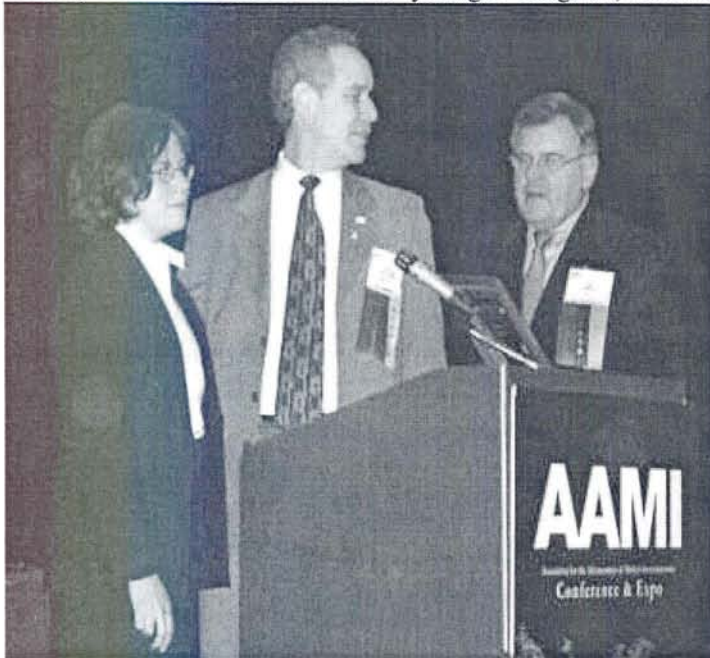


ACCE News

Vol. 12, No. 1 – January 2002

Bob Morris honored as the first recipient of the AAMI Foundation/ACCE Robert L. Morris Humanitarian Award

Bob Morris was posthumously honored as the first recipient of the annual humanitarian award that now bears his name at the AAMI Awards Luncheon in June of 2001 in Baltimore, Maryland. Ms. Julie Morris, Bob and Colleen Morris' younger daughter, received a check for \$1,000 and the inaugural plaque with Bob's name on it. Julie expressed her family's appreciation for honoring her father by creating this award in his name, and for recognizing Bob's humanitarian efforts and his passion for clinical engineering. The award was presented to Julie by incoming ACCE president, Elliot Sloane, on behalf of the entire AAMI and ACCE community. Joining them during the award presentation were Dr. Andrei Issakov of WHO, Antonio Hernandez, of PAHO, and Joe Welsh of Carelift International to announce additional letters of recognition and awards in Bob Morris's name. In recognition of Bob's longstanding support of the WHO and PAHO programs, those organizations have



Julie Morris, Elliot Sloane, Bill Betts

programs, those organizations have

American College of Clinical Engineering

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21 Bob's Lane Setauket, NY 11733

ACCE News

ACCE Mission

1. To establish a standard of competence and to promote excellence in Clinical Engineering Practice.
2. To promote safe and effective application of Science and Technology to patient care.
3. To define the body of knowledge on which the profession is based.
4. To represent the professional interests of Clinical Engineers.

Web - Accenet.org

President's Message

Elliot B. Sloane, Ph.D., ehsloane@villanova.edu

A Spoonful of Sugar...

My prior message reminded you not to take our medical miracles for granted. This time, I will share another positive message, based on 30 months of close personal observations with friends and family on the receiving end of the healthcare system. Believe me, I've seen some of the worst and best. This message will focus on the best, and I'll tell you its name up front: Thomas Jefferson University Hospital in Philadelphia. This is a hospital that remembers the "care" half of "patient care." The nurses do not disappear when needed and make time to listen, do the bathing and toileting chores kindly and on time, honor food requests promptly, and hold patients' hands and offer comfort. Even the orderlies and aides take the time to smile at the patients and share words of encouragement at every opportunity. Having spent similar blocks of time at several other local health systems, I can tell you that the caring and quality at TJUH is heads and shoulders above most of the rest.

Oh, yes, they provide excellent medical care, too. The doctors actually listen to patients and answer their questions. They reply to family questions, calls and emails, and they reconsider their opinions in the face of other expertise and new information. When the nurses cannot answer a question, they locate the doctor and follow through on their word to get the question answered. The doctors are confident, but are not too arrogant to recommend other facilities or physicians when they believe other care might be better for the patient than what they have to offer themselves. Honest. Effective. Efficient. Impressive.

It is an incredible contrast to some of the other prestigious facilities where I have watched patients be hurt and abused during the same period, but I'll hold that discussion for another place. For now, I'd like to pose this question: Why is TJUH different? After all, they do not charge any more for their services, they hire from the same

community of aides, nurses, and doctors, and they do not possess magic technology that others lack.

There is a one-word answer: Leadership. In my experience, an organization takes on the values and behavior of its leadership by not-too-simple a process. Leaders reinforce their values by rewarding and promoting behavior they like, and punishing behavior they don't. Over time, an organization shapes to the leader's values or the leader leaves. In TJUH's case, Tom Lewis has been the CEO for well over a decade, and some on his management team have also enjoyed long tenures. Many of you know several of those managers well: Ira Tackel, teammate Dave Bell, and the department's founder, Phil Katz, who is no longer there. Excellent leaders like Tom Lewis demonstrate loyalty, vision, commitment, compassion, and competence. That, in turn, inspires the very best from layer after layer of supervisors, which eventually sets the tone for new employees.

I have known all four of these remarkable men, and can tell you that each one demonstrates his convictions by actions, not just words. For example, in the past decade, Tom, Ira, and Dave have provided time and resources for local and international healthcare and education programs despite the economic pressures they caused. The reward for them seems to have been the strong loyalty, enthusiasm, and competent performance that their TJUH staff gives every day.

