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The Council on Clinical Information Technology

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From the Chairperson

By Joseph Schneider, MD, MBA, FAAP
Chairperson, Council on Clinical Information Technology

Inside this issue

"May you live in interesting times":
The Council on Clinical Information Technology Strategic Plan

"May you live in interesting times" is supposedly an ancient Chinese curse (see http://en.wikipedia.org/wiki/May_you_live_in_interesting_times). We certainly are in interesting times when it comes to the adoption of health information technology (HIT) in pediatrics. Some want us to move at warp speed in the adoption of HIT because the benefits are potentially huge. Others, particularly the average office-based physician who is being called upon to provide the funding, are moving slowly. Sadly, electronic medical records (EMRs) that have been adopted are being woefully underused, with only about 10% being used at their full capacity.

In connectivity, we are at a stage similar to when the first telephones were introduced. In e-prescribing, for example, the federal government is pushing adoption hard, but, between pharmacies that cannot handle e-prescribing (about 40%) and limitations on the classes of medications that can be e-prescribed, the percentage of e-prescribable medications nationally is far from 100% — so far from 100% that it's a hassle in some cases rather than a help.

What should the average pediatrician do? In terms of technology adoption, the answer to this question depends upon a number of things, including the number of years remaining in practice, the state in which he or she lives, and even the local competitive situation. For some, there is no choice — EMRs and e-prescribing must be done now. For many others, there is still time to let the markets develop better and cheaper products.

There is one place where no pediatrician can stand still, and that is in participation in the development of HIT legislation, standards, and products. The foundation of the future of pediatric practice is being laid every day by non-pediatricians as decisions are made about what systems, standards, and networks will prevail in medicine. A key strength of pediatrics, the small-office pediatrician, is the proverbial "canary in the coal mine"; but all of pediatrics is at risk.

Your Council on Clinical Information Technology (COCIT) is working constantly to make sure that pediatricians are represented in HIT legislation, standards, and product development. While, historically, this has been done mostly by the Executive Committee and a small number of others, we need to continue to expand participation because there is far more to be done.

(continued on page 3)

Electronic Medical Records for Pediatrics, 2008

By Eugenia Marcus, MD, FAAP
Vice Chairperson, Council on Clinical Information Technology

Towards the Electronic Patient Record (TEPR) is one of the longest-standing technology conferences devoted to the Electronic Medical Record (EMR). As a component of this meeting, members of the Council on Clinical Information Technology (COCIT) organize a Pediatric Day. The first part of this program has a competition, during which EMR vendors show their pediatric prowess by performing various mini-scenarios and demonstrating documentation skills that their EMR software can perform. These skills are chosen by the faculty and based on the functionality needed to take care of children and adolescents. The second part of the program is an enactment of a typical pediatric office visit followed by a demonstration of documentation of the entire visit, including front-desk, nursing, and physician interaction.

At the 2008 program held May 20, 2008, at the TEPR meeting in Ft Lauderdale, FL, the scored portion took a different format than in previous years. More emphasis was given to challenges pediatricians face when trying to get aggregate clinical information OUT of an electronic health record system. Given a database of patients with various abnormal values or missing data (eg, immunizations), the vendors had to display a series of reports that typically might be required in the pay-for-performance situation now becoming more prevalent. The challenge was to be able to get data out of the EMR in a usable form. (An example would be to find all the patients older than 18 months who have not had an MMR .)

After 10 questions, each vendor could not complete at least one question. This really raised the bar and set the expectations for next year's contest. It was a more advanced challenge. The judges were Eric Handler, MD, FAAP; William Zurhellen, MD, FAAP; and Alan Zuckerman, MD, FAAP.

The second part of the program was the checkup of a 9-year-old boy with well-controlled asthma arriving for his yearly checkup. This required software to document the typical checkup, and also what we call the "Asthma tune-up." The visit was complex and included many preventive-health points. The database was extracted from a live patient in the office and then deidentified. This gave the scenario greater authenticity.

Taking top honors was a tie between e-MDs and MediNotes (formerly Bond).

The Pediatric Documentation Challenge will be re-created at the American Academy of Pediatrics National

(continued on page 7)

From the Editor

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

Quality. It's a good word. It's short, 3 syllables, and follows the "u after q" rule; in general, a fine, upstanding part of the English language. But, when applied to medicine, what exactly does it mean? Will quality guarantee a good outcome for our patients? Certainly not, but it helps. If 2 pediatricians choose different treatments for the same disease, is one of them not practicing quality medicine? Maybe, maybe not. Does the study and application of clinical informatics promote quality? We all hope so, but the data are not always convincing.

Quality, it seems, can be an elusive goal. However, it is a goal that we can continue to move toward. Technology can help us improve quality; however, it is but one part of the big picture. The greatest tools ever invented are useless without a human being. Imagine me, a primary care pediatrician, trying to use a scalpel to remove a brain tumor; right tool, wrong user.

It is often said that the best surgeon is one who knows when not to operate. I think a similar case can be made with regard to clinical informatics. Technology, in and of itself, is pointless if it does not help us take care of kids. To do that, we need software and hardware. But, we also need trainers (who understand what we do), technical support specialists (who understand when it really is an emergency), and researchers (who want to understand why we do what we do). When we get all of these folks together, working in one direction, quality will follow.

"May You Live in Interesting Times"

(continued from page 1)

The COCIT Executive Committee has developed a draft strategic plan that is presented here so that we can make our membership aware of what directions we are recommending, to solicit feedback, to help gather volunteers (if you see something that you would like to work on, contact Beki Marshall, me, or Jeannie Marcus), and to make sure that we have not forgotten anything. The plan has the usual mission, vision, goals, and near-term objectives, as seen below and on the following page.

The COCIT strategic plan is designed to support the AAP "Agenda for Children," which can be found at http://www.aap.org/moc/strategicplan/default.cfm?jumpdown=yes#jumpdown.

We would love to hear your thoughts on this and get your participation, as this is a very ambitious agenda when combined with our programs such as the **Technology Learning Center, the Pediatric Office of the Future,** and the **Pediatric Documentation Challenge.** Please feel free to use the LISTSERV® e-mail discussion list (see page 26 for instructions), as it will increase participation.

The Council on Clinical Information Technology is doing a lot of work that helps both members and nonmembers. We thank you very much for the support you provide, either directly though participation or indirectly through your dues. We can do a lot more with more help, so please help increase COCIT's membership and increase your participation. It is only the future of pediatrics that is at stake in these "interesting times."

Council on Clinical Information Technology 2008-2010 Strategic Plan

Mission

The mission of Council on Clinical Information Technology **(**COCIT) is to provide strategic direction and leadership to promote affordable, child-friendly health information technology (HIT) and health information exchange (HIE) solutions that support quality care; and to drive the creation and successful deployment of systems that have these characteristics.

Vision

Every infant, child, and adolescent would be cared for in every venue with the necessary health information technology that is both cost-effective and improves the quality of health care, regardless of socioeconomic status.

Goals

Ensure HIT solutions are child-friendly, affordable, and cost-effective, and support quality care.

Support the usage of pediatric HIT and HIE in actual practice, with a particular focus on addressing the Child Health Priorities identified in the American Academy of Pediatrics (AAP) Strategic Plan.

Increase the visibility and effectiveness of the efforts of COCIT and the AAP in providing HIT and HIE direction and leadership.

Provide high value for COCIT members.

The following objectives are intended to be met in the next 1 to 3 years:

Goal #1

Ensure HIT solutions are child-friendly, affordable, and cost-effective, and support quality care.

Objective 1.1: Respond to requests for public comments from the Certification Commission for Health Information Technology (CCHIT), with special emphasis on requirements pertaining to the AAP Child Health Priorities.

Objective 1.2: Develop a list of prioritized elements that are not yet included in the CCHIT requirements.

Objective 1.3: Develop an implementation strategy based on the results of the Fall 2008 AAP Periodic Survey of Fellows addressing pediatrician adoption of electronic health records.

(continued on page 4)

COCIT 2008-2010 Strategic Plan

(continued from page 3)

Goal #2

Support the usage of pediatric HIT and HIE in actual practice, with a particular focus on addressing the Child Health Priorities identified in the AAP Strategic Plan.

Objective 2.1: Develop 2 electronic health passport test cases for children and youth in foster care.

Objective 2.2: Establish a work plan to address the intersection between electronic health records and immunization information systems.

Objective 2.3: Develop a plan for continuously improving the following COCIT offerings: Pediatric Office of the Future, Pediatric Documentation Challenge, Council Program for Council Members (including scientific abstract program), Technology Learning Center, EMR Review Web Site (including Buddy List).

Goal #3

Increase the visibility and effectiveness of the efforts of COCIT and the AAP in providing HIT and HIE direction and leadership.

Objective 3.1: Establish a schedule of topics and authors to write a monthly article on health information technology for a non-COCIT AAP publication.

Objective 3.2: Develop a policy statement on the role of HIT and HIE in pediatrics.

Objective 3.3: Develop a plan and establish priorities to advocate for consideration of child health care needs in HIT- and HIE-related legislation.

Objective 3.4: Create a 1- to 2-page concept paper on COCIT's activities to inform the work of the AAP Chief Quality Officer.

Objective 3.5: Develop a concept and/or grant proposal to develop an institute for HIT within the AAP whose mission would be to provide strategic direction and leadership in promoting affordable, child-friendly HIT and HIE solutions that support quality care and drive the creation and successful deployment of these solutions.

Goal #4

Provide high value for COCIT members.

