



***July 2009***  
***AARC Board***  
***Meeting***

**AMERICAN ASSOCIATION FOR RESPIRATORY CARE**

**Board of Directors Meeting**

**July 19<sup>th</sup>-21<sup>st</sup>, 2009 - Marco Island Marriott**

***Sunday, July 19***

5:00 – 7:00 pm Executive Committee Meeting (Committee Members only)  
7:00 – 8:00 pm AARC Finance Committee Meeting (All BOD and HOD welcome)

***Monday, July 20***

8:00 – 5:00 pm AARC Board of Directors Meeting  
8:00 am Call to Order

Announcements/Introductions  
Approval of Minutes  
E-motion Acceptance  
General Reports  
    President  
    VP Internal Affairs  
    VP External Affairs  
    Executive Office  
    House of Delegates  
    Board of Medical Advisors  
    Presidents Council

9:45 – 10:00 am  
10:00 am

**BREAK**

Standing Committee Reports  
    Audit Subcommittee  
    Bylaws Committee  
    Executive Committee  
    Federal Government Affairs  
    Finance Committee  
    Judicial Committee  
    Program Committee  
    State Government Affair  
    Strategic Planning Committee  
Specialty Section Reports  
    Adult Acute Respiratory Care  
    Continuing Care-Rehabilitation  
    Diagnostics  
    Education  
    Home Care  
    Long Term Care  
    Management  
    Neonatal-Pediatrics  
    Sleep Specialty Section  
    Surface and Air Transport  
Special Committee Reports  
    Benchmarking Committee  
    Billing Code Committee  
    Clinical Practice Guidelines Steering Committee  
    Fellowship Committee

International Committee  
Membership Committee  
Position Statement Committee  
Public Relations Action Team

12:00-1:30 pm

**Lunch Break**

Daedalus Meeting

1:30 – 4:00 pm

Joint Session

AARC Election Committee

AARC Secretary-Treasurer Financial Update – Karen Stewart  
Update 2015 – Bill Dubbs

Regulatory Affairs Update – Anne Marie Hummel

Legislative Update – Cheryl West/Miriam O’Day

4:00 – 4:15 pm

**BREAK**

4:15 pm

Social Networking - Nelson / Milligan

Conflict of Interest / Disclosures

5:00 pm

**RECESS**

***Tuesday July 21***

8:30 – 5:00 pm

AARC Board of Directors Meeting

8:30 am

Call to Order

Special Representatives

American Academy of Allergy Asthma & Immunology

AMA CPT Health Care Professional Advisory Committee

American Ass’n. of Cardiovascular & Pulmonary Rehab

American Association of Critical Care Nurses

American Heart Association

American Society for Testing and Materials (ASTM)

Clinical Laboratory Institute

Chartered Affililate Consultants

CLSI Point of Care

Comm. on Accreditation of Medical Transport Systems

Comm. on Accreditation of Allied Health Ed. Programs

Extracorporeal Life Support Organization (ELSO)

International Council for Respiratory Care (ICRC)

The Joint Commission (TJC) PTAC’s

Medicare Coverage Advisory Committee

National Asthma Education & Prevention Program

Natl Coalition/Health Pro Edu – Genetics (NCHPEG)

National Sleep Awareness Roundtable

Neonatal Resuscitation Program

Roundtable Reports

Asthma Disease

Consumer



ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

# *Minutes*

**AMERICAN ASSOCIATION FOR RESPIRATORY CARE**

Board of Directors Meeting

March 27, 2009

**Minutes**

**Attendance**

Tim Myers, BS, RRT-NPS, President  
Toni Rodriguez, EdD, RRT, Past President  
George Gaebler, MSED, RRT, FAARC, VP/Internal Affairs  
Joseph Lewarski, BS, RRT, FAARC, VP/External Affairs  
Karen Stewart, MS, RRT, FAARC, Secretary-Treasurer  
Patricia Doorley, MS, RRT, FAARC  
Debbie Fox, MBA, RRT-NPS, Past Speaker  
Lynda Goodfellow, EdD, RRT, FAARC  
Michael Hewitt, RRT-NPS, FAARC, FCCM  
Denise Johnson, BS, RRT  
Ruth Krueger, RRT, MS, CHC  
Douglas Laher, BSRT, RRT, MBA  
John Lindsey, RRT  
Robert McCoy, RRT, FAARC  
Doug McIntyre, RRT  
Frank Salvatore, BS, RRT, FAARC  
James Taylor, RRT  
Michael Tracy, BA, RRT-NPS, RPFT  
Brian Walsh, RRT-NPS, RPFT

**Guests**

Bill Sims  
Larry Wolfish  
Frank Sloan  
Casey Conway  
Cam McLaughlin  
Tom Lamphere  
Dawn Rost  
Debra Skees

**Absent**

Kent Christopher, MD, RRT FAARC, BOMA Chair (Excused)

**Consultant**

John Hiser, MEd, RRT, FAARC, Parliamentarian  
Dianne Lewis, MS, RRT, FAARC, President/Presidents Council

**Staff**

Sam Giordano, MBA, RRT, FAARC, Executive Director  
Tom Kallstrom, BS, RRT, AE-C, FAARC, Chief Operating Officer  
Ray Masferrer, RRT, FAARC, Associate Executive Director  
Steve Nelson, RRT, FAARC, Associate Executive Director  
Sherry Milligan, MEd, Associate Executive Director  
William Dubbs, MHA, MEd, RRT, Director of Education and Management  
Ann Marie Hummel, Regulatory Affairs Director  
Miriam O'Day, Federal Government Affairs Director  
Cheryl West, State Government Affairs Director  
Tony Lovio, Controller  
Brenda DeMayo, Administrative Coordinator

**CALL TO ORDER**

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:00

a.m. CST, Friday, March 27, 2009.

Secretary-Treasurer Karen Stewart called the roll and declared a quorum.

### **INTRODUCTIONS**

President Tim Myers asked members to introduce themselves.

### **SWEARING IN OF DIRECTORS**

Parliamentarian John Hiser administered the oath of office to Ruth Krueger and Dianne Lewis and declared them installed as Directors of the AARC Board.

### **APPROVAL OF MINUTES**

Karen Stewart moved “To accept the minutes of the December 11, 2008 meeting of the AARC Board of Directors as corrected.”

#### **Motion Carried**

Karen Stewart moved “To accept the minutes of the December 12, 2008 meeting of the AARC Board of Directors.”

#### **Motion Carried**

Karen Stewart moved “To accept the minutes of the December 16, 2008 meeting of the AARC Board of Directors as corrected.”

#### **Motion Carried**

### **E-MOTION RATIFICATION**

Karen Stewart moved to accept the following E-motions discussed over the BOD Listserv since December, 2008.

**EM-09-1-15.1** “That the AARC BOD ratify the Presidential appointment of Cheryl Hoerr, MBA, RRT to the Program Committee.”

**EM-09 1-29.1** “That the following charges be added to the Cultural Diversity Committee’s existing charges:

- Develop a mentoring program for AARC members with the purpose of increasing the diversity of the BOD and HOD.
- The Committee and the AARC continue to monitor and develop the web page and other assignments as they arise.

**EM-09-1-34.1** “That Joseph Huff be removed from the Ad Hoc Pinnacle Award

Committee, and that Tammy Jarnigan, RRT, Edward Conway, RRT and Douglas Laher, MBA, RRT be added to the Committee.

### **Motion Carried**

## **GENERAL REPORTS**

### **PRESIDENT'S REPORT**

President Tim Myers reported that the following were appointed to the JCAHO Ambulatory PTAC:

Mike Hewitt (Primary Representative)  
Suzanne Bollig (Alternative Representative).

### **PRESIDENTIAL APPOINTMENT RATIFICATION**

Debbie Fox moved to accept **FM 09-1-71c.1** “To ratify the Presidential appointment of Mike Hewitt and Suzanne Bollig as primary and alternative representatives respectively to the JCAHO Ambulatory PTAC.”

### **Motion Carried**

President Tim Myers updated members on the Tennessee Polysom issue stating that RTs practicing sleep in that state for decades would have to sit for a sleep exam at a cost of approximately \$1000. We want that provision deleted. We subsequently hired a lobbyist in the State of Tennessee to work on amending this law which also had other flaws in addition to the “RT to RPSGT” provision. A Chattanooga contingency obtained 98 signatures and sent them to the legislators saying that they wanted the “RT to RPSGT” provision deleted. Sam and President Myers went to Tennessee to speak before and explain to RTs why the AARC is opposed to this legislation. This action prompted many others to form a coalition in support of the AARC. Charlie Brooks will testify at a Tennessee hearing on AARC’s behalf in early April.

Hawaii and Alaska do not have RT licensure in their states, but Hawaii has finally moved in that direction. AAST and AASM oppose their efforts to obtain licensure. And, again, AARC defended the state’s action.

### **POTENTIAL CONFLICT OF INTEREST**

President Tim Myers advised members of a potential Conflict of Interest for a person on the AARC Board to also have a position on their state board. Someone in the HOD asked for a legal opinion who said they were approached by a director on the Board. He asked members to use caution in their interactions with others and to not speak for the entire Board.

### **RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:45 a.m.



CST, Friday, March 27, 2009.

## **RECONVENE**

President Tim Myers reconvened the meeting of the AARC Board of Directors at 10:00 a.m. CST, Friday, March 27, 2009.

## **AUDITORS REPORT**

Bill Sims, who is a partner with the Salmon Sims Thomas auditing firm, reported that it is his job to render an opinion on financial statements as to reasonable assurance under generally accepted accounting principles (GAAP). He was pleased to report that the Association received a clean opinion. Mr. Sims reviewed all of the financial statements and commented that the standard cash reserve for a non-profit organization is approximately 3 months, however AARC's cash reserve extends to 7 months in which it could operate with available cash should an emergency arise.

The auditor's suggestion for the Association was to develop an acceptable report of investment results to enable the leadership to determine that the investment return is reasonable in light of AARC's investment strategy.

## **LEGAL COUNSEL**

AARC's legal counsel, Larry Wolfish, stated he has represented the Association for more than 25 years. He discussed fiduciary responsibility of Directors of a non profit Board of Directors. He illustrated that while the Bylaws outline management and regulation of the organization, it is the Board's responsibility to carry out those regulations and supervise the officers of the organization's committees. He defined Conflict of Interest as:

...any situation in which a Director has direct or indirect outside personal interest which has the potential of being contrary to the best interest of the Association.

## **AARC INVESTMENTS**

AARC's investment advisors Frank Sloan and Casey Conway were introduced. Mr. Sloan reported on the management of AARC's investments stating last year's economic downturn reflected a panic in the market in October and November of 2008. Stocks and bonds markets are attractive right now. AARC's portfolio is generating half a million dollars in dividends. He stated his team meets with the Executive Office team regularly to stay on top of strategy for AARC investments. They recently also lowered allocations in the foreign sector while the U.S. dollar was weak. The credit crisis created fear in all markets and AARC funds were reallocated to more bonds than stocks. We're currently operating with 45% stocks and 55% bonds.

## **RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 10:50 a.m. CST, Friday, March 27, 2009.

## **RECONVENE**

President Tim Myers reconvened the meeting of the AARC Board of Directors at 11:15 a.m. CST, Friday, March 27, 2009.

## **EXECUTIVE OFFICE REPORT**

### **AARC Operations**

Operations Manager, Tom Kallstrom, reported that membership continues to grow. 384 members were added since Monday of this week bringing total members to 48,898. AARC launched its ASME program so RTs can now meet the asthma codes. He invited members to observe the MSU in Dallas this week at the Red Hat convention. The COPD educator course will be launched and go online later this year. The asthma prep course will be released in April.

### **Executive Office Miscellaneous Activities**

Executive Director, Sam Giordano, reported that he was appointed to a new research group funded by the NHLBI and AHRQ and is involved in the coordination of care area. This is a two-year project. He attended the NAMDRC board meeting and reported they are supportive to our position on polysom and are eager to support the Part B initiative. They will develop a letter of support in terms of the licensing issue and a new letter of support for the Part B initiative. US COPD had elections for officers in which Sam was voted Treasurer. The first version of the aerosol document has ended and will then go to version two for pharmacists and physicians, then version three aimed at patients. ATS asked Mr. Giordano to give a presentation at the Patient Advisory Roundtable (PAR). He suggested taking advantage of recruitment during this economy.

### **Project 2015 and Beyond Update**

Education Director Bill Dubbs updated members on Project 2015 and Beyond. The second installment is slated for April 6-8 in Dallas. About 45 attendees are expected. The proceedings of the first conference were printed in the recent issue of *RESPIRATORY CARE*. We will take the information from the first conference and apply that to the second conference which will be chaired by Tom Barnes. The third conference will occur late this year or early next year.

Mr. Giordano briefly discussed **HR 94-08-24** which states:

“Resolved that the AARC provide the option of direct deposit of state affiliate’s quarterly revenue sharing checks into affiliate’s checking account.”

He advised that this project would be addressed after receipt of affiliate feedback regarding their willingness to provide financial support for the program.

Karen Stewart moved to accept **Recommendation 09-1-1.1** “That the Executive Director be given the authority to freeze salary increases for all AARC employees beginning April 1, 2009 and ending March 31, 2010.

## **Motion Carried**

## **PRESIDENT'S COUNCIL**

Dianne Lewis reported members will be asked to provide the Board's nominees at this meeting for the Life and Honorary Membership Awards. Nominators will be responsible for receiving their nominee's CV or resume. She advised that the Council wishes to establish an Association historian, and are developing a job description and compiling past president interviews. Also under consideration is a museum or a virtual museum as well as evaluating funding of such a project.

Karen Stewart moved to accept **Recommendation 09-1-8.1** "That the AARC Program Committee establish the Barry Shapiro, MD lecture to be held every year at the International Congress."

Toni Rodriguez moved "To refer **Recommendation 09-1-8.1** to the Program Committee to determine logistics, feasibility and adaptation to our current structure."

## **Motion to Refer Carried**

## **RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 12:05 p.m. CST, Friday March 27, 2009.

## **RECONVENE**

President Tim Myers reconvened the meeting of the AARC Board of Directors at 1:15 p.m. CST, Friday March 27, 2009

## **OTHER REPORTS**

### **COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (COARC)**

CoARC Executive Director Tom Smalling stated there are currently 400 accredited respiratory care programs with one international satellite campus in Saudi Arabia. CoARC is looking forward to January 2110 when they will separate from CAAHEP. CoARC's new Chair elect is David Bowden. Mr. Smalling thanked Board member Lynda Goodfellow and the rest of program committee for their work on the summer forum for 2009. The CoARC executive office experienced a number of operational changes to improve infrastructure. Also planned is a revision of the strategic plan. Mr. Smalling thanked Tom Lamphere for his design of a manpower survey. The CoARC Standards were recently released to the public for comment with a deadline date of May 1 and will again make revisions at the July meeting. They hope to have it finished by January, 2010. Only 6 out of 400 programs are under probation.

## **STATE GOVERNMENT AFFAIRS REPORT**

Cheryl West reported on sleep issues. Sleep legislative issues of concern are occurring in varying degrees in Minnesota, Georgia Maryland, Hawaii, Kansas, Oklahoma, and of course in Tennessee. The AARC is responding to and assisting state societies in these challenges.

## **STANDING COMMITTEE REPORTS**

### **BYLAWS COMMITTEE REPORT**

Karen Stewart moved to accept **Recommendation 09-1-9.1** “That the AARC Board of Directors approve the proposed changes to the Louisiana Society for Respiratory Care’s bylaws.”

#### **Motion Carried**

### **NOMINATIONS FOR PRESIDENT-ELECT**

President Tim Myers urged members to nominate candidates for President-elect. The ballot must be approved by June 1<sup>st</sup>.

### **FINANCE COMMITTEE REPORT**

George Gaebler moved to accept **Recommendation 09-1-12.1** “That the AARC Board of Directors appoint Frank Salvatore as a special consultant to the AARC’s Audit Subcommittee.”

#### **Motion Carried**

George Gaebler moved to accept **Recommendation 09-1-61.1** “That the AARC Board of Directors fund Debra Koehl’s attendance at the AACVPR meeting in Philadelphia in October, 2009.”

George Gaebler moved “To accept **Recommendation 09-1-61.1** for information only.”

#### **Motion Carried**

George Gaebler moved to accept **Recommendation 09-1-13.1** “To provide the Board with a report on investment return.”

Jim Taylor moved “To refer **Recommendation 09-1-13.1** to the Executive Office and report back by the Summer Board meeting”

#### **Motion to Refer Carried**

### **STRATEGIC PLANNING COMMITTEE**

Karen Stewart moved to accept **Recommendation 09-1-16.1** “That the Strategic Planning Committee be granted an extension for the charge ‘make recommendations to

the Board for any needed revisions or adjustments in the Strategic Plan at the Spring 2009/2010 Board of Directors Meeting' until the summer 2009 Board meeting.”

Toni Rodriguez moved “To refer **Recommendation 09-1-16.1** to the President.”

**Motion to Refer Carried**

**STANDING REPORTS ACCEPTANCE**

George Gaebler moved “To accept the Standing Committee Reports.”

**Motion Carried**

**RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 2:50 p.m. CST, Friday, March 27, 2009.

**RECONVENE**

Past President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 3:15 p.m. CST, Friday, March 27, 2009.

**ACCEPTANCE OF AUDITOR’S REPORT**

Karen Stewart moved “To accept the 2009 auditors report.”

**Motion Carried**

**SPECIALTY SECTION REPORTS**

**CONTINUING CARE REHAB REPORT**

George Gaebler moved to accept **Recommendation 09-1-50.1** “That the AARC BOD consider a ‘How To’ program on pulmonary rehab programs to be incorporated into the 2009 Congress.”

Jim Taylor moved “To amend **Recommendation 09-1-50.1** to delete the phrase ‘to be incorporated into the 2009 Congress’.”

**Motion to Amend Carried**

**Amended Motion Carried**

Jim Taylor moved “To refer the amended **Recommendation 09-1-50.1** which states ‘That the AARC BOD consider a How To program on pulmonary rehab programs’ to the Executive Office with a report back by the Summer Board meeting.”

**Motion to Refer Carried**

## **MANAGEMENT SECTION REPORT**

Previously submitted recommendations were withdrawn.

## **SPECIALTY SECTION REPORTS ACCEPTANCE**

George Gaebler moved “To accept the Specialty Section reports as submitted.”

### **Motion Carried**

## **SPECIAL COMMITTEE REPORTS**

### **POSITION STATEMENT COMMITTEE REPORT**

George Gaebler moved to accept **Recommendation 09-1-26.1** “That the AARC BOD approve revision of the position statement entitled ‘Respiratory Therapist Education’ to incorporate the changes identified in ATTACHMENT “A”.

### **Motion Carried**

### **SPECIAL COMMITTEE REPORT ACCEPTANCE**

George Gaebler moved to accept “That the Board of Directors accepts the Special Committee reports as submitted.”

### **Motion Carried**

## **HONORARY MEMBERSHIP NOMINATIONS**

Ruth Kreuger moved “To enter into Executive Session.”

### **Motion Carried**

## **EXECUTIVE SESSION**

President Tim Myers convened the Executive Session at 4:00 p.m. CST, Friday, March 27, 2009.

## **EXECUTIVE SESSION ADJOURNED**

President Tim Myers adjourned Executive Session at 4:10 p.m. CST, Friday, March 27, 2009.

## **LIFETIME ACHIEVEMENT AWARD NOMINATIONS**

Denise Johnson nominated Alex Adams  
Mike Hewitt nominated Vijay Deshpande

James Taylor nominated Homer Engert

A paper vote was taken and the Board's nominee for the **Lifetime Achievement Award** is **Vijay Deshpande**.

**RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 4:15 p.m. CST, Friday March 27, 2009.

# AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

March 28, 2009

## Minutes

### Attendance

Tim Myers, BS, RRT-NPS, President  
Toni Rodriguez, EdD, RRT, Past President  
George Gaebler, MEd, RRT, FAARC, VP/Internal Affairs  
Joseph Lewarski, BS, RRT, FAARC, VP/External Affairs  
Karen Stewart, MS, RRT, FAARC, Secretary-Treasurer  
Patricia Doorley, MS, RRT, FAARC  
Debbie Fox, MBA, RRT-NPS, Past Speaker  
Lynda Goodfellow, EdD, RRT, FAARC  
Michael Hewitt, RRT-NPS, FAARC, FCCM  
Denise Johnson, BS, RRT  
Douglas Laher, BSRT, RRT, MBA  
John Lindsey, RRT  
Robert McCoy, RRT, FAARC  
Doug McIntyre, RRT  
Frank Salvatore, BS, RRT, FAARC  
James Taylor, RRT  
Michael Tracy, BA, RRT-NPS, RPFT  
Brian Walsh, RRT-NPS, RPFT

### Guests

Cam McLaughlin  
Tom Lamphere  
Dawn Rost  
Debra Skees

### Absent

Kent Christopher, MD, RRT, FAARC, BOMA Chair (Excused)

### Consultants

John Hiser, MEd, RRT, FAARC, Parliamentarian  
Dianne Lewis, MS, RRT, FAARC, Presidents Council President

### Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director  
Tom Kallstrom, BS, RRT, AE-C, FAARC, Chief Operating Officer  
Ray Masferrer, RRT, FAARC, Associate Executive Director  
Steve Nelson, RRT, FAARC, Associate Executive Director  
Sherry Milligan, MEd, Associate Executive Director  
Cheryl West, MHA, Director of Government Affairs  
Miriam O'Day, Director of Federal Government Affairs  
Anne Marie Hummel, Director of Regulatory Affairs  
William Dubbs, MHA, MEd, RRT, Director of Education and Management  
Tony Lovio, Controller  
Brenda DeMayo, Administrative Coordinator

## CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:00 a.m., CST, Saturday, March 28, 2009.



Secretary-Treasurer Karen Stewart called the roll and declared a quorum.

### **SPECIAL REPRESENTATIVE REPORTS**

#### **AMERICAN ASSOCIATION FOR CARDIOVASCULAR & PULMONARY CARE (AACVPR)**

Ruth Krueger moved to accept **Recommendation 09-1-61.1** “That the AARC BOD fund Debra Koehl’s attendance at the AACVPR meeting in Philadelphia in October, 2009.”

Ruth Krueger moved “To accept **Recommendation 09-1-61.1** for information only as this has already been budgeted”

#### **Motion Carried**

#### **AMERICAN HEART ASSOCIATION REPORT**

Joe Lewarski moved to accept **Recommendation 09-1-63.1** “That the AARC BOD support development of the new 2008 Guidelines for Cardiopulmonary Resuscitation.”

Joe Lewarski moved “To refer **Recommendation 09-1-63.1** back to the Chair, Rich Branson, for clarification.”

#### **Motion to Refer Carried**

#### **INTERNATIONAL COUNCIL REPORT**

John Hiser reported that the United Arab Emirates has formed our fourth international affiliate. He explained that we have both international affiliates and member countries of the International Council for Respiratory Care. We will start pushing for international affiliates and member countries that will grow into affiliates. Mr. Hiser further stated they do not have a seat in the House of Delegates.

#### **ACCEPTANCE OF ORGANIZATIONAL REPRESENTATIVE REPORTS**

Ruth Krueger moved “To accept the Organizational Representative reports as submitted.”

#### **Motion Carried**

### **ROUNDTABLE REPORTS**

#### **ASTHMA DISEASE ROUNDTABLE REPORT**

George Gaebler moved to accept **Recommendation 09-1-42.1** “That the AARC initiate a survey monkey to members of the AARC to advertise the different roundtables.”

George Gaebler moved “To refer **Recommendation 09-1-42.1** back to the Chair, Eileen Censullo, for clarification.”

**Motion to Refer Carried**

**INFORMATICS ROUNDTABLE REPORT**

George Gaebler moved to accept **Recommendation 09-1-47.1** “That resources (human and financial) should be allocated for recruitment of roundtable participants with diverse backgrounds. Group e-mails describing the informatics roundtable and requesting participation should be sent to AARC members.”

George Gaebler moved “To refer **Recommendation 09-1-47.1** back to the Informatics Chair, Constance Mussa.”

**Motion to Refer Carried**

George Gaebler moved to accept **Recommendation 09-1-47.2** “That the AARC make available to roundtable participants resources such as the AARC Uniform Reporting Manuals for Acute and Subacute Care, the National Board for Respiratory Care’s (NBRC) RRT Examination Matrix, and published, peer-reviewed respiratory care literature.”

Mike Tracy moved “To refer **Recommendation 09-1-47.2** back to the Informatics Chair, Constance Mussa.”

**Motion to Refer Carried**

**ROUNDTABLE REPORT ACCEPTANCE**

Ruth Krueger moved “To accept the Roundtable reports as submitted.”

**Motion Carried**

**ROUNDTABLE LIAISONS**

President Tim Myers named the Board volunteers who will act as liaisons for the following Roundtables:

Asthma Disease Roundtable	Lynda Goodfellow
Informatics Roundtable	Doug Laher
Military Roundtable	Ruth Krueger
Research Roundtable	Jim Taylor

**RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 8:55 a.m. CST, Saturday, March 28, 2009.

### **RECONVENE**

President Tim Myers reconvened the meeting of the AARC Board of Directors at 9:15 a.m. CST, Saturday, March 28, 2009.

### **AD HOC COMMITTEE REPORTS**

#### **AD HOC COMMITTEE ON VENTILATOR CARE – HUMAN RESOURCES**

George Gaebler moved to accept **Recommendation 09-1-33a.1** “That this entire project be re-focused and redefined as there are a number of serious logistical issues being noted that will severely affect the development of the last three Human Resources charges.”

George Gaebler moved “To refer **Recommendation 09-1-33a.1** to the President.”

#### **Motion to Refer Carried**

#### **ACCEPTANCE OF AD HOC COMMITTEE REPORTS**

Ruth Krueger moved “To accept the Ad Hoc Committee reports as submitted.”

#### **Motion Carried**

Director of State Government Affairs Cheryl West reported that the AARC is still very involved in tobacco regulation and is currently involved in various committees and coalitions, etc. to advance legislation.

### **FEDERAL REGULATORY AFFAIRS REPORT**

#### **CORF Regulation**

Director of Federal Regulatory Affairs Anne Marie Hummel reported that CMS is drafting a new CORF personnel regulation and noted that CMS is sensitive to any rule that would regulate CRTs out of a job. A new revised CORF personnel standard that will clarify RRTs and CRTs who are eligible to take the RRT exam and work in CORFs should be issued shortly.

#### **Pulmonary Rehab**

CMS has decided to do a proposed rule and national coverage determination (NCD). CMS believes using both regulations and NCD will cover the issue of codes and physician supervision. ATS, ACCP, and NAMDRS are scheduled to discuss the regulation process with CMS.

#### **Oxygen**

AARC along with home care groups, the ALA, and NECA to name a few have been involved in a work group focused on reform of the oxygen benefit under Medicare. The home care community wants Medicare to cease viewing home oxygen as an equipment benefit and view it as a patient-related services benefit.

## **FEDERAL GOVERNMENT AFFAIRS REPORT**

Federal Government Affairs Director Miriam O'Day provided an update on Congressional issues.

### **Medicare Initiative**

Ms. O'Day stated our legislation **HR 1077** and **S 343** – the Medicare RT Initiative was re-introduced in Congress and is gaining support. Representative Mike Ross has committed to approach Representative Henry Waxman (Energy & Commerce Chair) to place additional focus on the Medicare RT initiative. We have support from ACCP, Alpha-One Foundation and the COPD Coalition.

### **PACT**

The 2009 March DC Lobby Day was a success with 104 PACT representatives from 46 states and DC attending and lobbying Congress on our issues. We gained several new co-sponsors from **HR 1077** and **S343** from the PACT meeting. A webinar was conducted prior to the PACT meeting to brief participants on Hill issues. Anyone interested in background materials on our legislative issues may download pertinent materials from the AARC/PACT website.

### **Congressional Visits**

In early April Miriam will make congressional visits to gain guidance on how stimulus money will be distributed and if there are any opportunities for the RT profession.

## **RECESS**

President Tim Myers recessed the meeting of the AARC Board of Directors at 11:15 a.m. CST, Saturday, March 28, 2009.

## **RECONVENE**

President Tim Myers reconvened the meeting of the AARC Board of Directors at 11:35 a.m. CST, Saturday, March 28, 2009.

## **UNFINISHED BUSINESS**

### **LONG TERM OXYGEN THERAPY**

Pat Doorley moved to accept **Recommendation 08-3-53.1** "That the AARC facilitate a physician review of the literature on long term oxygen therapy (LTOT) with recommendation on necessary research to create evidence based procedures for home oxygen therapy: Organize and present an educational conference to review literature on oxygen therapy and equipment currently available for LTOT with an update on evidence based research that is current and identify missing science for the use of equipment and

procedures used in LTOT to create a roadmap for future LTOT research.”

Karen Stewart moved “To refer **Recommendation 08-3-53.1** to the President to develop an ad hoc committee to determine key terms and then forward to the Executive Office to conduct the literature search.”

**Motion to Refer Carried**

**POLICY REVIEW**

**Policy BOD 004**

Toni Rodriguez moved to accept **FM 09-2-84.1** “To table Policy BOD 004 as she will update it and bring back to the summer meeting.” (See ATTACHMENT “B”)

**Motion to Table Carried**

**Policy BOD 010**

Toni Rodriguez moved to accept **FM 09-1-84.2** “To replace “session” with “process,” and delete “mandatory” as this is at the discretion of the President, and delete #2 under Policy Amplification.” (See ATTACHMENT “B”)

Ruth Krueger moved to “To strike **FM 09-1-84.2** Policy BOD 010.”

**Motion to Strike Carried**

**Policy BOD 013**

Update Review Date.

**Policy CA 002**

James Taylor moved to accept **FM 09-1-84.3** “To strike Policy CA 002.” (See ATTACHMENT “B”)

Ruth Krueger moved “To refer **FM 09-1-84.3** to the Chartered Affiliate Committee to review, revise and update by the summer meeting, with Cam McLaughlin to convey the Board’s wishes to this committee.”

**Motion to Refer Carried**

### **Policy FM 001**

Update Review Date.

### **Policy FM 003**

Denise Johnson moved to accept **FM 09-1-84.4** “To amend FM 003 to change the ‘2’ to ‘3,’ remove ‘commencing with the 1990 annual budget, all’ and replace with ‘The,’ and Update Review Date.” See ATTACHMENT “B”)

### **Motion Carried**

### **Policy CT 002**

Update Review Date

## **NEW BUSINESS**

### **PRESIDENTIAL APPOINTMENT RATIFICATION**

George Gaebler moved to accept **FM 09-1-21.1** “That the Presidential appointment of Carrie Bourassa to the Federal Government Affairs Committee be ratified by the AARC BOD.”

### **Motion Carried**

### **END OF LIFE WHITE PAPER**

Sam Giordano stated an End of Life White Paper is being developed by Timothy McDonald, MD, JD, along with Wade Jones. George Gaebler volunteered his assistance with the project.

### **REVENUE SHARING**

George Gaebler moved to accept **FM 09-1-84.5** “To continue withholding Tennessee revenue sharing checks during 2009 to help offset the cost of the hired lobbyist.”

### **Motion Carried** – Unanimous

### **DISASTER RESPONSE**

Mike Hewitt moved to accept **FM 09-1-84.6** “That the AARC Board accept opening its disaster fund to the North Dakota and Minnesota areas that were recently declared disaster areas by President Obama.”

**Motion Carried**

**ARCF INVESTIGATOR GRANT FORM**

Brian Walsh moved to accept **FM 09-1-84.7** “That the ARCF develop a new investigator grant form and criteria that fosters the development of the respiratory therapist investigator which will include a form that is approximately 4-6 pages in length that explicitly directs the applicant on what is required to successfully apply.”

**Motion Carried**

**ARCF AWARDS NOMINATIONS**

**Forest M. Bird Lifetime Scientific Achievement Award**

Tom Barnes                      Nominated by Lynda Goodfellow

**Invacare Award for Excellence in Home Respiratory Care**

John Loyer                      Nominated by Frank Salvatore

**Sepracor Achievement Award for Excellence in Pulmonary Disease State Management**

Rhonda Vosmus                Nominated by Tim Myers  
Dom Coppollo                 Nominated by Lynda Goodfellow

**Charles H. Hudson Award for Cardiopulmonary Public Health**

(No BOD nominations at this time)

**NEXT AARC BOARD OF DIRECTORS MEETING**

President Tim Myers reported that the next meeting of the AARC Board of Directors will be held July 20-21 in Marco Island, FL.

**TREASURER’S MOTION**

Secretary-Treasurer Karen Stewart moved “That the expenses incurred at this meeting be reimbursed according to AARC policy.”

**Motion Carried**

**ADJOURNMENT**

President Tim Myers adjourned the meeting of the AARC Board of Directors at 1:50 p.m. CST, Saturday, March 28, 2009.

ATTACHMENT “A”

Respiratory Therapist Education  
Position Statement



# American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

## ***Position Statement*** **Respiratory Therapist Education**

It is the position of the American Association for Respiratory Care (AARC) that ~~to~~ adequately prepare graduate respiratory therapists to entry level respiratory therapists for clinical practice across a broad spectrum of sites and to prepare professional leaders to meet the demands of providing services requiring complex, cognitive abilities and patient management skills; ~~it is the position of the American Association for Respiratory Care (AARC) that:~~

- The minimum education leading to entry into the practice of respiratory therapy care should be successful completion of an associate degree respiratory ~~care~~ therapy educational program.
- ~~Programs should prepare graduates as respiratory therapists~~
- Programs that educate respiratory therapists, managers, researchers, faculty, and professional leaders should be accredited through a body, and a process, which will confirm that the programs meet minimum educational requirements.
- Respiratory therapists completing Graduate respiratory therapists, upon completion of the above-described minimum education, advanced training, and/or experience should be eligible to pursue and to obtain a credential that acknowledges the didactic preparation and related skills required for practice ~~as a respiratory therapist in the respective area of specialization.~~

~~This position statement is based on prior projects by the AARC, as well as current activities and data, which support the outcomes of those earlier projects. They include:~~

- ~~The AARC sponsored Delphi study conducted by the AARC Education Committee in 1989. This study engaged acknowledged experts in respiratory care to reach agreement in two areas:~~
  1. ~~The knowledge, skills, and professional characteristics needed for future respiratory care practitioners, and~~
  2. ~~The duration of educational preparation necessary to acquire these~~

competencies.

- ~~The 1991 profile of the future respiratory care practitioner created by the AARC Board of Directors.~~
- ~~The 1992 consensus conference on respiratory care education, which brought together more than fifty participants including foundation representatives, government officials, academicians, and clinical health care professionals to determine:
  1. ~~Curriculum content for the year 2001, and~~
  2. ~~Implications of that curriculum content for credentialing and accreditation.~~~~
- ~~The 1993 consensus conference, which resulted in the creation of an action plan to assist educational programs in developing respiratory therapists prepared to practice in the year 2001.~~
- ~~The reports published by the Pew Health Professions Commission in 1991 and 1993.~~

~~The findings of the education and practice related consensus conferences should be included in resource materials as new standards are developed for the accreditation of respiratory care educational programs. The AARC will continue to support the practice of respiratory care by providing continuing education opportunities, and collecting and sharing information on the changing healthcare environment as it impacts respiratory care education and practice.~~

Effective 1998

**Revised ~~2004~~ 03/2009**

ATTACHMENT "B"

Policies

# Policy Review

**BOD 004** - Continuous Quality Improvement Plan

**BOD 010** - Mandatory Orientation Sessions

**BOD 013** - Professional Attire

**CA 002** - Chartered Affiliate Requirements and Responsibilities

**FM 001** - Accounting Systems

**FM 003** - Annual Budget

**CT 002** - Medical Advisors

**American Association for Respiratory Care**  
**Policy Statement**

Page 1 of 2  
Policy No.: BOD.004

SECTION: Board of Directors

SUBJECT: **Continuous Quality Improvement Plan**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: May 8, 2004

**REFERENCES:**

***Policy Statement:***

The Board of Directors shall meet at a dedicated time and place identified by the President to systematically evaluate its effectiveness as the governing entity of the Association no less than twice annually.

***Policy Amplification:***

1. As part of this process, the Board of Directors shall use available data, statistical information, and continuous quality improvement methods.

**Quality Performance**

The Board of Directors is responsible for the efficient use of available resources to operationalize the mission statement and attain the strategic objectives of the AARC. Quality performance occurs through the continuous improvement of key processes and activities that contribute to the advancement of the art and science of respiratory care irrespective of venue.

**Quality Precepts**

- Continuous improvement of every process of planning operation and service delivery.
- Elimination of barriers which have the effect of adding costs through waste reduction and simplification.

# American Association for Respiratory Care

## *Policy Statement*

Page 2 of 2

Policy No.: BOD.004

- Alignment with outside organizations as partners.
- Management practices that focus on improvement of the systems in which members work.
- E  
emphasis on continuous process improvement rather than periodic inspection
- Continuous evaluation and improvement when working with related organizations.
- Promotion of member understanding of their jobs and individual roles in providing quality products.
- Creation of a caring organizational environment that is characterized by trust and integrity and strives to drive out fear and frustration for optimal performance; encourages suggestions for improvement and innovation; and promotes sharing of ideas.
- Communication about organizational goals and progress as essential for enlisting effective participation.
- Creation of budgets and performance management each year for monitoring progress internally.
- Improvement in statistical processes and planning, and application of quantitative methods for continued improvement.

DEFINITIONS:

ATTACHMENTS:

**American Association for Respiratory Care**  
**Policy Statement**

Page 1 of 1  
Policy No.: BOD.010

SECTION: Board of Directors  
SUBJECT: **Mandatory Orientation Sessions**  
EFFECTIVE DATE: December 14, 1999  
DATE REVIEWED:  
DATE REVISED: **May 8, 2004**

REFERENCES: AARC Policy FM.016 Travel Expenses Reimbursement

***Policy Statement:***

All persons elected to the Board of Directors shall **participate in** an orientation session.

***Policy Amplification:***

1. The newly elected members, along with all continuing members, are encouraged to **participate in** an orientation session as identified by the President.
2. Reimbursement shall be according to AARC Travel Reimbursement Policy.

DEFINITIONS:

ATTACHMENTS:

**American Association for Respiratory Care**  
**Policy Statement**

Page 1 of 1  
Policy No.: BOD.013

SECTION: Board of Directors

SUBJECT: **Professional Attire**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: May 8, 2004

**REFERENCES:**

***Policy Statement:***

All Officers, Directors, and guests shall adhere to appropriate attire requirements when attending business meetings and social gatherings.

***Policy Amplification:***

1. Unless otherwise determined by the President, business attire shall be required for all meetings of the Board, Finance Committee and Executive Committee meetings.
  - A. This requirement shall also apply to invited guests.
2. Attire worn to receptions and other social gatherings sponsored by other professional organizations (i.e. NBRC) shall be identified by the sponsoring group, unless otherwise defined by the President.

DEFINITIONS:

ATTACHMENTS:



# American Association for Respiratory Care Policy Statement

Page 1 of 1  
Policy No.: CA.002

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliate Requirements and Responsibilities**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES:

***Policy Statement:***

Chartered affiliates shall be responsible for providing necessary formal documentation required for Chartered Affiliate Membership in the AARC.

***Policy Amplification:***

1. Chartered Affiliates shall be required to provide the following written documentation to the AARC.
  - A. Proof of state and federal exempt tax status.
  - B. Proof of Chartered Affiliate Treasurers and other checking account signatories being bonded.
2. The Affiliate Charter shall remain the property of the Association, and replacement or additional copies must be purchased at cost plus handling.
3. **It shall be the responsibility of the Chartered Affiliates Committee to solicit and maintain documentation.**

DEFINITIONS:

ATTACHMENTS:

# American Association for Respiratory Care Policy Statement

Page 1 of 1  
Policy No.: FM.001

SECTION: Fiscal Management

SUBJECT: **Accounting Systems**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES:

***Policy Statement:***

The Board of Directors shall require the application of appropriate accounting systems and internal auditing procedures.

***Policy Amplification:***

1. The accounting systems and internal auditing procedures shall provide for the timely and accurate assessment of the budgetary and business operations of the Association.
2. Financial statements shall be:
  - A. Prepared in compliance with generally accepted accounting principles (GAAP)
  - B. Issued in a timely manner to the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

# American Association for Respiratory Care Policy Statement

Page 1 of 1  
Policy No.: FM.003

SECTION: Fiscal Management

SUBJECT: **Annual Budget**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES:

***Policy Statement:***

The budgetary process shall include appropriate approval processes and reviews.

***Policy Amplification:***

1. Commencing with the 1990 Annual Budget, all Association Annual Budgets submitted to the Board of Directors and House of Delegates for approval shall provide supplemental verification that major expenses conform to the approved Strategic Plan of the Association.
2. Annual Budget reviews shall:
  - A. Be presented to the Finance Committee with subsequent presentation to the Board of Directors.
  - B. Provide a detailed budget performance assessment with respect to the Association's Strategic Plan.
2. The Annual Budget shall be approved by the House of Delegates and Board of Directors prior to implementation.

