

ACCE News

Vol. 13, No. 1—January-February 2003

ACCE Healthcare Technology Foundation

The Board of Directors of the American College of Clinical Engineering took a bold move earlier this year in support of the creation of the new ACCE Healthcare Technology Foundation. Over 13 years ago, when the ACCE was created, a small group of visionary clinical engineers committed themselves to support the only organization that focused on the needs of their profession. Now, once again, leaders in the profession came together to inaugurate the first and only foundation dedicated to improving healthcare delivery by promoting the development and application of safe and effective healthcare technologies through the global advancement of clinical engineering research, education, practice and other related activities.

The Foundation board of directors and officers represent a cross section of experienced leaders in areas ranging from academia and service support to managers of hospital-based programs. The Foundation's website www.accefoundation.org is under construction at present; however, we hope that it will quickly become your source for professional information.

One of the first action items the Foundation is taking is the establishment of structure to assure that the training, education and certification processes applicable to the profession are of the highest value for the clinical engineering community.

The Foundation has the following purpose: *"Improving healthcare delivery by promoting the development and application of safe and effective healthcare technologies through the global advancement of clinical engineering research, education, practice and other related activities."* Dr. Yadin David is AHTF's first President.

Breaking News...

**HIPAA SECURITY RULE
RELEASED (see page 5)**

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American College of Clinical Engineering

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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 Building the Profession

Raymond Zambuto, rzambuto@techmed.com



The ACCE membership brochure says that ACCE is “*the only professional society for clinical engineers with international recognition.*” Our mission includes promoting excellence in the profession, promoting the safe and effective application of technology in patient care, defining the body of knowledge of the profession, and representing the professional interests of clinical engineers.

Throughout this special issue of *ACCE News*, we examine two ways in which ACCE is moving ahead with its Mission. Two dedicated groups of people, our Past Presidents and our members working on the certification project, have put in countless hours over the past year to advance the ACCE agenda.

Many of you know that the Certification saga goes back to 1999, when the AAMI-sponsored program suspended the acceptance of new applications. This was based on their estimates of cost, liability, and the value of the program to the community. ACCE, working through AAMI and the United States Certification Commission, attempted to restart the program, making at least two separate proposals. ACCE’s tenacity in this was based on a thorough

examination of the issues and the encouragement of many clinical engineers.

Finally, the ACCE program set out on its own, leaving open the option to seek reunification with the ICC at a later date. Since that point, many things have been accomplished.

While all this was going on, the Past Presidents of ACCE, led by Yadin David, were quietly putting together what would become the ACCE Healthcare Technology Foundation (AHTF) as a non-profit tax-exempt research and educational organization to meet ACCE’s goal for “*promoting the safe and effective application of technology in patient care.*” The Foundation’s birth was announced in the November 2002 *ACCE News* and is further profiled on page 10 of this issue by Yadin.

The AHTF will have a full plate of topics on the agenda as it enters the public arena. One of its first tasks was to take control of the certification program from ACCE. This separates the certification process from ACCE, since the College does not control the AHTF. This overcomes one of the primary problems with the old AAMI certification program. ACCE can now actively promote certification and continue to monitor the body of knowledge of the profession – two tasks which went wanting in the old process and certainly hastened its demise.

Under the guidance of the AHTF, a Healthcare Technology Certification Commission is being formed with representation from organizations concerned with the integrity and impact of clinical engineering. The United States Board of Examiners for Clinical Engineering Certification reports to the commission. Details of this relationship are provided on page 6 in an article by Caroline Campbell.

Clinical Engineers who were certified under the AAMI program, and who are still in professional practice, can apply to the new program for recognition of their Certification. Details are found on page 12 of this newsletter. It is important that those of us who have been certified demonstrate a commitment to that process by having that Certification recognized by the new, continuing program. It sends a message to our up and coming peers that it is important to us as professionals to establish a credentialing process.

It is easy to become trapped in the “chicken and egg” dilemma. There is no value in certification – i.e. increased pay, therefore why do it? But there will never be value in it if the employer cannot tell the difference between a certified and non-certified

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individual. And up until now, there has been no one to tell them...

That stops today!

ACCE will be telling them, because it's our job to tell them. And what we will be telling them is that clinical engineers, whether on staff or off, can make a difference. They can make a difference in patient safety, medical errors, patient information security, the cost of technology, litigation results, and other areas that directly translate to the public good and/or the cost of healthcare.

