



# ACCE News

Newsletter of the American College of Clinical Engineering

July/August 2010

Volume 20, Issue 4

## Membership Renewal

If you have not already done so, please renew your ACCE membership on-line at [www.accenet.org](http://www.accenet.org) by clicking on the yellow highlighted link at the top of the homepage and logging in. You may alternatively renew by mailing a check or money order to :

ACCE  
5200 Butler Pike  
Plymouth Meeting, PA 19462  
Al Levenson, Secretariat  
[Secretariat@accenet.org](mailto:Secretariat@accenet.org)

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## President's (Last) Message



It has been a great honor to serve the ACCE community as your President. Soon I will transition to the role of Past President and my responsibilities will be to primarily support the new President as he assumes his position. When I started this position, my first message was to thank the Presidents before me for all of their dedication and support of this organization. Now, two years later, I realize that I made an error in only thanking the ACCE Past Presidents. During my tenure, ACCE has become more organized financially, expanded our membership program to include corporate and institutional members, extended our advocacy activities, strengthened our relationships with

synergistic organizations, developed the ACCE Scholar Program, and many, many others all during a global economic crisis and a national drop in volunteerism (2009 America's Civic Health Index). If I sat here and wrote that I did it all myself, and I'm laughing at the absurdity of this statement even now, my nose would do a Pinocchio and grow so long so quickly that my computer's monitor would be damaged.

ACCE, as a volunteer organization, has done amazing things thanks to a group of intelligent, passionate, and hopeful members. I'd like to take a moment to recognize the Board of Directors that I've had the pleasure to work with these past two years:

The strong leadership of **Colleen Ward**, along with the other Members at Large: **Michael Fraai**, **Izabella Gieras**, **Arif Subhan**, and with additional consultancy support from **Frank Painter**, led to the release of the new Body of Knowledge survey which, when finished, will inform the CCE Board of Examiners as they prepare the questions for future exams.

Our Treasurer, **Julio Huerta**, has given up many of his free weekends to labor over ACCE finances. His regular reports as well as sound strategic advice kept ACCE financially steady over these years.

Secretary **Jim Welch** has provided many new innovative ideas for the organization and he can be credited with the ideas behind the ACCE Scholar Program which I think will be, strategically, a very important new initiative for both ACCE and the clinical engineering community.

**Paul Sherman**, Vice President, together with **Jon Blasingame**, developed the new membership programs that will invite corporations and institutions to serve as members of our community.

Immediate Past President **Steve Grimes** successfully created the opportunity to join IFMBE and AIMBE as part of our new initiative to connect with complementary organizations.

And **Mario Castañeda**, President Elect, has been dedicating much of his time to 'learning the ropes' as the intended successor. He has some amazing new ideas for ACCE that will impress all of you and help take ACCE to that next level!

(Continued on page 2)

# President's report continued

(Continued from page 1)

Through such hard work by volunteers such as these, ACCE continues to be recognized as a point of reference for the clinical engineering profession both in the United States and abroad. We continue to successfully achieve our mission:

- **To establish a standard of competence and to promote excellence in clinical engineering practice.**
- **To promote safe and effective application of science and technology in patient care.**
- **To define the body of knowledge on which the profession is based.**
- **To represent the professional interests of clinical engineers by identifying and developing**

## **programs around the topics of importance for Clinical Engineers.**

Although not a volunteer, I must recognize the outstanding support given by **Al Levenson**, who is resigning from his role as Secretariat when his contract expires. He has tirelessly served the ACCE Board and members with his services and is always the go-to person for our membership. His presence will be missed...in that role. We will work hard to help Al find a new committee to serve on now that he has some free time on his hands.

So, to these dedicated members and the many others not mentioned, but in no way forgotten, Thank You for your continued service. I very much look forward to working with you on many future ACCE projects!

Jennifer Jackson

[jljackson@accenet.org](mailto:jljackson@accenet.org)

## The ACCE Board and Committee Chairs

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## Certification in Clinical Engineering [CCE] Exam

# ACCE

AMERICAN COLLEGE OF CLINICAL ENGINEERING

**Exam Date** November 6, 2010

**US Application Deadline** August 14, 2010

For those taking the exam within the US & Canada

**International Application Deadline** July 17, 2010

For those taking the exam outside the US & Canada

Visit [www.acce-htf.org/certification/](http://www.acce-htf.org/certification/) for handbook, application and more information.

Email [secretariat@acce-htf.org](mailto:secretariat@acce-htf.org) if you have any questions.

## ACCE News

**ACCE News** is 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 e-mail [Secretariat@accenet.org](mailto:Secretariat@accenet.org)

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# Commentary: Are Pilot Projects Always Good Models for Later Expansion?

It is common for healthcare organizations to undertake pilot projects in advance of a subsequent potential roll out of the project to the larger organizational community, assuming of course that the pilot project is actually successful. For example pilot projects for real time locator solutions have been described at AAMI and elsewhere, and searching for “pilot project” at Biomedical Instrumentation & Technology yielded 18 articles with topics including alarms, event reporting, benchmarking, VoIP systems, infection control and others. In the large University academic environment we too have pilot projects such as new ways to teach (and retain) freshman engineers.

