Real World Test Plan for 2025

Contents

General Information

Plan Report ID Number : 20241104wrs
Developer Name : WRS Health
Product Name(s) : WRS Health Web EHR and Practice Management System
Version Number(s) : 7.0
Certified Health IT Product List (CHPL) ID(s) : CHPL Product Number: 15.02.05.2527.WRSH.01.01.1.211214
ONC-ACB Certification ID:15.02.05.2527.WRSH.01.01.1.211214

Developer Real World Testing Page URL : https://www.wrshealth.com/certified-ehr-what-to-look-for

Justification for Real World Testing approach

WRS Health is designed to meet the needs of diverse ambulatory care settings, providing robust support for outpatient care across various clinical environments. This test plan aims to demonstrate our ongoing commitment to ensuring that WRS Health solutions and services adhere to the criteria and standards set forth by the ONC Health Certification program. This plan demonstrates WRS Health's EHR and Practice Management software's continued compliance with certification standards in real-world production environments. The testing methodology will prioritize real patient data and production environments whenever possible to ensure genuine interoperability and functionality.

Synthetic data and test environments will only be used in cases where real-world deployment is insufficient to demonstrate the required capabilities. This approach ensures we can collect valid measures even for modules with low usage.

Generally, this RWT plan employs the following methodology:

1. Standard Based Evaluation - involves review and re-assessment of various event and transaction logs generated by the system. This approach includes manual data audit, report generation and gathering of transactional logs in the system. This method ensures that the system's functionality is evaluated against established standards and provides a detailed review of system performance through logs and audits.

2. Performance Measurement - evaluate the conformance of the system in each of the applicable criteria set via measurable outcomes of relevant system functions. This method primarily is presenting statistics and measures through dashboard reporting. Outcome evaluation will also be part of the test plan to recommend functionalities or changes that will further the progress of compliance. Performance measurement through statistics and dashboards provides a quantitative assessment of compliance, helping to identify areas for improvement and ensuring the system meets all applicable criteria.

3. Performance Outcome Indicators - the evaluation's outcomes will be reported, and the metrics obtained from this process will be monitored to detect unforeseen incidents and assess results and scenarios within a pre-established reporting timeframe. Regular assessments are planned to generate and verify reports, transactional logs, and data sources, ensuring alignment and compliance with the system's operations and

services. Regular assessments and monitoring ensure that any issues are promptly identified and addressed, maintaining alignment with system operations and compliance.

Standard Updates (SVAP)

Standard (and Version)	CMS Implementation Guide for Quality Reporting Document Architecture: Category III; Eligible Clinicians and Eligible Professionals Programs; Implementation Guide for 2022 170.205(h)(3) 2022 CMS Implementation Guide for Quality Reporting Document Architecture: Category I; Hospital Quality Reporting; Implementation Guide for 2022
Updated certification criteria and associated product	(c)(3)
CHPL Product Number	15.02.05.2527.WRSH.01.01.1.211214
Method used for standard update	SVAP
Date of ONC ACB notification	September 30, 2023
Date of customer notification (SVAP only)	December 6, 2023
Conformance measure	c3 - Use Case 4, Measures 3 and 5
USCDI updated certification criteria	N/A

Care Setting(s)

WRS Health is an ONC-certified product designed for ambulatory care settings. The Real World Testing Plan ensures consistent functionality and performance across all ambulatory environments where the product is marketed.

Measure(s) Used

USE CASE 1:

This use case evaluates the system's ability to create, access, download, transmit, and export clinical documents over secure networks, focusing on transitions of care, care plan management, and exporting electronic health information in compliance with ONC criteria.

Certification Criteria	Requirement	Relied Upon Software
§170.315 (b)(1): Transitions of Care	Send, receive, and validate CCDA documents.	n/a
§170.315 (b)(9): Care Plan	Enable a user to record, change, access, create, and receive care plan information.	n/a
§170.315 (e)(1): View, download, and transmit to 3rd party	Enable patients (and their authorized representative) to view, download, and transmit CCDA documents.	n/a
§170.315 (h)(1): Direct Project	Use direct messaging for secure health information exchange.	EMR Direct phiMail

§170.315 (b)(10): Electronic Health Information Export	Export a set of single patient records for patient access or for transition of care purposes.	n/a

Measure 1 : Metrics on number of CCDA imports

This measure will use dashboard metrics to display the total imports of CCDA documents. The testing process aims to validate compliance with §170.315(b)(1) - Transition of Care, specifically assessing the system's capability to effectively send and receive CCDA documents.

