cocitnews

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

"May you live in interesting times": Part II

Last fall, I wrote about the interesting times that we find ourselves in regarding health information technology (HIT). Things have gotten a lot more interesting since then, with global economic problems and a historic presidential election.

In times like these, it is important to have clear plans so that you focus your efforts on where you want to go. In last fall's newsletter, I outlined the Council on Clinical Information Technology (COCIT) strategic plan. It is simple, with 4 goals and a few objectives for each goal. Council on Clinical Information Technology Executive Committee members are responsible for moving one or more objectives of the plan forward, and we are making progress in many areas.

Unfortunately, as of this writing, the American Academy of Pediatrics (AAP) does not have a clear strategic plan that includes HIT. Given the limitations of funding that will exist for the new administration, it would seem critical for the AAP to have such a plan to focus efforts. For example, can anyone answer what the AAP *priorities* are, relative to subjects such as (1) achieving widespread electronic health record (EHR) implementation, (2) achieving widespread e-prescribing adoption, (3) adopting national standards for HIT, (4) pushing for transferable personal health record use for chronic children, and (5) pushing for funding for HIT for pediatricians? The list of things that could be prioritized is enormous, and not everything can be done.

The AAP is not ignoring HIT. On the contrary, the AAP has quite a number of activities going on. However, by not formally prioritizing and communicating key goals, a lot of energy will be spent on things that are much less important, and the danger exists that important things will be ignored.

As an example of how prioritization can be successful, the American Academy of Family Physicians, several years ago, described electronic health records as the "central nervous system" of the New Model of Family Medicine, which is the centerpiece of the Future of Family Medicine project (http://www.futurefamilymed.org/index.html). By stating effectively that EHR adoption is a top priority, family physicians have achieved significant successes in making their records electronic (now probably >50% adoption), far more than pediatrics.

The COCIT Executive Committee has been working hard over many years to get

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Future of Pediatrics?

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

At the end of February 2009 in Anaheim, CA, the American Academy of Pediatrics sponsored a 2½-day meeting on the Future of Pediatrics. Sadly, a major component of the future was missing. There was not a single topic, talk, or seminar on information technology, electronic medical records (EMRs), electronic tools, Web resources, or other things that are part of the practice of the future. While the selection of topics was excellent, the absence of technology talks was glaring.

Where is a talk on telemedicine? Will the children of rural America visit the cardiologist via the Internet? Will the pediatrician of the future monitor his or her patients with diabetes at home by reviewing their monitoring devices downloaded thru the physician's Web portal? Will parents fill out History of Present Illness, Family History, and Review of Systems on a form in a Web portal that will download into the EMR? Will parents make their own appointments on the Internet?

How will pediatricians do the disease management needed to improve the quality of care they deliver? Who is e-prescribing now, and who will be in the future?

I have put enough on that list for several conferences. However, I purposely put up an expanded list of topics to illustrate the depth and breadth of possibilities that will be part of the future of pediatrics and could have been included in the conference.

We are currently in a transition period from paper to electronics. This project is labor intensive and financially intensive. It demands a mindset to weave the electronic knowledge into the structure of the program. Perhaps the goal of this program was different. If so, then the title of the conference was a misnomer. The next Future of Pediatrics conference should be all about the transition to electronics. That is one of the big challenges for the future that is here now.

From the Editor

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

We have all heard the mantra before: keep it simple. The message itself is not that complex (just 3 words and 4 syllables). Yet, we hear it repeatedly. Just keep it simple.

But, keep what simple? What is *it*? I think *it* is everything. I know that it is important to keep my life simple, my relationships simple, and my explanations of pre-algebra to my sixth grader simple, but an electronic health record? I need to keep that simple, too? The answer is a resounding yes.

A blank sheet of paper is simple. For virtually every clinician, a blank sheet of paper is intuitive; clinicians know what to do with it. Heck, they have been using blank sheets of paper for a long time. A blank sheet of paper works. However, although it is simple, intuitive, and proven, a blank sheet of paper is also not many things. It is not available to everyone, everywhere, all the time. It is not helpful to guide clinicians to the proper diagnosis and treatment. Heck, it is often not even legible. So why is a blank sheet of paper so popular? I think because it is so simple.

One of the jobs of the clinical informaticist is to make the use of information technology as simple as possible. Sometimes that means not giving users all of the options that might be available. Sometimes it means asking users to change their work flows to standardize the way things are done in an office or hospital. Sometimes it is not so easy to keep things simple in the digital age.

As far as clinical informatics goes, we may need to modify the "keep it simple" directive slightly. How about, "keep it as simple as possible?" That rule points us in the right direction, but gives us some leeway to add a little complexity to improve the way we take care of patients. It seems simple enough to me.

"May You Live in Interesting Times"

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the AAP to include HIT somewhere in its strategic plans. Recently, our proposals were turned down again. It is time, in my opinion, to act, because a failure to act could be a significant setback to pediatrics and pediatricians.

What can be done? I have recommended that the AAP gather selected key informed representatives of sections, councils, and committees to provide the AAP Board of Directors with recommendations on what AAP priorities should be in HIT. Council on Clinical Information Technology members (and others) need to educate AAP Board members on the importance of this effort so that they take action. When we do have a plan, it needs to be widely communicated so that Congress, states, and our members all have a clear understanding of what needs to be done first, second, etc.

Council on Clinical Information Technology and non-COCIT members need to get involved in the prioritized HIT efforts by injecting HIT into *all* efforts of each section, committee, council, and chapter. Edmund Burke wrote that, "the only thing necessary for evil to triumph is for good men to do nothing." The evidence is clear—we cannot afford to wait any longer.

Organizational Change: Implementing Health Information Technology in the Inpatient Setting

By Timothy Hartzog, MD, FAAP
COCIT Member

Implementation of clinical information systems is a significant organizational change and organizational behavioral task. It is thought that the change from paper-based records to completely closed-loop medication systems is the most significant organizational change that occurs in hospitals. The work flow in the hospital is being fundamentally redesigned, and there is a shift in the power structure. Anyone who is serious about being a medical informatics specialist and implementing clinical information systems needs to read the collective works of Joan Ash, PhD, MLS, MS, MBA, and Dean Sittig, PhD.

I have had the distinct pleasure of taking classes taught by both of these outstanding informatics specialists. They have written about the unintended consequences of computerized provider order entry (CPOE), which include issues such as fundamental power shifts, loss of control experienced by physicians, and the loss of autonomy that information systems can create. With new informational sets, work is shifted to the physicians who must now know the specific order of tests and CPOE instead of having the nurse follow the information.

There also is loss of communication. For example, in the paper world, the clinician often takes the charts off the desk and talks to the unit secretary, perhaps telling her what he just ordered, with maybe a side chat about the kids' latest soccer game. In the computer world, you can actually write orders from miles away and never actually talk about them; therefore, there is a loss of face-to-face communication when clinical information systems are in place.

