CY 2025 Real World Testing Plan for Harris CareTracker

Executive Summary

This is the real world test plan for CY 2025 for our CareTracker certified EHR solution. As with last year's plan, it provides the real world test measurements and metrics that meet the intent and objectives of ONC's Condition of Certification and Maintenance of Certification requirement for real world testing (§ 170.405 Real world testing). We believe these test methods will be appropriate and value in accessing certification criteria and interoperability of exchanging electronic health information (EHI) within the care and practice setting of customers.

We have included our timeline and milestones for completing the real world testing in CY 2025, and information about compliance with the USCDI v1 and SVAP updates.

A table of contents is provided later in the plan quick access to any document section, including the testing measurements and metrics found at the end of this document. Our signed attestation of compliance with the real world testing requirements is on the following page.

Developer 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.

Authorized Representative Name:

Kim F Gaglio

Authorized Representative Signature:

Kim F Gaglio

November 4, 2024

General Information

Plan Report ID Number: HarrisCareTracker-RWT-2025

Developer Name: Harris CareTracker, Inc

Product Name(s): Harris CareTracker

Version Numbers(s): 9

- 15.04.04.1569.Harr.09.00.1.180701
- https://chpl.healthit.gov/#/listing/9589

Certified Health IT Criteria:

Product List (CHPL) ID(s) and Link(s): 315(b)(1)-(3), (b)(10); (c)(1)-(3); (e)(1); (f)(1), (f)(2), (f)(5); (g)(7), (9), (10); (h)(1)

Developer Real World Testing Page URL: https://amazingcharts.com/caretracker-real-world-testing/

Timeline and Milestones for Real World Testing CY 2025

- 1Q-2025: Health IT system is fully enabled for use in real world testing.
- 3Q-2025. Begin making plans to collect data for RWT measures. If necessary, engage clients to ask for their support and participation in real world testing.
- 4Q-2025. During the last quarter of the year, the CY 2025 real world test results will be captured according to our test plan. We also complete work for next year's Real World Test Plan and submit it by November 1, 2025.
- February 1, 2026. Real World Test Report will be completed and submitted according to ONC and ONC-ACB requirements and expectations.

Standards Updates (SVAP)

Currently, we are using all required ONC Certification Program standard version(s) unless noted differently below. Next year we will be updating our EHR to support the new standard versions according to the HTI-1 rule, including USCDI v3, and based on when we complete these updates, new SVAP version(s) may be captured in our CY 2025 RWT test results, and if so, we will note that in our CY 2025 RWT test report.

Standard (and version)	All standards versions including USCDI v1 are those specified in ONC Certification Program criteria.
Method used for standard update	N/A
Date of ONC-ACB notification	N/A
Date of customer notification (SVAP only)	N/A
UCSDI-updated criteria	This plan documents the support of all USCDI v1 data elements.

For our eCQM submission to CMS, we will be updating to the newest CMS implementation guide before the end of CY 2024.

Standard (and version)	CMS Implementation Guide for Quality Reporting Document Architecture: Category III; Eligible Clinicians and Eligible Professionals Programs; Implementation Guide for 2024 (November 2023)
Method used for standard update	SVAP
Date of ONC-ACB notification	Before end of CY 2024
Date of customer notification (SVAP only)	Before end of CY 2024

Real World Testing Measurements

The measurements for our real world testing plan are described below. Each measurement contains:

- Associated ONC criteria
- Testing Methodology used
- Description of the measurement/metric
- Justification for the measurement/metric
- Expected outcomes in testing for the measurement/metric
- Number of client sites to use in testing (if applicable)
- Care settings which are targeted with the measurement/metric

In each measurement evaluate, we elaborate specifically on our justification for choosing this measure and the expected outcomes. All measurements were chosen to best evaluate compliance with the certification criteria and interoperability of exchanging electronic health information (EHI) within the certified EHR.

Testing Methodologies

For each measurement, a testing methodology is used. For our test plan, we use the following methodologies.

Reporting/Logging: This methodology uses the logging or reporting capabilities of the EHR to examine functionality performed in the system. A typical example of this is the measure reporting done for the automate measure calculation required in 315(g)(2), but it can also be aspects of the audit log or customized reports from the EHR. This methodology often provides historical measurement reports which can be accessed at different times of the year and evaluate interoperability of EHR functionality, and it can serve as a benchmark for evaluating real world testing over multiple time intervals.

Compliance and/or Tool: This methodology uses inspection to evaluate if EHR is compliant to the ONC criteria requirements. It can be done through 1-v-1 inspection testing or utilize various tools to measure or evaluate compliance and interoperability. If an EHR Module capabilities is not widely used in production by current users, compliance inspection can provide assurance criteria is working as previously certified.

