

cocitnews

The Council on Clinical Information Technology

Volume 7, Number 2, Fall 2009

From the Chairperson and Vice Chairperson



By Joseph Schneider, MD, MBA, FAAP
Chairperson, Council on Clinical Information Technology, and
Eugenia Marcus, MD, FAAP
Vice Chairperson, Council on Clinical Information Technology

Inside this issue

From the Editor	3
Ultimate Interoperability	4
Tablet Versus Desktop	6
Report from the APA Medical Informatics SIG	7
The Pediatrician Blogger	8
Oberst Award Winner	9
One Pediatrician's EMR Experience	10
COCIT Executive Summary	11
Council Election Results Announced	11
Education Committee	12
Policy Committee	13
COCIT Educational Session at the NCE	14
New Book	16
New Members	17
Call for Nominations	19

American Academy of Pediatrics and Health Information Technology at a Crossroads

The election of Barack Obama and the health information technology (HIT) funding that is in the Children's Health Insurance Plan Reauthorization Act (CHIPRA) and the stimulus package (American Recovery and Reinvestment Act [ARRA]) has created a "tipping point" for how electronic medical records (EMRs) are used. How the American Academy of Pediatrics (AAP) responds to this opportunity/challenge will set the stage for the role of pediatrics in HIT/Quality for the next decade or longer.

To set the stage for where we are today, the Council on Clinical Information Technology (COCIT) used to be the Section on Computers and Other Technologies (SCOT) and the Task Force on Medical Informatics (TFOMI). A small band of dedicated members gradually grew this group into what we know today as COCIT (there were a few steps in between, of course...).

In 2003, the number one resolution of the AAP Chapter Forum called for the development of a standard EMR for children that would support pediatrician work flow. For the next few years, the AAP, with COCIT, attempted to take

a leadership position with initiatives, including the following:

- Educational offerings, such as the Technology Learning Center, an "Office of the Future" in 2007, HIT topics in *AAP News*/other publications and the annual Pediatric Documentation Challenge at the Toward an Electronic Patient Record (TEPR) conference, and the AAP National Conference & Exhibition (NCE) and other meetings
- Scientific programs, such as the increasingly popular COCIT/HIT Abstract Program at the NCE
- Tools such as the EMR Review Web site, the toolkit for office EMR implementation, and the recently added technology support of Pediatric Care Online
- Standards efforts, such as development of the Continuity of Care Record and HL7 Child Health leadership
- Leadership and participation in the formation and continued improvement of the Certification Commission for Health Information Technology (CCHIT)
- Informatics support through the Partnership for Policy Implementation (PPI), which incorporates informatics concepts into AAP policies so that they can be more easily adopted into EMRs.

(continued on page 2)



AAP and HIT at a Crossroads

(continued from page 1)

Additional programs on HIT have occurred at the NCE as the Section on Administration and Practice Management (SOAPM) and other sections/councils have started to realize the importance of this topic.

Subsequent years have brought additional resolutions at the Annual Leadership Forum. However, even with this, we have fallen behind.

Through the ARRA legislation, there is now an expectation for most physicians to have “meaningful use” of a “certified” EMR by 2014. Meaningful use includes the following:

- Certification by an as-yet-unspecified entity
- Information exchange (sometimes confused with “interoperability”) between EMRs and entities such as disease registries, hospitals, public health departments, etc
- Quality reporting
- e-prescribing (for ambulatory records)

The details of these requirements have yet to be defined. For Medicaid, there is a real danger that this could be defined differently for each state. A team of COCIT members is working on a definition of Meaningful Use that could be used by all Medicaid programs to avoid this possible problem.

For the AAP to help pediatricians meet these challenges, the AAP needs to go well beyond the activities listed above. It needs to develop new skills and structures. The Children’s Health Insurance Plan Reauthorization Act requires the development of a Model Child Electronic Health Record Format. Who else but the AAP could do this effectively? While the AAP has the skills to do this in its membership, the infrastructure to accomplish this does not yet exist.

For years, COCIT has been pushing AAP leadership to expand its infrastructure and skills in serving the HIT needs of its members. Now, with deadlines looming and others eager to take up any void that the AAP leaves, the AAP leadership is working on this.

In a presentation to the Board in May, Joe Schneider and Kevin Johnson, representing COCIT, laid out a vision to start the AAP on the path to creation of a “Center for HIT,” which would provide AAP leadership in the following areas:

- Membership support for EMR adoption, meaningful use, and funding support from Medicaid and other sources
- Oversight and direction setting for a different approach to the structure of the CHIPRA Model Child Health Record Format (see below)
- Regularly convening key leaders to coordinate efforts

so that pediatric informatics can proceed as fast as possible in a coordinated fashion

Bob Hall and Ramesh Sachdeva did an excellent job connecting this to the AAP legislative and quality agenda. Board members have responded enthusiastically to this.

In a subsequent meeting with Dr Blumenthal, the AAP leadership laid out components of the above to him. He was simultaneously informed and intrigued, and there is great opportunity in working closely with him through a Center for HIT.

As a brief dive into details, the different approach that has captured the interest of many is to investigate separating EMRs into the following 3 parts:

- Data. To provide a single “source of truth” for key elements of the longitudinal patient record, such as allergies, problems, etc, and to provide a means for smooth exchange of this information across multiple EMRs. An example of this could be a bi-directional link to a patient’s personal health record or a state immunization registry where the EMR could be updated with new information prior to each encounter.
- Rules/forms. To provide a mechanism to create “plug-ins” and “Web services” that would allow EMR vendors to use tools developed centrally without having to code them into their EMR. Examples of these are immunization algorithms, Bright Futures and other guidelines, order sets, etc. The ability to keep rules/forms up-to-date without having to reach each EMR installation is very compelling. The impact this would have on terminology standardization is another compelling argument for it. Examples are ISABEL (that can function as a Web service to an EMR) or drug databases that are used by EMRs currently (as an example of a sort of “plug-in”).
- Presentation. To allow the EMR to become more “browser-like,” in that it gets data from appropriate sources, sends it for rules/forms processing as above, and presents the data/results in a workflow-friendly fashion for pediatricians and others. Unlike browsers, the EMR would still need to store data locally for medicolegal purposes, downtimes, etc. These are among the many details that need to be worked out.

It is not possible to explain all of the nuances of this approach in an article of this length, so we’ll have more on it later. However, this concept has been presented to several national vendors and standards organizations, and it has been met with enormous interest. Several of them, such as the Systematized Nomenclature of Medicine (SNOMED), have independently reached the same conclusions.

(continued on page 3)

AAP and HIT at a Crossroads

(continued from page 2)

To accomplish this and the other key objections listed above, the AAP needs to quickly acquire the needed skills and resources. A “Center for HIT,” headed by pediatricians, is urgently needed. The Board presentation clearly identified this need. To get this going quickly requires seed funding, partnering with pediatricians already working in the fields of HIT/Quality, and a willingness to work with vendors committed to the needs of children.

