American Association for Respiratory Care
Board of Directors Meeting
November 29-30, 2007
Orlando, Florida

General Reports

PRESIDENTS ACTIVITY REPORT
AARC Board of Directors Meeting
Orlando World Center Marriott
Orlando Florida

It seems like only yesterday since I gave my acceptance speech at the International Congress, in NV. The first year of my Presidency has passed quickly and we have accomplished much as an Association thanks to the substantial support I have received from the Executive Office staff, my Executive Committee and AARC volunteer leadership Thank you for the opportunity to report on my activities. Upon review you will agree that as an Association we have been extremely busy and effective in our role as national and international spokesman for the profession.

The most exciting news is the introduction of HR 3968 our milestone legislation developed to improve patient access to RRTs in settings outside of the acute care hospital. Congressman Mike Ross (D-AR), an influential member of the Health Subcommittee of the House Energy and Commerce Committee, formally introduced the bill into the House of Representatives. I thank all of the people that have diligently worked behind the scenes to make this happen. They have done an excellent job in providing us with optimal political positioning. But now the real work must begin by gaining support for our initiative, patient by patient, professional organization by professional organization, legislator by legislator. This work can only be accomplished by grassroots respiratory practitioner participation. This victory is already ours. We just have to have the courage and faith in ourselves to reach out and take it. If we fail in this endeavor it is this generation of therapist who will be held accountable by our patients and future respiratory practitioners. . In all the talks I have given as President over the last year the one point that I have emphasized over and over is that this is our time. We must act now in behalf of out patients.

I have participated in and completed the following activities summarized below:

- Reappointment of Stephen Mikles, Ed.S, RRT as AARC representative to the COARC for a four year term.
- Appointed John Walton as financial consultant "expert" to assist the Audit committee in its duties per BOD directive.
- Nominated Susan R Gallo to stay on as our HCPAC rep. to the AMA CPT Coding committee.
- Appointed Marc Mays as AARC Representative to the NBRC Job Analysis Committee. This is the second appointment for Mr. Mays to this position.
- Accepted the resignation of Carolyn O'Daniels as AARC Commissioner Alternate to Commission on the Accreditation of Allied Health Education Programs. No replacement was appointed.
- Accepted the resignation of Charles Gutierrez as Chair of the Neuromuscular Round Table and appointed Louis Boitano as his replacement.

- Submitted comments on behalf of the American Association for Respiratory Care (AARC) on the Centers for Medicare and Medicaid Services' (CMS) national coverage determination request to review Medicare coverage of pulmonary rehabilitation.
- Submitted comments responding to the request for public comment on the NCA Tracking Sheet for Nebulized Beta Adrenergic Agonist Therapy for Lung Disease.
- Sent a letter of endorsement for a set of core competencies developed for respiratory therapists in tuberculosis education by the National Tuberculosis Curriculum Consortium (NTCC) as approved by the BOD in December.
- Submitted an information document on AARC's Medicare Part B Initiative to list serves serving AARC constituents.
- Communicated verbally and in writing to the Tennessee Society of Respiratory Care and the members of that state on the AARC's opposition to provisions of SB 495, the Tennessee Polysomnography Act.
- Comments to the Centers for Medicare and Medicaid Services on sleep testing in the home environment.
- Letter sent to the Food an Drug Administration (FDA) supporting a citizens petition aimed at keeping the (CFC) containing COMBIVENT inhaler on the market until a CFC-free substitute can be developed.
- Signed on as a "Friend of the NCHS" (National Center for Health Statistics) urging congress to guarantee the continued ability of this agency to collect essential medical statistics by increasing their budget by $8 million in FY 2008.
- As a member of the National Health Council (NHC), signed off on a letter that went out to the FDA commenting on what must be done to enhance and modernize the FDA's safety system without curtailing drug research or unduly slowing the delivery of new medications on the market.
- Contributed to the Joint Commission Taskforce on development of a pilot COPD disease Management program similar to their Stroke and other certification programs.
- Sent comments to the Center on Disease Control (CDC) in review of work prepared by their Proficiency Testing Work Group in the area of medical laboratory proficiency testing.
- Accepted the resignation of Alex Adams as chair of the Acute Care Section and appointed Nick Wider former section president to fill the position for the year.
- Letter of commendation to Dr. Thomas Barnes thanking him for his service and leadership as our representative to the American Heart Association (AHA) on the occasion of his resignation from the committee,
- Authorized the purchase of a new phone system for the Executive Office with the approval of the AARC BOD.
- A formal response to an inquiry by the Associate Director of the Standards Interpretation Group Accreditation and Certification Operations of the Joint Commission regarding CPAP and Bi-PAP usage in the home, and the appropriate circumstances regarding when to use technical personnel vs. licensed health care professionals, such as respiratory therapists.

- Submitted comments on the Centers for Medicare and Medicaid Services' (CMS) Proposed Changes to the Hospital Inpatient Prospective Payment Systems - Fiscal Year 2008.
- A letter to the North Carolina House Finance Committee supporting the North Carolina Society for Respiratory Care in their request that HR 2015, the North Carolina Polysomnography Act, be tabled for this session while the areas of concern are addressed.
- Communication of the "Litmus Test", unanimously passed by the AARC's Board of Directors, over the HOD/President' list serve. The Litmus Test provides five elements that must be included in any polysomnography licensure bill to garner the AARC support of the legislation.
- A letter to the Executive Director, Delaware Board of Medical Practice supporting the Delaware Society in their quest for new proposed RT Licensure regulations that would permit qualified RTs to provide conscious sedation.
- Submitted my "Annual Call for Volunteers for publication in the May issue of AARC Times.
- Appointed Suzanne Bollig, Carie Smith and Alphonoso Quinones as AARC representatives to the NBRC's Sleep Job Analysis Committee with BOD ratification at summer meeting.
- Submitted nominations to the CoARC Board of Directors to fill 2008 openings with AARC BOD ratification to include Tom Smalling (reappointment), Gary White and Tammy Miller (new appointments).
- The Executive committees approved the following surveys of the membership:
  - Survey of NBRC program directors assessing the work force preparedness of graduates in the area of sleep disorder testing and treatment.
  - Survey conducted by University of Arkansas Medical Sciences on behalf of the AARC Education Section Ad Hoc Committee on Preceptor Training to determine the extent of the need for a national preceptor training program for respiratory therapy.
  - A post presentation survey by Pat Evans of the University of Arkansas Medical Sciences after his Summer Forum presentation: "A method of Evaluating Inter-rater Reliability."
  - Diagnostic Section Survey PFT Lab Survey put forth by Charles McArthur Section Chair, Approved at July BOD Meeting
  -Ed Section Survey of members to obtain feedback from the regarding educational programming for 2008. Submitted by Jeff Ward Section Chair

New Since July 2007:

- Submitted comments to in opposition to CMS-1385-P -- Proposed Revisions to the Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008, that would negatively change the definition of respiratory services.
- Endorsement and support for H.R. 562, The Medicare Long-Term Care Hospital Improvement Act of 2007, legislation that will help ensure patients who suffer from higher severity of illness levels receive the proper diagnoses and quality of care in long-term care hospitals (LTCHs).

- Respiratory Therapists with the Registered Respiratory Therapist (RRT) credential and at least a baccalaureate degree are now eligible to become commissioned officers in the Therapist Category of the US Public Health Service.
- Rebecca Meredith (Lab) and David Vines (Home Care Alternate) reappointed to JACHO PTACs.
- Prototype letter sent to State Presidents urging them to petition their Governor's office in support of designating November as Chronic Obstructive Pulmonary Disease (COPD) Awareness Month.
- Received a proposal for development of a Conscious Sedation and a Research Roundtable.
- Suzanne Bollig and Pam Bortner appointed to the NBRC board of
- directors.
- Frank Miller resigned as chair of the Management Section.
- Rick Ford appointed to serve as Chair of the Management Section through 2008.
- Participated in the US COPD Coalition COPD Congressional Briefing for members of the US House of Representatives, the Senate and their staff in November.
- Commented on the Food and Drug Administration's (FDA) proposed rule: Use of Ozone-Depleting Substances (ODS); Removal of Essential-Use Designation for Epinephrine used in Oral Pressurized metered-dose inhalers (MDIs)
- Letter of support in behalf of the Delaware Society's legislation to permitting certain, specially qualified licensed respiratory therapists to provide IV administration of moderate sedation under the direct supervision of a physician.
- Issued a Letter of Support for the Massachusetts Society in their effort to change the Massachusetts Department of Personnel Administration classification of respiratory therapists as technicians and respiratory therapy as a "technical job".
- Authorized activation of the AARC Disaster Relief Fund to aid AARC members in California who have suffered losses due to the recent devastating fires.
- Strategic planning continues for conducting a series of conferences aimed at discerning emerging healthcare trends impacting the profession and charting appropriate professional initiatives in alignment. The planning committee recently met and established a March date for our first conference in 2008. This conference will focus on the future trends in healthcare that will impact the practice of respiratory care with a white paper summarizing the findings to follow. If all goes well we hope to conduct the second conference on knowledge, skills and attributes by the end of next year.

Speaking Engagements:

New Mexico Society for Respiratory Care, Winterfest, Ruidoso NM
Georgia Society for Respiratory Care, Student Boot Camp, Macon GA
AARC PAC Meeting Washington D.C.
AARC Leadership Meeting, Grapevine TX
Oregon Society for Respiratory Care Annual Meeting
Michigan Society for Respiratory Care Conference
AARC Corporate Partner Meeting, Grapevine TX
NBRC Spring Meeting/ Update, Olathe, KS
Mississippi Society for Respiratory Care Annual Meeting, Tunica Mississippi
Pacific NW Regional Conference, Seattle: Washington Society Respiratory Care
The Maine Event at the Spruce Point Inn at Boothbay Harbor, Maine Society for Respiratory Care
American Thoracic Society Meeting, San Francisco, CA
Alaska Society for Respiratory Care, ASRC Conference in Soldotna
Illinois Society for Respiratory Care, Annual Meeting
AARC Board of Medical Advisors, Grapevine TX
Carolina/Virginia Chap. of the Society of Critical Care Medicine, Chapel Hill NC
Georgia Society for Respiratory Care Summer Meeting, Savannah GA
Tri-State Meeting, Mississippi Society for Respiratory Care, Bay St. Louis MS
Arizona Society for Respiratory Care Annual Meeting, Tucson AZ
Massachusetts Society for Respiratory Care Annual Meeting, Sturbridge MA
European Respiratory Society Meeting, Stockholm Sweden
PSRC State Legislative Day and Conference, Harrisburg PA

I will be glad to answer any question pertaining to my report at the fall meeting.

M E M O R A N D U M

To: **AARC Board of Directors**

From: **Sam P. Giordano, MBA, RRT, FAARC**

RE: **Executive Office Report**

Date: **December, 2007**

INTRODUCTION

2007 has been a busy year for the AARC. We have strategically planned and initiated new products and projects, which we are excited about. The executive office staff has provided outstanding support in both routine day-to-day operations and undertaking existing and new projects and activities on behalf of the association. The following represents some highlights of our activities.

