



American Association for Respiratory Care

Board of Directors Meeting

Embassy Suites Outdoor World
Grapevine, Texas

April 22-23, 2010

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AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Budget Committees, and Board of Directors Meetings
April 22 - 24th, 2010

Thursday, April 22

5:30 – 7:30 pm Executive Committee Meeting (Committee Members only)
7:30 – 8:30 pm AARC Finance Committee Meeting (BOD and HOD members
welcome)

Friday, April 23

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 Officers/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 CoARC—Tom Smalling
 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 (Daedalus)

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 AARC “Social Media” Presentation--Milligan
- 5:00 pm RECESS**

Saturday April 24

- 8:00 – 5:00 pm AARC Board of Directors Meeting
8:00 am Call to Order
 Special Representatives
 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
 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
 Nat. Coalition for Health Professional Ed. In Genetics
 Neonatal Resuscitation Program
 National Sleep Awareness Roundtable
 Simulation Alliance
- 10:15 am Roundtable Reports
 Asthma Disease
 Consumer
 Disaster Response
 Hyberbaric
 Informatics
 Military
 Neurorespiratory
 Research
 Tobacco Free Lifestyle
- 10:45 AM Special Committee Reports
 Ad Hoc Committee on Cultural Diversity in Patient Care
 Ad Hoc Committee on Officer Status/US Uniformed Services
 Ad Hoc Committee on Oxygen in the Home
 Ad Hoc Committee Protocol Implementation Task Force
 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
Ad-Hoc Committee on Mass Casualty/Pandemic Preparedness
International Roundtable
Simulation Roundtable

NEW BUSINESS
- Ratification of Appointments
- Geriatrics Roundtable
- Policy Review

4:30 pm **ARCF Achievement Award Nominations**
 Bird Invacare
 Hudson

ANNOUNCEMENTS

TREASURER’S MOTION

ADJOURNMENT

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting, San Antonio, Texas
December 3, 2009

Minutes

Attendance

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

Guests

Cam McLaughlin

Absent

Joseph Lewarski, BS, RRT, FAARC, VP/External Affairs (Excused)

Consultants

John Hiser, MEd, RRT, FAARC, Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President/Presidents Council
Kent Christopher, MD, RRT FAARC, BOMA Chair

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
Anne Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Cheryl West, State Government Affairs Director
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:05 a.m. CST, Thursday, December 3, 2009.

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

APPROVAL OF MINUTES

Toni Rodriguez moved “To accept the minutes of the July 20, 2009 meeting of the AARC Board of Directors as amended.”

Motion Carried

Toni Rodriguez moved “To accept the minutes of the July 21, 2009 meeting of the AARC Board of Directors.”

Motion Carried

E-MOTION RATIFICATION

Toni Rodriguez moved “To accept the following E-Motions discussed over the BOD Listserv since July, 2009.”

E-Motion 09-3-15.1 “That the 2010 AARC Summer Forum be held at the Marco Island Marriott over the dates of July 16-18.”

E-Motion 09-3-84.1 “That the AARC BOD consider initiating its process for the formation of a new Roundtable for Geriatrics which would then replace the Ad Hoc Committee on Geriatrics.”

E-Motion 09-3-9.1 “That the AARC BOD approve the Florida State Bylaws.”

E-Motion 09-3-9.2 “That the AARC BOD approve the Connecticut State Bylaws.”

E-Motion 09-3-9.3 “That the AARC BOD approve the Arkansas State Bylaws.”

Motion Carried

GENERAL REPORTS

PRESIDENT’S REPORT

President Tim Myers reported that the Association continues to work on getting RTs recognized under Medicare Part B. AARC is looking at ways disclosures are reported and updated and refining of conflict of

interest. Membership, despite a poor economy, is still moving upward. The Association reported a membership of 49,557 as of the first of December. President Myers advised of the need to look at mechanisms to drive revenues. The Tennessee Board has developed a competency component on Scope of Practice for Polysomnography. On September 30, Dr. Kent Christopher, Sam Giordano and President Myers traveled to Chicago to meet with AASM leadership to discuss polysom issues. They compared scopes of practice between the two organizations as well as legislative advancements, and the new accreditation process of the American Academy of Sleep Medicine. Both organizations felt this meeting was a positive one and agreed that it would be prudent to meet once or twice a year to alleviate any misconceptions.

EXECUTIVE OFFICE REPORT

Sam Giordano stated the Association is still paying the Tennessee lobbyist due to the contractual obligations of monthly payments for one year, however his work with AARC is finished. The total amount spent on the lobbyist was \$72,000 while the revenue sharing for the Tennessee society would have amounted to about \$3,000. Economic pressures associated with this meeting are looking better than expected. However, we need to look at new opportunities and ways to supplement convention revenues yet still maintain our benefits to members. He reiterated that the Association needs to push for the patient's right to have access to respiratory therapists.

Tom Kallstrom reported on AARC's Ventilator Survey conducted for the Department of Health and Human Services. We had 25 states with 90% or better. Overall we had a 75% response rate for which HHS was pleased with the outcome. Results will be published in a peer-reviewed journal in the future. The COPD Educator Course finished its second beta test in Denver this fall and we'll convert it to an online course as we did with the Asthma course, and we will offer it to the states to co-market with AARC. This agreement allows them to receive 10% of the proceeds upfront. The current asthma course has doubled in the number of registrants this year with good pass rates. We are currently completing the budgetary process for the Fast Track Institute whose goal is to develop leaders and motivators of the profession.

Sam Giordano updated members on the 2015 and Beyond program stating we hope to publish results of the previous two conferences in May or June of 2010. This will also announce an invitation-only piece for the third conference which would possibly be planned around Summer Forum.

George Gaebler moved to accept **Recommendation 09-3-1.1** "That the AARC Board of Directors approves the revised 401K statement as presented below:

AARC 401K PLAN CODIFICATION

Periodically through the years, our 401K plan trustee, the Bank of Texas (BOT), files with the IRS, to comply with law, a variety of modifications and amendments to keep us legal. Then after that time, the IRS makes you summarize all that into a new plan document that codifies all the piecemeal changes up to that time. The last time we did this was in 2002. We are at that point again. Discussions with BOT indicate there are no substantive plan changes (i.e. contributions, benefits, basic operations, etc.) or additional new costs to the plan from what you know of the plan today. This is essentially a housekeeping action.

Thus, the following needs adoption:

WHEREAS, the AARC ("Association") currently maintains a tax-qualified plan known as the American Association for Respiratory Care Employees Retirement Plan ("the Plan");

WHEREAS, in recent years Congress has enacted numerous laws affecting the Plan, which include EGTRRA.

WHEREAS, the Association, following consideration of the various EGTRRA (Economic Growth and Tax Relief Reconciliation Act of 2001) and certain subsequent provisions, desires to adopt an updated EGTRRA restated Plan document.

NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING PREMISES, IT IS:

RESOLVED: that the Association amend its existing Plan by adopting the Bank of Oklahoma, N.A. Defined Contribution Prototype Plan and Trust as a restated plan and would generally be effective retroactive to the Plan Year beginning January 1, 2002 (with later effective dates as documented in Appendix A of the Adoption Agreement) to bring the Plan into compliance with regulatory requirements. To this end, the Executive Director is authorized and directed to execute the documents and take any other action deemed necessary or appropriate to maintain the Plan's qualified status.

RESOLVED: that the Association is hereby directed to give proper and timely notice to all interested parties of the amendment to the Plan and is further directed to retain a copy of the Plan in the business office of the Association for inspection by participants under the Plan.

RESOLVED: that Bank of Texas, N.A. be designated as a nondiscretionary Trustee under Section 8.02(B) of the Plan.

RESOLVED: that the Association be confirmed to serve as the Plan Administrator as provided in Section 1.41 of the Plan.

RESOLVED FURTHER: that the Association be confirmed as the Named Fiduciary as provided in Section 1.36 of the Plan."

Motion Carried

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:45 a.m. CST, Thursday, December 3, 2009.

RECONVENE

President Tim Myers reconvened the meeting of the AARC Board of Directors at 10:00 a.m. CST, Thursday, December 3, 2009.

HOUSE OF DELEGATES REPORT

HOD Speaker Cam McLaughlin stated all HOD members (not just HOD officers) will sign a conflict of interest statement. He stated they will work on a system of obtaining Conflict of Interest prior to names being placed on ballots.

STANDING COMMITTEE REPORTS

BYLAWS COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 09-3-9.1** “That the AARC Board of Directors accept the AARC Bylaws Committee’s recommendation for approval of the Arizona Society for Respiratory Care’s bylaws.”

Motion Carried - 1 abstention

George Gaebler moved to accept **Recommendation 09-3-9.2** “That the AARC Board of Directors accept the AARC Bylaws Committee’s recommendation for approval of the Wisconsin Society for Respiratory Care’s bylaws.”

Motion Carried

FINANCE COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 09-3-12.1** “That the AARC ratify replacement of a failed conference room projector at an expense of \$2,735.36.”

Motion Carried

George Gaebler moved to accept **Recommendation 09-3-12.2** “That the AARC ratify the replacement of one convention projector and one seminar projector at an expense of \$2,921.67.”

Motion Carried

SPECIALTY SECTION REPORTS

DIAGNOSTIC SECTION

George Gaebler moved to accept **Recommendation 09-3-51.1** “That the Board of Directors approve the use of the American Association for Clinical Chemistry (AACC) web-based certification program for laboratory Point of Care (POC) Coordinators. The program could be used as a mechanism for continuing education through the AARC.”

Michael Tracy moved “To refer **Recommendation 09-3-51.1** to George Gaebler to approach the section chair to determine if this is a CRCE approval request.”

Motion to Refer Carried

EDUCATION SECTION

George Gaebler moved to accept **Recommendation 09-3-52.1** “Request the program planning committee continue to offer a keynote type lecture at the Summer Forum in the education session from a retired or seasoned educator on their reflections in the classroom over the length of their career.”

Karen Stewart moved “To accept **Recommendation 09-3-52.1** for information only.”

Motion Carried

HOME CARE REPORT

Bob McCoy reported that many of the people who were previously in home care are now unemployed. Consequently, many DME suppliers are also out of business. Patients are going home from hospitals with equipment they may or may not be able to use correctly and with no access to respiratory therapists. He suggested soliciting all therapists to become part of the home care solution.

ACCEPTANCE OF SPECIALTY SECTION REPORTS

George Gaebler moved “To accept all specialty section reports as submitted.”

Motion Carried

ROUNDTABLE REPORTS

INFORMATICS ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 09-3-47.1** “Inclusion of a web page within the AARC website that contains pertinent information about RTs with expertise in various hospital information systems (45 roundtable participants have already provided this information.”

Karen Stewart moved “To refer **Recommendation 09-3-47.1** to the President.”

Motion to Refer Carried - President Myers will appoint an ad hoc committee to develop parameters and report back at the spring meeting. Doug Laher volunteered as well as George Gaebler.

MILITARY ROUNDTABLE REPORT

Dr. Forrest Bird will be honored this year with a flag ceremony using a flag that was previously flown in Afghanistan and Iraq. About 100 military people will be attending this meeting.

NEUROMUSCULAR ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 09-3-40.1** “That the name of the Neuromuscular Roundtable be changed to the Neurorespiratory Roundtable as it more fully reflects the practice of our members.”

Motion Carried

ACCEPTANCE OF ROUNDTABLE REPORTS

George Gaebler moved to accept “That the Roundtable reports be accepted as presented.”

Motion Carried

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 11:55 a.m. CST, Thursday, December 3, 2009.

JOINT SESSION

President Tim Myers convened the Joint Session at 1:35 p.m. CST, Thursday, December 3, 2009.

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

BOARD OF MEDICAL ADVISORS REPORT

BOMA Chair, Dr. Kent Christopher advised that BOMA was privileged to have special reports given by the International Committee Chair, John Hiser and International Council Committee Chair, Jerome Sullivan to better inform members of the global reach of AARC. He advised that both he and the 2010 BOMA Chair, Dr. Cliff Boehm are respiratory therapists as well as MDs. He stated that 3 physicians will be honored this year by receiving plaques commemorating their over 20 years service on BOMA. Members helped in refining the White Paper on Protocols as directed by the AARC Board of Directors.

ELECTION COMMITTEE REPORT

John Steinmetz reported on Vijay Deshpande’s behalf regarding the election results as follows:

President Elect	George Gaebler	842 Votes	42%
	Karen Stewart	1,172 Votes	58%
Director at Large	Charles McArthur	485 Votes	24%
	Albert Moss	647 Votes	32%
	Frank Salvatore	862 Votes	43%

Michael Hewitt moved “To enter into Executive Session.”

Motion Carried

EXECUTIVE SESSION

President Tim Myers convened Executive Session at 1:50 p.m. CST, Thursday, December 3, 2009.”

Motion Carried

Michael Hewitt moved “To adjourn Executive Session.”

Motion Carried

EXECUTIVE SESSION ADJOURNED

President Myers adjourned Executive Session at 2:25 p.m. CST, Thursday, December 3, 2009.

JOINT SESSION CONTINUED

GOVERNMENT AFFAIRS REPORT

Director of Government Affairs, Cheryl West gave a brief update on state activities including the status of various polysom licensure initiatives. Director of Regulatory Affairs, Anne Marie Hummel reported on regulatory issues such as who can order RT services, outpatient rehab benefit, and the DOT rules for patients using oxygen equipment on planes. Director of Federal Legislative Affairs, Miriam O’Day reported on current legislation in the House and Senate that affect respiratory patients including the Part B RT initiative and COPD appropriations at the CDC.

AMERICAN RESPIRATORY CARE FOUNDATION (ARCF) REPORT

ARCF Chair Michael Amato updated members regarding the Foundation’s activities. He thanked members for their monetary support and stated the Foundation continues to grow in spite of the hardships of the current economy.

Michael Hewitt moved “To adjourn the Joint Session.”

Motion Carried

JOINT SESSION ADJOURNED

President Tim Myers adjourned the Joint Session at 3:00 p.m. CST, Thursday, December 3, 2009.

REGULAR SESSION

President Tim Myers reconvened the meeting of the AARC Board of Directors at 3:15 p.m. CST, Thursday, December 3, 2009.

GENERAL REPORTS ACCEPTANCE

Denise Johnson moved “To accept the general reports as submitted.”

Motion Carried

2010 BUDGET APPROVAL

Ruth Krueger moved “To accept the AARC 2010 Budget.”

Motion Carried

ACCEPTANCE OF STANDING COMMITTEE REPORTS

George Gaebler moved “To accept the Standing Committee reports as submitted.”

Motion Carried

BILLING CODES REPORT

George Gaebler moved to accept **Recommendation 09-3-18.1** “That the AARC add a site for Frequently Asked Questions pertinent to billing and coding on the coding resource page on the AARC website and advertise the link on the listserv.”

Motion Carried

CLINICAL PRACTICE GUIDELINES REPORT

George Gaebler moved to accept **Recommendation 09-3-19.1** “That the Committee has excused Ira Cheifetz from his duties as member of the Committee per his request effective September 4, 2009.”

Mike Tracy moved “To accept **Recommendation 09-3-19.1** for information only.”

Motion Carried

George Gaebler moved to accept **Recommendation 09-3-19.2** “That Steven Sittig RRT-NPS, FAARC has been appointed and ratified by Tim Myers as a new member of the Clinical Practice Guidelines Committee to replace Ira Cheifetz after the summer meeting.”

Mike Tracy moved “To accept **Recommendation 09-3-19.2** for information only.”

Motion Carried

MEMBERSHIP COMMITTEE

George Gaebler moved to accept **Recommendation 09-3-24.1** “That the AARC implement the ‘Value of Membership Calculator’ on the AARC website and promote it to both state affiliates and general membership.”

George Gaebler moved “To accept **Recommendation 09-3-24.1** for information only.”

Motion Carried

POSITION STATEMENT COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 09-3-26.1** “That the AARC retire the position statement entitled ‘Age Appropriate Care of the Respiratory Patient’.” (See ATTACHMENT “A”)

Motion Carried

George Gaebler moved to accept **Recommendation 09-3-26.2** “That the AARC approve and publish the position statement entitled ‘Transport of the Mechanically Ventilated, Critically Injured, or Ill, Neonate, Child or Adult Patient’.” (See ATTACHMENT “A”)

Motion Carried

George Gaebler moved to accept **Recommendation 09-3-26.3** “That the AARC approve and publish the position statement entitled ‘Delivery of Respiratory Therapy Services in Long Term Care Facilities’.” (See ATTACHMENT “A”)

Motion Carried

George Gaebler moved to accept **Recommendation 09-3-26.4** “That the AARC BOD approve the Position Statement Review Schedule as presented.” See ATTACHMENT “A”

Motion Carried

AD HOC COMMITTEE REPORTS

AD HOC COMMITTEE ON CULTURAL DIVERSITY IN CARE MANAGEMENT REPORT

George Gaebler moved to accept **Recommendation 09-3-29.1** “That Mikki Thompson be reinstated to the Cultural Diversity in Care Management Committee.”

Karen Stewart moved “To accept **Recommendation 09-3-29.1** for information only.”

Motion Carried

ACCEPTANCE OF SPECIAL COMMITTEE REPORTS

George Gaebler moved “To accept the Special Committee reports as presented.”

Motion Carried

BOARD OF MEDICAL ADVISORS RECOMMENDATION

George Gaebler moved to accept **Recommendation 09-3-7.1** “That the AARC Board of Directors accept the attached revised version of the white paper entitled Guidelines for Respiratory Care Department Protocol Program Structure.” See **ATTACHMENT “B”**.

Motion Carried

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 4:30 p.m. CST, Thursday December 3, 2009.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting, San Antonio, Texas
December 4, 2009

Minutes

Attendance

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

Guests

David Bowton
Tom Smalling

Consultants

John Hiser, MEd, RRT, FAARC, Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President/Presidents Council
Kent Christopher, MD, RRT FAARC, BOMA Chair

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
Ann Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Cheryl West, State Government Affairs Director
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:30 a.m. CST, Friday, December 4, 2009.

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

TENNESSEE SOCIETY LETTER

President Tim Myers distributed copies of a letter from the Tennessee Society for Respiratory Care stating their concerns over the Board withholding revenue sharing checks from the Tennessee Society.

HOUSE OF DELEGATES RESOLUTIONS

Frank Salvatore moved to accept **HR 16-09-15** “Resolved that the AARC Executive Office explore and consider implementing a new discounted membership category for members who are over the age of 65.”

George Gaebler moved “To refer **HR 16-09-15** to the Executive Office to investigate and bring back at the summer meeting of 2010.”

Motion to Refer Carried

COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (CoARC) REPORT

2010 CoARC Chair David Bowton and Executive Director Tom Smalling reported on CoARC’s activities. They are seeking CHEA recognition which they expect to obtain in the coming year. Phase out of the 100-level program is underway. They are in the process of website reconstruction which will be available in early spring. CoARC recently acquired a new accounting firm, and are also contracting with Liaison International. The new draft standards which were approved by the CoARC Board is now in the hands of their sponsors.

POLYSOMNOGRAPHY DOCUMENT

“The Scope of Practice for Polysomnographic (Sleep) Technologies” approved by the AASM and dated November 7, 2009 was distributed to members to review. It was noted that there were several changes yet to be made. Therefore, members will review and send their changes over the Listserv and the Executive Office will get back with the AASM with a revised draft document.

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:50 a.m. CST, Friday, December 4, 2009.

RECONVENE

Past President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 10:15 CST, Friday, December 4, 2009.

ORGANIZATIONAL REPRESENTATIVES REPORTS

AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION (AACVPR) REPORT

Joe Lewarski moved to accept **Recommendation 09-3-61.1** “That the AARC provide continued support of this liaison position to the AACVPR as the Chair of the Continuing Care/Rehab Section.”

Karen Stewart moved “To accept **Recommendation 09-3-61.1** for information only.”

Motion Carried

AMERICAN HEART ASSOCIATION REPORT

Doug Laher moved to accept **Recommendation 09-3-63.1** “That the AARC continue to support a representative to AHA to assist in development of guidelines.”

Karen Stewart moved “To accept **Recommendation 09-3-63.1** for information only since this is already in the budget.”

Motion Carried

COMMITTEE ON ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS (CAAHEP)

President Tim Myers reported this organization will no longer be represented by AARC and therefore should be removed from the agenda and from the organizational representatives list.

JOINT COMMISSION ON ALLIED HEALTH ORGANIZATIONS (JCAHO) REPORT

President Tim Myers reported that this organization’s name has changed to “The Joint Commission” and should be changed on the agenda and the organizational representative list.

SIMULATION ALLIANCE REPORT

Patricia Doorley moved to accept **Recommendation 09-3-78.1** “That the AARC participate in and advertise through their normal marketing channels an upcoming project being organized for the purpose of drafting standards for using lung simulators for ventilator testing and for which Robert Chatburn will be the facilitator.”

Karen Stewart moved “To refer **Recommendation 09-3-78.1** to the President.”

Motion to Refer Carried

ACCEPTANCE OF ORGANIZATIONAL REPRESENTATIVE REPORTS

Joe Lewarski moved “To accept the organizational representative reports as presented.”

Motion Carried

POLICY REVIEW

Ruth Krueger moved “To accept **Policy BOD 004 – Continuous Quality Improvement Plan.**” (See ATTACHMENT “C”)

Ruth Krueger moved “To move ‘continually’ to precede ‘evaluate’ under the title Policy Statement, and replace ‘products’ with ‘services’ in the 7th bulletpoint.”

Motion Carried – Insert December 2009 under Date Revised.

Ruth Krueger moved “To accept **Policy HOD 001 – Correspondence.**” (See ATTACHMENT “C”)

Motion Carried – Insert December 2009 under Date Revised.

Patricia Doorley moved “To accept **Policy HOD 002 – Procedures/Rules**” (See ATTACHMENT “C”)

Motion Carried – Insert December 2009 under Date Reviewed.

Ruth Krueger moved “To accept **Policy MP 001 – General Operating Policies.**” (See ATTACHMENT “C”)

Ruth Krueger moved “To amend Policy Amplification #6 as follows:

All AARC members shall receive a communication of congrats and thanks from the President and Executive Director at 20 years and each subsequent decade of continuous membership.

Motion to Amend Carried – Insert December 2009 under Date Revised

Amended Motion Carried

James Taylor moved “To accept **Policy CT 002 – Medical Advisors.**” (See ATTACHMENT “C”)

Motion Carried – Insert December 2009 under Date Reviewed

NEW BUSINESS

AD HOC COMMITTEE ON MASS CASUALTY AND PANDEMIC ISSUES

George Gaebler moved to accept **FM 09-3-33.1** “To approve renaming and restructuring the previous three Ad Hoc Committees on Ventilator Capability and Capacity, Human Resources, and Logistics to encompass one Ad Hoc Committee entitled Ad Hoc Committee on Mass Casualty and Pandemic Issues.”

Motion Carried

INTERNATIONAL ROUNDTABLE RESEARCH PROPOSAL

Mike Tracy moved to accept **FM 09-3-48.1** “To accept the International Roundtable Research Proposal.”

Mike Tracy moved “To refer **FM 09-3-48.1** to the President to send back to the originator for clarification and narrowing the scope and name change. In the interim the Executive Office will confirm whether the 10 names are actual AARC members and this will be brought back at the spring meeting in April.”

Motion to Refer Carried

Past President Toni Rodriguez passed the gavel back to President Myers at 11:10 a.m. CST, Friday December 4, 2009.

GERIATRIC ROUNDTABLE PROPOSAL

George Gaebler moved to accept **FM 09-03-44.1** “That the AARC accept approval of the Geriatric Roundtable which would replace the Ad Hoc Geriatric Committee.”