As of this writing, the AAP Center for HIT is still in a formative stage. If we take bold steps, such as those outlined above, we can catapult the AAP back into a leadership position in HIT. Your COCIT leadership is very committed to making this happen and we very much need your support. Now is the time for action.

From the Editor



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



The American Academy of Pediatrics was recently represented by Andy Spooner, MD, MS, FAAP, at an HL7-sponsored meeting entitled Bridging the Chasm. This conference attempted to bring together medical organizations that span the multitude of clinical specialties. Their mission is lofty: “to help define the form, composition, content, and functionality of information technology for health care delivery.”

One of the speakers at this conference spoke about clinical terminology. He noted in the title of his presentation that doctors and health care administrators often “glaze over” when informatics is discussed. I doubt many Council on Clinical Information Technology members would deny having been in front of such an audience themselves. The speaker tried to ensure his audience didn’t get sleepy by including a slide that used 60-point font to exclaim, “People are dying because we don’t use the same names for the same things!”

I bet that kind of a statement will get your audience’s attention. While it is important to avoid hyperbole, it is also important to educate your audience that informatics is important. Decisions that are made about how information technology works in a clinical setting can have a huge impact on a patient’s outcome. While aspects of clinical informatics may be dry, they are important. Our colleagues who aren’t as involved with technology as we are need to understand this.

Have you had any particular success in generating interest in informatics among your non-techie physicians? What have you done? Or, is it what you haven’t done? Send me an e-mail at Craig.Joseph@epicsystems.com and describe your problem and how you solved it. Maybe you will see your name in the next edition of *cocitnews*.

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 log in to the Membership Information Change Form on the Member Center Web site at www.aap.org/moc. Under “Member Community,” click on “Update Contact Information.” 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.

Ultimate Interoperability: The Ability to Move a Patient Record From One Vendor's Electronic Health Record to Another Vendor's Electronic Health Record



*By Alan Zuckerman, MD, FAAP
COCIT Executive Committee Member*

Dr Zuckerman is the Cochair of the Advanced Interoperability Workgroup at the Certification Commission on Health Information Technology (CCHIT), has been a member of the Interoperability Workgroup at CCHIT since it was created in fall 2005, and was the Co-chair for 2 years.

Interoperability is the ability of electronic health records (EHRs) and other computer systems to exchange and use data. Interoperability has been as a priority of the Office of the National Coordinator for Health Information Technology and an important part of certification criteria at the Commission for Certification of Health Information Technology (CCHIT). Interoperability also will play an important role in the evolving definition of “Meaningful Use of EHR” that is expected to include increasing amounts of information sharing and exchange. While much has been achieved in the first 4 years of certification in areas such as electronic prescribing and electronic laboratory result reporting, some of the most important goals remain elusive.

The ultimate form of interoperability is the ability to move a complete patient record from one EHR to another even when both EHRs come from different vendors. This challenging goal will have great utility when EHRs become nearly universal and physicians and patients become more dependent on access to an EHR. Patients will always move or change physicians, and it is important that their data move with them. Innovations in user interfaces, decision support, and efficiency of use will become important reasons why a physician may want to move to a different EHR in the future.

Lack of portability of records between EHR systems from different vendors makes the process of EHR selection more difficult. There is appropriate concern about choosing the right EHR because of the high cost of moving information to another EHR in the future. There is concern about the financial health and continuity of service from a vendor because a business failure of an EHR vendor leaves a practice vulnerable, and sometimes with only mountains of paper printouts that will not support effective patient care. Even mergers, acquisitions, and major system

upgrades may not support easy transfer of previously entered data.

Many physicians assume that all certified EHRs will be able to share patient records, but this is not yet the case. The focus of certification today is on exchange of critical patient summaries to improve coordination of care and patient safety at the time of transfers between settings of care, such as emergency department visits or hospital admission and discharge. Another component of EHRs that also does not transfer easily is the templates that are often used to create notes. Sometimes these come from vendor and third-party libraries and, often, they must be custom built by the user.

During the current era of migration from paper to electronic records, we are learning a lot about what is needed to begin using an EHR and how long physicians will continue to pull the paper chart at each visit. A key implementation decision is what data to preload into the EHR before patients are seen and how that will be done. Transfer from one EHR to another EHR will require similar implementation planning and work unless we have a universal approach to records transfer. It is relatively unlikely that all EHRs from all vendors will move to single, common backend database, but that would certainly make the job easier.

The essential enabler of portable records is the separation of information in the electronic record into items of retrospective interest and those of prospective interest. Retrospective data are old clinical notes and reports that need to be searchable and available for reading, but that will never be revised or changed. Prospective data include data that will be used actively in future encounters, such as problems lists, medication lists, allergy lists, immunization history, growth chart, and laboratory results, which are data that will be reused, modified, and used as input to future clinical decision support.

An important pathway to transfer of retrospective data or narrative clinical notes and reports is the HL7 Clinical Document Architecture (CDA). While the CDA is not yet in widespread use, it is an extremely exciting and promising technology. A CDA has 3 sections: a header, narrative text, and structured and coded data extracted from

(continued on page 5)

Ultimate Interoperability

(continued from page 4)

the narrative text. This 3-part structure, and division into sections and subsections, allows a single electronic document to function both as a human readable document (viewable in any Web browser) and as a machine-readable document. The header identifies the document type and authors and links a document to a specific patient and health care event so that it can be automatically filed and indexed in an EHR. The narrative includes formatting tools and follows document type-specific headings and structure, such as a hospital discharge summary. The structured and coded data provide discrete access to a diagnosis and code, vital sign, or laboratory test result that is embedded in the narrative. If an EHR converted all of its documents, such as office visits, phone notes, imaging reports, etc, then old notes would be available in an accessible organized structure in a new EHR that imported the data.

The transfer of prospective data or clinical lists that will participate in data entry in future encounters can likewise be accomplished using existing standards for structured patient summaries, such as the Continuity of Care Document. Clinical lists, such as problems, medications, and allergies, need to travel with codes as well as text and have necessary supporting data fields to allow tasks such as refilling or changing a prescription. Data, such as growth charts, immunization history, and laboratory results must be imported in a form that can be integrated and merged with new data in the future. A list of all providers and all encounters (including specialists, emergency department, and hospital admissions) with most recent and next scheduled dates is another important type of clinical list. Also, family history now has standards for portable data that can be modified in the future and reused for risk calculations.

The CCHIT is developing a new program for advanced interoperability certification that will provide a framework to address these issues and encourage vendor participation in portability pilots. One of the limitations of current certification is that a vendor must pass 100% of the certification criteria, thus limiting the type of criteria that can be included if all vendors will have a chance to participate. Certification can be used as a gateway to incentives for EHR use. Creating an optional add-on for advanced interoperability will allow some vendors to take on the challenges earlier than when all vendors are ready, and, by proving feasibility of difficult tasks, will accelerate the expansion of interoperability.

