



ACCE News

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President's Message:



For the first time since 1996 the AAMI conference was held in Philadelphia. I was very thankful to not have to travel more than 45 minutes to get to the meeting. I was also fortunate to be able to stay at the conference hotel. I was therefore able to avoid the potentially long and unpredictable commutes on Philadelphia's Schuylkill Expressway before and after the long days of our conference. You'd think that I would have felt well rested after the AAMI meeting closed its doors. That wasn't the case. AAMI was such a whirlwind that I totally crashed when I got home on the Tuesday after the conference.

For me the conference unofficially got underway on Friday morning, May 30th for the "Manny Meeting". Its more formal name is the Annual Conference on Clinical Engineering Productivity and Cost Effectiveness. This was the 30th year of the "Manny Meeting" which has been informally named for Manny Furst who started the meeting and has been co-chairing the committee that plans, runs, and organizes it ever since. I've had the pleasure to serve as co-chair for the meeting's planning committee for about the last ten years. The "Manny Meeting" group is officially an AAMI Technology Management Subcommittee on Clinical Engineering Productivity and Cost Effectiveness. Our goal is to get together with leaders in the technology management profession to discuss the technology management challenges we are dealing with and to hopefully identify solutions that can help the entire technology management community.

Many ACCE and AAMI publications, presentations, and programs have been spawned from the discussions at the "Manny Meeting". This year's topics included best practices for responding to the Joint Commission's National Patient Safety Goal on clinical alarm safety; how clinical engineering and health technology management is, and/or should be, dealing with the latest regulatory decisions and rules on medical equipment maintenance (e.g., from CMS); and how FDA's new Unique Device Identifier (UDI) rule is expected to impact clinical engineering. Regarding the UDI rule we also discussed what clinical engineers should be doing now to prepare for the government's phased implementation of UDI. One piece of the discussion covered the types of changes to inventory management systems that will best help the UDI rule achieve one of its goals (i.e., to improve patient safety through better recall management).

AAMI hosted a fun opening reception on Friday night before the conference began. It was a nice way to catch up with old friends and colleagues before we all got down to the serious business of attending the education sessions and visiting the exhibit hall. For me, the only downside to the reception was that literally for every step I took towards the bar to use my free drink ticket I bumped into another person to catch up with. I never made it to the bar. I guess that's what happens when you've been lucky enough to attend the AAMI conference for about 25 years in a row. Such problems.

I was very proud to help kick off the formal part of the AAMI conference with ACCE's half-day clinical engineering symposium. The symposium focused on what I described in my last President's report as being the next big thing for clinical engineering. That is how to best utilize the "Big Data" we are gathering from medical device/EHR integration, real time location system implementations, data mining of clinical alarms, and many other sources. The data we are gathering has so much potential to help

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President's Message

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improve patient safety and patient care in general. In my introductory comments for the symposium I spoke about how clinical engineering can be a big player in the big data game and that we'll need the resources to understand how to best do this. The symposium was a good way to start that. And it was very well attended. Our best guess is that we had over 300 attendees.

We had an excellent lineup of speakers. It started off with an inspiring and funny keynote presentation by Carolyn McGregor from the University of Ontario Institute of Technology (UOIT). She spoke about how her early experience in the 1990s with business analytics for banking data in Australia eventually transitioned to healthcare. She is now a leading international researcher in the area of critical care health informatics and in particular on the use of Big Data in neonatal health. We were very fortunate to have such an accomplished presenter for our keynote. She was an excellent complement for the rest of our faculty who included Maria Cvach from Johns Hopkins Hospital, John Hoffman from Excel Medical Electronics Inc., Brian Gross from Philips Healthcare, and Hank Goddard from Mainspring Healthcare Solutions. Thank you very much to ACCE Education Committee Chair Jacob Johnson, ACCE Vice President Ilir Kullolli, and the rest of the planning committee for putting on such a great symposium.

Saturday night of the AAMI conference included the traditional annual face-to-face meeting for ACCE's Board and Committee Chairs. We got a lot accomplished. We reviewed ACCE's plans for the remainder of this year; discussed various financial matters, including our fundraising efforts; heard reports from our very active Committees; and reviewed next steps for the transition to a new Board after our upcoming annual election. But the biggest item on our agenda was a major change for our organization. We are now the

official home for the Healthcare Technology Certification Commission (HTCC)! The Commission runs the Clinical Engineering Certification program and it is now part of the American College of Clinical Engineering. The previous home for HTCC was with the Healthcare Technology Foundation (HTF). Recent changes in tax laws required HTF to divest its oversight and technically its ownership of the certification program. Last year HTF and HTCC embarked on an extremely thorough and thoughtful transition plan for the certification program. ACCE formally expressed its interest in taking on the certification last summer. We were fortunate enough to be selected by HTF and HTCC as the best fit for the future direction of the certification program.

The transition has been worked on by ACCE's Board, HTF's Board, and HTCC for much of the first part of this year. We formally signed off on the transition at the end of April 2014. I'd like to thank HTF President Tobey Clarke; HTF's Board; past Chair of HTCC, Petr Kresta; the HTCC; ACCE Secretariat Suly Chi; and the Secretariat for HTCC, Deb Huberty for doing a great job working through the long list of details to actually make the transition happen and get the certification program up and running under ACCE.

