Ennoble Care
2 University Plaza Drive, Suite 204
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2025 Real World Test Plan

Office Anywhere

For Criteria

§170.315 (b)(1), §170.315 (b)(2) , §170.315 (c)(1), §170.315 (e)(1) , §170.315 (g)(7), and §170.315 (g)(9), §170.315 (b)(10)

GENERAL INFORMATION

Plan Report ID Number: Ennoble Technologies Office Anywhere_RWTPlan_2025

Developer Name: Ennoble Technologies LLC

Product Name(s): Office Anywhere

Version Number(s): 2.1

Certified Health IT: 15.04.04.3094.Offi.02.01.1.221221

Developer Real World Testing Page URL: https://www.ennoblecare.com/rwt.html

JUSTIFICATION FOR REAL WORLD TESTING APPROACH

Currently the Certified Health IT module, Office Anywhere, is self-developed and not sold on the open market. Ennoble Technologies positions its Office Anywhere application as Ambulatory Care Electronic Health Record (EHR) Software. It is used in Ambulatory Home Care and Facility settings throughout the Eastern United States. The applicable 2015 Edition criteria that we will include in our Real World Test plan are:

§170.315 (b)(1)	§170.315 (b)(2)
§170.315 (e)(1)	§170.315 (g)(7)
§170.315 (c)(1)	§170.315 (g)(9)
§170.315 (b)(10)	

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These criteria were tested individually during the ONC certification process. However, in the real world these certified modules provide one seamless approach to accomplish the clinical and administrative documentation requirements and incorporate the features and functions of all the criteria mentioned in Table 1. To that end, the Real World Test plan will be designed to demonstrate how these combined certified criteria perform in the production environment. However, the (b)(10) criterion will be tested separately. This certified product is deployed in a single specialty and very narrow band of clinical settings, including Home Care and Facility Care which includes Assisted Living Facilities, Skilled Nursing Facilities, and Long-Term Care Facilities. Therefore, we will design our Real World Test plan to reinforce the capabilities that we encounter in these production environments. The Office Anywhere application does allow providers to fully satisfy their reporting requirements for the MIPS program.

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

Describe the measure(s) that will be used to support the overall approach to Real World Testing.

The Measure/Metrics and the Descriptions listed below will apply to the simultaneous and seamless use of the functionality of the applicable certified measures mentioned in Table 1. Upon receiving patient requests requiring utilization of the areas of the EHR software under test, if any, real world testing will be witnessed via a

Microsoft Teams session with the participants (current users belonging to our organization) using the production environment and real patient data. Upon completion we will observe and report the successful conformance of our customers using the certified technology as it was designed, to be able to complete the applicable ONC Certification criteria listed in Table 1 above. Because no such requests have been made by patients for many of these EHR areas to date, we will rely on mock testing in the production environment as a backup plan using a pre-designated set of test patients.

The Measure/Metrics and Descriptions for Measures 1 - 6 listed below will apply to multiple criteria simultaneously to demonstrate the functionality of these certified measures: § 170.315(b)(1) Transitions of care (Receive), § 170.315(b)(2) Clinical Information Reconciliation and Incorporation, § 170.315(b)(1) Transitions of care (Send), § 170.315 (e) (1) View, Download and Transmit to 3rd party, §170.315(g)(7 & 9) API, and §170.315 (c)(1) Record and Export. Measure 7 will apply to §170.315 (b)(10) EHI Data Export.

Measurement/Metric	Description
Measure 1: Clinician logs into Office Anywhere and receives a C-CDA from a referring provider via Direct Protocol with no Tech Support and no errors. C-CDA has demographic information adjusted so PHI is not visible. Successful receipt of C-CDA is achieved and observed.	Clinician begins a new patient encounter in the Office Anywhere certified software with a patient referred by another clinician. With a Direct Address and unique EMR Direct PhiMail credentials, the clinician is able to have a seamless login and secure receipt of C-CDA from the referring clinician using the Direct Protocol. The USCDIv1 Data Set standard will be demonstrated in these transactions through screenshots collected. Log files are also captured. These will all show the successful receipt of the C-CDA with all fields completed and arranged per provider preference. This will meet § 170.315(b)(1) (Receive).
Measure 2: The C-CDA is validated, and Clinical Information Reconciliation is performed. No errors are expected.	After successful receipt of the C-CDA, the clinician validates the C-CDA within Office Anywhere. Clinical information reconciliation for medication, medication allergy, and current problem list is performed using Office Anywhere software. The USCDIv1 Data Set will be demonstrated in these transactions through screenshots collected. Log files demonstrate the reconciliation. This will meet § 170.315(b)(2).
Measure 3: Updated C-CDA is sent back to referring partner. Successful sending of C-CDA is achieved and observed.	Clinician sends updated C-CDA with minimal delay back to referring clinician via Direct Protocol. Updated C-CDA is also sent to the patient portal. Confirmation of sent C-CDA is captured along with log files. This will meet § 170.315(b)(1)(Send).
Measure 4: Access via patient portal - Observation of the View, Download & Transmit functions is performed. This will demonstrate the portal as a key tool for the clinician to share the	Real-time patient data will be adjusted to protect PHI before Measure 3 is completed. A patient will have access to patient portal to view encounter summaries of their choice as human readable C-CDAs and download the C-CDA without assistance. Transmission of patient data will be sent to a provider (Edge

