Table 1: Practice Fusion Credit - Fully Met

Practice Fusion received full credit from NCQA for the criteria in Table 1 below. A Health IT solution must demonstrate it fully meets all required functionality and provides all required evidence specified by the criteria to receive this designation. Practices are fully excused from criteria met with "full credit" by a vendor solution and do not have to maintain any documentation for these requirements. Please refer to the standards and guidelines documentation available from NCQA for complete criteria requirements.

Criteria Description	Elective or Core	Practice Fusion Workflow Details	NCQA Required Evidence
TC 05 The practice uses a certified electronic health record technology system (CEHRT).	Elective	Practice Fusion EHR version 3.7 is certified as a combination 2014 Edition/2015 Edition certified Health IT product. Learn more	Certified electronic health record system (EHR) name
AC 12 Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.	Elective	Practice Fusion is a cloud based EHR, information is updated in real time and can be accessed by the practice after hours, through our secure login process. This helps ensure continuity of the medical record for care and advice when the office is closed.	Documented Process

Table 2: Practice Fusion Credit - Partially Met

Practice Fusion received partial credit from NCQA for the criteria in Table 2 below. A Health IT solution must demonstrate it fully meets one or more evidence components of the criteria to receive this designation. Practices are excused from providing a specific piece of evidence for vendor criteria designated as "partial credit." A vendor receives a "partial credit" designation when a Health IT solution demonstrates it provides some of the required evidence components specified by a criteria-level requirement. Please refer to the standards and guidelines documentation available from NCQA for complete criteria requirements.

Criteria Description	Elective or Core	Practice Fusion Workflow Details	NCQA Required Evidence
CC 21 B **External Electronic Exchange of Information**: Demonstrates electronic exchange of information with external entities, agencies and registries **B**. Submitting electronic data to immunization registries to share immunization services provided to patients.	Elective	Your practice should establish a connection to your state registry through the EHR if available. Additionally, your practice will need to document immunizations in the structured immunizations section of patient's chart. Learn more about connecting to your registry here. Learn more about documenting an immunization here.	Evidence of implementation

CC 21 C **External Electronic Exchange of Information**: Demonstrates electronic exchange of information with external entities, agencies and registries **C**. Making the summary of care record accessible to another provider or care facility for care transitions.	Elective	Your practice can create and export a Continuity of Care Document (CCD) from the patient's chart as part of meeting the requirements of this criteria. Learn more about creating and exporting CCDs here.	Report
KM 20 C **Clinical Decision Support (CDS)**: Implements clinical decision support following evidence based guidelines for care of a chronic medical condition	Core	Ensure Clinical Decision Support is enabled for your practice. Practice Fusion has several CDS reminders for chronic medical conditions, which allows your practice to choose the CDS alerts that are relevant to your practice and patients. Learn more about CDS Advisories here.	Identifies conditions, source of guidelines AND Evidence of implementation
CC 01 C, D **Lab and Imaging Test Management**: The practice systematically manages lab and imaging tests by: **C**. Flagging abnormal lab results, bringing them to the attention of the clinician. **D**. Flagging abnormal imaging results, bringing them to the attention of the clinician.	Core	Practice Fusion automatically flags abnormal lab and imaging results that are sent into the EHR by the lab or imaging partner. This helps to draw attention to abnormal results and can be implemented into result review and patient communication processes. Learn more about viewing lab and imaging results here.	Documented process AND Evidence of Implementation
QI 01, A, B, C (adult only) **Clinical Quality Measures**: Monitors at least five clinical quality measures across the four categories **A**. Immunization measures. **B**. Other preventive care measures. **C**. Chronic or acute care clinical measures.	Core	Practice Fusion allows practices to easily manage the CQMS they monitor through the eCQM dashboard, which includes many measures that qualify for the A, B, and C categories for adult patients. Your practice can monitor the CQMs that are relevant to your practice and patient population. Learn more about using the eCQM dashboard here.	Report

Table 3: Practice Fusion Credit - Practice Support

NCQA acknowledges and identifies how EHR functionality aligns with the Practice Support credits listed in Table 3 below. When a Health IT solution demonstrates aligned functionality that significantly supports a practice in meeting NCQA criteria-level requirements, it receives a “practice support” designation for these criteria. Your practice will need to provide evidence of meeting these requirements during the Recognition process. Please refer to the standards and guidelines documentation available from NCQA for complete criteria requirements.

