

ACCE News

Newsletter of the American College of Clinical Engineering

November-December 2014

Volume 24 Issue 6



2015 Advocacy Awards—Call for Nominations

ACCE Mentoring Program—Call for Volunteers

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President's Message



This article is a bit of a hodge-podge. I'm going to highlight some of our recent activities and Board decisions, discuss a membership idea and think about work/life balance. Finally, I want to share some thoughts regarding what's going on here in St. Louis and how those lessons may help us in ACCE.

ACCE has a new representative to Integrating the Healthcare Enterprise, Patient Care Devices Domain (IHE-PCD). Robyn Frick of East Maine Medical Center has volunteered for that responsibility. Manufacturers heavily participate in PCD; we really need the hospital community perspective. And, while Robyn is our official representative, there's plenty of room for other Clinical Engineers in the groups. Please consider it - it's actually pretty fun.

Almost from our creation, ACCE has worked with the World Health Organization. We've put together ACEWs and other activities with them and provided input on a number of issues. This past summer, WHO asked us to formalize the relationship by becoming a WHO Nongovernmental Organization (NGO). This gains us more stature with WHO overall and enables additional activities. We need to do a number of things to attain this goal; most of which is documenting what we already do. One is different. WHO wants independently audited financial reports for two years. ACCE has never, as far as we know, had our books audited. I believe we need to do this anyway, and efforts are underway. One of the Board's responsibilities is to be a good steward of your money. Audits are a way of ensuring we do so. That aside, becoming a WHO NGO raises ACCE's profile in world health, which helps the profession overall.

By the time this newsletter hits the ACCE website, the website should be revamped. A lot of people have reviewed their parts of the website, and we've had artists and designers look at the layout. I think you'll like the changes. I also want to thank AwarePoint for sponsoring the update and being patient with us while we've worked on it.

ACCE recently activated the Body of Knowledge (BOK) Workgroup again. Every few years this group surveys the field to determine what our jobs are and what skills we need to perform them. The Board of Certification uses those results to form the questions needed for the CCE exam. Joan Brown has been nominated as the new BOK Chair. She and her team will review the current version of Body of Knowledge (BOK). Stay tuned; the 2015 BOK Survey will be coming soon to your mailbox. If you're interested in helping with the BOK survey, please contact Joan Brown at bok@accenet.org.

AAMI contacted us about next year's conference. They have a LOT of changes in mind. Some of those affect ACCE activities directly, but most won't affect us much. When AAMI releases their plan, we can share more. I hope that will be in the next newsletter.

Last year we raised our membership dues. So far, there hasn't been much concern, as our overall membership rates are much lower than other organizations. I say overall, because there's one group

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President's Message

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that was affected more - students. ACCE doesn't have a student membership; we've always included students in our Candidate category. The dues change raised Candidate dues to \$38/year. While for most of us this isn't bad, but for students every penny counts. The change of \$8/year has a bit more impact. One member expressed concern and thought we may lose student members. I didn't think much of this until I looked up student member rates for AAMI and IEEE - both are \$30/year.

I think it's time for us to consider a Student membership. I have asked the Membership Committee to look into it. There are a number of reasons - the \$8/year difference being the trigger, but by no means the sole reason. ACCE is helping create CE programs in universities across the country. I think student memberships are a natural extension of that. In my undergraduate studies, I managed to find time and resources to join IEEE and be active in the local student chapter. It was pretty rewarding, and set the stage for my ACCE activities. We have a chance to extend the opportunity to others coming into this profession.

Balance - work to live or live to work? When I started thinking about what to include in this article, I was preparing for deer hunting season. I enjoy being in the woods; it's often very quiet and peaceful (except for the occasional boom). I take advantage of that to think about other things. I love this career choice and am grateful for the opportunities it's provided me, but Clinical Engineering isn't my life. I have other interests that have little to do directly with CE. Those who have seen me at the AAMI meetings at Charlotte and Philadelphia likely also know that my wife, Gini and I drove there in our 1940 Chevrolet street rod. I did about 80% of the work on the car myself, including welding, bodywork/modifications, assembling the engine and wiring the car

from scratch. I found that working on the car allowed my conscious mind to focus on a task at hand. While doing so, the rest seemed able to work on something else. Many times, work problem solutions showed up 'out of the blue'. Another hobby came about because of work; I now am active in Amateur radio. Working on WMTS brought up my old military wireless training. Rick Hampton and Jim Welch told me I should look at it again. The satisfaction of using a home-built antenna to talk to someone in the Falkland Islands is pretty amazing.