The effect will be slow at first, but it will grow, and the Certification after your name will come to make a difference. Not today, or tomorrow, but the day will come. Be ready!

Ray

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ACCE News

ACCE News is the official newsletter of the American College of Clinical Engineering (ACCE).

ACCE News is a benefit of ACCE membership; nonmembers may subscribe for \$60. To subscribe call (631) 751-7244.

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Letters

President's Message in *ACCE News*, November 2002 -

You have my support and vote on the upcoming bylaw revision. In my 30 years in this field, I believe that biomedical technicians, who worked so very hard in support of this field and the care and safety of the patient, should be viewed as peers and professionals. I say this as a biomedical technician, instructor, manager, and a member of ACCE. Thanks go to you and the Board.

Ron Cushman, BSOE,CBET

ACCE Welcomes New Members

The following are the new ACCE Members elected during the period October 2002 to January 2003. Congratulations and welcome!

- Thomas Christoffel
- Matthew Wheeler

PEOPLE ON THE MOVE AND IN THE NEWS

BinSeng Wang was inducted into the College of Fellows of the American Institute of Medical and Biological Engineering at its Annual Event on

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February 22, 2003. Only 1% of all biomedical engineers have been elected to this distinguished body.

Lou Schonder was elected Vice President of the Philadelphia Area Medical Instrumentation Association (PAMIA). Lou also serves PAMIA as Webmaster.

Matt Baretich authored the article, *Adapting to changing times focus of local society meetings*, in *AAMI News* 37(11):5, 2002. Jumping on the electrical safety bandwagon was easy. Knowing when to jump off is the challenge. Matt emphasized that the need to comply with Joint Commission (JCAHO) recommendations ought not to be confused with the need for performance improvement.

Stephen L. Grimes authored the article, *Compliance dates near for HIPAA requirements*, in *AAMI News* 38(1):9, 2003. Grimes is chair of the ACCE HIPAA Task Force and is recognized as one of the world's leading experts on the impact of HIPAA on medical device technology and clinical engineering. He writes a column for each issue of *ACCE News*. See page 5 for this issue's HIPAA Update.

Grimes was granted ACCE Fellow Status in December. Congratulations, Steve!

Ray Zambuto was featured in a front-page article in *Medical Device Daily* 6(226):1, 2002, about Technology in Medicine (TiM), the Massachusetts-based company, of which he serves as CEO. Titled, *Keeping medical technology in operation is focus of TiM*, the article described how TiM provides a full range of technology management services such as medical equipment repair, medical gas system testing, clinical engineering consultation, and environmental evaluations.

Bryanne Patail, Mark Bruley, Stephen L. Grimes, Eric Rosow, and Elliot B. Sloane each presented a paper at the Annual HIMSS Conference & Exhibition 2003 in San Diego, California, February 9-13, 2003.

Bob Berkovits, is chair of the IEEE Baltimore Annapolis Chapter of the Electromagnetic Compatibility Society. Bob's chapter is quite active having recently sponsored Captain Jon P. Casamento, USPHS, for a presentation on Electromagnetic fields from security screening devices and their interaction with implanted medical devices.

Yadin David and Paul Sherman spoke on *EMI and Wireless Communication* at the first National Summit on Electromagnetic Interference (EMI) with Wireless Communication and Computing Devices in Healthcare Facilities. This conference was sponsored by the Mobile Healthcare Alliance (MoHCA) and held prior to the Mobile Health Care Conference and Exhibition, at Las Vegas, NV, November 2002.

The summit was to identify stakeholders and risk issues involved with deploying wireless device in healthcare facilities. Director

Yadin is Director of the Biomedical Engineering at the Texas Children's Hospital, St. Luke's Episcopal Hospital and Texas Heart Institute and Paul Sherman is Biomedical Engineer at the VA Center for Engineering & Occupational Safety and Health.

Their session's goals were as follows:

1. Attract and involve stakeholders, those who need to be part of the discussion and process, to give perspectives;
2. Reach agreement about issues that need to be addressed; and
3. Provide understanding and guidance for a consensus paper that is intended to lead to a model policy.

