ACCE News

Newsletter of the American College of Clinical Engineering

In this Issue:

President's Message: Marshmallows and the Secret of Meaningful Use

The phrase 'meaningful use' is in my inbox every day and I feel that now there is no escape.   Emails and links to very informative articles asking, "What is it?", "What does it smell like? " and, "Does it come in different colors, and can I load it on my iPhone/NIBP device?" OK, I'll admit that the last one was my question, and if you read my newsletter column from the last issue, then hopefully you've cracked at least a small smile of recognition.

From the $850 billion American Recovery and Reinvestment Act (ARRA), $19 billion is earmarked for the adoption of electronic health records (EHRs) through incentive programs that will give generous payouts to 'meaningful users' of EHRs between 2011 and 2015. These programs, in the form of increased Medicare and Medicaid premiums, expire after 2015.   A "meaningful user" is one that utilizes a certified EHR in a "meaningful" way. The Secretary of Health and Human Services has the task to define the criteria for EHR certification and some of the key areas certainly address e-prescribing and interoperability. Ease of use is decidedly not included in the criteria. The Certification Commission for Healthcare Information Technology (CCHIT) was formed to certify EHRs and they will apply the criteria as defined by HHS once made available in early 2010. Some EHRs are already CCHIT-certified using previous criteria; the 2008 criteria was the latest version for ambulatory products and a 2007 criterion is applied to inpatient systems.

On April 29, 2009, Mark Leavitt, MD, PhD, as CCHIT Chair, testified before the National Committee on Vital and Health Statistics (NCVHS) that "Certification must step up to fulfill a more strategic role, serving not only to reduce risks, but as a dynamic coupling mechanism between advancing policies and the real-world development, marketing, adoption, and use of health IT." This was a brilliant answer to the question "What role does certification play in promoting meaningful use?" since the government still has not defined what 'meaningful use' is yet.

The government certainly isn't lacking for help in defining this all-powerful term. At this NCVHS meeting, 39 'witnesses' offered their opinions and many had made public their positions well before this meeting. Others, like HIMSS and the Markle Foundation have publicized their statements, while the numerous health care blogs have inspired many discussions from the rest of us on what we think. The final definition should help EHR consumers understand what is expected of them and how to qualify for the incentives. As this is a hefty investment for the majority of healthcare providers, many are finding it difficult to evaluate systems without these key criteria. Buy something later and they get a system fully equipped to meet the meaningful use requirement. Buy now and wait and see.

There exists a strong argument to start the purchase process now and there are even some encouraging physician groups to get out there and start shopping saying that the 'meaningful use'

President's Message

definition will not fall outside of most current workflows. And, since any complex healthcare technology purchase can take months or even years to evaluate, there really isn't a lot of time to waste especially those with rebate-like incentive plans attached.

If nothing else, there is value to start researching what products are currently available and how they might compliment the existing workflow, assuming that the institution or physician practice has looked inward and evaluated their own environment. As mentioned above, a CCHIT certified EHR is not evaluated for its ease of use and, since there is no 'one-size-fits-all' EHR product, the institution bears the burden to generate their own list of design requirements and gauge those to the commercially available solutions. IOM and AHRQ both clearly stated that most adverse events in healthcare are born from our own design mistakes and there has never been a better time to learn from our historical errors than now.

CCHIT and HHS both intend to include interoperability as part of the overall criteria for EHRs and meaningful use. The healthcare technology that we occupy ourselves with is a part of this plan. In the past, we knew of the possibility and the savings opportunities not just in costs, efficiency, and quality, but now that possibility is rapidly becoming a reality. But the benefits of that reality are focused so much on the financial benefits that hopefully we don't lose sight of some core values that started us on this path many years ago, namely patient safety.

The IT community is embracing Clinical Engineering because they see how our skills and experience can help them confront the challenges ahead. We can easily assist with analyzing the current technologies for their best fit with current inventory and service models and now seems like the perfect time to offer our hand. In our favor, we are usually stretched across both the clinical and the business ends of the institution that we can speak to both and offer sage advice on how to set priorities.

