

ACCE News

Vol. 13, No. 3 – May - June 2003

Annual Meeting in Long Beach

American College of Clinical Engineering

President's Message

Meet Me in Long Beach

Raymond Zambuto, rzambuto@techmed.com

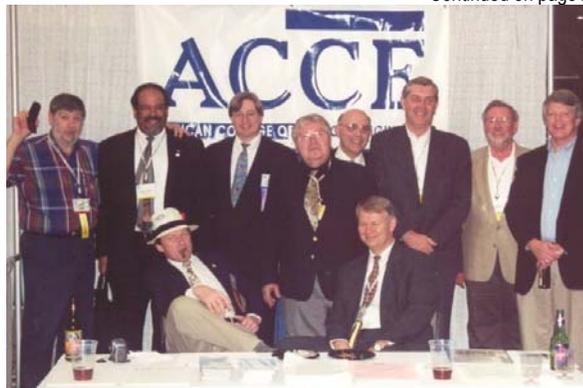
The upcoming ACCE Annual Membership Meeting will be the capstone on a week of networking, education, and ACCE activities during the Annual AAMI Conference and Expo in Long Beach, California.

On Friday evening, the first Annual Meeting of the ACCE Healthcare Technology Foundation (AHTF) will take place. AHTF is off to a running start since its formation late last year. A full report on its activities will be presented to the ACCE membership meeting.

On Saturday morning, the annual ACCE Clinical Engineering Symposium will kick off ACCE's educational contribution to the week. The focus this year is "The Future of Clinical Engineering: Technology That Enables Improved Patient Care."

A national faculty has been assembled by Ted Cohen to present a view of tomorrow's technologies and to discuss their effect on care and on the practice of clinical engineering. The discussion is sure to be lively after the symposium at the AAMI Welcome Reception.

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21 Bob's Lane

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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](http://www.accenet.org)

President's Message - continued from page 1

Sunday starts early for ACCE as the ACCE Executive Board hosts the leadership of the leading regional biomedical societies at a continental breakfast to discuss areas of common concern and ways in which we can work together for the common good of our professions. Ted Cohen will report on our progress at the membership meeting.



Later, during the AAMI Awards Luncheon, ACCE will present the Robert L. Morris Humanitarian Award to the person selected for this honor from a field of eminently qualified nominees who have worked to improve global health conditions through the application of health technology. This is clinical engineering at its finest. Be sure to attend and recognize our honoree.

Sunday marks the opening of the AAMI educational sessions and the Expo. ACCE will again have a booth in the exhibit area. Stop by to network, meet old friends or find new ones. ACCE members continue to make a major contribution to the educational program. Over 33% of the sessions have faculty who are ACCE members.

The ACCE Board of Directors will meet on Sunday evening to put the finishing touches on the reports for the membership meeting and to conduct other current business of the College.

ACCE's social highlight of the year, our Annual Reception and Membership Meeting will be held on

Monday evening. It promises to be a memorable time, with a special presentation by Yadin David on the new ACCE Healthcare Technology Foundation, reports on significant progress in our relationships with other societies, milestone news on certification, and the presentation of our annual awards by the Advocacy Committee.

The 2002-3 year has been one of growth, vibrancy, and recognition for ACCE. Join us in Long Beach for five days of learning, networking, and a little relaxation among friends, old and new. It may well be the best five days of your professional year.

See you at ACCE in Long Beach.

Ray

ACCE Members Presenting Papers at AAMI

Marvin Shepherd, Lee Welter, Doug George, Eric Rosow, Vinnie DeFrancesco, Manny Furst, Britton Berek, James Keller, Izabella Gieras, Salil Balar, Malcolm Ridgway, Elliot Sloane, John Hughes, Paul Sherman, David Francoeur, Thomas O'Dea, Mark Bruley, Steve Grimes, Binseng Wang, Ted Cohen, Bryanne Patail, and Frank Painter

SEE PAGE 11 OF THIS NEWSPAPER FOR A SCHEDULE OF ACCE EVENTS AND A DETAILED DESCRIPTION OF THE ACCE SYMPOSIUM.