George Gaebler moved “To refer **FM 09-03-44.1** to the President to establish goals and assign a chair.”

Motion to Refer Carried

BOMA SWAT TEAM

Kent Christopher asked members to consider a SWAT team of physicians that members can go to for medical information and resources that would be optional for states and international groups.

President Myers asked members to consider this concept, and it will be discussed at the Spring meeting.

AARC VIRTUAL MUSEUM

Karen Stewart moved to bring back to the table **Recommendation 09-2-8.2** “That the AARC Board of Directors investigate the feasibility of creating a ‘virtual museum’ for the Association and the profession of respiratory care” and **Recommendation 09-2-8.3** “That the AARC Board investigates the feasibility of creating and sustaining a museum for respiratory care in proximity to the AARC Executive Office.”

Karen Stewart moved “To refer **Recommendation 09-2-8.2 and Recommendation 09-2-8.3** to the President to set up an ad hoc committee to investigate feasibility and establish goals and objectives on how to move this forward by the summer meeting of 2010.”

Motion to Refer Carried

ELECTRONIC BOARD REPORTING MECHANISM

President Tim Myers asked members to report on their experiences with the electronic board reporting system. Comments follow:

- Charges weren’t listed on the report this time.
- Browser problems – Seems that if it works for the AARC system, it doesn’t work on the system used by the reporter.
- VP didn’t receive the notice that reports were ready for review.
- Add Board or BOMA Liaison on report, justification for recommendations, charges
- Charges set up individually with a space to type something under it.
- Attachments still a problem
- Create a field to fill in a blank for section numbers.
- Create a mechanism for tracking recommendations in a database.
- Create one document for charges and one document for recommendations
- Liaisons to get copies of reports too
- It “times out” before reporter can finish the report.

Steve Nelson stated that Higher Logic ties in with our database. A prototype will be demonstrated at the April meeting.

2010 HOUSE OF DELEGATES ELECTIONS

The 2010 House officers are as follows:

Speaker	Tom Lamphere
Past Speaker	Cam McLaughlin
Speaker-elect	Bill Lamb
Secretary	Sherry Tooley Peters
Treasurer	Deb Skees
Parliamentarian	Garry Kauffman

DONATION FOR INTERNATIONAL PROGRAM

John Hiser reported that \$10,000 was raised by the House of Delegates in support of the International Program.

OUTGOING BOARD MEMBERS

President Tim Myers acknowledged Ruth Krueger, John Lindsey, and Mike Tracy whose terms end in 2009 and stated his appreciation for their service to the Association.

TREASURER'S MOTION

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

Motion Carried

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

Motion Carried

ADJOURNMENT

President Tim Myers adjourned the meeting of the AARC Board of Directors at 12:40 p.m. CST, Friday, December 4, 2009.

ATTACHMENT “A”

Position Statements

American Association for Respiratory Care

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

Position Statement

Age Appropriate Care of the Respiratory Patient

Patients with respiratory disease should receive the highest quality of care in a timely and professional manner. Respiratory Therapists (RTs) have the training and expertise to deliver respiratory care to all age groups, from neonate to elderly. RTs are trained, tested, uniquely qualified, and specifically credentialed to provide respiratory care as attested in official supporting statements by the American Society of Anesthesiologists (ASA), the American College of Chest Physicians (ACCP), and the National Association for Medical Direction of Respiratory Care (NAMDRRC).

RTs provide services to all age groups across the continuum of care, including physician's offices, acute care hospitals, sub-acute care facilities, rehabilitation facilities, skilled nursing facilities, hospice facilities, and patients' homes. RTs should participate in the initial assessment of the patient to maximize the effective and efficient use of respiratory care service resources. The RT should work under a medical director and provide respiratory care services under medical direction, as ordered by a physician and/or in accordance with a prescribed respiratory care protocol or clinical pathway, and should offer recommendations for an appropriate regimen of care. RTs should be a part of the team providing education of the patient, family members, and other health caregivers regarding respiratory care to ensure appropriate disease management.

In accordance with the recommendations of two Education Consensus Conferences, the American Association for Respiratory Care (AARC) encourages respiratory care educators/managers to include: a gerontology module in respiratory care training program curricula, and clinical training at long term care and rehabilitation facilities to provide students with the opportunity to learn how to appropriately plan for and provide respiratory care services for geriatric patients. Topics focused on the geriatric patient and his/her special health care needs in departmental continuing education programs to assure the desired quality of care for this patient population, and to meet the requirements of health care organization accreditation for age-specific professional training.

Effective 1997

Reviewed 2001

Revised 2005

American Association for Respiratory Care

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

Position Statement

Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child or Adult Patient

Transport of the mechanically ventilated, critically injured or ill neonatal, pediatric and/or adult patient is always associated with a degree of risk. Whether these transports are considered external transports -- from one facility to another -- or internal transports -- from one area to another within a facility or system -- the risk needs to be minimized through careful preparation prior to the transport, continuous monitoring throughout the transport, and the use of appropriate transport equipment and personnel.

The American Association for Respiratory Care recognizes the following as the minimum standards for the safe transport of the mechanically ventilated, critically injured or ill, patient:

1. Transports will be performed by a team consisting of, at a minimum, a Certified or Registered Respiratory Therapist and a Registered Nurse with critical care experience.
2. One member of the transport team will have the appropriate advanced life support certification (NRP, PALS and/or ACLS).
3. A minimum of one member of the transport team will be competent in airway management. Appropriate airway management equipment will be readily available during the transport.
4. Transport monitors will provide real time measurement of all essential parameters.
5. All patients receiving mechanical ventilation will have some form of carbon dioxide monitor in place during transport as this monitor is useful in providing information regarding both airway placement and pulmonary blood flow.
6. A transport ventilator, or transport capable ICU ventilator, will be utilized for mechanical ventilation when possible.
7. A self inflating bag/valve/mask resuscitation device will accompany all patients on transport in case of ventilator failure, gas failure, or accidental extubation.
8. A trial of mechanical ventilation using the planned transport device will be conducted to assess patient tolerance and stability before proceeding with the transport whenever possible.
9. Appropriate and thorough documentation, using the facility's designated process, will occur for all stages of the transport in accordance with the facility's policies and procedures.

Developed: 11/10/2009

American Association for Respiratory Care

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

Position Statement

Delivery of Respiratory Therapy Services in Long Term Care Facilities

Long term care facilities are increasingly becoming the venue for the management of patients who require the full array of respiratory therapy services, from oxygen therapy and inhalation medication management to pulmonary rehabilitation and ventilator management. Long term care facilities should recognize the clinical value to the patient of utilizing a respiratory therapist to provide the complete spectrum of services that respiratory therapists are both educated and competency tested to provide.

The American Association for Respiratory Care recommends that the basic standard of care for long term care facilities be to employ Respiratory Therapists to render care to patients requiring mechanical ventilation. Additionally, the following basic standards are recommended to ensure the safe and efficient delivery of respiratory therapy services in long term care facilities:

1. A Certified, or Registered, Respiratory Therapist -- licensed by the state in which he/she is practicing if applicable -- will be on site at all times to provide ventilator care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing.
2. A Pulmonologist, or licensed physician experienced in the management of patients requiring respiratory care services (specifically ventilator care), will direct the plan of care for patients requiring respiratory therapy services.
3. The facility will establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.
4. Facilities will be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.
5. Clinical assessment of oxygenation and ventilation – arterial blood gases or other methods of monitoring carbon dioxide and oxygenation – will be available on site for the management of patients receiving respiratory therapy services at the facility.
6. Emergency and life support equipment, including mechanical ventilators, will be connected to electrical outlets with backup generator power in the event of power failure.

7. Ventilators will be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.
8. An audible, redundant ventilator alarm system will be located outside the room of a patient requiring mechanical ventilation to alert caregivers of a ventilator malfunction/failure or a patient disconnect.
9. A backup ventilator will be available at all times that mechanical ventilation is being provided to a patient.

Developed: 10/2009

ATTACHMENT “B”

Protocol Statement

American Association for Respiratory Care

Guidelines for Respiratory Care Department Protocol Program Structure

Ford Version 11.10.2008

The American Association for Respiratory Care (AARC) is the leading national and international professional association for respiratory care. The AARC encourages and promotes professional excellence, advances the science and practice of respiratory care, and serves as an advocate for patients, their families, the public, the profession and the respiratory therapist. The AARC recognizes and supports the use of therapist implemented protocols defined as:

*Initiation or modification of a patient care plan following a predetermined structured set of physician orders, instructions or interventions in which the therapist is allowed to initiate, discontinue, refine, transition, or restart therapy as the patient's medical condition dictates. **Note:** This definition should not be confused with programs that include discontinuation of therapy without a reorder, flagging therapy for physician reorder, standing orders or policies that dictate therapy durations*

Current medical literature supports the use of therapist implemented protocols as an effective tool for producing improved patient outcomes and appropriate allocation of services. Protocols have been attributed with:

- Helping respiratory therapists deliver appropriate and efficient care under conditions of an increased workload
- Assuring that all treatments have established indicators
- Reducing the volume of unnecessary care.

Evidence based literature supports the use of protocols to minimize unnecessary treatments and provide self-administration options for patients who demonstrate their ability to do so. Based on the demonstrated efficacy of therapist implemented protocols, it is the position of the American Association for Respiratory Care that institution-approved protocols should be used by respiratory therapists as the standard of care for providing respiratory therapy services under qualified medical direction.

It is recognized that the characteristics and structure of protocol programs throughout the country have some variability secondary to facility specific policy and practice. All programs however must comply with Federal and State regulations and standards

including those published by their State Licensing Boards, The Joint Commission as well as the Centers for Medicare and Medicaid Services. The AARC recommends that a policy and procedure governing the application of therapist implemented protocols be developed. The following policy guidelines are intended to promote compliance with such standards, however each department must refine their specific programs to insure regional compliance. Those responsible for drafting protocols and related policy should incorporate the following recommendations:

- Department policy must specify which respiratory therapists can deliver care outlined in the protocol, inclusive of the competencies required of individuals and demonstration of skills and knowledge.
- Medical Director oversight and accountability for services provided using protocols must also be specified in department policy.
- The protocols should be written to reflect the indications, precautions, and therapy specifics as outlined in the AARC Clinical Practice Guidelines, or other evidence based references.
- All policies related to protocols, as well as the protocols themselves, must be approved by the appropriate institutional governing bodies. .
- Policies for protocols must be compliant with other institutional policies related to the provision of care, with specific attention to pharmacy and nursing services. Because many therapist implemented protocols involve the administration of medication, there must be a single standard throughout the facility regarding the procurement, control and administration of medications.
- A physician order is required to implement respiratory therapy managed by protocols. The order may include a request for "Respiratory Protocol", a specific request such as "MDI Protocol" or other order details as specified and approved by the Medical Staff. (It should be noted that this is an area of contention with some surveying agencies when they encounter a facility that does not require a physician order)
- Protocols must include criteria, thresholds, and decision points that require the physician be notified for continuation of the protocol, options to consider including exemption from protocol with requirements for new non-protocol orders.
- Policy should also define emergent situations in which respiratory therapists can immediately initiate protocols without a physician order. Protocols initiated in this manner shall be reviewed and authorized by physician signature within 24 hours.

- A quality assurance mechanism should be in place to assess if the respiratory therapist is providing care in compliance with protocol as well as capturing adverse responses.

ATTACHMENT “C”

Policy Review

Policy Review

July, 2009

BOD 004 (Referral to Toni Rodriguez)

HOD 001

HOD 002

MP 001

CT 002

American Association for Respiratory Care Policy Statement

Page 1 of 2
Policy No.: BOD.004

SECTION: Board of Directors
SUBJECT: **Continuous Quality Improvement Plan**
EFFECTIVE DATE: December 1999
DATE REVIEWED: **December 2009**
DATE REVISED: **December 2009**

REFERENCES:

Policy Statement:

The Board of Directors shall **continually** evaluate its effectiveness as the governing entity of the Association.

Policy Amplification:

1. As part of this process, the Board of Directors **shall review planning, operation and service delivery to assure quality performance of the Association** based upon key quality precepts.

Quality Performance

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

Quality Precepts

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

American Association for Respiratory Care Policy Statement

Page 2 of 2
Policy No.: BOD.004

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

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: HOD.001

SECTION: House of Delegates

SUBJECT: **Correspondence**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES:

Policy Statement:

Correspondence and other information relevant to the function of the House of Delegates shall be appropriately routed.

Policy Amplification:

1. All correspondence pertinent to the function of the House of Delegates shall be sent to the Speaker of the House of Delegates.
 - A. The Speaker shall cause correspondence to be distributed appropriately to members of the House of Delegates.
2. All HOD Officers shall receive correspondence directed to the BOD and Board agenda books as approved by the President.
3. Newly elected House Officers shall receive a copy of the Association's Policy and Procedure Manual.

DEFINITIONS:

ATTACHMENTS: AARC Conflict of Interest Statement (See Appendix)
AARC Tobacco Free Pledge (See Appendix)

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: HOD.002

SECTION: House of Delegates

SUBJECT: **Procedures – Rules**

EFFECTIVE DATE: June 18, 2002

DATE REVIEWED:

DATE REVISED:

REFERENCES: Delegate Handbook

Policy Statement:

All procedural activities of the House of Delegates can be found in the Delegate Handbook and House Rules.

Policy Amplification:

Any information regarding the procedural activities of the House of Delegates, from committees to resolutions, can be found in the Delegate Handbook. The Delegate Handbook also contains the House Rules under which the House of Delegates operates.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 2
Policy No.: MP.001

SECTION: Membership
SUBJECT: **General Operating Policies**
EFFECTIVE DATE: December 14, 1999
DATE REVIEWED:
DATE REVISED:

REFERENCES: Bylaws, Code of Ethics, House Rules for Special Recognition

Policy Statement:

The Association's membership shall be subject to the provisions of Association Bylaws and Association policy.

Policy Amplification:

1. All personal records of Association members shall be the property of the Association and shall be held in strict confidence.
2. Members whose AARC membership has lapsed may reactivate their membership in the Association by payment of the current year's membership dues plus the fee set in the Annual Budget subject to the following conditions:
 - A. The lapse in membership has been for a maximum time period of one year.
 - B. The member must meet current Bylaws requirements for appropriate membership classification
3. AARC members shall be granted reciprocity of chartered affiliate membership without inter-affiliate transfer of current chartered affiliate dues paid.
4. All new and renewing members shall be required to complete the AARC membership application and subsequent renewal cards in their entirety.
5. The Membership Committee shall assure that a request for medical direction, when applicable, be included on the membership application.

American Association for Respiratory Care Policy Statement

Page 2 of 2
Policy No.: MP.001

6. All AARC Members with twenty (20) or more years of continuous membership shall receive a letter of congratulations and thanks from the President and Executive Director.
7. All nominations for Life Membership submitted to the House of Delegates by a delegation shall include curriculum vitae as justification, and a resolution recommending such action shall be submitted to the House at least sixty (60) days prior to the Annual Meeting of the Association.
8. Life Membership shall automatically be bestowed upon an AARC President upon completion of his/her term as Immediate Past-president.
9. All Active and Life Members of the Association employed within the boundaries of chartered affiliates shall be permitted to vote in the election of the delegation of that affiliate, regardless of their separate affiliate membership status.
10. That students enrolled in an accredited respiratory therapy education program be permitted to join AARC as student members at no charge with the following qualifications:
 - a. Access to *AARC Times* and *RESPIRATORY CARE* will be limited to the internet.
 - b. That 100% of the faculty in the program where the student is enrolled be either an active or associate member of AARC.”

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: CT.002

SECTION: Committees
SUBJECT: **Medical Advisors**
EFFECTIVE DATE: December 14, 1999
DATE REVIEWED:
DATE REVISED: **March, 2009**

REFERENCES:

Policy Statement:

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

Policy Amplification:

1. Special Committees and other groups shall have Medical Advisors as determined by the President.

A. BOMA shall submit names for Committee Medical Advisors to the President for appointment and ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
San Antonio, Texas
December 8, 2009

Minutes

Attendance

Tim Myers, BS, RRT-NPS, President
Karen Stewart, MS, RRT, FAARC, President-elect
Toni Rodriguez, EdD, RRT, Past President
George Gaebler, MSED, RRT, FAARC, VP/Int. Affairs
Joseph Lewarski, BS, RRT, FAARC, VP/Ext. Affairs
Frank Salvatore, BS, RRT, FAARC
Patricia Doorley, MS, RRT, FAARC
Debbie Fox, MBA, RRT-NPS
Lynda Goodfellow, EdD, RRT, FAARC
Michael Hewitt, RRT-NPS, FAARC, FCCM
Denise Johnson, BS, RRT
Douglas Laher, BSRT, RRT, MBA
Robert McCoy, RRT, FAARC
Doug McIntyre, MS, RRT, FAARC
James Taylor, MA, RRT
Brian Walsh, RRT-NPS, RPFT
Tony Stigall, MBA, RRT, RPSGT

Guests

Bill Lamb Speaker-elect
Debra Skees
Tom Lamphere, Speaker

Consultant

John Hiser, MEd, RRT, FAARC, Parliamentarian

Absent

Dianne Lewis (excused)
Cliff Boehm, MD

CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 9:00 a.m. CST, Tuesday December 8, 2009.

INTRODUCTIONS

President Tim Myers asked members to introduce themselves.

OATH OF OFFICE

John Hiser administered the oath of office to Toni Rodriguez and declared her installed as Past President.

NEW BUSINESS

ELECTION COMMITTEE NOMINATIONS

President Tim Myers called for nominations of a Board representative to the Election Committee.

Karen Stewart moved "To nominate Debbie Fox."

Motion Carried

President Tim Myers closed nominations and Debbie Fox was elected to serve as a Board representative on the Election Committee.

ELECTION OF SECRETARY-TREASURER

Karen Stewart moved "To nominate Colleen Schabacker."

Motion Carried

George Gaebler moved "To nominate Linda Van Scoder."

Motion Carried

A vote was taken and Linda Van Scoder was elected as Secretary-Treasurer of the 2010 Board of Directors.

2009 INTERNATIONAL CONGRESS REPORT

Sam Giordano reported on the 2009 Congress held in San Antonio, Texas noting that attendance exceeded 5,000.

RATIFICATION OF 2010 PRESIDENTIAL GOALS

George Gaebler moved "To ratify the 2010 Presidential Goals." (See ATTACHMENT "A")

Motion Carried

RATIFICATION OF 2010 STANDING COMMITTEES

Denise Johnson moved “To ratify the 2010 Standing Committees.” (See ATTACHMENT “A”)

Motion Carried

RATIFICATION OF 2010 SPECIALTY SECTIONS AND CHARGES

Toni Rodriguez moved “To ratify the 2010 Specialty Sections and charges as amended.” (See ATTACHMENT “A”)

Motion Carried

RATIFICATION OF 2010 SPECIAL COMMITTEES

George Gaebler moved “To ratify the 2010 Special Committees as amended.” (See ATTACHMENT “A”)

Motion Carried

RATIFICATION OF 2010 ORGANIZATIONAL REPRESENTATIVES

Frank Salvatore moved “To ratify the 2010 Organizational Representatives as amended.” (See ATTACHMENT “A”)

Motion Carried

RATIFICATION OF 2010 ROUNDTABLES

Frank Salvatore moved “To ratify the 2010 Roundtables as amended.” (See ATTACHMENT “A”)

Motion Carried

RATIFICATION OF 2010 AD HOC COMMITTEES

George Gaebler moved “To ratify the 2010 Ad Hoc Committees as amended.” (See ATTACHMENT “A”)

Motion Carried

UNFINISHED BUSINESS

George Gaebler moved to accept **FM 09-3-83.1** “That the AARC send a letter of approval of the CoARC Standards to CoARC.”

Jim Taylor moved “To table **FM 09-3-83.1** with a one week extension to allow members time to review the Standards document.”

Motion to Table Carried

2010 MEETING DATES

President Tim Myers advised members of the following Board meeting dates for 2010.

April 22-24	Dallas, Texas
July 18-20	Marco Island, Florida
December 3-5 and December 9	Las Vegas, Nevada

COMMENTS FROM PRESIDENT

President Tim Myers stated he is looking forward to working with this Board in 2010. He also advised members that Jim Taylor will mentor Tony Stigall, newly elected Board member.

COMMENTS FROM EXECUTIVE DIRECTOR

Sam Giordano stated he is looking forward to tackling sleep issues during 2010. He again advised that the AARC staff continues to perform well under the current economic circumstances and diminished staff.

DR. KENT CHRISTOPHER'S RECOMMENDATION

President Tim Myers stated that the recommendation brought before this body by Dr. Kent Christopher concerning a swat team of physicians will be brought back for discussion at the next Board meeting.

POSITION STATEMENT ON LONG TERM CARE

President Tim Myers advised that the Position Statement on Long Term Care will be presented to the Board of Medical Advisors (BOMA) for their input. Patricia Doorley will forward the statement to BOMA Chair Dr. Cliff Boehm who will present it to BOMA electronically for their comments.

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

Motion Carried

ADJOURNMENT

President Tim Myers adjourned the meeting of the AARC Board of Directors at 9:45 a.m. CST, Tuesday December 8, 2009.

ATTACHMENT "A"

AARC

2010

Goals & Committees

Committees

Sections

Roundtables &

Special Representatives

Timothy R. Myers, BS, RRT-NPS President

Revised 1/14/10

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

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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:

Bill Lamb, BS RRT CPFT
720 Bubbling Springs Ct
Wentzville MO 63385-3439
314/308-0599
636/327-0381 Fax
bill_rep@msn.com

Chair-elect:

Gary Wickman, BA RRT

2010 Past President:

Toni Rodriguez EdD RRT

Members:

Keith Seigel, RRT CPFT AE-C
Doug McIntyre, RRT

AARC Liaison: 2010 VP/Internal Affairs: George Gaebler, MEd, 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, 2010.
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:

John Steinmetz, MS, RRT
8160 Grizzly Bear Way
Las Vegas NV 89123-2541
702/270-9879
steinmetzjh@yahoo.com

Chair-elect:

Jim Lanoha, RRT

Members:

AARC BOD 1-yr Term – John Hiser, MEd, RRT, FAARC
AARC BOD 2-yr Term – Debbie Fox, MBA, RRT-NPS
Suzanne Bollig, BHS, RRT, RPSGT

AARC Staff: Kris Kuykendall

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:

Karen Stewart MS RRT – **(2010 President-Elect)**
Toni Rodriguez EdD RRT – **(2010 Past President)**
George Gaebler, MSED, RRT FAARC – **(2010 VP Internal Affairs)**
Joseph Lewarski, BS, RRT-NPS, FAARC – **(2010 VP External Affairs)**
Linda Van Scoder, EdD RRT FAARC– **(2010 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 yearly 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:

Bill Lamb, BS RRT CPFT - **(2010 HOD Speaker-elect)**
Debra Skees, BS RRT CPFT - **(2010 HOD Treasurer)**
Karen Stewart MS RRT – **(2010 President-Elect)**
Toni Rodriguez EdD RRT - **(2010 Past President)**
George Gaebler, MSED, RRT FAARC – **(2010 VP Internal Affairs)**
Joseph Lewarski, BS, RRT-NPS, FAARC – **(2010 VP External Affairs)**
Linda Van Scoder, EdD RRT FAARC – **(2010 Sec/Treas)**

AARC Staff: Tony Lovio

Audit Subcommittee

Objectives:

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

Chair:

2010 HOD Speaker-elect

Bill Lamb, BS RRT CPFT

720 Bubbling Springs Ct

Wentzville MO 63385-3439

314/308-0599

636/327-0381 Fax

bill_rcp@msn.com

Members:

2010 VP/Internal Affairs

George Gaebler, MEd, RRT FAARC – (2010 VP Internal Affairs)

Debra Skees, BS RRT CPFT (2009 HOD Treasurer)

Linda Van Scoder, EdD RRT FAARC 2009 Secretary/Treasurer

AARC Staff: Tony Lovio

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:

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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: Sam Giordano

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

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Patrick Dunne MEd RRT FAARC
Bill Galvin MEd RRT CPFT
Dave Pierson MD
Gary Kauffman MHS RRT FAARC
Dean Hess PhD, RRT FAARC (consultant)
Cheryl Hoerr, MBA, RRT

AARC Staff: Ray Masferrer

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 2009-2010 Board of Directors Meeting.
2. Recommend to the Board of Directors the future direction of the Association and the profession of Respiratory Care.