A 'cocktail chatter' item from Slate Magazine's weekly gabfest, a podcast which makes Italian traffic jams that much more viable, was an article from The New Yorker magazine titled, "Don't! The Secret of Self Control". This article covers a 30+ year psychology experiment at Stanford University based on subjects from the Bing laboratory. In the beginning, children were, one by one, brought into the nursery and presented with a single marshmallow. The researcher gave each child a challenge: eat the marshmallow now if you want, but if you can wait for a few minutes, then you can have two. Some gobbled up the marshmallows before the researcher could start the stopwatch; others applied different strategies to maintain self-control (closed their eyes, thought about something else, etc...). Following these children into adulthood, the results showed those with self-control appeared to be more successful in life, happier, less obese (which strikes me as odd if these were the kids willing to wait for 2 marshmallows instead of 1) than those that couldn't wait to indulge in the confectionary delight. The research analysis continues, but the initial findings discuss the skills of first evaluating the reward structure and then appropriately assigning the focus where it needs to go in order to reach the goal. As we move forward in the next few years, we have the power to strategically navigate the focus our peers so that we can all enjoy two marshmallows: one as the reward of hefty Medicare/Medicaid incentives to keep us all in business, and the other as the reward of safer patient environments.

See you across the waves at AAMI!

Jennifer

Haiku Contest

The haiku, in simple terms, is a 17 sylla-ble poem arranged in three lines of 5, 7, and 5 syllables respectively. The following is an example:

Patient Safety and
Clinical Engineering
Essential Partners

The ACCE Healthcare Technology Foundation is holding a contest for ACCE members to submit a haiku concerning clinical engineering.

The winning haiku will be published in the next issue of ACCE News and the winner will receive a check for $100-courtesy of William Hyman and Ismael Cordero– in addition to a certificate from the Foundation. The winner may choose to instead have the prize money donated to the Foundation in the win-

ner's name. Put on your creative hats! Email your submissions to William Hyman by June 30th at:

w-hyman@tamu.edu

ACCE Events at AAMI 2009

AAMI is just a few days away! ACCE will once again be there with a strong presence. Here is a list of the ACCE-sponsored events.

Clinical Engineering Symposium: Addressing Wireless Challenges in Healthcare Technology Management
Date: Saturday, June 6
Time: 8:00 AM - 12:00 PM
Location: Baltimore Convention Center

(From the AAMI Conference website) The healthcare industry is facing tremendous challenges in regard to wireless technologies and the way they interact with each other. The sheer number and types of devices and the varying number of manufacturers and users lead to ongoing questions about who's in charge and what hierarchy needs to be followed when it comes to supporting and securing the airwaves.

In this symposium, panelists will discuss the scope of wireless device problems and the recent efforts that the technology professionals and the industry are undertaking to address them. Representatives will discuss their perspectives on cost, safety, efficacy, regulation, security, and compliance, and will present their ideas and solutions for improving wireless technology use and implementation in the hospital. Through case study analysis and best practice examples, you will take away valuable information on best practices that you can share with your C-suite and colleagues in your own facility.

Presenters:
Mario Castaneda, CBET, MBA, Kaiser Foundation Hospitals
Leanne Cordisco, GE Healthcare
Rick Hampton, Partners HealthCare Systems
Jennifer Jackson, American College of Clinical Engineering
George Mills, MBA, FASHE, CHFM, The Joint Commission
Michael Robkin, Kaiser Permanente

Special 2-Part Education Session: Current Economic Issues and Their Effect on Healthcare Technology Management
Date: Monday, June 8
Time: Part 1: 2:30-3:45PM
Part 2: 4-5:15PM
Location: Baltimore Conference Center

(From the AAMI Conference Website) In these volatile economic times, hospitals are faced with budgetary challenges that haven't been seen in this country for generations. Finding ways to trim budgets and do more with less is essential to a healthcare institution's very survival. This timely two-part session will provide invaluable ideas on ways to trim expenses without negatively affecting services. You'll hear from numerous perspectives including biomeds as well as from a Senior Vice President and CFO. You will have the opportunity to share your ideas with industry leaders and many biomedical and clinical engineering colleagues from across the country regarding ways to survive and cope with mandated budget reductions, staff downsizing, and greater workloads. The ideas you will get and the networking you will do in this session, can make a tremendous difference to your hospital and your career.