ACCE Audio-Teleconferences: A Great Way to Learn



ACCE Teleconference participants from Texas Children's Hospital, St. Luke's Episcopal Hospital and Texas Heart Institute in Houston

Perspectives from ECRI JCAHO National Patient Safety Goals and Clinical Alarms

James Keller, jkeller@ecri.org

In the September 2002 issue of *ACCE News* I provided ECRI's perspectives on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goal regarding infusion pumps. In this issue I will be covering JCAHO's other device-specific National Patient Safety Goal, which addresses clinical alarms. Specifically, the goal states that hospitals should improve the effectiveness of clinical alarm systems. JCAHO recommends this be done (1) by assuring that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit and (2) that hospitals implement regular preventive maintenance and testing of alarm systems.

JCAHO should be commended for highlighting clinical alarms as one of its Patient Safety Goals. From our experience at ECRI, failure to properly manage clinical alarms is a huge problem in hospitals and we have investigated many serious incidents because alarms were not set correctly, were ignored or missed, were turned off, or were not set at all. Also, in an ECRI survey conducted in coordination with the American Association of Critical Care Nurses, we found that 35% of hospitals had not provided clinical training in monitor use for nurses in general care areas where monitors were being used. Nearly 29% of hospitals reported that nurses had not been trained in protocols covering alarm awareness and response. Clearly something needs to be done.

Of course, the easy part is realizing that a problem with alarms exists. The challenging part is coming up with a plan for dealing with the problem given the long list of technologies that have some type of clinical alarm – and that will pass muster with JCAHO inspectors. ECRI put together a comprehensive guide on developing effective alarm strategies and responding to JCAHO's alarm-safety goal in the November 2002 issue of *Health Devices*. Many hospitals have found this to be an invaluable resource for helping to develop (or revise) their alarm management plans and to prepare for upcoming JCAHO inspections. ECRI's article provides advice on what JCAHO expects, how U.S. hospitals should

respond to JCAHO's initiative, and how much in the way of time and resources will be required. In addition, the article provides broad recommendations on improving alarm safety and implementing a practical and safety-based alarm management program that apply to any hospital regardless of whether it is accredited by JCAHO or not.

The *Health Devices* article points out that because of the wide variety of devices with some type of clinical alarms in them, hospitals need to focus first on devices that are used on patients who are at the most risk should an alarm fail. These would include at least ventilators and physiologic monitors. The article also points out that regarding alarm testing, hospitals should not determine audibility by measuring the sound levels of alarms. Instead, users should examine whether an alarm is sufficiently audible in the environment in which it's being used. Various factors need to be included in this examination, such as staffing levels, floor layout, background noise, and the frequency of the alarm signal.

Feel free to contact me (jkeller@ecri.org or (610) 825-6000, ext. 5279) if you would like information on how to access ECRI's article on alarms or if you would like to discuss our philosophy and recommendations on alarm management. Members of ECRI's Health Devices and SELECTplus programs can view the November 2002 article online at www.ecri.org.

Jim Keller is Director of ECRI's Health Devices Group, ECRI, and a Member-at-Large for ACCE's Board.

HIPAA Update

Stephen L. Grimes, sgrimes@nycap.rr.com

Status

In 2003, hospitals and other covered entities must begin complying with the first two of the three major HIPAA rules associated with *administrative simplification*.

By April 14, covered entities are required to be in compliance with HIPAA's **Privacy Rule**. HHS's Office of Civil Rights (OCR) is charged with enforcement of the Privacy Rule. Preparations, which should be nearly complete by now, include

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development of policies, procedures and educational programs to ensure that use of *individually identifiable health information* (IIHI) is restricted to *treatment, payment* or [healthcare] *operations* (TPO) unless authorization is given by patient for other uses. Covered entities such as hospitals must also establish *Business Associate* agreements with individuals and organizations with whom they may exchange IIHI to insure those associates take appropriate measures to keep that information private

By October 16, covered entities are required to be in compliance with HIPAA's **Transaction & Code Sets (TCS) Rule**, unless they failed to file for a one year extension by 10/15/02 ... in which case they would must have been compliant since 10/17/02. HHS's Centers for Medicare and Medicaid Services (CMS) is charged with enforcement of the Security Rule. Preparations include adopting of new code sets and transaction standards and acquiring or modifying applications that will exchange data in the approved formats.