Chair:

2010 - Past President

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Members:

2010 Speaker-elect

Bill Lamb, BS RRT CPFT

2010 - Past HOD Speaker

Camden McLaughlin RRT

2010 VP Internal Affairs

George Gaebler, MEd, RRT FAARC

2010 VP External Affairs

Joseph Lewarski, BS, RRT-NPS, FAARC

2010 Secretary/Treasurer

Linda Van Scoder, EdD RRT FAARC

AARC Staff: TDB

Specialty Section Index

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2009-2010 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:

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Medical Advisor: TBD

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:

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Medical Advisor: Phillip Marcus

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:

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Medical Advisor: Richard Sheldon, MD and Robin Elwood, MD

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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:

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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:

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Chair-Elect:

Gregg Spratt RRT

Medical Advisor: Kent Christopher MD

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Long Term Care Section

Additional Charge:

1. Implement the Specialty Section Charges as listed.

Chair:

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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:

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Medical Advisor:

AARC Staff: Woody Kageler, MD

Neonatal-Pediatrics Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

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Chair-Elect:

Tiffany Mabe, RRT

Medical Advisor: Ira Cheifetz, MD

AARC Staff: TDB

Sleep Specialty Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:

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Medical Advisor: Paul Selecky MD

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Surface & Air Transport Section

Additional Charge:

1. Implement the Specialty Section Charges as listed.

Chair:

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Special Committees Index

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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 2010 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:

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Stan Holland RRT
Thomas Malinowski RRT FAARC
Doug Laher MBA, RRT
Janice Thalman MHS RRT

AARC Staff: Bill Dubbs, MEd, RRT, FAARC

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:

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Members:

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

Medical Advisor:

AARC Staff: Cheryl West

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:

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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: Ray Masferrer

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:

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Members:

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

AARC Staff: Brenda DeMayo

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:

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Members:

Jerry Bridgers CRT
John Campbell MA RRT-NPS
Julie Clarke BS RRT
Debbie Fox RRT
Carrie Bourassa RRT

AARC Staff: Cheryl West

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:

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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
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: Kris Kuykendall

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.
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:

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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: Asha Desai

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:

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Education on the Go
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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: Cheryl West

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:

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Michael J Hewitt RRT-NPS RCP

Ruth Krueger-Parkinson MS RRT

Patrick Johnson PhD RRT FAARC

Linda VanScoder EdD RRT

Nicholas Widder RRT

AAARC Staff: Brenda DeMayo

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:

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Members:

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Kathy Rye EdD RRT
Frank Freihaut RRT AE-C
Trudy Watson RRT
Ken Thigpen BS RRT

AARC Staff: Sam Giordano, MBA, RRT, FAARC

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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Ken Duet MA RRT
Pat Munzer MS RRT
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AARC Staff: Cheryl West

Special Representatives Index

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AMA CPT Health Care Professional Advisory Committee

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Governor – United States

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The Joint Commission (TJC)

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Special Representatives to CoARC

CHAIR:

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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.

Chair:

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ecensullo@dsg-us.com

Liaison: Lynda Goodfellow, EdD, RRT, FAARC

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.

Chair:

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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.

Chair:

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Liaison: Brian Walsh

Neurorespiratory 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.

Chair:

Lee R Guion MA RRT
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GuionL@aol.com

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 2010.

Chair:

Jonathan Waugh PhD RRT RPFT
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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.

Chair:

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Liaison: Joe Lewarski, BS 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.

Chair:

John Davies
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Carey NC 27513
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Liaison: Frank Salvatore, BS RRT FAARC

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.

Chair: Cliff Boehm, MD

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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.

Chair:

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Liaison: Doug Laher, MBA RRT

Geriatric Roundtable**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 youlunghealth.org for relevance and appropriateness for geriatric population.

Chair: Mary Hart, BS RRT AE-C

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Liaison: Debbie Fox, MBA, RRT-NPS

Ad Hoc Committee Index

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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.

Chair

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AARC Staff: TBD

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.

Chair:

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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.

Chair:

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AARC Staff: Bill Dubbs, MEd, RRT, FAARC

Ad Hoc Committee on Mass Casualty/Pandemic

Objectives:

1. TBD

Chair:

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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 cost of:
 - a. development of a "Center for Excellence" program
 - b. maintenance of said program
 - c. projected cost for program participants

Chair:

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Ad Hoc Committee on Learning Institutes

Objectives:

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Management Institute Chair: Richard Ford, BS, RRT, FAARC

Ad Hoc Committee on Home Oxygen

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Members:

Dr. Nick Hill

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E-Motions

E-Motions

Since Last Board Meeting in December, 2009

- 10-1-81.1 “That the AARC Board ratify the appointment of David Vines to be an AARC representative to the National Board for Respiratory Care (NBRC).”
- 10-1-80.1 “That the AARC Board ratify the appointment of Diane Flatland to CoARC.”
- 10-1-80.2 “That the AARC Board approve the CoARC Standards.”

GENERAL REPORTS

President's Report

Past President's Report

Executive Director Report



Federal Government Affairs Activity Report – April 2010

Cheryl A. West, MHA, Director Government Affairs
Miriam O'Day, Director Legislative Affairs
Anne Marie Hummel, Director Regulatory Affairs

The Congress

With Congress reconvening in January the partisan infighting between Democrats and Republicans has not diminished from last year.

As this report is written, the House just passed the Senate-approved version of the very contentious health care reform bill by a vote of 219 to 212, including a package of amendments known as a reconciliation bill. There were no Republican votes for either measure. The President is expected to sign the landmark bill on March 23 without waiting for the Senate to deal with the package of revisions, although the Senate plans to work on the House-passed revisions subsequent to the President's signing.

Legislation

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

The AARC's advocacy efforts remain focused on HR 1077 and S 343, the Medicare Respiratory Therapy Initiative.

Last fall, Congressman Ross, our primary House co-sponsor, added HR 1077 as an amendment to the House version of the health care reform bill during the final Energy and Commerce Committee mark-up process. Chairman Waxman accepted the amendment and AARC expected to see the provisions of HR 1077 in the final bill. Unfortunately, the Congressional Budget Office (CBO) estimated the cost of HR 1077 much higher than the original estimate. The initial cost estimate for HR 1077 was \$100 million over ten years. This estimate was significantly higher than the independent cost estimate AARC commissioned initially and we believe to be in error. However, we were told that the \$100 million estimate was acceptable to the Committee and our provisions would stay in the House health reform legislation. However, during the final bill mark-up a subsequent cost estimate for our provisions came in at \$2 billion (House). The primary Senate sponsor Blanche Lincoln introduced S 343 as an amendment to the Finance Committee bill and then withdrew the provision due to a \$3 billion over a ten-year period by CBO.

These billion dollar estimates are unsupportable. The AARC rushed the 2010 workforce data to the hill and prepared a "white paper" refuting the CBO score. AARC continues to seek a justification from CBO as to how the score was reached. This justification will help the Association renegotiate the provisions of the bill. It is important to understand the CBO assumptions because if the score is based on the Medicare population and

oxygen utilization or other factors this needs to be clarified; if the assumptions are based on the RT workforce we may require a legislative redraft. The AARC made the request for a new score one of the top priorities for the March PACT meeting.

The legislation continues to have support from consumer, patient and physician organizations and there is no known opposition. We will continue our efforts to have CBO revise its cost estimate and look for opportunities to add our bill's provisions onto "must pass" legislation.

Create a Specific COPD Program within the CDC

AARC continues to partner with the US COPD Coalition in its efforts to draft and introduce authorizing legislation to designate a COPD program at the CDC in the Chronic Disease Division. The US COPD Coalition Executive Committee hired a consultant to produce the legislative draft and build consensus with the Coalition members which include, ALA, ATS, ACCP and others. During the drafting process a decision was made to expand the legislative language to include more than just the CDC and to address the need for a comprehensive response to COPD across all federal agencies. It is hoped that when the legislation is introduced it will be supported by all US COPD membership organizations.

Repeal of Medicare DMEPOS Competitive Acquisition Program – HR 3790

When it became clear that last year's industry/consumer/professional association-wide effort to reform the Medicare home oxygen benefit would not come to fruition, the focus of the HME Industry turned to legislation that would overturn the Medicare Competitive Bidding Program law. Last fall, Rep. Kendrick Meek, (D-FL) introduced a bill that would repeal the Medicare competitive bidding program for all items of DME subject to the provision, not just oxygen equipment and supplies. The AARC sent a letter to Congressman Meek supporting HR 3790. This legislation is designed to be budget neutral by offering a series of limited cuts in all DME items except certain complex rehab items (power wheelchairs) and a freeze in the Consumer Price Index. With 176 co-sponsors so far, the bill is gaining support on the Hill and is close to reaching the magic number of 218, the number the HME industry believes is necessary to persuade the House to Act on the bill. As with any health related bill that has a significant number of co-sponsors, the provisions of such a bill would be added on to a "must pass" piece of legislation. It remains to be seen what the "must pass" legislation is to be.

Adding fuel to the fire is a new study conducted by economist Brian O'Roark at Robert Morris University in Pittsburgh and funded by the VGM Group, one of the most influential groups in the HME industry. It concluded that a national competitive bidding program might lead CMS to see short-term benefits, but in the long run, the HME industry will be compromised (competition will decrease, prices will be higher and services will be reduced) and patients will be worse off than before the government intervened.

Repeal of Medicare's 36-Month Cap on Home Oxygen Therapy under the DME Benefit – HR 2373

Introduced by Reps. Tom Price, R-GA, and Heath Shuler, D-NC last summer, the bill to repeal the law that limits rental payments for oxygen equipment and supplies to 36 months has been stalled. As you recall, the AARC opposed the initial legislation that created the 36 month rental cap that eventually became law. Unlike the bill to repeal the Medicare DME competitive bid program, (HR 3790), the 36 month repeal bill never included a "pay for" provision; that is, finding cost savings to replace the savings that have resulted from imposing the 36-month cap. Without "pay for" provisions, this essentially makes it impossible to move the legislation forward.

As this report is written, we understand that the sponsors of the bill have indicated a willingness to introduce an amendment if the HME industry can come up with a “pay for” provision fairly soon. Having initially withheld its support, AAHomecare released an issue paper calling for the addition of key improvements to the bill, including “linking” payment to beneficiary need and patient protections, while sparing oxygen patients from further reductions.” We expect the patient protections that AARC worked on previously with the stakeholders’ groups last fall to eventually make it into the amendment.

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.

Coalition for Health Funding

We continue to align the AARC with this very broad based group that collectively supports greater funding, via the budget process for programs within the US Public Health Service (PHS). In February AARC signed on to a letter to Congress requesting that the FY 2011 PHS budget be increased and funds directed to a number of programs including health professional education, biomedical research, and disease prevention and health promotion efforts.

Friends of National Center for Health Statistics (FNCHS) Coalition

AARC is among the 50 plus associations and organizations to sign onto Capitol Hill support letters to maintain the funding levels for the NCHS, and agency within the CDC that collects data NCHS collects data on chronic disease prevalence, health care disparities, emergency room use, infant mortality, causes of death, and rates of insurance to name a few.

Tobacco Partners

The AARC signed on to a joint letter that went to key Senators and House Members requesting that any health reform legislation include an important wellness and prevention component requiring states to cover comprehensive tobacco cessation benefits for all Medicaid recipients.

Political Advocacy Contact Team (PACT) Representatives

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

The 2010 PACT DC Hill Day was held March 9th. Ninety-nine respiratory therapists from 45 states and the District of Columbia came to Washington D.C. to represent the profession on Capitol Hill. As has become standard, we had over 300 scheduled Hill visits and generated support for both HR 1077/S 343 and a legislative concept proposal that would create a COPD program within the CDC.

This year the AARC partnered with members of the Alpha-1 Association and Alpha-1 Foundation. Respiratory patients accompanied the PACT members from their respective states to numerous Hill meetings. The Alphas brought a much needed patient perspective to Hill staff and Congressional members about the merits of our issues. It was an excellent addition to our efforts and we are most grateful to these patients and the Alpha organizations for making this possible. The logistics of adding pulmonary disease patients to our Washington meetings was challenging for both organizations and their respective staffs. The AARC has been commended by the Alphas for offering advocacy leadership and addressing these challenges.

This year the AARC also had the great honor of placing a wreath at the Tomb of the Unknown Soldier at Arlington National Cemetery. AARC President Tim Myers, AARC President Elect Karen Stewart, AARC Past President John Hiser and Georgia House of Delegate and PACT representative Bob DeLorme personally laid the AARC's official wreath on the Tomb. Because this event occurred the first day of the PACT meeting, many of our PACT reps came to Arlington Cemetery to watch the ceremony.

Regulations and Other Issues of Interest

Outpatient Pulmonary Rehabilitation (PR)

Since the final regulations were published late last year to implement the new PR benefit, AARC has been working with our sister pulmonary organizations – AACVPR, ATS, ACCP and NAMDRRC – to ensure that local Medicare contractors are up-to-date on the new provisions. In February a conference call was held with two contractors responsible for jurisdictions in the New England area as well as Connecticut and New York. Both expressed interest in working with our organizations as they develop new local coverage determinations (LCDs). One of our goals in working with the contractors is to find ways in which they may consider expanding coverage to other medical conditions in the absence of a national coverage determination by CMS. We will continue to monitor activities as new LCDs are drafted and provide comments as appropriate. AARC has also compiled a list of Frequently Asked Questions and will work with the other pulmonary organizations to ensure that we are all on the same page.

Instructions were also sent to contractors by CMS explaining the coding and billing requirements for COPD and non-COPD beneficiaries. It included examples of how to bill for 1- and 2-hour sessions. At a minimum a 1-hour session must contain 31 minutes and two one-hour sessions must total at least 91 minutes. CMS has also instructed contractors not to enforce the supervision requirements that impact pulmonary rehab and other therapeutic services provided to hospital outpatients in Critical Access Hospitals (CAHs) for the duration of 2010. Requiring a physician to be on site at all times services are being provided has caused an undue burden on these facilities, especially in rural areas. CMS will revisit the issue of supervision in CAHs in its annual rulemaking cycle for 2011.

Competitive Bidding

CMS continues to move forward with its implementation schedule for the competitive bid program. When implemented competitive bid will establish a system whereby DME providers in a specific geographical area will submit a bid price on specific product categories including oxygen and oxygen equipment. Those companies selected by CMS will win a contract to provide that specific category of services to the Medicare beneficiaries in that area. Those who do not win a contract will not be able to provide Medicare covered DME unless they decide to become “grandfathered in”, which means they agree to furnish services at the price CMS

pays the suppliers who won the bids. This is a simplified version of a complex program; however, that is the gist of it.

CMS briefed the House Energy and Commerce Committee on the program on March 9, highlighting the improvements they believe have been made to the program and laying out the timelines for Rounds 1 and 2. The Round 1 winners will be announced in June 2010, with new contracts and prices to begin January 1, 2011. Registration for Round 2 starts in the winter of 2010 with the winning bidders to be announced in the spring 2012. If all goes according to plan, Round 2 pricing will go into effect January 1, 2013. However, if as noted above the HR 3790 is enacted, the competitive bid program will be halted in its entirety.

Medicare Survey of Oxygen Patients

In order to satisfy a Congressional mandate in the Medicare Modernization Act to evaluate the competitive bidding program, CMS has contracted with ABT Associates, the company who developed the DME Supplier Standards, to design and conduct a survey of Medicare beneficiaries on their use of home oxygen equipment and supplies. Although CMS developed a similar survey instrument in 2007 and solicited AARC's endorsement as a way to encourage responses, that survey never got off the ground largely due to legislative and regulatory delays in implementing the program.

AARC submitted comments to CMS, together with the American Lung Association, National Association of Home Oxygen Patients, AACP and NAMDRG on ways to improve the survey instrument. Of note were additional questions we suggested that would delineate whether a RT provided education and training in the hospital as opposed to the home setting and whether the supplier informed the beneficiary of all types of oxygen equipment available, not just the ones the supplier had in inventory.

Prepayment Review of Certain Oxygen Equipment Completed

In our last report we notified you of a prepayment probe of claims for oxygen concentrators (E1390) and portable gaseous oxygen systems (E0431) to determine if items billed are in compliance with existing Medicare reasonable and necessary criteria.

According to Noridian, the Jurisdiction D DME MAC, the review found an 85% error rate on oxygen claims (86 out of 102 claims were denied, although the total claim volume was higher because some claims had multiple errors). Top reasons for the denials included lack of office visit notes to substantiate medical necessity based on certification and recertification requirements; failure to supply medical records when requested; no qualifying blood gas study submitted; and an invalid Certificate of Medical Necessity (CMN). With respect to the latter, the CMN was deemed invalid if the CMN contained the qualifying blood gas study but the medical record showed no entry of the correlating study. As a reminder, CMS has sent out "Dear Physician" letters about the need for patients' records to be documented and regular reviews to be conducted by the physician or his/her staff to assess medical need.

Prepayment Review of Nebulizers with Compressor to Begin

Like the initiative on oxygen claims, there is apparently a high volume of claims errors for nebulizers with compressors that have prompted a new prepayment review by the DME MACs. A common problem in these reviews is missing or incomplete records. Suppliers are reminded to be familiar with the coverage criteria and documentation requirements outlined in the local coverage policies which require a new order every 12 months

for ALL inhalation drugs even if the prescription has not changed. Among other things, the review will focus on the amount of solution and frequency of use, and clinical records documenting the treating physician's oversight, continued medical necessity and the patient's compliance with the treatment plan for aerosols.

GAO Study on Home Oxygen

The General Accounting Office (GAO) is conducting an independent study on home oxygen. They are looking at costs associated with equipment and services, access issues resulting from the 36-month rental cap and other payment changes, and beneficiaries' needs for different types of equipment. The study is expected to be concluded within a fairly short time frame.

At GAO's request, AARC provided them with information on states that require the services of a respiratory therapist in providing home oxygen. They specifically wanted to know how RTs fit into the provision of home oxygen and scheduled a conference call with the Executive Office to discuss specific questions. During the call, GAO staff was most interested in whether DMEs have the "power" to make the decisions on what equipment to use to fill the script and why we thought they made the decisions they do. As additional information, we sent them the 2002 *Chest* study (RTs doing oxygen management cut oxygen usage by one-third); the new COPD management study that showed RTs doing COPD management cut readmissions for COPD patients by 41%; the Medicare coverage policies on home oxygen; and linked them to our AARC website page on recognition awards for DME.

Revisions to Local Coverage Policies on CPAP and Respiratory Assist Devices (RADs)

The regional contractors responsible for DMEPOS have recently updated and revised local coverage policies regarding CPAP for the treatment of obstructive sleep apnea and bi-level respiratory assist devices with and without backup. The CPAP changes address physician credentialing and the interpretation of facility-based polysomnograms, revisions to the type of sleep tests, and coverage of replacement devices and/or accessories. The RAD policies add a new coverage provision for hypoventilation syndrome and a monitoring requirement for supplies and accessories.

New Safety Requirements from FDA for Long-Acting Beta Agonists (LABAs)

On February 19, AARC was invited to be on a special FDA conference call prior to media announcement about new safety requirements regarding LABAs used in the treatment of asthma. FDA is particularly concerned about proper use by pediatric and adolescent patients and emphasized that LABAs should never be used without the addition of an asthma controller medication such as an inhaled steroid. Further, FDA stressed that LABAs should be used only for the shortest period of time required to achieve control of asthma symptoms and then discontinued. Subsequent to the announcement, a leading panel of asthma experts criticized the FDA rulings and noted that they were counter to established asthma guidelines. One of experts, Dr. William Busse, wrote the 2007 "asthma bible" that most doctors follow.

FDA's Regulation of Tobacco Products

On March 18, the FDA announced new rules that will greatly restrict the way the tobacco industry can advertise and sell cigarettes and smokeless tobacco products, especially marketing efforts designed to appeal to children. One key provision includes a ban on tobacco companies sponsoring sporting and entertaining events. The next step in regulating tobacco products involves a new request for public comment on how use of dissolvable tobacco products may impact public health, including such use among children.

The FDA recently announced its roster of advisors to the Tobacco Products Scientific Advisory Committee which is tasked with submitting reports or recommendations on tobacco-related topics as part of FDA's new authority to regulate tobacco products. As noted in our last report, we recommended that Dr. Waugh be considered for nomination. Unfortunately, he was not listed in the roster just released. However, in the event there are future FDA regulations of interest to AARC requiring public input, we will continue to use his expertise in formulating comments.

2010 Office of the Inspector General (OIG) Work Plan

In the December 2009 report to the Board, we highlighted several areas in the OIG's 2010 Work Plan that could be of interest to AARC; namely, appropriateness of payments for polysomnography, enrollment standards for Independent Diagnostic Treatment Facilities (IDTFs), and a review of payments to DME suppliers of oxygen concentrators where there is a high-volume of claims. Added to that list is a review of suppliers' records and information from beneficiaries to determine whether oxygen equipment and other items of DME are categorized properly due to the evolution of products since the DME fee schedule was created over 20 years ago.

Since the OIG does not provide information on the status of jobs contained in its Work Plan, we are not able to update you on these activities. However, we will continue to monitor the OIG site as reports are published and report back as appropriate in the future.

OIG Issues Compendium of Unimplemented Recommendations – Cites 13-month Oxygen CAP

As you may recall, several years ago, 2006 to be exact, the OIG recommended that CMS reduce the rental period for home oxygen to 13 months. At the time, the OIG noted that the Medicare program and beneficiaries could save up to \$3.2 billion over 5 years if the change was implemented. While CMS apparently agreed with the recommendation, the agency said it had no legal authority to act on it. The OIG also recommended determining the necessity and frequency of non-routine maintenance and servicing for concentrators, and whether a new payment methodology for portable oxygen was appropriate.

On March 11, the OIG released a compendium of its unimplemented recommendations. As a status report, the OIG notes "We continue to encourage CMS to work with Congress to reduce the rental period." In fact, the 13-month cap was number six on a list of seven top-priorities that the OIG feels will have the most impact on the Medicare program. We know that reducing the rental period even more than the current 36-month would have a disastrous impact on patients. It is unclear right now what, if anything, CMS will do to re-address the issues outlined in the report. However, we will monitor the activities and report back as appropriate. Other top priorities on the list that involve DME issues include (5), ensuring compliance with the enrollment standards and (7) eliminating fraudulent or excessive inhalation drug claims in South Florida

Conclusion

We expect that the impending 2010 elections will impact the ability of Congress to accomplish legislative action, especially on high profile legislative proposals. However, the regulatory agencies continue to carry on as always and we will continue to respond to any new challenges or opportunities that may arise.

Miriam, Anne Marie and I will provide a verbal update on these or other issues at the April meeting.