DEFINITIONS:

ATTACHMENTS:

# American Association for Respiratory Care Policy Statement

Page 1 of 1  
Policy No.: CT.002

SECTION: Committees  
SUBJECT: **Medical Advisors**  
EFFECTIVE DATE: December 14, 1999  
DATE REVIEWED:  
DATE REVISED:

## REFERENCES:

### ***Policy Statement:***

Committees shall have Medical Advisors as requested by the President, identified by the Chair of the Board of Medical Advisors (BOMA) and appointed by the President.

### ***Policy Amplification:***

1. Special Committees and other groups shall have Medical Advisors as determined by the President.
  - A. BOMA shall submit names for Committee Medical Advisors to the President for appointment and ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

# ***General Reports***

## **PRESIDENT'S REPORT**

### **President's Activity Report July 20-21<sup>st</sup>, 2009 Marco Island Marriott**

- 1. Continue to develop and execute strategies that will increase membership and participation in the AARC.**
  - Ongoing strategies per the Membership Committee continue.
  - New initiatives to retain expiring student members are being considered and planned.
  - Recruitment initiative in Tennessee underway.
  
- 2. Promote patient access to respiratory therapists as medically necessary in all care settings through appropriate vehicles at local, regional and national venues**
  - Successful passing of the amendment of the Tennessee Polysomnography Law that will not require respiratory therapist to obtain an additional credential to practice in sleep diagnostics. Allows for three pathways of credentialing or competency verification (as approved by the Tennessee Respiratory Care Licensure Board)
  - Sent a letter to the AASM President requesting that they consider delaying implementation of the new Sleep Lab Accreditation personnel standards or they provide an exemption for appropriate credentialed, licensed respiratory therapist.
  - Activation of the AARC's 435 Plan for Senate support for the Medicare Part B bill initiative.
  - Continue legislative efforts with Congressman Ross and Senators Crapo and Lincoln for inclusion of Medicare Part B bill in the House and Senate Health Care Reform packages.
  - Working with CMS and other regulatory groups on language and initiatives that involve the practice of Respiratory Care.
  
- 3. Continue to advance our international presence through activities designed to address issues affecting educational, medical and professional trends in the global respiratory care community.**
  - Attend the 3<sup>rd</sup> European Respiratory Care Association meeting in Stresa, Italy. Attendance appeared to be in the 350-400 person range including attendees, faculty, and vendors. Provide a presentation on the They spent a lot of time kicking around the idea of developing a fellowship program like that of the AARC...several (8-9) of our past Fellows spoke extremely well of their experience from AARC/ARCF. They had a representative from each "society" represented at the meeting. They wanted 2 questions addressed by each group.
    - i. What is the Future of Respiratory Care / Respiratory Therapist in Europe
    - ii. What types of Educational Program(s) need to be developed to move the Resp Care forward.

- Promoted the International fellowship program at the American Thoracic Society meeting in San Diego this May.
  - Will attend the European Respiratory Society meeting in Vienna in September to promote the International Fellows program, Respiratory Care Journal and AARC membership.
  - Will travel to Tao Yuan, Taiwan to speak at The Respiratory Therapists Society of the Republic of China's Annual Respiratory Congress and RT Department of China Medical University.
- 4. Identify the clinical/non-clinical skills, attributes and characteristics of the “Respiratory Therapist for 2015 and Beyond” based on the expected needs of respiratory care patients, the profession and the evolving health care system.**
- Attended the 2<sup>nd</sup> 2015 consensus conference in April in Irving, Texas as a participant. More information regarding the discussions and output from this conference will be provided during the Summer BOD/HOD Joint Session by Bill Dubbs.
  - Provided a Conference 1 Summary to Corporate Partners and at Florida and Michigan State Society Meetings in the Fall.
- 5. Develop a leadership and mentoring institute (process) to promote the advancement and growth of respiratory research, management skill sets and education curriculums and practices to meet the future demands of the profession.**
- Have participated in several conference calls with committee as Steering Committee member. The group has done fantastic work on this initiative in a very short period of time. The group has developed a Mission/Vision statement and a scope of project strategic plan. Curriculum development for the core and all three “institutes” are well on their way to development. Dr. Toni Rodriguez, Committee Chair, will provide a more detailed report and answer questions in Marco Island in July.
- 6. Promote the access of quality continuing education to development and enhance the skill base of current practitioners to meet the future needs of our profession.**
- Go live day the week of March 15<sup>th</sup> with the web-based Asthma Educator Prep Course. This course
  - AARC’s continues its successful continuing education programs through Professor’s Rounds and Webcast.
  - The first COPD Educator course was offered just prior to the Florida State Society meeting to a packed house with excellent feedback. Potential for additional “Live” offerings are being discussed, as well as, a web-based version.
  - Specialty courses were added to the Summer Forum with huge savings to attendees at both meetings. An overview of these offerings will be provided at the Summer BOD meeting.

7. **Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.**
- Requested and received letters of support for Medicare Part B initiative from ATS, ACCP and NAMDRC.
  - Received letters of support for respiratory therapists scope of practice in Polysomnography from ACCP and NAMDRC.
  - Provided three names for CoARC's consideration as potential AARC appointees to the CoARC Board.
  - Will hold at Tripartite Meeting with CoARC and NBRC at Summer Forum.
  - Sent a letter to the ICRC appointing Patrick Dunne and Jerome Sullivan as the AARC's representatives.
  - Attended AARC Corporate Partner Meeting in April and provided an overview of Part 1 of the 2015 Consensus Conference.
  - Attended AARC BOMA meeting in June.
  - Wrote a letter to Senator Edward Kennedy supporting S982 that would authorize the FDA oversight of tobacco. This bill has since been approved by both the House and the Senate and was sent for President Obama's signature.
  - AARC representatives have participated in numerous patient advocacy and health care reform coalitions and groups through conference calls and meetings over the first 6 months.
  - Have had numerous conversations with many government agencies about the role of respiratory therapists in the health care arena, as well as, applied for several grants for project / program support.

#### **AARC Travels**

- April 1-5: **ERCA**—Strese, Italy
- April 6-8: **2015 Conference** – Irving, Tx
- April 16-17: **Corporate Partners** - - Irving, Tx
- April 18-20: **North Dakota State Meeting** - - Fargo, ND
- May 6-7: **Florida State Meeting** – Miami Beach, Fl
- May 16-20: **ATS Meeting** – San Diego, Ca.
- June 5-6: **BOMA** – Irving, Tx



## VICE PRESIDENT – INTERNAL AFFAIRS

Reporter: George Gaebler  
Last submitted: 2009-07-01 12:21:23.0

### ***Recommendations***

None at this time

### ***Report***

More reports were received on a timely basis this time than for the spring meeting. In many cases the missing reports as of the deadline are some of the same as for the Spring BOD meeting.

Reminders have been sent and they will be contacted for a report if they do not comply.

### ***Other***

[Insert other information here]

**VICE PRESIDENT – EXTERNAL AFFAIRS**

Reporter: Joseph Lewarski  
Last submitted: 2009-06-30 17:08:29.0

***Recommendations***

No Recommendations

***Report***

Nothing to report at this time

***Other***

## EXECUTIVE OFFICE

### Executive Office Report

Sam P. Giordano, MBA, RRT, FAARC  
Executive Director

July, 2009

#### **MEMBERSHIP**

Membership continues to be strong this year in spite of a weakened economy. Our goal is to hit the 50,000-member mark by year's end. We will continue efforts to retain and recruit members by emphasizing the cost benefits of membership in AARC in alignment with our membership recruitment strategy. As with every year we do see a drop in our numbers in late spring. Our latest numbers are close to 48,000 and we are on track to achieve our year-end goal. An updated count for end of June will be provided at the summer meetings. We continue to offer incentives such as discounts to our members, which includes a complementary ethics course as well as continuing to provide accredited distance learning education for *members only* through the Internet and our webcast series.

#### **EDUCATION**

##### **Webcasts**

We continue to promote our expanded capabilities with our webcast platform. Our audience continues to grow. The average viewer numbers in the first half of 2008 were 100 per live course (this was due to a platform that only accommodated 100 seats). In June 2008 we converted over to a platform that allows unlimited seats. In the last half of 2008, there were approximately 225 per live course. In 2009 the average per course has grown to 250 with another 200 who view the archived version. Evaluations remain very positive. The change to Elluminate has resulted in a substantially improved live webcast experience for the participants and much greater customer satisfaction. We continue to attract more viewers as we tout our webcasts as a viable platform for our members as the number of participants grows.

##### **Reimbursement College**

Reimbursement College II is still available for members free of charge. It has been available since the first of this year. Since this new version has been released it has had over 800 participants half of which have earned their CRCE for the course.

##### **Spirometry Course**

We have developed a special simple course for persons providing office spirometry in physician practices. This course is designed for non-therapists and will be marketed to physician practices and physician practice employees. While the course will definitely not prepare individuals to perform pulmonary function studies, we hope it will contribute to increasing the quality of simple office spirometry, and therefore eliminate wasted dollars in unnecessary testing or inaccurate diagnoses. Once this course is ready for market, which we anticipate to be toward the end of this year, we will invite our state societies who have signed contracts with AARC to enter into a marketing agreement in

order to open up a new revenue stream for the state societies as well as AARC.

## **PROJECTS**

### **COPD Educator Course**

The first course was held in Miami in early May. Approximately 125 attended the one-day program. This course, which is a joint effort with COPD Foundation, has now been expanded into a format that will be a day and a half. We are planning to roll out this expanded version in Denver in October, after which it will be transferred as an on-line course.

### **Asthma Management and Prep Course**

The on-line version of the Asthma Course was launched in June. It has received much attention and we our registration numbers have are exceeding our budget. We are working with our State Affiliates in an effort to partner with them at a state level. This timing of this release is good in that it comes at a time the matrix for the exam changes and the first group of AE-C certificants must re-take the exam.

### **Asthma Self Management Education (ASME)**

The ASME program was fully implemented in February. One facility (Maine Medical Center) has been awarded ASME recognition. Information and an application form are available on the AARC website at: <http://www.aarc.org/asme/>. We have received very few inquiries (approximately 3-4) and have received no applications that are pending at this time.

### **California Ethics Course**

Participant data is being provided to the Respiratory Care Board of California. To comply with the RCBC's requirement for a new test in 2010, we have solicited the authors of the current course to update the scenarios in the course modules and write new test questions. These are due to the RCBC on July 1. Once these revised modules are approved, we will produce the new ethics course during the second half of 2009 so it will be available on January 1, 2010.

### **Human Resource Survey**

The individual surveys for the therapist, educational program directors and acute care hospital directors were conducted from March 13 to April 14. It is noteworthy that the estimated number of practicing therapists has increased 9.2% since the 2005 survey rising from 132,651 to 145,117. An Executive Summary of the Human Resource survey will be published in the AARC Times later this year with a full report to be presented at the Congress.

### **2015 and Beyond**

The second conference titled "Educating the Respiratory Therapy Workforce: Identifying the Options" was held April 6-8. 42 attendees represented 18 different stakeholder organizations. Plenary sessions focused on reviewing the findings of the first conference, exploring the roles future roles for therapists in specific areas, and accreditation, credentialing and licensure issues. Participants in small group sessions developed competencies required by future respiratory therapists. The participants will now review these competencies in a web-based survey. The writing committee has begun work on the

paper describing the conference proceedings that will be submitted for publication on a peer-reviewed journal. A third and last conference is planned for early 2010.

### **Benchmarking**

A review of our subscribers revealed that the number of subscribers had steadily diminished to less than 100 and that approximately half of them had entered data. To dramatically increase the number of hospitals available for comparison, a benchmarking stimulus plan was developed. An important aspect of that program is providing an enrollment period from June 1-August 31 during which facilities may sign up for a two-month free trial. In the first two weeks of June, 115 new subscribers were attracted by this offer. We will continue to use our website and other communication channels to promote the benchmarking system. We will also be marketing the free trial to hospital administrators. With increasing pressure on managers to justify their resources we believe that this is the right time to push this tool.

### **PAP Adherence Document for Respiratory Therapists**

The PAP Adherence Document will provide guidance on ways that the home and hospital based RT can identify and work with patients to improve adherence of positive airway pressure devices in the home for management of patients with obstructive sleep apnea. The writing committee has completed their work and it is in its final stages of editing. It will then be available on our website and will offer free CRCE as a “member only” benefit by late summer.

### **A Guide to Aerosol Delivery Devices for the Respiratory Therapist**

The second edition of the aerosol delivery guide has been completed and is currently being edited. We have gathered a group of consumers who will serve as reviewers for content of the consumer guide and to review the document before we publish.

### **Peak Performance USA (PPUSA)**

PPUSA has been gaining steam since its release earlier this year. To date there has been over 3,000 visits to the website (an average of 75 visits a day). There are 200 RT departments participating with 286 distributed to schools. The Asthma and Allergy Foundation have endorsed PPUSA. An additional grant has been submitted to the government for funding to develop a teacher education component to PPUSA, which will measure effectiveness of the education provided by the RT. PPUSA is an important tool for the RT which allows them to partner with local schools and to be the asthma expert. This not only helps the schools but also brings community-wide attention to the respiratory therapist in a positive way.

### **Ventilator Inventory Survey**

We've been approached by the Federal Government to develop a method of surveying all acute care hospitals in order to ascertain the number of ventilators available to support mass casualty events including pandemics. While there is no assurance at this time that we will receive a grant from HHS, we are encouraged by our conversations with them and have submitted a proposal for funding. If the AARC is successful, we may have an opportunity to work with some of our state societies as subcontractors in order to assist in the project. I can't over emphasize the importance of this project since this will be the first time in the history of our country that a population survey targeting ventilator numbers has been undertaken. The results of this project will be used at federal and state

governments to assist them in guiding purchasing decisions for strategic stockpile ventilators.

## **ADVOCACY**

### **Your Lung Health**

This web site continues to be very active. Allergy and Asthma Health as well as Ask Dr. Tom are two of the most popular parts of this website. A recent survey was conducted of our patients and others who frequent this site. It was found that the majority of viewers are over 40 years of age (69%). Over half refer to this site weekly or monthly, 92% find the information they are looking for, and 60% are quarterly readers of Allergy and Asthma Health, an electronic magazine that is focused on patients. We have also gained insight on other topics that patients are looking for from this web site and will incorporate them. One other change that will occur later this year will be the addition of a panel of respondents who will assist Dr. Petty in fielding the questions for the Ask Dr. Tom component of the web site.

### **Mobile Spirometry Unit (MSU)**

We continue to work in partnership with the COPD Foundation to provide consumer access to basic spirometry. We are currently engaged in a case-finding study that will document the cost effectiveness of utilizing a hierarchical approach which includes a) administration of screening questions, b) peak flow measurement, and c) if necessary, spirometry FEV 6 and ratio. There are currently about 3,000 patients who have undergone the protocol. An abstract of this study has been accepted for presentation at ERS this year. We have a full summer and fall schedule and are hoping to complete the study by year's end.

### **Joint Commission Reviews**

The AARC continues to participate in the Joint Commission Standards Field Review process. By the time the BOD meets we will have participated in 9 field reviews in 2009. The reviews done includes:

- Responsibilities of the Individual in LTC (1) April
- Lab-Document and Process Requirements (1) April
- Lab-Non waived testing (1) March
- Provision of Care Treatment and Services-LTC (1) May
- NPSG and Universal Protocol- Hospital, CAH, LTC, LAB and Homecare June (5)

## **CONCERT**

The COPD Outcomes Based Network for Clinical Effectiveness and Research Translations (CONCERT) is a project sponsored by AHRQ/NHLBI. The purpose is to identify a research agenda for COPD that focuses on two major areas; the first improving chronic COPD care, and the second improving COPD care coordination. AARC is fortunate to be invited to participate. There are two working groups and we have representation on the working group that seeks to improve COPD care coordination. The first meeting was convened last May immediately following the ATS meeting. We nominated several research topics including improving the effectiveness of home oxygen with COPD patients, use of oxygen saturation as the primary dosing method for home oxygen, as well as the impact on quality allied health care resource utilization brought

about by the formal COPD education program.

These topics along with many others are currently being prioritized. The working groups will continue collaboration throughout the next year. Plans are to meet again after the ATS meeting in May of 2010. We will keep you posted regarding developments and progress in this endeavor.

### **Breathe Better Campaign**

As many of you may recall, the NHLBI has supported a public awareness campaign in order to make the general public more aware of COPD, its signs, symptoms, testing and treatment. The AARC along with our state societies have done a fantastic job of promoting awareness and providing high quality spirometry testing through its collaboration with the COPD Foundation. We recently received a Request for Proposal and have submitted a Letter of Intent requesting funding for COPD awareness. This year, we want to coordinate a national spirometry day in concert with World COPD Day in November. This was discussed at the state society leadership meeting this past spring. We are now ready to move ahead, hopefully, with a grant that will help defray expenses. We want to encourage every state society to target their respective state capitol for a COPD Awareness event on World COPD Day. Fortunately, this occurs in November so it will not detract from other public awareness efforts undertaken by AARC and state societies as part of RC Week.

### **COMMUNICATION**

#### **(Facebook and Twitter)**

The AARC launched an Engagement campaign this year for which we seek to reach out to all RTs. We want to reach newer RTs especially in their twenties and thirties who more commonly use this as a communication and socialization tool. Since starting this we have seen a significant number of active participants (over 3,000) on Facebook. This venue allows us to post messages to Facebook friends, which could serve as a means to bring in new members by announcing member benefits and sharing topics of interest that is linked to our main web page.

#### **RTs in the News**

We do a daily tracking of *RTs in the News*. This information is gleaned from the electronic press. Below is an accounting for the past three months.

RTs Featured for something related to the profession	145 (43% were members)
RTs featured for something not related to RT	47 (28% were members)
Deaths	13 (30% were members)
RTs featured in a negative way	14 (43% were members)
QRRCR mentions of RT Depts.	20

### **Conventions/Meetings**

In April we began the solicitation of potential exhibitors and we are happy to report that confirmations are coming in as in previous years. It is clear, however, that industry is

being very careful and cutting corners in every possible way. For the first time ever, this year we opted not to print the Exhibitors Prospectus (the booklet containing information on how to exhibit, etc) and instead we are offering it online. The feedback from the exhibitors has been great and we were able to reduce expenses.

By the time you meet this July the AARC Summer Meetings will be almost over. You may have noticed the Program Committee designed the programs in such a manner that attendees are able to minimize their expenses while maximizing value. Based on the number of pre-registrants as of today, we feel good about attendance and that expect to meet budget.

The program for the Congress in San Antonio is complete and we are now in the process of contacting. While some marketing of the 2009 Congress has continued since the Anaheim meeting, those efforts will intensify after the Summer Meetings.

Finally, the department has been involved with all necessary arrangements for a number of meetings:

1. COPD Courses (Miami Beach, May 6; Denver, October 1-2)
2. CPGs Committee meeting May 30
3. Board of Medical Advisors summer meeting\_ June 5-6
4. Educator Academy
5. Summer Forum\_
6. Mechanical Ventilation for Educators & Managers Course
7. Pediatrics Course for Educators & Managers Course
8. Board of Directors summer meeting\_
9. House of Delegates summer meeting\_
11. 2010 Spring BOD and State Affiliate Workshops
12. 2013 Congress in Anaheim \_

### ***RESPIRATORY CARE JOURNAL***

It is easy to report on the Journal because you get it in the mail every month and you are able to assess its value. As you may suspect, we continue to be pleased with the Journal and its role in advancing the science and arts of respiratory care. The number of submissions received increases every month. Since our last report the Journal added a new feature entitled "Editor's Commentary" in which the editor highlights the contents of the issue. The proceedings from the Journal Conference appeared in the May and June issues. A conference on sleep is planned for San Antonio immediately after the 2009 Congress. Please let us know if there is any additional information on the Journal that you would like to receive.

### **SUMMARY**

Given the high level of activity regarding health reform and our initiative to gain inclusion of qualified RTs under Part B, the profession is well-positioned to expand access to RTs outside the hospital which could save billions of dollars each year.

The economy is challenging all businesses as you know, and AARC is no exception. We continue to look for intelligent ways to cut costs and still maintain membership fulfillment as well as advancing our agenda on behalf of our patients. We do not anticipate any reduction of benefits and will continue to identify and open new revenue



streams, especially in partnership with our state societies. We look forward to the health reform debate, and with your help and support the positioning of RTs across the health care delivery spectrum.

I hope the foregoing information is helpful to you. If there is an item we have omitted or you would like more detail on any of our activities, please do not hesitate to contact me at your earliest convenience. I look forward to seeing all of you in Florida. Thank you.

## Referrals

**FM 08-3-83.2** “That the AARC Executive Office develops a proposal with workflow requirements and financial implications that encompass an online submission and transcript CRCE system. This system should allow the breakdown of five or more content categories to facilitate reporting to state licensure boards and NBRC. Three of those categories should mirror the NBRC requirements of general respiratory care, neonatal/pediatrics, and pulmonary function/diagnostics technology” **was referred to the Executive Office for cost analysis and report back in July.**

ACTION: The executive office staff reviewed the web-based CRCE system currently being developed, the existing web-based CRCE Lookup and existing CRCE transcript and CRCE certificate to evaluate the changes necessary to comply with this referral. This can be accomplished with modifications to 4 key CRCE Application and Reporting Processes:

### **(1) Additional CRCE application information:**

Note: Currently there are no specific content areas assigned to CRCE programs. For each session or module, program sponsors will assign a primary content identifier selected from a defined menu. If appropriate, they will also select an NBRC content designation modifier. Because beginning and ending times of each session are provided, this will allow assignment of an appropriate number of CRCE contact hours for each content category in each session or module. Suggested content identifiers and NBRC content designations are listed in the attached Appendix.

AARC Resources Implications: Programming modifications are required. Evaluation and final decisions about content assignment will be made by the AARC during the application review. This is not presently part of the review process and will add additional minutes to the evaluation of each program. Based on 2008 historical CRCE application volumes this will require 0.22 additional FTEs.(See Table 1- Incremental Change in Processing Time)

### **(2) CRCE Lookup modifications:**

Note: Currently CRCE Lookup provides only the total number of CRCE contact hours available for the course.

Traditional programs not offering partial credit and non-traditional programs: In addition to the total hours approved for the course, the number of contact hours for each content category in each course will be posted.

Traditional programs offering partial credit: In addition to the number of contact hours for each content category in each course, the maximum contact hours available for the course will be posted.

AARC Resources Implications: Programming modifications are required. It is anticipated that these modifications will allow this to occur without manual intervention.

### **(3) Course sponsor reporting requirements:**

Note: Currently course sponsors are required to report only the total number of CRCE contact hours earned by each course participant.

Traditional programs not offering partial credit and non-traditional programs: No real changes will be required since the hours of CRCE awarded to each participant are identical. Approximately 90% of courses submitted do not offer partial credit.

Traditional programs offering partial credit: For each participant the number of hours earned in each content category and the total number of hours earned is required. The number of CRCE contact hours earned cannot exceed the maximum number of hours available for the course. This will impact on approximately 10% of the programs submitted. The burden to the course sponsor is in direct proportion to the number of sessions within the program and the number of attendees that earn CRCE. The largest burden will fall to the 114 programs (1% of the total) offering 13 or more CRCE. The sponsors of these programs include the AARC, State Societies, FOCUS, ACCP, SCCM, AAST and others.

Suggestion: To assist course sponsors of traditional programs offering partial credit, an electronic document containing the title of each session with the CRCE contact hours approved in each specified content category and subcategory could be generated and provided to the course sponsor. This document could be reproduced by the course sponsor and distributed to the program participants who could use it to report the sessions they attended to the course sponsor. The course sponsor could use the reported information to develop the AARC course log and to issue course certificates.

AARC Resources Implications: Programming modifications are required.

#### **(4) Course Completion Certificate requirements:**

Note: Currently the CRCE Course Completion Certificate displays only the total available hours approved for the course. In addition to reporting the total available hours approved for the course, the number of contact hours earned for each content category must be reported on the course completion certificate. As described above, for the sponsors of traditional programs offering partial credit, this is an increase in requirements for course certificate information that will vary in direct proportion with the number of course attendees and the number of educational content categories contained in the course

AARC Resources Implications: Programming modifications are required.

#### **CRCE transcript modifications:**

Note: Currently the CRCE transcript displays the following fields for each course: course ID, Course Title, Start Date, End Date, Total Hours awarded.

The CRCE transcript must be modified to additionally display the hours awarded for each specified content category and subcategory for each course. Additionally for the inclusive dates queried, it will display the total hours earned in each specified content category and subcategory.

AARC Resources Implications: Programming modifications are required. It is anticipated that these modifications will allow this to occur without manual intervention.

## **Estimated Costs**

### **Programming**

The AARC's Information Technology Department estimated that these modifications will require approximately 80 hours of programming and testing and 100 hours of staff time for a total estimated cost of \$17,200.

### **Human Resources:**

This will require approximately 0.22 additional FTEs (Refer to table 1)

Appendix: The following content designations shall be assigned to each instructional session.

Content Area	Source	Comment:	Content Designation
Clinical Practice	AARC-CRCE	All areas of clinical practice addressed by NBRC, AE-C, and BRPT examination content areas and emerging respiratory therapy technology.	CLP
Management	AARC-CRCE	Management and supervision of personnel and operations including cost containment,	MGT
Education	AARC-CRCE	Program development, instruction, and evaluation. Includes respiratory disease management and health promotion.	EDU
Ethics and Law	AARC-CRCE	Medical ethics and legal aspects of healthcare.	ETH
Patient Safety	AARC-CRCE	Patient safety including medication errors*, errors related to the delivery of care, AIDS/HIV* and infection control*, and cultural competency.	PTS
Bioterrorism and Emergency Preparedness	AARC-CRCE	Includes issues related to planning for medical emergency situations.	BEP
The following modifiers may be assigned in conjunction with one of the above content designations			
<i>Neonatal-Pediatric</i>	<i>NBRC</i>	<i>Modifier to identify content appropriate for the NBRC's continuing competency programs</i>	<i>NPS</i>
<i>Pulmonary Function</i>	<i>NBRC</i>	<i>Modifier to identify content appropriate for the NBRC's continuing competency programs</i>	<i>PFT</i>
<i>Sleep Medicine</i>	<i>NBRC/BRPT</i>	<i>Modifier to designate that course content is specific to sleep medicine</i>	<i>SLP</i>

\*Designates content areas mandated by some state licensure boards.

Note: Clinical practice is the default category. Other categories may be used if the title and objectives are appropriate for that designation. When appropriate, modifiers can be assigned with the primary content designation.

**Table 1**

<b>Incremental Change in Processing Time</b>						
<b>Type of Program</b>	<b>Count</b>	<b>Min /App</b>	<b>Annual Hours</b>	<b>FTE</b>	<b>% Total Programs</b>	
No Partial Credit	10133	2.5	422.21	0.20	89.72%	
Partial Credit	1161				10.28%	
Repeat Only	606	0				
Initial Approval	555					
1 – 3.0 hours	51	2.5	2.13	0.00	0.45%	
3.1 – 8.0 hours	249	3	12.45	0.01	2.20%	
8.1 – 13.0 hours	141	4	9.40	0.00	1.25%	
13.1 – 21.0 hours	75	5	6.25	0.00	0.66%	
21.1 – 31.0 hours	23	6	2.30	0.00	0.20%	
Greater than 31 hours	16	8	2.13	0.00	0.14%	
<b>Total</b>	11294		456.87	<b>0.22</b>		

**HR 94-08-24** “Resolved that the AARC provide the option of direct deposit of state affiliate’s quarterly revenue sharing checks into affiliate’s checking accounts.”

## **PROPOSED REVENUE SHARING WIRE TRANSFER**

### **PROPOSAL**

In the first month of every calendar quarter (JAN, APR, JUL, OCT) the AARC pays to the various state affiliates a portion of the annual dues collected from the AARC membership. This payment, termed revenue sharing, is in the form of a check. Unfortunately, several of the states do not always cash these checks timely which results in an extra effort on the AARC’s part to facilitate the check ultimately clearing the bank. Some state affiliates have suggested using a wire transfer system to send the monies rather than a check. The following analyzes this proposal

### **ASSUMPTIONS**

We have assumed the following givens:

- We will NOT get 100% participation. That’s just reality. Maybe 80 to 90% is reasonable—We don’t know. Written agreements will be needed from the states participating.
- The controller is approved to send the transfers (vs. needing 2 check signers to approve the computer input (avoids disruption, time-consuming and signer availability issues)
- There will probably be several bank account changes or other wire transfer issues (lost transfers, etc.) during the year requiring time, investigation, etc.

### **CURRENT FACTS---**

- Costs are best estimates since most involve people time
- One time costs: \$3,500 (program set-up, testing and implementation)
- Ongoing annual costs: \$3,300 (quarterly data input, ongoing maintenance, bank transfer fees). Since participation is not 100%, uncashed check issue will not be eliminated. Consequently, more time will be spent and we will be less efficient utilizing two different payment systems.
- **PER-TRANSFER INTERNAL COST & SUGGESTED SOCIETY PRICING**
  - **Projected direct cost per transfer: \$22.35** (annual + one time cost spread over 3 years).
  - Given this cost, **I suggest a SOCIETY per transfer charge of at least \$25 to cover cost + contingencies.**
  - **KEEP IN MIND, this Society charge assumes a high level of participation. If it is less than 80-90%, the charge will need to increase to cover the fixed costs.**
  - The cost is as high because of low volume. Typically, transfer systems have much higher volumes (far more than 200 / year) justifying implementing this infrastructure.
- States that do not cash their checks timely are few. Of the 36 replacement checks sent in 2008, 22 went to four states (IL-5, HI-8, NJ-3, WV-6).
- Not counting the recently issued January 2009 checks, we only have 13 checks outstanding totaling about \$19,700 as of today---3/15/09, of which only 5 checks totaling \$5,247 are over one year old—the oldest being 4/07. Counting the 1/09 checks we have a total of 31 checks for \$43,300 outstanding at 3/15/09.
- Under current manual system, annual costs to follow up and reissue checks, based on 2008 re-issues, is \$1,350 or 40% of ongoing cost for transfer system.

At the spring meeting the Executive Office was directed to get feedback from the state affiliates regarding their willingness to support a direct deposit revenue check system. Below are the results:

### **State Affiliate Direct Deposit Survey Results**

A survey was developed on Survey Monkey and all state affiliates were made aware of it by email. This was followed by two reminder emails. The states were given 30 days to reply to the survey.

- 26 out of 50 states responded to the survey (52%)
- 46% were in favor of direct deposit and 54% were not
- Reasons for not wanting included
  - Cost (75%)
  - Prefer a check (25%)
- 32% had changed their bank accounts in the past two years



## HOUSE OF DELEGATES

Reporter: Camden McLaughlin  
Last submitted: 2009-06-29 12:46:03.0

### ***Recommendations***

None

### ***Report***

The House is in full preparation for the upcoming meeting at Marco Island, FL, on July 20-21. Primary focus since March BOD meeting has been in preparation for this meeting. The House Officers met in Dallas after the BOD meeting and most recently via conference call. Our center of attention has related to developing an agenda to assure completion of business with consideration of the goals that we are trying to accomplish.

I have focused on guiding committees on such key issues as nominations and elections related to conflict of interest, AARC Policy and chartered affiliates, and ways to engage the delegates to assure information is being shared with the affiliate boards. The House Officers have been appointed to serve as liaisons to each of the House committees which has proven to be useful with the recent committee charges.

Other House committees have been diligent with respective responsibilities and charges. Of note, Special Recognition committee has provided nominations for Outstanding Contributor Award and a call for Life and Honorary Members. Interestingly, I don't remember a time when there were no resolutions to present. This may be due, somewhat in part, to our emphasis on assuring appropriate resolution development

The agenda is somewhat typical of House summer meetings with the addition of two focused discussion times on *"The 3 PSG Questions"-Results found at the affiliate level, The state affiliate and its relationship with the state medical board, HOD consensus on AARC Budget/Financial review, and Change-Just One Thing*. The delegates were requested, via email in late June, to review these questions and come prepared to discuss and share the results from their affiliate. We look forward to five "affiliate best practice" presentations from the Affiliate Best Practices Committee. These presentations are always well received.

I appreciate the opportunity to serve the AARC and our profession through the House of Delegates. I am grateful for the thoughtful guidance of the AARC Board and President Myers along with the open communication. The monthly conference calls are valuable and time well spent. My thanks to our Executive Office and their diligence and assistance.

### ***Other***

[Insert other information here]

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## BOARD OF MEDICAL ADVISORS

### AMERICAN ASSOCIATION FOR RESPIRATORY CARE

#### Board of Medical Advisors Meeting

June 6, 2009

Grapevine, Texas

#### Agenda

##### Attendance

Kent Christopher, MD, RRT, FCCP, (ACCP) **Chair**  
Robert Aranson, MD (ACCP)  
William Bernhard, MD (ASA)  
Steven Boas, MD (AAP)  
Clifford Boehm, MD, RRT, (ASA)  
Terence Carey, MD (ACAAI)  
Ira Cheifetz, MD, FCCM, FAARC (SCCM)  
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)  
Phillip Marcus, MD, MPH, FCCP, FACP (NAMDRC)  
Richard Sheldon, MD, FACP, FCCP, FAARC (ATS)  
Joseph Sokolowski, MD, EMT-B, FACP, FCCP (ATS)  
Gerald Weinhouse, MD (ATS)

##### Guests

Tim Myers BS, RRT-NPS  
Michael Morris, MD  
Gary Smith  
Sherry Barnhart, RRT-NPS  
Tom Smalling, PhD, RRT  
Gary Gross, MD

##### Absent

Robin Elwood, MD (ASA)  
Russ Acevedo, MD, FAARC, FCCP, FCCM (ACCP)  
Robert Gould, MD (ASA)  
Bradley Chipps, MD (ACAAI)  
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)  
Jeffrey Vender, MD, FCCP (SCCM)  
Barry Fuchs, MD (ATS)  
Phillip Korenblat, MD, FAAAAI (AAAAI)

##### Consultant

Toni Rodriguez, EdD, RRT

##### Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director  
Ray Masferrer, RRT, Associate Executive Director  
Steven Nelson, MS, RRT, FAARC, Associate Executive Director  
Cheryl West, MHA, Director Government Affairs  
Bill Dubbs, RRT, MHA, MEd, RRT, Director Education & Management  
Brenda DeMayo, Administrative Coordinator

#### CALL TO ORDER

Chairman Kent Christopher called the meeting of the AARC Board of Medical Advisors to order at 8:15 a.m. CST, Saturday, June 6, 2009.

Dr. Christopher asked members to introduce themselves.

#### APPROVAL OF MINUTES

Dr. Bill Bernhard moved **“To accept the minutes of the December 14, 2008 meeting of the Board of Medical Advisors as corrected.”**

## **Motion Carried**

### **COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (COARC) REPORT**

Executive Director Tom Smalling, updated members on CoARC activities. He advised that they will elect two AARC representatives to the CoARC Board, a public member and an ACCP representative board member this year along with an at large board member. These positions serve 4-year terms and are allowed up to two consecutive terms. CoARC has received numerous letters from other organizations stating their support of CoARC's separation from CAAHEP which is now scheduled to occur November 11, 2009. CoARC's name will be changed from "Committee" to "**Commission**" on Accreditation for Respiratory Care. They will begin the application process for recognition by CHEA in November and won't have final determination until the end of 2010 whether they will have such recognition. CoARC hopes to finalize its new accreditation standards by their November 12 CoARC Board meeting. CoARC currently has 13 physician site visitors. An MD is only sent as a site visitor if there are physician-related issues at the school being visited. Programs with the "sleep add on" will be required to teach to the SDS specialty exam matrix under the proposed new Standards due to be finalized at the end of the year.

Bill Dubbs reported on data that shows 20% of program directors are "highly likely" to include the "sleep add on" to their program. Dr. Smalling reported that many programs feel adequately prepared to provide graduates to the sleep industry, but the actual percentage of students entering sleep is unknown. He identified a problem in getting adequately trained faculty in add on sleep programs as the pay differential between doers and teachers may make faculty recruitment difficult.

### **MILITARY REPORT**

Col. Michael Morris USA (Ret.) reported that the combined Army/Navy respiratory therapy school at Brooke Army Medical Center in Fort Sam Houston is currently on probation with CoARC citing its failure to meet the 80% threshold for CRT pass rates and not meeting established standards for consortium. They are working on the best consortium agreement terms with a community college and are awaiting contracting. Goals are to make the Associate Degree and NBRC credentialing mandatory. Eight weeks will be added to the curriculum by year's end for this 44-week course followed by a CRT exam. Since the Navy corpsmen have a higher number of credits to enter the program, they are only required to take a 36-week program followed by online credits required for the AD.

BOMA is willing to support advances made regarding warrant officer status at the appropriate time. That time may be after the AARC has obtained passage of the Part B initiative, as this will acknowledge RTs with a baccalaureate degree in the field.

### **NATIONAL BOARD FOR RESPIRATORY CARE (NBRC) REPORT**

NBRC President Sherry Barnhart thanked BOMA for the opportunity to share its updates. They launched the new Specialty Examination for respiratory therapists performing sleep disorder testing and therapeutics intervention at the AARC International Congress in December, 2008. To date they have tested over 70 candidates. The Adult Critical Care Job Analysis survey was mailed in April 2009. Results aren't in yet, but it is expected they will launch this examination in 2011. New test specifications for the CRT Examinations will be implemented in July of this year and in January 2010 for the RRT Examination. The NBRC has tested 16,634 candidates this year compared to 12,489 this

time last year.

Alterations in admission requirements due to moving to entirely 200 level programs are substantive changes. Additionally, CoARC's separation date from CAAHEP makes it somewhat difficult for NBRC in that they will have to revise every application, their website, etc., but this is something that can be accomplished without legal implications. When all programs go to 200 level, it should not affect the CRT designation.

## **RECESS**

Chairman Kent Christopher recessed the meeting of the AARC Board of Medical Advisors at 10:05 a.m. CST, Saturday June 6, 2009.

## **RECONVENE**

Chairman Kent Christopher reconvened the meeting of the AARC Board of Medical Advisors at 10:15 a.m. CST, Saturday June 6, 2009.

## **PRESIDENT'S REPORT**

AARC President Tim Myers reported that he developed 7 goals as President of the AARC and provided updates as follows:

1. AARC recorded its May membership at 49,600 with a goal of achieving 50,000 by the end of this year.
2. The Association fought a proposed law in Tennessee that would go into effect summer of 2010 requiring RTs to enroll in an A-Step program or obtain a second credential. The AARC hired its own Tennessee lobbyist and was able to pass a compromise provision. Our compromise was to have RTs either obtain the RPSGT or obtain the NBRC's SDS credential, or document competency through a mechanism developed by the Tennessee Board for Respiratory Care. This prevented RTs from being required to obtain another credential to practice sleep, not to mention the added expense of the exam.
3. In International activities Mr. Myers stated June 1st was the deadline for international fellowships. The International Committee will select the Fellows at the Summer Forum.
4. 2015 Update – See below “Respiratory Therapy 2015 and Beyond” paragraph.
5. The Continuing Education program at Summer Forum was expanded.
6. Networking: The Association received a support letter from ACCP and NAMDRC for AARC's position on sleep legislation. AARC has also received support letters for the Part B Initiative from ATS, ACCP and NAMDRC.
7. Post Graduate Training: A new Committee was developed this year under the direction of Past President Toni Rodriguez entitled Fast Track Leadership Institutes which is a mentoring tool designed to expand upon education, research, and management to create leaders in the Association as current aging leaders retire. This program consists of the Core course which includes all competencies needed and will be a pre-requisite to the education, research and management tracks. A Certificate of Completion will be issued. The Association hopes to integrate it into institutes of higher learning. Esteemed leaders of the Association Linda Van Scoder, Rick Ford and Rob Chatburn, were hand-picked by Ms. Rodriguez to develop and lead the three tracks.

## **RESPIRATORY THERAPY 2015 AND BEYOND**

Dr. Woody Kageler, a member of the 2015 Planning Committee and co-chair of the 2nd

and 3rd conferences, provided a project activity update. He reviewed the goals of the project which are to identify the knowledge, skills and attributes required of respiratory therapists to add value in the future healthcare system. This is to be achieved by holding 3 conferences. The first conference was held in March 2008. The proceedings of that conference were published in the March 2010 edition of Respiratory Care and described a vision of the future healthcare system and what respiratory therapists would be doing within that system. The second conference was held in April 2009. This conference reviewed in depth several of the respiratory therapist roles brought forth in the first conference and through a group process involving the attendees identified specific competencies required of respiratory therapists to fulfill the previously described roles. These competencies will be finalized after they are reviewed by the conference participants using a web-based survey instrument during late June. These competencies will likely appear as an appendix in the peer-reviewed paper that reports the proceedings of the second conference. Finally, a third conference to examine how to address specialty credentialing and describe the educational systems required to facilitate the acquisition of the required competencies will be held in early 2010.