I can't emphasize enough how important this transition is for the future of ACCE and the Clinical Engineering Certification program. During my formal remarks at the ACCE membership reception in Philadelphia I said that that Certification is "back where it belongs". It's part of an organization (ACCE) whose core responsibility is to advocate for the Clinical Engineering profession. Certification is, in my opinion, critical for the growth of clinical engineering. It helps legitimize the profession. Both go hand and hand. I expect that each will help the other grow. Clinical Engineering has been a very important part of our healthcare organizations' operations for a long time. The joining of certification

with ACCE will help to change the "very important" part of those operations to "vital", "instrumental", or keywords more typically associated the C-suites in our healthcare organizations. It's a great time to be a clinical engineer.

For those who made it to Philadelphia for this year's AAMI conference, it was great to see you. For those who didn't, hopefully we can connect next year in Denver or at the HIMSS conference in Chicago.

Feel free to contact me at the e-mail address for ACCE's President (president@accenet.org) if you have ideas that you'd like me to share in my next – and last – President's report or if you have any suggestions or feedback for ACCE's Board.

Jim Keller

president@accenet.org

ACCE News

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To subscribe e-mail Secretariat@accenet.org

Managing Editor

Jim Keller
jkeller@ecri.org
(610)825-6000

Co-Editors

Ted Cohen
tedcohen@pacbell.net
Jared Ruckman
jared.ruckman@live.com

Circulation & Address Corrections

Suly Chi, ACCE Secretariat
Secretariat@accenet.org

Advertising

Dave Smith
advertising@accenet.org

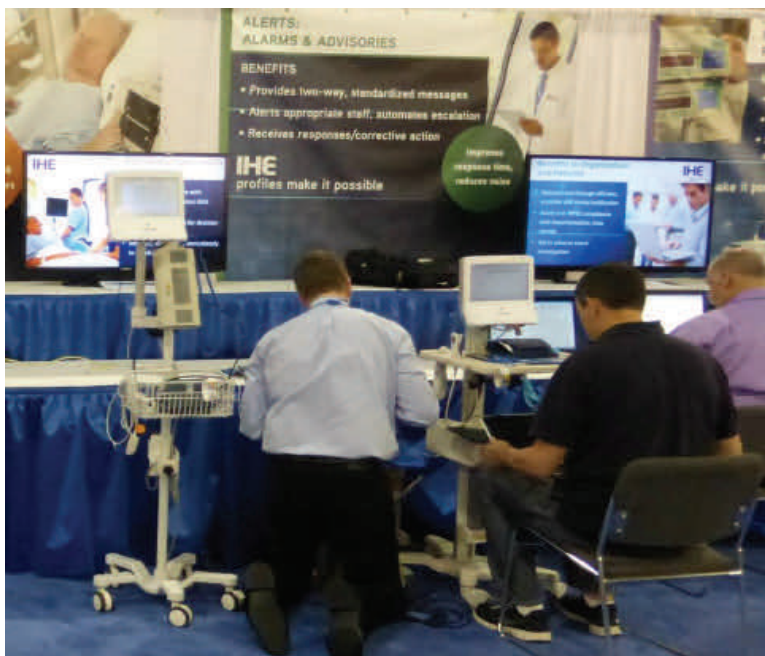
Images: ACCE at AAMI 2014



Suly Chi, ACCE's Secretariat, hanging out at the ACCE booth, left to right: Antonio Hernandez, ACCE's International Committee Chair, Suly, Kevin Ferguson, ACCE's "official" photographer, and James Wear, ACCE Membership Committee Chair and 2014 Lifetime Achievement award winner



Above: Jennifer Jackson and Michael Fraai enjoying the food at the ACCE reception and membership meeting



Left: Integrating the Healthcare Enterprise (IHE)/Patient Care Domain (PCD) demonstrates live physiological monitor data and infusion pump data streaming to an Electronic Healthcare Record using the IHE/PCD profiles.



Congratulations to Ghana Health Service, recipient of the ACCE/HTF Advanced Clinical Engineering Workshop (ACEW) award. Jim Keller, ACCE President, and Tom Judd, far right, present the award to Ghana Health's Director, Dr. Nicholas Adjabu (far left) and Clinical Engineering Manager John Zienaa (2nd from right).

From the Editors Desk: AAMI 2014

As usual, AAMI 2014 was packed full of sessions and meetings. I was fortunate to be able to attend this year having just come off of lower back surgery in April. Although I had to take it easy, I was involved in several presentations and managed to attend several meetings and a few educational sessions as well as the exhibit hall.

This article is focused on several broad themes, all of which were discussed at the conference, and which have been a keen interest of mine for several years. These topics are: Data and “big data” in healthcare in general and in Clinical Engineering/HTM in particular, Medical device/ IT interoperability, and Advancing the CE/HTM profession.

ACCE Symposium: Big Data

The AAMI 2014 conference started off with a bang with the presentation of the ACCE Clinical Engineering Symposium on the topic of “Leveraging Big Data in Clinical Engineering”. Moderated by ACCE President, Jim Keller, five “big data” experts Carolyn McGregor from the University of Ontario Institute of Technology, Maria Cvach from Johns Hopkins, John Hoffman from Excel Medical, Brian Gross from Philips Healthcare and Hank Goddard from Mainspring Healthcare Solutions captured the attention of the audience of over 300 attendees as they shared their expertise and successes in using big data to drive innovation in the healthcare setting. The speakers offered examples of the use of big data analytics in diverse areas such as automated detection of sleep/wake cycling, tracking the variance in heart rate to help predict the onset of sepsis, end-to-end clinical alarm management, and medical device service optimization.

