Board of Directors Meeting

December 4, 5 & 9, 2010

Las Vegas, Nevada

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Board of Directors Meeting
Las Vegas Hilton
Las Vegas, Nevada
December 3 – 5, 2010

Friday, December 3 - Pavillion IV (Hilton)

3:30 – 7:00 pm Executive Committee Meeting (Committee Members only)
7:00 – 8:00 pm AARC Finance Committee Meeting (All BOD and HOD Officers welcome)

Saturday, December 4 - Pavillion IV (Hilton)

8:00 – 5:00 pm AARC Board of Directors Meeting
8:00 am Call to Order
Announcements/Introductions
Conflict of Interests / Disclosures
Approval of Minutes - **p. 6**
E-motion Acceptance - **p.30**
#General Reports - p. 32
President - **p. 33**
President-Elect - **p. 37**
Executive Office - **p. 38**
2015 Report and Recommendations

9:45 - 10:00 am **BREAK**

10:00 am

General Reports Continued
VPs – External and Internal - **p. 50**
Government & Regulatory Affairs - **p. 51 thru 66**
Board Of Medical Advisors (BOMA) - **p. 67**
House of Delegates - **p. 76**
Presidents Council - **p. 79**

#Standing Committee Reports - 80
Audit Subcommittee - **p. 81**
Bylaws Committee - **p. 82**
Executive Committee - **p. 157**
Finance Committee - **p. 158**
Judicial Committee - **p. 159**
Program Committee - **p. 160**
Strategic Planning Committee - **p. 161**

12:00-1:30 pm Lunch Break: Daedalus Meeting

1:30 -4:00 pm

#Joint Session - p. 162

Welcome and Roll Call
American Respiratory Care Foundation (ARCF) - **p. 163**
AARC Elections Committee - **p. 168**
Government & Regulatory Affairs **(see p. 51-66)**
2010 Budget Report
Consideration of 2011 Budget

4:00 pm

#Specialty Section Reports - p. 170

Adult Acute Respiratory Care - **p. 171**
Continuing Care-Rehabilitation - **p. 172**
Diagnostics - **p. 173**
Education - **p. 175**
Home Care - **p. 177**
Long Term Care - **p. 179**
Management - **p. 180**
Neonatal-Pediatrics - **p. 181**
Sleep Section - **p. 182**
Surface and Air Transport - **p. 183**

5:00 pm RECESS

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Board of Directors Meeting
Las Vegas Hilton
Las Vegas, Nevada
December 3 – 5, 2010

Sunday December 5 - Pavillion IV (Hilton)

8:00 – 12:00 pm AARC Board of Directors Meeting

8:00 am Call to Order

#Roundtables - p. 185

- Asthma Disease Management Roundtable - **p. 186**
- Consumer Roundtable - (See Exec Office Rpt)
- Disaster Response Roundtable - **p. 187**
- Geriatrics Roundtable - **p. 188**
- Hyperbaric Roundtable - **p. 189**
- Informatics Roundtable - **p. 190**
- International Medical Mission Roundtable - **p. 191**
- Military Roundtable - **p. 192**
- Neuromuscular Roundtable - **p. 193**
- Research Roundtable - **p. 195**
- Simulation Roundtable - **p. 196**
- Tobacco Free Lifestyle Roundtable - p. 197

8:30 am **#Special Committee Reports - p. 199**

- Benchmarking Committee - **p. 200**
- Billing Code Committee - **p. 202**
- Clinical Practice Guidelines Steering Committee - **p.204**
- Fed Government Affairs Committee - **p. 207**
- Fellowship Committee - **p. 208**
- International Committee - **p. 212**
- Membership Committee - **p. 217**
- Position Statement Committee - **p. 219**
- Public Relations Action Team - **p. 230**
- State Government Affairs Committee - **p. 231**

9:00 am **BREAK**

9:30 am **#Special Committee Reports -**

- Ad Hoc Committee on Cultural Diversity - **p. 233**
- Ad Hoc Committee on International Affairs - **p. 234**
- Ad Hoc Committee on Mass Casualty/Pandemic Issues - **p 268**
- Ad Hoc Committee on Officer Status in the US Uniformed Services - **p. 269**
- Ad Hoc Committee on Oxygen in the Home - **p. 270**
- Ad Hoc Committee Protocol Implementation - **p. 271**
- Ad Hoc Pinnacle Award - p. 272
- Ad Hoc Committee on Leadership Institute - **p. 273**

9:45 am **#Organizational Representatives - p. 283**

AMA CPT Health Care Professional Advisory Committee (HCPAC) - **p. 284**
American Association of Cardio & Pulmonary Rehab (AACVPR) - **p. 288**
American Association of Critical Care Nurses (AACN) - **p. 289**
American Heart Association (AHA) - **p. 290**
American Society for Testing & Materials (ASTM) - **p. 291**
Chartered Affiliate Consultant - **p. 292**
Clinical Laboratory Institute (CLSI) - **p. 293**
Clinical Laboratory Institute CLSI Point of Care - **p. 294**
Commission on Accreditation of Medical Transport Systems (CAMTS) - **p. 295**
Extracorporeal Life Support Organization (ELSO) - **p. 300**
International Council for Respiratory Care (ICRC) - **p. 301**
Joint Commission on Accreditation of Health Care Organizations (JCAHO) PTACS - **p. 305**
Medicare Coverage Advisory Committee (MCAC) - **p. 308**
National Asthma Education & Prevention Program (NAEPP) - **p. 309**
National Coalition for Health Professional Education in Genetics (NCHPEG) - **p. 312**
National Sleep Awareness Roundtable - **p. 313**
Neonatal Resuscitation Program - **p. 314**
Simulation Alliance - **p. 316**

10:30 am **#UNFINISHED BUSINESS - p. 317**

Consideration of House Resolutions – HOD Past Speaker - **p 318**
AARC Policy & Procedure Manual Review - **p. 321**
NBRC - **p. 329**
CoARC - **p. 335**

11:15 am **#NEW BUSINESS - p. 336**

Oncology Roundtable - **p. 337**

ANNOUNCEMENTS
TREASURER'S MOTION
ADJOURNMENT

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
July 19, 2010 - Marco Island, Florida

Minutes

Attendance
Tim Myers, BS, RRT-NPS, President
Karen Stewart, MS, RRT, FAARC, President-elect
George Gaebler, MSEd, RRT, FAARC, VP/Int. Affairs
Joseph Lewarski, BS, RRT, FAARC, VP/Ext. Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
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
Cam McLaughlin, BS, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Tony Stigall, MBA, RRT, RPSGT
James Taylor, PhD, RRT
Brian Walsh, RRT-NPS, RPFT

Guests
Colleen Schabacker

Consultant
Dianne Lewis, MS, RRT, FAARC, President's Council President
Mike Runge, BS, RRT, FAARC, Acting Parliamentarian

Absent
John Hiser, MEd, RRT, FAARC, Parliamentarian (Excused)
Clifford Boehm, MD, RRT, BOMA Chair (Excused)
Toni Rodriguez, EdD, RRT, Past President (Excused)

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
Cheryl West, State Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:00 a.m. EDT, Monday, July 19, 2010. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum. Mike Runge will serve as acting Parliamentarian in John Hiser's absence.

WELCOME AND INTRODUCTIONS

Members introduced themselves and stated their disclosures as follows:

Linda Van Scoder – Indiana Society
Jim Taylor – Michigan Society
Dianne Lewis – Florida Society
Mike Hewitt - Florida Bylaws
Tony Stigall - Florida Bylaws
Lynda Goodfellow - Teleflex Medical consultant

APPROVAL OF MINUTES

Denise Johnson moved "To approve the minutes of the April 23, 2010 meeting of the AARC Board of Directors."

Motion Carried

Denise Johnson moved "To approve the minutes of the April 24, 2010 meeting of the AARC Board of Directors as amended."

Motion Carried

E-MOTION RATIFICATION

Karen Stewart moved "To ratify the E-Motions discussed over the Board Listserv since April, 2010 as follows:

10-1-80.1 "That the AARC Board of Directors review and nominate two of the three candidates provided (Tim Op't Holt, Pat Munzer and Barbara Larson) to be considered by the CoARC as a replacement for Stephen Mickles on the CoARC Board as an AARC Representative for one term."

10-1-44.1 "That the AARC form the International Medical Mission Roundtable."

GENERAL REPORTS

PRESIDENT'S REPORT

President Tim Myers thanked the Board for their time and swift responses to issues as they arose. He stated that judging from the national news reports hospitals are still experiencing hard times financially. Thus our profession has some unique challenges such as efforts to push Medicare Part B. AARC is currently in discussions for development of a virtual lobby day to be held soon. He expressed the need to find new revenue streams and increase membership. The Association lost volume from student memberships. AASM and AARC will soon be participating in a conference call to discuss current sleep issues. The number of International Fellows was reduced this year due to minimal funding. The 2015 and Beyond manuscript will be presented at the December BOD meeting. The Executive Office has introduced new programs as well as online programs benefitting members. President Myers stated the Association will look into palliative care as proposed by BOMA.

EXECUTIVE DIRECTOR'S REPORT

Sam Giordano reported that we can expect a constant barrage of challenges in this economy, but we and our state societies can meet them if we stay focused. The third and final phase of the 2015 conference has taken place. The 2015 planning group will present findings to the writing committee for preparation of the manuscript. We would like to share the manuscript with various groups for comparison's sake. The Association continues to develop publications to meet our members' expectations. The July *AARC Times* is online now, and the *RESPIRATORY CARE* Journal will be online next month. At the end of the year we will ask members to choose which publication they would prefer to receive (or both) in an effort to eliminate the Choice membership which is not feasible in today's economy. There is a high degree of interest in growing the profession in the Middle East. Mr. Giordano believes that AARC can be instrumental in helping them. He and Gary Smith will travel to Saudi Arabia in September.

Tom Kallstrom reported on Drive4COPD. We're in partnership with ALA (and others) to screen people for COPD which will be a positive way of getting people to know and understand the role of respiratory therapists. The COPD educator course and Asthma Prep course are both doing well. VAP will start this fall with 2 live workshops in MD/DC and PA which will hopefully position RTs to a higher level. Aerosol documents are progressing. Best Practices in Mechanical Ventilation will soon be online. We are currently working on a Safety Checklist project with a team of professionals to identify key words and search topics for a beta test followed by a white paper. We offer co-marketing for our COPD, Asthma and Spirometry courses to the states which will afford them a percentage of the registration fee. We'll soon seek funding to update our CPGs.

Ray Masferrer reported on the Vent workshop conducted at this meeting which was very well attended. We met (or exceeded) the budget for this workshop which was attended by 68 individuals. We believe the workshop enhanced the attendance of this year's Summer Forum which was over 300. The program content was excellent, and we're pleased with

overall attendance at Summer Forum. Approximately 60 people signed up for AARC Connect at Summer Forum and it appears to be progressing positively. Brian Walsh stated that AARC Connect is difficult in that responding to it doesn't allow for smart phone use at this time, however, there is an application at considerable cost for utilization of smart phones that AARC will investigate in the future.

George Gaebler moved "To postpone until tomorrow's meeting **Recommendation 10-2-1.1** as follows:

> "That the Quality Respiratory Care Recognition (QRCR) add a requirement to the criterion stating that benchmarking be part of their quality improvement processes."

Motion to Postpone Carried

HOUSE OF DELEGATES REPORT

Tom Lamphere reported concerns among HOD members regarding their not being able to vote on the budget which he recommends should be taken out of the Bylaws completely. He's charging chairs to perform self-examination of their committees and bring back to the next meeting. He also reported that there should be more instruction surrounding expectations of the Secretary/Treasurer's role in the House of Delegates.

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:30 a.m. EDT, Monday, July 19, 2010.

RECONVENE

President Tim Myers reconvened the meeting of the AARC Board of Directors at 9:45 a.m. EDT, Monday, July 19, 2010.

AMERICAN RESPIRATORY CARE FOUNDATION (ARCF) REPORT

Chair and Vice Chair Mike Amato and Dr. Neil MacIntyre respectively presented an overview of the Foundation's activities. Dr. MacIntyre stated the Foundation provides funding of Fellows in the International Fellowship program, journal conferences, and scholarships. It first began decades ago when there was an interest in funding scholarships. The Foundation became a bonafide charitable group in 1987. By 1997 ARCF was approaching the one million dollar mark. In 2007 they had a two million dollar endowment, however in the coming years expenses grew and the stock market declined. This year the Foundation had to temporarily liquidate its Sullivan endowment. Therefore, the reality is the need to raise money and cut costs. They are considering a direct solicitation, and in the future a fundraiser. The Foundation believes its future lies in new

RTs and intends to focus on that category of membership. ARCF Trustees are appointed every year for a one-year term with a balance of individuals who are RTs, and people from industry as approved by the current AARC President.

It was suggested that a golf tournament be planned for December. Another suggestion was the quarterly inclusion of ARCF awareness in AARC's publications as well as speakers foregoing their honorariums in favor of a contribution to the Foundation. Further suggestions should be addressed to Mike Amato in care of the AARC.

GOVERNMENT AFFAIRS REPORT

Government Affairs Director Cheryl West encouraged members to utilize AARC's Capitol Connection as a way to contact members of Congress. She updated members on Hawaii's successful efforts to gain licensure. Miriam O'Day reported on the CBO score that is the major obstacle for our legislation. Blanche Lincoln's senate seat may be in jeopardy which would affect passage of the bill. Anne Marie Hummel reported AARC resubmitted a letter to Congressman Meek to push the competitive bidding repeal which AARC supported in a separate letter.

ACCEPTANCE OF GENERAL REPORTS

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

Motion Carried

STANDING COMMITTEES

AUDIT SUBCOMMITTEE REPORT

George Gaebler moved to accept **Recommendation 10-2-10.1** "That the AARC Audit Subcommittee directs the AARC to retain its current Auditor and Audit Firm for the 2010 & 2011 Fiscal Audit periods."

Motion Carried

BYLAWS COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 10-2-9.1** "That the AARC Board of Directors accept and approve the Indiana Society for Respiratory Care proposed Bylaws revisions."

Motion Carried - Linda Van Scoder abstained.
George Gaebler moved to accept **Recommendation 10-2-9.2** "That the AARC Board of Directors accept and approve the Florida Society for Respiratory Care proposed Bylaws revisions."

While the Florida Society Bylaws met the established criteria for passage of Bylaws, the Board noted several potential problem areas for which George Gaebler will contact the Bylaws Chair to discuss.

Jim Taylor moved "To table **Recommendation 10-2-9.2**."

Motion to Table Carried - Tony Stigall and Mike Hewitt abstained.

EXECUTIVE COMMITTEE REPORT

Tim Myers reported the Committee discussed recommendations to the BOD, HOD resolutions, financial areas of the Association and International activities. Also discussed was Strategic Planning on a five year basis in the Executive Office concerning membership, educational programs, and other areas.

INTERNATIONAL ACTIVITIES

Jerome Sullivan, Chair of the International Committee and Vice Chair Hassan Alorainy presented. Mr. Alorainy stated Saudi Arabia is very well developed in respiratory and meets the same requirements as in the states. He's been involved in many international meetings, has arranged for 140 AARC memberships, has purchased Professor's Rounds every year, and applied for the Benchmarking system AARC utilizes. He believes the presence of Sam Giordano, Jerome Sullivan and Gary Smith will enhance proficiency and hopes to work with the NBRC in sitting for the RRT exam. Last year they held the 1st annual Gulf Thoracic Society in Abu Dhabi in collaboration with ACCP. In 2011 he hopes to have the same conference in collaboration with ACCP and sponsored in part with AARC with a free booth and ability to meet with heads of Saudi organizations. He hopes the Asthma Educator course will be available to them as well.

Jerome Sullivan reported ICRC has had a 22-year track record in Mexico. He advised of the development of the Latin American Board in which AARC is involved and Japanese sponsored RC seminars. The Korean Society for Respiratory Care will soon celebrate its 10th year, and the Indian society is going strong. The Saudi Arabian Respiratory Society has existed for 3 years, and the Irish program has recently come into play as well as Turkey, Argentina and Italy. He advised that AARC's name recognition is much higher today than in years passed.

International Fellows were chosen at yesterday's International Council meeting as follows:

Micheline Gmeiner	Austria
Guillermo Carlos Contreras Nogales	Peru
Hui-Qing Ge	China
Adil Al Otaibe	Saudi Arabia.
Darko Kristovic	Croatia (first alternate)

Mohammed Herrag Morocco (second alternate)

Host cities are as follows:

Dallas and Denver – China Fellow
Miami and Charlottesville – Saudi Arabian Fellow
Boston and Rochester – Austrian Fellow
Tampa and Durham – Peruvian Fellow

George Gaebler moved to accept **Recommendation 10-2-23.1** "That AARC establish an ad hoc committee to conduct a review to re-examine the structure, effectiveness, objectives and goals of the International Fellowship Program with conclusions and recommendations due in December 2010 to the AARC BOD and in February 2011 to the ARCF Board of Trustees."

Motion Carried – (President Myers stated the Committee will have representation from ICRC, International Committee and the ARCF, and will also examine the financial aspects of the Fellowship.)

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 12:00 noon EDT, Monday, July 19, 2010.

JOINT SESSION

President Tim Myers convened the Board of Directors at 1:40 p.m. EDT, Monday, July 19, 2010. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

President Myers welcomed everyone and emphasized the challenges ahead stating this can also be seen as an opportunity to implement change and therefore enhancing the Association.

The state of Hawaii was presented with a plaque for their efforts leading to state licensure. This marks the 49th state to regulate the profession through licensure.

ELECTION COMMITTEE REPORT

John Steinmetz, Election Committee Chair reported the House of Delegates has implemented electronic submission of reports. He advised of the following slate of candidates:

Neonatal Pediatric Section Chair-elect
1. Cynthia White
2. Tiffany Mabe

Director at Large
1. Gary Wickham
2. Denise Johnson
3. John Lindsey

Management Section Chair-elect
1. Roger Berg
2. Bill Cohagen
4. Fred Hill
5. Albert Moss
6. Cam McLaughlin

Education Section Chair-elect
1. Joseph Sorbello
2. Keith Terry

Secretary-Treasurer
1. Mike Tracy
2. Linda Van Scoder

Diagnostics Section Chair-elect
1. Matthew O'Brien
2. James Sullivan

Vice President/Internal Affairs
1. Susan Rinaldo Gallo
2. Mike Hewitt

Adult Acute Care Section Chair-elect
1. Keith Lamb

Vice President/External Affairs
1. Robert McCoy
2. George Gaebler

EXECUTIVE SESSION

Michael Hewitt moved "To enter into Executive Session."

Motion Carried

JOINT SESSION

President Tim Myers reconvened the meeting of the Board of Directors at 2:00 EDT, Monday, July 19, 2010.

AMERICAN RESPIRATORY CARE FOUNDATION (ARCF) REPORT

ARCF Chair, Michael Amato reported that unfortunately the economy has negatively affected the Foundation like most other charitable organizations in that income is down and expenses are up. Unrestricted contributions can be made to the ARCF on the website.

LEGISLATIVE AFFAIRS

Frank Salvatore advised members of a new program under consideration – Virtual Lobby Day.

Cheryl West reported that a blast e-mail was to be sent to all 50,000 members as well as a page on www.yourlunghealth.org advising members of AARC's August 4, 2010 Virtual Lobby Day when RTs, patients and supporters would e-mail and call Capitol Hill in support of the legislation of HR 1077 / S343.

Miriam O'Day reported that S.343/H.R.1077 Medicare Respiratory Therapy Initiative is at the CBO for a cost analysis and she is optimistic, further stating it's only a matter of time before it passes.

Anne Marie Hummel advised that AARC submitted comments regarding physician co-signing of RT orders. She also updated the Board on various Medicare regulatory issues we are currently involved in.

DRIVE4COPD

President-elect Karen Stewart and Tim Myers gave a presentation on AARC's newest program, Drive4COPD, a nationwide effort to screen Americans for this disease and ultimately extend the lives of those affected and assist their families. The goal is to screen 1,000,000 individuals who may be at risk. AARC will partner with celebrity ambassadors in the music, television and sports arena and ultimately target stakeholders. To date, 150,000 individuals have been screened using a 5-question questionnaire to determine at-risk individuals. Prizes will be awarded at this year's International Congress to the states showing the highest number of screenings. Additionally, AARC believes many thousands of Americans will have a clearer understanding of the role of the respiratory therapist via this project.

MOTION TO ADJOURN

Denise Johnson moved "To adjourn the Joint Session of the Board of Directors."

Motion Carried

JOINT SESSION ADJOURNED

President Tim Myers adjourned the Joint Session of the Board of Directors at 3:35 p.m. EDT, Monday, July 19, 2010.

REGULAR SESSION RECONVENED

President-elect Karen Stewart reconvened the regular session of the Board of Directors at 3:50 pm EDT, Monday, July 19, 2010.

ELECTION COMMITTEE REPORT

George Gaebler moved "To accept **Recommendation 10-2-10.1** "That the AARC develop a mechanism in which nominations can be submitted electronically."

Motion Carried

Joe Lewarski moved to accept **FM 10-2-1.1** "That **Recommendation 10-2-10.1** be referred to the Executive Office to convert the paper format into an electronic nomination."

Motion to Refer Carried

Pat Doorley moved to accept **Recommendation 10-2-10.2** "To revise AARC Policy No. CT.003 (#10) from 'the Elections Committee shall draw names by lot to determine the ballot positions of each candidate' to 'Voting will be by an online process with the order of candidate names randomly listed'."

Motion Carried – ***Policy***

FINANCE COMMITTEE REPORT

Linda Van Scoder moved to accept **Recommendation 10-2-12.1** "That the AARC BOD approve the expense of $1,337.44 in travel expenses for Karen Stewart to attend the BOMA meeting in June 2010."

Motion Carried

PROGRAM COMMITTEE REPORT

President Tim Myers reported for Ray Masferrer that there were approximately 300 in attendance at this year's Summer Forum with over 60 registered for the vent course and approximately that many registered for the Asthma Course. Overall, this meeting was considered a success.

STRATEGIC PLANNING COMMITTEE

President Tim Myers advised there is an outline in progress for a strategic plan with a draft to be reviewed in December.

SPECIALTY SECTIONS

HOMECARE SECTION REPORT

George Gaebler moved to accept **Recommendation 10-2-53.1** "That the AARC Board of Directors request that the NBRC investigate the need and potential for a specialty credential for respiratory therapists working in home care if it is determined that there is a need, and that the specialty credential be developed as soon as possible to address the educational requirement for respiratory therapists working in home respiratory care."

Denise Johnson moved "To postpone **Recommendation 10-2-53.1**."

Motion to Postpone Carried

SPECIAL COMMITTEES

MEMBERSHIP COMMITTEE

George Gaebler moved to accept **Recommendation 10-2-24.1** "Begin a membership campaign beginning in August, 2010 and ending November 1, 2010 as outlined in charge #3 in this report."

George Gaebler moved "To accept **Recommendation 10-2-24.1** for information only."

Motion Carried

POSITION STATEMENT COMMITTEE

George Gaebler moved to accept **Recommendation 10-2-26.1** "That the AARC BOD approve and publish the position statement entitled 'Home Respiratory Care Services'."

Linda Van Scoder moved "To postpone **Recommendation 10-2-26.1**."

Motion to Postpone Carried

RECESS

President-elect Karen Stewart recessed the meeting of the AARC Board of Directors at 5:05 p.m. EDT, Monday July 19, 2010.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
July 20, 2010 - Marco Island, Florida

Minutes

Attendance

Tim Myers, BS, RRT-NPS, President
Karen Stewart, MS, RRT, FAARC, President-elect
George Gaebler, MSEd, RRT, FAARC, VP/Int. Affairs
Joseph Lewarski, BS, RRT, FAARC, VP/Ext. Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
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
Cam McLaughlin, BS, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Tony Stigall, MBA, RRT, RPSGT
James Taylor, PhD, RRT
Brian Walsh, RRT-NPS, RPFT

Guests

Tom Lamphere

Consultant

Dianne Lewis, MS, RRT, FAARC, President's Council President
Mike Runge, BS, RRT, FAARC, Acting Parliamentarian

Absent

Clifford Boehm, MD, RRT, BOMA Chair (Excused)
John Hiser, MEd, RRT, FAARC, Parliamentarian (Excused)
Toni Rodriguez, EdD, RRT, Past President (Excused)

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
Cheryl West, State Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:00 a.m. EDT, Monday, July 20, 2010. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

MEMBERSHIP COMMITTEE REPORT CONTINUED

Denise Johnson moved "To bring back to the table **Recommendation 10-2-24.1** 'Begin a membership campaign beginning in August, 2010 and ending November 1, 2010 as outlined in charge #3 of the Membership Committee report'."

Denise Johnson moved "To refer **Recommendation 10-2-24.1** to President-elect for financial impact on the 2011 budget."

Motion to Refer Carried

POSITION STATEMENT COMMITTEE CONTINUED

George Gaebler moved to bring back to the table **Recommendation 10-2-26.1** "That the AARC BOD approve and publish the position statement entitled 'Home Respiratory Care Services'."

Michael Hewitt moved "To amend **Recommendation 10-2-26.1** of the Home Respiratory Care Services position statement as follows:

Delete the last paragraph which states:

> Therefore, it is the position of the AARC that practitioners who are employed to provide home respiratory care possess the Certified Respiratory Therapist (CRT) or Registered Respiratory Therapist (RRT) credential awarded by the NBRC as well as state licensure or certification where applicable. ~~In addition, the AARC recognizes that for most clients continued access to home respiratory care is dependent on private insurance coverage along with state and federal reimbursement programs~~.

Replace with the following:

> Although access to home respiratory care is limited at this time by reimbursement for services, it is the position of the AARC that Practitioners who are employed to provide home respiratory care possess the Certified Respiratory Therapist (CRT) or Registered Respiratory Therapist (RRT) credential awarded by the National Board for Respiratory Care, as well as state licensure or certification where applicable.

Motion Carried

Frank Salvatore moved to accept **FM 10-2-26.2** "To include all review and revision dates on each position statement from this point forward."

Motion Carried - ***Policy***

Karen Stewart moved to accept **FM 10-2-26.3** "That the Board request that the Position Statement Committee develop definitions for 'respiratory care', 'respiratory therapy', and 'respiratory therapist', and bring back to the December meeting."

Motion Carried

ACCEPTANCE OF SPECIAL COMMITTEE REPORTS

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

Motion Carried

BYLAWS REPORT CONTINUED

George Gaebler moved 'To bring back to the table **Recommendation 10-2-9.2** "That the AARC Board of Directors accept and approve the Florida Society for Respiratory Care proposed Bylaws revisions."

George Gaebler moved "To amend the Florida bylaws pertaining to **Recommendation 10-2-9.2** as follows:

> Under Section E: Student Member, substitute 'NBRC-AARC recognized Agency' with 'nationally recognized agency'."

Motion to Amend Carried – Mike Hewitt and Tony Stigall abstained.

Amended Motion Carried – Mike Hewitt and Tony Stigall abstained.

ACCEPTANCE OF STANDING COMMITTEE REPORTS

George Gaebler moved "To accept the Standing Committee reports."