Often pilot projects are undertaken in carefully selected subunits of the organization, and they are heavily staffed with both internal and vendor personnel. The subunits are typically selected in part by their personnel, and by how functionally isolated they are. Thus pilot projects tend to take place in conditions that are unlike the rest of the organization in geography, focus and personnel. In effect, the test bed is then not typical of the environments that might later see the roll-out.

In addition, the people participating in the pilot project are often enthusiastic about doing so, in part because it is a “project” and therefore represents something relatively new and exciting, as well as something they will get credit for through the recognition and annual review process. Participating personnel will likely be highly motivated to make the pilot project work because they want to be part of success, not part of failure. In the academic environment I have called this kind of participating personnel the “dedicated few”. They are almost by definition not typical, and they are willing to invest extra time in making their program a success. Following the dedicated few are the “it’s my turn and I will do a good job”. These are also valuable people, but they are unlikely to invest at the same level. After the “my-turn” group, performance deteriorates rapidly and I

will withhold my characterization of the groups that follow.

Given the careful selection, high motivation, and excess resources, pilot projects will tend to always be successful. It should be noted here however that the definition of success will often be post-hoc. That is, after the project is done the results will be observed and be declared to be good. This is distinct from having objective success criteria defined in advance against which it is agreed the project will be measured. In this regard a good set of up front questions are: What exactly is the problem you are trying to solve? How exactly will the proposed project solve that problem?, and How will you measure if it did?

The role of the vendor engineers is of special interest here. The vendor will have a more than usual special interest in making the pilot project a success because of the future sales potential both within and at other institutions. Thus the engineers will be there at an atypical effort level to adjust, play with, reconfigure, and, as I once heard it described at a presentation, finagle the pilot system to reach some measure of success. Assuming for example a computer based system, finagle is an interesting word. For one thing finagle actually has a negative connotation involving trickery. Beyond picky definitions, are finagled systems well documented, and are they replicable? If replicable, can inhouse personnel achieve the same result, or does only the vendor know the tricks and workarounds? If the latter, what happens during later attempts to enlarge and/or trouble shoot the application?

An important question then is whether pilot projects are really designed to be fair test beds, or are they designed in a way that they will always succeed regardless of their relevance to the rest of the institution? A related question is whether the champions of the project are devoted only to the project itself, rather than to a subsequent broadening. A recent report on the design of com-

puterized decision support systems (CDS) raised a similar question about the level of adoption of the system after it was built and tested locally. One interesting finding was that even those providers who had actively participated in the building of the CDS had limited enthusiasm for adopting it beyond the pilot point of application. In my interpretation this was in part because they had segmented being part of a project from their actual clinical practice. Of course it could also be that having helped build the CDS, they knew it wasn’t very good.

*William A. Hyman, President*

*Healthcare Technology Foundation*

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## ACCE Clinical Engineering Certification Study Guide

The American College of Clinical Engineering has prepared a Study Guide for the Clinical Engineering Certification examination offered by the Healthcare Technology Certification Commission established under the ACCE Healthcare Technology Foundation. The Study Guide is available through ACCE for \$30. To order a copy of the Guide, please make out a check payable to ACCE and send to:

Alan Levenson, ACCE Secretariat

5200 Butler Pike

Plymouth Meeting, PA 19462

Or e-mail [Secretariat@ACCEnet.org](mailto:Secretariat@ACCEnet.org) and include credit card information (name on card, type of card, card number, and expiration date). Applications are now being accepted for the **November 2009** exam. Applications and the applicant handbook can be found at [www.ACCEnet.org/certification](http://www.ACCEnet.org/certification)

*The ACCE Study Guide was written by an independent group of clinical engineers not associated with the exam process*

# ACCE@AAMI: Conference Activities Summary

AAMI (The Association for the Advancement of Medical Instrumentation) held their 2010 annual conference in Tampa, Florida and, once again, ACCE had a strong presence before and throughout the event.

## 2-Day CCE Review Course

On June 24 and 25, before the AAMI Conference began, ACCE conducted a 2-day CCE Review Course at the Tampa Convention Center. Approximately 14 participants dedicated 2 full days of intense review. Frank Painter coordinated the course and faculty included: Tobey Clark, Jennifer Jackson, Paul Sherman, Jim Wear, and Dave Wilder.

The course roughly followed the CCE Study Guide published by ACCE and all participants received a copy of this document as well as all the presentation materials. These in combination with further self-study and practical experience will help in preparing for the exam.

For more information about the CCE Review Course or how to purchase the course materials, please visit:

<http://accenet.org/default.asp?page=news&section=teleconference#ccet>  
[ele](#)

## The Clinical Engineering Symposium

For several years, ACCE has strived to produce a half-day symposium that exposes AAMI participants to emerging practice trends and cutting-edge techniques. Apparently we chose the right topic of interest because the room was standing room only at 8AM on Saturday, June 27. Titled “Medical Device Connectivity is Mandated for 2013; Are You Ready? — Meaningful Use and Its Impact on Healthcare Technology Management”, the symposium provided audience members with not only an update on the U.S. Government’s new healthcare IT reform programs and how medical devices play an active role, but also a review of tools and references already available for free to the public that can assist healthcare technology managers with their integration strategies.