The speakers presented the challenges that the healthcare industry currently faces in the analysis of big data sets that are so large that they cannot be processed using traditional data processing applications. Although these data sets

are key to driving knowledge discovery, as well as key to innovative patient safety and service improvements, big data analytics and use of big data in decision support is still in its infancy in the healthcare industry.

It was clear from the presentations that the time is right for Clinical Engineers to jump into the world of big data. Our technical expertise, along with our clinical knowledge and experience puts us in just the right position to unlock the potential of big data for our organizations. For additional information on the Symposium speakers and their specific presentations, visit the ACCE website at <http://www.accenet.org>.

IT/Medical device Interoperability

What can I say? In reviewing the program, IT issues (e.g. IT security, big data, benchmarking, wireless, business of interoperability, IEC80001, UDI, etc, etc.) have taken over half of the conference. Speaking of interoperability, I was the introductory speaker for the Monday course on “Managing Risks of Integrated Systems and Networks in Healthcare Environments”. This all-day course, co-sponsored by AAMI and The Health Technology Foundation, covered an introduction to interoperability, IEC 80001, project management and wireless. This was the first time this course was offered. It was very well received, and we hope to be able to teach it again in both face-to-face and on-line/video versions via AAMI University.

I was most impressed by a session on Integrating the Healthcare Enterprise/ Patient Care Devices (IHE/PCD) and the IHE/PCD demonstration in the exhibit hall. The exhibit demonstrated a couple of models of infusion pumps and one model physiological monitor sending real-time location, device status and maintenance-relevant data to a CMMS via HL-7 messages in a similar way that clinical data is transmitted to the EMR. This demonstrated that in the future,

hopefully the near future, maintenance-relevant data elements such as battery capacity, charge and life status, number of hours of use, self-test results device “demographics (e.g. model, serial number, UDI, IP address, software version), and much more will be automatically sent to the CMMS. This information, along with location information, and IHE-based RTLS which was also demonstrated here, can also be used for utilization studies (i.e. on/off, in use, infusion pumping). There is a tremendous amount of potential shown in this demonstration to radically change maintenance strategies and provide considerable additional utilization and alarm information to improve medical device management across a large number of devices. I hope all this potential comes to fruition in the next few years.

Data Management

Colleen Ward and I gave a presentation on “Tools and Methods for Improving Data Integrity in Computerized Maintenance Management Systems” discussing the people issues and software tools that can be used to help improve data integrity. Frank Painter, Matt Baretich and I spoke on AAMI’s HTM benchmarking including benchmarking data integrity and five ways to use benchmarking data: financial, staffing, technology management/ professional activities (e.g. incident evaluation) and best practices.

HTM Career and Department Development

The AAMI Technology Management Council introduced two new projects: HTM career ladder and HTM Levels. The HTM career ladder is a practical guide showing the way for career advancement, focused on the BMET career. A future guide will provide information for those aspiring to be managers.

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International Committee: Activities at AAMI

Key activities of the ACCE International Committee during the recent AAMI conference in Philadelphia were as follows:

The Annual Conference on Clinical Engineering Productivity and Cost Effectiveness, better known among clinical engineers as “Manny’s Meeting” celebrated its 30th anniversary. Congratulations to Manny and the Planning Committee for reaching this milestone. This group of more than fifty professionals, including several ACCE International Committee members, are leaders in the Clinical Engineering field and throughout the years have contributed to shape the profession. During the final comments of the agenda, Todd Cooper brought up the IHE International initiative in Colombia that is now officially chartered as IHE Colombia. IHE Colombia was publicly launched in May 2014, in the presence of Colombian key leaders from Academia, Business, and Government.

The ACCE booth at the AAMI exhibit hall was very busy and served as the “meet-and-greet” place for recent and longtime ACCE members, including the legendary veteran Joe Dyro.

Our ACCE Members Meeting/Award Reception on June 1st continued its tradition of recognizing the leaders in the field with ACCE awards; additionally, we had the opportunity to greet the ACCE International Members who attended the conference. Following the introduction, I provided an update of the International Committee activities to an audience that each year grows larger. The food was great. Congratulations to the organizers and sponsors of this event!

The International Committee had a special face-to-face meeting. The purpose of the special meeting was to explore, with PAHO officials Alexandre Lemgruber, Regional Advisor on Health Technologies, and David Novillo, Unit Chief of Knowledge Management and Organizational Learning, opportunities for strengthening the collaboration between PAHO and ACCE. Additional guests at this meeting included Adriana Velazquez from WHO, Jim Keller, AC-

CE President, Joseph P. Welsh from CHIRP, and Nicholas Adjabu, from Ghana Health Service, the 2014 ACCE/HTF ACEW Award winner. Adriana Velazquez, and Calil Saide joined by phone.

The PAHO officials were updated on the activities that ACCE and IHE are conducting to expand the use of standards, certification, and training in Latin America and the Caribbean. The example of the recently created IHE Colombia was presented as a model and strategy to deploy IHE in the region and PAHO was invited to join this process. The foundation of this model is a partnership among Academia, Business, and Government with clinical engineers as conveners and strategic leaders. See [page 9](#) for an article on IHE Colombia.