I think we should take our hats off to Thomas Jefferson University Hospital. While they have their own share of challenges and flaws, they are pretty damn good, and are getting even better. We should thank them for showing us that success in today's healthcare marketplace is not an illusion. For the right team, it is an achievable goal. Let's learn everything we can from their sterling example of excellent leadership in healthcare. We need to make this the rule, not the exception.

Have a great winter. - Elliot



Elliot Sloane

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Editorial - Bad Medicine

Elliot B. Sloane, Ph.D., ebuloane@villanova.edu

My resolution: 2002 will be the Year of the Clinical Engineer! I think that we Clinical Engineers have to seize the moment, and recommit ourselves to addressing the medical error debacle. My view is that the ingredients are in place for being forced to confront the worst year of medical incidents that we have ever seen, and I don't think that there is anywhere to hide. If we are complacent, our children, our parents, and our community will continue to be hurt and killed. We should make this the year for our growth and success as a professional community.

Why do I feel so strongly? First and foremost, I am hearing feedback from College members about internal institutional financial stress that is worse than ever before. Layoffs, wage rollbacks, staff shortages, and other draconian problems are affecting every segment of healthcare. Medical and insurance costs are soaring, but coverage is being reduced or withdrawn from large segments of our society, including our elders and our newly unemployed. From decades of experience, I see these factors as catalysts for disaster. Further, in the past few years I have also personally watched a helpless post-surgical patient dropped from a patient lift, observed a hospital-based infection create a permanent invalid out a healthy adult, and have had to fight endless battles to shield friends and family members from dangerous clinical interventions due to incompetent and inadequate processes. Other ACCE colleagues have been reporting dramatic increases in the number of expert witness requests, and if you have the stomach to read the financial news, you'll read about medical malpractice liability funds that are falling into bankruptcy. All of this is handwriting on the wall, from my perspective.

Who is at fault, and whom should we blame? Well, I think the answer is the same one found in the Pogo cartoon from Earth Day in 1971 (see www.planetwaves.net/pogo.html). Pogo takes an honest look at a polluted forest and states the obvious: "We have met the enemy and he is US!" I do not think there will be any major progress in the war to improve health care unless we 'fess up to the fact that we are all to blame for the problems, from bottom to top. Until we have the courage to say that, and assist that our colleagues in doing the same, healthcare will continue to make, and bury, its mistakes.

ACCE Welcomes New Members

The following are the new ACCE Members elected during the period October 2001 through December 2001. Congratulations and welcome!

- Thameen Ansari
- Darrel Crosswell
- Douglas K. George
- Diane Bihary

We all know that in truth, the main problem is a human one. Virtually every authority continues to cite human error as the dominant culprit. On reflection, though, I do not think that is nearly honest enough. Yes, people do make the majority of the mistakes, BUT you and I know these particular people, don't we? The vast majority of them are good, decent people who worry about providing for and protecting their own children and parents. They got to into healthcare originally to help people, not hurt them. I truly believe that doctors, nurses, administrators, technicians, salespersons, AND engineers get up every day wanting to do the right thing and to make a difference in patient's lives. Maybe you don't believe that, considering the daily harm that is being done, but I do. Think it over, though. Do you think that human nature is such that people could get up and go to work every day if they truly believed that they were going to be hurting and killing their patients. I think that the need for people to believe in what they do is actually the root of the problem AND the fulcrum point that will help us do the heavy lifting of this battle.

Could it be that the root of the problem is that most people in healthcare are getting by from day to day by deluding themselves, pretending that THEY are doing the right thing and that the problem is everyone else's? After all, denial is the first stage of grief, and the human mind has a remarkable capacity to mask reality for self-protection. Don't get up on your high horses about your department and staff, friends. I know that we are trying our best, but I think we also know that has not been good enough, either. I suggest that we also start considering the possibility, and the responsibility, that we could do better. In order to change the outcome in healthcare, Clinical Engineers need to adopt a new strategy that puts us in a position of responsible leadership to fix the problems. That means that the solution starts with us, folks, not with our institutions or even our professional associations.

I have no illusions about this process, though. It is likely to be a 5-10 year effort, but so what? If we don't start now, it may never happen! How do we make this a watershed year, then? In the next newsletter, I'll give you some suggestions about how we can succeed. Please email me YOUR ideas in the meanwhile, and let me know if YOU are willing to take an active role in ACCE leading the way to resolving the medical error problems that we face! (president@acce.org).

Clinical Engineering Without Clinical Engineers

Tom O'Dea for the ACCE Advocacy Committee

The Jan/Feb 2001 issue of *Biomedical Instrumentation and Technology* (BIT 35 (1): page1) contained an ad for a Director of Biomedical Engineering. While any open position is reason for encouragement, one of the requirements quoted was "a Bachelor's degree in Medical or Electrical Engineering (Master's preferred), certification and graduation as a medical equipment repairman etc.". This leads the reader to question whether the individual author of the ad, or the entire industry, is using the terms "clinical engineer", "biomedical engineer" and "biomedical equipment technician" interchangeably. Similarly, departments or supervisory units responsible for clinical equipment are referred to as clinical engineering or biomedical engineering departments. Of more concern is the fact that the leadership of such departments seems increasingly to reside in people who meet the definition of clinical engineer, i.e.,

"A professional who supports and advances patient care by applying engineering and management skills to healthcare technology."

only loosely. For example, in the salary survey for the 1998/1999 fiscal year published in the July/Aug 2000 issue of the *Journal of Clinical Engineering* (JCE, Vol. 25, #4, pp. 219-234), six of the nine respondents termed 'Clinical Engineering Supervisors' had only associate's degrees. Of the fourteen respondents in the category of "clinical engineer", four had only associates degrees or 'certificates'. Finally, of the "directors of clinical engineering departments" responding, less than half had bachelor's degrees or higher. No wonder then that the job posting showed such confusion. Where would these people get their "engineering skills?"