In addition, there is a tendency to become dependent on technology to the extent that, when the technology malfunctions, system flow and work slow or are greatly disrupted. Another problem can be "over alert" or "alert fatigue." With the incidence of numerous alerts, a threshold is crossed and providers begin ignoring them all. Drs Ash and Sittig also have done great work on the emotional aspects of CPOE. Computers illicit a wide range of emotions—some people love them while other people hate them, and rarely do you find a neutral thought about computers.

One of the key things in implementing any large clinical system is to understand that the task is, fundamentally, about changing people's behavior. Implementing a system that creates a good work flow is not about the technology. The fanciest touch screen in the world will not help if it has a bad user interface. That is why there also is body of literature developed around "special people" in medical informatics. Special people make the system work. The newest member of this class of people is the chief medical information officer (CMIO), who is usually a physician who practices medicine and is respected for his or her medical skills. This person also has a technical background with either some medical informatics training or computer training that allows him or her to translate between clinicians' needs and what the system can deliver. Computer programmers do not understand how clinicians process information and do not understand clinical work flows; therefore, the role of the CMIO is to deal with the technical

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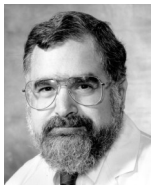
The Newborn Screening Use Case and New Roles for Health Information Technology in Newborn Screening



By Alan Zuckerman, MD, FAAP
COCIT Executive Committee Member

The American Health Information Community (AHIC) was established by United States Secretary of Health and Human Services Michael Leavitt in 2005 as an advisory body for health information technology (HIT) and health information exchange (HIE). It was scheduled to sunset at the end of 2008, to be replaced by a public private partnership Successor organization that will continue the process of identifying opportunities to use HIT to improve health care.

Much of the work of the AHIC was carried out by creating Use Cases, which led to identification of issues by the AHIC work groups, standards harmonization and interoperability specification development by the Health Information Technology Standards Panel (HITSP), certification criteria used by the Commission for Certification of Health Information Technology, Trial Implementations by the Nationwide Health Information Network contractors, and, in some cases, even pilot projects and incentives to promote adoption.

Thirteen use cases were developed by the end of 2008 and were used to create recognized standards. Many gaps remained, such as the failure to include immunization decision support and assessment in the interoperability specification developed for the immunization and response management use case. A single additional use case on Newborn Screening was created for ongoing work in 2009, along with several gaps and extensions to previous use cases, including both a Medical Home and Maternal and Child Health Extension/Gap. The Maternal and Child Health Extension/Gap and is closely related to the Newborn Screening Use Case. It covers many areas of data integration between different public health systems, such as newborn metabolic screening, early hearing detection and intervention, vital records, and Medicaid Early Periodic Screening and Development Testing.

Newborn Screening is an ideal final use case from the AHIC because of its important connection to both child health and personalized health care. Newborn Screening can be considered an area of mandatory interoperability because information must flow between the hospital or birthing center, public health agencies, primary care physicians, and specialists (including audiologists) who care for the more than 4 million infants who are screened each year. If this does not happen electronically, it must happen on paper, by fax, and by phone, with limited integration into the electronic health record (EHR) or future availability when the data are needed.

Getting the information to the correct physician is challenging because of changes to the infant name and primary care provider after the initial specimen is obtained. Completing the appropriate confirmatory testing and referral for all infants who fail to pass initial screening is also challenging, especially for hearing screening. While more than 98% of infants may get initial hearing screening in most states, it is not uncommon for half of those who fail to be lost to follow-up, have no diagnostic confirmation, or be designated as unable to contact. While the majority of those who fail to pass initial screening may have normal hearing, opportunities for early intervention are lost for some infants.

With help from the Newborn Screening Saves Lives Act of 2008, most states have moved the 29-test core panel recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) based on a report by the American College of Medical Genetics (ACMG). The ACHDNC continues to review new tests and appropriate screening strategies based on advances in treatment and diagnosis. Many states supplement their core panel with secondary screening targets and screen for additional conditions, including some hemoglobin traits.

The nature of newborn screening is changing, and the concept that "no news is good news," which worked in the past for rare and catastrophic conditions like PKU and congenital hypothyroidism, no longer applies to a range of conditions that are now included in screening panels. It is important to confirm that each infant's physician actually has seen and reviewed the results and taken appropriate action or filed information for future use. Closing the orders loop by confirming that all tests that were ordered have generated results is difficult when the physician who cares for the infant is not the same physician who ordered the test.

The coding and terminology of newborn screening results is different from other laboratory results because the reports usually focus on the condition for which screening is conducted (reported as positive or negative) rather than on the actual test performed or the quantitative result. One of the recommendations of the AHIC was that the Newborn Screening Use Case should call for electronic reporting of quantitative results, even if they are used

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Newborn Screening and HIT

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clinically, so that they will be available to advance population health and improve setting endpoints and selecting best testing methods.

The approach to naming conditions that are targets of newborn screening has evolved with the evolution of medical knowledge. Some conditions are named for clinical syndromes, some for enzyme defects, some for the abnormal analyte or substance that is measured, and, now, some for specific genetic abnormalities. Part of the Newborn Screening Use Case is a coding and terminology guide that links synonyms and alternative ways of naming and counting conditions. The National Library of Medicine's Unified Medical Language System likely will be expanded to include newborn screening conditions structured around the approach to designating screening targets developed by the ACMG. Having a national coding and terminology guide will facilitate uniform reporting and data sharing between states and interpreting reports when children move or seek care in different parts of the country.

Newborn screening is a moving target. Additional changes in screening programs and variations from state to state and over time are anticipated. In the future, it will be important to be able to identify, specifically, what screening tests actually were performed for any child as new tests are introduced for the same condition.

Privacy protections are important for genetic data. The Genetic Information Nondiscrimination Act of 2008 will help prevent discrimination in health insurance coverage and employment, and should help facilitate electronic sharing of newborn screening results when regulations are developed to prevent misuse of this information.

Many of the conditions detected by newborn screening are rare and seen only once in a pediatrician's lifetime, so electronic availability of educational materials is critical to both health care professionals and parents when unanticipated results are reported. The costs and problems created by false positives remain a concern. Education may be able to minimize the impact of repeat screening and confirmatory testing.

The use case will cover reporting the results of the initial screening tests, decisions about the need for repeat or second screenings, confirmatory testing, preparing a consult and referral report combining all available data, collecting family history when appropriate, and making all necessary medical and nonmedical referrals for treatment and public health reporting. It also is an opportunity to improve the process of transferring a basic newborn discharge summary to the primary care provider, as much of the key newborn data are needed to interpret screening results. Making this information available as quickly as possible after newborn hospital discharge will require electronic systems to speed reporting to the current location of care.