Presenters:
Britt Berek, MBA, CCE, CHFM, CPMM, ARAMARK Healthcare
Craig Fleischmann, University of Maryland Medical Center and University Specialty Hospital
Patrick Lynch, CBET, CCE, MBA, Global Medical Imaging
Keith D. Persinger, University of Maryland Medical Center and University Specialty Hospital

ACCE Annual Meeting and Reception
Date: Sunday, June 7
Time: 7-9PM PM
Location: Baltimore Marriott Inner Harbor, University Ballrooms 2-4

Come join us to network and reconnect with your peers. Presentations by our sponsors, Four Rivers Software Systems and Masimo Corporation.

Breakfast Symposium: Improving Patient Safety on the General Care Floor- Advances in Continuous Surveillance Monitoring
Date: Monday, June 8
Time: 7:00 am

Presented by Masimo and the American College of Clinical Engineering

Full Breakfast Served – Come Early – Limited Seating

Commentary: Who Are the Users of a Medical Device?

When we think of the users of a medical device we tend to primarily focus on the personnel who have the hands-on tasks of manipulating/operating the device for the direct benefit of the patient. Depending on the device these personnel may be therapists, nurses, physicians, or other providers. In some cases two or more of these groups may each play a role in sequence, at different times, or for different objectives. The patient may also be an active user, either by themselves or in conjunction with healthcare personnel or a family member. For example a PCA pump would be set-up by providers, but operated at least to a degree by the patient. As medical device use moves from the hospital to the home, patients themselves, or their family members or caregivers become the primary users. In such cases design and instructions aimed at and understood by lay users can be a critical component of safe and effective use.

However even in the hospital setting there are number of others "users" that may require consideration. The clinical engineering group is one such user, with responsibilities that may include initial set-up/installation, trouble shooting, maintenance, and repair. We can all recognize devices that were effectively designed with these functions in mind, those designed without these functions in mind, and those that appear to have been designed expressly to infuriate us. Of course the ability to even find a device is a classic challenge, and one that additional technology may play a useful role in. Other users may be our colleagues on the network side, who also wish (we hope) for their device life-cycle tasks to be facilitated by good design and careful selection.

Another important group are the non-direct-user personnel who may have set-up, moving and/or between case duties. Set-ups are preferably accomplished quickly, easily, with little room for error, and with suitable error detection and correction opportunities. Moving requires good grip surfaces, good casters, and good balance as well as tolerance to the reasonably anticipated bumps and bruises that may occur during routine moves. In this regard moving a device over thresholds or bumping into walls and doorways should not result in external or internal damage. On the other hand dropping it off the loading dock may be beyond reasonably survival expectations. Effective cleaning, disinfection and/or sterilization are essential and design can play an important part in how easily these tasks are accomplished. In addition, some users may be unintended. For example housekeeping or other personnel may find reason to interact with a medical device, as may the helpful family member who adjusts an infusion pump. These "off-line" activities may not receive the attention they deserve if the focus is limited to only what the device does and the direct clinical users, as opposed to how and where it is going to be used and all of the users who may play a role.

While ease of use is a design issue, equipment selection is a critical check on the design that results, and it is here that the hospital clinical engineering function can play a very important role. In this regard effective selection must include full consideration of all of the personnel who will have to interact with the device, not just the direct clinical user.

William Hyman, President, ACCE
Healthcare Technology Foundation

w-hyman@tamu.edu

International Report: Expert Advisory Meeting on Health Technology and Infrastructure

The World Health Organization convened an Expert Advisory Meeting on Health Technology and Infrastructure meeting on 21-23 April 2009 at the WHO headquarters in Geneva, Switzerland. Several ACCE members were invited to participate as expert

tional health technology policies and programs within the broad health service context, including feedback on use of decision-making and management tools. The meeting was expected to provide WHO with expert advice and guidance with regard to delineating further action for supporting Member States in their efforts in setting up effective national health technology policies, programs and systems, particularly as related to the revision and update of existing tools, or development of new ones to address identified gaps.

clearly define country needs and possible gaps in the internationally available healthcare technology management tools, specifically in biomedical engineering, concerning medical devices and delineate required action by WHO and other partners to respond to the identified needs in a concerted and aligned way.