Well then, does it matter? The distribution of job duties in the JCE between BMET supervisors, clinical engineering supervisors, and clinical engineers were similar except for personnel management functions. Indeed, average salaries for these job classes seem to be approaching each other, as clinical engineers' salaries were basically flat, supervisory clinical engineers' salaries were decreasing, and all categories of BMET salaries were increasing at a 5-6% annual

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rate. The industry seems to see little difference in the CE or BMET and thus may be opting for the lowest cost option.

How about the area of Technology Management? AAMI is interested in a credentialing process for technology managers, while supervisory level BMETs and clinical engineers both claim to fulfill this function at present. The influx of MBAs, either in addition to or in place of BMET or clinical engineers, indicates that knowledge of technology is being superseded by management skills in the healthcare setting.

A final complication is the confluence of information technology and medical instrumentation support. Sessions on inserting the BMET or CE into the IT environment abound at AAMI conferences, while IT personnel are already vitally involved in medical technology.

Confusion abounds! Clinical engineers are declining in both numbers and salary. Could this presage the replacement of certified BMETs with more generalized technicians?

I think that clinical engineers in the strict sense, that is, degreed engineers meeting the above definition, bring added value to the traditional clinical engineering activities of technology management, equipment and system support, and evaluation and minimization of patient risk. In addition, clinical engineers add entire new areas of equipment development and system interface to the value of the clinical engineering department. Indeed, without clinical engineers, the advancement of medical instrumentation is severely impeded. Thus, by AAMI advocating for clinical engineers, it is only fulfilling its stated mission of advancement of medical instrumentation.

In the area of technology management, clinical engineers are uniquely equipped to determine which innovations are the most efficacious and cost effective for a health care institution. Clinical engineers understand the physical environment, medical procedures, and staff abilities from an unbiased technical viewpoint. In addition to evaluating technology, the clinical engineer has the education and experience to seek out and understand innovative technologies. That's why they read BIT and attend networking opportunities such as AAMI meetings. There is no on the job training for this; no service schools; only application of engineering principles and practical knowledge.

Once a new system becomes part of the patient care environment, systems for environmental support,

staff education, effective use, infection control etc. must be set up. These are individual to the health care institution. For highly technical systems, the clinical engineer is the in the lead in this endeavor and needs maximum credibility for effective action. Thus proper credentials are essential.

Part of the aforementioned support system is a strategy for preventive and corrective maintenance. Here the clinical engineer works in cooperation with BMETs for the maintenance system that best suits hospital operations. At this time, service education may be provided. Without a strong clinical engineer, the efforts of BMETs are hindered by the lack of overall technical leadership and effective training. Indeed, expensive training may be wasted if the total environment is not cultivated.

Finally, unique to the clinical engineer is the assessment of patient risk in the technical environment. While medical error and harm have been heavily emphasized recently, overemphasis of risk leads to wasted resources. Electrical safety and 'Y2K' exemplify this overemphasis. Again, an overall knowledge of technical principles and the hospital environment, as opposed to specific service knowledge, is required for proper balance.

Education in all these areas must be provided to administration and medical staff as well day to day users. Credibility, experience and broad systems knowledge are required of the technical educator. Again, the clinical engineer has the tools for this role in the healthcare institution.

The clinical engineering department purports to supply all of the above, but I fear that without a clinical engineer as defined above at the helm, the depth to which the department can fulfill these needs is not sufficient. The "pure" administrator, lacking these requisites, is especially vulnerable unless closely supported by unbiased clinical engineering expertise.

Thus I believe that a clinical engineering department needs a clinical engineer with sufficient experience in the particular institution to know staff capabilities, the physical environment, the medical instrumentation systems and the needs of the patients. I believe that all involved in medical instrumentation, industry as well as clinical, will benefit from such an involvement.

I hope that this adds some clarity to the discussion.

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Certification Update

January 2002 Report from the U.S. Board of Examiners

Caroline Campbell, Chair,
Caroline.A.Campbell@MedStar.net

The US Board of Examiners for Clinical Engineering has completed its initial review of the National Organization for Competency Assurance (NOCA) standards that define appropriate and valid structures and methods for accreditation bodies. These standards essentially provide a roadmap for establishing and maintaining a credible certification program. An ad hoc committee of the USCC is also reviewing each standard to determine if any changes in the wording is needed to make them more applicable to medical technology professions, how the certification programs under the USCC umbrella should demonstrate compliance, and appropriate timelines for compliance. The ad hoc committee will finish its work on January 4th and make a presentation to the USCC on January 11th. The Board of Examiners will outline its work plan with timelines for the USCC at the January 11th meeting. Revisions to this work plan may be necessary based on the outcome of the ad

hoc committee's review of the NOCA standards; however, the Board has structured its work such that this can be easily accomplished. *It is exciting to see the momentum of this process build!*

With the draft work plan in place, the Board has begun developing policies and procedures including revision to the constitution and bylaws, policies covering examination processes, security and confidentiality, and discipline. The Board has also purchased a software package, Random Test Generator Pro, produced by Hirtle Software to assist in management of the developing examination questions. Development of questions is proceeding through interviews with content experts for pertinent subjects identified in the January 2001 body of knowledge survey. The Board has adopted Bloom's taxonomy as its exam question structure. Bloom's taxonomy is a categorization of the types of questions that can be developed to test a person's knowledge recall, ability to comprehend or apply knowledge, to analyze or synthesize information, or to judge the value of material for a given purpose. Use of Bloom's taxonomy enables the Board of Examiners to provide a thorough assessment of a candidate's competence, to equivalently randomize questions from the question databank for a particular individual's exam, and to ensure appropriate replacement of questions as the body of knowledge changes over time.