AARC State Government Affairs Activity Report

April 2010

**Cheryl A. West, MHA
Director Government Affairs**

Most state legislatures reconvened in January. Unfortunately, 2010 continued on the path of 2009, that is, states continue to struggle with the economic recession which is putting an enormous strain on all sectors of state spending. With the unemployment rate topping 10% nationwide, the ramifications on state budgets is as expected; more demand – less money. 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 state based health insurance programs, but again given the economic conditions, discussions will most likely remain just that, discussions. One pattern of legislation clearly emerging is an increase in legislation to raise tobacco taxes and an array of licensing fees (including professional licenses such as those for RTs) thereby bringing more revenue into the state coffers.

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

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

RT Licensure Legislation

Hawaii - The HSRC has once again mounted a legislative effort to gain licensure for RTs in the state. Again they are facing a skeptical legislature, doubting (for some unfathomable reason) the need to have HI RTs licensed. Moreover, the sleep interests in the state again are strongly opposing the RT licensing initiative. The HSRC had revised last years draft legislation which had garnered such opposition from the sleep interests. This year's version removed any references to sleep, however the sleep interests are still opposed, stating to legislators that enacting RT licensure will result in polysoms losing their jobs. The sleep interests are demanding that an extensive exemption be provided for any and all sleep personnel including "students". The HSRC is trying to placate the sleep interests in order to remove the obstacle to move forward with RT licensure by offering an exemption that is limited but is not sweeping.

Washington State - a bill that would, in addition to physicians add physician assistants and advanced practice nurses to supervise and write orders for RT services and therapists. This bill is supported by the WA RC State Society. There is an extreme shortage of physicians in the rural and more remote parts of the state. This bill would alleviate the problem of having enough physicians in these outlying areas available when respiratory therapists provide services.

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 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.

Illinois - strengthens provisions that address non licensed individuals who provide health related services only a licensed practitioner may provide (includes RT).

Maryland - has a bill that will provide scholarships for students entering into certain bachelor degree health programs (includes RT).

New Mexico - in a cost cutting effort this legislation would transfer many independent licensure boards, including RT and nursing to the NM Medical Board. The concern is that the legislation does not create advisory sub-committee under the Board of Medicine (BOM), which would mean all issues relevant to any profession would have to be addressed by the full BOM.

Indiana - Enacted would increase many licensing boards' authority (including RT) to issue cease and desist orders for those practicing a regulated profession without a license.

Louisiana -adds licensed respiratory therapists, radiologic techs, and clinical laboratory scientists to the definition of "health care provider" for the purposes of the medical malpractice acts for state and private services. Also a bill that imposes a criminal penalty against those who commit an act of battery against a health care provider. The bill goes on to add RTs in the definition of a health care provider.

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: **HI, OK, MS.**

Track asthma admissions to hospitals: **AR**

Asthma testing of school kids or use of asthma meds at school: **IL, MO, MS, SD.**

Plan for Comprehensive Treatment of Chronic Obstructive Pulmonary Disease legislation: **GA, KS, MO, OK, FL, VT, VA** (a resolution not legislation-less force of law).

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. Some interesting tobacco related legislation introduced:

Ban smoking in public places: **AL, IN, MS**

Ban smoking in correctional facilities: **MS**

Ban smoking in a car that has a child(ren) in it: **MS, UT, FL**

Prohibit the sale of cigarettes in health care facilities, including a pharmacy: **RI**

Prohibit selling cigarettes in vending machines: **NJ**

Challenges from Other Occupations

We continue to monitor legislative activities by other professions and disciplines. Seemingly small changes such as who may provide a service, qualifications 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.

Perfusion Licensure

Kansas - The KSRC has been working with the state society representing perfusionists as this discipline attempts to gain first time licensure. The KSRC is supportive of these efforts as long as the legislative language will not impede those licensed respiratory therapists from continuing to provide perfusion services, in particular ECMO.

Maryland - this legislation to license perfusionists was defeated during the legislative process. While there was a general exemption for licensed professionals practicing within their scope there was no explicit exemption for RTs doing ECMO.

Florida - efforts to license perfusion personnel has been underway since early 2009. The most recent draft includes an explicit exemption for RTs.

Medication Aides/Assistants/Home Health Aides Etc.

There is a growing and troubling trend for legislation to be proposed that would permit non licensed or “lesser” regulated disciplines to provide traditional services currently only permitted to be provided by licensed health professionals. This can be viewed as a state’s way to decrease costs when providing state sponsored health services, such as Medicaid services. Why pay the high cost of a nurse to visit a home patient when a nurse aide can be delegated to perform the same service? These efforts may also be occurring due to the shortage (and again the costs) of licensed health professionals and the greater number of patients in requiring services.

Arizona - in nursing homes would expand the services that can be delegated to medication aides.

Oklahoma - would permit the administration of medication to a resident of a residential care home; allowing any employee to assist a home resident with the use of prescription nebulizers or inhalers.

Georgia - there is a bill that would permit a nurse to delegate to non licensed individuals services that cover “health maintenance activities”. Since a nurse can argue they can provide RT services, the nurse can now delegate these RT services to nonlicensed personnel. The intention was benign - find a less costly way to assist stable disabled people in their homes, without the cost of providing, for example a licensed nurse, PT, or RT. However, health maintenance activities can easily cover ventilator maintenance and other RT related services. The GSRC is working with supportive legislators to refine the language.

Rhode Island- there is a bill that would permit CNAs, home health aides, and medical assistants (all unlicensed) to administer to homebound patients any prescription drug. Since oxygen is a prescription drug, this would open the door for aides to provide O2 to patients.

West Virginia- has a bill, vague on details that would permit unlicensed personnel to administer medications.

Sleep Disorder or Polysomnography State Legislative Activities

Hawaii - sleep interests in Hawaii continue to oppose the licensure of respiratory therapists. The argument used against licensing RTs is that given the scope of practice this legislation (among other items includes oxygen therapy), if enacted the result will be that polysoms will lose their jobs. An exemption provision for all polysoms has been added to the legislation in the hope that the sleep interests will cease their strong opposition.

New York - a polysom licensure bill, identical to legislation introduced in the previous 2 legislative sessions, has been introduced in both Houses of the legislature. This legislation exempts RTs, and requires that the polysoms graduate from an associate degree program in polysom. It also requires that until 4 associate degree polysom programs are established in NY, the NY Bd. of Education will approve *equivalent* educational programs. Of the 26 CAAHEP accredited polysom programs in the United States none are located in NY. Moreover, of the 26 CAAHEP accredited programs in the US, only 10 offer an associate degree. Therefore, if enacted without change the NY Bd. of Education will be very busy trying to find and approve polysom education programs that are comparable to one that offers an associate degree.

Kentucky - The KSRC and the KY Sleep Society have continued their open dialog to work out any differences in the proposed legislation to license polysoms in the state. The key sticking point is the request from the KSRC

to include a specific exemption for RTs. The positive aspect of the bill is that polysoms will be licensed under the Respiratory Care Licensure Board.

Virginia –The VSRC worked cordially with the KY Sleep Society to develop and enact a polysom licensure bill. The state of Virginia enacts licensure laws that are limited in detail, leaving extensive details to be decided via regulations. The polysoms will be licensed under the Board of Medicine and respiratory therapists are explicitly exempt from the provisions.

I will provide a verbal update at the April Board of Directors meeting.

House of Delegates Report

Reporter: Thomas Lamphere

Last submitted: 2010-03-31 08:57:16.0

Recommendations

[Insert recommendations here]

2010 GOALS

1. Develop and execute strategies with the Chartered Affiliates that will focus on membership and participation in the AARC.

a. Review the current AARC membership strategy and provide up to date report from the Membership Committee on both affiliate membership strengths & weaknesses.

i. AARC Membership Committee working on multiple projects aimed at membership recruitment and retention. One project involves recording webcasts aimed specifically at the state affiliate membership chairs and other leaders. These webcasts will be discussed at the upcoming AARC Leadership Workshop.

b. Conduct focus group meetings centered on enhancing membership in 2011 at the December HOD meeting.

i. Scheduled for December meeting.

2. Continue to strengthen good communication and enhance relationships between the Chartered Affiliates and the AARC.

a. Continue Best Practice presentations at both HOD meetings.

i. Multiple presentations scheduled for the Summer HOD meeting.

b. Search for ways to establish communication and sharing of information between the affiliates.

c. Search for ways to establish communication and sharing of information between the affiliates and the AARC.

i. "Big List To Take Home" from all HOD meetings proved successful in 2009 and will be continued in 2010.

- ii. Brainstorming session scheduled for Summer HOD meeting to obtain input from all affiliates on this topic.
- iii. Working with AARC Executive Office staff to brainstorm ways to improve communication between AARC and affiliates including email list-servers, social networking site, etc..

3. Continue to develop the processes of mentoring HOD members into leadership roles for the HOD and the AARC.

- i. In 2009, “Committee Co-Chairs” were established with the idea that the co-chair would assume the “chair” position the following year. However, this process needs to be refined as many co-chairs are no longer in the HOD in 2010. This topic will be discussed at the Summer HOD meeting and will include the Speaker-Elect for a smooth transition into 2011.

4. Continue to support and enhance the “Respiratory Therapist for 2015 and Beyond” project through communication, education, and specific committee guidance.

- i. Awaiting further information on the next steps in this project.

5. Continue to promote access to Respiratory Therapists by supporting the Respiratory Therapy Initiative through both the individual actions of the HOD members and through the actions of the state affiliates.

- i. A presentation will be given at the Summer HOD on the importance of having a state affiliate plan similar to 435 Plan. The presentation will include the “What, Why and How” on that type of program and will also include emphasis on the importance of active state affiliate participation in the AARC 435 Plan.

6. Conduct efficient and effective HOD meetings while continuously reviewing all HOD processes searching for ways to improve the efficiency and effectiveness of the meetings.

- a. Continue to strengthen resolution process through education and awareness.
 - i. A short presentation on the resolution process and the importance of this process will be given at the Summer HOD meeting.
 - b. Enhance committee chair roles through a complete review of charges, goal development, mentoring within the committees, assurance of “working” time during HOD meetings, and an evaluation process for committee chairs.
 - i. Ongoing. The HOD Officers have reviewed the charges and are making recommendations for changes to those charges.
- c. Continue allotted time to discuss issues related to reports.

d. Work to have an active and goal oriented HOD executive board.

i. HOD Officers are communicating regularly via email and conference calls.

7. 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.

i. Ongoing.

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.

i. Ongoing.

Board of Medical Advisors Report

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Medical Advisors Meeting
December 6, 2009
San Antonio, Texas

Minutes

Attendance

Kent Christopher, MD, RRT, FCCP (ACCP) **Chair**
Cliff Boehm, MD, RRT, (ASA) Chair-elect
William Bernhard, MD (ASA)
Ira Cheifetz, MD, FCCM, FAARC, (SCCM)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)
Joseph Sokolowski, MD (ATS)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
Richard Sheldon, MD, FACP, FCCP, FACP (NAMDRC)
Terence Carey, MD (ACAAI)
Brad Chipps, MD (ACAAI)
Robin Elwood, MD (ASA)
Christopher Randolph, MD (AAAAI)
Russ Acevedo, MD, FAARC, FCCP, FCCM (ACCP)
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
Phillip Marcus, MD, MPH, FCCP, FACP (NAMDRC)
Gerald Weinhouse, MD (ATS)

Guests

Col. Michael J. Morris RET
Tim Myers, BS, RRT-NPS
Karen Stewart, MSc, RRT, FAARC
Gary Smith
Sherry Barnhart, RRT-NPS FAARC
Lori Tinkler, MBA
Tom Smalling, PhD, RRT, RPSGT
David Bowton, MD, FCCP, FCCM
John Hiser, MEd, RRT, FAARC
Jerome Sullivan, PhD, RRT, FAARC
Hector Garza, MD
Ted Oslick, MD

Absent

Steven Boas, MD (AAP)

Consultant

Toni Rodriguez, EdD, RRT

Staff

Sam Giordano, MBA, RRT, FAARC
Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Director of Regulatory Affairs
Miriam O'Day, Director of Federal Government Affairs
Sherry Milligan, MBA, Associate Executive Director
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

Chairman Kent Christopher called the meeting of the AARC Board of Medical Advisors to order at 9:45 a.m. CST, Sunday, December 6, 2009.

APPROVAL OF MINUTES

Dr. Randolph moved “To accept the minutes of the June 6 meeting of the AARC Board of Medical Advisors as amended.”

Motion Carried

EXECUTIVE OFFICE REPORT

Executive Director Sam Giordano updated members on the *2015 and Beyond* project stating that BOMA members will receive copies of the 3rd Conference summary paper when completed. The 3rd Conference will hopefully take place summer of 2010. Surveys will be coming out after January 1st asking what RTs of the future will be doing as increasing numbers of patients will require respiratory care services as baby boomers age. He also advised of the meeting that took place in September between representatives from AARC, AASM and AAST. Overall, he felt the meeting was beneficial to all involved and believes it will promote future dialogue. There was interest in generating a letter acknowledging scope of practice overlap. Mr. Giordano made a plea for reinvigorated support from physician organizations. Members discussed the concept of hiring bachelors level respiratory therapists as well as the need for more respiratory care protocols. Also discussed was the output of respiratory schools versus the future (projected) needs. The impact of Part B initiative was discussed as it might relate to RTs making home visits to perform CPAP, O₂Rx, etc., under the direction of the physician with billing by the physician.

INTERNATIONAL RESPIRATORY CARE

John Hiser provided an overview of the International Fellowship Program and described the contributions of past Fellows to the AARC. These include translations of AARC materials into their native language and the authoring of articles appearing in AARC publications. He introduced, via a slide show, this year’s class of Fellows.

Jerome Sullivan updated the group on the International Council for Respiratory Care (ICRC) and gave an overview of the state of the profession throughout the world. He noted that the ICRC has been in existence for nearly 20 years. Mr. Sullivan described the International Education Recognition System (IERS) and provided an update on the programs now offered throughout the world that have been approved through the IERS system.

Dr. Hector Leon Garza expressed his gratitude to the AARC and described the evolution of the profession in Mexico. This year was the 10th Annual Conference in Mexico. He also described the certifying board system, the Latin American Board for Professional Certification in Respiratory Therapy (LABPCRT) developed in Latin America to credential respiratory therapists and reported on the numbers and pass rates from various Latin countries. The following countries are participating in the LABPCRT: Columbia, Costa Rica, Guatemala, Mexico, Panama, Venezuela, Argentina, Chile, Peru, Spain and Ecuador.

GOVERNMENT AFFAIRS REPORT

Cheryl West, Director of Government Affairs, provided a short update to her written report, discussing polysomnography issues around the country.

Anne Marie Hummel, Director of Federal Regulatory Affairs, gave an update on the new regulations on pulmonary rehab. She advised of a coalition of groups that have been working together to have a collective voice on the issue in communicating with CMS. They will be issuing a FAQ on the issue.

Miriam O'Day, Director of Federal Government Affairs, gave an update on the AARC's Part B Initiative and health reform legislation. Our legislation is currently not included in either the House or Senate version of health reform. She explained that the Congressional Budget Office has given an unreasonable, high dollar score to the AARC's bill, thus leading to our elimination from the various bills. We have supplied new manpower data to CBO and hope to get them to review our score again.

Questions from the group were taken. Anne Marie Hummel reviewed the Joint Commission's decision to accept the CMS interpretation that RTs can carry out orders from a nurse practitioner or physician assistant if a doctor cosigns in a timely manner. Also, the role of the medical director under the new pulmonary rehabilitation regulations was discussed.

COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE (CoARC) REPORT

2010 CoARC Chair, Dr. David Bowton, and Executive Director Tom Smalling, updated their written report and advised that CoARC's name now officially uses "Commission," rather than "Committee" reflecting the fact they are now an independent accreditor. They have agreements in place to use CAAHEP standards through June 1, 2010, but will then be promulgating their new standards. CoARC is looking for a reply from all sponsors in January. The members of BOMA affirmed their willingness to seek affirmation of the new CoARC standards from their respective medical groups.

CoARC will have a new website and new electronic reporting tool for schools to update their outcomes and assessments. The new website will allow students to research the outcomes of their schools.

In 2012, all 100-level programs will be phased out and students will need to fulfill their requirements at that time to graduate out of the system. He further stated that the medical director of a respiratory care program will remain one of the “key program personnel.”

NATIONAL BOARD FOR RESPIRATORY CARE (NBRC) REPORT

NBRC President Sherry Barnhart, updated her written report. She expressed that their 18th annual state board conference attracted 26 states and continues to be well received. She reported they will be looking at additional marketing initiatives after the first of the year for the new Sleep Disorders Specialty Exam.

Ms. Barnhart noted that the Critical Care job analysis has been completed and that test development will begin. Implementation of the test is expected to occur in early 2012.

Additional discussion occurred on the sleep credential including the need for the AASM to recognize the SDS exam. Mention was made of the importance of defending the copyrighted term “RRT” from use by non-respiratory care personnel (such as the Rapid Response Team).

MILITARY REPORT

Col. Mike Morris RET noted that things are moving, though slowly, with military education of respiratory therapists. New requirements for Army/Navy respiratory students in concert with Thomas Edison College will be earning their mandated degrees prior to taking their CRT. All Army/Navy/Air Force training will occur in San Antonio in the future.

This group will be looking at an issue with the Air Force, as students coming from that program must wait for one year before taking their CRT. This is not true with the other branches.

Dr. Morris noted that the military members attending the AARC International Congress were very appreciative of AARC’s support of them.

NEONATAL/PEDIATRIC SECTION

Ira Cheifetz gave an update of Neonatal/Pediatric Section activities. This section has the largest number of members with over 2,000. The listserv is the primary means of communication, with approximately 200 postings per month.

Section leadership sought the advice of BOMA, asking if they would be willing to be a soundboard for various surveys on research. Consensus of the group was that they would be willing to serve in an advisory capacity.

SECTION REPORTS

A discussion ensued regarding the interplay between chairs of Sections and their medical advisors. Several requests were made for being placed on Section email lists. It was pointed out that Roundtables do not require BOMA liaison appointments.

UNFINISHED BUSINESS

The physician membership category was discussed and it was suggested that BOMA members be Associate Members of the AARC. This will be conveyed to the AARC Board of Directors.

RECESS

BOMA Chair Kent Christopher recessed the meeting of the AARC Board of Medical Advisors at 1:30 p.m. CST, Sunday, December 6, 2009.

RECONVENE

BOMA Chair Kent Christopher reconvened the meeting of the AARC Board of Medical Advisors at 1:45 p.m. CST, Sunday, December 6, 2009.

PRESIDENT'S REPORT

AARC President Tim Myers updated the group on various activities. He first introduced Karen Stewart, AARC's President-elect, and then he reviewed several projects over the course of the last year as follows.

Membership

AARC membership stands at an all-time high of 49,600 members, growing at a pace of 3-4% over the last several years. Membership initiatives will remain on top of the agenda for next year.

Patient Access

Patients having access to respiratory therapists across the continuum of care remains a priority. He reviewed the disappointing numbers generated by the Congressional Budget Office and said the AARC remains committed to following through on the Part B Initiative. Recent Human Resource Data from the AARC shows only 2-3% of respiratory therapists would qualify under the Part B Initiative and that they projected a \$2 billion cost of the program is out of line.

Polysomnography Issues

President Myers reviewed the scope of practice encroachments experienced in Tennessee earlier this year and the actions of the AARC undertaken on behalf of its members in that state. He noted that, while not a perfect resolution to the matter, a compromise was reached allowing the Tennessee Board to issue a competency mechanism to assure the competence of individuals rendering sleep services in the state. That mechanism is being finalized.

Also, AARC met with AASM officials in September to discuss issues of mutual interest.

Project 2015 and Beyond

The AARC has concluded 2 of 3 in the conference series. The paper from the second conference is undergoing peer review. The third conference will focus on how to get ideas from the first two conferences implemented by 2015.

Fast Track Institute

As the profession looks to a rapidly aging workforce, a project to educate respiratory therapists in research, education and management is planned. A core curriculum is being developed and then specialty tracks in each of the three areas will help prepare future leaders.

Webcast

AARC continues to have tremendous reach with our webcasts. It has proven to be a method of delivering timely information quickly and to a large group.

Asthma Educator Course

This course is now online. Individuals who were among the first to take their AE-C are in the time frame when they will have to be Asthma pre course and COPD educator – online web based.

National Ventilator Survey

HHS requested AARC to conduct a survey of all ventilators in the country. 75% of hospitals reported in.

In fielding questions from the group, Tim Myers and Sam Giordano reviewed schooling options for sleep individuals. Also discussed was a review course for test preparation.

REPORTS FROM SUPPORTING ORGANIZATIONS

Several members gave a quick update of activities in their sponsoring organizations.

NEW BOMA MEMBERS

The following physicians will join BOMA beginning in 2010, and Dr. Bernhard was reappointed to serve through 2013.

Christopher Randolph, MD (AAAAI)
Harold Manning, MD (ACCP)
Peter Papadakos, MD (SCCM)
Lori Conklin, MD (ASA)

NEW BUSINESS

A position statement on the Long Term Care Section was reviewed. Questions and additional discussion will occur via email.

PRESENTATION OF AWARDS

Three BOMA members were noted for their longevity in the group. Paul Selecky has been a member of BOMA for 28 years, and William Bernhard has been a member for 20 years. Jeff Vendor, who was not present, will receive a plaque by mail recognizing his 25 years on AARC's Board of Medical Advisors.

ADJOURNMENT

Chairman Kent Christopher adjourned the meeting of the AARC Board of Medical Advisors at 2:45 p.m. CST, Sunday, December 6, 2009.

President's Council Report

Reporter: Dianne Lewis

Last submitted: 2010-03-29 15:22:44.0

Recommendations

That the AARC BOD approve changes to Policy BOD.001

Report

The Presidents Council has changed the policy to reflect the current practice for nominating and electing the Jimmy A Young Medalist. Beginning with section 3 A. the text underlined is to be removed and the text in bold print is to be added.

American Association for Respiratory Care

Policy Statement

Page 1 of 2

Policy No.: BOD.001

SECTION: Board of Directors

SUBJECT: **Awards**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: July 2005

REFERENCES: AARC Bylaws

Policy Statement:

Policy Amplification:

1. The AARC Executive Committee shall serve as the central clearinghouse and review body for newly established AARC awards and/or major revision of currently existing awards.
2. The Board of Directors shall be responsible for:
 - A. Submitting nominations for **AARC Life and Honorary** membership awards to Presidents Council.
 - B. Submitting nominations for certain awards for related organizations such as the American Respiratory Care Foundation (ARCF)
3. The **Jimmy A. Young Medal:**
 - A. **Each year at the annual meeting of the Presidents Council**, the Chair of the Presidents Council shall issue a call for nominations for the Jimmy A. Young Medal, distribute the selection criteria and a roster of past medalists. **Members of the Presidents Council will have sixty (60) days from the date of the annual meeting of the Presidents Council to submit nominations for the Jimmy A. Young medal. Each nomination must be accompanied by a summary of the nominee's achievements and contributions, limited to two typed pages must accompany each nomination. and must be submitted within the sixty(60) day period to the Jimmy A. Young Nominations**

American Association for Respiratory Care

Policy Statement

Page 2 of 2

Policy No.: BOD.001

Committee. Nominations must be postmarked no later than 60 days from the date of the annual meeting of the Presidents Council.

•B. **The Nomination Committee shall be appointed by the Chair of the Presidents Council. The Committee is comprised of five (5) members, all of whom are Presidents Council members and past recipients of the Jimmy A. Young Medal. The chair of the Nominations Committee will be elected by members of the committee and shall serve a two (2) year term. Committee members shall serve for a term of two (2) years.**

•B. The profiles and ballots will be distributed to each member of the Presidents Council. The ballots must be post marked no later than 90 days following the Presidents Council annual meeting

C. Nominations with a summary of the nominee's achievements and contributions shall be sent to members of the Presidents Council to the Committee within sixty (60) days from the date of the annual meeting of the Presidents Council. The Nominations Committee will review all nominations and forward a single recommendation to the Presidents Council for approval.