Objective 4.1: Establish a COCIT mentoring program to assist the general membership in getting involved with COCIT initiatives and HIT/HIE projects.

Objective 4.2: Develop a welcome kit for new members.

Objective 4.3: Develop a 2-page checklist for COCIT members that summarizes recommendations from the "Special Requirements for Electronic Health Records Systems in Pediatrics" clinical report, the Selecting and Implementing an Electronic Health Record toolkit, and other resources for pediatricians to use in the vendor selection process.

From the Vice Chairperson

By Eugenia Marcus, MD, FAAP
Vice Chairperson, Council on Clinical Information Technology, and
Cochairperson, CCHIT Child Health Work Group

Advocacy for Children Through the Certification Commission for Health Information Technology (CCHIT)

The Certification Commission for Health Information Technology (CCHIT) was formed in 2004 by 3 organizations: the Healthcare Information and Management Systems Society (HIMSS), the American Health Information Management Association (AHIMA), and the National Alliance for Health Information Technology (NAHIT). The founding organizations were joined by several additional specialty societies, including the American Academy of Pediatrics (AAP). Its purpose was to define the functionality of the electronic medical record (EMR). By certifying vendor products, CCHIT assures the purchasers that the EMR can perform the functions needed to take care of patients.

The functional requirements are the base of the software you eventually will use in documenting the encounter with the patient. Vendors are distinguished from one another through their implementations of the functionality. The Certification Commission for Health Information Technology allows the vendor to determine how functionality is displayed and how the work flow is organized.

Beyond documenting the patient encounter to create data, the software must allow the physicians to get information out. The Certification Commission for Health Information Technology requires EMR software to include reporting capability and disease management. Again, how each vendor does this and how they display the information is individual. The reporting feature should be the "wow" factor in deciding which EMR to select for your practice. Producing reports should be easy, and the reports should give you an overall picture of the care you deliver, sliced and diced anyway you want it.

In 2007, CCHIT established a Child Health Expert Panel to define the functionality needed specifically for the care of children. Staffed with pediatricians and child advocates representing all the stakeholders (vendors, private practice, nursing, academia, children's hospitals, etc), the panel set about reviewing the current requirements and identifying what was missing for the needs of children. Using the CCHIT guideline of giving the vendors 18 months' notice when a new requirement was added, minimal functionality was added for the 2008 first certification for child health. Much more functionality was roadmapped for 2009, 2010, and beyond. Given the short time frame before the 2008 certification, the functionality included in this first child health certification round were items considered widely available. The Child Health certification is in addition to certification for the ambulatory environment. Much of the functionality of the EMR is defined in general ambulatory functions, and the Child Health requirements are in addition. Going forward for 2009, there will be many more Child Health functions because the vendors will have had 18 months to prepare. (Eighteen months is the generally recognized time frame that vendors need from the time the first line of code is written until the function is included in the next release of the software.)

The AAP role in CCHIT has been to put forth capable candidates for every work group that is established. Pediatricians have been chosen and serve throughout the CCHIT work groups. In addition, when the functionality is proposed, it is put out for public comment. The AAP has reviewed this functionality and commented on it from the perspective of the needs of children. The AAP comments have a direct impact on the functionality that goes forth and is ultimately approved for certification testing.

The Alliance for Pediatric Quality, a consortium of pediatric organizations, including the AAP, The American Board of Pediatrics (ABP), the Child Health Corporation of America (CHCA), and the National Association of Children's Hospitals and Related Institutions (NACHRI), has taken on the responsibility of funding the pediatricians' participation. This includes the 1 or 2 face-to-face meetings a year, as well as the additional work group cochair meetings at which the pediatrician cochairs have met face-to-face. Most of the work of CCHIT happens in cyberspace in weekly or biweekly meetings using Webex technology and conference calling.

The Role of Personal Digital Assistants in Learning Enhancement

By Pradeep Alur, MD, FAAP
COCIT Member

The pediatric department was excited the day a world-renowned expert in pediatric cardiology was delivering a much-awaited lecture on recent advances in pediatric cardiology. The pediatric chair had asked the medical students and residents to attend this lecture. The expert talked about several newer modalities of diagnosis. He mentions BNP (type B natriuretic peptide) as a useful tool in evaluating clinically significant patent ductus arteriosus (PDA) and persistent pulmonary hypertension (PPHN) quite a few times. Most of the medical students and first-year residents did not have a clue about BNP, PDA, or PPHN. As the lecture finished, highly experienced members asked if the expert would recommend BNP testing routinely and whether such testing would obviate the need for other tests. Students and residents felt that BNP and PPHN were perhaps basic terms and should have been well-versed with them. They felt inhibited to join the discussion with the learned crowd, as their ignorance might be easily noticed and that they might be perceived as dumb or stupid.

How often does this happen? We surveyed 74 medical students, residents, nurses, and physicians to find out whether questioning (post-lecture) is important to enhance one's learning and whether anonymity is conducive to such learning. All responded that having their questions answered post lecture certainly enhances their learning. Sixty-five percent admitted that they are hesitant to ask questions in front of a large crowd. Seventy-two percent of them felt silly or stupid, at least once, asking a question after a lecture. Not surprisingly, 88% expressed that they would ask questions if they remained anonymous, whereas less than half of them would ask questions normally. Our informal survey reflects what educational experts have been exhorting.[1-5] Questioning is an active form of learning and helps to retain the information longer and apply it usefully.[2] Hence, many universities have created anonymous discussion forums to allow students to express their academic issues freely. Monash University conducted a survey and found that a Web-based anonymous feedback system is a popular and valued resource to its students, as a majority of the students recommended the system to other students.[3]

David Barnes showed that, by providing a means to ask questions anonymously, we provide a nonthreatening atmosphere of asking questions that aids understanding and enhances skills in their field of study.[4] Hence, anonymity is very important for learning effectively.[1,5] This prompted me to carry out a feasibility study of asking questions anonymously, using readily available technology. In the present study, I used existing hospital-wide wireless LAN (WLAN)802.11b/g network, Windows mobile-based pocket personal computers (PPC) and free voice over Internet protocol (VOIP) software—Skype. A small group of 7 physicians, who already owned PPC, agreed to participate in this feasibility study. Skype (for Windows mobile devices) was downloaded on to the PPC, and a unique ID was created for each of them. Similarly, Skype 2.5 version for the notebook computer was installed on notebook with Windows XP professional operating system and an ID was created. This notebook computer was placed at the speaker's podium.

We used one of the pediatric grand-round sessions for our study. At the end of the session, participating physicians typed questions on their PPC and sent them wirelessly to the speaker's Skype ID on notebook computer, using the chat format. The speaker was able to view the individual questions but was unaware of the sender's ID. Hence, senders remained anonymous. We did not encounter any dropped connections or failed transmission of questions. One physician had difficulty in establishing Bluetooth connection between PPC and portable keyboard. We did not study whether anonymity increased more post-lecture questioning, since our sole aim was to assess whether questions can be asked anonymously using existing technology without incurring additional expenditure. We think, using paper slips to send the questions to the speaker may not maintain the anonymity for several reasons, as passing a slip in front of others makes the individual prominent and, if there is only one individual sending the slip, he or she can no longer remain anonymous.

We successfully demonstrated that anonymous questioning is feasible in post-lecture session in our setup. As many institutions are deploying hospital-wide wireless network systems, and as personal digital assistants have become pervasive among the medical students and residents, and increasing numbers of physicians are also embracing this handheld technology,[6] we believe that our

(continued on page 7)

PDAs in Learning Enhancement

(continued from page 6)

simple solution is easy to adopt. Thus, providing nonthreatening atmosphere, learning can be enhanced among the students and residents alike.

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The Council on Clinical Information Technology Announces Election Results

Thank you to all members of the Council on Clinical Information Technology (COCIT) who voted in our spring 2008 election. We had a response rate of approximately 23%.

The Council on Clinical Information Technology is pleased to announce that Willa H. Drummond, MD, FAAP, was reelected to the Executive Committee. Dr Drummond began her second 3-year term on July 1, 2008.

According to the governance rules established for American Academy of Pediatrics Councils, the COCIT Executive Committee votes to select the Chairperson and Vice Chairperson. At the April 2008 COCIT Executive Committee meeting, Joseph H. Schneider, MD, MBA, FAAP, was elected to the position of Chairperson. Eugenia Marcus, MD, FAAP, was elected Vice Chairperson. Each began serving a 2-year term on July 1, 2008.

Dr Marcus's promotion to Vice Chairperson resulted in an additional vacancy on the Executive Committee. As a result, Eric G. Handler, MD, MPH, FAAP, was appointed to complete the remaining 2 years of Dr Marcus's Executive Committee term. Dr Handler received his MD from Chicago Medical School. He completed pediatrics training at LA County-USC Hospital and a pediatric rehabilitation fellowship at Rancho Los Amigos Hospital. Dr Handler is currently the Health Officer for Orange County, CA. His previous positions include Chief Medical Officer for the Florida Department of Children and Families, and Chief Medical Officer for the Boston Regional Office of the Centers for Medicare & Medicaid Services. Dr Handler's health information technology background includes the development of his own electronic health record in 1986 to help with the care of children with disabilities. He was instrumental in the development of a statewide telemedicine initiative in Florida to provide real-time assessments of suspected child abuse.

The next election will take place in Spring 2009. Executive Committee members Donna D'Alessandro, MD, FAAP; George Kim, MD, FAAP; Michael Leu, MD, FAAP; and Alan Zuckerman, MD, FAAP; will each be eligible for reelection. The COCIT Nominations Committee, chaired by Gregg Lund, DO, FAAP, will accept nominees for the ballot. A Call for Nominations can be found on page 27. Nominations must be received by December 1, 2008.