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PEOPLE ON THE MOVE AND IN THE NEWS

Mark Bruley recently gave an invited lecture as one of the closing speakers at a national patient safety conference sponsored by the Agency for Healthcare Research and Quality (AHRQ). *Making the Health Care System Safer: the Second Annual Patient Safety Research Conference* was held on March 2-4, 2003 in Arlington, VA bringing together 350 researchers from more than one hundred of the current AHRQ funded centers receiving patient safety research grants.

Mark, a 28-year veteran of ECRI and its Vice President for Accident and Forensic Investigation, presented visionary perspectives on patient safety research goals related to medical devices and healthcare informatics. In his presentation, *Engineering Controls: Identifying and Disseminating Safety Research Recommendations for Medical Devices and Healthcare Information Technology*, he defined "engineering controls" as *built-in design and performance features that create barriers and forcing functions to prevent humans from making errors*. Engineering controls can prevent certain medical errors from being made, independent of the user's familiarity with the device, and do not rely on user education tools for enhancing safety.

His research recommendations were the following:

1. Examine the existing patient safety research projects to define those that have a significant medical device or information technology component that is used in the clinical setting for diagnosis, treatment, therapy, or monitoring.
2. For those identified devices and technologies, determine which types of related medical errors can be prevented by the application of engineering controls.
3. Develop a clear means for disseminating the research findings to the manufacturing community so the engineering controls can be developed and put into practice.
4. Use information technology (IT) and the Internet to quickly and reliably relay recalls and safety alerts from manufacturers and health agencies to healthcare providers.

William Hyman served as a juror at the sixth annual Medical Device Excellence Awards (MDEA) competition. The MDEA program sponsored by Canon Communications LLC recognizes products that offer major advances in device design and that contribute to the healthcare field. MDEA entries are evaluated on several factors including product innovation, design and engineering excellence, end-user benefit, and cost-effectiveness in manufacturing and healthcare delivery.

Enrico Nunziata was elected Chairman of the Clinical Engineering Division of the International Federation of Medical and Biological Engineering (IFMBE). IFMBE is the international body which coordinates and promotes worldwide biomedical engineering efforts.

Manny Furst and **Elliot Sloane** continue to chair one of the most lively and informative meetings in the whole world of clinical engineering, the AAMI Healthcare Technology Management Committee. Informally known as Manny's Meeting, the 19th Annual meeting will be held in Long Beach, CA June 13, 2003.

Matt Baretich has recently achieved the status of ACCE Fellow.

Stephen L. Grimes was published in the latest issue of *IEEE Engineering in Medicine and Biology Magazine* 22(2):91, 2003. His article, *The Future of Clinical Engineering: the Challenge of Change*, addressed the question: Will clinical engineers be prepared to meet the challenges and opportunities brought about by extreme forces poised to change the landscape of the industry?

We need to be concentrating most of our efforts on the development of a healthcare system that provides long-term treatment programs for patients with multiple, chronic diseases.

Clinical engineering programs are arriving at a strategic inflection point. The long-term viability of clinical engineering as a distinct profession and service depends on

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the model these clinical engineering programs adopt for the future.

Clinical engineers can be expected to develop organizational, project management, strategic planning, and investigative skills to ensure 24 x 7 availability of safe and effective healthcare technology.

The *EMBS Magazine* is widely-read throughout the world by those involved in every aspect of the field biomedical engineering. Steve's focused, well-written paper describes the profession of clinical engineering and the American College of Clinical Engineering. He is to be applauded for his advocacy of clinical engineering by dissemination of information concerning its practice and potential to a wide audience.