Criteria Description	Elective or Core	Practice Fusion Workflow Details	NCQA Required Evidence
KM 05 **Oral Health Assessment and Services**: Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	Elective	To facilitate the coordination of care with oral health providers, Practice Fusion enables the practice to save a list of oral healthcare providers in the practice directory. The directory can be sorted by specialty, which helps practices easily identify oral healthcare providers in the referral workflow. Learn more about how to add contact to Directory here.	Documented Process AND Evidence of implementation
AC 07 **Electronic Patient Requests**: Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.	Elective	Practices using the Practice Fusion EHR can grant their patients access to the *Patient Portal* which will give them access to some of the meaningful health information you have documented for them, as well as the ability to request appointments electronically and view test results you have shared with them. Your practice must grant the patient access to their *Patient Portal*. Learn more about how to invite a patient to Patient Portal here.	Evidence of implementation
AC 08 **Two-Way Electronic Communication**: Has a secure electronic system for two-way communication to provide timely clinical advice.	Elective	Practices can enable patient messaging via *Settings*. Only patients that have set up their Patient Portal account would be able to exchange messages with the practice. Learn how to use patient messaging here.	Documented process AND Report
CM 03 **Comprehensive Risk-Stratification Process**: Applies a comprehensive risk- stratification process for the entire patient panel in order to identify and direct resources appropriately.	Elective	Documenting *Patient Risk Score* in the EHR and utilizing the *New Patient List Report* enables your practice to track and identify patients that are high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. As a result of risk stratification, your practice should be able to direct resources appropriately based on need. Learn more about how to document patient risk score here.	Report
CM 04 **Person-Centered Care Plans**: Establishes a person-centered care plan for patients identified for care management.	Elective	After documenting patient *Goals* and *Care Plan* in the encounter, the *Clinical Summary* print and export functions can help your practice demonstrate development of patient care plans for the patients identified for care management. The Clinical Summary includes the problem list, expected outcomes, treatment goals, and medication management in addition to the *Goals* and *Care Plan*. *Clinical Summaries* can be shared with the patient. Your practice can also demonstrate the implementation of a schedule to review and revise care plans as needed. Learn how to document Goals here. Learn how to print a Care Plan here. Learn how to create and export a CCD here.	Report OR Record Review Workbook and Patient examples

QI 18 **Reporting Performance Measures to Medicare/Medicaid**: Reports clinical quality measures to Medicare or Medicaid agency.	Elective	This will vary by the data submission method. Contact Customer Service for additional information on how to obtain evidence of submission. Learn more about the Practice Fusion QCDR here.	Evidence of submission
KM 02 **Comprehensive Health Assessment**: Comprehensive health assessment includes (all items required): **A**. Medical history of patient and family. **B**. Mental health/substance use history of patient and family. **C**. Family/social/cultural characteristics. **D**. Communication needs. **E**. Behaviors affecting health. **F**. Social functioning. **G**. Social determinants of health. **H**. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) **I**. Advance care planning. (NA for pediatric practices.)	Core	Your practice can demonstrate completing a comprehensive health assessment, which includes an examination of the patient's social and behavioral influences in addition to a physical health assessment by utilizing the *Past Medical History* and *Advanced Directives* of the patient's summary. The structured *Family History* section of the patient's chart should be used to document the medical history for the patient's first degree relatives. *Health Concerns* in the patient *Summary* can be used to demonstrate that social and cultural needs, preference, strength, and limitation are documented and evaluated. *Past Medical History* can be used to document and demonstrate risky and unhealthy behaviors that go beyond smoking status. This can include physical activity and alcohol consumption. The dedicated *Advanced Directives* section of the patient summary can be used to document *Advanced care planning* for non-pediatric patients. Learn how to add Advanced Directives here. Learn how to add Past Medical History here. Learn more about the Family History section here. Learn how to add Health Concerns here.	Documented process AND Evidence of implementation
KM 09 Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.	Core	The *Patient List Report* includes search criteria on patient race, ethnicity, and preferred language which practices can use to assess the diversity of their patient population. Learn how to use the *Patient List Report* here.	Report
KM 10 **Language**: Assesses the language needs of its population.	Core	The *Patient List Report* allows practices to run a report by preferred language, which enables the assessment of the language needs of the practice's patient population. Learn how to use the *Patient List Report* here.	Report
KM 12 A **Proactive Outreach**: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services: **A**. Preventive care services.	Core	In the *Chart Notes Report* practices can view a history of patient encounters and filter by chart note type, provider, and date. This report can aid practices in identifying patients that may be overdue for a visit type, prompting the practice to remind the appropriate patients about needed services. Learn how to use the Chart Notes Report here.	Report/list AND Outreach materials