- **Justification:** The metrics will verify that the application complies to the prescribed standards and methods under §170.315(b)(1) criterion. By analyzing the types of transmissions and the frequency with which end users import CCDA documents in EHR systems, this metric provides key insights into the system's operational performance and its adherence to required standards.

- **Test Methodology:** The activity logs of users and providers in different practices will be analyzed to determine the frequency and success rate of CCDA imports. The metrics will be used to assess the system's performance in facilitating information exchange, ensuring interoperability and confirming compliance with the necessary standards for the transition of care. Errors encountered during this process will be categorized, analyzed, and addressed to enhance system reliability and performance.

- **Expected Outcome:** It is anticipated that not all users will regularly import CCDA documents, however, the system is expected to demonstrate strong interoperability with a success rate above 99% and an error rate below 1%. The analysis of log files will verify the frequency of imports over time and provide valuable insights into the system's effectiveness in supporting seamless transitions of care.

Measure 2: Metrics on the generated CCDA documents

The measure will use dashboard showing the aggregated number of CCDA documents generated by healthcare practices over time, including Continuity of Care Document, Referral Note and Care Plan, both automated scheduled jobs or initiated manually upon request.

This will be tested to prove compliance to

- ✔ §170.315(b)(1) - Transition of Care, the ability for user to a user to create a transition of care/referral summary document
- ✔ §170.315 (b)(9): Care Plan, the ability for user to a user to create a Care Plan document

- **Justification:** The metrics abstracted from log files will illustrate that various CCDA documents are being generated regularly through automated events and manual operations. The generated documents will confirm compliance with the prescribed standards in §170.315(b)(1) and §170.315 (b)(9). By monitoring the generation of these documents, the system's adherence to the required criteria for transitions of care and care planning will be validated.

- **Test Methodology:** The logs of the generated CCDA documents will be validated and analyzed to ensure compliance with the standards specified in §170.315(b)(1) and §170.315(b)(9). The test will specifically review the activity logs, including continuity of care documents, referral notes, and care plans, whether generated by the system or manually, originating from both the Patient Portal and EHR.

- **Expected Outcome:** It is expected that a large number of CCDA documents will be generated daily through automated scripts; while a smaller number of CCDA documents would be manually generated on demand. The

expectation is to meet and exceed a 99% success rate for generating CCDA documents both manual and automated. Errors will be tracked, analyzed, and addressed to maintain this high success rate.

Measure 3: Metrics on the views and downloads of CCDA by practice users

This measure will use a dashboard of metrics showing the number of views and download activities of imported and generated CCDA by healthcare practices over time.

This will be tested to prove compliance to

- ✔ §170.315(b)(1) - Transition of Care, the ability to validate and display
- ✔ §170.315 (b)(9) - Care Plan, the ability to validate and display

- **Justification:** Metrics derived from historical logs, tracking the views and downloads of CCDA documents, will demonstrate the system's accessibility and seamless functionality for both viewing and downloading various CCDA documents. These recorded activities will serve as evidence of the system's ability to validate received transition of care and referral summaries. Additionally, the log files will confirm the system's adherence to the standard implementations of the specified criteria.

- **Test Methodology:** We will analyze patient activity and history logs to assess metrics related to the access, download, and transmission of CCDA documents. The test will evaluate these metrics, focusing on how frequently patients download CCDA documents and the methods they use to transmit transition of care data to external parties.

- **Expected Outcome:**It is expected that practices that routinely receive and send CCDA documents to other entities will generate regular CCDA views and downloads, demonstrating the product's ongoing interoperability functionality. We expect that authorized users will successfully view and download CCDA documents with a success rate of 99% or more. To ensure this functionality is maintained over time, error rates will be tracked allowing us to monitor and address any issues that could impact interoperability.