Survey/User Reported: This methodology evaluates interoperability and compliance of EHR Module capabilities through feedback from users. ONC has recognized that self-testing can be a viable method for evaluation and compliance, and this methodology can provide insight into how clinicians employ and use a feature which reveals actual value and impact of interoperability of the EHR Module.

Care and Practice Settings Targeted

Harris CareTracker is primarily targeted to general ambulatory practices with focuses on the family practice, internal medicine, and pediatrics specialties. Our measures were designed for these setting in mind. In each measure, we do also address the care settings targeted and note any necessary adjustment or specific factor to consider with this specific measure. For criteria that are not widely used by our customer base, we may test the respective measure in our own production-sandbox environment given lack of customer experience with the criteria functionality.

RWT Measure #1. Number of Transition of Care C-CDAs Successfully Sent

Associated Criteria: 315(b)(1), 315(h)(1)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many C-CDAs are created and successfully sent from the EHR Module to a 3rd party via Direct messaging during a transition of care event over the course of a given interval.

We will capture this measure for a minimum of three (3) months.

Measurement Justification

This measure will provide a numeric value to indicate both the how often this interoperability feature is being used as well as its compliance to the requirement. An increment to this measure indicates that the EHR can create a C-CDA patient summary record, including ability to record all clinical data elements, and by sending the C-CDA patient summary record, the EHR demonstrates successful interoperability of an exchanged patient record with a 3rd party. This measurement shows support for Direct Edge protocol in connecting to our 3rd party HISP, phiMail Server, for successful transmission.

Measurement Expected Outcome

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count.

A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can create the C-CDA patient summary record, including record required clinical data elements. In sending the C-CDA patient summary record, the EHR will demonstrate ability to confirm successful interoperability of an exchanged patient record with a 3rd party, including support for Direct Edge protocol in connecting to a HISP. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. This test will also examine our interface with our 3rd party HISP, phiMail Server. A successful and working integration with our HISP will be evident by the ability to exchange C-CDA messages.

We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #2. Number of C-CDAs Received and/or Incorporated

Associated Criteria: 315(b)(2)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many C-CDAs are successfully received and/or incorporated upon receipt from a 3rd party via Direct messaging during a transition of care event over the course of a given interval.

We will capture this measure for a minimum of three (3) months.

Measurement Justification

This measure will provide a numeric value to indicate both the how often this interoperability feature is being used as well as its compliance to the requirement. An increment to this measure indicates that the EHR can receive a C-CDA patient summary record, and by incorporating the C-CDA patient summary record, the EHR demonstrates successful interoperability of problems, medications, and medication allergies of patient record with a 3rd party. This measurement shows support for Direct Edge protocol in connecting to a HISP for successful transmission.

Measurement Expected Outcome

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count.

A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can create the EHR can receive a C-CDA patient summary record. In incorporating the C-CDA patient summary record, the EHR will demonstrate successful interoperability of problems, medications, and medication allergies of patient record with a 3rd party, including support for Direct Edge protocol in connecting to a HISP. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality.

We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #3. Number of NewRx Prescriptions Messages Successfully Sent

Associated Criteria: 315(b)(3)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many NewRx electronic prescriptions were created and successfully sent from the EHR Module to a pharmacy destination over the course of a given interval.

We will capture this measure for a minimum of three (3) months.

Measurement Justification

This measure will provide a numeric value to indicate both the how often this interoperability feature is being used as well as its compliance to the requirement. An increment to this measure indicates that the EHR can create a NewRx SCRIPT electronic prescription message and transmit it to a pharmacy, typically via the Surescripts Network. This measurement demonstrates our integration with our 3rd party ePrescribing solution, DrFirst.

Measurement Expected Outcome

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count.

A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can create the NewRx message and send over a production network, like the Surescripts Network, to a pharmacy. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. This test will also examine our interface with our 3rd party ePrescribing solution, DrFirst. A successful and working integration will be evident by the ability to exchange the SCRIPT ePrescribing messages.

We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #4. Number of EHI Exports Run

Associated Criteria: 315(b)(10)

Testing Methodology: Reporting/Logging

Measurement Description

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.

Measurement Justification

Exporting patient EHI is necessary for patients to have a comprehensive view of their health information. This measure will provide a numeric value, 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.

Measurement Expected Outcome

The measurement will produce numeric results of attempted and completed EHI Export of Patient EHI, both success and error, by the EHR Module over a given interval. We will likely utilize a database report to determine our measure count.

We expect this test will be completed with few, if any, technical errors, although we may observe some user-driven errors unrelated to the functionality of the EHR software. We will examine results to evaluate the performance of the EHR Module.

A successful export indicates compliance with the underlying ONC criteria and that the EHR can create an export of all patient's EHI. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience. Any observed errors may indicate either lack of understanding by the user, configuration setup issues, or product errors, and we will investigate as necessary.