Within twenty-one days following the established postmark deadline for return of the ballots, the ballots will be opened and counted by a Council member appointed by the Chair. Two AARC members must witness the opening and counting of the ballots. The result will be reported to the Chair of the Presidents Council.

D. An electronic vote for approval of the Committees recommendation by the Council shall occur no later than ninety (90) days from the date of the annual meeting of the Presidents Council. Results of the vote shall be compiled by the Chair of the Nominations Committee and reported to the Chair of the Council. The Chair of the Presidents Council shall inform the new recipient of the Jimmy A. Young Medal.

DEFINITIONS:

ATTACHMENTS: D: AARC AWARD GUIDELINES

Auditor's Report

Legal Counsel Report

Investment Report

CoARC Report

The CoARC report will be available at the meeting as a handout.

STANDING COMMITTEES

Bylaws Committee Report

Reporter: Billy Lamb

Last submitted: 2010-03-28 19:54:35.0

Recommendations

1. Add a field to the "AARC Chartered Affiliate Bylaws Status" tracking master list to reflect "Year Due for Review"

(http://www.aarc.org/state_society/aarc_hod/bylaws_status.html)

Report

Schedule for States Bylaws revisions is unclear, therefore a new field will be proposed to the tracking template reflecting the year each state's Bylaws are "DUE to Be Reviewed"

The Bylaws committee is presently reviewing the West Virginia Society for Respiratory Care's proposed revised Bylaws.

The Bylaws Committee expects revised Bylaws into the review process from New Jersey, Michigan and Iowa in 2010.

Elections Committee Report

Reporter: John Steinmetz

Last submitted: 2010-03-30 07:13:31.0

Recommendations

[The committee has no recommendations]

Report

[Committee is in the process of finalizing nominations]

Committee is finalizing candidate questions

Executive Committee Report

Finance Committee Report

Audit Sub-Committee Report

Reporter: Billy Lamb

Last submitted: 2010-03-31 18:49:27.0

Recommendations

1. The AARC BOD review AARC Policy FM. 018 which suggests rotating independant auditors every five (5) years and determine if the AARC should retain the current auditor or request another auditor for the 2010 audit or beyond.

Report

The AARC Audit Sub Committee met via conference call on Monday 15 March 2010 and reviewed the 2009 Draft Audit with the independant auditor. The audit subcommittee found the reported information to be fair and objective and reflective of the AARC's financial condition. The Audit Subcommittee finds the audit acceptable and has no unanswered questions or concerns.

Other

The current auditor has served the association for five (5) years and has performed very well. AARC policy suggests rotating independant auditors every five (5) years. It is the AARC Board of Directors option to retain the current auditor or request another auditor for 2010 or beyond.

Judicial Committee Report

Reporter: Patricia Blakely

Last submitted: 2010-03-03 09:41:32.0

Recommendations

No recommendations

Report

No formal complaints have been received for 2010. A pending complaint brought by the NYSSRC has been cancelled based on recommendation from the NYSSRC BOD.

Other

No additional information to report at this time.

Program Committee Report

Strategic Planning Committee Report

Reporter: Toni Rodriguez

Last submitted: 2010-03-30 16:54:34.0

Recommendations

No Recommendations at this time.

Report

No activity during this report period.

SPECIALTY SECTIONS

Adult Acute Care Section Report

Reporter: Michael Hewitt

Last submitted: 2010-03-25 14:56:43.0

Recommendations

[Insert recommendations here]

Report

The swap shop initiative that we have been working on for the better part of a year is ready for launch. However, with the upcoming launch of the AARC Connection site, we are holding off. We will launch the swap shop as part of the Connection rollout. The section thanks Sherry for all the work she has done assisting us with getting this initiative ready to launch.

A small group within the section is in the very early stage of becoming involved with the CPG committee to participate in the review and possible updating of specific CPG's of interest of the Adult Section.

Continuing Care-Rehabilitation Section **Report**

Reporter: Debra Koehl

Last submitted: 2010-03-08 13:27:48.0

Recommendations

- Based on feedback received from many pulmonary rehabilitation professionals. It is requested by these professionals that information in regards to RVU's be added to the AARC Uniform Reporting Manual.

Report

- Added Newsletter Editor, Gerilynn Connors to help in developing section newsletter.
- List serve has been active with many questions, concerns over new pulmonary rehabilitation guidelines. Questions answered and reviewed for correctness in information.
- Proposals were submitted for International Congress.
- This past congress with the changes in the new pulmonary rehabilitation guidelines I have seen an increase in newer people engaging in section list serve conversations.
- Working with Anne Marie Hummel in developing a FAQ paper in regards to new pulmonary rehabilitation guidelines
- Provided Sherry Milligan with a "blurb" about pulmonary rehab for the year of the lung information
- Recruiting new people to have provide articles, blurbs or other information for newsletters etc.

Diagnostic Section Report

AARC Activity Report
Spring, 2010

Chair: Melynn Wakeman

Liaison: Carl Mottram

Recommendation #1: The formation of a reciprocal agreement or alliance between the Diagnostics Section membership of the AARC and the Association for Respiratory Technology and Physiology (ARTP).

James Sullivan, BA, RPFT, of the Memorial Sloan-Kettering Cancer Center in New York, had the opportunity to speak at the 2010 ARTP annual conference, held in London in January 2010. Regarding pulmonary diagnostics, the United Kingdom is far ahead of the United States in many areas, and the ARTP is being used by WOLFAP (World Lung Function Accreditation Program) as one of their models for the creation of a global pulmonary laboratory accreditation standard. Approximately two-thirds of the pulmonary diagnostic technologists in the U.K. belong to the ARTP; Mr. Sullivan's opinion is that it is a vibrant, active organization. During his visit to London, Mr. Sullivan was able to speak with both Martyn Bucknall, current chair of the ARTP, and Dr. Brendan Cooper, past chair of the ARTP, and expressed his desire to develop some form of relationship between the AARC and the ARTP; this would facilitate the sharing of a great deal of knowledge and experience between practitioners that specialize just in pulmonary diagnostics. Both Mr. Bucknall and Dr. Cooper enthusiastically endorsed this idea, and were very willing to work with Mr. Sullivan to implement this. The details of this would need to be developed, but Mr. Sullivan suggests a reciprocal agreement, where membership in the AARC Diagnostics Section would offer some or all of the benefits the ARTP members enjoy, and visa-versa. Possibly an additional fee for the AARC Diagnostics Section members would be necessary to implement this, but this is another detail that can be worked out. Mr. Sullivan is willing to do whatever is needed on the AARC-end to facilitate this.

Education Section Report

Reporter: Lynda Goodfellow

Last submitted: 2010-03-25 12:49:05.0

Recommendations – No Recommendations

Report

[The Education Section has been very active since the last BOD meeting in December. Activities include:

1. Proposals for the Summer Meeting and Congress were reviewed with the Program Planning Committee liaison, Bill Galvin.
2. Articles for the Education Section Bulletin were submitted for spring edition. These include a "Notes from the Chair", an article on student recruitment strategies, and an interview with a hospital clinical educator. Bob Fluck is the new Ed Section Bulletin Editor.
3. Submissions for education related poster presentations for summer meeting are in review. More submissions were received than last year n=4.
4. Education Section List serve has been very active with discussions related to potential RT program closures.
5. Terry Volsko has agreed to chair the Educator Academy for the upcoming year.]

Home Care Section Report

Reporter: Robert McCoy

Last submitted: 2010-03-30 06:50:39.0

Recommendations

none

Report

Home Care section report

The home care section was able to reach the 1000 plus member level and will continue to have a position on the Board of Directors. The membership has adapted to the changing environment and is investigating opportunities to continue to provide clinical services in the face of continual reimbursement and regulatory challenges. According to a home care magazine article, there has been a 15% reduction in the number of providers as consolidation and business closures occur due to the unfavorable condition in the business.

The goal for this year has been to develop a closer working relationship with hospital RTs to improve communication and work towards a seamless transition for patients leaving the hospital to the home.

Late last year there was a webcast on the differences between hospital low flow oxygen therapy and long term oxygen therapy. The objective was to identify the differences in environment, products and patients activities related to LTOT. The webcast was well attended with over 200 participants. An article was just written by Greg Spratt and Bob McCoy on the top 10 things a home care therapist wants a hospital therapist to know about respiratory care in the home. Again, the objective is to raise awareness of the issue that will impact a patient's care when they leave the hospital and receive respiratory care in the home.

As more providers reduce the availability of respiratory therapy services, there will be a gap in clinical services that will need to be identified and bridged. Increasing the awareness of the needs of the home respiratory patients that will not be met by professional respiratory therapist will help identify the problem. Hopefully physicians will become more involved in solving the problem with outcome based research and more involvement in follow up of the patient after discharge.

The ad hoc committee for home oxygen therapy is working on the literature review and will have a review article identifying the next steps for applying what we know and addressing gaps in research.

The clinical focus of home care will continue as we attempt to move from an equipment model to a patient service model.

Robert McCoy

Home care section chair

Long Term Care Section Report

Gene Gantt

Board report 3-2010

Recommendation #1. That AARC President Timothy Myers send to all State Medicaid Directors, and Boards of Respiratory Care a letter introducing the Position Statement on "Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care" urging them to adopt these in state Medicaid policy. (Once such position statement is approved by the BOD).

COMMENT: With Healthcare Reform there will be a shift in care venues for patients requiring prolonged mechanical ventilation with an emphasis on the Skilled Nursing Facility arena. The shift will result in higher Medicare payment to SNFs in 2011. Having met with CMS on the subject we learned the difficulties of having the standards outlined in the position statement added to the conditions of participation. By using the approach of having these recognized on a state level we will accomplish raising the bar on monitoring, appropriate staffing and overall patient safety in the SNF arena. Presently there are no uniform standards of care under Medicaid from state to state and this position statement will be a resource to those states for framing the regulations needed for this level of care in the future.

The AARC should take the lead in developing this framework.

ACTIVITIES: The long term Care Section has been extremely active over the past 6 months. In November 2009 as Chair I had the opportunity to attend the National Association Of State Medicaid Directors (NASMD) annual meeting in Washington DC. Here I was able to meet with many Medicaid officials and discuss with them the issue of raising the bar in post acute/SNF care of the ventilated patient. The discussions were received very well and subsequently several states have adopted or are moving toward adopting standards of care which will recognize and require onsite respiratory care 24 hours per day.

In early March Anne Marie Hummel arranged a meeting for a meeting with a group of CMS (both Medicaid and Medicare) officials in Baltimore to discuss the need for quality standards such as those outlined in the position statement. Our discussions were of interest to CMS and well received. CMS outlined for us the requirements for these to become conditions of participation as standards or best practice. The process involves having these reviewed by the National Quality Form or other appropriate agency prior to formal submission to CMS. CMS also discussed with the group the need for quality measures to be developed for a future "pay for performance" reimbursement methodology which is under consideration. As the experts in the field the AARC LTC section was challenged to help in developing the measures. Additionally CMS discussed the new RUG 4.0 reimbursements which will double payment to Skilled Nursing

Facilities for the care of ventilated and tracheostomized patients. RUG 4.0 was scheduled for release in October 2010 but has been delayed 1 year due to the Healthcare Reform bill.

In early April I attended the American Public Health Services Association (APHSA) annual meeting in Washington DC. Here policy makers from state and federal agencies meet to discuss policy trends and changes in the delivery and financing of health care in the US. As anticipated there was broad discussion on the reform bill and its implications for state Medicaid agencies. The overwhelming take home notes involve the burden of cost this will place on already strained state budgets. Interestingly this has brought the need for cost effective, outcomes driven care of the ventilated patient to the forefront of the discussions. We are seeing a tremendous amount of interest and activity in the search for new cost efficient programs and services. This will undoubtedly spur the growth of ventilator programs in SNFs across the country. This is why it is important we move rapidly to implement standards and best practices in this arena to ensure patient safety and quality respiratory care services.

Management Section Report

Reporter: Douglas Laher

Last submitted: 2010-03-30 20:29:50.0

Recommendations

Recommendation #1: That the AARC Board of Directors charge the Position Statement Sub-Committee to draft a document (with support from the Management Section and Benchmarking Committee) on what should be an industry accepted definition for the term "missed treatments".

Justification: Many respiratory therapy departments utilize "missed treatments" as a quality assurance/performance improvement metric, and has been widely accepted by Joint Commission as an acceptable patient safety initiative. This metric is also captured with the AARC Benchmarking program and is reported to clients. For many subscribers, this metric is not populated because of the huge discrepancy of definitions." Instead of reporting the information inaccurately, many choose not to participate by uploading this data into the system as "zero" for the designated numeric value. Up until recently, this provided skewed and inaccurate data to benchmarking subscribers.

This is also a widely debated topic on the Management Section list serve, with no one able to provide a true definition for the term. Such a document would provide guidance to all AARC members.

Recommendation #2: That the AARC Board of Directors re-examine current list serve rules as they relate to posting of surveys; and to consider modifying said rules that would allow for the posting of informal survey postings that would not require the approval of the AARC Executive Committee.

Justification: There currently is no posted definition within the list serve rules that define the term "survey". This very broad term, defined by dictionary.com as; a) to take a general or comprehensive view of or appraise, as a situation, area of study, etc.; or b) to view in detail, esp. to inspect, examine, or appraise formally or officially in order to ascertain condition, value, etc. The term "query" as defined by the same source is; a) a question, or inquiry; or b) to ask or inquire about. These two similar terms, one disallowed by the Executive Committee without approval, and the other seemingly acceptable are two broadly defined terms that appear to have ambiguous similarities between the two.

Over the last few months, multiple section members have been found in violation of this list serve rule as a result of a posting a query (or survey) of 3 or more questions. Their questions; appropriate for content disseminated on the list serve were innocent efforts to gather and share information that is of benefit to section membership and in the spirit of the purpose of the list serve.

After reminding section membership of list serve rules and referencing the postings in question, a backlash of negative criticism has come the way of the AARC. Concerns exist over limiting invaluable information to section managers that are appropriate postings for AARC managers.

Would it be feasible to allow the section chair to provide approval of appropriate, yet informal postings that would otherwise be construed as a "survey" according to existing rules? Formal survey requests and those with imbedded links to an external survey tool must still be approved by the Executive Committee.

Report

1. Annual Business meeting was held in San Antonio, TX at the National Congress. Between 40-50 section members were present. 2009 goals and accomplishments were shared with the group. Scott Reistad was introduced as 2009 SPOY recipient.
2. Countless hours have been spent with Management Section liaison; Garry Kauffman on securing proposals for the 2010 Summer Forum and International Respiratory Congress, and planning for said events. A survey was sent out to section membership via the list serve to secure insight as to topics of interest and preferred presentation methodologies for each event. Much time has been spent on creating innovative approaches towards attracting more attendees. Presentations have been selected by the Program Planning Committee that meet program goals as defined by survey responses. Headliner presentations will be delivered by Scott Reistad ("You Asked and We Delivered"), "A View from the C-Suite", and a "Profit and Cash Workshop". Doug and Garry have worked closely with Dale Griffiths from the Executive Office on how to properly market Summer Forum and developing a value proposition to potential attendees that will stimulate attendance.
3. Winter 2010 Bulletin was distributed to section members in a timely fashion . Articles titled; "The Business of Healthcare" as well as "Face to Face: Effectively Communicating to Your Staff May be the Single Most Component of Successful Management", and "New Neonatal/Pediatric Transport Exam Now Available" were included. A small column was also written by the chair of the section congratulating Scott Resitad as the 2009 Specialty Practitioner of the Year. Managing editor Roger Berg has already secured four articles for the Spring Bulletin.
4. In conjunction with Debbie Bunch from the Executive Office, section eNewsletters for January, February, and March have already been disseminated in a timely fashion.
5. Section chair continues to work with Pinnacle Ad-Hoc Committee. Multiple conference calls have been held to review survey results from membership survey (sent 4th quarter 2009) and in developing proposed metrics which will expand upon current QRRCR program. See Board Report from Pinnacle Ad-Hoc Committee for further details.

6. All existing Swap Shop files continue to be re-examined for timeliness, appropriateness, relevance, and that support evidence-based practice. Progress to complete the review process for the entire Swap Shop in time for the Spring Board Meeting was thwarted in lieu of the displacement from full-time employment of the section chair. Project will resume as soon as prioritization allows.
7. Networking via the Management Section List Serve now is generating between 40-50 threads per day; of which 8-10 are new postings.
8. Section chair delivered a "Professor's Rounds" presentation in Dallas, TX on April 5, 2010 on "The Role of the Respiratory Therapist to Reduce Hospital Readmissions", and is also scheduled to present in Las Vegas, NV at an American Lung Association meeting on April 30, 2010 on the topic of "Reusing Disposable Medical Equipment".
9. All charges are on track, with the expectation that 100% compliance will be met by year-end.

Neonatal Pediatric Section Report

Reporter: Brian Walsh

Last submitted: 2010-03-30 12:54:51.0

Recommendations

None at this time.

Report

We continue to run just under 2,000 members (1966). The list serve remains very active and so does the section. I have assisted Dr. Cheifetz in developing pediatric topics for another wonderful AARC Congress. We have proposed another post graduate course for the Summer Forum. Our further development of the web page remains on hold as we transition to AARC Connect. All bulletins are on schedule.

Other

Nominations have been submitted for section chair for this fall. I look forward to assisting the new chair.

Sleep Section Report

Reporter: Antonio Stigall

Last submitted: 2010-03-30 11:44:37.0

Recommendations

None at this time.

Report

1. Membership is at 1082 with 170 members subscribed to list serve. There is an average of 16 posts per month on list serve.
2. The statistics for the NBRC SDS examination since its inception in December 2008 through March 19, 2010 are listed below:

Total Tested = 136, Total passed/credentials awarded = 124, First Time Pass Rate = 93.9%, Repeater pass rate = 20%.

Will promote the NBRC SDS credential on the sleep section to encourage RTs to take the SDS examination.

3. Once the new web site has been implemented, will work with Sherry Milligan to optimize services to promote membership growth and new section leadership.

Surface to Air Transport Section Report

Reporter: Steven Sittig

Last submitted: 2010-03-31 09:27:18.0

Recommendations

That the AARC look at a position paper in regards to the current development of a critical care paramedic level. This ongoing program development includes very minimal training typically an hour on ventilators followed by a 2 hour hands on lab. This then qualifies the medic to likely replace an RT in transport. There are other components such as 12 lead interpretation etc but the pulmonary issues are typically very weak. This could be a potential area of risk to patients. Also this may open the door for medics to replace RT's in the hospital setting

Report

The section submitted several lecture proposals for the upcoming AARC Congress. Still awaiting the decision from the program committee on what may have been accepted.

The quarterly bulletin and monthly E bulletins are being published on time and with relevant content.

We are in the process of developing a membership committee comprised of regional representatives to identify and recruit new members to the AARC and the transport section.

We continue to receive emails from transport RT's from across the country requesting information on numerous topics such as equipment and training.

I have reinstated an outreach communication program where I would contact section members personally, to see what we as a section can do to improve service and value to section membership.

SPECIAL COMMITTEES

Benchmarking Committee Report

Reporter: Richard Ford

Last submitted: 2010-03-10 19:11:11.0

Recommendations

None

Report

- 1. Doug Laher was welcomed as a member of the committee for 2010. Doug's expertise in the challenges of managing Respiratory Care will bring great value to the team.
- 2. A conference call with all members was conducted February 18th 2010. Agenda and minutes are available by contacting the Chair.
- 3. Over this period the benchmarking team has continued to provide technical support and advice to clients and those inquiring about the product, including the provision of regional lectures on staffing and benchmarking. These efforts will continue.
- 4. The Benchmarking Stimulus plan was launched last June, however the greater majority of those taking advantage of the free subscriptions never actually entered data, nor enlisted in the program. This was a strong indication that the cost of the program was not a major barrier, but the RC manager was either unable or unmotivated to enter required data. As a result the committee examined and eliminated several required fields that managers identified as barriers and has continued to focus on supporting existing and new clients who need assistance with data entry. In addition the AARC Executive Office has continued to personally notify clients who failed to enter data and also provides updates to the committee and clients on the number of hospital reporting data for recent quarters. These efforts have resulted in recent improvements with more current quarters of data available for comparisons.
- 5. At the time this report was prepared there were just over 90 current subscribers to AARC Benchmarking.
- 6. To better demonstrate value, a set of dashboards were developed and are now available. Considerable data analysis and design was performed and ongoing support

provided by Steve Nelson and Jim Mortensen of the AARC Staff. The public dashboard provides national averages for missed treatments and ventilator duration and the opportunity for viewers to learn more detail by becoming a subscriber. The subscriber dashboard provides key metrics with the ability to group data so members who know their metrics can easily see how they compare. These dashboards will provide substantial greater value to existing subscribers and anticipated to generate greater public interest in the product.

- 7. Major refinements were made in the calculations to determine averaged missed treatments, the users concur that the refinements made better reflect the % of missed treatments.

- 8. It was recognized that about 30% of clients were entering "0" for missed treatments. Investigation indicated this was a result of the inability for some to measure missed treatments with a level of confidence to report. The calculation for missed treatments was further refined by Devore, to eliminate counting of "0" to more accurately determine user averages.

- 9. In the months ahead the team will continue to identify opportunities for product improvement and demonstration of value.

Billing Codes Report

Reporter: Roy Wagner

Last submitted: 2010-03-29 15:24:56.0

Recommendations

No recommendations at this time.

Report

Summation of Committee Charges:

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

Plan: Solicitation of ideas for proposals for Susan to take to the AMA Advisory Meetings as appropriate with the American Association for Respiratory Care's position on this panel.

Action: Currently there is no further action on this Charge.

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: The Chair will work with the person responsible for the list serve to attempt to improve or implement a way to archive answers to repeat questions on the list serve. 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: No further action has occurred at the current time on this goal.

Clinical Practice Guidelines Report

Reporter: Ruben Restrepo

Last submitted: 2010-03-26 10:21:55.0

Recommendations

Recommendation #1: The committee has excused Mike Gentile from his duties as member of the committee per his request effective Dec 21, 2009.

Recommendation #2: The committee has been notified of this vacancy and hopes to get nominations to replace Mike before the end of April.

Recommendation #3: The committee has suggested adding one more member to the committee and hopes to get nominations also by the end of April.

Objectives:

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

Report:

1. To date, the Respiratory Care Journal Website lists a total of forty seven (46) CPGs.
 - a. Breakdown of 19 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/revise 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.
 - 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 society's 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 2010-2011:

1. A total of **27** CPGs were initially assigned for revision and update during 2009-2010.
2. **Two** CPGs have been accepted for publication in the June's issue of Respiratory Care. An Editorial explaining the transition from "reference-based" to "evidence-based" CPGs will also be part of that June's issue.
 - a. Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways
 - b. Providing Patient and Caregiver Training
3. A total of **3** CPGs are undergoing revision and are expected to be ready for submission before the end of the year.
 - a. Incentive Spirometry
 - b. Capnography Capnometry
 - c. IPPB
4. A meeting in Dallas has been planned to complete the revision and update of at least **7** additional CPGs.
5. Continue development of appropriate and new clinical practice guidelines in the evidence-based format.
 - a. EB-CPG on **Inhaled Nitric Oxide**. Although nearing completion, this CPG has been reassigned due to resignation of the leading author.
 - b. EB-CPG on **Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia** was originally scheduled to be completed in 2009 but still requires additional work.

Federal Government Affairs Report

Reporter: Frank Salvatore

Last submitted: 2010-03-30 12:49:32.0

Recommendations

No recommendations at this time.