The meeting with PAHO’s Authorities was followed by a VIP tour of the IHE Showcase at the Expo. An introduction to the IHE environment was provided by Manny Furst, Elliot Sloane, Paul Sherman, and John Garguilo. An explanation of interoperability, standards and certification of the medical technologies, and clinical information systems was also provided. The tour included a live demonstration of the different products in the Patient Care Device Domain (PCD) interconnected to

Electronic Health Records.

Finally, on behalf of IC Members I want to congratulate the ACCE-IC Members recipients of the AAMI ACCE and Biomedical Instrumentation and Technology (BI&T) Award this year:

Ismael Cordero: AAMI Foundation & ACCE’s “Robert L. Morris Humanitarian Award”; Shelly Crisler, AAMI Young Professional Award; James Wear, ACCE 2014 Lifetime Achievement Award; Binseng Wang, Outstanding Research Paper

Happy Summer!

Antonio Hernandez, Chair, ACCE International Committee

internationalchair@ACCEnet.org



L to R: John Garguilo, IHE and NIST, Alexandre Lemgruber, PAHO and David Novillo, PAHO in the IHE PCD booth in the AAMI 2014 exhibit hall

AAMI Update:

AAMI Unveils Career Guide, Annual Conference Wraps with Record Crowd, New FAQ Resource on Wireless Challenges in Healthcare

Choosing a career path in healthcare technology management (HTM)—where job roles and titles haven't been entirely clear or consistent, the required skills can vary by healthcare institution, and guidance resources have been lacking—can be onerous.

Sensing that challenge, AAMI's Technology Management Council designed a comprehensive plan to finally help HTM professionals understand the education and experience they need to move ahead in their chosen careers.

Attendees at a session at AAMI 2014 were among the first to see a draft of the AAMI Career Development Guide, a document that promises to help HTM professionals "create meaningful career goals and chart a path to advancement."

"We wanted to help produce a tool that would allow HTM to map out a path for their own advancement based on their desires," said co-moderator Karen Waninger, clinical engineering director at Community Health Network in Indianapolis.

The guide can help an individual on several fronts, Waninger said, including how to: Chart growth in a current position; Prepare for other opportunities; Create meaningful goals; Be more valuable in current and future roles; Help managers develop their direct reports.

The document contains an HTM career graph and ladder grids, as well as planning worksheets. There, HTM is broken up into three typical job families: technical specialist, clinical engineer, and leadership. A grid is laid out to show the progression of skills from level to level, and gives a

detailed description of each level.

The document also includes planning worksheets and self-assessments. "Go down the list and give yourself a rating," Waninger advised. "Get a respected peer to do an assessment on you as well. There's also a gap analysis that shows you where you need to focus for additional training and development."

Co-moderator Dave Scott, a biomedical technician at Children's Hospital of Colorado, said he has started using the guide in his own career, seeing the opportunity to brush up on his public speaking skills. "It's all about you taking the ownership of getting yourself ready to move into the position that you want," he said. "There's not someone out there who is going to do it for you."

Still to come is the creation of an HTM leadership development guide for healthcare organizations. The guide, which is in draft form, was written to help healthcare organizations identify and cultivate potential leaders among their HTM staff.

AAMI 2014 attracted the largest crowd ever, with 1,670 attendees registering for the event.

"We have worked hard on the 'community' aspect and coming together as a profession," said Ray Laxton, immediate past chair of the AAMI Board of Directors. "That opportunity is rare and helps us all with our professional growth." During the first-time attendee orientation, he told the audience that over the years, he has picked up a lot of tips and infor-

mation walking the hallways and talking with people.

A theme echoed throughout the conference was for biomed to get out of the basement. George Mills, director of engineering at The Joint Commission (TJC), told those attending his popular session that, to him, there is nothing more embarrassing in an accreditation survey than when members of a biomed department have to introduce themselves to the nursing staff. "That sends a big message about the culture of safety," he said.

Rick Boothman, chief risk officer at the University of Michigan Health System and a former trial lawyer, touched on a similar theme during his keynote address. "You don't get to work in a vacuum," he said, urging healthcare technology management professionals to wander their facilities to see how people are using the devices they service and maintain. "You have a lot to offer; get involved," he added.

Perhaps the biggest story of the conference was a bombshell dropped by Mills during his TJC update. In an announcement that shocked many in the audience, Mills revealed the introduction by the Centers for Medicare & Medicaid Services (CMS) of significant restrictions on the use of relocatable power taps, or RPTs. According to Mills, who said he doesn't agree with the rule, the federal agency now says that, effective immediately, "RPTs are not to be used with medical equipment in patient care areas." That includes operating rooms, patient rooms, and areas devoted to recovery, exams, and diagnostic procedures. While RPTs could still be used for non-patient care equipment, such as computers and printers, and in areas such as waiting rooms, offices, and nurse stations, attendees expressed concerns about potential tripping hazards.

"I can't give you what I can't give you," Mills said in response to one audience



Introducing a better way to manage your professional development.