MEMBERSHIP

Membership

As of November 1st, AARC has over 44,550 members. This is a 7% increase as compared to this time in 2006.It is fantastic that we have reached an all time high in membership on our 60th anniversary. We will continue to promote membership to non-members and retention to current members. This is seen through the great efforts of our volunteers, membership committee, partners, and executive office staff. There are 158 schools that participate in the web student program. Currently there are 6255 student members (2421 paid and 3834 free).

State Society/Partner Membership Efforts

Many of our states have actively promoted membership by purchasing bulk membership coupons. There have been 3857 bulk coupons sold so far in 2007 as of October (compared to a total of 4126 sold in 2006); 80% of sales are to state societies. We will continue to aggressively promote this program to companies and hospitals that purchase membership coupons for their staff or as an incentive for programs that they host locally.

Public Relations

In 2007 we initiated the "60 Second Checkup Program" which involves creating a brief radio spot relating to a pulmonary health tip and press releases on a lung health topic. RTs are used to provide the "tip" thus providing exposure for the profession, as well as promoting lung health to the public. Seven pulmonary related messages were released this year. We will be also be taping our popular Hometown Radio series onsite at the

convention this year. In addition to this, it is important that we get our message out with press releases. Some of the press releases sent out included:

- RC Week release
- Health tips releases to go with each 60 second check up topic
- Introduction of HR 3968
- National coverage for pulmonary rehab

In addition to this we developed a popular online Tool Kit for members with resource materials for RC Week. This is an important source for members wishing to promote the profession.

We also incorporated the National Heart Lung and Blood Institute's (NHLBI) Learn More Breathe Better campaign (http://www.aarc.org/rcweek/). This was very popular and feedback from the NHLBI indicates that a significant number of RTs took advantage of this offering.

MEETINGS AND CONVENTIONS

Asthma Certification Exam

We continue our mission to prepare respiratory therapists for the Asthma Educator Certification examination. In 2007 all Asthma Certification Courses exceeded budgeted forecasts beyond all expectations. There was a 38% increase in attendees. Most are respiratory therapists as well as small numbers of nurses and pharmacists. The National Asthma Education Certification Board recently shared data that revealed there are 2027 certificants. Respiratory therapists are in the majority (41% RT, 31% nurses, 7% pharmacists). Interestingly, respiratory therapist pass rates are only 65%. This is lower than that of nurses pass rates (79%). Surveys of therapists who attended the prep courses over the last 2 years have revealed a 10-12% increase in RT pass rates. We will continue to promote this important credential for our members in 2008 through a variety of initiatives. The Asthma Prep Course was presented in six (6) cities this past year. In 2008 we plan to offer the program in Houston, Tallahassee, Edison, NJ, Phoenix, and Philadelphia.

Programs

Three CRCE programs were offered in July 2007 in Reno. They included the traditional Summer Forum, Asthma Educator Certification preparation course and a Mass Casualty Journal Conference (funded by the AARC). As with past years the attendance was excellent and feedback from attendees has helped prepare us for programming in 2008.

AARC's 2007 International Congress

This year offers a record number of open forum presentations. The Program Committee worked hard to provide attendees with another conference rich with topics that are of current interest to our members. In addition the Asthma Prep Course and Ventilator Workshops will be offered immediately preceding the Congress. At the International

Congress we also offer two separate breakfast sessions. These sessions provide additional education and another opportunity to earn CRCE credits.

PUBLIC AWARENESS

At the Congress last year discussions were initiated that eventually resulted in the Mobile Spirometry Unit (MSU). The MSU is the result of a collaboration of the AARC and COPD Foundation. Its stated goal was to travel to selected cities across the country. Generally these venues were health events, most of which were NBC hosted health events. The AARC was able to interest over 30 members who shared their time to travel or volunteer locally for this event that lasted one to three days. AARC members traveled with the MSU to over 15 cities between February and November 2007. We are happy to report that we have screened over 9,000 people who fit the NHLBI selection criteria for screening of COPD. The people who were screened also got a chance to learn more about their pulmonary health as well as to meet and see a respiratory therapist in action. This created a very positive impression for those who were screened. The MSU and AARC also joined forces in Boston where the AARP Annual *Life Over 50* event was held. At all events we have had good press coverage, which helps us project our message.

We are planning to continue this effort with COPD Foundation with an aggressive schedule in 2008. As we travel the country we will be asking for more respiratory therapists to serve as volunteers for this important effort. We also encourage members to replicate these efforts locally.

Life and Breath Video

In 2007 we wrote and produced the new version of Life and Breath. Through the cooperation of Colin County Community College, Baylor Plano Heart and the main campus of Baylor hospital (all located in Dallas) we were able to secure a wide variety of respiratory therapists to be part of the taping. We also had support from our section chairs and BOD and HOD members who helped us review the script to make sure that was up-to-date and factual.

The response has been very positive. As of November we have sold 250 copies of the DVD since its release in August. The video is also available on line. We have had 5,210 downloads from that source.

High School Guidance Counselors

In June we presented our message to high school guidance counselors at their annual meeting in Denver. We also had a booth where we showed a tape of the High School Project (below) as well as Life and Breath. We offered to partner RTs to high schools that requested an RT to visit with their students. Over 50 requests have been made as a result. We encourage our state and local RTs to attend regional or state high school guidance counselor meetings as well. This has allowed us to get our profession on the minds of

teens at a critical decision making period of their life. We plan on attending the national meeting again in 2008.

High School Student Program

Through the generous support of Cardinal Health we have been able to share the High School Program with our members. A copy of the CD taped in Irving was given to state leaders in the spring. It also resides on the AARC web site. We have had 4,308 downloads from interested parties. Some state delegates have also taken on this project as a local initiative; the result being more students hearing about the profession as a possible career choice.

The second phase of the program is being planned for 2008. We will pilot the program in a large urban school district as well as provide the tools needed by interested RTs seeking to work with local schools.

Peak Performance

Peak Performance will be updated (it has been 10 years) and re-released in 2008 with the support of Monaghan Medical. A team of advisors met in Dallas in November and work is underway. We expect to release this at the 2008 Summer Forum. Again this effort will focus on students but primarily those in elementary and middle schools. The focus of this is to better prepare the schools for managing the patient with asthma and to provide better education to teachers, students and parents.

Your Lung Health

The website continues to enjoy popular support. We launched an electronic magazine called Allergy and Asthma Health, which is released quarterly. We generally get 1,700 downloads each time it is released. The Dr. Tom column (authored by Thomas Petty, MD) is still very popular and continues to get a lot of attention from those who go to the Your Lung Health Website. We will be presenting another Your Lung Health event in Orlando on Monday, December 3rd at a local senior center. RT volunteers will be on hand to do screening and provide pulmonary education to the general public.

EDUCATION AND MANAGEMENT

Allied Health Professionals Associates (AHPA)

The AARC has financially supported AHPA this year. Currently we are working with them in an effort to raise public awareness of the shortage of healthcare professionals. The goal is to let students be more aware of allied health professions, of which respiratory care is one of the largest. Also, we are happy to report that Bill Dubbs was elected to their board of directors and is currently guiding them in a major project focused on promoting allied health careers.

EPA Partnership

The grant awarded us from the EPA was extended into fiscal year 2008, as all of the granted money was not spent in 2007. This means that we will continue to offer a website that is specific to RTs who want to learn more about the triggers of asthma. So far in 2007 we have approximately 2,000 RTs who took the on-line course and subsequently went on to receive the CRCE.

Benchmarking System

The AARC Benchmarking System advanced from the beta testing phase in late summer. The Benchmarking system is now fully operational and available to subscribers representing the full range of acute care facilities. The system addresses the almost endless variety of respiratory care delivery models regardless of whether they're organized for a small community based hospital or a large university medical center. We currently have approximately 88 active subscribers (down from 97 in July) enrolled in the system. The drop occurred because the trail period expired in July and the remaining subscribers are those who are committed to the program for the long haul.

We want to enlist more centers and are aggressively pursuing this. In addition we are engaged in discussions regarding other opportunities; one of which is an offer of a cost reduction if hospital systems subscribe. On a broader scale we do sense some reluctance on the part of some managers to participate in the system. This is unfortunate since the system is designed to be an effective management tool to help guide decisions regarding adequate staffing. In an effort to get the word out in 2007 the AARC sponsored several speakers at state meetings to present talks and workshops on the Benchmarking program. We will continue efforts to provide more information regarding the value of the benchmarking program through 2008. The topic will also be addressed in two sessions during the International Congress this year.

Asthma Accreditation

Preliminary committee work on the standards has been completed and we are currently finalizing the application forms, reviewer's checklists, and costing issues. We continue to receive inquiries from our members about reimbursement and this once enacted will at least allow our members the capacity of billing for asthma education as dictated by the AMA CPT Codes.

Reimbursement College

The Reimbursement College was a huge success this past year. As of October 2007 there have been 1,167 members who took advantage of this 2 CRCE on-line course. We have met with Ikaria and we have decided to produce Reimbursement College Part II. The program will be offered as an on line program, similar to the current offering. Look for this later in 2008.

Aerosol Delivery Book for Respiratory Therapists

A very successful book was released in the first quarter of 2007. This popular book was made possible from a grant from Respironics. To date 132,921 downloads of the book

have been seen. They have come from around the world and we assume by many non-RTs. Plans are underway to develop a similar book that covers much of the same but directed at patients and at a level that they can understand.

Free Webcasts

This past year, we provided free webcasts to our members. Since we began this member benefit continuing education program two and a half years ago, we have produced 71 webcasts available to all AARC members and 11 special webcasts available to members of either the Sleep Section or Management Section. All webcasts are archived and can be found by visiting AARC's website. Unfortunately the response from section members was poor which resulted in many vacant seats so we have decided to not offer this as a section membership bonus, but instead offer interested section members first dibs for 2008 webcasts.

CRCE

In 2007 we saw a record number of CRCE awarded and based on our projections we expect to see 20% more this year as compared to last year. We also expect to offer the CRCE on line in early 2008.

AARC and International Respiratory Care

AARC again had a presence at the European Respiratory Society in Stockholm, Sweden in September. The response of interested medical professionals of our International Fellowship program was significant. We also were asked to make a presentation to the Respiratory subcommittee.

Mass Casualty Preparedness

A Journal Conference on this topic has held to a sold out group at the summer forum. The proceedings of which will publish soon in The Journal of Respiratory Care. The mass casualty committee has been active as well. An addendum to our original white paper on ventilator acquisition was written and is about to be released. Next will be a survey in early 2008 that all members will be asked to respond to regarding ventilator capabilities. The other committees in this area are working on logistics as well as human resource issues.