The **Security Rule** is the third of HIPAA's major rules. The final version of this rule was published in the *Federal Register* on February 20, 2003 just as this newsletter was going to press. We are still analyzing the differences between the proposed version of this rule, published back in August 1998, and the new final version. We will provide highlights in the March newsletter. This rule is critical because it is the part of HIPAA which will have the greatest impact on the clinical engineering community. The **Security Rule** requires that precautions are taken to insure the integrity, availability, and confidentiality of all *protected health information* that is maintained or transmitted electronically. This affects a significant portion of all diagnostic and therapeutic devices and systems.

Keep up with latest HIPAA developments:

In June 13-17, 2003, see our session on *HIPAA Security Guidelines* at the AAMI 2003 Conference in Long Beach.

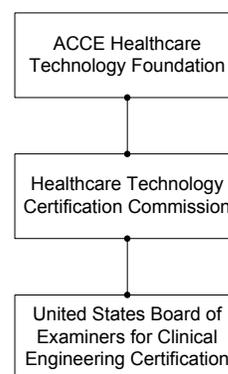


Certification Update Certification Structure in Place

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

The United States Board of Examiners for Clinical Engineering Certification was given a mandate by ACCE and the community to establish and maintain a credible certification program. While the process has taken more time than expected, the resulting structure and program exceed initial expectations and provide meaningful certification for clinical engineering professionals. The governance structure of the program is now in place and is depicted below.

Governance Structure for Clinical Engineering Certification Program



Because each of the entities in the governance structure are new organizations, their relationships, bylaws, and constitution have each needed to be developed and reworked so that they comprehensively address the requirements of a valid and defensible certification program and all fit together in a cohesive manner. This is tedious development work that ensures the appropriate authority of each entity related to the certification program. In this structure:

- The Foundation is responsible for the financial management of the Commission and the Board;
- The Commission is responsible for establishing performance criteria for the certification program, communication between the Board and the Foundation including about financial and budgetary matters, and is the authority by which all certifications will be issued;

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- The Board is responsible for developing and implementing all policies and operating procedures necessary to maintain the certification program in compliance with the standards set forth by the Commission.

In accordance with its responsibilities, the Commission has worked with the Foundation and the Board to project the financial needs to establish and maintain the certification program over its first few years. Although a large amount of volunteer labor is invested in the program, there are considerable expenses to bear including insurance costs, administrative support labor, document storage costs, and services that lie outside the realm of expertise of the program participants. One of the required services to support a defensible examination process is psychometric analysis. This analysis validates that the examination truly assesses the competence of the clinical engineers.

The Commission has adopted standards for the certification program based on those established by the National Organization for Competency Assurance (NOCA) which is a membership association of certification organizations providing technical and educational information concerning certification practices. These standards address the following:

- purpose, governance, and resources
- responsibilities to stakeholders
- assessment instruments
- recertification
- maintaining accreditation.

The certification program can be evaluated directly by NOCA for compliance with these standards only after the certification examination has been given twice at a national level. The Commission has directed the Board to develop a program based on these standards.

In accordance with its defined responsibilities, the Board has been drafting policies, procedures, and practices that address all of the standards as well as the pertinent legal issues. This includes developing justifiable eligibility criteria and an application form with supporting documents. One of the important early Board decisions was to adopt the body of knowledge as defined by the American College of Clinical

Engineering as the current performance domain against which competence will be measured. According to the certification program standards, it will be necessary for ACCE to periodically update that body of knowledge in order for the Board to continue to use it as the defined performance domain. Another important activity of the Board is to develop questions around the body of knowledge using recognized references as the basis for the questions. Using this approach, the questions (and answers) are defensible. As the questions are written, they are catalogued in such a way as to facilitate updating them in the future while remaining true to the breadth of the body of knowledge. The Board is currently evaluating test services to psychometrically analyze the questions and the examinations as well as to help establish a valid cut score. Finally, the Board is establishing appeals processes for any candidate that does not agree with a decision of the Board. While the examination development process described above consumes much of the Board's time, other issues are being addressed in parallel including

- development and maintenance of a registry of certified clinical engineers,
- processes related to recertification,
- administrative processes for storage and retrieval of appropriate documents, and
- development of an orientation and education program for Board members.

While all of this work is in progress, the Foundation, the Commission, and the Board are all committed to providing information to clinical engineers and the public. Because of the newness of the clinical engineering certification program, these entities are also sensitive to the need maintain credibility and hence strive to release information only when the interactive development of specific pieces of the program are nearing completion. The Foundation, Commission, and Board appreciate the patience of the ACCE members and their colleagues and looks forwards to disclosing the details about the certification program in the near future.