HealthTech



ACCE is an educational partner for Clinical Engineering Sessions at HealthTech 2002, in Baltimore, Maryland on April 21-23. Sessions are planned to cover topics in JCAHO, HIPAA, ISO9000, Managing Radiology Service Contracts, Disaster Planning, and the Future of Clinical Engineering. ACCE will also have a booth at HealthTech and a general membership meeting.

To learn more about HealthTech 2002, go to www.healthtechnet.com. Baltimore is a great conference venue. Mark your calendars now! When registering, be sure to identify yourself as an ACCE Member to assure the lowest registration fee.

Come To AAMI 2002 With ACCE



Come join ACCE for 4 days of learning and fellowship at AAMI 2002 in Minneapolis MN. ACCE is an educational partner of the AAMI annual meeting and ACCE members have been heavily involved in the planning committee for the annual meeting, to assure that the educational program will be relevant and timely for clinical engineers.

The highlight of ACCE's activities will be the Annual Symposium on Saturday, June 1st. This year's topic is of critical importance to clinical engineers.

Perspectives for Successful Leadership in Clinical and Information Technology Services

ACCE will also be hosting a reception and annual meeting for members – a great chance to catch up with old friends and to make new ones! ACCE has arranged for its members to receive a discount on registration fees. For more information on the Annual Symposium or the AAMI 2002 annual meeting, go to www.aami.org or www.ACCEnet.org. See you in Minneapolis!

On the Move and In the News

Dyro Selects Top Devices

Joseph Dyro, president of the Biomedical Resource Group (Setauket, NY) will judge medical devices in Anaheim in January 2002. The Medical Design Excellence Awards (MDEA), the premier awards program for the medical technology community, announced that a panel of experts has been selected to judge the entries to the 2002 competition. The MDEA competition recognizes outstanding achievements in medical devices and medical packaging, as well as the engineers, scientists, and designers who are responsible for cutting-edge innovations changing the face of healthcare.

Each year, CANON COMMUNICATIONS LLC selects an impartial multidisciplinary panel of jurors representing engineering, medicine, human factors, industrial design, manufacturing, and other healthcare and design-related fields. Dyro will join the juror panel for the 2002 competition.

Winning products will be announced in the winter of 2002 and honored at a ceremony during the Medical Design & Manufacturing (MD&M) East Conference and Exposition, June 4-6, 2002, at New York City's Jacob K. Javits Convention Center.

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THE VIEW FROM THE PENALTY BOX

David Harrington, davesbt@kersur.net

Well here we are in 2002. Some people projected that because of the Y2K problem we would be back to writing on tree bark and having all sorts of problems with technology. Well they were partly correct, we are having problems with technology, not the Y2K kind but advances coming quicker than most can adjust to them.

At Christmas the grandchildren got toys with more computing power in them than we had for the Apollo program. My kids all have about every gadget known to mankind, all of which will be replaced in a year or two with other gadgets that will also gather dust from lack of use. Sometimes we buy things because of the technology not for what the technology can do for others or us. Thirty years ago the estimate was 14 devices per bed in a hospital, including all the labs and specialty areas. The estimate now is in the low thirties. We have more than doubled the devices, reduced the people that actually have patient contact, while building huge departments of people to support the information systems and technology in healthcare, except for those who are responsible for the application of technology that actually affects patients. We are still only a few, and when technology problems occur guess which group has to solve the problems. It is not finance, information services, administration or risk management but we. Unfortunately we solve the problems then go back into our shells until the next one happens.

Many years ago I presented a paper on the future direction of healthcare technology where I stated that technology would be moving out of hospitals into the home. That paper was long forgotten until a neighbor had a stroke and other medical problems. He came home after hospital and rehab stays with IV pumps, leg compression unit, respiratory support, dialysis and enough drugs to bring profits to most of the drug companies. The caregiver, who raised 4 sons, was totally confused as to what could be used when, why the circuit breaker in the house kept popping, and what, if anything, all the alarms meant. In trying to simplify the mix of equipment it became very clear that the

company supplying the equipment was more interested in billing than the quality of care provided by that equipment. One IV pump for a medication that was to run over night had an alarm that went off every time the patient moved; so much for a restful sleep. A simple change in pressure alarm settings eliminated this problem. The leg compression unit, again to be used overnight, had a cycle buzzer that went off on every cycle. Clipping a wire supplying power to the buzzer brought peace and quiet. Just about all the devices needed a little adjustment to suit the patient and allow the caregiver some rest. I was not sure if this was an isolated incident or not so I did a little digging. The company that provided the equipment employs no biomedical engineers or technicians to do repairs and regular checks on equipment but if a device fails it calls a local ISO or the manufacturer for repair services. The company has one "home care trainer" to work with the care giver and is scheduled for 30 minutes on the day the patient comes home and 30 minutes in 10 to 14 days. The people delivering and setting up the equipment cannot do in-services, as they are minimum wage people with no formal training. This is the next area that Clinical Engineers and Biomedical Engineering Technicians will have to get involved with as the population ages and more healthcare is done at home in less in hospitals.

Some 50 plus years ago I can remember the family coming together to care for a terminally ill family member at home because hospitals were either not around or too expensive. Back then most people died at home in the care of family members. Is history repeating itself? I hope not!