Product Sales

As of the end of October we are 147% over our budgeted product sales. A large percent of our products are sold for respiratory care week so we expect to see this number grow by convention time. Newer products entered the pipeline during the third quarter of 2007 and more will be released in the first quarter of 2008.

Rental of Building

In July we changed our leasing agent. We are using Staubach and Associates. Staubach specializes in leasing office buildings in the Dallas metro area. We have seen more interest in the property but as of yet no serious offers. We are in monthly communication with Staubach so that we can review movement in the area. This is a tough time to lease property in the Irving community but will we continue to aggressively pursue leads.

Additional Activities

U.S. COPD Coalition

The Association continues to be involved as one of the leaders of the U.S. COPD Coalition. Since our last report, the Coalition has undertaken efforts to transition operations to the co-chairs, Barbara Yawn, MD, and David Manino, MD. AARC continues to be represented on the Coalition's Executive Committee, which is its Board of Directors. The Coalition has been active in supporting NHLBI's "Learn More Breath Better" campaign. On September 20th under the auspices of the Coalition, we had the opportunity to join forces with Grace and Ted Koppel in an effort to lobby Congress to favorably consider adoption of the Pulmonary Rehab bill. As a member of the Coalition's Executive Committee, I was privileged to participate in this activity, thus projecting the presence of our profession and our Association. The September meetings were devoted to the Senate side. We were fortunate to get face-to-face meetings with Senators Widen, Crapo and Grassley, as well as with other key Senate health staff.

The most recent activity undertaken by the Coalition was to organize and host a Congressional COPD Caucus Briefing on Capitol Hill. Among those speaking at this event were Elizabeth Nabel, MD, Director of NIH's National Heart Lung and Blood Institute, Senator Crapo and Grace Ann Koppel. Once again, the message was to provide favorable consideration to the Pulmonary Rehab bill.

After the briefing, I was again privileged to participate in Hill visits on the House side. We met with Congressman Pete Stark from California and Congressman Elliott Engle from New York. Mr. Engle's support for the Pulmonary Rehab bill was unqualified and he agreed to help us assure that this important piece of legislation is included in Medicare related legislation this year.

The Coalition is in the process of planning a strategic planning effort which is projected to occur before the end of the year. I also serve on the Coalition's nominating committee. Currently, we are preparing a ballot for the annual election which will include election of a new co-chair and two seats on the Executive Committee.

Project 2015 and Beyond

As reported previously we are developing a series of three conferences for the purpose of 1) identifying future roles of respiratory therapists in 2015 and Beyond, 2) the second conference will address education preparation and competency documentation issues for respiratory therapists 2015 and Beyond, 3) the third and final conference will build upon the previous two and focus primarily on developing a practical transition from the current infrastructure to what will be needed to prepare RTs practicing in 2015 and Beyond.

The first conference is scheduled to convene on March 3, 2008 in Dallas. All stakeholders identified by the planning group have been invited to attend each conference. The first conference is co-chaired by John Walton, MBA, RRT, FAARC and Charles Durbin, MD, FAARC. **Attachment 2** contains a list of topics and faculty as well as stakeholders for conference number one. This program was approved by the planning

group at its last meeting held October 29th in Chicago. You may recall you were provided with a list of all planning group members last summer. We are fortunate to have all perspectives represented in the planning process including those that circumscribed the organization and delivery of respiratory services in our nation's health care system.

HR 3968

As you are no doubt aware, the AARC was successful in getting its Part B provider initiative introduced in the House of Representatives by Congressman Ross (AR). I hope by the time you meet in Orlando, we'll be able to provide you with the Senate companion bill number which we anticipate being introduced at any time. This legislation, when passed and signed into law, will permit for the first time in our profession's history the employment of RRTs with bachelor's degrees in physician practices under Medicare's Part B provision. This will place our advance level therapist on par with physical therapists, nurse practitioners and physician assistants among others. The credibility of our profession will no doubt increase and this will ripple throughout all aspects of our profession and provide greater access to respiratory therapists by patients outside of the acute care setting.

Respiratory Therapists and PHS's Commissioned Officer Corp.

After almost 15 years of tireless effort on the part of many of the Association's leaders which began when Carl Wiezalis was President and continued to be supported by every President since Carl, registered respiratory therapists who are graduates of a Baccalaureate level CAAHEP accredited program in respiratory care are now eligible to join the Public Health Services Commissioned Officer Corp. This is, indeed, one of the biggest milestones in our profession's history. The significance cannot be underestimated. While initially there will be just a few positions available, there is no doubt that once our value is recognized within the context of PHS's mission, our status and credibility as a profession increases exponentially. For all too many years we have been thought of as technicians rather than therapists. By being eligible to join the Public Health services Commissioned Officer Corp, qualified respiratory therapists will be members of the "therapists" section of PHS. Our colleagues will be permitted to advance exactly the same as those currently commissioned such as physical therapists, occupational therapists, speech therapists, and others. This will not only help us help patients, but also provide further legitimization of the role of advance level respiratory therapists in settings outside of acute care facilities in both conventional and mass casualty scenarios. We will continue our close collaboration with PHS and assist them any way we can to assure their decision to commission RTs will help further their ever-expanding mission.

SUMMARY

I hope the foregoing provides you with a bit of insight as to what we've been doing at the Executive Office. If you'd like any more information regarding the foregoing, please do not hesitate to contact me at your convenience. Thank you.

Attachment 1
Investment Policy (Referred to in Recommendation)

AARC

PROPOSED
INVESTMENT POLICY AND PROCEDURES (Clean Copy)
(*December 2007*)

The Executive Director has been delegated by the Board of Directors the authority for management of the AARC's cash funds. Such investments must be carried within the guidelines provided herein which have been reviewed and approved by the Board of Directors.

Policy Statement

Maximum utilization of Association assets is a primary objective of the Board of Directors. Cash balances represent an available asset that, when effectively managed can contribute to the overall goal of providing services at reasonable costs. Although the investment of cash on either a short or intermediate term basis is not AARC's principal activity, it is the nature of business operations that there will be excess funds available. The objective of the investment guidelines contained herein is to allow the AARC to maximize its return on cash balances while operating within established limitations that will minimize the risk of financial loss.

A matter of primary importance in determining the application of excess cash is ensuring that funds will be available to meet upcoming cash requirements. This can be achieved through the anticipation of cash needs by preparing projections of cash flow. The Executive Office is responsible for the preparation of such projections. However, their accuracy depends on the cooperation and awareness of all directors, officers, committee chairs, etc. All departments should, on a timely basis, provide the Executive Director with any information regarding contractual obligations or other types of arrangements that will significantly affect cash flow.

An additional consideration in the management of cash balances is alternative uses of cash, such as early debt retirement and early payment on accounts in order to receive cash discounts. It is the AARC's position that decisions involving alternative uses of funds will be based on an evaluation and comparison of economic benefits to the Association. After an evaluation, it may dictate that these alternative uses may be more attractive investment alternatives. Generally, in such cases, these alternatives should be pursued. However, should early debt retirement become economically attractive, implementation would require the prior approval of the Board of Directors.

Investment Guidelines

In order to minimize the risk of loss to cash balances, it is necessary to determine levels of risk that are compatible with overall management philosophy. Based on this determination, guidelines can be established for use in the investment of funds. The

guidelines set out below establish not only the types of investments that are acceptable, but also limitations on the amount of any one of those investments that may be held at any point in time.
All investments of Association cash shall fall within the following guidelines:

- Fixed income-type investments
  - Range: 40-60% of entire portfolio; Optimum allocation: 45%
  - Acceptable investments (in no order of importance / use):
    - Bank CD's (FDIC insured ONLY), maximum in any one institution: $100,000
    - Repurchase agreements collateralized by government securities
    - Bankers Acceptances
    - Federal government or government agency securities
    - Corporate commercial paper with an S & P rating of A-1 or Moody's rating of P-1
    - Money market accounts trading at $1.00 / unit and comprised of the above type securities
    - Corporate bonds with a rating of no lower that "BBB" by S&P or "Baa " by Moody's.
      - Bond maturities may be staggered over a 10 year period with the average maturity not to exceed 5 years.
      - No one bond may comprise more than 7% of the total fixed income portfolio
    - Bond mutual funds
      - Must be primarily comprised of the above type of investments and
      - Must be judged to be of high quality by considering:
        - S&P or Moody's ratings
        - Past earnings records
    - May include so-called high yield or "junk bonds" (rated below "BBB" by S&P or "Baa " by Moody') but they may not comprise more than 7% of the total BOND PORTFOLIO.

- Equity investments
  - Range: 40-70% of entire portfolio; Optimum allocation: 55%
  - Single issues---Any stock EXCEPT those that are:
    - A Penny Stock (i.e. trading for less than $1 via OTC (pink sheets))
    - Highly speculative, for example:
      - Be trading with unusually high P/E ratios…50-75++ or
      - Have little or no history of any earnings
  - Stock Mutual funds must be:
    - Primarily comprised of the stock issues allowed for above and
    - Judged to be of high quality by considering:
      - S&P or Moody's ratings
      - Past earnings records / future growth

        - Fund manager experience and track record
- No investment in any security that is related to the tobacco industry is permitted
- No one equity security issue shall comprise more than 5% of the total equity portfolio and no one sector shall comprise more than 15% of the total equity portfolio.
- Alternative investments
    - No more than 5% of portfolio
        - Options, derivatives, future contracts, REITs
            - Range: no more than 2.5% of entire portfolio
            - Each trade must be approved by AARC CEO
        - Real Estate
            - Range: no more than 2.5% of entire portfolio
            - Each purchase must be approved by AARC CEO

Implementation

In implementing the cash management program, the following minimum objective must be retained:

1. Achieve maximum yields on invested funds while insuring reasonable protection of principal.
2. A return on investment / benchmark goal of 2% over the annual Consumer Price Index shall be the long-term (3-5 years) goal

The employment of outside investment counsel may be considered when implementing a part or all of this cash management program. Such professional service must be bound by these same guidelines while undertaking their investment management role Adequate accounting procedures must be developed, implemented and continually exercised. These procedures will insure adequate forward cash planning, proper controls over transfers of cash, establishment of maturity dates, recording and receipt of interest income and maintenance of individual accounting records for each investment.

All Association held negotiable instruments must be controlled using external safekeeping facilities. Access will be limited and must require a minimum of two appropriately designated representatives.

Any material deviation from these guidelines and their implementation procedures must be submitted to and approved by the Board's Finance Committee.

AARC

PROPOSED
INVESTMENT POLICY AND PROCEDURES (With Notes)
(*December 2007*)

PROPOSED POLICY--- CURRENT INVESTMENT POLICY WITH ADDITIONS (IN ITALICS) AND DELETIONS SHOWN >>

The Executive Director has been delegated by the Board of Directors the authority for management of the AARC's cash funds. Such investments must be carried within the guidelines provided herein which have been reviewed and approved by the Board of Directors.

