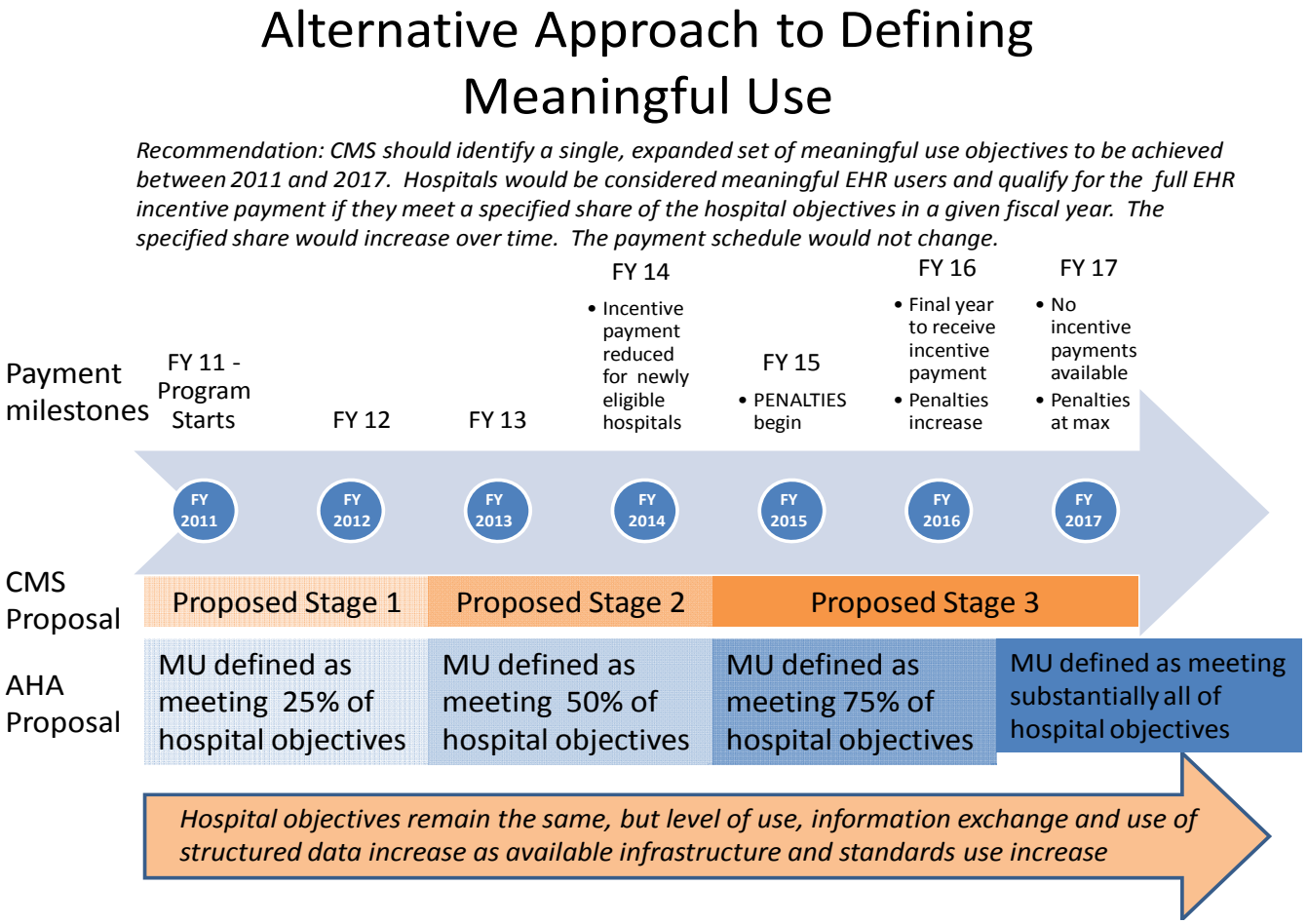
Attachment 1: Alternative Approach and Recommended Hospital Meaningful Use Objectives for 2011-2017

This attachment includes a graphic depiction of the alternative approach recommended in my comment letter and a complete list of the recommended hospital meaningful use objectives for 2011 to 2017, including recommended increases in the level of use, use of structured data, and health information exchange over time.