Motion Carried

ORGANIZATIONAL REPRESENTATIVE REPORTS

CLINICAL LABORATORY STANDARDS INSTITUTE REPORT

George Gaebler moved to accept **Recommendation 10-2-68a.1** "That the AARC BOD add a section on the AARC website and AARC Times specifically for newly published guidelines from partner organizations."

Jim Taylor moved "To accept **Recommendation 10-2-68a.1** for information only."

Motion Carried

NEONATAL RESUSCITATION REPORT

Joe Lewarski moved to accept **Recommendation 10-2-76.1** "That the AARC make a formal announcement to its members regarding the upcoming changes to the format of NRP (as referenced below) between the end of October 2010 and the beginning of February 2011."

President Tim Myers ruled **Recommendation 10-2-76.1** out of order.

SIMULATION ALLIANCE SOCIETY REPORT

Joe Lewarski moved to accept **Recommendation 10-2-78.1** "Continue relations with Simulation Alliance and consider sending representatives(s) to the taxonomy conference if possible."

George Gaebler moved "To refer **Recommendation 10-2-78.1** to the President-elect."

Motion to Refer Carried

Joe Lewarski moved to accept **Recommendation 10-2-78.2** "Consider financial support of an AARC sponsored conference to establish consensus guidelines for simulator use during testing of mechanical ventilator performance."

Joe Lewarski moved "To refer **Recommendation 10-2-78.2** back to President to discuss with Rob Chatburn."

Motion to Refer Carried

ACCEPTANCE OF ORGANIZATIONAL REPRESENTATIVE REPORTS

Joe Lewarski moved "To accept the Organizational Representative reports as presented."

Motion Carried

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:15 a.m. EDT, Tuesday, July 20, 2010.

RECONVENE

President-elect Karen Stewart reconvened the meeting of the AARC Board of Directors at 9:30 a.m. EDT, Tuesday, July 20, 2010.

ROUNDTABLE REPORTS

ASTHMA DISEASE MANAGEMENT ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 10-2-42.1** "That the AARC BOD consider my contacting Roundtable members to notify them of AARC Connect in an effort to expand the Asthma Disease Management Roundtable."

George Gaebler moved "To accept **Recommendation 10-2-42.1** for information only."

Motion Carried

DISASTER RESPONSE ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 10-2-39.1** "That the AARC BOD consider elevating the Disaster Response Roundtable to a Section to allow it to grow further."

Motion Defeated

NEURORESPIRATORY ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 10-2-40.1** "That the Neurorespiratory Roundtable Chair be allowed to begin the active process with Roundtable member volunteers of developing a detailed education program with the long range goal of a specialty certification within the AARC. Education options such as distance learning and online classes as well as CEU programs offered as part of the annual AARC Congress would all be explored, and to explore such possibilities with the appropriate members of AARC leadership."

George Gaebler moved "To refer **Recommendation 10-2-40.1** to the President-elect."

Motion to Refer Carried

TOBACCO FREE LIFESTYLES ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 10-2-41.1** "That the AARC BOD recommend inclusion of a national 'Tobacco Treatment Specialist' credential (available in several forms) in future discussion of '2015 and Beyond' material when specialty areas within the profession are considered or written about (such as Table 14 of 'Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond' in *RESPIRATORY CARE* 2010;55(5):601-616."

George Gaebler moved "To accept **Recommendation 10-2-41.1** for information only."

Motion Carried

ACCEPTANCE OF ROUNDTABLE REPORTS

George Gaebler moved "To accept the Roundtable reports as presented."

Motion Carried

AD HOC COMMITTEE REPORTS

AD HOC COMMITTEE ON PINNACLE AWARD REPORT

George Gaebler moved to accept **Recommendation 10-2-34.1** "Recommend for adoption to the present qualifications to establish a 2nd tier for the QRCR program."

George Gaebler moved "To postpone **Recommendation 10-2-34.1**."

Motion to Postpone Carried

AD HOC COMMITTEE FOR REVISION OF THE POLICY FOR SURVEYS REPORT

George Gaebler moved to accept **Recommendation 10-2-33.1** "That the AARC BOD approve the below changes to Policy BOD.027 submitted by the Ad Hoc Committee for the Revision of the Policy for Surveys."

American Association for Respiratory Care
Policy Statement

Policy No.: BOD.027

SECTION: **Board of Directors**

SUBJECT: **Policy for Surveys Conducted by the Association**
EFFECTIVE DATE: March 2001
DATE REVIEWED: July 2008
DATE REVISED: July 2010
REFERENCES: CT.0688b Revised

Policy Statement:

1. All surveys of the AARC membership must be reviewed and approved by the Executive Committee before permission will be granted for conducting them.

Policy Amplification:

Definition of Surveys: For the purposes of this policy a survey is a document requesting data answers which may be used to comprehensively consider an area of subject matter for the purposes of gathering data where the analysis could be considered for publishing or corporate use.

Definition of Listserve Questionnaires: Any question or questions posed that would be considered personal information gathering for one's own use in their area of interest or practice.

1. Information requests occurring within AARC Section mail lists (Listservs) do not require board review provided that they adhere to the rules governing them. ***See attachment A below***

Survey Procedure

1. The requester must submit a copy of the survey plus communication stating the intent of the survey to the AARC President c/o the Executive Office, no less than30 days prior to the requested distribution date. The President will distribute the material directly to the Executive Committee.

2. Prior to Executive Committee the Executive Director or designate will evaluate the survey based upon the following criteria:

A. Overall appearance (e.g. clarity of layout, correction of typographical and other areas, etc.
B. Have similar surveys have been done within the last 24 months?
C. Clarity of questions and appropriateness of format.
D. No redundancy of questions.
E. Has the appropriate demographic information is requested.
F. Has a survey been sent to the same population of AARC members during the last six months?

3. After Executive Committee review, the requester will be informed by the Executive Office of the Committee's decision. If revisions are needed, the requester shall submit the revisions to the AARC Secretary who will be authorized to approve or reject these revisions on behalf of the Executive Committee.
4. ***Approved Surveys will be done using web based survey systems or be forwarded only***

directly to requestor/author of survey and not using the AARC Listserve system.

Attachment A

AARC Listserv Rules

General

1. Message content must be relevant to the intent of the electronic mail list.
2. The following are not permitted to be posted:
    - Advertisements or motions for products, services, job
    - Meetings and events not sponsored by AARC
    - Poems, jokes and other forms of personal expression, chain mail, virus warnings, etc.
    - Copyrighted material from a source other than the AARC
    - Inquiries and promotions related to products/services by consultants, manufacturers, marketing firms, and other similar entities outside of the AARC.
    - Discussions relating to pricing or cost of goods as this may be considered price fixing and is a federal offense.

3. The AARC reserves the right to remove anyone for any reason from the AARC electronic mailing list.

A. The includes the archival entries on the Listserve that pertain to a subject considered inappropriate or in violation of the Listserve guidelines.

The Exchange of Information:

1. AARC members may use the Listserv to exchange information between other Listserv subscribers.

2. Information shared on Listservs may be distributed and used in other AARC sponsored forums, but may not be utilized for commercial purposes outside the AARC.

3. When you post a question, or series of questions, be sure that you title it with a good, concise, explanatory title in the subject line to clearly differentiate the message from others being posted or responded to.

4. Regarding information requests posted by Listserv clients, the Section and Roundtable Chairs determine if the Listserv posting represents a survey that requires Executive Committee approval. The following guidelines can be utilized to differentiate Listserv information requests from query requests.

    4.1 Surveys often include the capturing of user specific information and hospital/department demographics for comparison reporting.
    4.2 The creator of a survey may embed a separate link to ask specific questions so participants do not have the option to view other responses. If the creator of this type of inquiry tool has not expressively indicated results will be shared and accessible to all
    Listserv participants, the Section Chair will refer the individual to the Executive

Office as per Policy BOD 027.

5. The sender of the information request may instruct section participants to reply to the Listserv or reply directly to their personal email.

5.1 In the event responses are sent directly to the personal email of the individual who posted the information request, a summary of those responses should be posted so all

Listserv participants may share the information.

5.2 If your reply is simply a request to receive a copy of what someone has offered to share, or simply to agree with someone (such as: "Me too"), please do not reply to the entire group. Instead, send your response directly to the email address of the person who posted the message by clicking on your "Forward To" button, and typing in or cutting and pasting in the email address of the individual to whom you are responding.

Motion Carried - ***Policy***

AD HOC COMMITTEE ON PINNACLE AWARD CONTINUED

George Gaebler moved to bring back to the table **Recommendation 10-2-34.1** "That the AARC recommend for adoption to the present qualifications to establish a 2nd tier for the QRCR program."

Motion Defeated

Linda Van Scoder moved to accept **FM 10-2-34.1** "To direct the President-elect to work with the Ad Hoc Committee on Pinnacle Award for revision of the QRCR for 2011."

Motion Carried

EXECUTIVE OFFICE REPORT CONTINUED

George Gaebler moved to accept **Recommendation 10-2-1.1** "That the Quality Respiratory Care Recognition Program (QRCR) add a requirement to the criterion stating that benchmarking be part of their quality improvement processes."

George Gaebler moved to amend **Recommendation 10-2-1.1** "To include that the QRCR add a requirement to the criterion stating that the benchmarking be part of their quality improvement process. Use a process that periodically compares performance of the hospital on efficiency and quality metrics with similar hospitals for the purpose of identifying and achieving best practice."

Motion to Amend Carried

Amended Motion Carried

ACCEPTANCE OF SPECIAL COMMITTEE REPORTS

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

Motion Carried

OTHER REPORTS

Joe Lewarski moved "To accept the Other Reports as presented."

Motion Carried

UNFINISHED BUSINESS

HOUSE OF DELEGATES RESOLUTIONS

Denise Johnson moved to accept **HR 94-10-02** "Resolved that the AARC issue a white paper or similar document on the importance of respiratory care education programs, which could be disseminated to state legislatures, local governments, governors or any other interested parties."

George Gaebler moved "To refer **HR 94-10-02** to the President-elect."

Motion to Refer Carried

George Gaebler moved to accept **HR 87-10-04** "Resolved that the AARC investigate seeking outside grants and or funding to fund the AARC Disaster Relief Fund."

Motion Defeated – Doug MacIntyre abstained.

RECOMMENDATION TRACKING

President-elect Karen Stewart engaged members in determining the outcome of previous recommendations that have remained open to date.

RECESS

President-elect Karen Stewart recessed the meeting of the AARC Board of Directors at 11:10 a.m. EDT, Tuesday, July 20, 2010.

RECONVENE

President Tim Myers reconvened the meeting of the AARC Board of Directors at 11:30 a.m. EDT, Tuesday, July 20, 2010.

HOMECARE SECTION REPORT

George Gaebler moved to bring back to the table **Recommendation 10-2-53.1** "That the AARC Board of Directors request that the NBRC investigate the need and potential for a specialty credential for respiratory therapists working in homecare. If it is determined that there is a need, that the specialty credential be developed as soon as possible to address the educational requirement for respiratory therapists working in home respiratory care."

George Gaebler moved "To withdraw **Recommendation 10-2-53.1**."

Motion to Withdraw Carried

ACCEPTANCE OF SPECIALTY SECTION REPORTS

George Gaebler moved "To approve the Specialty Section reports as presented."

Motion Carried

NEW BUSINESS

Jim Taylor presented ideas on the use of Eluminate Technology (a meeting software) and partnering with AARC as a way of connecting various regions of Michigan.

Jim Taylor moved to accept **FM 10-2-1.3** "To accept that the Executive Office explore the feasibility of allowing chartered affiliates to utilize the Eluminate meeting systems software and to report back at the December BOD meeting."

Motion Carried

AACC

Bill Dubbs reported on the American Association of Clinical Chemistry (AACC) module whereby an individual is identified to oversee all of the Point Of Care Testing (POCT) in the hospital. President Myers will work with Bill Dubbs to create a survey of the membership to determine interest.

APPOINTMENT RATIFICATIONS

President Tim Myers advised of the following Presidential appointments:

Garry Kauffman – Chair of Informatics Roundtable

Julianne Stickley Perretta – Chair of Simulation Roundtable

Brian Walsh - Primary Rep of American Heart Association
Christine Slocum – Secondary Rep of American Heart Association

Lisa Trujillo – Chair of International Medical Mission Roundtable

Mike Hewitt moved to accept **FM 10-2-4.1** "To ratify the above Presidential appointments."

Motion Carried – Brian Walsh abstained.

President Tim Myers advised members that Melynn Wakeman resigned from the Diagnostic Section and Michael Tracy will act as the Interim Chair until the upcoming election.

DIAGNOSTIC SECTION INTERIM CHAIR APPOINTMENT

Frank Salvatore moved to accept **FM 10-2-51.1** "To ratify the appointment of Michael Tracy as Interim Chair of the Diagnostic Section."

Motion Carried

EXECUTIVE OFFICE POSITION FILLED

President Tim Myers advised members that Doug Laher has accepted the position of Associate Executive Director at the Executive Office thereby creating an opening for the Management Section Chair on the Board of Directors which will be filled by Cheryl Hoer.

MANAGEMENT SECTION DIRECTOR APPOINTMENT

George Gaebler moved to accept **FM 10-2-54.1** "To ratify the appointment of Cheryl Hoerr as Management Section Director."

Motion Carried

MEMBERSHIP DISCOUNTS FOR 65 AND OLDER

Brian Walsh moved to accept **FM 10-2-84.1** "That the President form an ad hoc committee to explore a discounted membership for members 65 and older and to report back to the BOD in December."

Motion Carried

TREASURER'S MOTION

Secretary-Treasurer Linda Van Scoder moved to accept "That the expenses incurred at this meeting be reimbursed according to AARC Policy."

Motion Carried

Joe Lewarski 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 12:10 p.m. EDT, Tuesday, July 20, 2010.

E-Motions

From July 2010 thru December 2010

10-3-33.1 "That the AARC BOD ratify the goals and objectives for the Ad Hoc Committee to Review the AARC International Fellowship Program as well as the Chair and Committee members as stated below:

Chair: Joe Lewarski
John Hiser (International Committee Chair)
Debbie Lierl (International Committee VC for International Fellowship)
Jerome Sullivan (ICRC President)
Hassan Alorainy (Former ARCF Fellow)
Michael Amato (ARCF Chair)

Goals and Objectives:

To conduct a review to re-examine the International Fellowship Program's:

- Goals and objectives (Mission and Vision)
- Committee's structure (infrastructure, number of members, COI, etc.)
- Effectiveness
    a. Financing (Revenue stream and expense)
    b. Selection Process: Fellows & Host cities)
    c. Receptions and Congress Functions
    d. Outcomes (based on Goals and Objectives)

10-3-17.1 "To ratify the appointment of Cheryl Hoerr and Marc Mays to the Benchmarking Committee."

10-3-15.1 "That the 2011 AARC Summer Forum be held in Vail, Colorado July 18-20 (Monday – Wednesday)."

10-3-34.1 "That the AARC BOD amend Recommendation 10-2-34.1 to replace the following sentence:

"Use a process that periodically compares performance of the

hospital on efficiency and quality metrics with similar hospitals for the purpose of identifying and achieving best practice”

With the below sentence:

“Use a process that periodically compares performance of the respiratory therapy department on efficiency and quality metrics with similar departments for the purpose of identifying and achieving best practice.”

General Reports

PRESIDENT'S REPORT

President's Activity Report
December 4-, 5th 2010
Las Vegas Hilton
Las Vegas, NV

It has indeed been an honor and privilege to work with dedicated and energetic Board of Directors and Executive Committee over the past year. The passion and focus in honoring the AARC's Mission and Vision and ensuring to serve as an advocate for our patients, their families, the public, the profession and the respiratory therapist has made my role as AARC President a professionally rewarding and memorable experience.

We have worked hard along with the Executive Office and our volunteers to accomplished much (as highlighted below) throughout 2010 during a stagnant economically and challenging times in the healthcare arena, but we have some unique challenges and opportunities that still lie before us, but I am confident that President-elect Stewart has set forth a visionary set of goals and objectives that will lead us to better places.

With a BIG thank you for your support and commitment over the past year, I look forward to working with President-Elect Stewart and the 2011 BOD and the commitment and drive that each of them will bring to our Association. I am confident that whatever challenges we will face with a stagnant economy and healthcare reform, we will continue to move the AARC and the respiratory therapist into a unique and critically necessary profession within the healthcare continuum of care. With that stated, some of the highlights of the past year include:

1. Continue to develop and execute strategies that will increase membership and participation in the AARC.

- Ongoing strategies per the Membership Committee have continued resulting in a 4.5% increase in membership.
- The development and successful implementation of AARConnect as a valuable professional/social network for our members.
- By-and-large, an overall increase in section membership that has resulted in all 10 of the Sections maintaining its membership above the 350 minimum fr the first time in recent memory.
- The rollout of the Membership Savings Calculator to define member benefits and savings.
- Development and addition of 4 new Roundtables; Geriatric, Informatics, International Medical Mission and Simulation.
- Develop an appropriate vehicle to address the future retirees of the Association that may wish to continue membership.

2. Promote patient access to respiratory therapists as medically necessary in all care settings through appropriate vehicles at local, regional and national venues.

- Continue legislative efforts with Congressman Ross and Senators Crapo and Lincoln for inclusion of Medicare Part B bill in the House and Senate Health Care Reform packages.
- Held our first Virtual Lobby Day on August 4th that saw thousands of e-mails and letters go to Capital Hill from therapists and patients in support of our Medicare Part B initiative.
- Working with CMS and other regulatory groups on language and initiatives that involve the practice of Respiratory Care surrounding medication delivery and utilizing of therapist-driven protocols.
- Based on the Position Paper on Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care, we have received some positive feedback from the States of Florida and Pennsylvania on about the best practices standards.

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.

- Attended the European Respiratory Society meeting in Barcelona in September to promote the International Fellows program, Respiratory Care Journal and AARC membership.
- Travel to Tao Yuan, Taiwan to speak at The Respiratory Therapists Society of the Republic of China's Annual Respiratory Congress and RT Department of China Medical University late last December.
- Actively worked with AARC members and key colleagues in Saudi Arabia to bring forth an application for consider of Saudi Arabia becoming an International Affiliate.
- Selected 4 new International Fellows to join us at the International Congress in Las Vegas in December
- We have seen a rapid growth and desire for AARC membership and products (benchmarking, webcast, Professor Rounds) with our colleagues in Saudi Arabia that has been the direct results of Hassan Alorainy, Sam Giordano and Jerome Sullivan's hard work and efforts over many years.

4. Identify the clinical/non-clinical skills, attributes and characteristics of the "Respiratory Therapist for 2015 and Beyond" based on the expected needs of respiratory care patients, the profession and the evolving health care system.

- Attended the 3rd 2015 consensus conference in July in Marco Island, Florida as a participant. Third conference manuscript is being finalized for peer-review.
- Provided a Conference 1 and 2 Summaries at Utah Society, Pennsylvania Society, Colorado Society, Tennessee Society, Tri-State Respiratory Meeting, New York Society, Delaware Society, Kindred National Respiratory Symposium.

5. Develop a leadership and mentoring institute (process) to promote the advancement and growth of respiratory research, management skill sets and education curriculums and practices to meet the future demands of the profession.

Have participated in regularly scheduled conference calls with committee as Steering Committee member. The group has continued to move this initiative forward under the direction of Dr. Toni Rodriguez, Committee Chair, who will provide a more detailed report and answer questions during Ad-Hoc Committee reports in Las Vegas.

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.

- The web-based Asthma Educator Prep Course has had a very successful second year and was join with an equally successful on-line version of the COPD Educator Course.
- AARC's has concluded its successful continuing education programs through Professor's Rounds and Webcast for 2010 and arrangements for series and professors are being finalized and scheduled for the 2011 series.
- We finalized an agreement with the European Respiratory Society to exchange speakers in 2010-11 for each others meetings
- A Second version of A Guide for Aerosol Delivery Device for RT has been completed and is available. A similar guide has been developed for patients and their families and is being reviewed by patient and support groups prior to distribution.
- Finalized a Sponsorship and Memorandum of Understanding with the Gulf Thoracic Society that will see us take a version of our successful Asthma Course and speakers for a respiratory therapy symposium (7 lectures) to Dubai for their 2nd Annual Meeting next April.
- Held two live workshops on the Prevention of VAP in Maryland and PA.
- The "Spirometry Driver's License" product has been completed and has gone live on the web.

7. Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.

- Witnessed and acknowledged the passage of a Respiratory Care Licensure Act in Hawaii.
- Worked with BI to promote a respiratory therapy initiative to screen at-risk patients in the Drive4COPD Campaign.
- Collaborated with HOD Officers on various issues and items of common interests.
- Met with ATS, ACCP and NBRC in September in Barcelona to discuss issues of common interest.
- Attended Tripartite Meeting with CoARC and NBRC at Summer Forum.

- Attended AARP Meeting in Orlando and cohosted a COPD screening initiative in cooperation with COPDFoundation.
- AARC representatives have participated in numerous patient advocacy and health care reform coalitions and groups through conference calls and meetings over the last 6 months.
- Have had numerous conversations with many government agencies about the role of respiratory therapists in the health care arena, as well as, applied for several grants for project / program support.
- Received kudos from the NHLBI for our work in furthering awareness of COPD.
- Supported HR6376 legislation to provide needed flexibility for facilities to establish and maintain Pulmonary Rehab programs.
- Supported HR 3790 to repeal the competitive bid program and include provisions that will assure the budget neutrality through other payment reductions

AARC Travels

- August 3-5: Tri-State Respiratory Conference—Biloxi, MS
- September 16-23: ERS – Barcelona, Spain
- September 29-October 1- AARP Meeting, Orlando, FL
- October 6-7: New York Society of Respiratory Care—Syracuse, NY
- October 27-28: Delaware Society of Respiratory Care—Newark, DE
- November 8-9: Kindred National Respiratory Care Symposium – Louisville, KY

As you can gather, 2010 has been a busy and prosperous year for AARC activities and initiatives that have all been directed at our Mission and Vision statement. None of thee endeavors or successes would have been possible without our volunteers, Executive Office staff and the BOD and HOD leadership.

On a personal note, the past two years have been an incredibly valuable profession achievement and learning process for me and I want to thank you all for your assistance, support and encouragement. I look forward to taking that next step in my service of AARC leadership in working side-by-side as Past President with our new President—Karen Srewart.

President-elect Report

AARC 2010 Fall Meeting Executive Office Report

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

Membership:

As of November 1, 2010 our member numbers are approximately 51,000. We will have a more current number to report at the meeting. In addition to this an analysis of other medical associations was completed. (See attachment 1). A membership strategy for 2011 will be completed in January and actuated through 2011. It will focus retention of existing members. Part of our messaging will also be to differentiate member benefits from non-members.

Advocacy and Public Awareness:

Drive4COPD. As you know the AARC has aligned with the Drive4COPD effort, which is a three-year commitment. We have been working closely with the campaign doing the following since the Summer Board Meeting:

- State screener competition. Three states will be awarded at the Awards Ceremony on December 6th. Our goal was to gather 500,000 screeners through the efforts of the states. This goal will not have been reached by November 22 (the date we tally determine state winners) but we will continue to achieve this goal through our three-year commitment to the Drive.
- Active participation in the November 4th Screen-Off being held in Dallas, Atlanta, New York City, and Los Angeles. RTs were present in all four cities as part of this effort.
- There have been numerous media events where assorted RTs communicated the COPD message as well as informing the public about the role of the respiratory therapist.

AARP
The AARC had a team of RTs present at the annual AARP event in Orlando in September. The AARC had an exhibit where we provided lung health education to attendees. We also did 350 drive4copd screeners and 250 spirometries (using the new protocol). Also as part of the event we participated in a live presentation on stage with Patty Loveless. As part of the program we described what that Drive4COPD was, what is COPD and the role of the respiratory therapist in the management and care of these patients.

Joint Commission

The AARC continues to participate in the Joint Commission Standards Field Review process. So far this year The Joint Commission has held only 3 field reviews. We responded to Standard MS.01.01.01 in the hospital accreditation manual and addressed medical staff governance in January, in May we responded to NPSG .03.07.01which focused on medication reconciliation in hospitals, and in August we responded to the proposed new and revised laboratory standards. We continue to distribute the weekly online TJC publication with commentary to focus managers on the issues important to respiratory therapy.

Conventions and Meetings

Summer Meetings

The 2010 Summer Forum held in Marco Island in July was another successful program. Attendees, as per their evaluation of the program, went home satisfied with the offerings. We also realized attendance exceeded expectations. A special addition to the July meetings was the presentation of the 1-day Clinical Preceptor Training Program offered at a discount as an enhancement to attract registrants to the Summer Forum program.

International Respiratory Congress

Plans are progressing very nicely for what promises to be a successful Congress. This year we will offer two post-graduate (full-day) courses the day before the Congress, one on Alpha-1 Antitrypsin Deficiency and another on current issues on mechanical ventilation.

Five breakfast symposia free of charge to Congress registrants will be presented in Las Vegas. In summary, we feel positive about the Congress attendance, but history has taught us that the final result will not be in until we shut down all the computers on December 9th.

National Ventilator Survey

Feedback from HHS was extremely complementary about the survey. We especially want to thank the states for their critical role in making this a success. The manuscript of the survey was published in October by Disaster Medicine Public Health Preparedness (October 15, 2010) See attachment 2. The manuscript described more detail about the results of the survey. The AARC is in communication with HHS and we are discussing future projects.

There will be a representative at the meeting from HHS recruiting for additional RTs to become part of DMAT teams and a new special strike team. We encourage our members to be a part of this.

Education

COPD Educator Course

COPD Educator Course was released the summer and as of November 1, 2010 there have been over 500 registrants. The COPD course has received nursing credits from the Illinois Nursing Association so this will help make it more marketable beyond RTs

The state affiliates that have signed the co-marketing agreement have been able to take advantage of this program and get 10% of the registration costs back to the state for those who register from that state.

Asthma Management and Prep Course
The Asthma Certification Prep Course has had 375 registrants.
The Asthma course continues to bring in registrants in line with budget. We anticipate offering this course live later in 2011. We were invited to submit a proposal the Gulf Thoracic Society to host our asthma educator program as a pre congress course. We just received word that our proposal was accepted.

Office Spirometry
The Office Spirometry program has been launched and we are currently marketing this program. This is designed for non-RT office employees. We recently engaged in a collaborative effort to promote the course in New Zealand. This is another product that we are now offering to our state affiliates as a co-marketing opportunity.

Web Casts

In 2010 we have presented 19 out of 20. We have one webcast remaining for 2010. We have 18 web presenters and webcast topics identified for 2011.We continue to attract a larger number of live participants (now averaging over 300) to our live webcasts. In addition to this so far this year another 7,000 webcasts have been viewed as an archived presentation.

Professors Rounds

8 topics and speakers have been selected for the 2011 series. We have commitment from all professors. Six of the featured professors are new to Professor's rounds. (See Attachment 3.)

2015 and Beyond

The final conference and the Public Input Session that was held last July. Please see the 2015 report for more detail.

PROJECTS

A Guide to Aerosol Delivery Devices for the Patients

This document is being released at the International Congress. As you recall this document is a patient friendly version of the guide that was developed for respiratory therapists. There will be a limited number of printed guides available and will be available on line at Yourlungthealth.org and AARC.org

A Guide to Aerosol Delivery Devices for the Non-Respiratory Therapist Clinicians
This document is in its last stages of review and will likely be released in the first quarter of 2011. Its intended reader is nurses, physicians, pharmacists, and other clinicians who educate patients about aerosol devices.