For a description of the symposium and

for a list of the tools and resources presented on during the symposium, please visit <http://accenet.org/>.

## The Member Reception

ACCE members and friends gathered at the Marriott for an evening of networking and to hear the latest news about the organization. Mary Logan, AAMI CEO, generously took time out

of her schedule to stop by, say a few words, and lead a toast to our 20<sup>th</sup> Anniversary.

Jennifer Jackson, ACCE President, led the formal part of the meeting by updating attendees on a very active year of activities. The 2010-2011 Teleconference Series was announced as were two new ACCE Pro-

*(Continued on page 5)*

# PCD Connectathon@AAMI

The Patient Care Device (PCD) domain of the IHE brought an interoperability demonstration to the AAMI exhibit hall in June (select a picture or pictures).

The demonstration complemented various sessions on this subject, including ACCE’s traditional Saturday Symposium, and brought reality to otherwise abstract discussions. Clinical engineering and vendor personnel were able to see some of the progress that has been made and talk to a few of the manufacturers that are actively engaged in bringing medical device interoperability to the market. Each system in the demonstration was provided by a different vendor (with one exception): two infusion pumps and two bedside monitors sending data, one clinical information system and a phone displaying alarms receiving data. The pumps were part of a bedside computer medication administration system supporting the five

rights safety program with medication management data sent by yet another vendor, and the phone was supported by an alarm manager.

In addition to the demonstration of existing technical progress, information was provided on “works in process”, including transactions carrying device data of great interest to clinical engineering staff: device condition (e.g., battery charge or failure), status (e.g., plugged into line power, in use), location (e.g., RFID), and other parameters. This emphasis on the PCD Medical Equipment Management Profile (MEM) facilitated discussions with CMMS, RFID and device vendors and CE users. The MEM working group (WG) now has sufficient interest to kick off its effort to develop standards-based, interoperable communications early in August. The WG wel-

*(Continued on page 6)*



2010 HIMSS IHE Patient Care Devices (PCD) Device Interoperability Display

# The View from the Penalty Box

Summer has arrived with heat, humidity, flash floods and all sorts of problems that our elected officials don't seem to want to address. Several months ago I mentioned that here in Massachusetts a bill was introduced into the legislature that required automakers to provide diagnostic software to independent auto repair operators and that I tried to get an attachment to the bill on requiring the OEM's to provide diagnostic software to hospitals and ISO's. The attachment was not allowed but the overall bill is still alive but will probably not be acted upon before the legislature adjourns for the year. I will try again next year.

For those of you that were at AAMI there were some new devices shown and some of the sessions were interesting. One that will potentially impact most of us was on infusion pumps. This was not a rehash of past problems but a discussion of future problems where the drugs come out of the pharmacy with some sort of a tag on them so that when they are inserted into the pump all the parameters are automatically set. Think about the technology that is involved here and the people that have to become more involved, such as the pharmacist, the drug dispensing system, the IT/electronic records folks, and the clinical engineers and technicians that will have additional testing to do on the pumps and that's just for starters. Now throw in the bad hand writing of the physician and the nurse with too many patients to cover and the potential for problems is very clear. It almost seems that the patient is not considered when all the technology is talked about.

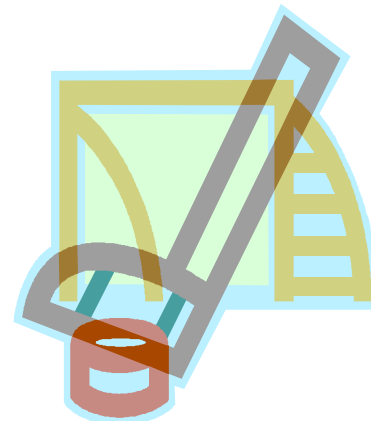
While I did not see a session at AAMI talking about the radiation overdosing from CTs this is a problem that really needs us to look at. If what is published in some of the radiology journals and newsletters is accurate the CT scanners will become the system of choice for just about all imaging where x-rays are used so we need to get more involved. As a minimum starting point we should all look at the physics reports on the machines and talk with the suppliers on what they are doing to reduce exposures. It may come down to where the techs doing the studies will have to changes

some settings on the machines and not just set it the "auto" button regardless of patient size.

At one of the receptions there was a discussion on the future direction of clinical engineering and there seems to be no definite trend on where we are heading. To many a closer relationship with the IT department is not viable as work habits of the groups are too different, basically where the patient stands versus where technology stands. In some of the smaller institutions the CE's are doing more in facilities, facilities planning, security, environmental health and continuing education for all staff members. Some CEs seem to be going more towards technology needs for handicapped patients with new advances in artificial limbs and patient mobility. Others seem to be concentrating on cost reductions and utilization of technology. The discussions really pointed out how diverse our profession is and that we seem to be able to move from one mode of thinking to another very easily and that for the vast majority of us this is a great field to be in as we are making a difference in people's lives.

In talking with the vendors it became clear to me that they do not always consider the clinical engineer as a key player in the decision process. One went so far as to say that the CE department was the last stop on an equipment purchase. Their first stop was the department looking for the technology then the finance/planning office with the loan package that they were offering on the devices. After that they go to materials and on to CE and the physical facility people if needed. Take the time and go out to talk with all the clinical departments on what they perceive their needs are for technology, also talk with the finance department on what the capital budgets for the next few years are projected at, and talk with the planning department on any new construction being considered. In other words be proactive instead of reactive on what is coming into your facility.