Measure 4: Metrics on the access and activity log for viewing, downloading, and transmitting of CCDA by patients

This will be tested to prove compliance to § 170.315(e)(1) View, download, and transmit to 3rd party,

- ✔ the ability to access WCAG 2.0 Levels A or AA patient portal
- ✔ the ability to view, generate, and download CCDA
- ✔ the ability to view access and activity logs

- **Justification:** This metric will demonstrate that end users can securely access CCDA documents through the WCAG 2.0-compliant patient portal. Activity logs will confirm the proper use of credentials and security measures, while providing statistics on CCDA views in both raw and human-readable formats, generation with time range options, and secure downloads. These metrics will validate the system's interoperability and functionality, ensuring it meets the standards for secure and accessible health information exchange.

- **Test Methodology:** This measure will leverage a dashboard of metrics from activity logs to track patient access and authentication to the WCAG 2.0-compliant patient portal, as well as activities related to viewing, generating, and transmitting CCDA documents.

- **Expected Outcome:** It is expected that when patients access the portal, they can successfully view and generate CCDA documents. We expect failed attempts to view, download, or share CCDA documents to remain within a 1% margin of error.

Measure 5: Metrics on the transaction reports of direct messages

This measure will use a dashboard to display comprehensive metrics on all direct message transactions, including messages sent and received by practices with or without CCDA attachments, messages sent by patients from the patient portal to transmit CCDA documents, and the final transmission status of all messages.

This will be tested to prove compliance to

- ✔ §170.315 (b)(1): Transitions of Care, the ability for practice users to transmit CCDA via Direct message
- ✔ §170.315 (b)(9): Care Plan, the ability for practice users to transmit CCDA via Direct message
- ✔ §170.315 (e)(1) View, download, and transmit to 3rd party, the ability for patients to transmit CCDA via Direct message
- ✔ §170.315 (h)(1) Direct Project, the ability of sending and reviewing Direct messages, with or without attachments, the ability of showing errors and final transmission status.

- **Justification:** This test method will demonstrate that both practices and patients can securely transmit CCDA documents via direct messages to other entities. The transaction report will provide metrics on CCDA documents sent through direct messages, with a focus on outgoing referrals from patients.

- **Test Methodology:** We will examine logs from various transaction reports related to direct messages to assess the frequency and methods used by providers for sending and receiving transitions of care. The primary goal of this review is to confirm compliance with the implementation standards.

- **Expected Outcome:** We expect practices that regularly send and receive CCDA documents to demonstrate consistent usage of Direct messaging, with a success rate of 90% or higher. ractices that do not frequently use Direct messaging (or whose counterparts lack support for Direct messaging) may show lower transmission rates, but the functionality will remain available and reliable when needed.

Measure 6: Metrics on Electronic Health Information Export

This measure will evaluate the system's capability to export electronic health information for patient access or transition of care, as required by §170.315(b)(10).

- **Justification**: The system's ability to export complete health information sets will demonstrate compliance with the ONC's certification requirements for health data portability and patient access.
- **Test Methodology**: Track the number of successful export requests, both patient- and provider-initiated, for single patient or bulk exports. Review logs for failed or incomplete exports, and analyze the reasons behind errors.
- **Expected Outcome**:
    - **Success Rate**: At least 95% of export requests are expected to complete successfully.
    - **Error Rate**: Less than 5% error rate, primarily due to validation issues or file formatting errors, with resolutions provided for all failures.

USE CASE 2:

This use case evaluates the system's capacity to create a single list of medications, medication allergies and problems by reconciling key clinical data elements from two different sources.

Certification Criteria	Requirement

§170.315 (b)(2): Clinical Information Reconciliation and Incorporation	(i) General requirements (ii) Reconciliation

Measure 1: Metrics on number of Clinical Information Reconciliation performed

This measure will use dashboard metrics to display the total number of reconciliations performed on clinical information. The associated log files will be reviewed to verify the accuracy of the data used in these reconciliation processes.

- **Justification:** The metrics will demonstrate that the system effectively supports the reconciliation of clinical data from two sources. These metrics will also confirm that the reconciliation process is an administrative function, accessible only to authorized and credentialed users.
- **Test Methodology:** The activity logs for Clinical Information reconciliation will be reviewed to verify the system's performance in executing reconciliation operations as specified in §170.315(b)(2). This review will also ensure that the implementation guides, including validation and verification of all required data elements, are properly supported.
- **Expected Outcome**: This functionality is anticipated to be used infrequently, likely by a small subset of practices. Despite the low frequency, we anticipate achieving a success rate exceeding 99% to confirm the functionality's availability and demonstrate the system's capacity for interoperability, in accordance with §170.315(b)(2).