The AAMI Foundation/ACCE

Robert L. Morris Humanitarian Award

Award Guidelines on behalf of The Manuel and Beatrice Sloane Foundation and the American College of Clinical Engineering in the name of the following perpetual award:

**AAMI Foundation/ACCE
Robert L. Morris Humanitarian Award**

1. The initial funding was \$14,000 to the AAMI Foundation with the goal of the ultimate funding should be around \$20,000 to make it a perpetual award.
 - a. ACCE would like to receive a list of donors so that ACCE and the Robert L. Morris family may personally thank them. The ACCE Board of Directors would like an annual summary of donations by March of each calendar year, so that appropriate written acknowledgements can be sent prior to each award presentation.
 - b. ACCE and AAMI will promote this award in hopes of obtaining further donations.
2. If the funding exceeds what is required to continue a perpetual award, AAMI and ACCE will meet to review and establish similar awards or other methods of honoring Robert L. Morris' memory.
3. If the award is ever terminated based upon a joint decision between the AAMI Foundation and Manuel and Beatrice Sloane Foundation, the remaining funds will be returned to a properly qualified foundation that is acceptable to the Manuel and Beatrice Sloane Foundation and follows the general guidelines provided in the award. In the absence of any such foundation over a two-year search period, the funds may be transferred to the Pan American Health Organization's Health Technology Management program in the names of the AAMI Foundation, ACCE and Robert L. Morris.
4. In the event that ACCE establishes a 501(c) 3 tax-exempt foundation, the Manuel and Beatrice Sloane Foundation may request that the funds be transferred to that foundation. The AAMI Foundation will not unreasonably deny or delay the transfer of funds if such a request is made by ACCE.
5. The award will be given at the AAMI Annual Conference to one recipient who meets the following criteria:
 - i. *Must be an Individual whose humanitarian or education efforts have applied health technology to improving global human conditions in developing countries. In general, clinical engineers, biomedical equipment technicians, and radiation physicists might be given preference, in honor of Robert M. Morris' career, but other scientific and clinical educators, practitioners and researchers who meet the general humanitarian and global health care criteria are acceptable.*
 - ii. *Must be able to show specific and outstanding contributions that clearly demonstrate from a technology standpoint, activities that have had a specific and substantial impact on improving global health care or related conditions;*
 - iii. *Each award nominee must be acceptable to the AAMI Foundation and ACCE Board of Directors and not in conflict with the mission of AAMI Foundation, ACCE, or the reputation and perceived mission of Robert L. Morris.*
6. The award funds will be used for plaques and \$1,000 honorarium. If future funding allows, the AAMI Foundation and ACCE Board of Directors may decide to either increase the honorarium and/or increase the number of awardees.
7. Travel and lodging for the next two years will be paid by WHO/PAHO based upon the letter sent to the AAMI Foundation.

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8. Future travel and lodging costs will be reviewed by ACCE, WHO, and PAHO for supplemental support.
9. The AAMI Awards Committee will select the recipient annually based on the nominations collected from AAMI and ACCE memberships. A Call for Nominations (to include the eligibility criteria) will be published in AAMI and ACCE publications several months prior to the AAMI Annual Conference, allowing sufficient time for discussion, decision, and publicity prior to the conference.
10. The Award will be presented jointly by representatives of ACCE and the AAMI Foundation unless one or the other organization declines to provide such representative.
11. Each plaque and award letter shall bear the full name and logo of the AAMI Foundation and the ACCE.

ACCE's 2002 Robert L. Morris Humanitarian Award Donation Challenge

Over \$14,000 was raised for the AAMI Foundation's Robert L. Morris Humanitarian Award, plus additional travel funding for next year's recipient from our good friends at WHO and PAHO. In order for this annual award in memory of Bob to be fully self-funded in perpetuity, we need to raise at least an additional \$6,000. To help us achieve this goal, the Manual and Beatrice Sloane Foundation has offered to match ACCE member donations, dollar for dollar, until that goal is reached. Please use your ACCE membership renewal form to make a generous donation to this fund, and help us ensure this award has is funded forever. Thank you for participating in our effort to commemorate Bob's unique friendship and his passion for Clinical Engineering. (Jennifer Ott – Chairperson, ACCE's Robert L. Morris Award Committee)

Morris Award (*continued from page 1*) – generously offered to donate travel funds for next year's Robert L Morris Humanitarian Award recipient. Carelift International presented one of their Directors Fund Award plaques in Bob's name, along with a commitment to provide a personal computer to a Red Cross Hospital in Mexico in Bob's name and a donation to the Morris award fund. Julie was kind enough to spend time with the ACCE board and meet with Bob's friends during her visit from Portland, OR.

She told us that her family was deeply touched by our collective efforts to honor and remember her father. Her mom was too overwhelmed to join us, but Julie did a great job on the family's behalf. She is warm, bright, and articulate, and is a credit to Bob and Colleen. Our thanks go to the AAMI board and staff for facilitating this award and arranging for Colleen's travel. Also, special thanks to George and Arlene Johnston for picking Julie up at the Baltimore Airport and making sure she got to meet everyone!

Management and Maintenance Of Medical Equipment in Vanuatu

Dr. Juliette E. Cook

The national health service of the Republic of Vanuatu provides for a population of 200,000 scattered over an archipelago of 80 islands. Vanuatu is Melanesian, located in the South Pacific Ocean, 1600km north east of Australia. The country has 5 hospitals ranging from 50 to 150 beds and a network of health centers, dispensaries and aid posts to serve the rural communities. There are approximately 2000 items of medical equipment on the Ministry of Health's inventory, ranging from x-ray fluoroscopy, diagnostic ultrasound and laboratory analyzers to incubators, sphygmomanometers and anesthetic equipment.