Work on the interoperability specification will take place in 2009. Council on Clinical Information Technology members should consider working with HITSP on this important project, as well as encouraging both their local newborn screening program and their EHR vendor to implement the interfaces and participate in pilot demonstrations of the newborn screening use case. Vendors need to hear that their customers definitely are interested in automating retrieval and filing of newborn screening results. Local HIEs also should include Newborn Screening (which can include the newborn hospital discharge summary data) in their activities.

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

Do 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 http://www.aap.org/donate/fcfdonate.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 Council on Clinical Information Technology (COCIT) dues and allow COCIT to continue ongoing programs or launch new programs. We appreciate your support!

Organizational Change

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aspects of running a complex medical organization with all the various subsystems, from materials management to clinical information systems. The CMIO is a person that bridges the gap between the physician and the technology. It is a fundamentally different role from any other role in the hospital. The good CMIO has to have a thick skin, be a respected clinician, be able to understand people's emotions, and be able to communicate in medical and technical lingo. Luckily, there are many ways that a good clinician can get the necessary medical informatics training, such as with programs like the American Medical Information Association's 10 x 10 program. As an Oregon Health Sciences University graduate suggested, "Once you get over the technical lingo, the rest is just fundamental clinical work flow."

The next type of special person is the "physician champion," who is the clinician who first adopts any new system and helps refine the system while, at the same time, rallies the less enthusiastic partners to use it. Physician champions are needed in every division of a hospital based on medical staff. For example, the pediatrician has a hard time understanding surgical work flows, and the surgeon has a hard time understanding bronchiolitis work flows. Therefore, the physician champions should have some time to work on informatics projects with the CMIO to accomplish the goal of successful implementation.

The next person is special even though he or she has a very negative attitude toward change and, especially, computers. People like this are called curmudgeons. They are people who have nothing good to say about CPOE or changes to clinical work flow. Most peoples' intuition tells them to run high and never to talk to this person; but the exact opposite is true. You must engage the curmudgeon verbally early in the process and try to fix the things you can. When shown by a legitimate clinician that he or she can make a connection and make changes to the system that improves things, the curmudgeon slowly will become neutral and, with any luck, eventually be supportive of the new technology. Part of any clinical implementation is to engage the entire spectrum of physician users.

In summary, Drs Ash and Sittig have put together an impressive body of work that describes the softer side of clinical information implementation. This essay presents some of the highlights of their findings and recommendations. Anyone who wants to be successful in implementing these systems must understand the likely underlying behavioral and organizational change issues that are involved.

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

Wish List for the Electronic Health Record Industry

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

There are some elephants in the room. They lurk there throughout your electronic health record (EHR) implementation, casting dark shadows on the shiny promises of health care automation. Everyone knows they are there, but no one wants to deal with them. If we try to talk about them, we very rarely end up with any solutions to the problems they pose.

As we think about how EHRs are going to look in the second decade of the 21st century, can we start talking about how our EHR systems can address these problems prospectively? To fulfill our EHR wishes, it will require a tremendous, cooperative effort between vendors, informatics researchers, and professionals. It is entirely possible that you will disagree with some of these wishes. It also is possible that some of these wishes are contradictory. All I can say is that these are the wishes I have when I look at the implementations with which I have been involved so far.

Wish 1: Solve the "doctor as secretary" problem.

It's easy to learn to type. It's easy to learn to select recipients for letters and cut and paste text. It's easy to pick essential data off a patient questionnaire and enter it into the computer. It's easy to learn to select billing codes. It's easy to look up the name of the procedure you want to perform from a list of procedures. It's easy to learn how to type 60 words per minute. None of this is hard, but why does it have to be the doctor to do these things? In fact, why design a system that even *allows* doctors to do these things? When we used paper for all our documentation, it made sense to give these tasks to the highest-paid person in the practice. Now that we have replaced these paper processes with much more laborious methods for getting data in, isn't it time to rethink how we distribute the work of documentation in the practice?

Wish 2: Embrace the population approach.

Electronic health records are, by definition, patient centered. There is nothing wrong with that. However, once we have data about our patient in the system, it is a shame that our tools for managing *populations* of patients are not as well-developed as the patient-centered record. It ought to be standard functionality that we can use our EHRs to identify high-risk patients within a population rapidly, to intervene or to institute large preventive health care measures. We can move the dial on health care quality a lot more efficiently if we can examine groups of patients within our practice. Yes, we can always "run reports," but this tends to be an activity that is skipped in favor of activities that are more directly related to individual patient care.

Wish 3: Really handle learners in the workplace.

Every EHR "handles" students and residents, but only by means of general-purpose, privilege-setting utilities within the program. No EHR that I am aware of knows the difference between a student review of systems (which an attending physician *can* review and include as documentation to support billing) and a student physical examination (which cannot be used to support billing). Most electronic ordering schemes allow an "ordering" provider (the resident) and an "authorizing" provider (the attending), but it is unusual to see a system that allows a full representation of the layers of medical education (from the attending, to the fellow, to the resident, to the intern, to the fourth-year student, to the third-year student, to the second-year student observer).

Wish 4: Tame the ugly print monster.

You can tell immediately when something has been "printed by a computer" versus something that a human typist laid out and printed. Why is it so easy? Because computer-generated reports from an EHR contain inexplicable runs of vertical blank space, page breaks that create "widowed" and "orphaned" lines of paragraphs, 2-page letters where page 2 contains only a single, blank "cc:" line, tabular output where column widths are not adjusted to minimize word wrap … the list goes on. Is it beyond modern computer technology to detect and prevent these typographic monstrosities? Maybe it is now, but there ought to be a way to build a layer of logic into print routines to analyze these problems and make the output look better. Some brilliant computer scientist surely can figure this out. It is not sufficient to say, "paper is going away, so let's not work on it." Paper reports (or at least reports laid out as if they are to be printed) will be with us a long time.

Wish 5: Make medication identifiers interoperable.

Incredibly, there is no universal way to express, in a computable form, that a patient is on a given medication. In 2001, the National Library of Medicine instituted the RxNorm project, intended to provide a universal way to identify drugs so that systems can interchange drug lists without loss of meaning. However, as of the end of 2008,

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EHR Wish List

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the standard in implemented systems is to use the drug ontologies that are provided by one of several drug database vendors. Of course, these ontologies are encoded differently; therefore, there is no way to share drug lists across systems without a tremendous amount of error-prone work.

Wish 6: Try to turn opinion away from the "everything-is-customizable-so-let's-customize-it" assumption.

When we buy most non-EHR software, we install it and use it. We do not enter into a long series of "design sessions" with the vendor to make the software act exactly the way we want it to work. With EHRs, we maximize dissatisfaction with the software by assuming that we ought to be able to customize the system. It is great to have a system that is customized to the needs of one's workplace, but it comes at a tremendous cost. Upgrades become more expensive. Customizations that alter system functionality usually result in limitations of system functionality, which, in turn, fuel user dissatisfaction even more.