USE CASE 3:

This use case examines how the system allows health care providers to handle electronic prescriptions.

Certification Criteria	Requirement	Relied Upon Software
§170.315 (b)(3): Electronic Prescribing	(ii)(A) Enable a user to perform the following prescription related electronic transactions in accordance with the standard specified in § 170.205(b)(1) and, at a minimum, the version of the standard specified in § 170.207(d)(3).	MDToolbox v5.0

Measure 1: transaction reports from Surescripts

To demonstrate compliance with §170.315(b)(3), we will utilize transaction logs provided by Surescripts; these logs display the quantity of eRx messages transmitted via the Surescripts network.

- **Justification:** Surescripts transaction logs are highly relevant for confirming compliance with §170.315(b)(3) because they directly capture Electronic Prescribing (eRx) transactions. This supports the requirement to show the capability of transmitting electronic prescriptions to pharmacies.
- **Test Methodology:** We will examine the logs to determine the quantity of eRx messages transmitted over a defined period of time. We will analyze these logs to quantify eRx messages transmitted over a specified period. The analysis will include examining transaction frequency, understanding the volume of electronic prescriptions sent, and identifying any errors or rejections in eRx transactions.
- **Expected Outcome**: We anticipate that the volume of eRx transactions across the Surescripts network will remain consistent throughout the year, with a low error rate. While some errors may occur due to data validation measures designed to ensure compliance with network standards, we anticipate a success rate of 95% or higher for the transmission and modification of electronic prescriptions.

USE CASE 4:

The EHR system allows users to generate QRDA files according to prescribed standards for submission to CMS and other quality reporting needs.

Certification Criteria	Requirement
§170.315 (c)(1): Clinical Quality Measures - Record and Export	(i) Record (ii) Export
§170.315 (c)(2): Clinical Quality Measures - Import and Calculate	(i) Import (ii) Calculate each and every clinical quality measure
§170.315 (c)(3): Clinical Quality Measures – Report	Enable a user to electronically create a data file for transmission

Measure 1: Metrics on number of recorded clinical data

This use case measures the system's ability to record, calculate, and report CQMs.

- **Justification:** The selected test approach will accurately count the users capturing clinical data within the EHR system, demonstrating the system's ability to meet CMS implementation guide standards. This will validate that the system supports all required data elements and adheres to the prescribed standards.
- **Test Methodology:** The test will analyze dashboard metrics showing the aggregated number of clinical data entries recorded by practices over time. These entries will include various elements such as ICD, CPT, SNOMED, LOINC, allergies, medications, immunizations, and vitals. Metrics will be assessed to ensure that Clinical Quality Measures (CQMs) are compliant with necessary standards and that all required data elements are supported.
- **Expected Outcome:** Practices are expected to consistently capture clinical data throughout the year. Usage trend metrics are expected to offer insights for enhancing accessibility and performance. We expect to achieve a success rate of 99% or higher, with an acceptable error margin of less than 10%. The system's ability to query and report the total number of recorded clinical data entries will confirm the availability of the functionality.

Measure 2: Metrics on the generated CQM reports

This measure will assess compliance with §170.315(c)(2): Clinical Quality Measures - Import and Calculate, by evaluating the system's ability to calculate and generate aggregated CQM reports.

- **Justification:** Metrics from system logs will demonstrate that end users can reliably utilize the EHR system to calculate and report on CQMs. This test will validate the system's accuracy in calculating each clinical data measure and help identify any issues with CQM report generation.
- **Test Methodology:** We will use a dashboard to track the total number of CQMs generated by practices throughout the year. This includes monitoring the frequency of report generation, such as monthly and quarterly reports.
- **Expected Outcome:** We expect all practices to generate at least one CQM report per provider annually, with most practices running reports on a monthly or quarterly basis. We aim for over 95% of uploaded files to be successfully imported, with less than a 5% failure rate due to formatting or validation issues.