patient's most current health information with the patient.	Protocol) and non-clinician using a standard email address. This will meet § 170.315 (e)(1).
Measure 5: Additionally, the patient will have the ability to access (by authentication) either partial or full encounter summaries by way of an API call from a 3rd-party application running on a patient-owned device to the API of the EHR.	This same patient will be enabled to present their authenticated credentials to use a 3rd-party application running on a patient-owned device to access either partial encounter summary data or a full encounter summary. They will have the ability to view and or transmit their information as they see fit. This will meet § 170.315 (g)(7 & 9)
Measure 6: Documentation of Medications (CQM68) is done without assistance. No errors are expected.	Twice per year per patient, at approximately six month intervals, clinical staff will complete Documentation of Medications (CQM68) within the appropriate location in the Office Anywhere software by completing the appropriate fields as they document the patient's medications, thereby meeting § 170.315(c)(1). It will be later reflected in the numerator and denominator of this MIPS CQM measure.
MEASURE 7: §170.315 (b)(10) Export USCDIv1 clinical data for a population of patients for use in a different health information technology product or a third-party system. This export can be used for many purposes, including data portability when a physician practice switches to a new EHR platform.	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.

ASSOCIATED CERTIFICATION CRITERIA

Measurement/Metric	Associated Certification Criteria	Relied Upon Software
Measures 1 -5 will be completed in one session.		
Measure 1	§ 170.315(b)(1) Transitions of care - Receive	EMR Direct version 2017
Measure 2	§ 170.315(b)(2) Clinical Information Reconciliation and Incorporation	EMR Direct version 2017
Measure 3	§ 170.315(b)(1) Transitions of care - Send	EMR Direct version 2017

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Measure 4	§ 170.315 (e)(1) View, Download and Transmit to 3rd party	EMR Direct version 2017
Measure 5	§ 170.315 (g)(7 & 9) API	MeldRx version 2
Measure 6	§ 170.315(c)(1) CQM – Record and Export	
Measure 7	§170.315 (b)(10) – EHI Data Export	MeldRx version 2

JUSTIFICATION FOR SELECTED MEASUREMENT/METRIC

Measurement/Metric	Justification
Measure 1: Clinician logs into Office Anywhere and receives a C-CDA from a referring provider via Direct Protocol with no Tech Support and no errors. C-CDA has demographic information adjusted so PHI is not visible. Successful receipt of C-CDA is achieved and observed.	The ability to electronically receive a C-CDA, without developer assistance, from another provider and or point of service by using the Edge Protocol is integral to the exchange of data and interoperability and inherent in a certified EHR. The C-CDA will use the USCDIv1 Data Set.
Measure 2: The C-CDA is validated, and Clinical Information Reconciliation is performed. No errors are expected.	A clinician must be able to perform clinical information reconciliation and incorporation for medication, medication allergy and the problems effectively, without developer assistance. As a result, a revised C-CDA using the USCDIv1l Data Set will be created which can then be shared with additional clinicians and be sent to the patient portal for patient access. The ability to do this as part of the test plan will show how clinicians can complete this task efficiently and without error. The most current information will be available to both clinicians and the patient as required by a certified EHR.
Measure 3: Updated C-CDA is sent back to referring provider. Successful sending of the C-CDA is achieved and observed.	To complete the ability to bi-directionally participate in the interoperability of patient information the certified EHR technology must be able to allow providers to send a C-CDA using the Edge Protocol, and the USCDIv1 Data Set.
Measure 4: Access via patient portal - Observation of the View, Download & Transmit	The patient portal is vital to all patients. Patients will be able to login at any time and view their most current information as well as share it with any other clinicians they might choose to visit. This allows the exchange of information by the patients

