MARCH 2009
BOARD OF DIRECTORS

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Budget Committees, and Board of Directors Meetings
March 26 - 28th, 2009
D/FW Airport Marriott North,
8440 Freeport Prkwy, Irving Tx

Thursday, March 26

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

Friday, March 27

AARC Board of Directors' Meeting

8:00 – 5:00 pm	AARC Board of Directors Meeting
8:00 am.	Call to Order Announcements/Introductions Swearing in of Directors Approval of Minutes E-motion Acceptance General Reports President Past President Executive Director Report
9:00 am.	Auditor's Report
9:30 am	Lawrence M. Wolfish, Wolfish & Newman, P.C. - Board Member Fiduciary Responsibility & Conflict of Interest
10:30 am	Frank Sloan – AARC Investment
11:00 am	**BREAK**
11:15 am	General Reports con't. Government & Regulatory Affairs House of Delegates Board of Medical Advisors Presidents Council Standing Committee Reports Bylaws Committee Elections Committee Executive Committee Finance Committee

12:00 pm **Lunch Break (Daedulus)**

1:30 pm **Reconvene**

1:30 pm Standing Committee Reports
- Audit Subcommittee
- Judicial Committee
- Program Committee
- Strategic Planning Committee

Specialty Section Reports
- Adult Acute Respiratory Care
- Continuing Care-Rehabilitation
- Diagnostics
- Education
- Home Care
- Long Term Care
- Management
- Neonatal-Pediatrics
- Sleep
- Surface and Air Transport

3:00 pm **BREAK**

3:15 pm Special Committee Reports
- Benchmarking Committee
- Billing Code Committee
- Clinical Practice Guidelines Steering Committee
- Federal Govt Affairs
- Fellowship Committee
- International Committee
- Membership Committee
- Position Statement Committee
- Public Relations Action Team
- State Govt Affairs

4:15 pm Nominations for Life & Honorary Membership

4:30 pm **RECESS**

Saturday March 28

8:00 – 5:00 pm	AARC Board of Directors Meeting
8:00 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)
	Chartered Affiliates
	Clinical Laboratory Institute
	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)
	Medicare Coverage Advisory Committee
	National Asthma Education & Prevention Program
9:30 am	**BREAK**
9:45 am	Special Representatives
	National Asthma Education & Prevention Program
	National Asthma Education & Prevention Program:
	Nat. Coalition for Health Professional Ed. In Genetics
	National Resuscitation Program
	National Sleep Awareness Roundtable
10:15 am	Roundtable Reports
	Asthma Disease
	Consumer
	Disaster Response
	Hyberbaric
	Infomatics
	Military
	Moderate
	Neuromuscular
	Research
	Tobacco Free Lifestyle

10:45 AM Special Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care
Ad Hoc Committee on Geriatrics
Ad Hoc Committee on Officer Status/US Uniformed Services
Ad Hoc Committee Protocol Implementation Task Force
Ad Hoc Ventilator Guidance Work Groups
-Human Resources Group
-Ventilator Group
-Logistical Group
Ad Hoc Pinnacle Award
Ad Hoc Committee on Learning Institutes

12:00 – 1:30 pm **LUNCH BREAK**

1:30 pm Other Reports

Committee on Accreditation for Respiratory Care (CoARC)
National Board for Respiratory Care (NBRC)
American Respiratory Care Foundation (ARCF)

2:30 pm **BREAK**

2:45 pm **UNFINISHED BUSINESS**

Previously Reviewed Policies:

CA 005 (Pg. 64)	BOD 005
SS 002 Revised	BOD 012
SS 003 Revised	BOD 015
SS 005	BA 002

NEW BUSINESS

- Ratification of Appointments
- Discussion: End of Life White Paper
- TSRC Motion
- Policy Review

4:30 pm ARCF Achievement Award Nominations

Bird	Invacare
Hudson	Sepracor

ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
December 11, 2008 – Anaheim, California

Minutes

Attendance
Toni Rodriguez, EdD, RRT, President
Timothy Myers, BS, RRT-NPS, President-Elect
Michael Runge, BS, RRT, Past President
Ruth Krueger, MS, RRT, VP/Internal Affairs
Karen Stewart, MS, RRT, FAARC, VP/External Affairs
Susan Rinaldo Gallo, MEd, RRT, Acting Secretary-Treasurer Pro Tem
Terence Carey, MD, BOMA Chair
Patricia Doorley, MS, RRT, FAARC
Debbie Fox, MBA, RRT-NPS, Past Speaker
Rick Ford, BS, RRT, FAARC
George Gaebler, MSEd, RRT, FAARC
Michael Hewitt, RRT-NPS, FAARC, FCCM
Denise Johnson, BS, RRT
Joan Kohorst, MA, RRT-NPS
Jim Maguire, PhD
Robert McCoy, RRT, FAARC
James Taylor, MA, RRT
Linda Van Scoder, EdD, RRT
Brian Walsh, RRT-NPS, RPFT

Absent
Colleen Schabacker, BA, RRT, FAARC, Secretary/Treasurer (Excused)

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

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
William Dubbs, MHA, MEd, RRT, Director of Education and Management
Cheryl West, MHA, Director of Government Affairs
Miriam O'Day, Director of Legislative Affairs
Dale Griffiths, Business Development Director
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Toni Rodriguez called the meeting of the AARC Board of Directors to order at 8:10 a.m. PST, Thursday, December 11, 2008.

Acting Secretary-Treasurer Pro Tem Susan Rinaldo Gallo called the roll and declared a quorum.

ANNOUNCEMENTS

Sam Giordano announced that Dr. Forest Bird received the prestigious President's Citizens Medal which recognizes citizens who have performed deeds of service for United States citizens.

APPROVAL OF MINUTES

Ruth Krueger moved "To accept the minutes of the July 14, 2008 meeting of the AARC Board of Directors."

Motion Carried

Ruth Krueger moved "To accept the minutes of the July 15, 2008 meeting of the AARC Board of Directors."

Motion Carried

E-MOTION RATIFICATION

Susan Rinaldo Gallo moved "To ratify the following E-motion addressed by E-vote since July 15, 2008:

Recommendation 08-2-26.1 "That the newly developed position statement entitled 'Inhaled Medication Administration Schedules' be approved by the AARC BOD."

Motion Carried

PRESIDENT'S REPORT

President Rodriguez reported that her presidency was her most challenging experience, yet the most exciting having met fantastic people and having seen places she would never have otherwise seen. She stated her title will end but her passion will remain with her and she will fight to ensure the Association is where it needs to be and at the right time and place, and that the main goal is advocating for patients.

PRESIDENT-ELECT REPORT

President-elect Tim Myers reported that the 2009 budget was finalized and thanked the Executive Office staff involved in that process. He has been working diligently on his goals and committees for 2009. He traveled to Hawaii, and to Berlin to attend the European Respiratory Society (ERS) meeting where AARC's International program was promoted as well as the Journal. He sits on the American Heart Association Pediatric Subcommittee and attended their recent meeting. He participated in a conference call on the protocol issue and advised that CMS has stepped back somewhat about how protocols would need to be ordered and the timing involved.

EXECUTIVE OFFICE REPORT

Sam Giordano commented that AARC was given a seat on the Ambulatory Services PTAC Committee of the Joint Commission. The Association will now have representation on three PTACs beginning in 2009 (homecare, laboratory, and ambulatory services).

Sam Giordano met with Senators Mike Crapo (ID) and Blanche Lincoln (AR) which proved to be a positive meeting. The Asthma Prep course is now available as a distance learning program. The second 2015 Conference is scheduled for April. The first Conference manuscript was finalized and will be published in the March issue of *RESPIRATORY CARE*. Ed O'Neil who heads the University of San Francisco Center is the Conference Chair, with co-chairs Woody Kageler and Tom Barnes. Members of this group will begin to conference using the Eluminate system which allows for unlimited seats. Sam Giordano was appointed to the COPD Foundation Board and attended their first Board meeting in November. He traveled to Tennessee in November and worked with our lobbyist and the Tennessee legislature as well as the Chair of the Government Affairs Committee of the Society. They intend to introduce legislation at the same time AARC will be introducing its legislation. Sam stated that during previous recessions we would track the ability of the Association to recruit, however this economy may be different due to possible downsizing in hospitals. We aren't sure health care is going to be insulated from the economy, and therefore need to leverage that information and encourage practice that avoids unnecessary care. The AARC needs to diligently pursue the Part B initiative to allow for RTs to expand beyond the hospital.

Tom Kallstrom reported the Asthma Self Management Education (ASME) program has been beta tested and the program awarded its first certification last month. We became aware of a competing force who is assuming the same name, however we have copyright protection for this program. We've completed the free EPA course which will be available online in January. The last asthma prep course is scheduled during this meeting. Ari Arzu has been recruited to write the Aerosol Guide draft. Ms. Arzu is a highly respected individual in her area of expertise who works with Georgia State. The revision draft is targeted to be released by Easter of next year. The Mobile Spirometry Unit (MSU) will be set up outside of the convention center, as well as a booth where RTs will be screened.

HOUSE OF DELEGATES REPORT

Debbie Fox moved to accept **FM 08-3-6.1** "That the Emirates Society application for International Affiliate of the AARC be approved."

Motion Carried Unanimously

EXECUTIVE OFFICE REFERRALS

Sam Giordano reported that **Recommendation 08-2-65.2** and **FM 08-2-01.2** have been implemented and are therefore closed.

George Gabler moved to bring back to the floor **HR 16-08.01** "Resolved that the AARC indicate on the current affiliate membership report whether an individual member has provided an e-mail address, whether they opt to share the address, and whether the address is active (no bounce back)" to the floor."

Motion Defeated as this is not feasible at this time.

Susan Rinaldo Gallo moved to bring back to the floor **HR 44-08-02** "Resolved that the AARC CRCE application process and member transcript be modified to separately break out the hours devoted to specific course content categories to ensure the usefulness of the transcript in reporting to state licensure boards."

Motion Defeated

Karen Stewart moved to bring back to the floor **Recommendation 08-2-56.1** "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."

Karen Stewart moved "To refer **Recommendation 08-2-56.1** to the Position Statement Committee for development utilizing information in Attachment B of the Executive Office Report." (SEE **ATTACHMENT "A"**)

Motion to Refer Carried

RECESS

President Toni Rodriguez recessed the meeting of the AARC Board of Directors at 9:55 a.m. PST, Thursday, December 11, 2008.

RECONVENE

President-elect Timothy Myers reconvened the meeting of the AARC Board of Directors at 10:25 a.m. PST, Thursday, December 11, 2008.

BOARD OF MEDICAL ADVISORS (BOMA) REPORT

BOMA Chair Dr. Terence Carey reported the AAAAI will become a sponsor of AARC and represent BOMA with the appointment of Dr. Phil Korenblat to begin in 2009. Dr. Carey spoke with Col. Michael Morris who said there was not much progress with the military efforts recently.

Dr. Carey stated that the Board referred the following motion to BOMA for their suggestions which he shared with the BOD.

> **Recommendation 08-2-58.1** "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 child."

Pat Doorley moved "To amend **Recommendation 08-2-58.1** as follows:

> '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'."

Pat Doorley moved "To refer the amended **Recommendation 08-2-58-1** to the Position Statement Committee for development."

Motion to Refer Carried

PRESIDENT'S COUNCIL REPORT

President's Council Chair, Dianne Lewis reported that the 2008 Life Membership award went to Susan Rinaldo Gallo, while the Honorary Membership was awarded to John Walsh.

She stated the Council is reviewing AARC's awards policies and further stated in the future there will be no more than one Life and one Honorary member awarded each year excluding the Past President.

BYLAWS COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 08-3-9.1** "That the AARC Board of Directors accept the Committee's recommendation for approval of the Oregon State Society Bylaws."

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-9.2** "That the AARC Board of Directors accept the Committee's recommendation for approval of the New York State Society Bylaws."

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-9.3** "That the AARC Board of Directors accept the Committee's recommendation for approval of the Georgia State Society Bylaws."

Motion Carried

George Gaebler moved to accept **Recommendation 08-3-9.4 "**That the AARC Board of Directors accept the Committee's recommendation for approval of the California State Society Bylaws."

Motion Carried

EXECUTIVE COMMITTEE MEETING REPORT

President Toni Rodriguez reported that officers of the HOD were invited to attend the second half of the Executive Committee meeting to discuss the HOD's position on polysom compared to the BOD's position on same. She stated the Association would find it difficult to push for Part B without the House's full support and understanding of the issues pertaining to polysom. The House Speaker will discuss this issue at the HOD meeting.

FINANCE COMMITTEE REPORT

Susan Rinaldo-Gallo reported that the Association's finances are in good standing.

Mike Runge moved to accept **FM 08-3-12.1** "That the AARC BOD accept ratification of the expense of $13,791.92 to replace two failed air conditioning units at the Executive Office."

Motion Carried

Ruth Krueger moved to accept **FM 08-3-12.2** "That the AARC BOD accept ratification of the expense of $1093.30 to replace a laptop used for MSU data collection."

Motion Carried

Ruth Krueger moved to accept **FM 08-3-12.3** "To permanently include the payment of dues when funding individuals affected by disaster and that it be retroactive to cover those individuals who were excluded previously."

Motion Carried

AUDIT SUBCOMMITTEE REPORT

George Gaebler moved to accept **Recommendation 08-3-13.1** "That the AARC BOD defeat **HR 04-07-23** as it is in direct conflict with what is not current practice for presentation of the AARC Budget to be presented and approved during Joint Session of the BOD and HOD."

Ruth Krueger moved "To accept **Recommendation 08-3-13.1** for information only."

Motion Carried

Mike Runge moved to bring back to the floor **HR 04-07-23** "Resolved that the House of Delegates will receive the proposed AARC budget on the first day of the HOD meeting in December. On the next day of the meeting, the HOD will vote regarding the proposed budget."

Motion Defeated

INTERNATIONAL COMMITTEE REPORT

John Hiser reported that AARC's International program currently comprises 21% of total (245) countries in its International Fellowship Program. This year's Fellows are from Nigeria, Peru, Mexico, Norway, Hong Kong, and China. Each sponsor contributes $5000 to fund international fellows. The Aerosol Delivery Device booklet has been a popular item. Podcasts are being utilized more often and soon will even implement Spanish podcasts.

POSITION STATEMENT COMMITTEE REPORT

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-26.1** "Revise the position statement entitled 'Verbal Orders' to incorporate the changes identified."
(SEE **ATTACHMENT "B"**)

Motion Carried

Karen Stewart moved to accept **Recommendation 08-3-26.2** "Revise the position statement entitled 'Pulmonary Rehabilitation' to incorporate the changes identified."
(SEE **ATTACHMENT "B")**

Motion Carried

Karen Stewart moved to accept **Recommendation 08-3-26.3** "Revise the position statement entitled 'Competency Requirements for the Provision of Respiratory Therapy Services' to incorporate the changes identified." (SEE **ATTACHMENT "B"**)

Motion Carried

Karen Stewart moved to accept **Recommendation 08-3-26.4** "Revise the position statement entitled 'Hazardous Materials Exposure' to incorporate the changes identified." (SEE **ATTACHMENT "B"**)

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-26.5** "Revise the 'Respiratory Therapist Education' position statement to incorporate the changes identified." (SEE **ATTACHMENT "B"**)

Linda Van Scoder moved "To refer **Recommendation 08-3-26.5** back to the Position Statement Committee to revise references pertaining to levels of education" (SEE **ATTACHMENT "B"**)

Motion to Refer Carried

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-26.6** "Retire the position statement entitled 'The Role of the Respiratory Care Practitioner in the Provision of Respiratory Care Services in the Hospitals and Alternate Sites Scope of Practice'." (SEE **ATTACHMENT "B"**)

Motion Carried

Karen Stewart moved to accept **Recommendation 08-3-26.7** "Revise the position statement entitled 'Tobacco and Health' to incorporate the changes identified." (SEE **ATTACHMENT "B"**)

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-26.8** "Approve the Position Statement Review Schedule as presented, which is to be used by the Position Statement Committee to systematically review, revise or delete (as appropriate) all current AARC position statements." (SEE **ATTACHMENT "B"**)

Motion Carried

SPECIAL COMMITTEE REPORT ACCEPTANCE

Pat Doorley moved "To accept the Special Committee reports as presented."

Motion Carried

STANDING COMMITTEE REPORT ACCEPTANCE

Ruth Krueger moved "To accept the Standing Committee reports as presented."

Motion Carried

HOMECARE SECTION REPORT

Ruth Krueger 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."

Ruth Krueger withdrew **Recommendation 08-3-53.1**.

RECESS

President-elect Tim Myers recessed the meeting of the AARC Board of Directors at 12:15 p.m., Thursday, December 11, 2008.

JOINT SESSION

President Toni Rodriguez convened the Joint Session at 1:45 p.m., Thursday, December 11, 2008.

Acting Secretary-Treasurer Pro Tem Susan Rinaldo Gallo called the roll.

ELECTION REPORT

Howard Derrick reported on the election of AARC's 2009 officers as follows:

Vice President/Internal Affairs	George Gaebler
Vice President/External Affairs	Joseph Lewarski
Secretary/Treasurer	Karen Stewart
Directors – One year term	John Lindsey
	Michael Tracey
Directors – Two year term	Patricia Doorley
	Denise Johnson
	James Taylor
	Michael Hewitt (Adult Acute Section)
	Robert McCoy (Home Care Section)
	Brian Walsh (Neonatal-Pediatric Section)
Directors – Three year term	Lynda Goodfellow (Education Section)
	Doug Laher (Management Section)
	Doug McIntyre
	Debbie Fox
Chair – Board of Medical Advisors	Dr. Kent Christopher
Chair – Presidents Council	Dianne Lewis
Past Speaker	Frank Salvatore
HOD Speaker	Cam McLaughlin
HOD Speaker-elect	Tom Lamphere
HOD Secretary	Dawn Rost
HOD Treasurer	Deb Skees

AMERICAN RESPIRATORY CARE FOUNDATION (ARCF) REPORT

Sam Giordano reported for the ARCF Chair Michael Amato. He stated the Foundation is hosting a fundraising event at this Congress. The ARCF provides funding for Journal Conferences and International Fellows. He stated the number of Fellows selected is determined by the number of city hosts and available funding.

STATE GOVERNMENT AFFAIRS REPORT

Cheryl West reported that Minnesota will go to full licensure while Hawaii and Alabama are working toward licensure. State governments generally are cutting back on health programs, but are raising taxes on cigarettes and other tobacco products. We continue to monitor state regulations and legislation to assure the integrity of the RT license.

REGULATORY AFFAIRS REPORT

AARC continues to work with government regulatory staff – most notably CMS. We have a number of ongoing issues including revision those RTs who would be appropriate to provide CORF services under Medicare, urging Medicare and Medicaid to establish "best practices" for ventilator care in nursing homes and disseminating our RT medication delivery position statement to appropriate agencies.

FEDERAL GOVERNMENT AFFAIRS REPORT

Miriam O'Day reported that AARC received commitments that our legislation will be re-introduced to both the House and Senate. Arkansas was instrumental in obtaining support from Senator Blanche Lincoln and Representative Mike Ross. We continue to work with pulmonary rehab stakeholders to assure that the implementation of the new pulmonary rehab benefit (January 1, 2010) goes smoothly. We are preparing for the PACT 2009 DC Hill Lobby Day (March 9-10) where we will push our legislative agenda mainly focused on the RT Initiatives bill.

Ruth Krueger moved "To enter into Executive Session."

Motion Carried

EXECUTIVE SESSION

President Toni Rodriguez convened Executive Session at 2:30 p.m., PST, Thursday, December 11, 2008.

Mike Runge moved "To adjourn Executive Session of the AARC Board of Directors."

Motion Carried

EXECUTIVE SESSION ADJOURNED

President Toni Rodriguez adjourned the Executive Session of the AARC Board of Directors at 3:05 p.m., PST, Thursday, December 11, 2008."

RECONVENE REGULAR SESSION

President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 3:30 p.m. PST, Thursday, December 11, 2008.

2009 BUDGET APPROVAL

Linda Van Scoder moved to accept **FM 08-3-12.4** "To accept the 2009 AARC Budget."

Motion Carried

THANK YOU LETTERS

Mike Hewitt moved to accept **FM 08-3-4.1**"That the Board approve sending thank you letters to the organizations who supported AARC's Part B legislative initiative (ATS, ACCP, COPD Foundation and Alpha-1."

Motion Carried

SPECIALTY SECTION REPORTS ACCEPTANCE

Karen Stewart moved "To accept the Specialty Section reports as presented."

Motion Carried

NEUROMUSCULAR ROUNDTABLE REPORT

Susan Rinaldo Gallo moved to accept **Recommendation 08-3-42.1** "That the AARC BOD develop an educational resource center on the AARC Neuromuscular Roundtable website including 1.) PDFs of key reference journal articles; 2.) Neuromuscular respiratory care protocols for diagnostic and respiratory care; 3.) A digest for previous neuromuscular respiratory forums, provide a forum for Listserv member needs, partner with the AARC in developing roundtable membership and integrate homecare disaster response protocol now being developed by the American College of Chest Physicians Homecare Steering Committee."

Tim Myers moved "To refer **Recommendation 08-3-42.1** to the Executive Office for feasibility and cost analysis."

Tim Myers withdrew the motion to refer **Recommendation 08-3-42.1**.

Denise Johnson moved "To refer **Recommendation 08-3-42.1** back to the Neuromuscular Roundtable Chair and ask him to clarify his intent by developing an action plan of the desired outcome."

Motion to Refer Carried - Ruth Krueger will convey the Board's sentiment to the incoming Chair.

HOUSE OF DELEGATES REPORT

Speaker of the House Frank Salvatore reported on the new budget presentation that admittedly needs tweaking to satisfy members. He thanked the Board for its continued

dialogue with the HOD. He advised that the House granted the committee an extension on **HR 22-08-04** until December 2009.

Ruth Krueger moved to accept **Recommendation 08-3-21.1** "That the AARC BOD remove the quarterly electronic newsletter from the charges of the Federal Government Affairs Committee."

Linda Van Scoder moved "To refer **Recommendation 08-3-21.1** to the President-elect."

Motion to Refer Carried

Ruth Krueger moved to accept **Recommendation 08-3-21.2** "That the AARC BOD remove the charge directing the Committee to submit reports through the Government Affairs staff liaison."

Linda Van Scoder moved "To refer **Recommendation 08-3-21.2** to the President-elect."

Motion to Refer Carried

GENERAL REPORTS ACCEPTANCE

Mike Runge moved "To accept the General Reports as presented."

Motion Carried

CONSUMER REPORT

Sam Giordano advised members of a $33,000 grant from Phillips Respironics to help defray costs to develop a guidance document to be completed in 2009 on Aerosol Delivery Devices.

POLICY REVISION

AD HOC COMMITTEE ON ROUNDTABLE POLICY REPORT - ***Policy***

George Gaebler reported that most roundtables are fairly active, with minimal maintenance, and topics were determined to be relevant. He advised the Committee's recommendation is to add **5a through d** (below) to Roundtable Policy No. RT-001:

> **5a** If the Listserv has three consecutive months with no posts the Roundtable Chair and AARC Board liaison will be notified of the lack of communication.
>
> **5b** The Roundtable Chair will post a query to see if the Roundtable needs to continue or has served its useful life and should be dissolved to its Listserv members.

5c If the Listserv replies indicate a desire to continue, then the 3-month probationary sequence will commence.

5d If the Listserv has no posts during the three-month probationary period, the roundtable shall be dissolved.

Mike Runge moved to accept **FM 08-3-36.1** "That the AARC BOD accept the proposed policy changes (above) to AARC Policy RT-001 on Roundtables."

Motion Carried

DISSOLVED COMMITTEE

Denise Johnson moved to accept **FM 08-3-36.2** "To dissolve the Ad Hoc Committee on Roundtable Liaison Policy."

Motion Carried

ROUNDTABLE REPORTS STATUS

The Board recommended to the President-elect and the newly elected Vice President for internal affairs that beginning in 2009 with each of the Roundtable reports the BOD liaisons are expected to give a verbal report on the status and activities of that Roundtable.

ROUNDTABLE REPORTS ACCEPTANCE

Susan Rinaldo Gallo moved "To accept the Roundtable reports as presented."

Motion Carried

RECESS

President Toni Rodriguez recessed the meeting of the AARC Board of Directors at 4:40 p.m. PST Thursday, December 11, 2008.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
December 12, 2008 – Anaheim, California

Minutes

Attendance
Toni Rodriguez, EdD, RRT, President
Tim Myers, BS, RRT-NPS, President-Elect
Michael Runge, BS, RRT, Past President
Ruth Krueger, MS, RRT, VP/Internal Affairs
Karen Stewart, MS, RRT, FAARC, VP/External Affairs
Susan Rinaldo Gallo, MEd, RRT, Acting Secretary-Treasurer Pro Tem
Debbie Fox, MBA, RRT-NPS, Past Speaker
Terence Carey, MD, BOMA Chair
Patricia Doorley, MS, RRT, FAARC
Rick Ford, BS, RRT, FAARC
George Gaebler, MSEd, RRT, FAARC
Michael Hewitt, RRT-NPS, FAARC, FCCM
Denise Johnson, BS, RRT
Joan Kohorst, MA, RRT-NPS
Jim Maguire, PhD
Robert McCoy, RRT, FAARC
James Taylor, RRT
Linda Van Scoder, EdD, RRT
Brian Walsh, RRT-NPS, RPFT

Absent
Colleen Schabacker, BA, RRT, FAARC, Secretary/Treasurer (Excused)

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

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
Cheryl West, MHA, Director Government Affairs
Miriam O'Day, Director Legislative Affairs
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Toni Rodriguez called the meeting of the AARC Board of Directors to order at 8:05 a.m. PST, Friday, December 12, 2008.

SPECIAL REPRESENTATIVE REPORTS

AMA CPT COMMITTEE REPORT

Susan Rinaldo Gallo reported that since her written report was submitted, an additional code pertaining to patient reassessment in Pulmonary Rehab has been created.

AMERICAN HEART ASSOCIATION (AHA) REPORT

Mike Runge moved to accept **Recommendation 08-3-63.1** "That the AARC continue to support AHA by maintaining a representative from the AARC."

Tim Myers moved "To refer **Recommendation 08-3-63.1** to the President-elect."

Motion to Refer Carried

SPECIAL REPRESENTATIVE REPORTS ACCEPTANCE

Karen Stewart moved "To accept the Special Representative reports as presented."

Motion Carried

UNFINISHED BUSINESS

New York Society Update

President Toni Rodriguez advised members that the New York Society was willing to work with the chapter on their mutual disagreement. The chapter chose mediation, while the NYSSRC chose binding arbitration. AARC's lawyers advised that binding arbitration was the preferable method. It is felt that the AARC leadership did all they could to resolve this and it is back in the hands of the New York Society.

RATIFICATION OF HYPERBARIC ROUNDTABLE CHAIR

Tim Myers moved to accept **FM 08-3-45.1**"To ratify the Presidential appointment of Dr. Cliff Boehm as Chair of the Hyperbaric Roundtable."

Motion Carried

George Gaebler moved to accept **FM 08-3-45.2** "To approve the goals of the Hyperbaric Roundtable as follows:

1. Establish an effective platform for networking and communication between the members of the Roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in hyperbaric medicine.
3. Bring the concerns and issues of your membership as related to research in respiratory care to the attention of the AARC Board of Directors as indicated.
4. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of hyperbaric medicine."

Motion Carried

RATIFICATION OF INFORMATICS ROUNDTABLE

Ruth Krueger moved to accept **FM 08-3-82.2** "To ratify establishment of an Informatics Roundtable."

Motion Carried

Susan Rinaldo Gallo moved to accept **FM 08-3-82.3**"To assign the President-elect the job of selecting a Chair and establishing goals for the Informatics Roundtable."

Motion Carried

AD HOC COMMITTEE ON LEARNING INSTITUTES

President Toni Rodriguez reported that she will continue the Ad Hoc Committee on Learning Institutes with the following structure:

Toni Rodriguez as Chair of the Learning Institutes:

Management Content Coordinator – Rick Ford
Education Content Coordinator – Linda Van Scoder
Research Content Coordinator – Rob Chatburn

RECESS

President Toni Rodriguez recessed the meeting of the AARC Board of Directors at 8:55 a.m. PST, Friday, December 12, 2008.

RECONVENE

President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 9:10 a.m. PST, Friday, December 12, 2008

COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (COARC) REPORT

CoARC Chair Shelley Mishoe reported that CoARC is separating from CAAHEP and will become a free-standing accrediting organization through an appeals process. She stated they will also change their name to the **Commission on Accreditation for Respiratory Care**. Executive Director Tom Smalling assured members that CoARC does not receive funding from any of the allied organizations and thwarted any questions of conflict of interest, or questions of objectivity. They don't anticipate any increase in costs.

Jim Taylor moved to accept **FM 08-3-79.1** "That the AARC Board of Directors support CoARC's move toward independent accreditation and supports their engagement with CHEA and ASPA."

Motion Carried Unanimously

HOUSE OF DELEGATES RESOLUTIONS

Denise Johnson moved to accept **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."

Karen Stewart moved "To refer **HR 94-08-24** to the Executive Office for investigation of feasibility and cost, and report back in March."

Motion to Refer Carried

RECESS

President Toni Rodriguez recessed the meeting of the AARC Board of Directors at 9:55 a.m. PST, Friday, December 12, 2008.

RECONVENE

President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 10:10 a.m. PST, Friday, December 12, 2008.

HOUSE OF DELEGATES RESOLUTIONS CONTINUED

Debbie Fox reported that the following resolution from 2003 remains open and asked the Board for their input.

Ruth Krueger moved to accept **HR 57 2003-28** "Resolved that the AARC adopt the following revenue sharing model:

We propose a plan that will encourage state affiliates to actively promote membership by financial reward. The program is two-tiered and bonuses would be annual and calculated at year-end based on yearly average affiliate AARC active and associate membership numbers.

a. Establish a sliding base rate using the AARC active and associate membership numbers.
b. State affiliate bonus based on annual affiliate AARC active and associate membership increase."

Motion Defeated

President Toni Rodriguez passed the gavel to President-elect Tim Myers at 10:30 a.m. PST, Friday, December 12, 2008.

POLICY REVIEW

Karen Stewart moved "To accept Policy No. FM 007."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM 008."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM 009."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM 010."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM 011."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM012."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM 013."
Motion Carried with addition of new review date

Karen Stewart moved "To accept Policy No. FM 014."
Motion Carried with addition of new review date

MAINTENANCE OF PREVIOUS OPEN RECOMMENDATIONS

Linda Van Scoder moved "To reconsider **Recommendation 08-1-9.1** That the AARC BOD accept the committee's recommendation for approval of the Massachusetts State Society Bylaws."

Motion to Reconsider Defeated

Mike Runge moved to bring back to the floor **Recommendation 08-1-28.1** "That more time is needed to write an appropriate statement regarding AARC guidelines for ethical behavior during mass casualty events."

Motion Defeated

Susan Rinaldo Gallo moved to bring back to the floor **Recommendation 08-1-28.2** "That the Ethics Committee continues to develop the Ethics Survey for respiratory care educators."

Motion Defeated

Karen Stewart moved to bring back to the floor **Recommendation 08-1-56-4** "That the AARC BOD authorize President Rodriguez or myself (Gene Gantt) as Chair of the Long Term Care Section to draft a letter to Health and Human Services Secretary, Michael O. Leavitt, requesting the development of a National Coverage Policy for Prolonged Mechanical Ventilation (similar to that of end stage renal disease) in order to remove the state-to-state disparities of coverage for those chronically ventilated in the US."

This recommendation was previously referred to the Executive Office and was completed. This recommendation is now closed.

FM 08-1-1.3 was defeated at this meeting. This recommendation is closed.

FM 08-1-83.1 was addressed at this meeting. This recommendation is closed.

Recommendation 08-2-32.1 – Rick Ford will report at this meeting. This remains open at this time.

Recommendation 08-2-26.2 – This recommendation was addressed at this meeting. This recommendation is closed.

Recommendation 08-2-53.1, 08-2-56.1 and 08-2-55.1 – The Board agreed to keep these recommendations open.

Recommendation 08-2-57-2 – This recommendation was addressed and is now closed.

Recommendation 08-3-58.1 – The Board agreed to keep this recommendation open.

Recommendation 08-2-65.1 – This recommendation is closed.

Recommendation 08-2-65.2 – This recommendation is closed.

FM 08-2-1.1 – This motion has been implemented and is now closed.

HR 16-08-01 - This resolution was defeated at this meeting and is now closed.

HR-44-08-02 - This resolution was defeated at this meeting and is now closed.

HR 22-08-04 - This resolution was referred to HOD and they're still working on it. The Board agreed to leave this open.

HR 29-08-05 - Toni Rodriguez will address this resolution at the Tripartite meeting at this Congress. The Board agreed to leave this open at this time.

FM 08-2-82.1 – This motion has been implemented and is now closed.

FM 08-2-04.7 – This motion has been implemented and is now closed.

President-elect Tim Myers advised members that in the future these outstanding motions, recommendations, and resolutions will be addressed by the Executive Committee approximately one month prior to each meeting, and if necessary, be brought before the Board for action on any remaining open.

NATIONAL BOARD FOR RESPIRATORY CARE (NBRC)

NBRC President Sherry Barnhart introduced Executive Director Gary Smith, as well as Lori Tinkler and Rob Shaw of the NBRC. Ms. Barnhart reported that in July, the proposed admission policy for the sleep disorders specialty exam was approved upon 2nd reading. The applications for Federally registered trademarks for the credential acronyms have been filed; CRT-SDS (for certified) or RRT-SDS (for registered). The Adult Critical Care Job Analysis Committee developed their task survey which will be mailed to a random sampling. The NBRC Board approved new changes to the Continuing

Competency program effective January 1, 2009. New proposals would allow RTs more options for those renewing or those whose credentials have expired.

NEW BUSINESS

AARC HISTORIAN

Dianne Lewis reported that AARC Historian Bob Weilacher has resigned and highlighted the importance of having an Association Historian. The President's Council is currently developing a job description for that position.

Susan Rinaldo Gallo moved to accept **FM 08-3-83.1**"That the AARC send a letter of thanks to Bob Weilacher for his many years of service as AARC Historian."

Motion Carried

PROTOCOL IMPLEMENTATION COMMITTEE REPORT

Rick Ford's Protocol Implementation Committee submitted their document entitled "Guidelines for Respiratory Care Department Protocol Program Structure" for Board input. There was discussion concerning whether it falls under the position statement category or that of a white paper. It was also suggested that this document be reviewed by the Board of Medical Advisors at their meeting on Sunday and the President-elect can refer it back to the Committee for development of a white paper.