The last point for you to consider. Ours is a great profession that helps countless people every day, be proud of what you do and let other people know about our



profession by writing, speaking and mentoring.

Have a great summer and hockey starts up again in mid September.

*Dave Harrington*

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## AAMI continued

*(Continued from page 4)*

grams: Corporate and Institutional Membership Categories and the ACCE Scholars Program. The presentation ended with a review of the ACCE Advocacy Award Winners, recognizing those outstanding individuals that have made a difference in our profession.

### AAMI-ACCE-HTF Leadership Meeting

Leadership representatives from AAMI, ACCE, and HTF met to discuss potential opportunities for future collaboration. This meeting was organized by AAMI as they admirably continue to reach out to organizations such as ACCE to find synergies and develop opportunities to share expertise and manpower as we all move into a new era of medical device technology management. Several ideas were presented, including potential projects around education and advocacy. If you have any ideas for potential collaboration with AAMI and/or HTF, please send them to [president@accenet.org](mailto:president@accenet.org). As these new projects become more defined, they will be shared with the ACCE community.

*Jennifer Jackson*

[jjackson@accenet.org](mailto:jjackson@accenet.org)

# ACCE Scholars Pilot Program Kicks Off

With our dedication to education, ACCE has launched a new pilot program entitled 'ACCE Scholars Program'. The objectives of this program are to connect Clinical Engineering graduate students with mentors from the ACCE Community. Together, and with approval from the students' institutions, we identify novel thesis project topics and provide some financial and a lot of professional support to help these students fully realize their research goals in preparation for a successful career in Clinical Engineering.

For this pilot study, we choose two students from the University of Connecticut's Clinical Engineering Master's Program: Allie Paquette and Jared Ruckman.

Allie's project is titled: "Wireless Network Infrastructure Requirements Needed for Continuous Monitoring of Pulse Oximetry to Improve Patient Safety-Related Outcomes" and the objectives of her program are:

To develop needs assessment tools for use by healthcare technology professionals to assist in defining the minimum network requirements needed to continuously monitor patient vital signs.

Develop of matrix of wireless infrastructure requirements to support common medical devices such as real time physiologic monitors, infusion pumps and ventilators.

To develop the necessary human resource criteria for the workforce assigned to support the system described above.

To report on the existing gaps between the typical skill sets of current healthcare technology professionals and those deemed required by the analysis performed as described above.

To develop the minimum necessary

technical tools required to support the system described.

Allie's ACCE mentor is Paul Sherman. She is receiving additional support from Michael Fraai, Rick Hampton, Jennifer Jackson and Jim Welch as needed.

Jared's project is titled: "Evaluation of the Clinical and Cost Effectiveness of Multi-wavelength, NonInvasive Co-Oximetry in the Emergency Care Setting or continuous monitoring in the ICU setting." The objectives to be realized are:

- \* To compare the use and maintenance requirements for technologies used for the analysis of total hemoglobin.

- \* To complete a Cost-Effectiveness or Cost-Utility comparison of non-invasive co-oximetry to that of more established hemoglobin tests.

- \* Develop a comparison of methods, accuracy and precision for common laboratory measurement with comparison to non-invasive multiwavelength co-oximeters

- \* To develop educational material and dissemination to the Clinical and Biomedical Engineering community on the subjects of multiwavelength pulse co-oximetry.

Jared's ACCE Mentor is Arif Subhan. He is receiving additional support from Jennifer Jackson, Michael Fraai, and Jim Welch as needed.

Frank Painter is providing project management support for this trial.

At the end of these projects, ACCE will incorporate the research findings into new education programs using a format still under review so that the ACCE community will benefit from the hard work and newly acquired knowledge of the ACCE Scholars.

Over the next few months, the ACCE Board of Directors will evaluate the program and consider whether or not to continue it beyond this year. If we decide to continue with the program, we will produce additional guidelines for the students and mentors and then we will be announcing a request for volunteer-mentors. Until then, if you would like more information about the program, please do not hesitate to contact me.

Jennifer Jackson

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## Mini-Connectathon continued

*(Continued from page 4)*

comes additional users and vendors – providing a collaborative environment designed to identify and prioritize needs and then bring solutions to the market place.

Many Expo visitors and vendors viewed the demonstration, and the companies demonstrating felt the effort was worthwhile. ACCE and HIMSS shared a 10 x 30 foot area, with HIMSS providing their booth space for the PCD demonstration. AAMI provided a prime location – both booths were visible from the entry doors.

The demonstration was supported by

the participating vendors and by the PCD cosponsors - ACCE and HIMSS.

We invite ACCE members to join this effort to implement standards-based messages for the EMR, the clinician and clinical engineering.

Readers can find additional information at [http://wiki.ihe.net/index.php?title=PCD\\_Getting\\_Started](http://wiki.ihe.net/index.php?title=PCD_Getting_Started) and [http://wiki.ihe.net/index.php?title=PCD\\_Profiles](http://wiki.ihe.net/index.php?title=PCD_Profiles).