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Managing Risks of Integrated Systems and Networks in Healthcare Environments Course

Over 40 people attended the training course at AAMI 2014. The joint training program was developed by HTF and AAMI to help Clinical Engineers and IT professionals obtain the tools necessary for risk management methodologies and mitigation. Preliminary feedback from the attendees indicated that it was very beneficial for the work they do and the presenters were knowledgeable and effective in presenting the materials. Next steps will be to consider additional locations to hold the course and utilizing resources within AAMI University to present the material to a larger audience. Special thanks to the course instructors: Ted Cohen, Sherman Eagles, Ken Fuchs and Phil Raymond. Kudos to Yadin David for his guidance and leadership in getting the program to this juncture! Todd Cooper also helped coordinate the course.

Alarms Roundtable

HTF was heavily represented at the Clinical Alarms Roundtable held Monday afternoon. Despite being the last session on the last day well over 60 people participated in the discussion. It probably helped that there was chocolate! The dialogue was a true roundtable where various HTF board members along with AAMI HTSI member Marilyn Flack engaged the audience with a variety of questions:

- What have we done over the last year?
- Are we where we want to be?
- Do we have the tools and resources necessary?
- What awaits us in the future?

The interchange stepped through the various aspects of the 2014 TJC National Patient Safety Goal and also touched on the 2015 and 2016 expectations. What we found is hospitals are at a wide range of compliance. HTF along with AAMI stand poised to help guide future direction so that everyone is not reinventing the wheel.

Stay tuned for more!

HTF Annual Meeting

HTF held its annual meeting on June 3rd at the Philadelphia VA. Thank you to our host Cathy Hranek the Chief of Biomedical Engineering at VAMC Philadelphia. The main focus was on fundraising and how to take HTF into the future. We are exploring an expert panel concept to allow industry or others access to the great source of knowledge we have within HTF. The concept has been touted at the recent National Teaching Institute and Critical Care Exposition and at AAMI 2014.

The board voted some current members back for additional terms: Marge Funk will begin her 2nd term, Nancy Pressly her third term on the advisory board, and Tom Bauld his first term on the advisory board. We are happy to welcome Karen Giuliano RN, PhD, MBA to the board as an advisory member. Karen comes to HTF with a wealth of experience as a product development specialist. We look forward to working with Karen on our future path.

One aspect we certainly want to grow is to continue our partnership with ACCE and its members. We need to work in collaboration on projects and funding. If any ACCE member is interested in joining HTF please contact Tobey or Jennifer. We are looking for some fresh perspectives as we continue the journey.

HTF in the News

HTF is Proud to Support the [AAMI Publication on Cybersecurity in Healthcare](#)

We feel this is an important endeavor and hope this recent release will encourage more people to want to learn more about the AAMI/HTF Training Program on Managing Risks of Integrated Systems and Networks in Healthcare Environments.

HTF is Published in American Jour-

nal of Critical Care Thanks to Board Member Marge Funk!

See article Attitudes and Practices Related to Clinical Alarms from the [May 2014 issue](#)

HTF Board Member Yadin David Participates in Medical Design Excellence Awards

See the [cover page here](#). Full information on the award process and winners can be found here: <http://www.canontradeshows.com/expo/awards/home/>.

Clinical Engineering Certification Program Transfers to ACCE

Through the primary efforts of Healthcare Technology Certification Commission Chair Petr Kresta and ACCE President James Keller, a smooth transition was made to transfer the CCE program to ACCE. Thanks to Petr, Jim and many others from HTF, HTCC, ACCE, and AAMI, the future is looking strong for clinical engineering certification.

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!

Tobey Clark, MSEE, CCE

President HTF

president@thehtf.org

Jennifer C. Ott, MSBME, CCE

secretary@thehtf.org

Perspectives from ECRI Institute: The Burden is on the User

In May, the *New York Times* published [an article about automotive recalls](#) that started with the story of a man who had a harrowing highway experience when the rear axle of his pick-up truck locked up at high speed. He had purchased the used truck a year earlier and was unaware that it had been recalled because of the axle problem.

The *Times* article went on to explain that “(t)he United States does not have a law requiring the repair of used vehicles — including rental cars — that have been recalled for safety issues before they are rented or sold to the public. Used-car dealers and rental car companies are allowed to fix problems when — and if — they see fit. And they are not required by law to disclose to customers that a vehicle is the subject of a recall.” I was amazed.

The story made me realize that the laws and regulations surrounding recalls vary from industry to industry. For example, when the Consumer Product Safety Commission (CPSC) announces the recall of a toy or scuba gear, it becomes illegal to resell the recalled product. So I would have assumed that it would be illegal to resell a recalled car that had not been repaired. Apparently not.

This story also highlights the difficulty manufacturers have in running effective recalls when their products are widely distributed and oftentimes not under the ownership (or management) of the original purchasers. A former colleague recently told me about setting up his dehumidifier on a humid day this spring and nearly setting his house on fire. He commented, “A 2-second Google search revealed this [CPSC recall](#) and my unit is among the affected products. I always thought product registration cards were for suckers, but maybe if I’d sent it in, I would have known about the problem when it was originally announced last fall.”

And we all know the difficulty we face managing recalls in the healthcare setting. ECRI typically publishes about 20 alerts per week related to capital medical equipment and

other health technology systems. It’s a big chore for technology managers to review them and to be effective in identifying when you are affected.

