Real World Testing 2025 Test Results

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Developer Name: Nth Technologies, Inc.

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Real World Test Plan Changes

Challenges faced during testing

Key challenges necessitating changes to the test plans included a small userbase exacerbated by all customers using nAbleMD 6.0c either not participating in government payers or utilizing the low-volume exception to MIPS/QPP participation, or accepting Medicare payment penalties as opposed to the labor of fully utilizing the tested functions of the software.

Changes made to the Test Plan

Because of low utilization, it was necessary to modify several test plans to confirm the operation of the software. These tests and modifications are detailed here:

- Transition of Care Testing – Outbound. Changes affected testing for:+
  - § 170.315(b)(7) – Security Tags – Summary of Care Send.
  - § 170.315(h)(1) – Direct Project
    Reason: no utilization of Direct Project transmission due to extra steps required of the practice. Practices not participating in MIPS did not see the value of utilizing this feature. No practices utilized the Security Tags feature for any patient chart during the year.
    Change: In order to demonstrate the functionality of Security Tags and Direct Project, the practice generated a transfer of care record for a test patient utilizing the DS4P Security Tag functionality and uploaded it to the SITE C-CDA USCDI V1 Validator for 170.315 b7 DS4P Ambulatory scenario. Additionally the clinic was encouraged to utilize the Direct functionality to transmit a C-CDA document to a referred provider and receive acknowledgement of receipt from that provider.
- Transition of Care Testing – Inbound. A change affected testing for:
  - § 170.315(b)(8) – Security Tags – Summary of Care Receive
    Reason: No clinic received C-CDA documents containing DS4P Security Tags
    Change: In order to demonstrate the functionality of Security Tags, a C-CDA was generated by the SITE C-CDA USCDI V1 Validator for 170.315 b7 DS4P Ambulatory scenario containing an ambulatory record and was imported to a test patient by the clinic and reconciled successfully.
- Clinical Quality Measures. A change affected testing for:
  - § 170.315(c)(1) – Clinical quality measures (CQMs) — record and export
  - § 170.315(c)(2) – Clinical quality measures (CQMs) — import and calculate
  - § 170.315(c)(3) – Clinical quality measures (CQMs) — report
    Reason: Not all measures were used by all providers at all clinics, so a mix of providers were used to collect data for as many measures as possible. One measure (CMS146v13) had no patient matching the initial population during the year of 2025 at the clinics being monitored
    Change: For CMS146v13, a practice was guided on generating a test patient record that would be in the Initial Patient Population and Numerator for the measure in order to demonstrate that the quality measure was properly calculated and reported.
- Application Access and API Testing A change affected testing for:
  - § 170.315(g)(9) – Application access – all data request
    Reason: The developer who requested access during the 2025 calendar year strictly utilized the FHIR interface instead of C-CDA creation.
    Change: To test the C-CDA creation a request was manually crafted and submitted for a test patient to create and retrieve the C-CDA.

Standards Updates

The Test Plan document specified certain standard versions that had been replaced as part of the annual updates that took place on 1/1/2025. These include:

Clinical Quality Measures:

• CMS22v12: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – Update to CMS22v13

• CMS68v13: Documentation of Current Medications in the Medical Record – Update to CMS68v14

• CMS69v12: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan – Update to CMS69v13

• CMS75v12: Children Who Have Dental Decay or Cavities – Update to CMS75v13

• CMS117v12 Childhood Immunization Status – Update to CMS117v13

• CMS122v12: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) – Update to CMS122v13

• CMS125v12: Breast Cancer Screening – Update to CMS125v13

• CMS138v12: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – Update to CMS138v13

• CMS146v12: Appropriate Testing for Children with Pharyngitis – Update to CMS146v13

• CMS155v12: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – Update to CMS155v13

• CMS165v12: Controlling High Blood Pressure – Update to CMS165v13

Transition of Care Testing – Outbound

Criteria Tested

This test covers the following criteria related to the transition of patient care out of the practice:

