

# Real World Testing Plan 2025



## GENERAL INFORMATION

**Plan Report ID Number:** Ezderm\_2025\_RWT\_Plan

**Developer Name:** Ezderm LLC

**Product Name(s):** Ezderm

**Version Number(s):** 4.0

**Certified Health IT:** 15.04.04.2987.EZDE.04.02.1.221213

**Product List (CHPL) ID(s):** 15.04.04.2987.EZDE.04.02.1.221213

**Developer Real World Testing Page URL:**

<https://www.ezderm.com/fully-certified>

## JUSTIFICATION FOR REAL WORLD TESTING APPROACH

Ezderm is a Dermatology-specific EHR utilized in private practices. Ezderm has established a plan to demonstrate interoperability and functionality of its certified module criteria in a real world setting with actual patient encounter data. By testing the methods described below, we will be able to demonstrate that all required testing criteria are being used by our users as designed and certified. The designed test plan will demonstrate that our EHR is functional and compliant with ONC guidelines and requirements as certified. This Test Plan will cover multiple criteria within the natural flow of a patient encounter.

170.315 (b)(1) - Transitions of Care

170.315 (b)(2) - Clinical Info Reconciliation and Incorporation

170.315 (b)(3) - Electronic Prescribing

170.315(b)(10) - Electronic Health Information Export

170.315 (c)(1) - Clinical Quality Measures (CQMs) —Record and Export

170.315 (e)(1) - View, Download, and Transmit to 3rd Party

170.315 (h)(1) - Direct Project

170.315 (f)(4) - Transmission to Cancer Registries

170.315 (g)(7) - Application Access - Patient Selection

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



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

**Standard (and version)**

N/A

**Updated certification criteria and associated product**

N/A

**Health IT Module CHPL ID**

N/A

**Method used for standard update**

N/A

**Date of ONC-ACB notification**

N/A

**Date of customer notification (SVAP only)**

N/A

**Conformance measure**

N/A

**USCDI-updated certification criteria (and USCDI version)**

N/A

### MEASURES USED IN OVERALL APPROACH

### DESCRIPTION OF MEASUREMENT/METRIC

#### Measurement/Metric

Care Coordination - Receiving C-CDA Encounter Summaries via Direct Messaging

#### Justification

Ability for users to go to their inbox to receive and view any Direct Messages that have been sent to them from outside sources which contain a C-CDA file.

Care Coordination -  
Importing/Reconciliation  
of Clinical Data into  
Patient Chart

Upon receipt of a C-CDA file, ability to match the document to the correct patient and subsequently import the clinical data into the patient chart.

Care Coordination -  
Reconciliation of Clinical  
Data Into Encounters

Once clinical information, received via C-CDA, has been imported into a patient chart, users then have the ability to reconcile clinical information within an encounter (Medications, Allergies, and Problems).

Clinical Documentation -  
Adding a Medication and  
Electronic Prescribing

User has the ability to check and address refill requests and add the desired medication and prescription details for a patient and send to a specified pharmacy electronically.

Clinical Documentation -  
Management of  
Electronic Prescriptions

Checking status of e-prescriptions to see if it was successfully sent, failed, or if an RX Change or Refill Request message has been transmitted by the pharmacy.

EHI - Electronic Health  
Information Export

We chose to concentrate on the aspects of this criterion that would:

1. Demonstrate an EHR's ability to export batches of patient data in a straightforward fashion
2. Facilitate interoperability by providing the exported data in the form of valid C-CDA files that conform to the HL7 standards as described in the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm).

Additionally, it includes a publicly accessible hyperlink to the export's format.

Care Coordination - Sending  
C-CDA Encounter Summaries  
via Direct Messaging

For any patient with the requisite clinical data entered into an encounter, users have the ability to generate a C-CDA document and send it to another physician via Direct Messaging.

Patient Engagement - Ability to Manage Health Information

Patient logs into the patient portal to view C-CDA file(s) generated from a given D.O.S. and can view, download, and transmit the document(s) directly from the portal.

Clinical Quality Measures - Record and Export

Ability for users to record data that would be necessary to calculate selected CQM's and export the information as a data file.

Public Health - Cancer Registry Reporting

For any patient with a reportable cancer diagnosis, the user has the ability to view, edit, and document necessary clinical information and generate a report that can be submitted to a cancer registry.

API - Client Login and Access Token

External party queries the patient using the API and retrieves the patient record. The system will receive the request to uniquely identify the patient and generate a token.

API - Getting All Patient Clinical Data

Using a patient data token, third-party requests all data categories for a specified date range to return the full Clinical Data Set as a C-CDA file.

## ASSOCIATED CERTIFICATION CRITERIA

**Measurement/Metric**

**Associated Certification Criteria**

**Relied Upon Software (if applicable)**

Care Coordination - Receiving C-CDA Encounter Summaries via Direct Messaging

170.315 (b)(1) - Transitions of Care  
170.315 (h)(1) - Direct Project

EMR Direct Version 2017

Care Coordination - Importing/Reconciliation of Clinical Data into Patient Chart

170.315 (b)(2) - Clinical Info Reconciliation and Incorporation

N/A

|                                                                            |                                                                         |                         |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------|
| Care Coordination - Reconciliation of Clinical Data Into Patient Chart     | 170.315 (b)(2) - Clinical Info Reconciliation and Incorporation         | N/A                     |
| Clinical Documentation - Adding a Medication and Electronic Prescribing    | 170.315 (b)(3) - Electronic Prescribing                                 | N/A                     |
| Clinical Documentation - Management of Electronic Prescriptions            | 170.315 (b)(3) - Electronic Prescribing                                 | N/A                     |
| EHI - Electronic Health Information Export                                 | 170.315(b)(10) - Electronic Health Information Export                   | MeldRx ver. 2.0         |
| Care Coordination - Sending C-CDA Encounter Summaries via Direct Messaging | 170.315 (b)(1) - Transitions of Care<br>170.315 (h)(1) - Direct Project | EMR Direct Version 2017 |
| Patient Engagement - Ability to Manage Health Information                  | 170.315 (e)(1) - View, Download, and Transmit to 3rd Party              | N/A                     |
| Clinical Quality Measures - Record and Export                              | 170.315(c)(1) - Clinical Quality Measures (CQMs) — Record and Export    | N/A                     |
| Public Health - Cancer Registry Reporting                                  | 170.315 (f)(4) - Transmission to Cancer Registries                      | N/A                     |
| API - Client Login and Access Token                                        | 170.315 (g)(7) - Application Access - Patient Selection                 | N/A                     |

API - Getting All  
Patient Clinical Data

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

N/A