EMRs for Pediatrics, 2008

(continued from page 2)

Conference & Exhibition (NCE) on October 12, 2008, at 2:00 pm in the Technology Learning Center. Everyone is invited to see the various EMR vendors face off.

Another opportunity to see this program will be the 2009 TEPR meeting, which has been moved to a winter-time slot in a warm venue (February 1-5 in Palm Springs, CA). The exact location and time slot for the program are being determined. Visit www.TEPR.com for updated information as it becomes available.

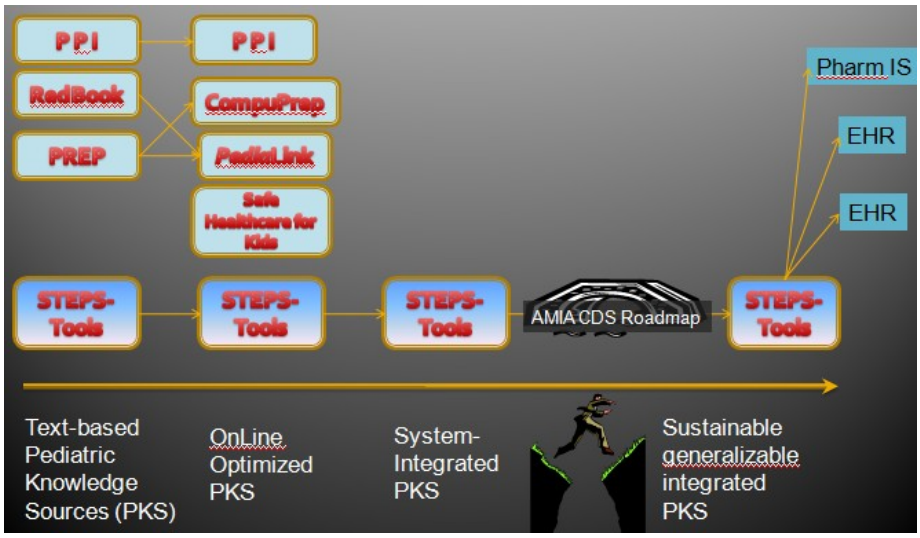
This article is reprinted from the August 2008 issue of AAP News.

Ensuring Safer Prescribing for Children: American Academy of Pediatrics Members Funded to Launch the Safety Through E-Prescribing System Tools Project

By Kevin Johnson, MD, FAAP, COCIT Member; Stuart Weinberg, MD, FAAP, COCIT Member; Coda Davison; and the STEPSTools Working and Advisory Group

Electronic (e) prescribing systems are computer programs designed to create and transmit complete, accurate, legible, and safe prescriptions and associated transactions (such as refills and forms related to prescribing). These systems have received national attention by groups such as the Institute of Medicine and the Centers for Medicare & Medicaid Services, and have been endorsed by most of our professional societies. They promise to address safety issues associated with ambulatory medication ordering, including errors related to dosing in children. These systems rely on 4 sources of knowledge to help a prescriber construct a prescription:

1. The medication's age- or weight-based dosing strategy
2. Knowledge about potential interactions or adverse events that should change which drug is prescribed
3. Knowledge about compounded forms of the medication that make a pill formulation suitable to give a young child
4. Knowledge about the therapeutic window of each medication that allows rounding to a safe, but convenient, dose for home administration



Although many (but not all) e-prescribing systems have tools in place to help with dosing and to alert about potentially unsafe prescribing, virtually no systems have adequately dealt with compounded forms of medications (try ordering levothyroxine) or have addressed an even more common issue: should the calculated dose of Digoxin 3.2 mL be rounded up to 4, down to 3, or given as calculated?

The knowledge for the first challenge—compounded formulations—often is scattered among a series of books, and generally is not available to many pharmacists in the community. The knowledge about dose rounding, much like the early days of knowledge about dosing in general, is empiric and typically unavailable in written form.

The goal of this project, creating Safety Through E-Prescribing System Tools (STEPSTools), is to build a small suite of tools that can be used **nationally** to provide a compounded formulation knowledge base and to provide information about dose rounding. These tools will be constructed in a way that facilitates the access to the knowledge for browsing/education (as might be needed by community pharmacies) as well as for integration into e-prescribing systems (as will be required by e-prescribing vendors). At the conclusion of the project, we will evaluate the usefulness of this knowledge base by integrating it into e-prescribing systems at Vanderbilt (RxStar), Cincinnati Children's Hospital (Epic), and a set of NextGen sites, thanks to Eugenia Marcus, MD. We are also in conversations with iScribe (CVS Caremark). We will conduct an evaluation to determine how often guidance from these Web services is accessed as well as how often rounding recommendations are followed. We also will evaluate the utility of the extemporaneous formulation knowledge base to both community pharmacists and pediatricians.

To achieve these goals, our team is creating an expert panel to construct a knowledge base. This group is called the STEPSTools Working and Advisory Group (SWAG), and consists of pediatricians, pediatric informatics experts, knowledge management experts, and pediatric pharmacy experts who will develop consensus-based recommendation guidance for rounding pediatric doses.

(continued on page 9)

Ensuring Safer Prescribing for Children

(continued from page 8)

The names of many SWAG members will be familiar to us all:

- Kevin Johnson
- Stuart Weinberg
- Andy Spooner
- Richard Shiffman
- Chris Lehmann
- Bob Grundmeier
- Tony Luberti
- Mark Simonian (AAP representative)
- Jeannie Marcus
- Ed Zimmerman

And a host of others.

One of the initial activities of the SWAG has been to construct a schema for this specific type of knowledge. This process has begun informally through e-mail discussions of the SWAG members. This is an opportunity for us to involve a series of key informatics innovations, including the National Library of Medicine's RxNorm project, HL7's clinical document architecture project, and, most importantly for this work, Web services using the WSDL framework to provide external systems with a way to integrate this knowledge.

This project also provides a tremendous opportunity for the AAP. As the figure shows, the AAP has been providing knowledge resources to the world's child health care providers. This knowledge remains largely in print form (eg, books, brochures) with more and more being converted to electronic formats, such as files available on PDAs, PDFs published on Web sites, and, now, online optimized knowledge sources such as Safe HealthCare for Kids. What we plan to do, with the help of the Agency for HealthCare Research and Quality funding we have received, is to take STEPSTools from a text-based knowledge source that we are currently creating, to an online knowledge source for pharmacists, and then across the wide chasm between a local implementation of this knowledge in an e-prescribing system and a national toolkit maintained by the AAP and in use by multiple e-prescribing systems and electronic health records.

Please check our Web site for the latest project updates (http://www.pedstep.org).

Council on Clinical Information Technology National Conference & Exhibition Educational and Scientific Abstracts (H) Program

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

Please join the Council on Clinical Information Technology (COCIT) at the American Academy of Pediatrics National Conference & Exhibition (NCE) in Boston, MA, on Sunday, October 12, 2008, from 9:00 am to 5:30 pm for its Council Program for Council Members (H Program). The program will include presentations by Kevin Johnson, MD, FAAP, and Stuart Weinberg, MD, FAAP, from Vanderbilt University, as well as the Scientific Abstracts and Posters Session.

The schedule of presentations and posters is published on page 21 in this issue of *cocitnews*. Abstracts will be distributed to NCE attendees, along with all NCE session handouts, on a CD-ROM. Slides (as made available by presenters) will be posted on the COCIT Web site following the NCE.

We hope to see you there!

COCIT gratefully acknowledges support for our NCE Poster-Viewing Reception from MediNotes Corporation.

Choosing Devices for Your Electronic Medical Record

By S. Andrew Spooner, MD, MS, FAAP
COCIT Member

You are implementing a technology system in your office. You have found some great software, but now it's time to buy the hardware you need to use the system. What do you pick? Your vendor will have suggestions, but you might want to think of the following factors when selecting the computers you will need in your office.

Computers in the Examination Room?

For an electronic medical record (EMR) or an e-prescribing system, you will want a computer in the examination room. While there are anecdotes about patients and families meddling with the examination room computers, basic security procedures are usually successful in making it impossible for patients to get into other patients' records or to get into trouble on the Internet. Sure, you could (occasionally) accidentally leave yourself logged in after you leave the room, but most parents are aware that the computer is the doctor's tool and will corral their kids appropriately. Good log-out habits are not hard to acquire, and most EMRs will not allow a person to do anything dangerous (like providing controlled substances) without special authentication, anyway.

Mobile or Fixed?

The main reason people want a mobile PC for their system is so that they can find out what the situation is in Room 4 before they walk into Room 4. If you cannot see the record of the patient in Room 4 until after you walk in, you may be caught unaware by the situation. The solution is to use a mobile computer (a laptop in a wheeled cart, or a tablet PC). Another solution is to use a fixed PC outside the examination room, like in the hallway. The latter is slightly undesirable in that you may have to log in and out on that hallway computer. But, mobile computers have problems, too—you have to worry about limited battery life, smaller screen size, slower processor speed, suboptimal pointing devices, and maybe even compromises in the application itself. One good compromise is to use a wireless tablet that can fit into a docking station in the room that provides AC power, a full-size keyboard, and a standard mouse. That will give you the ability to peek at a record before going into the room, and solve may of the problems that tablets have when it comes time to use the system in the room.

Wireless or Wired?

Your computer needs to get to some kind of network, in most cases. Whether it is a small, self-contained office network or the whole Internet, the computer in your examination room (or anywhere else in your office) will need a connection. Wired connections are more reliable and generally faster, but if you use a mobile solution, it is better to use a wireless network so that you do not need to plug and unplug network cables. Of course, standard security measures on these networks will prevent unwanted network users.