- § 170.315(b)(1) – Transitions of Care
- § 170.315(b)(7) – Security Tags – Summary of Care Send.
- § 170.315(b)(9) – Care Plan
- § 170.315(h)(1) – Direct Project

Test Method

The provider documents a referral to another provider in the patient's chart, then creates and transmits a Transfer of Care CDA document to the provider the patient is referred to, in a Direct message. The system automatically validates the CDA document during the creation process. Direct Messaging utilizes

the relied-upon Surescripts Clinical Direct Messaging interface. Additionally the practice was contacted and encouraged to create a document to transmit to another provider.

Modification

To ensure that a Transfer of Care record could be developed utilizing Security Tags, the practice was guided on creating a test patient with a restricted chart that would generate a C-CDA document utilizing the DS4P Release 1 profile. This document was then uploaded to the SITE C-CDA USCDI V1 validator utilizing the 170.315 b7 DS4P Ambulatory Scenario.

Metrics Collected

Denominator: Total number of documented referrals to other providers: 6073

Numerator 1: Total number of referrals to other providers where a CDA document was created: 2

Numerator 2: Total number of referrals to other providers where a CDA document containing Security Tags was created: 1

Numerator 3: Total number of referrals to other providers where a Care Plan was included in the CDA: 2

Numerator 4: Total number of referrals to other providers where the CDA was transmitted to the provider via Direct Message: 2

Expected Results

The metrics collected in the numerators demonstrate the practice's ability to use the four criteria over the course of the test period.

>50% of referrals have a CDA document created for the patient

<10% of the referrals will have Security Tags as they are rarely used

>10% of referrals will have a Care Plan included in the CDA document

>50% of referrals will be transmitted by Direct Message

Actual Results/Outcome

Practice engagement with both C-CDA creation process and transmission continues to prove difficult and did not meet our expectations. Encouraging customers to have new employees trained by the vendor continues to be an issue along with clinics reporting that they did not feel that they needed to go through the extra steps required to transmit the records since they were not participating in MIPS and did not feel that there was enough benefit to transmitting the Transfer of Care record to another provider despite integrating the C-CDA generation and transmission process into the referral reports. Providers continue to prefer faxed records, considering these to be "complete" compared to the C-CDA documents.

Key Milestones

Data collected from a primary ambulatory care setting from 1/1/2025-12/31/2025. Security Tag testing performed 9/5/2025. Reporting data retrieved from the practice database January 2026.

Transition of Care Testing – Inbound

Criteria Tested

This test covers the following criteria related to the transition of patient care into the practice and receiving clinical data from an external provider:

- § 170.315(b)(1) – Transitions of Care
- § 170.315(b)(2) – Clinical information reconciliation and incorporation
- § 170.315(b)(8) – Security Tags – Summary of Care Receive
- § 170.315(h)(1) – Direct Project

Test Method

Practice will receive and incorporate incoming patient Transfer of Care records into the patient's record. Records can be received either via Direct message or another communication method (e.g. thumb-drive). Direct Messaging utilizes the relied-upon Surescripts Clinical Direct Messaging interface.

Modification

In order to test the ability to receive Security Tags, the SITE C-CDA USCDI V1 validator utilizing the 170.315 b7 DS4P Ambulatory Scenario was used to generate a sample ambulatory C-CDA file containing DS4P Markings which was then incorporated by into a test patient record by the practice

Metrics Collected

Denominator A: Number of CDA documents received from outside providers: 4

Numerator A1: Number of CDA documents received where reconciliation and incorporation has taken place: 4

Numerator A2: Number of CDA documents received via Direct message: 1

Denominator B: Number of CDA documents received with Security Tags present: 1

Numerator B: Number of CDA documents with Security Tags where reconciliation and incorporation has taken place: 1

Expected Results

The metrics collected in the above numerators demonstrate the practice's ability to use the four criteria over the course of the test period.