Measure 3: Metrics on QRDA Category I and QRDA Category III activities

This measure will evaluate compliance with:

- ✔ § 170.315 (c)(1): Clinical Quality Measures - Record and Export, the ability of generating QRDA Category I data files
- ✔ § 170.315 (c)(3): Clinical Quality Measures - Report, the ability of generating QRDA Category I and QRDA Category III data files

- **Justification:** This test will confirm that the EHR system adheres to the implementation specifications for QRDA files as outlined in CMS guides. Metrics will evaluate the functionality of the export process and the frequency with which QRDA files are generated and accessed.
- **Test Methodology:** We will use a dashboard to track metrics including the total number of users requesting QRDA Category I data files, the count of system-generated QRDA Category I files for registry submissions, and the number of downloaded QRDA Category III files.
- **Expected Outcome:** In the first quarter of the year, during the CQM report submission period, we expect to see manual downloads of QRDA Category I and QRDA Category III data files. System-generated QRDA Category I files are expected to be produced monthly for clients who opt for monthly data submissions to registries. We expect the system to successfully generate at least 95% of the submitted files.

Measure 4: Metrics on the QRDA Category I import performed

This measure will assess compliance with §170.315(c)(2): Clinical Quality Measures - Import and Calculate, by evaluating the system's ability to import patient data from QRDA Category I files.

- **Justification:** This measure will confirm that end users can successfully import QRDA Category I data files into their actual practice using the system. The frequency of imports carried out by end users will demonstrate the availability of the import function, even though it may be rarely utilized in practice.
- **Test Methodology:** We will assess the total number of QRDA Category I imports to verify that users can perform data imports within the system. Import functions will be tested during clinical training to ensure users can utilize them in real-world scenarios. Metrics from these logs will be reviewed to confirm that the system accurately calculates each imported clinical quality measure.
- **Expected Outcome:** Given that this function is not commonly used in daily workflows, we expect imports to occur infrequently, primarily during clinical training. We anticipate a success rate of over 95% for file uploads, with less than a 5% failure rate due to data validation issues.

Measure 5: Metrics on CMS and specialty registry submissions

This measure will utilize a dashboard to track metrics showing the number of practices/providers that successfully download QRDA Category III data files from EHR, upload them to CMS, and receive acceptance. It will also monitor clinical quality measures performance scorecards from specialty registries reflecting the successful generation and export of QRDA Category I data files.

This will be tested to prove compliance to:

- ✔ § 170.315 (c)(1): Clinical Quality Measures - Record and Export, the ability of generating QRDA Category I data files
- ✔ § 170.315 (c)(2): Clinical Quality Measures - Import and Calculate, the ability to calculate the aggregated report.
- ✔ § 170.315 (c)(3): Clinical Quality Measures - Report, the ability of generating QRDA Category III data files

- **Justification:** Metrics will demonstrate the system's capability to generate valid QRDA Category III data files for CMS submissions and QRDA Category I files for specialty registries. These metrics will validate the system's compliance with CQM reporting standards.

- **Test Methodology:** The evaluation will include:
    - Tracking the number of practices/providers that successfully download QRDA Category III files from the EHR, upload them to CMS, and receive confirmation of acceptance.
    - Analyzing clinical data report cards from specialty registries to reflect CQM performance based on QRDA Category I file exports.

- **Expected Outcome:** We anticipate collecting CMS data submission confirmations from a subset of clients during the CMS submission window beginning in January 2025. Additionally, we expect to obtain scorecards from clients submitting data to FigMD for specialty registries. We aim for the system to successfully generate 99% of the submitted files.

USE CASE 5:

This use case evaluates the system's ability to transmit immunization, syndromic surveillance, and cancer registry data.

Certification Criteria	Requirement
§170.315 (f)(1): Transmission to Immunization Registries	(i) Create immunization information for electronic transmission in accordance to standards (ii) Enable a user to request, access, and display a patient's evaluated immunization history and the immunization forecast from an immunization registry in accordance to standards
§170.315 (f)(2): Transmission to Public Health Agencies - Syndromic Surveillance	Create syndrome-based public health surveillance information for electronic transmission in accordance to standards
§170.315 (f)(4): Transmission to Cancer Registries	Create cancer case information for electronic transmission in accordance…

Measure 1: Immunization message success

This measure will assess the success of immunization message transactions by utilizing dashboard metrics that display the total number of compliant transactions shared with state immunization registries. The evaluation will verify compliance with §170.315(f)(1) and HL7 specifications.