The meeting was well received by the participants, and added a unique opportunity to network with peers from all over the world in the beautiful spring setting of Geneva . Fun filled evenings with fine wine

WHO representatives, expert advisors and regional representatives posing in front of the WHO headquarters in Geneva

advisors, including Frank Painter, Mario Castaneda, Ismael Cordero, Azman Hamid, Jim Wear, Robert Malkin, Roger Smith, Antonio Hernandez and Elliot Sloan. Two key WHO meeting organizers were Adriana Velazquez and Andrei Issakov, also ACCE members. In addition to the organizers and expert advisors, there were many representatives from WHO regional offices and from member countries.

The purpose of the meeting was to review and analyze the country experience with developing and implementing na-

The recommendations of the meeting will be followed up by a smaller group of selected experts who will work on the revision and update of existing tools, and development of new ones, as required. The outcome of this work will be presented at a next meeting to be held in Rio de Janeiro in November 2009, and finalized at a third meeting in Cairo in June 2010 following the pilot country implementation of selected tools. Country and regional workshops may be held in between as needed.

The long-term objective of this work is to

and fondue also enhanced the experience. However, the best part of the meeting was the openness and willingness of everyone to share their knowledge and lessons learned to help solve the global problem of non-functional medical equipment.

Ismael Cordero

ismael.cordero@orbis.org

Perspectives from ECRI Institute

New Guidance Article on Clinical Engineering and IT Collaboration

We've been hearing a lot about the convergence of medical devices and information technology lately. This obviously has a huge impact on the clinical engineering (CE) and information technology professions. Both professions will see significant change over the next several years and will need to have a close collaboration on order for these converging technologies to be implemented effectively at their institutions.

ECRI Institute has been well aware of the need for clinical engineering and IT collaboration and has been working on a series of guidance articles to help hospitals deal with its many challenges. Our second article on this topic entitled "CE/IT Collaboration" was just published in the May 2009 issue of *Health Devices*. It follows an earlier article from the October 2008 issue of *Health Devices* entitled "Coping with Convergence: A Road

Map for Successfully Combining Medical and Information Technologies". The

new article provides some real-world examples of the challenges that can emerge with clinical engineering and IT collaboration along with ECRI Institute's recommendations for developing an effective collaboration between the two groups. Some example points include the following:

As the responsibilities of CE and IT increasingly overlap, effective collaboration between the two becomes more and more vital. Developing solutions that work is neither quick nor simple, but it has to be done.

One hospital's difficulties with implementing OR integration demonstrate why coordinating equipment purchases and planning is essential to help avoid costly errors. The earlier in the process this happens, the better.

Increasingly, computer equipment is being used in care areas—workstations on wheels are a notable example. It's important to make sure everyone is clear about who has responsibility for managing and maintaining this equipment.

IT may not be accustomed to fielding help desk calls that are literally life-or-death. CE and IT will need to work together to ensure that all calls are responded to with the appropriate urgency.

Both guidance articles are available on the member Web sites for ECRI Institute's SELECTPlus and Health Devices programs. Feel free to contact me at (610) 825-6000, ext. 5279 or jkeller@ecri.org if you would like discuss either article or any of our perspectives on CE/IT collaboration. Also, let me know if you have any questions on how to access this information on our Web site.

Jim Keller is ECRI Institute's Vice President for Health Technology Evaluation and Safety and a past Member at Large for ACCE's Board.
jkeller@ecri.org

Certification in Clinical Engineering (CCE) Exam

ACCE
AMERICAN COLLEGE OF CLINICAL ENGINEERING

Exam Date — November 7, 2009

US Application Deadline — August 14, 2009
For those taking the exam within the US & Canada

International Application Deadline — July 17, 2009
For those taking the exam outside the US & Canada

Visit www.acce-htf.org/certification/ for handbook, application and more information.