>50% of received CDA documents has been reconciled and incorporated into the patient's chart

>50% of received CDA documents have been received via Direct message

>50% of received CDA documents with Security Tags have been reconciled and incorporated into the patient's chart

Actual Results/Outcome

Continuing from last year's results we found that despite linking the C-CDA to the referral/transfer process to reduce the number of steps, the clinics receiving patients continued to prefer their

customized intake forms to standardized documents. Additionally, there continues to be a disconnect in practices between the clinical staff and the front desk staff where medical record handling is considered to be a clinical task while patient intake continues to be a "front desk" job. Additionally, clinics continued to prefer that the patient complete the practices' custom intake forms to collect information such as family histories that are often more focused than what was provided in the C-CDA documents. Many practices did not publish or provide their Direct Address contact information for other providers to use. We will continue to work with clinics to improve this workflow as much as possible.

Key Milestones

Data collected from a specialist ambulatory care setting from 1/1/2025-12/31/2025 Security Tag testing performed 9/5/2025. Reporting data retrieved from the practice database January 2026

Electronic Prescribing Testing

Criteria Tested

This test covers the following criterion for transmitting prescriptions to pharmacies.

- § 170.315(b)(3) – Electronic Prescribing

Test Method

The provider will use the relied-upon NewCropRx e-prescribing module to write prescriptions for the patients and either print or transmit the prescriptions electronically.

Metrics Collected

Denominator: Total number of prescriptions written by prescribers: 2857

Numerator: Total number of prescriptions transmitted electronically: 2842

Expected Results

The metric collected in the numerator demonstrates the practice's ability to use the criterion over the course of the test period.

>80% of prescriptions have been transmitted to pharmacies electronically

Actual Results/Outcome

The expected metric was met, indicating that the practice sent 99.4% of the prescriptions electronically. For the remaining 15 prescriptions, all were either printed or faxed.

Key Milestones

Data collected from a primary ambulatory care setting from 1/1/2025-12/31/2025. Reporting data retrieved from the practice database February 2026.

Patient Engagement Testing

Criteria Tested

- § 170.315(e)(1) – View, download, and transmit to 3rd party

Test Method

The practice may send patients seen during the 2025 calendar year test period messages following their encounter reminding the patient that they can access the patient portal to receive clinical data from the practice. Patients can log into the portal and View, Download, or Transmit their data as either a structured or human readable CDA document. The Transmit functionality via Direct Messaging utilizes the relied-upon Surescripts Clinical Direct Messaging interface.

Metrics Collected

Denominator: Number of unique patients with encounters performed by the practice during the test period: 1209

Numerator 1: Number of patients who have Viewed or Downloaded either the structured or human readable summary information from the patient portal: 148

Numerator 2: Number of patients who have Transmitted their summary information to another provider via Direct, using the patient portal: 1

Expected Results

Patient engagement can be difficult for practices to encourage. The metrics collected in the numerators demonstrate both the patient's ability to View, Download and Transmit their records from the portal included in nAbleMD, as well as the benefit of sending reminders to the patients to do so.

Numerator 1: > 5% of patients have Viewed or Downloaded their summary information from the patient portal.

Numerator 2: < 5% of patients have Transmitted their summary information through the patient portal using a Direct message, as most patients are not familiar with this and will not have another provider's Direct address to transmit to.

Actual Results/Outcome

For the first time, patients interested in Viewing or Downloading their clinical documents surpassed our expectations, with 12.2% of the patients requesting to view human-readable versions of their records. Patients continue to underutilize the ability to transmit records to another provider with a single patient utilizing the computer-readable version of the record, perhaps either expecting their provider to take care of this, or not being aware of their providers' Direct Addresses.

Key Milestones

Data collected from a primary ambulatory care setting from 1/1/2025-12/31/2025. Reporting data retrieved from the practice database February 2026.