Wish 7: Include patients in the information-gathering process.

It is rare these days to find any examples of patients and families directly editing their own information in an EHR. If they are doing it at all, it is in separate "personal health record" systems or "patient portals." With a health care system that is getting more complex, it is now time to create systems where patient data entry is not simply an add-on. Electronic health records need to include a patient-facing data collection process from the get-go. Sure, there are health literacy issues, but most patients in most practices can, if given an appropriate interface, manage the very important background information that is required for safe health care.

Wish 8: Make the facts about EHRs and productivity public.

There is little good, peer-reviewed literature on the impact of modern EHRs on productivity. There is a lot of anecdotal and vendor-collected information on how coding levels change, but not much literature how EHRs change how people work. Anecdotes about physicians staying in the office every night until 8:00 pm to finish EHR documentation could use verification or refutation through studies.

Wish 9: Develop a model of user authentication that circumvents the laborious log-in/log-off problem.

Health care is a team activity. Many different people do many things at the same time as other people; but, we are as tied to the concept of a "log-in session" as we were in the 1970's days of VT100 terminals. If a doctor, a nurse, a technician, a social worker, and a couple of administrative assistants all need to contribute (at their appropriate professional level) to the care of a patient, we have to have a way for them to do it without creating a new session and new documents. Health care documents need to comprise a patchwork of documentation from many job roles.

Wish 10: Preserve the "gist" of the patient's situation.

One of the first things to go when one implements an EHR is an easy way to tell, with one glance, what is happening with the patient. In other words, one loses the "gist" of the patient's medical situation. This is not the fault of the EHR; after all, most EHRs support the idea of a problem list. The problem with problem lists is that people do not use them. The problem list needs to move to the center of the user's experience. Problem management across the continuum of care should not be an optional nicety, but, instead, be the way EHRs work.

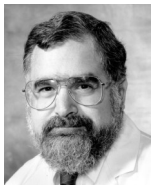
Wish 11: Segregate the regulatory documentation from valuable patient information.

Don't get me wrong; I do think it is important to evaluate patients' levels of pain and the adequacy of their pain control. I think it is important to reconcile their list of medications. I think it is important to document a physical examination and a certain level of detail to be reimbursed for certain level of service. However, for most patients, the details we record about them in the name of complying with regulations are irrelevant. We need to examine systems that take this information and keep it in the background until it is needed, leaving the truly salient features of their medical situation visible in the record.

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.

First Report of the State Alliance for eHealth



By Alan Zuckerman, MD, FAAP
COCIT Executive Committee Member

The State Alliance for e-Health (SAeH) is operated by the National Governors Association Center for Best Practices for the purpose of improving and promoting the use of health information technology (HIT) and health information exchange (HIE) at the state level. It issued its first report titled, *Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care,* in October 2008. The full report is available at http://www.nga.org/center/ehealth and provides a good summary of the need for more state activity in e-health and the critical role that states should play.

The work of the SAeH is very important to pediatricians who are interested in advancing the use of HIT, because most government HIT incentives for pediatrics will need to come from the Medicaid program, which is administered at the state level rather than from the federal Medicare program. Public health initiatives in HIT, such as Immunization Information Systems (IIS), or registries, and Newborn Screening Programs are also state activities rather than national programs. Improving interoperability with public health interfaces to electronic health records (EHRs) will require states to support development and implementation of standard interfaces.

The report identified 6 areas of opportunity for states to facilitate the use of HIT and developed several strategies for each recommendation.

1. Provide leadership and support for e-health efforts.
2. Address privacy and security.
3. Promote the use of standards-based, interoperable technology.
4. Streamline the licensure process to enable cross-state e-health.
5. Engage consumers to use HIT in managing their health and health care.
6. Develop workforce and agency capacity to support electronic HIE efforts.

Following are several specific recommendations that are of interest to pediatricians:

- *Designate a single authority for state government interagency coordination and collaboration with statewide public-private efforts.* Without a single authority and point of contact, issues will not move forward and opportunities to integrate information in separate databases and registries will be lost.
- *Establish a roadmap articulating vision and strategy for electronic HIE development.* Not everything can be accomplished at once. A coordinated, phased approach will be needed to bring HIE and IIS to all areas of the country.
- *Make a patient-centered, interoperable, and portable EHR available for every child by 2014.* One of the most visionary insights of the SAeH was the recognition that all children, not just those covered by Medicaid, must be included because of frequent changes in coverage and parental employment, as well as movement from state to state during childhood. Key data areas for a basic child health record were identified in the report.
- *Develop and implement incentive programs or reimbursement policies that support HIT adoption and electronic HIE.* Incentives are critical to stimulate private investment in technology that benefits many stakeholders. Pediatricians have been slow to adopt EHRs. Targeted incentives for child health providers will help.
- *Participate in national certification and standards-setting processes.* State governments are not covered by the federal executive order on use of recognized standards, and more state participation in encouraging the use of standards will accelerate adoption.
- *Direct the Medicaid and state employee health plan programs to implement standards-based personal health records (PHRs).* Personal health records are an important tool for enabling parents to share child health data with multiple providers over a child's lifetime. Medicare and other adult payers are implementing programs in this area. State participation will be needed to reach large numbers of children.

The American Academy of Pediatrics (AAP) has chapters in each state. The Council on Clinical Information Technology (COCIT) has liaisons for many of the state chapters, as well as direct interactions with many of the districts. Follow-up and monitoring of individual state responses to the SAeH report can become an important activity for COCIT liaisons. Comparing data and activities from other states can be a useful strategy for encouraging your own governor and state legislature to act on HIT opportunities by appealing to a sense of desire for parity and equality with other comparable states.

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Harriet Lane Handbook for PDAs

By Julie Youssef, MD,
AAP Section on Residents Liaison to COCIT

White coat, stethoscope, calculator, 2 pens, prescription pad, official hospital stamper, reflex hammer, penlight, 1½-pound *Harriet Lane Handbook (HL)* reference book … as an intern, my white coat was heavy! However, by my second year of residency, I got smart—I downloaded the electronic version of *HL* onto my Pocket PC, got rid of the white coat, and never looked back! I actually use several electronic medical programs on my personal digital assistant (PDA), but I find myself using *Harriet Lane* most often. Here is how the electronic version compares to the paper version.

Features

Identical in content to the book version, the electronic *HL* is a must-have resource for all residents, hospitalists, and beginning private practitioners. As in the text, the structure of the book includes major divisions into pediatric acute care, diagnostic and therapeutic information, drug formulary, dermatology and hematology color slides, algorithms, and medical calculators. The user navigates the textbook by clicking on hyperlinks to jump to the appropriate search topic.