Email secretariat@acce-htf.org if you have any questions.

Healthcare Technology Foundation News

New Officers and Board Members Announce

New Board officers were elected at the annual meeting of the Board of the Foundation, which preceded HIMSS in Chicago. These are: William Hyman, President; Tobey Clark, Vice President; Jennifer Ott, Secretary; Henry Montenegro, Treasurer and Wayne Morse, Immediate Past President. Yadin David will continue his active participation as President Emeritus. Two new Board members were elected: Larry Fennigkoh, Professor of Biomedical Engineering at the Milwaukee School of Engineering; and Nancy Presley, Special Assistant in the Center for Devices and Radiological Health of the FDA. Two new Advisory

Board members were also added: Mike Dashekfsky, Vice President at Nihon Kohden America; and Dan Schneider, President/CEO of The Schneider Group. It is very exciting for us to have three new components of the profession represented on our Board; FDA, the medical device industry, and the insurance industry. Continuing Board members are Thomas Bauld, David Dickey, Jim Keller, Henry Stankiewicz, and James Wear. In addition Jennifer Jackson represents ACCE, Caroline Campbell represents the Healthcare Technology Certification Commission, and Elliot Sloane continues as an Advisory Board member. Further details on the professional affiliations of the Board are available at our web site, http://www.acce-htf.org/.

The Board had a full day of strategic planning with respect to our current and planned projects, future funding opportunities and new collaborative initiatives. The development of patient safety brochures is ongoing with Dialysis soon to join Bringing Medical Devices from Home to the Hospital, and Home Oxygen Safety. These popular brochures are available as free downloads from the web site in both English and Spanish. Our contributions to clinical alarm safety are entering a new phase, and our leadership program, ExCEL will be adding additional activities beyond the award itself. The Marvin Shepherd Safety Award and clinical engineering certification are ongoing, and several new initiatives are in the planning stage. These activities are all volunteer based, and additional help is always welcome. The

Foundation Board also met with the ACCE Board, and both presidents are interested in new synergies between these co-named but separate organizations.

Donations of time and money to the Foundation

As always, the Foundation needs your help! We continue to work on the issue of improving clinical alarms and associated processes, and on the next patient safety brochures. We also have initiatives in other areas of broad interest to clinical engineering and healthcare delivery as listed on our web site. As we all know individually, and as organization members, active participants are essential to the performance of volunteer based activities. While it may sometimes appear that our organizations are run by "insiders", it is in fact easy to become one of them--just volunteer to work on a project, and then actively contribute. You then become known and more importantly recognized for your work, and hence a member of the too-short list of those who can be relied upon to play active roles. Please also remember the Foundation in terms of your personal donations. Donations "in honor/recognition of…" are also always welcome and will be recognized with a suitable communication to the honoree.

William A Hyman, ScD, PE, President ACCE Healthcare Technology Foundation *w-hyman@tamu.edu*

Jennifer C. Ott, MSBME, CCE, Secretary, ACCE Healthcare Technology Foundation *Jennifer.Ott2@Mercy.Net*

The View from the Penalty Box: Science

There was an essay in Newsweek back in March, by Sharon Begley titled "Why doctors hate science". In the essay she writes that many do not hate science but choose to ignore it by performing tests, prescribing medicines or doing diagnostic procedures that are not either necessary, cost effective or the best solution. Unfortunately all too many clinical engineers also fall into that trap of unneeded testing and procedures or tests that drive cost up. All I can say is how do you justify the electrical safety meter outside of the lab?

In another issue of Newsweek there was a news report on some politician making the statement "Why waste time trying to discover the truth when you can so easily create it".

As Clinical Engineers science is our second highest priority , with the patient being always the first priority, and so we need to base all of our work off of those two "foundations or pillars of our profession". This means that we have to speak out against bad science, unnecessary testing or work, duplications of efforts and push for better, safer, faster results for the patients.