While full portability of a patient record is the ultimate test of interoperability for the clinician user, there are several other areas of interoperability that will be explored as part of advanced interoperability development. To an engineer or medical informatician, ultimate interoperability means semantic interoperability where the full meaning of the data is preserved across systems through sophisticated coding and detailed information structure. For many years, clinicians have struggled with the different coding needs of billing systems and patient care systems. The *International Classification of Diseases, Ninth Revision*, used for billing, is not ideal for patient care, but the Standardized Nomenclature of Medicine (SNOMED) has been slow to move into use in EHRs. While double coding entries on problem lists (one code for billing and one for patient care) is unacceptable, most EHRs do have some solution, such as a local diagnosis or problem dictionary where several terms might map to the same billing code, or the use of extra modifier terms and narrative text comments to explain a diagnosis for clinical use. These work-around approaches to problem lists work fine within a single EHR, but the data they produce will not move with identical meaning to another EHR. Another target of advanced interoperability will be use of improved semantic coding, such as SNOMED for problems or RxNORM for medications. Eventually, all EHRs will need to move to better standardized coding to support meaningful use and clinical decision support, but we need more experience and demonstration to accelerate what has been a very slow process of change.

Another area of advanced interoperability will be type of interface to the Nationwide Health Information Network (NHIN) with advanced EHRs able to serve up documents to authorized users with patient consent even when the office is closed. Controls over privacy and appropriate logging and follow-up review of transactions and patient involvement will be critical to these activities.

The ability to move patient records between EHR systems from different vendors will have important benefits to individual patients and to entire practices. This year will, hopefully, mark the beginning of serious attempts to make this ultimate goal of interoperability something that we can demonstrate and someday include in the certification of all EHRs.

Tablet Versus Desktop



By Alice A. Loveys, MD, FAAP
COCIT Member

Practices that plan to go to electronic medical records (EMRs) also need to consider hardware solutions to best fit their needs. This article will focus on hardware for provider data entry for patient visits (specifically, laptop or tablet versus a desktop computer). Office considerations for this decision include the interplay of the patient experience, workflow, office and examination room design, costs, performance, and ergonomics.

Most providers value a personal experience for their patients. Doctors want to maintain eye contact during the visit and while they document. The laptop or tablet can have the familiar feel of holding a paper chart, and physicians can easily visualize how they will chart and interact with their patient. It is more difficult to imagine a desktop computer in the room as an added guest. Yet, a well-placed desktop monitor can enhance the patient experience and provide an opportunity to engage the patient in their care. Together, doctor and patient can view certain parts of the chart, laboratory results, images, consultant reports, or Internet Web pages. Even the smallest of examination rooms can accommodate a monitor and keyboard using available swivel arms. Desktops can be under a desk or mounted on a wall shelf out of reach of exploring patients. If the computer is always in the room, workflow must include steps for secure log-in and log-out each time a new care team member enters or exits the room.

With a laptop, security is ensuring the unit is always with the user. The provider carries it from room to room. Weight and size then become an important factor in laptop selection. The trade-off comes in screen size. Small screen size can create eye fatigue at the end of the day. The smaller the screen space, the less data that can appear on the screen at any one time without extra scrolling and clicks. I encourage docs to test drive the system they want to use on the equipment they are considering. Count the number of clicks or scrolls to see all the information on different screen sizes. The weight of a laptop also goes up with extended batteries that can make it through a 6- or 8-hour workday before requiring charging. Laptops add an extra workflow step of needing to periodically charge. A

“spare” laptop may be available to use while another one charges.

Some providers still will prefer to document after the visit and will not need to have hardware in the room. If space allows outside examination rooms, hallway stations can house computers for data entry or they can document at their desk.

The cost comparisons become slightly more complicated for desktops versus laptops. Desktops generally are less expensive for comparable central processing units and random access memory. These are 2 important factors that influence the speed of a computer and its ability to run EMR programs. Desktops are much less expensive when it comes to accompanying monitors and, hence, screen size. Desktops also have the advantage of being more easily “upgraded” than a laptop. Each year, computers get faster and memory becomes cheaper to add on. Dual monitors are becoming more popular as well. While this can be done with a laptop, the added workflow steps would make this prohibitive as a doctor moves room to room.

In large practices, the EMR programs can track in which room a given care team member is, but this can only be done when the hardware stays in the room, not with the mobile laptop. The connection to the server differs for laptops versus desktops as well. Both can use a wireless network or be “plugged” into or hardwired to the server. With a laptop, this would require an added step in each room to plug in. Not every office can accommodate wireless transmission, or extra equipment may be required to do so. Wireless routers add more hardware to purchase, maintain, and support. Hard-wiring is an initial cost with low, 3-year maintenance costs.

Accidents happen. Very rugged laptops that can handle a “drop” are available at a cost. Otherwise, consider “accident” insurance on the mobile device.

The decision of desktop versus laptop does not have to be made ahead of time either. There is no harm in purchasing both and trying them over a period of a month in the actual work setting to get the most true feel of which one the care team members prefer.

Report From the Academic Pediatric Association Medical Informatics Special Interest Group



By Donna D'Alessandro, MD, FAAP
COCIT Member

The Academic Pediatric Association (APA) Special Interest Group (SIG) on Medical Informatics held a successful panel discussion on "Careers in Medical Informatics" at the Pediatric Academic Societies meeting held in early May. Nationally recognized informaticians represented a breadth of careers and jobs in medical informatics and discussed how they got to be in their present career and jobs, what a typical day is like, what knowledge and skills are needed to be successful in the job, and what they see as the future of the field. The discussion was incredibly rich. In addition to Daniel Nigrin, MD, Chief Information Officer, Children's Hospital Boston, the Council on Clinical Information Technology (COCIT) members were Steven Downs, MD, Medical Informatics Fellowship Director, Indiana University; George Kim, MD, Medical Informatics Researcher, Johns Hopkins University; and Michael Leu, MD, Medical Director for Clinical Effectiveness, Seattle Children's Hospital.

Dr Steven Downs also presented an opportunity for members to become involved with the American Academy of Pediatrics "Partnership for Policy Implementation" (PPI) (<http://www.aap.org/visit/guidelineimplementation.htm>).

This is a program where informaticians assist guideline developers with improving the guideline clarity and their ability of to be implemented by pediatric health care professionals. The PPI is always looking for volunteers (especially those from COCIT).

The APA Medical Informatics SIG goals are to

- Provide a forum for Academic Pediatric Association (<http://www.academicpeds.org/>) members to discuss all pediatric medical aspects and present their scholarly work in the field.
- Offer an opportunity to network with other pediatric professionals who are interested in pediatric medical informatics.
- Introduce other pediatric professionals to the field of medical informatics.