Manny Furst PhD

E-mail

# Perspectives from ECRI Institute: New Patient Safety Blog

In the March/April 2010 issue of ACCE News I wrote about ECRI Institute's new activities with social media. I covered our recent purchase of Biomedtalk and our use of Twitter, Facebook, LinkedIn, and article discussion forums. We've recently expanded those activities with a [Patient Safety Blog](#). Different staff from ECRI Institute are contributing posts on risk management, medical technology, hazard and recall management, Patient Safety Organization, and general interest topics. You can find the blog on our home Web page ([www.ecri.org](http://www.ecri.org)) or by going directly to the following link/Web address:

<https://www.ecri.org/blog/Pages/HomePage.aspx>.

I've been able contribute a number of posts to the blog. My first piece covered a problem that happened to my brother during a minor surgical procedure related to the use of a low power electrosurgical unit. He was "shocked" by the electrosurgical unit primarily because the nurse practitioner performing his procedure didn't understand some basic principles of electrosurgery. The blog post is entitled "[The Shocking Results of Poor Device User Training](#)".

My second post covers a typical alarm-related problem investigated by ECRI Institute. It described a nurse frequently responding to a high-pressure ventilator alarm for a coughing patient. The nurse eventually tired of responding to the coughing-induced alarms and increased the pressure limit for the ventilator's alarm. The consequences of this type of change can be and have proven to be deadly. This one is entitled "[Are You Tired of Alarm Fatigue at Your Hospital?](#)".

I wrote another item directed towards patients who may be candidates for implant surgery. It provides sugges-

tions for questions to ask prospective surgeons, post-implant warning signs to be aware of, and refers to recent concerns about implant manufacturers' influence on surgeons. The title for this post is "[Patient Safety Tips for Medical Implants](#)".

My most recent post is about clinical engineering. I talked about how our profession is often considered to be among the unsung heroes of health-care. That's a nice thing, but our hospitals need us to be more high profile than unsung heroes. With the major challenges of today's complex medical technologies clinical engineers have to lead hospitals' technology management efforts. We're the ones who should understand the technical, clinical, safety, and cost issues surrounding those technologies better than anyone in the hospital. And we should therefore be the ones to take charge of these projects and be the leaders to help drive adoption of technologies that are consistent with our hospitals' strategic plans. As I said in my blog post, if we don't do it, someone else will. This post is entitled "[From Unsung Hero to Most Valuable Player](#)".

If you are reading this newsletter online you should be able to link to each of my blog posts from the title hyperlinks above. If not, you can get to them from the Web addresses below.

<https://www.ecri.org/blog/Lists/Posts/Post.aspx?ID=28>

<https://www.ecri.org/blog/Lists/Posts/Post.aspx?ID=35>

<https://www.ecri.org/blog/Lists/Posts/Post.aspx?ID=45>

<https://www.ecri.org/blog/Lists/Posts/Post.aspx?ID=50>

Each blog post has a comment section. Feel free to provide your perspectives on my posts or on those from our



Jim Keller is ECRI Vice President for Health Technology Evaluation and Safety, and a past Member at Large for ACCE's Board

other authors. We'd really value your contributions to ECRI Institute's latest social media initiative.

Feel free to contact me at (610) 825-6000, ext. 5279 or [jkeller@ecri.org](mailto:jkeller@ecri.org) if you would like to discuss our new social media tools.

Jim Keller

[jkeller@ecri.org](mailto:jkeller@ecri.org)

## Journal of Clinical Engineering – Call for Papers

The Journal of Clinical Engineering, which prints the ACCE News in each issue, is interested in papers from you. If you have an urge to write, and good clinical engineering activities or thoughts 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. He can be reached at [whyman@tamu.edu](mailto:whyman@tamu.edu). Completed manuscripts can be sent to William or Michael Leven-Epstein at [lecomm1@aol.com](mailto:lecomm1@aol.com).

# ACCE International: ACEW El Salvador

Antonio Hernández has been working for ten years to bring an Advanced Clinical Engineering Workshop to El Salvador. This summer, at long last, all of the critical factors came together. Although he was not able to attend in person, due to the heavy workload necessitated by his imminent retirement from the Pan American Health Organization (PAHO), Antonio was present in spirit and by video recording.

The July 12-16 workshop was sponsored by PAHO and the American College of Clinical Engineering. It was also sponsored by the *Universidad Don Bosco*, which educates clinical engineers and biomedical equipment technicians for the entire country of El Salvador. The workshop was made possible by the efforts of Francisco Rodríguez, a professor at the university. The United States Embassy in El Salvador also provided financial support for faculty travel.

ACCE faculty members were Izabella Gieras (Mount Sinai Medical Center, New York NY), Jennifer Jackson (ACCE President), Petr Kresta (Winnipeg Regional Health Authority, Winnipeg, MB, Canada), Nick Noyes (University of Connecticut Health Center, Farmington CT), and Matt Baretich (Baretich Engineering, Fort Collins CO). All of the faculty members had previous ACEW experience and took advantage of the opportunity to practice their Spanish language skills.