Yadin David crossed over the Rio Grande from Texas to Tec de Monterrey University in Mexico to meet the medical directors of the medical school and the hospital, the University President, and the Dean of Engineering and to lecture to the hospital physicians about an applied biomedical engineering program and clinical engineering. He also visited with the local hospital-based biomedical engineering group. Continuing education and post graduate training courses are being developed at the Monterrey University and will serve not only Mexico but also Central and South American countries. By the end of his visit he felt that the Biomedical Engineering program at Tec de Monterrey University would soon become a reality.

Perspectives from ECRI SARS and Equipment Maintenance

James Keller, jkeller@ecri.org

Many of ECRI's membership programs include consultation services in which member hospital staff can call, fax, or e-mail ECRI with questions or for ECRI's perspectives on a variety of technology-related issues. Recently, ECRI has fielded many inquires related to the disturbing new outbreak of Severe Acute Respiratory Syndrome (SARS) throughout Asia and other parts of the World. Most of the inquiries have come from clinical engineers seeking ECRI's perspectives on special precautions that should be used when servicing medical devices that may have been exposed to SARS. We have also been asked for our perspectives on simply what precautions a clinical engineer should take if he or she needs to enter a room with a patient that may have SARS.

Because SARS is such a new phenomenon, there is much that it is unknown and uncertain about this illness and the organism that causes it. However, ECRI is researching the topic as it relates to medical technology and will be publishing what it does know in a guidance article for its *Health Devices* publication. This article will, in part, be

based on the questions we have received from our member hospitals. The article will be available on the member areas of ECRI's SELECTplus and Health Devices Web sites during May of 2003 and will focus on precautions to take when servicing medical devices that may have been exposed to SARS.

Although the organism that causes SARS may be new, the methods of transmission, and therefore the infection control measures, are fortunately the same as those commonly used for many other diseases. Some key protective measures to follow are provided below. More extensive precautions and guidelines can be found in ECRI's upcoming article on SARS. Keep in mind that the measures provided below should already be part of your standard precautions for dealing with other transmissible diseases.

- ✓ Hand washing and good hygiene. Avoid any contact of your hands with your face, nose and eyes. Do not rub your eyes, eat, drink, or apply cosmetics any time that you working in the vicinity of potential SARS contaminated equipment or patients.
- ✓ Use of personal protective equipment (PPE). In addition to gloves, eye protection (goggles or face shield) and a gown must be used to minimize the risks associated with splatter and splash.
- ✓ Disinfection of exterior surfaces and surfaces that may have been directly exposed to the patient's exhaled breath or other secretions. EPA-registered hospital disinfectants are believed to be effective against SARS. According to the CDC, "There are no disinfectant products currently registered by the U.S. Environmental Protection Agency (EPA) specifically for the inactivation of the newly identified viruses associated with SARS. However, related viruses with physical and biochemical properties similar to the possible SARS agents are known to be readily inactivated by EPA-registered chemical germicides that provide low- or intermediate-level disinfection during general use." (*Interim Guidance for Cleaning of Commercial Passenger Aircraft Following a Flight with a Passenger with Suspected Severe Acute Respiratory Syndrome (SARS), March 30, 2003.*)
- ✓ Properly dispose of disposable components before servicing equipment.

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 SARS or would like to discuss any device-related transmission concerns regarding SARS. Members of ECRI's Health Devices and SELECTplus programs will be able to view the SARS guidance 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, slgrimes@nycap.rr.com

Keep up with latest HIPAA developments!

- "Counting Down Towards Compliance: What is the Final Security Rule's Impact on Clinical Engineering?" AAMI Annual Conference. Long Beach, CA; June 17, 2003"
- *HIPAA Security Rules and Medical Technology.*" ECRI Audio Conference. May 21, 2003
- "HIPAA's Implications for Clinical Engineering." American Society of Hospital Engineering (ASHE) 40th Annual Conference and Technical Exhibition. San Antonio, TX; July 16, 2003
- "HIPAA's Final Security Rule." ACCE Teleconference. November 20, 2003



Clinical Engineers of the Future ↓



Thejas N. Swamy, Hussain A. Ali, Steve Merritt, Ryan Felber, Stephanie Haapala, Zacarias DeLemos, Matthew Wheeler, Umair Siddiqui, Megan Miller, Evelyn Faillie, Prof. Frank Painter, Brian Fudge, Francisco Rodriguez, Sathesh Parachoor (l to r).