The point is - I have found these activities helpful at work, but more importantly they help remind me that there's more to life than work. Someone once told me, "No one ever lay on their deathbed wishing they'd spent more time on their career".

Many of you know that I live in St. Louis. The recent events here highlight the ongoing tensions in this locale. There are many reasons for what has happened, and the reactions following. St. Louis has a long history of racial tension that has never been adequately addressed. Many of those born in this area aren't even aware of those tensions, or think they're normal or worse, it's the other side's fault. Not growing up here, I see this differently. Few on either side of the issue are letting go of what happened in the past. Until that happens, they can't move on.

Over the last couple years HTCC and AAMI worked on HTM certification. More recently HTCC needed a new hosting organization. In both circumstances some ACCE members vehemently opposed any work with AAMI. This wasn't based on how AAMI currently operates, but on their actions that led to creation of the current CCE program and the founding of ACCE. The fact that only one person from back then is left at AAMI didn't matter. That personal anger disrupted the process and made rational decisions much more difficult. We need to let the past go; AAMI made some

mistakes. ACCE has made mistakes. We're human. One thing we do incredibly well is make mistakes. Both groups want what's best for the field; let's focus on that.

I want my articles to be conversation starters. You may not agree with me, or have a different perspective. Cool! Tell us what you think, either by email, posting on our Facebook page, or whatever method works for you (even radio- my call sign is KD0CIW).

Regards,

Paul Sherman

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ACCE News

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ACCE Job Website Job Postings

For posting job opportunities, please contact Dave Smith at advertising@accenet.org

2015 ACCE Advocacy Awards: Call for Nominations



The ACCE Board and Advocacy Committee recognize the past award winners and are pleased to announce that nominations are now being accepted for these awards. View the [awards criteria](#).

Please take the time to nominate worthy colleagues today and contact students to submit their papers. Just email the [nomination form](#) with recommended individual(s), justifications, and/or papers to advocacychair@accenet.org by January 30, 2015.

These awards will be presented at the 2015 ACCE Awards Banquet to be held at HIMSS in Chicago, IL in April 2015. Awardees will also be recognized on Sunday June 7, 2015 at the AAMI conference- ACCE 25th Anniversary celebration / membership meeting in Denver.

Thank you for submitting nominations!

Arif Subhan
ACCE Vice President

Mentoring Program: Call for volunteers

Are you interested in helping implementing the mentoring program for ACCE members? Do you wish to serve as a mentor?

If YES, please complete this short [survey](#) to give us your feedback on your interest area(s) for this emerging program. While we have a framework for the mentoring program, we lack details such as; how to select mentors and mentees, how to best match mentors with mentees, just to name a couple of more basic questions.

Suggested Mentor Task Force Functions

1. Develop any formal requirements and guidelines for a mentor program.
2. Review other professional mentor programs.
3. Establish a process to match mentors and mentees.
4. Develop a list of mentor areas needed.
5. Establish a list of mentors and areas of expertise.
6. Promote the mentor program. (Write an article.)

Gerald Goodman
Mentoring Chair
mentoring@accenet.org



View from the Penalty Box

As another year comes to a close we look back wondering why time seems to move so fast now and that there never seems to be enough time to get everything done, communicate with others, or even spend time just doing nothing. A piece of advice—do not wait until retirement to get things done, or communicate or do nothing because unless you are in a “home” with a drool cup, time really moves quickly.

As engineers we were taught to set priorities, stick with a schedule and budget, get things done, and move on. That is great when you deal with other engineers, but much of our “marching orders” come from uninformed people who somehow get to be administrators, agency people, and worst of all, legislators and lawyers. In healthcare we have way too many people “employed” (note I did not say working) who do not put the patient first. We are mostly a proud group that has always put the patient as our first priority; those that don't do not last too long in Clinical Engineering. Those people probably move to IT, as there does not seem to be enough patient concern. Instead, there's too much focus on just the data. I would like to also mention that 2 of my sons work in healthcare IT, which can make for some interesting discussions.