- **Justification:** Metrics derived from immunization message transaction reports provided by Iron Bridge will confirm that WRS is capable of and compliant with electronically transmitting data to immunization registries, in line with the prescribed standards.
- **Test Methodology:** We will review immunization message transaction reports from Iron Bridge to analyze the details of transactions exchanged with state immunization registries.
- **Expected Outcome:** We anticipate a higher volume of outbound messages from WRS to state registries compared to bi-directional messages, given that most practices maintain only outbound connections. Some messages may contain errors due to incomplete submission data. We expect to achieve a data transmission success rate of 90% or higher, with an error rate of less than 10% due to validation and data format issues imposed by the registries.

Measure 2: Metrics on generated syndromic surveillance messages

This measure will assess compliance with §170.315(f)(2) by using dashboard metrics to display the number of successfully generated syndromic surveillance messages.

- **Justification:** The volume of generated syndromic surveillance messages will demonstrate the system's capability to transmit data in accordance with the required implementation guidelines, proving compliance with the standard.
- **Test Methodology:** We will analyze reports detailing the total number of syndromic surveillance messages generated to ensure that the system correctly produces syndrome-based public health surveillance information for electronic transmission.
- **Expected Outcome:** We expect the system to generate accurate syndromic surveillance messages for all eligible events, achieving a success rate of 90% or higher. We anticipate less than 10% of transmissions will have errors due to validation issues and data format requirements imposed by public health agencies.

Measure 3: Metrics on generated cancer registry messages

This measure will assess the system’s capability to facilitate the electronic submission of cancer case information in compliance with §170.315(f)(4). We will use log files to track the number of successfully generated cancer registry messages and create dashboard metrics.

- **Justification:** The metrics will provide evidence that WRS EHR system includes a functional module capable of capturing vital cancer diagnosis data and generating registry reporting messages.
- **Test Methodology:** We will review log files that detail the number of cancer registry messages generated by the system and use this data to create dashboard reports.

- **Expected Outcome:** Given that none of our clients are treating cancer patients, we anticipate a very low volume of cancer registry message activities. For any reports generated, we expect a success rate of over 95%, with a transmission failure rate of less than 5%.

USE CASE 6:

This use case evaluates the use of FHIR-formatted APIs for patient and provider access.

Certification Criteria	Requirement
§170.315 (g)(7): Application Access - Patient	(i) Functional Requirements (ii) Documentation
§170.315 (g)(9): Application Access - All Data Request	(i) Functional Requirements (ii) Documentation
§170.315 (g)(10): Standardized API for patient and population services	(i) Functional Requirements (ii) Documentation

Measure: metrics on API access and activity

This measure will evaluate the successful utilization of all certified APIs under criteria (g)(7), (g)(9), and (g)(10) by examining individual transaction requests, API information sources, and API users. Additionally, it highlights WRS Health's capability to provide detailed API documentation (https://api.fhir.wrs.cloud/docs), which supports external developers in integrating with WRS Health system.

- **Justification:** This criterion assesses WRS Health's ability to respond to patient data requests using FHIR standards from authorized or registered applications.
- **Test Methodology:** We will track the frequency of data requests through FHIR applications to confirm that the certified capabilities are available and effective, irrespective of their usage frequency. System logs will be reviewed to assess the success rates for:
    - API Requests Served - the total number of successfully processed requests.
    - API Information Sources - instances where at least one successful response was provided, validating effective API functionality.
    - API Users - instances where at least one successful response was provided to current API users, confirming comprehensive API use.
- **Expected Outcome:** We anticipate a 100% success rate for returning authorized clinical record queries when data is available.

Schedule of Key Milestones

Key Milestones	Date / Time Frame
Client Communication for support and participation	January 2025
Collection of information as laid out by the plan	January 2025 – December 2025
End of Real World Testing period data collection/analysis	December 2025
Submission of Real World Testing Report to ONC-ACB	January 15, 2026

Attestation

This Real World Testing plan is complete and includes all required elements. We affirm that the testing will be performed in alignment with the applicable certification criteria and ambulatory care settings, and all real-world testing data will be collected as outlined in this plan. Upon completion of Real World Testing, the results will be compiled and submitted in accordance with ONC-ACB guidelines.

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