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New York City Metropolitan Area Clinical Engineering Directors Group

Ira Soller, ira.soller@downstate.edu

The New York City Metropolitan Area Clinical Engineering Directors Group, consisting of Directors and Supervisors of Biomedical/Clinical Engineering Departments, representing all of the major medical centers in the greater New York City metropolitan area met on January 21, 2003. **Barbara Maguire** & Nick Pinto of Weill Cornell Center of The New York Presbyterian Hospital hosted the meeting.

Patrick Vignona of Siemens Medical provided a presentation "*Latest Advances in Ventilator Technology*". Subsequent member discussion ensued relating to the ASHE warning/reminder about the Oct. 16 end of freeze on the licensing of high power mobile radio transmitters that could affect existing medical telemetry systems, clarification and methodology of implementation of JCAHO 2003 National Patient Safety Goals relating to infusion pumps and clinical alarm systems, the need to encourage AAMI to hold it's annual meeting & exposition in NYC, choices available in medical equipment management software, as well as other topics of interest to Clinical Engineering Directors.

For information, or manufacturers/vendors interested in making a presentation at a future meeting please contact: Ira Soller, Director of Biomedical Engineering, State University of New York, Downstate Medical Center, 450 Clarkson Ave., SMIC Box 26, Brooklyn, NY 11203. 718-270-3192 (phone), 718-270-3194 (fax), or ira.soller@downstate.edu.

Joint Commission Resources Offers Free Special Safety Report

Joint Commission Resources is offering a free report entitled *2003 JCAHO National Patient Safety Goals: Practical Strategies and Helpful Solutions for Meeting These Goals*. This report contains practical advice and helpful tips on incorporating the recently approved JCAHO National Patient Safety Goals. JCR views this

report as a starting point for meeting the goals and recommendations.

For your copy of the report go to www.jcrinc.com/subscribers/printview.asp?durki=3746.

Help ACCE Spread the Word!

**The Advocacy Committee is looking
for members to help promote ACCE
and Clinical Engineering. Contact
Izabella Gieras, President-Elect, at
IGieras@bsc-rscservices.com**

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THE VIEW FROM THE PENALTY BOX

David Harrington, dave@sbtttech.com

It is a brand new year and with it comes a new set of opportunities looking like problems for us to handle.

JCAHO has requirements on alarms that are impossible to meet without major funding.

The FDA is charging for pre-market approvals of new technology. Will that \$150,000.00 charge prevent new technology from reaching the market? My best guess is that the device market will become more like the drug market, new devices costing more doing the same as existing devices.

The Leap Frog Group, about 150 companies who are major purchasers of healthcare insurance are getting more active in pushing for lower costs. Unfortunately many companies in this group also charge very high service rates to hospitals.

The population that we serve is getting older and sicker, our buildings need upgrades and our systems have been patched together for years and some of the patches are coming undone.

These are the challenges that we face in the new year, but that is what makes our profession so interesting. *"A new day, a new challenge"* seems to be our mantra. But as a profession we are up to the challenge. We are ready to move forward and to make that difference in healthcare. The only question is how.

I propose that we collectively do the following. Share information quickly and freely. If you have a good source for parts, tell the world. If you have a good method of doing inspections, installation or removals, tell the world. If you know of a good person looking for a position, tell the world. We have a "jungle network" that is not used enough, post your ideas on this web site, check the website before starting a project to see if someone else has done something similar that you can adapt to your needs.

Clinical Engineers are some of the most creative people in the world. We overcome problems all the time but all too often we do not tout our accomplishments. Once, while I was traveling with Bob Morris, we ran into a problem. He told the person in charge of the hospital *"clinical engineers do the difficult quickly but the impossible takes a little longer"*. We solved the problem and provided that hospital with working equipment that has saved many lives over the past 5 years. Another time at a

convention one of the engineers was talking about a serious problem that he had. Well, we adjourned to the "office" and ordered several milk shakes. They come in green bottles, don't they? After several rounds we were able to come up with a solution to the problem. The clinical engineer went back to the hospital and did what we came up with. It worked great. He proudly proclaimed to all that at the next convention the "milk shakes" were on him. Unfortunately, 7 years later we are still waiting for the "shakes".