Clinical Quality Measure Testing

Criteria Tested

- § 170.315(c)(1) – Clinical quality measures (CQMs) — record and export
- § 170.315(c)(2) – Clinical quality measures (CQMs) — import and calculate
- § 170.315(c)(3) – Clinical quality measures (CQMs) — report

Measures certified, updated to the version for reporting year 2025:

- CMS22v13: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- CMS68v14: Documentation of Current Medications in the Medical Record
- CMS69v13: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- CMS75v13: Children Who Have Dental Decay or Cavities
- CMS117v13: Childhood Immunization Status
- CMS122v13: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
- CMS125v13: Breast Cancer Screening
- CMS138v13: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- CMS146v13: Appropriate Testing for Children with Pharyngitis
- CMS147v13: Preventive Care and Screening: Influenza Immunization
- CMS155v13: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- CMS165v13: Controlling High Blood Pressure
- CMS166v7: Use of Imaging Studies for Low Back Pain (NOTE: no longer reported) -

Test Method

Practices were updated to the 2025 reporting year versions of each of the supported quality measures at the beginning of the year.

During documentation, providers will request calculation of Clinical Quality Measure data, including whether the patient is included in the Initial Population or not, and whether the patient meets, is excluded/excepted, or does not meet the measure.

Note that an alternate test method was used for the quality measure marked with a * below

Metrics Collected

For each measure utilized by the practice:

Denominator: Number of patients with Clinical Quality Measure data calculated where the patient is included in the Initial Population

Numerator: Number of patient records included in the associated CQM report generated by the practice (NOTE: this is NOT the numerator of the quality measure report).

Measure	Setting	Denominator	Numerator
CMS22v13	FAM	1943	1241
CMS68v14	OBGYN	1136	728
CMS69v13	OBGYN	794	794
CMS75v13	PED	3445	11
CMS117v13	PED	150	150
CMS122v13	FAM	37	30
CMS125v13	OBGYN	299	268

CMS138v13	OBGYN	622	615
CMS146v13 *	PED	1	1
CMS147v13	PED	1851	690
CMS155v13	PED	2672	2454
CMS165v13	FAM	81	29
CMS166v7	FAM	52	44

Expected Results

For each measure, all of the encounters where the patient is included in the Initial Population will appear in a CQM report generated for the time range, which demonstrates the ability of the software to record the measure data, calculate the results and generate the appropriate report of the measure data.

Actual Results/Outcome

All quality measure calculations were able to be recorded and exported. Database upgrades and revised caching of data improved performance of the quality measure reports significantly. A suspiciously low incidence of documenting Diabetes Type 2 and Hypertension in the problem list was noted. Clinics were advised to remember to record chronic diseases in the problem list.

Key Milestones

Data collected from various ambulatory care settings for encounters dated 1/1/2025 -12/31/2025, data retrieved from the practice database February 2026.

Immunization Registry Testing

Criteria Tested

- § 170.315(f)(1) – Transmission to immunization registries

Test Method

The practice will document immunizations performed at the practice in the patient's chart. The automated communication system will transmit all records to the state registry and log the result of each communication to identify whether the result was accepted due to either a data entry error such as incorrect patient address records or other technical communication errors.

Metrics Collected

Denominator: Number of immunizations performed at the practice: 5542

Numerator: Number of immunizations performed at the practice with an acknowledgement indicating acceptance by the registry: 5539

Expected Results

The metric collected in the numerator demonstrates the practice's ability to use the criterion over the course of the test period.

>80% of the immunizations documented as being performed at the practice will be successfully reported to the state registry.

Actual Results/Outcome

Automated communication between nAbleMD and the state registry was able to report nearly all of the immunizations performed by the practice. On inspection, the three remaining immunizations were documented as being performed at a facility that was not configured as a reporting location, likely in error.

Key Milestones

Data collected from a pediatric ambulatory setting from 1/1/2025-12/31/2025, data retrieved from the practice database February 2026.