Policy Statement

Maximum utilization of Association assets is a primary objective of the Board of Directors. Cash balances represent an available asset that, when effectively managed can contribute to the overall goal of providing services at reasonable costs. Although the investment of cash on either a short or intermediate term basis is not AARC's principal activity, it is the nature of business operations that there will be excess funds available. The objective of the investment guidelines contained herein is to allow the AARC to maximize its return on cash balances while operating within established limitations that will minimize the risk of financial loss.

A matter of primary importance in determining the application of excess cash is ensuring that funds will be available to meet upcoming cash requirements. This can be achieved through the anticipation of cash needs by preparing projections of cash flow. The Executive Office is responsible for the preparation of such projections. However, their accuracy depends on the cooperation and awareness of all directors, officers, committee chairs, etc. All departments should, on a timely basis, provide the Executive Director with any information regarding contractual obligations or other types of arrangements that will significantly affect cash flow.

An additional consideration in the management of cash balances is alternative uses of cash, such as early debt retirement and early payment on accounts in order to receive cash discounts. It is the AARC's position that decisions involving alternative uses of funds will be based on an evaluation and comparison of economic benefits to the Association. After an evaluation, it may dictate that these alternative uses may be more attractive investment alternatives. Generally, in such cases, these alternatives should be pursued. However, should early debt retirement become economically attractive, implementation would require the prior approval of the Board of Directors.

Investment Guidelines

In order to minimize the risk of loss to cash balances, it is necessary to determine levels of risk that are compatible with overall management philosophy. Based on this determination, guidelines can be established for use in the investment of funds. The guidelines set out below establish not only the types of investments that are acceptable, but also limitations on the amount of any one of those investments that may be held at any point in time.
All investments of Association cash shall fall within the following guidelines:

- ***Fixed income-type investments***
  - ***Range: 40-60% of entire portfolio; Optimum allocation: 45%***
  - ***Acceptable investments (in no order of importance / use):***
    - ***Bank CD's (FDIC insured ONLY), maximum in any one institution: $100,000***
    - ***Repurchase agreements collateralized by government securities***
    - ***Bankers Acceptances***
    - ***Federal government or government agency securities***
    - ***Corporate commercial paper with an S & P rating of A-1 or Moody's rating of P-1***
    - ***Money market accounts trading at $1.00 / unit and comprised of the above type securities***
    - ***Corporate bonds with a rating of no lower that "BBB" by S&P or "Baa " by Moody's.***
      - ***Bond maturities may be staggered over a 10 year period with the average maturity not to exceed 5 years.***
      - ***No one bond may comprise more than 7% of the total fixed income portfolio***
    - ***Bond mutual funds***
      - ***Must be primarily comprised of the above type of investments and***
      - ***Must be judged to be of high quality by considering:***
        - ***S&P or Moody's ratings***
        - ***Past earnings records***
    - ***May include so-called high yield or "junk bonds" (rated below "BBB" by S&P or "Baa " by Moody') but they may not comprise more than 7% of the total BOND PORTFOLIO.***

- ***Equity investments***
  - ***Range: 40-70% of entire portfolio; Optimum allocation: 55%***
  - ***Single issues---Any stock EXCEPT those that are:***
    - ***A Penny Stock (i.e. trading for less than $1 via OTC (pink sheets))***
    - ***Highly speculative, for example:***

        - ***Be trading with unusually high P/E ratios…50-75++ or***
        - ***Have little or no history of any earnings***
    - ***Stock Mutual funds must be:***
        - ***Primarily comprised of the stock issues allowed for above and***
        - ***Judged to be of high quality by considering:***
            - ***S&P or Moody's ratings***
            - ***Past earnings records / future growth***
            - ***Fund manager experience and track record***
- ***No investment in any security that is related to the tobacco industry is permitted***
- ***No one equity security issue shall comprise more than 5% of the total equity portfolio and no one sector shall comprise more than 15% of the total equity portfolio.***
- ***Alternative investments***
    - ***No more than 5% of portfolio***
        - ***Options, derivatives, future contracts, REITs***
            - ***Range: no more than 2.5% of entire portfolio***
            - ***Each trade must be approved by AARC CEO***
        - ***Real Estate***
            - ***Range: no more than 2.5% of entire portfolio***
            - ***Each purchase must be approved by AARC CEO***

DELETED SECTION>>>>

- Asset allocation between debt instruments and equities will be 50%/50%.
- No less than 25% of the equities are to be invested in stocks which yield dividends.
- Interest bearing checking accounts held with previously approved financial institutions
- Commercial paper should be rated A-1 (by Moody's) or P-1 (by Standard & Poor's).
- Banker's Acceptances should be accepted by one of the 50 largest banks in the United States.
- Negotiable Certificates of Deposit should be issued by FDIC insured commercial banks located in Texas, one of the 50 largest in the United States or a FSLIC insured Savings and Loan Bank approved by the Board.
- Repurchase Agreements should be collateralized by instruments that fall within Association investment guidelines.
- Federal Government and Federal Agency securities are all approved investments.

Implementation

In implementing the cash management program, the following minimum objective must be retained:

1. Achieve maximum yields on invested funds while insuring reasonable protection of principal.
2. ***A return on investment / benchmark goal of 2% over the annual Consumer Price Index shall be the long-term (3-5 years) goal***

The employment of outside investment counsel may be considered when implementing a part or all of this cash management program. Such professional service must be bound by these same guidelines while undertaking their investment management role Adequate accounting procedures must be developed, implemented and continually exercised. These procedures will insure adequate forward cash planning, proper controls over transfers of cash, establishment of maturity dates, recording and receipt of interest income and maintenance of individual accounting records for each investment.

All Association held negotiable instruments must be controlled using external safekeeping facilities. Access will be limited and must require a minimum of two appropriately designated representatives.

DELETED SECTION>>>
Additionally, investment maturity dates must be consistent with the four different categories of internally managed funds:

1. ***Operating Cash*** – Invested with maturities ranging from 3 days to 1 year.
2. ***Trustee Funds*** – Invested typically with maturities of 1 year, but could be less if anticipating swings in market investment rates.
3. ***Funded Depreciation*** – Invested with intermediate term maturities of 1 year to 4 years, depending on trends in interest rates.
4. ***Development Funds*** – Since these funds were earmarked for the new programs, they should be invested in securities with maturity dates consistent with initiation of new programs.

Any material deviation from these guidelines and their implementation procedures must be submitted to and approved by the Board's ***Finance*** (DELETE: Budget) Committee.

Attachment 2

Topics/Speakers for 2015 & Beyond Conference #1
Stakeholders

Creating a Vision for Respiratory Care
In 2015 and Beyond

Overview of Process and Expected Outcomes (Methodology)

a. Explain role of audience (to provide input)
b. Explain role of speakers (to provide an overview of their assigned topics-will be recorded and transcripts generated)
c. Describe envisioned final product (description of role and rationale to support this)
d. Speakers will provide written summary of their topic writing committee.

Presenters: John Walton and Charles Durbin

Description of 2015 and Beyond: (unrestrained by current reimbursement and unmet needs)

a. Patient populations: what patients/consumers will respiratory therapists serve?
b. What will roles will they play in meeting the needs of these populations?
c. Where will they provide services?

Presenters: John Walton and Charles Durbin

Current Status of the Health Care System (quality, access, cost)

a. General background and trends
    i. Cost
    ii. Demographics
        1. Growth
        2. Aging
        3. Diversity
    iii. System-balancing acute in-patient treatment with chronic ambulatory management
b. Epidemiology-acute to chronic
c. Outcomes/Quality
    i. Overall quality/safety
    ii. Disparities of health outcomes
d. Consumer
    i. Service satisfaction demands
    ii. New location of care
    iii. New types of services needed-education
e. Technology
f. Workforce
    i. Trends in supply and demand
    ii. Underinvestment in education

Presenter: Ed O'Neil

Current Status of Respiratory Care within the Health Care System

a. Past and emerging status of respiratory disease

b. Mega cost drivers in respiratory care (i.e. technology, need to manage the chronically ill populations, growing respiratory patient population, aging population)
c. Wellness promotion (awareness of symptoms and prevention of hospitalization)
d. Quality disparities (care settings and disease populations)

Presenter: Patrick Dunne

What Respiratory Patients Need

a. Access and choice
b. Provision of care
c. Educational needs, self care
d. Monitoring
e. Management

Presenter: John Walsh

Special Considerations

Military

a. Current military health care needs
b. Military role in disaster planning
c. Potential impact of a military draft

Presenter: COL Michael J. Morris, MC, USA

Public health –the role of a respiratory therapist in scenarios such as a natural or national disaster: dirty bomb, chemical explosion or pandemic influenza.

Presenter: Judy Blumenthal

Current and Future Human Resources Issues (supply and demand, generational expectations, life style, remuneration, social value)

a. Physicians
b. Nurses
c. Allied Health
d. Respiratory Therapists

Speaker not required-Information provided as handouts

Demand Factors Impacting on the Responsibilities of the Respiratory Therapist

- Device and information technology changes
- Genomics
- Aging population
- Emerging medications and their associated delivery devices including inhaled medications

Presenter: Neil MacIntyre

Future Implications to the Healthcare System and to the Delivery of Respiratory Care (should no changes occur)

a. Costs
b. Access

c. Quality
d. Morbidity

Presenter: Gordon Rubenfield, MD - Ed O'Neil will coordinate with Gordon.

What Should Respiratory Therapists be doing in the Future to:

a. Constrain costs/ improve value
b. Foster innovation in delivery model
c. Maintain adequate patient access
d. Assure quality (adequate preparation)

Presenter unconfirmed as of 11-02-07

Future Respiratory Therapist Role across the Spectrum of Care (Based on Evidence**)**

a. Critical Care
b. Acute care
c. Long term care
d. Chronic Care Management
    i. Home care
    ii. Physician practice
    iii. Clinics
e. National emergencies

Presenter: Robert Kacmarek

Projected Required Knowledge, Skills, Attributes for Respiratory Therapists to Fulfill their Future Role

a. Critical thinking
b. Assessment
c. Communication
d. Cost/Reimbursement Awareness
e. Technical/Clinical Competency
f. Research/Outcome Measurement

Presenter: Woody Kageler

Development of Vision of Future Role Description for RT 2015 and Beyond (crafted by the writing committee)

a. Presentation to attendees at the conference
b. Discussion and feedback to direct the writing committee's deliberations
c. Develop Vision Statement of prior to departing conference

Adjournment

Development of Report and Recommendations (planning group-6 months)

Referrals

07-2-52.1 "That the AARC explore the establishment of a formal liaison with the Association of Air Medical Services (ASMS)."

I have undertaken preliminary consideration of the strategic implications related to forming a liaison with this group, but am not comfortable at this time making a recommendation to do so. I would like to have more time to develop a recommendation and request that the report back deadline be extended until the March 2008 Board meeting.

07-2-24.2 "That the AARC board launch an all new Ambassador Program during Respiratory Care Week that will last approximately 3 months and end in January, 2008."