Motion Carried

FELLOWSHIP FUNDING

John Hiser reported that the Virginia Society collected $4200, the Georgia Society contributed $1000, and another $5000 was submitted by the Massachusetts Society. Combined, this will fund two fellows.

CONTINUING RESPIRATORY CARE EDUCATION (CRCE)

Brian Walsh moved to accept **FM 08-3-83.2** "That the AARC Executive Office develop a proposal with workflow requirements and financial implications that encompass an online submission and transcript CRCE system. This system shall 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."

Pat Doorley moved "To refer **FM 08-3-83.2** to the Executive Office for cost analysis and report back in July."

Motion to Refer Carried

PAT LEE RECOGNITION

James Taylor moved to accept **FM 08-3-83.3** "That the President send a letter in recognition of Pat Lee's retirement."

Motion Carried

TREASURER'S MOTION

Susan Rinaldo Gallo moved to accept "That the expenses incurred at this meeting be reimbursed according to AARC policy."

Karen Stewart moved "To adjourn the meeting of the AARC Board of Directors."

Motion Carried

ADJOURNMENT

President Toni Rodriguez adjourned the meeting of the AARC Board of Directors at 12:15 p.m. PST, Friday December 12, 2008.

ATTACHMENT “A”

Recommended Minimum Standards
Ventilator Care in Rehab Facilities

Recommended Minimum Standards
Ventilator Care in Rehabilitation Facilities

Standard
1. A licensed respiratory care practitioner should be on site 24/7 for ventilator care, administration of medical gases, administration of aerosol medications, and to perform diagnostic testing and monitoring of life support systems.

Rationale
Ventilator and related care is very technology driven. It is not appropriate to provide this level of care without personnel who are specifically trained in the current technology. Appropriate personnel are essential for ongoing assessment of weanability. Most SNFs primarily utilize Licensed Practical Nurses; Ventilator Care is not in their scope of practice.

Standard
2. A Pulmonologist or physician experienced in ventilator care should direct the plan of care.

Rationale
This patient population requires specific therapeutic regimens and the physician should be experienced in this level of care.

Standard
3. The facility should establish admissions criteria to ensure the medical stability of patients prior to transfer from the acute care setting.

Rationale
Medical and respiratory stability criteria for this level of care were published in 1998 by the American Academy of Chest Physicians. These criteria will assure that acuity is appropriate for SNF care.

Standard
4. Arterial Blood Gas (ABG) should be readily available to document acid base status, and/or End Tidal Carbon Dioxide (edCO2) and continuous pulse oximetry measurements should be performed in lieu of AGB studies.

Rationale
These clinical measurements are essential for ensuring patient safety. These measurements aid in guarding against oxygen loss and patient disconnects.

Standard
5. There should be an audible, redundant external alarm system located outside of the patient's room to alert caregivers of a patient disconnection or ventilator failure.

Rationale

In the SNF environment standard ventilator alarms may not be heard outside the patient room. For patient safety an audible external redundant alarm system is essential.

Standard
6. Ventilator and emergency equipment should be connected to electrical outlets with backup generator power in the event of power failure.

Rationale
This ensures continued uninterrupted operation of the life support equipment in the event of a primary electrical failure.

Standard
7. Ventilators should be equipped with internal battery backup systems.

Rationale
In the event of total loss of power this assures that the ventilator will continue to function until the patient can be moved to safety.

Standard
8. Facilities should be equipped to employ the use of current ventilator technology consistent with meeting patients' needs for mobility and comfort.

Rationale
Ventilators should be capable of pressure support ventilation as well as PEEP and CPAP. They should also be of a size that allows patient mobility.

Standard
9. A backup ventilator should be available at all times if mechanical ventilation is provided to a patient.

Rationale
In the unlikely event of a total ventilator system failure, a replacement unit should be available.

ATTACHMENT “B”

Position Statements

Recommendation # 1: Verbal Orders

Registered and Certified Respiratory Therapists, subject to local health care institution policy and state licensure acts, may transcribe ~~physicians'~~ the verbal orders of Licensed Independent Practitioners (LIP) for drugs, devices, and treatments directly related to the provision of a patient's ~~respiratory~~ care.

Effective 3/90
Revised ~~3/00~~ 12/08

Recommendation # 2: Pulmonary Rehabilitation

A ~~program of~~ pulmonary rehabilitation program is a physician-supervised, evidence-based multi-faceted ~~continuum of~~ approach to providing services designed for persons with pulmonary disease and their families. ~~As a component of~~ A program includes, but is not limited to, physician prescribed exercise, education and training, psychosocial and outcomes assessment. The goals of this respiratory disease management approach ~~, the goals of pulmonary rehabilitation~~ are to improve, ~~restore~~ or maintain, the patients' ~~to their~~ highest possible level of independent function and to improve their quality of life. Pulmonary rehabilitation~~, generally conducted by~~ is a multi-disciplinary program and ~~team of specialists,~~ should be included in the overall management of patients with respiratory disease ~~to assist in alleviating symptoms and optimizing health~~. The respiratory therapist, by virtue of specialized education and expertise, ~~interest in the individual's respiratory care,~~ is uniquely qualified to function as the leader ~~a key partner in~~ of a successful pulmonary rehabilitation program.

Effective 1973
Revised ~~2002~~ 12/08

Recommendation # 3: Competency Requirements for the Provision of Respiratory Therapy Services

The complexities of respiratory therapy are such that the public is at risk of injury, and health care institutions are at risk of liability, when respiratory therapy is provided by inadequately educated and unqualified health care providers rather than by practitioners appropriately educated in the specialty of Respiratory Therapy.

~~Anyone~~ All health care practitioners providing respiratory therapy services to patients, regardless of the care setting and patient demographics, shall successfully complete formal training and demonstrate initial competenc~~y~~ prior to assuming those duties. This formal training and demonstration of competence shall be required of any health care provider regardless of credential, degree, or license.

~~Formal Training and Competency Documentation~~

Formal training is defined as a supervised, deliberate, and systematic ~~continuing~~ educational activity in the affective, psychomotor, and cognitive domains. It is intended to develop new proficiencies with an application in mind, and is presented with attention to needs, objectives, activities, and a defined method of evaluation.

The training shall be approved by a local, regional, or national accrediting entity. In the allied health field<u>s</u>, this training includes supervised pre-clinical (didactic and laboratory) and clinical activities, as well as documentation of competence through tests determined to be valid and reliable. The qualifications of the faculty providing this training shall be documented and also meet accreditation standards.

~~Prior to providing respiratory therapy services, competency shall be demonstrated in the following areas:~~

1. ~~Review all information contained in the patient's medical record regarding history, established diagnoses, current care regimen, and current signs and symptoms~~
2. ~~Assess the patient's overall cardiopulmonary status by interview, inspection, palpation, and auscultation~~
3. ~~Perform and assess diagnostic procedures. Diagnostic procedures include, but are not limited to: pulmonary function studies (spirometry before and after bronchodilator administration, PEFRs, inspiratory/expiratory pressures, lung capacities/volumes by gas and/or plethysmography methods, lung compliance, airway resistance, bronchoprovocation studies, cardiopulmonary exercise testing, indirect calorimetry), pulse oximetry, blood gas analysis, 12-lead ECG, and hemoximetry~~
4. ~~Initiate, monitor, and recommend appropriate continuous mechanical ventilation modalities and relevant care (e.g., tracheal tube cuff pressure, assessment of the patient's ability to be weaned from continuous mechanical ventilation)~~
5. ~~Determine the appropriateness of the prescribed respiratory care plan, recommend modifications where indicated, and participate in the implementation and further development of the respiratory care plan. Work interdisciplinarily to include the respiratory care plan with the overall care plan for the patient~~
6. ~~Select, assemble, and use equipment appropriate for the necessary respiratory therapy services, assuring its cleanliness and proper function. Identify and correct~~

malfunctions. Respiratory therapy equipment includes but is not limited to: oxygen administration devices; humidifiers; aerosol generators; ventilators; artificial airways; suctioning devices; gas delivery, metering, and clinical analyzing devices; manometers and gauges; resuscitation devices; high frequency chest wall oscillation devices; PEP devices; ECG machines; incentive breathing devices; patient breathing circuits; percussors and vibrators; environmental devices; and metered dose inhalers, fry powder inhalers, and spacers

7. Educate the patient and family members/other caregivers as to the planned therapy and goals
8. Observe universal precautions and other appropriate measures to protect the patient from nosocomial infection
9. Provide care to achieve maintenance of a patent airway, to include placement and care of an artificial airway and suctioning. This may include the insertion or oro- and nasopharyngeal airways, maintenance of proper tracheal tube cuff inflation, trach care, performing chest physiotherapy, and the administration of aerosol therapy
10. Administer medicated aerosols, including but not limited to bronchodilators, mucolytics, and anti-inflammatories with spontaneous ventilation including IPPB/IPV therapy
11. Provide therapeutic services to achieve and maintain adequate arterial and tissue oxygenation, which may include positioning to minimize hypoxemia; administering oxygen; initiate and adjust PEEP/CPAP/bi-level pressure devices and PEP therapy
12. Evaluate the patient's response to therapy and recommend and implement modifications to the care plan
13. Provide emergency respiratory therapy services such as CPR, newborn resuscitation, and placement of artificial airways
14. Provide respiratory care services utilizing techniques and practices that create a safe patient environment and follow accepted practices that enhance patient safety

Effective 11/98
Revised ~~10/04~~ 12/08

Recommendation # 4: Hazardous Materials Exposure

The Problem

The EPA defines a hazardous material as any substance or material in a quantity or form that poses an unreasonable risk to health, safety, and property when transported. ~~This~~ These materials ~~is~~ are extremely hazardous to the community during an emergency spill, or release, as a result of ~~its~~ their physical or chemical properties.

The Centers for Disease Control and Prevention (CDC) have classified emergency response and hospital personnel as high risk groups for exposure to infectious and toxic substances. Additionally, with the potential for attacks with Weapons of Mass Destruction, pre-hospital and hospital healthcare workers have an increased risk of exposure to toxic, biological ,and/or radioactive agents.

~~The EPA defines a hazardous material as any substance or material in a quantity or form that poses an unreasonable risk to health, safety, and property when transported. This material is extremely hazardous to the community during an emergency spill, or release, as a result of its physical or chemical properties.~~

The AARC's Position

- Respiratory therapists must be knowledgeable in treating, reversing, and avoiding the effects of ~~these~~ hazardous materials.
- ~~▪~~ Respiratory therapists must be alert to the potential effects of hazardous materials and be able to ~~support~~ provide care to ~~their~~ patients ~~until the effects wear off, or the materials are neutralized~~ when needed.
- Respiratory therapists, while providing care, must ~~avoid any of the deleterious effects of the agents to which the patients have been exposed~~ assure that they do not become victims, or carriers, of the same entities that have harmed their patients. This can be accomplished through the use of Personal Protective Equipment, isolation and decontamination procedures, and quarantine when recommended by professionals trained in hazardous materials incidents.
- The AARC supports efforts toward an epidemiological approach to the prevention of hazardous material exposure.

- The AARC supports the institutional development of appropriate hazardous material exposure guidelines that adhere to standards from both the Occupational Safety and Health Administration and the Joint Commission on Accreditation of Healthcare Organizations.
- The AARC encourages and endorses the inclusion and participation of respiratory therapists in the development of a community-wide plan for the management of exposure to hazardous materials.

~~**Bibliography**~~

~~Burgess JL, Keifer MC, Barnhart S, Richardson M, Robertson WO. Hazardous materials exposure information service: Development, analysis, and medical implications. Ann Emerg Med 1997;29(2):248-254.~~

~~Cos RD. Decontamination and management of hazardous materials exposure victims in the emergency department. Ann Emerg Med 1994;23(4):761-770.~~

~~Kales SN, Polyhronopoulos GN, Castro MJ, Goldman RH, Christiani DC. Injuries caused by hazardous materials accidents. Ann Emerg Med 1997;30(5):598-603.~~

~~Kirk MA, Cisek J, Rose SR. Emergency department response to hazardous materials incidents. Emerg Med Clinics of North America 1994;12(2):461-468.~~

~~Occupational Health & Safety Administration. Occupational Safety & Health Act. Hazardous waster operations and emergency response. 1970. 29-CFR 1910-120. Washington, DC.~~

~~EPA web site www.epa.gov~~

~~Note: Much material is courtesy of the Emergency Nurses Association.~~

Effective 5/7/02

Revised 12/08

Recommendation # 5: Respiratory Therapist Education

It is the position of the American Association for Respiratory Care (AARC) that ~~T~~ 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.
- The minimum education level leading to practice as a clinical specialist, manager, and professional leader should be a baccalaureate and/or graduate degree, or advanced training and experience.
- The minimum education level for respiratory therapy program faculty should be a masters degree and/or advanced training.
- ~~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~~ 12/08

Recommendation # 6: The Role of the Respiratory Care Practitioner in the Provision of Respiratory Care Services in the Hospitals and Alternate Sites Scope of Practice

The practice of respiratory care encompasses activities in: diagnostic evaluation, therapy, disease management and education of the patient, family and public. These activities are supported by education, research and administration.

Diagnostic activities include but are not limited to: (1) obtaining and analyzing physiological specimens; (2) interpreting physiological data; (3) performing tests and studies of the cardiopulmonary system; (4) performing neurophysiological studies, and (5) performing sleep disorder studies. Therapy includes but is not limited to application and monitoring of: (1) medical gases and environmental control systems; (2) mechanical ventilatory support; (3) artificial airway care; (4) bronchopulmonary hygiene; (5)

pharmacological agents; (6) cardiopulmonary rehabilitation; and (7) hemodynamic cardiovascular support.

The focus of patient and family education activities is to promote knowledge and management of disease process, medical therapy and self-help. Public education activities focus on the promotion of cardiopulmonary wellness.

Practice Settings

Elements of the scope of practice of respiratory care are performed in acute care hospitals and alternative sites where patient care is provided. Alternative sites include, but are not limited to; military and VA treatment facilities, physician offices, patients' homes, convalescent centers, clinics, skilled nursing facilities, and retirement centers.

The complexities of respiratory care are such that the public is at risk of injury and health care institutions are at risk of liability when respiratory care is provided by inadequately educated and unqualified health care providers rather than by practitioners with appropriate training and education.

Practitioner Qualifications

Practitioners who provide respiratory care services shall demonstrate their ability to meet the educational and experience requirements for the safe delivery of respiratory care services through competency validation mechanisms established by either legislative or regulatory acts of their respective states or commonwealth, or through a validated voluntary credentialing mechanism endorsed by the National Commission for Health Certifying Agencies.

Position

It is the position of the American Association for Respiratory Care that the respiratory care practitioner as a vital member of the health care team is essential to the provision of safe, appropriate, and cost-effective patient care in acute-care hospitals and alternative patient care sites.

Effective 7/87
Revised 2005

Recommendation # 7: Tobacco and Health

The American Association for Respiratory Care is a professional organization dedicated to the protection of health through public education and the provision of the highest standards of respiratory care. By virtue of their education and health care experience, respiratory therapists are professionals who have a clear understanding of the nature of cardiopulmonary disease and are in a position to act as advocates for healthy hearts and lungs. The AARC recognizes its responsibility to the public by taking a strong position

against cigarette smoking and the use of tobacco in any of its various forms. In view of the evidence, which confirms the health-threatening consequences of all tobacco in both active and passive forms, the AARC ~~strengthens its commitment toward and reaffirms its belief in the need for~~ is committed to the elimination of smoking and the use of any tobacco products and the inhalation of any toxic substance. The AARC is an advocate for both tobacco cessation and tobacco prevention programs.

The AARC acknowledges and supports the rights of non-smokers and pledges continuing sponsorship and support of initiatives, programs, and legislation to reduce and eliminate smoking. The AARC extends its concern beyond the smoking of tobacco to the use of smokeless tobacco by oral and nasal application. These products are linked to diseases of the gastrointestinal tract, mouth, and nose. There is also evidence that these products, when applied to the mucous membranes, diffuse into the circulation and cause ill effects in remote organs of the body.

Effective: 1991
~~Revised: 2000~~
Revised: ~~2005~~ 12/08

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2009-X)	2008	Schedule Review for 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		X			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	Revision Recommended 11/08			X		
Continuing Education	1990	2005	4		X			X	
Cultural Diversity	1994	2007	2			X			X

Definition of Respiratory Care	1987	2006	3		X			X	
Hazardous Materials Exposure	2002	2008	1	Revision Recommended 11/08			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			X		
Licensure of Respiratory Care Personnel	1990	2006	3		X			X	
Pre-Hospital Mechanical Ventilator Competency	2007	2007	2			X			X

Pulmonary Rehabilitation	1973	2008	1	Revision Recommended 11/2008			X		
Respiratory Care Scope of Practice	1987	2007	2			X			X
Respiraatory Therapist Education	1998	2008	1	Revision Recommended 11/2008			X		
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2007	2			X			X
Respiratory Therapy Protocols	2001	2007	2			X			X
The Role of the Respiratory Therapist in the Provision of Respiratory Care Services in the Hospitals and Alternate Sites Scope of Practice	1987	2008		Retirement Recommended 11/2008					

Telehealth	2001	2007	2			X			X
Tobacco and Health	1991	2008	1	Revision Recommended 11/2008			X		
Verbal Orders	1990	2008	1	Revision Recommended 11/2008			X		
				8	**6**	**8**	**7**	**6**	**8**

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
December 16, 2008 – Anaheim, California

Minutes

Attendance

Tim Myers, BS, RRT-NPS, President
Toni Rodriguez, EdD, RRT, Past President
George Gaebler, MSEd, RRT, FAARC, VP/Internal Affairs
Kent Christopher MD, BOMA Chair
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 (Excused)
Doug McIntyre, RRT
Frank Salvatore, BS, RRT, FAARC
James Taylor, RRT
Michael Tracy, BA, RRT-NPS
Brian Walsh, RRT-NPS, RPFT

Guests
Deb Skees

Absent
Dianne Lewis (Excused)

Consultant
John Hiser, MEd, RRT, FAARC, Parliamentarian

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
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 9:00 a.m. PST, Friday, December 12, 2008.

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

President Tim Myers welcomed newcomers to the Board and asked members to introduce themselves.

INTERNATIONAL CONGRESS UPDATE

Sam Giordano stated this year's International Congress has attracted 5500 attendees thus far and another 200 are expected. He advised that exhibitors have commented that they are happy with the flow of attendees.

RATIFICATION OF 2009 PRESIDENT'S GOALS

Toni Rodriguez moved "To ratify the President's 2009-2010 Goals." (**SEE ATTACHMENT "A"**)

Motion Carried

Toni Rodriguez moved "To ratify the 2009-2010 Committees and Charges."

Motion Carried

President Tim Myers stated the legislative bill dropped this year and that AARC will be working toward letters of support from physician groups and getting the 435 Plan in place for action.

Sam Giordano stated we will be more aggressive this year with a technical platform. We'll be offering special webcasts with members of the PACT (Political Action Contact Team). The Association is in touch with patient advocacy groups. We'll be pushing for members to send letters to the Hill prior to Hill Day. He stated we will be using webcasts and begin to utilize the Eluminate technology.

The Association is excited about the implementation of Conference #2 of the 2015 and Beyond program which is scheduled for April.

2015 AND BEYOND UPDATE

Bill Dubbs reported that the recently appointed Chair Ed O'Neil and Co-Chairs Tom Barnes and Dr. Woody Kageler are firming up the agenda for Conference #2 of the 2015 and Beyond project scheduled for April. The purpose of the second conference is to

build upon the information obtained in the first conference. This conference will examine what the RT would look like based upon the current health care system and what it would look like. It will identify skills, competencies, attributes and educational level required.

Toni Rodriguez is chairing the new learning institutes to be implemented in 2009 which will develop tomorrow's leaders in management, education and research. Ms. Rodriguez stated that the content coordinators for each institute have been chosen and are excited to begin this new program.

RATIFICATION OF SPECIALTY SECTION CHARGES AND APPOINTMENTS

Toni Rodriguez moved "To ratify the 2009-10 Specialty Section charges and appointments." **(SEE ATTACHMENT "A")**

Motion Carried

BOARD OF MEDICAL ADVISORS REPORT

BOMA Chair Dr. Christopher stated he is serving his second term as Chair of BOMA and pledged that he will work diligently with BOMA to accomplish the goals set forth. Dr. Christopher reported that Dr. Hector Leon will attend the next BOMA meeting to present an international perspective. He stated NAMDRC can help the association particularly with the LTOT issue. Additionally, he plans to invite President Myers and Past President Rodriguez to the Presidents Reception of the NAMDRC meeting to enlist NAMDRC's support on this important issue as well as Part B. He believes the current group of physicians on BOMA are an impactful group.

RATIFICATION OF SPECIAL COMMITTEE CHARGES AND APPOINTMENTS

Denise Johnson moved "To ratify the Special Committee charges and appointments." **(SEE ATTACHMENT "A")**

Motion Carried

RATIFICATION OF SPECIAL REPRESENTATIVES CHARGES AND APPOINTMENTS

Toni Rodriguez moved "To ratify the Special Representative charges and appointments." **(SEE ATTACHMENT "A")**

Motion Carried

RATIFICATION OF ROUNDTABLE CHARGES AND APPOINTMENTS

Toni Rodriguez moved "To accept the Roundtable charges and appointments." **(SEE ATTACHMENT "A")**

Motion Carried

RATIFICATION OF AD HOC COMMITTEE CHARGES AND APPOINTMENTS

George Gaebler moved "To ratify the Ad Hoc Committee charges and appointments." **(SEE ATTACHMENT "A")**

Motion Carried

UNFINISHED BUSINESS

Homecare Section Recommendation
President Tim Myers advised that the recommendation introduced on December 11 by Robert Mc Coy from the Homecare section will be brought back to the table at the March meeting since neither Mr. McCoy or Dr. Christopher were present at that time.

Goals and Objectives Document
President Tim Myers reported that the revised Goals & Objectives document will be placed on the website sometime in January for members to use since there will not be any further hard copies distributed.

Roundtable Clarifications
Past President Toni Rodriguez advised that at each meeting when the roundtable report is given, the board liaison will also speak to the number of roundtable members, level of activity, and any major topics of that roundtable.

The Board liaison for the Military Roundtable will be Tim Myers who will report Mike Runge's findings to the Board.

The Board liaison for the Moderate Sedation Roundtable will be Debbie Fox.

Past President Toni Rodriguez suggested that Board liaisons communicate with the chairs personally if they have questions regarding a particular report, which in turn would create better communication between liaisons and chairs.

NEW BUSINESS

ELECTION COMMITTEE ELECTION

President Tim Myers stated that previously the Board appointed people to the Election committee instead of conducting an election as prescribed by the Bylaws, and therefore, it was necessary to hold an election at this meeting for Election Committee members.

President Tim Myers called for nominations.

> Karen Stewart nominated George Gaebler to the Elections Committee.
> Joe Lewarski nominated John Hiser to the Elections Committee.
> George Gaebler nominated Toni Rodriguez to the Elections Committee.

President Tim Myers closed nominations and a paper vote was conducted.

President Tim Myers advised members that John Hiser will serve a 2-year term while Toni Rodriguez will serve a 1-year term on the Election Committee.

DIRECTOR AT LARGE APPOINTMENT

President Tim Myers advised that George Gaebler's Director at Large seat became vacant when he was elected Vice President of Internal Affairs and therefore called for nominations.

> George Gaebler nominated Ruth Krueger for the Director at Large position on the AARC Board.

Having received no additional nominations, Ruth Krueger was named Director at Large for a 1-year term.

RATIFICATION OF STANDING COMMITTEE CHARGES AND APPOINTMENTS

George Gaebler moved "To ratify the Standing Committee charges and appointments." **(SEE ATTACHMENT "A")**

Motion Carried

NEXT MEETING DATE

President Tim Myers reported that the next meeting of the AARC Board of Directors is scheduled for March 26-28 in Irving, Texas.

TREASURER'S MOTION

Karen Stewart moved "That the expenses incurred at this meeting be reimbursed according to AARC policy."

Karen Stewart moved "To adjourn the meeting of the AARC Board of Directors."

ADJOURNMENT

President Tim Myers adjourned the meeting of the AARC Board of Directors at 10:00 a.m. PST Friday December 12, 2008.

2009-10 Presidential Goals & Committees

AARC

2009
Goals & Committees

Committees
Sections
Roundtables &
Special Representatives

Timothy R. Myers, BS, RRT-NPS President

AS APPROVED BY THE AARC BOARD OF DIRECTORS 12/2009

Revised 1/26/09

AARC Presidential Goals – 2009-2010

1. Continue to develop and execute strategies that will increase membership and participation in the AARC.
2. Promote patient access to respiratory therapists as medically necessary in all care settings through appropriate vehicles at local, regional and national venues
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.
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.
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.
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.
7. Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.

Standing Committees Index

Standing Committees & Objectives

Bylaws Committee

Objectives:

1. Review amendments proposed by the Board of Directors, House of Delegates or Chartered Affiliates and submit its recommendations to the proponent.
2. Review Chartered Affiliate bylaws according to the established staggered schedule in which all are reviewed every 5 years for compliance with the AARC bylaws.
    a. Affiliate bylaws will only be reviewed for compliance with AARC bylaws. Errors in grammar, spelling, or internal inconsistencies will be the responsibility of the Chartered Affiliate. The Bylaws Committee may make recommendations regarding grammar, spelling, or internal inconsistencies but will not delay the approval process over such issues.
    b. Affiliate Bylaws will be considered in conflict with the AARC bylaws if non-AARC members are allowed to vote and/or hold a voting position on the Affiliate's Board of Directors.
    c. Affiliate Bylaws will be considered in conflict if Active members of the Chartered Affiliate are not Active members of the AARC.

Chair:
Keith Siegel RRT
1147 N Union Rd
Union ME 04862
207/596-8874 207/593-5290 Fax
vickis@tidewater.net

Chair-elect:
Bill Lamb, RRT

2009 Past President:
Toni Rodriguez EdD RRT

Members:
Joe Horn, BS, RRT
Doug McIntyre, RRT

AARC Liaison: 2009 VP/Internal Affairs: George Gaebler, MSEd, RRT FAARC

AARC Staff: TBD

Elections Committee

Objectives:

1. Screen candidates nominated for Director, Officer and Section positions.
2. Report the slate of nominees to the Board of Directors and House of Delegates by June 1, 2009.
3. The Elections Committee shall forward a roster of all nominees for the AARC Board of Directors to the current President, which would include all personal contact information for those individuals (i.e., e-mail, work address, work phone, etc.) for consideration in the committee appointment process.

Chair:
Vijay Deshpande
4823 Tomahawk Ct SW
Lilburn GA 30047
770/469-8699
vijay@gsu.edu

Chair-elect:
John Steinmetz, MS, RRT

Members:
AARC BOD 2-yr Term – John Hiser, MEd, RRT, FAARC
AARC BOD 1-yr Term – Toni Rodriguez, EdD, RRT
Suzanne Bollig, BHS, RRT, RPSGT

AARC Staff: TBD

Executive Committee

Objectives:

1. Act for the Board of Directors between meetings of the Board on all relevant matters as necessary.

Chair:
Timothy Myers BS, RRT-NPS
Rainbow Babies & Children's Hosp
11100 Euclid Ave, Mailstop 6043
Cleveland, OH 44106
216/844-7429 Fax 216/844-5352
timothy.myers@uhhospitals.org

Members:
Toni Rodriguez EdD RRT – **(2009 Past President)**
George Gaebler, MSEd, RRT FAARC – **(2009 VP Internal Affairs)**
Joseph Lewarski, BS, RRT-NPS, FAARC – **(2009 VP External Affairs)**
Karen Stewart MS RRT – **(2009 Sec/Treas)**

AARC Staff: Sam P. Giordano MBA RRT FAARC

Finance Committee

Objectives:

1. Submit for approval the annual budget to the House of Delegates and the Board of Directors.
2. In conjunction with the Executive Office, identify a financial expert to be appointed by the President and ratified by the BOD in time for the 2009 audit process.

Chair:
Timothy Myers BS, RRT-NPS
Rainbow Babies & Children's Hospital
11100 Euclid Ave, Mailstop 6043
Cleveland, OH 44106
216/844-7429 Fax 216/844-5352
timothy.myers@uhhospitals.org

Members:
Tom Lamphere, BS, RRT, RPFT - (**2009 HOD Speaker-elect)**
Deb Skees, RRT - **(2009 HOD Treasurer)**
Toni Rodriguez EdD RRT - **(2009 Past President)**
George Gaebler, MSEd, RRT FAARC – **(2009 VP Internal Affairs)**
Joseph Lewarski, BS, RRT-NPS, FAARC – **(2009 VP External Affairs)**
Karen Stewart MS RRT – **(2009 Sec/Treas)**

AARC Staff: TBD

Audit Subcommittee

Objectives:

1. Monitor the financial affairs of the Association in cooperation with external independent auditors.

Chair:
2009 HOD Speaker-elect
Tom Lamphere, BS, RRT, RPFT
225 Hampshire Dr
Sellersville PA 18960-2876
215/687-2904
ExecutiveDirector@psrc.net

Members:

2009 VP/Internal Affairs
George Gaebler, MSEd, RRT FAARC – **(2009 VP Internal Affairs)**

2009 HOD Treasurer
Deb Skees, RRT

2009 Secretary/Treasurer
Karen Stewart MS RRT – **(2009 Sec/Treas)**

AARC Staff: TBD

Judicial Committee

Objectives:

1. Review membership challenges, or complaints against any member charged with any violation of the Association's Articles of Incorporation, Bylaws, standing rules, code of ethics, or other rules, regulations, policies or procedures adopted, or any conduct deemed detrimental to the Association.
2. Conduct all such reviews in accordance with established policies and procedures.
3. Determine whether complaint requires further action.
4. Understand the appeals process available to members.

Chair:
Patricia K Blakely RRT
989 Chestnut Rd
Elgin SC 29045
803/786-6900
Patricia_Blakely@apria.com

Members:
Patricia Ann Doorley MS RRT FAARC
Donald Holt BS RRT CPFT
Susan Rinaldo-Gallo MEd RRT
Karen J Stewart MS RRT
Linda A Smith BS RRT

AARC Staff: TBD

Program Committee

Objectives:

1. Prepare the Annual Meeting Program, Summer Forum, and other approved seminars and conferences.
2. Recommend sites for future meetings to the Board of Directors for approval.
3. Solicit programmatic input from all Specialty Section and Roundtable chairs.
4. Develop and design the program for the annual congress to address the needs of the membership regardless of area of practice or location.

Chair:
Michael Gentile RRT FAARC
Duke University Med Ctr
Box 3911
Durham NC 27710
919/681-5795 919/681-2892 Fax
michael.gentile@duke.edu

Members:
Ira M Cheifetz MD FCCM FAARC
Patrick Dunne MEd RRT FAARC
Bill Galvin MSEd RRT CPFT
Dave Pierson MD
Colleen Schabacker BA RRT FAARC
Dean Hess PhD, RRT FAARC (consultant)
Cheryl Hoerr, MBA, RRT

AARC Staff: TBD

Strategic Planning Committee

Objectives:

1. Review the Strategic Plan of the Association and make recommendations to the Board for any needed revisions or adjustments in the plan at the Spring 2009/10 Board of Directors Meeting.
2. Recommend to the Board of Directors the future direction of the Association and the profession of Respiratory Care.

Chair:
2009 - Past President
Toni Rodriguez EdD RRT
Gateway Community College
108 N 40th St
Phoenix AZ 85034
602/392-5234 Fax 602/392-5244
toni.rodriguez@gwmail.maricopa.edu

Members:

2009 Speaker-elect
Tom Lamphere, BS, RRT, RPFT

2009 - Past HOD Speaker
Frank Salvatore Jr RRT

2009 VP Internal Affairs
George Gaebler, MSEd, RRT FAARC

2009 VP External Affairs
Joseph Lewarski, BS, RRT-NPS, FAARC

2009 Secretary/Treasurer
Karen J Stewart MS RRT FAARC

AARC Staff: TDB

Specialty Section Index

2009 Specialty Section Charges

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.

2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.

3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.

4. Identify, cultivate, and mentor new section leadership.

5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section's web page and provide timely responses to requests for information from AARC members.

Adult Acute Care Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:
Michael Hewitt RRT NPS
Memorial Hermann Hosp TX Med Ctr
6411 Fannin St Suite R515
Houston TX 77030
410/912-4988 410/543-7266 Fax
Michael.hewitt@peninsula.org

Medical Advisor: Russell Acevedo MD

AARC Staff: TDB

Continuing Care Rehabilitation Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.
2. Develop a Pulmonary Rehab Business Plan Template and Program Implementation Toolkit for AARC and section members.

Chair:
Debra Koehl MS RRT AE-C
9334 Moorings Blvd
Indianapolis IN 46256
317/962-5060 Wk 317/962-3384 Fax
dkoehl@clarian.org

Chair-Elect: Ericka Abmas RRT, AE-C

Medical Advisor: Jay Peters MD

AARC Staff: TDB

Diagnostics Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.
2. Work with the CPG Committee to review, revise and update Diagnostic specific CPG's.

Chair:
Melynn Wakeman, RRT, RPFT, RPSGT
8339 W. Alyssa Ln.
Peoria, AZ 85383-3878
(480) 301-8834
Melynnw@cox.net

Medical Advisor: Richard Sheldon MD

AARC Staff: TDB

Education Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.
2. Develop a recruitment strategy directed at advanced degree or standing candidates (i.e. military personnel) as well as high-school students.

Chair:
Lynda T. Goodfellow, EdD, RRT, FAARC
402 Loyd Rd.
Peachtree City, GA 30269-1352
(404) 413-1223 Fax (404) 413-1230
ltgoodfellow@gsu.edu

Medical Advisor: Richard Sheldon MD

AARC Staff: TDB

Home Care Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.
2. Assist Federal Government Affairs committee in passing legislation which will recognize respiratory therapists under the Medicare home health services benefit.

