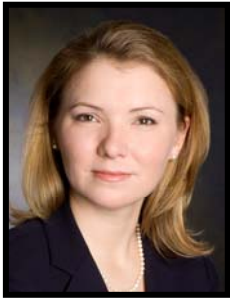


ACCE News

Newsletter of the
American College of Clinical Engineering

Volume 18, Issue 5:
September/October

President's Report



Browsing the New York Times this weekend, I came across Damon Darlin's article, "Technology Doesn't Dumb Us Down. It Frees Our Minds," a direct response to Nicholas Carr's article "Is Google Making Us Stupid?" in July/August 2008 issue of The Atlantic magazine. Mr. Carr introduces the idea that, through technology innovations, we are in an age of information overload where we are overwhelmed with content mostly because it is so readily available now, but we lack the time to reflect on the data, 'to draw our own inferences and analogies, foster our own ideas.'" Mr. Darlin challenges the theories of Mr. Carr by bringing up the questions of how we apply these innovations to our lives. He counters by defending the innovations, saying that they give us the opportunity to automate that which is tedious, leaving the ambiguous and new to contemplate. The technologies are presented to us as new tools that should be assessed for their applicability – they add value to our lives, or distract us from what is important.

Clinical engineers, by definition of our profession, provide

these assessment services to our clients. Those of us specialized in technology assessment review the current trends in both technology and medicine to advise which will add value to health-care and which are best left alone. With the onset of new IT technologies, our assessment parameters are changing and our roles as clinical engineers are following closely behind.

We often write about the emergence of IT in the CE workspace: medical devices are becoming IT systems and vice versa. Most of us are seeing or have seen our small data-exchange systems merging into larger enterprise-wide systems. Before, we could control a (relatively) small number of devices on a separate network with near-autonomous management of the technology. As the need for IT connectivity has entered our realm, we find that it has transformed our technology. For example, bedside patient monitors now have the option to display radiology images, recent lab results, and treatment suggestions from the web (as a patient, I would run for my life if I looked up from my bed and saw my physician browsing WebMD, but that is just me). As long as we have jurisdiction over this precious small area near the patient, we are preparing ourselves to manage this new distinctive functionality. Because this functionality depends on the IT in-

frastructure, we are learning to work with our IT colleagues to define where the overlap exists and where exactly we must find the synergy between clinical engineering and information technology. As ACCE members, we are fortunate to have many peers that are already exhibiting amazing leadership in defining this synergy between Clinical Engineering and Information Technology.

To recognize these pioneers, not only for the work they did but also for the inspiration that they give to others, ACCE and HIMSS jointly created the Excellence in Clinical Engineering and Information Technology Synergies Award. Created in 2006, three individuals have received this pres-

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Membership Renewal

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

ACCE
5200 Butler Pike
Plymouth Meeting, PA 19462

President's Report (cont)

tigious award: Ray Zambuto and Eliot Sloane in 2007 and John Hughes in 2008. Taken from the nomination form, each of the awardees has demonstrated innovative and effective synergies in the application of clinical engineering and information management systems technologies in support of the strategic initiatives of his/her organization

Each demonstrated a unique aspect to CE-IT synergy and they continue to influence their colleagues with their leadership and innovative spirit. As pioneers in our field, they serve as inspiration to us, and many other ACCE members have followed their example to create new paradigms in the area of CE-IT convergence. As their peers, we are obligated to recognize them, the co-workers that go above and beyond the traditional CE role to further shape our futures as technology managers.

I ask each one of you to review the nomination information available on our organization's website: www.accenet.org. There you will find both the award criteria and the nomination form. Please consider who from your organization is creating these synergies and should therefore be recognized internationally for their contributions. The nomination period is open through October 30, 2008. Please do not hesitate to send me or any member of the Board your questions about this very special award.

Best wishes to all of you for a great autumn season!

