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The Council on Clinical Information Technology

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From the Chairperson

By Mark M. Simonian, MD, FAAP
Chairperson, Council on Clinical Information Technology

New Technology, New Questions

In the past this has been a good opportunity to write briefly about all the different activities with which the Council on Clinical Information Technology (COCIT) has been involved. There will be authors in this issue that will go over many of the venues and programs we have attended to represent pediatricians addressing technology issues that can affect their practice. This time I thought I would mention three trips I took this year; one strictly as a geek who loves to see technology and the others speaking for COCIT at the Annual Leadership Forum (ALF) and the Spring Executive Committee meeting.

About 10 years ago I spent three days in Las Vegas at Comdex, a vendor and user conference that covered hardware and software products that were under development and others you would see the following week in local stores. That conference has disappeared, but the Consumer Electronics Show in Las Vegas last January continues that tradition with hundreds of exhibits and over 150,000 attendees. At a good pace, it could take the most athletic person more than three days to walk the acres of exhibits. I mention this conference because it is the ultimate indulgence to see the fastest, biggest, and baddest computers, cameras and camcorders, televisions and monitors, sound systems and home theater systems, and on and on. It is the largest show of its kind in the United States.

Many of these technologies will touch you and your patients in some way in your office and home. Hardware was more powerful with wireless and remote capabilities improving and built into almost everything. Technology prices are dropping, and the integration with other devices like printers, faxes, telephones and video is becoming more seamless. We applaud ourselves if we capture pictures and place them into the record. We now see video and audio captured on ubiquitous smart phones. I wouldn't be surprised to find something else in our electronic charts, including a video example of a child's classroom behavior and patient, parent, or pediatrician conversations in a few years. One day soon, I am expecting a parent to show me a video of a swollen throat or wild behavior in the child's classroom. Do I charge for this and start preparing for terabytes of information storage? I also saw tools that recognize terrorists or other societal bad guys. I can imagine these same technologies used in medical applications to identify genetic anomalies or syndromes from evaluations

done in the office. If you have ever wanted the ultimate geek experience, consider the Consumer Electronics Show (http://www.cesweb.org/default.asp).

The COCIT Executive Committee met for the Spring meeting the third weekend in March in Chicago. This meeting was partly dedicated to reviewing our past strategic plans and determining how we might update the strategic vision. The following weekend I represented the Council at the Annual Leadership Forum (ALF). We proposed two resolutions, both of which passed. Hopefully these will be incorporated into our future activities too. I had the privilege to speak to some of the leadership on Listservs and other technologies in one room. We have an opportunity to return to Chicago in June to expand and refine the strategic plan, and you will have received an update on that process and our ideas before this article is published. Dr Joseph Schneider, Vice Chair, and several members of the Executive Committee will meet with a facilitator at that event. Enjoy the remainder of this newsletter.

From the Editor

By Craig M. Joseph, MD, FAAP
Editor, cocitnews

I'm reading a book called *How Doctors Think* by Harvard hematologist/oncologist Jerome Groopman. Dr Groopman is a researcher and chief of experimental medicine at Beth Israel Deaconess Medical Center. In his book, he explores the how's and why's of some medical errors, but not in the traditional way of a Morbidity and Mortality Conference. He notes that only 5% to 20% of medical errors occur because physicians just didn't know the right tests to perform or medications to prescribe. The vast majority of medical misadventure is due to errors in how we think.

Dr Groopman spends a few paragraphs discussing electronic medical records generally, and templated documentation tools specifically. He's not a big fan of fill-in-the-blank notes because physicians can easily not ask questions that they should. He notes that EMR users may "risk more cognitive errors, because the doctor's mind is set on filling in the blanks on the template. He is less likely to engage in open ended questioning, and may be deterred from focusing on data that do not fit on the template."

Those of us involved in creating, implementing, maintaining, and improving electronic medical records should all take note of Dr Groopman's book. As practitioners, we need to ensure that we don't make the same mistakes of logic and reasoning that he outlines. As physicians involved in some aspect of information technology, we want to minimize the chance that the tools we provide for our fellow physicians will lead them down the path of misdiagnosis or maltreatment.

As the new editor of *cocitnews*, I look forward to meeting as many of you as possible at this year's National Conference & Exhibition in San Francisco. Please feel free to e-mail me with any comments regarding the newsletter or COCIT in general at Craig.Joseph@EpicSystems.com. Also, if you'd like to contribute an article that may be of interest to your fellow COCIT members, please contact me. I'll start working on the Spring 2008 issue in November!

I'd like to give a special thank you to Mark Simonian, MD, FAAP, and Beki Marshall for all of their assistance with my first edition of *cocitnews*. Thanks!

Interested in Joining COCIT?

To join COCIT, contact AAP Membership at 800/433-9016. Ask for Membership.
Or, e-mail us at membership@aap.org.

Raising the Bar on the Pediatric EHR

By Eugenia Marcus, MD, FAAP
Executive Committee Member, Council on Clinical Information Technology
(reproduced from the August 2007 issue of AAP News*)*

With the advent of the Certification Commission on Health Information Technology (CCHIT), a physician can be assured that a certified electronic health record (EHR) has all the basic functionality needed to run an office. But how do all these functions affect physician workflow?

In May, the Medical Records Institute sponsored its annual Towards an Electronic Patient Record (TEPR) conference in Dallas. A key part of the conference is the Clinical Documentation Challenge, in which EHRs from various vendors are compared.

Members of the AAP Council on Clinical Information Technology (COCIT) developed a pediatric scenario to put the EHRs to the test. Five vendors participated in the pediatric event, which was packed with attendees. Additional vendors were forced to withdraw due to the requirement that a practicing clinician be the presenter. In previous events, presentation quality and the presenter's ability to field audience questions improved when this criterion was met.

Three COCIT members familiar with EHRs through usage or development judged the event. None of the judges had a conflict of interest.

In 2001, the Academy published a policy statement on, "Special Requirements of Electronic Health Records Systems in Pediatrics." A revised version of the statement was published in March 2007 (*Pediatrics.* 2007;119:631-637). This statement served as the foundation for the pediatric Clinical Documentation Challenge requirements.

In recent years, the competitors were fairly evenly matched, with most able to meet all requirements. This year, some new challenges were introduced.

The scenarios and a pre-populated continuity of care record (CCR) were released to the participating vendors 24 hours before the presentation.

The morning scenario was a classic presentation of a 15-month-old well-child visit. The afternoon scenario was an adolescent girl new to the practice who arrived with an electronic summary of her medical records and needed an emergency summary form required by the school. New immunizations were available.

The vendors were challenged not only to complete all the elements, but to show how their software was updated by the information contained in the CCR.

Importing a CCR was a new challenge that most vendors can do under controlled test conditions. The CCR already is an approved standard of the American Society for Testing Materials. The challenge in this event was that the CCR contained live data taken from the software of an EHR vendor that did not participate in this year's challenge. The data were unencrypted and de-identified by CapMed, a company that specializes in personal health records.