When the above photograph was taken, the students depicted were attending a graduate level course in the Biomedical Engineering program at the University of Connecticut (UCONN) entitled "Clinical Engineering Fundamentals". This class, a seminar, held at the BEACON offices of Dr. Joseph Bronzino, was given by Cheryl Shaw (Massachusetts General Hospital), Michael Fraai (Brigham & Women's Hospital) and Eric Rosow (Hartford Hospital), all past graduates of the internship program, as well as Nick Noyes (UCONN Health Center) and Bob Zbuska (St. Francis Hospital). Nine students are involved in clinical engineering internships at teaching hospitals in the central Connecticut area and four are

graduate biomedical engineering students interested in engineering in the clinical environment.

In this current semester, Professor Frank R. Painter is teaching 16 students in the class *Engineering Problems in Hospitals*. Next semester the course will be *Human Error and Medical Device Accidents*, and the following semester, *Medical Instrumentation in the Hospital*. The program involves a two-year internship with a master's thesis and eight graduate level courses.

The program is described at the UCONN website www.bme.uconn.edu.

AAMI Annual Conference and Exposition

June 14-17, 2003

Long Beach, CA

www.aami.org

Mark Your Calendar!



**40th Annual Conference & Technical
Exhibition
San Antonio, Texas - July 14-16, 2003**

ACCE is an Education Partner for the Annual ASHE Conference in San Antonio TX. A full track of Clinical Engineering sessions has been organized, featuring many ACCE Faculty and topics relating to regulation, management, training, and technology. This is a great opportunity to combine Clinical Engineering education and networking with a look at adjacent technologies and issues facing health care engineering. Further information on the Conference can be found at www.ashe.org. Don't miss it!

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THE VIEW FROM THE PENALTY BOX

David Harrington, dave@sbtech.com

Fourteen Years in the Penalty Box

In May of 1989 I joined many of you in a meeting room at the convention Center in St. Louis during the AAMI convention to listen to my colleagues talk about forming another society. I listened to Yadin, Matt and several others talk about how the societies that we belong to did not really represent clinical engineers. Some seemed to favor manufacturers, some the plant engineers, some the researchers, and others were little more than mailing lists.

After that session I joined many there for some milk shakes and continued to talk about what needed to be done. Like good engineers we stepped up and volunteered to perform various functions to get the group moving forward.

We took a few arrows, as did many people trying new things, but in less than a year we had a clear definition of what clinical engineers are and what their educational requirements needed to be. A code of ethics was written, bylaws were crafted, and a newsletter was published. Much of the early work was done on such stellar computers as a Vic 20, Burroughs, and IBM PC computers with 5-inch floppies, about 5 Meg of hard drive and 64 K of RAM. This was also before email became common.

Over the next few years we had our struggles with losing members to the information technology (IT) field, others got caught in budget reductions, and probably less than 20% of those who signed on with the ACCE in 1989 are still in the same positions as they were then.

Many might contend that we poured too much effort into international programs and not enough into our United States programs. As strange as it may seem to many of you, the fact is that right from the beginning more than 15% of the ACCE membership is from outside of the US. ACCE has made a major impact on the profession worldwide. We have done it very quietly, like good engineers always do, and very effectively.

With our expertise and sharing of information we saved hospitals billions on the Y2K push. That was good because the IT people and others spent billions on upgrades simply because they let technology grow for the sake of growth while we put function before growth. But as usual nobody seemed to notice what a good job we did as a profession.