In most respects the workshop followed the standard curriculum for a country's initial ACEW. This included topics ranging from medical device regulation and medical technology planning to incident investigation and equipment maintenance and repair. Because El Salvador has extensive hospital construction and renovation underway, in response to damage from earthquakes and other natural disasters in recent years, we added a one-day track on construction and facility management issues.

Topics for the construction track included: the planning and design process; construction risk assessment; sterilization systems; fire safety systems; electrical safety systems; medical gas systems; mechanical systems; emergency manage-



ACEW workshop small group project members collaborate on their classroom project

ment; and healthcare facility management. This track was well received by workshop participants and we would recommend further development of these topics for future workshops.

As is now standard for these workshops, we defined several small group projects that participants worked on during the week. We had a number of potential projects in mind before the workshop but made the final selections only after the first day of the workshop when we were better able to assess the interests of the participants and identify projects with potential for actual implementation. Throughout the week the small groups put in many hours of work that resulted in excellent presentations on the last day of the workshop.

For example, three groups worked on decision-making regarding new equipment acquisition and equipment service alternatives. These groups worked on real projects that were underway in their facilities and gathered real data for use in decision-making. The results will be directly applied in their hospitals.

On the first day, workshop participants had identified a need for a clinical engineering professional association in El Salvador. One of the group projects was to design the association. The group surveyed other participants and reviewed bylaws of similar associations. They developed a mission statement and laid out one-year and five-year objectives. They went so far as to draft a web site for the association and schedule the first planning meeting. Faculty members sent e-mail messages to colleagues asking for resources, such as sample association bylaws, and the response was immediate and generous.

(Continued on page 9)



A Mayan temple tour during a break from the ACEW Workshop



# ACCE International El Salvador continued

(Continued from page 8)

Another project with great potential for the future was the establishment of a working group to draft national standards for topics ranging from medical device regulation to equipment donations. Members of this group decided

that an initiative by the clinical engineering community would be more effective than waiting for other sectors of the healthcare system. The active involvement of regional leaders in this group makes it likely that the strong start made during the workshop will lead to practical guidelines.

## Cairo: Third Technical Advisory Group Meeting for Healthcare Technologies

On June 20-22 the World Health Organization (WHO) organized the 3<sup>rd</sup> Technical Advisory Group for Healthcare Technologies (TAGHT) meeting in Cairo, Egypt.

The meeting was the third in a series in which experts and country representatives came together to develop action plans on how to implement and sustain effective healthcare technology management programs at the national and local level. The meeting was co-organized with the Eastern Mediterranean Regional Office (EMRO).

ACCE was well represented at this meeting by members Jennifer Jackson, Jennifer Barragan (WHO), Adriana Velazquez (WHO), and Ismael Cordero.

The objectives of the meeting were to:

- Identify the key components of an action plan for the implementation of national essential health technology pro-

grams and to measure the progress of the program adoption.

- Identify resources currently available, including tools developed by experts from the 1st and 2nd meetings but also additional resources that might support effective implementation.

- Develop a prototype tool to assist in identifying gaps in needs

The outcomes of this meeting together with the results of baseline country surveys and the tools developed in the previous expert sessions will be disseminated at Global Forum on Medical Devices in Bangkok, Thailand on 9 -11 September, 2010. For more information on this forum please visit: [http://www.who.int/medical\\_devices/gfmd/en/](http://www.who.int/medical_devices/gfmd/en/)

*Ismael Cordero*

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Most of the hospitals in El Salvador are part of either the Social Security system (for workers) or the Ministry of Health (for the unemployed), with a small private sector. Before and during the workshop, the faculty toured three hospitals: two general hospitals, one associated with the Social Security system and one with the Ministry of Health, and an oncology specialty hospital. Because of resource constraints, maintenance of medical equipment and healthcare facilities is difficult in El Salvador. However, we did see modern equipment and extensive evidence of efforts to maximize its potential for patient care.

An example of the challenges faced by hospitals in El Salvador is the century-old building still used by *Hospital Rosales*, a Ministry of Health facility. The building, donated by the Belgian government more than 100 years ago, was manufactured in Belgium then shipped and assembled in El Salvador. It consists of metal framing, panels, and fittings. Providing modern healthcare in this facility is almost unimaginable, but because there is no alternative, the people of El Salvador make it work.

During the workshop there were conversations with representatives of the *Universidad Don Bosco* and other regional leaders. Jennifer Jackson, ACCE president, discussed the potential for ongoing cooperation with the American College of Clinical Engineering. Matt Baretich, chairman of the Healthcare Technology Certification Commission, will provide resources for planning a regional certification program for clinical engineers.

El Salvador, the smallest of the countries in Central America, has a wealth of historical and natural resources. Faculty members found time to visit both the Pacific coast and the mountainous (volcanic) regions of the country. We toured artisanal markets, archeological sites, and a coffee plantation. We anticipate future workshops in El Salvador.