This burden is heightened by the fact that manufacturers, in the attempt to ensure that their recall notice gets through to someone who will act on it, oftentimes send several copies of each recall notice to a long list of standard healthcare professional titles. So duplicate copies of the recall tend to filter to the technology manager over days or weeks, forcing you to repeatedly review the same notice to ensure that it is indeed the issue that you already addressed and not a broadening of the recall or a different recall.

And to top things off, we are seeing an increasing trend in manufacturers placing the burden of monitoring for and preventing safety problems on the healthcare provider and technology manager.

Many field corrections these days are not field corrections at all, but rather the announcement of a newly identified safety problem with a commitment to provide a fix in the future and instructions on how to avoid the problem in the interim through user training and/or additional inspections.

Similarly, we are regularly seeing manufacturers take the stance that since a correctable safety problem that results from a defective design, component, or manufacturing/assembly process is only occurring in a limited percentage of installed units, they will treat it as an “as-needed service issue.” If you want the problem fixed proactively, you will have to pay time and materials for the service.

But there are steps you can take that, over time, will reduce the number of duplicate recall notifications that you receive from manufacturers and will influence manufacturers to take better care of all healthcare providers.

First, identify one department or title to



Eric Sacks, Director of ECRI Institute's Healthcare Products Alerts

which you want all medical equipment recall notices and safety bulletins sent and stipulate in all future purchase contracts that the vendor will send one copy of each recall notice to that specific department or title.

Second, when you encounter a problem with a device or system, whether in following the instructions in a field correction notice or in addressing multiple or repeat failures in a device, think carefully about how the vendor or manufacturer is supporting you. Think about whether the manufacturer is placing a new burden of “inspecting quality in” that was not part of your purchase agreement. If so, is there something that they could do to relieve you of that burden. If you aren’t satisfied with the service and support you are receiving on a medical device or if you perceive a safety problem, make a confidential problem report to ECRI Institute at: <https://www.ecri.org/Pages/ReportADeviceProblem.aspx>. The clout of the ECRI Institute member community can oftentimes influence an unresponsive vendor to improve service.

Eric Sacks

ESacks@ecri.org

From Advanced Clinical Engineering Workshops to IHE Colombia



The 49th Advanced Clinical Engineering Workshop (ACEW) was the catalyst for the creation of the Integrating the Healthcare Enterprise branch in Colombia (IHE-Colombia). The ACEW was part of the framework of a Course on Continuum Healthcare for Colombian leaders in Government, Academia, and Business from the North Coast Region.

Background

The Simon Bolivar University and the Chamber of Commerce of Barranquilla have for the past five years strengthened the Health Cluster through a Continuum of Care Strategy that coincided with the work that the American College of Clinical Engineering, the Pan American Health Organization, and IHE International had been developing for over a decade through Advanced Clinical Engineering Workshops in various countries of Latin America.

In August, 2013, these collaborative initia-

tives converged in Barranquilla and led to the establishment of the Colombian National IHE Committee sponsored by the University, the Chamber, and the BIOS Foundation; subsequently, on October 10, 2013, the Committee was formally recognized by the Board of IHE International as IHE-Colombia.

Activities

IHE-Colombia has, since its inception, been actively engaged in national and international promotional activities at key meetings, like the II PAHO-GHIA Symposium in Washington, the First International Forum on Medical Devices in Bogotá, the 50th ACEW in Sao Paulo, the II WHO Forum on Medical Devices in Geneva, the IHE-US Connectathon in Chicago, the HIMSS14 Interoperability Showcase in Orlando, where the Simon Bolivar University opted to become a ACCE Institutional Member, and the First International Congress of Metrology in Medellin.



Vladimir Quintero of Simon Bolivar University and IHE Colombia

On May 14, 2014 IHE-Colombia was formally introduced to policy and decision makers in the public and private sector in Colombia, as an international alternative to strengthening and improving the quality and safety of health services offered to citizens, and to validate the short term action plan with future members of IHE-Colombia.

Besides this dynamic promotion and networking activity, IHE-Colombia is working along three lines of action: a) to promote the strategic importance of adopting IHE profiles to establish efficient interoperability of systems and devices; b) to translate into Spanish key IHE documents to further advance in the dissemination of the message; and c) to train engineers and healthcare managers on the IHE domains, profiles and interoperability.

This intensive schedule has been possible thanks to the open cooperation of organizations including: IHE-International, IHE-US, HIMSS, ACCE, NIST, and the commitment of the following individuals: Elliot Sloane, Antonio Hernandez, Manny Furst, Tobey Clark, John Garguilo, Monroe Pattillo, Todd Cooper and many others.

Next steps

(Continued on page 10)



At the Launching of IHE-Colombia. Barranquilla, May 14, 2014. .From left to right: Alexis Messino, Simon Bolivar University; Paul Pelaez, Chamber of Commerce of Barranquilla; Mario Castañeda, CEO HealthITek; Mike McCoy, IHE-Internatoinal; José Consuegra, Director Simon Bolivar University; Teofilo Ruiz, CARI Hospital; Vladimir Quintero, IHE-Colombia;

From the Editors Desk:

(Continued from page 4)

The HTM Levels project was introduced on Sunday. This TMC-sponsored project involved creating an easy-to-complete, and soon-to-be-available from AAMI at no cost, qualitative checklist which describes three "levels" of HTM departments: Basic, Progressive and Advanced. HTM/CE managers can complete this checklist and easily determine areas for improvement. It also can be easily used to show your boss what you need to do to move your department from Basic to Progressive or from Progressive to Advanced.