## **RECESS**

Chairman Kent Christopher recessed the meeting of the Board of Medical Advisors at 11:20 a.m. CST, Saturday June 6, 2009.

## **RECONVENE**

Chairman Kent Christopher reconvened the meeting of the Board of Medical Advisors at 11:50 a.m. CST, Saturday, June 6, 2009.

## **GUEST PHYSICIAN**

Dr. Gary Gross was introduced who sat in for Dr. Korenblat who was unable to attend this meeting.

## **EXECUTIVE OFFICE REPORT**

Sam Giordano reported that the last few years the Association has enjoyed record-breaking membership numbers, and it is hoped that it will reach 50,000 this year.

### **Asthma Educator Course**

He advised that graduate pass rates are significantly higher for the asthma educator course. This course was produced in a studio and is now in the post-production process which will eventually go online. The COPD Foundation educator course, currently a beta course, was held on May 6 prior to the Florida Society annual meeting. Response was good, and it will also go online eventually.

### **Ambulatory PTAC**

The AARC was invited to have representation on the JCAHO ambulatory services PTAC for which the AARC is now represented on three PTACs. The Mobile Spirometry Unit (MSU) continues to thrive and we're always looking for venues such as VFW and American Legion, in which to set up its spirometry unit to get the word out to the approximately 12 million undiagnosed Americans.

### **Aerosol Guidelines Booklet**

Mr. Giordano advised that AARC developed an aerosol devices guidelines booklet aimed at RTs (technical with diagrams), but recently revised it and will be available within a month on the AARC website. This is a public service and therefore anyone can

download this booklet. We will also have a booklet for patients, and another one for therapists, pharmacists and nurses that we hope to release this fall.

#### Office-Based Spirometry

Steve Nelson reported that AARC was asked to develop a certificate of achievement for simple office-based spirometry. NBRC has received the initial test items and they are being reviewed. We hope to distribute it by October. We'll put the training outline online so anyone can offer the education. Students must take a test and then show they can successfully perform patient testing. They will return home with a one-year certificate. A year later they will be required to repeat the 10 tracings and upon passing will be issued an updated certificate of completion. Discounts on membership will be offered to physician assistants and medical assistants and other organizations that help with marketing.

#### Benchmarking

Bill Dubbs addressed the extremely negative impact the current economy is having on the financial health of hospitals. He stated that personnel cuts are generally a target for cost savings. Thus it is particularly important that respiratory therapy managers have evidence that the number of staff they have is appropriate for the scope of service. He described how the AARC Benchmarking System for acute care hospitals that allows managers to compare their staffing levels to similar hospitals and develop best practice. He stated that the current free trial period which is open through August 31 allows the managers to "test drive" the system for two months. Finally, he encouraged all BOMA members to make their department directors aware of this opportunity.

#### CONCERT

Mr. Giordano attended a new project sponsored by AHRQ and NHLBI entitled COPD Outcomes Based Network for Clinical Effectiveness Research and Translation (CONCERT). This two-year project is working toward improving chronic COPD management and COPD care coordination. One of the presenters at this meeting stated that the Canadian government hired RTs to make home visits and found it to be cost effective.

#### Home Oxygen

AARC, ATS, NAMDR, ACCP and ALA among other organizations were invited to participate in the Coalition for Oxygen Reform, a group led by manufacturers of HME oxygen devices and AA Homecare. We were invited as clinical advocate groups, however other groups have been in attendance representing industry. The Payment Working Group participated in a conference call recently and Sam received permission to share a document with BOMA from this conference call which was distributed to members.

#### Ventilator Survey

AARC was asked by the Department of Homeland Security to conduct a vent survey in the U.S. in an attempt to count vents in acute care facilities. A budget for this project was completed this week and we intend to complete the project this summer. Dr. Lewis Rubinson is the lead person on this project. There are 6200 hospitals in the U.S. including acute care, long term care, and critical care to be surveyed.

#### Sleep Apnea

Mr. Giordano stated that an ad hoc working group of which Dr. Paul Selecky was a member regarding CPAP and sleep disorders, has finalized a document that should be issued soon which will encourage better compliance in sleep apnea.

### **LEGISLATIVE AFFAIRS**

Director of Government Affairs Cheryl West stated the Medicare Respiratory Therapy Initiative may be added to the health reform legislation that both parties want. Support documents from NAMDRRC, ATS and ACCP have been received. There is support for the bill in the House to include our provision in any health reform legislation. Greater effort needs to be made to increase Senate support. It will take approximately 8 more weeks to hammer out the health reform issue.

She advised that AARC was able to reach a compromise in Tennessee regarding the sleep issue after Sam Giordano made 5 different trips to the Tennessee legislature. Virginia and Kentucky may have to address the difficult sleep issue. BOMA was asked to advise AARC of any physicians in these states willing to assist the AARC in our efforts to keep the integrity of the RT license.

World COPD Day will occur in November. The AARC wants to encourage people to go to state capitols and set up booths for peak flow, spirometry and education aimed at lawmakers and their staffs.

Last year Congress enacted a pulmonary rehab Medicare benefit which will be implemented January 1, 2010. This will be a very significant opportunity for the RT.

## **RECESS**

Chairman Kent Christopher recessed the meeting of the Board of Medical Advisors at 1:25 p.m. CST, Saturday June 6, 2009.

## **RECONVENE**

Chairman Kent Christopher reconvened the meeting of the Board of Medical Advisors at 1:40 p.m. CST, Saturday June 6, 2009.

## **MEDICAL ADVISOR REPORTS**

### **ACCP**

Dr. Aranson advised of a position paper coming out soon with other sister organizations on the role of respiratory care related to the care of donor lungs to recipients.

### **ATS**

Dr. Sheldon continues to urge his state of California to adopt ultrasonography.

### **ASA**

Dr. Boehm stated that aside from his role as the liaison to the Surface and Air Transport Section, he has also been asked to chair the new Hyperbaric Roundtable with 30 members actively contributing on the Hyperbaric Listserv. He intends to give a presentation on the clinical and management aspects of the respiratory therapist at the 2010 AARC Annual Congress.

## **UNFINISHED BUSINESS**

Dr. Christopher pointed out that following Robert McCoy's presentation on home care at the previous meeting, the concept of a small conference meeting on long-term oxygen therapy was presented to the AARC Board and has been referred to the Program Committee for their consideration.

Dr. Phillip Marcus will replace Dr. Jay Peters as medical advisor to the Continuing Care Rehab Specialty Section, and Dr. Robert Aranson will replace Dr. Cliff Boehm as

medical advisor to the Surface and Air Transport Specialty Section.

## **NEW BUSINESS**

### **Women on BOMA**

Dr. Christopher asked for input on encouraging women to join the Board of Medical Advisors.

### **AARC Membership and BOMA**

Dr. Christopher referred members to the BOMA Organizational Document B 5 which states that “BOMA members should be members of the AARC.” After much discussion, it was decided that this issue would be brought before the AARC Board under the BOMA Chair’s report at the summer meeting as any AARC BOD decision could potentially require a bylaws change in the area of categories of membership. The issue was that physicians are currently classified as associate members and it was suggested that this should be revised to include a new physician category.

### **Conflict of Interest**

President Tim Myers discussed the potential for conflict of interest issue which has resurfaced recently across healthcare. The AARC is re-evaluating its current position and documents on this timely topic. Discussion regarding potential conflict of interest regarding BOMA ensued.

Dr. Aranson moved **“To adopt the following language for BOMA’s Conflict of Interest statement and to include it in the BOMA Organizational Document:**

**Each BOMA member must disclose the nature and extent of any relationships or interests in activities that pose an actual or reasonably perceived conflict of interest relevant to that topic.”**

### **Motion Carried Unanimously**

### **BOMA Attendance**

Dr. Christopher reminded members that the BOMA Organizational Document outlines the position of BOMA regarding absences. He will contact members who have had excessive absences in recent years noting his concern and reminding them the document requires action as follows:

**A 4d:** Any member whose attendance at a regularly scheduled meeting is unsatisfactory (usually considered to be absence from two consecutive meetings) as determined by the Chairman and the member’s sponsoring society, will be replaced by the sponsoring society. The replacement shall serve the remainder of the term of the representative being replaced. The replacement will be eligible for nomination in accordance with the foregoing paragraph “c”.

Paragraph “c” states:

Any vacancy on BOMA shall be filled by the absent member’s sponsoring organization. Replacement appointees will complete the original term of office, and are eligible for re-nomination by the sponsoring organization for another full term.

### **BOMA Representatives**

BOMA urges sponsoring organizations to continue to educate potential new representatives regarding commitments as defined in the BOMA Organizational



Document. The updated BOMA Organizational Document will be sent to sponsoring organization Presidents and Executive Directors by the AARC administrative staff.

BOMA members offered their continued support of their sponsoring organizations by assisting in identification of candidates for open BOMA positions. BOMA members also expressed their availability in answering any questions or concerns identified by candidates under consideration by the sponsoring organization.

#### Presentations at Winter BOMA Meeting

Dr. Christopher advised that he invited Dr. Hector Garza from Mexico to speak at the next BOMA meeting about the international perspective of respiratory care and organizing a respiratory therapy department. Also invited are Jerome Sullivan (International Council) and John Hiser (International Committee).

Dr. Christopher will also ask the Chair of the Neonatal Pediatric Section, Brian Walsh, and BOMA member Dr. Ira Cheifetz to speak on the activities of that section.

#### **ELECTION OF 2011 BOMA CHAIR**

Dr. Richard Sheldon moved “**To nominate Dr. Joseph Sokolowski as the BOMA Chair for the 2011 ATS rotation.**”

**Motion Carried Unanimously**

#### **BOMA MEETING AT 2009 INTERNATIONAL CONGRESS**

The next BOMA meeting will be held in San Antonio on Sunday December 6, 2009 with the reception the evening prior.

#### **ADJOURNMENT**

Chairman Kent Christopher adjourned the Board of Medical Advisors meeting at 2:30 p.m. CST, Saturday June 6, 2009.

## PRESIDENTS COUNCIL

Reporter: Dianne Lewis  
Last submitted: 2009-06-22 13:14:46.0

### *Recommendations*

#### **Recomandations:**

**•1. That the AARC Board of Directors approve the position description for the AARC historian.**

Justification: The Immediate Past President and current AARC President requested the Presidents Council develop a position description for the Association's historian. The following position description was reviewed at the December 2008 business meeting of the Presidents Council as well as reviewed on the Presidents Council listserv in Spring 2009.

The Presidents Council recommends that compensation for the Historian be considered.

#### AARC Historian

The duties of the AARC Historian should include, but not be limited to the following:

- Schedule, conduct, record, and archive interviews with the AARC President, HOD Speaker, key Executive Office staff, key award recipients, and others as warranted by issues and projects.
- In conjunction with the Executive Office, archive materials annually such as the officary, staff directory, summary of relevant issues and trends, press releases, and photos of key events.
- Preserve and maintain archived materials in a secure location with ease of retrieval.
- Update and maintain a living history of the association to reflect milestones, challenges, and successes.
- Develop and maintain an updated presentation highlighting the history of the AARC.
- Provide content for articles and researchers upon request per Association policy.
- In conjunction with the Executive Office, develop and maintain a database to include rosters of elected officers, directors, committee chairs and members, Executive Office staff roster, and photos.
- Travel to the Executive Office and designated association meetings as requested.
- Submit reports as requested.

The Historian will need:

- access to a digital "camcorder" with multiple memory cards.
- a scanner to archive non-digitized photos and documents.
- computer with compatible versions of software such as Access for development of the database and software for photo editing.

- access to secure, climate controlled space if the expectation is to store hard copies of materials OR rental of backup server space if everything is digitized---plus allowance for updates as new technology emerges.
- an annual travel budget for trip(s) to Executive Office, International Congress to conduct interviews, obtain materials, coordinate databases.

The Historian should:

- be an AARC member for a minimum of 20 years.
- **2. That the AARC Board of Directors investigate the feasibility of creating a "virtual museum" for the Association and the profession of respiratory care.**

Justification: At the December 2008 business meeting of the Presidents Council, concerns were raised regarding the preservation of and accessibility to archived documents, videos, and photographs of significance to the Association's history. Concerns were expressed regarding storage, formats, and back-up of materials of historical significance.

The idea to create web access to digitized images of historical materials of the Association and the profession was discussed. The Presidents Council recommends that key historical documents, photographs, interviews and other materials be converted into appropriate electronic formats and could be linked to an expanded and enhanced "Timeline and History" portion of the AARC website-thus creating a "virtual museum."

An example of a virtual museum can be found at the ASA's Wood Library Museum website: <http://www.asahq.org/WLM>

- **3. That the AARC Board of Directors investigate the feasibility of creating and sustaining a museum for respiratory care in proximity to the AARC Executive Office.**

Justification: The Presidents Council recommends that the costs to establish and maintain a museum of respiratory equipment, documents and photos be investigated and recommends that if such a museum were to be established that it be located in the same general location as the AARC Executive Office.

Report

The emphasis of these recommendations is that the Presidents Council is concerned about preserving the AARC's history and finding a safe place to store and back up materials. Several Council members are willing to start scanning, tagging and organizing documents.

I would like to thank Trudy Watson for developing and organizing this project.

[Insert report here]

***Other***

[Insert other information here]

# ***Standing Committee Reports***

## AUDIT SUBCOMMITTEE

Reporter: Thomas Lamphere  
Last submitted: 2009-06-29 12:30:45.0

### *Recommendations*

None.

### *Report*

Audit reviewed during 1st quarter. Recommendation made to provide report to AARC Board of financial investment strategy on defined, regular basis will be discussed further at 2nd quarter meeting.

## BYLAWS COMMITTEE

Reporter: Keith Siegel  
Last submitted: 2009-06-18 17:20:15.0

### *Recommendations*

**Recommendation #1:** The AARC Board of Directors accept the AARC Bylaws Committee's recommendation for approval of the Arkansas Society for Respiratory Care's Bylaws.

**Justification:** The Arkansas Society for Respiratory Care (ASRC) has submitted Bylaws changes for review by the AARC Bylaws Committee. The AARC Bylaws Committee has carefully reviewed the proposed changes to the ASRC bylaws and determined that the changes are in compliance with the AARC bylaws, and there are no conflicts.

**Recommendation #2:** The AARC Board of Directors accept the AARC Bylaws Committee's recommendation for approval of the Connecticut Society for Respiratory Care's Bylaws.

**Justification:** The Connecticut Society for Respiratory Care (CTSRC) has submitted Bylaws changes for review by the AARC Bylaws Committee. The AARC Bylaws Committee has carefully reviewed the proposed changes to the CTSRC bylaws and determined that the changes are in compliance with the AARC bylaws, and there are no conflicts.

**Recommendation #3:** The AARC Board of Directors accept the AARC Bylaws Committee's recommendation for approval of the Florida Society for Respiratory Care's Bylaws.

**Justification:** The Florida Society for Respiratory Care (FSRC) has submitted Bylaws changes for review by the AARC Bylaws Committee. The AARC Bylaws Committee has carefully reviewed the proposed changes to the FSRC bylaws and determined that the changes are in compliance with the AARC bylaws, and there are no conflicts.

### *Report*

In addition to reviewing the state society bylaws listed above, the AARC Bylaws Committee also reviewed and recommended passage of the Louisiana Society for Respiratory Care (LSRC) proposed bylaws changes. The AARC Board of Directors approved the LSRC bylaws at its March, 2009 board meeting.

Plan: The Bylaws Committee will review state society bylaws as necessary, and make recommendations per committee charge.

Action: Ongoing

### *Other*

I would like to thank my committee for their invaluable help in carrying out our charge: Joe Horn, Doug McIntyre, Bill Lamb, George Gaebler, and Toni Rodriguez. I would also like to thank Sherry Milligan and Tina Sawyer for their help and guidance.

Finally, I want to thank Pat Lee. I know she has retired, but I've always wanted to publicly thank her for her years of friendship and support to the HOD. Thanks Pat!

**EXECUTIVE COMMITTEE**

## FEDERAL GOVERNMENT AFFAIRS

Reporter: Frank Salvatore  
Last submitted: 2009-06-22 12:53:10.0

### ***Recommendations***

[None]

### ***Report***

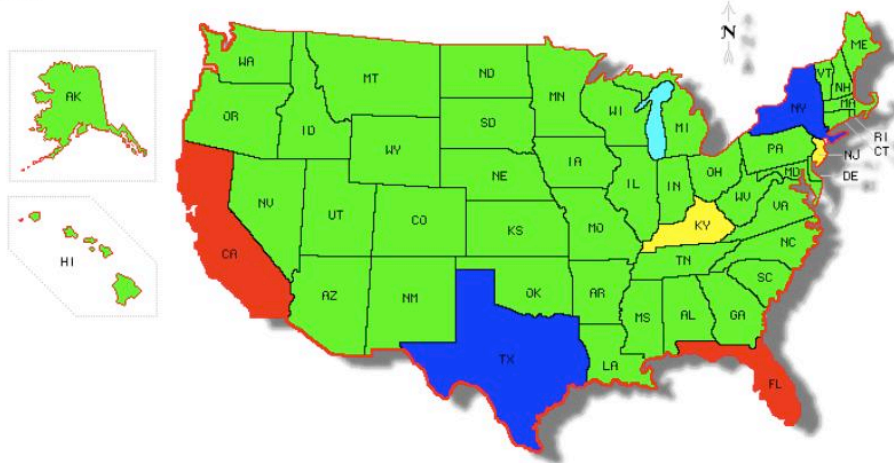
1. Continue implementation of a 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts.
  - a. Ongoing - we have used the 435 plan once since the March BOD meeting. We continue to work on shoring up the plan so that there is better communication between the PACT chairs and the members of the 435 plan in each state. Attached to this report is the current 435 plan map (435 Plan Update - July 2009.gif).
2. Work with PACT coordinators, the HOD and the State Governmental Affairs committee to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care.
  - a. Ongoing - attached is another map and excel spreadsheet that will allow you to visualize just how the communication within the states is doing. The map looks at the percentage of people writing to Congress using Capitol Connection versus the AARC Active Membership in each state. The excel document shows you the total number of messages from the states and is sorted by most to least. This is where I get the top 25 list.
3. Assist in coordination of consumer supporters.
  - a. Ongoing - was on a conference call with AARC and patient group in order to coordinate how to integrate the patient activists with the AARC 435 plan.

### ***Other***



435 Plan Update

- - 100%
- - 75% to 99%
- - 50% to 74%
- - 0% to 49%

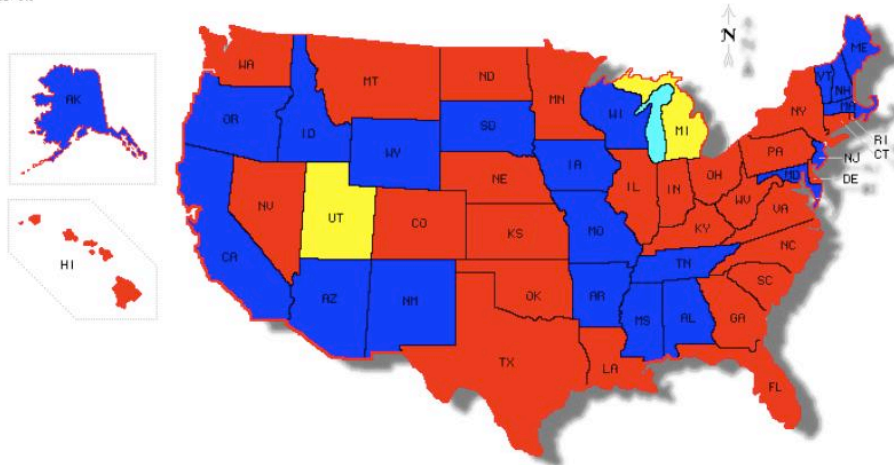


NOTES:  
 This map is updated for the March 2009 call for an update from the AARC PACT Committee Chairs for each state society.

6-22-09

Capitol Connection Messages - % of activists vs. Active AARC Members

- - 25% to 49%
- - 10% to 24%
- - 0% to 9%



NOTES:  
 This map is looking at the number of individual activists versus the total number of Active AARC Members in the state.

6-22-09



Activist State	E-mail	Printed	Total Activists	Total Advocacy Messages	AARC Active Members	% Activists vs. AARC Active Members
PA (Pennsylvania)	2091	60	617	2151	3480	17.7%
OH (Ohio)	743	38	293	781	1817	16.1%
NC (North Carolina)	741	33	259	774	1457	17.8%
NY (New York)	581	175	256	756	2373	10.8%
MI (Michigan)	707	17	261	724	911	28.6%
IL (Illinois)	646	69	237	715	1071	22.1%
GA (Georgia)	671	16	244	687	1521	16.0%
FL (Florida)	654	12	252	666	1891	13.3%
IN (Indiana)	595	17	212	612	1186	17.9%
TX (Texas)	484	7	186	491	1615	11.5%
CT (Connecticut)	438	2	132	440	650	20.3%
WA (Washington)	411	8	142	419	901	15.8%
CA (California)	379	14	145	393	2452	5.9%
VA (Virginia)	385	3	130	388	1121	11.6%
LA (Louisiana)	326	27	117	353	796	14.7%
NJ (New Jersey)	330	8	121	338	1771	6.8%
KS (Kansas)	278	7	84	285	555	15.1%
SC (South Carolina)	240	4	101	244	676	14.9%
UT (Utah)	213	6	81	219	249	32.5%
MO (Missouri)	212	5	80	217	1189	6.7%
CO (Colorado)	189	16	71	205	567	12.5%
MN (Minnesota)	131	71	78	202	496	15.7%
TN (Tennessee)	180	0	62	180	743	8.3%
KY (Kentucky)	175	4	75	179	432	17.4%
WI (Wisconsin)	152	10	66	162	717	9.2%
OK (Oklahoma)	160	0	59	160	431	13.7%
MA (Massachusetts)	156	2	60	158	797	7.5%
MD (Maryland)	151	6	59	157	855	6.9%
WV (West Virginia)	144	9	44	153	262	16.8%
AZ (Arizona)	142	11	57	153	783	7.3%
MT (Montana)	133	0	40	133	221	18.1%
AR (Arkansas)	131	0	57	131	613	9.3%
OR (Oregon)	120	1	36	121	376	9.6%
NE (Nebraska)	117	3	41	120	408	10.0%
AL (Alabama)	106	6	43	112	629	6.8%
ND (North Dakota)	107	1	33	108	284	11.6%
DE (Delaware)	99	4	38	103	231	16.5%
MS (Mississippi)	95	8	35	103	391	9.0%
HI (Hawaii)	92	1	21	93	173	12.1%
NV (Nevada)	80	0	29	80	213	13.6%
IA (Iowa)	80	0	31	80	327	9.5%
NM (New Mexico)	76	3	25	79	272	9.2%
RI (Rhode Island)	64	0	24	64	189	12.7%
SD (South Dakota)	61	0	18	61	228	7.9%
ID (Idaho)	56	0	20	56	243	8.2%
NH (New Hampshire)	47	1	13	48	290	4.5%
ME (Maine)	37	2	11	39	157	7.0%
VT (Vermont)	28	0	10	28		
WY (Wyoming)	22	0	8	22	105	7.6%
AK (Alaska)	3	0	1	3	44	2.3%
PR (Puerto Rico)	2	0	2	2	22	9.1%
VI (Virgin Islands)	2	0	1	2		
DC (District of Columbia)	2	0	2	2		

## **FINANCE COMMITTEE**

## **JUDICIAL COMMITTEE**

Reporter: Patricia Blakely  
Last submitted: 2009-05-29 14:47:35.0

### ***Recommendations***

There are no committee recommendations at this time.

### **Report**

The Chair has received one inquiry from an affiliate regarding the procedure for submitting a complaint. Copy of the P&P provided. No further communication has been received. The Chair reminded the inquirer that if the state affiliate has a Judicial Committee, that they should refer to their affiliate Judicial Committee first unless this poses a conflict of interest.

No other actions for the committee since the last BOD report.

### ***Other***

## **PROGRAM COMMITTEE**

### **AARC Activity Report Summer, 2009**

Report submitted by: Michael Gentile, RRT, FAARC  
Program Committee Chair

#### Charges:

1. Prepare the Annual Congress Program:  
Status: The program is in the final stages of confirming speakers. A significant challenge was to select only some of the many high quality proposals by the AARC Sections and members, as the number of submissions far exceeded available time and space. The program contains content from all areas of respiratory care and offers something for all attendees. We are also very grateful for your support and trust to the Program Committee.
2. Develop and design the program for the annual congress to address the needs of the membership regardless of area of practice or location. Assure educational opportunities for other health care related practitioners.  
Status: After reviewing over 300 proposals for almost 750 presentations, I can honestly say I feel we have met this goal. You will see a wide variety of topics for a wide variety of practitioners included in the agenda for the Congress.
3. Recommend sites for future meetings to the Board of Directors for approval.  
Status: We are presently looking for various sites and dates for future meetings. Dates in November are in line with our agreement with the AARC Board that we will seek dates other than December when considering future sites.

## **STATE GOVERNMENT AFFAIRS**

Submitted by email

Thomas McCarthy, RRT

The issue of Polysomnography continues to dominate the agenda in this arena. Resources continue to be utilized to address this issue, especially in several States where Polysom legislation that would shrink the scope of practice for RCP's has been proposed or is moving forward."

A concerted effort to defend the practice of Respiratory Care and maintain appropriate levels of care for patients has been initiated in each of these States by the AARC. Resources will continue to be utilized for this purpose.

The State Government Affairs Committee also reviewed and approved a loan/grant application submitted by the Minnesota Society for Respiratory Care. The loan/grant was to financially support the successful efforts by the MSRC to upgrade their RT registration law to full RT licensure.

## STRATEGIC PLANNING COMMITTEE

Reporter: Toni Rodriguez  
Last submitted: 2009-06-24 17:56:56.0

### ***Recommendations***

None

[Insert report here]

Per approval of President Myers, no report will be submitted until a summary of the 2nd **2015 Conference** is released. The findings of this conference will have significant impact on the future AARC Strategic Plan.

Toni L. Rodriguez Ed.D, RRT, Immediate Past President AARC

### ***Other***

[Insert other information here]

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# ***Specialty Section Reports***

## ADULT ACUTE RESPIRATORY CARE

Reporter: Michael Hewitt  
Last submitted: 2009-06-05 10:41:16.0

### *Recommendations*

[Insert recommendations here]

### *Report*

**Membership in the section remains stable. The listserv continues to be active, with pertinent discussions to adult acute care. The section is actively engaged in the implementation of Membership in the section remains stable. The listserv continues to be active, with pertinent discussions to adult acute care. The section is actively engaged in the implementation of a swap shop for the section website, similar to those in other sections. We have identified 4 individuals within the section to help review submissions before posting and have the support of and help of our medical liaison, Dr. Russ Acevedo. As we approach the Annual COngress in December, efforts will begin to solicit interested parties in succeeding me as Section Chair at the 2010 Congress in Las Vegas.**

## CONTINUING CARE-REHABILITATION

Reporter: Debra Koehl  
Last submitted: 2009-06-24 11:01:17.0

### ***Recommendations***

No recommendations at this time.

### ***Report***

- Am pleased that we are doing a mini how to do pulmonary rehabilitation at the Congress in December.
- We are all anxiously awaiting the new NCD on pulmonary rehabilitation and I expect lots of conversations and list serve activity when that draft is released.
- I have put out to the list the idea of a mid year web conference. I have not heard any responses.
- I have completed newsletters, articles and e-news letters for Deb Bunch as required.
- I have had discussions with other pulmonary rehab professionals about the tool kit for pulmonary rehab programs. Anticipate getting this project off of the ground before the end of the year.
- I am in the process of updating our section information on the AARC web page.
- I will be attending the AACVPR National Conference in October to represent the AARC. I anticipate very lively conversation about the new NCD.

### ***Other***

- I have been elected vice-president of the Indiana Society for Cardiovascular and Pulmonary Rehabilitation. They have wanted more representation from the RRT and pulmonary rehabilitation profession. I also sit on the state reimbursement and MAC committee as the pulmonary professional. This has allowed me to represent both RRT's, the AARC as well as pulmonary rehabilitation.

## DIAGNOSTICS

AARC Activity Report  
Summer, 2009

**Chair: Melynn Wakeman**

**Liaison: Carl Mottram**

**Recommendation #1:** That the Board of Directors approve the Diagnostic Section the ability to raffle two free attendance to the 55<sup>th</sup> Congress in San Antonio Texas. The raffle would be offered to educators of Pulmonary Diagnostics or Respiratory Care.

**Justification:**

By offering free attendance to Educators in these tough economic times would increase attendance. Educators are absolutely essential in raising the bar of our profession through distribution of the latest technologies and procedures presented through the AARC conference.

**Recommendation #2:** That the Board of Directors offers a mentoring program for newly appointed Chairs.

**Justification:**

By offering a mentoring program for all newly appointed Chairs, efficiencies will be created and a higher success rate will be achieved.

**Charges:**

Create a marketing plan for offering free attendance to the 55<sup>th</sup> Congress for two Educators.  
Create a policy and procedure for adding experienced mentors to assist newly appointed AARC chairs.

## EDUCATION

Reporter: Lynda Goodfellow  
Last submitted: 2009-06-01 15:31:26.0

### ***Recommendations***

[Insert recommendations here] No recommendations at this time.

### ***Report***

[Insert report here]

As Education Section Chair, I attended the 2015 Conference in April and presented "Delivery of Respiratory Therapy by Protocol." Related to charges of the section, 1. Summer forum program planning is complete. 2. The Spring issue of the Section Bulletin included "Notes from the Chair" and a job description was published for an Associate Editor for the Education Annual. An associate editor is needed to assist and to be mentored by the current editor. A new Associate Editor of the Bulletin, Robert Fluck, will begin with the Summer issue. 3. Lively communication through discussions is taking place on the list serve. Ten to fifteen topics per month have circulated on-line. 4. The Section web pages are being reviewed with older items being archived or removed, while new links and web resources were added. 5. A sub-committee was formed to discuss strategies for recruitment directed at advanced standing candidates as well as high school and military personnel. Draft recruitment strategy to be included for next BOD meeting.

### ***Other***

## HOME CARE

Reporter: Robert McCoy  
Last submitted: 2009-06-26 15:41:46.0

### *Recommendations*

None

### **Report**

Home Care section report

Home oxygen therapy, with home respiratory care closely following, is continuing to be a challenge. The federal budget is the focal point of significant changes in health care. CMS continues to target home oxygen as an opportunity to reduce payment with their point being that the equipment is relatively inexpensive and service is only required for delivery, maintenance and filling of portable oxygen.

The 36 month rental cap started in January of 2009 and the impact is still not clear as only rumors are available regarding RT staffing, DME business discontinuing service and economic options to service patients after the cap. Competitive bidding is still an option and is being considered for 2011 if not sooner. Home care providers are required to be accredited by the end of the year and a \$50,000 surety bond will be required by this October. All these issues focus on the delivery of home oxygen therapy and do not address home respiratory care or effective therapy that is expected by the physicians and patients. Cheryl will have a more in-depth report.

Respiratory therapists working in home care are being impacted and one of the larger providers, Walgreens, has eliminated several of their top therapists. More cuts in home care clinical staff are likely due to the need to reduce expense and there is a lack of clinical requirement for an RT to be on staff to delivery equipment.

Several options are available to address this issue. AA Homecare is attempting to move oxygen out of the DME equipment category and place in a service category. There are also attempt to eliminate the 36 month cap and the competitive bidding option. The AARCs position is to have therapist work under the physician's service as a physician extender. All or any of these would be better than the path home respiratory care is currently on.

Unfortunately, there are many opinions on home respiratory care, yet little evidence on the benefits a professional respiratory therapist provides, plus there is a lack of consistency in home respiratory services provided due to the lack of science, standards of practice and consistent clinical guidelines.

### **Plan**

I will be working with several specialty sections to help with the understanding of issues impacting home respiratory care. The goal is to raise awareness of how respiratory service, products, staff and economic issues impact a patient's care when they leave institutional care. Respiratory therapists should help their patients' transition from one service area to another. Education can help both the patient and the therapist understand and prepare for the move to

another treatment area. Hospital and rehabilitation therapist need to become more involved in a patients move to the home. The term seamless respiratory care could mean that the level of care does not change when the patients moves. Respiratory care should be the same everywhere and the goal of working with the different specialty sections is to determine how their skill and expertise could assist in the continuity and quality of care when the patient moves. More detail will be presented at the December BOD meeting.

***Other***

[Insert other information here]

## **LONG TERM CARE**



## MANAGEMENT

Reporter: Douglas Laher

Last submitted: 2009-06-23 16:54:41.0

### ***Recommendations***

[Insert recommendations here]

### ***Report***

1. Spring Bulletin distributed to section members on May 7, 2009. Articles specific to "Empowering Students", using "Delegation" as a tool to reduce stress at work, and "Work Life Balance" were highlighted. Managing editor; Roger Berg has already secured articles for the Summer Bulletin. Newsletters for March, April, and June have already been disseminated. There was a clerical oversight in the executive office that prevented the distribution of the May newsletter; however that information was included in the June newsletter.
2. Section chair continues to work with the Pinnacle Ad-hoc Committee in developing a survey to be posted on the Management List Serve. A preliminary survey was forwarded to the EC for approval; however changes were recommended. Revisions have been made, the committee to meet in Marco Island, and survey to be re-submitted to EC at Summer Forum.
3. All existing Swap Shop files continue to be re-examined for timeliness, appropriateness, relevance, and support evidence-based practice. Two new files (submitted by Roger Berg and Bill Cohagen) have been accepted for inclusion since last BOD meeting. Solicitation for Swap Shop submissions was sent via the Management List Serve on June 23, 2009.
4. Networking via the Management List Serve continues to generate roughly 40-50 new threads per day; of which 6-8 are new postings.
5. Thus far, two nominations have been submitted for the Specialty Practitioner of the Year Award. A thread was submitted via the Management List Serve on June 18, 2009 reminding section members of the award and the deadline for submission of August 31, 2009.
6. One EC approved survey was posted on the Management List Serve by The Ohio State University on current airway clearance practices. Results of survey to be shared with section members in July. Two additional surveys have been formally submitted. Feedback for enhancements has been given and will be reviewed by the EC for approval.
7. In lieu of the current economic crisis, The Best Practice Depot was created as a membership benefit in May, 2009. This tool allows section members to share operational and clinical best practices to reduce costs. An email blast was sent via the Management List Serve on May 27, 2009 to promote the release of this innovative tool. Four "Best Practices" have thus far been shared.
8. Email threads were posted via the Management List Serve on June 9<sup>th</sup> and June 19<sup>th</sup> soliciting attendance at the 2009 Summer Forum in Marco Island, FL. Email communication was also sent to all Ohio respiratory therapists soliciting the same on June 22, 2009.
9. As of June 1, 2009 there were a total of 1842 members in the AARC Management Section.
10. All charges are on track with the expectation that 100% compliance will be met by year-end.

### ***Other***

[Insert other information here]

## NEONATAL-PEDIATRICS

Reporter: Brian Walsh  
Last submitted: 2009-06-29 16:15:51.0

### ***Recommendations***

No recommendations at this time.

### ***Report***

In addition to my charges, I worked with Ray and the program committee to establish the Pediatric for Educators and Managers Course at the Summer Forum. In preparation for this course we conducted a survey that was well received.

### ***Other***

**SLEEP**

## SURFACE AND AIR TRANSPORT

Reporter: Dawn Filippa  
Last submitted: 2009-06-26 10:25:56.0

### ***Recommendations***

[Insert recommendations here]

### ***Report***

**Previously submitted Recommendation:** That the AARC create a position statement on the use of respiratory therapist at a minimum be involved in the transport of a ventilated acute critically injured or ill child.

**Justification:** There is always the threat that transport programs will replace transport RT's with paramedics. One of the basic concepts of neo/peds transport is to bring a higher level of care (equal to the receiving unit) to the patient. The most common NICU/PICU staffing model is with RN's and RT's. The AAP (American Academy of Pediatrics) Guidelines state that it is the skills, not the credential that should be considered in specialty team composition. RT's are vital for airway and ventilator management. We are needed because we concentrate on these things day in and day out, making us specialists.

### **Working with Position Statement Committee for Summer Forum 2009**

**Previously submitted Recommendation:** "That the AARC establishment of a formal liaison with the Association of Air Medical Services (AAMS)". This recommendation was referred to President Rodriguez for consideration to appoint in January of 2008 was ruled out of order as the Executive Office is already working on this.

**Justification:** The transport section has not received any feedback as to where we are with this. There is a growing presence of transport RT's at AMTC more and more every year. Our section has a meeting there and the question always arises as to why we are not mentioned as a sponsor. In addition, professions are labeled in colors, respiratory is labeled "white", and this is not even a color.

### **Other**

### **New and Ongoing Updates**

1. Steve Sittig was elected as Transport Section Chair elect.
2. Specialty Practitioner of the Year nominations are being sought at this time.
3. The Neonatal-Pediatric Transport Exam is currently being offered by The National Certification Corporation (NCC). Those who earn the Neonatal and Pediatric Transport certificate will be able to use the designation of C-NPT. The cost is \$150. A big Thank you to Sherry McCool, RRT, NPS, CFC, Children's Mercy Critical Care Transport, Missouri, a Transport Section member who was a member of the task force initiating this exam.
4. Continuing to build new working relationships with transport RTs across the country forming work groups to explore issues and activities of interest.

5. The transport section continues to grow in members.
6. The section had other record number submissions for the 55<sup>th</sup> AARC Congress in San Antonio, Tx.
7. Yearly section business meeting held during the past AARC congress in Anaheim with active discussion of topics of interest to the membership.
8. The monthly electronic bulletins and quarterly bulletins are being published on time with relevant content to the specialty with increasing submissions by the section membership.
9. Photo section on the Transport Section web page is currently under development.

***Special  
Committee  
Reports  
-1-***

## **BENCHMARKING COMMITTEE**

Reporter: Richard Ford  
Last submitted: 2009-06-02 15:43:59.0

### ***Recommendations***

None

### ***Report***

1. An assessment of the status of AARC Benchmarking was performed in March 2009. The key findings were as follows:

- a. The number of subscribers decreased from 123 in June of 2008 to 87 in March of 2009.
- b. Of the 87 participating facilities, only 54% had entered at least one quarter of data in 2008, and 48% not entered any 2008 data.

2. This situation resulted in a decreasing number of data sets available for comparison. The primary concern expressed by clients in past months was an inadequate numbers of facilities in their compare groups. The diminishing number of participants, as well as inability/unwillingness for existing clients to enter data, is a situation that will greatly devalue the program and was a call for immediate action through the Benchmarking Stimulus Package.

3. The Benchmarking Committee conducted conference calls on April 1 2009 and April 27 2009 to help refine the Benchmark Stimulus Package and develop action plans for team members in support of the program.

4. The Benchmarking Stimulus Package was developed in collaboration with the AARC Executive Office and the Benchmarking Team through the coordinating efforts of Bill Dubbs.

5. The details of the Stimulus Package and the assignment of action items/timelines can be obtained from Bill. The key stimulus is a 2 month free subscription with incentives for current data entry that began June 1 and will end on August 31... Additional elements of the plan include:

- a. Marketing aimed at attracting new subscribers
- b. Adopt new logo, rebrand AARC Benchmarking
- c. Increasing awareness through ongoing participation at state and regional meetings by members of the team
- d. Increasing awareness through publication in a variety of AARC forums, including AARC Times. (Piece by Jan Thalman and Stan Holland is ready for AARC Times)
- e. Series of early notifications of clients who fail to enter data, inclusive of personalized emails and follow-up direct calls.
- f. Expired subscription notices at 5, 3, and 1 month to give them every opportunity to evaluate value and secure funding.
- g. Retention of data for 6 months of expired subscriptions so it will remain available for comparison.
- h. Maintain the opportunity for a six month subscription rate of \$375
- i. Maintain the opportunity for additional system facilities to enroll for \$150

- j. Refining the focus of the newsletter and list serve
- k. Creation of a dashboard of key metrics, so all clients can have access to a common set of comparative data, without the need to develop a custom report.

6. The committee will also develop a series of small archived web cast to provide easy and simple instructions on how to enter and report data and get the most out of AARC Benchmarking.

7. There have been numerous minor technical issues in which the team has worked closely with Devore to resolve. Devore has worked well with the AARC and Benchmarking team to make needed changes at no or minimal expense.

***Other***

Many thanks for the commitment of the AARC Executive Office Staff for their hard work in the implementation of the Stimulus Program.



## BILLING CODE COMMITTEE

Reporter: Roy Wagner  
Last submitted: 2009-06-22 15:38:28.0

### *Recommendations*

No Recommendations at this time

### *Report*

Be proactive in the development of needed AMA CPT respiratory therapy related codes.