As a senior resident, I am constantly referring to my electronic *HL*. For example, while mentoring a medical student at the bedside, I was able to show the student a picture of a typical molluscum rash on my PDA as we compared it to the rash of the patient. I also have found the toxidromes to be immensely helpful as a last-minute review of appropriate signs, symptoms, and management of my patients who consumed toxins. It is important to note that the electronic *HL* is a very basic overview of common diagnoses and is, by no means, a thorough review of medical knowledge.

Usability/Navigation

Overall navigation through the electronic *HL* is fair. After using it for a few weeks, I finally was able to begin navigating the electronic book; unfortunately, it is not a very user-friendly program. Many times, I find that it is quicker to flip through the book rather than several screen links on my PDA. For example, in searching for the specific contents of intravenous (IV) fluid hydration, you must click the following: menu → contents → diagnostic and therapeutic information → fluids and electrolytes → parenteral fluid composition (a simple search for "intravenous fluids" is non-revealing). From there, you can search for the specific concentration of sodium in the IV fluid.

In all, this program does not provide a link between the medical calculators and the review of medical knowledge. Additionally, the user is unable to navigate between review material and the corresponding color slides. On the other hand, each page has a "back" link that help me backtrack in case I get lost within the depths of *HL*. In addition, if the program is abruptly ended, upon returning to *HL,* the last item that was being studied is opened.

The acute care and diagnostic and therapeutic information sections have excellent tables, algorithms, and lists of differential diagnoses that are useful and accurate information on a large volume of topics. The usability of these items is impressive. For example, while on call in the pediatric intensive care unit, I had a few minutes to review management of patients with traumatic brain injury, according to the electronic *HL*. A simple query on "increased intracranial pressure" led me to a basic review of the Cushing's triad, and different algorithms were available to me to further guide management, depending on whether I deemed the child "stable" or "unstable." These algorithms were one of my favorite features of this program.

Calculations

Another one of the strengths of the electronic *HL* is access to multiple popular medical calculators. Calculators included FENa, creatinine clearance, Glasgow Coma Scale scoring, growth chart calculators, and more. One helpful addition would be to have the original formula as well as a brief amount of information about the use of the formula. Again, there is no linkage between the calculators and the review material in the handbook. Otherwise, these calculators are quick and efficient programs that save time on the wards and clinics.

Drug Information

Probably one of the main reasons why I originally downloaded the electronic *HL* was for the drug formulary information. The formulary section contains comprehensive information on trade names, drug categories, forms, and dosing. One thing lacking is a built-in calculator to calculate weight-based dosing. On the other hand, there are several links within the drug information. For example, while searching amoxicillin, the user is reminded that it is renally eliminated, and there is a link to drugs in renal failure with a table explaining how to dose amoxicillin for renal failure. In addition, while searching for the dose of amoxicillin to be given for SBE prophylaxis, you are

(continued on page 11)

First Report of the State Alliance for eHealth

(continued from page 9)

Much of our attention has been focused on federal HIT initiatives and programs, but many of the changes we would like to see in HIT initiatives, electronic prescribing for children, interfaces to registries and public health programs, and regional HIE will require state action and funding. It seems prudent at this time to broaden our focus and pay more attention to HIT activities in our state.

Council on Clinical Information Technology members can play an important role by tracking what is happening in their individual states and sharing this with the membership. Key strategies to track include the following:

- Establishing a single authority and point of contact for HIT and HIE in your state
- Developing a road map for HIE development, including immunization registry and newborn screening interfaces and Web sites
- Developing a plan to create an interoperable and portable Child Health Record by 2014
- Offering incentives for HIT and HIE
- Participating in national standards setting and certification
- Implementing standards-based PHRs under Medicaid

The AAP can play an important role in raising the priority given to these projects, both nationwide and in each state, with proper attention given to the special requirements for children.

Harriet Lane Handbook for PDAs

(continued from page 10)

linked to a review of acquired heart diseases requiring SBE prophylaxis. This is an excellent way to cross-link information, and I found this to be much more time efficient than navigating the paper version. Another feature missing from this electronic version is the inability to cross-link several medications to screen for concurrent side effects. However, the electronic *HL* is simply the electronic version of what is in the paper version, so this flaw is to be expected.

So, in all, I recommend this program to anyone who owns both a PDA and a *Harriet Lane Handbook*. The electronic version serves as a great drug reference, drug calculator, and differential diagnosis guide. This review is based on Mosby's 17th edition of the *Harriet Lane Handbook*, which can be downloaded from www.us.elsevierhealth.com. The 18th edition was recently released by Skyscape. It will be exciting to see how the new Skyscape version of *HL* compares to this version by Mosby. Stay tuned to find out!

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.

The submission deadline for the fall 2009 issue will be June 1, 2009.

EXECUTIVE SUMMARY
COUNCIL ON CLINICAL INFORMATION TECHNOLOGY EXECUTIVE COMMITTEE

Executive Summary: Meeting of the Council on Clinical Information Technology Executive Committee
October 3, 2008—Conference Call
and
October 14, 2008—Boston, MA

The Executive Committee of the American Academy of Pediatrics (AAP) Council on Clinical Information Technology (COCIT) convened by conference call on October 3, 2008, followed by a face-to-face meeting on October 14, 2008, in conjunction with the AAP National Conference & Exhibition in Boston, MA.

Discussion topics included the following:

- There will be 4 executive committee positions open on the 2009 election ballot. Drs D'Alessandro, Kim, Leu, and Zuckerman will each be eligible to seek reelection.
- The COCIT budget was reviewed. The reserve fund has returned to a positive balance.
- The Executive Committee discussed ways to encourage COCIT members to submit nominations for the 2009 Byron Oberst Award.
- The Committee approved responses to several resolutions from the 2008 Annual Leadership Forum (ALF) and discussed possible resolutions for the 2009 ALF.
- The Executive Committee heard brief reports from the Policy, Education, and Applications Committees.
- A report was provided on legislative activity at the federal level.
- The COCIT Membership Chairperson, Dr Alice Loveys, reported on her efforts to increase COCIT membership and to provide increased value to COCIT members.
- The COCIT Publications Director, Dr Craig Joseph, reported on his efforts to seek contributions from COCIT members for the spring 2009 newsletter and for other AAP publications.
- The Executive Committee briefly discussed its proposal to include health information technology on the AAP Agenda for Children.
- The Executive Committee members reviewed their COCIT Strategic Plan Objective assignments. It was determined that at least one Executive Committee member should be assigned to each objective.
- Liaison reports were received from
  - ⇒ The AAP Section on Hospital Medicine
  - ⇒ The eHealth Initiative
  - ⇒ The Certification Commission for Health Information Technology
  - ⇒ The Steering Committee on Quality Improvement and Management
  - ⇒ The Section on Residents
  - ⇒ The American Health Information Community and the Health Information Technology Standards Panel
  - ⇒ The Physicians Electronic Health Record Coalition

The next meeting of the COCIT Executive Committee will be held in spring 2009 at a location to be determined.