Report

- The 435 plan was activated back on February 18, 2010. Activity using the Capitol Connection was swift for the period leading up to the Hill Day/PACT Meeting in DC.
- All charges are still ongoing. An emphasis on Charge #2 was employed with this last 435 Plan activation. My communications to the members of the PACT and HOD/President's List Serves specifically addressed the issue of communicating beyond the State Board members and the PACT committee themselves.
 - Last year for January 1 - March 1, 2009 we had a total of 5362 e-mails sent to Washington.
 - This year for January 1 - March 7, 2010 we had a total of 7317 e-mails sent to Washington. 5,926 of those came during the 435 plan activation alone.
- We still need to improve the state level communication plans. Even with 7,000 plus e-mails, that still only came from about 2,000 individual activists. We have a long way to go to get a rise out of the 49,000 plus!!

Other

I would like to thank the members of the Federal Government Affairs Committee who have done some good work during this first third of the year. I look forward to the rest of the year. As always, I have to give a big THANK YOU to Cheryl our Supreme Liaison and to the work done on our behalf by Miriam and Ann Marie. We would be no where without these three ladies working for our profession.

Attachments

Capitol Connection Statistics 2010 will be available at the meeting as a handout.

Fellowship Committee Report

Reporter: Patrick Dunne

Last submitted: 2010-03-06 16:01:14.0

Recommendations

No recommendations at this time

Report

The Committee continues to solicit nominations for 2010 induction as an FAARC. Eligibility criteria can be found on the AARC website. The deadline for receipt of nominations is August 31, 2010.

The leadership of the AARC is encouraged to identify and nominate those individuals whose professional contributions are deemed worthy of consideration for FAARC.

International Committee Report

Reporter: John Hiser

Last submitted: 2010-03-22 12:07:10.0

Recommendations

None

Report

1. Coordinate, market and administer the International Fellowship Program.

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. Periodically past fellow reports are appearing in the Currents section of *AARC Times*. The selection process was updated last year and will be refined again this year.

I recently had the privilege of presenting a report on the International Committee activities to the ARCT BOT at their March meeting in Irving, Texas.

BOT actions regarding international activities included:

BOD Recommendation 09-2-23 regarding the visiting dignitary program that was passed by the BOD last July and pending ARCF funding was accepted for information and further development and reconsideration at a later date. It was felt that this was a "great idea at the wrong time".

Recommendation to appoint a working group composed of representatives from the AARC, ARCF, NBRC and ICRC and industry to plan the 2010/2011 ARCF Fund Raiser and report back by July 2010.

A decision was made to base the number of 2010 International Fellows on the number of sponsors committed by June 1, 2010. One fellow will be invited for every 2 sponsors confirmed. Solicitation of new sponsors will begin earlier in the year beginning this year.

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.

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.

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

Dan Rowley, BS, RRT-NPS, RPFT

Bruce Rubin, MD, FAARC

Michael Runge, BS, RRT

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

Membership Committee Report

Reporter: Thomas Lamphere

Last submitted: 2010-03-26 09:23:00.0

Recommendations

None at this time.

Report

Charges:

1. Review, as necessary, all current AARC membership recruitment documents and toolkits for revision, addition and/or elimination based on committee evaluation.

The committee is reviewing the current documents and will provide a report and recommendations based on their review at the Summer AARC Board meeting.

2. In conjunction with the Executive office, develop a membership recruitment campaign based on survey results for implementation in 2009 and 2010.

The committee and Executive Office staff are currently brainstorming ideas for membership recruitment campaign targeted for July or August of 2010. These months were selected as they are historically two of the slower months for membership growth.

3. Identify and evaluate methods to recruit respiratory therapy students as ACTIVE members of the AARC.

A new Respiratory Care Student Center page has been created on the AARC website. This page contains information valuable specifically to our student members including:

- Information on the one time only \$40 discount to AARC members on any NBRC exam (excluding the CRT).

- Information on the reduced first year AARC membership dues for graduating students.
- A link to the AARC's new social networking page *AARCconnect*
- A list of trusted educational resources including the RC Journal, AARC Clinical Practice Guidelines, AARC Times and more!
- A link to the AARC's "Online CRCE Transcript" service.
-more!

A select group of students will be asked to review the page and provide feedback and suggestions for additional content. The page will then be advertised to all AARC student members, program directors, etc.

4. Develop a scientific, data-driven process to implement and measure the effectiveness of current and new recruitment strategies.

A new "AARC Membership Benefits Calculator" has been created on the AARC website. On this page, members can view a list of the most popular member benefits and services along with the associated costs of these programs. The member can select only those benefits/services that they personally utilize by checking a box next to the listed benefit/service. This will add the cost of the benefit/service to the total. At the bottom of the page the grand total of what "AARC Membership Saves You" is listed. This is a great way to show the financial value of AARC membership.

Other

Three short webcasts focusing on "How To Increase Membership" have been recorded by Sherry Milligan and Tom Lamphere. These webcasts focus specifically on the following topics:

- A discussion of AARC membership benefits
- How to use the AARC group membership discount to retain and recruit members
- The AARC Membership Benefit Calculator

Position Statement Committee Report

Reporter: Patricia Doorley
Last submitted: 2010-03-30 16:58:33.0

Recommendations

Recommendation # 1:

Approve and publish the position statement entitled "Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care". This statement is submitted for your review as Attachment # 1. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: This is a revision of the statement "Delivery of Respiratory Therapy Services in Long Term Care Facilities" that was originally approved by the AARC BOD in December 2009. When this statement was reviewed by BOMA at their December 2009 meeting (which followed the final meeting of the 2009 AARC BOD), there was a concern that the statement did not clearly identify the type of patient care facility that was being addressed by the statement. The BOMA identified the need for the statement to specifically address skilled nursing facilities that provide ventilator and advanced respiratory care to patients and to differentiate these facilities from long term acute care hospitals. Discussions between the Long Term Care Section Chair, Gene Gantt, and the Chair and past-Chair of BOMA, Drs. Boehm and Christopher respectively, have resulted in the revised statement presented for your consideration. There is still some discussion regarding the final language under consideration by the group so there may be additional revisions prior to the BOD meeting. I will submit an update of the revised statement if necessary prior to formal consideration of this recommendation.

Report

Charges:

1. Draft all proposed AARC position statements and submit them for approval to the Board of Directors. Solicit comments and suggestions from all communities of interest as appropriate.
 - No proposed AARC position statements have been submitted to the Committee for development.
 - The BOMA suggested a revision of the position statement entitled "Delivery of Respiratory Therapy Services in Long Term Care Facilities" and a revised statement is submitted for BOD consideration as Attachment # 1.

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

- The nine (9) position statements scheduled for review this year include:

- 1) Administration of Sedative and Analgesic Medications by Respiratory Therapists
- 2) Cultural Diversity
- 3) Health Promotion and Disease Prevention
- 4) Home Respiratory Care Services
- 5) Pre-Hospital Mechanical Ventilator Competency
- 6) Respiratory Care Scope of Practice
- 7) Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists
- 8) Respiratory Therapy Protocols
- 9) Telehealth

- All, but one, of the nine statements has been reviewed and/or revised during the past 3 years. The one exception, the "Health Promotion and Disease Prevention" statement was last reviewed/revised in 2005.

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

- The schedule (See Attachment # 2) has been revised to reflect the BOD actions through December 2009.

Attachments

Please contact demayo@aacrc.org or mortenson@aacrc.org to obtain the following attachment(s):

- Delivery of RT Services in Long Term Care Facilities 03162010.doc
- AARC Position Statement Review Schedule 032910.xls

American Association for Respiratory Care

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

Position Statement

Delivery of Respiratory Therapy Services in ~~Long Term Care~~ Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care

~~Long term care~~ Skilled nursing facilities are increasingly becoming the venue for the management of patients who require the full array of respiratory therapy services, from oxygen therapy and inhalation medication management to pulmonary rehabilitation and ventilator management. ~~Long term care~~ Skilled nursing facilities should recognize the clinical value to the patient of utilizing a respiratory therapist to provide the complete spectrum of services that respiratory therapists are both educated and competency tested to provide.

The American Association for Respiratory Care recommends that the basic standard of care for ~~long term care~~ skilled nursing facilities be to employ Respiratory Therapists to render care to patients ~~requiring mechanical ventilation~~. Additionally, the following basic standards are recommended to ensure the safe and efficient delivery of respiratory therapy services in ~~long term care~~ skilled nursing facilities delivering ventilator and/or high acuity respiratory care:

10. A Certified, or Registered, Respiratory Therapist -- licensed by the state in which he/she is practicing if applicable -- will be on site at all times to provide ventilator care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing.
11. A Pulmonologist, or licensed physician experienced in the management of patients requiring respiratory care services (specifically ventilator care), will direct the plan of care for patients requiring respiratory therapy services.
12. The facility will establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.
13. Facilities will be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.

14. Clinical assessment of oxygenation and ventilation – arterial blood gases or other methods of monitoring carbon dioxide and oxygenation – will be available on site for the management of patients receiving respiratory therapy services at the facility.
15. Emergency and life support equipment, including mechanical ventilators, will be connected to electrical outlets with backup generator power in the event of power failure.
16. Ventilators will be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.
17. An audible, redundant ventilator alarm system will be located outside the room of a patient requiring mechanical ventilation to alert caregivers of a ventilator malfunction/failure or a patient disconnect.
18. A backup ventilator will be available at all times that mechanical ventilation is being provided to a patient.

Developed: 10/2009

Revised: 03/2010

Position Statement Review Schedule will be available at the meeting as a handout.

Public Relations Action Team Report

Reporter: Linda Smith

Last submitted: 2010-03-29 19:41:11.0

Recommendations

There are no recommendations at this time.

Report

The focus of the PRAT Committee has been somewhat redirected since the AARC's commitment to support the Year of the Lung initiatives. A letter has already been posted on the Affiliate President's List Serve alerting them that a member of the PRAT team will be contacting them in the near future to give them the details on the AARC's Press Release Initiative. Committee members are currently making these calls. Each President will be asked to designate 3 - 4 members from different cities. These members will be asked to personalize a prepared press release and submit it to their local newspapers. The first press release is on asthma and is scheduled for publication in May to coincide with National Asthma Awareness activities. The committee will follow up to assess the success of this public relations campaign.

Three other releases are scheduled for later in the year as well as other activities.

State Government Affairs Report

Tom McCarthy, Chair
April 2010

No Recommendations

The focus of the State Legislative Affairs Committee remains with the issue of Polysomnography and the advent of new initiatives within the AASM and the BRPT to provide a new level of certification apart from the RPSGT credential.

The new credential will require a candidate to have graduated from high school, hold a BCLS card and have completed basic self study courses. No CAAHEP approved education is required. These newly credentialed individuals will be known as Certified Polysomnographic Technicians (CPSGT)

This initiative seems to be coupled with pathway implementations that will void the previously agreed to compliance with a requirement for all RPSGT candidates to graduate from a CAAHEP Program (previously set to go into effect July 2012). Essentially, this move abandons the BRPT commitment to embracing CAAHEP approved education programs and moves the BRPT closer into line with the AASM A-STEP program.

We will be monitoring and evaluating these initiatives to determine how they may effect the patients we serve.

Life and Honorary Membership **Nominations**

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.

Definition of Active Member: “Active Members are those practitioners actively involved in the respiratory care profession. An individual is eligible if he/she lives in the U.S. or its territories, and meets ONE of the following criteria: (1) is legally credentialed as a respiratory care professional if employed in a state that mandates such, OR (2) is a graduate of an accredited educational program in respiratory care, OR (3) holds a credential issued by the NBRC.”

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.

Definition of Associate Member: “Anyone who is working in a field related to the practice of respiratory care in the United States. Those working in medical equipment sales or manufacturing, physicians, other allied health practitioners not engaged in direct respiratory patient care, and individuals residing in foreign countries can be Associate Members.”

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

[Definition of **Special Member**: Any individual who has an interest in respiratory care but does not work in a field related to respiratory care. Special Members have the same rights and privileges as Associate Members (can not vote or hold office).

AARC Life and Honorary Members

<u>YEAR</u>	<u>LIFE</u>	<u>HONORARY</u>
1961		Alvin Barach, MD
1965	J. Addison Young	
1967	Arthur A. Markee	
1972	Don E Gilbert	
	Leonard Gurney	
	Jerome Heydenberk	
	Joseph Klocek	
	Brother Roland Maher	
	James Peo	
	P. Noble Price	
	Howard Skidmore	
	Leah W Theraldson	
	Virginia Trafford	
1973	Robert A Cornelius	
	Bernard M. Kew	
	James Whitacre	
1974	Louise H. Julius	John Brown MD
1975	R.J. Sangster	
1976		
1977	John J. Julius	H. Frederic Helmholtz, MD
	Easton R. Smith	
1978	Robert H. Miller	Meyer Saklad, MD
	George A. Kneeland	
	Samuel Runyon	
1979	Robert A. Dittmar	Huberta M Livingston, MD
1980	George Auld	Albert Andrews, MD
	Hilaria Huff	Vincent Collins, MD
	Vincent D. Kracum	Donald F. Egan, MD
	Jack Slagle	Ronald B. George, MD
	Bernard Stenger	Hurley L. Motley, MD
1981	John Appling	Sister Bernice Ebner
	Wilma Bright	John H. Newell
	James A. Liverett, Jr	
	Sister Mary of Providence Dion	
1892	Gareth B Gish	John Haven Emerson
1983	Robert E. Glass	William F. Miller, MD
		Robert H. Lawrence, MD
1984	John D. Robbins	James Baker, MD
		Duncan Holaday, MD

<u>YEAR</u>	<u>LIFE</u>	<u>HONORARY</u>
1985	James S. Allen Houston R. Anderson Thomas A. Barnes Julie S. Ely David H. Eubanks Glen N. Gee Gary L. Gerard Sam P. Giordano Robert L. Knosp Lillian Van Buskirk John R. Walton Robert R. Weilacher George A. West	Walter J. O'Donohue, MD
1986	Richard W. Beckham Paul Powers	Hugh Matthewson, MD
1987	Jeri E. Eiserman Edward A. Scully	John Hodgkin, MD
1988	Michael Gillespie Melvin G. Martin	Irvin Ziment, MD
1989	Gerald K. Dolan Ray Masferrer	Roger Bone, MD
1990	Paul J. Matthews, Jr	Alan Plummer, MD
1991	Larry R. Ellis Jerome M. Sullivan	Alfred Sofer, MD
1992	Patrick J. Dunne Phil Kittredge	David J. Pierson, MD
1993	Bob Demers Bernard P. Gilles	Richard L. Sheldon, MD
1994	Philip R. Cooper Dianne L. Lewis	Forest Bird, MD, PhD, ScD
1995	Deborah L. Cullen Patricia A. Wise	Neil R. McIntyre, MD
1996	Jim Fenstermaker Trudy J. Watson	Steven K Bryant, MBA
1997	Charlie G. Brooks, Jr. Pat Brougher	Charles Durbin, MD
1998	Kerry E. George <u>W. Furman Norris</u>	Barry A. Shapiro, MD
1999	Dean R. Hess Cynthia J. Molle	James K. Stoller, MD
2000	Jerry Bridgers Dianne Kimball	Michael T. Amato
2001	Robert Fluck Garry W. Kauffman	William Bernhard, MD

<u>YEAR</u>	<u>LIFE</u>	<u>HONORARY</u>
2002	Susan B. Blonshine William Galvin Carl Wiezalis	Sherry Milligan
2003	Margaret F. Traband J. Michael Thompson	Cheryl A. West
2004	David C. Shelledy Karen J. Stewart	Patricia A. Lee
2005	Janet Boehm Richard Branson	Jill Eicher
2006	John Hiser Lucy Kester	Marsha Cathcart
2007	Doug MacIntyre Joseph L. Rau	Kent Christopher
2008	Susan Rinaldo Gallo Michael W. Runge	John W. Walsh
2009	Vijay M. Deshpande	Dale L. Griffiths

Social Media Presentation

By Sherry Milligan

ORGANIZATIONAL REPRESENTATIVES

AMA CPT Health Care Professional Advisory Committee Report

Reporter: Susan Rinaldo Gallo

Last submitted: 2010-03-05 13:16:59.0

Recommendations

None at this time.

Report

- 1. A meeting was held in February which we did not attend.
- 2. I am honored to be nominated for another three year term as the AARC's CPT/HCPAC representative.
- 3. In November I submitted a question to the *CPT Assistant* editorial panel concerning the use of High Frequency Chest Wall Osculation (HFCWO) i.e. the Vest. Several of our members have expressed a concern and confusion about using CPT codes 94667 (Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation) and 94668 (subsequent). Historically these have been used for "hands on" therapy only. The Assistant panel met at the February meeting and this was on their agenda. The official response will appear in the May CPT Assistant publication. The word on the street is that it went favorably; we will be able to use those codes for HFCWO devices. However that's just a rumor until we see it in print.
- 4. A code proposal for a new device using new technology was presented by the ACCP; Acoustic Respiratory Measurements for Wheeze Rate. This technology was exhibited in the vendor hall last December. The CPT panel agreed to establish two Category III codes:
 - 1. 040XT1 Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report

- 2. 40XT2 Continuous measurement of wheeze rate during treatment assessment or during sleep for documentation of nocturnal wheeze and cough for diagnostic evaluation 3 to 24 hours, with interpretation and report

Typical Patient (040XT1): A 4-year-old boy presenting with shortness of breath during exercise. Spirometry flow/volume loop technically unsatisfactory due to inability to accomplish forced expiratory maneuver.

Typical Patient (040XT2): A 27-year-old male with a history of mild asthma, and daytime hyper-somnolence.

Category III codes are temporary codes used for emerging technology. Category III codes allow for data collection. Procedures must be performed by many HC professionals in multiple locations before being eligible for a Category I code (billable). The nature of emerging technology is such that it may not meet this requirement. When sufficient data has been collected a proposal for a Category I will be submitted.

Am Assn of Cardiovascular & Pulmonary Rehabilitation Report

Reporter: Debra Koehl

Last submitted: 2010-03-08 13:23:29.0

Recommendations

None at this time

Report

Our governmental affairs staff (Anne Marie Hummel) has been in contact with AACVPR staff in order to create a FAQ on the new pulmonary rehabilitation guidelines. This was based on an earlier conference call that we all participated in at the beginning of the year.

Other

AACVPR annual meeting is in October 2010 in Milwaukee Wisconsin.

**American Association of Critical Care
Nurses Report**

American Heart Association Report

Reporter: Richard Branson

Last submitted: 2010-03-29 08:46:50.0

Recommendations

Support AHA in development of statements and educational programs.

Report

The 2010 guidelines are in draft form. I have participated in the literature review and on the writing committee.

Other

AHA requires 2 meetings a year lasting nearly 5 days each. I cannot meet this commitment and suggest AARC appoint a new representative.

American Society for Testing and Materials Report

Reporter: Robert McCoy

Last submitted: 2010-03-29 07:19:13.0

Recommendations

None

Report

The next ASTM meeting will be held in New Orleans at the same time as the ATS meeting. The object of the timing of this meeting is to draw participants from the ATS to some of the breakout sessions for ASTM. If respiratory therapists are attending ATS it is hoped that they may be able to attend some of the meetings to provide expertise on standards that are most likely to impact the products they use routinely.

Domestic and international standards are being created that are guiding the development of new products. Standards organizations depend on input from clinicians using the products to guide the development of standards for safety and appropriateness. I will continue to seek participation from respiratory therapist in the specialty field that is being developed.

Robert McCoy

ASTM representative

Chartered Affiliate Consultant Report

Reporter: Garry Kauffman

Last submitted: 2010-03-07 10:09:15.0

Recommendations

None

Report

I worked with the New Jersey State Society for Respiratory Care Board of Directors in early January to create a new mission statement, operating principles, core strategies, and focused action plans aligned with each core strategy to improve operational performance. The NJSRC adopted the new mission statement and operational plan at their subsequent board meeting and has begun implementing the action plans.

I met with the leadership from the California State Society for Respiratory Care (Kathleen Adams) and the Washington State Society for Respiratory Care (Carl Hinkson) to plan strategic and operational business planning sessions for each affiliate. The goal for each planning session is to revise/create a mission statement, operating principles/core values, key initiatives, and an operating plan for each state society to achieve success in the domains of finance, customer service, education, and membership. I will include the outcome of each planning session in the next quarterly report.

Additionally, I followed up with state society leadership from New York, Pennsylvania, and West Virginia to check on their progress with their operational plans. Each state society continues to utilize their operational plans to measure, trend, and communicate performance, which all state society leaders indicated was progressing according to plan.

Respectfully submitted,

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

Clinical Laboratory Institute Report

Reporter: Susan Blonshine

Last submitted: 2010-03-29 17:54:58.0

Recommendations

[Insert recommendations here]

Report

1. Carl Mottram attended the annual CLSI Leadership meeting March 22-26, 2010 in Baltimore, Maryland.
2. The CLSI Subcommittee on Quality Management held a meeting at the 2010 Leadership Meeting to continue review and development of documents to address the Quality System Essentials in HS-1, A Quality System Model for Healthcare. Several draft documents will be ready for committee vote this year. Susan Blonshine is currently chairing the QSE for equipment. The document will go to committee vote in the next 60 days.
3. CLSI has called for nominations to review and revise the current H11-A4 document (Procedures for the Collection of Arterial Specimens). Potential members to represent respiratory therapy are needed.
4. CLSI has released its annual membership report. In Fiscal Year (FY) 2009, (July 2008 - June 2009), CLSI moved forward on multiple fronts to develop and promote laboratory best practices that improve the quality of medical care around the world. Along the way, it became in every way a more international organization.
5. Recently approved documents:

[EP18-A2-Risk Management Techniques to Identify and Control Laboratory Error Sources; Approved Guideline-Second Edition](#)

This guideline describes risk management techniques that will aid in identifying, understanding, and managing sources of failure (potential failure modes) and help to ensure correct results. Although intended primarily for in vitro diagnostics, this document

will also serve as a reference for clinical laboratory managers and supervisors who wish to learn about risk management techniques and processes.

C34-A3-Sweat Testing: Sample Collection and Quantitative Chloride Analysis; Approved Guideline-Third Edition

This document addresses appropriate methods of collection and analysis, quality control, and the evaluation and reporting of test results.

Clinical Laboratory Institute

Point of Care Report

Reporter: George Gaebler

Last submitted: 2010-03-31 08:16:40.0

Recommendations

None at this time

Report

I have been involved with standards updates for oximetry during this reporting period. No other issues pertinent to Respiratory Care have surfaced.

[Insert other information here]

Committee on Accreditation of Air Medical Transport System Report

Reporter: Steven Sittig

Last submitted: 2010-03-28 00:48:35.0

Recommendations

NONE AT THIS TIME

[Insert recommendations here]

Report

The CAMTS Board is scheduled to meet April 8th -10th in San Antonio Tx for the spring meeting of 2010. The board will be discussing the upcoming 8th Edition of the CAMTS Standards. I have sought input from transport section members as to content and language of several standards.

This year also marks the 20th year in existence and will be marked at our fall meeting in Ft Lauderdale. I have been asked to be a part of the planning committee.

Extracorporeal Life Support Organization Report

Reporter: Donna Taylor

Last submitted: 2010-04-01 06:58:45.0

Recommendations

No recommendations at this time

Report

Nothing to Report at this time

International Council for Respiratory Care Report

Reporter: Jerome Sullivan
Last submitted: 2010-03-30 11:28:38.0

Recommendations

No Recommendations at This time

Report

1) Proposed Fundamental Respiratory Care Support Course: The development of a Fundamental Respiratory Care Support (FRCS) Course was 1st proposed at an International Strategic Planning Session held at the AARC Executive Office in July 2004. Hassan Alorainy, RRT,BSRC, FAARC, Governor for Saudi Arabia to the ICRC, presented the proposal for the development of a multiple language translation of this course. The proposal called for the development of a four-day comprehensive Respiratory Care course intended for implementation outside of the United States for health care providers not experienced in respiratory care. The course would be offered under the auspices of the ICRC and the AARC. The FSRC Course is composed of two parts: the **Basic** component which can be completed as a stand-alone course of instruction however, the **Basic** component is a pre-requisite for the **Advanced** course.