Co-Marketing Opportunities with our State Affiliates
Office Spirometry Certificate, COPD Educator Course and Asthma Prep Course are all available to the states for co-marketing. Over the twelve months the sales of the asthma course and COPD has made over $9,000 available for co-marketing payments.

The state leadership has been made aware about this opportunity for the states to bring in 10% of the registration fees that are collected. Of course this is an offer only available to states that sign the revenue sharing agreement. To date there have been 41 states who have signed the revenue sharing agreement and 23 states who have joined the AARC in co-marketing these product lines.

Peak Performance USA (PPUSA)
PPUSA is now finishing its second year has reached over 50,000 school children with asthma. It has been implemented in 674 schools in 33 states. We continue to urge other organizations to support this outreach program. We will continue to promote this unique role that respiratory therapists can play in the community by partnering with a local elementary school.

Best Practices in Mechanical Ventilation
The AARC has new initiative called **Best Practices in Adjuncts of Mechanical Ventilation**. This member's only site will provide ability for members to share practices, policies and protocols. Dean Hess, Rich Kallet and Rich Branson will be vetting before they are posted on line. This will be a useful way to share successful practice with others. Currently there are several that are being reviewed and will be posted by the time of the Congress. We ask that you help us get the word out about this new initiative.

VAP Expert Workshop
In the fall the AARC hosted two live workshops that are directed at making the Respiratory Therapist the local VAP expert in their hospital. The workshops were held in conjunction with the Maryland/DC and Pennsylvania society meetings in September. We will be taking the workshops to spring affiliate meetings in Minnesota/Wisconsin, Michigan, and Colorado. We expect to transfer to an online training program on our web platform sometime in the summer of 2011.

COPD Education Kit
We received support from one of our Corporate Partners for the development of a COPD Education kit. The kit is to be used by RTs in the acute care hospital. This is a pilot

program in which we will invite 20 hospitals that will use it on at least 200 patients. We expect to initiate the project in January 2011.

Safety Checklist
The AARC has put a team together of RTs and physicians who have started a Meta analysis of safety practices relating to monitoring of oxygenation and respiratory status. Once completed next year will be part of a safety checklist that respiratory therapists can use in reporting patent status in hand offs.

Uniform Reporting Manual.

The URM is in last phase of development before we gather input from membership. This version of the URM will also focus on acute care hospitals and diagnostic laboratories (PFT, blood gases, non-invasive cardiology, sleep). We expect this to be released and available at the Congress in the fall. The development of the 2011 URM that will focus on acute care hospitals and diagnostic laboratories (PFT, blood gases, non-invasive cardiology, sleep and pulmonary rehabilitation) is now underway. An expert panel has been assembled and is working on their first priority to identify activities and procedures to be included in the survey of cohorts that will eventually provide us with time standards. We plan to do the surveys in January and complete the manual by the end of the first quarter in 2011.

Web Based Accreditation System

ATS (not associated with the American Thoracic Society) has been chosen as the contractor to develop the web-based CRCE application. We are working with the vendor to customize their CRCE web-based application to meet our needs as soon as some general issues affecting our database that were identified during the interview process are addressed.

Benchmarking System

As of the first of November there were 96 facilities participating in the benchmarking service. Although we remain above budgeted revenues in this area, lately we have noticed a slight slide in the rate of new and renewing subscribers after seeing a substantial spike in the early summer. Our persistent monthly follow-up with those who are falling behind in data entry has resulted in a much higher percentage of subscribers with current data. Members of the benchmarking committee now personally contacting new subscribers within one week after they have gained access to the system. This contact helps assure they know how to access and use the system.

Web Outreach
Our website, www.aarc.org has reached over 100,000 individual users in a one-month period. From 04 Oct-03 Nov 2010, we had 100,101 unique visitors per month.

AARConnect

AARConnect launch continues. Announcements have appeared in NewsNow and advertisements appear monthly in AARC Times. Additionally, each month's AARC Connection column (in AARC Times) mentions the product and cites some of the topic being discussed on Connect. It was promoted at Summer Forum and will have a significant presence at the Congress with demonstrations and sign up of attendees. There are over 5,000 members using this today.

Other Activities

AARC continues its collaboration with the COPD Foundation. As mentioned previously in this report, we continue to partner in selected public health events in order to provide spirometry to persons deemed at risk of COPD based on the results of the screening questionnaire. We hope to continue this "win-win" approach to first and foremost identifying the 12 million people with COPD that have not been diagnosed with the disease. Moreover, the profession continues to benefit from the expanded interface respiratory therapists have with the public in general by dint of these public health events.

The AARC also continues to play an active part of the leadership of the USCOPD Coalition. AARC's representative is a member of its Executive Committee and Board of Directors. The Coalition is currently in the initial planning phases of a 2011 COPD Update Conference. The conference will be convened in the fall of 2011. AARC and respiratory therapists will be involved in all aspects of conference planning, especially workshops. This project not only helps policy-makers and caregivers appreciate the changes that have occurred since 2003 in COPD treatment and management, but also serves as an excellent vehicle to emphasize the indispensable role that respiratory therapists play in the diagnosis, treatment, and management of patients with COPD.

It is important to note that for the first time in its history, the US COPD Coalition partners elected to hold its fall meeting in conjunction with the AARC International Respiratory Congress. This is the first time that the Coalition partners have voted to do so. The Coalition will meet on December 6th in the afternoon. All state societies will be invited to attend. Both the Coalition and the COPD Foundation have and continue to support AARC's Part B Initiative on behalf of the COPD patients that they represent. This provides us with an enormous amount of credibility in Washington at this time.

Summary

As you can see by the foregoing, 2010 has been an exceptionally productive and successful year for the AARC and its members. We've broken all-time membership records and continue to grow as we move forward into 2011. We've experienced some exciting opportunities to increase our interface with the public at large such as the Drive4COPD project. These efforts, when coupled with the heightened awareness of health care and pulmonary disease among policy-makers bode well for the profession and the patients it

serves. We at the Executive Office are excited about our success this year and even more enthusiastic as we look forward to 2011. Now that the mid-term elections are behind us we could expect us to see refinement of the Affordable Care Act and favorable consideration of our Part B initiative.

I hope that you find the foregoing of value. If I have neglected to cover a particular activity, please do not hesitate to contact me at your earliest convenience in order that I address it for informational needs. On behalf of all of us on the Executive Office staff, I want to thank you for your support and look forward to working with all of you next year.

Referrals

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

We continue to investigate methods for offering a retired member or age-discounted membership. At this time, an ad hoc committee is being formed. President Myers has directed that this committee include members of the House, Board and membership. We have reviewed the policies of other organizations and they all have an age and years of continuous membership as a component. Criteria for AARC retired membership is that to be eligible a member has to have been a continuous member for ten number of years prior. An analysis was completed of the existing membership who have had over ten years of membership. There are currently 13,629 members that fit that criteria. Those with concurrent ten-year membership is still being tabulated (at the time of this writing) and will be presented at the Board Meeting in Las Vegas.

FM 10-2-10.1 *That the **Recommendation 10-2-10.1** (That the AARC develop a mechanism in which nominations can be electronically submitted) be referred to the Executive Office to convert the paper format into an electronic nomination.*

We are currently building a web page submission system that will be ready to use beginning with the 2011AARC Election cycle. It will start with the nominations process and will automatically check a nominator's and nominee's status and eligibility for the election cycle. (For example, is the nominator an Active member; is the nominee an Active member with paid up dues and a member of a section, if applicable). Our current Candidate Information Form process will be integrated into this new system. We are hoping to build in functionality so that an individual's Candidate Information Form can be stored from year to year and does not have to be recreated with each year's election process. An admin section will be available so that Elections Committee members can

keep up with the submission process. We have been in communication with the Elections Committee Chair as well as incoming Chair.

FM 10-2-1.3
To accept that the EO explore the feasibility of allowing chartered affiliates to utilize the Eluminate meeting systems software and to report back at the December BOD meeting

Our current license does not permit us to timeshare, rent or act as a service bureau for third parties, therefore we cannot allow other entities to use the service. We can get a rider on our contract that would allow each of the states to use the service. There will be an additional cost to provide this. Our next step will be to determine costs and do a survey of the affiliates to determine how many intend to use this and for what purposes.

Attachment 1.

	Dues	**# members**	**Student cost**	**Retired member cost**
American Physical Therapy Association	$295	75,000	$90	$220
American Occupational Therapy Association	$225	41,000	$75	$112
American Speech Language, and Hearing Association	$551	135,000	NA	NA
American Academy of Physician Assistants	$275	43,000	$75	$75
American Society of Radiologic Technologists	$105	132,000	$30	$53
American Association of Sleep Technologists	$100	4,200	$50	NA
Association of Critical Care Nurses	$78	80,000	$52	$52
American Nurses Association	$179	NA	NA	
AARC	$78	51,000	$50	NA

Attachment 2.

ORIGINAL RESEARCH

Mechanical Ventilators in US Acute Care Hospitals

Lewis Rubinson, MD, PhD; Frances Vaughn, PhD; Steve Nelson, MS, RRT; Sam Giordano, RRT; Tom Kallstrom, RRT; Tim Buckley, RRT; Tabinda Burney, BS; Nathaniel Hupert, MD, MPH; Ryan Mutter, PhD; Michael Handrigan, MD; Kevin Yeskey, MD; Nicole Lurie, MD, MSPH; Richard Branson, MS, RRT

ABSTRACT

Objective: The supply and distribution of mechanical ventilation capacity is of profound importance for planning for severe public health emergencies. However, the capability of US health systems to provide mechanical ventilation for children and adults remains poorly quantified. The objective of this study was to determine the quantity of adult and pediatric mechanical ventilators at US acute care hospitals.

Methods: A total of 5752 US acute care hospitals included in the 2007 American Hospital Association database were surveyed. We measured the quantities of mechanical ventilators and their features.

Results: Responding to the survey were 4305 (74.8%) hospitals, which accounted for 83.8% of US intensive care unit beds. Of the 52 118 full-feature mechanical ventilators owned by respondent hospitals, 24 204 (46.4%) are pediatric/neonatal capable. Accounting for nonrespondents, we estimate that there are 62 188 full-feature mechanical ventilators owned by US acute care hospitals. The median number of full-feature mechanical ventilators per 100 000 population for individual states is 19.7 (interquartile ratio 17.2–23.1), ranging from 11.9 to 77.6. The median number of pediatric-capable device full-feature mechanical ventilators per 100 000 population younger than 14 years old is 52.3 (interquartile ratio 43.1–63.9) and the range across states is 22.1 to 206.2. In addition, respondent hospitals reported owning 82 755 ventilators other than full-feature mechanical ventilators; we estimate that there are 98 738 devices other than full-feature ventilators at all of the US acute care hospitals.

Conclusions: The number of mechanical ventilators per US population exceeds those reported by other developed countries, but there is wide variation across states in the population-adjusted supply. There are considerably more pediatric-capable ventilators than there are for adults only on a population-adjusted basis.

(*Disaster Med Public Health Preparedness*. 2010;4:199-206)

Key Words: surge mechanical ventilation, disaster respiratory care, mass respiratory failure, surge capacity

Severe public health emergencies may lead to mass respiratory failure,[1-3] and survival of patients with severe acute respiratory failure (ARF) depends on timely access to life-sustaining care, including mechanical ventilation. The profound need for respiratory support during these events highlights the importance of ensuring an adequate supply and distribution of medical equipment for mechanical ventilation. Planning for mass respiratory public health emergencies has been hampered by not knowing how many ventilators there are in US hospitals, how they are distributed across the country, and whether, taken together, the numbers and types of ventilators in hospitals will provide sufficient surge capacity to meet anticipated needs.

There was significant consternation during the 2009 influenza pandemic about whether there would be sufficient ventilators in the United States to handle various projections of surges in ARF,[4,5] but existing knowledge of device number and distribution severely limited analyses. Estimates of the number of full-feature ventilators, which are the first-line ventilators used in US hospitals for the vast majority of ARF, range from 54 000 to 105 000, but the full number has never been enumerated.[6,7] Uncertainty regarding US hospital ventilator capacity is further compounded when considering high-risk subpopulations such as children. One-quarter of the US population is children; not all full-feature ventilators can be used for small children or neonates. The number of full-feature ventilators in the United States that are capable of ventilating small children remains unknown. These uncertainties came to the forefront as the 2009 influenza pandemic unfolded, and there was a compelling need to enhance the accuracy and precision of the estimate of full-feature ventilators in US hospitals for adults and children, because these quantities reflect national ventilation capacity for ARF using usual, standard devices.

Public health emergencies may exceed full-feature ventilator capacity. For these scenarios, surge capacity strategies to repurpose additional positive pressure ventilation (PPV) equipment (eg, portable ventilators), which are owned by hospitals or maintained in public health

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Attachment 3.

Program Title/Sponsor	**Professor/** Moderator	Description
Tracheostomy: Current Practice/Smith Covidien	**AlexanderWhite,MD**/Dean Hess PhD, RRT, FAARC	This presentation will review the literature addressing the indications and proper technique for tracheal cannulation, tracheal airway devices, stoma care, as well as changing and decannulation practices. A review of current tracheostomy controversies will be included.
Four Evidence-Based Practices That Should be Mechanical Ventilation Standards	**Dean Hess PhD, RRT, FAARC** /Rich Branson MSc, RRT, FAARC, FCCM	This presentation will review the evidence supporting noninvasive ventilation, lung-protective ventilation, ventilator liberation protocols, and ventilator-associated pneumonia prevention.
The Many Faces of PEEP.	**Rich Branson MSc, RRT, FAARC, FCCM//** Dean Hess PhD, RRT, FAARC	This discussion will focus on the application of PEEP not only in the context of ALI/ARDS but also in other applications such as of PEEP for alveolar recruitment (ARDS), counterbalancing auto-PEEP, prevention of micro-aspiration, and facilitating speech
Sleep and Sleep-Disordered Breathing in the Hospitalized Patient	**Peter C. Gay MD**/Suzanne Bollig BHS, RRT, RPSGT, R. EEG T	This presentation will review a variety of sleep disordered breathing topics including the consequences of sleep deprivation and disruption in the hospital, the role of sleep and its impact on liberation from the ventilator, and post-operative management of the OSA patient. Sleep intervention protocols, and other sleep-related topics of the hospitalized patient
Management of the COPD Patient with Comorbidities.	**Robert A. Sandhaus, MD, PhD, FCCP**./ Tom Kallstrom, MBA, RRT, FAARC	This presentation will review best practices in managing COPD patients with an emphasis on management of co-morbid conditions that frequently afflict with these patients. Treatment strategies to maximize their care will be discussed.

Program Title/Sponsor	**Professor/** Moderator	Description
Noninvasive Ventilation of Neonatal-Pediatric Patients: Do We Really Want to Intubate	**Rob DiBlasi RRT-NPS, FAARC/Ira Chefetz MD, FAARC** ./ Tom Kallstrom, MBA, RRT FAARC	This presentation will identify clinical circumstances that favor the use of NIV to support ventilation and explore the evidence supporting the use of non-invasive ventilation in neonatal and pediatric patients
The Role of Safety Checklists in Healthcare: Bother or Necessity?	**Timothy McDonald MD, JD**/ Sam Giordano, MBA, RRT, FAARC	This presentation will review the history of the use of checklists and other standardized procedures to improve outcomes in various industries and discuss how they are being adopted for use in healthcare to reduce errors and improve patient safety.
Minimizing VAP in 2011- How Respiratory Therapists Can Contribute.	**Marcos I. Restrepo, MD**/ Tom Kallstrom, MBA, RRT, FAARC	This presentation will describe the best practices for reducing ventilator associated pneumonia and describe key roles respiratory therapists can play in institutional efforts to reduce VAP.

Attachment 4.

Month	Total Articles	Total Mem Articles	Total Non-Mem Articles	Mem Related Articles	Non-Mem Related Articles	Mem Non-Related Articles	Non-Mem Non-Related Articles	Mem Deaths	Non-mem Death	Mem Neg. Articles	Non-Mem Neg Articles
Jan	83	37	46	32	29	2	12	0	4	3	
Feb	65	24	41	17	22	6	10	1	7	0	
Mar	88	37	51	30	27	7	19	0	3	0	
April	65	26	39	20	20	6	11	0	6	0	
May	59	26	33	23	21	3	7	0	4	0	
June	62	22	40	17	26	4	10	1	2	0	
July	64	35	29	30	17	5	8	0	2	0	
Aug	28	9	19	7	5	2	2	0	3	0	
Sept	59	12	47	9	21	2	13	1	9	0	
Oct	54	18	36	12	19	6	13	0	2	0	
Nov	17	3	14	3	5	0	6	0	0	0	

VP Internal Affairs

Reporter: George Gaebler

Last submitted: 2010-11-08 09:39:02.0

Recommendations

None at this time

Report

I have addressed the reports that are my responsibility through the automated Board reporting system. As of the due date for reports we have had a larger than normal lack of response from our committee chairs and others due to report. Reminders and calls were made to get the reports into the system on-time.

VP External Affairs

See Ad Hoc Committee to Review International Fellowship Program – Page 234

State Government Affairs Activity Report
December 2010

Cheryl A. West, MHA
Director Government Affairs

As this report is written, most state legislatures have adjourned for the year. Some states are now engaged in preparing for the 2011 sessions. The majority of legislatures will come back into session in January.

As has been the case over the past two years, 2010 was again a financial struggle for states to balance their budgets with less revenue while the demands for state services increased. For your information The Council of State Governments anticipates in 2011 thirty nine states will have budget shortfalls indicating no end to the economic woes facing most states.

Many states in order to raise revenues have increased various state fees and taxes. States have made qualifying criteria for some state funded programs more difficult to meet and in many states reimbursement for Medicaid services have been reduced. Clearly one area of focus for the respiratory therapy profession has been an increase in what a state will charge to both obtain and renew a respiratory therapy license. These licensing fee increases certainly are not exclusive to our profession, but close scrutiny by the State Society on how much of an increase is being proposed is key to assuring that any increase in fees will be fair and equitable.

Guidance Document on Best Practices for Ventilator Care in Skilled Nursing Facilities (SNFs) and State Medicaid Directors

As mentioned in the July Report, Gene Gantt, AARC's Long Term Care Specialty Section Chair, has taken the lead in urging state Medicaid Directors to adopt the Guidance Document on Best Practices for Ventilator Care in SNFs. In addition to Tennessee Medicaid, which early on adopted the best practices document into its state nursing home policies, Pennsylvania has done so as well. Moreover, Florida, California and Maryland Medicaid programs have all expressed both interest and support for the Guidance Document. The AARC has formally endorsed this important Best Practice Guideline.

State Legislation

As noted in previous 2010 reports there have been numerous bills introduced that either specifically address the respiratory therapy profession or include the respiratory profession as part of legislation that impacts numerous licensed health care professions. For one reason or another, most legislation is not enacted into law. However, while the bills may not become law studying the legislation can provide a sense of what issues have enough constituent support to engender legislative activity.

RT Licensure Legislation

Hawaii – Hawaii is the 49th state in addition to Puerto Rico and the District of Columbia to gain licensure for the profession of respiratory care. The Hawaii Society is now engaged with the state agency that oversees professional licensure to work out the regulations that will actually implement the law. The major point of concern is the actual cost of the licensing fees which is under intense negotiations. The goal is to begin issuing licenses in the summer of 2011.

Connecticut- Concerns over violations of the RC Practice Act were raised regarding hospital based radiological technologists or other disciplines (nuclear medicine techs) who would disconnect a patient from oxygen, move the patient to the testing area, then reconnect the oxygen (and then do the reverse). The issue was whether these non-RTs when handling the oxygen were in violation of the RC Practice Act. In order to avoid this legal issue and mitigate the disruption to hospitals' routine procedures that a strict enforcement would create, Connecticut enacted a law that very narrowly defined the circumstances under which the above scenario could occur and the specific qualifications and competencies other personnel needed to possess in order to do so. As a point of note, Nebraska also seems to have run into this same situation, however no resolution to the issue in that state has been determined.

Other Legislation of Interest to the Profession of Respiratory Therapy

Louisiana-Enacted. Added licensed respiratory therapists and several other occupations to the definition of "health care provider" as it applies to medical malpractice laws.

Illinois-The State would establish the Long Term Acute Care Hospital Quality Improvement Transfer Program. Hospitals can voluntarily participate but must meet certain requirements, including maintaining on-site respiratory therapy coverage 24/7. In addition, one of the quality reporting measurements hospitals must provide will be the ventilator weaning rate; that is, the percent of patients discharged during the reporting period who have been successfully weaned off invasive mechanical ventilation.

Minnesota-Current law provides for an asthma demonstration program under MN Medicaid. A tweak of the authorizing law would add a new aspect to the demo that would include an in-home environmental assessment of asthma triggers as well as asthma patient education to be rendered by either a public health nurse or a certified asthma educator.

Massachusetts-The MSRC supported a budget amendment that directs MA Medicaid to establish a global or bundled payment for high-risk pediatric asthma patients including payment for asthma care management provided by certified asthma educators. Many RTs have received their certification as asthma educators. The AARC at the request of the MSRC wrote a letter of support to the legislator who sponsored this amendment. The amendment was included in the final state budget.

Rhode Island- Enacted. A bill that will require hospitals to track hospital acquired infections including ventilator associated pneumonia.

Respiratory Therapy Rules/Regulations

A change in the rules and regulations for the profession of respiratory therapy may have just as much impact on how respiratory therapists practice as does amending the licensure laws for RT. Some regulatory changes of interest:

Ohio & Wyoming- both states made significant revisions to the rules and regulations for the RT profession, including changes in licensure requirements and application procedures, fees, license renewal and continuing education, standards of professional conduct, complaints, and reinstatement of a license after disciplinary action.

Delaware, Florida, Idaho, Nevada, New Jersey, Oklahoma & Washington State- these states have amended requirements for continuing education credits for license renewals. These states revised in some fashion and to differing degrees the continuing ed requirements for license renewal.

Florida & Georgia- revised varying requirements pertaining to disciplinary criteria, action and recourse.

Washington State, Maine, Wyoming, & North Carolina- all revised licensure fees.

Of note in **Washington State** initially they proposed a 177% (to $335) fee increase for the RT license and license renewal. The proposed increase in fees for other professions was vastly lower. The quick and very clear response by the Washington State Society and very concerned Washington RTs resulted in the Agency rescinding the unjustifiable increase and accepting a more moderate increase that was in line with the increases for the other health professions.

North Carolina- The activist North Carolina Respiratory Care Licensure Board has issued a position statement regarding the practice of respiratory care as it relates to the management of respiratory care services. The RC Licensure Board also issued a position statement that will permit respiratory therapists on transport teams to enter into the state without having to obtain a NC license. Moreover, the Board is also considering the circumstances under which RTs may administer allergy injections.

You might find reading the various position statements and declaratory rulings of the NC RC Licensure Board enlightening. http://www.ncrcb.org/rules&Laws.html

Texas- issued a regulation that outlines the procedures for the issuance of criminal history evaluation letters

New Hampshire- Has adopted a new rule that incorporates the AARC Statement of Ethics and Professional Conduct as a licensure standard.

Challenges from Other Professions, Occupations & Disciplines

We continue to monitor legislative and regulatory activities by other professions, occupations 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 may be provided, can greatly impact and potentially diminish the respiratory therapy legal scope of practice.

Personal Care Assistants

Minnesota- The MSRC was successful in revising a bill that would have eliminated the Medicaid required training on ventilator maintenance for home care patients by unlicensed personal care assistants (PCAs). The MSRC was able to keep the mandated training requirement provision and made sure that the law reiterated that PCAs may not provide any clinical services to home ventilator patients.

Medication Aides/Assistants/Home Health Aides Etc.

OK, WV, RI, AZ had legislation that in some fashion would have permitted medication aides, home health aides or in some cases nurse aides to administer a variety of medications including a range of respiratory drugs. None of these bills were enacted.

Comment:

While neither the MN personal care assistant bill (as initially written) nor the various medication related legislation were enacted, there is a clear trend on the part of states to permit non-licensed or "less" regulated (and more often than not "less expensive") disciplines to provide traditional services currently only permitted to be provided by licensed health professionals. When this type of legislation is circulated and it impacts the RT profession, State Societies must be vigilant and respond with factual information as to the true impact such legislation will have on patient care.

Perfusion Licensure

Three states this past year, **KS, MD, and FL** had perfusion licensing bills under legislative discussion. None of the bills were enacted. It should be noted that the Florida perfusion bill included an exemption for respiratory therapists.

Sleep Disorder/Polysomnography State Activities

Maryland

Several years ago, Maryland enacted a polysom licensure law that did not include a specific exemption for the licensed respiratory therapist. The law did contain the standard exemption found in nearly all health profession licensure bills, i.e., "(Nothing shall prevent)…any individual licensed in this state by any other provision of law from engaging in the profession or occupation for which he is licensed" (or similar words with the same intent).

In essence this exemption provision says that other licensed professionals would not need to obtain any further credential or obtain an additional license (in this case, a polysom license) to continue to provide their services if it is construed that the licensed professional was practicing within their own scope of practice.

During legislative negotiations on the polysom licensure bill, the MD RTs in the state were assured that this standard exemption would cover the RTs and that RTs would not have to obtain either an additional polysom license or an additional credential.

The Maryland Polysomnography Licensure Board is now active and has issued a clear statement that beginning October 1, 2011 any RT providing anything now defined as sleep (a very expansive definition) will have to have a polysom license (requiring the RT to pay for additional training in order to qualify for a license, as well as pay for and take an additional test so that they may pay for another license- ($200 in MD) and keep paying ($200) to renew that polysomnography license.

Moreover, lawyers for both the MD Respiratory Care Board and the Maryland Board of Physicians have strictly interpreted the polysom statutory provisions and cross walked line by line the scopes of practice for RT and polysom. In Maryland as in most states that regulate polysom the scopes of practice are very task specific. In MD the polysom scope is not limited to the "staging, testing, scoring and evaluation of a sleep exam". Respiratory Therapy scopes of practice are, like nurse and physician scopes of practice more general.

In the case of Maryland, the RC and Physician Board's lawyers compared the scopes of practice between polysom. These Boards have concluded that if RTs provide any of the scope of practice that is not specifically in their own scope of practice but is in the polysom scope, then starting October 2011 MD RTs will be required to obtain a polysom license. The MD/DC Society is in the process of seeking a legislative solution to this unsupportable determination.

Comment:
Any legislative licensure effort by polysomnography interests must include a specific exemption provision in the legislation for respiratory therapists. Assurances during legislative negotiations that the standard general exemption for other licensed health professions will be all that is needed for the RT to be exempt from the requirement of obtaining an additional license or credential is simply inadequate as Maryland is proving.

Oregon-
The Respiratory Care Licensing Board proposed an unacceptable regulatory change to the licensure rules for respiratory therapists. The proposed changes would have taken a significant section of the respiratory scope of practice and legally permitted unlicensed sleep personnel to provide all the services enumerated in this one expansive section. It must be clearly stated that the proposal was generated from the lawyers and staff of the state umbrella licensing agency and not from the RTs who sit on the Board.