The Republic of Vanuatu is a developing country ranked 125 out of 174 in the United Nations Human Development Index (1999). Eighty percent of the population lives a subsistence lifestyle in rural and often isolated communities. Malaria and other vector borne diseases are rife and there is a high incidence of child mortality, approximately 100 deaths per 1000 live births. The Ministry of Health is heavily dependent on foreign aid to fund the provision of its health services.

As is all too common in developing countries (and developed countries too), maintenance of the health facilities and medical equipment in Vanuatu is extremely under resourced. There is a shortage of experienced maintenance technicians and a paucity of tools and spare parts. The Ministry of Health employs just one permanent maintenance officer. The remainders of the maintenance team are casual labor. The care of medical equipment, buildings and vehicles at each hospital is carried out by a team, typically consisting of a mechanic, an electrician, a plumber, a fitter and a grounds-man.

The difficulties of maintenance are further compounded by the acquisition of inappropriate equipment. Vanuatu often receives unsolicited donations and has a diverse inventory of manufacturers and obsolete models. Clinical personnel often damage equipment through incorrect use. There is no recurrent budget allocated for consumables and spare parts. Frequently equipment is subjected to harsh environmental conditions including high temperatures

and humidity and erratic power supplies (if electricity is available at all). The list is endless.

The Ministry of Health recognizes these problems and has identified the need to improve maintenance in its National Health Plan. To address this issue a National Policy for the Management of Medical Equipment has been developed and is being implemented. The most important aspect of this policy is the acknowledgement that maintenance of medical equipment is not purely a technical problem, but a management issue. For example a poor decision made by an administrator when acquiring new equipment will probably result in poor performance and maintenance of the equipment at a later stage.

The policy was developed by a multidisciplinary team of administrators, finance, clinical, and technical staff. It has been continuously supported by the executive committee of the Ministry of Health. A wide range of Ministry of Health employees, across various sectors and each province, donors and aid agencies were consulted and had an input during the policy's development. The National Policy for the Management of Medical Equipment covers the life cycle of medical equipment from the time a decision is made to acquire something new through to the end of its useful life when it is retired from service.

The first sections of the policy cover the planning process. It details certain criteria that must be satisfied prior to obtaining equipment. The criteria include identifying a clinical need and qualified users for the equipment. This ensures that only useful equipment that can be properly utilized is acquired. Historically Vanuatu has been offered and accepted items for which there is no clinical need or suitably qualified staff to use it. The result is redundant or misused equipment, which is both frustrating and dangerous to staff and patients.

The policy also covers the procurement process. It includes the criteria that must be specified on a purchase order or satisfied before accepting a donation. It includes obtaining a 2-year supply of consumables and spare parts, operating and service manuals, maintenance and user training and appropriate service

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and warranty arrangements. These should ensure that the maintenance team is equipped with the necessary resources to perform preventive and curative maintenance work on the equipment.

Perhaps the most important part of the planning and procurement process is that the policy states that the national Biomedical Equipment Management Committee must approve items before acquisition. This is a multi-disciplinary team comprising hospital administrators, finance, planners, technical services and clinical and allied health staff. They each contribute their field of expertise when considering and planning for new acquisitions. They ensure that the criteria specified in the policy are fully satisfied.

The National Policy for the Management of Medical Equipment also includes sections covering the inspection of new equipment, maintaining up-to-date inventory information, establishing a central technical library of manuals, commissioning and monitoring equipment and retiring equipment from service.

ACCE Board Meeting Highlights October 17, 2001

President's Report (Elliot Sloane)

Steve Grimes agreed to take chair the membership committee and has formed a committee.

Jim Keller will serve as Newsletter Manager. New material is always welcome for the newsletter.

Potential areas for involvement of At-Large Board Members in the ACCE activities include: (1) Topic generation for future teleconferences; (2) Promotion of teleconferences; (3) Symposium co-chair; (4) HealthTech Co-chair; (5) Membership survey tabulation and report

Pursuing growth and strength issues and opportunities, October 2 teleconference to establish relationships between BMETs, CEs, and academics was positive. Jim Keller suggested that ECRI and ACCE work together on some of the common activities.

Steve Grimes suggested a formation of the HIPAA Task Force.

It was suggested that those members that have achieved the Fellow status could be potential candidates for

It seems likely that Vanuatu will continue to be reliant on foreign aid for many years to come. Currently Australia is funding a Pacific Islands project, aimed at strengthening the technical capacity of hospital maintenance staff and assisting with the implementation of maintenance procedures. The World Health Organization is also actively supporting the implementation of the National Policy for the Management of Medical Equipment in Vanuatu. The co-operation and continuing commitment of the Ministry of Health and aid agencies to improving the management of medical equipment should enable Vanuatu to make better use of its limited resources. Maintenance services should gradually become more effective as a consequence of its policy and hopefully the delivery of health services in this part of Melanesia will be improved.

Juliet Cook is Maintenance Advisor, Manica Integrated Health Project, Mozambique. She was National Biomedical Engineer, Ministry of Health, Republic of Vanuatu from September 1998 to December 2000.

Emeritus Status. ACCE could stipulate an obligation to be active members in teleconferences, symposiums and others.

President's Elect's Report (Raymond Zambuto)

Frank Painter sent the "final" version of the WHO Memorandum of Understanding to Andre Issakov and is awaiting a response.

HealthTech agreement signed. A. Levenson, S. Grimes, R. Zambuto and B. Wang will make four presentations. One open session related to patient safety.

AAMI agreement was received from Shirley Nycum and is under review. Binseng Wang and Jim Keller will chair a session on regulatory issues at AAMI02.

Ray's committee responsibilities include: Advocacy, Membership, International, Bylaws, Nominating and HealthTech. Ted's responsibilities include: AAMI Liaison, Newsletter, CCE Committee, Education, and Annual Symposium.