In this past year challenges are being thrown at us from various agencies with little or no input from the clinical engineers that will have to make things work.

Many of us are struggling with the JCAHO National Patient Safety Goal number 6, patient alarms. This has the potential to be very costly and time consuming as we have to make old technology act like new and do it with very little

funding. We do not have the manufacturers stepping up to help us with the problem, unless we buy all new equipment. The clinical staff reads the requirements thinking that they are not involved while we try to tell them that they have to be.

Then we get hit with HIPAA. Going back to the Code of Ethics that we adopted 14 years ago there is a canon on respecting the patient's privacy. We have been doing it for years. But now because too many others were not as proactive as we were, we have about a thousand pages of lawyer talk telling us what we already do. Too bad the IT, medical records, and financial people did not have the same sets of ethics that we do. We could be saving billions; but again we took the arrows for the good of all.

Now there is another "skunk at the lawn party" called OSHA. Somehow the FDA has charged OSHA with inspecting hospitals. We had four inspectors arrive at the door of a hospital and they spent four days there going over data on air quality, how problems are handled, and all the documents they could get their hands on. They actually read those nice Policy and Procedure Books that get updated every three years and asked people questions on the contents. Do you want to venture a guess on how many members of the clinical and support staff actually read those manuals? My guess is zero; the last person to read them was the one who wrote them.

These are some of the reasons why this is such a great profession and so many truly outstanding people are in our profession. There is always something new coming at us over which we have little or no control, no budget to work with, and, all too often, too little assistance from those in other departments of our hospitals. We thrive on challenges.

So keep up the good work, keep on smiling and since we will never become the emperors we will work as usual to make the changes needed. We know what has to be done and all we need is the chance to show our skills.

We are ready. So, let's do it!



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CE Around the Globe

Enrico Nunziata, n.enrico@botte.net

EHTP in Mozambique

The second workshop on Essential Healthcare Technology Package (EHTP) for Training of Trainers was held in Cape Town, South Africa, Feb. 17-19, 2003. The aim of the workshop was to share the challenges, difficulties and successes experienced by those who started testing this methodology in countries such as South Africa, Kyrgyzstan, Namibia, Mozambique and China. Country counterparts from Namibia and Mozambique also attended the workshop providing the beneficiaries' perspective.

Tom Judd [*ACCE News* 12(2):20, 2002] presented EHTP methodology and its application in Kyrgyzstan. He also described his trip with Oleg Shereshevskiy in that wonderful part of the world.

EHTP methodology is a Decision Support System¹ (DSS) based on the concept of Intervention Oriented Resources Planning. EHTP methodology starts with the identification of the interventions or health services to be provided. Then, the procedures composing a given intervention are linked together based on existing Clinical Practice Guidelines (CPG). Finally, it is necessary to associate, to each procedure, the required resources (human resources (HR), infrastructure, drugs and medical devices). Once this exercise is completed for each intervention, it is possible to run simulation exercises based, e.g., on the number of patients or percentage of the target population needing that intervention and to calculate the dynamic list of resources used and their relative costs. "What if..."² analysis can be performed to simulate different situations/scenarios.

EHTP methodology and tools could be used in different Healthcare System settings, e.g., to model a casualty and emergency area, a radiology department, a national screening program, the top five diseases for different levels of care, all the services provided at any given health unit, or even an entire healthcare system.

Ministry of Health (MoH) of Mozambique, after addressing strategic issues such as the development of the Health Sector Strategic Plan, the definition of the Medium-Term Financing and Expenditures Scenarios and the preparation of a Sector wide Macro-Investment Plan, decided to test the EHTP methodology to see how it could assist the investment process as it enters into the micro-planning phase.

EHTP methodology will be implemented to identify, quantify, integrate and rationalize the resources needed at the PHC (Primary Health Care) level starting from the

definition of health interventions (promotive, preventive and curative) to be provided at this level of care. It is foreseeable that the methodology will avoid the process of adjusting pre-defined standards, which do not reflect necessarily the contextual situation of the country, allowing the creation of a country database with the currently available resources.