We can only assume there was outside pressure on the Agency that led staff to this ill conceived regulatory change. We also believe the effort was intended to permit unlicensed sleep personnel to provide oxygen titration, CPAP and several other sleep related RT tasks performed during a sleep test without these personnel being in violation of the RT practice act. However, the Oregon RT scope of practice is structured in such a way that these tasks are embedded within one extensive paragraph that includes a range of RT services, including PFTs, blood gas draws and *all* diagnostic testing procedures. If this proposed

regulation had become final, all of the listed RT services in the extensive scope provision could have legally been provided by unlicensed sleep personnel.

The Oregon State Society and the AARC submitted joint comments opposing the proposed regulations. Our comments offered alternatives to the proposed rules. At this time the Respiratory Therapy Board defeated this proposal, however the final decision will be made by the umbrella agency, the Oregon Health Licensing Agency.

We are grateful to the leadership of the Oregon Society and the many respiratory therapists who actively and professionally responded to this ill conceived proposal.

Connecticut- A proposed bill to license polysomnography personnel has been circulated for comment and positive discussions have occurred between the CT Society and the CT Sleep Society. There were several flaws in the proposed legislation including no specific exemption for RTs. Through mutual discussions there is now an agreement that a specific RT exemption will be included in the legislative provisions. At this time it is unclear whether the sleep licensure legislation will be introduced in the 2011 legislative session.

New Hampshire

The New Hampshire RT Licensure law includes a provision that authorizes the NH RT Licensure Board to issue regulations that will regulate polysomnographic technologists (RSPGTs). The RT Licensure Board has diligently worked with all interested parties to develop regulations that are equitable and fair. The AARC had several concerns regarding a few proposed provisions, and we have conveyed them to the Board. Overall, the draft regulations address the needs and interests of both the RTs and sleep personnel and the citizens of the state and we recognize the hard work and time that went into developing these extensive regulations.

California

Last year the legislature in California enacted a law that would regulate polysomnography personnel under the Medical Board of California. The law provided an exemption for respiratory therapists. The provisions of the law were rather general leaving it to the Medical Board to provide through regulations the specifics on acceptable training and credentials, definitions of personnel and the like. There are concerns that the proposed regulations will permit the exam and credential issued only the Board of Registered Polysomnographic Technologists (BRPGT) to be acceptable for polysom licensure. The California Society for Respiratory Care is engaged in requesting changes to key provisions to broaden the range of accrediting and credentialing entities (NBRC for example) and enlarge the foundation upon which RTs are exempted.

2011 Potential Sleep Disorder/Polysomnography Initiatives

In 2011 we anticipate increased state efforts to license polysomnographic personnel and the RT Societies should be prepared to work cordially with the sleep representatives but with a firm resolve to protect the integrity of the RT legal scope of practice.

It is still unclear which states will undertake this effort, but potentially **Kentuck**y may be poised to move forward this coming year. The KSRC and the KY Sleep Society have been negotiating in a positive manner over the provisions of the sleep licensure bill. However,

as currently written the proposed bill does not include a specific exemption for respiratory therapists. Given what has transpired in Maryland, this is most concerning.

A positive relationship between the Virginia Society for Respiratory Care and the VA Sleep Society this past year led to the passage of a **Virginia** polysom licensure law that satisfied the needs of both practitioners. The law included an exemption for RTs. We would anticipate the proposed regulations implementing this law should be issued shortly.

The same licensure bill for sleep personnel has been circulating in the **New York** legislature for several years and this year the legislation was passed by the NY Senate. The bill includes a provision that would exempt respiratory therapists. The bill has not moved forward beyond the Senate, but we would expect it to be re-introduced in 2011.

Conclusion

We anticipate that in 2011 state governments will continue to struggle to meet their budgets, raising the potential that fees and charges will rise and services will decrease. State societies must remain vigilant in monitoring proposed changes to their own laws and regulations as well as those of other professions and disciplines.

One last point to keep in mind is that in the Affordable Care Act- ACA- (aka Health Care Reform) there were numerous state related health provisions (not related to "health insurance reform") which will bring new funding to states to implement many alternate care site demonstration projects. Moreover funding is also being made available to states that offer grants for programs for asthma and chronic disease management. Assuming these provisions of the ACA are not rescinded by Congress, the funding for the programs should begin to roll out in late 2011 and continue to roll out over the following two years. A number of these new initiatives could include the participation by RTs. State Societies should monitor the rollout of these programs and be ready to advocate to the appropriate state agencies the inclusion of RTs where applicable in any of these new initiatives.

I will provide a verbal update at the meeting.

Federal Government Affairs
Activity Report – December 2010

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

The Congress

The midterm elections ushered in change. Divided government has now returned to Washington, D.C. after two years of purely Democratic control. The Republicans are now the majority in the House of Representatives and gained a number of seats in the Senate which remains controlled by Democrats. Knowing that the 112th Congress will have a Republican majority in the House will make the lame duck session which runs from mid-November to January particularly interesting. House Speaker Nancy Pelosi (D-CA) will soon turn over the gavel to Congressman John Boehner (R-OH) who has vowed to deal with the President's agenda in a straightforward and honest way. During the balance of the 111th Congress much remains to be done including dealing with expiring tax cuts, funding the government, Social Security and the expiring unemployment extension that allowed individuals to apply for up to 99 weeks of coverage. Also of note is that a number of veteran Democrats lost their seats and the Republicans who won this election are generally more conservative.

With respect to the healthcare reform law also known as the Affordable Care Act, it has been widely reported that Republicans will try to repeal this law. It is unlikely that repeal will take place. Instead, we will see Republicans wield their power through the appropriations process by being unwilling to fund the provisions of the Affordable Care Act so that the provisions cannot be implemented. Additionally, Republicans will assume the Chairs of powerful House Committees such as Energy and Commerce which will most likely go to the leadership of Congressman Joe Barton (R-TX). This will give the Republicans the opportunity to conduct hearings and exercise oversight of healthcare legislation and the actions of the Department of Health and Human Services.

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.

Our primary legislative champion and sponsor of HR 1077 Congressman Mike Ross (D-AR) held onto his seat in the midterm elections. The bill remains challenged by an unsupportable score (cost) from the Congressional Budget Office (CBO) and the legislation will most likely have to be reintroduced in the next session of Congress with a

technical amendment that clarifies the bill's intent. We came very close to crossing the goal line and achieving success as our bill was included in the initial versions of both the House and Senate healthcare reform legislation. However when CBO opined that our legislation would cost billions over 10 years, it was removed from the final package. We will have to fight again to get to the goal line.

In the Senate, Blanche Lincoln (D-AR), our champion and primary sponsor of the RT Initiative companion bill S 343 to HR 1077l, lost her seat to Republican Congressman John Boozman. This is a loss for the AARC and the Congressional COPD Caucus, as Senator Lincoln was a founder and co-chair of this important Caucus. We are, however, very pleased that our other Senate champion, Mike Crapo (R-ID) maintained his seat and won a third term in the US Senate. Senator Crapo is also a founder and co-chair of the Congressional COPD Caucus.

As of the midterm elections, HR 1077 had 36 members of Congress supporting the bill. Eleven of the bill's Republican co-sponsors have retained their seats and one of our Republican friends has moved to the Senate. Seventeen of our Democratic co-sponsors retained their seats; 5 lost the midterm elections; 1 retired; 1 ran for the Senate and lost. This leaves us with an uphill battle to gain co-sponsors for the bill and keep the drum beat strong that respiratory therapists must be recognized to improve patient care.

Our 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.

Virtual Lobby Day

On August 4th, 2010 AARC launched its first and very successful Virtual Lobby Day. The goal of the day was to have respiratory therapists, pulmonary patients, respiratory therapy students and supporters of the profession contact their members of Congress to urge the co-sponsorship of our Medicare legislation (HR 1077/S 343). We had over 7,000 messages reach Capitol Hill offices. We extend our thanks to all the State Societies, House of Delegates and state PACT representatives who undertook the task of organizing and inspiring a statewide response. We are especially grateful to the consumer and patient organizations that generated enthusiasm and participation from their members to reach out to the Hill as well. Thanks to the Alpha-1 Association, the COPD Foundation, Efforts, the Alpha-1 Foundation, and the COPD Alert for all their support.

Create a Specific COPD Program within the CDC

AARC is a long-time partner of the US COPD Coalition. The Coalition developed draft language for a bill that would designate a COPD program at the CDC in the Chronic Disease Division. The legislative language also includes provisions that address the need for a comprehensive response to COPD across all federal agencies. The Coalition is now looking for Hill sponsors to introduce the bill, with an eye towards enactment in the 112th Congressional session.

Prior to the August recess Congressman Cliff Stearns (R-FL) broke off the section of the draft bill, a section that addresses veterans and COPD and introduced it as a stand alone bill, HR 5996. This veterans' focused COPD bill is bipartisan and was introduced by co-founders of the COPD Caucus Congressman Stearns and Congressman John Lewis (D-GA). The bill when enacted will increase the ability of the U.S. Department of Veterans Affairs (VA) to diagnose, treat and manage COPD. A House hearing was held in September and the bill was supported by the VA and other veterans' organizations outside of government. The bill may be included in a larger veterans' package that will come to the floor of the House at an as yet undetermined time.

Repeal of Medicare DMEPOS Competitive Acquisition Program – HR 3790

Congressman Kendrick Meek, (D-FL) introduced HR 3790 last year to repeal the entire Medicare competitive bidding program for all items of DME, which includes a category for oxygen equipment and supplies. The AARC has sent two letters to Congressman Meek supporting HR 3790. Nevertheless, CMS has already begun to rollout the various phases of the program with full implementation of Round 1 commencing January 1, 2011.

As this report is written there are 257 co-sponsors for the bill, a very strong show of House support. However, the bill lacks a Senate version which involves convincing the Chairman of the Senate Finance Committee and other Democrats on the Committee that repeal of competitive bid is necessary. Senators sitting on the Committees overseeing Medicare have been strong proponents of competitive bidding. An additional hurdle is the CBO cost estimate of repealing the program. CBO states it will cost the Medicare program $20 billion dollars over ten years if competitive bid is not implemented. While disputing the CBO estimate, nevertheless, the HME Industry must offer Congress a way to "pay for" repeal and that will be extremely difficult given the previous reductions in Medicare DME reimbursement. As you may know, Congressman Meek, the sponsor of the legislation ran unsuccessfully for the Senate seat in Florida and will not return to Congress in January. If HR 3790 is not passed during the lame duck session of Congress, a new lead sponsor will have to be found when the new Congress convenes.

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

This legislation was introduced by Reps. Tom Price, R-GA, and Heath Shuler, D-NC in 2009 and would repeal the law that now limits Medicare rental payments for oxygen equipment and supplies to 36 months. The bill has not moved forward as the HME Industry has focused its advocacy efforts on the repeal of the Medicare competitive bid program. In addition, the same problem of finding a way to pay for cost of the repeal has stymied efforts to advance the bill. As you will recall, the AARC opposed the initial legislation (2006) that created the 36-month rental cap that eventually became law.

Physician Supervision of Therapeutic Hospital Outpatient Services – HR 6376

Currently the Medicare program restricts direct supervision for pulmonary rehabilitation (PR) programs in the hospital outpatient setting to physicians only, while permitting qualified non-physician practitioners (NPPs) to provide direct supervision for other

outpatient therapeutic services. Critical Access Hospitals (CAHs) must also meet these strict requirements for PR where for other services they have the flexibility to use NPPs.

Among the provisions, this bill, which was introduced recently by Reps. Earl Pomeroy, D-ND, and Jerry Moran, R-KS, would create a level playing field as it relates to PR services by permitting NPPs to provide direct supervision in addition to physicians. The AARC has sent a letter of support to the co-sponsors and are joined in our support by the American Hospital Association and other professional societies representing both physicians and PR organizations. However, it should be noted that Congressman Pomeroy lost his seat in the midterm elections, while Rep. Moran retained his, so the bill will most likely have to be re-introduced if it is to move forward. It does not represent any cost to the Medicare program and is viewed as a technical amendment to the current law.

Coalition Activities

The AARC continues its practice of participating in a number of Coalitions of like-minded associations and organizations to advance particular legislation and/or regulations. Our participation in select coalitions varies from urging greater funding for health and/disease research to promoting issues that will enhance the clinical support of patients with particular illnesses as well as advocating for stronger tobacco control rules and support of tobacco cessation programs

Since reporting on our coalition activities in the July Report we have since participated in the following:

Coalition for Health Funding

We continue to participate in advocacy efforts of this very broad based group that collectively supports greater funding, via the budget process for programs within the US Public Health Service (PHS) specifically and other health related programs run by the Health and Human Services (HHS) Department.

The newly created National Commission on Fiscal Responsibility and Reform is mandated to develop policy and recommendations targeting nondefense programs for discretionary spending freeze. The AARC signed onto a letter to the Commission urging it not to hold back funding for important federal programs in health, education, labor enforcement, job training, children's and social services programs which could and probably will be targeted. This joint letter was in addition to a previous letter sent earlier this year by the Coalition to Congress regarding FY 2011 budget cuts in health professional education, biomedical research, and disease prevention and health promotion programs.

The AARC also joined this Coalition in support of legislation, S 616 that would provide funding under the Public Health Service Agency to authorize a medical simulation enhancement program. The bill would support education programs establishing hands-on experience for their students, i.e. simulation of "real" experiences. Allied health schools would be eligible to participate.

Pulmonary Fibrosis Coalition

The AARC is supporting the efforts of a Coalition that is advocating the passage of HR 1079, a bill that would enhance funding at the CDC and NIH to expand the research, prevention, and awareness activities with respect to pulmonary fibrosis.

Tobacco Partners

The AARC signed on to a joint letter to Congress that opposed efforts by the House Small Business Committee to eliminate funding for the Prevention and Public Health Fund that was created in the provisions of the Affordable Care Act (ACA), i.e. Health Care Reform. The opposition to this amendment was strong enough that it was defeated.

Political Advocacy Contact Team (PACT) Representatives

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

We had a very successful 2010 PACT DC Hill Day this past March, with ninety-nine respiratory therapists from 45 states and the District of Columbia coming 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.

The 2011 PACT DC Hill Day is scheduled for March 7 and 8, 2011 and we have no doubt that it will be just as successful as the 2010 event.

As we did this year, in 2011 the AARC will again partner with members of the Alpha-1 Association and Alpha-1 Foundation. Pulmonary patients will be accompanying PACT members from their respective states to the Hill meetings.

Regulations and Other Issues of Interest

Outpatient Pulmonary Rehabilitation (PR)

The final 2011 rules on payment updates for pulmonary rehabilitation (PR) services in both the hospital outpatient and physician office settings have been released. Both physicians and hospital outpatient departments will see increases in their rates for PR services starting January 1, 2011.

With continued pressure from the hospital industry, the Centers for Medicare and Medicaid Services (CMS) has relaxed its requirements for direct supervision for outpatient therapeutic services, including PR, by only requiring the physician to be "physically immediately available" without specifying a particular physical boundary, such as having to be in the provider-based department of a hospital. Hospitals have challenged the definition of "direct supervision" for years so this responds to their concerns. Critical

Access Hospitals (CAHs) also benefit because CMS has decided to extend their notice of non-enforcement requiring direct supervision of all outpatient therapeutic services in that setting for another year. The agency plans to develop a process through future rulemaking to evaluate alternative supervision levels for specific types of outpatient services. The hospital industry has been pushing for an independent assessment because they believe there are other types of services that qualify for general supervision.

Trailblazer is the only Medicare contractor to date to issue a local coverage determination (LCD) based on the new PR benefit. AACVPR, AARC, ATS and NAMDRC submitted substantive comments on the draft proposal in August. One item of particular concern was the requirement of an 18-month separation between the initial 36 sessions and the subsequent 36 sessions based on medical need. A final LCD was issued in October with an effective date of December 14, 2010. The final rule drops the 18-month requirement in response to our recommendation.

Orders for Respiratory Care Services

For over a decade, Medicare policy required that only a physician (MD/DO) could write orders for respiratory care (RC). However, if the physician delegated authority to a licensed non-physician practitioner (NPP) such as a physician assistant or nurse practitioner to write a RC order for his/her patient and the hospital permitted such arrangements, to comply with the rules CMS required the physician to co-sign the order. Since many state laws have changed over time to permit NPPs to write orders as long as it is part of their scope of practice, CMS decided recently to update its rules to reflect current practice.

In addition to a doctor of medicine or osteopathy, other licensed and qualified practitioners can now write respiratory care orders without the physician having to co-sign the order as long as they are 1) responsible for the care of the patient, 3) acting within his/her scope of practice under state law; and 4) authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and state laws.

The important thing to note is that the new rule permits hospitals to have flexibility in developing their written policies consistent with their state laws. It does not mean that hospitals must adopt this new policy. This is especially true in the 34 states that still have respiratory care practice acts that require a physician to write a RC order. We would expect in those states that hospitals would 1) either continue to have a policy that only permits the physician to write a RC order, or, 2) require the physician to co-sign a RC order if the hospital determines that other licensed practitioners in those states meet the requirements laid out by CMS, which essentially means the physician is writing the order.

Competitive Bidding

CMS continues to move forward to implement the competitive bidding program for certain medical equipment and supplies, including oxygen and oxygen equipment. In testimony before a House subcommittee, the AARP recently endorsed the program with certain

caveats. Winning bids were announced on November 3. The program will begin on January 1, 2011.

Concerns continue to be expressed by the home medical equipment (HME) industry, patient advocates and supporters in Congress that the quality of care and patient access to HEM will be devastated if the Program is implemented. This fall a joint letter was sent to the Hill signed by 166 economists. The letter cited four basic but key flaws in the competitive bid program. Members of Congress sent this letter to CMS asking the Agency to consider both issues raised and the recommended changes set out in the letter.

Revisions to Local Coverage Policies on CPAP

As noted in our July report, when the DME regional contractors revised their local coverage policy earlier this year on Positive Airway Pressure for the Treatment of Obstructive Sleep Apnea, they included very prescriptive documentation that must be provided in the medical record when CPAP proves to be ineffective and the physician wants to move the patient to a bi-level RAD. Apparently this action led to questions and concerns regarding the ability to provide the specific documentation. As a result, the contractors simplified the requirements effective August 1, 2010. AARC's Home Care Section was apprised of the change.

New National Coverage Determinations (NCD)

Expansion of Smoking Cessation: In the July report, we informed the Board and House of a proposed NCD to expand smoking cessation counseling for outpatient and hospitalized Medicare beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease. Current policy requires a diagnosis of a tobacco-related disease or symptoms consistent with such diseases. CMS finalized the expanded policy on August 25, 2010.

Home Oxygen for Cluster Headaches: In a proposed decision memo issued October 8, 2010, CMS announced that evidence does not demonstrate that the use of home oxygen in Medicare beneficiaries who suffer from cluster headaches improves their health outcomes. However, CMS did conclude that this is a promising technology and proposed that it be covered by Medicare only when certain conditions are met as part of an approved prospective clinical study.

New Durable Medical Equipment Supplier Enrollment Standards

On August 27, 2010, CMS finalized a rule that was first proposed in 2008 that would add new enrollment standards for those durable medical equipment (DME) suppliers looking to contract with the Medicare program. The new standards, which became effective September 27, 2010, are designed to add stronger protections to help prevent fraud. With very few exceptions, DME suppliers can no longer contract out their services but instead must employ all licensed professionals on either a part-time or full-time basis. This

provision could have a limited impact on RTs who in the past have worked for a DME supplier through a contractual arrangement.

Inhalation Drugs/Nebulizers

The DME MAC Regional contractors recently revised coding, billing and coverage guidelines for two inhalation drugs and nebulizers. They are: 1) Tyvasol® (treprostinil inhalation solution) used in the treatment of patients with primary pulmonary hypertension and who meet the criteria for iloprost; and, 2) Cayston® (aztreonam lysine inhalation solution) indicated for patients with cystic fibrosis with a chronic type of infection. The nebulizer used with Cayston® has been deemed noncovered by Medicare because it is not sufficiently durable to meet the requirements under the DME benefit. These changes will be added to the LCD on Nebulizers in the near future.

The FDA also recently approved a new bronchial challenge test kit for the assessment of bronchial hyperresponsiveness in patients six years of age and older who do not have clinically apparent asthma. The trade name is ARIDOL™ (mannitol inhalation powder). It is not intended to be used as a standalone tool to assess asthma.

FDA Tobacco Updates

FDA continues it efforts to regulate the sale, marketing and distribution of tobacco products. Recent activities include the first stakeholder discussion series session with state and local tobacco control health officials and posting on FDA's website of an Enforcement Action Plan for Promotion and Advertising Restrictions on menthol and other cigarettes marketed to youth.

2011 Office of Inspector General (OIG) Work Plan

As mentioned in previous Board and House reports, the 2011 OIG Work Plan had a number of items of interest to AARC. Of particular note is an expected review of the appropriateness of Medicare payments for sleep test procedures and polysomnography. With respect to sleep testing payments provided at sleep disorder clinics and independent diagnostic testing facilities, work is in progress but not expected to be completed until 2012. This delay is a bit surprising given the tremendous increase in payments for polysomnography between 2001 and 2009 ($62 million to $235 million, respectively). Such rapid increases in payments generally will raise the priority of addressing a particular concern. In addition to looking at factors that have caused such an increase in payment, the report will also look at provider compliance with Federal program requirements.

Updates to the Skilled Nursing Facilities Prospective Payment System (SNF PPS) for 2011

The new RUG IV, MDS 3.0 system for SNF PPS payment went into effect on an interim basis on October 1, 2010. The policies that specified the major changes, however, were finalized in August 2009. The implementation date was delayed in order to accommodate overall system changes. The changes are designed to collect more specific and accurate data in order to ensure that payment is appropriate for high cost services, such as ventilator care. The changes also reflect a better description of the services that fall into the major

categories. The payment to SNFs for ventilator care has increased significantly. But keep in mind that while this might make it more financially attractive to employ RTs, there is no Medicare required mandate to do so.

Conclusion

The results of the 2010 mid term elections will bring changes to the realigned Congress starting in January.

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.

A verbal update on these or other issues will be provided at the December meeting.

Board of Medical Advisors (BOMA) Report

Reporter: Cliff Boehm, MD

Last Submitted: 2010-10-19 7:48 p.m.

Report to Chair of the ASA's Respiratory Care Committee

As BOMA chair, I convened the summer meeting of BOMA in Dallas, TX on June 19, 2010. My report consists largely of a condensed version of the minutes from that meeting.

The committee received reports form the following individuals/ organizations:

Item One: CoARC REPORT

Accreditation
CoARC Executive Director Tom Smalling highlighted issues on his written report. As of April 2010, CoARC has 21 accredited 100-Level programs, 59 200-Level programs and 9 polysom add-ons. They are phasing out the 100-Level programs. CoARC Standards have replaced the CAAHEP standards effective June 12, 2010. Differences include:

- They are now considered "standards" rather than "guidelines" to facilitate enforcement.
- Program staff will be required to have a certain number of years' experience in addition to the RRT credential.
- There are more specific criteria for competencies.
- Probation for programs will be one year rather than five.
- The CRT exam replaces the RRT exam as a measure of success.

Accreditation Standards
Dr. Smalling stated CoARC's emphasis on disclosure and they are now requiring more transparency to better advise students of entry into the profession. Therefore, over the next few months they'll be reporting outcomes of programs, graduation rates, attrition figures, enrollment numbers, job success and job placement.

Military Update
Military programs are in the process of conversion from 100-Level to 200-Level. The U.S. Army uses Thomas Edison consortium and is in the process of consolidation of all military training programs in healthcare at Fort Sam Houston.

CoARC Website

CoARC's new website is in effect as of this week.

Accreditation Fees
CoARC accreditation fees will increase in 2011 and they are now requiring students to be at the registered level. They currently have about 50 baccalaureate programs.

APSS Meeting
Dr. Smalling attended the Association for Professional Sleep Societies (APSS) meeting in San Antonio last week and presented an overview. Concerns were expressed by BOMA regarding the standards set for the "certified Polysomnographic Technologist". Only three months experience is required with a high school education to take the exam which is based on the Registered Polysomnographic Technologist exam with only 75 questions of a reduced level of difficulty. There was a discussion of a newly created position of "Non-Invasive Mask Intervention Specialist" and the potential scope of practice.

Item two: Dr. Sokolowski made a motion.

He moved and the motion carried "That the Board of Medical Advisors establish an advocacy section on BOMA to work with state and federal legislative representatives of AARC." The following physicians volunteered to work on the advocacy section of BOMA in conjunction with Cheryl West at the AARC Executive Office.

Dr. Joe Sokolowski
Dr. Bill Bernhard (available after September 6)
Dr. Christopher Randolph
Dr. Lori Conklin

Item 3: Report from the NBRC

NBRC President Dr. Gregg Ruppel presented highlights of his written report.

Adult Critical Care Exam
The last step in the 5-step procedure for implementing the Adult Critical Care exam began this January with an item writer training course. It is expected that the practice exam will be available in late 2011 or early 2012 and will consist of 170 items administered over 3.5 hours.

Pass Rates
Dr. Ruppel provided 2009 statistics on pass rates advising that so far this year the pass rates have exceeded the rates of the same time last year.

Albert H. Andrews Award
He stated this year's ***NBRC Albert H. Andrews Award*** will go to a long-standing member of BOMA, Dr. Richard Sheldon.

NBRC Participants in 2015 and Beyond
NBRC representatives Sherry Barnhart, Gregg Ruppel and Rob Shaw will participate in the final RT 2015 and Beyond 3rd conference this summer.

NBRC's 50th Anniversary
NBRC Executive Director Gary Smith reported that NBRC will sponsor a reception at AARC's Annual International Congress in December to celebrate NBRC's 50th anniversary.

NBRC International Activities
One of NBRC's goals is to support other countries in credentialing. The Latin American Board for Professional Certification in Respiratory Therapy is continuing to make progress. Mr. Smith will be traveling to Saudi Arabia next month along with Sam Giordano where he will discuss licensing their programs in Saudi Arabia.

Item four: President's Report

AARC President Tim Myers highlighted the goals presented in his report. He stated that the Board is pushing transparency in the form of disclosure at each meeting. They are also concentrating on methods of growing membership and providing programs the membership finds of value. Membership continues to increase. Currently AARC has 51,000 members.

HR1077 / S 343
The AARC continues to advocate passage of HR 107 / S 343 to have respiratory therapists recognized by Medicare.

Tennessee Meeting
He visited Tennessee to discuss past issues as well as moving forward to build a better relationship with the society. Conversations continue with AASM. A conference call with them will take place soon to discuss the RRT credential.

AARC International Activities
He stated the importance of current international activities and the RT 2015 and Beyond project. Another important program, The Leadership Institute, will be a web-based post graduate educational program aimed at AARC's future leadership. Implementing this program now will allow newcomers to take advantage of current mentors who have been with the AARC for many years.

AARC Online Courses
AARC has also launched the Asthma Educator Prep Course, the COPD Educator Course, and the Spirometry Achievement Certificate program, all of which are online programs.

AARC's Long Term Care Position Statement
AARC's Long Term Care on Mechanical Ventilation Position Statement was mailed to all state Medicaid directors this month asking them to support it. He thanked BOMA for their help in developing the position statement.