Four of the five companies were able to import the CCR as it was presented. The immunizations, demographics, allergies, medications and procedures of the new patient immediately populated the vendors' software.

The emergency information form, developed by the AAP Committee on Pediatric Emergency Medicine and the American College of Emergency Physicians, also was used with the Academy's permission. Points earned by the vendors for the morning and afternoon sessions were totaled, and the vendors were ranked at the end of the day.

There was a tie for first honors, which went to Bond Medical and Medical Communications Systems. Second honors was earned by e-MDs. Two vendors, Office Practicum and Practice Partner, also tied for third honors.

The Pediatric Documentation Challenge will be repeated at the AAP National Conference & Exhibition from 1:30-6:00 p.m. Saturday, October 27 in the Technology Learning Center. This presentation will not be judged.

Do We Know How To Find You?

To ensure that your contact information is kept up-to-date (so your colleagues can find you), please take the time to visit the Membership Information Change Form (www.aap.org/moc/memberservices/updatememberinfoform.cfm). You need to be logged into the Member Center to get to this link. If you prefer to contact us by phone or fax, you can do this by calling 866/THE-AAP1 and providing one of the AAP customer service representatives with your updated address information.

Top Terminology Troubles for Tots

By S. Andrew Spooners, MD, MS, FAAP
Immediate Past Chair, Council on Clinical Information Technology

"This system is not peds friendly!" How often have your heard that?

There are lots of ways that an electronic medical record system (EMR) can fail for pediatric care. It might have inadequate growth charts, cumbersome immunization recording, or lack weight-based dosing decision support.

But there is a way an EMR can fail for kids that has nothing to do with the "functions" of an EMR: it can have an inadequate terminology system. Terminology systems define what items can appear in pick lists, in problem lists, in check box forms . . . anywhere *structured data* (as opposed to free text) can appear. Unless the right terms are there, you may have to resort to free text to capture the concepts you want to express, or use an inappropriate term altogether.

Below are ten areas where pediatrics and terminology systems collide. When you look at EMR systems, keep these areas in mind to make sure your system can express the concepts (symptoms, signs, problems, therapies, etc.) you need to express.

1. **Lumping of diagnoses**. This is the big problem when the International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM) is used to encode diagnoses or problem lists. ICD-9-CM was never designed to be a descriptive terminology system for diagnoses. But because we need to use ICD-9 codes in bills, most EMR systems allow items on the problem list to map to the most relevant ICD-9 code. Two very different problems may map to the same ICD-9 code, and that's OK. The problem arises when one tries to use ICD-9 *itself* as a way to code problem lists. It does not work. For example, you may want to note that Child A's head is unusually large; you want this on the problem list so that you can monitor head growth a little more closely than you might ordinarily. Child B, on the other hand, has craniosynostosis and has been operated upon by neurosurgery; you want to add craniosynostiosis to his problem list. If your EMR supports only ICD-9 codes for problem list descriptions, you will find:

   756.0 Congenital Anomalies Of Skull And Face Bones

   This term has to suffice for both benign macrocephaly and pathologic craniosynostosis. This is not the fault of ICD-9. The problem is the application of this terminology system to a use for which it is inappropriate. The take-home point is that if your EMR uses only ICD-9 codes for problem lists, you have a big problem!
2. **Rare conditions that are more common in kids than adults**. Eponymous syndromes are rare individually, but common collectively in any pediatric practice. Grab your copy of Smith's *Recognizable Patterns of Human Malformation* to see if your EMR can record these rare syndromes.
3. **Symptoms and signs that are more common in kids than adults.** Adults can be fussy, can turn red, and have high-pitched cries, but, let's face it, all of these are terms that we only apply to babies. Conversely, "standard" review-of-systems templates contain terms that simply cannot be applied to the very young: headache, abdominal pain, anxiety. . . anything that requires introspection and self-report. Add to this the symptoms and signs related to school problems and you have quite a good list of terms that might be left off the screens of an "adult" EMR.
4. **Lumped concepts that ought to be separate in kids**. In terminology systems, terms can be "coordinated" by combining multiple concepts into a single term that is used as a single term in clinical documentation. "PERRLA" (pupils equal, round, and reactive to light and accommodation) is a good example of a term that arrives "pre-coordinated" for your use in some terminology systems. But since we do not evaluate an infant's pupils' accommodation to light, we need the term "PERRL" or we might have to document using the individual, uncoordinated terms.
5. **Point-of-view problems**. This is particularly important when one is describing events involving the interaction between a parent and child. For example, a list of breastfeeding symptoms may apply to the baby's behavior or the mother's. Pre-coordinated terms that embed an action on the part of the patient, when the action was really taken by the parent, are a problem here, too. Does "self-reported wheezing" make sense if it's the parent who is reporting it? Environmental exposure terms are also a problem, since a parent or caretaker's exposure is really the child's exposure. Does "Works with heavy metals" make sense to apply to a preschooler when it is the parent who does the working, but exposes the child secondarily?

6. **Things that change in kids that are assumed to stay the same in adults**. Educational status is a great example of this. One may have terms to indicate only what grade level was completed, ignoring the possibility that the patient might *still be* in second grade. If educational status is stored in the system as a feature of the patient (like an allergy) rather than of the encounter (like today's chief complaint), it may be difficult to track educational progress over time.
7. **Symptoms that depend on patient report**. Our patient's lack of ability to verbalize their signs and symptoms can occasionally cause problems with terminology. Even such common complaints as "headache" or "sore throat" don't quite do it for young kids.
8. **Symptoms and signs that are abnormal in adults but normal in kids, or vice versa**. Neonatal reflexes are the best example of this. The problem arises when one has a checkbox-style form where the user can indicate "all normal" based on internal definitions of normal. Unless there is age-sensitivity built into the form (or into the terms themselves, if semantics are built in, as in a system like Medcin) the interpretation of normal will be inaccurate.
9. **Descriptors of maternal physiology with implications for newborn**. In the first days of life, maternal and infant physiology are hard to extricate. For example, "group B Strep positive" for a mother means "colonized with group B Strep," and for a baby might mean "delivered of a group B Strep-positive mother" or "colonized with group B Strep based on surface cultures" or even "infected with group B Strep." It may require more coordination of terms to accurately reflect the nuances of what is meant clinically.
10. **Age-appropriate items**. Terminology management in most EMRs helps you with switching to gender-specific terms; for example, it's common to see some sort of automated switching of terminology from "Breast Self Exam" to "Testicular Self Exam" in a template for patient instructions depending on gender. But it is less common to see automated switching of terms based on age. Clearly, this is trickier.

How a given EMR handles terms is apt to be quite different from how any other EMR handles them. When you evaluate an EMR, pay close attention to how the terms satisfy child health data needs, and clarify with your vendor where you have a choice in terms and where you may be forced to use terms you cannot control. Also ask about whether the EMR uses or can use third-party terminology systems, which may be out of the vendor's control.