Currently H. Alorainy, Governor for Saudi Arabia to the ICRC, & J. Sullivan, ICRC President are identifying funding from outside the US to fund this project.

The primary purpose of the course is to enhance the care of respiratory patients around the world. Secondly, the provision of the course may help alleviate shortages and provide increased opportunity to recruit and train RT's outside the USA.

Fundamental Respiratory Care Support - Basic: A two day course consisting of lecture demonstrations and practice *Skill* stations to expose health care providers not experienced in respiratory care to the knowledge and skills required to provide basic Respiratory Care for patients in non-acute situations until a Respiratory Care Specialist becomes available or until transfer to appropriate facility.

Fundamental Respiratory Care Support - Advanced: A two day course consisting of lecture demonstrations and practice *Skill* stations to expose health care providers not experienced in respiratory care to the knowledge and skills required to provide advanced Respiratory Care for patients in acute situations until a Respiratory Care Specialist becomes available or until transfer to appropriate facility.

Depending on local needs and demand, at some point in the future the FRCSC curriculum could be delivered in modular format. A customized combination of curriculum elements (modules) could be delivered and a system of "stackable certificates" could be made available.

2) International Educational Recognition System: Development continues on the International Education Recognition System (IERS) which is designed to provide formal recognition to quality RC seminars, programs & schools around the world. These programs must meet or exceed educational guidelines developed & approved by ICRC in partnership with the AARC.

Recent IERS recognitions include:

- X International Congresso Respitoria, March 2009, Mexico City [IERS]
- Shonan Kamakura RT Seminar, July 2009, Kamakura, Japan [IERS]
- International Seminar on Non-Invasive Mechanical Ventilation, August 2009, Buenos Aires, Argentina [IERS]
- World Health Organization sponsored PFT Course, October 2009, Ho Chi Minh City, DeNang, Hanoi, Vietnam, [IERS]

Pending IERS recognitions:

- 2nd Chilean Symposium in Respiratory Therapy, May 25 - 26, 2010, Santiago, Chile
- 1st International Respiratory Care Conference, King Abdulaziz Medical City Postgraduate Training Center & the Saudi Society for Respiratory Care, May 25 - 26, 2010, Riyadh, Saudi Arabia
- University of Milan - Respiratory Physiotherapist Post-Masters Program
- Prince Sultan Military College, BS Degree, RT Program, Saudi Arabia - renewal status
- Intensive Care Respiratory Therapy, Maria Ferrer Hospital, June 2010, Buenos Aires, Argentina - pending

3) Intercoastal 3rd Assembly on Respiratory Care in China & Taiwan - November 8, 2009, Shanghai, China.

- 3rd Assembly of Physicians, RT's, Nurses & other professionals
- Seeking to develop cooperative relationships
- Enhance integration of quality RT between Taiwan & China

- Presentations on status of RT in 14 hospitals in China

4) Update on Brazil:

- Associacao Brasileira de Fisioterapia Cardio-Respiratoria (ASSOBRAFIR)
- Contact person - Luiz Gustavo Ghion, PT, ARCF International Fellow, 2001
- Scheduled to meet with President of ASSOBRAFIR March 18, 2010
- Discuss new ICRC Governor for Brazil
- Request letter to AARC President

5) Update on Germany: Discussions continue with the German Thoracic Society

Thorsten Hardebusch, MD member of *Deutsche Gesellschaft fur Pneumologie und Beatmungsmedizin (DPG)*

- Thorsten Hardebusch, MD, Director & Senior Physician Instructor for RT @ The Clinic for Pulmonary & Intensive Ventilatory Care & Sleep Medicine, Ludenscheid Hospital, Germany
- DPG - physician professional society spearheaded RT project since inception in 2005
- Ultimate goal to establish RT's as a recognized profession in Germany
- Graduates of program to use designation RT(DPG) as a credential
- Graduates known as *Atmungstherapeuten* the German word for Respiratory Therapist
Recruit physiotherapists & nurses with pulmonary intensive care experience
- All four centers in four different cities fully enrolled with waiting lists
- Grosshansdorf completed 2nd program - December 2009
- Gauting completed 2nd program - December 2009 & new course scheduled for Spring 2010
- Bad Berka begins 3rd program in the Fall 2010
- Ludenscheid running 3rd program & fully pre-enrolled for Spring 2011

6) AARC/ERS Discussing Joint Symposium and Potential Exchange of Speakers:

- Brendan Cooper, Stefano Nava, Sam Giordano exploring possibility of joint AARC/ERS Symposium
- Exchange of speakers discussed for ERS in Barcelona 2010
- Tim Myers, AARC President, to represent AARC in Barcelona at ERS
- Cooper sees important overlaps between US RT's & Assembly 9,2 & 1
- Nava suggests for 2011 a compare & contrast of practices between US & EU

7) ICRC Annual Business Meeting:

Meetings held in conjunction with AARC 55th International Congress, San Antonio, Texas

- **ICRC Executive Committee Sunday, December 6, 2009**
- **ICRC Business Meeting Tuesday, December 8, 2009**
- Reports received from 19 countries
- Reports received from 6 International Fellows
- Welcome comments from AARC, ARCF & NBRC
- Featured Presenter ICRC Business Meeting: Noel S. Tiburcio, MBA, RMT, RRT-NPS, President, Emirates Association for Respiratory Care Practitioners,UAE
- "Update on the Philippine Respiratory Therapy Act of 2009 & Status of the AARC's Newest International Affiliate in the UAE"

New Countries Admitted to Council

- Mainland China
- Guatemala
- Germany (Candidate Status)
- Vietnam (Candidate Status)
- Peru (Consideration List)

Ratification of New Governors

- Christiane Menard, Executive Director, Canadian Society of Respiratory Therapists
- Noel S. Tiburcio, MBA, RMT, RRT-NPS, President, Emirates Association for Respiratory Care Practitioners, UAE

Respectfully Submitted,

Jerome M. Sullivan, PhD, RRT, FAARC

President, ICRC

Joint Commission - Ambulatory PTAC **Report**

Reporter: Michael Hewitt

Last submitted: 2010-03-17 05:38:41.0

Recommendations

[Insert recommendations here]

Report

Nothing to report at this time.

Joint Commission - Home Care PTAC

Reporter: Dianne Lewis

Last submitted: 2010-03-29 15:20:42.0

Recommendations

none

Report

The AARC participated in a Home Care PTAC committee conference call in February. The purpose was to review and update "Revision of the Medication Reconciliation National Patient Safety Goal", Home Care Accreditation Program.

Also, we were told there will be no face to face meetings in 2010.

Joint Commission – Lab PTAC

Medicare Coverage Advisory Report

Nothing to report at this time.

National Asthma Education and Prevention Program Report

Reporter: Thomas Kallstrom

Last submitted: 2010-04-01 10:08:47.0

Recommendations

Report

The NAEPP last met during the AARC Congress (as often seems to happen). They have been active in promoting a pediatric component to the management of asthma called the National Asthma Control Initiative (NACI). This will be a four year project that will serve to engage a broader spectrum of end users of the NAEPP's EPR-3 Asthma Guidelines. The AARC will be an active partner in this process as it moves forward. The NACI will bring together organizations from local, regional, and national levels so that they can share best practices; pool and direct resources; identify new directions and learning opportunities; and do much more to ensure that the type of care asthma patients should receive and the care that they do receive are one and the same. An upcoming phase will be a *Champions Program* which we hope to highlight the efforts of Peak Performance USA.

The next meeting of the Coordinating Committee will take place in September, 2010.

National Coalition for Health Professional Education in Genetics Report

Reporter: Linda Van Scoder

Last submitted: 2010-03-29 13:10:09.0

Recommendations

None

Report

In November 2009 (after the deadline for the December BOD report) the Genetic Alliance asked that we sign on to a letter to the Secretaries of HHS, Treasury, and Labor. The letter addressed comments they had made concerning delaying implementation of aspects of the Genetic Information Nondiscrimination Act (GINA). The Genetic Alliance request was reviewed by President Myers and Cheryl West and the AARC did sign the letter.

In January I brought to the attention of President Myers and the Executive Office an opportunity to apply for NCHPEG's 2011 Targeted Education Program Grant. The \$40,000 grant, which is only available to NCHPEG member organizations, is to develop a discipline-specific genetics education tool. Past grant recipients include Nutrition & Dietetics, Physician Assistant, Speech-Language Pathology and Audiology, and Dentistry. Because the AARC's part time grant writer is overloaded, the decision was made not to submit a grant application this year.

The next NCHPEG meeting is in September. I will continue to monitor NCHPEG communications for opportunities for the AARC to participate.

Neonatal Resuscitation Program Report

National Sleep Awareness Roundtable

Report

Reporter: Mike Runge

Last submitted: 2010-03-03 09:43:39.0

Recommendations

None

Report

At the time of submission of this report, the National Sleep Awareness Roundtable has not met. I will keep the AARC Leadership informed if any changes occur.

Thank you!

Simulation Alliance Society Report

Reporter: Robert Chatburn

Last submitted: 2010-03-04 09:13:19.0

Recommendations

Continue dialog with Simulation Alliance. Conduct survey of select group of AARC members (education and management specialty section) to determine level of interest in participating in simulation activities. Create a list of contact information to be passed on to the SA.

Continue to support the AARC Simulation Roundtable. Accept and review a proposal from IngMar Medical Inc. to conduct a one day consensus conference in conjunction with the next Respiratory Care Congress to lay the foundation for a laboratory practice standard for lung simulation in ventilator performance testing. This could be conducted the day before the Congress and could potentially be funded by sponsorship from ventilator and lung simulator companies. Invited attendees would be selected from thought leaders who contributed to the informal meeting sponsored by IngMar Medical at the 2009 Congress.

Report

I attended the annual conference of the Society for Simulation in Healthcare in Phoenix this January. This was a fairly large conference, attended by about 2,000 members and with a vendor area with some 2 dozen booths. There I became familiar with the Society's agendas and focus, which is mainly high tech cardiopulmonary resuscitation simulation conducted in simulation centers. However, there is much interest in using simulations at all levels of complexity for medical education and research.

At the conference, I met my contact with SSH, Dr. Yu Ming Huang. Dr. Huang is the leader of the Simulation Alliance group who contacted the AARC. This is what I learned:

The Simulation Alliance (SA) grew out of the Society for Simulation in Healthcare (SSH) about 2 years ago, but intends to be a separate organization composed of member organizations (not individual practitioners). Its purpose is to be the coordinating center or clearinghouse to gather common goals and initiatives, share resources and develop guidelines and potentially even standards related to simulation-based education. Specific projects, including some of my own ideas, might be:

- Contact list of member organizations

- A standardized vocabulary or taxonomy related to simulation in education
- A website to provide the nexus of the gathered SA information, with links to/from member organization websites
- A standardized survey template for gathering information about simulation interest/projects in member organizations
- A registry of ongoing simulation in education projects/resources/resource people
- A registry of simulation centers
- A registry of vendors/commercial resources supporting simulation

As the appointed liaison from the American Association for Respiratory Care, I have an ongoing interest in helping with some of these projects, particularly the taxonomy issue. It may also be possible to recruit other members of the AARC having an interest in simulation who could help us.

In ongoing conversations with Dr. Huang, it has become clear that the AARC needs to assess the level of interest its members have regarding SA activities. Toward that end, I have received approval from the president and BOD to conduct a survey of the management and education specialty section members. This survey will be deployed, with the help of Bill Dubbs at the AARC office, using SurveyMonkey.com. I will provide survey results and recommendations in my next BOD report.

Goal of survey

- (1) to gauge the level of interest in simulation among the AARC membership and
- (2) to contribute data to the Simulation Alliance project.

Simulation Survey Draft:

Survey Introduction

The AARC has been asked to participate in a project sponsored by the Simulation Alliance (an offshoot of the Society for Simulation in Healthcare). The goal of the project is to develop a standardized vocabulary to improve communication among those using simulations (of any kind) for healthcare education. The goals of this survey are to (1) to gauge the level of interest in simulation among the AARC membership and (2) to contribute data to the Simulation Alliance project.

PAGE 1

- 1. On the scale below please indicate your level of interest in using simulation for training and competency documentation.

Very Interested Moderately Interested Neutral Mostly Disinterested Not at all Interested

- 2. Are you actively involved in simulation
 - a. Yes<<DIRECTED TO PAGE 2>
 - b. No <DIRECTED TO END OF SURVEY AND THANK YOU MESSAGE>

PAGE 2

My current level of involvement in simulation is (multiple check boxes, required):

1. Simple mathematical simulations (e.g., blood gas calculator)
2. Complex mathematical simulations (e.g., ventilator simulator)
3. Simple mechanical simulations (e.g., intubation simulators)
4. Complex mechanical simulations (e.g., IngMar ALS 5000 or TTL lung simulators)
5. Simulation center

My current simulation activates take place in (multiple check boxes, required):

1. Hospital
2. College/university
3. Private company

What words or terms related to education using simulation do you think we should consider for inclusion in an official glossary?

ROUNDTABLES

Asthma Disease Management Roundtable **Report**

Reporter: Eileen Censullo

Last submitted: 2010-03-25 12:06:08.0

Recommendations

Need to start list serve message to recruit new members to round table.

Report

Asthma Round Table meeting held in San Antonio, TX at our AARC Congress. Minutes were distributed to list serve. I did not receive any feed back from meeting.

List serve is always full of chatter and activity.

Consumer Roundtable Report

To be included in Executive Office report.

Disaster Response Roundtable Report

Reporter: Steven Sittig

Last submitted: 2010-03-27 22:07:07.0

Recommendations

None at this time

Report

1. Continued efforts to work with the Department of 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 role of the Respiratory therapist in the specialty of Disaster Response.
3. Continue to develop the use of the AARC's Disaster Response List Serve to foster involvement and provide an ongoing communication resource.
4. Ideas for submission for presentation at the AARC Congress were discussed.

Hyperbaric Roundtable Report

HBO Roundtable Report

The listserv took off like a rabbit when we first began it. Then it got very quiet for several months. After I “seeded” some clinical questions, a lot more discussions took place on a variety of subjects some were quite academic. We tactfully dealt with one individual who was using the listserv for his own non- scientific agenda.

Additionally, I have submitted the names of three very involved individuals to the planning committee for the Dec 2010 congress. We plan to provide three lectures in a ‘mini-posium’ format, providing an introduction to the specialty, and safety & economic aspects to running a chamber.

Clifford E. Boehm, MD, RRT

HBO Roundtable Moderator
Associate Chief of Anesthesia
Northwest Hospital
5401 Old Court Road
Randallstown, MD 21133-5185

Diving & Hyperbaric Medicine
R Adams Cowley Shock Trauma Center
22 S. Greene Street
Baltimore, MD 21201-1595

Informatics Roundtable Report

Reporter: Constance Mussa
Last submitted: 2010-03-30 12:19:51.0

Recommendations

Recommendation 1: Permission and help from the AARC is needed for the Informatics Roundtable to spearhead the development of a formal requirements document for a generic Respiratory Care Information System (RCIS) that can be added to extant EMR systems.

Justification: Analyzing and describing information systems requirements involve the application of not only information technology knowledge, but also knowledge of business/professional activities. Many systems have failed because they did not adequately address the true needs of the users for which they were built. Current EMRs are proprietary systems built by vendors who are not conversant with the true needs of RTs. The impact of this has caused great frustration among RC managers nationwide and includes:

1. Information (Outputs)
 - Lack of any information
 - Lack of necessary information
 - Lack of relevant information
 - Inaccurate information
 - Information that is difficult to produce
2. Inputs
 - RC data is not captured
 - RC data is difficult to capture
3. Stored Data
 - RC data is not well organized
 - RC data is not flexible - new information needs from stored data are not easily handled
 - RC data is not accessible

Recommendation 2: The AARC should consider writing a grant to facilitate the development of EMR functionality needed by the RC profession.

Justification: Automated information systems that support RTs' patient care activities would ultimately help to map respiratory care interventions to patient outcomes, providing information regarding treatment efficacy. Most respiratory care departments do not have the financial means to develop or purchase computerized information systems and those that do face daunting obstacles when trying to integrate stand-alone Respiratory Care Information Systems with their hospitals' EMR systems. The Respiratory Care profession needs financial help in confronting this important issue and would greatly benefit from the receipt of a grant.

Recommendation 3: Inclusion of a section/column in the RC Journal that focuses on RC Informatics Issues and Research.

Justification: Publishing papers that focus on RC Informatics in the RC Journal would serve both to stimulate the interest of the AARC's membership in informatics, as well as serving notice on our external constituencies that we, as an organization and as a profession, intend to be actively engaged in this important and rapidly growing field.

Report

Informatics Roundtable Report - March 2010

Executive Summary

This report presents information regarding the Informatics Roundtable. The roundtable provides a forum where AARC members exchange ideas on "respiratory care informatics" (i.e., the most effective and efficient means of capturing, manipulating, presenting, and transforming respiratory care data into useful information). The report includes a brief update on the activities of the group, a summary of a face-to-face meeting of Roundtable participants on December 6, 2009 as well as three important recommendations.

Recent Roundtable Activities

1. *Discussion of RC Informatics Roundtable Priorities - Focusing on Extant Information Technology (IT) Challenges to RC Information Management Versus a Broader Informatics Agenda*

There have been spirited discussions between Roundtable participants regarding the priorities of the Informatics Roundtable. Specifically, some members of the group have expressed displeasure with discussions that have focused on broader informatics issues such as (1) RC ontology development to facilitate data modeling for creating RC information systems or RC components within current electronic medical record (EMR) systems, (2) Requirements definition for a generic RC Information System (RCIS), (4) Defining core RC Informatics competencies for RTs, and (4) Educating RC students and practicing RTs to achieve core informatics competencies. Conversely, some members believe that the focus of the RC Informatics Roundtable should be on exchanging information about the challenges and opportunities of extant EMR systems (i.e., how to make the most of EMRs in terms of capturing and retrieving RC information, the difficulties with RC information management and processing being encountered by other RTs, etc.).

1. *Summary of Respiratory Care Roundtable Meeting - San Antonio, TX*

On December 6, 2009, The AARC Informatics Roundtable held its first face-to-face meeting. RC Informatics Roundtable Chair, Constance Mussa welcomed participants to the meeting and facilitated introductions.

Meeting Attendees

- Constance Mussa - NYU Langone Medical Center
- Steve Bemister - Covidien
- Sid Jacobi - Covidien
- Rick Ford - UC San Diego
- Michelle Russell Payne - MediServe
- John Viglo - MediServe
- Paul Olver - Bridge-Tech Medical
- Susan R. Gallo - MediServe
- Robert Sparaco - NYU Langone Medical Center
- Michael Terry - Loma Linda University Medical Center
- Ellen Perry - CPMRC
- Jim Fielder - Overlake Hospital Medical Center
- Steve Nelson - AARC
- Ahmed Mussa - Brooklyn Hospital Center

Definition of RC Informatics

Constance Mussa requested that the Roundtable propose a definition of RC Informatics, stating that informatics scholars from other healthcare disciplines have asserted that a definition provides:

- a description of the scope of [RC] Informatics
- guidance to those who are interested in [RC] informatics
- directions for practice, education, training, and research
- understanding of the legitimacy of [RC] Informatics as it relates to the practice of respiratory care [Staggers, N, and Bagley Thompson, C. (2002). *The Evolution of Definitions for Nursing Informatics: A Critical Analysis and Revised Definition. J Am Med Inform Assoc, 9(3): 255-261*]

It was suggested that Roundtable participants examine discipline-specific definitions of informatics promulgated by other healthcare professions, namely, nursing, medicine, and pharmacy, as this would provide guidance and avoid "re-inventing the wheel." Constance will provide Roundtable participants with current discipline-specific informatics definitions for review and comment.

How does RC Informatics Support the Practice of Respiratory Care?

The role of RC Informatics in the practice of respiratory care was discussed. This involved seeking clarification of whether a standard process (e.g., assessment, planning, implementation, evaluation) exists for practicing respiratory care and determining the relationship (if any) between this process and RC Informatics. Some Roundtable participants expressed the belief that respiratory care is indeed practiced based on assessment, planning, implementation, and evaluation, but the relationship between RC Informatics and the process of delivering respiratory care appears to be unclear. Constance suggested that since the patient care process is information-intensive and relies heavily on documentation, standardization of respiratory care language used to convey information about each step of the patient care process is essential. This implies that one important role of RC Informatics in supporting the practice of respiratory care pertains to information representation, namely, the creation of rational structures that represent the information unique to the respiratory care process. Providing an understanding of how respiratory therapists use data, information, and knowledge to deliver and manage respiratory care will assist in describing, defining, and modeling data and processes unique to the profession of respiratory care.

It was noted that RC Informatics started informally ~10 years ago and that Robert Chatburn's ongoing work with respiratory care device terminology standardization is a notable accomplishment in this endeavor.

A Respiratory Care Ontology was discussed (again!) and some attendees expressed the view that the immediate benefit to RTs of an ontology may be marginal. Constance pointed out that a Respiratory Care Ontology is necessary because it serves many important purposes including: (1) providing a basis for communication between people (2) facilitating representation and storage of RC data, (3) facilitating knowledge sharing within the RC domain and between other healthcare domains (4) supporting search and retrieval, (5) enhancing software development, and (6) facilitating classification and organization of data resources. Steve Nelson (AARC) suggested that development of an ontology could be a long-term goal of the Roundtable since it would require tremendous effort and resources, which are currently unavailable.

Respiratory Care Information Management and Current Hospital Information Systems - Challenges and Opportunities

The impact on respiratory care information management of current hospital information systems (HIS) was discussed. There was consensus among meeting attendees that an immediate goal of the Roundtable should be to help RC managers nationwide use existing health information technology (HIT) more effectively to manage RC information. There was unanimous agreement that current HIS provide inadequate support in the management and processing of respiratory care information. Attendees noted that providing support for respiratory care information management is important because it would help to integrate respiratory care with other healthcare disciplines. Some attendees made the observation that respiratory care information management is not supported by IT vendors because they have no financial incentive to do so. Constance suggested that since the American Recovery and Reinvestment Act has allocated money for improving HIT, and since there are a few vendors who have designed and built respiratory care information systems that can allegedly be interfaced with existing HIS, it may be beneficial for the AARC to apply for a grant to help RC Departments purchase the "best" of these systems. It was proposed that the Roundtable develop a Request for Proposal (RFP), which is a document that gives vendors information about the desired system's objectives and requirements and the general criteria that will be used to evaluate proposals. Participants suggested that the RFP could be developed by identifying important elements of RC data (independent of existing systems). The AARC's Uniform Reporting Manuals were identified as important data sources for the RFP.

Miscellaneous

Some meeting attendees stressed the importance of educating RC managers so that they can more effectively use IT to improve the management and processing of RC information. Attendees also emphasized that an important purpose of the Roundtable is to provide a forum for the exchange of ideas about RC information management. It was also suggested that the Roundtable should provide a way for RC managers to network with

other managers to obtain help with HIT when needed. Constance noted that the October 2009 RC Informatics Roundtable Report contained a recommendation for inclusion of a Web page within the AARC website that contains pertinent information about RTs with expertise in various hospital information systems. The Roundtable is awaiting the AARC's decision regarding that recommendation.