Military

President Myers advised that at its April meeting the AARC Board of Directors approved the motion to allow BOMA to create a permanent military position on BOMA.

Palliative Care

There was a brief discussion concerning palliative care and the absence of same within our infrastructure. President Myers advised that he will take this up with the Board at its July meeting and have the President-elect Karen Stewart include it in her committees for 2011.

Item Five: Executive Director's Report

COPD

Executive Director Sam Giordano encouraged the state societies to form a lung health event in conjunction with World COPD day which is an annual event in October. Mr. Giordano is a member of the US COPD Coalition which expects to update communities on COPD in March, 2011 regarding treatment and patient support of COPD.

Saudi Arabian and European Activities

Mr. Giordano advised that he was invited to attend the Gulf Thoracic Society meeting in Abu Dhabi. AARC was asked to form a partnership with them whereby AARC sends speakers to their meetings and share expenses for AARC exhibits at their meetings. While European countries don't widely use respiratory therapists, the Middle Eastern countries do. Asthma and COPD are each a growing problem there that has created more need for RTs. They are currently organizing schools and RT programs in universities. Dr. Stephano Nova asked that we submit a proposal for a mini symposium at the 2011 European Respiratory Society meeting. AARC complied and our proposal was accepted. We'll provide 2 speakers on issues of non-invasive ventilation for which there is a need in Europe. AARC continues to promote *RESPIRATORY CARE* Journal in Europe.

RT 2015 and Beyond

RT 2015 and Beyond was conceived in 2007 to determine the structure of the health care system in 2015 and the role of the RT in the future. Subsequently, 3 conferences were developed. The first in 2008 evaluated future system models and the roles of RTs. The results of this conference were published in 2009 in *RESPIRATORY CARE* Journal. The second conference which was held in 2009 dealt with the competencies which will be requirements for RTs in the future. This manuscript was published in *RESPIRATORY CARE* Journal in May 2010. The final conference which will be convened in July of this year will assess the process of evolution of the field of respiratory care in the future.

Dr. Woody Kageler indicated that this conference will present information elicited from surveys of directors of RT educational programs as well as managers of institutional respiratory care services. There will be an evaluation of Masters-prepared programs for RTs in the immediate future. The goal is to assess the future of educational programs with their associated competencies for RTs. At the conclusion of the conference there will be a presentation of the conference outcome to various groups to elicit feedback.

BOMA's comments included maintenance of an adequate supply of RTs and a mechanism to educate the current RT community for the demands of the future.

RTs
Mr. Giordano advised that using RTs in disease management is just one cost saving answer to hospital budgets. He believes that RTs can play another important role in decreasing exacerbations and subsequent hospital readmissions.
Item Six: Legislative Affairs Report

Louisiana
Cheryl West reported that a new Louisiana law defining "health care provider" includes RTs. Moreover, the new law covers "health care providers" as protected under malpractice insurance laws. The Louisiana Hospital Association was very supportive and worked closely with our Louisiana State Society for Respiratory Care.

Licensure
Hawaii has had difficulty in gaining licensure which is now sitting on the Governor's desk for signature or veto. We should have a final determination by the end of June. If Hawaii does become licensed it will be the 49th state to gain licensure (along with Washington DC and Puerto Rico). In a number of states, legislation has been introduced that would make it easier for non-licensed personnel to administer medications including RT related meds.

There is a growing concern relevant to proposed legislation which would allow non-licensed or less regulated disciplines to provide services, customarily performed by respiratory therapists in home or long-term care facilities to reduce costs.

Home Oxygen
CMS is undertaking a number of studies directed at the DME benefit, including the impact of the 36-month rental cap on home oxygen and the potential fallout to patients on the upcoming competitive bid program. CMS has contacted the AARC for its input on both of these issues.

Medicare Respiratory Therapy Legislation
HR 1077/S343, the Medicare Respiratory Therapy legislation co-sponsored by Blanche Lincoln (D-AR) and Mike Crapo (R-ID) and Congressman Mike Ross (D-AR) have sent a joint letter asking that the CBO undertake revisions on cost estimates for our legislation.

Physician Fees
There was an update on the current statutes of the impending 21% reduction in Medicare physician fees. We anticipate Congress will act quickly to postpone delay of this cut.
Item Seven: Medical Advisor Reports:

Dr. Kent Christopher reported that he and AARC Board member Bob McCoy co-chair the **Ad Hoc Committee on Oxygen in the Home.**

Dr. Paul Selecky reported that the **Specialty Section on Sleep** has a growing number of individuals on their Listserv. There were no recommendations.

Dr. Robert Aranson reported that the **Surface to Air Specialty Section** is exploring ramifications of paramedics possibly replacing respiratory therapists.

Dr. Cliff Boehm reported that the **Hyperbaric Roundtable** has an active Listserv. They plan to provide 3 lectures in a mini symposium ad AARC's International Congress in December on an introduction to the specialty and safety/economic aspects to running a chamber.

Item Eight: New Business

Selection of 2012 Chair
Dr. Phil Marcus was identified as the 2012 BOMA Chair.

Adult Acute Care Section Volunteer
Dr. Peter Papadakos volunteered to be the Adult Acute Care Section Medical Advisor replacing Dr. Acevedo.

Selection of 2011 Meeting Date
Due to the number of physicians not in attendance, Dr. Boehm advised that he will call for an e-vote from all physicians following this meeting.

There was also some discussion concerning the absences at summer BOMA meetings. Sam Giordano suggested a survey of all physicians to determine whether to use a webcast as an "emergency only" feature during summer meetings. Dr. Boehm will survey BOMA electronically following this meeting.

Position Statements
Two position statements were sent to Dr. Boehm asking for comments from BOMA; however, President Myers informed BOMA that this hadn't yet been brought before the Board.

Chairman Cliff Boehm ruled the position statements out of order.

Military Health
Dr. Bernhard advised BOMA of a possible high incidence of asthma symptoms from soldiers returning home from Afghanistan.

Other items not contained in the minutes form the Summer Meeting:
The members of BOMA are being encouraged to become associate members of AARC. While this has long been a technical requirement to be on BOMA, it has been poorly enforced. A new reason now exists other than demonstrating their commitment to AARC. That reason is that membership is required to join AARConnect. AARConnect is a new initiative similar to FaceBook and will be used to facilitate communication amongst various communities within AARC. Our BOMA community hopes to use it to enhance both written communication and quite possibly as a forum for video communication. The latter still in the "talk about it phase".

HOD Report

Reporter: Thomas Lamphere

Last submitted: 2010-11-08 21:33:34.0

Recommendations

None at this time.

Report

2010 SPEAKER GOALS

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

i. All HOD Officers were charged with creating a detailed job description. Officers were been encouraged to contact individuals who have held the position in the past and to utilize the Executive Office staff for additional information. Final drafts due prior to the December HOD meeting at which time they will be utilized for the incoming HOD Officers.

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

i. Attended the third RT for 2015 & Beyond conference as the Speaker of the HOD and provided a report to the HOD at our summer meeting. Bill Dubbs

has been invited to address the HOD at the winter meeting in Las Vegas to provide an update on this and other management/education activities.

3. 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. HOD members were updated on the initiative at the summer meeting and were encouraged to take action requested by the AARC lobbying team.

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

i. An "Ad-Hoc Committee of HOD Effectiveness" was created just prior to the summer meeting. The first committee goal was to review the current purpose of the HOD and what it is supposed to accomplish. The committee is now in the process of developing a specific "Statement of Purpose" for the HOD with hopes to present this at the winter HOD meeting. Committee members include:

a. Garry Kauffman (Past Delegate, Past AARC President) - Chair
b. Ken Thigpen (Past Speaker of the HOD, Past AARC Board Member)
c. Bill Lamb (2010 HOD Speaker-Elect, Bylaws Committee Chair)
d. Teri Miller (Current Delegate – GA)
e. John Hughes (Resolutions Committee Chair, 10 year HOD Delegate)
f. Sherry Milligan (AARC Exec. Office)

g. Tom Lamphere (2010 HOD Speaker)

ii. All HOD Officers were been charged with creating a detailed job description with specific annual charges, responsibilities & timelines for their respective positions. The final version of these documents will be provided to the incoming HOD officers this December and can be updated annually as necessary.

iii. All HOD Committees were charged with the task of evaluating their respective committee to determine its necessity, efficiency and effectiveness. Each committee chair was provided access to a copy of the past 3-4 years of their respective committee reports in order to review exactly what the committee has accomplished during that time frame. Committee chairs have been sent a survey tool to complete that asks a series of questions designed to help with the committee analysis. At the time of this report, several committees have completed the survey, however, several still remain incomplete. Once complete, the HOD Officers will then review the surveys and any other information provided by the committee chairs and provide a recommendation to both the Speaker-Elect and the full HOD in regards to possible elimination of unnecessary committees, combining committees, creation of new committees, etc..

iv. All HOD Officers were charged with reviewing current HOD processes to evaluate their necessity and effectiveness. The HOD Speaker & Speaker-Elect will review this information and make recommendations if needed at the winter meeting.

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

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

i. Ongoing.

ii. 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.

AARC House of Delegates Resolutions – Dec 2010

House of Delegates Resolution 87-10-07

Resolution Author: Jim Lanoha

E-mail:lanoharentals@charter.net

Phone Number: 225 931 8448

Author's State: LA

Co-Sponsors and Their States: none

Resolution:
Resolve that the AARC revise its disaster relief policy to allow the AARC President to consider activating the fund upon request of an affiliate president in the event of a state or local governmentally proclaimed state of emergency or disaster.

Rationale:
To allow members to apply for assistance when a major event is not proclaimed a Federal Disaster by the US President. As an example the governor of Ohio repeatedly requested that the tornado damage which occurred there be proclaimed a Federal Disaster to allow similar funds to be made available to residents of Ohio. Multiple times this request was denied. Similar politics were seen during the aftermath of Hurricane Katarina

Impact of Resolution:
General Membership, Affiliates, AARC Officers & BOD, Executive Office

Implementation Cost: less than $1000

Ongoing Cost: less than $1000

Relationship to AARC Strategic Plan: Develop human resources, Increase membership

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House of Delegates Resolution 36-10-08

Curt Merriman/Laurie Tomaszewski
E-mail:curt.merriman@comcast.net
Phone Number: 612-760-0904
Author's State: Minnesota
Co-Sponsors and Their States: None

Resolution:

Resolved that the AARC consider writing a postion paper to assist state affiliates work towards a provision in licensure language to allow for temporary license reciprocity for RT's transporting patients via an air or ground ambulance service.

Rationale:

Currently RT's have to maintain multiple state licenses if they are involved in the transportation of patients between states via air/ground ambulances. This may limit the RT's ability to perform this vital function because of the financial and logistical burden to maintain the multi state licenses. Ambulance services may opt to not utilize RT's because of this issue and replace with a paramedic whom already has the reciprocity issue resolved.

The temporary licensure status could specify to not exceed 12 hours per transport occurrence and also be limited to the transport of specific patient(s) and not to provide patient care to others while within the state.

Impact of Resolution: General Membership, Affiliates, State/Federal Legislation
Implementation Cost: $200
Ongoing Cost: None
Relationship to AARC Strategic Plan: Develop human resources

House of Delegates Resolution 43-10-09

Resolution Author: Connie Paladenech
E-mail:cpaladen@wfubmc.edu
Phone Number: 336-713-8850
Author's State: North Carolina
Co-Sponsors and Their States: none

Resolution:

It is proposed that additional criteria be added to the Quality Respiratory Care Department recognition. Specifically, the criteria should include criteria for management standards which state that the Respiratory Care Department Director/Manager is a qualified Respiratory Therapist.

Rationale:

In a cost-cutting initiative, some hospitals have chosen to eliminate the Director/Manager of Respiratory Care services and place a non-Respiratory Therapist in the leadership position for the service. An unqualified person in a leadership position responsible for day-to-day operations, policy development, and competency evaluations places patient safety at risk. It is imperative that the leadership of Respiratory Care services be provided by a qualified Respiratory Therapist.

Impact of Resolution:

General Membership, HOD, Affiliates, AARC Officers & BOD, Executive Office, Patients receiving Respiratory Care Services; Board of Medical Advisors
Implementation Cost: $25.00 - $50.00 to update webpage
Ongoing Cost: None
Relationship to AARC Strategic Plan: Develop art and science of RC, Develop human resources

President`s Council

Reporter: Dianne Lewis
Last submitted: 2010-11-07 09:09:08.0

Recommendations

NONE

Report

THis year the Council bestowed Life membership on William Dubbs, MEd,RRT,FAARC. No Honorary membership was granted.

Trudy Watson is busy trying to organize some interviews at the Congress of either Past Presidents, physicians or dignitaries attending. To date no trip to Dallas to organize historical data has occurred. Trudy and I will continue to work with the Executive Office to make this occur.

Standing Committees

Audit Sub-Committee

Reporter: Billy Lamb

Last submitted: 2010-11-08 06:52:21.0

Recommendations

No Reccomendations at this time.

Report

The Audit Sub Committee has reviewed the AARC Monthly financial reports and find them aceptable and representative of the AARC''s financial status.

Bylaws

Reporter: Billy Lamb

Last submitted: 2010-11-08 07:00:37.0

Recommendations

Recommendation #1
That the AARC Board of Directors accept and approve the Oregon Society for Respiratory Care Bylaws.

Recommendation #2
That the AARC Board of Directors accept and approve the Maryland/DC Society for Respiratory Care Bylaws.

Recommendation #3
That the AARC Board of Directors accept and approve the North Dakota Society for Respiratory Care Bylaws.

Recommendation #4
That the AARC Board of Directors accept and approve the Idaho Society for Respiratory Care Bylaws.

Recommendation #5
That the AARC Board of Directors Develop a Policy that defines actions that may be taken when a State Affiliate Bylaws are in conflict with the AARC Bylaws and are therefore Not approved or accepted by the AARC Bylaws Committee and the AARC Board of Directors.

Report
The Oregon, Maryland/DC, North Dakota & Idaho Society Bylaws meet the AARC Bylaws Committee and BOD Criteria for Affiliate Bylaws.

AARC Bylaws Tracking online spreadsheet has been updated.

The AARC Bylaws Committee has reviewed and assessed the AARC Bylaws and the implications & appropriate potential actions when a State Affiliate''s Bylaws are in conflict with and thereby NOT approved by the AARC Bylaws Committee or AARC Board of Directors. The AARC Bylaws Committee has consulted legal counsel. The AARC Bylaws Committee has sought and received input from the state chartered affiliates via the House of Delegates and offers the following for consideration:

If a Chartered Affiliate's Bylaws are in Conflict with the AARC's Bylaws:

1: The AARC Board of Directors Notifies the Affiliate of the specific conflict & requests a written response from the Affiliate.

2. The AARC BOD Considers Sanctions, beginning with a probationary period of six months to one year and notifies the Affiliate in writing.

3. The Affiliate''s AARC Revenue sharing may be reduced or withheld after the probationary period has expired.

4. If Non AARC Members are allowed to elect the Affiliates'' Delegates, those Delegates will not be seated in the AARC House of Delegates after expiration of the probationary period.

5. The AARC BOD may implement and or impose other sanctions as it deems appropriate, up to and including revocation of the Affiliate Charter.

Other

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 AARC are not Active members of the Charted Affiliate.

MDDC_proposed_revised_bylaws_2010.doc
June 3 By Law Change Request MD DC Bylaws letter.doc
ISRC Bylaws.doc
Bylaws update draft 2010.doc

Bylaws update2010 cover letter.doc
ISRC Bylaws1.doc
OSRC Bylaws.doc
MEMO re Oregon bylaws.doc

MEMO
7/6/2010
To: AARC Bylaws Committee
From: Linda Tier RRT
Oregon Delegate

Oregon has a few changes to our bylaws that we would like you to review. The primary changes are listed under the audit committee description of duties, where we would like to use an outside auditor to review our annual financial records. This is in keeping with the recommendation in the Affiliate handbook Secondly, we would like the option to move away from a mailed ballot for elections and membership approval. We would like the option to use our website, or a survey monkey type program for this function.

We have been notified that our bylaws are due for review by September 1st, so hopefully this will kill two birds with one stone !

If you have any questions, please don't hesitate to call me.

Linda Tier RRT
503 551-1547
ljtier@yahoo.com

OREGON BYLAWS

ARTICLE I-NAME

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

ARTICLE II-BOUNDARIES

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

ARTICLE III-OBJECT

SECTION 1. PURPOSE

The Society is formed to:

a. Encourage, develop, and provide educational programs for those persons interested in respiratory therapy and diagnostics, hereinafter referred to as Respiratory Care.

b. Advance the science, technology, ethics and art of respiratory care through institutes, meetings, lectures, publications, and other materials.

c. Facilitate cooperation and understanding among respiratory care personnel and the medical profession, allied health professions, hospitals, service companies, industry, government organizations, and other agencies interested in respiratory care.

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

SECTION 2. INTENT

a. No part of the monies of the Society shall inure to the benefit of any private member or individual, nor shall the Society perform particular services for the individual members thereof. b. The Board of Directors shall provide for the distribution of the funds, income, and property of the Society to charitable, educational, scientific, or religious corporations, organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payee or distributee are exempt from income taxation, and if gifts or transfers to the payee or distributee are then exempt from taxation under the provisions of Section 501, 2055, and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.

c. In the event of dissolution of this Society, whether voluntary or involuntary, all of it~~'~~s remaining assets shall be distributed in such manner as the Board of Directors of this Society shall by majority vote determine to be best calculated to carry out the objectives and purposes for which this Society is formed. The distribution of funds, income, and property of this Society upon dissolution may be made available to any similar charitable, educational, scientific, or religious corporations, organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payee or distributee ~~are~~ is then exempt from income taxation, and if gifts or transfers to the payee or distributee are exempt from taxation under the provisions of Sections 501, 2055, and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.

d. The Society shall not commit any act which shall constitute the unauthorized practice of medicine under the

Laws of the State of Oregon.

ARTICLE IV-MEMBERSHIP

SECTION 1. CLASSES

The membership classes of the Society shall be the same as the membership classes as specified in the AARC Bylaws.

SECTION 2. PREREQUISITES

Individuals are eligible to be members in this Society if they are members of the AARC as specified in the AARC Bylaws and provided their place of employment is within the defined boundaries of the Society.

SECTION 3. APPLICATION FOR MEMBERSHIP

Application for membership in the Society shall follow the procedure specified in the AARC Bylaws.

SECTION 4. ETHICS

If the conduct of any member shall appear to be in violation of the Articles of Incorporation Bylaws, standing rules, code of ethics, or other regulations, policies, or procedures adopted by the Society, or shall appear to be prejudicial to the Society's interests, a written report will be referred to the AARC Judicial Committee as specified in the AARC Bylaws.

ARTICLE V-OFFICERS

SECTION 1. OFFICERS

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

SECTION 2. TERM OF OFFICE

a. The term of office for officers shall be one (1) year except for Vice-President and Treasurer. The term shall begin immediately following the annual business meeting except for the Treasurer.

b. The Vice President, Secretary and Treasurer shall not serve more than two (2) consecutive terms in the same office.

c. The President-Elect shall complete immediate successive full one (1) year terms for the offices of President-Elect, President and Immediate Past President

d. The President-Elect, President and Immediate Past President are not limited to the number of terms they may serve in the same office.

e. The Vice President and Treasurer term of office shall be two (2) years. The Treasurer term of office shall begin with the fiscal year.

SECTION 3. VACANCIES IN OFFICE

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

b. In the event of a vacancy in the office of President Elect, the Vice President shall assume the duties, but not the office, of the President-elect and shall continue to serve as Vice President until the next scheduled election.

c. Any vacancy in the office of Vice President, Secretary, or Treasurer shall be filled by appointment of a qualified individual by the Board of Directors. Individuals so appointed shall serve until the next scheduled election.

d. In the event of a vacancy in the office of Immediate Past President, that office shall remain vacant and the duties shall be assigned by the President.

SECTION 4. DUTIES OF OFFICERS

a. President - The President shall be the Chief Executive Officer of the Society. The President shall: Preside at the Annual Business Meeting and all meetings of the Board of Directors; prepare an agenda for the Annual Business Meeting and submit it to the membership not fewer than thirty (30) calendar days prior to such a meeting in accordance with Article VII of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than thirty (30) calendar days prior to such a meeting; appoint standing and special committees subject to approval of the Board of Directors; be ex officio member of all committees except the Election and Nominating Committees;

and present to the Board of Directors and membership an annual report of the Society. The President or designee shall chair the Budget Committee. At the expense of the society, the President shall be bonded in an amount determined by the Board of Directors.

b. President-Elect - The President-Elect shall become the Acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability, and shall perform other such duties as shall be assigned by the President or Board of Directors. The President-Elect or designee shall chair the Publications Committee.

c. Vice President - The Vice President shall perform such duties as shall be assigned by the President and the Board of Directors. The Vice President shall assume the duties of the President-Elect in the event of the President-Elect's absence, resignation, or disability, but will continue to carry out the duties of the office of Vice President. The Vice President or designee shall chair the Program Committee.

d. Treasurer - The Treasurer shall have charge of all funds and securities of the Society, endorsing checks, notes, or other orders for the payment of bills and distributing funds in accordance with approved budget and depositing funds as the Board of Directors may designate. The Treasurer shall see that full and accurate accounts are kept; complete monthly trial balance within twenty (20) calendar days after the monthly closing of the books; make a

written quarterly financial report to the Board of Directors and complete and submit a yearly written report to the Board of Directors, which includes projections of cash flow, status of investments and availability of funds in accordance with the Society's investment policy and procedure. The Treasurer will coordinate and complete, with the society's CPA consultant, the state and federal tax filing requirements. The Treasurer shall maintain, at the Society's expense, professional liability insurance for the Board of Directors in an amount determined by the Board of Directors. At the expense of the Society, the Treasurer shall be bonded in an amount determined by the Board of Directors.

e. Secretary - The Secretary shall have charge of keeping the minutes of the Board of Directors' meetings and the Annual Business Meeting; executing the general correspondence; attesting to the signature of the officers of the Society; affixing the corporate seal to documents so requiring; and, in general, performing all duties as from time to time shall be assigned by the President or the Board of Directors. The Secretary or designee shall maintain and distribute the Society's letterhead stationary and template.

f. Immediate Past President - The Immediate Past President shall advise and consult with the President and shall perform such other duties as shall be assigned by the President or the Board of Directors. The Immediate Past-President shall chair the Nomination and Election Committee.

SECTION 5. EXECUTIVE COMMITTEE

a. The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Vice President, Secretary, Treasurer, and the Immediate Past-President.

b. The Executive Committee shall have the power to act for the Board of Directors between meetings of the Board and such action shall be subject to ratification by the Board at it's next meeting.

ARTICLE VI-BOARD OF DIRECTORS

SECTION 1. COMPOSITION AND POWERS

a. The executive government of this Society shall be vested in a Board of fourteen (14) Active Members consisting of the six Officers, six (6) Regional Directors: Central(2)**,** Eastern, Northern (2), Southern, and two (2) Delegates. The Delegates shall serve as voting members of the Board.

b. The President shall be the Chair and Presiding Officer of the Board of Directors and Executive Committee. The President shall invite in writing such individuals to the meetings of the Board as deemed necessary, who shall have the privilege of voice but not of vote.

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

SECTION 2. TERM OF OFFICE FOR REGIONAL DIRECTORS

a. The term of office is three (3) years and shall begin immediately following the annual business meeting. The term of office shall be staggered so that no more than two (2) Regional Directors are elected each calendar year.

b. Regional Directors may serve no more than two (2) consecutive elected terms of office.

SECTION 3. DUTIES

The Board of Directors shall:

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

b. Adopt and rescind standing rules, regulations, policies, and procedures of the Society.

c. Consider and approve the annual budget.

d. Perform such other duties as may be necessary or appropriate for the management of the Society.

SECTION 4. VACANCIES

a. Any vacancy that occurs in the office of Director shall be filled by appointment by the Board of Directors.

b. An appointed Director shall serve until the next scheduled election for that position, or until a successor is elected.

SECTION 5. MEETINGS

a. The Board of Directors shall meet immediately preceding and immediately following the Annual Business Meeting of the Society and shall hold not fewer than four (4) regular and separate meetings during the course of the year.

b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society shall require, or upon written request of the majority of the Board of Directors filed with the President and Secretary of the Society. Teleconference Board Meetings are considered interim in nature and related minutes require ratification by the Board of Directors at its next scheduled meeting.

c. A majority of the voting Board of Directors shall constitute a quorum at any meeting of the Board.

SECTION 6. ~~MAIL~~ VOTE

Whenever, in the judgement of the Board of Directors, it is necessary to present any business to the membership~~,~~ prior to the next Annual Business Meeting, the Board of Directors may, unless otherwise required by these Bylaws, instruct the Election Committee to conduct a vote of the Membership. ~~by mail~~. Such votes require approval of a majority of the valid votes received within thirty (30) calendar days after date of such submission to the membership. The result of the vote shall control the action of the Society.

ARTICLE VII-ANNUAL BUSINESS MEETING

SECTION 1. DATE AND PLACE

a. The Society shall hold an Annual Business Meeting in the first quarter of each calendar year; additional meetings may be held as required to fulfill the objectives of the Society.

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

SECTION 2. PURPOSE

a. The Annual Business Meeting shall be for the purpose of receiving reports of officers and committees, the results of the election, and for other business brought by the President.

b. Additional business meetings shall be for the purpose of receiving reports and for other business brought by the President.

SECTION 3. NOTIFICATION

Written notice of the time and place of the Annual Business Meeting shall be sent to all members of the Society not less than ninety (90) calendar days prior to the meeting. An agenda for the Annual Business Meeting shall be sent to all members not fewer than thirty (30) calendar days prior to the Annual Business Meeting.

ARTICLE VIII-SOCIETY DELEGATES TO THE AARC HOUSE OF DELEGATES

SECTION 1. ELECTION

Delegates of this Society to the House of Delegates of the AARC shall be elected as specified in Article VII, Section 5 of the AARC Bylaws. In addition, qualified candidates for the office of Delegate must have held an elected office or committee chairmanship within the past two years.

SECTION 2. DUTIES

The duties of the delegates shall be as specified in the AARC Bylaws and as stipulated in the Society job description.

SECTION 3. TERM OF OFFICE

The term of office for the Delegates shall be for four (4) years. The term of the Delegates shall be staggered so that a Delegate is elected every two years.

SECTION 4. BOARD OF DIRECTORS MEMBER

The Delegates shall be voting members of the Board of Directors.

ARTICLE IX-COMMITTEES

SECTION 1. STANDING COMMITTEES

a. The standing committees of the Society shall be: Audit, Budget, Bylaws, Education, Nomination and Election, Membership, Program, Publications, and Public Awareness. With the exception of Audit, Budget, Bylaws, Nomination and Election, Program and Publications, the chair of standing committees shall be appointed by the President subject to the approval of the Board of Directors. The Committee Chair terms are two (2) years with the exception of the Budget, Nomination and Election, and Publications Committees.

b. Decisions of standing committees may be appealed to the Board of Directors. A two-thirds (2/3) vote of the Board of Directors shall be required to sustain an appeal.