First draft of the Fall Member Survey was e-mailed to all for review.

Past President's Report (Jennifer Ott)

Issues related to commercial usage related to the Secretariat were discussed.

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ACCE Board Meeting Highlights December 19, 2001

Criteria for Bob Morris Humanitarian Award were discussed. Yadin David agreed to chair a committee to pursue 501 (c)(3) Foundation.

Jennifer discussed the FDA MedSun (Medical Product Surveillance Network) announcement. This product is designed to collect data on adverse events and situations indicating potential for harm associated with medical devices.

Treasurer's Report (Henry Montenegro)

Financial reports discussed by all present.

Ways for generating capital need to be discussed. Exec committee will review any potential suggestions and finalize the 2002 budget by December.

CCE Committee Report (Frank Painter)

The structure of the exam is currently under review. Application has been approved and will soon be available for advertising. Favorable review of ACCE was reflected in USCC June meeting minutes.

Membership Committee Report (Steve Grimes)

Ricardo Silva and Frank Boals recommendation for membership approved.

Education Committee Report (Jim Wear)

The ACEW Syllabus is still with Andrei Issakov at WHO. No feedback has been received yet and according to the contract it is required to complete the project.

There are 29 sites that are participating in one or more of the teleconferences in the 2001 Teleconferences Series. Eight sites are signed up for the entire series. The projected income is a record \$15,905.

International Committee Report (Tom Judd)

ACEW workshops in Costa Rica, Peru, and Brasilia are set for next year.

In June 2001, ORBIS offered to sponsor mini-International memberships for several years. Ricardo Silva would be the point person for these activities.

Newsletter Report (Joe Dyro & Jim Keller)

Jim Keller and Joe Dyro are implementing procedures for facilitating newsletter production.

Other Business

Jim Keller was invited to an FDA-sponsored teleconference related to nurses' concerns over medical errors. He suggested to the FDA the appropriateness of ACCE's involvement.

Jim Keller informed all the Board members of AHA's central focus on bioterrorism and disaster planning for their 2002 agenda.

President's Report (Elliot Sloane)

The Medical Errors paper has been finally released, however the Board members would like to see this activity continued. The ACCE Board is proposing to continue the Task Force on medical errors and is looking for a new champion. Please contact Matt Baretich if you are interested.

At Large Board Members have expressed great interest in pursuing different activities within the ACCE organization, such as member surveys, Symposium and HealthTech activities, International activities, teleconferences and the Newsletter.

ACCE is actively pursuing collaboration and support of different BMET organizations by organizing teleconferences with their representatives across the country. Relationships with ASHE and other BE associations have already been started.

President's Elect's Report (Raymond Zambuto)

ACCE is still awaiting feedback from Andre Issakov on the letter for the WHO Memorandum of Understanding. This will develop procedures on future WHO/ACCE relationships. Elliot will follow up on the current status of this activity with a formal letter.

Preparations for both HealthTech and AAMI are going according to schedule. Ray and Ted will contact Shirley Nycum regarding more substantial advertising of ACCE within AAMI publishing.

Ray has completed the membership survey and forwarded the finalized copy to Matt Baretich. Surveys will be sent out at least 7 days ahead of the membership renewals.

Vice President's Report (Ted Cohen)

Last AAMI Newsletter briefly made reference to the ACCE Symposium at the AAMI conference in 2002.

Past President's Report (Jennifer Ott)

Matt Baretich continues to send Secretariat logs to Izabella that she then presents at the Exec Board meetings. The logs include information on Secretariat's up-to-date activities.

The guidelines for the Bob Morris Memorial Fund are currently under revision. Brian Porras has received a check for \$600 from the NCBA (North Carolina

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Biomedical Association) symposium, which will go towards the Bob Morris Memorial Fund.

Yadin David is leading the effort to establish the 501 (c)(3) Foundation and already has a group together for this activity.

Jennifer will work with Brian Porras on the nominations.

Secretary's Report (Izabella Gieras)

The ACCE Historian database listing all the past ACCE officers and board members provided by Jennifer will be updated and maintained by Izabella.

Treasurer's Report (Henry Montenegro)

The Board has unanimously approved proposed 2002 budget.

CCE Committee Report (Frank Painter)

The CCE certification exam will be finished by the AAMI conference in 2002.

Membership Committee Report (Steve Grimes)

ACCE Board unanimously approved four candidates for membership: Thameen Ansari - Individual; Darrel Croswell - Individual; Douglas K. George - Individual; and Diane Bihary - Candidate.

The committee recommends the following changes to be made to ACCE's membership application: Online form on the ACCE website: remove reference to "Fellow" as this might not be appropriate on a new member application; list each membership category (candidate, associate, individual) on separate line preceded by check box as this might encourage a less ambiguous response by potential new members; will also correct miscellaneous spelling and grammatical corrections. The reference to "Fellow" will also be removed from the paper form.

The committee recommends the following membership drive activities: 1. The membership chair corresponds with current Candidate and Associate members to encourage them to examine their current experience level and credentials and consider their membership level to Individual where appropriate; 2. The membership chair corresponds with former College members to encourage them to rejoin as active members; and 3. The membership committee (Frank Painter and Steve Grimes) obtain list of clinical engineers from relevant sources and prepare a letter encouraging clinical engineers to join ACCE. Objective is 50 letters per year.

The committee recommends the adoption of an "Emeritus" membership category whose qualification

should be an Individual or Fellow member who (1) has been recognized for distinguished service to the profession or achievement in the field of Clinical Engineering, (2) has at least five continuous years membership in-good-standing in The College and (3) has reached the age of 62 and retired from full time employment in the profession of Clinical Engineering. The Board voted to present revised Bylaws (incorporating these recommendations) to a vote by the general membership at the earliest opportunity.