I recently played the "skunk at the lawn party" by sending out two articles from our local paper on healthcare reform and why not use the EMR system from the VA which is free and open software. Many of the responses were filled with "what ifs" and "where is the support" questions. Some were good points but none, in my opinion were strong enough not to move forward. As clinical engineers we can overcome most of the "problems" quickly and do workarounds on the others almost as fast but we seem to be happy sitting and doing nothing. I am very disappointed in the leadership of our profession for not mentioning that the VA had an open EMR system. Is everyone so intent on

getting into agreements with commercial systems that they forget that there is an open system available to those hospitals and medical groups that do not have deep pockets? One of the complaints on the VA system is that it is open and getting support may be a problem. Isn't that what clinical engineers have been doing for a long time, supporting equipment and software both open and proprietary by keeping things going. If our IT colleagues cannot handle open systems why not have the clinical engineering departments support the system so the IT people can go back to what they do best, making clients wait for service.

Maybe what we have to do is to start to offer support to the open systems that may be a great business opportunity for some of our members, and watch what happens. Or how about those service companies with large client bases getting involved with the EMR systems, talk about value added to their services.

Spring here in the Northeast means putting down fertilizer on our lawns and gardens but we cannot match the depth of fertilizer, a nice name for the bu*****t, being spread inside the beltway and in the press on the costs of healthcare. We have the insurance companies, manufacturers and hospitals promising to reduce costs by over 2 trillion dollars over the next 10 years. When you read the articles carefully this is not a cost reduction but just not raising costs as fast as they have been raising them. Then we have the next level of fertilizer spread by the politicians that brought us sub-prime mortgages, bonuses for failures, but if the bonuses were not paid there people might leave was the explanations given. Hey you failed so stay on and fail some more so you can get another bonus next year. In our business it would be "don't let the door hit you in the butt on the way out" but we are just clinical engineers and are not impor-

tant and we have never failed like them in our jobs.

And then there is academia where all bad ideas seem to originate from. Some of the proposals coming out from various groups indicate that they have absolutely no idea how healthcare works but some reporter has given them a pulpit and they are spreading the fertilizer also. Sooner or later CMS will discover the Golden Rule, "He who has the gold makes the rules" and since CMS pays over 60% of what most hospitals receive they have the ability to make the rules so my proposal is as follows for our profession, make friends with CMS and give them input on what we do and how we can help. Maybe just maybe we can apply the pillars of our profession if we get their attention.

Health, peace and prosperity

Dave Harrington

dave@sbttech.com

ACCE 2009-2010 Educational Teleconference Schedule

July 16, 2009

How to Prepare for the Certification in Clinical Engineering (CCE) Exam?

Frank R. Painter, MS, CCE, Director, Clinical Engineering Program, University of Connecticut;
Arif Subhan, MS, CCE, Senior Clinical Engineer, Masterplan

This session provides an overview of the CCE exam, the application process, eligibility requirements and resources offered by ACCE to prepare for the exam.

August 20, 2009

How to Prepare for the Certified Biomedical Equipment Technician (CBET) Exam?

Ed Snyder, BS, CBET, Biomedical Supervisor, Thomas Jefferson University Hospital; Matt Baretich, PhD, PE, CCE, President, Baretich Engineering; Arif Subhan, MS, CCE, Senior Clinical Engineer, Masterplan

This session will provide an overview of the CBET Exam offered by the ICC/USCC. It will review the application process, eligibility requirements and resources including teleconference series available to prepare for the exam.

September 17, 2009

NFPA 99 changes Affecting Clinical Engineering

Alan Lipschultz, CCE, PE, CSP, Director, Clinical Engineering

Christiana Care Health Services, Newark, DE

Chair, Medical Equipment Committee (responsible for revising the current

chapters 8 and 9 covering Gas and Electrical Medical Equipment)
"NFPA 99 - Health Care Facilities" has undergone a major revision. The new document is now a Code (similar to National Electrical Code or Life Safety Code) rather than a voluntary standard. A Code is designed to be adopted into law by different Authorities Having Jurisdiction. The NFPA 99 committee made a strong effort to strip out the "nice to have" language and only leave the "need to have" language. The Clinical Engineering community needs to understand the resulting document, especially if adopted into law in their area. Major changes include removing the requirement for periodic electrical safety checking. The requirements regarding isolated power in the operating room have been strengthened over the previous edition.