SECTION 2. SPECIAL COMMITTEES AND OTHER APPOINTMENTS

a. Special committees, sections, liaisons, and coordinators may be appointed by the President, subject to the approval of the Board of Directors.

b. Representatives of the Society to such external organizations as may be required shall be appointed by the President, with the approval of the Board of Directors.

SECTION 3. COMPOSITION AND DUTIES OF COMMITTEES

a. Audit Committee

1. The committee is responsible for the auditing of the financial affairs of the Society; and ensuring that no category of the budget is exceeded without the consent of the committee, and a two thirds (2/3) approval of the Board of Directors. t~~and prompt notification and explanation of such actions to the membership.~~ **With the assistance of the Treasurer, a year end audit of all chartered affiliate financial records will be performed by a CPA or private public accountant.**

2.Each Regional Director will appoint one (1) member to this committee.

3.The most recently elected Delegate shall serve as committee chair.

b. Budget Committee

1. The committee shall consist of the Executive Committee of the Board of Directors.

2. The committee shall submit a proposed annual budget to the Board of Director at the second Board of Directors meeting of the year.

3. The committee shall submit all reports to the Board of Directors.

4. The President or designee shall serve as chair of the committee.

c. Education Committee

1. The committee shall include at least one (1) member from each region of the Society. 2. The committee shall concern itself with continuing education programs and special education projects, as directed by the President.

d. Nomination and Election Committee

1. This committee shall consist of not fewer than three (3) Active Members.

2. The committee shall present a slate of nominees to the Board of Directors at the third Board of Directors meeting of the year. The final slate of nominees shall be approved by the Board of Directors before submission to the general membership.

3. The committee shall check and validate the eligibility of each nominee.

4. The committee shall prepare, ~~distribute, receive,~~ and verify all ballots. Provisions shall be made for write in votes for each position to be filled. ~~Ballots shall be returned enclosed in special envelopes provided~~. The deadline shall be clearly ~~indicated on the ballot~~. **communicated to the membership.**

5. The committee shall tally the votes within ten (10) days after the close of the election and report the results of the election at the fourth Board of Director meeting of the year.

6.The Immediate Past President shall serve as chair of the committee.

e. Membership Committee

1. The committee shall include the Regional Directors.

2. The committee shall submit an annual membership plan to the Board of Directors prior to the second Board of Directors meeting of the year. The plan shall include an annual membership drive and other recruitment activities.

3. The committee shall submit a membership status report to the Board of Directors at each Board Meeting.

4. The committee is responsible for membership recruitment activities and related materials at all Society sponsored events.

f. Program Committee

1. The committee shall consist of at least three (3) active members.

2. The committee shall prepare the program for the annual meeting of the Society.

3. The Vice President or designee shall serve as chair of the committee.

g. Public Awareness Committee

1. The committee shall consist of at least two (2) members of the Society.

2. The committee shall concern itself with dissemination of information regarding respiratory health issues.

h. Publications Committee

1. This committee will include the Webmaster, the newsletter editor and publishing staff.

2. This committee is responsible for the Society web page and publications.

3. The President-Elect or designee shall serve as chair of the committee.

i. Bylaws Committee

1. This Committee shall consist of at least four (4) society members, one of whom shall be a member of the Executive Committee. The more senior Delegate shall chair this committee.

2. This Committee shall receive and prepare all proposed amendments to the Bylaws for submission to the Board of Directors and the AARC Bylaws Committee. Proposed Bylaws amendments may be

initiated by members of the Society and the BOD of the Society. The Committee may also initiate such amendments for submission to the Board of Directors and the AARC Bylaw Committee representative.

3. Upon approval of the the AARC Bylaws Committee and the AARC Board of Directors the Committee shall prepare ~~and distribute~~ ~~by mail~~ the proposed Amendments to the Society membership for a vote ; for the changes to be approved there must be a 2/3 affirmative vote. ~~of those ballots.~~ ~~returned.~~

4. This Committee shall perform such other pertinent duties to meet the objective of the Society as may be assigned by the President or the Board of Directors.

SECTION 4. COMMITTEE CHAIR DUTIES

a. The chair shall perform those duties specified by the President and the Board of Directors to carry out the objectives of the Society.

b. The chair of each committee shall confer promptly with the members of that committee on work assignments.

c. The chair of each committee may recommend prospective committee members to the President. When possible, the previous chair shall serve as a member of the new committee.

d. All committee reports shall be submitted, in writing, to the Secretary prior to or during the Board of Directors meetings.

e. Members of any membership class, as well as non- members, may be appointed as consultants to committees. The President shall request recommendations regarding physician consultants from the Society Medical Advisor(s).

f. The chair is responsible to submit the committee budget to the Budget Committee as designated by the Treasurer prior to the second Board of Directors meeting of the year.

SECTION 5. VACANCIES ON COMMITTEES

In the event of vacancies occurring in any committee, the President may appoint members to fill such vacancies, subject to the approval of the Board of Directors.

ARTICLE X-AFFILIATION

The Society shall be affiliated with the AARC and shall abide by the rules and regulations of the AARC as promulgated.

ARTICLE XI-MEDICAL ADVISOR

SECTION 1. MEDICAL ADVISOR

The Society shall have at least one (1) Medical Advisor who: Is a licensed physician within the State of Oregon, will conform to the AARC/OSRC bylaws; has a defined, active role in respiratory care and is an Associate Member of the AARC (with his or her membership dues to be paid by the Society). The candidate will preferably be affiliated with the local chapter of the ASA, ACCP, ATS or SCCM.

SECTION 2. SELECTION

Medical Advisor candidates must be recommended by an active member of the Society. The Medical Advisor will be appointed by the Board of Directors. Continued status as Medical Advisor will be reviewed annually by the Board of Directors.

SECTION 3. DUTIES

a. The Medical Advisor shall serve as ex-officio member of all committees except for the Nomination and Election committee.

b. The Medical Advisor shall promote increasing clinical competency through support of educational activities, legal credentialing and professional credentialing activities.

c. The Medical Advisor shall serve as a communication link between the Society and the state medical societies.

d. The Medical Advisor shall serve as a resource person for educational programs.

e. The Medical Advisor should attend the annual meeting to address the membership.

f. The Medical Advisor is encouraged to submit a clinical or scientific article for publication in the society newsletter once per year.

ARTICLE XII-FISCAL YEAR

The Fiscal Year of the Society shall be from April 1 through March 31.

ARTICLE XIII-PARLIAMENTARY PROCEDURE

The rules contained in the most recent edition of "Robert's Rules of Order" shall govern whenever they are not in conflict with the Articles of Incorporation, Bylaws, Standing Rules, or other rules of the Society.

ARTICLE XIV-BYLAWS INTERPRETATION

In the event of a problem with the interpretation of the Bylaws, the question shall be referred to the Bylaws committee by the Board of Directors after a 2/3 majority vote in the affirmative. The decision of the Bylaws committee shall be final.

ARTICLE XV-AMENDMENTS

These Bylaws may be amended as specified in these Bylaws Article IX section 3. i.

June 7, 2010
Bill Lamb, BS, RRT, CPFT, FAARC
2010 Chair AARC Bylaws Committee
AARC Executive Office
9425 N. MacArthur Blvd, Suite 100
Irving, Tx 75063-4706

Dear Mr. Lamb,

The purpose of this letter is to request a change in the MDDC Society's Bylaws. This change is to extend the term of the office the President to 2 years and to conduct the election for the office of the President Elect every other year to coincide with the President's second year of his/her term. The term of office for the President Elect and the Past President would remain at 1 year. The purpose for this change is to provide the society with more continuity of service to its members and to its community of interests.

Attached, you can find the proposed change and a copy of the by-laws of the society for your review. Please contact me if you have any questions or concerns. Thank you for your time and consideration of this matter.

Sincerely,

Virginia

Virginia Forster, MA, RRT
Treasure and Chair By Laws Committee
MDDC Society for Respiratory Care
vforster@ccbcmd.edu
443-840-1798

Maryland/DC Bylaws

MD/DC SOCEITY BYLAWS-HYPERLINK *INDEX* TO ARTICLES & SECTIONS

BYLAWS OF THE MARYLAND - DISTRICT OF COLUMBIA SOCIETY FOR RESPIRATORY CARE
AS ADOPTED APRIL 1976
AND AMENDED APRIL 11, 1986
AND AMENDED APRIL 1990
AND AMENDED MAY 1996
AND AMENDED JANUARY 2005
AND AMENDED DECEMBER 2007

ARTICLE I – NAME

This organization shall be known as the Maryland -District of Columbia Society for Respiratory Care incorporated under the General Not - For - Profit Corporation Act of the State of Maryland, hereafter referred to as the Society.

ARTICLE II - AFFILIATION

The Society shall be chartered affiliate of the American Association for Respiratory Care, hereafter referred to as the Association, and shall abide by the rules and regulations of the Association as promulgated from time to time.

ARTICLE III - BOUNDARIES

The area included within the boundaries of this Society shall be the boundaries of the State of Maryland and the District of Columbia.

ARTICLE IV - OBJECT

SECTION 1. PURPOSE

The Society is formed to:

A. Encourage, develop, and provide on a regional basis educational programs for those persons interested in respiratory therapy and diagnostics, hereafter referred to as Respiratory Care.
B. Advance the science, technology, ethics, and art of respiratory care through institutes, meetings, lectures, publications, and other materials.
C. Facilitate cooperation and understanding among respiratory care personnel and the medical profession, other allied health professions, hospitals, service companies, industry, governmental organizations, and other agencies interested in respiratory care.
D. Provide education of the general public in pulmonary health promotion and disease prevention.

SECTION 2. INTENT

A. No part of the monies of the Society shall inure to the benefit of any private member or individual, nor shall the Society perform particular services for individual members thereof.
B. The Board of Directors shall provide for the distributions of the funds, income, and property of the Society to charitable, educational, scientific, or religious corporations organizations, community chest foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes if at the time of distribution the payees or distributees are then exempt from taxation under the provisions of the Internal Revenue Services

C. In the event of the dissolution of the Society, whether voluntary or involuntary, all of its remaining assets shall be distributed in such manner as the Board of Directors of this Society shall by majority vote determine to be best calculated to carry out the objectives and purposes for which the Society is formed. The distribution of funds, income, and property of this Society upon dissolution may be made available to any similar charitable, educational, scientific, or religious foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes if at the time of distribution the payees or distributees are then exempt from taxation under the provisions of the Internal Revenue Code.
D.The Society shall not commit any act which shall constitute the unauthorized practice of medicine under the laws of the State of Maryland or the District of Columbia.

ARTICLE V - MEMBERSHIP

SECTION 1. Classes

Section 1. -**CLASSES**

The Membership of this Society shall include three (3) classes: Active Member, Associate Member, and Special Member.

Section 2. -**ELIGIBILITY**

a. Membership eligibility shall be considered without regard to race, religion, ethnic origin, national origin, age, or sex.

b. **Active Members** in good standing of the Society shall be Active members in good standing of the AARC and shall be entitled to all the rights and privileges of membership of the Society including the right to hold office, hold committee chairs, and vote.

c. **Associate Members** in good standing of the Society shall be Associate Members in good standing of the AARC and

shall be entitled to all the rights and privileges of membership of the Society except that they shall not be entitled to hold office, vote, or serve as chair of any standing committee of the Society. Associate Members will be designated to a sub-class of Associate Membership (Foreign, Physician, and Industrial) corresponding to their AARC membership classification.

D. **Student Members** shall be individuals who are enrolled in an educational program in respiratory care accredited by, or in the process of seeking accreditation from, an AARC-recognized

agency. They shall be entitled to all the rights and privileges of membership of the Society except that they shall not be entitled to hold office, vote, or serve as chair of any standing committee of the Society.

E. **General Members** shall be individuals who have an interest in respiratory care and who do not qualify for other membership classifications. General Members shall have all the rights and privileges of membership of the Society except that they shall not be entitled to hold office, hold committee chairs, or vote.

f. **Special member:**

1. **Life Members** shall be members who have rendered outstanding service to the Society as Active Members. This sub-classification of Special Membership may be conferred by a majority vote of the AARC Board of Directors. Life Members shall be entitled to all the rights and privileges of membership of the Society including the right to hold office, hold committee chairs, and vote. Life members shall be exempt from the payment of dues.
2. **Honorary Members** shall be persons who have rendered distinguished service to the field of respiratory care. This subclassification of Special Membership may be conferred by a majority vote of the AARC Board of Directors, Honorary Members shall have all the rights and privileges of membership of the Society except that they shall not be entitled to hold office, hold committee chairs, or vote. Honorary Members shall be exempt from the payment of dues.
3. As a condition of membership, all Members shall be bound by the Bylaws, standing rules, code of ethics, and other rules, regulations, policies, and procedures adopted from time to time by the Society.

SECTION 2. CODE OF ETHICS

If the conduct of any member shall appear to be in violation of the Articles of Incorporation, Bylaws, Standing rules, Code of Ethics, of other regulations, policies or procedures adopted by the Association or the Society, or shall appear to be prejudicial to the interests of the Association or the Society, such member may be reprimanded, suspended, expelled, or have their membership status reclassified in accordance with the procedures set forth in the Association's policies and procedures.

ARTICLE VI - OFFICERS

SECTION 1. OFFICERS

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

SECTION 2. TERMS OF OFFICE

A. The terms of office for President-Elect, President and Immediate Past President shall be one (1) year. The term shall begin immediately following the annual business meeting.

B. The term of office for Treasurer shall be two (2) years. The term shall begin immediately following the annual business meeting.

C. The term of office for Secretary shall be two (2) years. The term shall begin immediately following the annual business meeting.

D. The term for the chapter representatives and the director at large will be two years. The term shall begin immediately following the annual business meeting.

E. The President-elect shall complete immediate successive terms for the office of President-elect, President and Immediate Past President before being eligible to serve a successive term in any elected office, except the Past President may serve as Delegate.

SECTION 3. VACANCY IN OFFICE

A. In the event of a vacancy in the office of President, the President-Elect shall become Acting President to serve the unexpired term and shall serve his own, the successive term as President.

B. In the event of a vacancy in the office of the President Elect, the Past President shall assume the duties, but not the office of the President Elect as well as his own until the Active and Life Menbership elects a qualified individual. Individuals so elected shall serve term as President and Past President.

C. Any vacancy in the office of, Secretary, or Treasurer, shall be filled by the election of a qualified individual by the Board of Directors. Individuals so appointed shall serve until the next scheduled election.

D. In the event of a vacancy in the office of Immediate Past President, the position shall remain vacant.

SECTION 4. DUTIES OF OFFICERS

A. **President** - The President shall be the Chief Executive Officer of the Society. He/She shall establish the goals and objectives of the Society, preside at the Annual Business Meeting and all meetings of the Board of Directors; prepare an agenda for the Annual Business Meeting and submit it to the membership not fewer than
(30) calendar days prior to such meeting in accordance with Article VIII, Section 3, of these Bylaws, prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) days prior to such meeting, appoint standing and special committees; assure that the annual external audit is performed, be an ex officio member of all committees except the Election and Nominating Committees, and present to the Board of Directors and membership an annual report of the Society. It shall be the final responsibility of the President to see that all reports are submitted and the Association requirements are met by the Officers and Board of Directors, subject to the approval of the Board of Directors.

B. **President-Elect** - The President-Elect shall become Acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability, shall be an ex officio member of all committees except the Election and Nominating committees, and shall perform such other duties as assigned by the President or the Board of Directors.

C. **Treasurer -** The Treasurer shall have charge of all funds and securities of the Society, endorsing checks, notes, or other orders for the payment of bills, disbursing funds in accordance with the approved budget, and depositing funds as the Board of Directors may designate. He/She shall see that full and accurate accounts are kept, make a written quarterly financial report to the Board of Directors, and make a complete written yearly report at the Annual Business Meeting. At the expense of the Society, he shall be bonded in an amount determined by the Board of Directors for the Entire (2) year term of office.

D. Secretary -The Secretary shall have charge of keeping the minutes of Board of Directors meetings and the Annual Business Meeting, shall submit all forms and reports to the Association Director of Membership Series as may be requested or required in a timely fashion. He/she shall execute the general correspondence; attest to the signature of the officers of the Society; and, in general, perform all the duties as from time to time shall assigned by the President or the Board of Directors.

C. **Past President –** The Past President shall perform such duties as assigned by the President or Board of Directors.

SECTION 5. EXECUTIVE COMMITTEE

A. The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Secretary, Treasurer, Immediate Past President, and Medical Advisor as a non voting member.

B. The Executive Committee shall have the power to act for the Board of Directors between meetings of the Board and such action shall be subject to ratification by the Board at its next meeting.

C. The Executive Committee shall function as the Budget Committee.

SECTION 6. ELECTION

A. The officers shall be elected by the active membership of the Society prior to the annual business meeting of the Society.

B. Only active members in good standing shall be eligible to hold office.

ARTICLE VII -BOARD OF DIRECTORS

SECTION 1. COMPOSITION AND POWERS

A. The Executive Government of the Society shall be Vested in active members consisting of the Officers, (1) Director At Large, (2) Delegation Members and (5) Chapter Representatives.

B. The President shall be Chairman and Presiding Officer of the Board of Directors and the Executive Committee. He shall invite such individuals to the meetings of the Board as he shall deem necessary, which shall have the privilege of voice but not vote.

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

B. The President shall be Chairperson and Presiding Officer of the Board of Directors and the Executive Committee. He/She shall invite such individuals to the meetings of the Board as he shall deem necessary, they shall have the privilege of voice but not vote.

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

SECTION 2. TERMS OF OFFICE

A. The term of office for Directors-at-Large shall begin immediately following the Annual Business Meeting and shall be for two (2) years.
B. No Director-at-Large shall serve more than two (2) consecutive terms.

SECTION 3. DUTIES

The Board of Directors shall:

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

B. Adopt and rescind standing rules, regulations, policies, and procedures of the Society.

C. Grant chapter status and have the power to revoke chapter status.

D. Perform such other duties as may be necessary or appropriate for the management of the Society.

E. Accept the slate of officers presented by the Nominations Committee no fewer than 90 (ninety) days prior to the Society's Annual Meeting.

F. Govern the activities of an Executive Director should the majority of the Board vote on the need to retain one.

SECTION 4. VACANCIES

A. Any vacancies that occur in the office of Director-at-Large shall be filled by appointment by the Board of Directors.
B. An appointed Director-at-Large shall serve until the next scheduled election, or until his successor is elected.

SECTION 5. MEETINGS

A. The Board of Directors shall hold its first Board meeting within five (5) Business days following Annual Installation Dinner and shall hold a minimum of 4 regularly scheduled meetings during the year.

B. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society may dictate.
C. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

D. Meetings of the Board of Directors may be in person, by telephone or video conferencing or other electronic means as shall be determined by the Board of Directors.

SECTION 6. MAIL VOTE

Whenever, in the judgement of the Board of Directors, it is necessary to present any business to the membership, prior to the next Annual Business Meeting, the Board of the Directors may, unless otherwise required by these Bylaws, instruct the Election Committee to conduct a vote of the membership by mail. Such votes shall require approval of a majority of the valid votes received within thirty (30) days after date of submission to the membership. The result of the vote shall control the action of the Society.

SECTION 7. MULTIPLE OFFICES

With the expectation of the President & Past President who may serve as a Delegate, no Officer, Director-at-Large, or Delegate shall hold Chapter Office simultaneously.

SECTION 8. ELECTION

A. The members of the Board of Directors shall be elected by the active membership of the Society prior to the Annual Business Meeting of the Society.
B. Only active members in good standing shall be eligible to hold office.

ARTICLE VIII - ANNUAL BUSINESS MEETING

SECTION 1. DATE AND PLACE

A. The Society shall hold an Annual Business Meeting at the beginning of each Calendar year.
B. The date and place of the Annual Business Meeting and additional meetings shall be decided in advance by the Board of Directors. The Board of Directors may cancel the scheduled meeting, set a new date and place if feasible or conduct the business of the meeting by mail provided the material is sent in the same words to the membership.

SECTION 2. PURPOSE

The Annual Business Meeting shall be for the purpose of receiving reports of officers and committees, the results of the elections, and for other business brought by the President.

SECTION 3. NOTIFICATION

Written notice of the time and place of the Annual Business Meeting shall be sent to all members of the Society not less than five (5) or more than sixty (60) calendar days prior to the meeting. An agenda for the annual business meeting shall be sent to all members not fewer than fifteen (15) calendar days prior to the Annual Business Meeting.

SECTION 4. QUORUM

The Majority of (7) voting members present shall constitute a quorum at any duly called business meeting.

ARTICLE IX - REPRESENTATION IN THE ASSOCIATION HOUSE OF DELEGATES

SECTION 1. PURPOSE

1. The Delegates, hereinafter referred to as the Delegation, shall serve as representatives of the general membership of the Society through the direction of the Board of Directors.
2. The president of the society will be seated as a third member of the delegation.

SECTION 2. DUTIES

A. The Delegation shall:

1. Attend all meetings of the House of Delegates, vote as directed by the Board of Directors and report the activities to the Board of Directors and the general membership.
2. Attend the Annual Business Meeting of the Association as the representative of the Active Members of the Society.
3. Furnish the Association Nominating Committee with the names of qualified Active Members for nomination to office.
4. At the direction of the Board of Directors, present proposed amendments to the Association Bylaws Committee.
5. Perform such other duties of the office as may be required.

SECTION 3. ELECTION

A. A Delegate shall be elected by the Active Members of the Society not fewer than ninety (90) calendar days prior to the Annual Business Meeting of the Association.

B. Only Active Members in good standing of the Society and who are not on the AARC Board of Directors shall be eligible to be elected as a Delegate.

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

D. In the event of a vacancy in the position of a delegate, the board of director's shall wait to the next scheduled election to replace the vacant delegate position. The president, being a seated member of the delegation will fulfill the delegate duties until the next scheduled election.

SECTION 4. TERM OF OFFICE

A. The term of office of an elected Delegate shall be four (4) years, with the exception of the president who serves as the third delegate and whose term is defined by these bylaws. The delegate term shall begin immediately following the Annual Business Meeting.

B. No person shall serve in the House of Delegates for more than 2 consecutive terms, or eight (8) years.

ARTICLE X - COMMITTEES

SECTION 1. STANDING COMMITTEES

The standing Committee of the Society shall be: Budget, Bylaws, Education, Election, Membership, Nominating, Public Relations, Publications, and Symposium. With the exception of the Budget Committee, the Chairpersons and members of Standing Committees shall be appointed by the President, subject to the approval of the Board of Directors. Committee terms shall be one (1) year.

SECTION 2. COMPOSITION AND DUTIES OF COMMITTEES

A. Budget Committee

1 The Committee shall be composed of the Executive Committee of the Board of Directors, with the President serving as Chairperson.
2 The Committee shall propose an annual budget to the Board of Directors.

3. The Committee shall review all written external auditors reports and report to the Board of Directors.

B. Bylaws Committee

1 The Committee shall consist of the Immediate Past President and three (3) additional Active Members.
2 Proposed amendments to the Bylaws may be submitted by any Active Member through the Board of Directors, to the Committee. The Committee shall review the proposed amendments and shall submit their recommendations to the Board of Directors at least sixty (60) calendar days prior to the meeting in which they are to be reviewed. Upon receipt of such recommendations, the Board of Directors may, but shall not be obligated to, withdraw the proposed amendments from further consideration. Such amendments must receive an affirmative vote of two-thirds (2/3) of the Board of Directors before being sent to the Association Board of Directors and then to the membership.

C. Education

1 The Committee shall consist of one (1) Active Member from each Chapter.
2 The Committee shall concern itself with continuing education programs, special education programs, and other projects as directed by the President or the Board of Directors.

D. Election Committee

1. The Committee shall consist of one (1) Active Member from each Chapter.
2. The committee shall prepare, distribute, receive, and verify all ballots. At least sixty (60) calendar days prior to the Annual Business Meeting, the Committee shall mail a ballot setting forth the slate of nominees to each Active Member in good standing, at the last address on record with the Society. Ballots shall be returned enclosed in the special envelopes provided to the Chairperson of the Election Committee, and must be postmarked at least ten
(10) calendar days prior to the Annual Business Meeting. The deadline date shall be clearly indicated on the ballot.
3. Elections shall be determined by a plurality of the vote cast. A tie vote shall be decided by lot.

E. Membership Committee

1 The Committee shall consist of at least three (3) Members.

2 The Committee shall review and evaluate membership services and benefits.

3 The Committee shall be responsible for the recruitment and retention of members.

F. Nominating Committee

1 The Committee shall consist of one (1) Active Member from each Chapter.
2 The Committee shall attempt to place in nomination at least two (2) Active Members who have been recommended by the Board of Directors or the general Membership for each of the offices of President-Elect, , Secretary, Treasurer, Director-at-Large, Delegate, and for each office of Chapter Representative.

3. The Chairperson of the Committee shall report the slate of nominees to the Board of Directors not later than October 15.
4. The Committee shall prepare a pertinent biographical sketch of each nominee's professional services and activities in the Society and Association, which shall be a part of the ballot.

G. Public Relations Committee

1 The Committee shall consist of at least four (4) Members, at least one (1) of which shall be a member of the Board of Directors.
2 The Committee shall concern itself with relations of the Society with the public, hospitals, health care institutions and associations, regulatory agencies, and other organizations, through the dissemination of information concerning respiratory care.

H. Publications Committee

1 The Committee shall consist of at least three (3) Members.
2 The Committee shall concern itself with the production of a newsletter and any other publications as directed by the President or the Board of Directors.

I. Symposium Committee

1 The Committee shall consist of at least four (4) Members, one of which shall be the Chairperson of the Education Committee, one of which shall be the Treasurer.
2 The Committee shall plan and organize the Annual Symposium as directed by the President and the Board of Directors.

SECTION 3. COMMITTEE CHAIR'S DUTIES

A. The Chairperson shall perform those duties specified by the President or the Board of Directors to carry out the objectives of the Society.
B. The Chairperson of each committee shall promptly appoint and confer with the members of his committee on work assignments.
C. The Chairperson shall submit a written quarterly report of Committee activities to the President.
D. Members of any membership class, as well as nonmembers, may be appointed as consultants to a committee.

SECTION 4. SPECIAL COMMITTEES AND OTHER APPOINTMENTS

A. Special committees may be appointed by the President, subject to the approval of the Board of Directors.

B. Representatives of the Society to such external organizations as may be required shall be appointed by the President with the approval of the Board of Directors.

SECTION 5. VACANCIES OF COMMITTEES

In the event of vacancies occurring in any committee with the exception of the Budget and executive, the President may appoint Members to fill such vacancies, subject to the approval of the Board of Directors.

ARTICLE XI - CHAPTER ORGANIZATION

SECTION 1. REQUIREMENTS

A. Ten (10) or more Active Members in good standing of the Society may become a Chapter of the Society.
B. The minimum geographical boundaries of an applicant for chapter status shall encompass entire states, cities, or counties, except that the District of Columbia shall be considered a state for the purpose of this section.

SECTION 2. ADMISSION PROCEDURE

A. The formal application for Chapter status shall be sent to the President and shall consist of a list of officers, membership, and minutes of the organizational meeting.
B. The granting of Chapter status is contingent upon a two-thirds (2/3) affirmative vote of the Board of Directors.