Meeting attendees informed Constance that the Huddle.net workspace that was created to facilitate information and document sharing among Roundtable participants was inaccessible from Roundtable participants' workplaces due to security concerns. It was agreed that the Roundtable listserv would now be used for all future Roundtable communication.

Military Roundtable Report

Reporter: David Vines

Last submitted: 2010-03-30 23:12:22.0

Recommendations

[None at this time]

Report

The Lectures on "The Role of Military Respiratory Therapists in War" were well attended at the convention in San Antonio. After the lectures the military round table met. We had a great turnout from the military members in attendance.

We discussed the difficulties in moving forward on the proposed strategy for obtaining officer status for respiratory therapists in the military. One of the difficulties is gaining support from key leadership within the armed services to help move things forward. Another is obtaining information (such as job descriptions) needed to build our case to demonstrate the need for officer status. Dario Rodriguez, SMSgt., USAF Superintendent, was in attendance and provided insight into obtaining officer status on the Air Force side. Dario made it clear that a higher level education would be required for the soldiers and that a clear career path would need to be created and supported by leadership.

The individuals in attendance were asked to spread the word about the round table and encourage others to join. We also staffed the AARC booth on Sunday and Monday afternoon to talk to military members in the exhibit hall about joining the roundtable.

Since the convention Sam and I reviewed the strategy below and decide it was still the best course of action. We also felt that we needed to seek Dario's help in moving forward on the Air Force side. Dario, Sam, and I recently participated in a conference call to discuss this strategy. Dario agreed to help obtain the mission statement or job descriptions for respiratory therapist in the Air Force. He also agreed to meet with key leadership on the career path for respiratory therapist in the Air Force to discuss the pros and cons of obtaining officer status and to access their support.

- 1. Officer status update- Current Strategy
- A. We will need to compare the mission for Respiratory Therapist in the Army and Air Force to the respiratory therapist in the civilian world.

- B. If possible we should conduct a survey to compare the current level of practice in military facilities to the level of practice in comparable civilian facilities. This survey could provide the information needed to do a cost analysis to demonstrate how money could be saved.
- C. We will need to identify the requirements for warrant officer status in both branches and the number of personnel that currently meets those requirements.
- D. We will need to agree on some significant leadership positions that should be officer positions. Looking at physician assistants who are warrant officers may provide some information.
- E. We should highlight some of the leadership positions in the AARC Times.
- F. If the NCOIC position is one that should be a warrant officer, then we should look at the current turnover in these positions.
- G. After collecting this information and identifying positions that should be a warrant officer, we can recommend that the AARC and it's members write Senators and Representatives to request that the Surgeon General form Army and Air Force create warrant officer positions.

Neurorespiratory Roundtable Report

Reporter: Lee Guion

Last submitted: 2010-03-28 21:53:30.0

Recommendations

Continue to encourage AARC members to participate in the Neurorespiratory Roundtable, encourage current NR members to speak at local and state conventions and respiratory care educational forums on the respiratory management of neuromuscular diseases, and work towards development of educational modules to be included in Respiratory Therapy programs throughout the country.

Report

There were a number of informative exchanges and responses to members' queries this past quarter. The most recent exchanges concerned the challenges of providing mobility to mechanically ventilated patients. We hope our on-line discussions will lead to a conference at which RCPs, patients, and the manufacturers of mechanical wheelchairs and portable mechanical ventilators can discuss compatibility issues and improvements in DC power capabilities.

Four members of the roundtable submitted presentation proposals for the 2010 International Congress in Las Vegas.

The members' request that the name of the listserv be changed to the Neurorespiratory Roundtable was granted by the board of directors of the AARC.

Members met at the 2009 International Congress in San Antonio and discussed areas of interest for the coming year. A summary of the meeting was distributed through the listserv and members unable to attend added topics to be pursued in the future.

In summary, the Neurorespiratory Roundtable continued to provide an important forum through which members post clinical questions, receive thoughtful responses and links to published research, and develop best practice in the management of our patients with neurorespiratory compromise.

Research Roundtable Report

Reporter: John Davies

Last submitted: 2010-03-31 09:20:32.0

Recommendations

[Need to stimulate more participation. There has not been much traffic.]

Report

Nothing new to report]

Tobacco Free Lifestyles Roundtable **Report**

Recommendations – None

Report

The TFL Roundtable work group in partnership with Steve Nelson finished the patient guide on tobacco treatment and prevention. AARC staff are pursuing funding for the printing of the patient guides. If need be, the guide may be released as an electronic publication.

The TFL Roundtable work group is eager to start work on the companion clinician guide as soon as we receive the go ahead from Steve Nelson.

TFL Roundtable member Mike Anders was lead author on an AARC Times update article addressing what interventions and therapies work for tobacco treatment.

TFL Roundtable chair Jonathan Waugh is scheduled to present at the 7th Generation Conference sponsored by the Osage Indian Nation on "Secondhand/third-hand smoke risks and strategies to avoid and prevent exposure (children versus adults)."

Steve Shideler, program director of the cardiopulmonary sciences program at the Univ of Central FL has made available his instructional material for the 15-hour course he created to teach clinicians about tobacco intervention. The materials were posted in the online Swap Shop area of the Education Specialty Section and members of the TLF Roundtable and Educ. Section were encouraged to use and contribute/enhance the material especially for training respiratory therapy students and practitioners. This is part of a push to get our profession more involved in tobacco intervention nationwide.

Other

I submitted a proposal for the upcoming AARC International Congress to have William Bailey, MD, to give two presentations designed to encourage respiratory therapists to better understand their role in tobacco intervention and make it a part of their routine daily practice.

Tobacco intervention is an activity for all practicing RTs to embrace and I invite recommendations on how to encourage our profession to better engage in this endeavor.

Respectfully submitted,

Jonathan Waugh, PhD, RRT, RPFT, CTTS

AD HOC COMMITTEES

Ad Hoc Committee on Cultural Diversity Report

Reporter: Joseph Huff

Last submitted: 2010-04-01 16:25:38.0

Recommendations

[None]

Report

Charge: Develop a mentoring program for AARC members with the purpose of increasing the Diversity of the BOD and HOD.

Status: The Committee will be mentoring a therapist at both the Summer and winter meeting. The Delegate from Florida and Nevada are helping with the selection process.

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

Status: Ongoing, Reviewing several sites and will submit to the AARC.

Other

Comments: Thanks to Erika Abmas and Evangeline S. De Luna for attending the winter HOD meeting SanAntonio]

Ad Hoc Committee on Officer Status **Report**

Included with Military Roundtable report.

Ad Hoc Committee on Oxygen in the Home Report

Kent Christopher, MD

Co-Chairs Dr. Kent Christopher and Robert McCoy assembled Patrick Dunne, Dr. Brian Carlin and Dr. Nicholas Hill as committee members. Following a conference call, each member forwarded articles they had encountered to Dr. Brian Carlin. He offered to have his university librarian perform a search for all articles on the topic and collate her search with the articles sent to her. She will obtain PDFs and possibly place references into EndNote, a reference management program. The article PDFs will be distributed to the committee members for review. A summary of findings will be submitted to the AARC BOD. The committee will then compose a review article based upon manuscripts pertinent to the topic for publication. The articles, reference management file and review article will serve as a foundation for moving forward with education and research regarding the topic.

Ad Hoc Committee on Protocol Implementation Task Force Report

Reporter: Emily Zyla

Last submitted: 2010-03-31 08:58:22.0

Recommendations

No recommendations at this time.

Report

The committee is working to update the protocol resources available on the web site; both contact resources and example protocols. I have several example protocols submitted by the Management Section but would appreciate other sample protocols from other specialty sections. Anyone willing to serve as a resource for protocols, should contact me with their preferred contact information so the AARC web site can get updated.

Ad Hoc Committee on Pinnacle Award **Report**

Reporter: Jerry Edens

Last submitted: 2010-03-18 07:39:57.0

Recommendations

Department Organization and Staffing

- Respiratory care is utilizes evidence based practice (ex:guidelines/ pathways and/or protocols)
- The department has a system in place to assess the work demand and adjust staffing appropriately to meet the needs of patients
- Programs are in place to engage staff in decisions as well as identify opportunities for improvement. Evidence of programs includes any of the following
 - Regularly scheduled staff meetings
 - Shared Governance Models in place
 - Results of employee survey tools are utilized to monitor staff satisfaction communication and engagement..

Staff Development

- Department has an ongoing training and education programs based on an annual needs assessment.
- At least 50% of the staff hold the RRT Credential
- o The department supports staff in the achievement of the RRT credential .
- o Policy requiring attainment of RRT for new graduates within a specified time period
- o Requirements for promotion require RRT credential

Professional Activities

- The department is active in the community by evidence of ongoing participation in events and programs sponsored through their facilities, or through other community or professional organizations. Examples of activities include:
 - o The sponsoring of activities that engage patients and their families
 - o Participation in respiratory professional society activities
 - o Community health fairs
 - o Asthma Camp or other activity of the same type

Report

Committee has had emails discussions and one phone conference since last report. Having assessed the present situation we decided to reduce the parameters of the Center of Excellence Award. Our recommendation is attached to the report. This would be in addition to the requirements set forth in the current QRQR program and the "next level". The recommendations from the management list serve; not willing to spend a lot of money and stating time restraints were our guidelines. We also recommend that for this level the document would require signatures of not only the CEO of the institution but also of the medical director for verification.

Ad Hoc Committee on Learning Institutes **Report**

Reporter: Toni Rodriguez

Last submitted: 2010-03-30 16:44:15.0

Recommendations

No Recommendations at this time.

Report

AARC BOD Report: Spring 2010

Ad-Hoc Committee: AARC Learning Institute

Original Charge: That this Ad Hoc Committee develop a Management, Research and Educational leadership 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:

- To foster leadership talent
- To teach the skills of academic leadership
- To advance the science of respiratory care

Summary of Activities Spring 2010:

1. A great article by Debbie Bunch on the project appeared in the February AARC Times.
2. A proposal was submitted to the Program Committee on behalf of the Institute to present an over view of the project at either the Summer Forum and/or the International Congress. The thought behind this was that we would get needed exposure for the project. The proposal was accepted and a Plenary Session will be presented on July 17, 2010 at the AARC Sumer Forum entitled: "Continuing Professional Development: The AARC Leadership Institute."
3. Upon reviewing everything that we did last year the Executive Office requested that a Survey of the membership be conducted to gage interest before be we invest not only time but dollars into the project. We have been working based upon our own assumptions related to this project so it was important to evaluate the interest of our potential consumers. The Executive office surveyed the Management List Serve as well as the general membership. Approximately 2000 surveys went out to each group with 198 RTs and 106 managers responding. See Appendix A and B for a recap of the survey results.
4. Names have been submitted by committee members for a panel of experts to review the competencies for each track. These individuals were chosen because of their standing as leaders in their areas of expertise (Management, Education, and Research). They will be asked to review the developed competencies for relevance. This will be the final step before the project is ready to contract curriculum developers.
5. A phone conference was conducted of the entire committee on March 24th to review project progress. At that time based upon survey results it was decided that a subcommittee of the Committee Chair, Executive Office Staff and President Myers should meet to finalize the project budget. This meeting is scheduled for March 31 via conference call. The committee also decided that the sole name "AARC Leadership Institute" would be applied to the project.

Committee Members:

Chair: Rodriguez, Toni Ed.D, RRT

Member: Chatburn, Robert (Research Institute Chair) RRT-NPS, FAARC

Member: Ford, Richard (Management Institute Chair) RRT, FAARC

Member: Myers, Timothy BS, RRT-NPS

Member: Van Scoder, Linda (Education Institute Chair) EdD, RRT, FAARC

Staff Liaisons: Giordano, Sam MBA, RRT,FAARC, Tom Kallstrom, RRT FAARC

Appendix A:

Survey: RT Membership:

198 RTs out of 2000 AARC members responded:

Ask if they saw a need to improve in these categories they said

Research 81%

Management 74%

Education 85%

Asked if they used these skills to do their job they said

Research 68%

Management 84%

Education 96%

Asked if they would be more successful with more info in these areas they said

Yes - 97%

Asked how the Leadership Institute could benefit their career they said

Confidence as a professional 88%

Promotion 63%

Job security 64%

Higher pay 56%

Autonomy 73%

Respect 84%

Asked if this was offered would they be inclined to use it they said

Yes - 94%

Appendix B

Manager Survey:

106 out of 200 managers responded

Ask if they saw a need for their staff to improve in these categories they said

Research 69%

Management 88%

Education 92%

Ask if they saw a need for themselves to improve in these categories they said

Research 83%

Management 90%

Education 87%

Asked if this program would be an asset to them as managers

Yes- 97%

Asked how leadership institute could benefit their Staff Members' career they said

Confidence as a professional 97%

Promotion 81%

Job security 57%

Higher pay 57%

Autonomy 85%

Respect 93%

Asked how leadership institute could benefit their OWN career they said

Confidence as a professional 80%

Promotion 61%

Job security 57%

Higher pay 44%

Autonomy 69%

Respect 86%

Asked if this was offered would they promote its use and they said

Yes - 95%

OTHER REPORTS

National Board for Respiratory Care Report



MEMORANDUM

Date: March 30, 2010

To: AARC Board of Directors, House of Delegates and Board of Medical Advisors

From: Gregg L. Ruppel, MEd, RRT, RPFT, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you my first update on activities of the NBRC as President. The Board of Trustees will meet April 19-24 to conduct its examination development activities and discuss business related items pertinent to the credentialing system. The following details the current status of examinations and significant activities in which the Board and staff are currently involved.

Adult Critical Care Examination Development to Begin

At its November meeting, the Board approved moving to the next step in its 5-step process for examination development. Test development activities began in January with an item writer's workshop aimed at adult critical care contributors. Work will continue at the April meeting with an expected launch of a full-length practice examination and self-assessment instrument in early 2011 and implementation of the credentialing examination in late 2011 or early 2012. The examination will consist of 170 items - 150 scored and 20 pretest items. Candidates will be given a 3.5 hour test administration time. The Board will consider admission requirements and a credential acronym for this examination this year.

Expected Graduation Provision for the CRT Examination to be Eliminated

The Board of Trustees considered a recommendation from the Admissions Committee and approved on first reading the elimination of the Expected Graduation Provision for the CRT Examination effective January 1, 2011. The Board will consider this on second reading April 24, 2010 where a 2/3 affirmative majority vote is required.

Revised Admissions Policies Approved on First Reading

The Admissions Committee brought forth the following resolutions to the Board of Trustees in February 2010 as a result of the change in CoARC's status to separate from CAAHEP and become an independent accrediting agency. A second-reading will occur in May 2010, and a 2/3 majority approval of these resolutions will be required before the revised policies can be implemented.

RESOLVED to modify admission policies for route 2.a. (as stated in the Candidate Handbook) of the CRT and CPFT Examinations to read:

Applicants shall have a minimum of an associate degree from a respiratory therapist education program 1) supported or accredited by the Commission on Accreditation for Respiratory Care (CoARC), or 2) accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and graduated on or before November 11, 2009.

RESOLVED to modify the admission policies for route 2.a. (as stated in the Candidate Handbook) of the RRT Examination to read:

Applicants shall be a CRT and have a minimum of an associate degree* from a respiratory therapist education program 1) supported or accredited by the Commission on Accreditation for Respiratory Care (CoARC), or 2) accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and graduated on or before November 11, 2009.

*Graduates of accredited 100-level respiratory therapist education programs are not eligible for admission to the RRT Examination under this admission provision.

2009 Examination and Annual Renewal Participation

Applications received, candidates tested and renewals processed hit an all time high in 2009. Over 30,000 individuals renewed their active status with the NBRC in 2009 by paying the \$25 annual renewal fee. 2010 is the first year of the NBRC switching to a calendar year renewal cycle; annual renewal notices were mailed to credentialed practitioners in late October of last year and credentialed practitioners were encouraged to renew their status by December 31. For 2010, we have processed 29,000 active status renewals.

To date, we have received nearly 6,700 applications across all examination programs; this is down over 3,000 applications from this time last year and likely attributed to the fact that last year was the deadline (February 28, 2009) for individuals who graduated prior to January 1, 2005 to earn the RRT credential without having to remediate.

Examination Statistics – January 1 – December 31, 2009

The NBRC administered over 40,000 examinations in 2009. Pass/fail statistics for the respective examinations follow:

<u>Examination</u>	<u>Pass Rate</u>	
<u>CRT Examination</u> – 13,415 candidates		
	<u>Entry Level</u>	<u>Advanced</u>
First-time Candidates	71.1%	78.4%
Repeat Candidates	27.5%	24.9%
<u>Therapist Written Examination</u> – 12,310 candidates		
First-time Candidates	70.6%	
Repeat Candidates	38.3%	
<u>Clinical Simulation Examination</u> – 13,120 candidates		
First-time Candidates	56.8%	
Repeat Candidates	47.8%	
<u>Neonatal/Pediatric Examination</u> – 842 candidates		
First-time Candidates	75.3%	
Repeat Candidates	46.7%	
<u>Sleep Disorders Specialty Examination</u> – 121 candidates		
First-time Candidates	94.0%	
Repeat Candidates	25.0%	
<u>CPFT Examination</u> – 304 candidates		
First-time Candidates	67.4%	
Repeat Candidates	39.0%	

RPFT Examination – 69 candidates

First-time Candidates	79.2%
Repeat Candidates	46.7%

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 integrity of the credentialing process.

American Respiratory Care Foundation
Report

Unfinished Business

Ad Hoc Committee on Mass
Casualty/Pandemic Preparedness

International Roundtable

Simulation Roundtable

New Business

Ratification of Appointments

Geriatrics Roundtable

Policy Review

Ratification of Appointments

Geriatrics Roundtable

Policy Review

American Association for Respiratory Care
Policy Statement

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Policy No.: BOD.022

SECTION: Board of Directors
SUBJECT: **Section Director Term of Office**
EFFECTIVE DATE: February 12, 2002
DATE REVIEWED: March, 2002
DATE REVISED:
REFERENCES: AARC Bylaws

Policy Statement:

The terms of office for the Section Director will be in accordance with the Association's Bylaws.

Policy Amplification:

1. As outlined in Article 5, Section 1, a Section Chair from each specialty section of at least 1,000 active members of the Association will serve on the Board of Directors as a Section Director. So long as the number of Section Directors is at least six (6), the number of At Large Directors shall be equal to the number of Section Directors. If the number of Section Directors is less than six (6), the number of At Large Directors shall be increased to assure a minimum of twelve (12) Directors. The Board shall then be comprised of six (6) officers and a minimum of twelve (12) Directors for a total of at least eighteen (18) Active Members.
2. If the active membership of a section exceeds 1,000 active members on December 31st of a year in which the section does not have a serving section director, the Chair of the Section will be sworn in as a Section Director at the next Annual Business Meeting of the Association. The term of the Section Director shall be for the remaining term of the Section Chair.
3. If the active membership of a specialty section is no longer at least 1,000 members as of December 31st of the year preceding completion of the term of the Section Director, the incoming Chair of that Section will not serve as a Section Director

American Association for Respiratory Care
Policy Statement

Page 2 of 2

Policy No.: BOD.022

4. In any situation in which reductions in the number of Section Directors will result in the number of At Large Directors exceeding the number of Section Directors, and at least twelve (12) Directors will be serving, the number of At Large Directors nominated by the Elections Committee and elected by the membership in the next Association election shall be reduced so the numbers of At Large and Section Directors on the Board of Directors following the Installation of those Directors shall be equal.

5. If at any time the number of Section Directors will decrease below six (6) the number of At Large Directors nominated by the Elections Committee and elected by the membership in the next Association election shall increase so there shall be twelve (12) Directors serving following installation of those persons.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Page 1 of 2

Policy No.: BOD.023

SECTION: Board of Directors
SUBJECT: **Board of Directors Listserv**
EFFECTIVE DATE: February 1, 2004
DATE REVIEWED:
DATE REVISED:

REFERENCES: AARC Bylaws

Policy Statement:

1. The BOD and Executive Committee will conduct business on a Listserv which is maintained by the Executive Office.
2. E-voting by the Board of Directors shall be conducted using specific guidelines (see following page) and established parliamentary procedure.

Policy Amplification:

1. The Secretary/Treasurer is responsible for posting these guidelines at the start of each new term of directors and officers.
2. Messages posted on the Listserv should not be forwarded to non-Board members.
3. Humor and personal messages should be marked “Not Business” or “NB” in the subject line.
4. All voting completed on the Listserv must be ratified at the following BOD meeting.
5. The Secretary/Treasurer is responsible for managing the e-voting procedure.

DEFINITIONS:

ATTACHMENTS: See “Guidelines for the Board of Directors E-Voting” on following page.

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: CA.004

SECTION: Chartered Affiliates

SUBJECT: **Affiliate Revenue Sharing Agreement**

EFFECTIVE DATE: December 31, 2003

DATE REVIEWED:

DATE REVISED: May 2004

REFERENCES:

Policy Statement:

Revenue sharing will be distributed to affiliates considered to be in good standing.

Policy Amplification:

1. The BOD shall set the amount of the revenue sharing for chartered affiliates in good standing.
 - A. The revenue sharing amount will be set annually.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 2
Policy No.: CT.001

SECTION: Committees
SUBJECT: Committee Charges
EFFECTIVE DATE: December 14, 1999
DATE REVIEWED:
DATE REVISED: May 9, 2004

REFERENCES:

Policy Statement:

Each committee of the Association shall comply with charges in accordance with the Bylaws and as identified by the President.

Policy Amplification:

1. All committee reports shall arrive in the Executive Office 35 days prior to the Board of Directors' meetings.
 - A. Committee reports which arrive after the due date shall be transmitted for consideration through electronic means as an addendum to the Board and House of Delegates agenda books.
 - B. Late committee reports shall be available for Board and House members not receiving electronic transmissions of late reports.
2. The committee chair shall be required to acknowledge the contributions of their committee members. This may be accomplished through references added to the committee reports and directly through letters to the committee members.
 - A. The chair of each committee shall forward to the President the name(s) of those committee members, if any, who have made significant contributions to the success of the committee throughout the year.
 - B. The President shall then send, at his/her discretion, letters of thanks to those she/he feels warrant same.

American Association for Respiratory Care Policy Statement

Page 2 of 2
Policy No.: CT.001

3. The Judicial Committee shall be required to submit no later than 30 days prior to the Association's annual meeting to the Executive Office the complete set of committee records and files for the current year's activities.
 - A. Required files shall include originals of all incoming and copies of all outgoing correspondence and memoranda arranged on a case by case or project by project basis.
 - B. Should the Executive Office not receive the required files within the required time, the President shall be notified, who shall then directly notify the Chair and request their transferal to the Executive Office.
4. All Committees shall be responsible to review policies and procedures related to their committee activities and report proposed changes to the President for revision of the policy and procedure manual.
 - A. All policies, procedures and proposed changes shall be in standard format.
5. The committee chair shall perform duties specified by the President and the Board of Directors to carry out the objectives of the Association.
 - A. The chair of each committee shall confer promptly with the members of that committee on work assignments.
 - B. In the event of committee vacancies occurring in any committee, the President may appoint members to fill such vacancies, subject to the approval of the Board of Directors.
6. Committee members of any member class, as well as non-members may be appointed as consultants to committees.
 - A. The President shall request recommendations regarding physician consultants from the Chair of the Board of Medical Advisors.
7. The Vice President of Internal Affairs will be the liaison to the BOD committees.

DEFINITIONS:

ATTACHMENTS:

ARCF Achievement **Awards**

Forrest M. Bird Lifetime Scientific
Achievement Award

Invacare Award for Excellence in Home
Respiratory Care

Dr. Charles H. Hudson Award for
Cardiopulmonary Public Health