"Informatics" for the Rest of Us

By Kristin Benson, MD, MS, FAAP
Executive Committee Member, Council on Clinical Information Technology

You are a primary care pediatrician. You know that we need computers for information management. Data in, data analyzed, information out. Maybe you even have an electronic medical record (EMR). But is it doing what it should? Here are some simple tests to find out if your data are properly computerized:

1. Data are only entered once. You can populate daycare and sports forms using the data from your last well child check. Data from parents, registration personnel, lab, radiology, and nursing are never entered more than once.
2. You never calculate a drug dose by weight. A computer does this better — it is not your job anymore.
3. Charting is done faster and more accurately than it ever was with paper.
4. You can look at the outcomes of patients in the practice. You can sort, query, and do simple statistics on de-identified data from your panel or practice.
5. You can see lab, X-ray, meds, summary notes, consultants, and follow-up plans listed by problem on a single page.

Not there yet? Join the rest of us. But keep your sights on the "Holy Grail" of using clinical data to inform medical decision-making and optimize patient care.

We physicians all need to understand what a database can and cannot do, what structured data is, how to work with our IT departments, and how to utilize computers, one of the *most powerful medical devices ever invented*! It is our responsibility as doctors to improve our competency and that of our colleagues in medical informatics.

What can you do? Here are some ideas and programs to consider:

- The AAP Council on Clinical Information Technology (COCIT) offers a full educational program each year at the National Conference & Exhibition (NCE), including an EMR Pediatric Documentation Challenge, a Technology Learning Center to exposure you to new technology, talks on various issues relating to pediatric systems, and a scientific abstract session of pediatric informatics research.
- There is a website full of helpful links and updates maintained by COCIT at http://www.aapcocit.org/. There is a growing EMR evaluation review project available through this site.
- The AAP Section on Epidemiology offers an excellent refresher in statistics at the NCE. Practice Research in Office Settings (PROS) is working on data collection at the point of care. The Section on Administration and Practice Management has a new "Practice Management Online" site at http://practice.aap.org.
- The American Medical Informatics Association (AMIA), a premiere informatics organization for medical professionals, has a "10X10" goal of training 10,000 health professionals in Health Informatics by the year 2010. AMIA has categorized IT training opportunities by level of time commitment and intensity on their website. You can easily find what suits your needs in the time you have available. The following categories of training are included:
    - Associate degree in informatics
    - Undergraduate degree in informatics
    - Masters degree in informatics
    - PhD in informatics
    - Informatics specialization within other degree programs
    - NLM-sponsored post-doctoral fellowships
    - Other post-doctoral research fellowships
    - Certificate program

  Contact information and details are available at http://www.amia.org/informatics/acad&training. CME credits are available for all the AMIA conferences, and there are pricey but excellent pre-conference seminars available. There is a wealth of information on their website. AMIA has distinguished itself for over 30 years with physician members who are pioneers and visionaries as well as scientists and clinicians. Two past members of the COCIT Executive Committee currently serve on the board: Kevin Johnson, MD, FAAP, and Chris Lehmann, MD, FAAP. One of the programs available is a 12-week online course developed by the Oregon Health and Sciences University, ending with an in-person session at the Annual AMIA Conference this November in Chicago. The fee is $2,000; you can find out more about this program

at: http://www.amia.org/10x10/partners/ohsu/description.asp

- National Library of Medicine Fellowships are available for physicians who wish to do graduate work but cannot financially afford to leave their practices.
- The "E-Health Initiative" at http://www.ehealthinitiative.org is a non-profit collaborative organization focusing on systems interoperability, public policy, and Regional Health Information Organization (RHIO) development. Continuing Medical Education (CME) credits are also available for these conferences.
- The Health Information Management Systems Society (HIMSS) at http://www.himss.org/ASP/index.asp has a national network of state and local chapters. They also sponsor a huge annual conference, with more of an industry focus.
- There are often resources through university informatics programs. For example, the University of Minnesota has an excellent weekly seminar on an array of topics in informatics available online at no cost.
- For those who can't bite off much, do a database tutorial online, work through a simple database using Microsoft Access and the help menu, or pick up a slim how-to book.
- Talk to your colleagues about clinical information management. If you don't have an EMR, do you have a committee looking into it? If you do, how is your pediatric department communicating with your IT department? Is there a forum for suggesting changes and/or standardization within your group?
- Check to see who your state COCIT representative is. Volunteer to represent COCIT in your state if there is none.
- Consider representing pediatrics at your RHIO organization.
- Consider doing a quality improvement or clinical research project using electronic data from your EMR.

Embrace the new challenges and advocate for informatics! We primary care doctors "in the trenches" need to be armed with everything computers can give us. We owe it to ourselves and our patients. And with an organized, informed voice we can someday get exactly what we need.

Child Health Functional Standards for EHRs

By S. Andrew Spooners, MD, MS, FAAP
Immediate Past Chair, Council on Clinical Information Technology
Co-Chair, Health Level 7 Pediatric Data Standards Special Interest Group

One-third of the US population is children, and over half receive care in non-pediatric settings. It is imperative that anyone using a computer system to provide health care to a child have access to a level of functionality that at a minimum will meet the basic needs of children.

In a continued effort to improve vendor systems for child health care and interoperability, the Health Level Seven (HL7) Pediatric Data Standards Special Interest Group (PeDSSIG) is working to publish child health functional standards for electronic health record systems. The work was registered with HL7 this summer as a "Child Health Functional Profile" (Child Health-FP) - a companion document to the HL7 Electronic Health Record-System Functional Model standard, which includes a number of important child health functions. Over 40 volunteers representing a variety of constituent groups are contributing to the Child Health-FP. The PeDSSIG plans to bring the Child Health-FP through the HL7 ballot process - anticipating it will ultimately become an HL7 standard in early 2008. It is hoped that this work will be useful to the new Child Health Expert Panel, which will be working through the Certification Commission for Healthcare Information Technology (CCHIT) to ensure that critical child health certification criteria are included in CCHIT's work.

For more information about the Child Health-FP and/or the PeDSSIG, please contact Joy Kuhl, PeDSSIG Administrative Co-Chair, at joy.kuhl@chca.com. The next PeDSSIG work group meeting will take place in January in San Antonio, Texas. You do not need to be an HL7 member to participate.

The work of the PeDSSIG is largely supported by the Alliance for Pediatric Quality - a collaborative of four national organizations representing pediatrics - American Academy of Pediatrics (AAP), American Board of Pediatrics (ABP), Child Health Corporation of America (CHCA) and National Association of Children's Hospitals and Related Institutions (NACHRI).

The Physicians Electronic Health Record Coalition

By William Zurhellen, MD, FAAP
Member, Council on Clinical Information Technology

The Physicians Electronic Health Record Coalition (PEHRC, pronounced "perk") was created three years ago by a consortium of twenty-three medical societies representing over 600,000 physicians, to facilitate the interchange of information. Its mission is to assist physicians, particularly those in small- and medium-sized ambulatory practices, to acquire and use affordable, standards-based electronic health records (EHRs) and other health information technology (HIT) for the purposes of improving quality, enhancing patient safety, and increasing efficiency.