SECTION 3. OFFICERS

A Chapter Representative shall be elected by the Active Members in good membership standing and shall serve for a two (2) year term but no more than three (3) consecutive terms. Other officers shall be elected as circumstances may require.

SECTION 4. DUTIES

A. The Chapters shall provide on a regional basis educational programs and such other activities as is consistent with the purpose of the Society.

B. The Chapter Representative shall serve as a voting member of the Board of Directors and shall represent the interests of the members of the Chapter.

C. The Chapter Representative shall submit a written quarterly report of Chapter activities to the President.

SECTION 5. SUSPENSION OR REVOCATION OF CHAPTER STATUS

The Board of Directors may suspend or revoke Chapter status of any Chapter with due and sufficient cause or upon the failure of a Chapter to maintain a membership of at least ten (10) Active Members in good standing of the Society, upon a two-thirds (2/3) affirmative vote of the Board of Directors.

ARTICLE XII - SOCIETY MEDICAL ADVISOR

A. The Society shall have a least one (1) Medical Advisor who Shall be appointed by the President, approved by the Board of Directors, and approved by the Board of Medical Advisors.
B. The Board of Directors and any Committees may consult With the Medical Advisor in regard to any matter. The Medical Advisor shall assist the appropriate committees Regarding educational programs, publication, and other Matters.
C. The Medical Advisor shall be invited to attend all regular Meetings of the Board of Directors and shall have the

privileges of voice but no vote.

ARTICLE XIII - FISCAL YEAR AND BUDGET

A. The Fiscal Year shall begin on January 1 and end on December 31.
B. The annual budget, proposed by the Budget Committee, shall be approved by the Board of Directors before implementation.

ARTICLE XIV -PARLIAMENTARY PROCEDURE

The rules contained in the most current edition of Robert's Rules or Order shall govern whenever they are not in conflict with the Bylaws of the Society.

ARTICLE XV - AMENDMENT

The Bylaws may be amended in accordance with Article X, Section
2.b.2. The Election Committee shall conduct a mail vote to amend the Bylaws, provided the proposed amendment is sent in the same words to each Active Member in good standing at the last address on record with the Society. Ballots shall be returned enclosed in the special envelopes provided to the Chairman of the Election Committee and must be postmarked on or before the date indicated. Not fewer than sixty (60) calendar days shall be allowed for return of the ballots. A two-thirds (2/3) affirmative vote of the valid ballots returned shall be required for adoption. The Election Committee shall cause the ballots to be tallied and the presiding officer shall declare and announce the result to the membership.

North Dakota Bylaws

August 25, 2010
RE: State Affiliate Bylaws Amendment

Dear AARC Bylaws Committee:

Enclosed are the proposed amendments to our state Society's Bylaws. The last review was completed in 2005. The Bylaws have been amended, primarily, to allow for electronic voting and modification of our standing committees. We would like to change the Legislative, Public Relations, and Sputum Bowl committees from standing committees to ad hoc status as these three committees are not needed on a continuous basis.

For inquiries or other correspondence, please contact:
Angela MacAdams
angela.macadams@sanfordhealth.org
(701) 234-6777

or

Lori Shoman
lori.shoman@sanfordhealth.org
(701) 234-6446

We look forward to working with you during this process. Thank you.

Sincerely,

Angela MacAdams

Bylaws of ~~T~~the North Dakota Society for Respiratory Care

~~January 2007~~ September 2010

Article I:

Name

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

Article II:

Boundaries

The boundary of this Society shall be within the boundary of the State of North Dakota.

Article III:

Object

Section 1. Purpose

a. To encourage and develop educational programs on a regular basis for those persons interested in the practice of Respiratory Care and to provide education to the general public.

b. To advance the science, technology, ethics and art of Respiratory Care through meetings, lectures, and the preparation and distribution of ~~a newsletter~~ **information** and/**or** other materials **as determined by the Board of Directors.**

c. To facilitate cooperation between Respiratory Care personnel and the medical profession, hospitals, service companies, industry, and other agencies within the State interested in Respiratory Care.

Section 2. Intent

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

b. Distribution of funds, income, and property of the Society may be made to charitable, educational, scientific or religious organizations, community chests, foundations or other kindred institutions maintained and created for one or more of the foregoing purposes if, at the time of distribution, the payees or distributees are exempt from income taxation under the provisions of Section 501, 2055, and 2522 of the Internal Revenue Code, or any later or other Sections of the Internal Revenue Code which amends or supersedes the said Sections. The Society may also distribute funds in honor of deceased active members in the form of memorials.

c. This Society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Illinois in which the parent Association is incorporated, or any other State.

Article IV:

Membership

Section 1. Membership

a. The membership of this Society shall be as defined in the AARC bylaws.

b. An individual is eligible to be a member of this Society if he/she is a member of the AARC as specified in the AARC Bylaws.

Section 2. Application for Membership

a. Application for membership in this Society shall follow the procedure specified in the AARC Bylaws.

Article V:

Officers and Directors

Section 1. Officers

a. The officers of the Society shall be: President, President-Elect (who automatically succeeds to the presidency when the President's term ends), Past President, Secretary, and Treasurer.

Section 2. Term of Office

a. The term **of each officer** shall be for two (2) years beginning July 1 of the year following the election. The President and President-Elect shall not serve more than one (1) consecutive term in the same office. The Secretary and Treasurer shall not serve more than two (2) consecutive terms in the same office.

Section 3. Vacancies of Office

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

b. In the event of a vacancy of any office, the Board of Directors shall, at the next meeting of the BOD, appoint a qualified member to fill the vacancy until the next scheduled general election, at which time the Society membership shall elect a new officer to serve the rest of the vacated term. In the event of the vacancy of the Past President, the Board of Directors, at the next meeting, shall elect a previous Past President to fill that vacancy.

Section 4. Duties of Officers

a. President

The President shall be the Chief Executive Officer of the Society. He/she shall preside at the annual business meeting and all meetings of the Board of Directors; prepare an agenda for the annual business meeting and submit it to the membership not fewer than thirty (30) days prior to such a meeting in accordance with Article VIII of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) days prior to such meeting;

appoint standing and special committees subject to the approval of the BOD; be an ex-officio member of all committees; present to the BOD and membership an annual report of the Society activities.

b. President-Elect

The President-Elect shall become acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability, and shall perform such other duties as shall be assigned by the President or the BOD. The President-Elect shall be a member of the Budget/Audit and Bylaws Committee.

c. Treasurer

The Treasurer shall have charge of all funds and securities of the Society; endorsing checks,
notes, or other orders for payment of bills; disbursing funds as authorized by the Board of
Directors and/or in accordance with the adopted budget; depositing funds as the BOD may
designate; and preparing of documents for annual audit and tax return. He/she shall see that full and accurate accounts are kept, submit quarterly reports to the BOD and AARC, and make written reports at all BOD and business meetings of the Society. He/she shall prepare, in conjunction with the Budget and Audit Committee, a proposed budget to be presented at the pre-board and annual business meeting preceding the year it will be in effect.

d. Secretary

The Secretary shall have charge of keeping the minutes of BOD, regular business meetings, and the annual business meeting; submitting a copy of the minutes of every meeting of the governing body and other business of the Society ~~to the Executive Office of AARC within fifteen (15) days following the meeting,~~ **to all members of the BOD within thirty (30) days and, if requested, to the AARC Executive Office** executing the general correspondence; and in general, performing all duties as from time to time shall be assigned by the President or the BOD. The Secretary shall also be responsible for ~~mailing~~ **submitting** the list of NDSRC Officers to the AARC following the annual election.

e. Past-President

The Past-President shall be an active member of the Bylaws Committee. The Past-President will be readily available as a resource to the current President and perform all other duties assigned by the President and the BOD.

Article VI:

Nominations and Elections

Section 1. Nominations and Elections Committee

a. The President shall appoint a Nominations and Elections Committee. It shall be the responsibility of the Nominations and Elections Committee to assure that the individual verifying the eligibility of each ballot, tallying the votes and reporting the results (in writing) to the BOD is not on the ballot.

Section 2. Nominations

a. The Nominations and Elections Committee shall prepare a slate of one (1) or more candidates for each office for approval by the BOD at least thirty (30) days before the scheduled election.

b. Only active members in good standing shall be eligible for nomination.

c. Active members may have their name placed in nomination upon written petition of at least ten (10) active members of the Society. The petition must be filed with the Secretary of the Society at least thirty (30) days before the scheduled election.

Section 3. Ballot

a. ~~The slate and biographical sketches and ballots shall be mailed~~ **The Nominations and Elections Committee shall be responsible for distributing the biographical sketches and ballots** to every active member in good standing and eligible to vote at least fifteen (15) days prior to the scheduled election.

b. The election of officers shall be by mail, **electronic,** ~~vote~~ **or other acceptable form of voting as determined by the Board of Directors** with provisions for write-in for each office. Ballots, to be acceptable, must conform to instructions supplied with the ballot. The deadline date shall be clearly indicated on the ballot.

Section 4. Election Date

a. The date of annual election shall be set by the Board of Directors.

Article VII:

Board of Directors

Section 1. Composition and Powers

a. The executive government of this Society shall be vested in a Board of Directors consisting of President, President-Elect, Secretary, Treasurer, Past President, two **(2)** Delegates and two **(2)** Directors at large.

b. The President shall be the Chairperson and presiding officer of the Board of Directors and the Executive Committee. He/she shall invite non-members/members to the meetings of the Board of Directors, as he/she deems necessary, with the privilege of voice, but not vote.

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

d. Voting members of the Board shall consist of the Officers, Directors at large, and Delegates. The President shall vote only in the presence of a tie vote.

Section 2. Duties

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

b. Adopt and rescind Standing Rules of the Society.

c. Determine enumerations, stipends, and other related matters, after consideration of the budget.

Section 3. Meetings

a. The Board of Directors shall meet immediately preceding and immediately following the annual business meeting of the Society and shall not hold less than one other regular and separate meeting during the calendar year.

b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society shall require, upon written request of four (4) members of the Board of Directors filed with the President and Secretary of the Society or upon phone request of four (4) members of the Board of Directors via phone conference with the President and Secretary.

c. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

Section 4. ~~Mail Vote~~ **Voting**

a. Whenever, in the judgment of the Board of Directors, it is necessary to present any business to the membership prior to the next regular or annual business meeting, the Board of Directors may, unless otherwise required by these Bylaws, instruct the Nominations/Elections Committee to conduct a vote of the membership by mail, **electronic, or other acceptable form of voting as determined by the Board of Directors.** The questions thus presented shall be determined according to a simple majority of the valid votes received ~~post-marked~~ prior to established voting deadline, except in the case of a constitutional amendment change in the Bylaws when a two-thirds (2/3) majority of the valid votes received is required. Any and all action shall be binding upon each member thereof. Any amendment to the Bylaws of this Society shall be presented to the membership at least fifteen (15) days prior to a ~~mail~~ vote, as provided in Article XVII of these Bylaws concerning amendments.

Section 5. Executive Committee

a. The Executive Committee of the Board of Directors shall consist of the President, President-Elect, immediate Past-President, Secretary and Treasurer. They shall have the power to act for the Board of Directors between meetings of the Board of Directors and such action shall be subject to ratification by the Board at its next meeting.

Section 6. Multiple Offices

a. No two (2) offices may be held simultaneously.

Article VIII:

Annual Business Meeting

Section 1. Date and Place

a. The Society shall hold an annual business meeting. Additional meetings may be held as required to fulfill the objectives of the Society whenever called by the President or petitioned by at least five percent (5%) of the voting members.

b. The date and place of the annual business meeting and additional meetings shall be decided in advance by the Board of Directors. In the event of a major emergency, the President may cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by mail**, phone, or other means**. (According to Article VII, Section 4 of these Bylaws).

Section 2. Purpose

a. The annual business meeting shall be for the purpose of receiving the annual reports of officers and committees and for other business brought by the membership and the Board of Directors.

b. Additional business meetings shall be called as deemed appropriate by the President or voting membership in accordance with Article VIII, Section 1, Part A.

Section 3. Notification

a. ~~Written notice~~ **Notification** of the time and place of the annual business meeting and agenda shall be ~~sent~~ **available** to all members of the Society not fewer than thirty (30) days prior to the meeting.

Section 4. Quorum

a. A majority of voting members registered at a duly called business meeting shall constitute a quorum.

Article IX:

Society Delegates to the American Association for Respiratory Care (AARC) and House of Delegates (HOD)

Section 1. Term of Office

a. Delegates to the AARC shall be elected by the membership for a four (4) year term of office with the exception of Article IX, Section 3. No person may serve more than eight (8) consecutive elected years in the AARC House of Delegates. The Delegates shall be past Board members.

Section 2. Duties

a. The Delegates are empowered by the Society membership to vote on its behalf on resolutions and other issues brought to the floor of the AARC House of Delegates. The Delegates are bound to vote as directed by the Society membership through the Society's Board of Directors. If no direction is given to the Delegates in this regard, the Delegates are free to vote as they deem to be in the best interest of the Society membership. The Delegates shall, at the expense of the Society, and with the authority of the Board of Directors, attend all House of Delegates meetings of the AARC. The Delegates will be voting members of the Society Board of Directors.

Section 3. Vacancies

a. If the office of one Delegate becomes vacant, the Society's Board of Directors shall appoint a substitute Delegate to serve until the next scheduled general election, at which time the Society membership shall elect a new Delegate to serve the remainder of the vacated term. If the offices of both Delegates are vacated, a special general election shall be held to fill the remainders of both vacated terms.

Section 4. Representation

a. There shall be two **(2)** Society Delegates to the AARC House of Delegates.

Section 5. Multiple Offices

a. Delegates may not hold concurrent elective offices.

Article X:

Committee Structure

Section 1. Standing Committees

a. The Chairperson of the following Standing Committees shall be appointed by the President, subject to approval of the Board of Directors.

1. Nominations/Elections
2. Program and Education
3. Bylaws
4. Publications
~~5. Public Relations~~
~~6~~**5**. Membership
~~7~~**6**. Budget/Audit
~~8. Legislation~~
~~9~~**7**. Scholarship
~~10. Sputum Bowl~~

Section 2. Special Committees and Other Appointments

a. Special committees may be appointed by the President.

Section 3. Committee Chairperson's Duties

a. The Chairpersons of each committee shall be responsible for appointing his/her committee members and assure their participation in committee activities.

b. All committee reports shall be made in writing and submitted to the President and Secretary prior to the meeting at which the report is to be read.

c. Physician non-members may be appointed as consultants to committees with recommendations for appointment coming from Society medical advisor(s).

d. Each committee Chairperson requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee.

e. Professional non-members may be appointed as consultants to committees pending approval by the Board of Directors.

Article XI:

Standing Committees

Section 1. Membership Committee

a. This Committee shall be responsible for the recruitment of new members and the retainment of current members. The membership Committee shall also act as a resource:

- o to the Board of Directors for active members wishing to participate in Society activities.
- o to the general membership of the Society as to how they may be involved in Society activities.

Section 2. Budget/Audit Committee

a. The Treasurer and President-Elect shall be members of this Committee, with the Treasurer being the Chairperson of the Committee.

b. The Committee will propose an annual budget for approval by the Board of Directors. Proposed budget shall then be submitted to the membership thirty (30) days prior to the annual business meeting. The budget shall then be voted on by the membership at the annual business meeting.

Section 3. Nominations/Elections Committee

a. This Committee shall prepare, for approval by the Board of Directors, a slate of nominees for the annual election. This Committee shall also receive, verify, and count the ballots for all elections held during the calendar year.

b. This Committee shall make the final critical appraisal of the candidates to see that the

nominations are in the best interests of the AARC and the Society through a consideration of personal qualifications.

~~Section 4. Nominations Committee~~

~~a~~ **c**. This Committee shall prepare, for approval by the Board of Directors, a slate of officers
for the annual election.

~~b. The Committee shall consist of at least four (4) members, with at least one (1) member for each Chapter, who shall serve for a term of one (1) year.~~

~~c~~ **d**. It shall be the duty of this Committee to make the final critical appraisal of candidates,
to see that the nominations are in the best interests of the AARC and the Society through
a consideration of personal qualifications and geographical representations as applicable.

Section ~~5~~**4**. Programs and Education Committee

a. The Committee shall be constructed as to provide experienced leadership and serve as a resource for those persons organizing education programs for the Society.

b. The Medical advisor(s) or his designate will be a consultant member of this Committee.

Section ~~6~~**5**. Bylaws Committee

a. This Committee shall include a Past Board of Directors member and the President-Elect.

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

Section ~~7~~**6**. Publications Committee

a. The Chair of this Committee shall be the Editor ~~of the Society's Newsletter~~ **of the Society's website and/or other publications.**

b. The membership of this Committee shall be appointed as deemed necessary by the Chair.

c. This Committee shall concern itself with the **distribution of information to** ~~production of~~ the Society**'s** ~~newsletter~~ **membership.**

~~Section 8. Public Relations Committee~~

~~a. This Committee shall concern itself with the relations of the Society with the public, hospitals, health care institutions and associations, regulatory agencies, and other organizations through the dissemination of information concerning Respiratory Care.~~

~~Section 9. Legislation Committee~~

~~a. This Committee shall concern itself with the business of the North Dakota Legislative assembly and its impact on health care in general and Respiratory Care, specifically.~~

~~b. The Society's lobbyist shall be a consultant to this Committee~~.

Section ~~10~~**7**. Scholarship Committee

a. This Committee shall concern itself with the distribution of scholarship monies, and the selection of the recipient(s) of those monies.

~~Section 11. Sputum Bowl Committee~~

~~a. This Committee shall concern itself with the organization and administration of the annual Sputum Bowl, assuring adherence to the NDSRC Sputum Bowl Organization Guidelines.~~

Article XII:

Directors at Large

Section 1. Directors

a. Two (2) Directors at large shall be elected in alternating years for a two (2) year term.

The Directors at large shall not serve more than two (2) consecutive terms in office.

b. Directors at large shall be voting members of the Board of Directors.

Section 2. Duties

a. Directors at large shall attend all Board of Directors meetings and perform duties as
assigned by the President or the Board of Directors.

Section 3. Vacancies

a. A vacancy of the office of Director at large shall be filled in accordance with Article V, Section 3 of these Bylaws.

Article XIII:

Society Medical Advisor

Section 1. Medical Advisor

a. The Society shall have at least one (1) Medical Advisor appointed by current President.

Article XIV:

Fiscal Year

Section1. Fiscal Year

a. The fiscal year of this Society shall be from July 1 through June 30.

Article XV:

Ethics

Section 1. Ethics

a. If the conduct of any Society member shall appear, by report of the AARC Judicial
Committee, to be in willful violation of the Bylaws or standing rules of this Society or the
AARC, or prejudicial to this Society's interests defined in the AARC Code of Ethics, the Board of Directors may, by a two-thirds (2/3) vote of its entire membership, suspend or expel such a member. A motion to reconsider the suspension or expulsion of a member may be made at the next regular meeting of the

Board of Directors. All such suspension or expulsion actions shall be reported immediately to the AARC Judicial Committee.

Article XVI:

Parliamentary Procedure

Section 1. Parliamentary Procedure

a. The rules contained in Roberts Rules of Order Revised shall govern whenever they are not in conflict with the Bylaws of the Society or the AARC.

Article XVII:

Amendments

Section 1. Amendments

a. These Bylaws may be amended at any regular or called meeting or by mail vote of the North Dakota Society for Respiratory Care by a two-thirds (2/3) majority of those voting, provided that the amendment has been presented to the membership in writing at least fifteen (15) days prior to the vote. All amendments must be approved by the AARC Bylaws Committee **prior to presentation and vote by the membership**. ~~and~~ **The amendments** shall become effective upon ratification by the AARC Board of Directors **and by the Membership.**

Idaho Society Bylaws

Bylaws of the Idaho Society of the

American Association for Respiratory Care

Revised October 2, 1999

Bylaws of the Idaho Society of the
American Association for Respiratory Care

Article I

Name

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

Article II

Boundaries

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

Article III

Object

Section 1. Purpose

a. To encourage and develop, on a regional basis, educational programs for those persons interested in the field of respiratory care.

b. To advance the science, technology, ethics, and art of respiratory care through regional institutes, meetings, lectures

and the preparation and distribution of a newsletter and other materials.

c. To facilitate cooperation between respiratory care personnel and the medical profession, hospitals, service companies, industry, and other agencies within the region interested in respiratory care; except that this Society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Illinois in which the parent Association is incorporated, or any other state.

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

Section 2. Intent

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

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

Article IV

Membership

Section 1. Classes

The membership of this Society shall include three (3) classes: Active Member, Associate Member and Special Member.

Section 2. Eligibility

An individual is eligible to be a member of this Society if they are a member of the AARC as specified in Article III of the AARC Bylaws and provided their place of employment is within the defined boundaries of this Society.

Section 3. Classification

The classifications and limitations of membership shall be as defined in Article III of the AARC Bylaws.

Section 4. Application for Membership

Application for membership in this Society shall follow the procedure specified in Article III, Section 6 of the AARC Bylaws.

Article V

Officers and Directors

Section 1. Officers

The officers of this Society shall be a President, a President-elect (who automatically succeeds to the presidency when the President's term ends), a Vice President, a Secretary, and a Treasurer.

Section 2. Directors at-large

There shall be two (2) Directors at-large. One (1) Director at-large shall be elected each year and such others as necessary in order to fill existing vacancies.

Section 3. Chapter Representation

The President of each Chapter shall be a member of the Board of Directors.

Section 4. Term of Office

a. The term of office for the President and President-elect shall be for one (1) year. The term of office for Vice President, Secretary and Treasurer shall be for two (2) years. The President and President-elect shall not serve more than one (1) consecutive term in the same office. The Vice President, Secretary, and Treasurer shall not serve more than three (3) consecutive terms in the same office.

b. The term of office for Directors at-large shall be for a two (2) year non-recurring term of office.

c. The term of office for officers and Directors at-large shall begin on January 1 in the year following their election.

Section 5. Vacancies in Office

a. In the event of a vacancy in the office of President, the President-elect shall become acting President to serve the unexpired term and shall serve their own, the successive term, as President.

b. In the event of a vacancy in the office of President-elect, the Vice President shall assume the duties, but not the office, of President-elect as well as their own until the next meeting of the Board of Directors at which time the Board shall elect a qualified member to fill the vacancy.

Section 6. Duties of Officers

a. President - The President shall be the chief executive officer of the Society. The President shall preside at the annual business meeting and all meetings of the Board of Directors; prepare an agenda for the annual business meeting and submit it to the membership not fewer than thirty (30) days prior to such a meeting in accordance with Article VIII of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board no fewer than fifteen (15) days prior to such a meeting, appoint standing and special committees and a Student Representative subject to the approval of the Board of Directors; be an ex-officio member of all committees except the Election and Nominations Committees; present to the Board of Directors and membership an annual report of the Society's activities.

b. President-elect - The President-elect shall become acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability; they shall perform such other duties as shall be assigned by the President or Board of Directors.

c. Vice President - The Vice President shall perform such duties as shall be assigned by the President and Board of Directors. The Vice President shall assume the duties but not the office

of the President-elect in the event of the President-elect's absence, resignation, or disability; and will also continue to carry out the duties of the office of the Vice President.

d. Treasurer - The Treasurer shall have charge of all funds and securities of the Society; endorsing checks, notes, or other orders for the payment of bills; disbursing funds as authorized by the Board of Directors and/or in accordance with the adopted budget; depositing funds as the Board of Directors may designate. The Treasurer shall see that full accurate accounts are kept; submit monthly trial balances to the Executive Committee within twenty (20) days after the monthly closing of the books; make a written quarterly financial report to the Board of Directors; and a complete written yearly report at the spring meeting of the Board of Directors. At the expense of the Society, they shall be bonded in an amount determined by the Board of Directors.

e. Secretary - The Secretary shall have charge of keeping the minutes of the Board of Directors meeting, regular business meetings and the annual business meeting; submitting a copy of the minutes of every meeting of the Board of Directors and other Society business meetings to the Executive Office of the AARC within thirty (30) days following the meeting; executing the general correspondence; and in general performing the duties as from time to time shall be assigned by the President or the Board of Directors.

Article VI

Nominations and Elections

Section 1. Nominations Committee

The Board of Directors shall elect a Nominations committee each year at least one hundred twenty (120) days before the annual business meeting to present a slate of nominees for the following year. The Chairperson shall report the slate of nominees to the Board of Directors at least sixty (60) days prior to the annual business meeting.

Section 2. Nominations

The Nominations Committee shall place in nomination the name of at least one (1) person for the positions of President-elect, Vice President, Secretary, Treasurer, Director(s) at-large and Delegate(s), when necessary. Only Active Members and Life Members in good standing shall be eligible for nomination. The Nominations Committee shall provide a pertinent biographical sketch of each nominee's professional activities and services to the organization, all which shall be a part of the ballot.

Section 3. Ballot

a. The Nominations Committee's slate and biographical sketches shall be mailed to every Active Member and Life Member in good standing and eligible to vote at least thirty (30) days prior to the annual business meeting.

b. If the Society's Board of Directors specifies that this vote shall be by mail, the list of nominees shall be so designed as to be a secret mail ballot with provisions for write-in votes for each office. Ballots, to be acceptable, must be postmarked at least five (5) days before the annual business meeting. The deadline date shall be clearly indicated on the ballot.

c. If the vote is to be conducted at the annual business meeting, the time, date, and place shall be clearly indicated on the ballot. Provisions shall be made for absentee ballots which allow all eligible members the opportunity to vote.

Section 4. Election Committee

The President shall appoint an impartial Election Committee which shall check the eligibility of each ballot and tally the votes at the annual business meeting.

Article VII

Board of Directors

Section 1. Composition and Powers

a. The executive government of this Society shall be vested in a Board consisting of the President, President-elect, Vice President, Secretary, Treasurer, immediate past President,

two (2) Directors at-large, two (2) Delegates, Student Representative and each Chapter President.

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

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

Section 2. Duties

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

b. Adopt and rescind standing rules of the Society.

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

d. Approve the area organization of a Chapter after review by, and upon recommendation of, the Publications, Public Relations and Chapter Affairs Committee.

Section 3. Vacancies

a. Any vacancy that occurs on the Board of Directors, with the exception of the President, the immediate past President, and Chapter Presidents, shall be filled by qualified members elected by the Board of Directors. Individuals so elected shall serve until the next regular election.

b. An elected President-elect shall serve until the next annual election and then automatically accede to the Presidency.

Section 4. Meetings

a. The Board of Directors shall meet immediately preceding and immediately following the annual business meeting of

the Society and shall not hold fewer than two (2) regular and separate meetings during the calendar year.

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

c. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

Section 5. Mail Vote

Whenever, in the judgement of the Board of Directors, it is necessary to present any business to the membership prior to the next regular or annual business meeting, the Board of Directors may, unless otherwise required by these Bylaws, instruct the Election Committee to conduct a vote of the membership by mail. The question thus presented shall be determined according to a majority of the valid votes received by mail within thirty (30) days after date of such submission, except in the case of a change in the Bylaws when a two-thirds (2/3) majority of the valid votes received is required. Any and all actions approved by the members in accordance with the requirements of this Article shall be binding upon each member of the Society. Any amendment(s) to the Bylaws of this Society shall be presented to the membership at least sixty (60) days prior to a mail vote, as provided in Article XVIII of these Bylaws concerning amendments.