Before we consider re-launching the Ambassador Program and marrying it with Respiratory Care Week, we feel it is necessary to undertake a multifaceted survey effort which can tell us what parts of the Ambassador Program were effective and what incentives were useful, and the type and amount of membership recruitment information we'll need to have in place in order to launch the program.

07-2-24.3 "That the AARC offer one free AARC International Congress registration to every state affiliate as part of a membership recruitment campaign."

This recommendation is under active consideration and will be addressed once we finish analyzing information gained from the previously mentioned membership surveys as well as that of an additional survey of our state societies. This additional survey will focus on incentives that may stimulate more effective membership recruitment efforts put forth on the part of state societies. While the membership marketing plan has been on our radar screen to be completed by the year's end, I have not been able to move this forward as fast as I'd like. I will once again, respectfully request that the Board extend this referral's report back deadline to March 2008.

Recommendations

07-3-1.1 "That the Board of Directors approve revision of AARC's investment policy as presented in **Attachment 1.**"

House of Delegates

AARC Activity Report
November 29, 2007

Speaker: Debbie Fox, MBA, RRT-NPS

Recommendations: None

Summary of House Activities:

The House of Delegates has a full Agenda for the Fall Meeting. We will be receiving Committee reports and Agency updates. The introduction of HR 3968 will be a major focus, as Delegates will add their energies to the PACT to coordinate grassroots involvement in their affiliate. This will be part of Government Affairs Report to be presented during the Joint Session with the Board. A follow-up report on Polysomnography issues will also be given during Joint Session. We started the discussion regarding the AARC Budget approval process and the Auditor's recommendation at our Summer Meeting at Reno. The House will continue this process as the Audit Subcommittee brings their recommendations forward. We have worked to strengthen our Resolution process to assure that resolutions are concise, developed and properly researched before submitted to the House for consideration. Three resolutions have been submitted for consideration at Orlando. The NBRC is presenting a review of the evolution of the credentialing process. This is planned to improve the understanding of the complexities of the credentialing process that the Delegates can communicate back to their state affiliate Boards and membership.

We will also be conducting Elections for 2008 House Officers during this meeting.
Nominations for Officers include:
Speaker-Elect: Tom Lamphere (PA), Cam McLaughlin (VA), Tom Wagner (CA)
Secretary: Deb Linhart (IL), Dawn Rost (ND) JoAnne Sandefur (SC), Roy Wagner (TX)
Treasurer: Ross Havens (IN), Joe Horn (TX)
Elections will also be held for Delegates to serve on the AARC Bylaws Committee (2) and the AARC Elections Committee (1).

The following is a brief listing of House Committee Activities:
Affiliate Best Practices: Coordinated four presentations of best practices at the Summer HOD meeting concerning Public Relations, conducting a Legislative Day, sponsoring a Student Survival program and planning successful Seminars.
Chartered Affiliates Committee: Recommended the North Carolina Society for Respiratory Care receive the 2007 Summit Award. Recognized 10 other state affiliates as Honorable Mention for their excellence in the categories of Education, Political Advocacy, Promotion of the Profession, Community Involvement and Membership.
Delegate Assistance Committee: Reviewed requests from state affiliates requesting assistance with Delegate travel expenses.

Elections Committee: Received nominations for House Officers, AARC Bylaws and AARC Elections Committee and will conduct the elections at the Fall Meeting.
HOD Legislative Affairs Committee: Provided communication link between HOD and PACT to strengthen grassroots legislative efforts at the affiliate level.
Orientation Committee: Conducted Orientation Session for 21 new Delegates in Reno, 9 new Delegates in Orlando.
Progress and Transition Committee: Completed Effectiveness Survey following House meetings and Historical Overview for the Delegate's Handbook.
Publications Committee: Published three issues of the HOD Record.
Resolutions Committee: Reviewed and submitted for consideration seven resolutions at the Summer Meeting; three resolutions at the Fall Meeting.
Special Recognition Committee: Recommended John Blewett (NM) to receive the Outstanding Affiliate Contributor Award and Doug McIntyre (LA) for AARC Life Membership.

My goals and the progress toward accomplishing the goals are listed below.
2007 Speaker Goals

1. Maintain open communication and collaborative working relationships with the AARC President, AARC Board of Directors, Specialty Section Chairs and the Executive Office.
   Ongoing.
   - *Monthly conference calls with the Board and House Leadership.*
   - *Frequent emails and phones calls between President Toni Rodriguez and myself.*
2. Assist the AARC President in achieving the AARC 2007 Goals.
   a. Each Delegation coordinate two consumer-related public relations events through their state affiliate.
   b. Each Delegation will report event back to the House via House listserve or during open microphone session.

   Ongoing.
3. Provide timely updates on Speaker and House activities to the HOD, BOD and Executive Office.
   a. Communicate on a regular basis.
   b. Utilize the House listserve to improve communication between House of Delegates meetings.

   Ongoing.
   - *Submitted articles for the HOD Record.*
   - *Use of HOD / Presidents Listserve for ongoing communication as needed.*
4. Promote PACT and Legislative Affairs activities by communicating consistent messages to the House in a timely fashion. Assist as needed to activate the 435 Plan.
   Ongoing.
   - *Reports from the Federal Governmental Affairs Committee, the State Government Affairs committee and the 435 Plan Update on the HOD Agenda for both House meetings.*

- *The House Legislative Affairs Committee functions to continue the involvement of the House in legislative activities. The Committee also fosters a partnership between the affiliate PACT Coordinators and the Delegates.*
- *Several members of the House (including Speaker and Speaker-Elect) attended the Washington DC PACT meeting as their affiliate PACT representatives.*

5. Promote opportunities to increase Active Membership and Specialty Section Membership.
   Ongoing.
   - *Reports from AARC Membership Committee during both House Meetings.*
6. Promote opportunities of collaboration to improve patient care and enhance public recognition of the Respiratory Care profession.
   Ongoing.

As my term as Speaker ends I would like to recognize all my House Officers for their assistance and input during the year; Past Speaker Denise Johnson, Speaker Elect Frank Salvatore, Secretary Cam McLaughlin, Treasurer Joe Horn. Team HOD was formed from their willingness to help whenever needed. I am certain Frank will do an excellent job as Speaker next year. I would also like to thank Patrick Dunne for his guidance and support as my Parliamentarian. The past year has been an enriching experience and I appreciate the support I have received from President Rodriguez, the Board, Sam Giordano and the AARC Executive office staff.

Respectfully submitted,

Debbie Fox, MBA, RRT-NPS
Speaker, AARC House of Delegates

Board of Medical Advisors

Presidents Council

Activities Report
Fall 2007

Chair: Dianne L. Lewis, MS, RRT, FAARC

The Presidents Council has completed their yearly task of choosing Life and Honorary members. Life Membership was granted to Douglas McIntyre, RRT, FAARC and Joseph Rau, Ph.D, RRT, FAARC. Honorary membership was bestowed on Kent Christopher, RRT, MD.

The Council will be holding its annual meeting at the International Congress in Orlando. If there is any way that we can assist the BOD do not hesitate to let us know.

It has been a pleasure serving as Chair.

Federal Government Affairs

AARC Activity Report
November 2007
Cheryl A. West, MHA
Director Government Affairs

The Congress

As this report is written Congress continues to move towards a December recess. With an eye towards the 2008 general elections, political maneuvering has seeped into the process. Neither party willing to give the other credit for a legislative "win", thus, enacting important legislation becomes problematic.

Legislation

As stated in past Board Reports, Ms. Miriam O'Day, of O'Day and Associates continues work on behalf of the AARC legislative agenda. Her presence in Washington, D.C. maintains a continuous Hill presence for the respiratory profession through meetings, direct lobbying and attendance at fundraising events.

HR 3968 Medicare Respiratory Therapy Initiative

In October, Congressman Mike Ross, (D-AR) introduced the AARC's Medicare Initiative, HR 3968 "The Medicare Respiratory Therapy Initiative Act of 2007". Congressman Ross sits on a key Medicare Committee in the House and his sponsorship of our initiative raises the profile to others overseeing the Medicare program. Congressman Ross made the decision to support and champion our Initiative through the efforts of AARC members who contacted their own House of Representative member (who in turn contacted Congressman Ross) and the tireless work from Miriam. Now that we have a bill we can proceed to aggressively seek out Hill co-sponsors as well as attract support from outside associations and organizations. At the writing of this report the American Thoracic Society; Alpha-1 Foundation, Alpha-1 Association, COPD Foundation, National Emphysema/COPD Association (NECA) and NTM Info & Research which serves individuals with Nontuberculous Mycobacterial Disease support our Initiative.

HR 3968 will revise the Medicare statute that regulates the "medical and other health services" benefit. The revision will permit respiratory therapists with the RRT credential and a bachelor degree to deliver respiratory care services without the physician being physically present when the services are being furnished (that is, under *general* physician supervision requirement rather than the current Medicare requirement of *direct* supervision, which mandates the physician must be personally on site).

Medicare allows a number of advanced-level allied health care providers such as physician assistants, nurse practitioners, and clinical nurse specialists the privilege of working under general physician supervision. HR 3968 will give respiratory therapists

with an RRT and bachelor degree similar recognition that they do not now have. This bill, when enacted will enhance patient access and encourage respiratory therapists to seek advanced credentials.

HR 3968 provisions are written in such a way as to not infringe upon respiratory therapists who are currently working in a physician's office or other care sites and who do not meet both the required credential and educational criteria.

Much work led up to the introduction of HR 3968. Throughout 2007, Miriam met, in some cases multiple times, with key members of the Medicare Committees of Jurisdiction -Senate Finance and both the House Ways and Means and Energy and Commerce Committees. There were requests from Hill staff for additional information on the profession and we created white papers to address issues on scope of practice and licensure law requirements; a chart reviewing allied health credentials in the Medicare laws and a document on oxygen re-evaluation and the role of respiratory therapists. In addition, Miriam has followed up on leads provided by grass root contacts made by respiratory therapists to gain support among all members of Congress and not just those on the essential Committees.

AARC has conducted outreach to physician groups to discuss our Medicare Part B Initiative and answer any questions or concerns that they may have. Because of this effort we have gained, as mentioned above, the written support of the American Thoracic Society, a key physician trade association with broad influence on Capitol Hill. In addition, the AARC's Board of Medical Advisors voted unanimously to support the Initiative. AARC has discussed our initiative with NAMDARC and ACCP as well as ALA in the hope that they will take a favorable position on the legislation.

S. 329 & HR 552

The Pulmonary and Cardiac Rehabilitation Act.