To pursue this mission, the PEHRC meets five times yearly, providing several important forums:

- Meeting with government and industry leaders to both acquire information on upcoming technology and programs, as well as to present practitioner concerns and needs.
- Exchanging and sharing ideas, information, activities, and strategies between the coalition members, such as the AAP's Toolkit on selecting and implementing EHRs.
- Presentations and reports on current activities and progress of other HIT organizations, such as the American Health Information Community (AHIC), the Health Information Technology Standards Panel (HITSP), Health Level-7 (HL7), and the Certification Commission for Health Information Technology (CCHIT), to develop an overall consolidated understanding of progress towards a National Health Information Network (NHIN.)

At the last meeting in June hosted by the American Urological Association at its Linthicum, MD, headquarters, PEHRC heard a report from CMS on the current 2007, as well as the upcoming 2008, Physicians Quality Reporting Initiatives (PQRI) performance measures to be released in the coming months. There also was a presentation by Liora Alschuler, of Alschuler Associates and co-chair of HL7's Structured Documents Technical Committee, on the current status of Common Document Architecture (CDA) development.

The American Academy of Pediatrics (AAP) and the other two primary-care academies, the American Academy of Family Practice and American College of Physicians, are in the forefront of the movement towards NHIN and EHR development and deployment, with representatives to virtually all major HIT entities. We appear to be far ahead in comparison to many other specialty academies, both in terms of the timeline as well as the involvement, in the HIT process—and are well-respected in the clinical IT world. BUT (isn't there always the proverbial big "BUT") there remains a major roadblock. The vendor world responds to a different drummer…the market dollar. The pediatric "market" for IT in terms of hardware and software sales is small in comparison to the adult, specialty, and institutional markets—as a result getting vendors to incorporate pediatric needs into the EHR is a difficult "sell."

What is slowly changing or eroding this roadblock is the realization that the dollar value of aggregate clinical information, stored in the longitudinal ambulatory-care EHR, is enormous, and pediatrics is a large part of that value. As a result of this trend, purchasers of healthcare information such as federal and state governments, healthcare payers, and employers are starting to press vendors to include pediatric indicators into the EHR, and will likely prove to be the strongest force in making sure that EHRs are pediatric-friendly.

This, however, brings up another traditional "roadblock" — that of the "double-edged sword." While all of us as pediatricians need access to aggregated clinical information for quality improvement and patient management, those same facilitators - federal and state governments, healthcare payers, and employers - want the information for purposes of cost-control and quality assurance. The major battle facing us as clinicians is to assure that the development and deployment of EHR and NHIN technology is dedicated to quality improvement by looking at episodes of care, outcomes, and costs-of-care, and not simply at the cost-containment which we all are experiencing now.

We must pay as much attention to what we get OUT of the EHR as to what, and how, we put information INTO the EHR. We must make sure that the methodologies of defined-episodes-of-care, outcomes measurement and analysis, costs-of-care are built in, not simply just "performance measures" based on cost or adherence to pre-defined guidelines. We have to make sure that EHRs can appropriately transmit and receive information between physicians and other service providers.

Practice decisions are risk/benefit or cost/benefit decisions—we need to ensure that the benefits of EHR and NHIN technology far exceed costs and risks. And that is what the PEHRC is all about.

Using High Quality Information to Balance Territorial and Compassionate Interests

By Phillip Gioia, MD, MPH, FAAP
Member, Council on Clinical Information Technology

Regardless of any theory of how improving health and treating disease should be done, we should design information systems to capture all relevant variables with economic factors being the key to improved efficiency and sustainability. This would be true with the modular approach to disease management of Professor Porter (makes sense in Boston or any large city) or holistic approach of Family Practice (General Pediatrician in a rural area) or with the use of market forces or with the use of government planning. All would benefit from knowing what works and at what cost. A data system that captured this information (financial and clinical) and that was available for administering private payments (insurance or self-pay) with or without high deductibles and government programs would also allow the health insurance and/or third party administrator market to be more transparent and elastic (allowing new competitors to easily enter the market without spending millions of dollars for a data system). Current Electronic Medical Records (EMRs) and Regional Health Information Organizations (RHIOs) are designed to make the market for medical care more elastic, thus helping the payers get medical care at a better price. We should similarly help our friends in the medical payer industry with pay for performance for payers.

I learned about markets at Columbia's University's School of Public Health at the expense of the New York State Health Department's Public Health Residency Program. I learned much more about running an office, health insurance and health economics there than in medical school or pediatrics residency. Before that I had thought of markets mainly as a place to get vegetables. We all know that when we or our patients try to buy health insurance in the health insurance marketplace we often find poor choices that are often very expensive and fail to meet our preferences. Well-functioning markets would allow competitors to come in at a lower price with a similar product to capture the demand for a low-cost product. Now the insurance costs are mainly decreased by increasing the upfront costs for the patient or family by getting higher deductibles.

Would it be possible to save money by keeping people healthy and/or limiting administrative costs? Preventing disease by improving safety, decreasing smoking and drug use, and controlling infections often takes difficult life style changes that take work and may fail to benefit health with in the financial year or health care contract. Decreasing administrative costs would cut financial resources for the present companies. Would someone else who is willing to work harder and make less money want to come into that low-profit but potentially large market for low-cost low-deductible insurance? Maybe, but now it takes huge start up costs to set up contracts with health care providers, set up healthcare payment data systems and to capitalize the insurance corporation to cover potential losses. These barriers make the health insurance marketplace inelastic. Even for a large community group or a large business that could be self-insured the setting up of contracts with health care providers and the data system creation is a large barrier. Large groups or organizations might pay for umbrella insurance to cover an unusual event that might occur, if they had a public or open data system that they might rent or pay a reasonable fee for use they might enter into contracts with well known local health care providers to improve their health and save their resources. This data system would network EMRs or act as the RHIO along with providing financial administration and analysis. This same publicly regulated or controlled data system may be used by large insurance companies to provide better service and save them on their data and administration costs. The public through the health departments may use the data to evaluate payment plans for their health care outcomes and their economic efficiency.

In *Your Way to Better World Health: Using Knowledge to Balance Territoriality and Compassion,* I discuss the need to balance the ancient vertebrate tendencies to protect territory and to want to help the young, the helpless, and the suffering. Much of our irrational behavior is explained from what we observe our fellow vertebrates doing. Our id represents our territorial part that gets defensive and anxious when threatened by change or conflict. Our ego tries to help others and is balanced with the id by the super ego. In healthcare, our passion to help people with an efficient system comes into conflict with the territorial interests of insurance or third party administrator companies (economic territories) and with the territorial interests of politicians, planners, bureaucrats, and academics (intellectual territories). Elastic or more open markets often decrease profits for companies in the short run, though in the long run it would guarantee private sector participation by improving private company efficiencies to enable them to compete and beat government programs that are inherently slower to change and adapt. This potential for future success is rarely enough to get us to change from a current success as Machiavelli notes in *The Prince:*

"It must be considered that there is nothing more

difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order, this lukewarmness arising partly from fear of their adversaries, who have the laws in their favour; and partly from the incredulity of mankind, who do not truly believe in anything new until they have had actual experience of it. Thus it arises that on every opportunity for attacking the reformer, his opponents do so with the zeal of partisans, and the others only defend him half-heartedly, so that between them he runs great danger."