Most of us will admit that going to a convention is a great place to learn, not just in the sessions or on the exhibit floor but in the halls and "office" where we tend to share information easily. I should also warn you that some clinical engineers have deformed arms, which do not allow them to reach their wallets when the "milk shakes" arrive in the "office". But the information gained, even if you have to buy the round, is generally very good and so much cheaper than if you had to hire a consultant.

My favorite definition of a consultant is a person that knows 150 ways to make love but can't find a partner. With that my penalty is up and it is back to the fun and games.



AAMI Annual Conference and Exposition

June 14-17, 2003

Long Beach, CA

www.aami.org

Mark Your Calendar!

ACCE News

ACCE Healthcare Technology Foundation

Yadin David, ybdavid@TexasChildrensHospital.org

At the August 2001 meeting, the ACCE board of Directors passed a motion to create an exploratory task force headed by Yadin David to investigate the establishment of a not-for-profit foundation. We all knew from the early starting days of the ACCE that in order to enable the organization to further reach important professional goals and to continue to build the legacy on which our field of practice is evolving the creation of a not-for-profit foundation and its associated fund raising potential was needed.

When the collective wisdom of senior members of our society – the exploratory task force – was put to test a report to the Board resulted showing that a Foundation will significantly enhance the ACCE mission and should be created as soon as possible. Additional support for this recommendation was provided by the AAMI decision to discontinue its support of the clinical engineering certification process. At a time when ACCE is the only organization that supports and recognizes the important role of clinical engineering in the safe and efficient development, integration and use of modern healthcare technologies, a closely related Foundation is just like finding an oasis in the middle of a desert.

In May 2002, the ACCE Board gave its approval for the creation of a Foundation and provided the seed money needed for filing and registering the Foundation at the state and Federal levels. A slate of Directors and Officers were selected and work began on the Foundation mission, objectives and by-laws. This moment could not have been reached if it were not for the dedication of individuals like Elliot Sloane, Jennifer Ott, Frank Painter, Ira Tackel, Ray Zambuto, Matt Baretich, Wayne Morse, Marvin Shepherd, Tom Bauld, and Joe Dyro. However, most of all, it was the assistance provided by Joe Welsh that made this dream become a reality. The impact from the work of these dedicated individuals will probably not be felt immediately, but future generations of clinical engineers and other practicing professionals in healthcare delivery system stand to benefit greatly. There are those of us in our profession known to be Doers, others known to be Professionals, and still yet others who are Dreamers. This bunch represents a

combination of all these groups. The first order of business is to organize a way to jump-start and sustain the certification process.

At the end of 2002, the ACCE Healthcare Technology Foundation was inaugurated and registered in the Commonwealth of Pennsylvania and preceded to file under the 501-C-3-tax code as a not-for-profit foundation with the Federal authorities. The Foundation's purpose is as follows:

Improving of Healthcare Delivery by Promoting the Development and Application of Safe and Effective Healthcare Technologies Through the Global Advancement of Clinical Engineering Research, Education, Practice and Other related Activities.

Continuing the ACCE tradition, Yadin David was elected as the Foundation first president, Ira Tackel as its Treasurer and Jennifer Ott as its Secretary. Other members include:

Elliot Sloane, Frank Painter, Ray Zambuto, Matt Baretich, Wayne Morse, Marvin Shepherd, Tom Bauld, Joe Dyro and Joe Welsh.

This is our Foundation, let's all help make it bigger than life, make it a professional dream come true. With your support we will identify and capture today's gaps and replace them with bridges that will build the vision of a desired future.

TELECONFERENCE HELP WANTED

Have you ever attended a teleconference? If so, you know what a great service this is to the clinical engineering community.

ACCE's very successful Audio Teleconference Series seeks to expand its committee. We particularly need someone who can help with administering and promoting the program. No experience needed. Existing committee members will train you. This is a great way to get involved with light duties that have a big impact.

Please contact Ted Cohen for more information at
ted.cohen@ucdmc.ucdavis.edu.

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ACCE Board Meeting Highlights - December 18, 2002

President's (Ray Zambuto)

Growth & Strength Issues and Opportunities –ACCE will maintain a dialogue with BMET organizations. ASHE is interested in working with us at their annual meeting and also on teleconferences.

