REAL WORLD TESTING RESULTS REPORT

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

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

Developer Name: **CompuGroup Medical US**

Product Name(s): **CGM eMDs**

Version Number(s): **Version 10**

Certified Health IT Product List (CHPL) Product Number(s): **15.04.04.2700.eMDs.10.02.1.221227**

Developer Real World Testing Plan Page URL: https://emds.com/certifications/

Developer Real World Testing Results Report Page URL: https://emds.com/certifications/

WITHDRAWN PRODUCTS

Product Name(s):	N/A
Version Number(s):	N/A
CHPL Product Number(s):	N/A
Date(s) Withdrawn:	N/A
Inclusion of Data in Results Report: [Provide a statement as to whether any data was captured on the withdrawn products.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.]	N/A

SUMMARY OF TESTING METHODS AND KEY FINDINGS

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 two approaches to demonstrate successful real-world implementations.

- Summative Testing
- Interactive Testing

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 criterion for **CGM eMDs**.

STANDARDS UPDATES (INCLUDING STANDARDS VERSION ADVANCEMENT PROCESS (SVAP) AND UNITED STATES CORE DATA FOR INTEROPERABILITY (USCDI))

Both required and voluntary standards updates must be addressed in the Real World Testing plan. 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.

Indicate as to whether optional standards, via SVAP and/or USCDI, are leveraged as part of the 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.

[X] 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)

CGM eMDs is marketed primarily to ambulatory practices. eMDs does not market differently for different specialties, nor does the certified Health IT function differently in different care settings.

Care Setting	Justification
Primary Care	Specialties are primarily focused on the Family Medicine, Pediatrics and OB/GYN practices.
General Specialties	Serve the ENT, Neurology and Cardiology care settings
Orthopedic Specialties	Serve the Physical Therapy, Orthopedics, Podiatry, etc.
Surgical Specialties	Are deployed in the General Surgery, Plastic Surgery, Hand Surgery, etc. care settings.
Behavioral Health	Server all mental and behavioral health care settings

METRICS AND OUTCOMES

Within this section is a list of the results collected from the **CGM eMDs v10** 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 CGM eMDs 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 criterion with “0” values in Summative Testing. These files are referenced and remain on file with CGM eMDs.

The following metrics were measured by querying data either from CGM eMDs customers hosted by CGM (251 sites) over a 90-day period or – in the case of eprescribing metrics -- from transaction data collected by CGM Platform Services which is responsible for routing eprescribing messages. The resultant reports were then saved to show the usage of the criterion.

(from 85 FR 25766)

Associated Criterion(a)	Measurement / Metric	Relied Upon Software (if applicable)	Outcomes	Challenges Encountered (if applicable)
170.315(b)(1) Transitions of care	Over a 90-day period: 1) Number of CCDAs created 2) Number of CCDAs sent via edge protocols 3) Number of CCDAs received via edge protocols	Updox	Pass with Exception 1) 52,662 2) 3095 3) 0	For CCDAs received, there was an error in our reporting tool that led to the data not being captured. However, the totals for the b2 criterion show that incoming CCDAs are regularly being used for reconciliation, which is also a sufficient real-world test of the system’s ability to receive CCDA files.
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		Pass 1) 20,545 2) 1,246 3) 42,682	Recorded only reconciliations with changes, since a reconciliation without changes could also be noted for record-keeping even if a CCDA was not present. As such, these numbers do not represent all instances but are sufficient to demonstrate the functionality is operational.
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	First Databank	Pass 1) 3,062,179 2) 47,807 3) 540,786 4) 1,237,806	

170.315(b)(6) Data export	Over a 90-day period: 1) Number of times a data export was performed for a patient		Pass 1. 20,287	This represents the total number of data exports regardless of whether they were exported individually or in bulk. Both methods were verified as functional and compliant in interactive testing.
170.315(b)(9) Care Plan	Over a 90-day period: 1) Number of times a Care Plan CCDA was produced	Updox	Pass 1. 32,353	
170.315(f)(1) Transmission to immunization registries	Over a 90-day period: 1) Number of immunization records submitted to the immunization registry 2) Number of immunization history records received by the Health IT module from the registry		Pass 1. 75,528 2. 0	The ability to receive immunization history records from an immunization registry cannot be captured by the CGM reporting system. An interactive test was performed to demonstrate this capability. See below for details.
170.315(g)(7) Application access — patient selection 170.315(g)(9) Application access — data category request 170.315(g)(10) Standardized API for Patient and Population Services	Over a two-week period: 1) Number of FHIR API responses from the CEHRT that include a patient's Clinical Summary CCDA document. 2) Total number of FHIR API responses made by the CEHRT. Data source: reports from CGM's FHIR network which will tabulate traffic through the production FHIR API.	Cloverleaf	Pass 1. 0 2. 61,250	