The legislation will require Medicare to issue a national coverage policy for pulmonary rehabilitation, a long sought after goal of the pulmonary rehabilitation community. Support in the form of co-sponsorship from Congress continues to increase (at this writing there are 138 co-sponsors for the House bill and 34 Senators for S. 329). In July the Centers for Medicare and Medicaid Services (CMS) released the final rule on pulmonary rehabilitation National Coverage stating among various reasons for not providing coverage that they lacked the statutory authority to do so - leaving the impetus on Congress. The House bill HR 552 was left out of the House Ways and Means Medicare Package which passed as the CHAMPS Act. The Senate stripped Medicare reform from their version of the CHAMPS bill known as SCHIP, leaving the door open for another round of negotiation on Medicare reform before the end of the year. The opportunity that exists now is to have S. 329 included in a Medicare package that goes from the Senate to the House and to have the House ready to receive this provision.

Sam Giordano and Miriam O'Day and members of the US COPD Coalition escorted Mr. Ted Koppel and his wife Grace Anne Dorney Koppel on visits with members of the Senate Finance Committee.

As a result of these meetings, several significant actions have taken place. First, the bill was officially scored by CBO at $20 million over five years which Senate Finance members believe is reasonable. Second, Senator Grassley agreed to have CBO evaluate a cost saving idea developed by AARC, ATS, AACVPR, NAMDARC and ACCP. The so called "pay-for" would provide a mechanism for individuals on Medicare who are discharged from the hospital with supplemental oxygen to be re-evaluated on a timely basis. An independent review of hospital discharge data which was funded by the above mentioned groups showed that approximately 85% of those discharged on supplemental oxygen were not re-evaluated.

Many questions remain open-ended about re-evaluation including who, where, and when which will need to be negotiated. The presumed cost savings to the system could "pay for" the cost of pulmonary rehabilitation. Members of the US COPD Coalition met with CBO to discuss the scoring of the "pay-for". Finding a way to "pay for" S. 329 significantly enhances the chances that it will be included in a Senate Finance Committee Package that reaches the House. Senate Finance Committee members have reported that Pulmonary Rehab is part of the Medicare package, the question is will it remain in the package.

The Koppel's have agreed to lobby the House leadership on this issue in November. We believe that the Medicare package will not be marked-up in Committee and will move straight to the floor which means that the outside world will not see the bill until possibly 12 to 24 hours before it is acted upon. We do not know but speculate that this Medicare package may get wrapped up into a Continuing Resolution or Omnibus Bill giving us significantly less control over the process.

HR 621 & S 1484

The Home Oxygen Patient Protection Act of 2007.

As you are aware the Deficit Reduction Act required Medicare beneficiaries to assume ownership of their home oxygen equipment after 36 months of rental. HR 621 and the companion bill in the Senate 1484 would repeal this provision. The AARC supports this legislation, believing that patients should not have to take on the responsibility of performing maintenance and servicing of their oxygen equipment.

Congress with the goal of showing the American public that it is fiscally responsible has embraced the aforementioned Pay as you Go policy. This policy demands that any legislation which will cost money must be paid for by specifically finding a source of funding in the budget, which often means suggesting payment cuts in other programs or services (which of course have their own protective constituencies) or raising taxes or user fees (no support there either). Unfortunately, the Medicare DME benefit, which covers home oxygen therapy, is a key area where Congress looks to find money. Congress has proposed that the current 36 month rent to own should be reduced to 18 months. The money "saved" will go to fund other changes in Medicare (such as eliminating the impending Medicare payment cuts to physicians). The AARC is adamantly opposed to the 18 rent to own proposal as it will impact an even greater

number of Medicare beneficiaries who would have to assume responsibility for their oxygen equipment at an even earlier point in time.

S 605

The Allied Health Reinvestment Act

We continue to encourage respiratory therapists to contact their Congressional members to support this bill that provides funding to allied health education programs and scholarships to qualified individuals entering into various allied health professions.

HR 493/ S 358

The Genetic Information Nondiscrimination Act. The AARC sent letters of support to the key sponsors of this bill. If enacted, this legislation would prohibit genetic information obtained through medical testing to be accessible to other third parties such as employers or insurance companies. The request to send a letter came from the National Coalition for Health Professional Education in Genetics. The AARC is a member of the Coalition with Linda Van Scoder as our representative. The House of Representatives passed this bill and it was placed on the Senate calendar. Under Senate rules any Senator may place a hold on a bill preventing it from moving forward through the legislative process. Unfortunately S. 358 has been placed on hold and press reports state that two concerns have been voiced the first being that the bill does not have a strong "firewall" between the two titles (title 1 covers health insurance and title 2 employment) which could lead an individual to sue both their insurance company and employer if they are discriminated against. And secondly that the definition of genetic testing varies in each title. When the hold is removed from the bill S. 358 should come to the floor of the Senate for a vote. The President has indicated that he will sign GINA into law if it is presented to him by Congress.

HR 1108 and S. 624

The Family Smoking Prevention and Tobacco Control Act

AARC continues its long time alliance with the Partners for Effective Tobacco Policy (PARTNERS) Coalition. This spring the AARC voiced its support for legislation that would give greater regulatory authority to the FDA to oversee tobacco products. The AARC has joined with 250 other associations and organizations to support this bill. Among the provisions of the bill:

- Restrict tobacco marketing and sales to kids;
- Require changes in tobacco products to make them less toxic and less addictive; and
- Stop tobacco companies from misleading the public about the health consequences of using their products

The impact on Congress is increased when the Partners can show extensive public support for this issue. To that end state respiratory therapy societies have had an opportunity to join the list of distinct organizations and associations that are listed as supporters of this tobacco initiative.

Coalitions and Appropriation Bills

As you know, the AARC participates in numerous health care coalitions. The above mentioned PARTNERS/Tobacco Coalition is just one of them. This is the time of year when committees determine the Fiscal Year 2008 funding levels for various agencies. The AARC has signed on with several coalitions to support increasing funding to health education programs in the Department of Health and Human Services, to increase the research funding for chronic diseases at the Centers for Disease Control and Prevention, and increase funding for medical research at the National Institutes of Health.

Participation in these coalitions in addition to supporting worthy efforts, affords the AARC an opportunity to network with other health care associations and make additional Hill contacts which is advantageous to our own specific legislative agenda.

US COPD Coalition

As stated above the US COPD Coalition participated in the successful inclusion of the pulmonary rehab bill in the Senate Finance Committee Medicare Package. Sam Giordano continues to sit on the Coalitions' Executive Committee which recently named Miriam O'Day to serve for one year as the chair of the policy committee. As this is written an upcoming event will be a COPD Congressional Briefing sponsored by the Coalition and hosted by the COPD Congressional Caucus. Featured speakers include: Senator Mike Crapo (R-ID); Elizabeth Nabel, MD, Director, NIH, NHLBI, Grace Anne Dorney Koppel, National Patient Advocate and spokesperson for the NHLBI, COPD Learn More Breathe Better Education and Awareness Campaign and Congressman Cliff Stearns (R-FL). The briefing is set to take place in the Capitol to attract participation from both House and Senate Health Staff.

March 2008 PACT Capitol Hill Lobby Day

When advocating for (or against) Congressional legislation a key strategy is to have members of Congress and their staff "see" just who the advocates are. Which is why it is so important that once a year in Washington, D.C. we make sure that the face of the respiratory therapy profession is "seen" on Capitol Hill. The 2008 PACT Lobby Day is scheduled for March 9-11. Preparations are already under way from PACT members as well as AARC staff to assure that we achieve the greatest impact in advancing our issues.

Regulations

Regulations issued by government agencies can have just as much impact on providers and practitioners of services as do the laws that are enacted by Congress. While we often focus on regulations issued by CMS that cover the Medicare programs other agencies also impact the delivery of respiratory therapy services.

US Public Health Service (PHS)

For many years, the AARC has advocated that the Public Health Service (PHS) add qualified respiratory therapists to the professions of the Therapist Category as Officers in the Commissioned Corps. This fall the PHS with the approval of the Office of the Surgeon General agreed, and respiratory therapists who hold the RRT credential and a

bachelor degree in respiratory therapy now may apply and join the PHS. Respiratory therapists now have another career pathway as Commissioned Officers at PHS. Congratulations to the Profession. For more information link to http://www.cc.nih.gov/rm/pt/RT.htm

CMS/Medicare Regulations

Durable Medical Equipment Issues

Competitive Acquisition (Bid)
The implementation of the Competitive Bid Program for Medicare DME will commence in the Spring of 2008. Under the competitive bid program only DMEs that have submitted bids and have been selected by CMS as "winners" may provide Medicare equipment and supplies to Medicare beneficiaries in the bid area.. Home Oxygen therapy equipment and supplies is a designated category for competitive bid. CMS is rolling the program out in 10 selected Metropolitan Statistical Areas (MSAs). Bids from suppliers were submitted in September and the selection of the "winners" will be announced in March of 2008.

CMS in order to monitor the impact of the Competitive Bidding Program has retained Abt Associates a well-known independent health care market analysis firm to devise an assessment instrument to study the impact on beneficiaries under the Competitive Bid Program. Abt Associates requested the AARC provide, through an interview process our input and suggestions on the development of the monitoring instrument. Our point to Abt researchers was that CMS needs to monitor the DME beneficiary for increased doctor visits or hospital admissions. If, for lack of a better term, l"ow ball" bids are selected as winners, then the support and services of DMEs which may be currently provided could and probably will cease, thus impacting the quality of care and potential health of the beneficiary.

DME Accreditation and Quality Standards
DMEs participating in the Competitive Bid Program are required to be accredited from CMS approved accrediting entities. Accrediting agencies must survey the DMEs based on a set of quality standards established by CMS.

Incorporated in the DME quality standards was a section on oxygen equipment and supplies. There is a CMS requirement that DMEs must adhere to the guidelines set forth in three of AARC's Clinical Practice Guidelines: Home Oxygen Clinical Practice Guideline, IPPB and Long Term Invasive Mechanical Ventilation in the Home . The AARC's Clinical Practice Guideline Steering Committee requested a cadre of working groups to update both the Home Mechanical Ventilation and the Home Oxygen Therapy CPG. The revised Guidelines were released (and sent to CMS) in August. Many thanks are extended to Joan Kohorst, Home Care Section Chair, Bob McCoy, Home Care Section Chair Elect, Joe Lewarski, former Home Care Section Chair, and Tim Myers, Chair of the Clinical Practice Guidelines Steering Committee, and all the many RTs who provide input during the revision process.

CMS National Policy Decision on Nebulizers
CMS requested comments regarding the possibility of issuing a national coverage policy for the use of nebulizers. The AARC submitted comments supporting the need to move away from inconsistent and ad hoc decisions made at the local Carrier level and move to one national policy. Most stakeholders on the issue did not expect CMS to agree to a national policy and indeed the final decision by CMS was to continue to permit decisions on coverage to remain on the local level.

Other Regulatory Issues

Pulmonary Rehabilitation
In January 2007, CMS requested public input as the agency once again began deliberating on whether to issue a national coverage policy for outpatient pulmonary rehabilitation. The AARC submitted comments, and as we have done in years past, strongly the issuance of a comprehensive national Medicare pulmonary rehabilitation policy. As mentioned above, and as expected, CMS made the decision not to issue a national policy. It is clear to all stakeholders in the rehab community that the only way to resolve the issue of a pulmonary rehab Medicare policy is to enact the Pulmonary Rehab legislation (S 329 and HR 552), thereby mandating a national Medicare coverage policy from CMS.