Cheers,



Jennifer Jackson
President, ACCE
jenniferljackson@yahoo.com

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

CCE Certification: New Applicants and Renewals

1. The next CCE exam will be given on November 1, 2008 in 28 cities around the US. The deadline for applications is September 1, 2008. Please see the website: <http://www.acce-htf.org/certification> to view the handbook and application for this exam.

2. In 2007, ACCE released the results of the new "Body of Knowledge Survey". The US Board of Examiners for Clinical Engineering, chaired by Patrick Lynch, made adjustments in the mix of questions based on that survey. The changes are included in the 2007 CCE Handbook which is available on the ACCE-HTF website.

3. Renewal: CCE renewal is required once every three years. The CCE Renewal Handbook and Renewal Application Form can be downloaded from the CE certification website: <http://www.acce-htf.org/certification>. The renewal fee can be paid by check or by credit card on the ACCE HTF website.

4. Any questions can be directed to Cheryl Shaw, the certification program's secretariat, at certification@acce-htf.org.

ACCE News

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Medical Device Connectivity – IT Convergence

The pace of connectivity between bedside medical devices and IT infrastructures continues on an accelerated pace. The pace is driven by the increasing demand for moving data from and to the point of care. No area of the hospital is excluded from this generalized need. The intent is to improve patient care outcomes while reducing cost through improved patient flow efficiencies and by reducing avoidable adverse events. The challenge becomes how to provide such connectivity within the financial constraints facing health care providers and without introducing new risks to patient safety.

Clinical Engineers are uniquely positioned to take a leadership role in the evolution currently unfolding.

Regulatory and standards bodies are recognizing the unavoidable trajectory of device connectivity utilizing standard IT

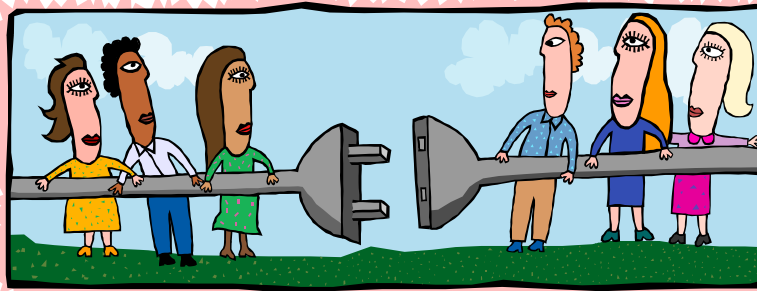
infrastructures. The FDA published a Proposed Rule (Docket No. 2007N-0484) to Reclassify Medical Device Data Systems (MDDS) from a Class III device to a Class I device. The Proposed Rule (Federal Register Feb 8, 2008; Vol 73 No. 27) is an attempt by the FDA to clarify the FDA's view of when an IT network is considered a part of a medical device, especially when such a system is used to transport medical data across an IT network. Presentations by FDA personnel since the public notice suggest that an IT network becomes part of the overall medical device system when such connections are made. This suggestion that an IT network becomes part of the medical device has raised concerns regarding the application of Design Controls as required by Good Manufacturing Practice to Hospital IT Networks. Over 50 public comment responses

have been received by the FDA for consideration before a Final Rule is promulgated. At issue is how broad is the scope of MDDS and if applied to Hospital IT networks (as the Proposed Rule and FDA personnel suggest) how will Hospitals conform to the new Regulation.

In addition, the International Electrotechnical Commission (IEC) has developed a committee draft (IEC 62A/591) under project number IEC 80001 titled; Application of risk management for IT-networks incorporating medical devices. The draft, published

and mitigated. IEC 80001 defines a framework of clearly defined responsibilities. Top management is responsible for establishing policies to determine acceptable risks criteria, a process for managing such risks, assign responsibilities to execute the risk management process, provide resources, approve the risk management file, monitor effectiveness, and provide suitable review for process effectiveness. Furthermore, top management must ensure participation from IT Department AND Medical Device Engineering. Although IEC 80001 is in the Draft stage, it is likely to become a significant reference document for guidance, especially hospital certification authorities in sorting out the roles and responsibilities shared by biomedical engineering departments, IT departments and the multiple vendors supplying medical devices and non-medical device components to the complete end to end systems.