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.

The Council on Clinical Information Technology Election: Please Vote!

The 2009 American Academy of Pediatrics section and council elections will be conducted online from March 1 through 31. This year, the Council on Clinical Information Technology will have 4 open positions on the ballot. Please watch your e-mail for specific voting instructions.

COMMITTEE UPDATES

Education Committee

By Kristin Benson, MD, FAAP
COCIT Education Committee Chairperson

"Electronify that!" is a new phrase I have been hearing a lot lately. It reminds me of the commands I bark into Dragon, our speech recognition system, such as "copy that!" and "scratch that!" Unfortunately, even if "electronify" were a real word, it would not be done so easily. However, the Council on clinical Information Technology (COCIT) Education Committee is working to help provide the Health Information Technology (HIT) learning opportunities that you will need in your practice. Policy decision making at the "30,000-foot level" likely will have a big effect on you soon. In addition, there are burgeoning electronic resources and tools to help you practice medicine as soon as today.

With the new administration in Washington, DC, there is considerable anticipation of national health care reform. Change is needed because of rising costs and lack of universal coverage. Electronic health records (EHRs) are an important piece of health care reform, and digitizing our data will be an inevitable requirement going forward. Elements of health care reform and compensation redesign, such as "comparative effectiveness" measures, Health Care Home (or Medical Home) qualifications, pay for performance, and quality reporting, are not possible on a large scale without EHR.

However, the business case for an EHR system is still not financially persuasive for many small and medium practices. It is often difficult for physicians to know what investments to make and when. As functionality continues to evolve, the vendor market evolves, too. In addition, we have complex, unanswered organizational and legal questions about privacy, security, data sharing, and standards that may affect your decisions. For some physicians, there is a steep learning curve ahead to pick up computer skills. President Obama has stated his interest in making considerable investments in HIT, perhaps as much as $10 billion a year for 5 years. You will need to be ready and informed to make good decisions if you are considering an EHR.

Meanwhile, we want you to practice with the best tools there are, including HIT tools. If you already have an EHR, you can work to optimize it. If you do not have an EHR, you can do groundwork by standardizing processes and work flows and trying freestanding and online applications. Following is a summary of the educational opportunities that are currently available through COCIT:

- The COCIT Web site is accessible through the American Academy of Pediatrics (AAP) portal, or at www.aapcocit.org. You can find links to Policy publications and various HIT resources, conference materials, publications, and electronic tools. You can access the EMR Review Project for EHR reviews by fellow pediatricians.
- The 2008 National Conference & Exhibition (NCE) provided a slate of talks in the Technology Learning Center (TLC) and in the main sessions. 2008 recordings are available for a fee at http://www.dcprovidersonline.com/aap/. The H-Program Scientific Session provided talks by pediatric HIT experts and an afternoon of pediatric HIT abstract and poster presentations.
- For the 2009 NCE, we will focus on functionality around the priorities of the Strategic Plan of the AAP, including the Medical Home. Relating to these, we will have main session and TLC talks on E-prescribing, Computerized Provider Order Entry, interoperability and information sharing, Personal Health Records, technology basics, and others. The TLC will offer talks sponsored by COCIT and other sections having to do with technology and patient care on an individual and group practice level. This will be year 6 of the Pediatric Documentation Challenge, a presentation by a variety of vendors to show how well their software can document a typical office-visit scenario. We are, again, planning the "Pediatric Office of the Future," an Exhibit Hall demonstration of innovative computerized devices and applications for patient care and connectivity.

I would like to acknowledge the other Education Committee members, George Kim, MD, FAAP, Alice Loveys, MD, FAAP, and Lewis Wasserman, MD, FAAP, who have contributed much valuable time and expertise. We hope you will find something useful in our COCIT educational offerings, and welcome any suggestions or comments. If you wish to submit NCE abstracts, posters, or presentation proposals, contact me at kb0293@gmail.com.

Policy Committee

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

The Council on Clinical Information Technology (COCIT) Policy Committee has been very productive this last year. In addition to our annual meetings in the spring at the American Academy of Pediatrics (AAP) headquarters and during the National Conference & Exhibition, we meet by phone at least quarterly. We continue to make progress on some important policies that we hope will give guidance to standards-setting groups and government, as well as to help pediatricians and other health care providers who use an electronic medical record to improve the quality of health care for children and adolescents.

Special thanks go to George Kim, MD, FAAP, and Christoph Lehmann, MD, FAAP, who had their policy, **"Pediatric Aspects of Inpatient Health Information Technology Systems,"** published in the December 2008 issue of *Pediatrics* (*Pediatrics.* 2008;122:e1287-e1296). They did an outstanding job with a complex subject. I also would like to thank the entire Policy Committee for its help and feedback to Drs Kim and Lehmann. Dr Lehmann remains an active participant in COCIT and is a great example of how a COCIT member can contribute without being a member of the COCIT Executive Committee or Policy Committee.

Policies in Progress

Using Personal Health Records to Improve Efficiency, Safety, and Quality of Health Care for Children
Alan Zuckerman, MD, FAAP, along with Joseph Schneider, MD, MBA, FAAP, has responded to the comments from other AAP committees, sections, and councils, and the statement has been submitted for review by the AAP Board of Directors. We hope the statement will make it through the approval process in early 2009 and be published soon thereafter. The Personal Health Records (PHRs) policy statement provides recommendations that the AAP and all pediatricians can take to support the development and use of PHRs for children.

E-mail Communication
Eugenia Marcus, MD, FAAP, is working on this statement from COCIT with Jeff Brown, MD, FAAP, the coauthor from the Section on Telehealth Care (SOTC). The challenge for this statement will be to construct it as a single policy on non–face-to-face care. Donna D'Alessandro, MD, FAAP (another COCIT Executive Committee Member), also has been helping Dr Marcus with background references for the statement. The authors will be meeting by conference call to develop the statement. Dr Marcus would like to write the statement in a way that will grant some transparency to non–face-to-face care and alleviate payer concerns.

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. Dr Kim and William Zurhellen, MD, FAAP, have taken the lead on what we originally dubbed the "Dream Statement." This has evolved to be, potentially, a policy statement with an accompanying technical report. The policy committee has reviewed a draft Intent for Statement and draft statement. The draft statement included a diagram that illustrated the flow of information through the medical home. We hope this work will continue to move forward in early 2009.

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 for the latest version of this statement. The revised draft was sent to the AAP for peer review in early 2009.

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. Mark Del Beccaro, MD, FAAP, from COCIT will review the AAP Board comments and give feedback to COPEM.