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2011/2012 Meet 25% (8) of: < 100 beds Meet 15% (5) of:	2013/2014 Meet 50% (17) of: < 100 beds Meet 30% (10) of:	2015/2016 Meet 75% (26) of: < 100 beds Meet 60% (20) of:	2017 Meet substantially all of:
1. CPOE (10% or more)	1. CPOE (10% or more)	1. CPOE (50% or more)	1. CPOE (substantially all)
2. Drug-drug/drug-allergy checks	2. Drug-drug/drug-allergy checks	2. Drug-drug/drug-allergy checks	2. Drug-drug/drug-allergy checks
3. Drug-formulary checks	3. Drug-formulary checks	3. Drug-formulary checks	3. Drug-formulary checks
4. Structured problem list	4. Structured problem list	4. Structured problem list	4. Structured problem list
5. Structured medication list	5. Structured medication list	5. Structured medication list	5. Structured medication list
6. Structured medication allergy list	6. Structured medication allergy list	6. Structured medication allergy list	6. Structured medication allergy list
7. Record demographics	7. Record demographics	7. Record demographics	7. Record demographics
8. Record vital signs	8. Record vital signs	8. Record vital signs	8. Record vital signs
9. Record smoking status	9. Record smoking status	9. Record smoking status	9. Record smoking status
10. Incorporate structured clinical-lab data (50%)	10. Incorporate structured clinical-lab data (50%)	10. Incorporate structured clinical-lab data (75%)	10. Incorporate structured clinical-lab data (subst. all)
11. Patient lists by condition	11. Patient lists by condition	11. Patient lists by condition	11. Patient lists by condition
12. 5 clinical decision support rules	12. 5 clinical decision support rules	12. 25 clinical decision support rules	12. 25 clinical decision support rules
13. Electronic copy of health information to patients on request	13. Electronic copy of health information to patients on request	13. Electronic copy of health information to patients on request	13. Electronic copy of health information to patients on request
14. Electronic copy of discharge instructions and procedures at discharge, upon request	14. Electronic copy of discharge instructions and procedures at discharge, upon request	14. Electronic copy of discharge instructions and procedures at discharge, upon request	14. Electronic copy of discharge instructions and procedures at discharge, upon request
15. Exchange key clinical information	15. Exchange key clinical information	15. Exchange key clinical information (CCD)	15. Exchange key clinical information (CCD)
16. Summary care record	16. Summary care record	16. Summary care record	16. Summary care record
17. Immunization registries (capability)	17. Immunization registries (capability)	17. Immunization registries (submit data if possible)	17. Immunization registries (submit data if possible)
18. Reportable lab results (capability)	18. Reportable lab results (capability)	18. Reportable lab results (submit data if possible)	18. Reportable lab results (submit data if possible)

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19. Syndromic surveillance data (capability)	19. Syndromic surveillance data (capability)	19. Syndromic surveillance data (submit data if possible)	19. Syndromic surveillance data (submit data if possible)
20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary	20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary	20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary	20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary
21. Use of evidence-based order sets (1 department)	*21. Use of evidence-based order sets (3 departments)*	*21. Use of evidence-based order sets (5 departments)*	*21. Use of evidence-based order sets (substantially all departments)*
22. Electronic medication administration record (eMAR) (1 department)	*22. Electronic medication administration record (eMAR) (3 departments)*	*22. Electronic medication administration record (eMAR) (5 departments)*	*22. Electronic medication administration record (eMAR) (substantially all departments)*
23. Bedside medication administration support (barcode/RFID) (1 department)	*23. Bedside medication administration support (barcode/RFID) (3 departments)*	*23. Bedside medication administration support (barcode/RFID) (5 departments)*	*23. Bedside medication administration support (barcode/RFID) (substantially all departments)*
24. Record nursing assessment in EHR (1 department)	*24. Record nursing assessment in EHR (3 departments)*	*24. Record nursing assessment in EHR (5 departments)*	*24. Record nursing assessment in EHR (substantially all departments)*
25. Record nursing plan of care in EHR (1 department)	*25. Record nursing plan of care in EHR (3 departments)*	*25. Record nursing plan of care in EHR (5 departments)*	*25. Record nursing plan of care in EHR (substantially all departments)*
26. Record physician assessment in EHR (1 department)	*26. Record physician assessment in EHR (3 departments)*	*26. Record physician assessment in EHR (5 departments)*	*26. Record physician assessment in EHR (substantially all departments)*
27. Record physician notes in EHR (1 department)	*27. Record physician notes in EHR (3 departments)*	*27. Record physician notes in EHR (5 departments)*	*27. Record physician notes in EHR (substantially all departments)*
28. Multimedia/Imaging integration (e.g., X-Ray viewing)	*28. Multimedia/imaging integration (e.g., X-Ray viewing)*	*28. Multimedia/imaging integration (e.g., X-Ray viewing)*	*28. Multimedia/imaging integration (e.g., X-Ray viewing)*

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29. Generate permissible discharge prescriptions electronically *30. Contribute data to a PHR* *31. Record patient preferences (language, etc.)* *32. Provide electronic access to patient-specific educational resources* *33. Reporting of RHQDAPU quality measures through existing process*	*29. Generate permissible discharge prescriptions electronically* *30. Contribute data to a PHR* *31. Record patient preferences (language, etc.)* *32. Provide electronic access to patient-specific educational resources* *33. Medication reconciliation across settings of care (pilot)* *34. Reporting of some RHQDAPU quality measures through EHR*	*29. Generate and transmit permissible discharge prescriptions electronically* *30. Contribute data to a PHR* *31. Record patient preferences (language, etc.)* *32. Provide electronic access to patient-specific educational resources* *33. Medication reconciliation across settings of care (if possible)* *34. Reporting of some RHQDAPU quality measures through EHR*	*29. Generate and transmit permissible discharge prescriptions electronically* *30. Contribute data to a PHR* *31. Record patient preferences (language, etc.)* *32. Provide electronic access to patient-specific educational resources* *33. Medication reconciliation across settings of care* *34. Reporting of all appropriate RHQDAPU measures through EHR*

Notes:

1. *ITALICIZED objectives from the HIT PC recommendations for 2013 and 2015*
2. *List Excludes proposed objectives on electronic insurance verification and electronic billing in all years, and medication reconciliation in 2011/2012 only.*