Intellectuals on the right will be threatened by a data system that the government may use to regulate and adapt the free market to best meet the needs of our nation. Intellectuals on the left will be threatened by the economic evaluation of human services that appeal to our compassion though may be unsustainable given our present technology and resources. Similar problems exist in creating a rational energy market as noted by Vijay Vaitheeswaran in *Power to the People* (http://www.vijaytothepeople.com/). The website http://pages.prodigy.net/pcgioia has the first two chapters of the book *Your Way to Better World Health: Using Knowledge to Balance Territoriality and Passion.* The rest are available for purchase (my intellectual territory), though free copies are available for those in need (my compassion) and for book reviewers (a mix of territorial interests and compassion).

COCIT Announces 2008 Oberst Award Winner

The Council on Clinical Information Technology (COCIT) Executive Committee has selected David M. N. Paperny, MD, FSAM, FAAP, to receive the 2008 Byron Oberst Award. The Award is presented each year to a COCIT member who has made a significant contribution to the field in one or more of the following areas:

- Improving pediatric clinical information systems
- Educating child health professionals in the use of clinical information technology
- Creating health policies that promote better use of pediatric clinical information systems

Current COCIT Executive Committee members are not eligible to receive the award.

Dr Paperny has been in the forefront in the development and implementation of novel clinical software systems for use in Adolescent Medicine, as typified by his Teen Health Advisor system, used by Kaiser Permanente. Dr Paperny has contributed to professional education through his participation in COCIT's Technology Learning Center and through his service as a faculty member at the AAP National Conference & Exhibition (NCE) and other AAP educational offerings. He has acted in an advisory capacity, using his technical expertise, in AAP-related activities, such as Bright Futures. He has been a long-term active member of COCIT and its predecessor, the Section on Computers and Other Technology (SCOT), serving on the SCOT Executive Committee and on the COCIT Nominations Committee. Dr Paperny has also been active within the Kaiser structure and within his AAP Chapter to promote children's health and the use of technology to improve both the delivery and the quality of care.

The Award, which includes a plaque and honorarium check, will be presented to Dr Paperny on Sunday, October 28, 2008 at 12:00 noon during the COCIT's Council Program for Council Members (H218) at the AAP National Conference & Exhibition (NCE) in San Francisco, California. Dr Paperny will be asked to give a brief lecture. All are invited to attend.

Content Submission

Would you like to contribute to this newsletter? Articles should be approximately 500 to 1,000 words in length. Submit articles to Craig M. Joseph, MD, newsletter editor, at Craig.Joseph@EpicSystems.com.

Watch the Council on Clinical information Technology (COCIT) Web site at www.aapcocot.org for information on submission deadlines for the Spring 2008 issue.

Automated Result Notification (ARN) - An Innovative Tool for Inpatient Care

By Chris Longhurst, MD, MS, FAAP
Member, Council on Clinical Information Technology

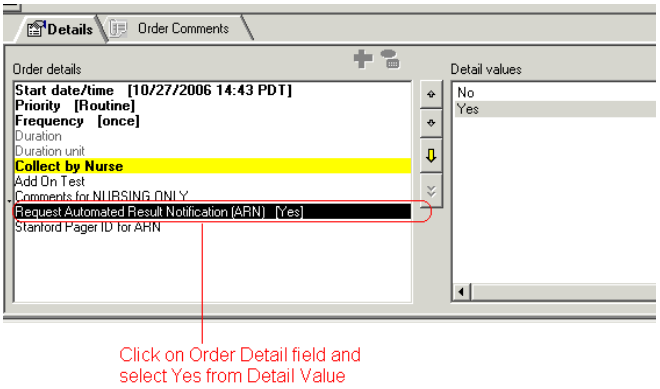
The workflow of clinicians in the inpatient setting is highly interruptive by its very nature. "Push" is a key modality for satisfying the information needs of clinicians in this type of environment, and pagers are a key tool for pushing content.[1] Shortly after the introduction of wireless pagers in the 1980s, this disruptive technology spread nationwide like a virus and permanently altered the nature of hospital communication.[2,3] Despite the popular adoption of mobile phones in the late 1990s, pager use continues unabated in healthcare.[4] Recent data from our own institution suggests that alphanumeric paging technology has the potential to reduce interruptions in patient care and improve physician work efficiency and satisfaction.[5] This same technology can also be leveraged by coupling it to the hospital information system.

In 2002, Poon et al. described an innovative system that allows ordering physicians to request selected lab results to be delivered by alphanumeric pager.[6] The authors concluded, "this feature has been heavily used by clinicians at our hospital and may reduce delays in patient care. Although further evaluation is needed to measure the direct effects, its popularity suggests that other clinical information systems should consider implementing a similar feature."

Inspired by this work, we developed a similar tool in our Cerner system at Lucile Packard Children's Hospital (LPCH) called Automated Result Notification (ARN). When placing a lab order in PowerChart®, our clinicians now have the opportunity to decide if they want to be automatically notified by pager when results are available. To avoid violating Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, we do not deliver the actual lab result, but rather a message such as "Requested results are available for patient 4000000-2 on 2N." This message alerts the physician to login to the system and review the relevant result. Unlike the so-called "Shabot alerts" for critical results, ARN pages are delivered only when requested by the ordering physician.[7,8]

Much like "flight status notification" obviates the need for customers to repeatedly check flight times, ARN eliminates the need to repeatedly check the clinical information system for desired data. This process improvement tool was readily understood and adopted by our physicians as evidenced by its ongoing usage rates. One LPCH doctor recently commented, "This tool is especially useful on the transplant patients. When subsequent Prograf doses are based on that morning's Prograf level, having the ability to receive a page when the lab is available is extremely useful. It ensures that we do not forget about the lab (and hence the patient possibly receiving a sub-optimal or super-therapeutic dose again) and it allows us to function more efficiently without needing to check every 10 minutes to see if the lab has arrived. The same holds true for all labs that may hold up discharge. For example, patient A can be discharged if his repeat K is less than 4.5."

Available data suggest that physicians would prefer even more information pushed than is currently practiced, as long as the clinicians themselves can choose what is delivered.[1] Given the success of ARN for laboratory orders, we plan to extend this tool to other clinical categories in the near future as we continue to measure usage and outcomes data.



[1] Wagner MM, Eisenstadt SA, Hogan WR, Pankaskie MC. Preferences of interns and residents for email, paging, or traditional methods for the delivery of different types of clinical information. Proc AMIA Symp. 1998; 140-4.
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[4] http://en.wikipedia.org/wiki/Pager
[5] Nguyen TC, Battat A, Longhurst C, Peng PD, Curet MJ. Alphanumeric paging in an academic hospital setting. Am J Surg. 2006; 191:4:561-5.
[6] Poon EG, Kuperman GJ, Fiskio J, Bates DW. Real-time notification of laboratory data requested by users through alphanumeric pagers. J Am Med Inform Assoc. 2002 May-Jun;9(3):217-22.
[7] Shabot MM, LoBue M, Chen J. Wireless clinical alerts for physiologic, laboratory and medication data. Proc AMIA Symp. 2000;:789-93.
[8] Reddy MC, McDonald DW, Pratt W, Shabot MM. Technology, work, and information flows: lessons from the implementation of a wireless alert pager system. J Biomed Inform. 2005 Jun;38(3):229-38.