The Siren Song of the Cheap PC

A quick trip through the Sunday newspaper advertising supplements will show you a wide selection of complete PC systems for just a few hundred dollars. Are these the kinds of computers you want? Maybe not. The quality of the monitor (screen) is one of the first things that manufacturers sacrifice to make that $400 price point; after a long day of well checks, attention-deficit/hyperactivity disorder, and gastroenteritis, your eyes are not going to be happy with a cheap display. It usually will be more cost effective to spend more on systems with excellent, high-quality monitors, as speedy a processor as you can afford, and plenty of memory (RAM) to allow the application to perform as speedily as possible. Electronic medical records are not as processor intensive as, for example, a 3-D game, but you will come to regret every extra second that a computer lags because its processor is trying to catch up with your mouse clicks. Your time is too valuable; factor that into your decision about PCs.

Examination Room Configuration

If you have decided to put a PC in the examination room, you are going to want to set it up to allow the kind of interaction you want. Most parents really appreciate the doctor's willingness to share a look at the screen (to review growth charts or medication lists, for example), so you might want to consider placing the monitor so you can do this. Swing-arm devices to attach the monitor to the wall serve the dual purpose of making the monitor position very flexible, and freeing up horizontal space on the countertop. If you are lucky enough to have uniform examination rooms, the same solution can work for all rooms. Most of us work in offices where examination rooms are highly variable, so we need to budget for room modifications like adjusting counter height, carving out new desk space, or mounting PCs under desks to get them out of the way.

(continued on page 11)

Choosing Devices for Your EMR

(continued from page 10)

Printers… Where and How Colorful?

It is tempting to want a printer in each room, but the kind of high-quality, high-volume printers that we usually need in a business environment (as opposed to el cheapo inkjets) take up lots of room and entail surprisingly high maintenance costs. It may be more affordable and easier to manage to buy just 1 or 2 very reliable business printers (black and white lasers are the usual choice) and put them in a central location, rather than each examination room. Color printing, while it is a lot cheaper than it used to be, may not be worth the price once you factor in the very high cost of supplying color ink.

Monitors… How Big and How Many Pixels?

The, "How big?" question is easy: As big as you can afford. Seventeen inches (diagonal) would be considered a minimum in most situations. As with other information technology, monitors keep getting cheaper, so 20- to 24-inch screens are a reality. There is no such thing as a screen that is too large; and, now that tube-based (CRT) monitors are a thing of the past, we can fit large LCD flat-panel screens practically anywhere. Of course, a monitor's performance is not defined solely by size. For a given screen size, you can have different resolutions and varying color quality. Most of us do not need diagnostic-quality monitors for radiographs, so we can get away with less sophisticated graphics processing. But when it comes to judging the quality of a monitor, it is important to remember that, generally, you get what you pay for, and there is no other way to judge how well your eyes will like a monitor than to use it for a while under lighting conditions similar to those in your practice.

Microphones for Voice Recognition or Dictation

Automated voice recognition in EMRs is a lot better than it used to be, and lots of people use it. It is still necessary to train the computer to your voice, and, no matter what the advertisements say, this process takes a very long time. It is not necessary to spend a tremendous amount of money on microphones, but mics built in to tablet PCs or the "freebie" mics you might get with a system will not work as well as one optimized for voice recognition.

Maintenance

Buying high-quality PCs and peripherals will not eliminate the need for maintenance. If you are not willing to deal with the consequences of malfunctioning computers yourself, it may be in your best interest to contract with a local systems provider for on-call support. If you decide to go this route, be sure to nail down the specifics of what level of service they are guaranteeing. Will they come personally to fix problems? If a PC cannot be fixed within a certain period of time, will they replace it? You also need to have a plan for backup hardware for those times when your system (or network) may go down. That plan may be as simple as going to paper forms and backfilling essential data later or as elaborate as having special downtime PCs that will allow you to use the system un-tethered from the server, where the application usually resides.

Conclusion

Set aside some time and money to consider hardware issues in your system implementation. Think about spending a little more for better quality, and be sure you have a plan for maintenance that will keep your office humming.

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 Joseph, MD, FAAP, newsletter editor, at Craig.Joseph@EpicSystems.com.

Watch the Council on Clinical Information Technology (COCIT) Web site at www.aapcocit.org for information on submission deadlines for the Spring 2009 issue.

CCHIT Certified® 2009 Launches: Child Health Work Group to Expand Certification Criteria for Ambulatory Systems

By Beki Marshall, Manager, Health Information Technology Initiatives, AAP Division of Pediatric Practice, and Joy Kuhl, MBA, Director, Health Information Technology, Alliance for Pediatric Quality

Since the inception of the Certification Commission on Health Information Technology (CCHIT) in 2005, pediatricians, many of whom are members of the American Academy of Pediatrics (AAP) Council on Clinical Information Technology (COCIT), have worked to ensure that electronic health record systems (EHRs) that carry the CCHIT Certified® label meet requirements necessary for use in pediatric settings. These requirements include the ability to calculate drug dosing based on patient weight, recording immunizations that are administered in a multi-dose series, and other requirements identified in the AAP Clinical Report, Special Requirements for Electronic Health Records Systems in Pediatrics (*Pediatrics.* 2007;119(3):631-637) and the Child Health Functional Profile for EHRs developed by the HL7 Pediatric Data Standards Special Interest Group.

In July 2008, CCHIT began offering the opportunity for ambulatory EHR system vendors to apply for separate, optional Child Health certification. Vendors seeking Child Health certification are asked to demonstrate that their EHRs include a set of unique pediatric criteria as identified by the CCHIT Child Health Expert Panel, including the ability to capture patient growth parameters and to display growth charts. Pediatricians can now begin considering whether or not a vendor received the Child Health certification when selecting an EHR system for their practices.

This summer, CCHIT announced newly formed work groups charged with expanding certification criteria in 2009. The Alliance for Pediatric Quality (the Alliance), which includes the AAP, The American Board of Pediatrics, the Child Health Corporation of America, and the National Association of Children's Hospitals and Related Institutions, is pleased to see so many of its constituents represented on the new work groups. The Alliance provided a letter of support to CCHIT for 16 potential volunteers—11 of which were selected and who, along with another 5 pediatric volunteers who applied directly to CCHIT, are now participating in the following:

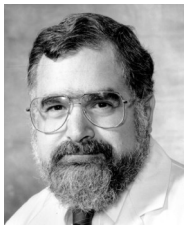
- Ambulatory Work Group
- Cardiovascular Medicine Work Group
- Child Health Work Group
- Emergency Department Work Group
- Interoperability Work Group
- Inpatient EHR Work Group

This broad pediatric representation will help ensure that the needs of child health care are considered during the development of new certification criteria within the various work groups. It is expected that, in 2009, we also will see an expanded set of Child Health certification criteria for ambulatory systems, including criteria for managing the following:

- **Adolescent Privacy**
  The needs and rights of adolescents and their legal custodians, including unique challenges related to the acquisition, use, and disclosure of identifiable health data.
- **Developmental Screening**
  Normal well child screening for behavioral concerns, blood pressure screening, developmental delay screening, including a check for autism, hearing, vision, height, and weight, and may include lead screening and tuberculosis screening.
- **Immunizations**
  The US Advisory Committee on Immunization Practices (ACIP), the AAP, and the American Academy of Family Physicians recommend a specific immunization schedule for children and adolescents each year.
- **Chronic Health**
  The top 3 child health chronic health concerns will be addressed, including the following:
  - Obesity affects at least 18% of children and teens.
  - Asthma affects nearly 9% of children and teens, a doubling since the 1980s.
  - Attention-deficit/hyperactivity disorder (ADHD).

It is anticipated that the CCHIT certification process positively influences the ability of EHRs to support health care providers in providing effective, efficient, high-quality care. For more information about CCHIT, visit www.cchit.org.

Electronic Prescribing of Controlled Substances: A Lesson in Putting Security Best Practices to Use in the Real World



By Alan E. Zuckerman, MD, FAAP
COCIT Executive Committee Member

The dream of electronic prescribing (e-prescribing) for controlled substances has finally moved closer to reality with the publication of the Drug Enforcement Agency (DEA) Notice of Proposed Rule Making (NPRM) on Electronic Prescribing of Controlled Substances (EPCS) in the *Federal Register* on June 27, 2008, after 8 years of delays. Hopefully, a final rule will be in place by the end of 2008. After that, it will not be long before pediatricians can send monthly refill prescriptions for Ritalin or Concerta to pharmacies, making it easier to keep children with attention-deficit/hyperactivity disorder (ADHD) on their chronic medications.

A close examination of the DEA's proposed rule is a lesson in a wide range of computer security technologies. In fact, an important argument used by the DEA to support its sophisticated requests is that the Certification Commission for Health Information Technology (CCHIT) is already asking for these technologies, and electronic health record (EHR) vendors are implementing them at least on an optional basis.

The DEA is part of the Department of Justice and has a very different set of concerns from most physicians. Physicians want to make technology easy and efficient to use so that it does not slow down work flow. The DEA is concerned with diversion of controlled substances through fraudulent prescriptions, identity theft, or abuse by practitioners or staff. The DEA has 3 concerns that are underlying their approach to EPCS. They want to prevent diversion by making it difficult, detect diversion by improved review of electronic records, and, finally, if diversion occurs, they want to be assured of the ability to prosecute offenders without risk of technical loopholes that could raise reasonable doubts in the evidence or increase the cost of prosecution. The concerns of law enforcement about their ability to function in an electronic world were just as important in delaying the rules as physician objections to the use of biometric authentication.

