**Emory+Children’s Pediatric Research Retreat**

**Friday January 27, 2012**

Environmental Exposures Roundtable Session Summary

Discussion Leader: Lyndsey Darrow, PhD

Scribe: Chenise Anderson RN, BSN

Attendees

Chenise Anderson

Sydney Archer

Jamie Blackmon

LouAnn Brown

Lyndsey Darrow

Teresa Gauthier

Jason Hansen

Carol Hogue

Maeve Howett

Julie Kable

Michael Schechter

Tami Thomas

Rita Willis

In this brief discussion the group explored challenges with obtaining reliable data for exposures, tools to measure various chemical exposures and education for healthcare providers as well as patients.

1. Challenges with capturing reliable environmental exposure information
	* Many clinical flowsheets simply lack fields where information on environmental exposures may be captured
	* At best, there is a single question regarding smoking in the home.
	* Stigmas around recreational behaviors lead parents to offer dishonest answers during examination.
	* The challenges of even identifying the targeted population can be difficult
	* Although EPIC has various levels of functionality, CHOA has only purchased clinical modules. Unfortunately, what is currently in production does not support data extraction very well. Clinicians, researchers and statisticians struggle to obtain comprehensive reports significant to research outcomes.
2. Possible solutions towards identifying and managing environmental exposure data within the CHOA patient population
	* Linking screenings at birth through the health department was one suggestion. Although labor and delivery clinicians were not represented in this session, it was believed that each newborn is screened for alcohol and street drugs at birth
	* Partnering with the Pediatric Biomarkers Core could benefit providers by screening samples such as meconium, hair and placenta
	* There was a suggestion to increase efforts at research education among doctors and nurses who might not be directly involved in research. First, the opinion was expressed that there is often too little awareness about environmental exposures among clinicians, and second, a better general understanding of research methods among clinicians might lead to more research opportunities and indirectly better data recording in electronic medical record systems.
	* Could CHOA maybe systematically link to birth records or other rich data sources, which would open new doors in terms of research questions that could be answered?
	* ACTSI is an informatics group that may possibly fill in the gaps that exist in EPIC to help make it more research friendly. The Emory+Children’s Informatics Core may also be able to help in this regard (contact Dr. Prabhu Shankar for more information at prshank@emory.edu)
	* To increase awareness of research resources in our community and leverage institutional knowledge, it was recommended that a searchable database with personnel  (including investigators and clinical research nurses) and research topics (i.e., keywords for exposures as well as disease outcomes and organ systems) be developed so that studies can benefit from prior experience of research in these study populations. In the development stage of a proposal there are often concerns about feasibility (e.g., recruitment success, loss to follow-up) and similar studies may have already been conducted in the same environment. This would help prevent people from constantly reinventing the wheel.
3. Research resources available/needed
	* Pilots –pilot funding is available to help jump-start larger research projects; Emory+Children’s Pediatric Research Center Pilots are due March 1st, 2012
	* There was also appreciation for the investments in infrastructure like electronic medical and personnel to help access those data resources. A number of people in the group were interested in research on early life exposures to common environmental exposures such as smoking, alcohol, illegal drugs (e.g., cocaine)  and prescription drugs; systematic recording of those exposure data on the medical record might help better identify high risk population  to target for research studies, not to mention improve clinical care.
	* Consent to participate in research could be requested upon entry into the CHOA system: Apparently at St. Jude as well as children’s hospitals in other cities (Denver was an example), children or their parents automatically asked to sign a blanket consent form for participation in clinical research studies. They can always decline, but those that accept provide contact information and basic information. This also speaks to the culture of the institution and how they present themselves to patients as a major research institution.
	* “Clinical Research Nurse Core” This could help smoothly facilitate the collection of pilot samples (could pay per blood sample, for example instead of figuring out percent effort of a research nurse). This core could be where an investigator goes first to inquire about the feasibility of a proposed study in the CHOA clinical population. People also recognized there were issues with buying banked clinical research nurse core time, e.g.,  IRB tends to require identifying specific research nurses for specific  projects.
	* Kris Rogers in a sense already directs a research nurse core at CHOA, although this isn’t formalized or publicized, and tapping and expanding the resource of clinical research nurses could be made easier. Kris can be contacted for access to a the nurse/coordinator pool which currently provides support for implementation of funded studies.