Chair:
Robert McCoy BS RRT
Managing Director
Valley Inspired Products
15112 Galaxie Ave
Apple Valley MN 55124-6985
952/891-2330
bmccoy@inspiredrc.com

Medical Advisor: Kent Christopher MD

AARC Staff: TDB

Long Term Care Section

Additional Charge:

1. Implement the Specialty Section Charges as listed.

Chair:
Gene Gant RRT
102 W Court Square
Livingston TN 38570-1812
931/823-3702
gene.gantt@linde-rss.com

Medical Advisor: Terence Carey MD

AARC Staff: TDB

Management Section

Additional Charges:

1. Review and update the SWAP SHOP so that resources are current and reflect recent changes in CPG and Standards. The process will be conducted by the review committee and will conclude with a "new call" for resources for posting.
2. Update the AARC Guidelines and Standards, Administrative Standards for Respiratory Care Services and Personnel.
3. In collaboration with the AARC Director of Management and Education, initiate planning for revision of the AARC Uniform Reporting Manual.

Chair:
Douglas S. Laher, MBA, BSRT, RRT
Fairview Hospital
18101 Lorain Ave
Cleveland, Ohio 44111
216/476-7191 216/476-7821 Fax
Douglas.Laher@fairviewhospital.org

Medical Advisor:

AARC Staff: TDB

Neonatal-Pediatrics Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:
Brian Walsh RRT NPS RPFT
29 Holbrook St.
Norfolk, MA 02056
857/218-4610 617/730-0381 Fax
Brian.walsh@childrens.harvard.edu

Medical Advisor: Ira Cheifetz, MD

AARC Staff: TDB

Sleep Specialty Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:
Karen Allen CRT RPSGT
5505 Bobby Jones Blvd
Billings MT 59106-1129
406/238-6263 406/238-6262
jkyrallen@aol.com

Chair-Elect:

Medical Advisor: Paul Selecky MD

AARC Staff: TDB

Surface & Air Transport Section

Additional Charge:

1. Implement the Specialty Section Charges as listed.

Chair:
Dawn R Filippa RRT
49 Perri Ln
Broad Brook CT 06016
860/545-4369 Wk 860/370-9054 Hm
Diamond1103@cox.net

Chair-Elect:
Steven E. Sittig, RRT-NPS, FAARC

Medical Advisor: Clifford Boehm MD

AARC Staff: TDB

Special Committees Index

Benchmarking Committee

Objectives:

1. The implementation of productivity metrics than include a common time factor for ventilator days and provision of educational material on the utility of this metric.

2. The implementation of the new outcome measure for ventilator duration and the provision of educational material on the utility of comparing this outcome. This includes what changes may need to be made in the department profile to better differentiate the types of ICU and patients and reasons for variation in comparative data.

3. Investigate, through client feedback, what other outcomes are important to compare and the feasibility of incorporating them in the program.

4. For each committee member to serve as an AARC Benchmarking expert to assist in providing existing and potential clients with direct assistance regarding data entry and results interpretation.

5. To provide proposals at both the 2009 AARC Summer Forum and International Congress on the value and use of Benchmarking and Best Practice.

6. To advise the AARC in the development of programs to retain the existing client base and attract new users.

7. To write a team publication for The Respiratory Care Journal regarding the use of benchmarking as a comparative tool and a mechanism to develop and adopt best practice.

Chair:
Richard Ford BS RRT FAARC
Resp Care Dept – 8771
University of California
San Diego Medical Center
200 W Arbor Dr
San Diego CA 92103
619/543-2593 619/543-3251 Fax
rmford@ucsd.edu

Members:
Robert Chatburn RRT-NPS
Stan Holland RRT
Thomas Malinowski RRT FAARC
Karen Stewart MS RRT
Janice Thalman MHS RRT

AARC Staff: TDB

Billing Codes Committee

Objectives:

1. Be proactive in the development of needed AMA CPT respiratory therapy related codes.
2. Act as a repository for current respiratory therapy related codes
3. Act as a resource for members needing information and guidance related to billing codes.
4. Develop a primer on the process of 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.

Chair:
Roy Wagner RRT
2716 Monet Place
Dallas TX 75287
972/419-1536 972/419-1545 Fax
roy.wagner@tphrhealth.com

Members:
Karen Boyer RRT
Susan Rinaldo Gallo MEd RRT
Colleen Schabacker BA RRT

Medical Advisor:

AARC Staff: TDB

Clinical Practice Guidelines Steering Committee

Objectives:

1. Continue to review and revise existing clinical practice guidelines that are greater than 5 years from their publication date.

2. Continue to update and revise the existing clinical practice guidelines from expert opinion to an evidence-based format, as appropriate.

3. Develop appropriate and new clinical practice guidelines, as dictated by current standards of practice, in the evidence-based format.

Chair:
Ruben Restrepo RRT, FAARC
The University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
MSC 6248
San Antonio, TX 78229-3900
(210) 567-8858 Fax (210) 567-8852
restrepor@uthscsa.edu

Members:
Ira Cheifetz, MD
Kathleen Deakins BS, RRT-NPS
Michael Gentile RRT
Carl Haas MLS RRT
Dean Hess PhD RRT (consultant)
Michael Tracy BA RRT-NPS
Brian Walsh RRT-NPS RRT
Nick Widder RRT

AARC Staff: TDB

Fellowship Committee

Objectives:

1. Review applications of nominees for AARC Fellow Recognition (FAARC).
2. Select individuals who will receive the AARC Fellow recognition prior to the International Respiratory Care Congress.

Chair:
Patrick Dunne MEd RRT FAARC
827 Rodeo Rd
Fullerton CA 92838
714/870-4440 Fax 714/870-0124
pjdunne@sbcglobal.net

Members:
Robert C. Cohn, MD FAARC
Dean Hess PhD RRT FAARC
John D. Hiser, RRT, CPFT FAARC
Richard M. Ford, RRT FAARC

AARC Staff: TDB

Federal Government Affairs Committee

Objectives:

1. Continue implementation of a 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts.
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.

Ongoing Objectives:

1. Assist in coordination of consumer supporters

Chair:
Frank Salvatore Jr RRT
1903 Revere Rd
Danbury CT 06811-2661
frank.salvatore@snet.net

Members:
Jerry Bridgers CRT
John Campbell MA RRT-NPS
Julie Clarke BS RRT
Debbie Fox RRT

AARC Staff: TDB

International Committee

Objectives:

1. Coordinate, market and administer the International Fellowship Program.
2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International functions of the Congress.
3. Strengthen AARC Fellow Alumni connections through communications and targeted activities.
4. Coordinate and serve as clearinghouse for all international activities and requests.
5. Continue collegial interaction with existing International Affiliates to increase our international visibility and partnerships.

Chair:
John D Hiser MEd RRT CPFT
Tarrant County College
828 Harwood Rd NE Campus
Hurst TX 76054-6574
817/515-6574 Fax 817/515-6700
john.hiser@sbcglobal.net

Members:
Deborah Lierl, MEd, RRT **Vice Chair/Int'l Fellows**
Hassan Alorainy BS RRT, **Vice Chair/Int'l Relations**
Michael Amato MBA
Arzu Ari PhD, MS, MPH
Yvonne Lamme RRT MEd
Hector Leon MD
Vijay Deshpande MS RRT
James Maguire PhD
Bruce Rubin MD
Daniel Rowley BS RRT-NPS RPFT
Jerome Sullivan MS RRT
Michael Runge BS RRT
Derek Glinsman RRT
Theodore Witek DrPH
John Davies RRT

AARC Staff: TDB

Membership Committee

Objectives:

1. Review, as necessary, all current AARC membership recruitment documents and toolkits for revision, addition and/or elimination based on committee evaluation.
2. In conjunction with the Executive office, develop a membership recruitment campaign based on survey results for implementation in 2009.
3. Identify and evaluate methods to recruit respiratory therapy students as ACTIVE members of the AARC.
4. Develop a scientific, data-driven process to implement and measure the effectiveness of current and new recruitment strategies.

Chair:
Thomas Lamphere RRT
225 Hampshire Dr
Sellersville PA 18960-3876
215/687-2904
ExecutiveDirector@psrc.net

Members:
Suzanne Bollig RRT
Joe Horn BS RRT
Garry Kauffman RRT
Douglas Laher BSRT RRT MBA
Debbie Markese RRT
Nicholas Widder RRT
Emily Zyla BS RRT

AARC Staff: TDB

Political Action Committee

Objectives:

1. Continue to provide funds for use in political support.
2. Develop a plan for promoting State Affiliate donation to the PAC.
3. Increase awareness of the Political Action Committee.

Chair:
Gail Varcelotti BS RRT
Education on the Go
110 Horizon Dr
Venetia PA 15367
varcelotti@yahoo.com

Members:
Patricia Blakely RRT
Carrie Bourassa RRT
Colleen Schabacker BA RRT
Julie Clarke RRT
Tom Stripln MEd RRT RPFT
Frank Salvatore RRT
Joe Huff RRT
Lynn Lenz BS RRT

AARC Staff: TDB

Position Statement Committee

Objectives:

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.
2. Review, revise or delete as appropriate using the established three-year schedule of all current AARC position statements subject to Board approval.
3. Revise the Position Statement Review Schedule table annually in order to assure that each position statement is evaluated on a three-year cycle.

Chair:
Patricia A Doorley MS RRT
181 Buttercup Ln
Charlottesville VA 22902
434/977-8747
pad2a@hscmail.mcc.virginia.edu

Members:
Kathleen Deakins BS, RRT-NPS
Michael J Hewitt RRT-NPS RCP
Ruth Krueger-Parkinson MS RRT
Patrick Johnson PhD RRT FAARC
Linda VanScoder EdD RRT
Nicholas Widder RRT

A AARC Staff: TDB

Public Relations Action Team (PRAT)

Objectives:

1. Each member will agree to do interviews (radio) and provide information for the written press release that corresponds to the interview topic.

2. Continue to assist Your Lung Health (AARC's consumer website) with reading and editing clinical stories, messages, etc for the website. These will be assigned through the EO on a PRN basis.

3. Communicate with each State Affiliate encouraging the establishment of a public relations committee.

4. Update the current Public Relations material and develop a mechanism to make the PR "tools" more easily available to the State Affiliates.

Chair:
Linda Smith RRT
8726 Gerst Ave
Perry Hall MD 21128-9647
W-443/829-9403
rugbydpd@erols.com

Members:
Jerry Edens BS MEd RRT
Kathy Rye EdD RRT
Frank Freihaut RRT AE-C
Trudy Watson RRT
Ken Thigpen BS RRT

AARC Staff: TDB

State Government Affairs Committee

Objectives:

1. Assist the State Societies with legislative and regulatory challenges and opportunities as these arise.

2. Work with Federal Governmental Affairs Committee and the HOD 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.

3. Assign each committee member a region of the country to serve as the key contact person for the states within that region.

Chair:
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Roundtable Index

Asthma Disease Roundtable

Objectives:

1. Recruit additional members and begin to actualize the vision of an effective and efficient roundtable for individuals involved in asthma disease management.
2. Review asthma information on yourlunghealth.org and recommend corrections, additions and deletions to the AARC.

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Liaison: Timothy Myers

Consumer Roundtable

Objectives:

1. Continue to develop objectives for the consumer roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for consumers.
3. Increase consumer networking by providing safety and public policy alerts and distributing information necessary to transform respiratory patients into prudent buyers of respiratory services.
4. Develop a mechanism where consumers can give input regarding information that they need to empower themselves to make educated decisions about the treatment and management of their disease process.

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Disaster Response Roundtable

Objectives:

1. Continue to work with Health and Human Services in regards to their call for a list of Respiratory Therapists that could be called to duty in cases of national/state emergencies.
2. Continue to develop the use of the AARC's Disaster Response List Serve to foster involvement and provide an ongoing communication resource.
3. Foster ideas for presentation at the AARC Congress.

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Liaison: Brian Walsh

Neuromuscular Roundtable

Objectives:

1. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in respiratory care research.
2. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of respiratory care medical research.

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Liaison: James Taylor

Tobacco Free Lifestyles Roundtable

Objectives:

1. Conduct a survey to assess the needs and potential vision of AARC members of the Tobacco Free Lifestyle Roundtable.
2. Review and revise the smoking cessation resources on the AARC Website.
3. Increase the Tobacco Free Lifestyle roundtable membership to section status in 2009.

Chair:
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Liaison: Denise Johnson

Military Roundtable

Objectives:

1. Continue to develop relationships and strategies to achieve officer status for respiratory therapists in the U.S. uniformed services.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all military healthcare practitioners with an interest in respiratory care.
3. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of the practice of respiratory care in the military.

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Liaison: Mike Runge/Tim Myers

Moderate Sedation Roundtable

Objectives:

1. Establish an effective platform for networking and communication between the members of your roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in moderate sedation.
3. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of moderate sedation.

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Liaison: Debbie Fox, MBA, RRT, FAARC

Research Roundtable

Objectives:

1. Establish an effective platform for networking and communication between the members of your roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in respiratory care research.
3. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of respiratory care medical research.

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Liaison: Timothy Myers

Hyperbaric Roundtable

Objectives:

1. Establish an effective platform for networking and communication between the members of the Roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in hyperbaric medicine.
3. Bring the concerns and issues of your membership as related to research in respiratory care to the attention of the AARC Board of Directors as indicated.
4. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of hyperbaric medicine.

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Liaison: George Gaebler MSEd RRT

Informatics Roundtable

Objectives:

1. Establish an effective platform for networking and communication between the members of the Roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in hyperbaric medicine.
3. Bring the concerns and issues of your membership as related to research in respiratory care to the attention of the AARC Board of Directors as indicated.
4. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of informatics and respiratory care.

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Ad Hoc Committee Index

Ad Hoc Committee on Cultural Diversity in Patient Care

Objectives:

1. Research and compile a comprehensive list of related links and resources on cultural diversity in health care for inclusion on the AARC web site to include but not limited to:
   - Info related to specific cultural groups
   - Linguistic/communication competence
   - Case studies in cultural competence
   - Workforce diversity
   - Disparities in healthcare
   - Cultural Competence
2. Develop a mentoring program for AARC members with the purpose of increasing the Diversity of the BOD and HOD.

3. The Committee and the AARC will continue to monitor and develop the web page and other assignments as they arise.

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Ad Hoc Committee on Geriatrics

Objectives:

1. Continue working with the AARC Times staff to assure each AARC Times issue has an article for "Coming of Age".
2. Prepare fact sheets on what respiratory therapists should know related to the following topics suitable for publication in AARC communications or website posting:
    a. Common respiratory prescription medications used by older adults.
    b. Immunizations for older adults
    c. Communicating with the geriatric patient
    d. Geriatric end of life/palliative care.
3. With Executive Office, review material on Yourlunghealth.org for relevance and appropriateness for geriatric population

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Medical Advisor – Robert W Parker MD

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Ad Hoc Committee on Officer Status in the US Uniformed Services

Objective:

1. Continue to develop relationships and strategies to achieve officer status for respiratory therapists in the US uniformed services.

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Ad Hoc Committee on Protocol Implementation

Objectives:

1. Develop and document a process to review, catalog and collate existing protocols and ensure that the protocols correlate with standards of care and practice.
2. Based on the data obtained from Protocol Survey Project, in conjunction with the Executive Office, develop a comprehensive strategic plan to promote the use of protocols and other care delivery models (best practices) to management consultants and employers of respiratory therapists.

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Ad Hoc Committee on Ventilator Guidance Work Groups

HUMAN RESOURCES ISSUES GROUP

Objectives:

1. Provider protection issues
    a. Review the "state of the art" regarding provider protection within the context of pandemics (SARS, H5N1).
2. Develop, if necessary, guidelines to make providers aware of all aspects of provider protection and develop a list of education resources, which can be utilized to teach and train personnel as appropriate to adopt and follow generally accepted provider protection practices.
    a. Identify what resources will be necessary in order to assure full compliance with provider protection guidelines.
3. Develop a system, which can be adopted by RT's and others to assure maintenance of skills, knowledge, competencies and all other resources necessary to assure both initial and ongoing acceptable provider protection practices. This must include material resources as well as skilled maintenance.
    a. Review the full range of strategies and tactics, which can be, employed successfully resulting in a supplemental workforce to assist RTs in managing large numbers of ventilator patients.
4. Identify what duties can be taught to non-respiratory medical or paramedical personnel in order to position them to support respiratory therapists and the management of ventilatory patients.
    a. Develop a system that will assure adequate initial and ongoing skills acquisition and maintenance for adjunct personnel will be utilized to assist respiratory therapists.
5. Identify the minimum education and training requirements necessary for RTs to utilize ventilators, which are included in the national strategic stockpile, as well as ventilators that have been purchased by state and other government agencies throughout the United States.
6. Develop a list of suggested competencies and equipment that the Respiratory Therapy departments may use as a guideline in order to prepare for Pandemic or Mass Casualty situations

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Ad Hoc Committee on Ventilator Guidance Workgroup

VENTILATOR CAPABILITIES AND CAPACITY GROUP

Objectives:

1. Ascertain to what extent conventional ventilators can be leveraged in mass casualty scenarios. This exercise should include ventilators employed on a day-to-day basis in all care settings including the home.

2. Explore the viability of utilizing less than ideal ventilators to relieve demand for ventilators possessing a wider range of clinical capabilities (i.e. utilization of non invasive vents).
    a. Review the current state of the art regarding triage strategies for both disaster and pandemic scenarios.

3. Survey hospitals and other care settings in order to identify ventilators that are no longer in use but still operational as a possible source of additional ventilatory support. The survey should also attempt to learn what logistical limitations such as circuits, fittings, etc., are available if these ventilators were to be employed in a clinical setting.

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Ad Hoc Committee on Ventilator Guidance Workgroup

VENTILATOR LOGISTICAL SUPPORT GROUP

Objectives:

1. Identify all material resources necessary to optimize utilization of all ventilators contained in national or sub national reserves or stockpiles. This resource identification exercise should include options related to power sources, ventilator circuitry and connectors, oxygen supply, cleaning, reprocessing, etc.

2. Identify a system which can be employed by agencies at all levels to assure appropriate inventory maintenance of both ventilators and all peripheral equipment including emergency or backup power supplies.

3. Review the literature and develop guidelines with regard to requirements for circuit changes, reuse, etc. as they relate to both pandemic and disaster mass casualty scenarios. Recommendations regarding minimum amounts of logistical equipment should be generated based on objective evidence and anticipated demand.

4. Review and consideration of recommendations for the purpose of optimizing utilization of all aspects related to logistical support including re-supply of disposable items, organization and distribution and ongoing inventory maintenance of ventilators and their accessories and power supplies.

5. Develop a list of potential power sources, which can be employed in the full range of mass casualty scenarios.

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Ad Hoc Committee on Pinnacle Award

Objectives:

1. To redesign the current QRCR Program with a hierarchical format to include:
    a. Generic core quality standards at Level 1
    b. Special standards as identified by specialty sections (i.e. Long-Term Care, Sleep, Children's Hospitals) for their unique facilities at level 2
    c. And generic Pinnacle standards at Level 3
2. To research the perceived need for such a program by hospital managers
3. To research the cost of:
    a. development of a "Center for Excellence" program
    b. maintenance of said program
    c. projected cost for program participants

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GENERAL REPORTS

**PRESIDENT REPORT

** PAST PRESIDENT REPORT

** EXECUTIVE DIRECTOR REPORT

Federal Government Affairs
AARC Activity Report - March 2009

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Miriam O'Day
Director Legislative Affairs
Anne Marie Hummel
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The Congress

The 111th Congress reconvened in early January. The Obama Administration and Congress are facing a multitude of extraordinary challenges not the least of which is the deep recession the country is in and what it will take to put the country back on the path of economic health.

The focus on the economy will color much of what Congress will undertake this year. Already the Obama Administration has signaled that a full review of entitlement programs, including Social Security and Medicare must be undertaken. Acknowledgment that the "system", in particular the Medicare program cannot continue as is, signals that significant changes are planned. What those changes will be and how the respiratory profession will fare with those changes remains to be revealed. How potential Medicare changes will fit into the overall promise to reform the health care system of the country again is also yet to be determined.

The withdrawal of former South Dakota Senator Tom Daschle from consideration of the post of Secretary of the Health and Human Services Department, the agency overseeing the Medicare/Medicaid Programs under the Centers for Medicare and Medicaid Services (CMS) – also throws into turmoil the future of significant health reform. Senator Daschle is noted for his expertise in health issues and was seen as a bridge to his former Senate colleagues as a way to move health reform legislation forward. As this report is being written it is unclear how quickly health reform will be addressed on the Hill.

With any new Congress there are a significant number of new members and there has been the usual reshuffling of Committee assignments including those who sit on the key health-related Committees of both Houses. While there has been certain "ramp up" time for Congress to adjust, we anticipate that by the PACT Washington D.C. Lobby Day in early March all systems will be well into operation mode. We will provide a full briefing on the outcome of our DC PACT Lobby Day at the Board meeting.

Legislation

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 fundraisers for supportive legislators, and is our liaison to other health oriented organizations.

Children's Health Insurance and Tobacco Tax Increases

Congress and the Obama Administration moved quickly in January to enact a law that had been previously debated and vetoed during the last Congressional session. The law now extends health coverage to a wider population of nearly 4 million children. Payment for the expanded services comes from an increase in the federal tax on cigarettes, going from the current 39 cents to $1.01 per pack beginning in April. Some state Governors are unhappy about the federal increase in this tax as the states are relying on their own increases in cigarette and tobacco taxes to offset their budget shortfalls. The new federal tax limits the states from raising the price of tobacco products any higher.

The Medicare Respiratory Therapy Initiative Reintroduced: HR 1077 and S 343

HR 1077 and S 343 have been reintroduced in the 111th 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). 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's 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 will seek co-sponsorship for the legislation at our annual PACT meeting. We are also seeking an official Congressional Budget Office (CBO) Score and looking for a legislative vehicle in which to attach our initiative. This legislation has no known opposition and we have extended the number of consumer/patient organizations who have offered their support.

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

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 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 will include this again as an agenda item at the March PACT meeting.

The Family Smoking Prevention and Tobacco Control Act

For nearly two decades the AARC has worked with public health associations organized under one coalition umbrella (Tobacco Free Kids) sponsored by the American Lung Association, American Cancer Society and the American Heart Association.

The key focus of the Coalition's legislative efforts has been to pass legislation that will give the FDA greater regulatory authority over the tobacco industry including advertising and promotion to the pubic. The legislation was close to passage in the last session of Congress and with the new Administration and new Congress we anticipate enactment may come quickly this year. The AARC is proud to be listed as one of the 950 organizations that support the legislation. Moreover, nearly every state respiratory therapy society has taken the opportunity to list itself as a supporter of the legislation.

National Sleep Awareness Roundtable (NSART)

The AARC has been asked to participate and send representatives to a Washington, D.C. based coalition of organizations involved in sleep research and federal policy issues. AARC has two representatives, AARC Past President Mike Runge and AARC Director of State Government Affairs, Tom McCarthy.

Political Advocacy Contact Team (PACT) Representatives

As noted in every Federal Activity Report, PACT representatives are a cornerstone to our success in both Washington, D.C. and at the state level. PACT reps are appointed by their state society and have volunteered to lead the grassroots efforts on behalf of the profession.

The 2009 PACT meeting will be held March 9-10 and as this report is written, final preparations are nearly completed. There will again be over 100 RTs (104) coming to Washington to lobby on behalf of the profession. The key focus for our legislative efforts this year will be to gather more co-sponsors for our Respiratory Therapy Medicare Initiative legislation.

As is noted in every report our thanks again go to the respiratory therapists 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.

In addition, this year we have been fortunate to have Natalie Napolitano, BS, RRT-NPS, AE-C a pediatric respiratory therapist at Fairfax Hospital in Virginia as our legislative intern. Natalie is completing her Masters in Public Health at George Washington University and has brought her skills to our lobbying efforts and in organizing the March PACT meeting. This type of involvement greatly benefits the AARC membership and should continue to be encouraged.

Regulations

Based in the Washington, DC area, Anne Marie Hummel as AARC's Director of Regulatory Affairs is raising the AARC's profile in the area of regulatory affairs. While our focus remains centered on the administration of the complex Medicare program we are addressing, other federal agencies and the policies they put forth. Anne Marie's presence also provides the AARC with the opportunity to represent AARC at Washington-based meetings held by government agencies as well as organizational coalitions.

Definition of Respiratory Therapist in the Comprehensive Outpatient Rehabilitation Facility (CORF) Setting

As you know, CMS published final rules in late November 2008 that revised the definition of what CMS considers to be a "skilled" respiratory therapist in the CORF setting. The new definition restricts coverage to registered respiratory therapists only.

Although we provided the language in support of CMS' final policy decision, we came to the conclusion subsequent to publication of the final rule that CMS had misunderstood our earlier comments and were basing their revised definition on the fact that they had not been paying for CRT services in the CORF for several years. What CMS failed to understand was the fact that CRTs with advanced level education who are eligible to sit for the registry exam have been covered under CMS' longstanding definition of respiratory therapist. And, it was that definition that CMS used to establish the G codes for respiratory therapy services back in 2002.

In early December we submitted an issue paper to CMS outlining the problems with the definition and the unintended consequence that some CRTs could lose their job unless the definition was revised. Upon further review, CMS agreed that they had erred and indicated they would take action to correct the situation. Unfortunately, to correct a final regulation once it has been published takes time. CMS was told recently by its legal counsel that new rulemaking (i.e publishing regulations) would be required.

A meeting with CMS took place on February 4, 2009 to review the definition once more to make certain CMS will get it correct the next time around. The language we provided to staff would consider CRTs eligible to take the registry exam, RRTs, and those who have equivalent training and education as determined by the National Board for Respiratory Care to be "qualified" to furnish services in the CORF. Specifications are being drafted now; however, the timeframe for publication is unknown. Our best guess at the earliest would be in the next couple of months.

Outpatient Pulmonary Rehabilitation – National Coverage

As part of a working group comprised of the National Association for Medical Direction of Respiratory Care (NAMDRC), American Thoracic Society (ATS), American Association for Cardiovascular and Pulmonary Rehabilitation (AACVPR) and the American College of Chest Physicians (ACCP), we have been involved in drafting a set of specific recommendations regarding the new pulmonary rehabilitation Medicare benefit category that becomes effective January 1, 2010. This stakeholder input was requested by CMS at a multi-society meeting that took place at CMS headquarters in October 2008.

As an integral part of the initiative, the working group also developed model national coverage determination language for CMS review based on two recent local coverage policies -- one issued by National Government Services and the other by Mutual of Omaha (now part of the Wisconsin Physicians Service Insurance Company (WPS), the new Medicare Administrative Contactor for Jurisdiction 5). These local policies are deemed by the workgroup to be excellent examples of the type of details that should be contained in national policy.

One area of concern to AARC during the development process was defining qualified personnel in a manner that ensured respiratory therapists could not be excluded in any way. The final working group draft describes the delivery of pulmonary rehab services that use "a physician-directed multidisciplinary qualified staff with appropriate expertise and credentials based on state licensure laws and the professional's scope of practice." Coverage criteria state that services must be "delivered by licensed/registered health professionals in accordance with state and federal regulations."

CMS also suggested that it would be prudent to establish permanent codes through the AMA's CPT Editorial Panel. Susan Rinaldo Gallo, RRT, MEd will be reporting separately on coding.

HHS National Vaccine Plan

Staff from the National Vaccine Program Office in the Department of Health and Human Services invited AARC to provide input on their new national vaccine plan prior to seeking public comment and to become an active stakeholder in assisting the office in meeting its goals and objectives.

AARC identified several resources and tools it can use in taking on a variety of initiatives. Examples include improving our grassroots efforts at the local level to generate interest in the value of vaccines and the need for immunizations; using our section chairs and "list servs" to enhance delivery of timely information; partnering with organizations such as the COPD and Alpha-1 Foundations to promote the vaccine program; using our consumer web site, Your Lung Health, and the AARC Times as vehicles to communicate with the public, health care professionals and patients; developing information on the benefits and risks of getting vaccinated from the RT perspective; and updating our human resources survey to track immunization rates among RTs.

HHS Action Plan to Prevent Healthcare-Associated Infections

The Department of Health and Human Services is launching a massive communications and message strategy regarding healthcare-associated infections (HAIs) in an effort to reduce, prevent and work towards the eventual elimination of the majority of such infections.

The plan outlines key actions for achieving identified short and long-term objectives and is intended to enhance collaboration with external stakeholders to strengthen the coordination and impact of national efforts. Identified targets include: 1) Central Line-associated Bloodstream Infections (CLABSI), Clostridlum difficile Infections (CDI), Catheter-associated Urinary Tract Infections (CAUTI), Methicillin-resistant Staphylococcus aureus (MRSA) Infections, Surgical Site Infections (SSI), and Ventilator-associated Pneumonia (VAP).

HHS has developed a list of targeted audiences, potential partners to help get the word out, advice on how to personalize prevention messages based on the type of audience, the top ten messages as part of its outreach strategy and five top campaign messages. The latter includes hand hygiene, healthcare personnel and patient vaccinations, prompt removal of catheters and other devices, and antimicrobial stewardship. AARC has asked to add its name to the list of Professional Associations and offered to use its tools and resources, many of them identified above as part of the National Vaccine Plan initiative, to promote the outreach and messaging strategies.

Oxygen Reform Initiative

As this report is written, the DME industry has been working on reform legislation that will redefine the home oxygen benefit. The industry hopes to eliminate the oxygen rental cap and remove home oxygen from competitive bidding. The AARC has participated in a number of ongoing meetings that have been convened in Washington, DC and via teleconference and offered input on behalf of our membership and the patients we serve.

Beginning in October 2008, AAHomecare and the Council for Quality Respiratory Care (CQRC) launched an oxygen reform initiative aimed at changing the way Medicare pays for oxygen equipment. They convened a group of stakeholders to assist in developing a

legislative proposal that would be patient-centered and hired Leslie Norwalk, former CMS Administrator, to lead the process and facilitate the meetings. Rounding out the group are the AARC, American Lung Association, ATS, NAMDRC, National Emphysema COPD Association, and the National Home Oxygen Patient's Association.

Over the last several months, the group has developed a comprehensive draft reform proposal that would essentially establish a budget neutral, case-mix adjusted prospective payment system for oxygen, allowing for outliers, geographic wage index adjustments and rebasing. The impetus for the proposal is to allow Medicare to pay for the services that are associated with the delivery of oxygen equipment, to eliminate the 36 month oxygen rental payment cap, and to remove oxygen from the competitive bidding requirement.

The reform measures would take the equipment component out of the Medicare DME benefit category and establish payment based on ambulation, liter flow, prescription for liquid oxygen or oxygen generating portable equipment (OGPE), and the patient's mental acuity. Current DME suppliers would be become Medicare "providers." Key components of the proposal include re-testing requirements, quality improvement measures, the establishment of an Advisory Committee reporting to the Secretary, HHS, improved accreditation standards, redefining the Certificate of Medical Need (CMN) process, and patient safeguards.

AAHomecare and CQRC have informally discussed the proposal on the Hill and recently unveiled the plan to its members. However, a number of regional home medical equipment organizations said they could not support the long-term plan because it failed to address the more pressing problems of the 36-month oxygen rental cap and competitive bidding. AAHomecare leaders believe that Congress will not budge on the O2 cap unless there is a reform measure in place. AAHomecare has formed a new coalition to try and reach some form of compromise among the DME stakeholders.

At its February 12 meeting, the original stakeholder group discussed patient safeguard issues and will next review legislative language. At AARC's request, consideration is being given to bringing in patient advocacy groups at a separate meeting to get their perspective on the proposal. As this is a very active issue, a detailed verbal update will be provided at the meeting.

Conclusion

The activity at the federal level for both regulatory and legislative issues will continue throughout the rest 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 March meeting.

State Government Affairs Activity Report

March 2009

Cheryl A. West, MHA
Director Government Affairs

Most state legislatures reconvened in January. All states are struggling with the economic recession that is putting an enormous strain on all sectors of state spending. As unemployment rises individuals lose their employer based health insurance and apply for state sponsored health and social programs such as Medicaid, SHIP and unemployment insurance. In light of the budgetary pressures, expansion of existing state health services, to include respiratory therapy becomes a very difficult endeavor. Many states are at least attempting to discuss reforming their own health insurance programs, but again given the economic conditions, discussions will most likely remain just that, discussions. One pattern of legislation clearly emerging are bills that would raise tobacco taxes, thus bringing more revenue to the states.

As always noted, legislation introduced is never guaranteed to be enacted into law.

Respiratory Therapy Licensure Legislation

Thus far in this relatively new legislative season, there are few bills that specifically address respiratory therapy licensure. None have been enacted at this writing.

Hawaii - introduced legislation to license respiratory therapists. Legislation has followed AARC Model Practice Act. 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) as noted in **Attachment #1**. AARC has responded to the AASM/AAST letter in **Attachment #2.**

Moreover, at request of Hawaii Society for Respiratory Care the AARC submitted testimony to two key legislative committees in support of moving forward with RT licensure. Hawaii government rules require that any profession seeking licensure must first be reviewed by a state agency which will recommend for or against supporting licensure. As this report is being written, the RT licensure proposal has avoided having to go through the process and legislation is proceeding through the Senate. How licensure efforts will fare in the House is still unclear and the effort may still be sent back to the agency review committee.

Minnesota- the MSRC has launched a well planned legislative effort to upgrade RT registration to full licensure. Legislation has been introduced. The MSRC has garnered support from outside stakeholders and has hired a lobbyist. Unfortunately, the one special

interest that is raising issues comes from the sleep industry which wants to insert a blanket exemption for polysom trainees, technicians and technologists.

Montana has a bill that would revise the composition of the RT licensure board. The interesting point is that it would call for one of the RT Board members to be proficient in both pulmonary function and sleep diagnostics.

Oregon also has 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. Also there us a bill that raises RT (and other profession's) licensing fees.

Georgia has a bill that will make numerous changes in licensure application, renewal, discipline criteria, changes supported by GSRC.

Nevada would include in the RT licensure law an additional exemption for individuals serving in the US armed forces.

Kansas and Connecticut both raise licensure fees for RTs.

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

As has been the case for many years state legislatures continue to introduce and pass legislation that will encompass in one catch all bill provisions of many licensure acts. The focus has most often been on standardizing 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, none of these bills have been enacted.

Mississippi: A bill that creates a Volunteer Health Care Practitioners Registry to respond to declared emergencies.

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 ed for many professions

Other Legislation of Interest to the Profession of Respiratory Therapy

There are other bills of interest to the profession. We encourage state societies to voice their support or become more actively involved in the passage, (or opposition) of these

bills. Raising the profile of the state society and thus the respiratory therapy profession by weighing in on legislation that might not directly impact the profession (i.e. issues revolving around licensure) is beneficial to everyone.