KM 22 **Access to Educational Resources**: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	Core	Within the EHR, links to patient facing education materials are displayed as 'Patient education materials'. These can easily be printed and shared with the patient.	Evidence of implementation
AC 05 **Clinical Advice Documentation**: Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.	Core	Any message sent to the patient using the patient messaging feature will automatically be documented as part of the patient chart. All other clinical advice provided to the patient can be documented in an encounter note. Because the EHR is cloud based and accessible from any computer, the same clinical documentation process in the EHR can be used during and after hours. Learn how to use patient messaging here.	Documented process AND Evidence of implementation
CC 04 C **Referral Management**: The practice systematically manages referrals by: **C**. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.	Core	Referrals or specialist reports sent from the EHR will automatically be logged in the patient's *Timeline*. Your practice can refer to the date of the referral and the 'Follow up received' checkbox to determine if a response is overdue and contact the recipient of the original referral as needed. Learn how to use the Referrals report here.	Documented process AND Evidence of implementation
CM 01 B, C, D 02, 04, 05 **Identifying Patients for Care Management**: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management: **B**. High cost/high utilization. **C**. Poorly controlled or complex conditions. **D**. Social determinants of health.	Core	**B**. To demonstrate high cost/ high utilization identification process, your practice can demonstrate use of the 'Adjusted Clinical Groups' (ACG) risk score category, which measures health status by grouping diagnoses into clinically cogent groups. The goal of the ACG system is to assign each individual a single, mutually exclusive ACG value, which is a relative measure of the individual's expected or actual consumption of health services. **C**. To demonstrate identifying patients with poorly controlled or complex conditions, your practice can demonstrate use of the 'Hierarchical Condition Category'. This model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual's health conditions and demographic details. Your practice can also demonstrate use of the Minnesota Tiering system, which groups patients into "complexity tiers" based on the number of major condition categories from which they suffer. **D**. To demonstrate identifying patients with social determinants of health your practice can demonstrate use of the Elder Risk Assessment risk score category. This is specifically for adults over 60 and uses gender, marital status, number of hospital days	Protocol for identifying patients for care management OR CM03

		over the prior two years, and selected comorbid medical illness to assign an index score to each patient. Your practice also has the flexibility to use the 'Other' risk score category to track an alternate group of patients. In this case it is important to maintain consistent protocol in how the 'Other' risk score category is utilized within your practice. Learn how to document risk score here.	
QI 01 B, C (pediatric) Clinical Quality Measures (CQMs): Monitors at least five clinical quality measures across the four categories: **B**. Other preventive care measures. **C**. Chronic or acute care clinical measures.	Core	Practices can easily manage the CQMs they monitor through the eCQM dashboard which includes Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents and Screening for Depression and Follow Up Plan, which qualify for B and C for pediatric patients. Learn how to use the eCQM Dashboard here.	Report