One of most innovative features of the NPRM is the use of third-party, in-person identity proofing that will no longer allow e-prescribing vendors to create new accounts for their customers on their own. Today, vendors can create such accounts with only a faxed copy of a medical license, DEA certificate, and telephone verification. Under the proposed rules, in-person certification of identity by a hospital credentialing office, state licensure board, or a law enforcement agency will be required to open an account by providing this third-party certificate to your vendor. This is reasonable given the 3-year length of DEA certification and what is at stake for stolen physician identity. This is an appropriate best practice in other industries and will be coming to health care.

The requirement for level 4 two-factor authentication is raising the bar on user login, but not really above where many of us are already and what other federal agencies are doing. Cryptographic tokens cannot be duplicated, the on-board keys cannot be extracted, and they can be revoked remotely if lost or stolen. Most are very easy to use just by plugging into a USB port with the need to type changing passwords or use a smartcard reader. I use one in my hospital to access laboratory results and images from home and to sign medical records and orders in the hospital or at the office simply by plugging in my USB token and typing my password. The small cost (under $50) of the device that can have multiple uses is worth the saving in time and travel. Expensive, time-consuming, and unreliable biometric technologies will not be required, but can be used optionally to replace the password as the second factor. There will be no attempt to authenticate or identify the patient at the office and again at the pharmacy.

Timeouts for inactivity are an important, but often a very annoying, security protection. The DEA is asking for a 2-minute inactivity timeout, which might appear to suggest that it will be impossible to use an EHR capable of EPCS. It is important to understand that the timeout applies only to the special authentication for signature after the prescription is written. It is perfectly reasonable to expect the signature process to be completed within 2 minutes. It recommends, and some vendors already have implemented, a separate password for signature from that used for system log-in to write a prescription or use an EHR.

The DEA is very aware of, and sensitive to, variant work flows in offices and hospitals. Residents in training will be able to use their institutional DEA number, but they will need an individual suffix. The National Council for Prescription Drug Programs (NCPDP) Script standard is being modified to handle these new expanded DEA numbers. Every controlled substance prescription must be signed by one, and only one, prescriber who is totally

(continued on page 14)

Electronic Prescribing of Controlled Substances

(continued from page 13)

responsible for the legitimate use of controlled substances. No longer will supervisor DEA numbers be allowed for counter signature. Office staff can prepare the controlled substance prescription, such as a list of monthly stimulant refills for patients with ADHD, but the physician will need log in, select each one to sign, and take full responsibility for each prescription signed.

At the end of each month, every prescriber will get a log of his or her controlled substance prescriptions for the month to verify, to detect possible fraud. Logs maintained by vendor systems could be altered to divert drugs. The monthly log check will be as tamperproof as possible and will protect the physician from undetected use of his or her identity.

There are 3 different approaches to sending an electronic prescription to a pharmacy once it has been written. Many systems today will switch automatically between electronic messaging, computer-generated fax, and printing on paper for wet signature. Today, many systems let you send and print with one press of a button, and automatically switch the send from electronic messages to fax, if the pharmacy is not yet accepting electronic prescriptions. This is totally unacceptable for controlled substances where faxes are forbidden. Even the common practice of sending and giving a printout to the patient leaves the system open to diversion of the duplicate prescription. Any printing will be done only for insertion in the EHR and not produce a valid or usable prescription. It still will be possible to use the EHR or e-prescribing system to print on tamperproof paper for manual use in pharmacies not on the network, but only if the prescription is never sent electronically.

Electronic prescribing inherently involves 3 separate systems: one for the prescriber, one for the network (such as SureScripts or RxHub), and one in the pharmacy. One of the reasons for the success of e-prescribing is the use of a network or switches that not only route the prescription and verify its format, but also translate between versions and types of standards like XML and EDIFACT. This makes it easy for an EHR to talk to a pharmacy. The DEA will allow translation, and even later annotation, as long as the original content does not change. This common practice would make it impossible to use conventional PKI digital signature. What is proposed instead is an electronic signature on the physician side with full review and expression and documentation of intent to sign, which is then followed by a cryptographic digital signature on the pharmacy side that will allow future checks on message integrity (not change the prescription data), third-party authentication of the signer, and true non-repudiation that will keep law enforcement happy. The physician's electronic signature is backed up with sophisticated authentication (login) and the pharmacy handles the digital signature part with immediate transmission and digital signature on receipt as soon as the physician is finished.

Anything good is worth doing right, and doing computer security right will never be cheap or without some inconvenience. The rules proposed by the DEA are not beyond our means, nor do they call for unreasonable extra time or insurmountable barriers to work flow. Considering the time currently spent on monthly ADHD medication refills and the number of children who stop taking regular medication because of the hassle of dealing with controlled substances, this approach can save time for both pediatricians and parents while offering important health benefits to children with learning problems. Digital Signature technologies were introduced to physicians 10 years ago in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security NPRM and, since then, all efforts at PKI and even many 2-factor authentication systems have been abandoned as too difficult for health care. Successful implementation of the DEA NPRM for EPCS will finally bring true digital signature to health care in an area where the risk and importance justifies the cost.

The DEA is very realistic about the fact that this will not be easy and will not be accepted quickly. It estimates that it will take 15 years for EPCS to approach 100%, and that the first year may see only 6% of prescriptions move by EPCS, which is way below the state of adoption of EHR and e-prescribing today. It has responded appropriately to the many objections raised 2 years ago at its conference on EPCS in July 2006. At that conference, I spoke on behalf of the American Academy of Pediatrics about the need for EPCS and the feasibility to move forward with realistic, but appropriately justified, technologies for high-level security that does not slow work flow. Controlled substances are over 10% of prescriptions written. It is very difficult to maintain a separate manual system for controlled substances while moving toward e-prescribing. The time has come to clarify and accept these rules and to start implementing them in our practices.

EXECUTIVE SUMMARY
COUNCIL ON CLINICAL INFORMATION TECHNOLOGY
EXECUTIVE COMMITTEE

Sofitel Chicago O'Hare—Rosemont, IL
April 5, 2008

The Council on Clinical Information Technology (COCIT) Executive Committee met in Rosemont, IL, on April 5, 2008. The Executive Committee discussed the following items:

- Dr Kevin Johnson was selected to receive the 2008 Byron Oberst Award, pending approval by the Council Management Committee.
- Dr Joseph Schneider was elected Chairperson, and Dr Eugenia Marcus was elected Vice Chairperson of COCIT. Each will serve a 2-year term beginning July 1, 2008. Since Dr Marcus had not completed her term on the Executive Committee, Dr Schneider will appoint someone to fill her position for the remainder of the term.
- The Executive Committee is working to finalize COCIT's Strategic Plan. A Survey Monkey survey will be used to identify the top 5 objectives from the Strategic Plan, which will be incorporated into COCIT's Annual Report of Councils.
- Staff will work with the COCIT Executive Committee to respond to several resolutions that were referred to COCIT from the 2008 Annual Leadership Forum.
- The Policy Committee will look more closely at tying its statements in to education and implementation activities.
- Dr Leu gave an update on the development of Pediatric Care Online and will advocate having more COCIT Executive Committee members serve as reviewers.
- Dr Leu gave a report on the identification of potential members of the Application Committee, as well as potential projects for this group.
- An update was given on enhancements to the Electronic Medical Record Review Web site.
- An update was given on the reorganization of the COCIT Education Committee, as well as plans for the 2009 American Academy of Pediatrics (AAP) National Conference & Exhibition (NCE).
- Drs Kevin Johnson and Stuart Weinberg were present to discuss their STEPSTools grant-funded project to develop an interactive, electronic knowledge base for pediatric prescribing and to seek AAP involvement in the project.
- An update was given on federal government activity related to health information technology. In particular, an update was given on the draft e-MEDS bill, which would provide incentives for e-prescribing and penalties for failing to prescribe electronically.
- Liaison reports were given on the Certification Commission for Health Information Technology, the American Health Information Community/Health Information Technology Standards Panel, the eHealth Initiative, the National Medical Association, and the Physicians Electronic Health Record Coalition.

The COCIT Executive Committee will next meet on Tuesday, October 14, 2008, in conjunction with the AAP NCE in Boston, MA.

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.

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!

COMMITTEE UPDATES

Education Committee

By Kristin Benson, MD, FAAP
COCIT Education Committee Chairperson

The Council on Clinical Information Technology (COCIT) is working to provide pediatric-friendly educational resources for American Academy of Pediatrics (AAP) members to help you successfully adopt and use Health Information Technology (HIT) in your practices. HIT does not just mean electronic health record (EHR) software. HIT is more comprehensive, and means all types of computerized information management. HIT will open your practice to the power of data, computerized data analysis, and automatic reporting of information when and where you need it. This is an exciting and evolving field, and an area of medicine where each of us can be a pioneer.

Our fall National Conference & Exhibition (NCE), again, will feature the Technology Learning Center (TLC). This is a specified site within the conference hall reserved for HIT talks. In past years, it was equipped with computer terminals, software trial programs, and innovative electronic office product devices. This year, it will remain a venue for COCIT talks. A number of faculty will be speaking and available for questions in the TLC throughout the NCE. In the future, we hope to provide talks integrated with clinical topics prioritized by the AAP for the general membership. We will continue to provide TLC for personal technology tools and innovations you can use on your own.