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in December of 2007 has received support from regulatory bodies, industry and the health care community. The Standard is a "PROCESS standard that covers activities, particularly RISK MANAGEMENT, required by the RESPONSIBLE ORGANIZATION and MANUFACTURER when MEDICAL DEVICES are integrated into a network or when such integrations are changed." RESPONSIBLE ORGANIZATION is the hospital and administration responsible for compliance with this standard. ISO 80001 amplifies the need for quality systems and good engineering principles to be applied to the design, implementation and management of hospital IT infrastructure. The standard adopts ISO 14971, Medical devices-Application of Risk management to medical devices as the normative reference for a mechanism by which risks are identified, clas-

Concurrent with the regulatory and standards evolution, medical device vendors are responding to market demands for device connectivity using existing IT networks. The demand to improve patient safety as well as streamline patient flow and work flows is driving IT connectivity. For example, Smart Infusion Devices in integrated drug libraries are being broadly adopted. Requirements for routine updates to embedded drug libraries as well as quality reporting is driving Infusion Pump providers to integrate IT- Standards based wireless connectivity. Most companies have adopted some form of IEEE 802.11 wireless capabilities that rely on the hospital IT infra-

(Continued on page 6)

ACCE Healthcare Technology Foundation News: ExCEL Award Presented to Dr. Easty in Toronto

The first award in the ACCE Healthcare Technology Foundation's ExCEL program was presented to Dr. Anthony C. Easty at a well attended event at his home institution, Toronto General Hospital, on September 4th. Dr. Yadin David represented the Foundation at the presentation ceremony. The event brought together administrators, physicians, clinical engineers from surrounding hospitals, students, and special guests. Among those in attendance was Dr. Robert Bell, President and Chief Executive Officer of the University Health Network, who provided congratulatory remarks for Tony and specifically commented on the value of holding the event within the recipient's institution, thus adding additional local recognition for both the recipient and the award, and thereby promoting the professional contributions of clinical engineering to the institution and the community. In addition to Dr. Bell, other administrative attendees included Dr. Joseph Cafazzo, Director, Medical Device Informatics and Human Factors, University Health Network and Lydia Lee, Chief Information Officer, The SIMS Partnership.

The local written announcement of the event noted that the award had been established by the ACCE Healthcare Technology Foundation to define and recognize superior leadership at the institutional level. With respect to Dr. Easty the announcement said that he "has built a legacy of exemplary leadership in the field of clinical engineering" and that as a result of these efforts "UHN's Medical Engineering Department is credited as one of the best worldwide". In the spirit of the award itself it was also said that Dr. Easty is a revolutionary thinker who redefined UHN's view of technology and its role in transforming healthcare, including his role in establishing the Healthcare Human Factors Group at the Centre

for Global eHealth Innovation, the largest group of its kind based in a healthcare institution. Such forward thinking and action oriented activity is what the clinical engineering profession needs to reach its own goals of contributing significantly to the healthcare enterprise.

Dr. Easty shared the Foundation's view of the importance of this award, and its local presentation, saying that "It really did work well. The whole concept of presenting the award in the workplace was a brainwave. It has generated a lot of interest in our profession here at my hospital."

It will be important to the profession that the second ExCEL award be presented and received with equal recognition and enthusiasm. The next application deadline for the ExCEL award is December 31, 2008. Further information including the application materials can be found at http://www.accefoundation.org/leadership_award.asp

Financial Support

The ExCEL Award program needs ongoing financial support from individuals and organizations that share its objectives and values. Financial contributions are tax deductible and may be made through the ACCE Healthcare Technology Foundation (www.accefoundation.org). Please keep in mind that donations can also be made in recognition of or in honor of another individual, making it an excellent vehicle for professional gifts and remembrances.