Track hospital acquired infections including vent associated pneumonia: AL, MS, MO, NY, MN, NM

Plan for Comprehensive Treatment of Chronic Obstructive Pulmonary Disease legislation: OK.

Assign a Department of Health staff to assure that issues regarding COPD are addressed: IL
Asthma testing, use of asthma meds in schools : CT, IL, MS, MO, OK, NY, ME

Hospital staffing bills (focus is on nurses) : CA, FL , NY, PA, TX, MN (but says do not lose focus on other professions and mentions RT).

Providing Medicaid coverage for ventilator patient care at skilled nursing facilities and through private duty nursing in the patient's home: WV.

Tobacco Legislation

Increase in tobacco taxes: over 16 states, too numerous to mention have legislation to increase cigarette or tobacco taxes. Many states, such as Mississippi, have multiple bills that would do this.

Expand smoke free places: IN. MS, OK, SC, VA, IN

Expand smoking cessation programs: MO, MS, SC, KY

Restrictions on mail order sales of tobacco products: SC, SD

Cannot smoke in a car with a child younger then 16: NE

Cannot smoke in a car with a child no age limit: NM

Cannot smoke in a car with child in car seat: RI

Prohibit selling of tobacco products to anyone under the age of 19: NY

Limit tobacco sales over the internet: SD

A business that sells tobacco products must also sell smoking cessation products: OR

Challenges from Other Occupations

We continue to monitor legislative activities by other professions and disciplines. Seemingly small changes in who may provide a service, qualifications to provide a service, what is permitted to be provided as a service and where services can be provided, can greatly impact and potentially diminish the respiratory therapy legal scope of practice.

Sleep Disorder or Polysomnography State Legislative Activities

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 to be considered a profession and be licensed as such that all disciplines must require formal, accredited education as a cornerstone to moving ahead with licensure. To that end the provisions of the 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.

Maryland

The Maryland polysom licensure law was enacted in 2005, 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 over 4 years in which to establish a CAAHEP approved sleep program.

In the years since the enactment of the law, no CAAHEP polysom education programs have been established in Maryland (although one is pending approval). Legislative efforts were undertaken in 2008 to amend the 2009 deadline. However, these efforts were not successful. The sleep stakeholders again introduced a bill that will delay the deadline until 2012. The MD/DC will support legislation that would delay implementation of the entire polysom licensure law, but not legislation that would delay just the education requirement, thereby still permitting the issuance of licenses to those with limited or no education.

Tennessee

AARC continues to work closely with the lobby firm we have engaged to delete a provision in the polysomnography licensure law. This provision, effective 2010 will require any respiratory therapist providing any sleep related service now defined as polysomnography to obtain the credential of a registered polysomnography technologist the RPSGT. We continue to gather support among respiratory therapists in the state. We have received a letter of support from the American College of Chest Physicians that supports our TN efforts (Attachment #3).

Oklahoma
Legislation has been introduced, that unlike polysomnography personnel licensure bills, is aimed at setting standards for sleep entities not affiliated with hospitals. In essence, this bill will regulate the "doc in boxes" sleep businesses. The initial requirements of the bill are focused on the business side, not the personnel side, of the equation. The OSRC has been monitoring the bill and informed that an amendment has been added to permit only RPSGTs and RRTS with the NBRC add on Sleep Specialty credential to provide sleep testing in these facilities. We have advised the OSRC to oppose this restriction that will limit all respiratory therapists from continuing to provide sleep services, a component of the scope of practice.

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, GA law will not permit physicians to delegate to unlicensed personnel what is in the scope of practice of another licensed health profession. Therefore, polysoms (and HME provider delivery personnel) who are not licensed cannot provide CPAP and Bi PAP.

The sleep community has responded by finding a sponsor for a polysom licensure bill, based on the identical bill used in Tennessee, (minus the requirement that the RT must become a RPSGT). GA has a lobbyist who will be working to oppose the provisions of the bill that are detrimental to the health and safety of the citizens of Georgia as well as infringe on the RT scope of practice.

Kansas
A bill to license polysomnography personnel in KS was introduced in the legislature. There were several provisions of the legislation not acceptable to the respiratory profession and the KSRC. The bill contained specific exemptions to the provisions of the bill for nurses and dentists, but none for the respiratory therapists, who above any other profession has the most sleep education and testing. 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.

California
Last year the California legislature passed a polysomnography licensure bill, only to have it vetoed. The bill (and nearly 800 other passed 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 the decision on how to regulate the un-tested trainees and technicians up to the Board of Medicine. The bill with the same provisions has been re-introduced. The CSRC will closely monitor the progress of the bill to ensure that no unexpected changes are made to the legislation.

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 meeting.

ATTACHMENT 1

American Academy of Sleep Medicine
American Association of Sleep Technologists

One Westbrook Corporate Center, Suite 920
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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.pdft 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:

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In addition, an AASM contact person is Bruce Blehart (BBlehart@aasmnet.org),

and an AAST contact person is Christopher Waring (CWaring@aastweb.org).

Sincerely,

Mary Susan Esther, MD
President,
American Academy of Sleep Medicine

Jon Atkinson, BS, RPSGT
President,
American Association of Sleep Technologists

cc: Danilo Ablan, MD
Carol Yoshimura, RPSGT

ATTACHMENT 2

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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February 17, 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 Licensure of Respiratory Therapists**

Dear Chairman Yamane:

I am writing on behalf of the American Association for Respiratory Care (AARC) to offer full support and endorsement of HB 1823, legislation that will license respiratory therapists in the State of Hawaii.

The AARC is a professional organization representing over 48,000 respiratory therapists across the country. Among the AARC's goals are to advocate on behalf of pulmonary patients for appropriate access to respiratory services provided by qualified respiratory therapist professionals and to benefit respiratory health care providers.

Respiratory Therapists

Respiratory therapists are health care professionals whose work includes the diagnostic evaluation, management, education, rehabilitation and care of patients with deficiencies and abnormalities of the cardiopulmonary system. Respiratory therapists treat, across the health care site continuum, high-risk patients with both acute and chronic conditions. Respiratory therapists treat patients of all ages who require mechanical ventilation and those with other intensive care needs, as well as patients suffering from chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis and sleep disorders such as sleep apnea.

Respiratory therapists also provide the application of medical technology/equipment and the use of treatment protocols across all care sites including, but not limited to, the hospital, clinic, physician's office, sleep laboratory, rehabilitation facility, skilled nursing facility and the patient's home.

Respiratory Therapist as a Licensed Profession

The AARC unequivocally supports HB 1823 that will finally license respiratory therapists in Hawaii. Currently, 48 states, the District of Columbia and Puerto Rico have licensure laws in place for the respiratory therapist. Today, Hawaii and Alaska are the only two states that have yet to recognize the critical need to protect the health and safety of their citizens by regulating both the practice and profession of respiratory therapy. The addition of Hawaii to the nationwide list of licensed states would be significant. Hawaii, of course, recognizes the importance of licensing many, many health professionals such as nurses and physical therapists. There should be nothing to preclude the Hawaii licensure of respiratory therapists, who provide not just life-enhancing, but life-sustaining health services and procedures.

Reasons to License Respiratory Therapists in Hawaii

State legislatures undertake the process of requiring licensure of a health profession because there is a recognition that without mandated standards and criteria from those who provide the services, the health and safety of the citizens of the state is jeopardized.

Licensure of the respiratory therapist can ensure that respiratory therapy services provided to patients in any care setting are performed by the respiratory therapist who meets standards of accredited education and competency. As individuals, we expect at least as much from professions performing services not nearly as technical, life-sustaining, or critical to the well-being of family and friends. We should expect the same from the respiratory therapist performing life-sustaining procedures, diagnostic evaluations and rendering interpretations of a patient's condition.

Traditionally, hospital control has been considered appropriate in regulating the services provided within its domain. But this view was developed at a time when the hospital was at the apex of medical care in the United States. It was a time when physicians made house calls and sicker patients were sent to hospitals for treatment.

Today, the health paradigm is quite different. The hospital is not the only alternative for medical care. More and more respiratory therapists are providing services as employees of durable medical equipment companies, home health care agencies, hospice centers, outpatient clinics and centers, sleep disorder laboratories, physicians' offices, and as asthma disease managers and smoking cessation counselors. In such cases, without licensure laws, employers may take less time to provide the necessary oversight to determine whether the person who is providing respiratory therapy has the appropriate education and training or is competency tested. Further, with large numbers of patients being discharged "sicker and quicker" in today's cost containment environment, more

fragile patients will need care by licensed and competent staff outside of the acute care arena.

Advantages to License Respiratory Therapists

Licensure for respiratory therapists in the State of Hawaii has numerous advantages. It provides the least restrictive regulation for public protection by requiring the individual to have successfully graduated from an accredited respiratory therapy education program and have passed a valid competency examination. Continuing education requirements help maintain and update a therapist's knowledge in the field. These requirements alone establish a baseline for competency in providing respiratory therapy services.

Although respiratory therapists work at the direction of a physician, they often practice without direct supervision and exercise a great degree of independent judgment, especially outside of the hospital setting. A high degree of specialized education and clinical skill is essential in treating serious respiratory illnesses. Without assurances as to the competency of the individual, injury and even death can result from even the most routine interventions (e.g., administration of medical gases) due to incompetent practice. Licensure adds a safety net for patients.

State respiratory therapy licensing boards across the nation participate in a consortium that submits disciplinary action activities to a clearinghouse administered by the National Board for Respiratory Care (NBRC). Respiratory therapy licensing boards may access this data bank when reviewing licensure applications. With licensing, Hawaii would have access to all the other respiratory therapy state licensing board disciplinary data bases to verify the status of the respiratory therapist applicant.

Other Licensed Professionals and Competency Tested Personnel are not Impacted by HB 1823

HB 1823 contains two standard provisions found typically in all other health professional licensure laws, including respiratory therapy licensure laws. These provisions would allow other ***licensed*** individuals to perform respiratory therapy services that are within their particular scope of work.

The second provision provides the standard ***exception/exemption*** that would permit individuals who have passed an examination in one or more respiratory care functions to perform these procedures as long as the board approved the testing body offering the examination. This particular exception/exemption is standard in other respiratory therapy licensure laws, thus is not unique to HB 1823. There have been no reports that this exception/exemption has resulted in limitations in patient access to care provided by qualified health care professionals who meet the criteria of having passed a competency examination.

Response to the February 4, 2009 American Academy of Sleep Medicine and the American Association of Sleep Technologists Letter Opposing HB 1823

We are aware that the American Academy of Sleep Medicine (AASM) and the American Association of Sleep Technologists (AAST) (formerly the Association of Polysomnography Technologists (APT)) are opposed to licensure of respiratory therapists in the State of Hawaii.

The letter cites several areas of opposition and makes statements that demand correction and factual data.

The AASM/AAST letter opposes the inclusion of one element of the respiratory therapist's scope of work outlined in the proposed bill. This element involves services denoted as *sleep diagnostic studies* (item 16 under "respiratory care services.)

Respiratory Therapy Licensure will Cause Credentialed Sleep Technologists to Lose Their Jobs

Because HB 1823 contains the legitimate aspect of respiratory therapy, i.e., sleep diagnostics, practiced for decades, the AASM/AAST erroneously states that licensure of respiratory therapists will cause the 31 Registered Polysomnographic Technologists (RPSGTs) in Hawaii and the four Hawaiians who will soon be registered as RPSGTs to lose their jobs.

That is not correct. As with all respiratory therapy licensure laws, HB 1823 has two exemption provisions that address the concerns as noted earlier:

1. Other licensed health professions, and;

2. Personnel who are credentialed in their discipline (in this case the RPSGT).

The first exemption is for other licensed health professionals (such as nurses). Indeed the RPSGT would not qualify under that exemption as RPSGTs are not licensed in Hawaii.

Under the second exemption, those who are not licensed but are competency-tested and hold a credential the RPSGTs would indeed qualify.

Therefore, these provisions exempt qualifying practitioners whose own scope of practice or services might overlap with the codified respiratory therapy scope of practice from having to meet any of the provisions of the respiratory therapy licensure law.

The primary rationale for AASM/AAST's opposition to HB 1823 and concern about RPSGTs' employment in the state is based on the fact that there are no assurances that the board would approve an exception to permit sleep technologists who have passed the discipline's valid competency examination and earned the credential of Registered

Polysomnographic Technologists (RPSGT) to continue to perform sleep diagnostic functions for which they have been tested.

The fact that there are overlaps among various health care professions is not new. Respiratory therapists, for example, share certain duties with nurses, physical therapists, medical technologists, paramedics and pharmacists such as chest or breathing therapy related to pulmonary care, arterial blood sampling and blood gas analysis, and the administration of drugs and medications. Licensure of respiratory therapists across the nation has not impacted those professions nor caused health care specialists to lose their jobs. No respiratory therapy licensure board or committee has ever denied any discipline an exemption if the examination for the practitioner is deemed valid and reliable.

The examination that tests the competency and awards the credential of RPSGT is administered by the Board of Registered Polysomnographic Technologists (BRPT). Just as with the respiratory therapy testing and credentialing board, the National Board for Respiratory Care (NBRC), the BRPT is also a member of the National Organization of Certification Associations and is accredited by the National Commission for Certifying Agencies (NCCA), the accreditation body of the National Organization for Competency Assurance (NOCA).

As examples the respiratory licensure boards/committees for Alabama, Colorado, Nebraska, New Hampshire, North Carolina, Oklahoma, and South Carolina, specifically exempt the RPSGT from any provisions of the practice act. These exemptions were based on the competency testing exemption that the AASM/AAST letter voices so much concern.

With 13,000 sleep technologists having passed their competency examination and earning the credential of RPSGT and with 48 states, the District of Columbia and Puerto Rico having licensure laws in place for respiratory therapists, it is highly unlikely that licensure in Hawaii will impact the soon to be 35 RPSGTs in Hawaii from performing procedures for which they have been tested and credentialed.

To appease the unwarranted concerns with this issue the AARC would support including an amendment to HB 1823 that would explicitly exempt those holding the RPSGT from the provisions of the respiratory therapy licensure law.

Sleep as a Unique Profession?

The AASM/AAST also describes what they believe is a unique profession. They provide a link to the educational requirements set forth by the Board of Registered Polysomnographic Technologists (BRPT). These requirements allow applicants who hold a credential in one of the following allied health fields – Respiratory care - (RRT, CRT), Nursing - (RN/LPN), Electroneurodiagnostics – (R. EEG T.), Physician Assistant (PA), PhD, Medical Doctor (MD), DO (Doctor of Osteopathy), or (DC) Doctor of Chiropractic or National EMT-P – the opportunity to complete an additional six-month educational program in polysomnography and sit for the BRPT exam.

In their letter, the AASM.ASST contend that respiratory therapists who have failed to complete the additional education requirements **"do not have the skill set that effective sleep care demands."** They imply that this position is supported by the fact that the National Board of Respiratory Care (NBRC) has established a new sleep disorders specialty exam with the credential of Sleep Disorders Specialists for respiratory therapists who are already certified or registered.

The scope of practice set forth in health professions licensure law is never tied to a specialty credential. A licensed physician who takes a specialty examination and is credentialed as a pulmonologist or cardiologist for example, is not separately licensed by law as a pulmonologist or cardiologist, but as a physician. This same premise applies to the licensure of the respiratory therapist.

The NBRC has developed advanced practitioner examinations that acknowledge mature and experienced practice of respiratory therapists in areas that have always been part of the respiratory therapy scope of practice. Currently, specialty examinations and credentials are available for Neonatal Pediatric Specialists (NPS) and Sleep Disorder Specialists (SDS). A Critical Care Specialist examination is under development by the NBRC.

Respiratory therapists who do not hold one of these specialty credentials are certainly qualified to render care in those areas. It is not necessary for a respiratory therapist to hold the NPS designation in order to provide services to children or infants, just as the SDS credential (and the Critical Care credential) not be required for respiratory therapists to practice in those areas. These specialty credentials are simply a method to recognize advanced level experience and professionalism. All respiratory therapists are qualified by virtue of education, training, and testing to work in neonatal care, sleep services, and critical care.

Respiratory Therapists are Educated and Tested in Sleep Disorder Services

We could spend time in this letter refuting the AASM/AAST allegations as to the competency of respiratory therapists to perform sleep disorder services. We could and would be pleased to provide extensive details as to the educational requirements in sleep disorder procedures and therapeutics that all respiratory therapy accredited education programs must meet in order to be an accredited program. Moreover, we can easily document the portions of the credentialing exam matrix respiratory therapists are required to successfully pass covering the areas of sleep disorder services. But that is not the issue. What is at issue, though, is the basic requirement for education and credentialing between the profession of respiratory therapy and the discipline of sleep personnel.

The AASM/AAST letter describes the skills that are required for personnel providing sleep services. In order to obtain the credential of RPSGT, an individual can elect one of two curriculums.

The first is a polysomnography education program accredited by the nationally recognized Commission on Accreditation of Allied Health Programs (CAAHEP). There are currently19 CAAHEP accredited polysomnography education programs nationwide. The AARC was one of the organizations that fully supported the creation of accredited academic programs in polysomnography, a.k.a., sleep disorder services. These education programs based in established colleges will require course work from the student from one to two years, and will award a certificate of completion.

The second available pathway now available is termed "A-Step program," developed by the AASM, consisting of an 80-hour, on-the-job training course followed by 14 online modules (45-60 minutes per module). We are not aware that this on-the-job training course is accredited by any nationally recognized education entity. The AASM has bestowed its own "accreditation" on its A Step training course.

Once an individual has completed the A-Step 80-hour on-the-job requirement, he or she can be employed in a sleep facility while they complete the online module training

Neither a CAAHEP-accredited education program nor the A-Step on-the-job training course for sleep personnel is available in Hawaii. Therefore, not even the very basic training in sleep is available in Hawaii. The AASM/AAST letter cites the complexity of providing sleep services when, in fact, components that are "sleep services" are merely acquired on the job.

With respect to the curriculum for respiratory therapy, an individual must have an associate degree as a minimum to graduate. There are over 350 accredited respiratory therapy education programs in the United States. Kapiolani Community College in Honolulu has a CAAHEP accredited respiratory program.

The requirement suggested in the AASM/AAST letter that respiratory therapists must complete an additional six months of education in polysomnograpy and be credentialed by the BRPT in order to be considered qualified to perform such services stems from the fact that the AASM is trying to effectively lobby other state legislatures to establish polysomnography regulations that would prevent respiratory therapists from carrying out the scope of practice for which they are eminently qualified. Some legislative initiatives go so far as to state specifically that respiratory therapists will be disciplined if they are performing sleep disorder services and are found not to have the added credential.

Respiratory therapists have been performing a full range of sleep disorder services including testing and therapeutics as part of their scope of work for decades. The AARC conducted a nationwide search of all respiratory therapy state licensure boards to determine if there were any complaints, disciplinary actions or any negative events lodged against a respiratory therapist in the performance of any aspect of polysomnography services.

No respiratory therapy licensure board in any state has ever taken issue with or had to initiate disciplinary action against a respiratory therapist providing polysomnography or sleep disorder services. There has never been any negative clinical incident reported against a respiratory therapist providing polysomnography or sleep disorder services. No challenge has ever been raised that when a respiratory therapist is providing services now defined as polysomnography or sleep disorder services that the therapist is practicing outside his/her scope of practice. Sleep disorder services have been historically considered a part of the respiratory therapy scope of practice and respiratory therapists are educated and tested on the components of sleep disorder services.

The AARC believes that patient's should have access to the best care possible. Hawaii's bill to license respiratory therapists in the state should in no way be a detriment to permitting both respiratory therapists and credentialed RPSGTs from providing services they are qualified to perform.

Respiratory Therapists have been Providing Sleep Services for Decades

Several years ago, the AARC and the APT (or AAST as it is known today) jointly developed a clinical practice guideline on polysomnography, which refers to the collective process of monitoring and recording physiologic data during sleep. The guideline states that personnel should have the knowledge and demonstrated ability to perform a certain level of responsibilities and must be a credentialed or licensed registered polysomnographic technician (RPSGT), a registered electroencephalographic technologist (REEGT), a respiratory care practitioner, or a registered nurse. This is further justification that credentialed RPSGTs should not be impacted by licensed respiratory therapists in the State of Hawaii. Moreover, it is further documentation that respiratory therapists are legitimately qualified to provide the full range of sleep services.

A comprehensive survey of polysomnography sleep personnel was released in 2003. The Salary, Demographic, and Education Needs Survey Report commissioned by the APT/AAST reported the following:

> "Typical respondents spent most of their time in hospital based sleep disorders centers organized **under a respiratory care department** (43%)" . . .Individuals requiring polysomnographic services often have other clinical co-morbidities, such as, systemic and pulmonary hypertension, cardiac arrhythmias, and obesity. The patient's clinical condition is **a key reason why respiratory therapists perform a significant number of sleep related services."** (*emphasis added)*

Conclusion

While we have taken a significant portion of this letter to refute the misleading statements contained in the AASM/AAST letter, the critical element to be considered in licensing is patient care and access to qualified health professionals. That is the premise of the legislation which states that the practice of respiratory care should be regulated to

“protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.”

We strongly encourage the legislature to pass this long anticipated action and bring Hawaii in line with the rest of the country.

Sincerely,

Timothy R. Myers, BS, RRT-NPS
President

ATTACHMENT 3

AMERICAN COLLEGE OF CHEST PHYSICIANS®

Timothy R. Myers, RRT-NPS
President, American Association for Respiratory Care
9425 N. MacArthur Blvd
Suite 100
Irving, TX 75063-4706

February 12, 2009

Re: ACCP Tennessee Polysomnography State Licensure

Dear Mr. Myers:

The American College of Chest Physicians (ACCP) is aware that many states, including Tennessee, are in the process of passing, or have passed, legislation impacting licensure for health professionals who provide sleep diagnostic and therapeutic services.

ACCP continues to be concerned about any legislation that fails to provide a pathway to the highest quality care possible. Ongoing efforts to establish standards for individuals who render health services to the citizens of any state should be supported. However, legal requirements must be carefully written so as not to impede or restrict the performance of the legally permitted services by other qualified licensed health professionals.

We are concerned that the Tennessee law licensing those engaged in polysomnography included provisions that have created unintended consequences for the licensed respiratory therapist. The Tennessee licensure act contains two provisions, which together, will impact every respiratory therapist in the state whether or not they are engaged in providing polysomnography services in any health care setting.

Expansive Scope of Practice

The scope of practice in the Tennessee licensure law sets forth what is now legally defined as polysomnography. The scope of practice makes the following a legal polysomnography service

Therefore, by law, any individual who educates the patient on therapeutic treatment is practicing "polysomnography." This provision is not site specific, nor confined only to facilities that provide sleep services. Thus this provision applies to any care site, including inpatient hospitals and patient homes – anywhere that educating the patient on sleep treatment would be rendered.

Exemption Clause for Other Licensed Health Professionals

As with all other health professional licensure laws, the polysomnography act contains a standard exemption provision. This exemption provision states that nothing in the law will impact nor affect other licensed health professions who are practicing those services permitted within their own scope of practice. Therefore, other licensed health professionals such as nurses or physical therapists who are currently or in the future will be providing services now defined as polysomnography will not be impacted by this law nor required to meet any of the mandated standards within the law.
However, this exemption does not apply to licensed respiratory therapists.

Licensed respiratory therapists have been specifically named in the law for additional credentialing in polysomnography. Yet respiratory therapists have been legally providing sleep disorder services, now defined as polysomnography, under their own scope of practice for decades, without any negative consequences, legal actions or state sanctions.

Because of the expansive scope of practice definition and the legislative language that carves out specific requirements for the respiratory therapist among all other licensed health professions, the ACCP supports the deletion of the following provision:

> *63-31-107 (a) (5)*
>
> *"A respiratory therapist licensed under chapter 27 of this title 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. 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."*

In 2007, the ACCP approved a Position Statement on Polysomnography. It states that trained and competent specialists must provide diagnostic and therapeutic services. ACCP firmly believes that competency testing for the credentialing of individuals performing polysomnography ensures the knowledge level of technologists entering the field.

We also are aware that many sleep facilities employ respiratory therapists, not as sleep technologists, but as therapists who provide the full range of sleep disorder services from diagnostics to education to therapeutics. They have been trained and tested.

ACCP continues to be concerned about any legislation that fails to provide a pathway to the highest quality care possible and infringes on the legal scope of practice of other licensed health professionals.

Sincerely,

James A.L. Mathers, Jr., MD, FCCP
President
American College of Chest Physicians

Date Submitted: February 28, 2009

Committee/Section: House of Delegates

Representative: Camden McLaughlin

Charges:

None

Recommendations:

None at this time

Report:

January 2009, began on the run with two key issues as ìleftovers of the December HOD meeting. First, several inquiries/concerns were expressed regarding the perceived issue of "conflict of interest" with the Speaker-elect position, this person's employment, and AARC responsibility, i.e., finance committee and chair of audit subcommittee. Due diligence was completed, at my request, to have AARC attorney, Larry Wolfish, review and provide comment. The letter was received on January 30, 2009, and such person was not in conflict. It is my understanding that further discussion on the relationship of potential conflict of interest will continue at the March BOD meeting. With that knowledge, the HOD will begin work to develop policy to avoid such perceived conflict in the future.
Secondarily, during executive session of the HOD in December, a resolution was developed regarding the polysomnography issues. We soon discovered that this resolution would not be effective as a resolution, but would require a different mechanism to make it efficient. On a BOD/HOD (2P/3S) conference call, it was determined that the best approach would be to develop a cover letter requesting that the state affiliates support our Association, along with an attachment guiding the state affiliates to submit three questions to their respiratory care licensure boards. These questions are written so to elicit statement of facts and not seek an opinion or particular viewpoint. There have been several eyes and drafts and this document should be out by the March BOD meeting.

The House Officers participated in a conference call to plan for the March BOD meeting along with initial development of House goals and preliminary work for the summer House meeting. Work in the House has continued with confirmation of committee chairs and members, committee charges, assigning of House officers as liaisons to committees, submitting articles for The Record, along with attempting to keep up with tasks on the House calendar. These are the House Speakers goals which were developed with President Myers goals in mind:

1. Develop and execute strategies with the Chartered Affiliates which will focus on membership and participation in the AARC.
    a. Conduct focus group meetings centered on Affiliate behaviors that encourage AARC membership at the summer 2009 HOD meeting.
    b. Request AARC membership chair charge HOD members with obtainable goals for Affiliates to increase membership.
2. Continue to strengthen good communication and enhance relationships between the Chartered Affiliates and the AARC.
    a. Conduct focus group meetings centered on what affiliate behaviors assure good communication at the summer 2009 HOD meeting.
    b. Continue Best Practice presentations at both HOD meetings.
    c. Conduct efficient and effective HOD meetings.
3. Develop a process for to successfully implement a program to mentor HOD members into leadership roles for the HOD and the AARC.
4. Enhance the ìRespiratory Therapist for 2015 and Beyondî project through communication, education, and specific committee guidance.
5. Continually improve HOD meeting effectiveness.
    a. Continue to strengthen resolution process through education and awareness.
    b. Enhance committee chair roles through a complete review of charges, goal development, mentoring within the committees, assurance of ìworkingî time during HOD meetings, and an evaluation process for committee chairs.
    c. Continue allotted time to discuss issues related to reports.
    d. Work to have an active and goal oriented HOD executive board.

6. Maintain open communication and collaborative working relationships with the AARC President, AARC BOD, and AARC Executive Director/Office to enhance goals and objectives

a. Participation in monthly conference calls with President(s), Speaker(s), and Executive Office.

b. Routine communication with President Myers with discussions related to AARC, BOD, HOD issues. Assist President Myers with obtaining Presidential Goals through HOD involvement and support.

Appreciate the support and the pleasure to work with the AARC BOD and look forward to a productive year.

Other:

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Medical Advisors Meeting
December 14, 2008
Anaheim, California

Agenda

Attendance

Terence Carey, MD (ACAAI) **Chair**
Gerald Weinhouse, MD (ATS)
Robin Elwood, MD (ASA)
Kent Christopher, MD, RRT, FCCP, FAARC (ACCP)
Clifford Boehm, MD, RRT (ASA)
Russell Acevedo, MD, FAARC, FCCP, FCCM (ACCP)
Robert Gould, MD (ASA)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
Bradley Chipps, MD (ACAAI)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)

Guests

Robert McCoy, BS, RRT, FAARC
Shelley Mishoe, PhD, RRT, FAARC
Gary Smith, BS, FAARC
Tom Smalling, PhD, RRT, RPFT, RPSGT
Toni Rodriguez, EdD, RRT
Tim Myers, BS, RRT-NPS
Harry Roman, MA, RRT
Sherry Barnhart, RRT- NPS, FAARC
Mike Hewitt, RRT-NPS, FAARC
Lori Tinkler, MBA

Absent
Steven Boas, MD, (AAP)
Jeffrey Vender, MD, FCCM (SCCM)
Richard Sheldon, MD FACP, FCCP, FAARC (ATS)
Phillip Marcus, MD, MPH, FCCP, FACP (NAMDRC)
Ira Cheifetz, MD, FCCM, FAARC (SCCM) (Excused)
Joseph Sokolowski, MD, EMT-B, FACP, FCCP (ATS) (Excused)
William Bernhard, MD (ASA) (Excused)
Jay Peters, MD (ACCP)
Barry Fuchs, MD (ATS)

Consultant
Michael Runge, BS, RRT, BOMA Liaison (AARC Past President)

Staff
Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, BS, RRT, AE-C, FAARC, Chief Operating Officer
Ray Masferrer, RRT, Associate Executive Director
Cheryl West, MHA, Director Government Affairs
Miriam O'Day, Director Legislative Affairs
Bill Dubbs, RRT, MHA, MEd, RRT, Director Education & Management
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

BOMA Chair Dr. Terence Carey called the meeting of the AARC Board of Medical Advisors (BOMA) to order at 10:10 a.m., PST, Sunday, December 14, 2008.

Dr. Carey asked members to introduce themselves

APPROVAL OF MINUTES

Dr. Kent Christopher moved **"To accept the minutes of the July 26, 2008 meeting of the AARC Board of Medical Advisors."**

Motion Carried

CHAIR REPORT

Pulmonary Rehab
After over 14 years, the pulmonary rehab bill was finally passed this year.

Medicare Respiratory Therapy Initiative
The Medicare Respiratory Therapy initiative was stalled at the end of this year, however Blanche Lincoln (AR) and Mike Crapo (AR) have committed to reintroduce the legislation in 2009.

AARC Membership
AARC membership has increased after a stagnant period of time, and now exceeds 48,000 members with a goal of 50,000 in 2009. Key factors to the increase in membership were Toni Rodriguez's travels to 43 state meetings during her 2-year presidency. Her grassroots approach, and her tremendous ability to motivate were also a factor. The retention rate grew, and at that same time we offered quality education on demand, distance learning, expanded live seating capability in webcasts which also enables video conferencing. The AARC has also added over 500 international members.

ACAAI
The ACAAI has appointed Dr. Phil Korenblat as its representative to BOMA, who will begin his term at the summer 2009 meeting.

Position Statements
The position statement on nebulized treatments was sent to CMS in August 2008.

Dr. Carey stated that BOMA presented the Board with its suggestions for the creation of a position statement on the use of respiratory therapists being involved in the transport of a ventilated patient. Dr. Carey shared BOMA's suggestions to the Board and it was then referred to the Position Statement Committee for development. Dr. Carey requested an early review of the final draft.

2015 and Beyond
The first conference of the 2015 and Beyond project was completed and the conference manuscript will appear in the March issue of *RESPIRATORY CARE*.

Military
Col. Michael Morris was unable to attend this meeting but Dr. Carey advised the Assistant Director of the Military Respiratory Therapy School at Fort Sam Houston, Harry Roman, MA, RRT will present an update on military issues.

Dr. Carey advised members that he attended all the AARC Board meetings of the AARC this year and believed the Association under Toni Rodriguez's leadership was a positive leap forward.

SECTION CHAIR REPORTS

In an effort to create closer relations with the Sections, Dr. Carey invited two of AARC's section chairs to present a verbal report on their Section's activities and provide a Q&A format for BOMA and the Section Chair. Other Section Chairs will be invited to future BOMA meetings.

Adult Acute Section
Chair, Michael Hewitt reported that he developed two goals; one of which is to take his section to 2,000 members before his term is up. They currently have just under that figure, but he still has two more years to obtain that goal. His second goal was to refine The Adult Acute Section Listserv by outlining some strict Listserv rules. This provided for more robust exchanges over the Listserv and members have come forward wishing to submit articles, and offer suggestions.

He also stated that he believes RTs need to step forward with solutions to problems. He presents the President's Address to the 2007 Congress whenever possible which tends to motivate students. He believes it is essential to empower students as never before. Mr. Hewitt feels positive about where the Association is headed. He advised that Dr. Acevedo and Dr. Carey have been supportive to the Section.

Home Care Section
Chair, Bob McCoy believes BOMA could be a great asset to the Section. Home care has little evidence on standards, procedure, or policies, and no consistency of care. The biggest challenge is obtaining scientific evidence of home care. He perceives that with the 36 month policy currently in place many of the home care companies will be going out of business soon, and when this happens many patients will not have access to service. He sees the focus to be on equipment rather than therapy. Mr. McCoy believes we will have at-risk patients as early as January 1st when their home care provider no longer exists and patients will not have access to professional help.

Mr. McCoy believes the Homecare industry will lose $600-700 million dollars the first year. 25% of oxygen patients will be capped out. Concentrators don't seem to last a full five years and there's no track record for concentrators made in China. It is expected patients will have exacerbations, develop pneumonia and return to hospitals. More patients will die in those 36 months. Dr. Selecky added that patients on continuous oxygen therapy generally live 3 years or less.

Miriam O'Day advised that the only thing that will change CMS's mind regarding the 36 month cap is documented patient harm. She offered her assistance to work with BOMA on appropriations language for oxygen therapy data.

Past President Toni Rodriguez advised members that the Board asked Dr. Carey to bring this issue to BOMA. She stated AARC has a research fund in place for adequate proposals, however the BOD requested BOMA's input on feasibility and suggestions on how it might be accomplished.

Toni Rodriguez summarized that there are two issues; durable medical equipment and patient car. AARC supports those who provide durable medical equipment to our patients, however, the priority of the Association is to advocate for quality patient care. Conducting a literature search may be viable in that it may at least identify those items already accomplished and then identify the items that need to yet be accomplished. Implementing some research projects and working with Miriam O'Day for Federal appropriations language is an option. Education of therapists is necessary for those working in a hospital who do not have a clear understanding of home care. Also needed are education initiatives at the physician level.

COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (COARC) REPORT

CoARC Chair Shelley Mishoe and CoARC Executive Director Tom Smalling advised BOMA that at their November CoARC Board meeting members unanimously voted to separate from CAAHEP. The target date to complete the process is January 15, 2010. Their name will change to Commission on Accreditation for Respiratory Care.

Toni Rodriguez advised BOMA the AARC Board passed a motion to support this action.

CoARC would transition from CAAHEP to CHEA, an organization recognizing excellence. Six states would have issues with licensure to work with but their attorneys who are experienced with such transitions don't see this as a reason not to go forward with the decision. From an accreditation standpoint, there will be no adverse affects. There will be a few technicalities and unintended consequences affecting NBRC in that all admission requirements will need to be changed. The changes will require two readings 120 days apart with 2/3 majority. NBRC will go to a different accrediting agency once CoARC becomes separate.

NATIONAL BOARD FOR RESPIRATORY CARE (NBRC) REPORT

NBRC President Sherry Barnhart and Executive Director Gary Smith reported that in July, the proposed admission policy was approved upon 2nd reading. The applications for Federally registered trademarks for the credential acronyms have been filed; CRT-SDS (for certified) or RRT-SDS (for registered). The Adult Critical Care job Analysis committee developed their task survey which will be mailed to a random sampling. The NBRC Board approved new changes to the Continuing Competency program effective January 1, 2009. New proposals would allow RTs more options for those renewing or those whose credentials have expired.

RECESS

BOMA Chair, Terence Carey recessed the meeting of the AARC Board of Medical Advisors at 12:20 p.m. PST, Sunday, December 14, 2008.

RECONVENE

BOMA Chair, Terence Carey reconvened the meeting of the AARC Board of Medical Advisors at 12:50 p.m. PST, Sunday, December 14, 2008.

EXECUTIVE DIRECTOR REPORT

Sam Giordano thanked Dr. Carey for his leadership of BOMA in 2008 and his support of the AARC. He emphasized the importance of working on Part B next year stating that the more physician organization letters of support, the better. He added that Miriam O'Day and Cheryl West can follow up with sample letters for anyone wishing to send letters of support. Mr. Giordano advised that Long Term Oxygen Therapy is not a good fit with the DME benefit. Patients suffer, and DME companies are hurting. Patient groups have expressed a desire to partner with us on our 435 Plan. Sam met with the Senator that sponsored the sleep legislation that was passed who is formerly a nurse. She is receptive. He reiterated that physicians speaking for respiratory therapists is valuable in avoiding the perception of a turf issue between RTs and sleep specialists.

Miriam O'Day stated the Part B initiative will be introduced, but the question is whether it will have a vehicle. Chances are better with the new administration than the previous one. Cost is still reasonable and the climate is correct. The bill will be dropped in January.

Mr. Giordano advised that AARC will mount some significant recruitment efforts, and will also have dialogue with people in the military to ease into respiratory care on the civilian side. The Asthma Management course is complete and we expect to have that course laid out by the end of the month and put it on the road and on the internet. The Asthma Educator program has been successful and there are talks of a Certified COPD Educator program in the future. We had a quarter of a million downloads of the Aerosol

Delivery Device Guidance Document that was released in April of last year from the AARC website. We recently received funding for production of two more versions of the Aerosol Guidance Document. Version 2 will be for nurses, physicians, and pharmacists, and Version 3 for patients. We hope to roll those out in September of next year.

STATE GOVERNMENT AFFAIRS REPORT

Cheryl West reported that she was contacted by delegates from the state of Georgia with questions about who is appropriate to perform BIPAP and CPAP. Their attorney general replied by stating both must be performed by licensed respiratory therapists, which in turn prompted a letter from AASM. The Sleep people believe they should be licensed in the same manner as RTs which would then allow them the entire scope of practice. An update was provided regarding efforts by other disciplines – most notably sleep, but also perfusionists and EMS personnel to amend their scopes of practice in certain states. Of note, the state of North Carolina has adopted the AAR Uniform Reporting Manual as "best practices."

REGULATORY ISSUES UPDATE

Cheryl West stated Anne Marie Hummel is working with CMS on revising the definition of who can provide pulmonary rehab services. CMS will get clarification so that RTs aren't put in a position of being out of work. CMS contacted the regions and stated there is a position statement on 30-minute medication delivery in NC.

FEDERAL GOVERNMENT AFFAIRS REPORT

Miriam O'Day reported that her focus is on the Respiratory Therapy initiative. She is also involved with pulmonary rehab and the coding issue that discusses who is eligible to practice and receive pulmonary rehab. AARC's PACT meeting will be held March 9-10. November was national and international COPD Day. She also advised that we received a professional judgment from CDC for a COPD designation. ATS, ACCP, NAMDRC, AACVPR, and ALA are all supportive of this. NHLBI is committed to go into phase 2 of the public relations campaign for COPD. The new contract begins in January and runs a 3-year cycle.

OUTGOING PRESIDENTS REPORT

Past President Toni Rodriguez stated that she appreciated BOMA's work and its rapid turnaround. She feels the relationship between BOD and BOMA has strengthened in recent years. Dr. Carey stated that the BOD looks upon Toni Rodriguez as a true leader and she has done an excellent job of representing the Association these past few years.

AARC BOARD REFERRALS

Guidelines for Respiratory Care Department Protocol Program Structure

Toni Rodriguez stated that problems in some states arose when JCAHO came to hospitals to perform their evaluations. They were dinging some of the hospitals about protocols not requiring physician approval of each step along the protocol. It was a matter of individual site visitors misinterpreting what JCAHO was looking for. So we began looking at the entire topic, and appointed an ad hoc committee to look at guidelines that any hospital could use in evaluating their protocol program. It made us aware we did not have such guidelines. Rick Ford, Chair of the Ad Hoc Committee brought forward this document. Before putting final touches on it, the Board wanted BOMA's opinion of the document. The Board did decide that it will be a white paper with references added to it. Dr. Carey requested a copy of the final draft of the protocol document to share with BOMA.

Dr. Elwood moved "To return the 'Guidelines for Respiratory Care Department Protocol Program Structure' document with suggestions from BOMA and that additional comments could be made at a later date by e-mail directed to Tim Myers or Toni Rodriguez. BOMA will vote on the final revised document by e-mail."

Motion Carried

RECESS

BOMA Chair, Dr. Terence Carey recessed the meeting of the AARC Board of Medical Advisors at 2.00 p.m. PST, Sunday, December 14, 2008.

RECONVENE

BOMA Chair Dr. Terence Carey reconvened the meeting of the AARC Board of Medical Advisors at 2:10 p.m. PST, Sunday, December 14, 2008.

PRESIDENT'S REPORT

2009 AARC President Tim Myers stated that the Association holds BOMA in high esteem for its work in assisting AARC, and he will begin to motivate the House of Delegates to rely on BOMA as well. His 2009-10 goals reflect a return to core values and he will use the mission and vision statement as a roadmap to success to move the profession forward with a "patients first, then respiratory therapists" attitude. AARC formed relationships with affiliated groups who will help with the Part B initiative. The first conference of the 2015 and Beyond program studied where the RT will be in 2015 and beyond. The conference manuscript will be published in the March 2009 issue of

RESPIRATORY CARE, AARC's science journal. The Learning Institutes chaired by Toni Rodriguez was created to mentor and develop managers in management, education, and research. President Myers reported that many of AARC's published materials are translated into other languages. He will continue to broadcast the benefits of the Journal which continues to receive more international submissions.

2015 AND BEYOND UPDATE

Dr. Woody Kageler reported briefly on the second conference of the 2015 and Beyond project stating this will probably be the most difficult of the three conferences as it will address controversial questions such as levels of education and whether it is an internship type of arrangement. The Planning Committee is currently working on selection of speakers.

MILITARY UPDATE

Assistant Director of the Respiratory Therapy School at Fort Sam Houston, Harry Roman, MA, RRT, thanked BOMA for its support the last few years, especially in obtaining CoARC accreditation. He advised that in 2011 Fort Sam Houston will be the largest allied health school in the world as they are in the process of building roads and erecting buildings in anticipation of this. They will also have a cadaver lab. They will begin joint training with the NAVY and later become interservice. The military is currently looking for a college that will provide all the core training they will need which will be packaged into an entry level 2-year degree. Then they will need a bachelors degree and officer status.

MEDICAL ADVISORS REPORTS

ASA
Dr. Elwood stated ASA is actively pursuing new people of a younger age as the age of current members has risen.

NAMDRC
Dr. Selecky directed members to his written report included in book as well as inclusion of the Watchline.

SECTION REPORTS

Dr. Cliff Boehm stated he would like to see the number of members from each of the sections.

NEW BOMA MEMBERS

Dr. Phil Korenblat will begin his term on BOMA in 2009 representing AAAAI. Also joining BOMA is Dr. Robert Aranson representing ACCP.

BOMA CHAIR ELECT 2010

Dr. Elwood moved "To nominate Dr. Cliff Boehm as the Chair-elect to begin his term in 2010."

Motion Carried

LONG TERM OXYGEN THERAPY

BOMA Chair Dr. Terence Carey brought back the issue of Long Term Oxygen Therapy and engaged discussion from members. After much discussion it was agreed that a small conference was the preferable course of action, with representation from all necessary players.

Toni Rodriguez provided a summary of the LTOT discussion that she will take back to the Board as follows:

- This is a Project on which AARC should take the lead;
- BOMA Supports conducting a small conference;
- Ask representatives from ATS, ACCP, AAP and NAMDRC, and that the reps would Participate;
- 7 physicians 5 therapists (as neutral as possible) to review literature;
- Approach is that oxygen therapy is beneficial, but focus on literature and define standards for application as well as standards for equipment and equipment design;
- Does the RT add value;
- Should be implemented in a timely manner but understand the process will define its own timeline. Should not designate a specific timeline based upon political expediency;
- Explore the possibility of AARC funding, or unrestricted grants. Avoid industry money to avoid the perception o a self-serving study.

Dr. Selecky moved "To approve BOMA's comments on an LTOT Small Conference with AARC taking the lead and including physicians from ATS, ACCP, NAMDRC, AAP, American College of Physicians, American Academy of Family Practice and respiratory therapists to be taken back to the Board of Directors of the AARC and the Boards of the participating sponsoring organizations for approval."

Motion Carried Unanimously

NEXT MEETING DATE

BOMA Chair, Dr. Terence Carey advised members the next meeting will be held June 6 in Dallas with a reception to occur the evening prior.

APPRECIATION

BOMA Chair Dr. Carey expressed his appreciation of Toni Rodriguez and Sam Giordano, as well as the physicians who take valued time out of their schedules to attend these BOMA meetings. He also thanked Brenda DeMayo for her assistance.

The membership joined Dr. Kent Christopher in thanking Dr. Carey for his Chairmanship this past year.

ADJOURNMENT

BOMA Chair, Dr. Terence Carey adjourned the meeting of the AARC Board of Medical Advisors at 4:15 p.m. PST, Sunday, December 14, 2008.

Date Submitted: March 1, 2009

Committee/Section: Presidents Council

Representative: Dianne Lewis

Charges:

None

Recommendations:

That the AARC Program Committee establish the Barry Shapiro,MD Lecture to be held every year at the International Congress

Justification: The Presidents Council feels strongly we need to honor the memory of Barry Shapiro,MD. We would like a lecture and award to be established similar to the Egan and Kittredge Lectures(to include honrarium,plaque and lecture). The lecture should be either a topic pertaining to Medical Direction of Respiratory Care or diagnostic therapeutics of Respiratory Care. The following criteria will be utilized to choose the indiviual who will receive the award.

1. Has been a Medical Director of a Respiratory Department or program for at least 15 years.
2. Be a member of the AARC for 15 years.
3. Be an advocate for the respiratory therapist and the profession on a local and national basis.
4. Be a role model for future Medical Directors of Respiratory Care.
5. Participate in research in the area of pulmonary medicine, diagnostic respiratory care, or respiratory education.

Report:

The Presidents Council had a busy meeting in Anaheim. Fourteen past presidents attended. We discussed the Shapiro award and the AARC Historian position. We are in process of finalizing the Jimmy A. Young medal winner. We are revising policies that govern our awards and developing the Historian job description with the assistance of Bob Wielacher and Trudy Watson. Bob also made a trip to Dallas this spring and met with Sam.

Other:

At this meeting we need to request nominees from the BOD for Life and Honorary members. I have included the criteria, list of previous winners and the Presidents Council revised policy.

File Attachment: Presidents Council1.doc

File Attachment: Presidents Council2.htm

CRITERIA

Candidates for AARC Life Membership

1. Must be and have been an active member (one who has the right to vote and hold office) of the AARC for a period of at least fifteen (15) years.

2. Must have served in the AARC in an official capacity, i.e., national officer, Board member, committee chair or member, House of Delegates, etc., for at least seven (7) years, not necessarily consecutively.

3. Must have made an extraordinary contribution to the AARC and its affiliates.

4. Must have been active in affiliate operations and have served in an official capacity at the affiliate level.

Candidates for AARC Honorary Membership

1. Must have been active in AARC affairs for a period of at least ten (10) years or worked in a field related to the goals of the Association for at least ten (10) years.

2. Must otherwise be eligible for associate membership in the AARC at the time of consideration.

3. Must have made a special achievement, performance, or contribution to the AARC, its affiliates, the NBRC, ARCF or the profession of respiratory care.

Candidates for the Jimmy A. Young Medal

1. The Young Medal is awarded to an individual who has made "... meritorious contributions to the AARC and to the advancement of respiratory care."

From: Dianne Lewis [dlewis53@gmail.com]
Sent: Monday, June 30, 2008 4:39 PM
To: AARC Presidents Council
Subject: Life and Honorary members amended motion
Following is the amended motion. Please vote yea or nay. Votes need to be returned to me by July10,2008. Thanks, Dianne

That the Presidents Council award Life and Honorary membership. There will be no more than one Life and one Honorary member awarded each year excluding the Past President. The Past President will be awarded Life membership immediately following his|her term as Past President. The Council is not mandated to elect Life and Honorary members each year if they so choose.

STANDING COMMITTEE REPORTS

Date Submitted: March 3, 2009

Committee/Section: Bylaws

Representative: Keith Siegel

Charges:

1. Review amendments proposed by the Board of Directors, House of Delegates or Chartered Affiliates and submit its recommendations to the proponent.
2. Review Chartered Affiliate bylaws according to the established staggered schedule in which all are reviewed every 5 years for compliance with the AARC bylaws. a. Affiliate bylaws will only be reviewed for compliance with AARC bylaws. Errors in grammar, spelling, or internal inconsistencies will be the responsibility of the Chartered Affiliate. The Bylaws Committee may make recommendations regarding grammar, spelling, or internal inconsistencies but will not delay the approval process over such issues. b. Affiliate Bylaws will be considered in conflict with the AARC bylaws if non-AARC members are allowed to vote and/or hold a voting position on the Affiliate°¶s Board of Directors. c. Affiliate Bylaws will be considered in conflict if Active members of the Chartered Affiliate are not Active members of the AARC.

Recommendations:

The AARC Bylaws committee recommends that the AARC Board of Directors approve the proposed changes to the Louisiana Society for Respiratory Care's bylaws.

Report:

Having reviewed the proposed changes to the bylaws of the Louisiana Society for Respiratory Care, the AARC Bylaws Committee finds that they are in compliance with the AARC bylaws (see attached).

Other:

The Bylaws Committee Chair is working with the Executive Office to determine which state affiliates are due for bylaws review.

File Attachment: Bylaws1.doc

Louisiana Society for Respiratory Care

February 11, 2009

AARC Bylaws Committee

To Whom It May Concern:

Proposed LSRC Bylaws Amendments

The LSRC Board of Directors would like to present the following proposed amendments to the LSRC Bylaws. The rational for the changes follows:

- To allow BOD members to hold an elected office for two years, and allow elections to take place every two years, following the policies of the AARC.
- To allow the boundaries of the state chapters to be easily redrawn after a shift in population such as what we experienced after the 2005 and 2007 hurricane season.
- To allow many of the time frames for nominations and reporting to be removed from the Bylaws and placed in the Policy and Procedure Manual
- To change the Judiciary/Advisory Committee to the Respiratory Care Advisory Committee and make the committee description fit the language of the new Practice Act for RT in the state of Louisiana
- To no longer allow voting via proxy at the meetings to be in line with AARC bylaws

If you have any questions about the proposed amendments, please contact me via e-mail at adulle@lsuhsc.edu or by phone at 318-813-2935. Please note that text that is underlined in the proposal are words being added and text that is striken through is being deleted.

Thank you for your hard work and dedication to this committee. We look forward to hearing your response on this matter. Have a fabulous day!

Ashley Dulle, BS, RRT, AE-C
Chairman, LSRC Bylaws Committee
LSRC President 2009

Louisiana Society of the American Association
for Respiratory Care
Bylaws

Approved: July 27, 1974---------Effective January 1, 1975

Amended: April 19, 1985

Amended: February 1, 1991

Amended: November 15, 1994------Effective January 1, 1995

Amended : Sept. 26 1998-------Effective January 1, 2000

Amended: August 28, 2000-------Effective January 26, 2001

ARTICLE I
NAME

This organization shall be known as the Louisiana Society of the American Association for Respiratory Care, a chartered affiliate of the American Association for Respiratory Care, hereinafter referred to as the "AARC", which is incorporated under the General Not For Profit Corporation Act of the State of Illinois. The Louisiana Society is incorporated under the General Not-For-Profit Corporation Act of the State of Louisiana.

The short name of this organization shall be the Louisiana Society for Respiratory Care, and shall hereinafter in these Bylaws be referred to as the "Society".

ARTICLE II
BOUNDARIES

The area included within the boundaries of this Society shall be the boundaries of the State of Louisiana.

ARTICLE III
OBJECT

Section 1.Purpose

a.To encourage and develop on a regional basis educational programs for those persons interested in the field of Respiratory Care.

b.To advance the science, technology, ethics, and art of Respiratory Care through regional institutes, meetings, lectures, and the preparation and ~~distribution of newsletters~~ *up keep of website* and other materials.

c.To facilitate cooperation between Respiratory Care personnel and the medical profession,

hospitals, service companies, industry, and other agencies within the State interested in Respiratory Care; except that this Society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Illinois in which the parent Association is Incorporated, or any other state.

d. To provide education of the general public in pulmonary health promotion and disease prevention.

Section 2.Intent

a.No part of the net earnings of the Society shall inure to the benefit of any private member or individual, nor shall the corporation perform particular services for individual members thereof.

b.Distribution of the funds, income, and property of the Society may be made to charitable, educational, scientific, or religious corporations, organizations, community chests, foundations or other kindred institutions maintained and created for one or more of the foregoing purposes if at the time of distribution the payees or distributees are exempt from income taxation under the provisions of Section 501, 2055, and 2522 of the Internal Revenue Code, or any later or other sections of the Internal Revenue Code which amend or supersede the said sections.

ARTICLE IV
MEMBERSHIP

Section 1.Classes

The membership of this Society shall include three classes: Active Member, Associate Member, and Special Member.

Section 2.Eligibility and Classification

a.Membership eligibility and classification shall be established in accordance with Article III of the AARC Bylaws.

b.Only members in good standing of the AARC shall be members of this Society with the exception that the AARC Board of Directors may confer Honorary or Life Membership.

Section 3.Annual Registration

Each Society member must annually reassert AARC membership by whatever means the AARC Board of Directors deems appropriate.

ARTICLE V
OFFICERS AND DIRECTORS

Section 1.Officers

The officers of the Society shall consist of President, President-Elect, Immediate Past President, Vice-President, Secretary, and Treasurer.

Section 2. Directors-at-Large

a.There shall be ~~three (3)~~ *four (4)* Directors-at-Large. ~~One (1)~~ *Two (2)* Director*s*-at-Large shall be elected ~~each year~~ *every two year*s and such others as necessary in order to fill existing vacancies.

b.When multiple vacancies are being filled, the member with the most votes shall fill the longest term, the member with the second highest number of votes shall fill the next longest term, and so on according to the number of votes received.

Section 3.Chapter Representation

Each Chapter shall be represented on the Board of Directors by the Chapter President.

Section 4.Term of Office

a.The term of office for Society Officers shall be for ~~one (1) year~~ *two (2) year* term. The term shall begin immediately following the Annual Business Meeting following their election.

b.The ~~President and~~ President-Elect shall not serve more than one (1) consecutive term in the same office.

c.The Vice President, and Secretary, and the Treasurer shall not serve more than three (3) consecutive terms in the same office.

d.The term of office for Directors-at-Large shall begin immediately following the Annual Business Meeting following their election and shall be for a ~~three (3)~~ *four year term* nonrecurring term of office.

Section 5.Vacancies in Office

a.In the event of a vacancy in the Office of President, the President-Elect shall become acting President to serve the unexpired term and shall serve the successive term as President.

b.In the event of a vacancy in the office of President-Elect, the Vice-President shall assume the duties, but not the office, of President-Elect as well as the Vice-Presidency until the next meeting of the Board of Directors at which time the Board shall elect a qualified member to fill the vacancy. This individual shall serve the remainder of the term as President-Elect and then accede to President for a regular term as if elected by the membership.

c.In the event of a vacancy in the office of Vice President, Treasurer, or Secretary, the Board of Directors shall elect a qualified member to fill the vacancy until the Annual Business Meeting following the next election.

d.In the event of a vacancy in the office of Immediate Past-President, that office shall remain vacant until filled by the normal process of Presidential succession.

Section 6.Duties of Officers

a.President

The President shall be the chief executive officer of the Society. The President shall preside at the Annual Business Meeting and all meetings of the Board of Directors and present an

annual report of the Society; prepare an agenda for the Annual Business Meeting and submit it to the membership via *the LSRC website* not fewer than thirty (30) days prior to such a meeting in accordance with these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board of Directors not fewer than fifteen (15) days prior to such meeting; appoint standing and special committees subject to the approval of the Board of Directors, and present an annual report of the Society's activities to the Board of Directors and the membership. The President shall automatically become and serve in the office of Immediate Past President following the completion of their *two year* term and perform such duties as assigned by the President with voting privileges.

b.President-Elect

The President-Elect shall become acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability; and shall perform such other duties as shall be assigned by the President, the Board of Directors, or elsewhere by these Bylaws. The President-Elect shall serve as Chair of the Nominations and Elections Committee. The President-Elect shall be a one year term.

c.Vice-President

The Vice-President shall assume the duties but not the office of the President-Elect in the event of the President-Elect's absence, resignation, or disability; and will also continue to carry out the duties of the Vice-President.

d.Treasurer

The Treasurer shall have charge of all funds and securities of the Society; endorsing checks, notes, or other orders for payment of bills; disbursing funds as authorized by the Board of Directors and/or in accordance with the adopted budget; depositing funds as the Board of Directors may designate. The Treasurer shall see that full and accurate accounts are kept, submit quarterly trial balances to the Executive Committee; make a written financial report to each meeting of the Board of Directors. At the expense of the Society, the Treasurer and all other signatories of Society (not Chapter) checks shall be bonded in an amount determined by the Board of Directors. The outgoing Treasurer shall automatically become Immediate Past Treasurer as a non-voting member of the BOD in order to insure smooth transition of all society finances. Immediate Past Treasurer may hold another concurrent office. The Treasurer, the President or the President-Elect shall be included on all Society's financial institute's signature cards.. All debt to accounts will require two signatures.

e.Secretary

The Secretary shall have charge of keeping the minutes of the regular meetings of the Board of Directors, the annual business meeting, and meetings of the Executive Committee; ~~submitting a copy of the minutes of every meeting of the governing body and other business of the Society to the Executive Office of the AARC within ten (10) days following the meeting~~; executing the general correspondence; affixing the corporate seal on documents so requiring; and in general, performing all duties as from time to time shall be assigned by the President or the Board of Directors.

f. Immediate Past President

The Immediate Past President shall serve on the executive committee with voting privileges and assist in formulation of the LSRC annual budget and also serve on the Legislative Committee.

ARTICLE VI
NOMINATIONS AND ELECTIONS

Section 1.Nominations

a.Calendar of Nominations Process

i.Nominations shall open not later than May 15~~, and shall remain open for at least twenty-five (25) days and not more than sixty (60) days~~.

ii.The Nominations Chairperson shall report the slate of nominees to the Board of Directors not later than August 15 for their approval.

iii.On written petition of ten (10) or more Active members filed at any office of the Society, no later than September 1, any other member or members eligible to hold office will be added to the approved slate.

iv.The Nominations Committee shall present the slate of nominees to the Elections Committee no later than September 15.

v.Ballots shall be mailed to the membership no later than October 10. The membership shall have no less than twenty-five (25) calendar days to return their ballots.

vi.Returned ballots must be postmarked not later than November 10.

b.The Nominations Committee shall determine the eligibility of all nominees. Only Active or Life members may be candidates.

c.The Nominations Committee shall name at least two (2) nominees for all Offices, Board of Directors positions, and vacancies.
i.If, despite every reasonable effort, the Nominations Committee is unable to assemble a slate with at least two (2) candidates for each position, the Board of Directors may authorize publication of a ballot with only one (1) candidate for some or all of the positions to be filled.
ii.If, despite every reasonable effort, the Nominations Committee is unable to solicit any nominee for any position(s), the Board of Directors shall appoint a qualified member to serve the next term.

Section 2. Ballot

a.The Nominations Committee's slate and biographical sketches shall be mailed to every Active or Life Member in good standing according to the last available membership galley at the time of mailing at their last address on the record of the Society not later than October 10.

b.The Ballot shall be so designed as to be a secret mail ballot with provisions for write-in votes for each office. Ballots, to be acceptable, must be postmarked by the stipulated deadline date, which shall be no later than November 10. The deadline date shall be clearly indicated on the ballot.

Section 3. Elections Committee

The President shall appoint an impartial Election(s) Committee which shall prepare the ballots, conduct the election, check the eligibility of each returned ballot and tally the votes not later than November 20. The results of the election shall be announced at the last regular Board of Directors meeting of the calendar year.

ARTICLE VII
BOARD OF DIRECTORS

Section 1.Composition and Powers

a.The executive government of this Society shall be invested in a Board of Directors of no fewer than twelve (12) members and no more twenty (20) voting members consisting of the Officers, Delegates, and Directors-at-large (as defined in Article V, Sections 1 & 2) and the President of each chapter (as defined in Article XII, Sections 3 & 5).

b.The President shall be Chairperson and presiding officer of the Board of Directors and the Executive Committee. The President shall invite in writing such individuals to the meetings of the Board of Directors as deemed necessary, with the privilege of voice but not vote.

c.The Board of Directors shall have the power to declare an office vacant by a two-thirds (2/3) vote, upon refusal or neglect of any member of the Board of Directors to perform the duties of that office, or for any conduct deemed prejudicial to the Society. Written notice shall be given to the member that the office has been declared vacant.

d.The Society's Medical Director and Immediate Past Treasurer shall be non-voting members of the Board of Directors.

e.No Board of Directors member may hold concurrent Board of Directors-level elective offices. This limitation does not preclude Board of Directors members from holding chapter offices other than Chapter President.

Section 2.Duties

a.Supervise all business and activities of the Society within the limitations of these Bylaws.

b.Adopt and rescind standing rules of the Society.

c.determine remuneration, stipends, the amount of membership dues for the following year, and other related matters, after consideration of the budget.

d.Receive and act upon the reports and recommendations of the special and standing committees.

Section 3.Vacancies

a.Any vacancy that occurs on the Board of Directors, with the exception of the President, Immediate Past President, Immediate Past Treasurer, Delegates and the Chapter Presidents, shall be filled by qualified members elected by the Board of Directors. Individuals so elected shall serve until the Annual Business Meeting following the next annual election.

b.An elected President-~~Elect~~ shall serve until the Annual Business Meeting following the next annual election and then accede to the~~ Presidency.~~ *Past President*

c.In the event of a vacancy among the Chapter Presidents, the respective Chapter(s) shall fill the vacancy through their defined ascendancy process. This individual must be eligible to be a member of the Society's Board of Directors. In the event the chapter fails to name a replacement, the Board of Directors shall appoint a qualified member ~~from within the geographic boundaries of the respective chapter. Failure to name a replacement in this circumstance will not open the chapter to possible dissolution.~~

Section 4.Meetings

a.The Board of Directors shall meet as part of the Annual Business Meeting of the Society and shall not hold fewer than two (2) regular and separate additional meetings during the calendar year. The planned dates and locations of these additional meetings shall be presented at the Annual Business Meeting. In the event of an emergency or unexpected circumstances, the date and location of these additional meetings may be changed, provided the members of the Board of Directors are given at least fifteen (15) days notice of the new date and location; or the business of the scheduled meeting may be conducted by mail vote in accordance with Section 5 of this Article.

b.Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society shall require, or upon written request of three (3) members of the Board of Directors filed with the President and Secretary of the Society.

c.A majority of the voting members of the Board of Directors shall constitute a quorum at any meeting. ~~If any voting member of the Board of Directors is unable to attend a meeting of the Board of Directors, that voting member may convey to any member of the Board of Directors a proxy granting that individual authority to for the absent voting member. Except in the most extenuating circumstances, the proxy should be written and specify the meeting for which it is intended. Proxies shall be counted in determining the presence of a quorum. Each member of the Board of Directors may carry only one proxy at any meeting.~~

Section 5.Mail Vote

Whenever, in the judgment of the Board of Directors, it is necessary prior to the next regular or annual business meeting, the Board of Directors may, unless otherwise required by these Bylaws, instruct the Elections Committee to conduct a vote of the membership by mail. The question thus presented shall be determined according to a majority of the valid votes received by mail within thirty (30) days after date of such submission, except in the case of a change in the Bylaws when a two-thirds (2/3) majority of the valid votes received is required. Any and all action approved by the members in accordance with the requirements of the Bylaws shall be binding upon each member of the Society.

Section 6.Executive Committee

The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Vice-President, Immediate Past-President, Secretary, Treasurer and Immediate Past Treasurer. The Immediate Past Treasurer is a non-voting member. The Executive Committee shall have the power to act for the Board of Directors and such action shall be subject to ratification by the Board at its next meeting. The Executive Committee shall also function as the Budget and Audit Committee.

ARTICLE VIII
ANNUAL BUSINESS MEETING

Section 1.Date and Place

a.The Society shall hold an annual business meeting within sixty (60) days following the end of each calendar year.

b.The date and place of the annual business meeting shall be decided in advance by the Board of Directors. In the event of a major emergency the Board of Directors shall cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by mail provided the material is sent in the same words to the voting membership.

Section 2.Purpose

The Annual Business Meeting shall be for the purpose of installation of the new Board of Directors, receiving reports of officers and committees, and for other business brought by the President.

Section 3.Notification

Written notice of the time and place of the Annual Business Meeting shall be sent to all members of the Society, or published in an official Society publication which is mailed to all members, *or posted on LSRC website* not fewer than ninety (90) days prior to the meeting. An agenda for the Annual Business Meeting shall be likewise distributed to the membership not fewer than thirty (30) days prior to the meeting.

Section 4.Quorum

A majority of the voting members registered at a duly called Annual Business Meeting shall constitute a quorum. ~~Proxies will not be recognized at the Annual Business Meeting.~~

ARTICLE IX
SOCIETY DELEGATES TO THE AARC HOUSE OF DELEGATES

Section 1.Election

a.Delegates of this Society to the House of Delegates of the AARC shall be elected as specified in Article VII of the AARC Bylaws.

b.To be nominated for the position of Delegate from this Society the nominee must attend a minimum of 75% of all Society Board of Directors meetings for two years prior to their vying for said position.

c.The society's delegation will consist of up to three delegates, one of whom may be the President. If the President selects a designee, he or she must be a member elected by the entire membership of the LSRC. For the other members of the delegation, one will be elected every two years for a four year term. The delegates will be limited to five consecutive terms.

Section 2.Duties

The duties of the Delegates shall be as specified in the Bylaws of the AARC.
The Delegate on their 3rd or 4th year in elected office shall actually prepare all reports for the society and act as a mentor to other society delegates and cast the LSRC's vote while the house is in session. In the absence of the delegate in their 3rd or 4th year the delegate in their 1st or 2nd ` year of elected office will assume the afore mentioned responsibilities. The 1st/2nd year and 3rd/4th year Delegate shall serve as Co-Chair's of the Fundraising Committee for the Society.

Section 3.Board Member

The Delegate*s* shall be voting members of the Society Board of Directors.

Section 4.Multiple Offices

Elected Delegates may not hold concurrent elective offices.

Section *5*.Vacancy

a In the event of a vacancy in the position of Delegate, the Board of Directors may designate a qualified member to fill the role but not the office of Delegate until the next annual election..

b.The President may be designated to attend the House of Delegates in the place of any of the Delegates if they are unable to attend. In the event the President is seated in place of the 3rd or 4th year Delegate the1st or 2nd year delegate shall be the lead member of the delegation.

ARTICLE X
COMMITTEES

Section 1.Standing Committees

The members of the following Standing Committees shall be appointed by the President, subject to the approval of the Board of Directors, to serve for a term of ~~one (1~~*) two (2)* years.

a. Membership
b. Budget and Audit
c. Elections
d. ~~Judicial/Advisory~~ Respiratory Care Advisory Committee
e. Nominations
f. Education

----1. Program
----2. Scholarship
----3. Pelican Bowl
---4. *Pioneer*
g. Bylaws
h. Public Relations
----1. Publications
----2. Chapter Affairs
i. Legislative
j. Fundraising

Section 2. Special Committees and Other Appointments
Special committees may be appointed by the President to carry out specific tasks.

Section 3. Committee Chairperson's Duties

a.The Chairperson of each Committee shall confer promptly with the members of the committee on work assignments. *If a committee has written policies or procedures they will reviewed and approved by the BOD annually*

b.The Chairperson of each committee may recommend prospective committee members to the President. When possible, the Chairperson of the previous year shall serve as a member of the new committee. The Chairperson shall submit a written report to the President and Secretary of the Society at ~~least ten (10) days prior to~~ each Board of Directors meeting.

c.Nonmembers or physician members may be appointed as consultants to committees.

d.Each committee Chairperson requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee at least ninety (90) days prior to the annual business meeting.

ARTICLE XI
DUTIES OF COMMITTEES

Section 1.Membership Committee

a.This committee shall consist of one (1) member of the Board of Directors and one (1) member from each chapter.

b.This committee shall encourage recruitment and retention of applicants for membership in the AARC and report to the Membership Committee of the AARC as required by the AARC Bylaws.