The SIG encourages anyone who is interested in using computers in medicine in to join the SIG. For more information, visit the Web site at http://www.academicpeds.org/specialInterestGroups/sig_med_informatics.cfm, or contact Donna D'Alessandro at donna-dalessandro@uiowa.edu.

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 Pediatrician Blogger



By Mark M. Simonian, MD, FAAP
COCIT Immediate Past Chairperson

To keep their patients and families updated, doctors are using newsletters, flyers, and other advertising to distribute health information and promote their practice. Seeking newer methods to stay in touch, pediatricians and their patients are surfing the Internet more than ever before. Through this popular communications tool, professionals are providing information about health topics with their patients, friends, and even other health care professionals, including hospitals, consultants, and diagnostic centers. In addition, a few doctors are using a tool popularized in the last few years, called *blogging*, to reach their health information-starved practice and community.

A blog is a diary or commentary and comes from the term, Weblog. It is a type of Web site that had its origins dating from early 1990s. These may be in the form of simple text, but many newer blogs include pictures, audio, or video. These commentaries allow observations or notations and are often arranged in the order in which they were written. Even before blogging technology was available, doctors could communicate to a worldwide audience by way of the Internet. These physician communities developed through commercial services. Forums, including bulletin boards, provide threads of text to be shared among interested readers. As the software matured, more of the online population was able to produce their content without much technical knowledge. Many Web services provide free blogging tools (like www.Blogger.com) and other subscription online services (like www.SquareSpace.com or www.WordPress.com) to support those interested in these messages and content.

Blogging covers all types of general topics. There has been an increase in focused content like political or health information, including a specialty area like pediatrics. The emphasis of these pediatric and other medical blogs reflect current issues that appear in the news, with commentaries normally limited to use in their practice. I paraphrase one blog author who states, "Blogging provides a new power to the publishing community." Some pediatricians are now enjoying this new *power* in their professional practice, reaching beyond the walls of their office.

A recent search using Google, with the key words, "pediatric blogs," lists more than 400 blogs that focus on child and adolescent topics. The links are often the same site repeated many times—an artifact of any search tool. The real number is unknown, because checking the sites reveals many topics that are not sponsored by pediatricians.

Original authors are enterprise sites (like hospitals or health systems) or other specialists or interest groups (like psychologists or technology consultants).

Although it appears that many pediatric practices have not adopted blogging technology yet, there is potential benefit, promoting better dialog with families at a schedule that is favorable to the practitioner and patients. For example, the recent story of the H1N1 influenza type A virus has triggered many fears through every media story headline. A pediatrician can quickly respond to the intense emotion and calm patients with a unique professional perspective and medical judgment based on principles oriented to children and adolescents. Patients and parents can directly respond with questions not reflected in the initial commentary. The back and forth can be a great resource for the public and engage patients. This empowers families to be more involved with the care of their children based on a resource they trust outside of the face-to-face office environment.

These messages are triggered by the news items in a practice or by an individual pediatrician or a reflection of comments to an original topic. Blogging is a dynamic resource to communicate up-to-date information on current medical topics or direct to a specific community (autism). This is an excellent way to show how your practice interacts in a community, such as support for a health initiative (human papillomavirus vaccine), local charities, or just vacation news.

The blogging tool is also more engaging than a static message on a topic on a practice Web site. The online tools are powerful and easy to use, formatting the page or pages into a magazine-like presentation. The ability to add images is a strength of blogging tools. Adding pictures of the staff, doctors, or events in which they are engaged is a potent method to bring lookers to the Web or blogging site. In an age where every phone has a camera and many cameras easily fit in pockets and purses, pictures are ubiquitous and add to the appearance of a community on the practice site. Even video now can be posted to share events and people.

With all the content, space was an issue for any site. There are fewer limits on the disc or storage space needed to share all the content with gigabytes available, even on free sites. Where space is a concern, online sites are easily linked through www.YouTube.com for video sharing and storage. This type of image technology used to be limited

(continued on page 9)

The Pediatrician Blogger

(continued from page 8)

to specially trained professionals, but they are so easy to use that the number of general blog sites grows daily.

The American Academy of Pediatrics (AAP), not known for its early adoption of new information technologies, often waits for a recognized user demand or adoption. The AAP Web site (<http://www.aap.org>) at this time was not using blogging. It has enabled many other methods to communicate with communities of pediatricians and extended members of the health care community, such as Listservs and discussion groups as well as standard e-mail. As pediatric Web sites integrate more blogging, it is hoped there will be an effort to incorporate some use on the member's pages or affiliated pages.

The Council on Clinical Information Technology (COCIT) site, maintained by Stuart Weinberg (<http://www.aapcocit.org>), hasn't hinted about using blogging as a method of information exchange. Time and demand will drive this tool in the technology center of the AAP.

The author decided it was time to test an online service because his Internet service provider was not meeting the

needs of an active Chapter Web site. Engaging the membership and allowing some committee independence to submit and interact on the Web site was a recent goal in a strategic planning session. A blog might be a solution so that each committee could contribute and comment. In the early stages, this looks like it will meet the needs of committees and special groups. Time will tell if this just adds to the choice of communications tools or a unique solution that will best solve the distribution and interaction of content for a large membership. The following are some sites you can view to see how a few others have used a blog as the solution to their personal and practice needs:

- <http://peterjung.blogspot.com/>
- <http://pediatrics.about.com/mbiopage.htm>
- <http://genesispeds.wordpress.com>
- <http://www.preferredpediatrics.blogspot.com>
- <http://www.aapca1.org>
- <http://www.aapdistrictii.org/>

The Council on Clinical Information Technology Announces the 2009 Oberst Award Winner

The Council on Clinical Information Technology (COCIT) Executive Committee has selected Stephen M. Downs, MD, FAAP, to receive the 2009 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 Downs received his MD and Master's in Medical Informatics from Stanford. He completed residency in

Pediatrics at the University of North Carolina (UNC) at Chapel Hill and a health services research fellowship in the Robert Wood Johnson Clinical Scholars Program.

At UNC, Dr Downs was faculty in the Division of

Community Pediatrics. He also held joint appointments in the Department of Biomedical Engineering and the School of Public Health. He directed the Duke-UNC Training Program in Medical Informatics and consulted for the American Academy of Pediatrics in the development of clinical practice guidelines. He is currently chairperson of the AAP Partnership for Policy Implementation.

Dr Downs is director of the Indiana University/Regenstrief Biomedical Informatics Research Training Program. His efforts in the area of pediatric informatics include his many publications and, among other things, his leadership in the Indianapolis Pediatrics Informatics Summit of 2004.