October 15, 2009

IEC 80001 Application of risk management for IT-networks incorporating medical devices

Rick Hampton, Wireless Communications Manager, Partners HealthCare System, Boston, MA; Todd Cooper, President, Breakthrough Solutions Foundry Inc, San Diego, CA

This session will review the IEC 80001-1 draft standard, which is scheduled for release in late 2010, and examine issues and strategies for its application to biomedical and clinical engineering practices. It will also look beyond the foun-

dational IEC 80001-1 standard to other proposed guidance documents that will facilitate implementation projects and technology specific applications. The standard is being co-developed by the ISO TC215 / IEC SC62A Joint Working Group 7.

November 19, 2009

IHE Status & Update

Emanuel Furst, PhD, CCE, President, Improvement Technologies, LLC; Todd Cooper, President, Breakthrough Solutions Foundry Inc, San Diego, CA

Integrating the Healthcare Enterprise (IHE) International brings health I.T. users and vendors together to identify and develop open standards-based solutions to specific real-world integration problems. The IHE Patient Care Device (PCD) group has not only worked on general medical device interoperability issues but is now focusing on the use of I.T. for Medical Equipment Management (MEM). This session reviews the IHE PCD work program with special emphasis on MEM white paper and development of related profiles.

December 17, 2009

Evidence-Based Maintenance

Binseng Wang, ScD, CCE, FAIMBE, FACCE
Vice President, Performance Management & Regulatory Compliance, Aramark

Clinical engineering (CE) professionals have realized for some time that the "preventive maintenance" (PM) that they have been performing for many years is no longer able to prevent any failures,

ACCE 2009-2010 Educational Teleconference Schedule

although some safety and performance inspections (SPIs) can help detect hidden and potential failures that affect patient safety. To help CE professionals decide whether they should continue to PM or not, a systematic method for determining maintenance effectiveness has been developed. This method uses a small set of failures codes to classify problems found during repairs and PMs and SPIs. Analysis of the failure patterns and their effects on patients and users allows CE professionals to compare different maintenance strategies and justify changes in strategies, such as decreasing scheduled maintenance, deploying statistical sampling, or even eliminating scheduled maintenance.

January 21, 2010

Benchmarking Best Practices & CE Performance Data

Matt Baretich, PhD, PE, CCE, President, Baretich Engineering; Frank R. Painter, MS, CCE, Director, Clinical Engineering Program, University of Connecticut

AAMI's Benchmarking Solution is an online self-assessment tool for clinical engineering programs. It combines quantitative benchmarking with qualitative review of best practices. In this session you'll hear from two of the "subject matter experts" who helped design the tool. You'll learn about the design of a tool that integrates best practices and benchmarking measures to effective compare individual CE programs with each other, creating an effective performance improvement initiative.

February 18, 2010

The Joint Commission Update

George Mills, MBA, FASHE, CEM, CHFM, Senior Engineer, Standard Interpretation Group, Joint Commission

This session will provide an update on the Joint Commission standards, scoring and survey process for medical equipment.

March 18, 2010

How to Manage a Successful Imaging Services Group

Grant Smith, CRES, Assistant Director, Imaging Engineering & Diagnostic Support, Duke University Health System

April 15, 2010

Standards and Standards efforts in the Medical Device-Information System Interface

Bridget Moorman, MS, CCE, President, BMoorman Consulting, LLC

It will provide a review of all the current efforts in the standards arena pertaining to medical device interoperability to include The Continua Alliance, IHE-PCD, ASTM and HITSP. Find out what is new and how a CE or BMET can use the information to better manage any interoperability projects they may have.