My wife recently had a hip replacement in a local hospital. It was clean, well-staffed, had up-to-date technology and was not part of the big networks from Boston. She was discharged after 3 days to a rehab facility that was poorly staffed, had lousy food, was not that clean, and had technology out of the 80's. Ironically, it was rated very high by the state. It was close to home so visits were easy. I also went to two of the hospi-

tals associated with the big networks. Generally they were not so clean, the food was not great, and the technology was disappointing in that it was old, in both hospitals. The equipment seemed to be held together by stickers. Please have your staff remove all the old stickers when they inspect or PM a device, it makes it look so much better, while letting the patient know that we care. Remember the patient comes first, always

The New England Society of Clinical Engineers (NESCE) recently held its regional symposium. Looking at the number of Biomedics and engineers attending, along with the HTM's, local programs are in trouble. The societies running these programs will have to look at why people are not attending like they used to. Is it that there are so many free programs offered, online? Is it because they are going to national shows? I hear that those numbers are down also. Are they going to the ones put on by Tech Nation/Medical Dealer? Or are the online programs, such as our webinars, although not free, meeting the needs? At some point I think that the Joint Commission or CMS is going to require documentation that those working with devices have continuing education. It seems ridiculous that people in the low level positions in hospitals and nursing homes must show continuing education while we do not. The way technology is growing, we need that training more than the person cleaning commodes. Those CEU's need to be reasonably priced, have a test upon completion, and a certificate of completion so we can show that we are working to keep the patient first in our process. It shouldn't come secondary to the paperwork and whatever else will be thrown at us in the future.



As ACCE begins its 25th year, it is important to thank those who were responsible for getting the ACCE started. They include AAMI, who were not thrilled that we wanted more information in the magazines and conventions. Also ASHE, who did not know where we fit in hospitals; Should we be part of the electrical shop, materials, nursing finance or maybe our own department? To the AHA, yeah, we were needed, but what do we do with them? Note they were saying the same about IT at that time. Lastly, thank you to the states who stated that there are too few of you to require registration as you cannot afford the cost of the regulating agency. Yadin and company stepped forward and created the ACCE to try to push our profession and to connect all of us working out of basements in hospitals, around the world, into an organization that helped all of us keep that patient first. Thank you all for these past years on behalf of all the patients you have helped. KEEP UP THIS GREAT WORK.

Dave Harrington
Dave@sbtech.com

ACCE Board Update

I just got back from attending the "The National Coalition to Promote Continuous Monitoring of Patients on Opioids" meeting in Chicago, where I represented the ACCE. AAMI's Healthcare Technology Safety Institute (HTSI) convened the meeting, which was attended by representatives of multiple medical societies, patient advocates on this topic, hospital representatives from organizations in the forefront of this field, and manufacturers who make equipment to assist in the continuous monitoring. More infor-

mation on the meeting itself is available at <http://www.aami.org/htsi/opioids/index.html>. A summary of the discussion from the meeting will be published in December and made available on the just mentioned web site.

Alan Lipschultz
Member-at-Large

Perspectives from ECRI Institute

Optimization and Value-Add—Clear Strategies or False Idols?

By Robert Maliff

In nearly every hospital we visit on behalf of ECRI Institute, optimizing performance and adding value are the hot topics – almost as hot as cost reduction strategies. And they certainly are big issues in Clinical engineering. However, optimizing equipment maintenance and adding value in technology management are often interpreted differently by each member of a hospital's senior leadership team – especially when compared with Clinical Engineering's leadership understanding, which then creates a quagmire for all.

As we all know, healthcare reform has not made operating a hospital any easier, and capital and operational funds have been severely constrained for years now. It's not uncommon for hospital leaders to impose a freeze on capital expenditures – often for years at a time – and we're often told to look for operational savings wherever they might be unearthed.

Countering this cost emphasis are the regulatory requirements – both long existing and new ones – that are imposed upon us.

Recent discussions we've had with one hospital were centered on it being understaffed and unable to keep up with its equipment management program's PM schedule. At another with a contracted service, the focus was on how to lower costs. Still, at a third hospital, it was centered on Clinical Engineering's ability to coordinate the trial of a cardiopulmonary reporting system. Optimization at each of these hospitals required a different end result, and that may change as senior leadership changes as well.

So how do we optimize our health technology management operations and our support of the patient while at the same time improve our direct operating expenses?

First is communication, followed by communication, communication, and more communication.