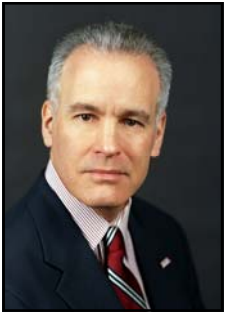
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Dr. Anthony C. Easty (left) receiving the award from Dr. Yadin David, Immediate Past President and President Emeritus of the ACCE Healthcare Technology Foundation

Perspectives from ECRI Institute: Benchmarking for Clinical Engineering Departments



Wouldn't you rather drive the bus than get run over by it? We need to think about benchmarking in that way. Benchmarking is used in all professionally managed

service industries. Just as physicians are driven by evidence-based medicine, we are driven by benchmarking. Several companies, including The Thomson Corporation (they recently purchased Solucient Inc.), provide benchmarking data for clinical engineering departments. Independent service organizations (ISOs) have data regarding clinical engineering (CE) department performance and they use that data when they prepare quotations to replace in-house CE departments. There have been several fine articles in CE publications over the past year about benchmarking. In short, it's all around us and you need to understand the issues so that you can lead the conversation (otherwise your boss will lead the conversation for you!).

Benchmarking is a process that helps a manager discover where to focus attention to improve an activity. It requires a measure of a process (an indicator) and an anticipated value for the indicator (a benchmark). For example, Inspection Completion Rate (sometimes called PM completion rate) is an indicator that measures the process of completing the required maintenance of medical equipment (according to the Joint Commission the benchmark value is 100% for devices a facility defines as "life-support"). In manufacturing, all of the inputs to the manufacturing process are studied in great detail as are the details of the manufacturing equipment; sophisticated statistical

models are applied and benchmarking takes a very mathematical form called "statistical process control". For service industries, the inputs and context are often less well known than they are in manufacturing so benchmarking becomes a blunt, but still effective instrument.

In our experience, the key issues in benchmarking are: understanding error or uncertainties in the indicators, understanding the factors that influence the indicator (context), and testing possible relationships between indicators. Let's look at the uncertainties in a typical indicator such as inspection completion rate. This metric is typically determined from the number of completed inspections shown in your computerized maintenance management system (CMMS) for a specific month. For example, a spot check of biomedical equipment technician (BMET) paperwork reveals that several technicians had open (unrecorded) inspection work orders. The difference between the actual and unrecorded inspections is the "error" of that measurement.

It is necessary to identify factors that influence an indicator (context). Indicators are determined within a specific work environment. For example, achieving a high inspection completion rate for fixed equipment is usually less of a challenge than achieving that same rate for mobile equipment. In other cases, the factors that impact the indicator are not always obvious. That's why most people feel comfortable when they conduct internal benchmarking since the context is most likely to be stable within an institution. Many are concerned that unknown factors make it hard to interpret information from other institutions (external benchmarking).

ECRI Institute is committed to

benchmarking. We are convinced that sharing data, and properly interpreting it, are the keys to improving efficiency in the provision of equipment maintenance. Improved efficiency will reduce the time spent on activities that don't benefit patient safety or equipment performance, freeing time to deliver other valuable technology management services (e.g., tracking hazards and recalls, equipment planning).

We have conducted audits of clinical engineering departments for many years and contributed to the benchmarking literature (last year, we worked with AAMI on a study of benchmarking CE department activities). We are so convinced of the importance of benchmarking that we will launch a web-based tool (BiomedicalBenchmark™) in October to help users access and share data about equipment acquisition cost, service contract cost, expected life, failure rates, CE department composition and activities, and maintenance procedures. We are sure that the data contributed will help identify best practices, and reduce the time spent on equipment maintenance, and support better purchasing decisions.