The teleconferences are held the 3rd Thursday of each month at 12 Noon Eastern Time (9:00AM Pacific Time etc). Unless otherwise noted, the teleconferences are one hour long; typically a 45-50 minute presentation followed by 10-15 minutes of Q and A. Registrants will receive the call-in number and presentation material prior to each session. For ACCE members, the cost of each session is $150 per site. For non-members the cost of each teleconference is $195* per site. This allows for four (4) participants from

each site using one phone line, each additional participant is $10. If nine (9) teleconferences are purchased the tenth one is free. CDs of each Teleconference will also be available for $50 each.

The brochure and registration form for the teleconference can be downloaded from:

http://accenet.org/default.asp?page=news&section=teleconference#acce-tele

For questions please contract Alan Levenson

Email: Secretariat@accenet.org

Phone (Voicemail): (610) 825-6067

Special ACCE Membership Discount *

- Buy the series at $1395 and receive 25% off your first year of ACCE membership

- Register and pay for the teleconference series

- For each applicant:

- Complete the ACCE membership application, available at http://www.accenet.org

- Send in all application materials and a check for $45 (reduced membership fee)

- Write ACCE Teleconference Series at the top of the application

Applications will be reviewed by the Membership Committee and Board of Directors using criteria outlined in the ACCE Bylaws. Applicants will be individually notified of acceptance by email or by letter. *This offer applies to new applicants only.

Images from the 2009 Annual HIMMS Meeting

Steve Grimes introducing Mario Castaneda and Thomas Langston during the Clinical Engineering and IT Leadership Symposium: Navi-

Front and center.: Tobey Clark and Paul Sherman are engaged at the symposium

From L-R: Ray Zambuto, Jennifer Jackson, Todd Cooper, and Elliot Sloane at the HIMSS Awards Banquet where Todd Cooper received the ACCE/HIMSS Excellence in Clinical Engineering and Information Technology Synergies Award

William Hyman receiving the ACCE Lifetime Achievement Award at the ACCE awards reception

Izabella Gieras receiving the service award at the ACCE awards reception

ACCE
AMERICAN COLLEGE OF CLINICAL ENGINEERING

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

We are on the Web:

www.accenet.org

The ACCE Board and Committee Chairs

President .... Jennifer Jackson
President Elect .... Mario Castaneda
Vice President .... Paul Sherman
Secretary .... Jim Welch
Treasurer .... Julio Huerta
Member-at-Large... Izabella Gieras
Member-at-Large... Tony Easty
Member-at-Large... Arif Subhan
Member-at-Large...Colleen Ward
Past President.. Stephen Grimes
Education Committee Chair...Arif Subhan
Membership Committee Chair.......................................Carol Park
HIPAA Task Force Chair ....   Stephen Grimes
Advocacy Committee Co-Chairs .... Eric Rosow, Pat Lynch
IHE PCD Task Force Co-chairs
 ....Todd Cooper, Ray Zambuto, Elliot Sloane
International Committee Chair.................................... Tony Easty
Medical Errors Task Force Chair ....Elliot Sloane
Nominations Committee Chair ....Steve Grimes
Professional Practices Committee Chair ....Paul Sherman
Body of Knowledge Committee Chair ....Open
Strategic Development Committee Chair ....Izabella Gieras
Secretariat .... Alan Levenson

Calendar of Events

June4-5, 2009
CCE Prep Review Course
Baltimore, MD

June 6-8, 2009
AAMI Conference
Baltimore, MD

June 11-12, 2009
9th National Convention of the Italian Association of Clinical Engineering (AIIC)
The Role of Clinical Engineering for Patient Safety in Critical Care Areas
Palermo, Italy   www.aiic.it
Sponsored by ACCE

July 16, 2009 📞 How to Prepare for the Certification in Clinical Engineering (CCE) Exam

August 20, 2009 📞 How to Prepare for the Certified Biomedical Equipment Technician (CBET) Exam

September 7-12, 2009
Medical Physics and Biomedical Engineering
World Congress 2009
Munich, Germany

September 17, 2009 📞 NFPA 99 changes Affecting Clinical Engineering

October 15, 2009 📞 IEC 80001 Application of risk management for IT networks incorporating medical devices

November 7, 2009
CCE Exam
28 cities in US

November 19, 2009 📞 IHE Status & Update

📞 = ACCE Teleconference