Real World Testing Plan Results Report 2025

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GENERAL INFORMATION

Plan Report ID Number: EZDERM_2025_RWT_Plan_Results
Developer Name: EZDERM LLC
Product Name(s): EZDERM
Version Number(s): 4.0
Certified Health IT: 15.04.04.2987.EZDE.04.01.1.220602
Product List (CHPL) ID(s): 15.04.04.2987.EZDE.04.01.1.220602
Developer Real World Testing Page URL:
https://www.ezderm.com/fully-certified
Developer Real World Testing Results Report Page URL:
https://www.ezderm.com/fully-certified

CHANGES TO ORIGINAL PLAN

Summary of Change	Reason	Summary of Change
No changes were made to the original plan.	N/A	N/A

SUMMARY OF TESTING METHODS AND KEY FINDINGS

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 plan results will demonstrate that our EHR is functional and compliant with ONC guidelines and requirements as certified. 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.

Real World Testing is meant to support testing that was conducted prior to certification being granted. It is not intended to duplicate the methods or results previously demonstrated. Instead, this test plan was developed to demonstrate that the certified capabilities have been successfully deployed for providers to use at their discretion in live settings.

EZDERM created and shared a document with the providers assisting with the testing in our designated Care Setting, that outlines step-by-step instructions on how to complete each necessary workflow in the system in an introductory call. We then tracked the number of successful workflow completions against failures during the testing window. An open channel for feedback was provided along the way.
Our users were able to successfully and easily complete most workflows without issue for criteria that are part of their everyday workflow. Challenges lied in testing criteria that are not part of their everyday processes.

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

[   ] Yes, we have products certified with voluntary SVAP or USCDI standards.
[✓] No, none of our products include these voluntary standards.

Standard (and version)	N/A
Updated certification criteria and associated product	N/A
CHPL Product Number	N/A
Conformance measure	N/A

CARE SETTING(S)

Care Setting	**Justification**
Private Dermatology practice(s)	EZDERM is marketed to dermatologists exclusively as it is a dermatology-specific EHR, intended to be used only in this type of care setting. Single provider practices represent a significant portion of our user base, so we will want to test this setting.

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METRICS AND OUTCOMES

Measurement/Metric	Description
Care Coordination - Receiving C-CDA Encounter Summaries via Direct Messaging	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.

Outcomes - Care Setting: Single-provider private Dermatology practice

Measurement/ Metric	Associated Certification Criteria	Relied Upon Software (if applicable)	Outcomes	Challenges Encountered
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	We tested our user base to get reporting values on C-CDAs received. We reported the numbers of C-CDAs received over the testing period as follows: 8 total C-CDA Encounter Summaries received at the practice across 4 user accounts. In all cases the patient summary record arrived from an outside source and documented/displayed the required clinical data elements.	
Care Coordination - Importing/ Reconciliation of Clinical Data into Patient Chart	170.315 (b)(2) - Clinical Info Reconciliation and Incorporation	N/A	Users are able to choose to import clinical data transmitted by C-CDA into a patient's chart. We report the number of C-CDA documents reconciled into patient charts over the testing period as follows: Users chose not to manually reconcile the information for any CCDA received. In lieu of this, we have used synthetic data to replicate the workflow for 5 different test patients. No errors recorded, the clinical information from the CCDA was successfully reconciled and displayed in each patient's chart.	Users chose not to manually reconcile the information for any CCDA received, meaning synthetic data had to be used for testing these measures.

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Care Coordination - Reconciliation of Clinical Data Into Encounters	170.315 (b)(2) - Clinical Info Reconciliation and Incorporation	N/A	Users are able to reconcile imported clinical data into a patient's encounter. We reported the number of C-CDA documents reconciled within patient encounters over the testing period as follows: Users chose not to manually reconcile the information for any CCDA received. In lieu of this, we have used synthetic data to replicate the workflow for 5 different test patients. No errors recorded, the clinical information previously added to the patient's chart was also successfully reconciled into each patient's newly created encounter.	Users chose not to manually reconcile the information for any CCDA received, meaning synthetic data had to be used for testing these measures.
Clinical Documentation - Adding a Medication and Electronic Prescribing	170.315 (b)(3) - Electronic Prescribing	N/A	Users were able to create new prescriptions per patient and send them electronically to a specified pharmacy. We tested to get reporting values on NewRx electronic prescriptions sent. We reported the number of NewRx electronic prescriptions that were successfully sent over the reporting period as follows: 629 successful submissions, 3 failed submissions.	
Clinical Documentation - Management of Electronic Prescriptions	170.315 (b)(3) - Electronic Prescribing	N/A	Users were able to manage prescriptions per patient and review outgoing and incoming RX-related messages. We tested our user base to get reporting values on the management of different actions available to our users within the EZDERM Prescriptions module including, but not limited to, change and refill requests. We reported the numbers for these actions as follows: Total Refill Requests - 44, Approved Refill Requests - 19, Denied Refill Requests - 2, Canceled Rx - 3, Change Rx Requests - 6, Approved Change Rx Request - 4, Denied Change Rx Request - 0	