Section 2.Budget and Audit Committee

a.This committee shall be composed of the Executive Committee and the Medical Advisor(s).

b.The Budget and Audit Committee proposes an annual budget for approval by the Board of Directors. The budget shall then be submitted to the Society ~~newsletter~~ *website* for publication at ~~least thirty (30) days~~ prior to the Annual Business Meeting.

Section 3.Elections Committee

a.This committee shall prepare, receive, verify, and count ballots for all elections held during the calendar year.

b. This committee shall consist of at least five (5) voting members of the Society. No member of this committee is eligible to be placed on a Society ballot during their term on the committee, although they will remain eligible to run for chapter offices other than Chapter President. Members of the Board of Directors may be on, or chair, the Elections Committee provided they are not in their final year of their term or are willing to decline all nominations for the year(s) they serve on this committee. This committee shall be chaired by the President- Elect.

c.This committee will work in conjunction with the Nominations committee for the timely election of officers. The ballots shall be true secret ballots, with the process completed within the time frames defined in Article VI of these Bylaws.

d.It shall be the duty of the Chair of the Elections committee to notify the various candidates of the results of the election not later than November 27. If the Chair is unable to reach any of the candidates by this date, the President of the Society shall be notified immediately.

Section 4.~~Judicial/Advisory Committee~~ Respiratory Care Advisory Committee

a. This committee shall consist of ~~four (4)~~ six (6) members. These ~~four~~ six members shall be the Respiratory Therapists represented on the Respiratory Care Advisory Committee of the Louisiana State Board of Medical Examiners.

~~b. This Committee shall receive written complaints against any individual Society member charged with any violation of the Society or AARC Bylaws, the Respiratory Care Practice Act of the State of Louisiana or any of its associated rules and regulations, or otherwise with any conduct deemed detrimental to the Society, or the AARC, the profession, or patient/public welfare. Complaints related strictly to violation of Society or AARC rules will be referred to the AARC Judicial Committee for consideration of appropriate actions. Complaints relative to public or patient welfare or violations of State law will be referred to the Respiratory Advisory Committee of the Louisiana State Board of Medical Examiners for evaluation and any appropriate action. Any action taken by the Louisiana State Board of Medical Examiners will be reported to the AARC Judicial Committee.~~

b. This Committee shall:

(1) Advise the board on issues affecting applicants for licensure and regulation of respiratory therapy in the state.

(2) Provide advice and recommendations to the board regarding the modification, amendment, and supplementation of rules, regulations, standards, policies, and procedures for respiratory therapy licensure and practice.

(3) Serve as liaison between and among the board, licensed respiratory therapists, and professional organizations.

(4) Review and advise the board on issues affecting requests for temporary licenses.

(5) Conduct audits on applications to ensure satisfactory completion of continuing education and competency as specified by the board's rules.

(6) Perform such other functions and provide such additional advice and recommendations as may be requested by the board.

Section 5.Nominations Committee

a.This Committee shall prepare for approval by the Board of Directors a slate of candidates for officers, delegates, directors-at-large, and Chapter Presidents for the annual election.

b.The Committee shall be chaired by the President-Elect and consist of at least four (4) Active Members, with a least one (1) Active Member from each Chapter, who shall serve for a term of one (1) year.

c.It shall be the duty of this Committee to solicit nominations from the membership, determine the eligibility to hold office of each submitted nominee, prepare a slate of those nominees who meet the criteria for eligibility to hold office, present the slate to the Board of Directors for review and approval, and collect the information for the biographical sketches to be included with the Ballot. These obligations shall be accomplished in accord with the time frames defined in Article VI of these Bylaws.

d.The Nominations Committee shall work closely with the Elections Committee in processing ballot distribution.

Section 6.Education Committee

a.This Committee shall consist of at least six (6) members and be so constructed as to provide experienced members for program and education planning.

b.The Medical Advisor(s) will be a consultant member of the Committee.

c.The Committee shall encourage and assist Chapters in the efforts to conduct educational programs and maintain a list of educational materials for the Society.

d.There will be three subcommittees of the Education Committee. These committees are Program, Scholarship, *Pioneer* and Pelican Bowl.

1.Program Subcommittee shall plan, coordinate, budget, implement and publicize the State Annual Meeting. Members shall be invited to join as need indicates.

2.Scholarship Subcommittee shall advertise, coordinate, and award the Society scholarships.

3.The Pelican Bowl Subcommittee shall plan, coordinate and implement the Pelican Bowl at the Society's annual meeting; complete all necessary correspondence with the teams, the Society and/or the AARC.

4. Pioneer Committee shall honor and induct new members.

Section 7. Bylaws Committee

a.This Committee shall consist of three (3) members, one (1) of whom shall be a Past-President, with one (1) member being appointed annually for a three (3) year term, except as is necessary to establish and maintain this rotation.

b.The Committee shall receive and prepare all amendments to the Bylaws for submission to the Board of Directors. The Committee may also initiate such amendments for submission to the Board of Directors.

Section 8.Public Relations

a. The Committee shall maintain such liaison as has been established by the Board of Directors with other organizations whose activities may be of interest to the members of this Society. This shall include the preparation of exhibits, programs, and other items to bring the message of respiratory care and the AARC to medical, nursing, and hospital groups as well as educational facilities where using such material can be expected to recruit new people to the field of respiratory care. Such material shall be subject to the approval of the Medical Advisor(s).

b. Coordinate state wide observances of the National Respiratory Care Week.

c. Delegate and maintain PR mailing list for State Society.

d. Establish correspondence with programs across the state and serve as a resource to them.

e. There will be two subcommittees of the Public Relations Committee. These committees are Publications and Chapter Affairs. Each subcommittee shall consists of at least three (3) members, one (1) of whom shall be a Past President, with members being appointed annually by the President for a one (1) year term, subject to reappointment.

1. The Publications Subcommittee shall concern itself with the execution of a Society ~~Newsletter~~ *Website* and all other publications of this Society with the public, hospitals, and other organizations through dissemination of information concerning respiratory therapy.

2. The Chapter Affairs Subcommittee shall receive applications for Chapters and review the proposed Policies and Procedures for compliance with the objectives of Section XII of the bylaws of the Society, and report its findings to the Board of Directors.

i. Review amendments to existing Chapter Policies and Procedures.

ii. Review the minutes of all meetings of the Chapter and advise the Chapter President and Secretary of any irregularities or other recommendations.

iii. Coordinates the Chapter of the Year Program as well as the Affiliate of the Year award program.

iv. Collect information on Respiratory Care Departments within the state which are undergoing any type of patient care restructuring; monitor statewide supply and demand trends and restructuring. Report this information to the Board of Directors.

Section 9.Legislative Committee

a.This committee shall consist of the President, Past-President, President Elect, President of Chapter VI and others as appointed by the chairperson. The chairperson shall be appointed by the President.

b.This Committee shall inform the Board of Directors of all legislative activity pertinent to the role of the respiratory care practitioners. The Committee shall communicate directly with the lobbyist and network all information to the Board of Directors.

Section 10. Fundraising Committee

a. This committee shall be chaired by the 1st/2nd year and 3rd/4th year Delegates. Committee members shall be appointed by the President.

b. The duties of this committee is to carry out fundraising activities as directed by the Executive Committee.

ARTICLE XII
CHAPTER ORGANIZATIONS

Section 1. Boundaries

The Society may be divided into a maximum of ten (10) chapters and no fewer than (3) chapters. *Boundaries of the chapters will be determined by the association's operating rules.*

~~a.Chapter One (I) boundaries comprise the Parishes of:~~
~~- Caddo~~
~~- Webster~~
~~- Red River~~
~~- DeSoto~~
~~- Claiborne~~
~~- Bossier~~
~~- Bienville~~

~~b.Chapter Two (II) boundaries comprise the Parishes of:~~
~~- Union~~
~~- Morehouse~~
~~- Jackson~~
~~- West Carroll~~
~~- Richland~~
~~- Franklin~~
~~- East Carroll~~
~~- Madison~~
~~- Tensas~~
~~- Ouchita~~
~~- Caldwell~~
~~- Lincoln~~

~~c.Chapter Three (III) boundaries comprise the Parishes of:~~
~~- Sabin~~
~~- Winn~~
~~- LaSalle~~
~~- Vernon~~
~~- Grant~~
~~- Concordia~~
~~- Avoyelles~~

- Natchitoches
- Rapides
- Catahoula

d.Chapter Four (IV) boundaries comprise the Parishes of:
- Beauregard
- Allen
- Jefferson Davis
- Calcasieu
- Cameron

e.Chapter Five (V) boundaries comprise the Parishes of:
- Evangeline
- St. Landry
- St. Martin
- Acadia
- Vermillion
- Lafayette
- Iberia

f.Chapter Six (VI) boundaries comprise the Parishes of:
- Point Coupee
- Iberville
- Ascension
- East Baton Rouge
- Washington
- Livingston
- West Baton Rouge
- St. Helena
- East Feliciana
- West Feliciana
- Tangipahoa

g.Chapter Seven (VII) boundaries comprise the Parishes of:
- Assumption
- St. James
- St. John the Baptist
- St. Mary
- Terrebonne
- St. Charles
- Lafourche

h.Chapter Eight (VIII) boundaries comprise the Parishes of:
- Jefferson
- St. Tammany
- St. Bernard
- Plaquemine

i.Chapter Nine (IX) boundaries comprise the Parishes of:
- Orleans

Section 2.Organization

The rules under which the Chapter is governed shall not be in conflict with these Bylaws.

Section 3.Officers and Chapter Representation

a.The President of each active Chapter shall be a voting member of the Society's Board of Directors.

b.The Active Members of this Society employed within the Chapter boundaries shall elect a President and Secretary and other officers as circumstances may require. The Secretary shall be the official correspondent for the Chapter to the Society.

c.The membership in a Chapter shall be determined by ~~place of employment~~ *address listed with AARC* with stipulations by petition.

Section 4.Activities

Each Chapter organization shall be encouraged to expand the membership of the Chapter and to develop educational activities and such other activities as is consistent with the Articles of Incorporation and these Bylaws.

Section 5.Responsibilities of the Chapter President

a.Represent the Chapter from which elected.

b.Submit a written report with three copies at each Board of Directors meeting, relating to the activities in the Chapter.

c.Carry out the duties and responsibilities as detailed in the Chapter Handbook.

Section 6.Chapter Admission Requirements

a.Ten or more Active Members of the Society meeting the requirements for affiliation may become a Chapter of the Society upon approval of the Chapter Affairs Committee, subject to ratification by the Board of Directors of the Society. Members of Chapters must be members of the State Society.

b.The formal application shall be sent to the Society's office and shall consist of a list of officers, membership, minutes of the organizational meeting, Chapter Bylaws, geographical location (by parishes) and a letter requesting approval of the proposed Medical Advisor.

c.Active Chapters are defined geographically in Article XII, Section 1. In addition, an active chapter must maintain no less than twenty (20) active members and must submit to the Nominations Committee no less than two (2) candidates for Chapter President.

Section 7.Duties

a.Two copies of the minutes of the governing body and business meetings of the Chapter shall be sent to the Society's Board of Directors ~~within ten (10) days~~ following the meeting: One copy shall be forwarded to the Society Secretary, the other to the Chairperson, Chapter Affairs

Committee.

b.The names and addresses of Officers and Medical Advisor shall be sent to the Society's office ~~within ten (10) days~~ following the meeting.

Section 8.Dissolution of Chapter

a.Any chapter which no longer wants to maintain its separate identity may petition to dissolve by simply failing to place into nomination potential president of that chapter.

b.The boundaries of that chapter shall then be incorporated into a neighboring chapter as determined by the Board of Directors and consent of the neighboring chapter.

ARTICLE XIII
SOCIETY MEDICAL ADVISOR

The Society shall have at least one (1) Medical Advisor who shall conform to Article X, Section 3 of the AARC Bylaws. Each Chapter shall have at least one (1) Medical Advisor. Together, they shall form a Board of Medical Advisors of which the Society Medical Advisor shall be Chairperson.

ARTICLE XIV
FISCAL YEAR

The fiscal year of this Society shall be from January 1 through December 31.

ARTICLE XV
DUES AND ASSESSMENTS

Section 1.Active, Associate Members ~~Employed~~ Within the Society's Boundaries

Society dues shall be considered paid in full upon payment of AARC dues. Compliance with Article III, Section 7, paragraph a, of the AARC Bylaws is required for Society membership.

Section 2.Active, Associate Members Not ~~Employed~~ Within the Society's Boundaries.
a. This is considered a separate state membership, in which does not qualify these members to vote for the AARC Delegation.

Annual Society dues for each category of membership other than Honorary and Life shall be determined for the following year by the Board of Directors after consideration of the budget.

Section 3.Assessments

The Society shall retain the right to assess fees if it is necessary to carry on local activities. The amount of this fee will be set by the Board of Directors yearly as needed.

ARTICLE XVI
ETHICS

If the conduct of any Society member shall appear, by report of the Society or the AARC Judicial Committee, to be in willful violation of the Bylaws or standing rules of this Society or the AARC, or prejudicial to this Society's interests as defined in the AARC Code of Ethics, the Board of

Directors may, by a two-thirds vote of its entire membership, suspend or expel such a member. A motion to reconsider the suspension or expulsion of a member may be made at the next regular meeting of the Board of Directors. All such suspension or expulsion actions shall be reported immediately to the AARC Judicial Committee.

ARTICLE XVII
PARLIAMENTARY PROCEDURE

The rules contained in Robert's Rules of Order Revised shall govern whenever they are not in conflict with the Bylaws of the Society or the AARC.

ARTICLE XVIII
AMENDMENTS

These Bylaws may be amended at any regular or called meeting or by mail vote of the Louisiana Society of the AARC by a two-thirds majority of those voting, provided that the amendment has been presented *or posted on website* to the membership in writing at least sixty (60) days prior to vote. All amendments must be approved by the AARC Bylaws Committee and shall become effective upon ratification by the AARC Board of Directors.

Date Submitted: March 6, 2009

Committee/Section: Election

Representative: Vijay Deshpande

Charges:

1. Screen candidates nominated for Director, Officer and Section positions.
2. Report the slate of nominees to the Board of Directors and House of Delegates by June 1, 2009.
3. The Elections Committee shall forward a roster of all nominees for the AARC Board of Directors to the current President, which would include all personal contact information for those individuals (i.e., e-mail, work address, work phone, etc.) for consideration in the committee appointment process.

Recommendations:

None.

Report:

BOD REPORT

Election Committee Chair (Vijay Deshpande)

The committee sent letters soliciting nominations for the following positions:

1. At-Large Members ---------- Letter sent to HOD on 2/17/2009
2. Officers ---------- Letter sent to BOD on 3/5/2009
3. Chair-elect---------- Letter sent to the membership of the Critical Care /Rehabilitation (CCR) Section on 2/26/2009
4. Chair-elect---------- Letter sent to the membership of the Neonatal-Pediatric Section on 2/26/2009
5. Chair-elect---------- Letter sent to the membership of the Home Care Section on 2/26/2009
6. Chair-elect---------- Letter sent to the membership of the Sleep Section on 2/26/2009

Once the nominations are received the committee will screen the candidates for Directors, Officers and specialty section Chair-elects. By June 1, the committee chair will submit the final slate of candidates to the BOD and HOD for their review. Upon approval from the BOD and HOD the committee will submit the slate to the general membership for voting.

The Election Committee will receive and verify all ballots. The ballots will be counted and the results will be reported at least 21 days prior to Annual Business meeting.

Other:

Date Submitted: February 22, 2009

Committee/Section: Executive

Representative: Tim Myers

Charges:

1. Act for the Board of Directors between meetings of the Board on all relevant matters as necessary.

Recommendations:

No recommendations at this time.

Report:

The Executive Committee will not meet until the evening prior to the start of the Board of Directors meeting in Dallas. A verbal report will provided.

Other:

Date Submitted: February 22, 2009

Committee/Section: Finance

Representative: Tim Myers

Charges:

1. Submit for approval the annual budget to the House of Delegates and the Board of Directors.
2. In conjunction with the Executive Office, identify a financial expert to be appointed by the President and ratified by the BOD in time for the 2009 audit process.

Recommendations:

Recommend that the AARC Board of Directors appoint Frank Salvatore as a special consultant to the AARC's Audit Subcommittee.

Report:

The Finance Committee will not meet until the evening prior to the start of the Board of Directors meeting in Dallas. A verbal report will provided.

Other:

Recommendation Rationale:
In efforts to avoid disenfranchising the HOD and violating the AARC Bylaws should an audit subcommittee member from the HOD be found in Conflict of Interest (COI) to participate, AARC President recommends that the AARC BOD consider this special appointment for 2009 until policies and procedures can be put in place to avoid this potential COI.

We will have a letter from AARC's legal counsel that address this concern for COI. We will also have both AARC legal counsel and our outside auditors at the AARC BOD meeting on Friday morning to discuss issues of COI.

**AUDIT COMMITTEE NOT AVAILABLE 3/12/09

Date Submitted: March 3, 2009

Committee/Section: Judicial

Representative: Patricia Blakely

Charges:

1. Review membership challenges, or complaints against any member charged with any violation of the Association°¶s Articles of Incorporation, Bylaws, standing rules, code of ethics, or other rules, regulations, policies or procedures adopted, or any conduct deemed detrimental to the Association.
2. Conduct all such reviews in accordance with established policies and procedures.
3. Determine whether complaint requires further action.
4. Understand the appeals process available to members.

Recommendations:

There are no recommendations at this time.

Report:

The Committee has not received any membership challenges or complaints at the time of submission of the report.

Other:

Program Committee
AARC Activity Report
Spring, 2009

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

Charges:

1. Prepare the Annual Meeting Program, Summer Forum, and other approved seminars and conferences.
   Status: The committee met in Dallas, TX on Feb. 26 – 28, 2009 to review over 300 proposals. All those who did not make the draft of the final program are to be notified in a timely manner. We are now starting to confirm those who made the latest draft. We are very grateful to all the individuals and groups that submitted Requests for Proposals and those who contribute to the different programs and activities. We are also very grateful for your support and trust to the Program Committee.

2. Recommend sites for future meetings to the Board of Directors for approval.
   Status: We are presently looking for sites for future meetings. The pros and cons of numerous possible locations were discussed.

3. Solicit programmatic input from all Specialty Sections and Roundtable chairs. Review with each section all selections pertaining to their specialty before finalization. The Program Committee decisions shall be final.
   Status: Proposals for the Summer Forum and the Congress from all Section Chairs were received. While some Specialty Sections and Roundtable chairs submitted substantial proposals, others provided minimum feedback. The Program Committee encourages input from all AARC member the create programs applicable to all aspects of Respiratory Care.

4. 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, 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.

Date Submitted: March 6, 2009

Committee/Section: Strategic Planning

Representative: Toni Rodriguez

Charges:

1. Review the Strategic Plan of the Association and make recommendations to the Board for any needed revisions or adjustments in the plan at the Spring 2009/10 Board of Directors Meeting.
2. Recommend to the Board of Directors the future direction of the Association and the profession of Respiratory Care.

Recommendations:

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 2009/10 Board of Directors Meeting" until the Summer 2009 BOD Meeting.

Rational:

The results of the first 2015 Conference were just released in the March 2009 issue of Respiratory Care providing insufficient time for a through review of the findings in light of our current Strategic Plan.

Report:

Charges:

1. Review the Strategic Plan of the Association and make recommendations to the Board for any needed revisions or adjustments in the plan at the Spring 2009/10 Board of Directors Meeting.

Action:

None taken as of March 6th 2009. See recommendation

2. Recommend to the Board of Directors the future direction of the Association and the profession of Respiratory Care.

Action:

Completion of this charge is dependent on completion of charge #1, therefore no action taken as of March 6th 2009.

Respectfully Submitted

Chair:
2009 - Past President
Toni Rodriguez EdD RRT

Committee Members:
2009 Speaker-elect
Tom Lamphere, BS, RRT, RPFT
2009 - Past HOD Speaker
Frank Salvatore Jr RRT
2009 VP Internal Affairs
George Gaebler, MSEd, RRT FAARC
2009 VP External Affairs
Joseph Lewarski, BS, RRT-NPS, FAARC
2009 Secretary/Treasurer
Karen J Stewart MS RRT FAARC
AARC Staff: TDB

Other:

SECTION REPORTS

Date Submitted: February 20, 2009

Committee/Section: Adult Acute

Representative: Michael Hewitt

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. Identify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section's web page and provide timely responses to requests for information from AARC members.
6. Implement the Specialty Section Charges as listed.

Recommendations: none

Report:

We are in the discussion stages of possibly establishing bth a swap shop and "roundtable" type activities on the Adult Acute Care site. Two well qualified and enthusiastic section members have stepped forward and expressed interest in being the point people for both of these. Once we gather more information and a plan & goals, we will approach the office and seek the appropriate input.

We remain under 2,000 section members at this time, but are actively seeking additional members with 2,00 being the next benchmark for the section.

Activity on the section site remains steady if not breakneck. Some of the decrease is related to the elimination of the blog like commentaries that we saw in the past. The results of that are less traffic but a higher quality discussion.

Other:

**CONTINUING CARE-REHAB REPORT NOT AVAILABLE 3/12/09

**DIAGNOSTICS REPORT NOT AVAILABLE 3/12/09

Date Submitted: February 21, 2009

Committee/Section: Education

Representative: Lynda Goodfellow

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. Identify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section°¶s web page and provide timely responses to requests for information from AARC members.
6. Implement the Specialty Section Charges as listed.
7. Develop a recruitment strategy directed at advanced degree or standing candidates (i.e. military personnel) as well as high-school students

Recommendations:

No recommendations at this time.

Report:

Activities related to above charges include:

1. Approximately 40 proposals were reviewed with a member of the program committee. A ranking of proposals in terms of interest/relevance and if proposal is best for Summer Forum or Congress meeting was completed.
2. Section Bulletin included a submission from the new chair in the Winter issue. Will submit another "Notes from the Chair by March 1. Will also continue to ask for a section member to assist editor of Education Annual as the Associate Editor.
3. On the list-serve, members were asked to submit how they are using resources produced by the AARC. This includes the use of CPGs in the classroom, legislative updates, etc. Also, members were asked what resources they would like to see developed in the future that would be useful in their practice. A list is being formed with the goal to have recommendations in the next BOD report.
4. "Advertising" for Associate Editor in Section bulletin. New coordinator for Summer Forum abstracts review committee recruited (Nancy Weissman) and will coordinate review of Summer absracts for upcoming meeting. Ms. Weissman replaces Dr. Ellen Becker.
5. List serve is very active. Review of new materials for Section web page is on-going. Communicated personally to all members who submitted proposals through AARC abstract central if they copied proposal to me.
6. on-going
7. No work to report as of this date.

Other:

Date Submitted: March 6, 2009

Committee/Section: Home Care

Representative: Robert McCoy

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. Identify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section°¶s web page and provide timely responses to requests for information from AARC members.
6. Implement the Specialty Section Charges as listed.
7. Assist Federal Government Affairs committee in passing legislation which will recognize respiratory therapists under the Medicare home health services benefit

Recommendations:

none

Report:

Medicare changes in reimbursement began Jan. 1 with the 36 month capped rental of oxygen therapy equipment. Economic impact on a home care providerís ability to continue to provide services associated with LTOT will be impacted. Home care providers are adapting their programs to control costs and it is unknown what impact this will have on patient care. Many issues remain un-answered (such as equipment service, patients moving out of town etc.). Competitive bid is a continual option being discussed by CMS with the full impact of the consequences of this program being unknown. The new administration is focusing on healthcare so more changes are anticipated. At this time the home respiratory therapist does not know what impact all the economic changes will have on their ability to provide clinical services; at this time the focus is on equipment, process and payment.
Charges for the Home Care Section Chair:
1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
Four proposals were sent to the program committee for consideration for the international congress. Feedback from the home care section membership is that this is too long a lead time to propose timely topics as the political landscape is changing the services a home respiratory therapist provides. A shorter lead time would provide an opportunity for more timely and relevant topics.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
In cooperation with the home care section bulletin editor, four section bulletins will be produced for the section members. A home care specific web cast is planned for 2009.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
Section membership is concerned with the political issues facing the home care therapist. The AARC political action is representing these members, yet there is still concern. A clinical focus is necessary to demonstrate how a home

respiratory therapist training and skill is necessary for the delivery of respiratory services in the home. At this time, equipment is the only reimbursed respiratory product in home care.

4. Identify, cultivate, and mentor new section leadership.

A new home care section chair will be elected this year. Candidates are being identified and nominated.

5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section°¶s web page and provide timely responses to requests for information from AARC members.

The list serve is active when relevant topics are brought up

6. Implement the Specialty Section Charges as listed.

In process

7. Assist Federal Government Affairs committee in passing legislation which will recognize respiratory therapists under the Medicare home health services benefit

When asked, have provided input on Federal Government activities

Other:

**LONG TERM CARE REPORT NOT AVAILABLE 3/12/09

Date Submitted: March 5, 2009

Committee/Section: Management

Representative: Douglas Laher

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. Identify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section°¶s web page and provide timely responses to requests for information from AARC members.
6. Review and update the SWAP SHOP so that resources are current and reflect recent changes in CPG and Standards. The process will be conducted by the review committee and will conclude with a °ßnew call°® for resources for posting.
7. Update the AARC Guidelines and Standards, Administrative Standards for Respiratory Care Services and Personnel.
8. In collaboration with the AARC Director of Management and Education, initiate planning for revision of the AARC Uniform Reporting Manual.

Recommendations:

1. An electronic tool has been discussed with the executive staff liaison, with preliminary work already initiated to allow for section members to post operational and clinical "best practices" as measures to reduce costs during current economic crisis. Information would be instantaneously downloaded into a database, and made available for immediate viewing by section members. (See charge #3)

2. Preliminary discussions have been held with executive staff liaison to discuss potential of creating a Management Section mentoring data base; in which willing mentors would post their names, photo, contact information, and area of expertise on the section website so that they may be a resource to younger/inexperienced/up-and-coming managers. (See charge #4)

Report:

1. Annual Business meeting was held in Anaheim, CA at the National Congress (led by past chair Rick Ford). Between 40-50 section members were present. 2008 goals and accomplishments were shared with the group. Stan Holland was introduced as 2008 SPOY recipient. The recently piloted Leadership Book Club was also introduced. Incoming section chair; Doug Laher was introduced. Special thanks were given to Rick Ford for his years of exemplary service. While no new business or recommendations were brought forward, questions were asked about updates to the URM and if/when another Human Resource Survey would be disseminated.
2. Three targeted email threads were posted on the management list serve soliciting lecture proposals for the 2009 Summer Forum and International Respiratory Congress. Roughly 120 proposals were submitted through Abstract Central and received by the planning committee. Section chair reviewed all proposals with planning committee liaison, and narrowed the number or proposals to be reviewed by the planning committee to 40-50.
3. Management Section Winter Bulletin distributed to section members on Feb. 9, 2009. Articles specific to the 2008 practitioner of the year, highlights of the 2008 Congress, cost reductions, product differentiation, and the Leadership Book Club were submitted. Managing editor; Roger Berg already has secured articles for publication in the Spring Bulletin. January and February eNews Letter have been distributed.
4. Section chair currently working with the Pinnacle Ad-hoc Committee in developing a survey to be posted on the Management Section list serve. If approved by the executive committee, survey will be posted; with results to assist in the development of the Pinnacle award/distinction.
5. Two new files have been submitted for review by the Swap Shop (BiPAP protocol, and BiPAP/ventilator documentation flowsheets). A new panel of reviewers has been identified

for 2009 (12 total). All existing reviewers were asked to remains on the panel; in addition to adding 6 new members. All existing resources in the Swap Shop have been scheduled for review and re-examination to ensure timeliness, appropriateness, relevance, and support evidence-based practices. Solicitation via the management list serve sent on 3/5/09 requesting call for new submissions to Swap Shop.
6. Networking via the list serve continues to generate roughly 30-35 postings per day.
7. All charges are on track, with the expectation that 100% compliance will be met by year-end.

Other:

**NEONATAL PEDS REPORT NOT AVAILABLE 3/12/09

Date Submitted: March 5, 2009

Committee/Section: Sleep

Representative: Karen Allen

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. dentify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section°¶s web page and provide timely responses to requests for information from AARC members.
6. Implement the Specialty Section Charges as listed.

Recommendations:

No other recommendatons

Report:

1. Portable Home Sleep Testing continues to be an important pathway for sleep centers/labs to consider. Although some labs have introduced this procedure into their list of services, there is still question as to reasonable reimbursement.
2. Approximately 10 candidates took the first Sleep Disorders Specialty Exam on December 15, 2008.
3. A previously submitted recommendation regarding the AARC Quality Respiratory Care Recognition (QRCR) program for Sleep Centers/labs is still awaiting further consideration.

4. Through a generous grant from ResMed, a select group of sleep section members is writing îThe Clinicianís Guide to Promoting Long Term Adherence and Compliance in PAP Therapy for Sleep Disordered Breathingî in an effort to provide a written reference for the PAP clinician when working with patients using PAP therapy. Completion of the rough draft is expected in Spring, 2009.

Other:

Date Submitted: March 5, 2009

Committee/Section: Surface to Air

Representative: Dawn Filippa

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section°¶s members. Proposals must be received by the Program Committee by deadlines in Jan 2009 and Jan. 2010.
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings.
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. Identify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section°¶s web page and provide timely responses to requests for information from AARC members.
6. Implement the Specialty Section Charges as listed.

Recommendations:

None at this time.

Report:

Surface and Air Transport Section Board Report March 2009

Chair: Dawn Filippa, RRT, EMT-P
Liaison: Ruth Krueger Parksinson

New and Ongoing Updates

1. Continuing to build new working relationships with transport RTís across the country, forming work groups to explore issues and activities of interest.
2. The transport section continues to grow in members.

3. The section continues to submit a record number of lecture proposals to the 55thAARC congress in San Antonio, Tx.
4. Yearly section business meeting held during the past AARC congress in Orlando with active discussion of topics of interest to the membership.
5. Yearly section business meeting held during the past AMTC congress in Tampa with active discussion of topics of interest to the membership.
6. The AARC Transport Section Web page will be adding transport photographs.
7. 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.
8. The transport section chair is working with the Position Statement Committee on developing a statement regarding the Use of a Respiratory Therapists in Transports.
9. The Neonatal-Pediatric Transport Exam is currently being developed by The National Certification Corporation (NCC) and we hope will be available for summer 2009. The NCC Board of Directors has authorized a designation for those who successfully complete the certification process. Those who earn the Neonatal and Pediatric Transport certificate will be able to use the designation of C-NPT.

Respectfully submitted by Dawn Filippa, RRT, RN, EMT-P

Other:

SPECIAL COMMITTEE REPORTS

Date Submitted: February 18, 2009

Committee/Section: Benchmark

Representative: Richard Ford

Charges:

1. The implementation of productivity metrics than include a common time factor for ventilator days and provision of educational material on the utility of this metric.
2. The implementation of the new outcome measure for ventilator duration and the provision of educational material on the utility of comparing this outcome. This includes what changes may need to be made in the department profile to better differentiate the types of ICU and patients and reasons for variation in comparative data.
3. Investigate, through client feedback, what other outcomes are important to compare and the feasibility of incorporating them in the program.
4. For each committee member to serve as an AARC Benchmarking expert to assist in providing existing and potential clients with direct assistance regarding data entry and results interpretation.
5. To provide proposals at both the 2009 AARC Summer Forum and International Congress on the value and use of Benchmarking and Best Practice.
6. To advise the AARC in the development of programs to retain the existing client base and attract new users.
7. To write a team publication for The Respiratory Care Journal regarding the use of benchmarking as a comparative tool and a mechanism to develop and adopt best practice.

Recommendations:

None

Report:

1. Stan Holland was approved as our new member, all others members of this team will continue to serve through 2009

2. Bill Dubbs and Rick Ford provided a set of lectures at the 2008 Congress in which AARC Benchmarking was featured. These lectures generated new inquiries about signing up for AARC Benchmarking.

3. A new productivity metric using a constant time standard for a ventilator day was validated and implemented,

4. A new outcome metric reporting average ventilator duration was validated and implemented

5. Work began with Devore to report the ventilator duration on the summary and trend reports for comparison with other centers. Ventilator duration was a recently added metric but further request were made to incorporate this important metric in the Trend and Summary reports for all compare groups. We anticipate this change will be complete by the time the BOD meets in March.

6. The data entry template tool was revised to better reflect the % of MDI, HHN, and IPPB methods of medicated aerosol delivery. This was in response to a clients observation and new tool was updated and available within 72 hours of it being brought to our attention. This also reflects the responsiveness we have to user request and the ability to rapidly make changes. Something the commercially available systems are unable to do.

7. Committee members continue to serve as expert advisors to those using AARC Benchmarking and maintain their availability for questions and assistance

8. At the time this report was submitted their were 95 clients.

Other:

Date Submitted: March 2, 2009

Committee/Section: Billing Codes

Representative: Roy Wagner

Charges:

1. Be proactive in the development of needed AMA CPT respiratory therapy related codes.
2. Act as a repository for current respiratory therapy related codes
3. Act as a resource for members needing information and guidance related to billing codes.
4. Develop a primer on the process of 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.

Recommendations:

No recommendations at this time.

Report:

Chair: Roy Wagner, RRT

Summation of Committee Charges:

1. 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 Careís position on this panel.

Action: Ongoing

2. 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

3. 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.

4. 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: Ongoning.

Other:

Date Submitted: February 9, 2009

Committee/Section: CPGs

Representative: Ruben Restrepo

Charges:

1. Continue to review and revise existing clinical practice guidelines that are greater than 5 years from their publication date.
2. Continue to update and revise the existing clinical practice guidelines from expert opinion to an evidence-based format, as appropriate.
3. Develop appropriate and new clinical practice guidelines, as dictated by current standards of practice, in the evidence-based format.

Recommendations:

Recommendation #1: No recommendations at this time.