functions is performed. This will demonstrate the portal as a key tool for the clinician to share the patient's most current health information with the patient. The amount of time should be no more than 3 minutes total for 3 tasks and there should be no errors.	themselves which is key to giving control of their health information. This is an essential part of certified EHR technology.
Measure 5: Additionally, the patient will have the ability to access (by authentication) either partial or full encounter summaries by way of an API call from a 3rd-party application running on a patient-owned device to the API of the EHR.	The certified EHR technology must provide the patient with an additional ability to obtain their medical information via a request from an application of their own, outside of the domain of an EHR. This functionality will supplement the capabilities that are achieved with a patient portal.
Measure 6: Documentation of Medications (CQM68) is done without assistance. No errors are expected.	Clinical staff must be able to perform medication reconciliation and enter proper documentation into the record without developer assistance. The clinician's actions will be captured and logged to indicate that the requirement for a given eCQM (CMS68) has been satisfied. The ability to do this as part of the test plan will show how clinical staff can complete this task efficiently and without error.
MEASURE 7: §170.315 (b)(10) Count of single patient export files created during a 3-month timeframe. This demonstrates the ability to export single patient files containing all their EHI.	Count of single patient export files created during a 3-month timeframe. This demonstrates the ability to export single patient files containing all their EHI. This metric will also provide information on the demand for this capability.

CARE SETTING(S)

Care Setting	Justification

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Facilities: • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	The Office Anywhere is currently used by Ennoble staff providers in the Ambulatory Home Health setting and the Internal Medicine specialty. Because Office Anywhere is strictly software for internal use, all Office Anywhere users are Ennoble Staff; therefore testing can be performed by Ennoble staff in the production environment without any privacy implications. This test plan will demonstrate that the overall functionality is the same for each provider. We will get feedback from the actual users. We will confirm that the EHR accommodates the specific workflow of for this point-of service. We will be conducting the Real World Testing with clinicians delivering care to patients in their homes. These are the Ennoble Technologies' target audience. The ability to complete all measures successfully with these clinicians will be documented through observation of the completed tasks. Deviations from the designed process, if any, will be noted and addressed.

EXPECTED OUTCOME

Measurement/Metric	Expected Outcomes
Measure 1 § 170.315(b)(1) Transitions of care (Receive)	The Real World Testing will demonstrate that the clinician can receive C-CDA R2.1 C-CDA Document payload type in the designated setting. Using the Edge Protocol SMTP protocol. Both Referral Notes and Discharge Summaries will be evaluated. The received document will be evaluated for the ability to: • Receive and validate and display any recorded errors if not a valid C-CDA documents. • Parse and present a pre-configured human readable display of all USCDIv1 Data Set from the relevant C-CDA formatted to USCDIv1. Office Anywhere is compliant with standards for these criteria and vocabulary code sets in all of these measures. A 0% error rate is expected. Expected outcomes will include the following data points: total number of events tested, number of passed (i.e., successful) events, number of failed events, and a success rate expressed in percentage (successes / total number of events). A 95% completion success rate is expected within the established normal time (usually under 30 seconds) to complete each function. As detailed in this plan under the "Schedule of Key Milestones" section, each measure/metric will be tested at least once a quarter with our clinician RWT groups to ensure the expected outcomes are reliably attained
	The Real World Testing will demonstrate that the receiving clinician will be able to validate the C-CDA, compliant to the USCDIv1l Data Set, perform reconciliation successfully for medication, medication allergy and problems at any time without delay and create an updated C-CDA, compliant to the USCDIv1 Data Set, as required to demonstrate EHR exchange of information and interoperability. A 0% error rate is

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Measure 2 § 170.315(b)(2) Clinical Information Reconciliation and Incorporation	expected. Expected outcomes will include the following data points: total number of events tested, number of passed (i.e., successful) events, number of failed events, and a success rate expressed in percentage (successes / total number of events). A 95% completion success rate is expected within the established normal time (usually under 30 seconds) to complete each function. As detailed in this plan under the "Schedule of Key Milestones" section, each measure/metric will be tested at least once a quarter with our clinician RWT groups to ensure the expected outcomes are reliably attained
Measure 3 § 170.315(b)(1) Transitions of care (Send)	The Real World Testing will demonstrate that the clinician can send R2.1 C-CDA Referral Notes and Discharge Summaries compliant to the USCDIv1l Data Set using the SMTP Edge Protocol. We will successfully validate the receipt of the sent documents. A 0% error rate is expected. Expected outcomes will include the following data points: total number of events tested, number of passed (i.e. successful) events, number of failed events, and a success rate expressed in percentage (successes / total number of events). A 95% completion success rate is expected within the established normal time (usually under 30 seconds) to complete each function. As detailed in this plan under the "Schedule of Key Milestones" section, each measure/metric will be tested at least once a quarter with our clinician RWT groups to ensure the expected outcomes are reliably attained

Measure 4
 	
§ 170.315 (e) (1) View, Download and Transmit to 3rd party
	The Real World Testing will demonstrate that the clinician can enable patients (and their authorized representatives) to view, at a minimum, the USCDIv1 Data Set; laboratory test report(s); and diagnostic image reports. Enable patient (and their authorized representative) to view for health information filtered by a specific date and date range.
	