EHI - Electronic Health Information Export	170.315(b)(10) - Electronic Health Information Export	MeldRx ver. 2.0	EZDERM is able to export batches of patient data as C-CDA documents and utilizes Darena's MeldRx product, as outlined here: https://darena.health/onc-hti1-certified We were able to create single patient export files on demand. 20 files were generated for test patients.	
Care Coordination - Sending C-CDA Encounter Summaries via Direct Messaging	170.315 (b)(1) - Transitions of Care 170.315 (h)(1) - Direct Project	EMR Direct Version 2017	Users are able to generate a C-CDA file for any given patient and choose to send the file to an external provider via Direct Messaging. We tested a sample of our user base to get reporting values on C-CDAs sent as well as track C-CDA error occurrences. We reported the number of C-CDAs sent over the testing period by users as follows: 0 sent CCDAs. In lieu of this, we have used synthetic data to replicate the successful generation and sending of 1 CCDA file.	Direct Messaging is not the primary method with which the user sends patient information via transitions of care, these were done via fax or efax. The measure was tested using synthetic data for a test patient.
Patient Engagement - Ability to Manage Health Information	170.315 (e)(1) - View, Download, and Transmit to 3rd Party	N/A	Clinical documentation is accessible to patients via the patient portal, where they can select the desired date range and generate their health information in the appropriate format and can transmit the data. We recorded the instances of patient portal access by reporting the number of new patient accounts created, health information Viewed, Downloaded, and Transmitted over the reporting period as follows: New patient portal accounts - 17, View Health Information - 2, Download Health Information - 1, Transmit Health Information - 0 In lieu of this, we have used synthetic data to replicate this workflow via the patient portal. 10 test cases were generated and the ability to View, Download, and Transmit was successful in each.	Patients unwilling to go through some of these workflows as part of a government mandated testing process.

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Clinical Quality Measures - Record and Export	170.315(c)(1) - Clinical Quality Measures (CQMs) — Record and Export	N/A	Users are able to capture the required elements for the selected CQMs and report the data in the proper data format. The measurement counted and listed the CQMs tracked and reported for over the reporting period as follows: Number of reported measures - 0, Number of files - 0 In lieu of this, we have used synthetic data to generate a report for 2 CQMs (CMS50v7 and CMS156v7) commonly used in the Dermatology specialty. The report was generated and exported successfully containing data for 15 unique test patients.	Users infrequently use the CQM section of the system as EZDERM offers a dedicated MACRA/MIPS reporting module that is the more common alternative.
Public Health - Cancer Registry Reporting	170.315 (f)(4) - Transmission to Cancer Registries	N/A	Users were able to generate cancer case data for patients with applicable diagnoses and generate a report that can be uploaded to state registries. We recorded the report(s) generated and transmitted by our users during the reporting period as follows: 0 Cancer Registry Reports generated. In lieu of this, we were able to generate and export a report using synthetic data for 5 patient encounters.	
API - Client Login and Access Token	170.315 (g)(7) - Application Access - Patient Selection	N/A	A patient can use their desired application and device and call the API, and then a token will be generated, upon authentication, for use in subsequent measures. We will track for any errors detected during the retrieval and displaying of results. Errors encountered during the testing period: 0	Patients unwilling to use API to take to a third pary for generation of Application Access. Used a test patient in the Care Setting account to ensure proper functionality via Postman

API - Getting All Patient Clinical Data	170.315 (g)(9) - Application Access - All Data Request	N/A	Using the API and previously generated token, information from all data categories will be generated into a complete C-CDA for the selected timeframe. We will track for any errors detected during the retrieval and displaying of results. Errors encountered during the testing period: 0	Patients unwilling to use API to take to a third pary for generation of Application Access. Used a test patient in the Care Setting account to ensure proper functionality via Postman

KEY MILESTONES

Key Milestone	Care Setting	Date/Timeframe
Prepare the EZDERM application for use in collecting data for the 2025 real world testing.	Ambulatory Settings: Private Dermatology practice	Q1 2025
Identified the user practices that will participate in the test plan.	Ambulatory Settings: Private Dermatology practice	Q1 2025
Confirmed that the Real World Test Plan participants are able to log into their accounts and are ready to start the testing.	Ambulatory Settings: Private Dermatology practice	Q1 2025
Initiated and conducted Real World Testing with participants	Ambulatory Settings: Private Dermatology practice	Q3/Q4 2025

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Ended the Real World Test to coincide with the end of the 2025 calendar year.	Ambulatory Settings: Private Dermatology practice	Q4 2025
Real World Test analysis and generation of the report.	Ambulatory Settings: Private Dermatology practice	January 2026
Submitted Real World Test Report to ACB	Ambulatory Settings: Private Dermatology practice	January 2026

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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