Again, we have to thank Jennifer Mansour and Beki Marshall for their amazing support for the Policy Committee. We want to congratulate Jennifer on the birth of her new baby girl, Maren, and, again, thank Beki for filling in for Jennifer while she is on family leave.

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

Please consider being involved by sending us ideas for statements or helping with policy development.

Report From the National Conference & Exhibition 2008 Education/Scientific Session and Byron Oberst Award Presentation

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

The Council on Clinical Information Technology (COCIT) 2008 National Conference & Exhibition Education/Scientific Session (H Program) was held Sunday, October 12, at the Hynes Convention Center in Boston, MA. Invited presentations, "Measures of Quality of Care and How They Are Used: Carrot vs Stick" by Stuart T. Weinberg, MD, FAAP, and "The New Medical Record: From Folder to Datastream" by Kevin B. Johnson, MD, MS, FAAP, FACMI, generated much discussion and questions from the audience.

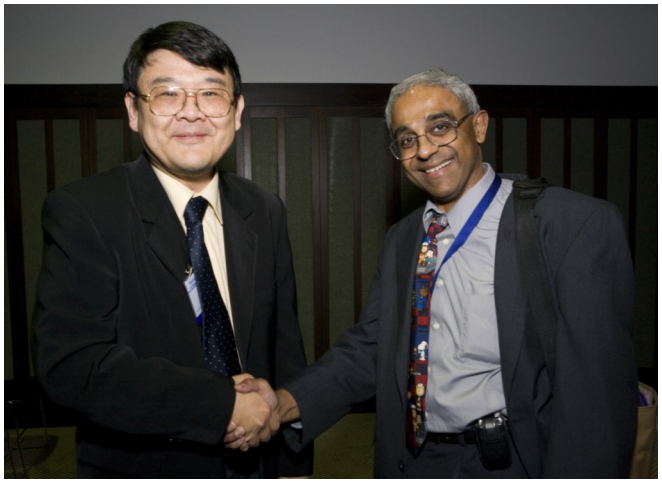
Dr Weinberg, COCIT Webmaster, past executive committee member and winner of the 2004 Byron Oberst Award, covered definitions and concepts in health care quality by different organizations and agencies and how they impact the types of data that will need to be reported by practices in the near future. Dr Johnson, past applications committee chair and winner of this year's Byron Oberst Award, showcased numerous national and local information technology projects to improve pediatric practice and the health of children.

In his Oberst Award presentation, Dr Johnson reviewed the history of COCIT (from its previous incarnations as the Section on Computers and Other Technologies, the Steering Committee on Clinical Information Technology, and the Task Force on Medical Informatics) and included a brief biography and recently taped interview with Byron Oberst himself (who is happily retired and residing in Omaha, NE). Visit http://www.aapcocit.org/cocit_tasks.php?task=oberst to view a letter from Dr Oberst.

The afternoon Scientific Session of platform presentations and posters on topics ranging from electronic health records to resident education and consumer health was well attended and generated many questions from the audience. The Best Paper Award went to Vinay N. Reddy, MD, MS, MSE, FAAP, for "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" by VN Reddy, LA Smidchens, and CJ Barger from Michigan State University, Western Michigan University, and the William Beaumont Hospital.

Many thanks go to our expert panel of judges: Kris Benson, MD, MS, FAAP; Donna D'Alessandro, MD, FAAP; Willa Drummond, MD, MS, FAAP; Chris Lehmann, MD, FAAP; Michael Leu, MD, FAAP; Gregg Lund, DO, FAAP; Mark Simonian, MD, FAAP; Andy Spooner, MD, MS, FAAP; and Alan Zuckerman, MD, FAAP.

Materials from the H Program are posted on the COCIT Web site (http://www.aapcocit.org/cocit_tasks.php?task=education).



COCIT Abstract Chairperson George Kim, MD, FAAP, presents the 2008 Best Paper Award to Vinay N. Reddy, MD, MS, MSE, FAAP.

COCIT Chairperson Joseph H. Schneider, MD, MBA, FAAP, presents the 2008 Byron Oberst Award to Kevin B. Johnson, MD, MS, FAAP, FACMI.

Applications Committee

By Michael Leu, MD, FAAP
COCIT Applications Committee Chairperson

It has been a busy year and we have a few successes on which to report.

From our 2007 survey, the most requested tools from Council on Clinical Information Technology (COCIT) members were to support the identification and management of pediatric obesity. Towards that end, we worked closely with Ernest Post, MD, FAAP, to update his growth chart spreadsheets to be more widely usable, including adding a 99th percentile curve after some brief discussions with the Centers for Disease Control and Prevention (CDC), while we await their final recommendations for those cutoffs. We also created an Excel library which calculates percentiles for height, weight, head circumference, body mass index, and blood pressure (based on CDC tables[1] and National High Blood Pressure Education Program Working Group recommendations[2]) . These tools have been made available for beta testing, with distribution to more than 40 pediatricians and pediatric obesity researchers from the National Initiative for Children's Healthcare Quality (NICHQ) LISTSERV®. These tools are available on the Seattle Children's website at http://obesity.seattlechildrens.org/growth_charts.htm. The NICHQ expert committee recommendations are available at http://www.nichq.org/childhood_obesity/index.html. For these and more resources, go to http://obesity.seattlechildrens.org.

At the request of Pradeep Alur, MD, FAAP, we looked into the possibility of creating a Pocket PC®-based clinical calculator for the prediction of morbidity and mortality of extremely premature infants[3] as a more convenient resource than the clinical calculator already available on http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/epbo_case.cfm. Lynda Lin, MD, a pediatric resident at the time, successfully created this application for use on Pocket PCs with qVGA screens. If you are interested in beta testing this application or in contacting Dr Lin, please feel free to send me a note (see e-mail addresses on the last page).

We have also contacted all COCIT members who expressed interest, during our member survey, in developing electronic tools for inclusion on our COCIT Applications Committee / Technical Advisory Board. This Board is forming for 2 reasons.

1. The American Academy of Pediatrics (AAP) is starting to think about how it might better be able to integrate its content with electronic and personal health record systems (including *Pediatric Care Online*, *Red Book*, and *Patient Education Online*.)
2. The Applications Committee is also involved in helping to provide technical guidance for diverse initiatives, such as electronic foster care passports, immunization forecasters, and basic developmental screening activities.