HIMSS & AAMI –Elliot Sloane believes the way for ACCE to build its own relationship with HIMSS is through the pathway of patient safety and medical errors. Elliot called for an ACCE member who could present at a HIMSS teleconference. The person must have good credentials and integrate the safety and medical errors topic with computers and information systems to relate it to HIMSS.

Elliot received Antonio's assurance that someone from PAHO could speak passionately on patient safety and medical errors, since these were now big international issues. Antonio asked if we could include the reuse of single-use devices as part of the patient safety-medical errors initiative. Elliot said the challenge with that is to relate it to information technology, but it could be done through supply chain management and record keeping, but we would have to find someone who could make that connection strongly. The same with drugs and pharmaceuticals.

President-Elect (Izabella Gieras)

Member Survey responses are being received and analyzed.

Vice President (Ted Cohen)

AAMI Liaison—Many ACCE members will be speakers and session chairs at AAMI 2003. ACCE will meet with the California Medical Instrumentation Association and other BMET associations during the ACCE/AAMI Annual Meetings in Long Beach.

ACCE Symposium—Most speakers have been confirmed.

Past President (Elliot Sloane)

Website Update—Matt Baretich will email pdf copy of membership directory to all members. This will also be posted on website for password protected access.

ACCE Board Recruiting Activities—Names of prospective board candidates are being solicited.

Bylaws Revisions—Proposed Bylaw Revisions to be put to a vote.

Bob Morris Memorial Fund—Nominations are requested.

Foundation Update—A filing of the Foundation as a not-for-profit organization has been made with the Commonwealth of Pennsylvania. The certification process will become a committee of the Foundation and the marketing and promotion within the industry will be the function of the ACCE, this to prevent a conflict of interest with the body that actually does the certification.

Treasurer (Henry Montenegro)

The 2003 budget was approved by unanimous vote.

ACCE will end 2002 with a significant surplus as a consequence of the teleconferences and ACEWs.

Joe Skochdopole identified an agent offering a reasonable \$100,000 general liability policy.

Caribbean Workshop Update (Antonio Hernandez)

St. Lucia, Dominica, El Salvador, and Honduras are possible sites for ACEWs in 2003. See Ad below!

Membership Committee (Dave Francoeur)

The Board unanimously approved the following: Steve Wixon (Emeritus), Thomas Christoffel (Individual), Matthew Wheeler (Candidate), and Steve Grimes (Fellow).

The Membership Committee has changed and clarified the Membership Application Form.

Education Committee (Alan Levenson)

A replacement for Alan Levenson is needed to coordinate the teleconference program in 2003.

HIPAA Task Force Report (Steve Grimes)

See HIPAA Update in this newsletter on page 5.



ACEW Faculty Wanted

Advanced Clinical Engineering Workshops rely upon volunteer faculty. All expenses paid for week long ACEWs around the globe. A great way to help others and to learn about healthcare systems worldwide.

Contact Frank R. Painter - frpainter@earthlink.net

ACCE News

Calendar of Events

- IEEE 29th Annual Northeast Bioengineering Conference, Newark, NJ, March 22-23, 2003, nebc2003.njit.edu/.
- IEEE EMC 2003 International Conference, Istanbul, Turkey, May 11-16, 2003, www.ortra.com/emc2003.
- 6th ACCE Symposium, Long Beach, CA, June 14, 2003, www.accenet.org.
- AAMI 2003 Conference & Expo, Long Beach, CA, June 14-17, 2003, www.aami.org.
- World Congress on Medical Physics and Biomedical Engineering, Sydney, Australia, August 24-29, 2003, www.wc2003.org.
- 25th Annual International Conference of the IEEE Engineering in Medicine and Biology Society, Cancun, Mexico, September 17-21, 2003, <http://itzamma.uam.mx/cancun>.

Attention Certified Clinical Engineers!!

The Clinical Engineering Certification Program administered by the United States Board of Examiners for Clinical Engineering will recognize the certification of clinical engineers who were previously certified under the program suspended by AAMI and who have remained in professional practice.

Applications are now available to apply for listing with the new program.

Practicing Clinical Engineers who are currently renewed under the suspended ICC / AAMI program, or whose AAMI renewal previously lapsed are eligible to apply for recognition under the new program until July 1, 2003.

To obtain an application for recognition under the new program, or to obtain more information contact ACCE at:

certification@accenet.org or (610) 825-6067.

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