In particular, the test phase will model the interventions delivered at Health Center Type-I (a Clinic with preventive medicine, first aid, infectious diseases and maternity attention programs and ward capacity limited to 15-beds) and at Urban Health Center (similar to Type-I but with no ward capacity). The test phase has the following objectives:

- To identify Healthcare Technology (HT) and produce an Essential Equipment List for the Primary Level of Care;
- To model how available resources can be used to meet the requirements of the health services delivery protocol identifying critical gaps;
- Evaluate the financial and logistical impact in protocol modifications.

The test phase is carried out by multidisciplinary groups of experts at different level within the MoH pyramid. The groups are as follows:

Process Responsibility	Human resource
EHTP National Coordinator	MoH Director of the Directorate of Planning

Implementation Group Coordination	Human Resource
EHTP Group Coordinator	Personnel of the MoH Directorate of Planning
Technical Assistantship	Expert from WHO

Implementation Group	Human Resource
Coordinator	Same as EHTP Group Coordinator
Drugs	Responsible/Expert of the MoH Department of Drugs
Logistics and Cost	Department of Logistics and Finance
Equipment & Infrastructure	Department of Maintenance of the MoH
Human Resources	MoH Human Resources Directorate

Expert Panel	Human Resource
Clinical and Diagnostic Protocols	Responsible of Clinical Practice of Maputo City Directorate of Health; Nurse Supervisor of the Maputo City Directorate of Health; Chief Nurse of one Health Center of the City of Maputo (HC Bagamoio) and responsible of the various sector within the HC

The test, which began in mid-January 2003, will have a six-month duration. WHO provided initial funding, and other donors provided the rest to complete the test phase.

¹ "Enhancing Health Services Management", edited by Steve Cropper and Paul Forte, Open University Press, 1997.

² For example, using the "what if..." analysis it is possible to evaluate, in term of resources and associated cost, the changes needed for the introduction of a new Malaria drug.

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During the first two months of the project the activities were oriented toward data collection on human, infrastructures, and other resources already available at the Ministry level. These data were used to build the basic blocks of the country database. Presently, all the interventions delivered at PHC are being analyzed and modeled along with the procedures and techniques used. During this modeling process the technologies associated to the procedures are identified and added to the database. This phase should be completed by the end of April 2003 and simulation of different scenarios will be carried out during the month of May after a committee of experts revises the collected data.

The expected results at the end of the test are as follows:

- The creation of a database of the resources needed at PHC;
- The definition of “*Appropriate*” Standard Lists for PHC in Mozambique;
- An initial model for “*optimal*” utilization of available resources;
- A model for “*Scenarios*” building and simulation depending on different resource allocations and service expansion.

A derived, not originally planned, result will be the organization and integration in one package of all the CPGs for PHC that are presently dispersed among the various vertical programs.

The EHTP methodology is still in its initial implementation stage in different countries and at different levels of healthcare systems. Nevertheless, it appears to be, during its daily implementation, a valid DSS especially from the point of view of rational planning of HT as discussed during the Cape Town Workshop. Soon some initial results will be available and presented. And, as a consequence, more detailed discussion on the methodology and its impact on Healthcare System Planning will be possible.

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 Board Meeting Highlights February 19, 2003

President Ray Zambuto discussed growth, strength, and opportunity issues. Strategic planning involving liaison with other organizations will be aired at an upcoming meeting in Long Beach at the annual ACCE meeting. Agreement was reached on Guidelines for Reviewing Contracts and Agreements.

President Elect Izabella Gieras forwarded a list of nominees for the Robert Morris Award to AAMI. She is temporarily filling the shoes of the former Advocacy Chair Brian Porras. Steve Grimes and Matt Baretich have completed the latest edition of the WHO ACEW Syllabus.