If none of our chosen sites have records of any patient requested EHI Exports, we will substitute a test with synthetic patient data in an environment that mirrors production use.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #5. Number of Quality Measures Successfully Reported on to CMS

Associated Criteria: 315(c)(1)-(c)(3)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many eCQM quality measures were successfully reported on by the EHR Module to CMS over the course of a given interval.

The interval for this measure will be twelve (12) months.

Measurement Justification

This measure will provide a count and list of electronic clinical quality measures (eCQMs) which are calculated and submitted to CMS for a given program, like MIPS. Clinical quality measures are only used for the respective CMS programs and any production measures should utilize submission to CMS.

We will utilize various reports and audit logs to determine our measure count, and if necessary, obtain clinician user reported activities to document this interoperability feature. Because CQM criteria, 315(c)(1)-(c)(3), all work collectively together in the eCQM functionality of the EHR Module, this measurement is used for all three.

Measurement Expected Outcome

The measurement will count and list eCQMs submitted to CMS for the annual submission. We expect any of our EHR Module to be able to calculate and submit any of our certified CQMs to CMS as needed by our customers.

A successful measure submission indicates compliance to the underlying ONC criteria. It will show that the EHR can do calculations on the eCQM and that they are accepted by CMS. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality.

We will use the measure result to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #6. Number of Patients Given Access to Portal

Associated Criteria: 315(e)(1)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many patients are given login access to their patient portal account over the course of a given interval.

We will capture this measure for a minimum of three (3) months.

Measurement Justification

This measure will provide a numeric value to indicate how often this interoperability feature is being used. An increment to this measure indicates that the EHR can supply patient health data to the patient portal and provide an account for the patient to use in accessing this data.

Measurement Expected Outcome

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count.

A successful measure increment indicates compliance to the underlying ONC criteria. It will show that the EHR can submit patient health data to the patient portal on a regular and consistent basis as well provide an account for the patient to use in accessing this data. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality.

We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #7. Number of Patients Who Accessed/Logged in to Portal

Associated Criteria: 315(e)(1)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many patients are successfully logged into and accessed their patient portal account over the course of a given interval.

We will capture this measure for a minimum of three (3) months.

Measurement Justification

This measure will provide a numeric value to indicate both the how often this interoperability feature is being used as well as its compliance to the requirement. An increment to this measure indicates that patients can log into their patient portal to view, download, or transmit their health data. This measurement shows support for Direct Edge protocol in connecting to our 3rd party HISP, phiMail Server, for successful transmission.

Measurement Expected Outcome

The measurement will produce numeric results over a given interval. We will utilize various reports and audit logs, including Automated Measure (315.g.2) reports, to determine our measure count.

A successful measure increment indicates compliance to the underlying ONC criteria. It will show that patients can log into their patient portal to view, download, or transmit their health data. Successfully completing this measure also implies users have a general understanding of the EHR functional operations for this EHR Module and an overall support for the user experience while not completing this measure may indicate lack of understanding or possibly lack of use or need for this functionality. This test will also examine our interface with our 3rd party HISP, phiMail Server. A successful and working integration with our HISP will be evident by the ability to exchange C-CDA messages.

We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #8. Engagement with IIS/Immunization Registries

Associated Criteria: 315(f)(1)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many immunization registries are connected and engaged with bi-directional exchange capabilities with the EHR Module.

Measurement Justification

This measure will provide a numeric metric value of the number of IIS/immunization registries that have successful connections and interoperable engagements with the EHR as well as tracking any connectivity errors or downtime due to the EHR operations. We will utilize various reports and IIS transaction logs to determine our measure count. During the year, we will examine the log information for a minimum period of three (3) months to determine an appropriate sample of this measurement. This measurement shows support for our integration with our 3rd party lab interface provider, Hi-PaaS (Iron Bridge), for successful transmission.

Measurement Expected Outcome

We expect any immunization registries to be able to successfully connect and exchange with the EHR and observing these connections will indicates compliance to the underlying ONC criteria. It will show that the EHR can create the HL7 immunization record, including ability to record the required clinical data elements. In sending the immunization message, the EHR will demonstrate ability to confirm successful interoperability of patient's immunization data to an IIS/immunization registry. This test will also examine our interface with our 3rd party lab interface provider, Hi-Paas (Iron Bridge). A successful and working integration will be evident by the ability to exchange immunization messages.

For connected IIS/immunization registries, we expect very few errors or downtime due to the EHR Module's functionality with a success rate of at least 95%.

We will use the measure count to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #9. Compliance of C-CDA Creation and C-CDA Scorecard Average

Associated Criteria: 315(b)(1)

Testing Methodology: Compliance and Tool

Measurement Description

This measure is tracking compliance the EHR Module criteria functionality of creating a C-CDA and measuring its C-CDA Scorecard average.