*Matt Baretich*

[mfb@baretich.com](mailto:mfb@baretich.com)



Meeting participants at the entrance to the Eastern Mediterranean Regional Office (EMRO) in Cairo Egypt

# Healthcare Technology Foundation: Reorganization and Collaborations Proceeding



Following the AAMI meeting in Tampa the Foundation held its annual meeting which focused on defining the process by which the Foundation will move from being a group primarily of project “doers” to the more traditional foundation role of being project initiators and funders. This transition requires us to identify both project opportunities and new sources of funding. Once both projects and funds are in place, the intent is to then (or in parallel) identify and fund others to execute the projects. It is our intention for ACCE to have first call on contracting to execute a project, thus maintaining our strong link between ACCE and the Foundation. Mike Dashefsky has been providing valuable guidance in this restructuring.

This year saw only a few changes in the Board given our two year terms. Jim Keller moved from regular Board member to Advisory Board member as a result of completing two full terms on the Board. Elliot Sloane completed his term on the Advisory Board, after being on the Board in various capacities since its inception. His contributions to the Foundation have been significant and we thank him. Dan Schneider also completed his term on the Advisory Board. The President of ACCE is an automatic member of the Advisory Board as is the Chair of the Healthcare Technology Certification Commission (HTCC). The current CCE certification program, which includes both a U.S and a Canadian component, is managed by the U.S. Board of Examiners for Clinical Engineering Certification, which in turn is part of the HTCC.

Various members of the Board of the Foundation played an active role in the AAMI annual meeting educational pro-

grams. Bill Hyman presented on the FDA’s Medical Device Data System (MDDS) proposed rule. Jim Keller gave two presentations: Clinical Engineering’s role in supporting the next generation of medical technology, and Managing patient-owned equipment. Dave Dickey was involved in three presentations: Adventures in rigid and flexible scope service; An in-house model, Measuring CE’s impact on patient care and clinical outcomes; and Outsourcing vs. Insourcing CE departments: Evaluating options and managing the change. Dave and Caroline Campbell also served a technical leadership role for the meeting. Tobey Clark was part of the CCE examination training team and Board members also participated on a number of AAMI committees, as well as the meeting described below.

## AAMI, ACCE, and the Foundation

Several Foundation Board members

participated in an important meeting with AAMI and ACCE leadership to help define appropriate ways for us to work together rather than having, at times, competing interests. This initiative was welcomed by all participants so that unproductive duplication and splintering of the voice of clinical engineering can be avoided.

Donations to the Foundation are always welcome, including those “in honor/recognition of...” Such donations will be recognized with a suitable communication to the honoree. These donations are ecologically sound and keep our resources working for us.

*Jennifer C. Ott, Secretary*

[Jennifer.Ott2@Mercy.Net](mailto:Jennifer.Ott2@Mercy.Net)

*William A. Hyman, President*

[w-hyman@tamu.edu](mailto:w-hyman@tamu.edu)

Healthcare Technology Foundation

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## Wanted: Articles for ACCE News

Are you interested in practicing your writing skills? Do you desire to see your name and perspective in print? Do you have some “editorial comments” that you wish to “get off your chest”? Do you have some commentary, good or bad, about Clinical Engineering working with IT?



The ACCE News is looking for some good quality articles of

interest to Clinical Engineers. Articles can be on any subject pertinent to the Clinical Engineering profession. Length should be from approximately 500 to 1500 words. Editorial and topic assistance is available from the editors. If interested, contact co-editors Ted Cohen or Ismael Cordero at

[Theodore.cohen@ucdmc.ucdavis.edu](mailto:Theodore.cohen@ucdmc.ucdavis.edu)

or

[ismael.cordero@orbis.org](mailto:ismael.cordero@orbis.org)

# ACCE's 2010-2011 Educational Teleconference Series

The ACCE Education Committee is pleased to offer three teleconference series for its 2010-2011 program:

## IT for Clinical Engineering Series

Date	Title
2-Sep, 2010	Medical Devices and US Healthcare Reform
21-Oct, 2010	PACS Administration
4-Nov, 2010	Networking Basics
2-Dec, 2010	Networking Basics 2: Wireless
6-Jan, 2011	CE-IT: New Job Opportunities
3-Feb, 2011	ISO 80001-I
3-Mar, 2011	RFID
14-Apr, 2011	Home Health
5-May, 2011	HL7 interfacing
2-Jun, 2011	IHE PCD

## Healthcare Technology Management Series

Session Date	Session Title
16-Sep, 2010	Real Life Risk Management
21-Oct, 2010	PACS Administration
18-Nov, 2010	Incorporating Standards into Your Practice
16-Dec, 2010	Clinical Engineers Can Make Healthcare Safer
20-Jan, 2011	New PM Paradigms
3-Feb, 2011	ISO 80001
17-Mar, 2011	Budgeting and Finance in Healthcare Technology
14-Apr, 2011	Technology for Home Health
19-May, 2011	Negotiating Service Contracts
16-Jun, 2011	Staffing for Performance Excellence

The teleconferences are held each month at 12 Noon Eastern Time (9:00AM Pacific Time etc). Please refer to the schedule below for the scheduled dates. Unless otherwise noted, the teleconferences are one hour long; typically a 45-50 minute presentation followed by 10-15 minutes of Q and A. Registrants will receive the call-in number and presentation material prior to each session.