To find out more about our new product visit our Web site at www.ecri.org/biomedicalbenchmark or contact me at jgaev@ecri.org; (610) 825-6000, extension 5368. It would be a pleasure to hear from you.

Jonathan A. Gaev,
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IT Convergence (cont)

structure because these devices are found throughout the hospital where proprietary connectivity infrastructure would be too expensive to justify. A growing number of physiologic monitoring companies for both spot checks and continuous monitoring have also adopted integrated IT connectivity solutions. Ventilator companies are certain to follow this trend. IT infrastructure providers have recognized this emerging market and are establishing organization and customer centric focus in health care applications.

The relatively short lifecycle of wireless and wired standards based alternatives has added complexity to how devices connect and which of the growing number of standards are supported by the IT infrastructure. For example, many of the early generation medical devices adopted Wi-Fi standards that were state of the art at the time they were developed. Since then,

many of these standards are either no longer supported or are in the sunset phase of their life cycle. How these devices and their associated infrastructures are supported while migrating to more current connectivity technology needs appropriate planning, a particular discipline found in Biomedical Departments.

The challenge becomes how hospitals navigate this rapidly evolving new technology space. The risks associated with failure of the IT infrastructure when supporting medical devices must be carefully considered from aspects of risks, benefits and costs. Early generations of IT infrastructures were based on loading characteristics and use cases known at the time they were deployed. The adoption of medical device connectivity places new loading characteristics and new use case scenarios on existing networks. Failure to recognize these new requirements can

lead to unintended consequences if not considered at the time of medical device connectivity. In addition, the rapid expansion of connectivity across all markets has opened up new areas of concern such as the security of hospital networks from unauthorized intruders. Nonetheless, IT infrastructures can be cost effectively designed or upgraded to support mission critical and life critical applications. To ensure such networks are effective requires a close collaboration between Biomedical Engineering Departments with their IT counterparts.

Clinical Engineers are uniquely qualified to lead their organization through this transition period. It is no longer a question of whether medical devices should connect to IT infrastructures, but determining the best plan for integration depending of the strategic directives set by the hospital leadership. Developing a close collaborative relationship with the IT department is paramount in developing a realistic plan based on clinical needs and financial constraints. The IEC 80001 draft provides a framework for dialogue between the hospital technical expertise, medical departments, and administrative stakeholders. Clinical Engineers understand the needs and requirements of the clinical environment, IT departments understand the capabilities of their infrastructures and requirements for enterprise deployment, support, and security. Together, in collaboration with end users, they can steer their institutions to an effective integration with measurable benefits to patient safety, more effective and efficient health care delivery, and lower costs.

Jim Welch

Secretary, ACCE

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**Advance Your Career
From the Comfort of Your Office**
ACCE teleconference series starts from July 17, 2008



Since 1995, ACCE has been offering audio teleconferences on current and emerging topics in clinical engineering. This year's topics include 2009 Joint Commission medical equipment standards, revisions to NFPA 99, applying Reliability Centered Maintenance (RCM) techniques to equipment maintenance, certification in clinical engineering (CCE), radiation and MRI safety, fundamentals of RF/Wireless, CE/IT Collaboration—a case study in medical device interface, and much more!

A group of leading clinical engineers will speak at the next ACCE teleconference series.

The teleconference series, which consists of 10 sessions, will be held on the third Thursday of each month at noon Eastern Standard Time. Each session will last one hour, and will include a 45 to 50 minute presentation followed by 10 to 15 minutes of Q & A.

Please visit the ACCE website at www.accenet.org for more details and registration information. Inquiries about the series should be directed to secretariat@accenet.org.

Each registrant receives a CEU certificate from the University of Arkansas for Medical Sciences for each session they participate in.

International Report: Peru Embraces Medical Technology Management

At Pontificia Universidad Católica de Perú (PUCP), the clinical engineering group CENGETS has made progress towards improving medical technology in Peru. Professors Luis Vilcahuamán and Rossana Rivas of PUCP/CENGETS have several active projects with the Ministry of Health including the recently approved development of a National Technology Agency to support healthcare technology management. Currently, there is no "FDA" in Peru responsible for medical devices – only pharmaceuticals, and little technology management.

Professors Vilcahuamán and Rivas will accompany Dr. Hernan Garrido-Lecca, Health Minister, and his team to China representing the healthcare technology sector on an economic mission. Peru recently hosted the Asia Pacific Economic Cooperation Forum in Lima with CENGETS as a key participant. Another CENGETS project of great interest to Dr. Garrido-Lecca, an inventor and a

graduate of Harvard (MBA) and MIT (MS), is the design of apparatus to assist with vertical birth – the traditional birth position in the Andes and Amazon regions.

CENGETS most recently sponsored workshops on medical device quality assurance in Lima and Cusco. Faculty included Miguel Angel Castro, former biomedical engineering professor and Fluke Biomedical distributor, from Bogota, Colombia, Professors Vilcahuamán and Rivas, and Tobey Clark, University of Vermont (UVM).



From left to right: Luis Vilcahuaman (CENGETS) Miguel Angel Castro (Fluke Colombia), Tobey Clark (University of Vermont), the Peruvian Minister of Health Hernan Garrido-Lecca, and Rosanna Rivas (CENGETS)

This hands-on training on metrology and medical device inspection followed the medical equipment/HTM online course given at PUCP which was developed by PUCP, Universidad CES in Colombia, and UVM.

There has been active communication between CENGETS and ACCE members Antonio Hernandez, Tom Judd, Mario Castanada, Gordon McNamee, and Clark who were faculty for a PAHO workshop in 2007, and most recently by Ismael Cordero, of ORBIS which will be holding a workshop in Trujillo in 2009 and who plans to collaborate by supporting the development of the National Technology Agency.

Activities Ahead

In late October a healthcare technology management workshop focusing on managing and delivering services, acquiring technology and building regional capacity will be held in Bridgetown, Barbados. Elliot Sloane will be the workshop leader with Caroline Campbell of Trimedx, Matt Baretich of Baretich Engineering, Tobey Clark of the University of Vermont and Antonio Hernandez of PAHO.

2009 promises to be a very busy year for ACCE international workshops. In January International Aid will be sponsoring a workshop in Ghana. Jennifer McGill of MedTex Consulting will be the workshop leader and accompanied by ACCE faculty Bill Gentles of Ontario, Canada and Evelyn Fan, clinical engineer at Brigham and Women's in Boston.

Workshops in Argentina, Panama, Honduras, El Salvador, Peru, Brazil and possibly in Vietnam, Laos or Tanzania are also being contemplated.

Ismael Cordero

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CCE Review Course on CDs

Purchase the CCE Review Course on CDs. This review was taped live at a five-session, 8-hour CCE Review Course, presented by a faculty of clinical engineers who have broad experience working in hospitals, independent service organizations, consulting, government, and industry. Topics of the CCE examination are reviewed by a subject specialist and the 8-hour audio course includes Q&A from the audience, PowerPoint presentations, reference list, and sample questions. Topics covered in the course are: Introduction to the CCE Exam, CE Program Management, Financial and Service Contract Management, Technical Supervision, CMMS, Technology Assessment, Product/Vendor Selection, Capital Planning, Clinical Trials Management, Building Plan Review, Building Design and Human Factors, Regulatory/ QA Issues, Risk Management/Safety, Education, Product Development, Repair/Systems Thinking and Other Miscellaneous Clinical Engineering topics. The Audio Course is available for \$300 (ACCE members) and \$345* (nonmembers). For more information or to purchase please contact Alan Levenson at secretariat@accenet.org. Additional information is also available on the ACCE website: <http://www.accenet.org>.

View from the Penalty Box: Election Time

In the last issue of the ACCE News I proposed that organizationally it might be a good fit if Clinical Engineering departments that are not independent departments, report to Finance.

From the comments that were sent to me some of you agree that it might be a good option. Regardless of whom we report to and what our titles are we need to keep in mind that the patient is always our first priority.

As we run up to our election we have so many “promises” from those running for office that we should have a new healthcare system here in the US in a matter of months after they are elected or re-elected. Call me a cynic but until there is either term limits for elective officials or fund raising is banned for political contests nothing will change. Unfortunately all too many in power, either real power or perceived power, aka the press, do not understand what healthcare is all about. Sometimes I am not sure if most of the hospital administrators understand what healthcare is all about, they seem to concentrate on building an empire and feathering their nests with the patients coming in way down their list of priorities. Unfortunately many of the device suppliers have the same set of priorities so the chance of change is about the same as the Cubs winning the World Series.

Another topic that seems to be getting some notice is ISO standard 17025 which pertains to service organizations on how items are tested in the field. There has been some discussion on various Web sites about how everyone would be better served if the standard was adapted. I have not fully reviewed the standard but from what I have read it will not be easy for many hospitals and service companies to comply with. It will also take quite a bit of capital expense to get all the

needed test equipment. I have a problem with spending thousands of dollars for test equipment that may only be used once or twice a year. We might be able to get the word to manufacturers asking them to write their test procedures using commonly available test instruments that are in a hospital not some very specific device that is used for engineering testing as part of the design process. Also, much of the testing can be done with a good “self test” software program installed into the device.

Speaking of manufacturers, there was a recent article in MDT about the differing device testing requirements between European and US devices. This adds costs to both US and European manufacturers that could be avoided. Most of the voluntary standards have been harmonized with AAMI and many of our ACCE members leading the charge from the US. Hopefully the FDA will re-look at how it does things and moves towards the harmonization of approval requirements. But with the courts ruling that companies cannot be sued for problems with devices the FDA has approved, the FDA may be a little gun shy.

One benefit of retirement is that I have time to read all the newsletters and magazines that are out there on clinical equipment. I am not sure how many of these “break throughs” will ever make it to market and into the hospitals but our fellow engineers, in industry, are trying to make improvements to the technology that is available to treat patients. Some of these new devices will challenge you in the support area as we will have to improve some of our skills. We will need to better understand programming, networking and communication, verbal more than data transfer. We will have to better communicate with the users of these devices, learn-

ing about their problems with devices or programs so we can make or arrange for corrective actions when needed.

We need to listen, very carefully, to our clients and respond to their needs in a timely basis or we will be not any better than the IT people. If we do our jobs to the best of our abilities and promptly respond to user/patient problems with well thought out solutions on a continuing basis the IT groups will become part of Clinical Engineering as we understand technology, patient care and communicating with people. Just my thoughts.

Please remember to vote.

Dave Harrington

dave@sbtttech.com



9 Pass CE Certification Exam - Congratulations!

The United States Board of Examiners for Clinical Engineering Certification, the Healthcare Technology Certification Commission (HTCC) and the ACCE Healthcare Technology Foundation (AHTF), would like to acknowledge the certification of the following clinical engineers who successfully completed the certification exam in 2008: Prachi V. Asher, MS, CCE; Bruce Hansel, PhD, CCE; Richard Ivnik, MS, CCE; Leonid Layvand, CCE; Michael McDonald, MS, CCE; D. Courtney Nanney, CCE; Tracy Rausch, CCE; Alberto Vasquez, MSMOT, CCE; and Matthew Wheeler, MS, CCE. **Congratulations on your achievement!**

The Joint Commission Improves its Accreditation Process



According to the Joint Commission, its commitment to quality includes helping health care organizations better help patients. The Joint Commission

also claims to be committed to an accreditation process that brings benefits to organizations seeking to deliver safe, high-quality care. In today's rapidly changing health care environment, it is essential for the standards and accreditation processes to remain relevant.

Beginning January 1, 2009, The Joint Commission will be implementing many changes to its accreditation services resulting from the Standards Improvement Initiative (SII) that started in 2006. SII is the culmination of an intensive review and redesign of The Joint Commission's standards, its scoring and its decision-making process.

This multi-year improvement project includes a phased approach which includes extensive engagement from the field. The focus of SII includes categorizing elements of performance (EPs) based on their direct impact on care, and revising and reorganizing current standards and EPs to make them clearer, eliminate redundancies, and create a simpler and more logical order. The accreditation decision-making process has also been revised to link accreditation decisions to the "criticality" of the issue to patient care and/or safety. In other words, the more critical the issue, the shorter the time an organization has to resolve non-compliant standards related to the issue.

The goals of SII affect every aspect of the accreditation process, including the following:

- Enhanced clarity and relevance of current standards and EPs
- Tailored standards language rele-

vant for each program

- Deleted redundant or non-essential standards
- Consolidated similar standards
- Revised the decision process to more accurately reflect organizational performance related to safety and quality of care
- Refined scoring and decision processes to be more objective and focus on the "criticality" of the issue
- Revised manual chapter overviews, introductions, standards, rationales, and EPs that are easier for health care organizations to use
- Enhanced, reorganized manuals for easier use
- Color-coded tabs added to print manuals to distinguish standards and requirements from accreditation policies and procedures
- Single-user license electronic Editions of the accreditation manuals will be provided for the first time.

Phase 1

Implementation is planned for **January 1, 2009** and includes the following programs:

- Ambulatory care
- Critical access hospitals
- Home care
- Hospitals
- Office-based surgery

Phase 2

Implementation is planned for **January 2010** and includes the following programs:

- Behavioral health care
- Laboratory
- Long term care (including Medicare/Medicaid certification-based long term care)

Make sure not to miss the ACCE teleconference lead by George Mills, Senior Engineer, Standard Interpretation Group, Joint Commission, on this topic on October 16th.

Ismael Cordero

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ACCE Board-Secretary's Report

The newly elected Board of ACCE has been initiated according to the by-laws. For those of us new to position we appreciate the support of our more seasoned members. Discussions and initiatives on which the Board focused:

- Continuation of annual meeting and symposium at the HIMSS annual meeting with a complimentary continued presence at the AAMI annual meeting.
- Promoting the recognition of health care technologists through the ACCE Excellence in IT Award
- Participating in international areas of interest.

- Providing inputs to proposed changes in the NFPA 99 standard.
- Better understanding the issues of interest to members in the field of IT technology through participation in the HIMSS Analytics survey.
- Contributing to advanced biomedical research through participation at the annual IEEE-EMBS conference.
- Expanding Clinical Engineering excellence through the promotion and support of the CE Certification program.

Jim Welch

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The ACCE Board and Committee Chairs

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ACCE Clinical Engineering Certification Study Guide

The American College of Clinical Engineering has completed 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 and include credit card information (name on card, type of card, card number, and expiration date). Applications are now being accepted for the **November 2008** exam. Applications and the applicant handbook can be found at www.ACCEnet.org/certification

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

Calendar of Events

October 8-10, 2008 New England Society of Clinical Engineering Sturbridge, MA.	Medica 2008: 40th World Forum For Medicine Dusseldorf, Germany
October 9-10, 2008 CCE Prep Review Course Sturbridge, MA.	April 4-9 HIMSS '09 Chicago, IL
October 29-30, 2008 Managing Today's OR Suite Washington, DC	June 6-8, 2009 AAMI Conference Baltimore, MD.
November 8-11, 2008 Healthcare Design.08 Washington, DC	June 4-5, 2009 CCE Prep Review Course Baltimore, MD.
November 12-14, 2008 Association of Healthcare Value Analysis Professionals Scottsdale, AZ	
November 19-21, 2008	

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