Finally, returning to my back surgery, I received excellent care, however, it was surprising to me some of the "crazy" things that can happen as we all implement Electronic Medical Records (EMR). For example, a couple of days prior to surgery I received an automated, EMR-based secure e-mail from my anesthesiologist. One of the questions on it was whether I was pregnant. Shouldn't the EMR screen out that question for males? My surgery was delayed

for two days, yet the day after my surgery was supposed to have been done, I was called at home to see how I was progressing post-surgery. The day after my actual surgery, when I could have used a call, I was not called, presumably because it was a Saturday. These are minor, however, it seems like software designers and implementers should be able to improve these programs that health care workers have become so dependent on to manage their workflow. I use my healthcare provider's patient care portal regularly and it is as great tool. The EMR provides patients and healthcare workers a tremendous communication tool, but I'm afraid it will be an expensive "work in progress" for a very LONG time as it gets "fine-tuned" to become efficient, cost effective and strives to meet everyone's needs.

Have a great summer!

Editor's Note: Thanks to Colleen Ward for assisting with this article.

Ted Cohen

tedcohen@pacbell.net

ACEW Leads to IHE Colombia

(Continued from page 9)

IHE-Colombia's near future is full of activities and challenges:

1) Produce a Hemispheric Conference to explore a shared hemispheric vision about the impact of Healthcare Information on the quality safety and cost effectiveness of the Health Services provided to the population, as well as related business opportunities, is planned for late August.

2) Plan and negotiate terms for the participation of a delegation of Colombian Companies in Sao Paulo, during the HIMSS Latin America.

3) Design a new workshop on the topic

of Interoperability and Enterprise to offer in October.

4) Plan, design and implement the First Connectathon in Latin America to take place in Barranquilla, and hosted by the Simon Bolivar University.

Again, all these projects will only be possible through the intense collaboration of the abovementioned organizations, as well as the Clinical and Biomedical Engineering networks in the continent.

Vladimir Quintero

vquintero@ihe.net.co

Visit us at <http://ihe.net.co>

Award Winners

ACCE congratulates the following recent awards winners:

AAMI awards to ACCE members:

Mark Bruley: AAMI & Becton Dickinson's Patient Safety Award

Ismael Cordero: AAMI Foundation & ACCE's Robert Morris Humanitarian Award

Patrick Lynch: HTM Leader of the Year

Shelly Crisler: AAMI's young Professional

Alan Lipschultz: The Spirit of AAMI award

Binseng Wang & Salil Balar: BI&T Best Research Paper

Samantha Herold: recipient of The 2014 Michael J. Miller Scholarship

ACCE Awards:

George Mills: Honorary member and ACCE Challenge award

Bruce Hansel: ACCE/HTF Marv Shepherd Safety award

Ken Fuchs: Professional Achievement in Technology/Professional Development

Erin Spannon: Professional Achievement in Technology/Professional Development

James Wear: ACCE 2014 Lifetime Achievement award

Robert Hijazi: TomO'Dea Advocacy

Dan Zhou: Antonio Hernandez International Clinical Engineering award

Ghana Health Service: ACCE/HTF International ACEW award

Adam Darkins, MD: HTM Champion

Katherine Chan: Student paper award

Michelle Hanbidge: Student paper runner-up

Christine Vogel: Student paper runner-up

View from the Penalty Box

I hope that all of you that attended the AAMI meetings and the ACCE sessions came away from those meetings with some good ideas that can help all of us slow the rise of costs in our places of work. Due to family problems, I was not able to make it this time. My first AAMI was in 1972 and I got a lot of good information from that one and most of the others over the years.

One of the hot topics seems to be the right to repair. Many of us have been doing that fight for years and some took the stand that if the company did not allow us to repair a device or system we did not purchase it. I hope that we, as a profession, continue to demand repair information on the technology we use in our institutions. Yes, there are some boards that we cannot fix, but we can, and have, repaired most of the problems in the past. We need to keep on doing that.

I get a large number of newsletters every day and in scanning them many report the same information, but a few have some really interesting items. In one recent newsletter, they projected that only four hospitals in the US will be in compliance with the CMS requirements for electronic medical records. Not 4% of the hospitals but four out of the 5,000 or more hospitals that get Medicare/Medicaid payments. Remember Y2K and how Clinical Engineering got all of the problems with devices taken care of well in advance and the IT people just wanted more money to install out-of-date systems. How did the IT groups become so powerful? We'll see if the low projection holds. More importantly, what can Clinical Engineering do to help hospitals, particularly small hospitals, meet all the CMS/HITECH/ARRA requirements?

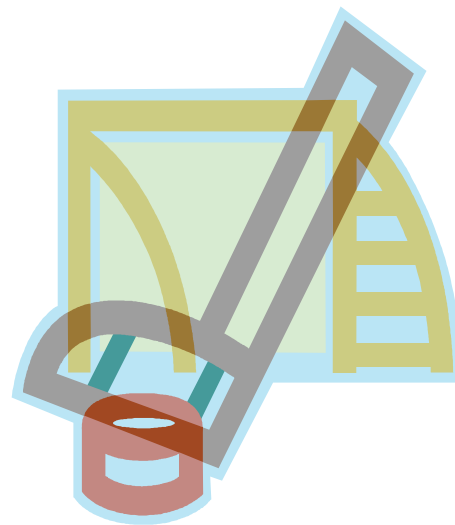
In another newsletter, I see that companies are becoming very frustrated with the FDA approval process with over 50% of the 510(k) submittals being rejected. Remember a 510(k) cleared device is supposed to be substantially equivalent

to a previously cleared product. Is this one of the reasons that the introduction of newer technology is lagging?