New last year, and continuing and expanding this fall, is the "Pediatric Office of the Future." This is a demonstration in the Exhibit Hall of some of the latest computerized devices and tools that are available to make your office run smoother. It is supported by vendors who are exhibiting their products, and will allow a "hands-on" opportunity to see and try these products.

A growing list of EHR software vendors also will be in the Exhibit Hall. Check your NCE program for these vendors. Consider signing up with a "Docent" who will go with you and help you ask the best questions. These docents are COCIT volunteers who will be available at the Office of the Future to assist you.

For 5 years, the "Pediatric Documentation Challenge" has been offered in the TLC. This is a demonstration of vendors designed to showcase the ability of their software to provide appropriate pediatric documentation. A common scenario is presented and the audience watches as the EHR is demonstrated. It is the only TLC offering that does not provide continuing medical education (CME) credits.

The "H-Program" is again offered at the NCE. There is a morning program of lectures followed by a scientific abstract session in the afternoon. This is an excellent opportunity to see what is happening in the pediatric informatics field, to ask questions, to get ideas, and to network with colleagues.

We are completing work on a *Pedia*Link module, called "Electronic Medical Record (EMR) Implementation." This is a general overview of the issues involved in selection and implementation of an EMR that can be completed online for CME credit.

The COCIT Web site is a great portal to select links and up-to-date information on pediatric HIT. From there, you can link to the EMR Review Project. This is a site with EMR evaluations from practicing AAP pediatricians. It includes ratings on various features of the software and vendor support.

The Council on Clinical Information Technology is working hard to advocate for your needs as pediatricians. Our members sit on various national standards organizations. Policy statements are published to inform our membership and the business community of the specific needs of pediatricians with HIT. Council on Clinical Information Technology policy statements are published on the AAP Web site for your learning and review.

Your feedback will help us serve your needs. Please feel free to contact me (bens0293@UMN.edu) if you have any comments or suggestions for the COCIT Education Committee.

Pharmacies to Launch National E-Prescribing Consumer Awareness Campaign

In April 2008, thousands of independent pharmacies joined with CVS/pharmacy, Duane Reade, Giant Foods, Kerr Drug, Kroger, Longs Drugs, Osco Drug, Rite Aid, Sav-On Pharmacy, Stop & Shop, Walgreens, Wal-Mart, and other chain pharmacies to launch a nationwide consumer awareness campaign to support electronic prescribing (e-prescribing). Through a media relations effort, in-store signage, and educational materials, the campaign serves to inform patients about the benefits of e-prescribing and encourages them to pass the word on to their doctor.

As a result, practices may receive more inquiries from patients for e-prescriptions.

On pharmacy front doors and counters, patients see signs indicating "e-prescriptions filled here" and "give your prescription a head start." The campaign Web site (www.LearnAboutEprescriptions.com) educates patients about the benefits of e-prescribing and will identify which local physicians and pharmacies e-prescribe by simply having the patient type in his or her zip code.

For electronic medical record (EMR) users, this program has special implications. Many EMR users prepare and submit prescriptions to pharmacies electronically, but are unaware that they arrive on paper at the pharmacy's fax machine. Because these types of transmissions are not considered to be transmitted electronically (they are not able to be received by a pharmacy computer), prescribers that manage prescriptions in this way will not be identified as e-prescribers on the campaign Web site.

Plus, these types of prescriptions will be affected by significant changes to Centers for Medicare & Medicaid Services (CMS) prescribing regulations that will go into effect the first of next year.

As of January 1, 2009, all computer-generated prescriptions for Medicare Part D patients must comply with the National Council for Prescription Drugs Program script standard and thus be transmitted electronically and not by computer-generated fax. If not, prescriptions must be printed and then manually faxed—a time-consuming process.

For practices that use an EMR to *print* prescriptions, it is important to note that any prescription sent electronically to a pharmacy computer is exempt from the CMS April 1 requirement that written Medicaid prescriptions must be on a tamper-resistant blank.

To help American Academy of Pediatrics (AAP) members assess their readiness to e-prescribe, including confirming if their prescribing application is compliant with the new CMS regulations, the AAP is participating in a nationwide electronic prescribing assessment program along with the American Academy of Family Physicians, the American College of Cardiology, the American Osteopathic Association, the Medical Group Management Association, and The Center for Improving Medication Management.

Members are encouraged to visit www.getrxconnected.com/AAP to take a free E-Prescribing Readiness Assessment. Non-EMR users can generate a customized *Guide to Selecting E-Prescribing Technology* and get details on the business and social case for e-prescribing.

The national "Get Connected" program is planned to continue through January 2009.

The Council on Clinical Information Technology Electronic Medical Record Resource:

www.aapcocit.org/emr

The Council on Clinical Information Technology (COCIT) officially launched the Electronic Medical Record (EMR) Review Web site in July 2005. Please help us make this a valuable tool for all American Academy of Pediatrics members by rating your EMR today!

Still looking for an EMR? We have more than 120 reviews posted! See your colleagues' rankings and review comments based on their experiences.

COCIT's EMR Resource: www.aapcocit.org/emr

The Quality Improvement Innovation Network

By Keri Thiessen and Jill Healy, QuIIN Staff

The Quality Improvement Innovation Network (QuIIN) was established in 2005 to further enhance the American Academy of Pediatrics efforts of transferring evidence-based medicine into the daily routine of practice. In this effort, a network of practicing pediatricians and their staff teams have organized to improve the health care and outcomes for children and their families by volunteering to test new and revised tools, interventions, and strategies identified to implement evidence into practice. This network provides "real-world laboratories," using the science of quality improvement to implement and test interventions that, in the end, provide the pediatrician with tested tools to improve care.

Most recently, QuIIN members and their staff participated in **Safe and Healthy Beginnings,** an improvement project conducted by QuIIN in partnership with the Center for Health Care Quality (CHCQ) at Cincinnati Children's Hospital Medical Center and funded by the AAP, McNeil Consumer Healthcare, and the Centers for Research and Education on Therapeutics (CERTS). This improvement project was designed to ensure a safe and healthy beginning for all newborns by testing measures, strategies, and tools based on the 3 key aspects (ABCs) of the AAP revised hyperbilirubinemia guidelines (*Pediatrics.* 2004;114:297-316):

- Assessment of risk for severe hyperbilirubinemia prior to hospital discharge
- Breastfeeding support
- Care coordination between the nursery and primary care

For this project**,** 22 clinical teams from QuIIN (10 newborn nurseries and 12 primary care practices) came together in a face-to-face session to learn about the interventions themselves and the quality improvement methods needed to implement and test these changes. Quality improvement methods included providing practices with knowledge on the Model for Improvement, a QI method, which assists the physician in clarifying (1) what he or she is trying to accomplish; (2) how to determine if the intervention or change to the intervention is an improvement; and (3) what change can be made that would result in improvement. To achieve the aims each team set, teams learned about rapid-cycle testing (Plan, Do, Study, Act [PDSA]) as well as the use of run charts in reporting and analyzing the data during the testing cycle. Safe and Healthy Beginnings teams implemented the interventions, made adjustments accordingly, and collected data on these improvements over a period of 5 months**.**

The result of this improvement project will be *Safe and Healthy Beginnings: A Resource Toolkit for Hospitals and Physicians' Offices,* a set of resources tested by the pediatrician, for the pediatrician, in delivering care for the newborn. The Safe and Healthy Beginnings Toolkit is anticipated for release at the AAP 2008 National Conference & Exhibition. In addition, the specific data results and conclusions for this project are anticipated for publication at a later date.

The Quality Improvement Innnovation Netword would like to recognize those clinical teams who volunteered their time, staff, and ideas for the first of what we hope to be many projects, designed to improve care for children.

Florida: Atlantic Coast Pediatrics and Cape Canaveral Hospital (Merritt Island)
Illinois: Loyola University Medical Center (Maywood); Indiana: Jeffersonville Pediatrics and Clark Memorial Hospital (Jeffersonville); Tippecanoe Community Healthy Clinic and Lafayette Home Hospital-Greater Lafayette Health Services (Lafayette)
New York: Long Island City Community Pediatrics, Resident Group Practice at Helmsley Tower 5, and NY Presbyterian Hospital-Komansky Center for Children's Health (New York)
North Carolina: Sandhills Pediatrics and Moore Regional Hospital (Southern Pines)
Ohio: Oxford Pediatrics and Adolescents and McCullough Hyde Memorial Hospital (Oxford)
Pennsylvania: Roseville Pediatrics/LGMG (Lancaster)
Texas: Lyndon B. Johnson Hospital Pediatric Clinic and LBJ General Hospital Well Baby Nursery (Houston); FM 1960 Cypresswood (Spring)
Wisconsin: Aspirus Doctors Clinic and Riverview Hospital (Wisconsin Rapids)
Utah: Utah Valley Pediatrics and American Fork Hospital (American Fork)

For more information on QuIIN or the QuIIN pilot project, Safe and Healthy Beginnings, go to http://www.aap.org/moc/quiin or e-mail QuIIN staff at quiin@aap.org.

The Council on Clinical Information Technology Announces the 2008 Byron Oberst Award Winner

The Council on Clinical Information Technology (COCIT) Executive Committee has selected Kevin B. Johnson, MD, MS, 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 Executive Committee members are not eligible to receive the award.

Dr Johnson received his MD and completed his pediatric residency at Johns Hopkins University School of Medicine. He also received a MS in Biomedical Informatics from Stanford University. He currently serves as Associate Professor of Pediatrics and Biomedical Informatics, as well as Vice Chair of the Department of Biomedical Informatics at Vanderbilt University Medical Center in Nashville, TN.