Objectives:

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

Report:

Report (Same as Dec í08)
1. To date, the Respiratory Care Journal Website lists a total of forty seven (46) CPGs.
i. Two (2) are listed as evidence-based guidelines (EBGs) and the remaining are listed as expert panel guidelines (EPGs).
ii. Two (2) EPGs have been combined.
iii. Three (3) EPGs have been retired.
iv. Twelve (12) adopted CPGs (see numeral 1.e.).

b. Eleven (11) CPGs have been updated/revised and published since 2004.
c. After verifying the last date of publication:
i. Eighteen (16) EPGs are at least 5 years old but less than 10 years old. One of them has been replaced by other societyís CPG.
ii. Both EBGs are older than 5 years.
iii. Nineteen (13) EPGs are at least 10 years old but less than 15 years old. One of them has been replaced by other societyís CPG.
iv. Six (6) are older than 15 years.
d. To date, twelve (12) CPGs have been adopted from other medical societies.
i. Three (3) of these CPGs are older than 5 years.
Action Plan for 2009:
1. A total of 27 CPGs have been assigned for revision and update during 2009.
a. One (1) CPG is undergoing expedited review by the committee to be published in the first semester of 2009.
i. Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways.
2. The remaining 3 CPGs older than 5 years will await revision in 2010.
3. Continue development of appropriate and new clinical practice guidelines in the evidence-based format.
a. EB-CPG on Inhaled Nitric Oxide is nearing completion.
b. EB-CPG on Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia is scheduled to be completed in 2009.

Other:

File Attachment: CPGs1.doc

File Attachment: CPGs2.xls

American Association for Respiratory Care

CPG Steering Committee Activity Report
Spring 2009

Chair: Ruben D Restrepo MD RRT FAARC **Liaison**: Ruth Krueger-Parkinson MS, RRT **Vice President, Internal Affairs**

Recommendation #1: No recommendations at this time.

Objectives:

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

Report (Same as Dec '08)

1. To date, the Respiratory Care Journal Website lists a total of forty seven (46) CPGs.
    i. Two (2) are listed as evidence-based guidelines (EBGs) and the remaining are listed as expert panel guidelines (EPGs).
    ii. Two (2) EPGs have been combined.
    iii. Three (3) EPGs have been retired.
    iv. Twelve (12) adopted CPGs (see numeral 1.e.).
    b. Eleven (11) CPGs have been updated/revised and published since 2004.
    c. After verifying the last date of publication:
        i. 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.
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    d. To date, twelve (12) CPGs have been adopted from other medical societies.
        i. Three (3) of these CPGs are older than 5 years.

Action Plan for 2009:

1. A total of **27** CPGs have been assigned for revision and update during 2009.
    a. One (**1**) CPG is undergoing expedited review by the committee to be published in the first semester of 2009.
        i. Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways.
2. The remaining **3** CPGs older than 5 years will await revision in 2010.
3. Continue development of appropriate and new clinical practice guidelines in the evidence-based format.
    a. EB-CPG on **Inhaled Nitric Oxide** is nearing completion.

b. EB-CPG on **Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia** is scheduled to be completed in 2009.

STATUS OF CLINICAL PRACTICE GUIDELINES AS OF DEC 2008

	ASSIGNED		>10y	PUBLISHED	Notes
Expert Panel Guidelines					
Use of Positive Airway Pressure Adjuncts to Bronchial Hygiene Therapy	CHEIFETZ	9	15	1993	
Capillary Blood Gas Sampling for Neonatal and Pediatric Patients	CHEIFETZ	22	14	2001	
Selection of an O2 Delivery Device for Neonatal and Pediatric Patients 2002 Revision & Update	CHEIFETZ	27	6	2002	delete '95 v on web
Discharge Planning for the Respiratory Care Patient	DEAKINS	12	13	1995	
Providing Patient and Caregiver Training	DEAKINS	15	12	1996	
Training the Health-Care Professional for the Role of Patient and Caregiver Education	DEAKINS	17	12	1996	09-2006??
Postural Drainage Therapy	GENTILE	2	17	1991	
Sampling for Arterial Blood Gas Analysis	GENTILE	6	16	1992	
Directed Cough	GENTILE	7	15	1993	
Patient-Ventilator System Checks	HAAS	5	16	1992	
In-Hospital Transport of the Mechanically Ventilated Patient 2002 Revision & Update	HAAS	24	6	2002	
Bland Aerosol Administration 2003 Revision & Update	HAAS	28	5	2003	
Assessing Response to Bronchodilator Therapy at Point of Care	REST/FINK	11	13	1995	
Selection of an Aerosol Delivery Device for Neonatal and Pediatric Patients	REST/FINK	14	13	1995	
Selection of a Device for Delivery of Aerosol to the Lung Parenchyma	REST/FINK	16	12	1996	
Selection of Device, Administration of Bronchodilator, and Evaluation of R/ to Tx in Mechanically Ventilated Pts	REST/FINK	18	9	1999	
Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways	RESTREPO	8	15	1993	
Suctioning of the Patient in the Home	RESTREPO	19	9	1999	09-2006??
Incentive Spirometry	TRACY	1	17	1991	
Pulse Oximetry	TRACY	3	17	1991	
Body Plethysmography 2001 Revision & Update	TRACY	21	7	2001	
Humidification during Mechanical Ventilation	WALSH	4	16	1992	
Surfactant Replacement Therapy	WALSH	10	14	1994	
Capnography/Capnometry during Mechanical Ventilation 2003 Revision & Update	WALSH	29	5	2003	
Intermittent Positive Pressure Breathing 2003 Revision & Update	WIDDER	30	5	2003	09-2006??
Blood Gas Analysis and Hemoximetry 2001 Revision & Update	WIDDER	20	7	2001	
Polysomnography	WIDDER	13	13	1995	
Exercise Testing for Evaluation of Hypoxemia and/or Desaturation 2001 Revision & Update		23	7	2001	
Oxygen Therapy for Adults in the Acute Care Facility 2002 Revision & Update		25	6	2002	
Pulmonary Rehabilitation		26	6	2002	

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STATUS OF CLINICAL PRACTICE GUIDELINES AS OF DEC 2008						
	>10y	>5y	Last Published		Notes	
	Evidence-Based Guidelines					
1		6	2002			Weaning and Discontinuing Ventilatory Support
2		5	2003	HESS	Revision by Hess SEPT 08 ????	Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia
	Expert Panel Guidelines					
3			2004			Application of Continuous Positive Airway Pressure to Neonates Via Nasal Prongs, or Nasopharyngeal Tube, or Nasal Mask 2004 Revision & Update
4	13		1995			Assessing Response to Bronchodilator Therapy at Point of Care
5		5	2003			Bland Aerosol Administration 2003 Revision & Update
6		7	2001			Blood Gas Analysis and Hemoximetry 2001 Revision & Update
7		7	2001			Body Plethysmography 2001 Revision & Update
8			2007			Bronchoscopy Assisting
9	14		1994			Capillary Blood Gas Sampling for Neonatal and Pediatric Patients
10		5	2003			Capnography/Capnometry during Mechanical Ventilation 2003 Revision & Update
11			2004		Combined	Defibrillation during Resuscitation
12			1993			Directed Cough
13	13		1995			Discharge Planning for the Respiratory Care Patient
14	15		1993			Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways
15		7	2001			Exercise Testing for Evaluation of Hypoxemia and/or Desaturation 2001 Revision & Update
16	16		1992			Humidification during Mechanical Ventilation
17		6	2002			In-Hospital Transport of the Mechanically Ventilated Patient 2002 Revision & Update
18			1991			Incentive Spirometry
19			2008			Infant/Toddler Pulmonary Function Tests—2008 Revision & Update
20		5	2003	NICK		Intermittent Positive Pressure Breathing 2003 Revision & Update
21			2007			Long-Term Invasive Mechanical Ventilation in the Home—2007 Revision & Update
22	13		1995		2003 ASA 2005 AHA	Management of Airway Emergencies
23			2004			Metabolic Measurement using Indirect Calorimetry during Mechanical Ventilation 2004 Revision & Update
24		7	2001		ATS 1999	Methacholine Challenge Testing 2001 Revision & Update
25			2004			Nasotracheal Suctioning 2004 Revision & Update
26			1994		RETIRED Need to be removed from list	Neonatal Time-Triggered, Pressure-Limited, Timed-Cycle Mechanical Ventilation

27		6	2002			Oxygen Therapy for Adults in the Acute Care Facility 2002 Revision & Update
28			2007			Oxygen Therapy in the Home or Alternate Site Health Care Facility—2007 Revision & Update
29	16		1992			Patient-Ventilator System Checks
30	13		1995			Polysomnography
31	17		1991			Postural Drainage Therapy
32	12		1996			Providing Patient and Caregiver Training
33		6	2002			Pulmonary Rehabilitation
34	17		1991			Pulse Oximetry
35			2007			Removal of the Endotracheal Tube 2007 Revision & Update
36			2004		Combined	Resuscitation and Defibrillation in the Health Care Setting 2004 Revision & Update
37	16		1992		Not on the grid	Sampling for Arterial Blood Gas Analysis
38	12		1996			Selection of a Device for Delivery of Aerosol to the Lung Parenchyma
39	13		1995			Selection of an Aerosol Delivery Device for Neonatal and Pediatric Patients
40		6	2002			Selection of an Oxygen Delivery Device for Neonatal and Pediatric Patients 2002 Revision & Update
41		9	1999			Selection of Device, Administration of Bronchodilator, and Evaluation of Response to Therapy in Mechanically Ventilated Patients
42		9	1999		2005 ATS/ERS	Single-Breath Carbon Monoxide Diffusing Capacity 1999 Revision & Update
43	12		1996			Spirometry 1996 Revision & Update
44		7	2001		2005 ATS/ERS	Static Lung Volumes 2001 Revision & Update
45		9	1999	KATHY		Suctioning of the Patient in the Home
46	14		1994			Surfactant Replacement Therapy
47	12		1996			Training the Health-Care Professional for the Role of Patient and Caregiver Education
48			2004			Transcutaneous Blood Gas Monitoring for Neonatal and Pediatric Patients 2004 Revision & Update
49	15		1993			Use of Positive Airway Pressure Adjuncts to Bronchial Hygiene Therapy
	Combined and Retired Guidelines					
1			2004		Combined	The Defibrillation during Resuscitation guideline has been combined with the new Resuscitation and Defibrillation in the Health Care Setting.
1			RETIRED			Neonatal Time-Triggered, Pressure Limited, Timed-Cycle Mechanical Ventilation
2			RETIRED			Delivery of Aerosols to the Upper Airway
3			RETIRED			Selection of Aerosol Delivery Device
	Guidelines from Other Organizations					
1			2005		AHA (Circulation)	2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care
2			2005		AACP (Chest)	ACCP Device Selection and Outcomes of Aerosol Therapy: Evidence-Based Guidelines
3					ACCP	ACCP Mechanical Ventilator Weaning Protocols Driven by Nonphysician Health-Care

		7	2001		(Chest)	Professionals: Evidence-Based Clinical Practice Guidelines
4			2007			NAEPP Asthma Guidelines
			2004		SCCM (CCM) Link does not work 1	SCCM Guidelines for the Inter- and Intrahospital Transport of Critically Ill Patients
5			2008		Public Health Service website	Smoking Cessation Guidelines from the Surgeon General
						Pulmonary Function Testing
6			2005		ATS/ERS (Eur Respir J)	ATS/ERS Standardization of Lung Function Testing: General Considerations for Lung Function Testing
7			2005		ATS/ERS (Eur Respir J)	ATS/ERS Standardization of Lung Function Testing: Standardization of the Measurement of Lung Volumes
8			2005		ATS/ERS (Eur Respir J)	ATS/ERS Standardization of the Single Breath Determination of Carbon Monoxide Uptake in the Lung
9		6	2002		ATS (AJRCCM)	ATS Statement: Guidelines for the Six-Minute Walk Test
10		9	1999		ATS (AJRCCM)	ATS Guidelines for Methacoline and Exercise Challenge Testing
						Management of Airway Emergencies
11		5	2003		ASA (Anesthesiology)	ASA Practice Guidelines for Management of the Difficult Airway
12			2005		AHA (Circulation)	AHA—Adjuncts for Airway Control and Ventilation

STATUS OF CLINICAL PRACTICE GUIDELINES AS OF DEC 2008

	ASSIGNED		>10y	Last Published	Notes
Expert Panel Guidelines					
Incentive Spirometry	TRACY	1	17	**1991**	
Postural Drainage Therapy	GENTILE	2	17	1991	
Pulse Oximetry	TRACY	3	17	1991	
Humidification during Mechanical Ventilation	WALSH	4	16	**1992**	
Patient-Ventilator System Checks	HAAS	5	16	1992	
Sampling for Arterial Blood Gas Analysis	GENTILE	6	16	1992	
Directed Cough	GENTILE	7	15	**1993**	
Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways	RESTREPO	8	15	1993	
Use of Positive Airway Pressure Adjuncts to Bronchial Hygiene Therapy	CHEIFETZ	9	15	1993	
Surfactant Replacement Therapy	WALSH	10	14	**1994**	
Assessing Response to Bronchodilator Therapy at Point of Care	REST/FINK	11	13	**1995**	
Discharge Planning for the Respiratory Care Patient	DEAKINS	12	13	1995	
Polysomnography	CHEIFETZ	13	13	1995	
Selection of an Aerosol Delivery Device for Neonatal and Pediatric Patients	REST/FINK	14	13	1995	
Providing Patient and Caregiver Training	DEAKINS	15	12	**1996**	
Selection of a Device for Delivery of Aerosol to the Lung Parenchyma	REST/FINK	16	12	1996	
Training the Health-Care Professional for the Role of Patient and Caregiver Education	DEAKINS	17	12	1996	09-2006??

STATUS OF CLINICAL PRACTICE GUIDELINES AS OF DEC 2008

	ASSIGNED		5-10y	Last Published	Notes
Evidence-Based Guidelines					
Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia	HESS	1	5	2003	
Nitric Oxide			5		
Expert Panel Guidelines					
Ventilated Pts	REST/FINK	2	9	1999	
Suctioning of the Patient in the Home	RESTREPO	3	9	1999	09-2006??
Blood Gas Analysis and Hemoximetry 2001 Revision & Update		4	7	2001	
Body Plethysmography 2001 Revision & Update	TRACY	5	7	2001	
Capillary Blood Gas Sampling for Neonatal and Pediatric Patients	CHEIFETZ	6	14	2001	
Exercise Testing for Evaluation of Hypoxemia and/or Desaturation 2001 Revision & Update		7	7	2001	
In-Hospital Transport of the Mechanically Ventilated Patient 2002 Revision & Update	HAAS	8	6	2002	
Oxygen Therapy for Adults in the Acute Care Facility 2002 Revision & Update		9	6	2002	
Pulmonary Rehabilitation		10	6	2002	
Selection of an O2 Delivery Device for Neonatal and Pediatric Patients 2002 Revision & Update	CHEIFETZ	11	6	2002	delete '95 v on
Bland Aerosol Administration 2003 Revision & Update	HAAS	12	5	2003	
Capnography/Capnometry during Mechanical Ventilation 2003 Revision & Update	WALSH	13	5	2003	
Intermittent Positive Pressure Breathing 2003 Revision & Update	WIDDER	14	5	2003	09-2006??
The following expert panel guidelines will be considered for revision between 2010-2011:					
Application of Continuous Positive Airway Pressure to Neonates Via Nasal Prongs, or Nasopharyngeal Tube, or Nasal Mask 2004 Revision & Update				2004	
Defibrillation during Resuscitation				2004	Combined
Metabolic Measurement using Indirect Calorimetry during Mechanical Ventilation 2004 Revision & Update				2004	
Nasotracheal Suctioning 2004 Revision & Update				2004	
Resuscitation and Defibrillation in the Health Care Setting 2004 Revision & Update				2004	Combined
Transcutaneous Blood Gas Monitoring for Neonatal and Pediatric Patients 2004 Revision & Update				2004	
Combined and Retired Guidelines					
The Defibrillation during Resuscitation guideline has been combined with the new Resuscitation and Defibrillation in the Health Care Setting.				2004	Combined
Neonatal Time-Triggered, Pressure Limited, Timed-Cycle Mechanical Ventilation				RETIRED	
Delivery of Aerosols to the Upper Airway				RETIRED	
Selection of Aerosol Delivery Device				RETIRED	
Guidelines from Other Organizations					
As of 1/28/2009 these are the latest versions these organizations have posted. Ruben					
					SCCM (CCM)

SCCM Guidelines for the Inter- and Intrahospital Transport of Critically Ill Patients				2004	Link does not work 1
ACCP Mechanical Ventilator Weaning Protocols Driven by Nonphysician Health-Care Professionals: Evidence Based Clinical Practice Guidelines			7	2001	ACCP (Chest)
Pulmonary Function Testing					
ATS Statement: Guidelines for the Six-Minute Walk Test			6	2002	ATS (AJRCCM)
ATS Guidelines for Methacoline and Exercise Challenge Testing			9	1999	ATS (AJRCCM)
Management of Airway Emergencies					
ASA Practice Guidelines for Management of the Difficult Airway			5	2003	ASA (Anesthesiology)

Committee/Section: Fellowship Committee

Representative: Patrick Dunne

Charges:

1. Review applications of nominees for AARC Fellow Recognition (FAARC).
2. Select individuals who will receive the AARC Fellow recognition prior to the International Respiratory Care Congress.

Recommendations:

There are no recommendations at this time.

Report:

The activities of this Committee will commence in earnest following the deadline for the submission of nominees for FAARC for 2009.

In the interim, members of the AARC leadership are encouraged to nominate individuals for this prestigious recognition. Eligibility criteria can be found on the AARC website.

Other:

Date Submitted: March 2, 2009

Committee/Section: International Committee

Representative: John Hiser

Charges:

1. Coordinate, market and administer the International Fellowship Program.
2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International functions of the Congress.
3. Strengthen AARC Fellow Alumni connections through communications and targeted activities.
4. Coordinate and serve as clearinghouse for all international activities and requests.
5. Continue collegial interaction with existing International Affiliates to increase our international visibility and partnerships.

Recommendations:

None

Report:

1. Coordinate, market and administer the International Fellowship Program.
This year we will celebrate 20 years that the AARC, ARCF and ICRC have worked together to bring respiratory professionals to the USA. We are in the process of gearing up for this year. The web site and the online application have been updated. A call for applicants has been posted on the international fellows list serve, the city host list serve, the HOD/Presidents and the BOD list serves. We have also discussed having an ìInternational Cornerî in AARCTimes which would introduce the fellows to the general membership through articles written by the host and

possibly the fellows. A working group is looking at the selection process with the goal of assuring that selection is unbiased and based upon selecting the most qualified applicants. Two other working groups are looking at a ìVisiting Dignitary Programî and an ìAARC International Student Internship Programî. Our goal is to have detailed program descriptions along with BOD recommendations and justifications for both programs ready for the July BOD meeting. A survey of the past fellows and past hosts is being developed and should be completed by the time the BOD meets this March. Fellow Pins that were developed last year were given to the new fellows at the Congress last December. Approximately 25 pins were mailed to past fellows who requested them via the Past International Fellows List Serve.

2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International functions 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.
We continue to work on improving communication and on targeted activities.
Past International Fellow Mohammed Al Ahmari, BSRC, MSc., RRT from Saudi Arabia continues his work to translate the aerosol booklet into Arabic.

In the future, we hope to have translated other resource materials deemed of interest and benefit to the world community of respiratory therapy providers.

The International Fellows List serve shows 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 continue to correspond with other medical associations, societies and practitioners. AARC representatives will attend the ERS again this year.

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 the ARCF last February 28th. Updates will be provided to the Corporate Partners on April 17th.

I want to thank Kris Kuykendall for all of her hard work and also thank the Vice Chairs and Committee Members.

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, RRT, 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

Other:

**MEMBERSHIP COMMITTEE REPORT NOT AVAILABLE 3/12/09

Date Submitted: March 4, 2009

Committee/Section: Position Statements

Representative: Pat Doorley

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.
2. Review, revise or delete as appropriate using the established three-year schedule of all current AARC position statements subject to Board approval.
3. Revise the Position Statement Review Schedule table annually in order to assure that each position statement is evaluated on a three-year cycle.

Recommendations:

Recommendation # 1:

Revise the position statement entitled ìRespiratory Therapist Educationî to incorporate the changes identified in Attachment # 1. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: This statement was last reviewed in 2008 and the revision was submitted to the BOD for consideration at the December 2008 meeting. The revised statement included language that addressed the levels of education for practitioners and faculty. Anticipating the outcomes from the Respiratory Care 2015 Initiative will result in changes in the educational requirements for respiratory therapists practicing in diverse venues, the BOD referred this statement back to the Committee to revise the references pertaining to levels of education. Those references have been removed from the statement.

Report:

Charge # 1

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"

"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"

Charge # 2

The six (6) position statements that will be reviewed this year include: (1) AARC Statement of Ethics and Professional Conduct, (2) Age Appropriate Care of the Respiratory Patient, (3) Continuing Education, (4) Definition of Respiratory Care, (5) Health Promotion and Disease Prevention, and (6)Licensure of Respiratory Care Personnel.

Charge # 3

The Position Statement Review Schedule (See Attachment #2) has been revised to reflect the BOD actions for 2008. Currently three of the twenty one statements have not been reviewed within the past 3 years. All three are scheduled to be reviewed by the end of 2009.

Other:

File Attachment: Position Statements1.doc

File Attachment: Position Statements2.xls

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 ~~T~~ 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

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	X			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	X			X	
Cultural Diversity	1994	2007	2		X			X

Definition of Respiratory Care	1987	2006	3	X			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	2006	3	X			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

Respiraatory Therapist Education	1998	2008	1	X			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**

Date Submitted: March 5, 2009

Committee/Section: Public Relations Action Team

Representative: Linda Smith

Charges:

1. Each member will agree to do interviews (radio) and provide information for the written press release that corresponds to the interview topic.
2. Continue to assist Your Lung Health (AARC's consumer website) with reading and editing clinical stories, messages, etc for the website. These will be assigned through the EO on a PRN basis.
3. Communicate with each State Affiliate encouraging the establishment of a public relations committee.
4. Update the current Public Relations material and develop a mechanism to make the PR °ßtools°® more easily available to the State Affiliates.

Recommendations:

No Recommendations.

Report:

1. Each member will agree to do interviews (radio) and provide information for the written press release that corresponds to the interview topic.
Relevant topics are being discussed. Once topics are decided upon, the interviews will be coordinated with the EO.

2. Continue to assist Your Lung Health (AARC's consumer website) with reading and editing clinical stories, messages, etc for the website. These will be assigned through the EO on a PRN basis.
The EO has not made any requests.

3. Communicate with each State Affiliate encouraging the establishment of a public relations committee.

A letter has been written which is being reviewed by the committee. Once it is fine tuned the letter will be sent to the State Affiliates.

4. Update the current Public Relations material and develop a mechanism to make the PR ìtoolsî more easily available to the State Affiliates.
The committee will begin reviewing the entire web site to identify the PR material currently available.

Other:

SPECIAL REPRESENTATIVES REPORTS

**AAAAI REPRESENTATIVE REPORT NOT AVAILABLE 3/12/09

Date Submitted: March 5, 2009

Committee/Section: AMA CPT

Representative: Susan Rinaldo-Gallo

Charges:

None

Recommendations:

None at this time.

Report:

1. I attended the February AMA CPT meeting at which over 100 codes were discussed.
2. It was necessary to withdraw the proposals for six Pulmonary Rehab Type I CPT codes (Patient Evaluation, Patient Re evaluation, Exercise individual, Exercise group, Education individual, Education group). Although we had addressed all the issues brought forward prior to the meeting and made revisions to the proposal, there were additional issues of contention which we were not made aware of. The CPT panel preferred that CMS take the lead and issues new G codes based on the January 2010 NCD. Note that the AARC has submitted input concerning this NCD. Although this action by the AMA CPT will have no negative impact to the Pulmonary Rehab community, it was a real disappointment for the groups who have worked on these codes for the past two ñ three years (AACCP, ATS, AACVPR, and AARC). Please note that the current G codes for Pulmonary Rehab remain intact and continue to be used for reimbursement.
3. Unattended Sleep Study codes were proposed. If successful these new CPT codes would replace the G codes: G0398, G0399, and G0400. Based on the input of the AARCís sleep resources we expressed our support and participated in this work group. The America Academy of Sleep Medicine opposed these codes. The CPT editorial panel choose to accept two Category III CPT codes: 1. unattended sleep study measuring heart rate, oxygen saturation, respiratory analysis, and sleep time, and 2. unattended sleep study measuring a minimum of heart rate, oxygen saturation, and respiratory analysis. Category III codes are used together statistics only and are not used for reimbursement. This similar to the Pulmonary Rehab codes, where CMS has granted

G codes but the AMA has not accepted proposals to convert these to Type I CPT codes.
4. A new code for Infant Pulmonary Function was proposed and looked favorable. This is new technology which uses raised volume rapid thoracoabdominal compression (RVRTC) to measure forced expired flows (FVC, FRC and ERV). This is used for infants or children through 2 years of age. The device looks like a plastic infant size body box with a jacket that wraps around the infants chest.
5. New CPT codes are not official until the book is released each January.
Revised 3-6-2009

Other:

**AACVPR REPRESENTATIVE REPORT NOT AVAILABLE 3/12/09

Date Submitted: March 5, 2009

Committee/Section: ACCN

Representative: Karen Gregory

Charges:

None

Recommendations:

None

Report:

I am honored to serve in this role as representative for the AARC to the American Association of Critical Care Nurses. I have contacted AACN and am in the process of meeting with the AACN liaison to identify topic content and issues. I will continue follow-up regarding ventilator associated pneumonia that was discussed by George Gaebler.

Thank you for inviting me to serve as representative for the AARC.

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

Other:

Date Submitted: March 3, 2009

Committee/Section: American Heart

Representative: Rich Branson

Charges:

None

Recommendations:

Support development of new 2008 guidelines for cardiopulmonary resuscitation.

Report:

I attended the AHA meeting in New Orleans. I will be working on evidence based guidelines with the BLS committee.

Other:

Date Submitted: March 6, 2009

Committee/Section: ASTM

Representative: Robert McCoy

Charges:

None

Recommendations:

None

Report:

The December 2009 meeting of ASTM's F29 will not be held at the same time and place as the AARC annual congress. ASTM will not be exhibiting at the AARC 2009 Congress. The cost and logistics were not practical for this sub committee to meet to try to draw respiratory therapist to participate in their meeting. Reports on ASTM activities that may impact specialty sections of the AARC will be posted on the AARC web site as agreed at the last BOD meeting and notices sent to specialty section chairs when a new item is added that may be of interest to the group. The ASTM with ISO is actively addressing issues impacting heath care and is reviewing current standards and establishing new standards to improve medical equipment safety and standardization.

Other:

Date Submitted: February 20, 2009

Committee/Section: Chartered Affil Consul

Representative: Garry Kauffman

Charges:

None

Recommendations:

None

Report:

I have been approached just in the past week by two state society leaders to discuss the program and have provided them with an overview of the service provided. I will contact President Myers if there is interest by any of the state leadership.

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

Other:

**CLI REPRESENTATIVE REPORT NOT AVAILABLE 3/12/09

Date Submitted: February 26, 2009

Committee/Section: CLSI

Representative: Susan Blonshine

Charges:

None

Recommendations:

None

Report:

1. C46-A2ó Blood Gas and pH Analysis and Related Measurements; Approved Guideline-Second Edition has received the required approval and is ready for publication. Carl Mottram and myself served as advisors for the document.
2. The Clinical and Laboratory Standards Institute (CLSI) has administered the secretariat for International Organization for Standardization (ISO) Technical Committee (TC) 212 on behalf of the American National Standards Institute (ANSI) since its inception in 1995. TC 212 developed and published 17 approved standards. These standards cover quality management in the clinical laboratory, reference systems, in vitro diagnostic products, and antimicrobial susceptibility testing. After careful deliberation, the CLSI Board of Directors resolved to relinquish the roles of secretariat for ISO/TC 212 and its four working groups in order to focus its resources on new opportunities. CLSI formally notified ANSI of its decision by providing the requisite one-year notice of termination, effective 3 November 2009.
3. Carl Mottram assumed the position of Chairholder of the Area Committee on Quality Systems and Laboratory Practices effective January 2009. This has been typically a position for clinical laboratory trained individuals so we are very pleased with the appointment.
4. Gregg Ruppel has been nominated to the subcommittee for revision of the Pulse Oximetry document.
5. Susan Bloshine has been nominated for a new standing subcommittee on quality management which will be managed by the Area Committee on Quality Systems and Laboratory Practices.

6. In February, CLSI announced the new CLSI Quality Forum. Members of the CLSI community asked for a discussion group on quality management for the medical laboratory. The goal of the CLSI Quality Forum is to encourage open and informative discussions on any number of topics such as:
streamlining laboratory processes;
enhancing employee potential;
meeting accreditation requirements;
reducing risk of medical errors; and
improving patient safety.

The subjects addressed will be whatever the users want them to be. Itís free. Sign-up is simpleójust complete the online registration form. An ID and password and instructions for logging onto the system will be sent by e-mail. The CLSI Quality Forums group is housed within CLSIís Forums and easily accessed from the home page of the website. Using CLSIís Forums, teams can work together effectively, share ideas, collaborate, and create and manage content.

7. Recently Approved Documents:

C28-A3óDefining, Establishing, and Verifying Reference Intervals in the Clinical Laboratory; Approved GuidelineóThird Edition

This document provides guidance for determining reference values and reference intervals for quantitative clinical laboratory tests.

GP21-A3óTraining and Competence Assessment; Approved GuidelineóThird Edition

This document provides background and recommended processes for the development of training and competence assessment programs that meet quality regulatory objectives.

Other:

Date Submitted: February 22, 2009

Committee/Section: CAMTS

Representative: Steven Sittig

Charges:

None

Recommendations:

None at this time.

Report:

The CAMTS BOD continues to meet quarterly with the next meeting to take place in April 2009. The organization is working with other professional organizations to help improve the safety of helicopter transport in light of the tragic year in 2008.

Other:

Date Submitted: February 9, 2009

Committee/Section: CAAHEP

Representative: Linda Van Scoder

Charges:

None

Recommendations:

No recommendations.

Report:

CAAHEP will hold its annual meeting April 19 & 20 in San Antonio and I will be attending, along with Bill Dubbs. We expect that CoARC's impending withdrawal from the organization will be on the agenda. Lively discussion may ensue.

Other:

Date Submitted: March 8, 2009

Committee/Section: ELSO

Representative: Donna Taylor

Charges:

None

Recommendations:

None at this time

Report:

I attended the Extracorporeal Life Support Organization (ELSO)Steering Committee meeting last month at the 25th Annual Children's National Medical Center Symposium: "ECMO and the Advanced Therapies for Respiratory Failure" in the capacity of Respiratory Liason. In my report to the committee I commented on the large number of emails and calls I continue to receive questioning what Respiratory Therapists can do regarding the extracorporeal circuit. Even though Respiraroty Therapists are cited in the ELSO textbooks and manuals in various capacities, in some institutions they are still limited by the hospital policies. The ELSO steering committee has offered to publish a position statement regarding RRTs and extracorporeal support. This may be an additional aid for those RRTs who have limits imposed on them regarding ECMO because of individual hospital policies. I will keep the AARC updated on the progress of this position statement. Also, the FDA has agreed to allow the ELSO registry ECMO bridge to transplant patients to serve as a control group for the Berlin Heart patients in order for the Berlin Heart to apply for FDA approval in the USA. This is an unprecidented action by the FDA in allowing this type of study.
The ELSO registry is being sought after by other companies and organizations to pool and or take on their data collection for various patient populations.
Respectfully submitted,

Donna Taylor, RRT-NPS

Other:

Date Submitted: March 6, 2009

Committee/Section: Int'l Council

Representative: Jerome Sullivan

Charges:

None

Recommendations:

No recommendations at this time.

Report:

The International Council for Respiratory Care (ICRC)
Spring 2009 Board Report

1. The International Council for Respiratory Care (ICRC) continues to emphasize its strategic partnership with the AARC in all its activities and meetings. The primary goal of the ICRC is to actively advocate for the globalization of Respiratory Care by supporting projects and activities which stress the importance ìcommon interests not credentialsî.

2. ICRC Meetings held in conjunction with AARC 54th International Congress - Anaheim California

ICRC Executive Committee Meeting ñ Sunday, December 14, 2008

ICRC Business Meeting ñ Monday, December 15, 2008 7:30 AM ñ 4:30 PM

3. ICRC Business Meeting

Attendees from 27 Countries
108 Participants & Guests

4. ICRC Business Meeting Action Items:

Motion Passed: Effective July 1, 2009 ICRC Governors must hold AARC Associate Membership (the appropriate classification for an International Member).

Motion Passed: Effective July 1, 2009 ICRC Governors must represent a professional, constituent society/group in their home country. The letter of representation must be filed with the ICRC President within 3 months of the Councilís Annual Business Meeting.

Motion Passed: The following countries were newly admitted to the Council

United Arab Emirates (UAE)
Mainland China (Candidate Status)
Guatemala (Candidate Status)

Motion Passed: Elected Member of the Executive Committee

Patrick J. Dunne, MEd, RRT, FAARC (USA)

Motion Passed: Review & revise Council Strategic Plan via web cam meeting. Previous discussions on the use of this technology will be renewed with Steve Nelson and the Executive Office.

Motion Passed: Term of Office for Governors and Officers will be 2 years

Motion Passed: The Council will hold a Business Meeting Outside of North America. Referred to the President

Motion Passed: The Operational Rules Committee shall review & revise the ìCriteria and Expectations for Governorsî. Report back to the President & Executive Committee by May 2009.

5. ICRC Activity Update: H. Alorainy, Governor for Kingdom of Saudi Arabia and J. Sullivan, Council President, in cooperation with the AARC Executive office worked with a group of dedicated RTís in the United Arab Emirates (UAE) to establish a new professional respiratory care society. Due to the work of these RTís and their newly elected President, Noel S. Tiburcio, MBA, RMT, RRT-NPS the Emirates Association for Respiratory Care Practitioners (EARCP) was established. As a result EARCP was approved as:

AARCís newest International Affiliate
ICRCís newest Member Country

EARCP has over 155 members with approximately 135 holding dual AARC International Membership. 96% of the membership is comprised of Filipino RTís. Also the Coordinator for the Health Authority in Abu Dhabi is working with EARCP to establish CME requirements for RTís. Finally as a result of EARCPís efforts the Philippine House & Senate are considering Bills to license RTís, and the Departments of Health & Education plan to administer an RT Certification Examination in October 2009.

6. ICRC Activity Update: ICRC Governor for Taiwan to Peer Review RC Journal Chinese Podcast Translation.

Hui-Ling Lin, MS, RRT, RN ñ provides podcast translation
Chia-Chen Chu, MS, RRT, FAARC, Governor for Taiwan ñ provides translation peer review

7. ICRC Activity Update: Mexican Association for Respiratory Therapy and Hector Leon Garza, MD sponsored :

X Congresso International de Terapia Respiratoria & Latin American Board RT Certification Examinations
March 4 -7, 2009 Mexico City
J. Sullivan, Council President was an invited speaker at the Congress.