Measurement Justification

This measure will provide assurance of compliance to the EHR Module criteria, specifically ability to create a C-CDA and evaluate it against the ONC C-CDA Scorecard tool. The C-CDA scorecard is designed for production use and measures how artifacts created by health IT compare against the HL7 C-CDA implementation guide and HL7 best practices.

The Scorecard will both indicate any C-CDA errors as well provide a numeric scoring result to indicate how well our C-CDA complies with certification requirements and supports interoperability within production setting.

To avoid disclosing PHI, we will only work with test patients from the actual production environment or an appropriately production-mirrored environments to best evaluate production capabilities available to end users.

Measurement Expected Outcome

The user will have the EHR create C-CDA from a patient record containing clinical data elements required in the criteria. We will run C-CDA through the Scorecard tool to obtain a result. We will also confirm the process and steps done by the user meet the criteria requirements of the EHR Module and works as expected in production as in a controlled test environment.

A high score from the Scorecard indicates strong support for interoperability, and a lower score indicates opportunity for improvement. We will use this measure to establish a historic baseline of expected interoperability use so it can be used in subsequent real world testing efforts.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #10. How many different syndromic surveillance registries do you connect with?

Associated Criteria: 315(f)(2)

Testing Methodology: Survey/User Reported

Measurement Description

This is a survey measure to determine the number of syndromic surveillance public health registries you use.

Measurement Justification

This measure will survey users to determine real world interoperability and usability, specifically many different public health syndromic surveillance registries are used by the provider.

A survey or user reported outcomes can often provide more information on the impact and value of an interoperability element than a standard software test evaluation. This survey measure will the number and names of syndromic surveillance public health registries which are integrated with the EHR.

Measurement Expected Outcome

The user will be asked the survey question and given the survey answer choices below:

- Numeric answer to the question, and if willing, the names of the other systems.

The answer will provide insight into how clinicians view both the use and value of this interoperability feature. For example, response may show that additional training is needed to better utilize the feature or that it is not currently utilized as currently designed. It will provide a benchmark for evaluate future surveys as well as to share insight into any new development for improvements or enhancements of the health IT system.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #11. Number of applications/3rd party systems using API capabilities

Associated Criteria: 315(g)(7), (g)(9)-(g)(10)

Testing Methodology: Reporting/Logging and Survey/Self-Test

Measurement Description

This measure will determine how many 3rd party systems or applications are integrated and using the EHR's FHIR API interface. This measure will allow us to verify our certified API is working with 3rd party applications to access USCDI patient data.

Measurement Justification

This measure will determine how many 3rd party systems or applications are integrated and using the EHR's FHIR API interface. This measure will allow us to verify our certified API is working with 3rd party applications to access USCDI patient data. This measurement also shows support for integrated 3rd party API service provider, Interoperability Engine (EMR Direct).

Measurement Expected Outcome

The measurement will provide a count of FHIR applications which have registered with our server for patient access as well as applications actively connecting to our FHIR server. We will utilize our FHIR API form which developers use to request API access as well as additional reports and audit logs to determine the number of API applications enabled for our system. We will also query clinician users to determine the API applications they have approved for use on their system.

We expect that our 3rd party API service provider, Interoperability Engine (EMR Direct), will be fully integrated and working with our EHR, and successful query of the API resources will prove this.

We do not believe many of our clients will be using API capabilities next year, but for those who do, we expect it work and return appropriate clinical data.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics specialties that we support and target.

RWT Measure #12. Number of Sites using Electronic Case Reporting

Associated Criteria: 315(f)(5)

Testing Methodology: Reporting/Logging

Measurement Description

This measure is tracking and counting how many client practices are connected and engaged with bi-directional exchange with the electronic case reporting registry through our EHR Module.

Measurement Justification

This measure will provide a numeric metric value of the number of clients sites who have onboarded and are successfully exchanging electronic case reporting (eCR) messages with public health agencies sites. This measure will show the breadth of use and adoption of this capability by indicating how many different public health agencies are receiving eCR messages from our customers we use in our testing. This measure will also test our integration of our relied upon software of eCR FHIR Now App (Version 3.0) to produce the eCR message and our EMR Direct phiMail Web (Version 1.0.30) HISP to deliver the eCR message to its destination site.

Measurement Expected Outcome

We expect our clients who successfully complete onboarding with their eCR state and local registries to exchange data with minimal errors that are within the acceptable range required by the guidelines of the agencies. However, we are not sure how many clients will elect to utilize electronic reporting next year given this functionality is relatively new in our platform.

We will utilize various reports and logs to determine how many sites have completed this onboarding and are successfully exchanging eICR messages and receiving back reportability responses from the state agencies.

During the year, we will examine the log information for a minimum period of three (3) months to determine an appropriate sample of this measurement.

Care Settings

We designed this measure to test the family practice, internal medicine, and pediatrics practices that we support and target.