There is some new technology being used that has the potential for both great benefits and harm. That technology is the 3D printer. You've seen the reports on the newscasts that a pre-teen and his father "printed" out an artificial hand for the boy, or that a surgeon implanted cartilage grown in a lab and then "printed" the tissue that went into the knee that's impressive.

The time has come for all in healthcare to stop "kicking the can down the road", and start working together on solving our problems. So many of the problems are computer based with programs not talking to other programs. How many of you remember the battles between Word™ and Wordperfect™ when the PC first came into wide use? How is it possible to have a translate tab on the Word™ tool bar that converts most languages into English. I'm not sure if it goes the other way as I have no need to do it. These are standard programs we are talking about, with retail prices well under a thousand dollars and we can communicate with almost everyone in the world. With this type of power our IT colleagues cannot get simple information into a medical record that is transportable to other physicians and institutions. We must be missing something or over complicating problems is the new norm. We went to the moon using slide rules instead of computers to do calculations, but we cannot seem to get medical information and information on how our technology is performing into databases that can be accessed by others.

How many of us, while investigating which device to purchase, have had problems coming up with hard facts from our own databases and from others whom we ask? Recently I had to go through over 200 equipment records to find a common problem with a device.



Sometimes the problems were described differently, sometimes the problem was mentioned as a minor problem but I found in over 70% of the trouble calls and repairs the same problem was present in various levels. In talking with the vendor, they admitted that they knew about the problem, but it was never enough of a problem to issue a recall. So much for that vendor ever again getting into this hospital's purchasing group.

In closing, it is difficult for me to watch hockey in June, since the season used to be over in April, or go to a baseball game in late March and have a snow delay, or see football games in August and February. My take on these extended seasons is that the owners are following Congress in trying to delay everything as long as possible. Is it me or is the main work of Congress to get re-elected? At least those of us in clinical engineering want everything to move towards better patient care at reasonable costs. Keep up the outstanding work and we will win in the end! Have a great summer!

Dave Harrington

Dave@sbtech.com

AAMI Update

(Continued from page 6)

member, who said his facility would have to go back and reconfigure power cords and strips.

“Wireless support has been added to my responsibilities, and I don’t know anything about it. Where can I go to learn?”

That is the first question in a new document of FAQs dealing with the wireless challenge in healthcare. Released by AAMI, the project is the work of AAMI’s Wireless Strategy Task Force, which was created in the fall of 2012 to dig deeper into the wireless challenges that many healthcare facilities now face.

The free new resource, *FAQs for the Wireless Challenge in Healthcare*, contains a total of 70 questions, covering a wide array of topics, including regulatory matters, architecture and network design, prepurchase and pre-installation information, security,

Would You Like to Write for ACCE News?

The ACCE News is always looking for good, short (~ 500—1,500 words), previously unpublished articles. Short technical articles, case studies, controversial issues, opinion pieces (in good taste of course), Other Clinical Engineering-related material is always welcome.

If you have any ideas about a one-time article, a continuing series, or a column, please contact one of the editors and we will discuss it with you.

Ted Cohen, Co-editor

tedcohen@pacbell.net

Jared Ruckman, Co-editor

jruckman@live.com

and management of the wireless network.

“The more ubiquitous the use of wireless solutions, the more challenges there are,” said Steve Baker, senior principal engineer at Welch Allyn. “To aid in understanding those challenges in health delivery organizations where the number of different devices with wireless is staggering, we developed this document to help healthcare technology and IT experts, as well as facilities management professionals, get a handle on the issues and gain an understanding of some of the fundamental precepts of wireless networks”

Baker led the FAQ project for AAMI, writing much of the content. He was assisted by Rick Hampton, wireless communications manager at Partners HealthCare Systems, Scott Coleman, network technologies manager at Welch Allyn, and Paul Sherman, a consultant retired from the Veteran’s Administration. All are members of the task force.

You can download a free copy of the FAQs at www.aami.org/hottopics/wireless/AAMI/042514_WirelessFAQ.pdf

As you reflect on the lessons learned at AAMI 2014, mark your calendars for AAMI 2015. The conference is scheduled for June 5-8, 2015 in Denver CO. See you there!

AAMI Staff

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.learned at AAMIlel.levinepstein@gmail.com](mailto:michael.learned@AAMIlel.levinepstein@gmail.com)

Journal of Clinical Engineering

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ACCE Job Website Job Postings

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

ACCE Welcomes Our New Members

Name	Class	Job Title	Company	Country
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ACCE Calendar

July 10, 2014 (rescheduled)

Educational Webinar #10: Hybrid ORs

July 12, 2014

CCE written exam application deadline for applicants testing outside US & Canada.

August 9, 2014

CCE written application deadline for US and Canada

August 13, 2014: CCE Review Webinar #1

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