Vice President Ted Cohen reported that the Annual Symposium is on track and that an ACCE Integrating the Healthcare Enterprise (IHE) Task Force was formed.

Jennifer Barbee has taken the reigns from Al Levenson as ACCE Teleconference Program coordinator.

Past President Elliot Sloane mentioned that there was not much feedback from the fall membership survey to suggest significant changes to the ACCE Website. Recently passed bylaws revisions will be posted on the site. The ACCE Healthcare Technology Foundation has been established.

Treasurer Henry Montenegro reported a healthy surplus owing largely to the highly successful teleconference series.

Tony Easty, International Committee Chair, reported ACEW developments and options for expanding the scope of INFRATECH, the PAHO-sponsored Listserv.

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Certification Update

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Caroline Campbell



Greg Davis



Dick Congdon



Gary Evans



Paul Ostrowski



Jim Wear



Bruce Barkolow



Bill Paulsen



Tijun (TJ) Wang



Bill Hyman

US Board of Examiners
for Clinical Engineering Certification
April 2003

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Calendar of Events

- IEEE EMC Symposium, June 16-19, 2003, Boston, MA.
- 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.
- 40th Annual ASHE Conference and Technical Exhibition, San Antonio, TX, July 14-16, 2003.
- 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 October 31, 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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Annual ACCE Symposium - The Future of Clinical Engineering: Technology That Enables Improved Patient Care

Physician Perspective - *Managing Clinical Information for the Next Decision*

Thomas Tinstman, MD, UC Davis Health System

Nurse Perspective - *Technology That Enables Improved Patient Care*

JoEllen Koerner, RN, Simulus

Healthcare via the internet - *Impact of Online Patient-Physician Consultation*

Marcos Athanasoulis – Relay Health

Patient Safety – *Managing Medical Errors: Clinical Engineers are uniquely positioned to address the “what” and how” of Patient Safety*

Bryanne Patail, Veterans Health Administration

Integrating the Healthcare Enterprise (IHE) 2003 – *Moving Beyond Standards for System Integration to Interoperability across the Healthcare Enterprise*

Joyce Sensmeier, RN, Healthcare Information and Management Systems Society (HIMSS)

The Smart Hospital – *Patient Monitoring Meets Information Technology*

Greg Farah, Siemens Medical Systems, Inc.

Surgical Robotics and OR Automation - *Impact on surgical precision, efficiency of the operating room, and communication between surgical staff*

Darrell Uecker, Computer Motion, Inc.

Using Simulation Methods to Improve System Design

Mark Winter, Simulus

Technology Management Education – *Required Education Skill Set Development for Future Technology Managers*

Elliot Sloane, Villanova University; Frank Painter, Technology Management Solutions

Future Repair Paradigms - *Remote Diagnosis and Repair*

Dick Roessler, Beckman Corporation

Planned Maintenance - *What is the Prudent Minimum for Clinical Engineering’s New Paradigm?*

Malcolm Ridgeway, Masterplan, Inc

The Future of Clinical Engineering: *Can Clinical Engineers Adapt?*

Stephen Grimes, GENTECH; Eric Rosow, Hartford Hospital

Schedule of ACCE Events in Long Beach, CA

Friday	Saturday	Sunday	Monday	Tuesday
13-Jun	14-Jun	15-Jun	16-Jun	17-Jun
		ACCE Booth Open 5:30-8:00pm	ACCE Booth Open 9:45 am-1:00pm & 4:00-6:30 pm	ACCE Booth Open 11:00am - 1:30pm
AHTF Board Meeting 6:00 - 9:00pm	ACCE Annual Symposium 8:30-5:00	ACCE / Regional Biomedical Societies Summit 7:00-8:30 am	ACCE Reception & General Membership Meeting 6:30-9:00pm	
		ACCE/ Robert Morris Award presented at AAMI Awards Luncheon 11:30am - 1:00pm		
		ACCE Board Meeting 7:00-9:00pm		
33% of the Educational Sessions will have ACCE Faculty!!!				