Plan: Send communication via e-mail to the committee members with ideas and solicitation of ideas for proposals for Susan to take to the AMA Advisory Meetings as appropriate with the American Association for Respiratory Care's position on this panel.

Action: There are no current suggestions

Act as a repository for current respiratory therapy related codes.

Plan: Collect data as necessary or assigned that is related to respiratory therapy billing codes.

Action: Ongoing

Act as a resource for members needing information and guidance related to billing codes.

Plan: Answer inquiries on the list serve as identified. This action seems to be the most effective way to communicate to the membership. Articles are written and published as the need arises.

Action: The Committee will continue to monitor the list serve for questions to billing and coding issues. The list serve has been very busy with many questions. The response from the members on this list serve is very positive.

Develop a primer on the process for developing or modifying codes to include: definitions, development/review process, types and categories, reporting services using CPT codes and submitting suggestions for changes to CPT codes.

Plan: The Committee will develop a data base program where current CPT codes can be listed with definitions, types and categories, services to be reported and discussion on suggestions for change will be documented and kept in order to have history on accomplishments, suggestions and changes that may occur.

Action: No further action has occurred at the current time on this goal. The Committee will re-focus on this goal during the next quarter.

## CLINICAL PRACTICE GUIDELINES STEERING COMMITTEE

### CPG Steering Committee Activity Report Spring 2009

**Chair:** Ruben D Restrepo MD RRT FAARC

**BOD Liaison:** Unassigned

**Staff Liaison:** Ray Masferrer

**Recommendation #1:** The committee has excused Carl Haas from his duties as member of the committee per his request effective May 19<sup>th</sup>, 2009.

**Recommendation #2:** Arzu Ari PhD RRT has been appointed and ratified by Tim Myers as a new member of the committee to replace Carl Haas.

**Recommendation #3:** After meeting May 30<sup>th</sup>, the committee has recommended appointing Steven Sittig RRT-NPS FAARC as a new member of the committee.

#### Objectives:

- Review and revise existing clinical practice guidelines that are greater than 5 years from their publication date.

#### Report:

- To date, the Respiratory Care Journal Website lists a total of forty seven (46) CPGs.
  - Breakdown of 19 CPGs:
    - Two (2) are listed as evidence-based guidelines (EBGs) and the remaining are listed as expert panel guidelines (EPGs).
    - Two (2) EPGs have been combined.
    - Three (3) EPGs have been retired.
    - Twelve (12) adopted CPGs (see numeral 1.e.).
  - Eleven (11) CPGs have been updated/revise and published since 2004.
  - After verifying the last date of publication:
    - Eighteen (16) EPGs are at least 5 years old but less than 10 years old. One of them has been replaced by other society's CPG.
    - Both EBGs are older than 5 years.
    - Nineteen (13) EPGs are at least 10 years old but less than 15 years old. One of them has been replaced by other society's CPG.
    - Six (6) are older than 15 years.
  - To date, twelve (12) CPGs have been adopted from other medical societies.
    - Three (3) of these CPGs are older than 5 years.

#### **Action Plan for 2009-2010:**

- A total of 27 CPGs were initially assigned for revision and update during 2009-2010.
- A total of 5 CPGs are undergoing revision and will be updated as evidence-based CPGs before the end of the year. A template was created during the meeting in Dallas on May 30<sup>th</sup>, 2009 and will be used for future revisions and updates.
  - Incentive Spirometry
  - Providing Patient and Caregiver Training
  - Capnography Capnometry

- Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways
- IPPB
- Continue development of appropriate and new clinical practice guidelines in the evidence-based format.
  - EB-CPG on **Inhaled Nitric Oxide** is nearing completion.
  - **EB-CPG on Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia is scheduled to be completed in 2009.**

## FELLOWSHIP COMMITTEE

Reporter: Patrick Dunne  
Last submitted: 2009-06-09 15:09:55.0

### *Recommendations*

There are no recommendations at this time.

### **Report**

As of this writing, we have received 9 complete nominations for 2009 AARC Fellows. The deadline for receipt of completed nominations is August 31, 2009, so I anticipate the Committee will have its customary number of 25-30 nominations by the September meeting to select this year's recipients.

The leadership of both the AARC Board of Directors and the House of Delegates is encouraged to consider nominating worthy AARC members for this distinguished recognition by the above mentioned deadline. Full information for qualifications and nominating procedure can be found on the AARC website.

### *Other*

Nothing else to add.

## INTERNATIONAL COMMITTEE

Reporter: John Hiser

Last submitted: 2009-06-25 18:20:18.0

### ***Recommendations***

***Recommendation:*** *That the AARC approve the proposed International Guest Program.*

### **Justification:**

In order to enhance our efforts to globalize respiratory care we recommend establishing a an international guest program that allows us to invite prominent individuals to our country for the purpose of allowing time to visit with our president, executive director and other chosen leaders and selected representatives of health related organizations. The visit would allow for structured tours of internationally known health care facilities, colleges and universities and visits selected experts in health care provision, reimbursement and regulation here in the US. The time of the visit may or may not coincide with the International Congress and would depend on the availability of the guest and on the availability of the individuals and institutions that the guest would be scheduled to visit.

The invited guest would be an individual who has demonstrated by position and reputation a high degree of influence in health care delivery and/or the education system of their country. The intent would be to invite a person who has the ability to influence changes in their country.

Unlike the AARC international fellowship program this would be an "invited" guest as opposed to an "accepted" guest. They would not complete and submit an application. They would be invited because we know for a fact that they are in a position to introduce respiratory care as a profession in their country. They may not necessarily be a health care provider. They may be a president or CEO of a prominent health related organization, a university president, or a government official.

A fundamental part of our international fellowship program has always been to try to select people who can make a difference in their own countries. However, due to the fact that we can only select individuals from those who apply and due to the length of the international fellowship program, we are somewhat limited in our ability to bring in the true decision makers. This program would further enhance our efforts to globalize respiratory care.

ESTIMATED COST: \$8000 to \$12,000

Business Class airfare - \$ 8,500

Hotel accommodations - \$1,000

Food & incidentals - \$750

## Report

### 1. Administer the International Fellowship Program.

As of today June 24, 2009 we have 44 applicants for International Fellows and 14 applicants for City Hosts. All applications along with a new benchmark system for ranking applicants and a committee member worksheet have been sent to the committee for their evaluation. The committee will meet on Sunday July 19th during the Summer Forum. I'll be sharing the final selection of fellows and hosts with BOD and HOD at your July meetings. Six fellows will be accepted this year.

We surveyed the 2008 Fellows and Hosts this year using Survey Monkey. The results of that survey are being used to further improve the operations of the committee.

2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International portion of the Congress. The committee continues to work with the ICRC to help coordinate and help prepare the presentations given by the fellows to the council.

3. Strengthen AARC Fellow Alumni connections through communications and targeted activities.

As you know the "Guide to Aerosol Delivery Devices" was translated to Chinese and Spanish. A group from Italy headed by Sergio Zuffo is now working on translating the document to Italian. They will be the first group to translate the recently revised version of the guide. Hopefully similar revisions will be made for the Chinese and Spanish versions. Respiratory Care now has podcasts in Chinese and Spanish. There are also news updates on the ICRC website in Chinese and Spanish.

We continue to be on the look out for other educational materials that may be translated in the future.

The International Fellows List serve continues to show a considerable amount of activity and continues to be valued by our past fellows.

4. Coordinate and serve as clearinghouse for all international activities and requests.

We continue to receive requests for assistance with educational programs, seminars, educational materials, requests for information and help with promoting respiratory care in other areas of the world.

5. Continue collegial interaction with existing International Affiliates to increase our international visibility and partnerships.

We are corresponding with other medical associations and societies and will be manning a booth again this year at the ERS.

The international activities of the AARC continue to be of great interest to

both the ARCF and to our AARC Corporate Partners. Updates on our activities were provided to both groups at their meetings in February and April respectively.

I want to thank Kris Kuykendall for all of her hard work. None of this could be done without her help. I also want to thank the members of the committee. They've been very busy.

***Vice Chairs***

*Debra Lierl, MEd, RRT, FAARC, Vice Chair for International Fellows*

*Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations*

*Committee members:*

*Michael Amato, BA, Chair ARCF*

*Jerome Sullivan, PhD, RRT, FAARC, President ICRC*

*Arzu Ari, PhD, MS, MPH*

*John Davies, MA RRT FAARC*

*ViJay Desphande, MS, RRT, FAARC*

*Hector Leon Garza, MD, FAARC*

*Derek Glinsman, RRT, FAARC*

*Yvonne Lamme, MEd, RRT*

*James Maguire, PhD*

*Dan Rowley, BS, RRT-NPS, RPFT*

*Bruce Rubin, MD, FAARC*

*Michael Runge, BS, RRT*

*Theodore J. Witek, Jr., Dr.PH, FAARC*

## **MEMBERSHIP COMMITTEE**

Reporter: Thomas Lamphere  
Last submitted: 2009-06-29 10:50:52.0

### ***Recommendations***

1. Develop a series of webinars designed to provide detailed information to affiliate membership chairs on various membership recruitment tool and information including, but not limited to: AARC Bulk Membership Program, US Postal Service Online Services, Sending Email to Affiliate Membership, Adding "Fun" To Membership Benefits, How To Accept Credit Card Payments
2. implement the first one hour webinar by September 30, 2009 (if possible) and invite affiliate membership chairs, Presidents and Delegates.

### ***Report***

The Membership Committee has had a difficult time implementing a plan for 2009. However, in an effort to bring together the people in the state affiliates who are handling the membership activities in their respective states, a message was sent out in March to the President/Delegate list serve seeking the contact information for these individuals. Over 30 states responded to the request for the contact information and these individuals were then surveyed regarding the various successful and unsuccessful membership strategies they utilized in their affiliate both now and in the past. Unfortunately, only 10 affiliates responded to the survey.

During the quarter, the Membership Committee Chair was contact by several states requesting information on various programs including the bulk membership program, accepting credit card payments, and more. Over the past two years, these same questions keep coming up and although much of this information has been presented to the House of Delegates, it appears that in at least some states, the information is not making it back to the person who is handling membership. Therefore, the committee is recommending that a series of webinars be held to answer these questions. The webinar can then be archived and referenced by new membership chairs in the affiliates as they change over the course of the next several years.

### **Other**

The committee continues to work with the AARC Executive Office on a non-member survey. The major obstacle is obtaining a non-member listing of RTs to survey.



## POSITION STATEMENT COMMITTEE

Reporter: Patricia Doorley  
Last submitted: 2009-06-23 15:18:04.0

### ***Recommendations***

#### Recommendation # 1:

Revise the position statement entitled "AARC Statement of Ethics and Professional Conduct" to incorporate the changes identified in Attachment # 1. Text to be deleted appears with ~~strike through~~ and text to be added appears with underline.

Justification: This statement was last reviewed in 2007. The current revisions are submitted to improve the readability of the statement and to clarify the patient's right to request the disclosure of protected information.

#### Recommendation # 2:

Revise the position statement entitled "Continuing Education" to incorporate the changes identified in Attachment # 2. Text to be deleted appears with ~~strike through~~ and text to be added appears with underline.

Justification: This statement was last reviewed in 2000. The current revisions are submitted to update the statement to reflect current language related to patient care and continuing education activities as well as to reflect the current focus on the use of multimedia and interactive educational techniques to improve retention.

#### Recommendation # 3:

Revise the position statement entitled "Definition of Respiratory Care" to incorporate the changes identified in Attachment # 3. Text to be deleted appears with ~~strike through~~ and text to be added appears with underline.

Justification: This statement was last reviewed in 2006. The current revisions are submitted to broaden the clinical definition to encompass all the patient populations served by Respiratory Therapists as well as to acknowledge the medical equipment and supply companies as identified venues of practice.

### ***Report***

#### Charges:

1. Draft all proposed AARC position statements and submit them for approval to the Board of Directors. Solicit comments and suggestions from all communities of interest as appropriate.

At the December 2008 BOD meeting, the Position Statement Committee was charged with creating two new position statements. The charges read:

- "That the AARC create a position statement on the use of respiratory therapists (at a minimum) being involved in the transport of a ventilated acute critically injured or ill neonate, child or adult" -- Draft statement under review by Transport Section members and selected others
- "That the AARC develop a position statement on Respiratory Care Services in Long Term

Care using the existing voluntary ORCR standards and the Tennessee Standards of Ventilator Care in Rehabilitation Facilities as a framework" - Draft statement in development

2. Review, revise or delete as appropriate using the established three-year schedule of all current AARC position statements subject to Board approval.

The six (6) position statements under review this year include:

- AARC Statement of Ethics and Professional Conduct - Revise with recommendations submitted for July 2009 BOD consideration
- Age Appropriate Care of the Respiratory Patient - under review
- Continuing Education - Revise with recommendations submitted for July 2009 BOD consideration
- Definition of Respiratory Care - Revise with recommendations submitted for July 2009 BOD consideration
- Health Promotion and Disease Prevention - under review
- Licensure of Respiratory Care Personnel - Reviewed with no recommendations for revision

3. Revise the Position Statement Review Schedule table annually in order to assure that each position statement is evaluated on a three-year cycle.

**The schedule (See Attachment # 4) has been revised to reflect the BOD actions through March 2009.**

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2009-X)	2009	Schedule Review for 2010	Schedule Review for 2011	Schedule Review for 2012	Schedule Review for 2013
AARC Statement of Ethics and Professional Conduct	1994	2006	3	Revisions Submitted			X	
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2007	2		X			X
Age Appropriate Care of the Respiratory Patient	1997	2005	4	X			X	
Competency Requirements for the Provision of Respiratory Therapy Services	1998	2008	1			X		
Continuing Education	1990	2005	4	Revisions Submitted			X	
Cultural Diversity	1994	2007	2		X			X
Definition of Respiratory Care	1987	2006	3	Revisions Submitted			X	
Hazardous Materials Exposure	2002	2008	1			X		
Health Promotion and Disease Prevention	1985	2005	4	X			X	
Home Respiratory Care Services	2000	2007	2		X			X
Inhaled Medication Administration Schedules	2008	2008	1			X		
Licensure of Respiratory Care Personnel	1990	2009	0	Review Completed			X	
Pre-Hospital Mechanical Ventilator Competency	2007	2007	2		X			X
Pulmonary Rehabilitation	1973	2008	1			X		
Respiratory Care Scope of Practice	1987	2007	2		X			X
Respiratory Therapist Education	1998	2009	0	Revised 03/2009			X	
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2007	2		X			X
Respiratory Therapy Protocols	2001	2007	2		X			X
Telehealth	2001	2007	2		X			X
Tobacco and Health	1991	2008	1			X		
Verbal Orders	1990	2008	1			X		
				7	8	6	7	8

# American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

## Position Statement

# AARC Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapists shall:

Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals. ~~Actively maintain and continually improve their professional competence and represent it accurately~~  
Seek educational opportunities to improve and maintain their professional competence and document their participation accurately

Perform only those procedures or functions in which they are individually competent and which are within their scope of accepted and responsible practice

Respect and protect the legal and personal rights of patients ~~they treat~~, including the right to privacy, informed consent and refusal of treatment

Divulge no protected information regarding any patient or family unless disclosure is required for the responsible performance of duty, authorized by the patient and/or family, or required by law

Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals

Promote disease prevention and wellness

Refuse to participate in illegal or unethical acts

Refuse to conceal, and will report, the illegal, unethical, fraudulent, or

incompetent acts of others

Follow sound scientific procedures and ethical principles in research

Comply with state or federal laws which govern and relate to their practice

Avoid any form of conduct that is fraudulent or creates a conflict of interest, and shall follow the principles of ethical business behavior

Promote health care delivery through improvement of the access, efficacy, and cost of patient care

Encourage and promote appropriate stewardship of resources-

Effective 12/94

**Revised ~~12/07~~ 07/2009**

# American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

## Position Statement

# Continuing Education

~~The need~~ It is critical for all health care practitioners to participate in continuing education in order to enhance their knowledge, improve their clinical practice and meet state licensure and national credentialing requirements. ~~is well established.~~ Participation in continuing education, whether mandatory or voluntary, offers the potential to be one of the most powerful tools to ensure safe, efficient, and quality patient care. ~~In recognition of the value of and need for participation in continuing education,~~ The American Association for Respiratory Care recognizes the value of, and need for, participation in continuing education and recommends that practitioners participate in ~~continuing education~~ educational activities each year. AARC members may utilize the Continuing Respiratory Care Education (CRCE) system as the mechanism for recognition and documentation of such activities. ~~The AARC also supports~~ encourages Respiratory Therapists, striving who have completed the required entry level education, to pursue baccalaureate and graduate degrees ~~after the required entry level education.~~ relevant to their professional pursuits.

~~AARC members may utilize the Continuing Respiratory Care Education (CRCE) system as the mechanism for recognition and documentation of such activities.~~

~~The AARC encourages~~ Respiratory Therapists are encouraged to select their continuing education activities ~~carefully in order to meet their own~~ relevant to their personal and professional needs. Providers of continuing education activities (which can include clinical institutions, educational institutions, public and private associations or organizations, and proprietary corporations) are encouraged to ~~assist respiratory therapists in their efforts with~~ conduct needs assessments in order to design and develop valuable educational activities which that will enable practitioners to meet their professional goals. The use of multimedia, multiple instructional techniques, and multiple exposure strategies are also encouraged to improve retention.

Effective: 1990

Revised: 2000

**Revised: 2005 07/2009**

# American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

## Position Statement

# Definition of Respiratory Care

Respiratory Care is the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health. Respiratory Therapists ~~apply~~ employ scientific principles to ~~prevent~~, identify, and treat, and prevent acute or chronic dysfunction of the cardiopulmonary system. Knowledge and understanding of the scientific principles underlying cardiopulmonary physiology and pathophysiology, as well as biomedical engineering and technology, enable respiratory therapists to provide patient care services effectively. ~~offer preventative care to, as well as assess, educate, and treat patients with cardiopulmonary deficiencies.~~

As a health care profession, Respiratory Care is practiced under medical direction across the health care continuum. Critical thinking, patient/environment assessment skills, and evidence-based clinical practice guidelines enable respiratory therapists to develop and implement effective care plans, patient-driven protocols, disease-based clinical pathways, and disease management programs. A variety of venues serve as the practice site for this health care profession including, but not limited to:

- acute care hospitals
- sleep disorder centers and diagnostic laboratories
- rehabilitation, research and skilled nursing facilities
- patients' homes
- patient transport systems
- physician offices
- convalescent and retirement centers
- educational institutions
- medical equipment companies and suppliers
- ~~field representatives and wellness centers.~~

**Effective 12/99**

**Revised 12/06 07/2009**



## **PUBLIC RELATIONS ACTION TEAM**

Reporter: Linda Smith  
Last submitted: 2009-07-01 04:45:51.0

### ***Public Relations Action Team Recommendations***

There are no recommendations at this time.

### ***Report***

1. Relevant topics are being discussed. Once topics are decided upon the interviews will be coordinated with the EO.
2. The EO has not made any requests.
3. A letter to be sent to affiliate presidents is ready for distribution.
4. The committee is identifying all of the PR material on the web site is looking at how to best display it.



***Special  
Representatives  
Reports***



## AMA CPT HEALTH CARE PROFESSIONAL ADVISORY COMMITTEE

Reporter: Susan Rinaldo Gallo  
Last submitted: 2009-06-01 15:20:48.0

### ***Recommendations***

None at this time.

### ***Report***

#### 1. Clarification of Continuous Treatment Codes

In March, the AMA conducted a review of all time based codes. I submitted the explanation for the codes below.

*These codes are reported by the day of service. If the continuous aerosol began at 9:00 pm and continued until 2:00 am, 94644x1 and 94645 x2 would be reported for the treatments given between 9:00 pm and 12:00 midnight. Additionally, 94664x1, and 94645 x 1 would be reported for the treatments given between 12 midnight and 2:00 am.*

*94644            Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour*

*94645                        each additional hour (List separately in addition to code for primary procedure)*

The take home message is that 94644 (first hour) must be reported **each** day of service, not just on the initial hour of the first day.

#### 2. Unattended Sleep Studies

At the February 09'' meeting the CPT editorial panel accepted two Category III CPT Codes for Unattended Sleep Studies.

1. Unattended sleep study measuring heart rate, oxygen saturation, respiratory analysis, and sleep time
2. Unattended sleep study measuring a minimum of heart rate, oxygen saturation, and respiratory analysis.

Category III codes are temporary codes used to facilitate data collection and assess new services and procedures. CMS is very much in favor of Unattended Sleep Studies and has issued G Codes (NCD CAG-00093R2). The AMA Editorial Panel has been asked to RECONSIDER and assign Type I (reimbursable) codes to Unattended Sleeps Study. This will be debated at the June 5th meeting. The American Academy of Sleep Medicine strongly opposes the change to Type I codes.

#### 3. June 5th meeting

I am not attending the June 5th meeting. The AARC budget approves travel for two of the three annual meetings. The June meeting generally has the lightest agenda; therefore this is the one to skip.

#### 4. Please send questions and comments my way.

## AMERICAN ASS'N. OF CARDIOVASCULAR & PULMONARY REHAB

Reporter: Debra Koehl  
Last submitted: 2009-06-24 10:51:24.0

### ***Recommendations***

No recommendations at this time.

### **Report**

Everyone is awaiting the new NCD for pulmonary rehabilitation to be released by CMS. At that point I expect lots of discussion and recommendations if changes are needed.

I will have more to report from the AACVPR after attending the October meeting in Pittsburg.

**AMERICAN ASSOCIATION OF CRITICAL CARE NURSES**

Reporter: Karen Gregory

Last submitted: 2009-07-01 17:29:34.0

Date submitted: June 25, 2009

Committee/Section: American Association of Critical Care Nurses

Representative: Karen Gregory, MS, APRN-BC, CNS, RRT, AE-C

Charges: Meet with AACN liaison to determine meeting dates and goals and objectives

Establish education objectives for ventilator associated pneumonia

Recommendations: None

Report:

Conference call with the AACN liaison to establish meeting schedule, goals and objectives, and educational top will soon be scheduled. Continue follow-up regarding ventilator associated pneumonia.

Respectfully submitted,

Karen L. Gregory, MS, APRN-BC, CNS, RRT, AE-C

## AMERICAN HEART ASSOCIATION

Reporter: Richard Branson  
Last submitted: 2009-06-29 11:24:36.0

### ***Recommendations***

Support AHA in the development of the 2010 emergency cardiac care guidelines.

### **Report**

BillDubbs attended the meeting for me due to a conflict. AHA continues to look to AARC for expertise in evaluating devices for airway control and ventilation during ECC. Bill, Terry Volsko and I will continue to support AHA in this regard. I have been named to the writing committee for airway and ventilation devices.



## AMERICAN SOCIETY FOR TESTING AND MATERIALS (ASTM)

Reporter: Robert McCoy  
Last submitted: 2009-06-26 15:30:52.0

### *Recommendations*

none

### **Report**

ASTM meeting Vancouver BC May 18-19, 2009

Attended and participated in F29 group meeting on tubing connectors and endotracheal tubes.

Summary of the endotracheal tube section

- ISO 5361-1:1999 Tracheal tubes and connectors standard is now 10 years old and is in need of revision.
- This international standard is roughly based on earlier, more detailed versions:
- ANSI Z-79 series (1973 to 1984) now obsolete
- ASTM 1242 (1986 to 1996) now obsolete
- Over the years the five-part ISO 5361 standard has been reduced to two parts
- ISO 5361-1:1999 Part 1 covers the very basic elements of simple tracheal tubes. Specialty tracheal tubes are not included in the scope. The current standard now incorporates the rudiments of the old parts 2, 3, and 5.
- Part 4, ISO 5361-4:1987 Cole tracheal tubes for infants, remains the final published sub-part, and will probably be incorporated into the part-1 standard in this revision process.
- Cole type tubes are rarely used because their funnel-shaped mid-section has been associated with increased injury rates to the cricoid and vocal cords in infants.
- The simplification of ISO 5361-1 over the years has led to the elimination of many specifications and requirements once considered essential for prolonged ventilation.
- Gone are the earlier requirements for:
- tracheal tube cuff performance, (pinhole testing, air seal tests, liquid seal tests);
- tubing kink resistance and stiffness;
- radiopaque markings;
- Dimensions for placement of cuffs on the smallest sizes of pediatric tubes.
- The current standard also lacks references to common ISO 14971 Risk management requirements for medical devices (now included in all modern standards)

- The clinical requirements for tracheal tubes are now more rigorous than they were 10 years ago.
- The current standard was intended for very "basic" tracheal tubes used for short term gas anesthesia cases. These cases are now commonly performed by supralaryngeal airways (LMA-type devices).
- Many patients needing positive pressure ventilation in emergency rooms and ICUs now commonly receive non-invasive ventilation (NIV) using a mask instead of a tracheal tube. Tracheal tubes are still important to ventilate patients that suffer respiratory failure, especially those requiring long-term ventilatory support, yet the current (1999) standard is not detailed enough to describe requirements for performance under long term ventilation.
- Newer tracheal tubes have been developed that claim reduced aspiration around cuffs, reduced VAP infection rates.
- Many different types of performance tests have been published to support these claims, resulting in confusing and conflicting claims among competing manufacturers.

#### ASTM WK23835 - New Specification for Environmental Requirements for Medical Equipment Used in Mass Casualty Events.

This item was a concern of the Mass Casualty roundtable. The issue was discussed at the meeting, yet the issue was environmental capabilities of the ventilator not performance. The F29 SC3 group will be watching this issue and if performance becomes an issues, SC 3 will recommend that they work on the standard.

An attempt was made to get more therapist involvement in the ET standard (above) yet without feedback from the critical care group. It is assumed that there is still a misunderstanding of how standards impact the products the therapist use and a lack of understanding of how the therapist can become involved.

I will continue to attempt to bring experts in specialty areas into the process of reviewing and developing standards for equipment used by respiratory therapist.

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## CLINICAL LABORATORY INSTITUTE

Reporter: Susan Blonshine

Last submitted: 2009-06-23 09:20:25.0

### ***Recommendations***

none

### ***Report***

1. The Area Committee on Quality Systems and Laboratory Practice (AC-QS & LP) chaired by Carl Mottram has several guidelines in process which may be relevant to the respiratory community and in particular ABG and pulmonary laboratories. These include;

- a. GP5-P Clinical Laboratory Waste Management
- b. GP33-P Accuracy in Patient and Sample Identification
- c. GP34-P Validation and Verification of Tubes and Additives for Venous and Capillary Blood Collection
- d. GP35-P Development of Quality Indicators
- e. GP36-P Challenges to Clinical Laboratory Operations During a Disaster
- f. H18, Procedures for the Handling and Processing of Blood Specimens

2. At the Leadership conference in April the AC - QS and LP formed a standing sub-committee titled Quality Management Systems (SS-QMS) with a charge to develop and manage the portfolio of quality system essential (QSE) guidelines. The SS-QMS has several revised and new documents in the pipeline for 2009-10 to address the QSE's. They include;

- a. HS1-A3, A Quality System Model for Healthcare.
- b. GP22-A3 Continuous Process Improvement
- c. GPXX Quality System Essential - Equipment

3. Susan Blonshine, an advisor to the Area Committee on Quality Systems and Laboratory Practices and observer on SS-QMS was nominated and accepted the Chair of the working group for Quality System Essential: Equipment.

4. Recently Approved Documents:

*GP31-A-Laboratory Instrument Implementation, Verification, and Maintenance; Approved Guideline*

This guideline provides information about assessing instrument performance and function from the time of instrument purchase to the routine performance of clinical testing.

### ***Other***

none

## CHARTERED AFFILIATE CONSULTANT

Reporter: Garry Kauffman  
Last submitted: 2009-06-19 15:43:44.0

### ***Recommendations***

I would recommend including business planning and operational performance measurement either as part of the Spring leadership program or as part of the International Congress. I would be delighted to provide this educational program.

### ***Report***

I have had several phone conversations and personal conversations with state society leaders in response to questions concerning strategic planning, business planning, and operational performance measurement. I have shared various forms that I utilize as part of these processes and have received favorable feedback. On 6/19, with the approval of the WVSRC president, we utilized a conference call methodology for me to remotely facilitate a strategic planning 1/2 day session with the WVSRC BOD. The output of the session was the development of a strategic plan, mission statement, core values, and operating plan to guide the WVSRC. The feedback was most positive from all WVSRC BOD members.

### ***Other***

Respectfully submitted,

Garry W. Kauffman, MPA, FACHE, RRT, FAARC

## CLSI POINT OF CARE

Reporter: George Gaebler  
Last submitted: 2009-06-29 14:58:30.0

### *Recommendations*

None

### *Report*

The Committee made minor revisions to pulse oximetry measurement guidelines for which I reviewed and concurred with the changes as they were minor in nature.

### *Other*

**[Insert other information here]**

**COMM. ON ACCREDITATION OF MEDICAL TRANSPORT SYSTEMS**

Reporter: Steven Sittig  
Last submitted: 2009-06-16 13:41:59.0

***Recommendations***

***NONE AT THIS TIME***

[Insert recommendations here]

***Report The CAMTS BOD met in April in San Antonio for the 1st quarter meeting of 2009. New policies were discussed in addition to the accreditation process. The second meeting of the BOD is scheduled for early July in Dallas Tx. We have invited Sam Giordano to attend to meet the entire BOD and observe the accreditation process.***

[Insert report here]

***Other***

[Insert other information here]

## COMM. ON ACCREDITATION OF ALLIED HEALTH ED. PROGRAMS

Reporter: Linda Van Scoder  
Last submitted: 2009-06-22 13:32:40.0

### ***Recommendations***

[No recommendations]

### ***Report***

[Bill Dubbs and I attended the annual CAAHEP meeting in April. Nothing of interest to the AARC happened at the meeting. Since CoARC is leaving CAAHEP we will not need to attend any more meetings after this year.]

### ***Other***

[Insert other information here]

## **EXTRACORPOREAL LIFE SUPPORT ORGANIZATION (ELSO)**

Reporter: Donna Taylor  
Last submitted: 2009-07-01 15:24:08.0

### ***Recommendations***

No recommendations at this time.

### ***Report***

Due to repeated requests for information from other ECMO centers and those starting up an ECMO program, I brought this up to the Extracorporeal Life Support Organization Steering Committee during our meeting in February. As a result of this, the committee proposed that a statement be drafted by ELSO in support of Registered Respiratory Therapists managing ECMO. I am drafting a statement based on the AARC's and other groups statements on RRTs and plan to present this to the ELSO Steering Committee at the fall meeting in Ann Arbor, Michigan.

### ***Other***



## INTERNATIONAL COUNCIL FOR RESPIRATORY CARE (ICRC)

Reporter: Jerome Sullivan  
Last submitted: 2009-06-29 15:30:40.0

### ***Recommendations***

No Recommendations at this time.

[Insert recommendations here]

### ***Report***

1) **Association of Respiratory Care Practitioners in the Philippines (ARCPP):** The Council is currently working to identify a new Governor for the Philippines. Mr. Noel Tiburcio, MBA, RMT, RRT-NPS from the United Arab Emirates (UAE) is working with Mr. Cesar Bugaoisan, Public Relations Officer for the ARCPP as the contact person to begin this dialogue.

The **ARCPP** has been successful in gaining Philippine House of Representative approval of House Bill No. 6410, The Philippine Respiratory Act of 2008. This Act is to establish Respiratory Care as "recognized health profession" and to establish Licensure for RC practitioners. Senate Bill No. 3139, Philippine Respiratory Act of 2009 is currently under consideration in the Senate and has been referred to the Committee on Civil Service & Government Reorganization and to The Committee on Finance.

The **ARCPP Annual Meeting** will be held August 19-20, 2009 in Manila. Mr. Noel Tiburcio, MBA, RMT, RRT-NPS from the UAE is an invited speaker to this meeting and will serve as the ICRC's Ad Hoc representative to this meeting.

2) **The Latin-American Board for Professional Certification in Respiratory Therapy** met on March 3, 2009 in conjunction with the **X Congresso on Respiratory Therapy** in Mexico City. ICRC President, Jerome Sullivan was in attendance as the Consejo approved new Policies & Procedures and elected new officers. The meeting was attended by representatives from the following countries; Spain, Mexico, USA, Guatemala, Argentina, Chile, Ecuador, Columbia, Peru, Venezuela and Costa Rica.

3) **ICRC By Laws and Policy & Procedure Revision Committee:** The preliminary Committee Report has been submitted to the President for referral to the Executive Committee. The committee has submitted an extensive report which includes the provision for removal and replacement of a Governor for non attendance at the ICRC Annual Business Meeting for two consecutive years.

4) **International Education Recognition System (IERS):** The revision of the *Guidelines* has been finalized and currently Steve Nelson, AARC Executive Office is working to post the revisions to the web site.

Gustavo Olguin, Governor for Argentina, has submitted an application to **IERS** for recognition of his August, 2009 Seminar on Non Invasive Ventilation. The application is currently under

review and will be complete following final action by the IERS Executive Committee.

5) **Visiting Dignitary Proposal & International Fellowship Program:** Several Governors to the ICRC are members of the AARC International Committee and will be joining the Committee at the AARC Summer Meeting in Florida to help identify Fellows for the 2009 program. In addition a subcommittee of the International Committee consisting of Hassan Alorainy, Derek Glinsman and Jerome Sullivan have submitted a proposal to establish a **Visiting Dignitary AARC Guest** category to John Hiser for consideration by the Committee & the AARC BOD.

6) **3rd Intercoastal Conference on Respiratory Care of China & Taiwan:** The 3rd in an important series of meetings between representatives of Respiratory Care in China and Taiwan will take place November 5-8, 2009 in Shanghai, China. ICRC President, Jerome Sullivan will be an invited presenter at this meeting.

[Insert report here]

***Other***

[Insert other information here]

**THE JOINT COMMISSION (TJC) PTAC'S  
AMBULATORY**

Reporter: Michael Hewitt  
Last submitted: 2009-06-05 10:41:29.0

***Recommendations***

[Insert recommendations here]

***Report***

We have gone through the orientation process and have begun participating in the scheduled conference calls around issues of interest to the PTAC. No definite time or need for a formal in person meeting for the committee has been identified. Virtually all of the issues discussed at the conference calls have involved topics involving areas not directly affecting us up front. Nothing specific to Respiratory or any of our ambulatory related activities has been an agenda item to this point. We will continue to participate and monitor, reporting back to the board as indicated and required.

***Other***

[Insert other information here]

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**THE JOINT COMMISSION (TJC) PTAC'S  
HOMECARE**

Reporter: Joseph Lewarski  
Last submitted: 2009-06-30 17:06:34.0

***Recommendations***

None

***Report***

Lewarski has stepped down and the President has recommended a new representative

***Other***

**[Insert other information here]**

**THE JOINT COMMISSION (TJC) PTAC'S  
LABORATORY**

Reporter: Rebecca Meredith  
Last submitted: 2009-06-24 15:09:27.0

***Recommendations***

No recommendations. We continue to review each standard line by line as part of the Standards Improvement Initiative (SII). The minutes are attached.

[Insert report here]

***Other***

[Insert other information here]

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Notes  
Standards Improvement Initiative (SII)  
*Laboratory Accreditation Program*  
Professional and Technical Advisory Committee (PTAC) Meeting  
March 16, 2009

Document and Process Control Chapter

**SII Chapter Outline: DC**

- I. Pre-Analytic Phase of Laboratory Testing
  - A. Procedures for Collecting Specimens (DC.01.01.01)
  - B. Request for Laboratory Tests (DC.01.02.01)
  - C. Specimen Identification (DC.01.03.01)
  
- II. Post- Analytic Phase of Laboratory Testing
  - A. Testing Procedures (DC.02.01.01)
  - B. Testing Staff Identification (DC.02.02.01)
  - C. Reporting (DC.02.03.01)
  - D. Records Retention (DC.02.04.01)

**Discussion Questions: DC**

1. Please discuss any requirements in Attachment D that you perceive to be “new” (not in the current DC Chapter). Note: Attachment E is a useful report for tracking the history of the revised elements of performance.

**The members of the PTAC did not identify requirements they perceived as new.**

2. Please discuss your overall impression of the revised chapter, specifically:
  - clarity and logic of the standards, rationales, and elements of performance;
  - successful elimination of redundancy;
  - support of quality and safety; maintenance of existing level of expectations (i.e., expectations to the field were not increased; expectations essential to quality and safety were not decreased or deleted); and
  - applicability to the organizations served within your accreditation field.

**The members of the PTAC do not like the acronym “DC.”**

3. Is the revised DC chapter an improvement on the current chapter?

**The members of the PTAC did not specifically comment on the improvement of the chapter; however, they did say they like that the document and process requirements have been moved to their own chapter.**

**Notes:**

***DC.01.01.01, EP 1***

The bullet that says “Patient identification” (line 5) should come first because it has the highest error rate.

The word “unique” should be added before “patient identification.”

References that describe procedures for collecting specimens should be added to this EP.

The members of the PTAC urge Joint Commission staff to consider that this EP only requires the organization to follow procedures for collection, but those procedures may be incorrect. Surveyors look at the appropriateness of the procedures, which goes beyond what this EP requires. Consider making the requirement more prescriptive, but keep in mind that what works for one organization, does not work for all organizations. The national guidelines or an ongoing quality improvement program that evaluates procedures may provide better direction.

***DC.01.01.01, EP 3***

Replace the word “its” with “the laboratory’s.”

***DC.01.02.01***

PARKING LOT: Require organizations to make an online test index available to staff.

***DC.01.02.01, EP 5***

This EP should emphasize collection time. Change “Date and, when relevant, the time” to “Time and date” in bullet 8 (line 29); and change “Date and time” to “Time and date” in bullet 9 (line 30).

***DC.01.03.01, EP 2***

There is a typo in this EP (line 40); “indentifier” should be “identifier.”

***DC.02.01.01, EP 1***

Add more information to this requirement about when manufacturer’s instructions can be used.

***DC.02.02.01, EP 2***

Many people have the same initials, a unique identifier should be required.

***DC.02.03.01, EP 6***

There is a typo in this EP (line 84); “eas” should be “was.”

***DC.02.03.01, EP 10***

The members of the PTAC think this requirement is probably not complied with very much because it is not relevant on the report. Staff clarified the background of the requirement and explained that this is a requirement that was based on a congressional inquiry and can not be deleted. The information does not have to be displayed on the header, but it must be on the report, whether paper or electronic. The time can be removed, but date must be there – PTAC recommended leaving it as is because date could not be removed.

***DC.02.04.01, EP 2***

There is a typo in this EP (line 104); “histocapability” should be ‘histocompatibility.’

***DC.02.04.01, EP 4***

The writer’s notes (text in brackets) should not appear in the report or the EP.

The term “printout” should be changed to “record.”



Notes  
Standards Improvement Initiative (SII)  
*Laboratory Accreditation Program*  
Professional and Technical Advisory Committee (PTAC) Meeting  
March 16, 2009

Emergency Management Chapter

**SII Chapter Outline: EM**

- I. Foundation for the Plan (revised EM.01.01.01)
- II. The Plan for Emergency Response
  - A. General Requirements (revised EM.02.01.01)
  - B. Specific Requirements
    1. Communications (revised EM.02.02.01)
    2. Resources and Assets (revised EM.02.02.03)
    3. Security (revised EM.02.02.05)
    4. Staff (revised EM.02.02.07)
    5. Utilities (revised EM.02.02.09)
    6. Patients (revised EM.02.02.11)
    7. Disaster Volunteers
      - a. Not Applicable
      - b. Volunteer Practitioners (revised EM.02.02.15)
- III. Evaluation
  - A. Not Applicable
  - B. Evaluating the Plan through Exercises (revised EM.03.01.03)

**Discussion Questions: EM**

4. Please discuss any requirements in Attachment D that you perceive to be “new” (not in the current EM Chapter). Note: Attachment E is a useful report for tracking the history of the revised elements of performance.

**The members of the PTAC did not identify requirements they perceived to be new.**

5. Please discuss your overall impression of the revised chapter, specifically:
  - clarity and logic of the standards, rationales, and elements of performance;
  - successful elimination of redundancy;
  - support of quality and safety; maintenance of existing level of expectations (i.e., expectations to the field were not increased; expectations essential to quality and safety were not decreased or deleted); and
  - applicability to the organizations served within your accreditation field.

**The members of the PTAC had an overall favorable impression of the revised chapter.**

6. Is the revised EM chapter an improvement on the current chapter?

**The members of the PTAC were generally satisfied that the revised chapter was an**

**improvement over the current chapter.**

**Notes:**

The chapter overview should address the three types of emergencies: (1) damage to the laboratory/organization; (2) a traumatic event; or (3) an infectious outbreak.

***EM.01.01.01, EP 4***

A reference to the Clinical and Laboratory Standards Institute (CLSI) document addressing how to respond to emergencies should be added to this EP.

***EM.02.02.01***

PARKING LOT: Add an EP that requires the organization appoint a laboratory spokesperson to handle internal communication during an emergency.

***EM.02.02.03, EP 3***

Delete the phrase “the following:” from this EP.