One Pediatrician's Electronic Medical Record Experience



By Grant Allen, MD, FAAP
COCIT Member

I have a fairly unusual experience in pediatrics. I have never known a paper chart in practice. We had paper charts in residency, but I hope those are now gone. I joined a practice that went through all the difficulties of transitioning years before I finished residency. It started with charting phone calls, then prescriptions, and then went live with the patient visits. Six years into practice, we still come across teens whose immunizations are not in the record; but that is increasingly rare. In fact, the electronic medical record (EMR) was a huge selling point to me for the practice (besides the great town, the beautiful lake, the friendly people, and great partners). As one of my senior partners likes to comment, my third-grade handwriting teacher did a terrible job. I defend myself by telling him that Mrs Browning told me she didn't know how to teach lefties how to write and, therefore, I never learned. My partner, of course, writes better than a typewriter. He makes Times New Roman look like chicken scratch. If Microsoft had owned the rights to his handwriting, we'd all be typing in New Hamilton today. In fact, while I only write handwritten prescriptions at the hospital (our hospital's EMR is only for nurses; we are in the midst of budget problems for full implementation), my Luddite partner still enjoys pulling his pad out of his back pocket, getting his rollerball ink pen out, and writing a prescription, much as physicians have for generations. He even still has a very worn doctor bag handed down from a well-respected senior physician. For those of you who are not aware, physicians used to have doctor bags to carry around their tools as they went from house to house seeing patients. If you fail to see the utility of such an accessory, you obviously have not made a house call. I, the more technically aware, have to gather up my otoscope and stethoscope, odds and ends, and stuff my pockets to get in the house.

Back to the Luddite. Our large group practice is fully integrated with our EMR (except Dr Hamilton who likes to handwrite his prescriptions, and always has). He is what most would call a late adopter. We have had office EMR for 10 years, and yet he is still on paper prescriptions. He charts better than most of us in the EMR. Yet, when it comes to prescriptions, he still relies on his faithful pen and paper. I think he likes being old-fashioned, or that he enjoys making sure everyone else knows he has excellent penmanship. However, it is starting to cause problems. Since he doesn't use the print or fax functions of the prescriptions, he only charts the name of the medication, not the dose or the timing. So, the nurses get phone calls from pharmacies and parents (not about *legibility*, mind you)

about the medication, and no one knows what he wanted; we have no record. So, our Luddite finally may be forced into compliance, certainly not because the partners want it (after all, it has been 10 years), but because the nurses *need* it. Our support staff rely on the EMR to speed their responses to any of thousands of questions about immunizations, follow-up visits, pharmacy calls, and prescriptions.

I don't think you could find a single person in our practice from billing, phones, nurses, or physicians who would ever go back to the way it was. My partners speak of the days of paper charts like they were the days before antibiotics. Life was so hard—stacks of charts lying around everywhere, never being able to find a record, immunizations not where they should be—with wasted hours of productivity. That doesn't mean life is all roses. Sometimes the computers crash, or sometimes the upgrade isn't what we expected and it still doesn't do all the things we would like. In a perfect world, my nurse would scan a barcode off the vaccine, and the lot number and all related information would appear in my chart. The data also would magically appear in our Vaccines for Children log. Some of these are far-off dreams. However, some dreams are not so far off. We want to start an oral health project with fluoride varnish. The information technology office person makes our template for charting. The template logs all the data that we need to be paid by Medicaid and notifies the health department of the referral, and, voila, we have a new chartable service for our patients.

As we enter the age of MOC (dreaded maintenance of certification), I believe that our data collection tools through our EMR will make this a less-dreaded process. Mind you, there certainly will be tweaks in the process. Data collection relies on proper data entry. (I don't like using the pick lists so, many times, I freestyle in the comments.) I think it's great for the record, but it will be terrible for data collection. So, as we all modify our practice to move into the 21st century, some of us will have to start using the eRx, and some of us will have to get the information technology person to help modify the pick list to our preferences, and, hopefully, all our dreams (interoperability, data collection, ease of entry, universal vaccine barcodes, and on and on) will come true. A lot of this likely will change. Look where we are today—vaccines, antibiotics (and their restrained use), outpatient treatment of diseases from which children died in the last century. Where will we be in 5 years? 50 years? Terribly exciting isn't it?

EXECUTIVE SUMMARY

COUNCIL ON CLINICAL INFORMATION TECHNOLOGY

EXECUTIVE COMMITTEE

Executive Summary: Meeting of the Council on Clinical Information Technology Executive Committee April 19, 2009—Elk Grove Village, IL

The Executive Committee of the American Academy of Pediatrics (AAP) Council on Clinical Information Technology (COCIT) convened on April 19, 2009, at AAP headquarters in Elk Grove Village, IL.

Discussion topics included the following:

- Christoph U. Lehmann, MD, FAAP, was elected to serve a 3-year term, beginning July 1, 2009, on the Executive Committee. George Kim, MD, FAAP, Michael Leu, MD, FAAP, and Alan Zuckerman, MD, FAAP, were reelected. The Executive Committee will conduct a needs-assessment exercise to advise the Nominations Committee on selecting candidates for the 2010 election.
- The Annual Reports of Councils for FY 2008-2009 was reviewed. The report will be finalized and submitted for review by the Advisory Committee to the Board on Practice by August 1, 2009.
- The Executive Committee discussed ways to encourage COCIT members to submit nominations for the 2010 Byron Oberst Award.
- The Committee reviewed several resolutions that were referred to COCIT from the 2009 Annual Leadership Forum (ALF). Responses are due by November 1, 2009.

- The Executive Committee heard brief reports from the Policy, Education, and Applications Committees.
- A report was provided on several updates that were made to the EMR Review Web site.
- The COCIT Membership Chairperson, Dr Alice Loveys, reported on her efforts to increase COCIT's membership and to provide increased value to COCIT members.
- A brief report was provided on the Partnership for Policy Implementation.
- Liaison reports were received from
 - The Certification Commission for Health Information Technology
 - The Health Information Technology Standards Panel
 - The eHealth Initiative
 - The Physicians Electronic Health Record Coalition

The next meeting of the COCIT Executive Committee will be held in fall 2009 in conjunction with the AAP National Conference & Exhibition.

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

Council Election Results Announced

Thank you to all members of the Council on Clinical Information Technology (COCIT) who voted in our spring 2009 election. We had a response rate of approximately 25%.

The Council on Clinical Information Technology is pleased to announce that Christoph U. Lehmann, MD, FAAP, was reelected to the Executive Committee after a brief hiatus. Dr Lehmann began his 3-year term on July 1, 2009.

The next election will take place in Spring 2010. Executive Committee members Kristin Benson, MD, FAAP; Mark Del Beccaro, MD, FAAP; Eric Handler, MD, FAAP; and Gregg Lund, DO, FAAP; will complete their current terms. Of these, only Dr Handler will be eligible for reelection. The COCIT Nominations Committee will accept nominees for the ballot. A Call for Nominations can be found on page 19. Nominations must be received by December 1, 2009.