2003-2004 Teleconference Series

May 15, 2003

Working with Your IT Department

Eric Rosow, Alan Lipschultz and Vinnie DeFrancesco

The first session of this teleconference series focuses on the relationship between the Clinical Engineering and IT departments. The speakers will cover how CE & IS groups relate, share examples of some of the projects they have worked on, and express their thoughts on what they feel were the successes and challenges of those experiences.

June 19, 2003

JCAHO Environment of Care Update

Ode R. Keil

Become familiarized with the latest changes to the Environment of Care (EOC) standards for 2003 while learning how to efficiently integrate the new standards and interpretations into your CE program.

July 17, 2003

Management of Medical Technology

Dr. Eliezer (Elie) Geisler

What is the “new” field of management of medical technology (MMT)? This presentation addresses the intersect between technology, healthcare delivery and management. Topics explored: how medical technology is utilized and implemented by healthcare delivery organizations, how it can be evaluated, and what are the managerial and organizational barriers as well as the facilitating factors that impinge upon the adoption and utilization of medical technology in the healthcare organization.

August 21, 2003

Six Sigma Methodologies for Clinical Engineering

Ian R. Lazarus

What is Six Sigma? And how can it be implemented in the CE department? Learn how a method created in the manufacturing industry can be used in healthcare organizations and departments to control costs, improve quality by reducing “defects”, and enhance customer service.

September 18, 2003

Disaster Preparedness-The Role of Clinical Engineering:

Duane Mariotti and Yadin B. David

How can Clinical Engineering departments assist their healthcare organizations in preparing for disaster? Topics discussed will focus on technology needs for responding to disasters, from medical and personal protective equipment to telecommunications, information technology, security and facilities issues. Speakers will discuss their stories and lessons learned in using technology to respond to disaster.

October 16, 2003

A Simpler Risk-Based Approach to PM Inspections

Malcolm Ridgway

The current consensus that much of the traditional PM workload is a waste of valuable resources has grown steadily during a period of seemingly endless debate about how we can make our PM programs more effective. This new method allows us to reduce each series of PM inspections to a simple, single measure (the *Risk Score*) that can be used to characterize the effectiveness and levels of safety of the PM program parameters being used.

November 20, 2003

HIPAA’s Final Security Rule

Stephen L. Grimes

HIPAA’s Security Rule is finally out! And this new federal regulation will have a major impact on the future of biomedical technology programs. Learn how the CE community needs to adopt a new mindset in order to effectively address data security issues centered on the need to preserve the integrity, availability and confidentiality of health data maintained or transmitted by biomedical devices and systems.

December 18, 2003

Attributes Sampling Applied to Clinical Equipment Inspections

Binseng Wang

Hospitals can now use statistical sampling techniques to manage equipment under the revised JCAHO standards. The attributes sampling technique used for over 50 years in industrial production will be reviewed as a tool to optimize the use of limited resources.

January 15, 2004

Integrating the Healthcare Enterprise (IHE)

Joyce Sensmeier

The IHE initiative is sponsored by the Healthcare Information and Management Systems Society (HIMSS) and the Radiological Society of North America (RSNA), which promotes the coordinated use of established technical communication standards (e.g. DICOM and HL-7) to address specific medical systems integration needs. Learn more about this initiative, upcoming projects, and some examples of how this initiative has been applied.

February 19, 2004

Clinical Engineering and Healthcare Facilities Engineering-Engineering for Patient Care

Matthew Baretich

Clinical Engineering and Facilities Engineering have historically had very different organizational cultures. However, there are also many parallels and many opportunities for cooperation in healthcare facility design and operation. This presentation is about ways to create synergy and to apply our engineering skills more broadly for improved patient care.

To register for this series, complete the registration form on www.accenet.org or contact Jennifer M. Barbee at 703.312.5847