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) Transitions of care

Summary Description
Pass With Exception **Method: Summative Testing** The purpose of this test was to show that CDA documents are able to be created and exported. A query of 251 hosted sites' historical audit logs for a 90-day period was performed for the 170.315(b)(1) criterion. This number of sites accurately represents all Care Settings listed above. The resulting totals show that this module was active throughout the period and therefore demonstrates a compliant result. The exception is that for CCDAs received, there was an error in our reporting tool that led to the relevant data not being captured. However, the totals for the b2 criterion show that incoming CCDAs are regularly being used for reconciliation, which is also a sufficient real-world test of the EHR's ability to receive CCDA files.
Justification
This criterion requires the ability of a certified Health IT module to create CCDAs according to specified standards and vocabulary code sets, as well as send and receive CCDAs via edge protocols. However, it is not possible to consistently and reliably demonstrate that all required standards and code sets were used because not all CCDAs created in a real-world setting contain all the necessary data elements. Furthermore, it is not feasible to obtain copies of CCDA documents from "outside" developers or providers who have no incentive to participate in this exercise. Therefore, we intend to demonstrate the required certified capabilities by demonstrating how often CCDAs are created and exchanged with other systems to demonstrate the certified capability is available and effective, regardless of the frequency it is used. Our expectation is there will be moderate utilization by providers with a high success rate.
Results Supporting Documents
Please contact the CGM eMDs team for any results spreadsheets, recordings and workflow screenshots if needed.

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

Summary Description
Pass **Method: Summative Testing** The purpose of this test was to show that CDA documents are able to be imported, matched to a patient, reconciled, and new CDA documents created and exported. A query of 251 hosted sites' historical audit logs for a 90-day period was performed for the 170.315(b)(2) criterion. The resulting totals show that this module was active throughout the period and therefore demonstrates a compliant result.
Justification
This criterion requires the ability of a certified Health IT module to take a CCDA received via an outside system and match it to the correct patient; reconcile the medication, allergy, and problem lists; and then incorporate the lists into the patient record. The expectation is each of these steps is done electronically within the certified Health IT module. Therefore, we intend to record the frequency that providers are electronically reconciling and incorporating CCDAs that were received from outside providers to demonstrate the certified capability is available and effective,

regardless of the frequency it is used. Our expectation is there will be moderate utilization by providers with a high success rate.

Results Supporting Documents

Please contact the CGM eMDs team for any results spreadsheets, recordings and workflow screenshots if needed.

170.315(b)(3) Electronic Prescribing

Summary Description

Pass **Method: Summative Testing**

The purpose of this test was to show that an active connection from EHR customer sites to an ePrescribing solution was deployed.

A query of our prescribing network's traffic for a 90-day period was performed for the 170.315(b)(3) criterion. The resulting totals show that the relevant functions were being actively used in the period and therefore demonstrate a compliant result.

Justification

This criterion requires the ability of a certified Health IT module to perform prescription-related electronic transactions (eRx) using required standards. However, it is not possible to demonstrate the correct standards were used because it is not feasible to obtain copies of eRx documents from "outside" companies or pharmacies who have no incentive to participate. Therefore, we intend to demonstrate the required certified capabilities are effective by demonstrating how often eRx transactions are performed by examining use of our eprescribing router. This will demonstrate that not only are the eRx transactions sent from the certified Health IT module, but that the transactions are successfully received by the eRx clearinghouse. Our expectation is there will be high utilization by providers with a high success rate.

Results Supporting Documents

Please contact the CGM eMDs team for any results spreadsheets, recordings and workflow screenshots if needed.

170.315(b)(6) Data Export

Summary Description

Pass **Method: Summative Testing**

The purpose of this test was to show that our customer can export patient data from our EHR without any assistance from CGM eMDs.

A query of 251 hosted sites' historical audit logs for a 90-day period was performed for the 170.315(b)(6) criterion. The resulting totals show that the relevant functions were being actively used in the period and therefore demonstrate a compliant result.

Justification

This criterion requires the ability of a certified Health IT module to export a summary of a patient's record in CCDA format according to specified standards and vocabulary code sets. However, it is not possible to consistently and reliably demonstrate that all required standards and code sets were used because not all CCDAs created in a real-world setting contain all the necessary data elements. Therefore, we intend to demonstrate the certified capability is available and effective, regardless of the frequency it is used. Our expectation is there will be moderate utilization by providers with a high success rate.

Results Supporting Documents
Please contact the CGM eMDs team for any results spreadsheets, recordings and workflow screenshots if needed.