	Enable patient (and their authorized representatives) to download an ambulatory or inpatient summary (as applicable to setting) in the following formats:
	
	• Human readable format
	• Format C-CDA document summary will include, at a minimum, the USCDIv1l Data Set; laboratory test report(s); diagnostic image reports.
	For all settings, patients (and their authorized representatives) will be able to transmit the C-CDA summary through both:
	
	  ○ Email transmission to any email address
	  ○ The Edge protocol of electronic transmission
	• When transmitted, the ambulatory or inpatient summary will be compliant to the USCDIv1 Data Set; laboratory test report(s); diagnostic image reports; and:
	• Enable patient (and their authorized representative) to download for health information filtered by a specific date and date range.
	For all view, download, and transmit capabilities, the following information will be recorded and made accessible to the patient (and authorized representative):
	
	• The action that occurred
	• The date and time each action occurred

	• The user who took the action; and the addressee to whom the summary was transmitted A 0% error rate is expected. Expected outcomes will include the following data points: total number of events tested, number of passed (i.e., successful) events, number of failed events, and a success rate expressed in percentage (successes / total number of events). A 95% completion success rate is expected within the established normal time (usually under 30 seconds) to complete each function. As detailed in this plan under the "Schedule of Key Milestones" section, each measure/metric will be tested at least once a quarter with our clinician RWT groups to ensure the expected outcomes are reliably attained
Measure 5 § 170.315(g)(7 & 9) API	The Real World Testing will demonstrate that the clinician has the functionality within Office Anywhere to receive a request with sufficient information to uniquely identify a patient and return an ID or other token that can be used by an application to subsequently execute requests for that patient's data. The EHR will demonstrate the functionality to respond to requests for patient data for all of the data categories specified in the USCDIv1 Data Set at one time and return such data (according to the specified standards, where applicable) in a summary record formatted according to the standard adopted C-CDA standard. The requests will respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range. A 0% error rate is expected. Expected outcomes will include the following data points: total number of events tested, number of passed (i.e., successful) events, number of failed events, and a success rate expressed in percentage (successes / total number of events). A 95% completion success rate is expected within the established normal time (usually under 30 seconds) to complete each function. As detailed in this plan under the "Schedule of Key Milestones" section, each measure/metric will be tested at least once a quarter with our clinician RWT groups to ensure the expected outcomes are reliably attained
Measure 6 § 170.315(c)(1)	The Real World Testing will demonstrate that the clinician will be able to record all of the data that would be necessary to calculate the certified eCQMs (CMS068). Data required for CQM exclusions or exceptions will be codified entries, which may include specific terms as defined by each CQM, or may include codified expressions of "patient reason," "system reason," or "medical reason." The expected outcome is a documentation rate no less than 75% of patients having their medications documented on a semi-annual basis.
MEASURE 7: §170.315 (b)(10)	The number of single-patient export files generated over a 3-month period will be tracked. Real-world testing will demonstrate an organization's ability to create single-patient EHI export files in compliance with the 170.315(b)(10) criterion. The expected outcome is a non-zero count, though we anticipate low numbers since many organizations may continue using their existing methods for exporting single-patient data, such as interoperability tools or manual processes.

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SCHEDULE OF KEY MILESTONES

Key Milestone	Care Setting	Date/Timeframe
Prepare the Office Anywhere application for use in collecting data to support the RWT plan.	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	December 2024
Identify the users that will participate in the test plan.	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	December 2024 & January 2025
Confirm that the Real World Test Plan participants are able to log into their accounts and are ready to start the RWT plan documentation.	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	January 2025
Conduct the series of Real World Testing with the participants on a regular basis (minimum, once a quarter) to obtain feedback on their progress and or if there are any issues to address.	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	Quarterly 2025

End the Real World Test to coincide with the end of the Year.	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	December 2025
Real World Test analysis and generation of the report	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties:** • Internal Medicine	January 2025
Submit Real World Test Report to ACB before established deadline	**Facilities:** • Ambulatory – Home Health • Ambulatory – Facility-Based Care **Specialties**: • Internal Medicine	January 2025

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ATTESTATION

The Real World Testing plan must include the following attestation signed by the health IT developer authorized representative.

Note: The plan must be approved by a health IT developer authorized representative capable of binding the health IT developer for execution of the plan and include the representative's contact information.[i]

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: Jonathan Taylor

Authorized Representative Email: jtaylor@ennoblecare.com

Authorized Representative Phone: (973) 435-9463

Authorized Representative Signature:

Jonathan Taylor

October 29, 2024