Health Care Survey Testing

Criteria Tested

- § 170.315(f)(7) – Transmission to public health agencies — health care surveys

Test Method

No customers utilized this functionality. Additionally, NHCS does not appear to provide any real-world testing support for this functionality. In lieu of this, a clinic was encouraged to generate a NHCS IG Version 1.2 Document using a test patient record and upload this document to the NIST validator provided by NHCS to confirm that it was accepted with no errors. The document and validation report were provided to Nth Technologies, Inc.

Metrics Collected

Denominator: Number of encounters meeting the criteria for reporting in survey data: 1

Numerator: Number of encounters reported in survey data: 1

Expected Results

All encounters meeting the criteria for reporting in survey data are reported.

Actual Results/Outcome

Testing demonstrated that the clinic could produce a valid NHCS IG Version 1.2 Document.

Key Milestones

Testing performed at a specialist ambulatory clinic 9/5/2025.

Application Access and API Testing

Criteria Tested

- § 170.315(g)(7) – Application access – patient selection
- § 170.315(g)(9) – Application access – all data request
- § 170.315(g)(10) – Standardized API for patient and population services

Test Method

We believe transitioning to a standardized API for requesting access to records will increase requests to access records, however due to small size of the practices and bases, this information will be collected across all customers utilizing the software.
Application Access and Standardized API testing shall consist of receiving a request for Application Access, then measuring that patient data was successfully requested and received for the desired patient via the Standardized FHJR API. The "All Data Request" criteria is separately tested by submitting requests for the generation of a C-CDA document.

Metrics Collected

Denominator: Total number of Application Access requests: 2 new applications

Numerator 1.1: Total number of applications granted access to patient data: 1

Numerator 1.2: Total number of applications, that requested and received at least one patient record via FHIR: 1

Denominator: Total number of requests for all data for a particular patient in C-CDA format**:** 1

Numerator 2: Total number of requests that were completed: 1

Expected Results

The metric collected in the numerator demonstrates the practice's ability to use the criteria over the course of the test period.

Numerator 1.1: >50% of the applications requesting access to patient data receive access to the patient data.

Numerator 1.2: >50% of the applications requesting access to patient data receive at least one requested patient record.

Numerator 2: >50% of the "all data" requests are completed

Actual Results/Outcome

Two new application access requests were received towards the end of the 2025 calendar year from third-party software developers reaching out to establish an interface utilizing the FHIR specification. One application, a provider-launch product was able to successfully register using the publicly posted documentation. The other, a patient-launch application, had difficulty with the directions and was not able to complete the process until January. We identified weaknesses in our documentation that will be improved to better support both provider and patient launch apps. Additionally, as FHIR has become standardized, all data requested was requested via the FHIR endpoints rather than the C-CDA creation and retrieval API. Due to this, the C-CDA endpoint was manually tested with a test patient to confirm that the C-CDA document could be generated and retrieved with all patient data. Future Real World Testing will utilize an updated test plan to reflect more use of FHIR as well as utilize additional request logging implemented in 2026 for Insight data collection.

Key Milestones

Data collected from a specialist ambulatory care setting from 1/1/2025-12/31/2025. Reporting data retrieved from the practice database January 2026.

EHI Export

Criteria Tested

- § 170.315(b)(10) – EHI Export

Test Method

Three practices discontinued usage of nAbleMD during the 2025 calendar year. The clinics were provided instructions in using the EHI Export functionality and one clinic chose to make use of this functionality and was able to complete the export unassisted. The new vendor was provided the publicly available documentation link.

Metrics Collected

Denominator: Total number of export requests: 1

Numerator: Total number of export requests completed without intervention: 1

Expected Results

We expect the practice to be able to retrieve the exported data without any assistance or intervention once trained how to complete the export. Therefore we believe that 100% of the requests should be completed.

Actual Results/Outcome

One practice utilized the self-export feature. As in the previous year, clinics expected to have nAbleMD support produce exports for them, to encourage use of the self-export feature the clinics were advised that there would be an additional charge for not using the feature.

Key Milestones

Testing performed at an ambulatory clinic 11/1/2025-1/31/2026

Attestation

This Real World Testing result document 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: 2/6/2026