8. ICRC Activity Update: ICRC Continues to Support International Standards for Pulmonary Function.

Council members are cooperating with Paul Enright, MD, & Brendan Cooper, PhD, to forward The World Lung Function Accreditation Project (WOLFAP).

The featured presenter at the ICRC Business Meeting in Anaheim, 2008 was Brendan Cooper, MSc, PhD, Consultant Clinical Scientist Respiratory Medicine ñ University Hospital Birmingham Lung Investigation Unit, Queen Elizabeth Medical Center. Dr. Cooperís presentation was entitled:

ìUniversal Spirometry Drivers License ñ Avoiding the Wrecks, But Carrying On Down the Quality Road!î

9. ICRC Activity Update: Saudi Arabian Commission for Health Specialties Establishes Respiratory Care Scientific Committee.

J. Sullivan appointed Advisor to the Committee

October 2008 the RC Committee established ìStandards & Guidelines for the Profession of Respiratory Care in Saudi Arabia. The BS Degree has been established as the entry level point and the Committee continues to work on requirements for education, licensure examinations and credentials.

10. Additional ICRC Action Items:

Ruben Restrepo, MD, RRT, FAARC was ratified for a 2 year term as The Governor for Columbia.

Motion Passed: ìThe ICRC encourages USA Respiratory Care Educational Programs to make a concerted effort to establish CAAHEP/CoARC approved satellite programs in other countries to enable individuals in those countries to qualify for NBRC Examinations.î

Respectfully submitted,

J. Sullivan

Other:

**TJC AMBULATORY REPRESENTATIVE REPORT NOT AVAILABLE
3/12/09

Date Submitted: February 17, 2009

Committee/Section: JCAHO Lab PTAC

Representative: Rebecca Meredith

Charges:

None

Recommendations:

None

Report:

There has been no activity.
There is an on-site meeting scheduled for Monday, March 16, 2009 in Chicago. We will continue to work on the standards improvement project which reveiws the standards line-by-line.

Other:

Date Submitted: February 26, 2009

Committee/Section: JCAHO Homecare PTAC

Representative: Joe Lewarski

Charges:

None

Recommendations:

No recommendations at this time.

Report:

Nothing to report at this time

Other:

**MCAV REPRESENTATIVE REPORT NOT AVAILABLE 3/12/09

Date Submitted: February 10, 2009

Committee/Section: NAEPP

Representative: Tom Kallstrom

Charges:

None

Recommendations:

None

Report:

The NAEPP completed the Expert Panel Report titled Guidelines Implementation Panel Report for Expert Panel Report III which was officially released in January, 2009. This is a two year effort that the AARC was a part of in the development of the document. This allows the reader to see how the EPR III can be utilized via respiratory therapists as well as other medical professionals. This was something that was missing after the other EPR Guidelines were released in recent years. It can be downloaded at the NHLBI:NAEPP web sitehttp://www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.htm

Other:

Date Submitted: February 9, 2009

Committee/Section: NCHPEG

Representative: Linda Van Scoder

Charges:

None

Recommendations:

None.

Report:

NCHPEG has not met since last fall. A new executive director, Alan Kinniburgh, began in January. Dr. Kinniburgh had previously been CEO of the National Hemophilia Foundation. On February 4th I participated in a NCHPEG membership committee conference call that included Dr. Kinniburgh. The focus of the call was ways to improve membership and income. It was the opinion of the committee that substantial fees increases would not be appropriate at this time. Instead, we felt that NCHPEG needed to improve the value of membership. I asked that they partically focus on allied health professionals who are not experts in genetics (e.g., respiratory therapists). That suggestion was well received.

Other:

Committee/Section: Neonatal Resusc

Representative: John Gallagher

Charges:

None

Recommendations:

There are no recommendations at this time.

Report:

The NRP Steering Committee (NRPSC) will meet on March 23 & 24, 2009 at the headquarters for the American Academy of Pediatrics in Elk Grove, Illinois. The meeting will focus on the progress that has been made on the development of the sixth edition of the programís textbook since our last meeting in October of 2008, as well as other work pertinent to the committee members. As the liaison for the AARC I have been active in the update of Lesson 3 ñ Use of Resuscitation Devices for Positive-Pressure Ventilation.

In addition to the textbook revision, I have worked closely with other members of the NRPSC to draft and edit articles for the NRP Instructor Updates. Articles that I have contributed to have included PEEP and CPAP: How Are They Different and What Are Their Roles in NRP? and Q & A About the Laryngeal Mask.

Following the meeting in March, the steering committee plans to meet in October of 2009 in Washington, D.C. for the NRP Current Issues Seminar and NRPSC Meeting. The agenda for that meeting has net yet been announced.

Other:

**NATIONAL SLEEP AWARENESS REPRESENTATIVE REPORT NOT AVAILABLE 3/12/09

ROUNDTABLE REPORTS

Date Submitted: March 3, 2009

Committee/Section: Asthma Disease

Representative: Eileen Censullo

Charges:

1. Recruit additional members and begin to actualize the vision of an effective and efficient roundtable for individuals involved in asthma disease management.
2. Review asthma information on yourlunghealth.org and recommend corrections, additions and deletions to the AARC.

Recommendations:

Would it be possible to do a survey monkey to members of AARC to advertise the different roundtables? This way we could advertise for all roundtables at same time while promoting the AARC.

Report:

Review of asthma information is ongoing and will have completed list in second quarter.
New members of asthma roundtable recommendations are listed above.

Other:

Asthma roundtable meeting was held in Anaheim on December 15, 2008. I was unable to attend due to my father's illness but Tim Opt Holt chaired the meeting in my absence. Attached is the meeting minutes. I plan to do the same in Orlando this year.

File Attachment: Asthma Disease1.doc

Asthma Roundtable minutes
December 15, 2008

Discussion was held among the roundtable members attending. The following items were brought forth.

1. The roundtable may need to be better publicized, as some think it is not well-known.

2. The diagnostic section should be supported for their proposal about bronchial provocation testing.

3. Make the membership more aware of GOLD and NAEPP guidelines.

4. Some type of asthma resources pages should be made available to the roundtable. This may take the form of an asthma resources page on the AARC website. This might consist of forms or programs submitted by roundtable participants.

5. A suggestion was made for the program committee to have an asthma education symposium to consist of lectures on barriers to asthma education, mimics of asthma, telemedicine for asthma education and reimbursement for asthma education.

6. Publication of asthma education-related articles in the RCJ was encouraged.

7. A toolkit from the Asthma Initiative of Michigan (www.getasthmahelp.com) was promoted.

Submitted by Tim Op't Holt

**CONSUMER ROUNDTABLE REPORT NOT AVAILABLE 3/12/09

INCLUDED IN EXECUTIVE OFFICE REPORT

Date Submitted: March 3, 2009

Committee/Section: Disaster Response

Representative: Steven Sittig

Charges:

1. Continue to work with Health and Human Services in regards to their call for a list of Respiratory Therapists that could be called to duty in cases of national/state emergencies.
2. Continue to develop the use of the AARC°¶s Disaster Response List Serve to foster involvement and provide an ongoing communication resource.
3. Foster ideas for presentation at the AARC Congress.

Recommendations:

none at this time

Report:

The list serve continues to be utilized for roundtable members to share information and network with others in this area of interest.State and regional groups continue to develop plans for various disaster response scenerios.

Other:

Date Submitted: March 2, 2009

Committee/Section: Hyperbaric

Representative: Cliff Boehm

Charges:

1. Establish an effective platform for networking and communication between the members of the Roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in hyperbaric medicine.
3. Bring the concerns and issues of your membership as related to research in respiratory care to the attention of the AARC Board of Directors as indicated.
4. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of hyperbaric medicine.

Recommendations:

None at present.

Report:

LISTERV is up & running. Many discussions have/ are occurring including: initial training and CEUs in HBOT, staffing patterns, physician support, mechanical ventilation in the chamber, utility of air breaks, marketing of our services. We have begun early discussions regarding a symposium on HBOT for the AARC Congress.

Other:

Date Submitted: March 4, 2009

Committee/Section: Informatics

Representative: Constance Mussa

Charges:

1. Establish an effective platform for networking and communication between the members of the Roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in hyperbaric medicine.
3. Bring the concerns and issues of your membership as related to research in respiratory care to the attention of the AARC Board of Directors as indicated.
4. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of informatics and respiratory care.

Recommendations:

Recommendation 1: Resources (human and financial) should be allocated for recruitment of roundtable participants with diverse backgrounds. Group emails describing the informatics roundtable and requesting participation should be sent to AARC members.

Justification: Informatics spans a broad spectrum, including research, teaching, and clinical care. Consequently, individuals with backgrounds in each of these areas would make substantive contributions to the roundtable, and ultimately, to the development of a respiratory care informatics program.

Recommendation 2: Make available to roundtable participants, resources such as the AARC Uniform Reporting Manuals for Acute and Sub-acute Care, the National Board for Respiratory Careís (NBRC) RRT Examination Matrix, and published, peer-reviewed respiratory care literature.

Justification: Examination of the above resources will help roundtable participants determine if the data, information, and knowledge of respiratory care are unique to the profession and substantially different from the structure of medical information on a whole. Such a determination would support the need for the development of a Respiratory Care Ontology.

Report:

Informatics Roundtable Report

Executive Summary

This report presents information regarding the recently formed Informatics Roundtable and includes an overview of the reason for its existence, the proposed agenda, and recommendations. The mandate for the roundtable was to provide a forum where AARC members may exchange ideas on ìrespiratory care informaticsî, i.e., the most effective and efficient means of capturing, manipulating, presenting, and transforming respiratory care data into useful information.

Respiratory Therapists, like other health care professionals, need and use prodigious amounts of information to deliver and manage patient care. Despite this, clinical respiratory care practice is not sufficiently analyzed or driven from the perspective of information science. More significantly, there is a paucity of valid clinical respiratory care data to measure outcomes related to respiratory care interventions and to determine the value of respiratory therapists to the patient care process. Lack of valid and reliable clinical respiratory care data is probably a result of inadequate information systems that do not provide the means for respiratory therapists to accurately and efficiently plan, document, communicate, evaluate, analyze, and understand their care.

The formation of the Informatics Roundtable illustrates the growing awareness among respiratory care educators, researchers, and practitioners that effective and efficient management of respiratory care information is essential. The quality of the computing and technological environment of respiratory care departments nationwide greatly

influences their ability to provide safe, cost-effective care. Unfortunately, existing hospital information systems and ad hoc stand alone respiratory care information systems have not adequately addressed the information retrieval, storage, and processing needs of respiratory therapists. The Informatics Roundtable is the first step in the process of identification, development, and implementation of the most effective techniques for respiratory care information retrieval, storage, and processing.

Proposed Informatics Roundtable Agenda

1. Devise a strategy for recruiting more RC practitioners, educators, and researchers to participate in the informatics roundtable
2. Identify and select an appropriate methodology for identifying Respiratory Care concepts (e.g., RC Diagnoses & Interventions)
3. Identify and select an appropriate methodology for describing identified Respiratory Care concepts
4. Discuss the need for a ìRespiratory Care Ontologyî ñ a formal description and classification of the concepts and relationships within the domain of respiratory care
5. Determine the domain and scope of a Respiratory Care ontology

If implemented, the recommendations included in this report will facilitate implementation of the proposed informatics agenda.

Other:

**MILITARY ROUNDTABLE REPORT NOT AVAILABLE 3/12/09

**MODERATE SEDATION ROUNDTABLE REPORT NOT AVAILABLE 3/12/09

Date Submitted: March 3, 2009

Committee/Section: Neuromuscular

Representative: Lee Guion

Charges:

1. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in respiratory care research.
2. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of respiratory care medical research.

Recommendations:

We will strive to increase membership of the neuromuscular roundtable by: 1) publicizing the growth of respiratory management of patients with diaphragmatic weakness (ALS, muscular dystrophies, spinal cord injuries); 2) collaborating on best practice models for lung expansion and secretion mobilization in these patients; 3) encouraging the NBRC to include a module on the respiratory management of neuromuscular patients in the written and clinical simulation exams; 4) designing education modules on neuromuscular disease for faculty of accredited programs of respiratory care; 5) submitting formal proposals for presentations at our state and international conventions; and 6) increasing communication with other specialty areas, including home care and subacute care whose members manage patients with progressive neuromuscular diseases. As interest in the respiratory management of neuromuscular diseases grows, the AARC and its neuromuscular roundtable, or committee, will continue to provide state-of-the-art information and up-to-the-minute dialogue and exchange of ideas.

Report:

During the 2008 AARC convention members of the neuromuscular roundtable met to discuss our priorities and how best to communicate best practice in the respiratory management of neuromuscular and spinal cord injury patients within our area of expertise and to our colleagues whose practice is primarily in tertiary care. To this end I have submitted a formal proposal to the AARC program committee for presentations on respiratory management of progressive neuromuscular disease geared toward RCPs practicing in the acute care setting. Our hope is to share our expertise while emphasizing continuum of care, safe and effective hospital discharge planning, and cross communication among specialty areas within respiratory care.

Members of the roundtable continue to explore and refine best practice by sharing our expert opinions, published research, and new ideas and medical technology. We challenge one another while remaining respectful of differences in opinion when quality research is lacking. Discussions are spirited and informative. Participants are appreciative of the support and information provided by members of the roundtable.

Recognition of the need for research and best practice in the management of ALS and other neuromuscular diseases, muscular dystrophies, and spinal cord injuries is growing. New technologies and exploration of the human genome have changed our focus from end-of-life to palliative care and disease maintenance. Respiratory therapists who practice in these areas are at the forefront of respiratory care in the 21st century.

Other:

Date Submitted: March 10, 2009

Committee/Section: Research

Representative: John Davies

Charges:

1. Establish an effective platform for networking and communication between the members of your roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in respiratory care research.
3. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of respiratory care medical research.

Recommendations:

1. Continue to recruit new members
2. Raise awareness of the Roundtable both within the AARC environment and outside
3. Establish a vehicle for the enhancement of Respiratory research
4. Encouragement of research involvement for respiratory therapists new to research

Report:

1. Ongoing recruitment of new memebers
2. Submission of a research symposium to the program committee for the International congress
3. Future examination and discussion on selected articles of interest

Other:

Date Submitted: March 6, 2009

Committee/Section: Tobacco Free Lifestyle

Representative: Jonathan Waugh

Charges:

1. Conduct a survey to assess the needs and potential vision of AARC members of the Tobacco Free Lifestyle Roundtable.
2. Review and revise the smoking cessation resources on the AARC Website.
3. Increase the Tobacco Free Lifestyle roundtable membership to section status in 2009.

Recommendations:

None.

Report:

1. The charge to complete a survey of the TFL roundtable membership was conducted. The summary is listed in the attached file (answers for open-ended questions 3-5 not included).

2. The charge to review and revise smoking cessation resources on the AARC website has been and continues to be done by Gaylene Lee, the person in charge of updating the Tobacco Resources page.

3. The charge to increase the TFL roundtable membership is being addressed by promoting membership in the roundtable in several formats in the past 6 months including a recent ARCF/EPA webtraining module, presentations at the AARC International Congress, and the AARC Times.

4. Roundtable members Alisia French, Jay Taylor and I have recently authored articles on tobacco treatment in the AARC Times.

5. Two proposals for tobacco-treatment presentations have been submitted by roundtable members for the upcoming International Congress in San Antonio.

Other:

File Attachment: Tobacco Free Lifestyle1.pdf

Tobacco-Free Lyfestyle Roundtable Membership

1. Please rank the importance of the following activities for the roundtable to address (where "1" is most important and "6" is least important). You will have opportunity to propose items not on this list in the box at the bottom of the screen.

	1	2	3	4	5	6	Rating Average	Response Count
Offer introductory skills training for tobacco intervention and prevention. This would not be like the comprehensive 1-2 week programs, it would be an introductory mini-workshop (2-4 hours) to: motivate clinicians to discuss smoking history with their patients, show them effective ways to ask and advise, identify referral possibilities for their patients, and how to access advanced training.	**31.6% (6)**	10.5% (2)	21.1% (4)	15.8% (3)	15.8% (3)	5.3% (1)	2.89	19
Make available a guide on how to set-up a smoking cessation service (outpatient vs. in-patient) including reimbursement methods, training programs, and working with other staff to streamline referrals.	**26.7% (4)**	**26.7% (4)**	6.7% (1)	20.0% (3)	6.7% (1)	13.3% (2)	2.93	15
Keep our fellow RTs aware of and interested in tobacco intervention/prevention by contributing articles, news items, case-studies, mini-clinics, etc. to our profession's journals and magazines.	**25.0% (5)**	15.0% (3)	20.0% (4)	5.0% (1)	**25.0% (5)**	10.0% (2)	3.20	20
Collaborate with members of the AARC Educational Specialty Section to create tobacco education materials for instructors who do not have training/expertise in tobacco treatment/prevention but want to inform their students the best they can.	**27.8% (5)**	11.1% (2)	22.2% (4)	22.2% (4)	5.6% (1)	11.1% (2)	3.00	18
Serve as reviewers for tobacco-related abstract and manuscript submissions.	0.0% (0)	**31.6% (6)**	5.3% (1)	21.1% (4)	26.3% (5)	15.8% (3)	3.89	19
Create and distribute a survey to assess the demographics of smoking-related issues in the RT profession (how many RTs/RT								

students currently smoke, how many hospitals have a smoking cessation service, how many RTs have received training in tobacco counseling, how many RTs regularly discuss smoking habits with their patients, what training do RT students receive on tobacco, etc.).	16.7% (4)	20.8% (5)	20.8% (5)	8.3% (2)	8.3% (2)	**25.0% (6)**	3.46	24
						What other needs not previously listed should we consider?		4
						answered question		**26**
						skipped question		**0**

2. In the previous question you ranked the importance of six items. Please rank these same items but with regard to which are most feasible (time, talent, cost) for the roundtable to address ("1" is most feasible and "6" is least feasible)?

	1	2	3	4	5	6	Rating Average	Response Count
Offer introductory skills training for tobacco intervention and prevention. This would not be like the comprehensive 1-2 week programs, it would be an introductory mini-workshop (2-4 hours) to: motivate clinicians to discuss smoking history with their patients, show them effective ways to ask and advise, identify referral possibilities for their patients, and how to access advanced training.	20.0% (3)	**26.7% (4)**	6.7% (1)	0.0% (0)	**26.7% (4)**	20.0% (3)	3.47	15
Make available a guide on how to set-up a smoking cessation service (outpatient vs. inpatient) including reimbursement methods, training programs, and working with other staff to streamline referrals.	**26.7% (4)**	6.7% (1)	13.3% (2)	20.0% (3)	20.0% (3)	13.3% (2)	3.40	15
Keep our fellow RTs aware of and interested in tobacco intervention/prevention by contributing articles, news items, case-studies, mini-clinics, etc. to our profession's journals and magazines.	21.4% (3)	21.4% (3)	**42.9% (6)**	14.3% (2)	0.0% (0)	0.0% (0)	2.50	14
Collaborate with members of the AARC Educational Specialty Section to create tobacco education materials for instructors who do not	12.5%	12.5%	18.8%	25.0%	**31.3%**			

have training/expertise in tobacco treatment/prevention but want to inform their students the best they can.	(2)	(2)	(3)	(4)	**(5)**	[illegible]	[illegible]	[illegible]
Serve as reviewers for tobacco-related abstract and manuscript submissions.	12.5% (2)	**25.0% (4)**	18.8% (3)	18.8% (3)	0.0% (0)	**25.0% (4)**	3.44	16
Create and distribute a survey to assess the demographics of smoking-related issues in the RT profession (how many RTs/RT students currently smoke, how many hospitals have a smoking cessation service, how many RTs have received training in tobacco counseling, how many RTs regularly discuss smoking habits with their patients, what training do RT students receive on tobacco, etc.).	27.8% (5)	**33.3% (6)**	0.0% (0)	5.6% (1)	11.1% (2)	22.2% (4)	3.06	18
						answered question		**20**
						skipped question		**6**

3. How can we most effectively increase our membership to reach the goal of raising this roundtable to section status?

	Response Count
	11
answered question	**11**
skipped question	**15**

4. In what aspects of tobacco prevention/intervention do you have experience?

	Response Count
	16
answered question	**16**
skipped question	**10**

5. In what ways would you be willing to share your knowledge and/or participate in the previously mentioned activities?		
		Response Count
		13
	answered question	13
	skipped question	13

6. Please provide the following information in order to contact you.			
		Response Percent	Response Count
Name:		100.0%	17
Credentials:		100.0%	17
Work Address:		100.0%	17
Phone #:		100.0%	17
Preferred Email:		100.0%	17
	answered question		17
	skipped question		9

SPECIAL COMMITTEE REPORTS

Cultural Diversity in Care Management Committee
AARC Activities Report
Spring 2009

Chair: **Joseph R. Huff** **Liaison:** **George Gabler**

Charge: Research and compile a comprehensive list of related links and resources on cultural diversity in health care for inclusion on the AARC web site to include but not limited to:

- Info related to specific cultural groups
- Linguistic/communication competence
- Case studies in cultural competence
-Workforce diversity
-Disparities in healthcare
-Cultural Competence

Status: Reviewing the following web site as an additional resource for the Culture Diversity Web Page.

http://www.cossa.org/communication/diversity_workshop/diversity.html

Charge: Develop a mentoring program for AARC members with the purpose of increasing the Diversity of the BOD and HOD.

Status: See attached Guidelines Draft for the Mentoring Program. Goal is to have a selection process in place to have the first Interns attend the Summer BOD and HOD Session.

Charge: The Committee and the AARC will continue to monitor and develop the web page and other assignments as they arise.

Status: Ongoing

Attachment 1

DRAFT

Cultural Diversity Mentoring

Guidelines

Purpose: This initiative will give culturally diverse members a better knowledge of the functions of the Board of Directors and the House of Delegates.

Increase the involvement of Culturally Diverse Members on the Board of Directors and the House of Delegates.

The member will be selected from applications requesting to be mentored by members of the Board of Directors and the House of Delegates.

1. Candidates will come from the active membership.
2. Candidate will attend the Summer and Fall Meeting.
3. Candidate will spend time observing the activities of the HOD at the Summer Meeting.
4. Candidate will spend time observing the activities of the BOD at the Fall meeting.
5. Funding will be shared by the State Affiliate wishing to participate.
6. Candidates will be active on their State Board or have the approval of their State Board to submit an application.

Date Submitted: March 3, 2009

Committee/Section: Ad Hoc Geriatrics

Representative: Mary Hart

Charges:

1. Continue working with the AARC Times staff to assure each AARC Times issue has an article for °ßComing of Age°®.
2. Prepare fact sheets on what respiratory therapists should know related to the following topics suitable for publication in AARC communications or website posting:
   a. Common respiratory prescription medications used by older adults.
   b. Immunizations for older adults
   c. Communicating with the geriatric patient
   d. Geriatric end of life/palliative care.
3. With Executive Office, review material on Yourlunghealth.org for relevance and appropriateness for geriatric population.

Recommendations:

None currently.

Report:

1. Congress Meeting Proposals submitted from committee.
2. Discussing Topics for next year's COA articles for the AARC Times.
3. Considering expanding from ad-hoc committee to Round Table.
4. Committee members working with NBRC to submit Geriatric questions for RT exam.

Other:

**AD HOC COMMITTEE OFFICER STATUS REPORT NOT AVAILABLE 3/12/09

**AD HOC COMMITTEE PROTOCOL IMPLEMENTATION REPORT NOT AVAILABLE 3/12/09

Date Submitted: February 22, 2009

Committee/Section: Ad Hoc Vent Human Resources

Representative: Steven Sittig

Charges:

1. Provider protection issues a. Review the 'state of the art' regarding provider protection within the context of pandemics (SARS, H5N1).
2. Develop, if necessary, guidelines to make providers aware of all aspects of provider protection and develop a list of education resources, which can be utilized to teach and train personnel as appropriate to adopt and follow generally accepted provider protection practices.
   a. Identify what resources will be necessary in order to assure full compliance with provider protection guidelines.
3. Develop a system, which can be adopted by RT's and others to assure maintenance of skills, knowledge, competencies and all other resources necessary to assure both initial and ongoing acceptable provider protection practices. This must include material resources as well as skilled maintenance.
   a. Review the full range of strategies and tactics, which can be, employed successfully resulting in a supplemental workforce to assist RTs in managing large numbers of ventilator patients.
4. Identify what duties can be taught to non-respiratory medical or paramedical personnel in order to position them to support respiratory therapists and the management of ventilatory patients.

    a. Develop a system that will assure adequate initial and ongoing skills acquisition and maintenance for adjunct personnel will be utilized to assist respiratory therapists.
5. Identify the minimum education and training requirements necessary for RTs to utilize ventilators, which are included in the national strategic stockpile, as well as ventilators that have been purchased by state and other government agencies throughout the United States.
6. Develop a list of suggested competencies and equipment that the Respiratory Therapy departments may use as a guideline in order to prepare for Pandemic or Mass Casualty situations.

Recommendations:

That this entire project be refocused and redefined as there are a number of serious logistical issues being noted that will severely affect the developmemt of last three HR charges. A projected severe shortage of logistical supplies such as power, food and general supplies would effect the number of additional staff needed to be trained. A conference call with the group chairs, Rich Branson and executive office staff will be scheduled.

Report:

No new progress to report. Inlight of the ongoing findings of the logistics group headed by Nick Kuhnley, we have held off in developing the last three charges. The first three charges were submitted and awaiting feedback.

Other:

**AD HOC COMMITTEE VENTILATOR GROUP REPORT NOT AVAILABLE
3/12/09

Date Submitted: March 9, 2009

Committee/Section: Ad Hoc Vent Logistics

Representative: Nick Kuhnley

Charges:

1. Identify all material resources necessary to optimize utilization of all ventilators contained in national or sub national reserves or stockpiles. This resource identification exercise should include options related to power sources, ventilator circuitry and connectors, oxygen supply, cleaning, reprocessing, etc.
2. Identify a system which can be employed by agencies at all levels to assure appropriate inventory maintenance of both ventilators and all peripheral equipment including emergency or backup power supplies.
3. Review the literature and develop guidelines with regard to requirements for circuit changes, reuse, etc. as they relate to both pandemic and disaster mass casualty scenarios. Recommendations regarding minimum amounts of logistical equipment should be generated based on objective evidence and anticipated demand.
4. Review and consideration of recommendations for the purpose of optimizing utilization of all aspects related to logistical support including re-supply of disposable items, organization and distribution and ongoing inventory maintenance of ventilators and their accessories and power supplies.
5. Develop a list of potential power sources, which can be employed in

the full range of mass casualty scenarios.

Recommendations:

none

Report:

Our white paper on oxygen sourcing for Alternate Care Facilities has gone into neutral while awaiting information and updates necessary to proceed. Our meetings continue at a pace of every two weeks.
We are continuing to develop and modify both strategies for resource scarce situations (oxygen & ventilators), and templates for RC Manager facility & critical supply assessments.

Other:

Date Submitted: March 6, 2009

Committee/Section: Ad Hoc Committee on Learning Institutes

Representative: Toni Rodriguez

Charges:

None

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 over arching 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.

Spring Report, 2009:
Two conference calls were conducted by the Steering Committee to include February 4th and March 5th 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.

The committee will next meet after the spring 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.

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

Other:

Attachment A:
AARC Learning Institute

Vision Statement
The Learning 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.

Mission Statement
The mission of the Learning Institute is:
ï To foster leadership talent
ï To teach the skills of academic leadership
ï To advance the science of respiratory care
Strengths
ï Organized professional society for over 62 years
ï Broad membership comprised of skilled clinical specialists, administrators, managers, educators, scientists, and various support people
ï Official membership is over 48,000, representing a pool of respiratory care practitioners numbering over 140,000
ï Has board of medical directors comprised of physician thought leaders
ï Has professional, scientific journal with strong editorial board
ï Strong core of dedicated volunteers, educators, managers, clinicians, and researchers who consistently contribute to the academic literature
ï Has a political action committee and staff dedicated to political advancement of profession
ï Scientific and administrative leaders have long tenure - over 30 years
ï Profession is seen as vital by hospital administrators, physicians, nurses, and government agencies
ï AARC has technological infrastructure to develop a web based
Weaknesses
ï The average age of a respiratory care practitioner (RCP) is 48 years
ï 50% of leadership in hospitals and educational programs (ie, the professionís mentors) will retire in the next 5 years
ï The time and money required to produce the professionís mentors is less available to the current generation of RCPs entering the field
ï The profession has no formal leadership development plan
ï Economic restrictions have flattened organizational charts and decreased the opportunities for professional development
ï Few respiratory care programs to offer graduate degrees

ï Salaries for respiratory therapists are generally lower than comparably trained health care professionals, especially for post graduate and advanced positions

Opportunities

ï Employment of respiratory therapists is expected to grow 19 percent from 2006 to 2016, faster than the average for all occupations

ï Job opportunities are expected to be very good

ï With only a 2 year degree, median annual earnings of wage-and-salary respiratory therapists are almost $50,000

ï The worsening economy tends to attract people to the profession, which will help alleviate the national staffing shortage

Challenges

ï The profession of respiratory care has become so technologically complex that school preparation is just an entry ticket

ï There is a national staffing shortage

ï The number of vacant positions is growing faster than the number of graduates from RC schools

ï 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

ï Technological advances in the field are outpacing the ability of educational programs to train new graduates

ï Job demands are increasingly requiring a 4 year degree but most programs are 2 years and unable to expand to 4

ï Current clinical skill set requires continuing quality improvement

OTHER REPORTS

COMMITTEE ON ACCREDITATION
CoARC
FOR RESPIRATORY CARE

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 March 2009

I. Accredited Respiratory Care Programs as of March 1, 2009:

	100-level	200-level	Polysomnography
CAAHEP accredited	27	332	10
Letter of Review	0	53	N/A
Approval of Intent	0	9	2
Letter of Intent	6 – supplementary materials pending		

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) upon the recommendation of CoARC currently has a total of **359** accredited Respiratory Care programs. Twenty-seven of those programs are Certification-level (100-level) and 332 are Registry-level (200-level). An additional 53 programs hold a Letter of Review (LoR) which is a CoARC 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).

CAAHEP upon the recommendation of CoARC also accredits polysomnography programs as add-ons to accredited Respiratory Care programs. There are currently 10 such accredited Polysomnography programs. There are also a total of 14 domestic satellite campuses, 3 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 complete roster of Committee members is available at: www.coarc.com/committee_members.htm.

III. CAAHEP Approves Change in Initial Accreditation Timeframe

In January, the CAAHEP Board approved the change in the time period for initial accreditation for respiratory care programs from three years to five years. This change is effective for any initial recommendation from this point forward, but is not retroactive to any program that has already been approved.

IV. Update on Independent Accreditor Status

At its November Board meeting, CoARC made the decision to proceed with the process of separating from CAAHEP and become a freestanding accreditor for respiratory therapy programs. The AARC, CoARC's sponsors and the educational programs were notified by letter on November 17th, 2008, along with the National Network of Health Career Programs in Two Year Colleges (NN2) and the Association of Schools of Allied Health Professions (ASAHP). To date, we have received written responses from the AARC, ASA, ATS, NN2, and ASAHP stating that they will continue their support of CoARC following its

separation from CAAHEP scheduled for January 15, 2010. CoARC is working with CAAHEP leadership on a separation agreement. The Commission on Accreditation for Respiratory Care, in its new configuration, will continue to foster excellence in respiratory therapy education. It will continue to hold programs to uniform national standards as part of a private, voluntary, non-governmental accreditation system. The CoARC intends to seek recognition from the Council for Higher Education Accreditation (CHEA) and participate as an active member in the Association for Specialized and Professional Accreditors (ASPA). 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 will be working with its sponsoring organizations to develop progressive drafts of the new Standards over the next several months. The first draft will be released for public comment in early March. In addition to the input from CoARC sponsors, open hearings will be scheduled on the proposed *Standards* to permit consideration from all applicable communities of interest regarding what should and what should not be included in the *Standards*. 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 16th, 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 13th Annual H. F. Helmholz, Jr. Educational Lecture on Sunday, July 19th. 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 (date/time to be determined).

Sincerely,

Shelley Mishoe

Shelley C. Mishoe, PhD, RRT, FAARC
Chair

MEMORANDUM

Date: March 12, 2009

To: AARC Board of Directors, Board of Medical Advisors 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 will meet 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

The new Specialty Examination for Respiratory Therapists Performing Sleep Disorders Testing and Therapeutic Intervention was launched at the AARC International Congress in December 2008. Despite our efforts to recruit test takers, including a reduced fee and a $25 American Express Gift card, we only had 6 candidates attempt the examination in December. To date, we have now tested a total of 8 candidates. Until we have a sufficient number of candidates take the examination, we are unable to finalize the cut-score and release examination results.

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. We expect the survey to be 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 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 the end of February, over 7,000 applications had been received compared to just under 4,000 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. 2009 annual renewal notices were mailed to credentialed practitioners in mid-November 2008 and a second notice is scheduled to mail by the end of March.

Examination Statistics – January 1 – December 31, 2008

The NBRC received over 36,000 applications and administered nearly 35,000 examinations across all credentialing programs in 2008. Pass/fail statistics for the respective examinations follow:

Examination	***Pass Rate***	
CRT Examination –12,335 candidates		
	Entry Level	
Advanced		
First-time Candidates	78.6%	78.6%
Repeat Candidates	26.4%	26.5%
Therapist Written Examination –10,536 candidates		
First-time Candidates	68.8%	
Repeat Candidates	37.2%	
Clinical Simulation Examination – 10,529 candidates		
First-time Candidates	57.2%	
Repeat Candidates	49.4%	

Neonatal/Pediatric Examination – 842 candidates

First-time Candidates	76.6%
Repeat Candidates	46.3%

CPFT Examination – 393 candidates

First-time Candidates	62.1%
Repeat Candidates	37.1%

RPFT Examination – 86 candidates

First-time Candidates	73.3%
Repeat Candidates	50.0%

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.

**ARCF REPORT NOT AVAILABLE 3/12/09

POLICY REVIEW

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

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.

- Alignment with outside organizations as partners.
- Management practices that focus on improvement of the systems in which members work.
- 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

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:
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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

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

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

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

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

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: