


2016 AARC ANNUAL REPORT:

# Realizing Our Potential



*The Association continued to work toward a 21st-century vision of respiratory care in 2016.*



Our health care system is demanding more and more from clinicians. In 2016, the AARC took a series of carefully measured steps to ensure the profession will be ready.

In the volatile world of health care in which we live today, the only sure thing is that there is no sure thing. Researchers are constantly coming up with new theories about the treatment of disease, and manufacturers are introducing more and more technologically driven solutions. Politicians continue to tweak medical benefits, and providers have no choice but to react, and react, and then react again.

In the midst of these developments, though, one premise comes shining through: to compete in the new era of health care, clinicians must work smarter, more cost effectively, and with greater attention to the way their care affects not just the immediate medical needs of their patients but their needs over time as well. Positioning the respiratory therapist to be

that kind of clinician has been at the top of the AARC's agenda for a number of years now, and 2016 saw a continuation of those efforts.

"There are no guarantees for anyone in health care, and respiratory therapists are no exception," says 2015–2016 AARC President Frank Salvatore, MBA, RRT, FAARC. "In order to achieve a level playing field with our colleagues in nursing and other disciplines, we must be ready to make the disciplined choices and decisions that must be made to maintain our professional role as the lung health experts."

On the following pages, you will see how the AARC took the lead in this increasingly complex environment in 2016 and what that leadership means for our profession going forward. ■

# all about EDUCATION

Like it or not, we live in a world of degree-creep, and nowhere is that more evident than in health care. Disciplines like physical therapy and occupational therapy that previously had entry levels at the four-year degree level have slowly but surely upped the ante, so that some of them now require master's degrees or above to begin practice. Others, like nursing, are reserving their best jobs for graduates with a bachelor's degree or higher.

Respiratory therapists have long been educated at the associate's degree level, and no one disputes the competency of RTs with that level of education

to handle the traditional duties of the therapist. To take on a larger role in patient education and disease management, however, the profession must move beyond the associate's degree, and the AARC took the lead in making that happen in 2016.

Early in the year, the Association released a new RT Education Position Statement calling for all new respiratory care educational programs to award, at a minimum, a bachelor's degree in respiratory care. The statement built on the Association's earlier goal calling for 80% of respiratory therapists to either hold or be working toward a bachelor's degree by the year 2020.

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## More on education



**Two new courses** were added to AARC University in 2016. Clinician Training on Tobacco Dependence for Respiratory Therapists provides guidance for the delivery of personalized, tailored tobacco-cessation interventions offered in a variety of environments for a range of patient types.



Congenital Heart Defects is designed to assist the clinician in performing patient assessments, gathering appropriate information, and using pertinent clinical information to make clinical decisions in the treatment of infants and children with congenital heart defects.

**The Association's popular live course**, Pulmonary Disease Educator, was transferred to the online setting to give more therapists the chance to learn



the patient education skills they need to serve in expanded disease management roles in their facilities.

## The long-awaited Neonatal-Pediatric Specialist Course

was finalized. The 20 CRCE course is aimed at helping RTs understand more about the care of our smallest patients while also preparing them to sit for the Neonatal-Pediatric Specialist credentialing exam offered by the NBRC.



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The Position Statement was quickly backed up by the Commission on Accreditation for Respiratory Care, which announced a proposed revision to its Accreditation Standards for Entry into Respiratory Care Professional Practice. The revision states that all newly created RT educational programs must award baccalaureate degrees or higher. The standard is scheduled to go into effect in 2018.

Leaders deemed these moves to be a step in the right direction. “The time has come for our profession to advance its educational level,” 2015–2016 AARC President Frank Salvatore, MBA, RRT, FAARC, was quoted as saying. “We’re faced with situations where state legislatures and/or education departments are demanding fewer credit hours at the associate’s level. Respiratory therapists today need more clinical time in order to fully learn not only the advanced technologies we work with today but also to learn how to interact with our patients in ways that will be more meaningful toward educating

them about their disease, and even working on keeping them out of the hospital in the future. Less time in RT school does not achieve that.” Education Section Chair Ellen Becker, PhD, RRT-NPS, FAARC, agreed. While noting that “students who are enrolled in AS degree programs will have a wonderful start to their careers,” she emphasized that “educators can no longer teach the increased number of required RT competencies in a two-year respiratory care program.”

Association leaders believe RTs educated at the baccalaureate level will be able to assume an expanded set of responsibilities on the job and envision a new credential to reflect those enhanced responsibilities as well. To that end, initial steps were also taken toward the development of an advanced practice role for RTs, with leaders issuing a request for proposals early this year among academicians interested in researching the need for this role in the care of patients with cardiopulmonary disorders.

These developments, coupled with the Association’s ongoing commitment to serving the continuing education needs of its members, were front-burner issues throughout the year. ■

## AARC Continuing Education: 2016 Recap

How much do AARC members value the continuing education provided to them by the Association? The answer is in the numbers:

- **More than 40,000 courses** were purchased on the AARC University webpage in 2016, with about 25,000 in the free-for-members category.
- **Attendance at AARC webcasts topped 8,000.**
- **Overall, 16,000 people took part** in one or more AARC continuing education courses last year, up by more than 5,000 from 2015.





# PARTNERSHIPS

## pave the way

Health care doesn't occur in a vacuum, and neither does professional advocacy. For that reason the AARC maintains healthy relationships with scores of other groups and organizations, and in 2016 we saw a strengthening of those bonds.

A partnership with the Centers for Disease Control and Prevention (CDC) Tips From Former Smokers™ campaign that began in 2015 continued in 2016, with the Association pledging to bring the Tips message directly to its members. "We were honored when the CDC approached the AARC in late 2015, inviting us to partner with them in their 2016 Tips campaign," said AARC Executive Director Thomas Kallstrom, MBA, RRT, FAARC. "We are at the front of the line providing patient care and self-management education, and we are in a key position to influence our patients and caregivers about the dangers of tobacco. Certainly the RT can play a powerful role in counseling these patients." The campaign gained momentum among respiratory therapists throughout the year and now is continuing in 2017.

Likewise, the National Heart, Lung, and Blood Institute (NHLBI) COPD Learn More Breathe Better® campaign benefited from AARC involvement. As a Breathe Better Network Leadership Member, the Association has input into the program to help providers educate their patients about COPD and was proud to promote the resources available through the initiative to members.

Efforts like these paid off when the NHLBI decided to host a first-ever town hall meeting aimed at developing a National COPD Action Plan mid-year. Frank Salvatore joined AARC House of Delegates Speaker-elect Keith Siegel, BS, RRT, CPFT, at the session, and together they made sure the

RT's voice was heard. "It was an honor to represent the AARC along with President Salvatore at this historic meeting," Siegel was quoted as saying. "This country has long needed a comprehensive national COPD policy, and the work that was done in Bethesda represents a giant step toward achieving that goal."

When a draft of the action plan was released for comments in November, the AARC was again front and center, weighing in on the proposals from the RT's perspective. Thanks to the groundwork laid by the AARC's ongoing relationship with the NHLBI, the Association found itself in the enviable position of supporting much of what the plan delivered. "This document encompasses many facets where respiratory therapists will be crucial to its success," said 2017-2018 AARC President Brian Walsh, PhD, RRT-NPS, RRT-ACCS, AE-C, RPFT, FAARC. "The value that respiratory therapists bring to this far-reaching endeavor is evident in our comments."

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James Kiley, PhD, director of the division of lung diseases at the NHLBI, wrote the AARC in appreciation of its input. “We greatly appreciated the American Association for Respiratory Care’s careful review and the helpful feedback you offered during the most recent public comment period for the draft Plan. In particular, your ideas regarding the role of respiratory therapists, medication management, and patient-centric management tools were carefully considered as we continued to finalize the Plan.”

Of course, not every policy and program goes the AARC’s way, and the power of the AARC to respond swiftly when necessary was tested late in the year when the Centers for Medicare and Medicaid Services



(CMS) issued unexpectedly lower rates for pulmonary rehabilitation programs. In concert with sister organizations, the Association reviewed the rates and issued comments aimed at restoring adequate reimbursement for these life-enhancing programs. A meeting was held between CMS, the AARC, and other interested parties, and a data review was initiated to clarify the impact the new rates will

have on programs.

That review provided the information needed to continue the dialogue with the government agency, which has indicated a willingness to work with the pulmonary community as rates are developed for 2018. ■

## More on professional partnerships

**A report outlining the results** from the second annual National COPD Readmission Summit convened by the COPD Foundation stressed the important role RTs play in the care of COPD patients. “Respiratory therapists should be included as central members of the health care team for people with COPD while hospitalized and post-discharge. For those organizations that have not yet

included respiratory therapists in their COPD care teams, as well as those who have integrated them into their care processes, efforts should be made to clearly elucidate the role of respiratory therapy and therapists at every stage of care,” wrote the authors. The AARC was a major



## Safe Initiation and Management of Mechanical Ventilation,

a white paper published by the AARC and the University HealthSystem Consortium, emphasized the need to ensure competency of clinicians operating mechanical ventilators. The paper grew out of reports that around 9% of all safety intelligence data show that clinicians with



# YOUR VOICE

## in Washington, DC

The nature of our elected officials and their willingness to course-correct at every turn means the **AARC must remain vigilant** to developments coming out of our nation's capital. The Association maintains a professional legislative staff to keep track of legislation and regulations with the potential to impact respiratory care, and our annual Capitol Hill Advocacy Day

ensures legislators hear directly from respiratory therapists in their own states and districts about the key concerns of the profession and the patients it cares for.

This monumental task proceeded as usual during 2016, with another successful Capitol Hill Advocacy Day in April and ongoing communication with legislators and regulatory agencies throughout the year.

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no competency training in ventilator use were making changes to ventilator settings. Competency, training, and the interdisciplinary approach required to improve outcomes were defined.

**Improved access to respiratory therapists** for patients with chronic lung conditions was the main topic of a white paper issued by the

Institute for Patient Access. Written by a working group of physicians and RTs, the paper makes the case that respiratory therapists play an important role in the care and education of respiratory patients and that there is a pressing need for their expertise in all care settings. Reimbursement issues that curtail access to RTs outside of the acute care hospital are addressed. The AARC got involved after being contacted by the Institute to provide content experts for the paper.

**The AARC continued to partner with the CDC** to present CDC Strategic National Stockpile Ventilator Workshops designed to bring RTs up to speed on the ventilators that will be called into action should the nation face a major disaster or terrorist event involving a large number of respiratory patients. ■



# Advocating for Patients

Patients are the priority at the AARC every day, whether it involves lobbying Congress or developing a new continuing education course. But the Association works hard to connect with patients on a more personal level, too, through ongoing partnerships with patient organizations, and we also sponsor a patient advocacy event in conjunction with the AARC International **Respiratory Convention & Exhibition**. For the past two years, that event has taken the form of a Respiratory Patient Advocacy Summit. The 2016 session was aimed at bringing patients and caregivers together to talk about key issues of concern so caregivers could learn directly from patients and their families what they need to better manage their chronic lung conditions. Speakers addressed everything from living with



cystic fibrosis, to the top five concerns of asthma patients, to a “harmonicas for health” program designed to improve quality of life

for people with chronic lung disease. A roundtable session gave everyone a chance to air their concerns and brainstorm new ways to advocate for the better management of respiratory conditions.

These patient advocacy efforts are increasingly leading to joint initiatives with patient organizations. Last year, the Association finalized grants for joint ventures with the Pulmonary Fibrosis Foundation and the Allergy & Asthma Network that should come to fruition this year. Funding has also been acquired for an update to all three of the AARC's Aerosol Delivery Guides (including one for patients) and a new guide on pulmonary arterial hypertension. ■

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**Among other things, the AARC:**

**Stressed the need to add spirometry, pulmonary rehabilitation, and management of patients in need of supplemental oxygen as quality measures in the new**



physician payment system. The Association also emphasized the value of including the integration of RTs in the care team and evidence-based standards such as the AARC's Clinical Practice Guidelines on home oxygen. **Supported the inclusion** of questions relating to mechanical ventilation in a CMS survey regarding patient/family experiences with care in long-term care hospitals.

**Supported the inclusion of “clinical staff”** that could include RTs as part of CMS chronic care management services, with respect to 24/7 access to care.





# when you need us AARC IS THERE

AARC members have been helping their fellow members in times of need for 25 years now through a special fund set up to issue grants to members who have lost property as a result of federally declared natural disasters.

2016 saw a flurry of activity in this area, as the Disaster Relief Fund was activated to assist members in Florida, Georgia, South Carolina, and North Carolina who were affected by Hurricane Matthew; those in Louisiana, Mississippi, and West Virginia living in areas ravaged by extreme flooding; California members af-

ected by wildfires; and members in Louisiana, Mississippi, Alabama, and Florida who were victims of other severe weather events.

Go to the AARC website to donate online, or call AARC Customer Service at (972) 243-2272 to contribute via phone. ■



**Supported increasing rates** for pulmonary rehabilitation.

**Opposed new payment policies** for certain off-campus outpatient departments that could adversely affect pulmonary rehabilitation programs.

**Encouraged President Obama** to require the U.S.

Food and Drug Administration (FDA) to publish final deeming rules regarding their authority to regulate all tobacco products.

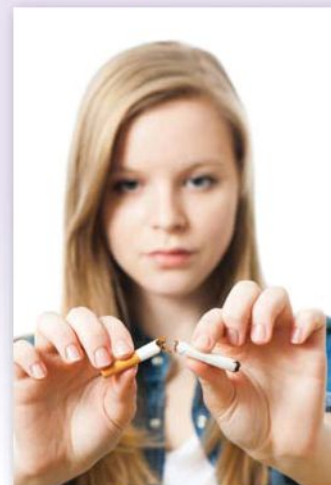


**Encouraged Congressional leaders** to ask the Congressional Budget Office to estimate long-term health savings in future cost estimates that are possible from wellness and disease prevention, especially for patients suffering from chronic conditions.

**Supported funding** for the CDC's National Asthma Control Program.

**As a member of the Tobacco Partners' Coalition**, signed on to letters to the U.S. FDA and Congressional committees supporting regulations and other policies calling for greater control of tobacco products.

**As a member of the Telehealth Coalition**, signed on to various letters to CMS and others supporting the expansion of telehealth services under Medicare. ■



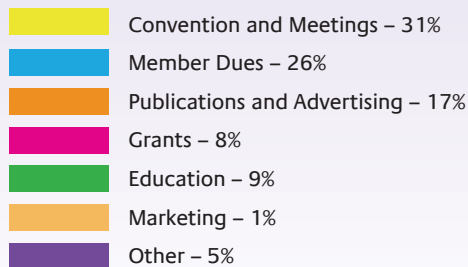
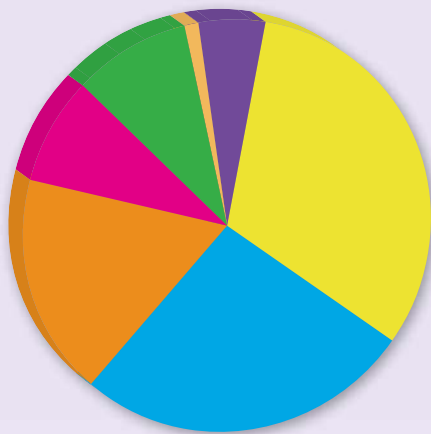
# 2016 Annual FINANCIAL REPORT

In February 2017, the AARC engaged the public accounting firm Salmon Sims Thomas and Associates to conduct an audit of its financial operations. It issued an unqualified opinion stating that the AARC's financial statements were presented fairly and conform to generally accepted accounting principles.

In 2016, the AARC's total revenues (excluding investments) were \$9,932,669, and total expenses were \$9,335,816. Figures 1 and 2 highlight the sources of last year's revenues and expenses. Net assets at the end of 2016 were \$24,935,823. ■

**Figure 1.**

Total Revenues in 2016 (Excluding Investments)



**Figure 2.**

Total Expenses in 2016