For ACCE members, the cost of each session is \$150 per site. For non-members the cost of each teleconference is \$195 per site. This allows up to four participants from each site using one phone

## ISO 80001-I Series

Session Date	Session Title
April 28, 2011	Regulatory Perspective
July 14, 2011	Working with Vendors
July 28, 2011	What Can Be Learned from ISO 14971
August 4, 2011	Implementation Strategies: Case Study 1
August 18, 2011	Implementation Strategies: Case Study 2

line. Each additional participant will cost \$10. If nine teleconferences are purchased the tenth one is free.

A complete 10-session series is \$1,350 for ACCE members and \$1,755.50 for non-members.

If the *IT for CE* and *HTM* series are purchased together it will cost \$2,040 for members and \$2,652 for non-members.

Teleconference CDs are available approximately 1 week after the teleconference for \$50 for registered Teleconference Attendees or \$150 for non attendees by credit card or check on the [Educational Offerings](#) page of the ACCE Mall. To order by check please contact: [Secretariat@ACCENet.org](mailto:Secretariat@ACCENet.org). Reference materials, if available, can be found on the Publications and reference tab under [Reference Material](#).

To download the registration form go to:

[http://accenet.org/downloads/TCon\\_Order\\_Form.doc](http://accenet.org/downloads/TCon_Order_Form.doc)

### Special ACCE Membership Discount for new applicants only.

Buy a 10 session series at \$1395 and receive 25% off your first year of ACCE membership.

For each applicant:

- Complete the [ACCE membership application](#)
- Send in all application materials and a check for \$45 (reduced membership fee)

Write **ACCE Teleconference Series** at the top of the application. Applications will be reviewed by the Membership Committee and Board of Directors using criteria outlined in the ACCE By-laws. Applicants will be individually notified of acceptance by email or by letter.

# ACCE

AMERICAN COLLEGE OF CLINICAL ENGINEERING

## ACCE Mission

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

We are on the Web:

[www.acenet.org](http://www.acenet.org)

 Cleveland Clinic

## Executive Director - Clinical Engineering

Cleveland Clinic is a world leader and model for the future of healthcare. We seek an exceptional executive for a once-in-a-lifetime professional opportunity to lead the clinical engineering function of the most technologically advanced healthcare system in the world.

Cleveland Clinic's physician-led, Institute model of care uniquely joins clinicians, researchers, academics and administration in optimizing collaboration for delivering world-class patient care. Reporting directly to the Chief Operating Officer, the Executive Director of Clinical Engineering will oversee the clinical engineering function of the Cleveland Clinic main campus, 10 regional hospitals and 17 community health and surgery centers. You will champion the clinical engineering vision and articulate the clinical engineering strategy to all levels of the organization.

We seek a recognized leader with an outstanding clinical applications background; demonstrated engineering skills in instrumentation design and functionality; ability to manage complex, large-scale systems implementations; proven inclusive leadership and managerial skills and the ability to interact and communicate effectively with clinicians and administration.

A Ph.D. degree in clinical or biomedical engineering is required along with a minimum of 10 years of direct experience in the field plus 5 years of senior management experience in a major hospital environment.

Qualified applicants should send an introductory letter and curriculum vitae to the following:

**John H. Petre, Ph.D.**  
Chair, Search Committee  
[petrej@ccf.org](mailto:petrej@ccf.org)

**Scott M. Simmons, MBA**  
Director  
[simmons1@ccf.org](mailto:simmons1@ccf.org)

Cleveland Clinic is proud to be an equal opportunity employer.  
Smoke/drug-free environment.

## Calendar of Events

### September 9-11, 2010

Global Forum on Medical Devices  
Bangkok, Thailand  
[http://www.who.int/medical\\_devices](http://www.who.int/medical_devices)

### September 16-17, 2010

Second Annual Medical Device Connectivity  
Conference & Exhibition  
Hyatt Regency, Mission Bay  
San Diego, CA  
<http://www.tcbi.org/index.php?conference=2amc2010>

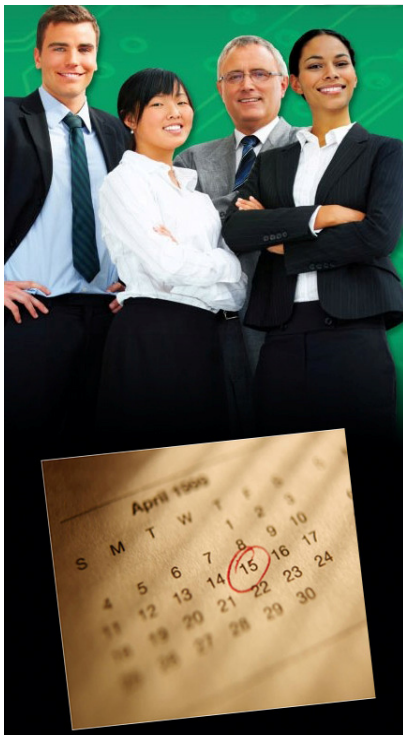
### October 5-6, 2010

AAMI/FDA Summit on Infusion Devices  
Silver Spring MD

### February 21-24, 2011

Annual HIMSS Conference and Exhibition  
Orlando, FL

Note: See page 11 for ACCE Teleconference series schedules





AAMI and FDA SUMMIT ON INFUSION DEVICES

OCTOBER 5-6, 2010 - SILVER SPRING, MD