Next, we each have to work with our leadership to get on their dashboard. Whether it's a simple metric like progress in meeting monthly PM completions or a more complex ones like devices tagged in the ongoing RTLS implementation or alarm loads/unit as we address the National Patient Safety Goal, we as clinical engineers have to work with our CMMS partners in supplying this information to hospital and system leadership.

Most of the contracted multivendor service providers will provide this quite easily – if asked to do so. If we are in-house service and cannot produce such information, no wonder that we might be outsourced

We have to ensure our performance results are being spread in real-time rather than at the bimonthly or quarterly Environment of Care committee meeting where we get 2 minutes to say where our PM program is in regards to monthly compliance. And, while an excellent practice, the department tours during National Biomedical/Clinical Engineering Appreciation Week does not count toward our education of senior leadership.

Value optimization is all about being current with measureable and timely performance metrics. Being out-of-sight is not good since we are then out-of mind, and it



Rob Maliff has been assisting healthcare organizations with capital, strategic, and safety initiatives for more than 20 years. As a Director in ECRI's Applied Solutions Group, he leads that group's programs supporting clinical alarms, patient safety, value analysis and capital planning, as well as technology management programs. He has an MBA in Health Administration from Temple University and a Bachelors in the Science of Engineering from Duke University. He is an active member of Healthcare Information and Management Systems Society (HIMSS) and the American College of Clinical Engineering.

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becomes ever harder to expand our programs improving technology management and patient safety. We need to ensure that we are providing the right performance information to leadership so they can, in partnership with us, make the best decisions.

Journal of Clinical Engineering Call for Papers

The Journal of Clinical Engineering prints selections of the ACCE News in each issue and is interested in papers from you. If you have an urge to write, and good clinical engineering activities or ideas to share, please consider JCE as one of your outlets. One type of article not seen in a while is the Department Overview which presents how your department is structured and how it performs its functions. Shorter "Perspective" pieces are also welcome. You can discuss manuscript ideas with fellow member William Hyman, who is one of the editors of JCE.

Contact: w-hyman@tamu.edu.

Send manuscripts to William or Michael Leven-Epstein at: michael.levinepstein@gmail.com

AAMI Update

AAMI, FDA Event to Place Spotlight on Risk

After a positive reaction to last year's inaugural event, the AAMI/FDA S3 Challenge will return this coming spring with a focus on the ever-more important task of managing risk.

Designed as an interactive forum to discuss standards, synthesis, and solutions, S3 Challenge 2015 will focus on one standard: ANSI/AAMI ES60601-1, Medical electrical equipment—Part 1: General requirements for basic safety and essential performance. Attendees will participate in open discussions about electrical and mechanical hazards and the importance of risk assessment and management as a part of design, good manufacturing, and the pre- and postmarket performance of medical devices. Presentation topics include the construct of the 60601 series, electrical hazards, mechanical hazards, and making the case of conformance.

Scheduled for April 1–2, 2015, in Herndon, VA, near Dulles International Airport, the event will bring together professionals in the medical technology industry to work to solve some of the most vexing issues surrounding the use of global standards.

The event will be divided into four sessions, each consisting of two parts. Experts from the U.S. Food and Drug Administration will help audience members understand the standard and identify possible gaps in knowledge. The event will conclude with an open exchange of ideas to identify ways to prove conformance to ANSI/AAMI ES60601-1:2005/(R)2012 and its amendments.

“We’re in the process of inviting speakers and other logistics, but we’re well on our way to creating another informative, impactful event,” said Deborah Reuter, AAMI’s senior vice president of education. “We considered attendee feedback from the inaugural event, and we’ll have a number of surprises in store for next year’s participants.”

Get more information, including the agenda, at www.aami.org/S3.

Campaign to Promote Continuous Monitoring of Patients on Opioids

Working with the support of key industry partners, the AAMI Foundation, has debuted a multiyear initiative to highlight a potentially devastating patient safety problem involving patients who are on opioids.

For patients in pain, the use of such drugs can be invaluable to their well-being and healing. However, their use comes with risks, and can result in respiratory depression, even death, in some patients.

To that end, the AAMI Foundation has assembled The National Coalition to Promote Continuous Monitoring of Patients on Opioids, and the group held its kickoff meeting last month in Chicago. Patient safety advocates, researchers, executives in the medical device industry, clinicians, hospital administrators, healthcare technology professionals, representatives from stakeholder-professional societies, and families who have lost loved ones to respiratory depression connected to opioids gathered to build the case for continuous monitoring of all patients receiving opioids.