PARKING LOT (general): Enhance the requirements that address contract arrangements with other laboratories to support planning and response during emergencies.

Notes  
**Laboratory Accreditation Program**  
**Professional and Technical Advisory Committee (PTAC) Meeting**  
**March 16, 2009**

**Review of the National Patient Safety Goals**

The PTAC is requested to review the proposed revisions to the NPSGs and discuss the following:

1. Should any of the NPSGs proposed for deletion (in whole or in part) be retained in the Goals? (see Key Point 4)

**No.**

2. Should any of the abbreviations “not to use” in the current NPSG.02.02.01 (page 5) be retained for the laboratory program?

**No; however, the notes for this requirement (NPSG.02.02.01, EP 2/IM.02.02.01, EP 4 ) should be added to the hospital manual.**

3. Conversely, are there any NPSGs (in whole or in part) that are being retained (see Key Point 4) that should be considered for deletion or movement to standards?

**The PTAC recommended that NPSG.13.01.01 be deleted entirely rather than being moved into the standards (see Key Point 8).**

4. Although NPSG.01.01.01 is being retained as an NPSG, there is some debate about whether EP 1 should be retained or deleted. Current EP 1 requires the organization to actively involve the patient in the identification process and when active patient involvement is not possible, a designated caregiver verifies identity. If EP 1 is deleted, the concepts of active patient involvement and the caregiver would be incorporated into a rationale. Is it important to retain EP 1 as a scoreable requirement or can it be covered effectively in the rationale?

**The revised EP 1 should include the concepts of active patient involvement, but should not require the involvement of other floor personnel. Also, the members of the PTAC feel the EP should require two unique patient identifiers.**

5. Is the content of the retained NPSGs clear?

**The members of the PTAC did not identify any NPSGs that were unclear.**

6. The focus of NPSG.02.03.01 (page 7) was narrowed to address critical results only rather than the results of both critical tests and critical results. Should the focus on critical tests be retained in the interests of patient safety?

**The members of the PTAC felt the narrowed focus was appropriate.**

7. Are there potential improvements for NPSG.07.01.01 (page 10) on hand hygiene?

**The members of the PTAC feel it is important to keep the expectations for hand hygiene high and would support modifications to the NPSG that would improve the evaluation of this issue.**

8. Element of Performance 1 for NPSG.13.01.01 (page 12) is recommended to move to the Provision of Care chapter for the non-laboratory accreditation programs. This chapter does not exist in the laboratory standards manual; if this EP is to be retained in standards, what would be an appropriate location?

**This requirement should be deleted for the laboratory program and should not be moved to the standards.**

## NOTES

### NPSG.01.01.01, EP 1

There is a CLSI document that pertains to this requirement, consider adding it as a reference.

### NPSG.01.02.01

The members of the PTAC feel it is reasonable to delete this requirement in its entirety.

### NPSG.02.01.01

Change “critical test results” to “critical test result communication”

### NPSG.02.03.01, EP 1

This EP should focus on a partnership with the larger organization.

“The organization, together with the laboratory develops a plan for managing critical results of tests and procedures in association with clinical leadership that addresses the following: ...”

This EP should clearly convey the difference between giving information to an authorized prescriber versus giving to someone who will report it.

**Notes**  
**Standards Improvement Initiative (SII)**  
**Laboratory Accreditation Program**  
**Professional and Technical Advisory Committee (PTAC) Meeting**  
**March 16, 2009**

**Quality System Assessment for Non-Waived Testing Chapter**

**SII Chapter Outline: QSA**

- III. Proficiency Testing
  - A. Participation in Proficiency Testing Program (QSA.01.01.01)
  - B. Maintaining Records of Participation (QSA.01.02.01)
  - C. Handling and Testing of Proficiency Testing Samples (QSA.01.03.01)
  - D. Independent Performance of Proficiency Testing (QSA.01.04.01)
  - E. Non-Regulated Analytes and Regulated Analytes for which Compatible Proficiency Testing Samples are Not Available (QSA.01.05.01)
  
- IV. Quality Control
  - A. Establishing Quality Control Procedures through Test, Method, and Instrument Validation (QSA.02.01.01)
  - B. Calibration and Recalibration (QSA.02.02.01)
  - C. Calibration Verification (QSA.02.03.01)
  - D. Instrument-Based Testing with Electronic or Internal Monitoring Systems (QSA.02.04.01)
  - E. Noninstrument-Based Testing with Internal Quality Control Systems (QSA.02.05.01)
  - F. Specialty and Subspecialty Quality Control Policies (QSA.02.06.01)
  - G. Quality Control Ranges with Valid Statistical Measurements (QSA.02.07.01)
  - H. Correlation to Evaluate Same Test Performed with Different Methodologies or Instruments or at Different Locations (QSA.02.08.01)
  - I. Quality Control Testing in the Same Manner as Patient Testing (QSA.02.09.01)
  - J. Monitoring the Accuracy and Precision of the Analytic Process (QSA.02.10.01)
  - K. Surveillance of Patient Results (QSA.02.11.01)
  - L. Investigation and Corrective Action (QSA.02.12.01)
  - M. Reagent Storage, Preparation, Evaluation, and Tracking (QSA.02.13.01)
  - N. Reagent and Solution Labeling (QSA.02.14.01)
  
- V. Autopsy Services
  - A. Performance and Supervision of Autopsy (QSA.03.01.01)
  - B. Cadaver Storage and Preservation (QSA.03.02.01)
  - C. Patient's Clinical Record includes Autopsy Results (QSA.03.03.01)
  
- VI. Bacteriology, Mycobacteriology, and Mycology
  - A. Testing of Chemical and Biological Solutions, Reagents, and Antisera (QSA.04.01.01)
  - B. Verification of Antibacterial, Antimycobacterial, and Antifungal Susceptibility Testing Systems (QSA.04.02.01)
  - C. Quality Controls for Stains (QSA.04.03.01)
  - D. Testing of Microbiological Culture Media (QSA.04.04.01)
  - E. Culture Incubation (QSA.04.05.01)

- VII. Blood Transfusion Service and Donor Center
  - A. Blood Transfusion Service (QSA.05.01.01)
  - B. Blood Donation (QSA.05.02.01)
  - C. Safe Collection, Handling, Processing, Testing, and Labeling of Blood and Blood Components (QSA.05.03.01)
  - D. Identification of Recipients Potentially Infected with Human Immunodeficiency Virus (HIV) (QSA.05.04.01)
  - E. Identification of Recipients Potentially Infected with Hepatitis C Virus (HCV) (QSA.05.05.01)
  - F. Compatibility Testing (QSA.05.06.01)
  - G. Identification of Donor and Recipient Blood (QSA.05.07.01)
  - H. Transfusion-Related Activities (QSA.05.08.01)
  - I. Returning Unused Blood or Blood Components (QSA.05.09.01)
  - J. Releasing Blood and Blood Components to the Blood Supplier or Another Organization (QSA.05.10.01)
  - K. Reporting and Investigating Suspected Transfusion-Related Adverse Events (QSA.05.11.01)
  - L. Maintaining Blood and Blood Components for Emergencies (QSA.05.12.01)
  - M. Monitoring and Evaluation of Patients and Reporting of Suspected Transfusion-Related Adverse Events (QSA.05.13.01)
  - N. Suspected Transfusion-Related Adverse Events Investigation (QSA.05.14.01)
  - O. Suspected Transfusion-Related Adverse Events Interpretation (QSA.05.15.01)
  - P. Temperature Ranges for Blood and Blood Components (QSA.05.16.01)
  - Q. Alarm Systems (QSA.05.17.01)
  - R. Blood and Blood Component Inspection (QSA.05.18.01)
  - S. Blood and Blood Component Supply (QSA.05.19.01)
  - T. Blood Collection Labeling (QSA.05.20.01)
  - U. ABO Group and Rh Type (QSA.05.21.01)
  - V. Reactivity Testing for Reagents (QSA.05.22.01)
  - W. Sera, Antisera, Cells, and Reagents (QSA.05.23.01)
  - X. Testing Performed Before Blood Administration (QSA.05.24.01)
  - Y. Sample Retention for Transfused Blood (QSA.05.25.01)
  - Z. Record Retention (QSA.05.26.01)
  
- VIII. Clinical Chemistry
  - A. Quality Control Testing (QSA.06.01.01)
  - B. Blood Gas Quality Control Testing (QSA.06.02.01)
  
- IX. Clinical Microscopy
  - A. Specimen Criteria (QSA.07.01.01)
  - B. Microscopic Examination of Urine Sediment (QSA.07.02.01)
  
- X. Cytology
  - A. Staff Qualifications and Number (QSA.08.01.01)
  - B. Specimen Testing (QSA.08.02.01)
  - C. Quality Improvement Process (QSA.08.03.01)
  - D. Workload Limits (QSA.08.04.01)
  - E. Staining (QSA.08.05.01)
  - F. Quality Assurance System (QSA.08.06.01)
  - G. Slide Review (QSA.08.07.01)

- H. Reporting (QSA.08.08.01)
- I. Slide Maintenance, Storage, and Retrieval (QSA.08.09.01)
  
- XI. Cytogenetics
  - A. Quality Control and Testing (QSA.09.01.01)
  - B. Sample Identification (QSA.09.02.01)
  - C. Stages of Testing and Results (QSA.09.03.01)
  - D. Interpretive Report Information (QSA.09.04.01)
  - E. Abnormal Case Retention (QSA.09.05.01)
  
- XII. Embryology
  - A. Testing Procedures (QSA.10.01.01)
  - B. Method Validation (QSA.10.02.01)
  - C. Record Maintenance (QSA.10.03.01)
  - D. Media Quality Controls (QSA.10.04.01)
  - E. Tracking (QSA.10.05.01)
  - F. Receipt and Transfer of Specimens (QSA.10.06.01)
  - G. Record Retention (QSA.10.07.01)
  
- XIII. Hematology and Coagulation
  - A. Procedure and Test Parameter Verification (QSA.11.01.01)
  - B. Coagulation Quality Control Testing (QSA.11.02.01)
  
- XIV. Histocompatibility
  - A. Quality Control Practices and Method Validation (QSA.12.01.01)
  - B. Recipient and Donor Crossmatching (QSA.12.02.01)
  - C. Human Leukocyte Antigen Serologic Typing (QSA.12.03.01)
  - D. Histocompatibility Testing (QSA.12.04.01)
  - E. Sera Screening (QSA.12.05.01)
  - F. Mixed Lymphocyte Cultures (QSA.12.06.01)
  - G. Interlaboratory Reproducibility Validation (QSA.12.07.01)
  
- XV. Histopathology
  - A. Specimen Submission and Exception (QSA.13.01.01)
  - B. Accompanying Information and Diagnoses (QSA.13.02.01)
  - C. Specimen Receipt and Identification (QSA.12.03.01)
  - D. Specimen Examination (QSA.12.04.01)
  - E. Managing Electron Microscope Hazards (QSA.12.05.01)
  - F. Staining Quality (QSA.12.06.01)
  - G. Specimen Retention (QSA.12.07.01)
  
- XVI. Immunology and Syphilis Serology
  - A. Antigen Reactivity (QSA.14.01.01)
  - B. Testing (QSA.14.02.01)

- XVII. Molecular Testing
- A. Testing Policies and Procedures (QSA.15.01.01)
  - B. Validation (QSA.15.02.01)
  - C. Quality Control Limits, Reference Ranges, and Reportable Ranges (QSA.15.03.01)
  - D. Test Run Verification (QSA.15.04.01)
  - E. Reporting (QSA.15.05.01)
- XVIII. Molecular Genetics
- A. Testing Policies and Procedures (QSA.16.01.01)
  - B. Reporting (QSA.16.02.01)
- XIX. Parasitology
- A. Reference Materials and Calibrated Measuring Device (QSA.17.01.01)
  - B. Staining (QSA.17.02.01)
- XX. Provider-Performed Microscopy Procedures (PPMP) (QSA.18.01.01)
- XXI. Radioimmunoassay
- A. Testing Procedures (QSA.19.01.01)
  - B. Quality Control System (QSA.19.02.01)
- XXII. Semen Analysis (Andrology) (QSA.20.01.01)
- XXIII. Virology
- A. Testing Methodologies (QSA.21.01.01)
  - B. Record Maintenance (QSA.21.02.01)
  - C. Cell Cultures and Processes (QSA.21.03.01)

**Discussion Questions: QSA**

7. Please discuss any requirements in Attachment D that you perceive to be “new” (not in the current QSA Chapter). Note: Attachment E is a useful report for tracking the history of the revised elements of performance.
8. Please discuss your overall impression of the revised chapter, specifically:
- clarity and logic of the standards, rationales, and elements of performance;
  - successful elimination of redundancy;
  - support of quality and safety; maintenance of existing level of expectations (i.e., expectations to the field were not increased; expectations essential to quality and safety were not decreased or deleted); and
  - applicability to the organizations served within your accreditation field.
9. Is the revised QSA chapter an improvement on the current chapter?
10. From your perspective, is it clear what is required when you read the phrase “are accompanied by supporting clinical information” in proposed QSA.13.02.01, EP 2?

**PTAC thinks this is clear.**



11. Revised QSA.14.02.01, EP 2 requires “the laboratory to document that modifications to manufacturers’ specifications for syphilis testing are equivalent.” Has your laboratory ever made modifications to manufacturers’ specifications for syphilis testing?
12. From your perspective, is the term “cell controls” in the proposed QSA.21.03.01, EP 2 clear? Is there an alternative term that could be used in place of “cell controls?”
13. Should The Joint Commission accept the Clinical Laboratory Improvement Amendments (CLIA) exceptions for calibration verification?

These exceptions are:

- For automated cell counters, the calibration verification requirements are considered met if the laboratory follows the manufacturer’s instructions for instrument operation and tests 2 levels of control materials each day of testing provided the control results meet the laboratory’s criteria for acceptability.
- If the laboratory follows the manufacturer’s instruction for instrument operation and routinely tests three levels of control materials (lowest level available, mid-level, and highest level available) more than once each day of testing; the control material results meet the laboratory’s criteria for acceptability and the control materials are traceable to National Institute of Standards and Technology (NIST) reference materials, the calibration verification requirements are met.

**Notes:**

***QSA.01.01.01, EP 8***

There is a typo in line 48; the word “gain” should be “again.”

***QSA.01.02.01, EP 2***

A footnote should be added to this EP. PTAC member Gerald Hoeltge will email his recommendation for the text of the footnote.

***QSA.01.04.01, EP 1***

PTAC recommends changing “date” to “submission deadline” and deleting “by which...”

***QSA.01.05.01, EP 1***

The first bullet (lines 102 and 103) is confusing. It would help to elaborate on “for example, peer comparisons” and to clarify that proficiency testing would be preferable.

The first and second bullets should be switched (line 104 before line 102)

Add bullet for proficiency testing for non-regulated analytes (should be bullet 1).

**QSA.02.01.01**

“Verify” vs. “validate” – evaluate for each time “validate” is used; The Joint Commission should use the terms the same way that CLIA uses them.

Verification – what you do when you first bring the test in.

Validation – what you do ongoing once the verification is done.

**QSA.02.04.01**

The PTAC feels the standard and the organization of EPs in the standard is not clear.

**QSA.02.04.01, EP 2**

The PTAC recommends adding the idea of EP 8 as a note to EP 2. (See notes about QSA.02.04.01, EP 4)

**QSA.02.04.01, EP 4**

The term “validation” should be changed to “evaluation” (line 199).

This EP is missing the notion of why to choose the frequency and number of control samples. This EP should cover all the factors that are important to determine the frequency and number of samples, the whole testing process needs to be evaluated. (EP 8 contains the essence of what should be done before EP 4, not *just* when a negative result occurs)

**QSA.02.05.01, EP 1 & EP 3**

Change the word “it” to something more descriptive.

**QSA.02.08.01, EP 1**

Note 2 has too many negatives, the note needs to be re-worded.

There is a typo in line 278; the word “methodologies” should be “methodologies.”

**QSA.02.10.01, EP 8**

This EP does not make sense; “capable of detecting errors” should be changed to “capable of detecting extraction errors.”

**QSA.02.10.01, EP 10**

The PTAC suggested revising this EP in the following way: “...with a calibrator containing all ~~known~~ substances or drug groups, ~~as~~ identified ...”

**QSA.02.10.01, EP 13**

The term “validated” should be changed to “reportable.”

**QSA.02.11.01, EP 3 & EP 4**

These EPs sound too similar which causes confusion. PTAC recommends further revision to re-word these EPs.

**QSA.02.11.01, EP 3**

The bullet for “abnormal test results” should be changed to “unusual test results” or “unanticipated test results.”

**QSA.02.11.01, EP 4**

The phrase “the results” should be changed to “all results.”

**QSA.02.12.01, EP 11**

The word “duplicates” should be changed to “copies.”

**QSA.02.13.01, EP 9**

An example for PH should be added to this EP.

In current example, “distilled” should be changed to “deionized”

Add a reference to the CLSI document pertaining to water quality.

**QSA.02.14.01, EP 2**

Another bullet should be added the list for “date opened.”

**QSA.02.14.01, EP 3**

Add a reference to the materials safety data sheet and a reference to the EC (chemical safety) EPs.

**QSA.02.14.01, EP 5**

PARKING LOT: This EP only addresses expired reagents and solutions; there should be requirements for expired collection devices.

**QSA.04.01.01**

The Joint Commission requirements for QC in microbiology should not go above and beyond CLIA requirements; they require time and money, but do not provide additional value.

**QSA.04.01.01, EP 4, EP 5, & EP 6**

“Quality controls” needs to be defined. Clarify if a positive and negative control is needed to be in compliance with these EPs.

**QSA.04.01.01, EP 6**

Make sure the germ tube requirement in EP 6 doesn’t conflict with the note in EP 2.

**QSA.04.04.01, EP 3 & EP 5**

The PTAC recommends combining EP 3 and EP 5 and adding a reference to the CLSI M22. If the EPs are not combined, reference the CLSI M22 in both EPs.

**QSA.04.04.01, EP 6**

The phrase “inadequate performance and/or” should be added before “deterioration;” a documentation requirement should also be added.

**QSA.04.05.01, EP 1**

An example, such as appropriate temperature, should be added to this EP.

**QSA.05.01.01, EP 4**

The note in this EP should be clearer. The note should explain that someone qualified (a technical supervisor or physician, not a resident) could still perform the review.

**QSA.05.02.01, EP 6**

The term “emergency medical care” should be moved in front of the word “available.”

**QSA.05.03.01, EP 4**

The notes should be deleted and a reference to the FDA website that details what the tests must be should be added.

**QSA.05.04.01 & QSA.05.05.01**

There should be only one standard for people infected with a transfusion disease. There is no need to differentiate between HIV, Hepatitis C, etc.

**QSA.05.05.01**

PARKING LOT: Make this standard apply to Hepatitis B too. Standards QSA.05.04.01 & QSA.05.05.01 apply to HIV, Hepatitis C, but not Hepatitis B – and they should!

There are other dangerous infectious diseases that should be addressed too.

**QSA.05.06.01, EP 3**

The word “tests” should be changed to “evaluates.”

**QSA.05.08.01, EP 2**

This EP should require two identifiers. Add the phrase “two identifiers” after the word “matching.”

**QSA.05.13.01, EP 2**

The word “all” should be added before “suspected” and the phrase “, whether or not the licensed independent practitioner responsible for the patient deems it necessary to report the event” should be deleted; also change “licensed independent practitioner” to “authorized prescriber.”

**QSA.05.16.01**

PARKING LOT: Add an EP that addresses transport conditions (specifically about pneumatic tubes).

**QSA.05.17.01, EP 5**

This EP should also require that staff follow the organization's policies and procedures when responding to the alarms.

**QSA.05.20.01, EP 4**

PARKING LOT: Require the specimen label to include the staff ID.

**QSA.05.20.01, EP 6**

The intent of this EP is unclear and the term "staff" should be changed to "individuals."

**QSA.05.24.01, EP 1**

The note should be deleted.

**QSA.06.01.01, EP 1**

The word "runs" in the 2<sup>nd</sup> sentence of the note should be changed to "tests."

**QSA.06.01.01, EP 2**

The word "entire" should be deleted and the text in QSA.11.02.01, "a range of clinically significant values on each day" should be used.

**QSA.07.01.01, EP 2**

This EP should also include contamination as a reason a urine specimen may not be acceptable.

**QSA.08.01.01**

The phrase "are responsible for" should be deleted from the text of this standard.

**QSA.08.03.01, EP 1 & EP 2**

These EPs should apply to ALL aspects of the laboratory, not just cytology services.

**QSA.08.06.01**

Some standards in the cytology section use the phrase "gynecological and non-gynecological specimens;" this standard uses the phrase "reproductive tract slides". Consistent terminology should be used.

**QSA.08.06.01, EP 2**

This EP needs to be clarified. The EP should clearly state if machines are allowed to read in addition to cytotechnologists?

**QSA.08.07.01**

It may not be possible for one person to read everything that needs to be read, change “*The* cytology technical supervisor” to “A cytology technical supervisor” (in the standard and EPs).

**QSA.09.01.01, EP 5**

The phrase “or clone” should be added to the end of the EP.

**QSA.10.01.01, EP 3**

Examples should be added to this EP for further clarification; such as introcytoplasmic sperm injection, oocyte and embryo biopsy, and assisted hatching.

**QSA.10.02.01, EP 1**

There is a typo in line 997; the word “enbryo” should be “embryo.”

**QSA.10.03.01, EP 2**

In the second bullet (line 1006), the term “washing” should be changed to “processing.”

**QSA.10.04.01, EP 1**

The phrase “documentation of quality control performed by the manufacturer meets this requirement” should be added to the 7<sup>th</sup> bullet (line 1022).

**QSA.10.05.01, EP 1**

PARKING LOT: The “or” should be changed to “and” so that the EP requires labeling the cryopreservation container with the patient’s name, unique identifier, and the date the specimen was frozen.

**QSA.10.05.01, EP 3**

A link to the EC section that pertains to temperature monitoring should be added to this EP.

**QSA.10.07.01, EP 1**

The word “by” was omitted from this EP and should be added; “...or longer if by federal, state, or local laws.

**QSA.11.01.01, EP 3**

Change the phrase “entire range” to “a range of clinically significant values on each day.”

**QSA.11.01.01, EP 4**

Delete the phrase “using an automated hematology test system.”

**QSA.11.01.01, EP 5**

Delete the phrase “as part of an automated hematology test system.”

**QSA.11.02.01, EP 2 & EP 3**

There is a typo in line 1072 and line 1074; the word “qulaity” should be “quality.”

**QSA.12.02.01, EP 7**

Add class “Class I” to this EP.

**QSA.12.03.01**

Delete the word “serologic” from the text of the standard.

**QSA.12.03.01, EP 1**

Add the phrase “If serologic testing is performed,” before bullets 1 and 2.

**QSA.12.04.01, EP 1**

The phrase “The histocompatibility testing, that is,” should be deleted from bullet 1. In bullet 2, the term “cadaver donor” should be changed to “deceased donor.”

**QSA.12.05.01, EP 1**

The word “cell” should be deleted from this EP.

The term “histocompatible” should be changed to “histocompatibility” and the phrase “necessary to” should be added before the word “support.”

*With the revisions above, the EP should read:* Appropriate to the study or individual procedure performed, the laboratory uses a cell panel for screening individual sera from potential organ or tissue graft recipients for characterization of antibodies against ~~histocompatible~~ histocompatibility antigens to the level to necessary to support clinical transplant protocol.

**QSA.13.01.01, EP 1**

The fourth bullet does not read well, review and revise the language of the bullet (line 1191). Make sure to change “clinical staff laws” to “institution staff laws” when making the revisions.

**QSA.13.04.01, EP 5**

The members of the PTAC do not feel organizations comply with this EP.

**QSA.14.02.01, EP 2**

This EP should be deleted because of redundancy.

**QSA.15.01.01, EP 2**

The phrase “might be” should be changed to “is usually.”

**QSA.15.02.01**

The word “validation” should be changed to “verification.”

**QSA.15.05.01**

PARKING LOT: Add an EP that requires the laboratory reports for molecular testing to include the limits of interpretation.

**QSA.15.05.01, EP 6**

PARKING LOT: This EP should apply to all aspects of the laboratory, not just molecular testing.

**QSA.17.01.01**

Use consistent terminology; some of the EPs refer to “the micrometer” and some refer to “ocular lens.” The PTAC recommends using the term “ocular micrometer.”

Rearrange the EPs within this standard. EP 4 should be the second EP; EP 2 should be the third EP; EP 5 should be the fourth EP; and EP 3 should be the fifth EP.

**QSA.17.02.01, EP 1**

The term “verifies” should be replaced with “performs quality control for” and the phrase “with quality control materials” should be deleted.

PARKING LOT: An EP should be added that requires the organization to provide reference materials for identification.

**QSA.18.01.01, EP 1**

A reference to the HR chapter (training/competence section) should be added.

**QSA.21.01.01, EP 1**

The word “and” should be changed to “add/or.”

**QSA.21.02.01, EP 1**

The phrase “host systems” should be changed to “cell lines.”

**QSA.21.02.01, EP 2**

The phrase “to detect or identify” should be inserted after “used.”

**QSA.21.02.01, EP 3**

Examples should be added to this EP.

**QSA.21.03.01**

Change the phrase “identify erroneous virology” to “assess the accuracy of.”



**QSA.21.03.01, EP 1**

Delete the note.

**QSA.21.03.01, EPs 2 – 10**

Delete the word “its.”

**QSA.21.03.01, EP 2**

This EP is not clear, needs further revisions for clarification.

**QSA.21.03.01, EP 5**

Change “cells” to “cell lines.”

**QSA.21.03.01, EPs 7 – 10**

Add the phrase “Controls for” before the start of each EP (similar to EP 6).

PARKING LOT (general): Mohs surgery should be addressed in the standards.

PARKING LOT (general): Apply LAB organization/oversight standards to HAP & AHC programs

## MEDICARE COVERAGE ADVISORY COMMITTEE

Reporter: Karen Stewart  
Last submitted: 2009-06-22 08:00:45.0

### ***Recommendations***

[Insert recommendations here]

### ***Report- Nothing to report at this time, no meetings and no correspondance***

[Insert report here]

### ***Other***

[Insert other information here]

**NATIONAL ASTHMA EDUCATION & PREVENTION PROGRAM**

Reporter: Thomas Kallstrom  
Last submitted: 2009-06-01 10:38:01.0

***Recommendations***

none at this time

***Report***

The NAEPP has not met since the last board meeting. There is nothing to report at this time

***Other***

[Insert other information here]

## NATL COALITION/HLTH PRO EDU – GENETICS (NCHPEG)

Reporter: Linda Van Scoder  
Last submitted: 2009-06-22 13:16:55.0

### ***Recommendations***

[No recommendations]

### ***Report***

[In February I participated in two conference calls with the membership committee where, among other things, we discussed how NCHPEG could provide more benefits to member organizations. We recommended that NCHPEG should place more emphasis on establishing genetics content for non-genetics trained health professionals and provide help in the genetics aspects of member organizations' educational programs and materials. These recommendations still need to be approved by the NCHPEG BOD.

In May, on behalf of the AARC, I responded to a survey sponsored by the Secretary's Advisory Committee on Genetics, Health, and Society. They are trying to gather information on the genetic and genomic educational needs of patients and the general public. SACGHS has identified genetics education and training of health professionals as a priority and will be developing recommendations to the HHS Secretary.]

### ***Other***

[I plan to attend the annual NCHPEG meeting in September.]

## NATIONAL SLEEP AWARENESS ROUNDTABLE

Reporter: Mike Runge  
Last submitted: 2009-06-29 15:28:33.0

### ***Recommendations***

No Recommendations

### ***Report***

Have not recieved notification of meeting dates that have been set by the National Sleep Awareness Roundtable

### ***Other***

[Insert other information here]

## NEONATAL RESUSCITATION PROGRAM

Reporter: John Gallagher  
Last submitted: 2009-06-30 09:23:50.0

### *Recommendations*

No recommendations at this time.

### *Report*

The NRP Steering Committee (NRPSC) met on March 23 & 24, 2009 at the headquarters for the American Academy of Pediatrics in Elk Grove, Illinois. The meeting focused on the progress that has been made on the development of the sixth edition of the NRP textbook and associated media. As the AARC liaison, I have been active in the discussions that have related to airway management and have assisted in the update of Lesson 3 - Use of Resuscitation Devices for Positive-Pressure Ventilation.

In addition to the textbook revision, a great deal of time has been devoted to the redesigning of the instructional DVD for providers. The NRPSC has been busily developing new scenarios that will include the most up-to-date information and equipment to aid in the comprehension of course content. The new scenarios will be video recorded during the month of July.

The NRPSC plans to meet on October 15-17, 2009 in Washington, D.C. for the NRP Current Issues Seminar and NRPSC Meeting. The agenda for this upcoming meeting will include the evaluation of NRP Research Grant submissions and finalization of textbook revision.

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# ***Roundtable Reports***

## **ASTHMA DISEASE**

Reporter: Eileen Censullo  
Last submitted: 2009-05-29 13:17:25.0

### ***Recommendations***

Roundtable Guidelines were posted to roundtable to prevent advertisement of any products and to familiarize members to rules.

Visit [yourlunghealth.org](http://yourlunghealth.org) regularly and will recommend any additions or corrections to AARC as necessary.

**New members recruited at asthma event in Northeast Region of US**



## CONSUMER

## DISASTER RESPONSE

Reporter: Steven Sittig  
Last submitted: 2009-06-16 13:38:47.0

### *Recommendations*

#### ***NONE AT THIS TIME***

[Insert recommendations here]

***Report The list serve continues to have valuable information discussed. The updated State Disaster Chairs list is nearly complete . We continue to recruit new members to this roundtable.***

[Insert report here]

#### ***Other***

[Insert other information here]

## HYBERBARIC

Reporter: Clifford Boehm  
Last submitted: 2009-06-03 14:55:04.0

### ***Recommendations***

*Be given time at a major AARC meeting (Summer Forum or AARC International Respiratory Congress) to present a series of lectures regarding Hyperbaric Medicine and the Respiratory Therapist.*

### ***Report***

*We have successfully begun our listserv with 30 participants enrolled. Topics that have been discussed include: general introductions, department staffing patterns, prevention and treatment of seizures, other forums for information exchange, locations for formal courses on hyperbaric medicine, aspects of physician coverage and many other topics.*

*We approached the AARC International Congress program committee to begin a mini symposium regarding Hyperbaric Medicine for the 2009 congress committee but have been told we are in a "stand by" status. Apparently most of the program has been finalized. We remain available to put together a series of lectures describing the clinical practice of hyperbaric medicine (indications and contraindications, etc.) and respiratory therapy's role in the care of their patients. We would also like to include a lecture on the business management of HBO services.*

### ***Other***

[Insert other information here]

## INFORMATICS

Reporter: Constance Mussa  
Last submitted: 2009-07-01 19:50:35.0

### ***Recommendations***

[Nothing to report at this time.]

### ***Report***

[Insert report here]

### ***Other***

[Insert other information here]

## **MILITARY**

## **MODERATE SEDATION**

## NEUROMUSCULAR

Reporter: Lee Guion

Last submitted: 2009-06-21 14:36:55.0

### ***Recommendations***

Continue to support members of the Neuromuscular Roundtable and publicize its benefits to RCPs and others who work with patients with motor neuron diseases, muscular dystrophies and other muscle wasting diseases. Encourage members to submit presentation proposals to their state respiratory care organizations and poster presentations and lectures to the AARC for inclusion at future conventions.

### ***Report***

1) Members of the Neuromuscular Roundtable have been encouraged to enroll new members. As Chair of the roundtable I presented at the California Society for Respiratory Care on motor neuron diseases in June 2009 and lectured to Respiratory Therapy students in northern California on best practice in the management of muscle wasting diseases. In all instances attendees, students and faculty were encouraged to join our on-line support and discussion group. Past chair and current member Louis Boitano published an article in Respiratory Care on caring for patients with impaired cough.

2) At last years' AARC convention members of the Neuromuscular Roundtable met to discuss our role within the profession in general and the AARC in particular. Although we work in a variety of post acute health care settings with a heterogeneous patient population, we shared one common experience: our colleagues in tertiary care centers were largely unfamiliar with neuromuscular and muscle wasting diseases. Our patients' conditions, best practice and respiratory equipment were unfamiliar to RCPs in the emergency, critical care and med/surg units. There was little communication between RCPs in the acute and post acute settings upon hospital discharge.

At the request of our convener and the group I submitted 2 presentation proposals to the program planning committee for the 2009 convention to address these concerns, one of which was accepted: Management of the neuromuscular patient for the acute care therapist.

### ***Other***

[Insert other information here]

## **RESEARCH**

Reporter: John Davies  
Last submitted: 2009-06-25 11:06:00.0

### ***Recommendations***

Nothing to report at this time.

### ***Report***

[Insert report here]

### ***Other***

**[Insert other information here]**



## TOBACCO FREE LIFESTYLE

Reporter: Jonathan Waugh  
Last submitted: 2009-07-01 11:58:16.0

### ***Recommendations***

None at this time.

### ***Report***

1. The TFL Roundtable mailing list activity has significantly increased, especially with discussion of legislation leading up to the FDA regulation of tobacco products and rules for pulmonary rehabilitation reimbursement.
2. A writing work group composed of TFL Roundtable members has been working with Steve Sittig to create a pocket on quitting tobacco for patients and the public, to be printed by the AARC. The guide is nearly completed and soon work will begin on a companion guide for clinicians. We are collaborating with Steven Schroeder, MD, of the Smoking Cessation Leadership Center (UC-San Francisco).
3. Several proposals on tobacco treatment were submitted for consideration by the planning committee of the AARC Congress.

### ***Other***

We would like to create a teaching module on tobacco treatment and prevention specifically designed for RT educators. I am discussing this with Lynda Goodfellow, chair of the Education Specialty Section.

Respectfully,

Jonathan Waugh, PhD, RRT, RPFT, CTTS, FAARC

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# ***Joint Session Reports***

**AARC Election Committee**

Reporter: Vijay Deshpande  
Last submitted: 2009-06-24 13:39:54.0

***Recommendations***

[Insert recommendations here]

***Report***

***BOD REPORT***

***Election Committee Chair (Vijay Deshpande)***

***The Election Committee reviewed nominations for Director and Section Chairs. The committee discussed each nominee based on the selection criteria. As per our discussion during the conference call, the following slate of nominees was submitted to the BOD and HOD. The committee decided to use the system to randomly rotate names on the online voting. Thus the names will be cycled through and in a different order for each voter.***

***PRESIDENT ELECT: 1. George W Gaebler  
2. Karen J. Stewart***

***DIRECTOR AT LARGE: (Select only ONE)***

- 1. Charles McArthur***
- 2. Albert Moss***
- 3. Frank R. Salvatore, Jr.***

***SECTION CHAIR- ELECT***

***CONTINUING CARE - REHABILITATION***

- 1. Debie Koehl (No other candidate nominated)***

***SLEEP***

- 1. Karen Pfister-Fegeley***
- 2. Tony Stigall***

***HOME CARE***

- 1. Tim Buckley***

**2. Greg Spratt**  
**NEONATAL-PEDIATRICS**

- 1. Tiffany G. Mabe**
- 2. Natalie Napolitano**

***Upon approval from the BOD and HOD, the committee will coordinate with the AARC executive office to distribute the ballot to active members at least 60 days prior to the AARC Business meeting in December. The committee will then receive and count the ballots no less than 21 days before the Annual Business meeting.***

**AARC Secretary-Treasurer Financial Update – Karen Stewart**

## **Update 2015 – Bill Dubbs**

## Regulatory Affairs Update



### Federal Government Affairs Activity Report – July 2009

*Cheryl A. West, MHA, Director Government Affairs*  
*Miriam O'Day, Director Legislative Affairs*  
*Anne Marie Hummel, Director Regulatory Affairs*

#### The Congress

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The first 6 months of the 111<sup>th</sup> Congress focused mainly on addressing economic issues including the stimulus package, the banking and mortgage bailout efforts and now the 2010 federal budget.

It is well understood that in Washington, DC politics the “honeymoon period” for a new administration doesn’t last very long. Any legislation that is either controversial or represents a major shift in policy needs to be pushed forward quickly, usually within the first year, or run the real risk of the issue being bogged down in partisan politics. And, pretty much everything the Administration has asked for is in one way or another controversial, sometimes merely by necessity.

Therefore, it is of no particular surprise that a proposal for major health care reform is embedded in the budget package. Any attempt to reform the nation’s health care system is, by definition, a controversial effort.

In terms of how the larger impact of national health care reform will directly impact our Hill issues consider the following:

The provisions of our key legislative issue, the Medicare Respiratory Therapy Initiative, HR 1077 and S 343 will be added to whatever large Medicare bill is moving through Congress. This is how all Medicare legislation is enacted. Stand-alone Medicare bills are not passed separately.

The health community knows that the temporary “physician fee fix” will expire in July, thus requiring Congress to yet again enact some Medicare legislation to address this perennial problem. Into this mix we add the proposed health care reform which is attached to the proposed Obama 2010 federal budget. The question that remains is whether a large Medicare bill will be passed separately or whether Congress intends to include all the various Medicare bills, including our own RT bill, as part of the “fix” to the health care system.

As this report is written, political will and economic necessity to reform the healthcare system are strong.

## **Legislation**

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Miriam O'Day, the AARC Director of Legislative Affairs, continues to advance our legislative agenda on Capitol Hill. As a representative for the AARC, she attends Hill staff meetings, Congressional hearings, press conferences, campaign fund raisers for supportive legislators, and is our liaison to other health oriented organizations.

### **Children's Health Insurance and Tobacco Tax Increases**

One of the first acts of the new Congress was to quickly enact an extension and expansion of the Children's Health Insurance Program. The law now extends health coverage to a wider population of nearly 4 million children. To pay for the expansion, Congress approved an increase in the federal tax on cigarettes, going from the current 39 cents to \$1.01 per pack.

### **Medicare, Medicaid, and Maternal Child Health (MCH) Tobacco Cessation Promotion Act of 2009 – HR 1850 and S 770**

Introduced by Senators Durbin (D-IL) and Kennedy (D-MA) and House Representatives Degette (D-CO) and Platts (R-PA), this bill would create a Medicare and Medicaid benefit that would cover smoking cessation programs provided by qualified smoking cessation counselors. The bill would also provide block grants under the MCH statute to cover smoking cessation programs. While respiratory therapists are not specifically mentioned in the bill language, the qualifications as a smoking cessation counselor would be set by regulations. The AARC will certainly be involved in providing input on the qualifications and abilities of respiratory therapists when the regulatory writing stage is reached, assuming the bill is enacted. Miriam worked with Senator Durbin's staff to include this legislation as a priority for the recent United for Lung Health Advocacy Day in Washington, DC.

### **The Medicare Respiratory Therapy Initiative Reintroduced – HR 1077 and S 343**

HR 1077 and S 343 have been reintroduced in the 111<sup>th</sup> Congress by our original sponsor in the House, Congressman Mike Ross (D-AR) and co-sponsors in the Senate, Blanche Lincoln (D-AR) and Mike Crapo (R-ID). To recap, the Medicare Respiratory Therapy Initiative will add respiratory therapy services to the "medical and other health services" benefit category under Medicare Part B. This legislation will permit respiratory therapists with an RRT credential and a bachelor degree to deliver respiratory therapy services without the physician being physically present when the services are being furnished, i.e., under general physician supervision.

The provisions of these bills remain the same as in the last session of Congress with the exception of the implementation date, which is changed to January 2010. We continue to gain co-sponsors for the legislation. As this report is written there are 19 co-sponsors for HR 1077 and 7 co-sponsors for S 343.

We now have support from Congressman Ross to request the Congressional Budget Office (CBO) to provide an official "score" on the cost of our legislation, a key to having Congress move to add our provisions onto whatever Medicare vehicle will move through Congress.



Congressman Ross put this legislation at the top of his list of requests that were given to Chairman Waxman in a private meeting. This legislation has no known opposition and we have extended the number of consumer/patient organizations who have offered their support. We stand a strong chance of being included in a House sponsored Healthcare reform package.

Miriam O'Day attended a fundraiser for Congressman Ross (D-AR) and asked for his continued support and leadership with the House Committees of jurisdiction over the legislation.

### **Coalition Activities**

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The AARC continues its tradition of participating in a number of Coalitions of like-minded associations and organizations to advance particular legislation and regulations. Our participation in select coalitions varies from urging greater funding for research to promoting issues that will enhance the clinical support of patients with particular illnesses.

The US COPD Coalition held its annual face-to-face meeting in San Diego during the ATS Meeting. Sam Giordano currently serves on the Executive Committee and is the Treasurer; Miriam O'Day chairs the legislative committee for the Coalition. The Coalition is working to strengthen its relationship with state and local organizations and enhance its membership. The NHLBI gave an update on the COPD Learn More Breathe Better Campaign, and the change in PR firms to Porter Novelli, who will be charged with enhancing the Campaign.

