that the system works in the real world for many of our users.

Expected Outcomes:

Measurement/Metric	Expected Outcomes
170.315(b)(1) Transitions of care and 170.315(h)(1) Direct Project	
1. 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. 2. Demonstration of the ability to receive a C-CDA through Direct messaging into the Inbound Documents Queue and save it into the EHR. 3. Total number of successfully transmitted C-CDAs (CCD, and referral Note) based on receipt of ACK messages 4. Total number failed C-CDA (CCD, and Referral Note) transmissions based on receipt of ACK messages. 5. Total number received C-CDAs via inbound Direct messaging	1. Documentation evidencing receipt of C-CDAs in to recipient EHRs when sent by the client via Direct Messaging statuses via HISP in timeline. 2. Documentation evidencing receipt of external C-CDAs in to the client's EHR via Direct messaging via HISP into the Inbound External Documents Queue. 3. Identification of volume of aggregated successful transmissions of C-CDAs via Direct Messaging from HISP by month. 4. Identification of volume of aggregated failed transmissions of C-CDAs via Direct from HISP Messaging by month. 5. Identification of volume of aggregated received transmissions of C-CDAs by month.
170.315(b)(2) Clinical information reconciliation and incorporation	
1. Demonstration of correctly matching an incoming C-CDA document to the appropriate patient record. 2. Demonstration of reconciling medication information received from an external C-CDA document with the existing medication list. 3. Demonstration of reconciling allergy and intolerance information received from an external C-CDA document with the existing allergy list. 4. Demonstration of reconciling problem information received from an external C-CDA document with the existing problem list. 5. Demonstration of generating a C-CDA Continuity of Care Document (CCD) containing the reconciled and incorporated clinical information.	1. Successful matching of incoming C-CDA documents to the correct patient record. 2. Accurate reconciliation and incorporation of medication information into the patient's existing medication list. 3. Accurate reconciliation and incorporation of allergy and intolerance information into the patient's existing allergy list. 4. Accurate reconciliation and incorporation of problem information into the patient's existing problem list. 5. Successful generation of a C-CDA Continuity of Care Document (CCD) containing the reconciled and incorporated clinical information.
170.315(b)(10) Electronic Health Information Export	
Enable authorized users to timely create an export file(s) with all of a single patient's electronic health information. A user must be able to execute this capability at any time the user chooses and without subsequent developer assistance to operate.	Ongoing monitoring of percentages of successful performance of Electronic Health Information Exports by month for single patients"" and authorized users are expected to be able to export EHI for a patient population while transmission errors are tracked and analysed.
170.315(b)(11) Decision Support Interventions	
1. Total number of unique patient encounters by the provider. 2. The number of times that DSI was utilized over the course of the year.	DSIs are expected to trigger appropriately within clinician workflows, supporting evidence-based decision-making without disrupting usability. Clinicians can configure interventions by role, review supporting evidence, and provide feedback, demonstrating effective real-world performance and workflow integration.

170.315(c)(1) Clinical quality measures – record and export	
1. Record and generate the CQM export file QRDA 1 for selected measures as identified by the provider and practice. 2. System counts the total number of successful submissions as reported by clients".	1. Generating QRDA I files to demonstrate compliance with certification criteria. The CQMs utilize RX Norm, ICD-10, SNOMED, and CPT Code sets to calculate the numerators and denominators. The QRDAs will capture this data and demonstrate that the system conforms to the standard value sets. 2. Total number of CQM measures selected by the provider and successful submission as reported by the clients. 3. Total number of defects identified and resolved during the QRDA I generation. 4. Generating QRDA III files to demonstrate compliance with certification criteria. The CQM's utilize RX Norm, ICD-10, SNOMED, and CPT code sets to calculate the numerators and denominators. The QRDAs will capture this data and demonstrate that the system confirms to the standard value sets.
170.315(c)(3) Clinical quality measures--report	
1. Generate CQM QRDA I & III files and export for the applicable measures that was selected by the provider. 2. System counts the total number of successful submissions as reported by clients	1. Total number of CQM measures selected by the provider and successful submission as reported by the clients. 2. Total number of defects identified and resolved during the QRDA III generation. 3. The user can establish connection with the API and receive a token to confirm access. 4. Identification of aggregated volume of successful patient authentications for accessing EHI via a patient-facing API by month.
170.315(f)(1) Transmission to Immunization Registries	
1. Demonstration of generating an HL7 v2.5.1 VXU immunization message containing the required patient and vaccination information. 2. Demonstration of generating immunization messages using CVX codes for historical vaccines and National Drug Code (NDC) codes for newly administered vaccines, as applicable. 3. Demonstration of transmitting immunization messages and processing the corresponding acknowledgment messages. 4. Demonstration of enabling a user to request, receive, access, and display a patient's evaluated immunization history and forecast from an immunization registry.	1. Successful generation of HL7 v2.5.1 VXU immunization messages containing the required patient and vaccination information. 2. Accurate representation of historical and newly administered vaccine information using the applicable CVX and NDC codes. 3. Successful transmission of immunization messages and appropriate processing of acknowledgment messages to identify successful transmissions and errors. 4. Successful requesting, receiving, accessing, and displaying of a patient's evaluated immunization history and forecast from an immunization registry.
170.315(g)(7) Application access – patient selection	
1. For Application Access Patient Selection, a connection can be established to the API for the specified patient. 2. Total number patient API authentication events.	
170.315(g)(9) Application access – all data request	
1. For Application Access All Data Request, a request is made for the specified patient over all time for all data. 2. Total number of all data requests (C-CDAs) received	1. A user will be able to request a full history of the patient records containing all elements of the CCDS over the period of all time. 2. Identification of aggregated volume of patient requests for all data elements via a patient-facing API by month.
170.315(g)(10) Standardized API for Patient and Population Services	
1. Capture the total number of applications utilized by customers during a reporting period. 2. Capture total number of times users or systems utilize applications to access information for multiple patients during a reporting period	The API is expected to perform as intended in live environments, allowing authorized applications to query and retrieve standardized clinical data. Review if applicable parties are able to gain access with a >1% error rate.

SCHEDULE OF KEY MILESTONES:

Key Milestone	Care Setting	Date/Time Frame
RWT Plan publication to CHPL	Internal Medicine Primary Care Practice Other Specialties	Nov-26
RWT Prepare Project Plan	Internal Medicine Primary Care Practice Other Specialties	Jan 2027-Feb 2027
RWT – Testing and Outcomes documentation	Internal Medicine Primary Care Practice Other Specialties	Mar 2027-June 2027
RWT results aggregation	Internal Medicine Primary Care Practice Other Specialties	July 2027-Dec 2027
RWT Results submission to Drummond for publication	Internal Medicine Primary Care Practice Other Specialties	Jan-2027

ATTESTATION:

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

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