“We have a problem that stems from the best of intentions—easing the suffering of patients. However, some patients suffer severe respiratory depression from the use of opioids,” said Marilyn Neder Flack, senior vice president of patient safety initiatives at AAMI and executive director of the Healthcare Technology Safety Institute. “Since it is currently not possible to predict which patients will have this type of reaction, periodic monitoring of these patients will not detect the early onset of when the patient starts to be in trouble. Failure to promptly detect this change in the patient’s condition can be deadly. The good news is that a solution is out there—continuous electronic monitoring.”

This effort is unlike past initiatives in this space in that the goal is to develop recommendations for how hospitals can overcome the barriers to continuous monitoring of these patients. Presentations will demonstrate strong financial justification and improved patient outcomes when continuous monitoring is used. Powerful testimonials are expected from families who will talk about their losses.

The campaign is expected to unfold in phases over several years. Through the use of webinars, publications, online resources, conference proceedings, and general outreach, members of the coalition hope to rally the entire healthcare community behind the idea that continuous monitoring must become standard operating procedure for patients on opioids.

The current industry partners for this initiative are Covidien, CareFusion, Masimo, Respiratory Motion, the San Diego Patient Safety Council, Connexall, Sotera Wireless, PMD Solutions, Smiths Medical, and Early Sense. These companies are contributing their time and money to support the work of this new coalition.

For more information about the coalition and its plans, please visit www.aami.org/htsi/opioids/index.html.

Top 10 Device Challenges

Healthcare technology management (HTM) professionals face a number of challenges as they make sure the equipment they maintain provides safe and effective care. A recent survey, which includes responses from 195 hospitals across the United States, reveals what problems keep them up at night.

Ensuring that networked devices and systems work properly topped the list of medical device-related challenges, according to the results of a survey commissioned by AAMI. The survey, the results of which appear in the September/October issue of AAMI’s BI&T (Biomedical Instrumentation & Technology) journal, found that 62% of those surveyed rate the networking issue as “challenging” or “extremely challenging.” Meanwhile, 52% name integrating data into electronic health records as their top concern. Maintaining infusion pump systems (44%) came in at number three.

The results reflect those seen in previous AAMI-commissioned surveys, indicating that there are no easy solutions for these ongoing complex problems. Other challenges making the list are cybersecurity, device incident reporting, recalls, spectrum and wireless management, battery management, endoscope management, and nonhospital devices being brought in by patients.

AAMI Staff

Healthcare Technology Foundation News

New Coalition on Monitoring for Patients on Opioids Kicks off with Support from the HTF

On November 14th the AAMI Foundation launched a multiyear initiative to highlight a significant patient safety issue—that of patients on opioids. For hospitalized patients in pain, control of their pain is essential for optimal recovery. Unfortunately, there is a broad therapeutic dose range with opioids, so the specific dose needed for each individual patient is not always clear. There are serious risks associated with opioid use, including severe respiratory depression which can cause brain damage and even death. In addition, concurrent use of sedatives seems to make respiratory depression more likely. While continuous monitoring of oxygen saturation is fairly common in the hospital, the continuous monitoring of respiratory rate that is needed to detect respiratory depression associated with opioid use is not.

The day included several sessions from both clinical and industry leaders with expertise on the topic. But by far the most poignant moments resulted from the stories told by both patients and families who had experienced this devastating issue firsthand. Cindy Abbiehl and her husband Brian, talked about their daughter Amanda, who died at the age of 18 while hospitalized for a throat infection. She had been placed on a patient-controlled analgesia pump (PCA) which allowed her to administer her own pain medication, without having her respiratory rate monitored. Cindy and Brian left the hospital one evening, satisfied that Amanda's pain was finally under control. They expected to return the next morning to take her home, but instead received a call from the hospital telling them their daughter had died. There are no words to describe this degree of heartache, especially knowing that it could have been prevented had appropriate respiratory monitoring been used.

Participants included invited patient safety advocates, researchers, executives in the medical device industry, clinicians, hospital administrators, healthcare technology professionals, representatives from stakeholder-professional societies, and families who have lost loved ones to respiratory depression connected to opioids. In addition to the industry partners, there were 17 co-convening organizations, and Paul Coss, RN and Karen Giuliano, RN, PhD attended on behalf of the HTF.