Dr Johnson previously served on the COCIT Executive Committee in the role of Chair of the Technology Committee. In this role, he developed the "EHR: Where's the Value?" Speaker's Kit and the "Implementing an Electronic Health Record" Toolkit. He currently serves on the Board of Directors of the American Medical Informatics Association. In addition, he has participated on numerous committees and study sections for the Agency for Healthcare Research and Quality, the National Library of Medicine, the American Board of Pediatrics, and the Ambulatory Pediatrics Association. He is a frequent speaker at the American Academy of Pediatrics National Conference & Exhibition (NCE).

In addition to his personal achievements, Dr Johnson has served as mentor and friend to many in the field of pediatric informatics.

The Award, which includes a plaque and honorarium check, will be presented to Dr Johnson on Sunday, October 12, 2008, at 12:00 noon, during COCIT's Council Program for Council Members (H2015) at the NCE in Boston, MA. Dr Johnson, who is also one of the featured speakers during the morning portion of the session, will be asked to give a brief lecture. Everyone is invited to attend.

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.

AAP Council on Clinical Information Technology
Call for Nominations
2009 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 2009 National Conference & Exhibition in Washington, DC. 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 2009 awards, nominations and supporting materials must be received by January 2, 2009.

Return the completed nomination form (see back page) 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!

Joseph H. Schneider, MD, MBA, FAAP
Chairperson
Council on Clinical Information Technology

Previous Byron Oberst Award Recipients

2008: Kevin B. Johnson, MD, MS, FAAP
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

Council on Clinical Information Technology
Council Program for Council Members
Sunday, October 12, 2008
H2015

9:00 am **Measures of Quality of Care and How They Are Used: Carrot vs Stick**
Stuart T. Weinberg, MD, FAAP

10:15 am **The New Medical Record: From Folder to Datastream**
Kevin B. Johnson, MD, FAAP

11:30 am **Questions & Answers/Meet the Faculty**

12:00 noon **2008 Byron Oberst Award Presentation**

Lunch Break (On Your Own)
Council Business Meeting

1:15 pm Break

Scientific Abstract Session

1:30 pm **Inaccuracy of Manually Maintained Provider Sign-Out Medication Lists—The Need for Data Integration**
Bokser SJ,[1,5] Yeung MK,[2] Cucina RJ,[3,5] Herrick BE,[4,5] Blum MS.[3,5] [1]Department of Pediatrics, University of California, San Francisco, San Francisco, CA; [2]School of Medicine, University of California, San Francisco, San Francisco, CA; [3]Department of Medicine, University of California, San Francisco, San Francisco, CA; [4]Department of Family and Community Medicine, University of California, San Francisco, San Francisco, CA; and [5]Department of Information Technology, University of California, San Francisco, San Francisco, CA

1:45 pm **Just Because It's in Google Doesn't Mean It's Accurate: Search-Engine Rank, Third-Party Links, and Accuracy of Web Pages on Children's Cough**
Reddy VN,[1] Smidchens LA,[2] Barger CJ.[3] [1]Department of Pediatrics and Human Development, Michigan State University/Kalamazoo Center for Medical Studies, Kalamazoo, MI; [2]College of Education, Western Michigan University, Kalamazoo, MI; and [3]Department of Nursing Scholarship, Quality, and Research, William Beaumont Hospital, Royal Oak, MI

2:00 pm **Internet Use to Obtain Health Information Among Adolescents in an Urban Healthcare Network**
Afolayan A, Mella C, Manzoor Z, Lewis C, Bainbridge R, Adeniyi A, and Neugebauer R. Pediatrics, Bronx-Lebanon Hospital Center, Bronx, NY

2:15 pm **Automated Extraction of Medical Diagnoses From Clinical Trial Announcements Using Natural Language Processing: Proof of Concept**
Solti I,[1] Strandjord TP,[2] and Tarczy-Hornoch P.[1] [1]Medical Education and Biomedical Informatics, University of Washington, Seattle, WA and [2]Pediatrics, University of Washington, Seattle, WA

2:30 pm **Patient Satisfaction During Inpatient EMR Implementation**
Spahr RC, Hutchison R, and Gerdes J. Service Quality, Geisinger Medical Center, Danville, PA

2:45 pm Break

Scientific Abstract Session (continued)

3:00 pm **A Set of Novel Educational Strategies to Enhance Pediatric Residents' Knowledge and Assessment of Child Development**
Leiner M, Shirsat P, Handal G, Rosas-Blum E. Pediatrics, Texas Tech University Health Sciences Center, El Paso, TX

3:15 pm **PPAS: Design and Development of a Physician Performance Assessment System for a Multihospital System**
Lighter DE. Medical Affairs, Shriners Hospitals for Children, Tampa, FL

(continued on page 22)

COCIT Council Program for Council Members

(continued from page 21)

3:30 pm **Disaster Preparedness and the General Pediatric Practice: An Application and Extension of the Current AAP Policy**
Serota FT and Serota JB. Ambler Pediatrics, Ambler, PA

3:45 pm **Using Clinical Questions to Guide and Index Content of a Web-based Clinical Information Resource**
Norlin C,[1] Kerr LM,[1] and Rocha RA.[2] [1]Pediatrics, University of Utah School of Medicine, Salt Lake City, UT; and [2]Biomedical Informatics, University of Utah School of Medicine, Salt Lake City, UT

4:00 pm **The Feasibility of Measuring Developmental Screening Services Using the Electronic Health Record: A Case Study at Park Nicollet Health Services**
Benson KA,[1] Kitty C,[2] Weiner J,[2] Fowles J,[3] and Kind E.[3] [1]Pediatrics, Park Nicollet Health Services, Minnetonka, MN; [2]Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD; and [3]Park Nicollet Institute, Park Nicollet Health Services, Minneapolis, MN

4:15 pm Break

4:30 pm **Reception/View Posters/Best Paper Award Presentation**

COCIT gratefully acknowledges support for the Poster-Viewing Reception from MediNotes Corporation.

P1 **Resident Use of Public Internet Search Engines (PISE) to Search the Scientific Literature**
Bove M, Leafe M, Teeter E, and Stryjewski G. Pediatrics, Alfred I. DuPont Hospital for Children/Thomas Jefferson University, Wilmington, DE

P2 **The Readability of Pediatric Patient Information Materials—Will Families Understand Our Handouts and Brochures?**
Swartz EN. Pediatrics, University of Alberta, Edmonton, Alberta, Canada

P3 **"Infobuttons" for a Personal Health Record**
Fontelo P, Liu F. Office of High Performance Computing and Communications, National Library of Medicine, Bethesda, MD

P4 **What Information Italian Parents Receive on HPV Immunization When Surfing on the Web**
Tozzi AE[1], Buonuomo PS,[1] Ciofi Degli Atti ML,[1] and Gamba F.[2] [1]Pediatrics, Bambino Gesu Hospital, Rome, Italy; and [2]Communication Science, La Sapienza University, Rome, Italy

P5 **Cardiosuite—Another Showcase of Innovative PDA Application to Improve Self-Directed Learning**
Lin Y. Pediatrics, Texas Tech University Health Sciences Center, El Paso, TX

P6 **The Influence of Quality Criteria on Parents' Evaluation of Medical Web-Pages: An Italian Randomised Trial**
Buonuomo PS,[1] Currò V,[2] Zambrano A,[2] Onesimo R,[2] Vituzzi A,[3] and D'Atri A.[3] [1]Department of Pediatrics, Ospedale Pediatrico "Bambino Gesu" IRCCS, Rome, Italy; [2]Department of Pediatrics, Ambulatory Pediatrics, Policlinico Universitario "A. Gemelli", UCSC, Rome, Italy; and [3]Centro de Ricerca sui Sistemi Informativi, LUISS Guido Carli, Rome, Italy

P7 **Documentation Errors in the NICU: Comparison of Manually and Computer-Generated Daily Progress Notes**
Khosravi AH, Kim GR, Lawson EE, Lehmann CU. Department of Pediatrics, The Johns Hopkins University School of Medicine, Baltimore, MD

P8 **Office of the Future, or No Office at All**
Goldstein R. Wellbody, Blue Valley Pediatrics, Leawood, KS

5:30 pm Adjourn

Other Council on Clinical Information Technology-sponsored Sessions
American Academy of Pediatrics National Conference & Exhibition
October 11-14, 2008
Boston, MA

Saturday, October 11

S1104
4:00-5:30 pm
Challenges for the Rural Pediatrician
Steven Wegner, MD, JD, FAAP
(Cosponsored by Council on Community Pediatrics Rural Health Special Interest Group, Committee on Practice and Ambulatory Medicine, Section on Administration and Practice Management, and District CATCH Facilitators)

S2091
2:00-3:30 pm
The Pediatrician's PDA: Handhelds, Smartphones, and More—Best Practices for Integrating Mobile Devices Into Your Practice
David C. Stockwell, MD, FAAP
S. Andrew Spooner, MD, MS, FAAP

H1022
3:00-4:00 pm
Section on Administration and Practice Management
Panel Discussion
Mark M. Simonian, MD, FAAP

Monday, October 13

S3111
4:00-5:30 pm
The Pediatrician's PDA: Handhelds, Smartphones, and More—Best Practices for Integrating Mobile Devices Into Your Practice
David C. Stockwell, MD, FAAP
S. Andrew Spooner, MD, MS, FAAP