Medicare Coverage Policy on CPAP for OSA patients
This April, CMS requested public comment as it considered revising the current Medicare coverage policy for sleep testing of patients with OSA. Among the revisions CMS is contemplating would be to permit home testing of patients. Current policy requires that testing be performed only at sleep centers or labs. The AARC submitted comments in which we recommend that to help assure quality, all sleep facilities providing testing under Medicare should be accredited, the physicians overseeing sleep tests should have a specialization in sleep medicine and that Medicare explicitly define what is meant by "qualified sleep personnel". We recommended the definition of qualified personnel include credentialed polysomnographic technologists, ENDs and respiratory therapists .

Medicare Annual Inpatient Hospital PPS Update
The annual regulations issued by CMS to update payment policies for inpatient hospitals contained, as per usual, other non-payment issues. The AARC submitted comments on issues raised in the proposed rule, including the need to track ventilator associated pneumonia (VAP). The final CMS rules recognized the AARC's comments on VAP (while delaying designating VAP as a preventive measure until a code can be developed) by including a direct link in the regulations to the AARC's CPG on VAP.

The same final CMS regulation also affirmed the importance of providing preventive services such as smoking cessation counseling and encouraged hospitals to develop system approaches that would include team members such as respiratory therapists (specifically mentioned) to provide this patient education.

Medicare Physician Fee Annual Update
This annual proposed regulation provides updates and changes to the coverage of physician services. The regulation this year also included a section directed to the provision of respiratory therapy services under the Medicare Comprehensive Outpatient Rehabilitation Services (CORF) benefit.

CMS is proposing significant and onerous changes to the services that a respiratory therapist may provide in CORFs. The regs propose to eliminate Medicare CORF coverage for patient assessment and diagnostic testing that are provided by the respiratory therapist. The AARC strongly objected to this proposed rule change stating that this would directly conflict with respiratory therapy education, testing, and scope of practice. The AARC submitted a detailed rebuttal to this proposed rule and we now are waiting for the issuance of the regulations in final form.

Food and Drug Administration (FDA) Montreal Protocols

Removal of Epinephrine as OTC drug
Through a complicated regulatory process, the FDA is proposing that within 3 years it will remove epinephrine as an over the counter drug. Using the International Initiative (Montreal Protocols) that the US government is party to, the US is phasing out medications (and other products) that contain CFCs. The FDA has concluded that there are other substitutes to epinephrine and thus within the next 3 years this product will be removed from the market. The AARC submitted comments in support of the proposed rule, citing the need for patient education, training and monitoring when taking any aerosolized medication for respiratory illness.

Removal of Combivent containing CFCs
Another FDA recommendation, also based on the Montreal Protocols, is to remove the drug Combivent as an "essential use" drug. Unlike the issue of epinephrine, there is no one to one substitute at this time for Combivent. Patients will be required to take and pay for 2 drugs as a replacement for the one drug that is Combivent. The AARC submitted comments that opposed early removal of this drug until a true one to one substitute is available and gave personal testimony at the FDA hearing which took place in August. A final rule has yet to be issued.

Conclusion
This has been an extremely active year in terms of regulatory and legislative activity. The AARC continues to expand its involvement in a wide range of issues related directly and indirectly to the profession. In addition we explore partnerships with a variety of organizations representing consumers professions and other advocates that share a similar agenda and vision as the AARC.

Miriam O'Day and I will provide a verbal update on these or other issues at the Board meeting.

State Government Affairs

November 2007
Cheryl A. West, MHA
Director Government Affairs

Most legislatures have recessed for the 2007 session. However, in some states (Florida for example) bills are being pre-filed in anticipation of reconvening in January 2008. We urge the state societies to prepare for the coming legislative session by making sure that their state legislative/government affairs committees, their PACT and their 435 Plans are up and ready to respond to state (or federal) issues that undoubtedly will come up next year.

In terms of health legislation, state legislatures will continue to be focused on measures addressing Medicaid, Children's Health Insurance Programs and efforts to enact state "universal" health insurance laws. We also expect legislatures to pass legislation that will raise tobacco taxes and extended smoking bans in a variety of public places.

Following is a recap of 2007 issues.

Respiratory Therapy Licensure

In several states, legislative and/or regulatory revisions affected RT licensure laws. Some changes were more extensive than other revisions. Some examples:

Texas
There was great concern early in the year that the Texas legislature in an effort to trim costs would eliminate state licensure for respiratory therapists. A formidable lobbying effort on the part of the Texas Society and the AARC stopped this misguided issue from going forward.

The TSRC has also been working closely with the TX RC Licensure Board to revise regulations to address such issues as how many CEs will be accepted when acquired from online sessions rather than live onsite seminars or meetings.

Louisiana
The Louisiana Society worked diligently with the legislature to extensively update the RT practice act, and then moved directly into the regulatory writing process. The State Society has maintained tight control over the process, which is far more difficult these days, as many other special interests attempt to insert their agenda into both legislation and regulations.

New Jersey
NJ law requires a periodic review of all licensure regulations, and the NJ RC Licensure regs are due for review. The primary focus is on the sections of the RC practice act

dealing with continuing education requirements and the practice by unlicensed respiratory assistants. Working closely with the New Jersey RC Licensure Board, the State Society is revising sections of their regulations. Once the revised regulations are published the regulations will be open for public comment.

Maryland
There was legislation (enacted) to: clarify disciplinary issues that RTs are subject to; increase the monetary penalty for violations of the act and impose penalties on employers who do not report these violations. A similar bill was enacted in Vermont.

Pennsylvania
The PSRC is leading an effort to clarify through legislation that RTs are to be considered licensed and not certified. The bill also takes the opportunity to update the scope of practice to recognize the roles and services RTs are now regularly providing.

Other Legislation Specifically Affecting Respiratory Therapy Licensure

Below is a listing of various bills that addressed directly or indirectly RT licensure. The bills can provide insight into some of the topics various states are addressing regarding the profession.

Unless noted, as this report is written these bills have not yet been enacted.

Continuation (i.e. extend the sunset dates) of RT Licensure Boards in future years: AZ (enacted), AR (enacted), IL (enacted), TN, WV (enacted)

Amends RT Licensure Bd. duties: MO, MT (enacted), VT

Technical RT corrections: UT, KY, NE- application requirements (enacted)

Utah: changes respiratory therapists to respiratory therapy practitioners (enacted)

Montana legislation that prohibits student RTs from being compensated for their services.

Maine: provides more flexibility to the RC Licensure Board to determine regulatory issues, such as setting fees (enacted).

Mississippi: the license of an RT who is on active duty in the military will not expire while the individual is on active duty- (enacted).

New Hampshire: changes the number of RC Board positions.

Increase in RT License Fees: North Carolina (enacted), Nevada (enacted), RI (enacted)

Generic Licensure Legislation that affects Respiratory Therapy Licensure

State legislatures continue to introduce and pass legislation encompassing in one catch-all bill provisions affecting many licensed professions. The focus has most often (but not exclusively) been on standardizing disciplinary criteria and appeal actions so that there is uniformity across the professions.

The following states have bills under consideration that will impact numerous licensure boards, including respiratory therapy.

Changes in disciplinary criteria: AZ (enacted), MD, MI, VA, WA

Changes in licensure renewal/reinstatement times: IN (enacted), IA, MS

Licensure Boards will not refund fees: IA

Amends Licensure Board duties in general: MT (enacted), NE (enacted)

Licensure Boards with similar professions can hold joint meetings: MT (enacted)

Cannot assault "public figures"- includes RTs: KY, OH

Require criminal background checks: OH, IL (enacted)

Trauma Care defined-includes list of professionals, RT on the list-OH (enacted)

Limited scope of practice changes for many professions, appeals, renewals, etc: NE (enacted)

Volunteers during a declared disaster or emergency not in violation of licensure laws: KY (enacted)

Other Legislation of Interest to the Profession of Respiratory Therapy

States propose and sometimes enact health legislation that while not directly affecting the respiratory profession, provides the opportunity for the profession to raise its profile in the state.

Legislation that has been considered by various state legislatures.

Ban alcohol vaporizing devices: AL, IN, KY, MD (enacted), MO, NC, ND (enacted), SC, VT, WA.

Emergency response/planning with the mention of RTs: KY, MS, OR.

Track hospital acquired infections including ventilator associated pneumonia: AL, AR, GA, IL, IN, KS, MS, NM, NC (enacted), NY, OR, SC, WA, WV.

Disease Management Program expansions: IN, GA, KY, MN, MS, MO, NJ, OR, WA.

DME Licensure law changes: AL (enacted), AZ, FL (enacted)

Asthma testing, use of asthma meds in schools: AL (enacted), KS, MT, OK, OR (enacted) TN. (TN also enacted a resolution to form a Committee to study prevalence of asthma in the state).

Nebulizers must be available on site at schools that have nurses on staff: NY (enacted)

Nevada Resolution by Legislature that Department of Health should "recognize importance of early diagnosis and treatment of persons with COPD and those at greatest risk for the disease:" Adopted.

Smoking related bills of interest:

Increase in tobacco taxes: Many states, too numerous to list, have raised the taxes on tobacco products.

Expand smoke free places: IL, IA, ME, MS, NE, NM, NC (enacted), OK, OR, PA, TX.

Expand smoking cessation programs: AZ, CA (enacted) CT, FL (enacted) IL, IN, IA, KY (enacted), ME, MD, MS, MO, NM, SC, UT, VT, WV.

Diverting Tobacco Settlement Funds to health related programs: CO (enacted), CT (enacted), IL.

CT- a bill that would apply Tobacco Settlement funds to buy vans to transport emphysema, cancer and other patients with lung disease who are former smokers.

NE - no foster parent can smoke in a home with a child younger than 13.

OR- cannot smoke in zoos (enacted), OK had similar bill.

RI- cannot smoke in a car with a child who is restrained in a car seat. Another bill will prohibit smoking on public beaches.

UT (and similar one in IL) prohibits smoking in a car with any child.

NY has a bill that would prohibit selling of tobacco products to anyone under the age of 19 and in 2010 the age limit is raised to 21.

OK has a bill that raises the age of purchase of tobacco products immediately to age 21.

Challenges from Other Disciplines

AARC continues to closely monitor the efforts of other disciplines to enact legislation that would impinge on the practice of respiratory therapy and impact the quality of respiratory care services provided to the public.

Nurse Aides and Medication Aides/Assistants:
While there was no legislative/regulatory activity of major concern this session, state societies should continue to monitor this discipline. When addressing nurse aides/assistants, state policymakers have focused on requiring background checks. However, when laws or regs are opened for provisions such background checks, other provisions can also be inserted. Monitoring for expansion in the delivery of aerosol medications is one such area to track.