The multi-year goal of this initiative is to develop recommendations for how hospitals can overcome the barriers to continuous monitoring of these patients. Once developed, these recommendations will be



Paul Coss, RN and Karen Giuliano, RN, PhD, HTF board Members, at the AAMI sponsored dinner the evening before the Coalition kick-off.

disseminated to both the lay and healthcare community through a series of webinars, publications, business case presentations, online resources, conference proceedings, and general outreach. The goal is to make continuous respiratory monitoring a standard of care for all patients on opioids.



HTF in the News

HTF Board Member, Paul Coss participated in a Ten Questions article for AAMI. Please see the link here:

[Biomedical Instrumentation & Technology Interviews HTF Vice President in July/August Issue: Ten Questions with Paul Coss.](#)

HTF Board Member, Barrett Franklin was featured in AAMI video on Healthcare Technology Management. Please see the link here:

[HTF Board member Barrett Franklin featured in AAMI video on Healthcare Technology Management.](#)

Be sure to visit the HTF website, www.thehtf.org to see our programs and resources. While you are there, feel free to hit the DONATE NOW button. We will accept them anytime and they are always tax deductible!

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*Jennifer C. Ott, MSBME, CCE
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*Karen Giuliano, RN, PhD
Advisory Board Member, HTF*

Journal of Clinical Engineering Subscriptions for ACCE Members

ACCE members receive a discounted subscription to the [Journal of Clinical Engineering](#) for only \$99! (Originally \$222). You must [login](#) to the ACCE website to view the code. Then visit LWWW.com to enter code.

Founding of the Chinese College of Clinical Engineers (CCCE) at the First China International Congress of Clinical Engineering & Information Technology

By Zhou Dan (zd99@vip.sohu.com) and Zheng Kun (zhengkun@zju.edu.cn)

The First China International Congress of Clinical Engineering & Information Technology, co-organized by the Chinese College of Clinical Engineers (CCCE) and the Chinese Society of Clinical Engineering (CSCE), with support of other related associations, took place in Wuxi, China, from September 24 to September 26, 2014. More than seven hundred professionals, including some from overseas, attended this Congress.

Mr. Zheng Kun, host of the Congress and vice Chairman of CCCE, opened the Congress and introduced the distinguished guests present. The first announcement was the official founding of CCCE as a division of the Chinese Medical Doctors Association (CMDA). CMDA is a very prestigious and influential professional association in China, whose members thus far are mostly physicians and surgeons. Dr. Li Ming-Xia, CMDA membership Director, formally announced the foundation of CCCE. Dr. Zhou Dan was elected as its Chairman and other seven leading clinical engineering (CE) professionals were elected as Vice Chairmen. More than one hundred and twenty CE professionals already signed up as members of this new CE organization. CMDA President Zhang Yan-ling delivered an enthusiastic speech, congratulating the new CE organization and encouraged all CE professionals to join CCCE and collaborate with CSCE to contribute to healthcare through better technology management. The establishment of CCCE under CMDA is a symbol of the high recognition of clinical engineers by the Chinese medical community. It's an important milestone which bears significance in CE development in China.

During the opening ceremony, Dr. Yadin David, Vice Chairman, HTTG-IUPESM, and board member, IFMBE's Clinical Engineering Division; Professor Peng Ming-Chen, Vice President, Biomedical Engineering College of Capital Medical University, Emeritus

Zheng Kun works in the information technology department at Children's Hospital of Zhejiang University School of Medicine. Prior to his current position, he worked as a clinical engineer and healthcare technology manager in the Clinical Engineering department. He obtained his Certification in Clinical Engineering in 2005 through the CCE certification program organized by the Clinical Engineering Society of Chinese Medical Association.

Chairman of CSCE; Professor Jiang Zong-Yi, Chief Editor of International Medical Devices and International Rehabilitation Engineering & Devices publications, also gave their welcome comments in the opening ceremony.

In addition, Dr. Binseng Wang, Fellow ACCE, Fellow AIMBE, invited Dr. Yadin David and Professor James Wear to join him to deliver, on behalf of the American College of Clinical Engineering (ACCE), the 2014 Antonio Hernandez International Award to Dr. Zhou Dan, recognizing his extraordinary contributions to the advancement of CE in China. After that, a book series called **Guides for Healthcare Technology Management** edited by Dr. Zhou Dan was official released. Director Feng Lei, of the publisher **CN-healthcare.com** explained the publishing process of this book series and donated some samples to Congress attendees.