S3110
4:00-5:30 pm
Across the Continuum: Using Telemedicine, E-mail, and Telephone Care to Manage Chronic Problems in Pediatrics
Christoph U. Lehmann, MD, FAAP
Sanford M. Melzer, MD, FAAP
(Cosponsored by Section on Telephone Care, Section on Administration and Practice Management, and Section on Clinical Pharmacology and Therapeutics)

S3115
4:00-5:30 pm
Pay for Performance Primer for Pediatricians (P4PP4P)
Thomas K. McInerny, MD, FAAP
(Cosponsored with Committee on Child Health Financing, Steering Committee on Quality Improvement and Management, and Private Payer Advocacy Advisory Committee)

(continued on page 24)

Other COCIT-sponsored Sessions

(continued from page 23)

S3112
4:00-5:30 pm
EHR 101: Choosing and Using an EHR—Best Practices for Implementing an EHR in Your Practice
Mark M. Simonian, MD, FAAP
(Cosponsored with Section on Administration and Practice Management, Section on Clinical Pharmacology and Therapeutics, Section on Emergency Medicine, and Section on Hospital Medicine)

Tuesday, October 14

S4070
2:00-3:30 pm
EHR 101: Choosing and Using an EHR—Best Practices for Implementing an EHR in Your Practice
Mark M. Simonian, MD, FAAP
(Cosponsored with Section on Administration and Practice Management, Section on Clinical Pharmacology and Therapeutics, Section on Emergency Medicine, and Section on Hospital Medicine)

Technology Learning Center
American Academy of Pediatrics National Conference & Exhibition
October 11-14, 2008
Boston, MA

The Council on Clinical Information Technology (COCIT) invites you to the Technology Learning Center! Our faculty will be available to answer questions and help guide you through whatever information technology challenge you are facing. Discussion topics will focus on electronic health records, electronic prescribing, online educational resources, and a host of other topics.

Lectures this year will explain how to use the most current technology at the point of care to improve care and reduce errors. We continue to offer the Pediatric Documentation Challenge™, where you can see, firsthand, how electronic health records can work in your office.

Saturday, October 11

E1083
7:00-8:00 am
HL7: A Framework for Medical Information
S. Andrew Spooner, MD, MS, FAAP

E1024
8:30-10:00 am
Certified EHRs: A Gold Standard for Functionality and Compatibility
Alan Zuckerman, MD, FAAP

E1068
12:30-1:15 pm
Technology in Perspective: The Bleeding Edge
Alice Loveys, MD, FAAP

E1087
2:00-2:45 pm
Staying One Step Ahead: Use the Web Effectively to Keep up With Genetic Advances
Marc S. Williams, MD, FAAP

(continued on page 25)

Technology Learning Center

(continued from page 24)

E1093
3:00-3:45 pm
Digital Photography in the Office
Christoph U. Lehmann, MD, FAAP
E1110
4:00-4:45 pm
PubMed
NLM faculty TBD
E1111
5:00-5:45 pm
Technology in Perspective: RHIO, SHIO, and NHIN—Whose Information Is It?
Eugenia Marcus, MD, FAAP

Sunday, October 28

E2043
7:00-8:00 am
Multimedia, the AAP, and Your Practice
David M. N. Paperny, MD, FAAP
E2044
8:30-10:00 am
EHR 202: The Power User's Guide to EHR
Donald E. Lighter, MD, MBA, FAAP
E2077
12:30-1:15 pm
Pediatric EHR
S. Andrew Spooner, MD, MS, FAAP
E2100 and **E2101**
2:00-5:45 pm
Pediatric Documentation Challenge (no CME credit)
Eugenia Marcus, MD, FAAP
Joseph H. Schneider, MD, MBA, FAAP

Monday, October 29

E3008
7:00-8:00 am
Technology in Perspective: EHR 001—Signs of Readiness
Gregg Alexander, DO, FAAP
E3050
8:30-9:15 am
Multimedia, the AAP, and Your Practice
David M. N. Paperny, MD, FAAP
E3051
9:30-10:15 am
Digital Photography in the Office
Christoph U. Lehmann, MD, FAAP
E3091
2:00-2:45 pm
Patient Safety's Friend: Information Technology
Richard Shiffman, MD, FAAP
E3099
3:00-3:45 pm
*Pedia*Link as a Key to Maintenance of Certification Success
Henry Bernstein, MD, FAAP
E3120
4:00-5:30 pm
Partnering With Parents to Leverage the Quality Movement to Improve Practice
Christina Bethell, PhD, MBA, MPH

Tuesday, October 30

E4006
7:00-8:00 am
Technology in Perspective: EHR 001—Signs of Readiness
Gregg Alexander, DO, FAAP
E4031
8:30-9:15 am
Technology in Perspective: RHIO, SHIO, and NHIN—Whose Information Is It?
Eugenia Marcus, MD, FAAP
E4040
9:30-10:15 am
PubMed
NLM faculty TBD
E4058
12:30-1:15 pm
Technology in Perspective: The Bleeding Edge
Alice Loveys, MD, FAAP
E4078
2:00-2:45 pm
*Pedia*Link as a Key to Maintenance of Certification Success
Henry Bernstein, MD, FAAP
E4085
3:00-3:45 pm
Patient Safety's Friend: Information Technology
Richard Shiffman, MD, FAAP
E4097
4:00-5:30 pm
EHR 202: The Power User's Guide to EHR
Donald E. Lighter, MD, MBA, FAAP

COCIT LISTSERV® E-mail Discussion Lists

COCIT Announcements E-mail List

All COCIT members are automatically subscribed to the *cocitnews* 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-news@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 also have 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 the e-mail lists mentioned above:
Digest Version: If you would 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

The Council on Clinical Information Technology maintains an online discussion board on the COCIT page of the AAP Member Center (www.aap.org/moc). To post a message to the discussion board, or to see previous postings, log into the AAP Member Center. On the left-hand side of the screen, you will see a drop-down box with a list of the sections to which you belong. Select "Council on Clinical Information Technology" from the list. On the COCIT page, click on the COCIT Discussion Group link.

RESPONSE REQUESTED BY DECEMBER 1, 2008

COUNCIL ON CLINICAL INFORMATION TECHNOLOGY (COCIT)

CALL FOR NOMINATIONS

The American Academy of Pediatrics (AAP) Council on Clinical Information Technology (COCIT) seeks nominees to run for election to the Executive Committee. Four positions are up for election.

Successful Executive Committee Member candidates will serve 3-year terms, to begin July 1, 2009.

Summaries of responsibilities for Executive Committee Members can be found on the AAP Member Center Web site at http://www.aap.org/moc/MEMBCOMM.cfm (look under Section, Council, and Committee Information). The Council chairperson will appoint a nominations committee to review the nominees and select the candidates for the ballot. Submission of this form does not guarantee inclusion on the ballot.

If you would like to be considered for candidacy, or if you would like to nominate a colleague, please:

1. **Complete this form.**
2. **Attach a brief biographical sketch (no more 250 words) which will be used on the ballot if you are nominated.**
3. **Fax it to 847/434-8000, ATTN: Beki Marshall, *no later than December 1, 2008.***

Name: (Please Print) _____

Address: (Please Print) _____

Telephone: _____

Fax: _____

E-mail: _____

Current Position: _____

Fax **(847/434-8000)** to Beki Marshall **on or before December 1, 2008.** Thank you.

Please Welcome Our New Members!

The following individuals joined the Council on Clinical Information Technology between January 29 and August 19, 2008:

John B. Bennett, II, MD, FAAP
Westlake, OH

Klaus M. Boel, MD, FAAP
Jeffersonville, IN

Clayton A. Buie, MD, FAAP
Alabaster, AL

David K. Butler, MD, FAAP
Pearland, TX

Richard P. Charette, MD, FAAP
Lake Quivira, KS

Chandana Chatterjee, MD, FAAP
Columbia, MD

William H. Cook, Jr, MD, FAAP
Radford, VA

Marietta M. DeGuzman, MD, FAAP
Pearland, TX

Capt. John P. Fernald, MD, FAAP
Roanoke, VA

Kerry F. Fierstein, MD, FAAP
Plainview, NY

Jeffrey E. Fireman, MD, FAAP
Deerfield, IL

Lloyd D. Fisher, MD, FAAP
Grafton, MA

Elisdel M. Garcia-Bousquet, MD, FAAP
Frederick, MD

Radley D. Helin, DO, FAAP
Evanston, IL

William M. Kendrick, MD, FAAP
Weston, FL

Kenneth M. Klebanow, MD, FAAP
Columbia, MD

Susan J. Kressly, MD, FAAP
Warrington, PA

Cynthia L. Kuelbs, MD, FAAP
San Diego, CA

Jeffrey D. Merrill, MD, FAAP
Berkeley, CA

Cheryl Morrow-White, MD, FAAP
Cleveland Heights, OH

Frances C. O'Hare, MD
Jamaica Plain, NY

Michael A. Padula, MD, FAAP
Philadelphia, PA

Lee A. Pyles, MD, FAAP
Edina, MN

Dilli Ramesh, MD, FAAP
Troy, MI

Tommy J. Schechtman, MD, FAAP
Jupiter, FL

Clifford A. Selsky, MD, FAAP
Orlando, FL

Joel W. Steelman, MD, FAAP
Fort Worth, TX

Robert P. Stephens, MD, FAAP
Parma, OH

Carol F. Teplis, MD, FAAP
Elgin, IL

Keith Toms, MD, FAAP
Hopkinsville, KY

Joel A. Wolk, MD, FAAP
Cedarhurst, NY

Dana E. Wollney, MD, FAAP
Columbia, MD

AAP Council on Clinical Information Technology
Nomination Form
2009 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, 2009, will be considered for the 2010 award.