170.315(f)(1) Transmission to Immunization Registries

Summary Description
Pass **Method: Summative Testing** The purpose of this test was to show that the EHR is able to transmit immunization data to a registry and meets the reporting requirement for the designated care settings. A query of 251 hosted sites' historical audit logs for a 90-day period was performed for the 170.315(f)(1) criterion. The resulting total shows that this module was active throughout the period and therefore demonstrates a compliant result. **Pass** **Method: Interactive Testing** The CGM reporting system is not able to capture inbound QBP traffic. Therefore, an interactive test was performed of the EHR's ability to receive immunization history records. CGM demonstrated the module function in a live production system. A CGM interface engineer queried a state immunization registry for a live patient's immunization history record. A valid history record was received. All PHI was removed from test result documentation that was retained.
Justification
This criterion requires the ability of a certified Health IT module to transmit immunization data to a registry using a specified format. We intend to record the frequency that immunization data is submitted to registries by providers to demonstrate the certified capability is available and effective, regardless of the frequency it is used. Our expectation is there will be moderate utilization by providers with a high success rate.
Results Supporting Documents
Please contact the CGM eMDs team for any results spreadsheets, recordings and workflow screenshots if needed.

170.315(g)(7) Application Access — Patient Selection and 170.315(g)(10) Standardized API for Patient and Population Services

Summary Description
Pass **Method: Interactive Testing** The purpose of this test was to show that the EHR is able to fulfill an API request that enables external applications to request a unique patient identifier from the certified Health IT module that can be used to request additional patient data, which is then supplied in a standard (FHIR) format. A query of our FHIR network's traffic for a 90-day period was performed to test these criteria. The resulting totals show that the relevant functions were being actively used in the period and therefore demonstrate a compliant result.
Justification
This criterion requires the certified Health IT module to provide an API and supporting documentation that enable external applications to request a unique patient identifier from the certified Health IT module that can be used to

request additional patient data via a standard (FHIR) format. We intend to record the frequency that FHIR API requests for patient data are successful to demonstrate the certified capability is available and effective, regardless of the frequency it is used. Our expectation is there will be low utilization by providers with a high success rate.

Results Supporting Documents

Please contact the CGM eMDs team for any results spreadsheets, recordings and workflow screenshots if needed.

170.315(g)(9) Application Access — All Data Request

Summary Description

Pass **Method: Interactive Testing**

The purpose of this test was to show that the EHR is able to fulfill an API request that enables external applications to request all categories of patient data defined in the CCDA from the certified Health IT module.

Due to low or zero adoption of this criteria, health IT developer demonstrated the module function in their system as an interactive test demonstrating a compliant result.

CGM created 3 test patients in a production version of the API, to represent 3 different care settings: Primary Care, Specialty, Surgical

CGM then used PostMan to send queries, representing an app that we expect to see patients use to perform the following functions to show that they are available and ready to be used in the Real World.

1. Provide credentials to identify the patient to the API, and receive a token in return
2. Use those credentials to query for a CCDA document

Justification

This criterion requires the certified Health IT module to provide an API and supporting documentation that enable external applications to request all categories of patient data defined in the CCDA from the certified Health IT module.

Results Supporting Documents

Please contact CGM eMDs for a recording of this interactive test if needed.

KEY MILESTONES

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

Key Milestone	Care Setting	Date/Timeframe
Scheduling and logistics	Primary Care -General Specialties -Orthopedic Specialties -Surgical Specialties -Behavioral Health	01/02/2024 – 07/30/2024
Data collection	Primary Care -General Specialties -Orthopedic Specialties -Surgical Specialties -Behavioral Health	08/01/2024-11/30/2024

Review Data	Primary Care -General Specialties -Orthopedic Specialties -Surgical Specialties -Behavioral Health	12/01/2024-12/08/2024
Writing Report	Primary Care -General Specialties -Orthopedic Specialties -Surgical Specialties -Behavioral Health	12/08/2024-12/15/2024
CGM eMDs 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: • 170.315 (b)(1) Transitions of care • 170.315 (b)(2) Clinical Information Reconciliation and Incorporation • 170.315 (b)(3) Electronic Prescribing • 170.315 (b)(6) Data Export • 170.315 (b)(9) Care Plan • 170.315 (f)(1) Transmission to immunization registries	Primary Care -General Specialties -Orthopedic Specialties -Surgical Specialties -Behavioral Health	09/01/2024-11/30/2024
CGM eMDs executed interactive testing to show that the criterion are functional. The following metrics were tested interactively as detailed in the outcomes section above: • 170.315(g)(9) Application access—all data request	-Primary Care -General Specialties -Orthopedic Specialties -Surgical Specialties -Behavioral Health	09/01/2024-11/01/2024

ATTESTATION

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.

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Date: 12/15/2024

[i] https://www.federalregister.gov/d/2020-07419/p-3582