### **The Centers for Disease Control and Prevention (CDC) Chronic Disease COPD Program Appropriations Request**

AARC continues to partner with the US COPD Coalition to support a public health program that would address COPD in the Chronic Disease and Health Prevention Division of the Centers for Disease Control and Prevention (CDC). We are asking that Congress fund \$1 million to be directed to the CDC for a COPD Action Plan.

Earlier this spring the AARC activated its 435 Plan to solicit support emails from our members during a strategic point in the appropriations process. The chief Senate sponsors of this appropriations request needed to generate interest and support from other Senators. This is done by gathering Senate signatures on a "Dear Colleague" letter. We asked AARC members to urge their own Senators to sign on to the Dear Colleague, thus generating interest and support for the appropriation.

As the result of the AARC's advocacy the CDC has named a COPD "Czar" who is going to review the BRFSS state modules and propose a core question for 2011. The COPD Czar will evaluate surveillance and begin planning a partners meeting to establish a national COPD Action Plan.

### **The Family Smoking Prevention and Tobacco Control Act**

The AARC continues to partner with public health associations organized under the coalition

umbrella (Tobacco Free Kids) sponsored by the American Lung Association, American Cancer Society and the American Heart Association.

This spring we have worked with our Coalition partners to move HR 1256, the Family Smoking Prevention and Tobacco Control Act. This earlier this year the bill passed both House and Senate and was signed into law by the President. This ends a nearly 10 effort to enact these provisions. The key components of the bill will give the FDA greater regulatory authority over the production and marketing of tobacco products. These enhanced efforts will be paid for by user fees on the Tobacco Companies.

### **Political Advocacy Contact Team (PACT) Representatives**

As noted in every Federal Activity Report, PACT representatives are the cornerstone to our success in both Washington, DC and at the state level. PACT representatives are appointed by their state society and have volunteered to lead the grassroots efforts on behalf of the profession.

The 2009 PACT DC Hill Day was held March 9-10. There were 104 respiratory therapists from 46 states and the District of Columbia who represented the profession on Capitol Hill. We again had over 300 scheduled Hill visits and gained co-sponsors for HR 1077 and S 343, support for the CDC appropriation for COPD, and urged members to join the Congressional COPD Caucus.

Our thanks again go to the respiratory therapists and our voluntary leadership who take time away from work and family to come to Washington and advocate for the profession. And as always, recognition must be given to the state societies who helped fund their PACT representatives to attend this important event.

### **Regulations**

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Anne Marie Hummel is the AARC's Director of Regulatory Affairs. While our focus remains centered on the administration of the complex Medicare program, AARC continues to be proactive when other federal agencies, such as the Food and Drug Administration (FDA) or the Departments of Education or Transportation, issue rules that impact the profession. Representing the AARC, Anne Marie also attends various coalition meetings of groups who advocate both Congress and the various agencies on issues of importance to the profession.

### **Definition of Respiratory Therapist (RT) in the Comprehensive Outpatient Rehabilitation Facility (CORF) Setting**

In the next few months, we expect CMS to publish a correction to the RT definition they published late last year restricting coverage to those individuals holding the RRT credential. CMS has been willing to work with us on the definition and are very concerned that whatever they propose will not put RTs out of a job.

We expect them to keep the current definition of RT technician and go back to the long-standing definition of RT, which includes CRTs with advanced level training who are eligible

to take the registry exam. There are no other regulations, regardless of the setting, that define either RT or RT technician, so it's important, especially for the inpatient setting, that the "technician" definition is maintained since the majority of CRTs with entry-level training only work in the hospital setting. We do not plan to oppose the use of the term "RT technician" this time around even though we have explained to CMS that the term is obsolete.

### **Oxygen on Airlines**

A year after its publication, the final rule from the Department of Transportation requiring domestic and foreign airlines to permit passengers with electronic respiratory assist devices to board the plane went into effect May 13, 2009. There are two primary conditions for use – the devices must be tested and labeled by the manufacturer as safe for air travel and be able to be stored safely in the cabin in accordance with Federal Aviation Administration rules.

The devices permitted include portable oxygen concentrators (POCs), respirators, ventilators and CPAP devices. Passengers are required to bring along a sufficient number of backup batteries for the trip and, if using a portable oxygen concentrator, must also have a medical certificate from their physician. Advance notification and check-in may also be required. A complaint resolution office is available in case of disputes.

### **Outpatient Pulmonary Rehabilitation (PR) – National Coverage**

CMS will publish both a proposed rule and a proposed national coverage determination (NCD) to implement the new PR benefit. The proposal will most likely be contained in the annual hospital outpatient PPS update, which at this writing we expect shortly. It will be interesting to find out what, if any, recommendations CMS includes with respect to the NCD, since AARC, along with other stakeholders, sent CMS a "model" to use in developing the policies.

Coding still remains an issue, since the CPT application for six new codes was withdrawn. ACCP, ATS and NAMDRRC plan to meet with CMS staff during the open comment period to make a plea for new codes. Because the current codes were established to recognize respiratory therapy services specifically, we will make sure that AARC is included in the meeting.

### **Home Oxygen Reform Initiative**

Working with AAHomecare, the National Oxygen Coalition (NOC) has developed a compromise proposal for a home oxygen reform package that AARC and others have been working on since last fall. The NOC proposal keeps the major provisions of eliminating oxygen from competitive bid and doing away with the 36-month rental cap, but makes some substantive revisions from earlier proposals such as establishing a bundled payment rate, eliminating case-mix adjusters and defining patient categories around the term "portability." Also as part of the reform package, AARC, working with other stakeholders including the American Lung Association, drafted specific language to define patient protections and safeguards which has been shared with members of the Senate Finance Committee as they

review various health care reform initiatives.

Further refinements to the payment structure are under consideration based on recent recommendations from Sam Giordano who stressed the need to set payment based on oxygen saturation levels as opposed to liter hours which was proposed by NOC. The workgroup is considering a transitional payment structure that would require a new payment methodology be established within 12-18 months of initial implementation.

### **Medicare Policies on Sleep Studies**

As local Medicare contractors make the final transition to Part A/B Medicare Administrative Contractors (A/B MACs) scheduled to be completed by October 2009, several will be looking at draft policies regarding polysomnography and sleep studies.

We have identified two local contractor policies that require non-hospital sleep facilities be accredited by the American Academy of Sleep Medicine (AASM) **only** as of January 1, 2010. Most local contractor policies permit accreditation by both the Joint Commission and the AASM. We have learned from the Joint Commission that they have sent letters to the contractors regarding the impact of eliminating the Joint Commission as an accrediting body. AARC also plans to write to the contractors to make them aware of the impact on respiratory therapists if the policy of only allowing the AASM to accredit non-hospital based facilities stands.

### **Inpatient Rehabilitation Facilities (IRF)**

As part of its annual prospective payment system updates, CMS is proposing changes to the inpatient rehabilitation facility classification requirements for 2010 as well as revisions to the manual instructions. These revisions are due to the volume of denied claims and variations in interpretations by contractors as to what constitutes IRF admissions. The primary distinction between the IRF environment and other rehabilitation settings is the intensity of the therapy services which require at least 3 hours of intensive therapy a day (one of which must be physical therapy or occupational therapy) at least 5 days a week

The Washington State Society President alerted AARC to the fact that there is an opportunity for RTs to be recognized for the time they contribute in this setting, even though it represents a small segment of the RT profession overall. Some hospitals in Washington State have been working with the local Medicare Contractor to include RT as a covered service based on individual patient needs. AARC plans to submit comments on the proposed rules and changes to the manual instructions to ensure that CMS is aware of the value RTs can bring to the patients in the IRF setting.

### **Conclusion**

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The activity at the federal level for both regulatory and legislative issues will continue throughout the remainder of the year. We fully anticipate responding to and providing input on a variety of issues that impact the profession.

Miriam, Anne Marie and I will provide a verbal update on these or other issues at the July meeting.

## Legislative Update – Cheryl West/Miriam O’Day

### AARC State Government Affairs Activity Report

July 2009

Cheryl A. West, MHA

Director Government Affairs

The 2009 legislative sessions are over for most states. It was very clear from what was (and was not) enacted, that all states were struggling and continue to struggle with the economic recession and the impact it is having on state funded programs and services. It was evident that legislation expanding state programs such as Medicaid did not move forward. Further, in years past one could find legislation that would create programs that addressed asthma or COPD disease management programs. That type of legislation was scarce in 2009. What one did see was legislation that revised, aka reduced Medicaid payments, raised tobacco taxes, and shifted the money from the Tobacco Settlement out of prevention and cessation programs into the “general” funds to pay for other state programs.

Due to the length of the discussion on sleep issues at the end of this report, I have limited the details on state legislation.

#### **Respiratory Therapy Regulations**

Changing the rules or regulations that detail state RT licensure can have just as much impact as amending the actual statutory provisions of the RT licensure law. Here are examples of respiratory therapy rule changes.

**Florida** - revises policies for licensure by endorsement, BLS no longer accepted as a CEU course.

**Iowa** - All licensure boards, including RT, have enhanced rules for background checks.

**Kansas** - Regs on student permits, renewal of license, change of licensure fees.

**Maine, Massachusetts** - raise licensure fees.

**Nevada** - Revises the procedure for renewing lapsed licenses.

**New Mexico** - Numerous changes for fees, licensure qualifications, application procedures and temporary licenses.

**Tennessee** - amends CEUs requirements and disciplinary criteria.

**Wisconsin** - amends policy for temporary licenses.

## **Respiratory Therapy Licensure Legislation**

As always noted, legislation introduced is never guaranteed to be enacted into law. Those bills that have been enacted are noted.

**California** bill that revises the RCP Licensure Board authority to revoke or suspend a RT license if licensee or applicant has issues of substance abuse. Another provision also exempts RTs from liability for the provision of specified services rendered during a state of war, state of emergency, or local emergency.

**Georgia** – Enacted. Provisions in an extensive Medical Practice bill that limit the time for temporary license.

**Kansas and Connecticut** - both raise licensure fees for RTs

**Montana** - has a bill that would revise the composition of the RT licensure board.

**Nevada** - would include in the RT licensure law an additional exemption for individuals serving in the US armed forces.

**Oregon** - a bill that adjusts the composition of the RT licensure board and reaffirms that the Oregon Society for Respiratory Care may make recommendations to the Governor as to RT nominees. There is also a bill that raises RT (and other professions) licensing fees.

**Vermont** - appropriations to support colleges that have programs for RT (and nursing and dental hygienists).

**West Virginia** - has legislation that would give the RT Licensure Board authority to adjust and revise RT student temporary permits.

## **Generic Health Profession Licensure Legislation that Includes Respiratory Therapists**

State legislatures continue to introduce and pass legislation that will cover in one catch-all bill requirements for a variety of different licensed professions. This legislative method is efficient and creates standardized rules for a cross section of professions. The focus has most often been disciplinary criteria and appeal actions so that there is uniformity among the professions.

The following states have bills that impact numerous licensure boards including respiratory therapy. Again, unless noted, none of these bills have been enacted.

**Mississippi** - A bill that creates a Volunteer Health Care Practitioners Registry to respond to

declared emergencies.

**Georgia**- Enacted. Medical Practice revisions will permit Medical Bd. to order a physical or mental examination of any of its licensees including RTs.

**Iowa** - a consumer protection bill that addresses consumer right against fraudulent actions by health professions including RTs.

**New York** - prohibiting participation in torture and improper treatment of prisoners by health care professionals, includes RTs.

**Ohio** - large health professions bill, amends the disciplinary criteria in the RC Act so that the RT must have done a RT related offense.

**Oregon** - Requires a licensee under any health professional regulatory board to report prohibited conduct of another health professional who is licensed to the appropriate licensure board. Another bill would prohibit licensure boards or the state agency from assessing to the licensee the costs or attorney fees accrued by the state for disciplinary proceedings.

**Oklahoma** - a bill on Volunteer Medical Professional Services Immunity: expands the circumstances where numerous professions would be immune from liability.

**Kansas** - addresses “distance learning” for continuing education for many professions. Also a bill that addresses non-disciplinary resolution to licensure issues, including RT.

### **Challenges from Other Occupations**

We continue to monitor legislative activities by other professions and disciplines. Seemingly small changes such as who may provide a service, qualifications for the personnel to provide specific services, the specific services or tasks that are permitted and where these tasks and services may be provided, can greatly impact the respiratory therapy legal scope of practice. Seemingly, small changes can diminish the scope of practice for the respiratory therapists and/or insert additional requirements for respiratory therapists to continue to provide what was once legally accepted as part of their own scope of practice. At the same time these “small” changes can sometimes legally permit personnel who do not possess the same education or competency documentation to provide what are essentially respiratory therapy services.

While the issue of sleep and polysomnography takes center stage, efforts undertaken by other disciplines or professions can also be of concern.

For example, a bill was introduced in Kansas that would have created the “advanced” paramedic and EMT who would be permitted to provide “advanced services”. There is absolutely nothing inherently wrong with this. However, what was not stated in the legislation were the specifics of what would be defined as “advanced services” nor what would be required to become “advanced” in terms of education and competency testing. The bill left these details up to the EMT Licensing Board to determine. While, in all likelihood,



what would be specified would be completely acceptable, that is not guaranteed. The open ended nature of the wording is of concern since the EMT Board **could** issue rules that say advanced EMS personnel can do all manner of services with limited training. While this particular bill was not enacted I use it to illustrate the take home point of “*the devil is in the details*”.

Over the past few years there have been a few bills in state legislatures that would license perfusionists. Again, nothing objectionable with that effort. However, a careful read of the provisions show that in some cases only licensed perfusionists can provide ECMO services. There are some specially trained respiratory therapists who provide ECMO services. Without a specific exemption for these particular RTs, a new license with additional education would be required for the RT to continue to provide ECMO services that have been permitted under their own scope of practice.

Another example, would be RTs who are part of air and ground transport teams. At the request of the AARC’s Transport Section Chair, Steve Sittig, we are closely monitoring state legislation and regulations pertaining to the transport of patients. Evidently there is movement in some states to specifically list the personnel who may be permitted on patient transport teams. There is some concern that the list will either not include RTs at all or only permit RTs who hold additional mandatory credentials.

These are examples of why it is imperative for state societies to have strong and active government or legislative committees and utilize your PACT representatives to organize grass root responses. Monitoring legislation and the more elusive regulations are key, but so is making sure that the society officially comments on and makes their ‘presence known’ to policy makers.

### **Sleep Disorder or Polysomnography State Legislative Activities**

Clearly, the focus of our attention regarding other disciplines has been on polysomnography legislative efforts. We continue to update you on the activities at the state level and our growing concern that proposed or enacted state legislation to regulate or license polysomnography personnel contain provisions that specifically target the respiratory therapist. We have noted that in several states the licensure bills under debate have followed a standard template which singles out the respiratory therapist for further testing and credentialing.

The American Association of Sleep Technologists (AAST) has made the attached template its official Model Practice Act for Polysomnography personnel. **(See Attachment 1)**

This Model Practice Act is a near replica of the polysom licensure law enacted in Tennessee, including the provision that RTs will have to take an additional exam in order to continue to provide the same sleep services they have always provided under their own scope.

Please see Section 4 item 5 of the template legislation. You will note no other licensed profession has been singled out for additional testing except the respiratory therapist. Please also note if RTs do not comply with additional credentials the RT will be subject to

disciplinary action by the RT licensure board.

*(5) A respiratory therapist licensed under Section \_\_\_\_\_, may provide sleep-related services under the general supervision of a licensed physician if the licensed respiratory therapist is credentialed by the Board of Registered Polysomnographic Technologists or other nationally recognized body. Respiratory therapists performing sleep-related services shall be subject to disciplinary action by the board of respiratory care if they fail to adhere to the standards established under this chapter.*

## **Update on Sleep Legislation and Regulation**

**Hawaii** - legislation was introduced to license respiratory therapists. The provisions for the RT licensure bill conformed to the AARC Model Practice Act.

At the request of the Hawaii Society for Respiratory Care the AARC submitted testimony to two key legislative committees in support of moving forward with RT licensure.

Within days of introduction, a joint letter opposing Hawaii RT licensure was sent from the American Academy of Sleep Medicine (AASM) and the American Association of Sleep Technologists (AAST). **(See Attachment 2)**

While initially it appeared that licensure legislation might go through this session we surmise that the sleep opposition raised enough issues that the RT licensure effort in HI will have to go through a regulatory review process before licensure can be attempted again.

**Minnesota** - the MSRC launched a well planned legislative effort to upgrade RT registration to full licensure this year. The legislation was moving without opposition through the legislature until stakeholders representing sleep interests intervened and demanded that specific exemptions for polysom personnel, including those who had not been competency tested be included in the provisions. If such exemptions were not included the sleep interests stated that they would kill the bill in its entirety. Weighing the alternatives the MSRC agreed to more limited exemptions for sleep personnel. The provisions for the respiratory therapy upgrade to full licensure were attached to a much larger health related bill that the Governor signed into law in late May. Respiratory therapists in Minnesota will now be licensed. Congratulations.

### **Tennessee**

As noted above the provisions of the TN polysom licensure law have evolved into the model practice act advocated by the AAST to be used in future state polysom licensure efforts.

The issue over provisions of the polysomnography licensure law and the impact on respiratory therapists in TN has been a very difficult and unfortunate one. The AARC has been committed to amending the polysom licensure law to rescind the provision that requires the respiratory therapist to obtain an additional credential in order to continue to provide polysom services under their own scope of practice. And as you are aware the majority of the Board of Directors for the Tennessee Society did not support the AARC position and did not

support the efforts to amend the law.

It is essential not only to the RTs in TN but nationwide to restore the scope of practice and remove the requirement for an additional test. To that end the AARC employed a TN based health lobbyist in order to advocate our position. AARC President Tim Myers has continued the efforts begun under AARC President Toni Rodriguez's term of office by keeping the lines of communication open between the leadership of the TSRC and the AARC. Earlier this spring the AARC and the leadership of the TSRC reached a compromise provision that would provide 3 pathways to document RTs competency when providing polysom services. The compromise was for RTs providing what is now defined as polysom to either 1. take the RPSGT exam 2. take the NBRC's new SDS exam or 3. meet standardized competency guidelines developed and approved by the Respiratory Care Licensure Board.

Despite the intense opposition to the compromise by the TN Sleep Society, the bill was passed by both Houses and awaits the Governor's signature.

### **Oklahoma**

Legislation has been enacted that unlike polysomnography licensure bills, is directed at setting standards for sleep facilities not affiliated with hospitals. The requirements of the new law are focused on the business side, not the personnel side of the equation. Provisions require all non-hospital sleep facilities to be accredited by the Joint Commission, the American Academy of Sleep Medicine or the Accreditation Commission for Healthcare. The bill went through numerous revisions, and the leadership of the OSRC was very involved in the process assuring that unacceptable amendments to the respiratory profession were not included.

### **Kentucky**

A representative from the newly formed KY Sleep Society was circulating a draft of legislation that would license polysoms. The bill followed the model licensure template supported by the AAST. This includes the provision that singles out the respiratory therapist for an additional credential. A copy of this draft was provided to State regulatory/licensure staff. The General Counsels office reported back that it could not support licensing a discipline that does not require accredited education or competency testing for all personnel. Two criteria that polysom personnel cannot meet at this time.

### **North Carolina**

In 2007 an effort was launched to license polysoms using the now AAST model template language. The Agency governing the licensure regulation dismissed this effort citing the same opinion Kentucky has rendered: polysoms have not evolved to a level where practitioners are graduates of accredited schools and all practitioners are required to be competency tested.

This year another effort has been launched, in a more limited fashion. The bill under discussion would purport to *register* (not license) polysom technologists. To register a discipline or profession is really a *title protection* effort. That is other professionals can provide the services but one cannot publically hold themselves out as, in this case, polysom technologists. However, upon closer review of the language there is a provision that states

that one cannot *provide* polysom services unless one is registered as a polysom technologist. And that provision makes it a licensure bill. As noted previously, the devil is in the details.

The NCSRC and the NC Respiratory Care Board have been closely working with both the sleep community and state legislators to provide input into the proposed bill. All parties agree that due to the Respiratory Care Board's position statements and declaratory rulings that clearly state that sleep disorder services are part of the RT scope of practice any legislation affecting sleep personnel will exempt and not impact licensed respiratory therapists.

### **District of Columbia**

Because DC is not a state, following legislation from DC can be somewhat difficult . Legislation is proposed and enacted by the DC Council and then has to be approved by Congress (which is fairly pro forma but an additional step nevertheless). A bill to license polysom personnel was approved by the DC Council. The bill explicitly exempts licensed respiratory therapists from any provision of the polysom requirements. The bill however leaves the details, scope of practice, education and testing up to the regulatory writing process. The regulation writing process will need to be closely monitored.

### **Virginia**

The preferred path for a discipline in this state to gain licensure is to have the Virginia Board of Health Professions determine that the discipline in question is indeed a profession thus warranting support for legislation mandating licensure. While this is the preferred path, any discipline/profession can directly approach the legislature and move licensure legislation without the Board of Health Professions support.

The Virginia Sleep Medicine Society sent an extensive statement to the Board of Health Professions providing their rationale as to why the discipline of polysomnography needs to be licensed and that it has achieved the benchmarks needed to qualify as a profession. The letter outlined the clinical complexities of polysom, while playing down the OJT nature of the training of personnel. However the letter did deal in great detail on the shortcomings of respiratory therapists regarding their educational preparation to provide polysomnography. **(See Attachment 3)**

The Virginia Society has submitted its own statement citing the education and testing background of respiratory therapists and sleep disorder services. The VSRC letter also supported the need to regulate polysom personnel recommending that if licensure efforts or support for those efforts moves forward that legislation should be written to regulate polysom under the Respiratory Care Licensure Board.

### **New York**

The polysomnography licensure bill under discussion in 2008 has been re-introduced this session. This legislation is supported by the NY State Education Department- the department under which many health professions are licensed, including respiratory therapy. The Department believes that in order for any discipline to be considered a profession and require licensure that all personnel must be graduates of accredited education programs and be competency tested. To that end the provisions of the NY polysom bill make it clear that only accredited associate level education will be acceptable (after an appropriate grandfather

period, so as not to disrupt current staffing) as a pathway to polysom licensure. Thus far, the bill has not moved forward in this year's legislative session.

### **Maryland**

The Maryland polysom licensure law was enacted in 2006, with the support of the sleep community. As with the New York legislation mentioned above, the state of Maryland adheres to the philosophy that to be considered a *profession* warranting state licensure, graduation from accredited education programs is a necessity. Thus, a provision within the MD polysom licensure law required that by the September 2009 applicants for polysom licensure must be graduates of CAAHEP accredited programs. This gave the sleep community 3 years in which to establish CAAHEP approved sleep programs.

In the years since the enactment of the law, only one CAAHEP polysom education program has been established in Maryland (and that was very recent). Legislation was introduced and enacted this session that will delay the implementation of polysom licensure until 2011. Presumably by then there will be more CAAHEP accredited polysom education programs available.

### **New Jersey**

A polysom licensure law was enacted several years ago. As with the Maryland polysom licensure law, this bill was passed well before the model polysom licensure template provisions was endorsed.

The NJ polysom law does not single out the RT for further credentials. It does provide the standard provision that exempts other licensed professions from having to obtain a polysom license if their own scope of practice includes the services now defined as polysom.

After many years proposed regs have been issued. The proposed rules contain areas of concern that deviate from the law. For example, there is no specific end date when the OJT training course A Step, (which now appears in the regs but never mentioned in the law) will cease to be a educational pathway to licensure. This type of OJT training course should only be permitted for a specific time to be replaced by nationally recognized accredited academic polysom education programs approved by CAAHEP or other national accrediting bodies. The proposed regulations also would require all sleep labs to be accredited only by the AASM. This would create a monopoly that would legally prevent the Joint Commission or other accrediting entities from being recognized as legitimate accreditors of sleep labs and centers in New Jersey. We are opposed to the creation of this monopoly.

### **Georgia**

A recent interpretation of the GA Medical Practice Act and the GA Respiratory Therapy Licensure law determined that only a licensed health professional may provide C-PAP and/or Bi -PAP to patients. Moreover, this interpretation was based on a more far reaching issue that the interpretation of GA law will not permit physicians to delegate to **any** unlicensed personnel services or procedures that are in the scope of practice of another licensed health profession.

This restrictive ruling regarding the limitation of physician delegation has had the effect of

disrupting many services provided by unlicensed personnel and not just in the areas sleep and DME, but in areas such as services provided by medical assistants, or laser techs etc.

Initial efforts to promote a polysom licensure bill were not successful (the Governor of Georgia let it be known that he would not sign a licensure bill). However, intense lobbying of the GA Governor by sleep stakeholders has resulted in a Governor backed bill that was introduced and passed that provided an exemption for polysom personnel from this sweeping delegation ruling. The new law defines “polysomnography services” and permits the delegation exemption only to apply to those specific services. Respiratory therapists are explicitly exempt. However, in addition to this stand alone exemption the law notes that polysoms are also exempt from all provisions of the respiratory care licensure law.

### **Kansas**

A bill to license polysomnography personnel in KS was introduced in the legislature. There were several provisions of the legislation unacceptable to the leadership of the KSRC. The bill contained specific exemptions for nurses and dentists, but none for the respiratory therapists, who above any other profession have the most sleep education and competency documentation and logically should be exempted from the provisions of the bill. Several KSRC members including Debbie Fox, Karen Schell and Suzanne Bollig testified at a Senate hearing opposing certain provisions of the legislation and requesting these be revised before moving forward.

The KS Legislature determined that the supporters of licensing polysom personnel had not gone through the state agency review process that would determine if legislation for licensure of polysoms is warranted. Therefore, legislation would not move forward until the review process was completed.

### **California**

Last year the California legislature passed a polysomnography licensure bill, only to have it vetoed. The polysom bill (and many other bills) was vetoed not on its merits but from an internal budgetary struggle between Governor Schwarzenegger and the legislature.

The CSRC worked to make sure there was a provision in the bill that would exempt the RT. The bill would license polysom technologists and leave up to the Board of Medicine the decision on how to regulate the polysom trainees and technicians i.e. those who have not passed a competency exam. The bill with the same provisions has been re-introduced and is expected to pass quickly.

In anticipation that some special interests will raise the question whether the sleep disorder services are part of the RT scope of practice, the CA Licensure Board has issued proposed regulations that clarify that sleep disorder services are part of the RT scope. A copy of proposed regulations is attached. **(See Attachment 4)**. The AARC has commented in support of the proposed regulatory change.

### **Conclusion**

2009 has already proved to be a very active year on the state level, especially in terms of sleep/polysomnography issues. We continue to expect intense activity in this area over the

coming months. I will provide an update at the July meeting.

# **ATTACHMENT 1**

## **AAST Model Certification Legislation**



# American Association of Sleep Technologists

One Westbrook Corporate Center • Suite 920 • Westchester, IL 60154

Phone 708-492-0796 • Fax 708-273-9344 • [www.aastweb.org](http://www.aastweb.org)

## MODEL LEGISLATION, EXEMPTION LANGUAGE, AND CERTIFICATION FOR POLYSOMNOGRAPHIC TECHNOLOGISTS • POLYSOMNOGRAPHIC TECHNICIANS • POLYSOMNOGRAPHIC TRAINEES

### MODEL LICENSURE LEGISLATION

\_\_\_\_\_ (*insert bill number*)

(State) Statute \_\_\_\_\_ is amended by adding the following language as a new chapter thereto:

#### SECTION 1. Definitions, Scope of Practice

As used in this chapter, unless the context requires otherwise:

- (1) “Board” means the board of medical examiners;
- (2) “Direct supervision” means that the polysomnographic technologist providing supervision must be present in the area where the polysomnographic procedure is being performed and immediately available to furnish assistance and direction throughout the performance of the procedure;
- (3) “General supervision” means that the polysomnographic procedure is provided under a physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure;
- (4) “Sleep technologist” means a person who is credentialed by the board of registered polysomnographic technologists and is licensed by the board to engage in the practice of polysomnography under the general supervision of a licensed physician;
- (5) “Polysomnographic technician” means a person who has graduated from an accredited educational program described in \_\_\_\_\_ but has not yet passed the national certifying examination given by the board of registered polysomnographic technologists, who has obtained a temporary permit from the board, and who may provide sleep-related services under the general supervision of a licensed physician;
- (6) “Polysomnographic trainee” means a person who is enrolled in an Accredited Sleep Technologist Education Program (A-STEP) that is accredited by the American Academy of Sleep Medicine and who may provide sleep-related services under the direct supervision of a polysomnographic technologist and technician as a part of the person’s educational program;
- (7) “Polysomnographic student” means a person who is enrolled in an educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs, A-STEP and other nationally recognized bodies as provided in \_\_\_\_\_ and who may provide sleep-related services under the direct supervision of a polysomnographic technologist as a part of the person’s educational program;
- (8) “Practice of polysomnography” means the performance of any of the following tasks, under the general supervision of a licensed physician:
  - (a) Monitoring and recording physiologic data during the evaluation of sleep-related disorders, including sleep-related respiratory disturbances, by applying the following techniques, equipment, and procedures:
  - (b) Continuous or bi-level positive airway pressure titration on spontaneously breathing patients using a mask or oral appliance, provided the mask or oral appliance does not extend into the trachea or attach to an artificial airway;
  - (c) Supplemental low flow oxygen therapy (less than six (6) liters per minute) utilizing

nasal cannula or continuous or bi-level positive airway pressure during a polysomnogram;

(d) Capnography during a polysomnogram;

(e) Cardiopulmonary resuscitation;

(f) Pulse oximetry;

(g) Gastroesophageal pH monitoring;

(h) Esophageal pressure monitoring;

(i) Sleep staging (including surface electroencephalography, surface electrooculography, and surface submental electromyography);

(j) Surface electromyography;

(k) Electrocardiography;

(l) Respiratory effort monitoring, including thoracic and abdominal movement;

(m) Blood flow monitoring;

(n) Snore monitoring;

(o) Audio or video monitoring;

(p) Body movement monitoring;

(q) Nocturnal penile tumescence monitoring;

(r) Nasal and oral airflow monitoring;

(s) Body temperature monitoring; and

(t) Monitoring the effects that a mask or oral appliance used to treat sleep disorders has on sleep patterns; provided, however, the mask or oral appliance shall not extend into the trachea or attach to an artificial airway;

(u) Observing and monitoring physical signs and symptoms, general behavior, and general physical response to polysomnographic evaluation and determining whether initiation, modification, or discontinuation of a treatment regimen is warranted;

(9) Analyzing and scoring data collected during the monitoring described in subdivisions (a) and (b) for the purpose of assisting a licensed physician in the diagnosis and treatment of sleep and wake disorders which result from developmental defects, the aging process, physical injury, disease, or actual or anticipated somatic dysfunction;

(a) Implementation of a written or verbal order from a licensed physician which requires the practice of polysomnography; and

(b) Education of a patient regarding the treatment regimen which assists that patient in improving the patient's sleep.

(c) A licensed dentist shall make or direct the making and use of any oral appliance used to treat sleep disordered breathing and shall evaluate the structures of the patient's oral and maxillofacial region for purposes of fitting the appliance; and

(d) The practice of polysomnography shall take place only in a hospital or a standalone sleep laboratory or sleep center; provided, however, the scoring of data and the education of patients may take place in settings other than a sleep laboratory or sleep center; and

(10) "Sleep-related services" means acts performed by polysomnographic technicians, polysomnographic trainees, polysomnographic students, and other persons permitted to perform such services under this act, in a setting described in subdivision (9)(C) which would be considered the practice of polysomnography if performed by a polysomnographic technologist.

## **SECTION 2. Exemptions**

(1) Nothing in this chapter shall be interpreted to limit or restrict a health care practitioner licensed under \_\_\_\_\_ from engaging in the full scope of practice of such person's profession.

(2) Nothing in this chapter shall apply to diagnostic electroencephalograms conducted in accordance with the guidelines of the American Clinical Neurophysiology Society.

### **SECTION 3. Educational Requirements**

(1) On and after July 1, 2010, any person who is engaged in the practice of polysomnography must be licensed as provided in this chapter. It shall be unlawful for any person to engage in the practice of polysomnography after that date unless the person has been duly licensed as a polysomnographic technologist under the provisions of this chapter and other nationally recognized bodies.

(2) Prior to July 1, 2010, any person who is engaged in the practice of polysomnography without being licensed under this chapter shall not be deemed to be in violation of this chapter.

(a) A person seeking licensure as a polysomnographic technologist must be of good moral character, must be at least eighteen (18) years of age, must pay the fees established by the board for licensure, and must present proof that the person meets all the following requirements:

(1) The applicant must have met one (1) of the following educational requirements:

(a) Graduation from a polysomnographic educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs;

(b) Graduation from a respiratory care educational program that is accredited by the Commission

on Accreditation of Allied Health Education Programs and completion of the curriculum for a polysomnography certificate established and accredited by the Committee on Accreditation for Respiratory Care of the Commission on Accreditation of the Allied Health Education Programs;

(c) Graduation from an electroneurodiagnostic technologist educational program with a polysomnographic technology track that is accredited by the Commission on Accreditation of Allied Health Education Programs; or

(d) Successful completion of an Accredited Sleep Technologist Educational Program (A-STEP) that is accredited by the American Academy of Sleep Medicine; provided, however, this option shall not remain available after July 1, 2012, if there are at least \_\_\_\_\_ polysomnographic technologist educational programs in California which remain accredited by the Commission on Accreditation of Allied Health Educational Programs for two (2) years. If there are not \_\_\_\_\_ such accredited educational programs by July 12, 2012, this option shall remain available until there are four (4) such programs which have been accredited for two (2) years;

(2) The applicant must have passed the national certifying examination given by the board of registered polysomnographic technologists;

(3) The applicant must be credentialed by the board of registered polysomnographic technologists; and

(4) The applicant must meet any additional educational or clinical requirements established by the committee.

(c) Any person who is engaged in the practice of polysomnography on July 1, 2007, shall be eligible for licensure under this chapter without meeting the educational requirement of subdivision (b)(1), provided the person meets the requirements of subdivisions (b)(2) (4).

(d) To be eligible for renewal of a license to engage in the practice of polysomnography, a polysomnographic technologist must continue to be credentialed by

the Board of Registered Polysomnographic Technologists or other nationally recognized body.

#### **SECTION 4. Polysomnography Practitioners**

**(a) The following classes of persons may provide sleep-related services without being licensed as a polysomnographic technologist under the provisions of this chapter:**

(1) A polysomnographic technician may provide sleep-related services under the general supervision of a licensed physician for a period of up to one (1) year from the date of the person's graduation from one (1) of the accredited programs described in Section \_\_\_\_\_, and the board may in its sole discretion grant a one-time extension of up to three (3) months beyond this one-year period;

(2) A polysomnographic trainee may provide sleep-related services under the direct supervision of a polysomnographic technologist as a part of the person's educational program while actively enrolled in an Accredited Sleep Technologist Educational Program (A-STEP) that is accredited by the American Academy of Sleep Medicine;

(3) A polysomnographic student may provide sleep-related services under the direct supervision of a polysomnographic technologist as a part of the person's educational program while actively enrolled in a polysomnographic educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs;

(4) A person who is credentialed in one of the health-related fields accepted by the Board of Registered Polysomnographic Technologists may provide sleep-related services under the direct supervision of a polysomnographic technologist, for a period of up to one (1) year, while obtaining the clinical experience necessary to be eligible to sit for the examination given by the board of registered polysomnographic technologists; and

**(5) A respiratory therapist licensed under Section \_\_\_\_\_, may provide sleep-related services under the general supervision of a licensed physician if the licensed respiratory therapist is credentialed by the Board of Registered Polysomnographic Technologists or other nationally recognized body. Respiratory therapists performing sleep-related services shall be subject to disciplinary action by the board of respiratory care if they fail to adhere to the standards established under this chapter.**

(b) Before providing any sleep-related services, a polysomnographic technician must obtain a temporary permit from the board. While providing such services, the technologist must wear a badge that appropriately identifies such person as a polysomnographic technician.

(c) Before providing any sleep-related services, a polysomnographic trainee must give notice to the board that the trainee is enrolled in an A-STEP educational program accredited by the American Academy of Sleep Medicine. Trainees must wear a badge that appropriately identifies the trainee as a polysomnographic trainee while providing such services.

(d) Before providing any sleep-related services, a person who is obtaining clinical experience pursuant to subdivision (a)(4) must give notice to the board that the person is working under the direct supervision of a polysomnographic technologist in order to gain the experience to be eligible to sit for the examination given by the board of registered polysomnographic technologists. The person must wear a badge that appropriately identifies such person while providing such services.

(e) Polysomnographic students shall not receive compensation for the sleep related services they provide and shall wear badges that appropriately identify them as students.

#### **SECTION 5. License Renewal**

- (1) Licenses shall be issued and renewed by the board pursuant to the biennial issuance and renewal system of the division of health related boards.
- (2) Any person who has been issued a license to practice under this chapter who wishes to retire that license shall file with the committee an affidavit on a form to be furnished by the committee stating the date on which the person retired from such practice and such other facts as shall tend to verify such retirement as the board deems necessary. Any such person who thereafter wishes to reenter practice must request reinstatement of licensure.
- (3) Any license issued by the board shall contain the name of the person to whom it is issued, the address of the person, the date and number of the license and such other information as the board deems necessary. The address contained on the license shall be the address where all correspondence and renewal forms from the board shall be sent. Any person whose address changes shall, within thirty (30) days thereafter, notify the board of the address change. The most recent address contained in the board's records for each license holder shall be the address deemed sufficient for purposes of service of process.
- (4) Every person issued a license pursuant to this chapter shall either keep such license prominently displayed in the office or place in which such person practices or have it stored in a place from which it can be immediately produced upon request of a patient or representative of the department of health.
- (5) Any person whose license has been lost may make application to the committee for a replacement. Such application shall be accompanied by an affidavit setting out the facts concerning the loss of the original license.
- (6) Any person whose name is changed by marriage or court order may surrender his or her license and apply to the board for a replacement license.

#### **SECTION 6. License Restrictions**

The board has the power to impose any sanctions on a licensee, up to and including license revocation, if the licensee is found guilty of violating any of the provisions of this chapter or of committing any of the following acts or offenses:

- (1) Making false or misleading statements or committing fraud in procuring a license;
- (2) Immoral, unethical, unprofessional or dishonorable conduct;
- (3) Habitual intoxication or personal misuse of narcotics, controlled substances or any other drugs or the use of alcoholic beverages or stimulants in such manner as to adversely affect the person's ability to practice polysomnography;
- (4) Conviction of a felony or of any offense involving moral turpitude or any violation of the drug laws of this or any other state or of the United States;
- (5) Violation or attempted violation, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or any lawful order of the board or any criminal statute of this state;
- (6) Gross malpractice, ignorance, negligence or incompetence in the course of professional practice;
- (7) Making or signing in one's professional capacity any document that is known to be false at the time it is made or signed;
- (8) Engaging in the practice of polysomnography when mentally or physically unable to safely do so;
- (9) Making false statements or representations or being guilty of fraud or deceit in the practice of polysomnography when mentally or physically unable to safely do so;
- (10) Having disciplinary action imposed by another state or territory of the United States for any acts or omissions that would constitute grounds for discipline of a person

licensed to practice polysomnography in this state; provided, further, that a certified copy of the order or other document memorializing the disciplinary action by the other state or territory shall constitute prima facie evidence of a violation of this section;

(11) Undertaking any duties that are outside the authorized scope of practice of a licensed polysomnographic technologist, as set forth in this chapter;

(12) Violating the code of ethics adopted by the committee for polysomnographic technologists;

(13) Use or attempted use of a polysomnographic procedure or equipment for which the licensee has not received sufficient education or training in the proper use of that procedure or equipment;

(14) Promoting the sale of services, drugs, devices, appliances, or goods to a patient so as to exploit the patient for financial gain;

(15) Willfully failing to file, or willfully impeding the filing of, any report or record which is required by law;

(16) Knowingly engaging in the practice of polysomnography with an unlicensed person, knowingly aiding an unlicensed person in the practice of polysomnography, or knowingly delegating a task involved in the practice of polysomnography to an unlicensed person;

(17) Knowingly failing to meet appropriate standards for the delivery of polysomnographic services;

(18) Breaching patient confidentiality;

(19) Paying or agreeing to pay any sum or providing any form of remuneration or material benefit to any person for bringing or referring a patient, or accepting or agreeing to accept any form of remuneration or material benefit from a person for bringing or referring a patient; or

(20) Any other unprofessional or unethical conduct specified in the rules of the board.

#### **SECTION 7. Misdemeanor**

Any person who engages in the practice of polysomnography in violation of the provisions of this chapter is guilty of a Class B misdemeanor.

#### **SECTION 8. Jurisdiction**

(1) The board shall have the authority to petition any circuit or chancery court having jurisdiction over any person who is practicing without a license, or to whom a license has been denied, or whose license has been suspended or revoked by action of the board, to enjoin such person from continuing to practice within this state.