COMMITTEE UPDATES

Education Committee



By Kristin Benson, MD, FAAP
COCIT Education Committee Chairperson

My kids tease me because I manage to relate nearly everything under the sun to electronic health records (EHRs). Although this seems ridiculous to them, perhaps if you have worked in the field of health information technology (HIT) you can sympathize! Over the last few years, HIT has spiraled into the domains of policy, legislation, finance, and health care reform, among others. Despite the lack of widespread implementation of EHRs, an infrastructure continues to grow and evolve. Whether HIT contributes to a reorganization of practices into integrated care systems remains to be seen. However, notable policy expert Dr Donald Berwick, in a “Perspective” in the May 20, 2009, issue of the *New England Journal of Medicine*, suggests that “integrated delivery systems need to become the mainstay of organizational design” to bring costs under control. He notes, “such integrated systems also have strong incentives to invest in primary care.” With the many stakeholders involved, we need to present an organized voice for children.

Once we are all electronic, the “optimization” phase will go on indefinitely. Decision support of amazing sophistication and streamlined workflows are on the horizon. We have barely scratched the surface of what can be done with the treasure trove of clinical data becoming available. I have read, with delight, a growing number of Listserv e-mails about helpful findings from practices as our colleagues start to use electronic data and data analysis for themselves.

The fall 2009 American Academy of Pediatrics (AAP) National Conference & Exhibition (NCE) is designed to help you keep up with developments that affect your practice. We are sponsoring a Plenary Session on the interoperability of electronic records. Main session talks include EHR and the Medical Home, using your own data, and electronic records for foster care. The Technology Learning Center (TLC) will be a separately designated venue for the last time this fall. Subsequently, our COCIT talks will all be integrated into the main program. This fall, you can look for TLC topics on transitioning to an EHR,

smart phones and mobile devices, database basics, computerized order entry, pay for performance, and many others. We will be offering the Pediatric Documentation Challenge again so that you can see how vendors compare on a typical pediatric office visit scenario.

Please read the article by Dr George Kim that describes an exciting H-program focused on Medical Home functionality and EHRs. We have a distinguished panel that will provide insights on this high-priority topic. As in past years, we also will offer a Pediatric Informatics scientific abstract and poster session as part of our H-program.

Even if you cannot come to the NCE, you can make use of online learning. American Academy of Pediatrics members are welcome to visit our Web site at www.aapcocit.org. There are links and updates maintained by our COCIT Webmaster, Dr Stuart Weinberg. These include our EHR Implementation Toolkit, a “Buddy List” for EHR support listed by state and by vendor, the EMR Evaluation Project with pediatrician-submitted ratings of various commercial EHRs, and past newsletters. Our COCIT members are invited to enter the “Members Only” section to view our council minutes and various other materials and resources. The E-Health Initiative (EHI) members’ Web site is available to AAP members at www.ehealthinitiative.org, with a wealth of resources on legislation, privacy and security, and interoperability. (Check with Beki Marshall for log-on and password information.) The American Medical Informatics Association (AMIA) continues to be a premier academic organization for clinical informatics with its “10X10” Informatics training program, online resources, and biannual conferences.

As always, we welcome your participation. Planning for the 2010 NCE already has been done, but we welcome proposals for NCE 2011 starting next fall. There is much to do, and COCIT is an excellent way for pediatricians to learn more, become involved, and help guide the changes. Even if you get teased by your kids, you will be seeing the importance of informatics everywhere you turn!

Policy Committee



By Mark Del Beccaro, MD, FAAP
COCIT Policy Committee Chairperson

Things are certainly moving fast on the health information technology (HIT) scene with the federal push through the American Recovery and Reinvestment Act (ARRA). Writing this article in the spring of 2009 for the next newsletter almost ensures that many things will change by the time this makes it to “print.” The policy committee has been working with the Council on Clinical Information Technology (COCIT) Executive Committee to respond to the many questions regarding meaningful use and the pediatric specific needs for HIT. Fortunately, there has been good progress with our policy statements, which can serve as foundational documents in these discussions.

If you are involved in discussions at the local, state, or federal level on HIT, please remember to look at the COCIT/American Academy of Pediatrics (AAP) statements related to these issues. We are also seeking volunteers who would like to participate in the policy creation or policy revision process. This year, we have a couple of policies that need to be dusted off and revised, including the following: (1) Special Requirements for Electronic Health Record Systems in Pediatrics and (2) E-Prescribing in Pediatrics: The Rationale and Functionality Requirements.

Additionally, the Policy Subcommittee has identified the following topics for potential policy statements during the coming year: (1) Pediatric Aspects to Health Information Exchange; (2) Management of Health Care for Children and HIT; and (3) Pediatric Clinical Decision Support. If you would like to be involved in any of these policies, please let us know.

Policies in Progress/Press

Using Personal Health Records to Improve the Quality of Health Care for Children

Alan Zuckerman, MD, FAAP, and Joseph Schneider, MD, MBA, FAAP, along with George Kim, MD, FAAP, and Michael Leu, MD, FAAP, have successfully completed this policy, which was published in July 2009. The Personal Health Records (PHR) policy statement provides recommendations that the AAP and all pediatricians can take to support the development and use of personal health records for children.

E-mail Communication Between Pediatricians and Their Patients Will Be Renamed to Non-Face-to-Face Care

Eugenia Marcus, MD, FAAP, is lead author for this policy. The committee agreed to expand this topic and de-

velop a policy statement and accompanying technical report entitled “Non-Face-to-Face Care.” The policy statement will serve as the broad, over-arching policy with information, including advocacy for reimbursement. The technical report will include specific details on other communication mechanisms (eg, e-mail, telemedicine, video conferencing, etc) and *Current Procedural Terminology* codes, where available. Both documents will be coauthored by the Section on Telehealth Care.

Pediatric Requirements in Assessing the Longitudinal Ambulatory Patient Health Care Record

This work came out of the Policy Committee’s strategic planning meeting in the spring of 2008. Drs Zurhellen and Kim have taken the lead on what we originally dubbed the “Dream Statement.” This has evolved to potentially be a policy statement with an accompanying technical report. The policy committee has reviewed a draft Intent for Statement and draft statement. The statement draft included a diagram that illustrated the flow of information through the medical home. We hope this work will continue to move forward.

Telemedicine II: Liability, Legislative, and Jurisdictional Issues for Pediatrics

The Council on Clinical Information Technology has provided feedback to the Committee on Medical Liability and Risk Management (COMLRM) for the latest version of this statement, and we are awaiting feedback from COMLRM and the AAP Board.

Emergency Preparedness for Children With Special Health Care Needs (Joint with the Committee on Pediatric Emergency Medicine as lead)

The Committee on Pediatric Emergency Medicine (COPEM) was in the process of responding to comments from the Board of Directors. Dr Del Beccaro from COCIT will review the AAP Board comments and give feedback to COPEM.

I and the Policy Committee cannot thank Jennifer Mansour and Beki Marshall enough for their help. We could not accomplish nearly as much without them. We look forward to a productive year and hope to hear from you via e-mail or at the National Conference & Exhibition this fall.