Paramedics and EMTs (EMS Personnel)
Monitoring of any change in law or regulations for these practitioners is important. EMS personnel are by definition permitted to provide "out of hospital" services, including an array of respiratory therapy services. We certainly support the provision of the full range of emergency services these critical practitioners provide outside the hospital.

However, some state hospital associations (the primary advocates) are pressured by their members (often rural and/or few bed hospitals) to seek legislative or regulatory relief that will eliminate the phrase "out of hospital" from the definition of EMS personal. The intended result is that hospitals could legally hire EMS personnel (paramedics or EMTs, and in some cases First Responders) and have them provide services, including respiratory therapy services, anywhere within the facility.

While there are several states that have amended their laws to permit EMS personnel to provide services in the emergency room, we are most concerned when laws or regs are changed that permit EMS personnel to provide services "on the floor" and be hired to provide respiratory therapy services in lieu of the respiratory therapist. While this was not an issue in any state this year, that does not mean it will remain dormant in the coming year(s).

Perfusionists
There are several states that introduced legislation to amend or initiate licensure for these practitioners. Nebraska has enacted a licensure law and PA, NV and NY have had legislation introduced.

State Societies must review any legislation to assure that provisions are non-exclusionary. Respiratory therapists, who might currently under their scope of practice be providing perfusion services should be able to continue to do so unimpeded through appropriately worded exception clauses.

Polysomnography State Licensure Activities 2007

This past year saw several states address the issue of regulating individuals who provide sleep disorder services. The apparent legislative route being taken on the state level is that of licensure. While the AARC supports state regulation of individuals who provide sleep services, which by definition encompasses respiratory therapy services, licensure for these individuals can become a problematic vehicle. There are inherent difficulties in licensing any discipline that does not have an infrastructure of formal accredited education and a requirement for all practitioners of the discipline to be tested for competency prior to rendering clinical services to patients.

As the leaders of the AARC, you have received briefings and information on the concerns raised with provisions of various state polysomnography legislation. The AARC Board of Directors approved a Guidance Document on Polysomnography Licensure outlining the provisions that must be included in any proposed polysomnography licensure legislation. This document is designed to provide a clear and measured path to regulate those who provide polysomnography services, while assuring patient safety and maintaining the integrity of the scope of practice of respiratory therapists.

Since being issued this Spring, we have distributed copies of the Guidance Document to the Board of Directors and House of Delegates on several separate occasions. It is again attached to this Report. The Guidance Document has been sent to the State Society Presidents, State PACT Representatives and all Respiratory Care State Licensure Boards/Committees.

The American College of Chest Physicians (ACCP) has issued a Position Statement on Polysomnography Licensure. The Statement clearly supports non-exclusionary legislative language and the need to assure patient safety through competency testing. The ACCP statement is attached to this report.

State Polysomnography Activity

Tennessee- The state of Tennessee has enacted a polysomnography personnel licensure law. The AARC analysis of the bill concludes that this law will negatively impact the profession of respiratory therapy and will permit individuals who have not been competency tested to provide respiratory related sleep services to patients. The law also requires the licensed respiratory therapist who has been providing sleep disorder services to sit for an additional competency exam in order to continue to provide the same services they have been providing for years. We continue to work with interested Tennessee state associations to address the flaws in the law.

North Carolina – Two polysom licensure bills were introduced this session. The first bill would have regulated polysoms under the North Carolina Respiratory Care Board. The sleep community nationwide is opposed to any licensure bill that would place the polysoms under any Respiratory Care/Therapy Licensure Board. Moreover, this particular North Carolina bill included provisions which would have limited the on-the-

job training pathway to licensure. The sleep community in NC was opposed to any limitation for on-the-job training. This bill did not move in the legislature.

A substitute polysomnography licensure bill was introduced which was supported by the sleep community. This bill was a near duplicate of the aforementioned Tennessee licensure law, and the NC bill included the provisions opposed by the AARC. However, in NC, opposition to the provisions of this bill was strong and widespread among various associations including concerned physicians. This bill did not move forward in the legislature.

New Mexico- Earlier this year legislation was introduced to license polysoms under the Respiratory Care Advisory Board. As noted above the sleep community appears not to support legislation that regulates polysoms under the auspices of a Respiratory Care Board or Committee. Therefore, this bill did not advance through the legislature.

New York- Many health professions in NY are regulated under the State Education Department. This Department takes a very strong view that licensure should only be granted to disciplines that require formal accredited education. Therefore, the draft bill, which has not been introduced in the legislature, would require graduation from CAAHEP accredited education programs as part of licensure. An on-the-job pathway to polysom licensure would not be acceptable. This draft has not moved forward.

California – An effort to license polysoms has been initiated by the CA Respiratory Care Board. Licensure would be under the CA Respiratory Care Licensure Board. We have been informed that the sleep community and the American Academy of Sleep Physicians (AASM), a major proponent of polysom licensure, opposes the provisions of the draft bill.

Mississippi- The sleep community, including respiratory therapists involved in sleep services have approached the Mississippi Society to begin discussions to formulate possible polysom licensure legislation for the 2008 legislative session. The leadership of the MSRC is very much aware of the negative impact on patient safety and the respiratory therapy profession that can be created when a bill is not drafted with appropriate patient and professional safeguards.

Louisiana-Several years ago the LSRC was involved in working with the sleep community in drafting a polysom licensure law that was non exclusionary to the RT, required sleep personnel to be graduates of CAAHEP accredited schools and required competency testing of all sleep personnel within a reasonable time frame.

The proposed regulations implementing the polysom licensure law have been issued for public comment. The regulations that have been proposed divert in the extreme from the law. The proposed regulations insert an open ended on-the-job pathway (never part of the law), as well as completely revising the definitions of personnel clearly set forth in the law. These discrepancies have been pointed out to the LA state licensure board attorneys.

We anticipate that 2008 will be just as active, if not more so in the area of polysom state legislation and regulation.

I will provide a verbal update on these and other issues at the summer meeting.

Guidance Document for Reviewing Polysomnography Legislation

2007

The American Association for Respiratory Care Board of Directors has unanimously adopted the following guidance document on state legislative initiatives to license or regulate individuals providing polysomnography services.

Optimum Legislative Structure

It is the position of the AARC's Board of Directors that the optimum structure for regulating the discipline of polysomnography is the following:

Under the Respiratory Care Practice Act credentialed polysomnographic technologists (RPSGTs) will be granted a limited license to provide respiratory-related services consistent with the AARC's Guidance Document on Scope of Practice (see attachment 1).

> ***Reasoning***: All respiratory therapists must be graduates of accredited educational programs and must have earned a professional credential by passing a valid and reliable competency examination. The Board of Registered Polysomnography Technologists (BRPT) administers a valid and reliable examination. Therefore individuals who have obtained the RPSGT credential may provide those respiratory therapy services, and only those respiratory services, that are contained within the BRPT examination matrix.

Current Legislative Direction

The AARC's support of a legislative revision of Respiratory Care Practice Acts that will provide a limited license for credentialed polysomnographers is the preferred way to address this scope of practice issue. This is not, however, the direction that the sleep community and its supporters are pursuing. Separate stand alone state licensure for polysomnographic personnel is the agenda.

This document provides clear guidance for reviewing and analyzing provisions related to polysomnography services in any state legislative proposals. The AARC will assist any state society in its efforts to assure that

these conditions are met. If these conditions are not or cannot be included in the legislation, the AARC will actively oppose the measure.

Litmus Test For Assessing Polysomnography Licensure Legislation

In order to assure safe and effective respiratory care will be provided to our patients, please make sure that the answer to each of the following questions is YES .

1. Does the proposed legislation explicitly exempt the licensed respiratory therapist from obtaining further education or training in polysomnography?

2. Does the proposed legislation explicitly exempt licensed respiratory therapists from additional examinations and professional credentials in polysomnography?

3. Does the proposed legislation require physician delegation for the non-credentialed individuals?

4. Does the proposed legislation recognize other nationally accepted competency examinations and professional credentials in addition to the Registered Polysomnographic Technologist (RPSGT) credential?

5. Does the proposed legislation limit, to a maximum of 36 months, the time an individual who does not have the RPSGT credential and who is working under physician delegation may practice and continue to provide sleep services?

Rationale and Further Explanation

1. Does the proposed legislation explicitly exempt licensed respiratory therapists from obtaining further education or training in polysomnography services?

> ***Reasoning***: As it has been for decades, sleep testing and treatment continues to be part of the respiratory therapy scope of practice.

2. Does the proposed legislation explicitly exempt licensed respiratory therapists from additional examinations and professional credentials in polysomnography?

Reasoning: Licensed respiratory therapists must meet the education and testing requirements set forth by the state as respiratory care practitioners and are therefore practicing under the scope of practice that includes sleep testing and treatment.

3. Does the proposed legislation include a clear and specific provision that requires the non credentialed individuals such as polysomnography technicians and trainees, who have not earned the RPSGT or other nationally recognized credential, to work under the explicit *delegation* of a licensed physician (as defined under the state's Medical Practice Act)?

Reasoning: Physician delegation means that individuals who provide health care services and who are not licensed or competency tested, provide these services "off the physicians'" license. This is how, respiratory therapists, prior to licensure could provide an array of health care services to patients. This is how respiratory therapists in Alaska and Hawaii, states that do not license respiratory therapists, do so today. Because non licensed, non competency tested individuals are delegated responsibility by the physician under the physician's license, it is incumbent upon the physician to assure and assume responsibility for the quality and safety of services performed by these individuals.

4. Does the proposed legislation contain a provision to authorize the licensure board to accept other nationally recognized competency examinations and professional credentials in addition to the RPSGT?

Reasoning: It is standard language in health licensure laws to provide the licensure regulatory boards or committees the flexibility of assessing the merits of other accrediting, examination or educational entities as the profession evolves and these new legitimate entities emerge and are established. This avoids the situation where one entity has a monopoly on the education or testing of the profession or occupation.

5. Does the proposed legislation limit, to a maximum of 36 months, the time an individual who does not have the RPSGT credential and who is working under physician delegation may practice and continue to provide sleep services?

Reasoning: It is not in the interests of patient safety and quality of care to permit, in perpetuity, an individual who has not documented competency via a valid examination to continue to provide that polysomnography portion of the respiratory care scope of practice. A time frame for the documentation of competency and obtaining the RPSGT credential must be mandated by law.

Conclusion:

In order for the AARC to stand in support of polysomnography licensure legislation, all of the conditions above must be met. By meeting these conditions, all providers of polysomnography testing and treatment services will be either a credentialed or licensed practitioner themselves or will be employed by the licensed physician and working off that physician's license through delegation. In this case, the physician will be responsible for the safety and quality of care delivered by the non-licensed personnel.

Furthermore, this approach is non-exclusionary, as it provides a mechanism to assure safety and accountability, without restricting sleep or polysomnography services to the licensed respiratory therapist.