(2) Jurisdiction is conferred upon the circuit and chancery courts of this state to hear and determine all such causes and to exercise full and complete jurisdiction in such injunctive proceedings.

#### **SECTION 9. Abbreviations**

Any person who is licensed to engage in the practice of polysomnography in this state shall have the right to use the title "polysomnographic technologist" or the abbreviation "PSGP." No other person may use such title or abbreviation or any other words or letters indicating that the person is a polysomnographic technologist.

#### **MODEL CERTIFICATION LEGISLATION**

SECTION 1. \_\_\_\_\_ is added to the (Business and Professions) Code, to read:

(a) Notwithstanding any other provision of law, a certified polysomnographic technologist may engage in the practice of polysomnography, as defined in subdivision (b) below, under the following circumstances.

(1) He or she works under the supervision and direction of a licensed physician and/or surgeon.

- (2) He or she satisfies one the following educational requirements:
- (a) Has graduated from a polysomnographic educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs;
  - (b) Has graduated from an electroneurodiagnostic technologist educational program with a polysomnographic technology track that is accredited by the Commission on Accreditation of Allied Health Education Programs; or he or she has completed the Respiratory Therapy Sleep Add On Training, part of the RT Training Program accredited by the Commission on Accreditation of Allied Health Education Programs; or other nationally recognized body.
  - (c) Has successfully completed an Accredited Sleep Technologist Educational Program (ASTEP) that is accredited by the American Academy of Sleep Medicine.
- (3) He or she has passed the national certifying examination given by the board of registered polysomnographic technologists or;
- (4) Has passed a national certifying exam of equal value to the Board of Registered Polysomnographic Technologists; exam must include a sleep add-on section to the exam;
- (5) He or she is credentialed by the Board of Registered Polysomnographic Technologists or other nationally recognized body.
- (6) He or she has completed a fingerprint and background check.
- (7) He or she performs the services
- (a) "Polysomnography" means the treatment, management, diagnostic testing, research, control, education, and care of patients with sleep and wake disorders. Polysomnography shall include, but not be limited to, the process of analysis, monitoring and recording of physiologic data during sleep and wakefulness; to assist in the treatment and research of disorders, syndromes and dysfunctions that either are sleep related, manifest during sleep or disrupt normal sleep and wake cycles and activities. Polysomnography shall also include, but not be limited to, the therapeutic use and diagnostic use of oxygen, the use of positive airway pressure including CPAP and bilevel modalities, and maintenance of nasal and oral airways that do not extend in the trachea.
  - (b) "Polysomnographic technologist" means a person who is certified by the board to practice polysomnography under the direction of a licensed physician.
  - (c) "Polysomnographic technician" means a person who holds a temporary certification issued by the board who practices polysomnography under the supervision of a certified polysomnographic technologist or a licensed physician.
  - (d) "Polysomnographic trainee" means a person who holds a provisional certification issued by the board and who performs polysomnography under the direct supervision of a certified polysomnographic technologist or a licensed physician.
  - (e) As used in this section, "supervision" shall not be construed to require the physical presence of the supervising physician and surgeon.

#### **MODEL EXEMPTION LEGISLATION**

Exemptions: (Section \_\_\_\_\_)

This act does not prohibit a polysomnographic technologist, technician, or trainee, as defined in the job descriptions jointly accepted by the American Academy of Sleep Medicine, the Association of Polysomnographic Technologists, the Board of Registered Polysomnographic Technologists, and the American Society of Electroneurodiagnostic Technologists, from performing activities within the scope of practice of polysomnographic technology while under the direction of a physician licensed in this State.

**ATTACHMENT 2**

**AAST Letter to Hawaii**





American Academy of Sleep Medicine  
American Association of Sleep Technologists



One Westbrook Corporate Center, Suite 920  
Westchester, Illinois 60154  
708.492-0930

February 3, 2009

The Honorable Ryan I. Yamane, Chair  
Committee on Health  
Hawaii State Legislature  
House of Representatives  
Room 441  
State Capitol  
415 Beretania Street  
Honolulu, Hawaii 96813

Re: HB 1823 – Legislation pertaining to the Licensure of Respiratory Care Practitioners

Dear Chairman Yamane:

The American Academy of Sleep Medicine (AASM) and the American Association of Sleep Technologists (AAST) are pleased to take this opportunity to submit this letter for the hearing record on HB 1823. We are joined in this submission by the Hawaii Sleep society representing the medical and polysomnographic technologist professionals in Hawaii. The AASM represents over 8,300 Sleep Medicine practitioners and more than 1,600 accredited sleep facilities. The Academy is the leader in setting standards and promoting excellence in sleep medicine health care, education and research. The AAST is the premier allied health membership association of professionals dedicated to improving the quality of sleep and wakefulness in all people, with a membership of more than 4200 sleep technologists.

**For all of the good intentions behind the idea of establishing licensure standards in Hawaii for respiratory care therapists, the proposal before the Committee carries unintended problems and it should not be supported. The proposal would have the effect of placing all of the polysomnographic technologists, commonly referred to as sleep technologists, in Hawaii out of work, and it would have the further effect of creating an access to care problem in the state for patients in need of sleep related care.**

- This alarming situation would occur under the proposed legislation as a significant aspect of care provided by sleep technologists would be usurped by the provision under the definition of “respiratory care services” at subsection (16)

specifying that “sleep diagnostic studies” are within this definition.

- Under the proposed exceptions language in Section 10(b), the thirty-one Registered Polysomnographic Technologists (RPSGT) in Hawaii and the four Hawaiians presently on the pathway to registration could find themselves deemed in violation of the law as they practice their profession (as do respiratory care practitioners in Hawaii) without state licensure. The exception authorized by Section 10(b) is only applicable to “other appropriately licensed persons.”
- While our sleep technologists who have earned the RPSGT credential possibly could continue their profession under the exception proposed in Section 10(c), as they have passed an examination that should be recognized and that serves as the basis for licensure in other jurisdictions, that recognition has to come from the proposed Board of Respiratory Care and there is no assurance that the Board would be inclined to grant the required approval.

Sleep technologists and respiratory care practitioners have very different scopes of practice. Just as a sleep technologist does not have the knowledge or skills to perform all of the various duties of a respiratory therapist, an individual solely credentialed as a respiratory therapist does not have the expertise to prepare a patient for and administer sleep diagnostic studies. This is evident from the educational requirements set forth by the Board of Registered Polysomnographic Technologists (BRPT), <http://www.brpt.org/>, the entity that has tested over 13,000 sleep professionals in the process of conferring the RPSGT credential. The BRPT also allows qualified respiratory therapists, those who have completed an additional six months of education in polysomnography, to sit for the BRPT examination. Respiratory therapists who choose not to participate in the six-month added education program receive very limited to no polysomnographic training in their respiratory care curriculum. This position is supported by the fact that the national certifying organization for respiratory care therapists offers a sleep disorders specialty examination and a corresponding credential, Sleep Disorders Specialist, for already certified or registered respiratory therapists. Information on this newly established respiratory care specialist is found at this link from the American Association for Respiratory Care: <https://www.nbrc.org/Examinations/SDS/tabid/92/Default.aspx>.

Sleep technologists practice a unique profession. They routinely use technology and skills that include: electroencephalography, used to monitor brain activity and neurological sleep-stage; electro-oculography, used to monitor subtle eye movements important in determining neurologic sleep stage; and electromyography to monitor muscle activity during sleep.

An effective sleep technologist must understand the appropriate electronic and physiological applications of these and other technologies, and he or she must have the education to know how to effectively interpret and safely use them. This is a unique skill set used in the course of sleep diagnostic studies, and these skills are not easily mastered. A technologist must also be knowledgeable on an extensive range of sleep disorders in order to facilitate appropriate testing protocols that serve as the building blocks for our physician colleagues in establishing an appropriate patient treatment modality. The technologist needs to have an advanced understanding of seizures, pharmacological

implications on sleep and the brain, and age and gender differences that occur in sleep.

The autonomy of the profession of Sleep Technology is confirmed by the specific knowledge and skill-sets that can only be attained by polysomnography-specific training and credentialing. A respiratory care therapist who has not passed the BRPT examination or who has not completed the six months of added education and passed the examination to earn the SDS credential does not have the skill set that effective sleep care demands.

To get a better understanding of the sleep technologist profession, information is available on the AAST web site at <http://www.aastweb.org/pdf/JobDescriptions.pdf> that provides detailed descriptions of the responsibilities for a Polysomnographic Trainee, a Polysomnographic Technician, and a Polysomnographic Technologist.

We also have to take exception with the potential broad grant of authority that the proposed Board could exercise pursuant to Section 10(a)(6). Under this Section, the proposed Board would have no checks in what it might determine to be “advances in the art and techniques of respiratory care” that could be “learned through formal or special training acceptable to the board.” This is the type of potential blank check that should not be included in licensure legislation.

Finally, we have to question whether this legislation is necessary given the reality of experiences in Hawaii given that: neither the respiratory care nor the sleep technologist profession has been subject to licensure; there has been no documentation identifying a clear need for licensure; and both professions work pursuant to physician direction. This proposed new licensure requirement for respiratory therapists surely will add expenses that ultimately will be borne by patients (the state’s Auditor has yet to even initiate the analysis required by Section 26H-6 of the Hawaii Revised Statutes), and the proposed legislation before the Committee will create substantial hardships for our members and our patients.

We appreciate being able to provide this information for the Committee, and the Hawaii Sleep Society hopes to have the opportunity to provide testimony at future hearings on this matter. The following is the contact information for the leadership of the Hawaii Sleep Society for further notice and to respond to your questions:

Danilo Ablan, MD, *President*  
667 Elepaio Street  
Honolulu HI 96817  
(808) 671-1558  
[danmayablan@yahoo.com](mailto:danmayablan@yahoo.com)

Carol Yoshimura, RPSGT, *Secretary*  
94-100 Huki Place , No. S-202  
Waipahu HI 96797  
(808) 547-9119  
[c.yoshimura@kuakini.org](mailto:c.yoshimura@kuakini.org)

In addition, an AASM contact person is Bruce Blehart ([BBlehart@aasmnet.org](mailto:BBlehart@aasmnet.org)), and an AAST contact person is Christopher Waring ([CWaring@aastweb.org](mailto:CWaring@aastweb.org)).

Sincerely,

/S/

Mary Susan Esther, MD  
President,  
American Academy of Sleep Medicine

/S/

Jon Atkinson, BS, RPSGT  
President,  
American Association of Sleep Technologists

cc: Danilo Abla, MD  
Carol Yoshimura, RPSGT

**ATTACHMENT 3**

**Virginia Academy of Sleep Medicine**

VASM



#### 2009 Officers

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**Melz Rappeshaun, MD**  
107 Royal Forest, Suite G  
Leesburg, VA 20175

February 23, 2009

Virginia Board of Health Professions  
Perimeter Center, 9960 Mayland Drive, 2nd Floor Conference Center,  
Room 4  
Richmond, Virginia

#### Members of the Board:

We recently established the Virginia Academy of Sleep Medicine (VASM) to serve as the voice of the Virginia sleep medicine profession on issues affecting sleep practitioners on both federal and state levels. The VASM includes physicians, PhD's, sleep technologists, sleep technicians and other key sleep medicine stakeholders. Thus, the VASM provides a forum for the exchange of sleep related information between all Virginia professionals involved in the science and clinical practice of sleep medicine. **We endeavor to promote the highest standards in clinical sleep medicine, sleep education and public health.**

We appreciated our opportunity to contribute to the December 17, 2008 and February 3, 2009 meetings of the Regulatory Review Committee. We now respectfully submit our comments to the Virginia Board of Health Professions (Board) regarding the need to regulate Polysomnographers in the Commonwealth of Virginia. We ask that the Board establish regulations for the sleep technology profession. We believe that an ultimate goal of licensure for the field of polysomnography will best serve the interest of Virginians.

We have included our responses below to the Board's standard evaluative criteria used to assess the need to regulate any health care occupation or professions in Virginia (i.e. "the Criteria"):

**(1) The risk of harm posed by the unregulated practice of the profession must be identifiable:**

*Direct injury to patients evaluated and treated in a sleep laboratory is uncommon, but significant risks are present with unregulated practice. A sleep technologist often is alone with two patients while they are prepared to sleep, and intermittently while they sleep for about six hours, often in an isolated laboratory. The technologist stands immediately next to the patient and moves closely around the patient's head, chest and abdomen for about 30-45 minutes while attaching*

*physiologic sensors by paste, tape, and other methods. The technologist is expected to identify significant abnormalities in brain, lung, and heart function in real time and to intervene when required. Patients could potentially be harmed by technologists as they sleep, and they may be harmed if technologists fail to recognize medical problems or take needed clinical actions when breathing or heartbeat stops. Public protection requires that technologists undergo background screening, complete nationally standard education, and demonstrate clinical competence by appropriate national standards.*

1. PSG technologists directly monitor cardiopulmonary and neurological functions, usually without continuous supervision. Many patients studied in a sleep laboratory have significant medical disorders and are at increased risk for sudden and serious events such as cardiac arrhythmias, seizures, and diabetic emergencies. PSG technologists should have appropriate training to recognize such events and take immediate action.
2. Skin or eye irritation can result from electrodes, adhesives, solvents, or monitoring devices. Also, masks and headgear used to apply positive airway pressure (PAP) can cause discomfort and skin irritation.
3. Inadequate test results may lead to misinterpretation and inappropriate treatment decisions. More commonly, tests may need repeating to obtain adequate information (with the potential for inconvenience and increased costs).

Establishing educational and training requirements for the profession will help to instill the sleep technologist with the capabilities to perform these important medical duties in a competent and successful fashion. Mandating these requirements should help to ensure that patients receiving sleep tests are protected and provided with the highest standard of care.

**(2) Specialized skills and training are needed which require assurance of initial and continued competency:**

*The sleep technologist monitors patients who often manifest complicated medical problems as they enter the testing environment. The technologist is responsible to identify significant abnormalities in brain, lung, and heart function in real time, and to intervene when required in a timely fashion, while working alone and without direct supervision of a physician. The technologist is required, for example, to identify significant sleep apnea and oxygen loss when it occurs and to then start positive airway pressure (continuous positive airway pressure (CPAP) or Bi-level positive airway pressure) therapy on an expeditious basis. The technologist is required to recognize serious heart rhythm abnormalities and seizures as they occur and to initiate emergency protocols. Without initial and continued competency these skills are not assured, and at present the standards of care are widely variable in actual practice in Virginia. National standards for training and demonstration of competency are now available.*

Specialists in sleep medicine understand the unique aspects of performing polysomnography. Accordingly, two professional and educational development programs for sleep technologists have been developed. Registered polysomnographic technologists (RPSGTs) must complete



a program offered by the *Commission on Accreditation of Allied Health Education (CAAHEP, <http://www.caahep.org/>)* or the *Accredited Sleep Technologist Education Program (A-STEP, <http://www.asnmnet.org/asjep/>)*. After completing one of these programs the individual is eligible to sit for the *Board of Registered Polysomnographic Technologists (BRPT, <http://www.brpt.org/>)* exam. Individuals who pass the exam are Registered Polysomnographic Technologists (RPSGT). An RPSGT holds the highest level of core knowledge, skills, abilities and attributes.

The CAAHEP goal is: "To prepare competent entry-level polysomnographic technologists in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains".

The CAAHEP curriculum ensures the achievement of program goals and learning domains. Instruction includes classroom, laboratory and clinical activities.

The following are the general education requirements to complete a CAAHEP sleep technologist program.

**General Education Competencies:**

1. Written and oral communication
2. Mathematics
3. Computer skills including keyboard entry, word processing
4. Social and behavioral sciences
5. Critical thinking skills
6. Evidence based scientific literature and technology assessment

**Basic Science and Technical Knowledge:**

1. Human anatomy and physiology, with emphasis on cardiopulmonary and neurological systems
2. Basic physics
3. Basic pharmacology
4. Electricity and electronics

**Fundamentals of Patient Care Competencies:**

1. Medical terminology
2. Patient care principles
3. Ethical and medical-legal issues
4. Infection control
5. Basic Cardiac Life Support (BCLS)

**Polysomnographic Technology content areas:**

1. Polysomnographic instrumentation
2. Sleep/wake physiology and pathophysiology
3. Patient and equipment preparation for polysomnography
4. Patient monitoring
5. Patient safety
6. Polysomnographic procedures



7. Therapeutic intervention
8. Polysomnographic data analysis and reporting
9. Professional development

The Accredited Sleep Technologist Education Program (A-STEP) also fulfills the education requirements for the RPSGT Certification Exam offered by the BRPT. The American Academy of Sleep Medicine (AASM) developed A-STEP to promote the standardization of sleep technologist education and training. A-STEP equips students with the knowledge and skills they need to excel in the profession of sleep technology. There are two components that make-up the A-STEP program.

The first step consists of 80 hours of instruction and training through an A-STEP provider. The coursework involves consistent, basic instruction about sleep, sleep disorders, sleep studies and patient care, and it concludes with an online examination. Students who complete the course proceed to begin the second step which requires that they complete the AASM A-STEP Self-Study Modules.

There are 14 online educational modules that make up the A-STEP Self-Study Modules.

Each of the online educational modules covers one of these topics:

- Introductory Topics
- Patient Interaction & Professional Behavior
- Patient Assessment
- Performing Polysomnography 1: Theory
- Performing Polysomnography 1: Preparation & Setup
- Performing Polysomnography 2: Recording and Monitoring
- Scoring Sleep Studies
- Arousals, Artifacts, & Arrhythmias
- Sleep Related Breathing Disorders
- Positive Airway Pressure & Oxygen
- Evaluation of Sleepiness
- Movement Disorders; Disorders of Arousals and Seizures
- Pediatric Sleep
- Miscellaneous Topics
  - Sleep Deprivation
  - Insomnia
  - Medications & Sleep
  - Esophageal pH
  - Alpha intrusion

Individuals who complete either the CAATTEP or A-STEP programs are then eligible to sit for the *Board of Registered Polysomnographic Technologists (BRPT)* exam. The BRPT is an independent, non-profit certification board that seeks to cultivate the highest professional and ethical standards for polysomnographic technologists by providing an internationally recognized credential.

Established in 1978 to benefit the developing field of polysomnographic technology and set credentialing standards for technologists, the BRPT builds and enhances public trust by ensuring that RPSGTs hold the highest level of core knowledge, skills, abilities and attributes.

The BRPT's credentialing program has grown from eight technologists certified by the first RPSGT administration in 1979 to more than 13,000 Registered Polysomnographic Technologists today. These credentialed technologists have made a commitment to professionalism, competence and ethics by meeting the BRPT standards for certification.

**(3) Autonomous practice exists for the profession which requires independent judgment and functioning:**

*As noted above sleep technologists are under a physician's general supervision and most often have no direct on-site supervision while alone with patients overnight. The validity of the diagnostic sleep study and possible intervention often rests entirely on their independent judgment and action.*

Sleep technologists must be able to perform a number of sleep tests autonomously and may be called on to make a variety of clinical and technical judgments. This may involve polysomnography, other diagnostic and therapeutic services or patient care and education. Some of the specific duties which require the independent judgment and functioning of the sleep technologists include:

**Gather and Analyze Patient Information**

- Collect, analyze and integrate patient information in order to identify and meet the patient-specific needs (physical/mental limitations, current emotional/physiological status regarding the testing procedure, pertinent medical/social history), and to determine final testing parameters/procedures in conjunction with the ordering physician or clinical director and laboratory protocols.
- Complete and verify documentation.
- Explain pre-testing, testing, and post-testing procedures to the patient.

**Testing Preparation Procedures**

- Prepare and calibrate equipment required for testing to determine proper functioning and make adjustments if necessary.
- Apply electrodes and sensors according to accepted published standards.
- Perform appropriate physiologic calibrations to ensure proper signals and make adjustments if necessary.
- Perform positive airway pressure (PAP) mask fitting.

**Polysomnographic Procedures**

- Follow procedural protocols (such as Multiple Sleep Latency Test (MSLT), Maintenance of Wakefulness Test (MWT), parasomnia studies, positive airway pressure (PAP), oxygen titration etc.) to ensure collection of appropriate data.
- Follow “lights out” procedures to establish and document baseline values (such as body position, oxyhemoglobin saturation, respiratory and heart rates, etc.)
- Perform Polysomnographic data acquisition while monitoring study-tracing quality to ensure signals are artifact-free and make adjustments, if necessary.
- Document routine observations including sleep stages and clinical events, changes in procedure, and significant events in order to facilitate scoring and interpretation of polysomnographic results.
- Implement appropriate interventions (including actions necessary for patient safety and therapeutic intervention such as continuous and bi-level positive airway pressure, oxygen administration, etc).
- Follow “lights on” procedures to verify integrity of collected data and complete the data collection process (reports the physiological and instrument calibrations and instructs the patient on completing questionnaires, etc.)
- Demonstrate the knowledge and skills necessary to recognize and provide age specific care in the treatment, assessment, and education of neonatal, pediatric, adolescent, adult, and geriatric patients.
- Oversee and perform difficult and unusual procedures and therapeutic interventions.

#### **Polysomnographic Record Scoring**

- Score sleep/wake stages by applying professionally accepted guidelines.
- Score clinical events (such as respiratory events, cardiac events, limb-movements, arousals etc.) according to center specific protocols based on national guidelines.
- Generate accurate reports by tabulating sleep/wake and clinical event data.

#### **Service Management and Professional Issues**

- Comply with applicable laws, regulations, guidelines and standards regarding safety and infection control issues.
  - Perform routine and complex equipment care and maintenance.
  - Evaluate sleep study related equipment and inventory.
  - Maintain current CPR or BCLS certification.
  - Demonstrate effective written and spoken communication skills.
  - Demonstrate appropriate social skills.
  - Respond to study participant’s procedural-related inquiries by providing appropriate information.
  - Demonstrate the ability to analyze complex situations and apply policy.
  - Comply with the BRPT Standards of Conduct.
- (4) **The scope of practice is distinguishable from other regulated professions, despite possible overlapping professional duties, methods of examination, instrumentation, or therapeutic modality;**

*About 25 years ago polysomnography was available in a few medical practices. Sleep technologists were trained in-house and often had backgrounds in electroencephalography, respiratory medicine, or other health fields. The major concern is to distinguish sleep technology from respiratory therapy. Most sleep technologists work with outpatients in dedicated sleep centers; respiratory therapists often work with hospital inpatients, or in outpatient settings that offer diagnostic testing that very rarely includes polysomnography. Subspecialist sleep technologists may have defined positions performing night-time testing, daytime testing of sleepiness, data reduction or "scoring" of polysomnograms in preparation for physician interpretation, sleep testing for clinical trials and research, in sleep medicine education, and in management. The scope of practice for sleep technologists is easily and increasingly separable from that of other independent health professionals.*

Although the scope of practice for sleep technologists and respiratory therapists may overlap in some areas, there are vast differences between the two professions. Sleep technologists perform the following duties which are not included in the respiratory therapist's education or training:

- Electroneurodiagnostics
  - EEG signal processing
  - AC / DC amplifiers
  - Sensor instrumentation
  - Appropriateness of Filters
  - Adjusting Sensitivity
- Patient Hook Up
  - International 10-20 System
  - Selecting a Montage
    - Standard Sleep Montage
    - Seizure Montage
    - Full Montage
  - Application of electrodes and sensors
  - Impedance checks
  - Performing Polysomnography
  - Performing Multiple Sleep Latency Testing
  - Performing Maintenance of Wakefulness Testing
- Acquiring Data
  - Identify electrocardiographic (EKG) abnormalities
  - Sleep staging
  - Report Generation
- Titrating Positive Airway Pressure (PAP)
  - Indication for use of PAP in the Sleep Lab setting
  - Appropriateness of increasing continuous positive airway (CPAP) pressure
  - When to use Bi-Level positive airway pressure

- o Adaptive Servo Ventilation
- Recognizing and Troubleshooting Artifacts and Abnormal Events
  - o EKG artifact
  - o Movement artifact
  - o Slow wave artifact
  - o 60 Hz artifact
  - o Electrode popping
  - o Amplifier blocking
  - o Bruxism
  - o Seizure
  - o Alpha Intrusion

One must complete a thorough and demanding educational polysomnography program and pass a certifying exam in order to successfully perform the duties of a sleep technologist. Respiratory therapy programs provide an education on the important medical profession of how one treats and cares for patients with breathing or other cardiopulmonary disorders. They do not typically provide the necessary education or training in sleep. After reviewing the curriculum of ten respiratory care programs active in Virginia, we do not find evidence that they offer the courses or training in sleep that one must receive in order to successfully and safely perform sleep procedures.

- (5) **The economic cost to the public of restricting the supply of practitioners and cost of board and agency operations to regulate the profession are outweighed by the benefit to the public:**

*Untrained personnel often are recruited into a very rapidly growing medical field, and their performance is not assured. During the last few years our profession has developed national standards for education, and relevant training opportunities are increasingly available in Virginia. A regulatory process that begins now and that is implemented with adequate notice and planning will improve the public's access to expert sleep testing and will not limit public access to care. It is likely that the costs of regulation will be borne by the technologists through licensing fees.*

Sleep disorders have a number of consequences. OSAS is a commonly under-diagnosed condition that occurs in 4 percent of middle aged men and 2 percent of middle aged women. The prevalence increases with age (up to 10 percent in persons 65 and older), as well as with increased weight. Complications of OSAS include excessive daytime sleepiness, concentration difficulty, coronary artery disease, and stroke. It is estimated that 10 percent of patients with congestive heart failure have OSAS. Also, untreated OSAS is associated with a several-fold increased risk of motor vehicle accidents. Children with OSAS have more academic difficulties. It is estimated that some 100,000 car crashes occur each year in the USA secondary to sleepiness. Therefore, we believe that it is important that sleep disorders be correctly diagnosed and treated. Ensuring proper training of sleep technologists is a key component to correct sleep medicine treatment. Regulation of polysomnography will not

limit access to care or compromise care. We believe that reasonable licensing costs can be administered to aid the state in its regulatory duties.

Some have advocated the requirement that the field of respiratory care subsume polysomnography. The VASM understands that respiratory care is important to the medical care of patients. However, some national data would suggest that there are not enough respiratory therapists to fulfill respiratory care duties and to work as sleep technologists. We believe that the vast majority of respiratory therapists do not have the educational background or skill set to perform polysomnography. If sleep technologists were to be precluded from performing their duties due to a requirement that they also be trained in respiratory care, the ramifications would create an access to care sleep medicine crisis.

**(6) There are no alternatives to regulation which adequately protect the public:**

*The VASM believes that the best and most efficient means to regulate the profession of sleep technology would be to regulate through the same channels that other allied health professionals are regulated by the Virginia Board of Medicine.*

**(7) If regulations are required, the least burdensome level of regulation which will protect the public will be recommended:**

*Licensure for sleep technologists will include completing an educational program (either CAAHEP or A-STEP) and passing a nationally recognized certification exam. The overseeing authority for the licensure of sleep technologists will be the Virginia Board of Medicine.*

Please feel free to contact us if you have any questions or need further information regarding our comments.

Sincerely,



Robert Daniel Verona, MD, President  
Virginia Academy of Sleep Medicine  
757/388-3098



Richard A. Parisi, MD, President-Elect  
Virginia Academy of Sleep Medicine  
804/285-0100

**ATTACHMENT 4**

**Respiratory Care Board of California  
Specific Language**

**Respiratory Care Board of California  
Scope of Practice: Sleep & Wake Disorders**

**Specific Language**

1

**California Code of Regulations  
Title 16, Division 13.6  
Article 6. Scope of Practice**

§1399.363. Sleep and Wake Disorders

Respiratory care as a practice includes, but is not limited to, the treatment, management, assessment, diagnostic testing, control, education, and care of patients with sleep and wake disorders. This shall include, but not be limited to, the process of analysis, monitoring, and recording of physiologic data during sleep and wakefulness to assist in the treatment of disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep activities. It shall also include, but not be limited to, the therapeutic and diagnostic use of oxygen, the use of positive airway pressure including continuous positive airway pressure (CPAP) and bilevel modalities, adaptive servo-ventilation, and maintenance of nasal and oral airways that do not extend into the trachea.

Note: Authority: 3722, Business and Professions Code. Reference: Sections 3702 and 3702.7, Business and Professions Code.



***Special  
Committee  
Reports  
-2-***

**AD HOC COMMITTEE ON CULTURAL DIVERSITY IN PATIENT CARE**

**Cultural Diversity in Care Management Committee  
AARC Activities Report  
Summer 2009**

**Chair:** Joseph R. Huff                      **Liaison:** George Gabler

**Charge:** Develop a mentoring program for AARC members with the purpose of increasing the Diversity of the BOD and HOD.

**Status:** A Best Practice Presentation will be given by Mikki Thompson at the Summer HOD Meeting. The presentation will focus on mentoring members of the AARC who are minority's. Mikki Thompson will highlight the plans of the committee to introduce cultural diverse respiratory therapist to the operations of the HOD and BOD. The first candidate attending the meeting will be from this years Summer Forum's hosting state. The candidate attending the Fall Congress will come from the State of Texas.

**Charge:** The Committee and the AARC will continue to monitor and develop the web page and other assignments as they arise.

**Status:** Ongoing

**AD HOC COMMITTEE ON GERIATRICS**

**AD HOC COMMITTEE ON OFFICER STATUS/US UNIFORMED SERVICES**

## AD HOC COMMITTEE PROTOCOL IMPLEMENTATION TASK FORCE

Reporter: Emily Zyla  
Last submitted: 2009-06-29 11:02:42.0

### ***Recommendations***

None at this time

### ***Report***

Currently working on updating the information on the AARC website under Protocol resources.

1. The Peer Reviewed Literature resource is under way, please forward me a list of any articles you feel should be added to the list. I have done search on several medical literature search engines but there are always articles which defy search criteria.
2. We also need updated protocol resources for the web site and am asking all Membership section chairs to petition your listserves to share their updated protocols for the AARC website. The protocols based on the most current EBM will be posted as example to the website. I have had several AARC members contact me asking for example protocols and I would love to be able to share updated versions.
3. The AARC website also has a list of "Protocol Resources" which is sadly out of date. I have been working on contacting those on the list to see if they would still be interested in having AARC membership contact them with questions. If any one is willing to serve as a resource for the membership, please forward your name to me (or solicit your membership section for volunteers) and let me know what type of protocols you work with. I have had several requests lately for Neonatal or Pediatric Ventilator Weaning protocols and would love to give them a resource for those areas.

### ***Other***

Anyone wishing to send copies of protocols to share, peer reviewed articles on protocol use or is willing to serve as a resource may contact me at [emily.zyla@spectrum-health.org](mailto:emily.zyla@spectrum-health.org). Thank You.

**AD HOC VENTILATOR GUIDANCE WORK GROUPS  
-HUMAN RESOURCES GROUP**

Reporter: Steven Sittig  
Last submitted: 2009-06-16 13:46:13.0

***Recommendations***

***NONE AT THIS TIME***

[Insert recommendations here]

***Report.*** The workgroup is still awaiting direction from the executive office on how the groups original objectives can be reformulated and addressed as per the the direction recieved from the last AARC BOD meeting minutes.

[Insert report here]

***Other***

[Insert other information here]

**AD HOC VENTILATOR GUIDANCE WORK GROUPS  
-VENTILATOR GROUP**

## AD HOC VENTILATOR GUIDANCE WORK GROUPS -LOGISTICAL GROUP

Reporter: Robert Kuhnley  
Last submitted: 2009-06-26 16:26:43.0

### ***Recommendations***

[Insert recommendations here]

### ***Report***

[

Our Group has submitted the Oxygen & Ventilator Utilization recommendation lists for scarce resources to Richard Branson for review. These documents are intended to provide Respiratory Care Departments and their corresponding Facilities Management Departments with recommendations for dealing with scarce resource conditions. This is very last minute, considering its need could arise in as short a time frame as four months hence.

A template is under construction which will allow RC Departments to identify and catalog all necessary equipment, supplies, and provisions in anticipation of scalable responses to surge utilization of ventilators and oxygen during disaster or pandemic incursions. Recommendations for addressing critical supply backorder & higher use rates(surge) will be included. Should be ready in about 4 weeks for review.

We are also preparing a document for liquid/gas mathematical conversions, as well as bulk facility recommendations to give RC managers the ability to assess their facility capability, address surge utilization of oxygen & ventilators, and address decreased bulk delivery situations (less than half the RC Managers surveyed knew their facility's bulk oxygen capacity, much less their current consumption data, and timelines).

Generally, most States have not progressed very far in identifying their goals and needs. Very few have developed re-allocation methodology. Individual facilities have poor definition of critical supplies, capacities, and altered utilization needs. Our Group believes the place to begin is at the department/facility level where the action takes place, and work our way up, rather than placing the initial effort on higher level recommendations. Also a priority should go toward addressing local infrastructure necessary to even allow mechanical ventilation to occur.

We are continuing to develop our Alternate Care Facility Oxygen paper, although we may have lost our progression & leadership from Dr. Louis Rubinson. He has been assigned to a new group project dealing with the anticipated return of H1N1 in the Fall (with increased virulence). We have many unanswered questions pertaining to Federal Gulf experiences, Home Care patient involvement, etc. which we will have to procure through new sources. We are finding that most items identified in our group's charges, and those covered by our group, have little written resource or little existing evidence. The State of Minnesota has addressed almost every issue of surge utilization and ACF planning



(employing RCPs), and that has provided us with a solid starting point for our group's efforts.

Although we continue to meet about every two weeks, we are all manager-directors, and heavily constrained by our local cost containment and economy issues, and facility priorities continue to compete for our time on these projects.

]

*Other*

**[Insert other information here]**

## AD HOC PINNACLE AWARD

Reporter: Jerry Edens  
Last submitted: 2009-06-15 14:01:28.0

### *Recommendations*

None at this time

Report

#### **Center of Excellence Award sub committee to Pres. Myers**

We have developed a survey tool and submitted it to the board it came back to us with recommendations. I believe though recommendations have been addressed. Upon approval of the committee it will be sent back to Pres Myers who will then allow it to be sent out on the management list serve.

After a designated time period the results will be summarized/ reviewed by the sub-committee and then forwarded on to the board. It is my hope that the response will be favorable to go forward.

At that time it will be decided how the promotion for the award will be developed and how to proceed.

Included in this document is the survey that will be sent out to management probably survey monkey

The original intent and purpose of the Quality Respiratory Care Recognition program established by the AARC in 2004 was to help consumers make choices about their health care by recognizing hospitals that promote patient safety by providing access to respiratory therapists to deliver their care. The AARC is currently evaluating this program to determine if it still meets the needs of departments.

The climate in the health care arena is not the same as when this recognition programs was developed. Consumers are not the only external customers concerned with the quality of health care and the advantages one hospital provides over another. Potential new hires are also looking for the departments that are delivering excellent care and are working to develop that edges that will set them apart. The recruitment and retention AND the competition for top notch therapists has become a goal for most every department, home care company or long term facility

The AARC has assembled a committee to examine the structure of the current program. The following survey has been developed to gather information to aid them in determining what actions need to be taken in regards to the current QRCCR program. As our target demographic, we invite you to participate in an informal survey to aid us in identifying what actions may need to be taken to enhance the current QRCCR program.

Please take a few moments to share your thoughts; it should take no more than 5 minutes to complete.

Thank you in advance for your time and input.

Center of Excellence Sub-Committee,  
Jerry R, Edens, RRT, M.Ed

1. Is your department currently participating in the QRCCR program? Y/N

1. Why or why not?

*Please use the scale below in answering questions 3-6:*

5 = Strongly Agree    4 = Agree    3 = Neutral    2 = Disagree    1 = Strongly Disagree

1. The Quality Respiratory Care Recognition program as it stands now meets needs for all consumers to use in identifying the quality of a respiratory care department.

1. Would the development of a new program that recognizes excellence through evaluation of best practice and key outcome and performance measures be of value to customers.

1. I support a new program/tool created to recognize the outstanding achievements, and quality of respiratory care departments utilizing quality metrics or other measurable outcomes in the evaluation process.

1. The development of a new program would be helpful in competing for staff recruitment/ retention.
  
1. A site visit from a surveyor (travel and expense to be paid by the hospital estimated cost \$1,000- \$2,000) is needed to validate information, metrics, or other quality outcomes identified on the application.
  
1. If a new program/tool is created to identify the quality of a respiratory care department, my department would be willing to pay an application fee of:

\$0      < \$100      \$100 - \$300      \$300 - \$500      \$500 - \$1000      > \$1000

1. If a new program/tool was created to recognize the outstanding achievements, and quality of respiratory care departments, I would desire the following from the AARC as appropriate recognition (in addition to being named on the AARC website). Select all that apply.

Certificate      Plaque      Trophy      Banners/Poster      Press Release to Local  
 Media      Logo created to use on official department documents/emails  
 Recognition in AARC Times      Recognition at AARC Congress      Other

1. If a new program/tool was created to recognize the outstanding achievements, and quality of respiratory care departments, I would be willing to invest the following amount of time to complete an application if increased recognition was awarded:

< 1 hour      1 - 4 hours      4 - 8 hours      1 - 3 days      3 - 5 days      > 1 week

***Other***

[Insert other information here]

## AD HOC COMMITTEE ON LEARNING INSTITUTES

Reporter: Toni Rodriguez  
Last submitted: 2009-06-24 17:40:18.0

### ***Recommendations***

None

### ***Report***

#### **Ad Hoc Committee on Learning Institutes**

**Original Charge: That this Ad Hoc Committee develop a Management, Research and Educational leadership Institute that would incorporate the following overarching concepts:**

The Institute will provide educational resources for respiratory care practitioners ready for the next step in their career through advanced study.

The Institute would provide career guidance as well as mentorship in the areas of education, management and research.

The long term goal of the institute is that its courses would be accepted by degree granting institutions.

There is a core of basic knowledge essential to success in any of the sub specialties of the Institute.

#### **Summer Report 2009:**

Four conference calls have been conducted since the last report: 5/15, 6/3, 6/17 and 7/15. All committee members participated in both calls.

Since the last report the Committee has concluded the following:

1. Members agreed that title "**Fast Track Program**" offered the most potential as a name for the initiative. FAST standing for:

F - fellowship for

A - advanced

S - skill

T - training

Therefore the initiative for now be known as the FAST program a component of the American Association of Respiratory Care Leadership Institute.

2. Members agreed to the following concepts related to course development:

•- Each course to be approximately a semester long (45 - 50 hrs).

- Courses should be open entry/exit and self-paced.
  - Even with open entry/exit format there will be a maximum set time for completion established.
  - Program enrollment should include an expiration date if student is striving for certificate.
  - Modules will be standardized.
  - A platform for online instructional delivery will need to be identified
  - Possible quizzes will be given after each class with an overall final test.
  - It is hoped that individual faculty can lecture on more than one class
  - A module would consist possibly of an opening lecture, then read and learn, then testing
  - The Core should be a prerequisite to the other tracks
  - We want to ultimately market to other disciplines as well as the profession
  - We will not obtain Board approval on competencies, but approval will be necessary at such time that funding is needed
  - A number of people will be contracted to develop the modules, but on going there will be one online contact for each of the curriculums ie; Core, Research, Education and Management (4 online people)
  - Two sets of agreements may be required; one boilerplate agreement for course developers and one for the ongoing online expert.
  - Ultimately we will need to determine job descriptions so that a rate of pay can be determined.
  - The certificate of completion to read "AARC Leadership Institute" and then state "FAST Track Program"
  - It was decided that a content expert will write the modules, and a software expert will then take on the formatting portion. This will promote consistency while still allowing some degree of creativity.
3. Members voted unanimously to approve a revised Strategic Plan with time line. (See Attachment A)
  4. Members developed preliminary course competencies for all classes (See Attachment B)
  5. Steve Nelson discussed the pros and cons of various online platforms for presenting educational material. He believes "**Moodle**" is possible software which will integrate well with the AARC's current database program.

**Next Steps:**

1. To finalize a module format as to design and projected features.
2. Develop a budget for module development/up keep, platform acquisition/up keep

and ongoing instruction support.

3. Prepare a proposal for funding to be presented to the AARC BOD by the December meeting.
4. Develop RFP for solicitation of module developers.

The committee will next meet after the summer AARC Board of Directors meeting to provide Board Members with the opportunity to comment on the work completed thus far. Please direct any comments or concerns to project coordinator Toni Rodriguez Ed.D, RRT.

### **Spring Report, 2009:**

Two conference calls were conducted by the Steering Committee to include February 4th and March 5<sup>th</sup> 2009. All committee members participated in both calls.