Proposal to address HIPAA issues as part of the HIPAA Task Force has been sent out prior to the meeting. List of potential committee candidates has also been proposed. Following a discussion, it was concluded that the ACCE Bylaws do not preclude non-members from participating as committee members. The Board unanimously voted to establish the HIPAA Task Force as an ad hoc Committee (Steve Grimes, chair) in accordance with proposal.

Education Committee Report (Jim Wear)

The 2001 teleconference series continues doing well and will be completed in January. Twenty-nine sites have participated this year and the income is a record \$16,155. Thanks go to Al Levenson for all his hard work and diligence in recruitment.

International Committee Report (Tom Judd)

Antonio Hernández advised the Board of requests for invited speakers to Caribbean locations and the expansion of international programs. Changes in personnel took place in ORBIS. Ray will follow up with Tom Judd on the international activities.

Advocacy Committee Report (Tom O'Dea)

A number of responses have been received to the articles published during the summer in *BIT* and *24x7* on the topic of the unique and critical role of clinical engineers in healthcare operations. It was recommended not to respond directly to the articles in *BIT* but to continue the open discussions with other clinical engineering representatives and to establish strong networking links. The Advocacy Committee also recommends that the qualifications for certification be amplified to show that experience is a strong factor in achieving CCE status. ACCE could establish liaison with other groups such as AAMI, ASHE, JCAHO to emphasize the necessary role of engineering as distinguished from management and equipment repair, in the medical error, financial, and advancement of medical instrumentation areas.

Newsletter Report (Joe Dyro & Jim Keller)

Kathy Zaverton accepted the position as the new ACCE advertising manager. Jim is working on more manageable schedule timeframe to set milestones for the ACCE newsletters.

Advanced Clinical Engineering Workshop Havana, Cuba

Yadin David, ybdavid@TexasChildrensHospital.org

The organizing committee and the local clinical engineers, including those from Venezuela, were of great help. Adriana Velásquez and Ricardo Silva were simply wonderful translators. Since they knew the subject matter well, when they translated for the English-speaking faculty, they connected the faculty with the students and, thus, improved upon the presentations field well. Close to 40 participated in the workshop. A mock technology acquisition process worked effectively. In this exercise participants played the roles of those who should participate in technology acquisition, e.g., administrator, financial manager, nurse, physician, and clinical engineer. The Habana Libra hotel had excellent accommodations and facilities. The ACEW occurred during the II Latin America Congress. At the end of each day an exciting cultural experience awaited the participants including Cohibas, the best Cuban cigars, and Havana Club fluids derived from the juice of the sugar cane.

HIPAA Update

Stephen L. Grimes, slgrimes@nycap.rr.com
Senior Consultant & HIPAA Project Manager
Technology in Medicine

Acknowledging that the initial schedule may have been too impractical for many healthcare organizations, the House and Senate each recently passed bills extending for one year the compliance deadline for HIPAA's administrative simplification for electronic transactions and code sets.

HIPAA (the *Health Insurance Portability and Accountability Act of 1996*) required the Department of Health and Human Services to develop a series a rules affecting electronic transactions and code sets, privacy of individually identifiable health information, and the security of a patient's health data. The rules pertaining to electronic transactions and code sets had been finalized and the original compliance date set for October 16, 2002. The new compliance date for this rule is now October 16, 2003. The privacy rule has also been finalized and its compliance date is April 14, 2003. Both the Senate bill (S. 1684 passed on November 27) and the House Bill (H.R. 3323 passed on December 4) specifically state the compliance deadline for the privacy rule remains unchanged.

HIPAA's security rule, a proposed version of which was published in August 1998, has yet to be released in its final form. William Braithwaite, Senior Advisor on Health Information Policy at HHS and the federal government's most visible official on HIPAA issues, told attendees at a HIPAA Summit in Washington, DC in late October that the final version of the security rule was in the process of being signed off on and that he expected publication of the final version before the end of the year. Finalization of the security rule in late 2001 or early 2002 will automatically establish the rule's compliance deadline at a date falling late in the first quarter or early in the second quarter of 2004.

HIPAA's rules promise to substantially transform all aspects of the healthcare process. The security rule, in particular, will have a major impact on the future of clinical engineering services. Because of HIPAA's impact and because 2 years does not provide an abundance of lead time to achieve compliance given the scope of preparation that must be done, the ACCE board voted last month to establish an ad hoc committee on HIPAA. The purpose of this committee is two-fold. First, the committee is to insure that clinical engineering interests are represented when HIPAA policy and implementation issues are debated. Second, the committee will insure that the ACCE membership is kept informed of those HIPAA developments that impact clinical engineering and will provide the membership with guidelines for dealing with these issues.

Calendar of Events

- 11th Annual Event of the American Institute for Medical and Biological Engineering, Feb. 28 – March 3, 2002, Washington, DC. www.aimbe.org/meetings_2002.htm
- HealthTech 2002, April 21-23, 2002, Baltimore, MD. Contact Ray Zambuto, www.techmed.com.
- 5th Annual ACCE Symposium, June 1, 2002, Minneapolis, MN. Contact Ted Cohen, www.accenet.org.
- AAMI, June 1-4, 2002, Minneapolis, MN, www.aami.org.
- 2nd European Medical & Biological Engineering Conference, Vienna, Austria, Dec. 4-8, 2002, www.embec.org.

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Robert L. Morris Humanitarian Award **Call for Nominations**

Nominations for this year's award are due by March 15, 2002.
Please submit your nominations to Jennifer C. Ott, ACCE Past President.
See page 9 of this newsletter for details of the Award.

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