We have been fortunate to find 9 pediatricians with more than 90 years of combined informatics experience to work with me to formulate strategies for how we can facilitate creation and dissemination of these electronic solutions. Let me introduce our Applications Committee/ Technical Advisory Board:

- Michael Leu, MD, MS, MHS, FAAP (Chair), Seattle, WA
- Louis Appel, MD, MPH, FAAP, Austin, TX
- William Ching, MD, PhD, FAAP, Chicago, IL
- Allen Hsiao, MD, FAAP, New Haven, CT
- George Kim, MD, FAAP, Baltimore, MD
- Sheryl Morelli, MD, FAAP, Mercer Island, WA
- Stephen Morgan, MD, FAAP, Boston, MA
- Fredric Serota, MD, JD, FAAP, Ambler, PA
- David Stockwell, MD, FAAP, Washington, DC
- William Zurhellen, MD, FAAP, Putnam Valley, NY

Thank you to our new Advisory Board members for their willingness to work with the AAP and COCIT to create a technology strategy for providing the best health care to all children! If you would like to be informed about our activities, please add yourself to the AAP-EPRODUCTS LISTSERV® (see instructions on the following page).

1. See http://www.cdc.gov/growthcharts.
2. Blood pressure percentiles and index from National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents. The fourth report on the diagnosis, evaluation, and treatment of high blood pressure in children. *Pediatrics*. 2004;114:555-576.
3. Tyson JE, Parikh NA, Langer J, Green C, Higgins RD. Intensive care for extreme prematurity—moving beyond gestational age. *N Engl J Med.* 2008;358:1672-1681.

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 electronic medical records, 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 Rapid Response Team (COCIT-RRT) E-mail List

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 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:

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.

HIT Articles in January 2009 Supplement of *Pediatrics*

The January 2009 *Pediatrics* issue supplement contains many articles of interest to Council on Clinical Information Technology members. The titles are listed below, and the entire articles may be downloaded at http://pediatrics.aappublications.org/content/vol123/Supplement_2/.

Fairbrother G, Simpson L. It is time! Accelerating the use of child health information systems to improve child health. *Pediatrics.* 2009;123:S61-S63

Miles PV, Miller M, Payne DM, Perelman R, Saffer M, Zimmerman E, Alliance for Pediatric Quality. Alliance for Pediatric Quality: creating a community of practice to improve health care for America's children. *Pediatrics.* 2009;123:S64-S66

Hinman AR, Davidson, AJ. Linking children's health information systems: clinical care, public health, emergency medical systems, and schools. *Pediatrics.* 2009;123:S67-S73

Spooner SA, Classen DC. Data standards and improvement of quality and safety in child health care. *Pediatrics.* 2009;123:S74-S79

Menachemi N, Brooks RG, Schwalenstocker E, Simpson L. Use of health information technology by children's hospitals in the United States. *Pediatrics.* 2009;123:S80-S84

Ferris TG, Johnson SA, Co JP, et al. Electronic results management in pediatric ambulatory care: qualitative assessment. *Pediatrics.* 2009;123:S85-S91

Menachemi N, Struchen-Shelhorn W, Brooks RG, Simpson L. Influence of pay-for-performance programs on information technology use among child health providers: the devil is in the details. *Pediatrics.* 2009;123:S92-S96

Britto MT, Wimberg J. Pediatric personal health records: current trends and key challenges. *Pediatrics.* 2009;123:S97-S99

Rattay KT, Ramakrishnan M, Atkinson A, Gilson M, Drayton V. Use of an electronic medical record system to support primary care recommendations to prevent, identify, and manage childhood obesity. *Pediatrics.* 2009;123:S100-S107

Miles P. Health information systems and physician quality: role of the American Board of Pediatrics maintenance of certification in improving children's health care. *Pediatrics.* 2009;123:S108-S110

MacTaggart P, Bagley B. Policy and system strategies in promoting child health information systems, including the role of Medicaid, the State Children's Health Insurance Program, and public financing. *Pediatrics.* 2009;123:S111-S115

Rosenbaum S, Abramson S, MacTaggart, P. Health information law in the context of minors. *Pediatrics*. 2009;123:S116-S121

Brinner KA, Downing, GJ. Advancing patient-centered pediatric care through health information exchange: update from the American Health Information Community Personalized Health Care Workgroup. *Pediatrics.* 2009;123:S122-S124

Conway PH, White PJ, Clancy C. The public role in promoting child health information technology. *Pediatrics.* 2009;123:S125-S127

Please Welcome Our New Members!

The following individuals joined the Council on Clinical Information Technology between August 20, 2008, and February 17, 2009:

Johnye I. Ballenger, MD, FAAP
Cambridge, MA

Timothy D. Johnson, DO, FAAP
Kansas City, MO

Fred D. Kern, MD, FAAP
Bridgewater, MA

Col. Harry F. Laws II, MD, FAAP
Noblesville, IN

Robert D. Lehman, MD, FAAP
Chesapeake, VA

Tal A. Minuskin, MD, FAAP
Sturgeon Bay, WI

Julie Youssef, DO
Port Jefferson, NY

Out With the Old, In With the New

For those of you who joined the Council on Clinical Information Technology (COCIT) before July 2006, you may remember some or all of our previous names (Section on Computers and Other Technologies [SCOT], Task Force on Medical Informatics [TFOMI], and Steering Committee on Clinical Information Technology [SCOCIT]). As our name changed over the years, so did our Web site address.

www.aapscot.org retired in Fall 2008. www.aapscocit.org will retire on March 24, 2009.

Please bookmark COCIT's current Web Site at www.aapcocit.org. Also, if you are still using the old @aapscot.org or @aapscocit.org e-mail aliases, they will no longer work. Please visit http://www.aap.org/moc/ and update your e-mail address. You also may wish to take advantage of the American Academy of Pediatrics e-mail alias service and get your aap.net address.

Byron Oberst Award Winners All at the 2008 NCE

(Left to right): 2004 Oberst Award winner Stuart Weinberg, 2008 Award winner Kevin Johnson, and 2007 Award winner David Paperny

American Academy of Pediatrics Call for Abstracts
National Conference & Exhibition
October 17-20, 2009
Washington, DC

SUBMISSION DEADLINE: APRIL 17, 2009

Section and council programs provide a forum for the discussion of clinical matters or research related to a particular subspecialty or special interest area. Submissions by American Academy of Pediatrics (AAP) members and non-members are welcome; participation is open to health professionals in any field.

The following sections and councils accept abstracts for presentation at the AAP National Conference & Exhibition:

- Adoption and Foster Care
- Breastfeeding
- Cardiology and Cardiac Surgery
- **Clinical Information Technology**
- Community Pediatrics
- Critical Care
- Emergency Medicine
- Epidemiology
- Hospital Medicine
- Injury and Poison Prevention
- Medicine-Pediatrics
- Orthopaedics
- Perinatal Pediatrics
- Residents
- School Health
- Sports Medicine and Fitness
- Surgery
- Transport Medicine
- Urology

Abstracts are not accepted for general pediatrics or for other pediatric subspecialties or special interest areas not listed above.

Submit electronically at http://aap.confex.com/aap/2009/cfp.cgi.

Questions? Contact abstracts@aap.org or 847-434-4079.