The first call centered on acquainting the Institute Chairs with the purpose and scope of the project. Brainstorming identified the following preliminary concepts:

- 1. Initial planning will focus on developing a vision for the project that incorporates structure, processes and solutions that maximize the potential for achieving the desired goals without giving thought to resource constraints.
- 2. Emphasis will be placed on education modules that will lead to a Certificate of Completion rather than awarding a credential.
- 3. A Certificate of Completion will not be awarded until completion of the Core Courses modules as well as the required Course Track modules (i.e. Management, Education or Research).
- 4. Continuing education credits will be awarded at the completion of each module.
- 5. We will build the courses ourselves using committees of qualified individuals to develop core content. Ultimately we will tape lectures to be used in web-based instruction modules.
- 6. Once the curriculum is developed we will invite the decision makers who bestow credit to evaluate.

The second call asked each Institute Chair to answer the following questions:

1. What is your vision for your portion of the Institute or the Institute as a whole?
2. Who do you envision as the market for your portion of the Institute or the Institute in general?

In response to question number 1, Rob Chatburn provided an excellent vision and mission statement with supporting SWOT Analysis. The committee revised and accepted his document as a basis for future planning (Attachment A).

Potential markets for the Institute were identified as follows:

Research:

- Practitioners and managers employed in an academically affiliated health care facilities
- Educators with a desire to improve clinical research skills
- Practitioners currently working in industry who seek increased skills in the area of understanding and interpreting research that supports their current product line.
- Current research coordinators with a desire to better understand or expand their skill set into clinical research.

Management:

- First line managers such as supervisors, directors of individual programs and project coordinators with a desire to improve their management skills and/or build their resume for career advancement.
- Existing directors and managers interested in leadership development without the time or money to commit to college based educational programs

Education:

- Practitioners that serve as informal educators in the clinical environment with the desire to pursue a career as a formal educator and/or improve instructional skills to include: department education coordinators, part-time faculty and clinical preceptors.
- Formal educators who have transferred to teaching from the clinical environment without benefit of formal education.

Respectfully submitted:

**Chair:**

Toni Rodriguez EdD RRT

**Steering Committee Members:**

Sam Giordano MBA RRT FAARC

Timothy Myers BS RRT-NPS

**Education Institute Chair:** Linda Van Scoder, EdD, RRT

**Research Institute Chair:** Robert Chatburn, RRT-NPS, FAARC

**Management Institute Chair:** Richard Ford, BS, RRT, FAARC



## **Attachment A:**

### **Strategic Plan Leadership Institute**

Prepared by

Robert L. Chatburn, RRT-NPS, FAARC

Revised 06-17-09

#### **1. Introduction**

The organization for which this plan was developed is the American Association for Respiratory Care (AARC). The AARC is a professional society for respiratory therapists with more than 42,000 members nationwide. There is an executive director, a board of medical directors, a chief operating officer, a publisher (for the professional journal Respiratory Care), and various administrative staff numbering about 20.

The AARC faces two significant challenges in the near future that may actually threaten its survival. First is a growing gap between labor supply and demand. Data from the US Department of Labor and a 2006 AARC Labor Survey indicate that the demand for respiratory care (RC) is growing steadily but the output of graduates from approved respiratory care programs is declining. The average age of a practicing respiratory therapist is 48 years and has been increasing since the 2002 AARC survey, indicating an insufficient influx of younger people into the profession.

Perhaps an even more pressing issue is the fact that the current generation of AARC educators, senior researchers, and mentors has no replacements. These people were trained and mentored during an historic period when RC departments were viewed by hospitals as revenue centers and there was time available for people to mentor and be mentored. Now RC departments are viewed as cost centers, educational and research positions have been drastically reduced and the average therapist struggles through each day to get the assigned workload done. Compounding the problem is the attitude among younger people entering the field that they prefer to have a job and personal time off rather than be dedicated to developing professional skill, which increasingly require unpaid time at work. In short, the AARC is in drastic need of succession planning. We are too busy chopping wood to sharpen our ax.

The strategic planning committee has been formed as follows:

- **Chairman**
- Tony Rodriguez, RRT, EdD (past AARC president)
- **Committee members**
- Rob Chatburn BS, RRT-NPS, FAARC (research)
- Rick Ford BS, RRT, FAARC (management)
- Linda Van Scoder, RRT EdD (education)
- **Consulting members**

- Tim Myers, RRT, (current AARC president)
- Tom Kallstrom, RRT (AARC operations officer)
- Sam Giordano, RRT (AARC executive director)

## **2. Organizational Mission Statement**

### *AARC Vision/Mission Statement*

*The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist*

While necessarily vague, this mission statement accurately reflects the actual programs of the AARC. The AARC serves respiratory therapists in the United States and supports affiliate programs in several other countries. It hosts an annual Summer Forum, dedicated primarily to educators and managers. The main annual meeting is the International Congress, dedicated to scholarly presentation of research and didactic sessions. The publication arm of the AARC also hosts at least two annual meetings devoted to a specific clinical top. The presentations from this meeting are published in the profession's journal, Respiratory Care.

## **3. Vision, Mission, and Goals of Strategic Plan**

### *AARC Leadership Institute*

The Leadership Institute will be the first AARC sanctioned program designed to provide advanced training to ensure the future continuity of leadership, discovery, and education within the profession of Respiratory Care.

Our vision for the Leadership Institute is that it will be the primary source for academic advancement in the areas of

- Biomedical research in pulmonary medicine
- Management of cardiopulmonary departments in hospitals
- Respiratory care programs in colleges, universities and hospital staff development.

## **4. Plan**

### *Critical issues to be addressed*

The crucial issues this plan will address are (1) the rapid attrition of the current generation of the profession's leaders in education, research, and management due to retirement and (2) the lack of formal and informal resources within hospitals and schools to train the next generation of leaders.

### *Strategic Plan*

The strategy for achieving these goals is the formation of an online educational resource, called the AARC Leadership Institute, which will allow asynchronous learning as well as affiliation with physical institutions for lab work.

The goals of the Leadership Institute are to:

- Provide a source of academic mentoring to replace the current mentors leaving the field
- Identify and cultivate the next generation of leaders in the field of respiratory care

The Leadership Institute will be conducted primarily as a distance learning program, similar to on-line degree courses offered by universities. Partnerships could also be established with physical laboratories at select universities and hospitals around the country. The faculty would be content experts approved by the steering committee. The program would be directed by an executive board.

The program would be self paced but must be completed within \_\_\_\_\_ months long and when successfully completed, would award a certificate of merit to the enrollee. Eventually, through partnerships with universalities, this certificate could be applied toward BS and MS degrees in respiratory care. Successful completion of the program would involve learning the skills of academic enquiry (including both scientific and administrative arenas).

Attendees for the Leadership Institute will be recruited from the general population of AARC members, or other healthcare providers, using advertisement in the professional journals, promotions at state and national meetings, emails and the AARC Internet presence including its official website.

*Implementation Plan*

The operations of the Learning Institute oversight committee are driven mainly by volunteer efforts of the major learning tracks (ie, research, management, and education) with guidance from AARC officials (volunteer past and current presidents of the AARC and paid AARC administrators). The key implementation activities, responsibilities and deadlines are shown in the table below:

<b>Activity</b>	<b>Responsibility</b>	<b>Deadline</b>
Establish oversight committee	Tony Rodriguez	completed
Identify funding resources	Sam Giordano	ongoing
Create curriculum		
Research	Rob Chatburn	Jun-09
Management	Rick Ford	Jun-09
Education	Linda Van Scoder	Jun-09
Develop course template	All	Dec-09
Create website infrastructure	Executive Office	Dec-09
Recruit guest instructors		
Research	Rob Chatburn	Feb -10
Management	Rick Ford	Feb -10
Education	Linda Van Scoder	Feb -10
Develop Budget	Giordano, Rodriguez	Dec-09
Final program approvals	Board of Directors	Dec-09

**5. Summary of Situation Analysis**

**Strengths**

- Organized professional society for over 60 years
- Broad membership comprised of skilled clinical specialists, administrators, managers, educators, scientists, and various support people
- Official membership is over 48,000, representing a pool of respiratory care practitioners numbering over 155,000
- Has board of medical directors comprised of physician thought leaders
- Has professional, scientific journal with strong editorial board
- Strong core of dedicated politicians, educators, and researchers who consistently contribute to the academic literature
- Has a political action committee and staff dedicated to political advancement of profession
- Scientific and administrative leaders have long tenure - over 30 years
- Profession is seen as vital by hospital administrators, physicians, nurses, and government agencies

### **Weaknesses**

- The average age of a respiratory care practitioner (RCP) is 48 years.
- 50% of leadership in hospitals and educational programs (ie, the profession's mentors) will retire in the next 5 years
- The time and money required to produce the profession's mentors is no longer available to the current generation of RCPs entering the field
- The profession has no formal succession plan

### **Opportunities**

- Employment of respiratory therapists is expected to grow 19 percent from 2006 to 2016, faster than the average for all occupations
- Job opportunities are expected to be very good
- With only a 2 year degree, median annual earnings of wage-and-salary respiratory therapists are almost \$50,000
- The worsening economy tends to attract people to the profession, which will help alleviate the national staffing shortage

### **Challenges**

- The profession of respiratory care has become so technologically complex that school preparation is just an entry ticket
- There is a national staffing shortage
- The number of vacant positions is growing faster than the number of graduates from RC schools
- The rate limiting factor for expanding school programs is clinical sites at hospitals, but hospitals cannot afford to expand their educational offerings due to the labor shortage
- Technological advances in the field are outpacing the ability of educational programs to train new graduates
- Job demands are increasingly requiring a 4 year degree but most programs are 2 years and unable to expand to 4

### **Critical Issues**

- The profession has no formal succession plan
- The time and money required to produce the profession's mentors is no longer available to the current generation of RCPs entering the field
- Mentorship is required for individuals to actively participate in either advanced management or academic positions
- Most RC graduates come from 2 year programs and most of them have no classes on research methodology
- Most RC college programs have little or no content related to management or adult learning/teaching skills

## **6. Summary Statement**

This plan directly addresses the key organizational issues identified in the SWOT analysis, namely, the rapid attrition of the current generation of the profession's leaders in education/research/management due to retirement and the lack of formal/informal resources within hospitals and schools to train the next generation of leaders. The action steps are relatively straight-forward and both the AARC as an organization and the committee members as experienced volunteers have the interest and ability to carry out the plan. The timelines are probably a little optimistic. When the AARC formed an oversight committee to develop a benchmarking website, the process took over a year. However, that project depended critically on third party programmers and there were many unexpected developmental problems.

The AARC is affiliated with the American Respiratory Care Foundation, endowed with over a million dollars earmarked for research and education initiatives. With that resource and the expected funding from several major international RC industrial partners, funding should not be the rate limiting step. One potential concern might be the ability to recruit competent faculty from among the AARC fellowship. While they all have extensive academic experience, this may not translate adequately into online teaching skills required by the project. Perhaps more thought should be devoted to expanding the plan to allow for "training the trainers".

Any benefit from this program will necessarily be delayed at least 2 years beyond the establishment of the Leadership Institute. Even highly motivated students will require a year to finish the course and at least another year to get anything published or to appear as speakers at the AARC National Congress. Nevertheless, this project is the best investment in the future the AARC can make at this time.

## **Attachment B:**

### **Core Curriculum Competencies:**

#### **45 - 50 Contact Hours**

#### **CCC 101 Introduction to Human Communication:**

Course Description: Theory and practice of communication skills in public, small groups and interpersonal setting.

#### **Competencies:**

1. Describe the process of interpersonal communication in terms of models and principles.
2. Describe the nature and function of communication on all levels within organizations.
3. Identify the components of listening and common barriers to the process.
4. Identify and explain the elements of nonverbal communication.
5. Identify strategies for conflict resolution within small groups.
6. Explain the impact of cultural and gender variables on interpersonal communication.
7. Prepare and demonstrate the effective delivery of a verbal presentation to a small group.

#### **CCC102 Health Information Management and Informatics:**

Course Description: The use of technology to support and sustain information management within the healthcare environment.

#### **Competencies - Basic Computer and Health Information Literacy Skills**

#### **Pre-Requisites**

- \*Demonstrate proficiency in the Windows operating environment.
- \*Resolve minor technical problems associated with use of computers.
- \*Demonstrate use of email, addressing, forwarding, attachments, and netiquette.
- \*Create and name or rename subdirectories and folders.
- \*Demonstrate how to save work to a computer file, and printing and copy a file.
- \*Create and edit a formatted document using tables and graphs
- \*Demonstrate use of the essential aspects of file organization, information storage (such as disk or flash drive), protection from data loss, and basic computer skills.

#### **Competencies:**

1. Demonstrate Internet/intranet communication and topic search skills
2. Use basic word processing, spreadsheet, database, and desktop presentation applications as applicable to your work.
3. Use statistical analysis packages.
3. Differentiate between the types and content of patient health records (such as paper-based, electronic health records, and personal health records).
4. Know the architecture and data standards of health information systems.
5. Demonstrate an understanding of the relationship of telemedicine and its application to all care settings.
6. Identify legal and regulatory requirements related to the use of personal health information and apply policies and procedures for access and disclosure.

### **CCC 103 Financial Planning and Budgeting Principles:**

Course Description: Fundamental theory of accounting principles and procedures as they relate to healthcare.

#### Competencies:

1. Demonstrate generally accepted accounting principles (GAAP).
2. Explains income statement, balance sheet and cash flow
3. Prepare a simplified balance sheet and income statement.
4. Demonstrate knowledge of ratio analysis, cost-benefit analysis and cost-effectiveness analysis
5. Demonstrate knowledge of strategic planning, strategic financial planning, operational planning and capital budgeting.

### **CCC 104 Small Group Problem Solving and Decision Making**

Course Description: An organized approach to problem solving, decision making and small group management.

#### Competencies:

1. Define the role of the facilitator, team leader and team members.
2. Discuss the impact of group dynamics in facilitating small group communication.
3. Explain how listening and speaking skills facilitate communication. Identify methods for identifying and defining problems
4. Select a problem and develop a solution based upon established problem solving protocol to include: study design, data analysis, selection of best solution, action plan analysis, implementation and follow up.

5. Define the steps in effective team building
6. Identify effective conflict management and intervention techniques.
7. Discuss strategies to be used in conducting effective meetings.
8. Identify ways to monitor group progress.

### **CCC 105 Basic Management Skills**

Course Description: The functions of management, specific roles and responsibilities of the supervisor and the application of leadership principles in addressing on-the-job situations and handling work related conflicts.

#### **Competencies:**

- 1. Demonstrate an understanding of what it is to manage and to lead in the role of a successful department manager.
- 2. Describe the roles, functions of management and the responsibilities of supervisors and how they impact effective relationships in the workplace.
- 3. Examine different leadership styles, explaining the advantages and disadvantages of each.
- 4. Explain how to be successful in communicating with others based on their leadership style.
- 5. Demonstrate an understanding of the characteristics of effective leaders, how to identify mentors, and gain from the example of others.
- 6. Evaluate how to motivate others and coach them to improved performance
- 7. Demonstrate an appreciation for teams, the importance of prioritizing conflicting demands, achieving desired outcomes and accountability for the achievement of outcomes.

-

#### **Education Curriculum Competencies**

### **45 - 50 Contact Hours**

### **ECC 101 Principles and Methods of Respiratory Therapy Adult Education (7 hrs)**

Course Description: Basic principles of adult education and application in the field of Respiratory Care.

#### **Competencies:**

1. Describe various structures for respiratory therapy programs.
2. Describe program accreditation requirements to include: faculty, physical & financial, resources and record keeping.
3. Compare and contrast andragogy and pedagogy.
4. Identify and meet the instructional needs of adults.
5. Describe how gender and cultural differences affect education.



### **ECC 102 Developing Respiratory Therapy Courses and Evaluation of Learning (12 hrs)**

Course Description: Preparation, administration and evaluation of student learning.

#### Competencies:

1. Use an occupational analysis to assist in course construction.
2. Demonstrate how to find existing course resources.
3. Construct learning objectives.
4. Develop a course syllabus.
5. Develop course lectures/presentations.
6. Evaluate a course.
7. Discuss methods used to measure learning.
8. Write and administer an examination with analysis of test results.
9. Evaluate student writing (e.g., case studies and research)

### **ECC 103 Clinical Instruction Techniques for Students and Employees (7 hours)**

Course Description: Application of instructional techniques in the clinical environment.

#### Competencies:

1. Develop clinical competency evaluations
2. Instruct learners in the patient care setting
3. Describe the methods to provide constructive feedback to learners
4. Conduct clinical evaluations
5. Describe how to assure inter-rater reliability in conducting clinical evaluations

### **ECC104 Classroom and Laboratory Instruction Techniques (7 hours)**

Course Description: Instruction and analysis of didactic and laboratory learning

#### Competencies:

1. Prepare a class lecture.
2. Develop case study exercises.
3. Develop role playing scenarios.
4. Use problem based learning techniques.
5. Explain the methods for evaluating instruction.
6. Find classroom and laboratory resources.

### **ECC105 Educational Technology (6 hours)**

Course Description: The application of instructional technology.

#### Competencies:

1. Discuss the use of computer technology in the classroom.
2. Describe internet-based classroom management systems (e.g., Blackboard®).
3. Discuss the use of patient simulators.
4. Discuss web-based instruction/distance learning.

### **ECC 106 Continuing education (7 hrs)**

Course Description: Assessment and development of continuing education in the work environment.

#### Competencies:

1. Assess employee's needs for continuing education.
2. Develop a department education plan.
3. Assess a department education plan.
4. Assure education and documentation requirements are met.

### **Management Curriculum Competencies:**

**45 - 50 hrs**

### **MCC 101 Health Care Infrastructure and Economics**

Course Description: This course describes health care delivery systems in place throughout the world with a focus on the economic drivers of health care reform in the US and the strategies and programs that may best serve patients in the years ahead.

#### Competencies:

1. Explain the history and evolution of healthcare systems in the US.
  1. Discuss how changing demographics and consumer expectations affect the health care environment.
  2. Explain how re-imburement, coding and revenue management drive the economy of the healthcare environment.
  3. Describe the role and application of technology in the future of healthcare delivery.
  4. Explain disease management and its application in future healthcare delivery systems.
  5. Develop department level strategies to thrive in a changing health care environment.

6. Describe the role of workforce development in future healthcare delivery.

### **MCC 102 Leadership and Your Organization**

**Course Description:** This course will explore how to set organization and personal goals, developing value added roles, and become a culture builder within their organization.

Competencies:

- 1. Describe the key characteristics and skills required to succeed as a leader.
- 2. Explain the difference between "managing" and "leading"
- 3. Inventory your own leadership style
- 4. Based upon your leadership style, how can you be successful within your organization.
- 5. Explain how to set organizational and personal goals.

### **M103 Leadership and Team Building**

Course Description: This course will identify the core competencies of leadership, inclusive of understanding how best to build effective teams in the work environment.

Competencies:

- 1. Describe the principles of servant leadership.
- 2. Explain the concepts of appreciative inquiry and shared governance.
- 3. Identify strategies to build relationship and engage staff
- 4. Describe the role of communication in trust building among staff members
- 5. Discuss effective strategies in team building.

### **MCC 104 Integrated Business Topics for Managers**

Course Description: An application of service lines or cost centers that can be managed as a business within the health care systems.

Competencies:

- 1. Compare and contrast a service line with a cost center.
- 2. Develop operational objectives for a service line..
- 3. Develop a strategic plan for business operating within a healthcare system
- 4. Develop a program business plan for a business operating within a healthcare system
- 5. Discuss how to market a service line.

- 6. Explain the role of customer service and satisfaction to business success.
- 7. Explain various strategies for negotiating and conflict resolution.

### **MCC 205 Law and Ethics, Practice and Application**

Course Description: This course will provide an understanding of issues surrounding the credentialing and licensing of the health care workforce, and how to draft internal policies that facilitate compliance, competency, and safety.

#### Competencies:

- 1. Explain the role of State and Federal government in regulation of the healthcare environment.
- 2. Identify the role and function of primary regulatory agencies related to safe, quality healthcare delivery.
- 3. Explain the role and function healthcare work force credentialing and licensing.
- 4. Demonstrate how to draft internal policies.
- 5. Explain mechanisms to evaluate the compliance, and competency of internal policies.
- 6. Discuss the role of patient safety in healthcare administration.
- 7. Discuss the moral and ethical issues related to patients and employees.

### **MCC 206 Managing Human Capital**

Course Description: The basic knowledge and skills required for dealing with people will be introduced or enhanced through this course.

#### Competencies:

- 1. Describe basic principles for leading and motivating a diverse workforce.
- 2. Identify and discuss the State and Federal government imposed labor laws.
- 3. Explain the role of additional agencies including organized labor which impact the healthcare workforce
- 4. Explain how to attract and retain top workforce talent.
- 5. Explain practices for screening and hiring employees.
- 6. Discuss employee evaluation systems.
- 7. Describe the steps in progressive disciplinary action.
- 8. Discuss employee compensation to include: salary/payroll management, pay for performance, and appropriate alignment of salaries maximize recruitment and retention.

## **MCC 207- Finance and Budgeting for Department**

Course Description: This course provides an introduction to basic hospital finance.

### Competencies:

- 1. Identify and define basic terminology related to hospital finance.
- 2. Identify and explain common hospital reimbursement models.
- 3. Define CPT coding and explain its importance to hospital finance.
- 4. Explain the purpose and function of a charge description master.
- 5. Demonstrate each of the following techniques essential to department budget management: projection of work demand, micro costing, forecasting trends, benchmarking and variance analysis.
- 6. Explain what defines a key business relationship.
- 7. Describe several approaches to achieving effective staffing.
- 8. Explain the concepts of equipment/inventory control.
- 9. Explain the principals of the capital budgeting and participate in the process.

## **MCC 208 Data Driven Performance Improvement**

Course Description: Designed to familiarize the student with the principles of information systems designed to improve the safety and effectiveness of health care.

### Competencies:

- 1. Identify and explain department level information systems to include charting, charging and activity capture.
- 2. Explain the principles of quality improvement and demonstrate how the process is used in effective department management.
- 3. Identify and explain processes designed to capture the outcomes of quality improvement initiatives.
- 4. Define customer service and explain its role in consumer driven improvement initiatives.
- 5. Explain the role of business research in hospital fiscal management.
- 6. Demonstrate the effective use of statistical techniques in identifying areas of concern and developing metrics and models to track outcomes.

### **Research Curriculum Competencies:**

**45 - 50 hrs**

## **RCC 101 Over-view of Respiratory Care Research and Ethics**

Course Description: The importance of clinical research to the profession of respiratory care to include ethical and theoretical considerations.

Competencies:

- 1. Explain the importance of research to the profession of Respiratory Care.
- 2. Explain the importance of ethics in research design and implementation.
- 3. Obtain a certificate of completion for the National Institutes of Health online course "Protecting Human Subjects".
- 4. Explain the scientific method
- 5. Develop your own example of a study problem with hypothesis based upon the scientific method.

**RCC 102 Performing Physical Measurements in Research.**

Course Description: The identification, operation and utilization of physical measurements in conducting clinical research.

Competencies:

- 1. Identify the devices used in performing physical measurement in clinical research.
- 2. Demonstrate the interface and integration of physical measurement devices in performing clinical research.
- 3. Explain how to assure and document accuracy of results obtained through physical measurement devices.
- 4. Build a U-tube manometer and use it in a research problem.

**RCC 103 Developing a Research Study**

Course Description: The steps in developing a clinical research study.

Competencies:

- 1. Explain the steps in developing a research study.
- 2. Identify a research problem and explain its relevance to the practice of respiratory care.
- 3. Based upon your identified research problem develop the study idea to include:
  - a. Identification of the major outcome variable and how it will be measured.
  - b. A timeline for the experiment and data collection.
  - c. Explanation of how study subjects will be obtained.

## **RCC 104 Conducting a Research Study**

Course Description: The process of conducting a research study.

### Competencies:

- 1. Explain the relevance of a literature search to research.
- 2. Discuss how literature resources are classified based upon their rigor.
- 3. Conduct a literature search on Pub Med and download a minimum of 5 background articles.
- 4. Prepare a clinical research design to include: sample size with justification, process to obtain/enroll study participants and experiment design.
- 5. Develop a research protocol based upon the IRB study protocol.

## **RCC 105 Basic Statistics**

Course Description: Concepts of basic statistics utilized in clinical research.

### Competencies:

- 1. Discuss basic statistical concepts.
- 2. Explain statistics for nominal measures and how to apply in clinical research data.
- 3. Explain statistics for ordinal measures and how to apply in clinical research data.
- 4. Explain statistics for continuous measures and how to apply in clinical research data.
- 5. Apply appropriate statistical analysis to clinical research data.

## **RCC 106 Reporting Clinical Research Results**

Course Description: How to report clinical research results for dissemination in various formats.

### Competencies:

1. Identify the formats for reporting and sharing clinical research results.
2. Write a research abstract
3. Write a research paper based on conducted clinical research.
4. Prepare a poster presentation on the research paper completed in #3.

**CoARC**

**NBRC**

**ARCF**





*Sponsored By:*

The American Association for Respiratory Care • The American College of Chest Physicians  
The American Society of Anesthesiologists • The American Thoracic Society

## CoARC Update July 2009

### I. Accredited Respiratory Care Programs as of June 26, 2009:

Status	100-level	200-level	Polysomnography
Accredited	27	349	12
Letter of Review	0	52	N/A
Approval of Intent	0	6	2
Letter of Intent	6 – supplementary materials pending		

CoARC currently has a total of **376** accredited Respiratory Care programs. Twenty-seven of those programs are Certification-level (100-level) of which only 7 remain as a stand-alone program. The other 20 are associated with an institution that offers a 200-level program. An additional 52 programs hold a Letter of Review (LoR) which is a status signifying that a program seeking Initial Accreditation has demonstrated sufficient compliance with the accreditation *Standards* through the Letter of Review Self Study Report (Letter of Review SSR) and other documentation. A LoR authorizes the sponsor to admit its first class of students. A LoR is recognized by the National Board for Respiratory Care (NBRC) toward eligibility for the Respiratory Care credentialing examination(s).

CoARC also accredits polysomnography programs as add-ons to accredited Respiratory Care programs. There are currently 12 such accredited Polysomnography programs. There are also a total of 14 domestic satellite campuses, 5 evening formats, and 1 international satellite program (National Institute for Specialized Health in Riyadh, SA).

### II. Board Membership Changes

Dr. Sherif Afifi, MD, was recently elected to the Board at our March 5th meeting as a representative of the American Society of Anesthesiologists. The CoARC Board is conducting elections at its July meeting for a public member, an ACCP representative board position, two AARC representative board positions, and one at-large board position. The complete roster of Committee members is available at: [www.coarc.com/committee\\_members.htm](http://www.coarc.com/committee_members.htm).

### IV. Update on Independent Accreditor Status

The Committee on Accreditation for Respiratory Care (CoARC) has made a decision to change its original separation date of January 15, 2010 to **November 11, 2009**. This decision is due to the fact that we were recently informed that October will be the last month in which the Commission on Accreditation of Allied Health Professions (CAAHEP) will be acting on recommendations from CoARC. CoARC believes that it would be in the best interests of both

organizations, and would provide clarity to respiratory care programs, for CoARC to conduct its November Board meeting as a freestanding accreditor. CoARC recently signed a separation agreement with CAAHEP as part of the requirements for transition. CoARC is in the process of developing a Frequently Asked Questions (FAQ) document regarding our transition.

As CoARC moves closer to the separation date, we will continue to keep our programs, sponsoring organizations, and the public informed of the status of the transition. In addition, CoARC will provide, in several venues, retraining for key personnel, site visitors, and others on the new accreditation standards and other policies and procedures that have been revised as a result of the transition.

#### V. Accreditation Standards Revisions Process

In preparation for its planned separation from CAAHEP, CoARC has been drafting new Standards. The first draft was released for public comment in early March and the comment period ended on May 1<sup>st</sup>. CoARC is in the process of reviewing the comments and making revisions for a planned release of the second draft sometime shortly after the July Board meeting. There will be a short comment and revision period for the second draft. Once the final draft is reviewed and approved, it will be sent to CoARC's sponsoring organizations for formal endorsement. There will be an anticipated transition period in 2010 from the current CAAHEP Standards to the new CoARC Standards.

#### VI. 2009 Summer Forum Activities

In conjunction with the 2009 AARC Summer Forum in Marco Island, FL, CoARC will present a **Key Personnel Workshop** to instruct new, as well as experienced program directors and directors of clinical education on how to properly achieve credentialing success, conduct a program resource assessment, submit self study documents, and prepare for site visits. On Thursday July 16<sup>th</sup>, CoARC will continue to host a Meet the Referee session, where programs can sit down one-on-one with a Committee member to discuss the specifics of their program. Following this session, CoARC will host an awards reception for educators. Mr. Joseph Sorbello will be presenting the 13<sup>th</sup> Annual Dr. H. F. Helmholtz, Jr. Educational Lecture on Sunday, July 19<sup>th</sup>. The title of Mr. Sorbello's presentation is "*Evidence-Based Guidelines and Practice: How Are We Doing in Respiratory Care?*" CoARC will also be holding a public hearing on the proposed new Standards during the Summer Forum on Saturday morning at 8 AM (room TBD).

Sincerely,



Shelley C. Mishoe, PhD, RRT, FAARC  
Chair



## MEMORANDUM

Date: July 2, 2009

To: AARC Board of Directors and House of Delegates

From: Sherry L. Barnhart, RRT, RRT-NPS, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you this update on activities of the NBRC. The Board of Trustees met the week of April 20, 2009 to conduct its examination development activities and discuss business related items pertinent to the credentialing system. We are off to a busy start for 2009 and the following details the current status of examinations and significant activities in which the Board and staff are currently involved.

### ***Sleep Disorders Testing and Therapeutic Intervention Examination Launched***

We launched the new Specialty Examination for Respiratory Therapists Performing Sleep Disorders Testing and Therapeutic Intervention at the AARC International Congress in December. We offered candidates who applied before December 31, a \$50 discount off the new applicant fee of \$300. While we hoped to have about 60 candidates for the launch, we only had 6. We then launched the examination in the CBT network on January 2 with delayed score reporting until such time as we had enough candidates to finalize the cut-score.

Despite our marketing efforts, we still had not been able to attract enough candidates to take the examination so that test scores could be released. In an effort to entice more candidates to apply for and take the examination, the Executive Committee approved a reduction in the examination fee to \$100 (and to refund the difference to those candidates who had already applied and paid) for a set period of time until May 22, 2009. I am happy to report that we have now tested over 100 candidates, final scoring is complete and all candidates have been provided their examination results. All candidates who now attempt this examination receive instant results on the day of their examination.

## ***New Test Specifications to be Introduced for CRT and RRT Examinations***

New test specifications for the CRT Examination will be implemented with examinations administered in July 2009. A revised practice test and self assessment examinations are now available through the NBRC's website. Test content for the RRT Examinations will change with examinations administered in January 2010 and an updated practice test and self assessment examinations will be available in July.

## ***Adult Critical Care Job Analysis***

The job analysis committee convened in November 2008 to begin development of the task survey. The job analysis survey was mailed in April 2009 to a random sampling of RRT's who earned the credential at least 3 years ago, acute care hospitals and long-term care facilities with an ICU. Test development activities will begin in 2010 with an expected launch of the examination in early to mid 2011.

## ***2009 Examination and Annual Renewal Participation***

Receipt of applications for the credentialing examinations has exceeded those received through a similar period in 2008. Through June 30, over 24,000 applications had been received compared to approximately 19,000 this time last year. Much of this increase can likely be attributed to individuals who were subject to the February 28, 2009 deadline to earn the RRT credential, but also new graduates coming out of accredited education programs. 2009 annual renewal notices were mailed to credentialed practitioners in mid- November 2008 and a second notice was sent in late March. To date, over 26,000 credentialed individuals have renewed their active status with the NBRC.

## ***Examination Statistics – January 1 – June 30, 2009***

The NBRC has administered over 22,000 examinations through June 30, 2009. Pass/fail statistics for the respective examinations follow:

<b><u>Examination</u></b>	<b><u>Pass Rate</u></b>	
<b><u>CRT Examination</u></b> – 7,570 candidates		
	<b><u>Entry Level</u></b>	<b><u>Advanced</u></b>
First-time Candidates	72.9%	80.9%
Repeat Candidates	27.3%	25.9%
<b><u>Therapist Written Examination</u></b> – 6,764 candidates		
First-time Candidates	71.1%	
Repeat Candidates	40.0%	

Clinical Simulation Examination –7,168 candidates

First-time Candidates	58.5%
Repeat Candidates	48.3%

Neonatal/Pediatric Examination – 402 candidates

First-time Candidates	74.5%
Repeat Candidates	49.4%

Sleep Disorders Specialty Examination – 102 candidates

First-time Candidates	94.1%
Repeat Candidates	NA

CPFT Examination – 140 candidates

First-time Candidates	60.0%
Repeat Candidates	42.1%

RPFT Examination – 32 candidates

First-time Candidates	83.3%
Repeat Candidates	42.9%

Your Questions Invited

If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need to be fully informed. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and all of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the continued integrity of the credentialing process.



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June 30, 2009

The ARCF processed 44 applications for International Fellows and 14 applications for City Host. These applications were sent to the International Committee for review, with selection by them during the Summer Forum.

There were 23 applicants for the ARCF student awards. These applications are now being sent to reviewers. We have had a great response again from the Education Section to help with the review process.

We are still awaiting all of the nominations for the Achievement Awards (Bird, Hudson, Invacare, and Sepracor). These will be reviewed and voted on by the Trustees in September.

The Foundation has applied for a number of external grants.

The NACI had grants available for Asthma education. We applied for a grant to extend the Peak Performance program to include an education program with continuing education credits for the school staff. The results of that application will be announced in October.

AHRQ solicited grants for conferences that provide information to improve clinical effectiveness. We applied for a grant for an upcoming journal conference. Announcement date is in September. We are also applying for grants and sponsorship from industry for the conference.

The community grants from the funds raised by the Ventilator 5K events have drawn a lot of interest. This year we have had 8 applications. We have funded Camp Asthmania in South Carolina, a program to inform High School Guidance Counselors in Kansas about Respiratory Therapy as a career option. In the past we have funded asthma camps, and smoking cessation program startup costs. None of the patient grants have been approved yet, they are all awaiting letters of medical necessity.

Respectfully submitted,

Michael Amato  
Chair

# ***Unfinished Business***

White Paper on Protocols

Ratification of Appointments/Charges

- Home Care PTAC: Dianne Lewis
- CPG Committee: Arzu Ari & Steve Sittig
- Simulation Alliance: Robert Chatburn

Outstanding Recommendations & Referrals Review

LTOT EBM Project



# AARC Policy & Procedure Manual:

## **Policy Review**

**July, 2009**

**BOD 004 (Referral to Toni Rodriguez)**

**HOD 001**

**HOD 002**

**MP 001**

**CT 002**

**American Association for Respiratory Care**  
**Policy Statement**

Page 1 of 2  
Policy No.: BOD.004

SECTION: Board of Directors

SUBJECT: **Continuous Quality Improvement Plan**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: May 8, 2004[rodriguez1]

**REFERENCES:**

***Policy Statement:***

The Board of Directors shall ~~meet at a dedicated time and place identified by the President to systematically~~ evaluate its effectiveness as the governing entity of the Association continually[rodriguez2]. ~~less than twice annually.~~

***Policy Amplification:***

1. As part of this process, the Board of Directors shall review planning, operation and service delivery to assure quality performance of the Association [rodriguez3] based upon key quality precepts.[rodriguez4] ~~use available data, statistical information, and continuous quality improvement methods.~~

**Quality Performance**

The Board of Directors is responsible for the efficient use of available resources to operationalize the mission statement and attain the strategic objectives of the AARC. Quality performance occurs through the continuous improvement of key processes and activities that contribute to the advancement of the art and science of respiratory care irrespective of venue.

**Quality Precepts**

- Continuous improvement of every process of planning operation and service delivery.
- Elimination of barriers which have the effect of adding costs through waste reduction and simplification.

# American Association for Respiratory Care

## *Policy Statement*

Page 2 of 2  
Policy No.: BOD.004

- Alignment with outside organizations as partners.
- Management practices that focus on improvement of the systems in which members work.
- - mphasis on continuous process improvement rather than periodic inspection
- Continuous evaluation and improvement ~~when working~~ of working relationships [rodriguez5]with related organizations.
- Promotion of member understanding of their jobs and individual roles in providing quality products.
- Creation of a caring organizational environment that is characterized by trust and integrity and strives to drive out fear and frustration for optimal performance; encourages suggestions for improvement and innovation; and promotes sharing of ideas.
- Communication about organizational goals and progress as essential for enlisting effective participation.
- Creation of budgets and performance management each year for monitoring progress internally.
- Improvement in statistical processes and planning, and application of quantitative methods for continued improvement.

DEFINITIONS:

ATTACHMENTS:

# American Association for Respiratory Care Policy Statement

Page 1 of 1  
Policy No.: HOD.001

SECTION: House of Delegates

SUBJECT: **Correspondence**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES:

***Policy Statement:***

Correspondence and other information relevant to the function of the House of Delegates shall be appropriately routed.

***Policy Amplification:***

1. All correspondence pertinent to the function of the House of Delegates shall be sent to the Speaker of the House of Delegates.
  - A. The Speaker shall cause correspondence to be distributed appropriately to members of the House of Delegates.
2. All HOD Officers shall receive correspondence directed to the BOD and Board agenda books as approved by the President.
3. Newly elected House Officers shall receive a copy of the Association's Policy and Procedure Manual.

DEFINITIONS:

ATTACHMENTS: AARC Conflict of Interest Statement (See Appendix)  
AARC Tobacco Free Pledge (See Appendix)

**American Association for Respiratory Care**  
**Policy Statement**

Page 1 of 1  
Policy No.: HOD.002

SECTION: House of Delegates

SUBJECT: **Procedures – Rules**

*EFFECTIVE DATE:* June 18, 2002

DATE REVIEWED:

DATE REVISED:

REFERENCES: Delegate Handbook

***Policy Statement:***

All procedural activities of the House of Delegates can be found in the Delegate Handbook and House Rules.

***Policy Amplification:***

Any information regarding the procedural activities of the House of Delegates, from committees to resolutions, can be found in the Delegate Handbook. The Delegate Handbook also contains the House Rules under which the House of Delegates operates.

DEFINITIONS:

ATTACHMENTS:

**American Association for Respiratory Care**  
**Policy Statement**

Page 1 of 2  
Policy No.: MP.001

SECTION: Membership  
SUBJECT: **General Operating Policies**  
EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES: Bylaws, Code of Ethics, House Rules for Special Recognition

***Policy Statement:***

The Association's membership shall be subject to the provisions of Association Bylaws and Association policy.

***Policy Amplification:***

1. All personal records of Association members shall be the property of the Association and shall be held in strict confidence.
2. Members whose AARC membership has lapsed may reactivate their membership in the Association by payment of the current year's membership dues plus the fee set in the Annual Budget subject to the following conditions:
  - A. The lapse in membership has been for a maximum time period of one year.
  - B. The member must meet current Bylaws requirements for appropriate membership classification
3. AARC members shall be granted reciprocity of chartered affiliate membership without inter-affiliate transfer of current chartered affiliate dues paid.
4. All new and renewing members shall be required to complete the AARC membership application and subsequent renewal cards in their entirety.
5. The Membership Committee shall assure that a request for medical direction, when applicable, be included on the membership application.

## American Association for Respiratory Care Policy Statement

Page 2 of 2

Policy No.: MP.001

6. All AARC Members with twenty (20) or more years of continuous membership shall receive a letter of congratulations and thanks from the President and Executive Director.
7. All nominations for Life Membership submitted to the House of Delegates by a delegation shall include curriculum vitae as justification, and a resolution recommending such action shall be submitted to the House at least sixty (60) days prior to the Annual Meeting of the Association.
8. Life Membership shall automatically be bestowed upon an AARC President upon completion of his/her term as Immediate Past-president.
9. All Active and Life Members of the Association employed within the boundaries of chartered affiliates shall be permitted to vote in the election of the delegation of that affiliate, regardless of their separate affiliate membership status.
10. That students enrolled in an accredited respiratory therapy education program be permitted to join AARC as student members at no charge with the following qualifications:
  - a. Access to *AARC Times* and *RESPIRATORY CARE* will be limited to the internet.
  - b. That 100% of the faculty in the program where the student is enrolled be either an active or associate member of AARC.”

DEFINITIONS:

ATTACHMENTS:

# American Association for Respiratory Care Policy Statement

Page 1 of 1  
Policy No.: CT.002

SECTION: Committees  
SUBJECT: **Medical Advisors**  
EFFECTIVE DATE: December 14, 1999  
DATE REVIEWED:  
DATE REVISED: **March, 2009**

## REFERENCES:

### ***Policy Statement:***

Committees shall have Medical Advisors as requested by the President, identified by the Chair of the Board of Medical Advisors (BOMA) and appointed by the President.

### ***Policy Amplification:***

1. Special Committees and other groups shall have Medical Advisors as determined by the President.

A. BOMA shall submit names for Committee Medical Advisors to the President for appointment and ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS:



# ***New Business***