Thanks to all our current Policy Subcommittee members: Mark Del Beccaro, MD, FAAP (Chair); George Kim, MD, FAAP; Gregg Lund DO, FAAP; Jeannie Marcus, MD, FAAP; Joe Schneider, MD, FAAP; Eric Tham MD, FAAP; and Alan Zuckerman, MD, FAAP.

Council on Clinical Information Technology Educational Session (H-Program) at the National Conference & Exhibition Sunday, October 18, 2009—Washington, DC



*By George R. Kim, MD, FAAP
COCIT H Program Chairperson*

Please join the Council on Clinical Information Technology (COCIT) at the 2009 NCE in Washington, DC, for its Educational (H-Program) sessions on Sunday, October 18, 2009. In addition to the Scientific Abstract competition and Poster sessions, we will have an Expert Panel with presentations and a Q&A on the pediatric Medical Home and health information technology. We acknowledge and thank our expert panel of judges: Kris Benson, Mark Del Beccaro, Willa Drummond, Chris Lehmann, Michael Leu, Gregg Lund, Mark Simonian, and Alan Zuckerman.

Schedule Overview

9:00 am - 12:00 noon	Scientific Abstracts Competition and Poster Session (all day)
12:00 noon - 1:00 pm	Byron Oberst Award and presentation
1:00 pm - 4:00 pm	Expert Panel presentations
4:00 pm - 5:00 pm	Expert Q&A and reception

Scientific abstract presentations (order to be determined)

Deep Disparities Exist in Use of Pediatric Patient Portal

Rachel T. Idowu and Gretchen Purcell Jackson
Vanderbilt University School of Medicine, Nashville, TN

Development of a Knowledge Base for Pediatric Medication Dose e-Rounding

Jill S. Helmke, Kevin B. Johnson, Stuart T. Weinberg, Coda Davison, and Marvin Palmer
Vanderbilt University Medical Center, Nashville, TN

Health Informatics for Pediatric Disaster Preparedness Planning

Rita V. Burke, Tanya Ryutov, Robert Neches, and Jeffrey S. Upperman
Children's Hospital and Keck School of Medicine USC, Los Angeles, CA,
University of Southern California, Marina Del Rey, CA

Identification of Medical Errors in the Electronic Health Record

David C. Stockwell, Hima Vinodrao, and Brian R. Jacobs
Children's National Medical Center, Washington, DC

Implementation of Clinical Decision Support to Improve Influenza Vaccination

Marguerite Swietlik, Ann-Christine Nyquist, Joseph Kosowicz1, Lalit Bajaj, Amy Poppy, Jennifer Soep, Myra Kiker, and Eric Tham
The Children's Hospital and the University of Colorado Denver School of Medicine, Aurora, CO

Implementing Clinical Decision Support to Aid in the Diagnosis, Evaluation, and Treatment of Hypertension in Children and Adolescents

Tyler Watlington, Marguerite Swietlik, Georgette Siparsky, Eric Tham, Lalit Bajaj, Robert Brayden, and Michael Kahn
The Children's Hospital and the University of Colorado Denver School of Medicine, Aurora, CO

(continued on page 15)

Council on Clinical Information Technology Educational Session (H-Program) at the National Conference & Exhibition

(continued from page 14)

Patient Acquired Images in Pediatric Postoperative Care Results in Reduction of Unnecessary Emergency Department Visits

Van Anh T. Ginger, James Hotaling, Thomas Lendvay, Byron Joyner, Margaret Shnorhavorian, Richard Grady, George Drugas, and Martin Koyle
Seattle Children Hospital, Seattle, WA

Standard Terminologies and Pediatric Data Sets: Deriving a Minimum Terminology Set for Pediatric Data Needs

Deborah H. Batson and Michael G. Kahn
The Children's Hospital Colorado, Aurora, CO

Unintended Consequences of Weight based Dosing Causing Medication Errors in Computerized Physician Order Entry

Eric Tham, Teresa Fisher, Amy Poppy, Marguerite Swietlik, Lalit Bajaj, Daniel Hyman, and David Kaplan
University of Colorado Denver School of Medicine and The Children's Hospital, Denver/Aurora, CO

Presentations on the Health Information Technology and the Pediatric Medical Home

2:00 pm **Applying Health Information Technology in the Medical Home**
Chris Lehmann, MD

2:45 pm **Sharing Patient Health Data to Facilitate Care Coordination**
Janet Marchibroda, PhD

Expert panel on the Pediatric Medical Home and Health Information Technology: Care Coordination and Health Information Technology Standards Development

Janet Marchibroda, Chief Healthcare Officer, IBM, manages its health care campaign, including strategy, thought leadership, and policy. She came to IBM earlier this year after serving as CEO for the eHealth Initiative, developing consensus among multiple and diverse stakeholders on strategies that will drive better health care for patients through information technology. Ms Marchibroda was recognized in 2005 as one of the Top 25 Women in Healthcare by *Modern Healthcare* magazine, and, in 2006, for the Federal Computer Week Top 100 Award.

Christoph Lehmann, Director of Clinical Information Technology, Johns Hopkins Children's Center, serves on the Board of Directors of the American Medical Information Association (AMIA) and on the Executive Committee of COCIT. His primary research interest is in application of clinical information technology to patient safety in pediatrics/neonatology.

Kevin Johnson, Vice Chair of Biomedical Informatics at Vanderbilt University, is a past member of the Executive Committee of COCIT and the 2008 winner of the Byron Oberst Award. His research interests include development of clinical information systems to improve patient safety and compliance with practice guidelines and the development of online and mobile technologies to increase electronic prescribing.

Alan Zuckerman, Cochair Interoperability Working Group of the Certification Commission for Healthcare Information Technology (CCHIT), is a member of the Executive and Policy Committees of COCIT and the Director of the Primary Care Informatics Program at Georgetown University.

New Book

Pediatric Informatics: Computer Applications in Child Health

Edited by: Christoph U. Lehmann, George R. Kim, Kevin B. Johnson

Springer 2009, 472 p 44 illus, 40 in color, Hardcover

ISBN: 978-0-387-76445-0

American Academy of Pediatrics (AAP) Bookstore Listing: https://www.nfaap.org/netFORUM/eweb/DynamicPage.aspx?webcode=aapbks_productdetail&key=caaaa548-02a0-4291-b31f-83fc3d1c14c8

As the interest in and the adoption of health information technology (electronic health records [EHRs], personal health records [PHRs], computerized physician order entry [CPOE], and messaging standards [HL7]) increase in response to demands for higher quality, safety, and accountability in patient care, pediatricians and policy makers must be aware of the impact of these technologies on child health and patient safety. Pediatricians must be ready and able to provide their expertise in a timely manner to guide development of electronic tools at the practice and institutional levels that will improve the safety and efficiency of pediatric care. Informed child advocates must understand and represent the unique health care and safety needs of children at organizational, regional, and national levels to guide development of health information networks that will leverage the best of what technology has to offer to pediatric care.