EXECUTIVE SUMMARY
COUNCIL ON CLINICAL INFORMATION TECHNOLOGY
EXECUTIVE COMMITTEE

March 24, 2007
AAP Headquarters
Elk Grove Village, IL

The Council on Clinical Information Technology (COCIT) Executive Committee met in Elk Grove Village, Illinois on March 24, 2007. The Executive Committee discussed the following items:

- The Fiscal Year (FY) 2006-2007 budget was reviewed. It is estimated that COCIT's reserve fund should have a positive balance by the end of 2007.
- The Committee reviewed the status of the 2007 Section/Council elections and were reminded of the need to complete an Annual Report of Councils for FY 2006-07.
- The Committee reviewed nominees for the 2007 Byron Oberst Award and will select a recipient, pending approval by the Council Management Committee and the Advisory Committee to the Board on Practice.
- The Committee discussed a process for more timely response to calls for public comments and requests from outside organizations.
- Plans were discussed for the 2007 AAP National Conference & Exhibition (NCE), the Technology Learning Center (TLC), and topic proposals for the 2008 NCE. The 2007 TLC proposal includes a demonstration area in the Exhibit Hall and a new Pediatric Office of the Future exhibit. The Office of the Future will allow attendees to walk through a health information technology-equipped pediatric office. Both the demonstration area and the Office of the Future are tentative until corporate sponsorship can be secured to cover the expense of these activities.
- Plans were discussed for the scientific program that will take place during the 2007 NCE. This year, for the first time, the Call for Abstracts was distributed to informatics fellowship training programs.
- Dr Simonian and Ms Marshall continue to work to identify a newsletter editor for the Fall 2007 issue.
- Plans were discussed to increase the level of difficulty of the Pediatric Documentation Challenge™ for both the Toward an Electronic Patient Record (TEPR) conference and the 2007 NCE. Plans include requiring vendors to demonstrate use of the AAP/American Academy of Emergency Physicians Emergency Information Form for Children With Special Needs. Use of this form by vendors will require permission from the AAP; however, no licensing fee will be charged to the vendors.

Designate Your Friends of Children Fund Contribution for COCIT's Activities!

Did you know that you can designate your tax-deductible Friends of Children Fund contribution to specific programs or even a Section or Council? You can donate online at https://www.aap.org/sforms/fcfform.htm. Toward the bottom of the form, where it says, "Please apply my gift to:" select "a program of my choice" and type "COCIT" in the text box. Donations received in this manner will supplement your COCIT dues and allow COCIT to continue ongoing programs or launch new programs. We appreciate your support!

- An update was provided on the new Applications Committee. One of the tasks of this committee will be to work with the AAP Division of Product Development on electronic tools to be part of the Pediatric Care Online project that will launch early in 2008.
- The committee discussed the recent move of COCIT Members Only web site content to the AAP's Member Center. Content may still be accessed through a link on the COCIT home page, but members may now use their AAP ID and password to access that content. In addition, plans were discussed to continue promoting the AAP EMR Review Web site to *AAP News* in hopes of attracting new reviews.
- Liaison reports were given on the Continuity of Care Record, the eHealth Initiative, the Certification Commission for Health Information Technology, the Health Information and Management Systems Society Electronic Health Record Vendors Association, the Health Information Technology Standards Panel, the National Medical Association, the Physicians Electronic Health Record Coalition, the Section on Hospital Medicine, and the Steering Committee on Quality Improvement and Management.
- Updates were provided on the work of the Partnership for Policy Implementation and legislative advocacy efforts by the AAP Washington Office.

The COCIT Executive Committee will next meet on Monday morning, October 29, 2007, during the AAP NCE.

For a complete set of minutes or further information on specific items, please contact Rebecca Marshall, Manager, Health Information Technology Initiatives, at 800/433-9016, ext 4089 or bmarshall@aap.org.

COMMITTEE UPDATES

Policy Committee

By Mark A. Del Beccaro, MD, FAAP
Chairperson, Council on Clinical Information Technology Policy Committee

The members of the Policy Committee continue to work both on policy development and serve on a variety of health information technology (HIT) working groups trying to make sure the needs of children and adolescents are taken into account in public policy and software development.

The current membership of the Policy Committee includes:

- Eric Tham, MD, MS, FAAP, who recently finished his fellowship in Pediatric Emergency Medicine and his Masters in Biomedical Informatics. He will be joining the faculty at Denver Children's Hospital. Eric has also been selected to serve on the new Certification Commission for Health Information Technology (CCHIT) Emergency Department EHR Workgroup and the Child Health Expert Panel.
- Greg Lund, DO, FAAP, who recently relocated from Plantation, Florida to Park City, Utah and is recently retired as a Medical Informatician from Pediatrix Medical Group. After taking the summer to enjoy family time, he will be looking to rejoin the informatics world in another capacity.
- Willa Drummond, MD, FAAP, works as a neonatologist in Florida and has a strong interest in medical terminology. She is also joining the CCHIT Child Health Expert Panel.
- Eugenia Marcus, MD, FAAP, who continues her great work as a pediatrician in Newton, Massachusetts. Among her informatics work, she is continuing on the CCHIT Ambulatory EHR Workgroup and is a Co-Chair for the new Child Health Expert Panel.
- Joseph Schneider, MD, MBA, FAAP, is CMIO at Dallas Children's and is the Council on Clinical Information Technology (COCIT) Vice Chair.
- Alan E. Zuckerman, MD, FAAP, is a practicing pediatrician and Director of Primary Care Informatics at Georgetown University School of Medicine. Dr Zuckerman is the Co-Chair for the CCHIT Interoperability Expert Panel.
- I will continue this year as the CCHIT Inpatient Functionality Workgroup Co-Chair.

With the exception of Eric Tham, these Policy Committee Members are also currently on the COCIT Executive Committee.

We would also like to thank Andy Spooner, MD, MS, FAAP (COCIT Immediate Past Chair), Kristin Benson, MD, FAAP (Executive Committee Member), George Kim, MD, FAAP (Executive Committee Member) and Mark M. Simonian, MD, FAAP (COCIT Chair) for their many efforts including working with the Policy Committee. As always we are greatly indebted to Beki Marshall for her help in all things that keep our committee moving. It is a great time working with everyone in these efforts and on COCIT.