Professor Gao Guan-Xing, the vice chairman of CCCE and chairman-elect of CSCE, presided over the main forum session, in which five distinguished guests delivered their great keynote presentations. Dr. Yadin David gave a speech entitled "The Current Status Quo of Clinical Engineering Education and Suggestions". Professor Zhang Jiang, the Chairman of CSCE, Vice Chairman of CCCE, delivered a lecture with the topic "Reflections on the Development of Chinese Clinical Engineering". Mr. Lin Nian-You, from Taiwan clinical engineering field, shared his rich experience on "Regional Clinical Engineering Integration and Operation". Dr. Binseng Wang provided a wonderful lecture entitled "American Medical Equipment Service Market-

Experience and Lessons Learned." Finally, Mr. Liu Fan, director of Information Technology Department, Beijing People's Hospital of Beijing University, which is also the first and only hospital in China to earn the EPR (Electronic Patient Record) Level 7 certification from HIMSS, presented on "Hospital Logistics Engineering and Information Systems".

The plenary session was followed by four parallel forums. Topics included Medical Equipment Maintenance and Service, Logistics Engineering and Information Systems, Mobile Health and Regional Information Integration, and Medical Imaging and Information Systems. During the coffee breaks, the attendees were able to meet with vendors to see and discuss new medical equipment and service opportunities in the Exhibit Hall.

The accelerated development of CE in China reflects the country's rapid economic and healthcare growth, with massive investments in the health sector. In support of this collective effort, clinical engineers in China have become increasingly better organized and influential. In addition to organizing annual international congresses, a program of CE certification has been established for several years. Currently, China has 252 certified clinical engineers (33 during this Congress), and 102 registered engineers (44 during this Congress). The rigor of these certification programs can be appreciated by its passing rate of only about 50%.

Welcome New Members

Let's welcome our newest members, approved by the Membership Committee and supported by the Board of Directors.

Candidate Members:

Alexander S. Gadecki—Graduate Student/Clinical Engineering Intern, UConn/Providence VA Medical Center, Providence, RI

Patrick Garzon—Graduate Student/Clinical Engineering Intern, UConn/John Dempsey Hospital (UConn Health Center), Farmington, CT

Troy K. Templin—Student, University of Florida, Gainesville, FL

Individual Members:

Mick Spivey—CE Xray Services Engineer, Wellmont Health Systems, TN

Corporate Members

Thomas M. Chenail—Regional Director of Operations, ABM Healthcare, MA—Associate Member

Rick Merry—Regional Director of Operations, ABM Healthcare, MA—Associate Member

Institutional Members:

Sara Manning—Biomedical Engineer Intern, St. Louis VA Healthcare System, MO—Individual Member

ACCE Calendar

January 15, 2015

Educational Webinar: Part 2: Career Development for Device Integration

January 26, 2015

IHE NA Connectathon 2015, Cleveland, OH

January 28, 2015

IHE NA Connectathon Conference, Cleveland, OH

January 30, 2015

Last day to submit your nomination for 2015 ACCE Advocacy Awards

April 12-16, 2015

[HIMSS 2015 Annual Conference & Exhibition](#), McCormick Place, Chicago, IL

June 5-8, 2015

[AAMI 2015 Conference & Exhibition](#), Denver, CO

June 19, 2015: ACCE's 25th Anniversary



The ACCE Board and Committee Chairs

| | |
|--|-------------------|
| President..... | Paul Sherman |
| President Elect..... | Ilir Kullolli |
| Vice President..... | Arif Subhan |
| Secretary..... | James Panella |
| Treasurer..... | Don Morge |
| Member-at-Large..... | Shelly Crisler |
| Member-at-Large..... | Joan Brown |
| Member-at-Large..... | Ismael Cordero |
| Member-at-Large..... | Alan Lipschultz |
| Past President..... | Jim Keller |
| Education Committee Chair..... | Jacob Johnson |
| Membership Committee Chair..... | James Wear |
| Advocacy Committee Chair..... | Tom Judd |
| Revenue Planning Committee..... | Mario Castaneda |
| International Committee Chair..... | Antonio Hernandez |
| Nominations Committee Chair..... | Jim Keller |
| Body of Knowledge Committee Chair..... | Joan Brown |
| Secretariat..... | Suly Chi |