“Pediatric Informatics: Computer Applications in Child Health” is a current summary of important trends in the use of information technology for pediatric care, written by pediatric professionals and child advocates involved in the development of health information systems. Written for pediatricians, information technology professionals involved in the development of systems for child health, and informaticians, this book presents the special needs of children and pediatric care in collecting and managing biomedical data, information, and knowledge from multiple perspectives (ambulatory practice, hospitals, and regional organizations), with the common thread that children are a vulnerable population with special needs that require special considerations in technology development and use.

The text, published by Springer in July 2009, will be available from the publisher and through the AAP Bookstore (with a discount for AAP members).

Contents

Section I. Introduction to Pediatric Informatics

Snapshots of Child Health and Information Technology; Informatics and Pediatric Health Care

Section II. Special Considerations in Pediatric Care

Core Pediatric Data; Neonatal Care and Data; Special Health Information Needs of Adolescent Care; Children with Developmental Disorders and Other Special Needs; Pediatric Emergency and Pediatric Critical Care Considerations

Section III. The Pediatric Data-Knowledge-Care Continuum

Complexity in Healthcare Information Technology Systems; Pediatric Care, Safety, and Standardization; Evidence-Based Medicine and Pediatrics; Clinical Practice Guidelines: Supporting Decisions, Optimizing Care; Diagnostic Decision Support; Managing Pediatric Knowledge Resources in Practice; Supporting Continuing Pediatric Education and Assessment

Section IV. Informatics and Pediatric Ambulatory Practice

Pediatric Care Coordination: The Business Case for a Medical Home; Prioritizing Pediatric Investment for IT in Smaller Practices; Aligning Pediatric Ambulatory Needs with Health IT; Electronic Health Records and Interoperability for Pediatric Care; Ambulatory Computerized Provider Order Entry (ACPOE or E-Prescribing); Telemedicine Applications in Pediatrics; Personal Health Records; Privacy Issues; Electronic Mail in Pediatric Practice; Information Management by Patients and Parents in Health and Disease

Section V. Informatics and Pediatric Inpatient Practice

Overview of Pediatric Inpatient Medication Delivery; Prescribing/Ordering: Computerized Order Entry and Decision Support; Dispensing: Pharmacy Information Systems; Medication Administration and Information Technology; Understanding and Preventing Errors; Error Reporting Systems

Section VI. Frontiers in Pediatric Informatics

Communities of Pediatric Care and Practice; Developing Pediatric Data Standards; The Case for a Pediatric Terminology; Pediatric Research and Informatics

Section VII. A Vision and Current Landscape of Pediatrics

The Moving Picture of Pediatric Informatics; Appendix: A Community of Child Health and Informatics

Please Welcome Our New Members!

The following individuals joined the Council on Clinical Information Technology between February 18, 2009, and June 14, 2009:

Christopher P. Bonafide, MD
Philadelphia, PA

John Anthony Boyle, DO, FACOP, FAAP
West Bloomfield, MI

Selam G. Bullock, MD, FAAP
Clayton, NC

Kenneth Michael Carlson, MD, FAAP
Salem, OR

Shannon Leah Mason Dean, MD, FAAP
Madison, WI

James David Fuchs, MD, FAAP
Kattskill Bay, NY

Marvin Bruce Harper, MD, FAAP
Boston, MA

Timothy P. Hickman, MD, MEd, MPH, FAAP
Kansas City, MO

Brian Richard Jacobs, MD
Washington, DC

Tyler Krohn, MD
Studio City, CA

Edwin Lomotan, MD
Cheshire, CT

G. Ronald Nicholis, MD
Shawnee, KS

Evan B. Pockriss, MD, FAAP
Lawrence, NY

Vijay Kishore Prasad, MD, FAAP
North Platte, NE

George Rogu, MD, FAAP
Commack, NY

Ellen Maria Schumann, MD, FAAP
Weston, WI

Amy Jost Starmer, MD
Newton, MA

Nancy Jane Wright, MD, FAAP
Las Vegas, NM

Steven Todd Yedlin, MD, FAAP
Berkeley, CA

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 2010 issue.

COCIT LISTSERV[®] E-mail Discussion Lists

Get Involved—Join the COCIT Rapid Response Team (COCIT-RRT) E-mail List today!

The COCIT-RRT list has been established to involve COCIT's membership in responding to requests for feedback and comments from the Certification Commission for Health Information Technology, the National eHealth Collaborative, or pending legislation. To subscribe, send a message to listserv@listserv.aap.org with, SUB COCIT-RRT in the message body.

COCIT Announcements E-mail List

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

COCIT (General) E-mail List

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

COCIT AAP-EProducts E-mail List

There is an additional Listserv specifically for a discussion on the development of AAP electronic products and Web services. Members of the AAP Electronic Products team 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 of 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.

COUNCIL ON CLINICAL INFORMATION TECHNOLOGY (COCIT)

CALL FOR NOMINATIONS

Officer Listing

COCIT Chairperson

Joseph H. Schneider, MD, MBA,
FAAP
DrJoeS@POL.net

COCIT Vice Chairperson

Eugenia Marcus, MD, FAAP
EMarcus@PediatricHealthcare.com

Applications Chairperson

Michael Leu, MD, FAAP
Michael.Leu@SeattleChildrens.org

Education Chairperson

Kristin Benson, MD, FAAP
bens0293@UMN.edu

Policy Chairperson

Mark A. Del Beccaro, MD, FAAP
Mark.DelBeccaro@SeattleChildrens.org

Communications Director

Craig M. Joseph, MD, FAAP
Craig.Joseph@EpicSystems.com

Webmaster

Stuart T. Weinberg, MD, FAAP
STWeinberg@AAP.net

COCIT Staff

Jennifer Mansour
JMansour@AAP.org

Beki Marshall
BMarshall@AAP.org

**Interested in Joining
COCIT?**

To join COCIT, contact AAP
Membership at 800-433-9016
Ask for Membership.
E-mail: membership@AAP.org

Please note: Inclusion in this publication does not imply an endorsement by the American Academy of Pediatrics. The AAP is not responsible for the content of resources mentioned herein. Web site addresses are as current as possible, but may change at any time.

Opinions expressed are those of the authors and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Copyright © 2009 American Academy of Pediatrics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Printed in the United States of America.

The American Academy of Pediatrics Council on Clinical Information Technology (COCIT) seeks nominees to run for election to the Executive Committee. 4 positions are up for election.

Successful Executive Committee Member candidates will serve 3-year terms, to begin July 1, 2010.

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; and
3. Fax it to 847-434-8000, ATTN: Jen Mansour, *no later than December 1, 2009.*

Name: _____

Address: _____

Telephone: _____

Fax: _____

E-mail: _____

Current Position: _____

Fax (847-434-8000) to Jen Mansour on or before December 1, 2009. Thank you.