The following policies currently are currently being worked on by members of COCIT:

- Alan Zuckerman, MD, FAAP, and Joseph Schneider, MD, MBA, FAAP, are working on a statement dealing with personal health records. This is a rapidly evolving area but having a policy from the American Academy of Pediatrics (AAP) will be a great tool for discussion in various governmental and vendor communities
- Chris Lehmann, MD, FAAP, and George Kim, MD, FAAP, continue to work on their technical report entitled "Pediatric Aspects of Inpatient Health Information Technology Systems." This will be an important work that will serve as a reference by many organizations including the CCHIT.
- Eugenia Marcus, MD, FAAP, and Donna D'Alessandro, MD, FAAP, have completed their first round draft intent statement for revising the Email Communication Clinical Report. This will certainly be a timely and important policy statement as more and more families and providers are faced with the challenges of email communication.

COCIT Policy Committee (thanks to Drs Drummond, Schneider, Tham, and Zuckerman who have helped me on this one) is also participating as a co-author on the revision of the Committee on Pediatric Emergency Medicine's Emergency Preparedness for Children with Special Health Care Needs Statement and its accompanying Emergency Information Form.

Following a strategic planning retreat this June, the Policy Committee will reassess what policies are lacking. While this may seem a bit "dry," it is important to remember these are used by the AAP to influence a variety of initiatives and to provide AAP direction to standards setting groups and software developers. Please let us know what issues you think we should tackle and we gladly welcome COCIT members with expertise addressed by these policies to participate in policy development.

Applications Committee

By Michael Leu, MD, MS, MHS, FAAP
Chairperson, Council on Clinical Information Technology Applications Committee

Thank you for responding to our online survey! We found that over 70% of members surveyed currently use electronic tools to help with clinical practice. Some of these appear to be commercially available online reference materials (ePocrates, the AAP *Red Book*, growth charts from the Centers for Disease Control and Prevention), free clinical calculators (for appointments, gestational age, rehydration, total parenteral nutrition), and self-developed handheld and online patient-tracking systems.

Some of the tools you requested were for growth charting, preventive care reminders, immunization calculations, asthma management, creatinine clearance, lab flow sheets, developmental screening, and management tools for ADHD and obesity. It was requested that, in addition to being made available on handhelds or PCs, tools be provided such that they can be integrated with existing electronic health/medical record systems.

To achieve these goals, I am seeking members of the Council on Clinical Information Technology (COCIT) to help me to:

- prioritize the order and timeframe for tools we are targeting;
- obtain/adapt existing tools, or develop them if necessary;
- test tools prior to their general release; and
- create a dissemination infrastructure (so tools can be made available to all AAP members on the appropriate platforms).

I am currently contacting survey respondents who expressed an interest in helping, to figure out how we can best coordinate efforts. We have also created a listserv, AAP-EPRODUCTS, to communicate - feel free to join the listserv if you would like to be kept up to date. If you'd like to help out, or if you would like more detailed survey results, please contact me at Michael.Leu@SeattleChildrens.org.

COCIT NCE Scientific Abstract Session

By George Kim, MD, FAAP
Chairperson, Council on Clinical Information Technology Abstract Committee

Please join the Council on Clinical Information Technology (COCIT) at the AAP National Conference & Exhibition (NCE) in San Francisco on Sunday, October 28, 2007 from 2:00 pm – 4:45 pm in the Palace Hotel's Ralston Ballroom for its Scientific Abstract Session. This year's concentration of submissions focuses on experiences and research with information technology such as electronic health records and how they are being used in pediatric settings such as emergency, primary care, and neonatal intensive care.

Presenters will be judged by a panel of COCIT members on the basis of their presentation and the significance of the results of their research to child health. All presentations will be eligible for the annual prize that will be decided right after the sessions. Titles of presentations are published on pages 15-16 in this issue of *cocitnews*. Abstracts will be distributed to NCE attendees, along with all NCE session handouts, on a CD-ROM, and slides (as made available by presenters) will be posted on the COCIT website.

We hope to see you there!

H218 – Council on Clinical Information Technology
Sunday, October 28, 2007

9:00 am **Electronic Health Records: Which One Is For You?**
Peter Kenny, MD, FAAP
Stuart Weinberg, MD, FAAP
The AAP as an organization desires to promote electronic health record use among its members, but AAP members have been facing two major barriers: unclear return on investment and systems that do not work well in pediatric settings. In this session, we will discuss the economics of EHRs, with an eye toward return on investment for pediatric group practices. We will also learn how to identify features of EHR systems that ensure they will work successfully in the pediatric setting. How one actually implements EHR systems (hardware selection, workflow design, system customization, training, and support) will wrap up this energizing session. The goal of the session is to help future users of EHRs achieve a working familiarity with EHR applications such that the participants will leave the session ready, able, and eager to select and purchase an EHR for their clinical practice.

12:00 pm **Council Business Meeting**

1:30 pm **Break**

2:00 pm **Scientific Abstract Session**
Clinical Information technology is an emerging field with new applications, devices and software entering the clinical arena every day. In order to allow COCIT members and general pediatricians to keep up-to-date with the latest scientific developments in clinical information technology, COCIT presents a scientific abstract session each year. The quality of abstracts in the past years has turned this session into the premier research venue for pediatric clinical informatics. Special emphasis has been placed in the past years on evaluative studies that evaluate the impact of new technologies on the pediatrician and his patients.

2:00 pm **Pediatric Electronic Health Record As an Integrated, Comprehensive Solution To Communication: An Italian Experience**
Buonuomo PS[1], Onesimo R[2], Ricci F[3], and Curro V[2]. [1]Unità Operativa di Reumatologia, Dipartimento di Medicina Pediatrica, IRCCS Ospedale Pediatrico "Bambino Gesù", Rome, Italy; [2]Department of Paediatrics, Università Cattolica del Sacro Cuore, Policlinico "A. Gemelli", Rome, Italy, and [3]IRPPS, CNR, Rome, Italy.

2:15 pm **Evidence Based Assessment of ADHD in the Primary Care Setting**
Pedigo TK. Pediatric & Adolescent Psychology P.C., Savannah Child Study Center, Savannah, Georgia.

2:30 pm **An Innovative PDA Appication To Optimize Learning/Teaching In The NICU**
Lin Y and Levin GGarrett. Dept.of Peds., Texas Tech Univ. HSC, El Paso, TX.

2:45 pm **Improvement Of Quality and Timeliness Of Discharge Summaries**
Pappas RM[1], Marks M[1], Gowans K[2], Hilden J[2], and Worley S[1]. [1]General Pediatrics, Children's Hospital Cleveland Clinic Foundation, Cleveland, OH, and [2]Pediatric Hematology-Oncology, Children's Hospital Cleveland Clinic Foundation, Cleveland, OH.

3:00 pm **Who Cares To Know: Defining Neonatal Critical Laboratory Values**
Stavroudis TA[1], Hemachandra AH[1], and Lehmann CU[1,2]. [1]Division of Neonatology, Johns Hopkins University, Baltimore, Maryland, and [2]Division of Information Science, Johns Hopkins University, Baltimore, Maryland.

3:15 pm **Break**

3:30 pm **Workflow Improvement And Increased Housestaff Satisfaction After Integration Of Sign-Out Documents Into The Electronic Medical Record**
Bernstein JA, Imler DL, and Longhurst CA. Pediatrics, Stanford University School of Medicine, Stanford, CA.

3:45 pm **Underdiagnosis of Pediatric Hypertension – An Example of the Potential of Electronic Medical Record Research for Clinical Pediatricians**
Kaelber DC[1,2], Hansen ML[2], and Gunn PW[2]. [1]Internal Medicine and Pediatrics, Harvard University, Boston, MA, and [2]School of Medicine, Case Western Reserve University, Cleveland, OH.

4:00 pm **Staff Perceptions Of Advantages and Disadvantages Of a Commercial Pediatric Electronic Medication Administration Record**
Edwards PJ[1,2], Metcalfe L[1], Jose J[2], and Sainfort F[1]. [1]Center for Pediatric Outcomes & Quality, Georgia Tech Health Systems Institute, Atlanta, GA, and [2]Children's Healthcare of Atlanta, Atlanta, GA.

4:15 pm **Child Health Profile For Children With Special Health Care Needs**
Lozzio CB, Liao MZ, Shelton BJ, and Hancock B. Medical Genetics, University of Tennessee-Graduate School of Medicine, Knoxville, Tennessee.

4:30 pm **Parent and Provider Impressions Of Emergency Planning For Children With Special Health Care Needs (CSHCN); Midwest Emergency Medical Services For Children Information System (MEMSCIS.COM)**
Pyles LA[1,2], Jamrozek K[1], Hannan JC[3], Scheid M[1], and Hines CI[2,3]. [1]Pediatrics and Emergency Medicine, University of Minnesota, Minneapolis, Minnesota; [2]Emergency Medical Services for Children Resource Center of Minnesota, Minneapolis, MN; and [3]Emergency Medicine, Children's Hospitals and Clinics of Minnesota, Minneapolis, MN.

4:45 pm **Adjourn**

COCIT LISTSERV® E-mail Discussion Lists

COCIT Announcements E-mail List

All COCIT members are automatically subscribed to the COCIT-NEWS e-mail list. This list was created for announcements and newsletter distribution. If you have an announcement you would like posted on the list, please send it to COCIT-NEWS@LISTSERV.AAP.ORG. If you would like to be removed from this list, please send a message with "UNSUB COCIT-NEWS" in the body of the message to LISTSERV@LISTSERV.AAP.ORG.

COCIT (General) E-mail List

Most COCIT members also participate in this list, which encourages open discussion of items of interest to COCIT members. Discussions may include topics such as EMRs, Practice Management Software, hardware, and other topics related to clinical information technology. To subscribe to the list, send a request with SUB COCIT in the message body to LISTSERV@LISTSERV.AAP.ORG. If you already subscribe to this list and would like to send a message to the list, send your message to COCIT@LISTSERV.AAP.ORG.

COCIT AAP-EProducts E-mail List

There is an additional listserv specifically for a discussion on the development of AAP electronic products and web services. Members of the AAP Electronic Products team have also subscribed to this list so that they can keep COCIT members posted on new product development and get feedback from you. To subscribe to the new list, send a message to LISTSERV@LISTSERV.AAP.ORG with "SUB AAP-EPRODUCTS" in the body of the message.

COCIT-RES E-mail List

The COCIT-RES list has been established to encourage open discussion among Resident members of COCIT on health information technology issues faced during residency. To subscribe, send a message to listserv@listserv.aap.org with "SUB COCIT-RES" in the message body.

COCIT-HOSP E-mail List

The COCIT-HOSP list has been established to encourage open discussion among hospital-based COCIT members on health information technology issues faced in your institutions. To subscribe, send a message to listserv@listserv.aap.org with "SUB COCIT-HOSP" in the message body.

***** For all of the above email lists:**
Digest Version: If you'd like to participate in a list, but wish to limit the number of e-mails you receive, try the digest version. Send a message to: LISTSERV@LISTSERV.AAP.ORG and in the body of the message, enter the following text: SET [listname] DIGEST MIME NOHTML where [listname] is the name of the list (without the brackets).
To withdraw from a list, send a request with UNSUB [listname] in the message body to LISTSERV@LISTSERV.AAP.ORG, where [listname] is the name of the list (without the brackets). You must send these commands from the e-mail address under which you are subscribed.

COCIT Online Discussion Board

COCIT maintains an online discussion board on the COCIT Web site (www.aapcocit.org). To post a message to the discussion board, or to see previous postings, click on "COCIT Members Only" and log in. Then scroll down and click on "COCIT Discussion Group."

AAP Council on Clinical Information Technology
Call for Nominations
2008 Byron Oberst Award and Lectureship

Nominations are being sought for an award to recognize pediatricians who have made significant contributions to the use of clinical information technology in pediatrics.

The Byron Oberst Award will be presented to a Fellow of the American Academy of Pediatrics (FAAP) who has made a significant contribution to the field in one or more of the following areas:

- Improving pediatric clinical information systems
- Educating child health professionals in the use of clinical information technology
- Creating health policies that promote better use of pediatric clinical information systems

Current members of the COCIT Executive Committee are ineligible to receive the award.

The award will be presented during the Council on Clinical Information Technology program at the AAP 2008 National Conference & Exhibition in Boston, MA. The winner will receive an honorarium and reimbursement of travel expenses to attend the program. The winner will also be expected to give a brief lecture during the program.

To be considered for the 2008 awards, nominations and supporting materials must be received by January 2, 2008.

Return the completed nomination form to:
Beki Marshall
Manager, Health Information Technology Initiatives
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007
bmarshall@aap.org
fax: 847-434-8000

Thank you!

Mark M. Simonian, FAAP
Chairperson
Council on Clinical Information Technology

Previous Byron Oberst Award Recipients

2007: David M. N. Paperny, MD, FSAM, FAAP
2006: Richard Shiffman, MD, FAAP
2005: S. Andrew Spooner, MD, MS, FAAP
2004: Stuart T. Weinberg, MD, FAAP
2000: William Zurhellen, MD, FAAP
1994: Donald E. Lighter, MD, MBA, FAAP
1992: M. William Schwartz, MD, FAAP
1991: James V. Lustig, MD, FAAP
1990: Olle Jane Z. Sahler, MD, FAAP
1989: Vincent A. Fulginiti, MD, FAAP

AAP Council on Clinical Information Technology Nomination Form
2008 Byron Oberst Award and Lectureship

(Please print or type.)

_____
Name of person submitting nomination

_____
Address

_____
City/State/Zip

_____
Phone Office or Home (circle one)

_____
Nominee

_____
Address

_____
City/State/Zip

_____
Phone Office or Home (circle one)

_____
Educational Background

Please indicate below why you feel the above individual should receive the award. Use additional sheets if necessary. A brief letter, biosketch, and/or supporting materials will be helpful to the committee when considering the nominee.

_____

Submit all materials to:

Beki Marshall
Division of Pediatric Practice
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007
847/434-8000 (fax)
bmarshall@aap.org

Nominations received after January 2, 2008 will be considered for the 2009 award.