Section 6. Executive Committee

The Executive Committee of the Board of Directors shall consistent of the President, President-elect, Vice President, immediate Past President, Secretary, and Treasurer. They shall have the power to act for the Board of Directors between meetings of the Board of Directors, and such action shall be subject to ratification by the Board at its next meeting. The Executive Committee shall also function as the Budget and Audit Committee.

Section 7. Multiple Offices

No Officer, Director at-large, or Delegate shall hold Chapter office simultaneously.

Article VIII

Annual Business Meeting

Section 1. Date and Place

a. The Society shall hold an annual business meeting in the fall of each year; additional meetings may be held as required to fulfill the objectives of the Society.

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

Section 2. Purpose

a. The annual business meeting shall be for the purpose of receiving reports of officers and committees, the results of the election, and for other business brought by the President.

b. Additional business meetings shall be for the purpose of receiving reports, and for other business brought by the President.

Section 3. Notification

Written notice of the time and place of the annual business meeting shall be sent to all members of the Society not fewer than ninety (90) days prior to the meeting. An agenda for the business meeting shall be sent to all members not fewer than thirty (30) days prior to the annual business meeting.

Section 4. Quorum

A majority of the voting members registered at a duly called business meeting shall constitute a quorum.

Article IX

Society Delegation to the AARC House of Delegates

Section 1. Composition

The Delegation of the Society to the House of Delegates of the AARC shall be composed of two (2) Delegates and the President-elect.

Section 2. Election

Delegates shall be elected as specified in Article VII of the AARC Bylaws.

Section 3. Term of Office

A Delegate will be elected every two (2) years to serve a two (2) year term commencing on January 1 in the year following their election.

Section 4. Duties

a. The duties of the Delegation shall be as specified in the AARC Bylaws.

b. The Delegation shall submit a written report of any House of Delegates meeting attended to the Society President and Secretary within sixty (60) days following the meeting.

Section 5. Board Member

Each Delegate shall be a voting member of the Society Board of Directors.

Section 6. Multiple Offices

Delegates may not hold concurrent elective offices.

Article X

Committees

Section 1. Standing Committees

The members of the following standing committees shall be appointed by the President, subject to the approval of the Board of Directors, to serve for a term of one (1) year, except as indicated in Article VI, Section 1 of these Bylaws.

a. Membership
b. Budget and Audit
c. Election
d. Nominations

e. Program and Education
f. Bylaws
g. Publications, Public Relations and Chapter Affairs

Section 2. Special Committees and Other Appointments

Special committees may be appointed by the President.

Section 3. Committee Chairperson's Duties

a. The President shall appoint the Chairperson of each committee.

b. The Chairperson of each committee shall confer promptly with the members of the committee on work assignments.

c. The Chairperson of each committee may recommend prospective committee members to the President. When possible, the Chairperson of the previous year shall serve as a member of the new committee.

d. All committee reports shall be made in writing and submitted to the President and Secretary of the Society at least ten (10) days prior to the meeting at which the report is to be read.

e. Non-members or physician members may be appointed as consultants to the committees. The President shall request recommendations for such appointments from the Medical Advisor(s).

f. Each committee Chairperson requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee.

Article XI

Duties of Committees

Section 1. Membership

a. This Committee shall consist of one (1) of the Delegates and two (2) other members of the Board of Directors.

b. This Committee shall investigate and evaluate the background and experience of applicants for qualification and classification for membership in AARC and report to the

Membership Committee of the AARC as required by the AARC Bylaws.

Section 2. Budget and Audit Committee

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

b. They may propose an annual budget for approval by the Board of Directors. The proposed budget shall then be submitted to the membership at least thirty (30) days prior to the annual business meeting. The budget shall then be ratified by the membership at the annual business meeting.

Section 3. Election Committee

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

b. The Committee shall consist of at least four (4) members who shall serve for a one (1) year term of office.

Section 4. Nominations Committee

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

b. The Committee shall serve for a one (1) year term of office and shall be appointed from members or former Society officers.

c. It shall be the duty of this Committee to make the final critical appraisal of candidates to see that the nominations are in the best interest of the AARC and the Society through a consideration of personal qualifications and geographical distribution as applicable.

Section 5. Program and Education Committee

a. This Committee shall consist of at least three (3) members and be so constructed as to provide experienced members for program and education planning.

b. The Medical Advisor(s) or their designate will be a consultant member(s) of this Committee.

Section 6. Bylaws Committee

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

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

Section 7. Publications, Public Relations & Chapter Affairs Committee

a. This Committee shall consist of at least three (3) members, one (1) of whom shall be a past President, with members being appointed annually for a one (1) year term subject to reappointment.

b. This Committee shall concern itself with the execution of a Society Newsletter and all other communications of the Society with the public, hospitals and other organizations through the dissemination of information concerning respiratory care.

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

d. Receive applications for Chapters and review the proposed Bylaws for compliance with the objectives of the Society, and report its findings to the Board of Directors.

e. Review amendments to existing Chapter Bylaws.

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

Article XII

Chapter Organizations

Section 1. Boundaries of Chapter

Boundaries of each Chapter shall be as prescribed by the Society Board of Directors.

Section 2. Organization

The internal organization, except where in conflict with these Bylaws, shall not be the concern of this document.

Section 3. Officers and Chapter Representation

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

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

c. Membership in the Chapter shall be determined by place of employment.

Section 4. Activities

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

Section 5. Responsibilities of the Chapter President

a. Represent the Chapter from which they are elected.

b. Submit a written report at least fifteen (15) days prior to each Board of Directors meeting, relating to the activities in their Chapter.

Section 6. Chapter Admission Requirement

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

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

Section 7. Duties

a. A copy of the minutes of the governing body and business meetings of the Chapter shall be sent to the Society's office within thirty (30) days following the meeting.

b. The names and addresses of officers and medical advisor(s) shall be sent to the Society's office within thirty (30) days following the meeting.

Article XIII

Society Medical Advisor

The Society shall have at least one (1) Medical Advisor. Each Chapter shall have at least one (1) Medical Advisor. Together, they shall form a Board of Medical Advisors of which the Society Medical Advisor shall be Chairperson.

Article XIV

Fiscal Year

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

Article XV

Dues

Section 1. Amount

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

Section 2. Payment

Dues shall be payable on or before January 31, and become delinquent on March 10. Any member whose dues are not paid by March 10th shall be dropped from the Society membership after suitable notification. Any member who has been dropped may be reinstated during the calendar year by payment of his current dues plus a reinstatement fee determined by the Board of Directors on an annual basis.

Article XVI

Ethics

If the conduct of any Society member shall appear to be in willful violation of these Bylaws or standing rules of this Society or the AARC, or prejudicial to this Society's interests as defined in the AARC Code of Ethics, the Board of Directors shall, by a two-thirds (2/3) vote of its entire membership, report the member and the circumstances to the AARC Judicial Committee.

Article XVII

Parliamentary Procedure

The rules contained in the current edition of Robert's Rules of Order shall govern whenever they are not in conflict with the Bylaws of the Society.

Article XVIII

Amendments

Amendments to these Bylaws must be approved by the AARC Bylaws Committee and the AARC Board of Directors. Following such approval, these Bylaws may be amended at any regular or called meeting or by mail vote of the Idaho Society of the AARC by a two-thirds (2/3) majority of those voting, provided that the amendment has been presented to the membership in writing at least sixty (60) days prior to the vote.

Executive Committee

Finance Committee

Judicial Committee

Reporter: Patricia Blakely

Last submitted: 2010-11-02 13:41:13.0

Recommendations

No recommendations at this time.

Report

The Chair has received one (1) formal complaint. I am in preliminary review at this time. Legal counsel has been notified. Further action is pending based on completion of review and consultation with counsel.

Other

No other complaints have been received at the time of this report.

AARC Program Committee

Activity Report
Winter, 2010

Chair: Michael A. Gentile, RRT FAARC

Charges:

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. Review with each section all selections pertaining to their specialty before finalization. The Program Committee decisions shall be final.

4. Develop and design the program for the annual congress to address the needs of the membership regardless of area of practice or location. Assure educational opportunities for other health care related practitioners.

Progress:

The 56th AARC Congress Program has been published both in print and online. The Congress will take place December 5-9 in Las Vegas, NV. We will have 170 speakers and 300 abstracts presented at the Open Forum with 250 presentations covering all aspects of Respiratory Care as well as other health care related topics. Easy Street will be open for proposal submission from November 3, 2010 - January 5, 2011. The Program Committee will convene on February 10-13 to plan the 2011 Summer Forum and Annual Congress. The Program Committee sincerely thanks the BOD and membership for all of their support and contributions.

Strategic Planning Committee

Reporter: Toni Rodriguez

Last submitted: 2010-11-04 17:43:48.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

No report at this time.

Joint Session

- **Welcome & Roll Call**
- **ARCF Report**
- **AARC Elections Committee Report**
- **Government & Regulatory Report**
- **2010 Budget Report**
- **Consideration of 2011 Budget**

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

ARCF Report

The foundation continues to address challenges from the effects of a depressed economy. As you may know, we depend on investment income to fund many of the awards and activities. We are continually evaluating our investments to try and optimize revenue in a very uncertain investment environment. In addition, operational expenses are a significant burden and are being carefully reviewed by the Trustees. A portion of the endowment had to be liquidated this year, which is unsustainable.

The foundation received a grant from Pfizer of $44000 to print and distribute the Tobacco Cessation Guide. This pocket-sized guide is intended to be used by respiratory therapists to help hospitalized patients quit using tobacco products. It contains a postage reply card so that we can track success for follow-up. It was created by the Tobacco-Free Lifestyle Roundtable, Jonathan Waugh, Chair. There will be copies available at the AARC theme booth in the exhibit hall. There are plans underway to create a clinician's guide to help respiratory therapists become better educated about smoking cessation.

Corporate sponsorship for journal conferences is still difficult to obtain. The first one in 2010 had a shortfall of approximately $17000. The second, being held as this report is written, is expected to have a positive return of about $16000.

The foundation has agreed to fund at least one journal conference each year. The ARCF board will continue to evaluate whether it is still able to fund more than one conference annually. The ARCF has funded most of the Journal Conferences since 1991. As you will see from the attached list ARCF has contributed hundreds of thousands of dollars for this purpose. Even in these difficult times we continue to support the conferences and are now soliciting for funding of a spring Journal conference in 2011 on Pulmonary Diagnostics.

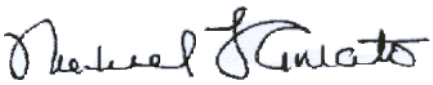
The foundation awards and scholarships are being presented this week. The expenses of the awards are exceeding the income generated by investments. The foundation has sent invoices to the named awards for funds to cover the shortfall. As you are already aware, the ARCF board decided not to give out two awards this year due to the extreme shortfall in the funds. The total cost of the awards, including transportation, lodging and registration will be approximately $50,000 this year.

We are holding the second annual ARCF Fundraiser and International Reception. This year we have combined it with the Corporate Fellows Reception and have seen a modest increase in the number of pre-registered attendees. We expect to grow this into an event that draws more attendees each year as its reputation spreads.

The foundation funded four International Fellows this year. We are pleased to welcome the participants from Austria, China, Peru and Saudi Arabia. We also want to give a special thank you to the city hosts that volunteer so much time and effort to make the visits a success. The cost of the program continues to be approximately $5000 per fellow. This program is being reviewed by the AARC Board.

In summary, the foundation continues to look for growth potential, control operational expenses, and become more widely recognized for its contributions to the profession of respiratory care. Challenges exist, but we believe the future is bright.

Sincerely,



Michael T. Amato, MBA

Chair

Journal Conferences

- Neonatal/Pediatrics Respiratory Care — Aug & Sept 2011
- Patient-Ventilator Interaction — Jan & Feb 2011
- Sleep Disorders: Diagnosis and Treatment — Sept & Oct 2010
- Controversies in Respiratory Care II — Jan & Feb 2010
- Respiratory Care and Cystic Fibrosis — May & June 2009
- Non-Invasive Ventilation in Acute Care: Controversies and Emergency Concepts — Jan & Feb 2009
- Meeting the Challenges of Asthma — May & June 2008
- Mechanical Ventilation in Mass Casualty Scenarios — Jan & Feb 2008
- Airway Clearance: Physiology, Pharmacology, Techniques, and Practice — Sept & Oct 2007
- Respiratory Controversies in the Critical Care Setting — April & May 2007
- Neuromuscular Disease in Respiratory and Critical Care Medicine — Aug & Sept 2006
- Metered Dose Inhalers (MDIs) and Dry Powder Inhalers (DPIs) in Aerosol Therapy — Sept & Oct 2005
- Ventilator-Associated Pneumonia — June & July 2005
- Applied Respiratory Physiology: Use of Ventilator Waveforms and Mechanics in the Management of Critically Ill Patients — Jan & Feb 2005
- Computers in Respiratory Care — April & May 2004
- COPD: Translating New Understanding into Improved Patient Care — Dec '03 & Jan '04

- Current Trends in Neonatal and Pediatric Respiratory Care March & April 2003
- Liquid Nebulization: Emerging Technologies Nov & Dec 2002
- Invasive Mechanical Ventilation in Adults: Implementation, Management, and Follow-Up March & April 2002
- Evidence–Based Medicine in Respiratory Care Nov & Dec 2001
- Tracheal Gas Insufflation (TGI): Current Status and Future Prospects February 2001
- Palliative Respiratory Care Nov & Dec 2000
- Consensus Conference V: Aerosols and Delivery Devices June 2000
- Long-Term Oxygen Therapy Jan & Feb 2000
- Artificial Airways June & July 1999
- Inhaled Nitric Oxide Feb & March 1999
- Sleep-Disordered Breathing April & May 1998
- Consensus Conference IV: Noninvasive Positive-Pressure Ventilation April 1997
- Emerging Health Care Delivery Models and Respiratory Care January 1997
- Mechanical Ventilation: Ventilatory Techniques, Pharmacology and Patient Management Strategies April & May 1996
- Resuscitation in Acute Care Hospitals April & May 1995
- Consensus Conference III: Assessing Innovation on Mechanical Ventilatory Support September 1995
- Controversies in Home Respiratory Care April & May 1994
- Oxygenation in the Critically Ill Patient June & July 1993
- Emergency Respiratory Care June & July1992

- Consensus Conference II: The Essentials of Mechanical Ventilators September 1992
- Respiratory Care of Infants and Children June & July 1991
- Consensus Conference I: Aerosol Delivery September 1991
- Noninvasive Monitoring in Respiratory Care June & July 1990
- Pulmonary Function Testing June & July 1989
- PEEP June & July 1988
- Mechanical Ventilation June & July 1987
- Neonatal Respiratory Care June & July 1986
- Monitoring of Critically Ill Patients June & July 1985
- Perioperative Respiratory Care May & June 1984
- The Management of Acute Respiratory Failure May 1983
- Complications of Respiratory Therapy April 1982

Election Committee

The slate of nominees approved by the BOD and HOD was submitted to the general membership for vote. The ballot count was made and the results certified on November 8, 2010 by John H. Steinmetz, AARC Elections Committee Chair, Timothy R. Myers, AARC President, and attested by Sherry Milligan, AARC Elections Committee Liaison. The results are as follows:

Office	Votes	Vote%
Secretary-Treasurer		
Michael Tracy	844	37%
Linda I. Van Scoder *	1434	63%
Vice President for External Affairs		
George W. Gaebler *	1220	54%
Robert McCoy	1036	46%
Vice President for Internal Affairs		
Michael J. Hewitt	904	39%
Susan Rinaldo-Gallo *	1392	60%
Directors at Large		
Harold Frederick (Fred) Hill, Jr. *	867	16%
Denise Johnson *	1294	23%
John W. Lindsey, Jr.	803	14%
Camden J. McLaughlin *	947	17%
Albert W. Moss	783	14%
Gary Wickman	846	15%
Specialty Sections	**Votes**	**Vote%**
Adult Acute Care		
Keith D. Lamb *	242	98%
Diagnostics		
Matthew J. O'Brien *	77	57%
James Sullivan	58	43%
Education		
Joseph G. Sorbello *	229	73%
Keith A. Terry	79	25%
Management		
Roger L. Berg	162	37%
Bill Cohagen *	272	62%
Neonatal-Pediatrics		
Tiffany G. Mabe	98	43%
Cynthia C. White *	129	57%

* Denotes winner

I want to thank the committee members Suzanne Bollig, Jim Lanoha, John Hiser, and Debbie Fox, as well as, Sherry Milligan and Beth Binkley, committee liaisons from the AARC executive office for their hard work.

Specialty Sections

Adult Acute Care Section

Reporter: Michael Hewitt

Last submitted: 2010-11-02 10:38:05.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

1) The Adult Section's version of a swap shop is up and running within the AARC Connect Adult site. Many thanks to Joy Hargett from Houston and Sherry Milligan from the home office in getting this project launched. This has been a work in progress for a long time.

2) Section membership remains robust, with >1,600 currently registered.

3) It is with great pleasure that the Chair announces that Joe Hylton of North Carolina is being inducted as a Fellow of the AARC in Las Vegas. Joe is a long time member and major contributor to the section and the section bulletin.

4) It is also with great pleasure that the Chair announces that the 2010 Section SPOY is Dan Rowley from Virginia. Also a long time member and contributor to the section, Dan is well known for his clinical, leadership and community related efforts. He is also a member of the FAARC community within the AARC.

Congratulations to both of these outstanding practitioners for their accomplishments.

Continuing Care Section

Submitted 11/7/2010

Debbie Koehl

Recommendations

None at this time

Report

- Assisted AARC office with article found at www.curetoday.com in regards to shortness of breath in cancer patients.
- Began working on URM project with Bill Dubbs.
  - Obtained assistance from other section members.
  - Shared information with AACVPR in order to gain their support.
- Continuing to produce quarterly section newsletter. Successfully recruited Editor, Gerilynn Connors to assist.
- Continue strong relationship with Anne Marie Hummel and Cheryl West in regards to legislative issues for Pulmonary Rehab practitioners.
- Spoke at Michigan Society for Respiratory Care state meeting on the topic of PR reimbursement.
- Represented AARC at the AACVPR annual meeting.
- Continue to monitor section list serve in regards to member needs and questions.

Other

Would like to thank Anne Marie Hummel for her constant support and availability in regards to pulmonary rehabilitation legislative and CMS questions and issues. She continues to provide timely support, not only to me but other Continuing care members as well.

Diagnostics Section

Reporter: Michael Tracy

Last submitted: 2010-11-01 09:17:23.0

Recommendations

No recommendations at this time

Report

BOARD OF DIRECTORS REPORT

DIAGNOSTIC SECTION

NOVEMBER 2010

Interim Section Chair: Mike Tracy

1. Work with CPG Committee to review, revise and update Diagnostic specific CPG''s.

    a. No action required at this time

2. 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.

    a. No action required at this time

3. In cooperation with Executive Office Staff, plan and produce four section bulletins, at least one Section Specific thematic Webcast/chat and 1-2 Web-based section meetings.

a. Rick Weaver, bulletin editor, continues to produce excellent quality bulletins.

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

a. Section membership has grown to 917 (867 active)

b. ongoing

5. Identify, cultivate and mentor new section leadership.

a. Election for new section chair underway at this time.

b. Specialty Practitioner of the year, Jo Ann Ikehara, was selected in October.

c. Ongoing

6. Enhance communication with and from section membership through the section Listserv, review and refinement of information for your section's Web page and provide timely responses to requests for information.

A Ongoing

Education Section

Reporter: Lynda Goodfellow
Last submitted: 2010-11-08 11:50:11.0

Recommendations

no recommendations

Report

All charges for 2010 have been met or in process.

Charge #1: complete

Charge#2: Communication has continued with Military Roundtable members regarding recruitment of military personnel (current and future) into respiratory therapy. One strategy is the The Campus Liaison Officers (CLOs). CLOs are college/ seminary faculty members, administrators, and administrative professionals who are affiliated with a Community College or University level educational facility. Specifically, the purpose of this program is to increase diversity community awareness of the opportunities and upward mobility available to all persons in the Navy as well as to increase Navy diversity officer accessions. In discussions with the Military Roundtable, this option is going well. More information about the CLO program is on the Military Roundtable discussion board.

Charge #3: complete

Charge #4: Four section bulletins were produced in 2010. Two webcasts related to education were presented in 2010 (Effective Communication and Cultural Competency). No web-based section meetings were planned but did meet face-to-face twice in 2010.

Charge 5: Section membership is stable.

Charge 6: Nominations for new leadership were solicited and the election of a new Education Section chair occurred.

Charge #7: Timely communication was transitioned from the AARC list-serve to AARC Connect in 2010. There are 1219 subscribers who have written over 420 postings with over 35 files uploaded. Discussions were particularly lively after the Summer Forum in July in regards to the 2015 and Beyond Conference.

(The CLO document will be available for BOD review at the Board Meeting.)

Attachments

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

- CLO_Information[1].pdf

Home Care Section

Reporter: Robert McCoy

Last submitted: 2010-11-04 15:54:04.0

Recommendations

none

Political issues

Cheryl will give a more complete update on political issues.. The competitive bid winners have been announced and the process seems to be moving forward. The goal to defeat the competitive bid process may have been impacted with the current election so we will have to wait to see what direction the new Congress takes. There is new evidence from a group of economist that competitive bid will not work as intended, yet it is unknown if CMS will listen to the evidence. Home respiratory care continues to be impacted by economic and political pressures and needs a strong clinical evidence to establish a foundation for change. It is unknown what impact the competitive bid will have on respiratory services in the home, yet expectations are that it will not be positive.

Clinical

The board directed LTOT literature review is moving forward with over 300 articles identified for review. Dr. Christopher has categorized the articles and our committee will be reviewing the articles when they are acquired. The plan is to compare the details of the research related to methods and materials to determine if the evidence reflects current practice. It is the opinion of the group that most articles related to LTOT will not reflect the products and procedures used in home oxygen therapy today. Dr. Christopher will have more information in his report.

The value of the professional home respiratory therapist is a high priority project. At the 2010 AARC Congress there will be a presentation on the clinical benefits and economic value of a professional home respiratory program presented by Klinginsmith home health care. This model will be used moving forward to document clinical and economic value of effective respiratory services. Others are collecting data that will be shared with other researchers.

NAMDRC hosted a meeting on LTOT in the home at Medtrade last month. The objective of this meeting was similar to the oxygen consensus conferences chaired by Dr. Petty. The recommendation to titrate oxygen delivery for all activity levels was the goal to get consensus from the group and approach CMS to revise their payment procedure based on oxygenation rather than liter setting. Another objective was to work towards agreement from the manufacturers on labeling of delivery setting on individual oxygen system. More information will be available at the board meeting regarding the outcomes of the NAMDRC meeting.

Action items

There will be a meeting following the home care section business meeting to discuss transitions from hospital respiratory care to home respiratory care. The Home Care and Management sections will invite key individuals to this discussion to open a dialogue of the issues impacting effective respiratory care in the home and how the hospital RT can become involved and help to improve the effectiveness of home respiratory care. Tom Kallstrom and Doug Laher will help facilitate the discussion and help move the process along.

Long Term Care Section

Management Section

Reporter: Cheryl Hoerr

Last submitted: 2010-11-08 11:09:56.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

A sufficient number of management focused proposals were submitted for presentation at the International Respiratory Congress. Garry Kauffman functioned as program committee liaison for the management section and worked diligently to incorporate member feedback for more interactive sessions into the upcoming program.

Three section bulletins have been published on schedule this year; the fall bulletin will be published prior to the end of the year.

Several webcasts in 2010 were focused on management topics; specifically "Coding and Billing" in March 2010, and "Reducing Missed Treatments and Ventilator Days - The Hidden Solution" in May 2010.

Membership in the Management Specialty Section stands at approximately 1800. Five nominations for Management Specialty Practitioner of the Year were received and evaluated by a review committee composed of nine management section members. Ken Thigpen was chosen as the 2010 Management SPOY. Elections were conducted for the Management Section Chair and Roger Berg will assume those duties in 2011.

Discussion on the Management Section Listerv continues to be plentiful; managers continually remark about the usefulness of this valuable resource.

Neonatal Pediatric Section

Sleep Section

Reporter: Antonio Stigall

Last submitted: 2010-11-08 12:05:34.0

Recommendations

[No Recommendations at this time.]

Report

[At the time of this report, the sleep section is at 973 subscribers.

The sleep section has nominated Sheri Tooley-Peters as the Specialty Practitioner of the Year.

Sleep section chair assisted sleep section members via AARC Connect regarding questions on various topics. When called upon, acted as a resource to Director of Government Affairs on sleep legislative issues. Also assisted the URM Expert Panel in revising Sleep Disorders Section.]

Surface to Air Transport Section

Reporter: Steven Sittig

Last submitted: 2010-11-06 13:58:11.0

Recommendations

That the AARC BOD consider the feasibility of creating a position statement in regards to state reciprocity for transport RT's.

Currently many transport RT's are required to carry multiple state licenses as they may be called to transport a patient from one state to another. Some states have reciprocity but many do not which incurs a large expense to hospitals and transport services which utilize RT's in their teams. Most EMS services operated under a "mutual aid " compact where multiple state licenses are not then needed. With out such support from the AARC, many transport RTs'could be replaced by less trained parmedicals attempting to provide such critical modalites as mechanical ventilator support.

The position statement could limit say time in the outside state to say 12 hours a day and that while in another state the transport RT's would be practicing under there state scope of practice and medical direction.

Report
[The transport section continues to be active on the list serve via AARConnect .The quarterly bulletins are being submitted on time and receiving very positive feedback. The section meeting is planned for the upcoming AARC Congress where out 2010 Transport Specialty practitioner of the year will be recognized. Increasing membership is a priority for the upcoming calendar year.

The section was well represented at the recent Air Medical Transport Conference in Ft Lauderdale this past October with several transport RT's presenting quality lectures at this national conference.

Other
The Transport Section is teaming with the Education Section to update the AARC IV course which was originally issued in 1997. Once volunteers are recruited from both

sections, we will update the course which has seen a major increase in requests for the material.
We are planning to start a national regional membership group to reach out to transport RT's to join the AARC and specifically the transport section. Regional representatives will have better knowledge of where RT's are involved in transport.

Roundtables

Asthma Disease Mgmt Roundtable

Reporter: Eileen Censullo

Last submitted: 2010-10-19 11:08:43.0

Recommendations

1. Start page on Facebook

Report

1. Sent messages out to gather information about AARC Connect.

2. Sent message out to see if interest in holding Roundtable meeting at Congress

Disaster Response Roundtable

Reporter: Steven Sittig

Last submitted: 2010-11-01 02:25:16.0

Recommendations

NONE AT THIS TIME

Report

The Disaster Response Roundtable continues to disseminate important information via the listserve. We continue to work on increasing membership as we become closer to the mandated membership for specialty section status. We are hoping to have an informal meeting at the upcoming AARC congress.

[Insert report here]

Other

[Insert other information here]

Geriatrics Roundtable

Reporter: Mary Hart

Last submitted: 2010-10-18 14:42:44.0

Recommendations

None

Report:

Charges:

Continue working with the AARC Times staff to assure each AARC Times issue has an article for "Coming of Age".

Prepare fact sheets on what respiratory therapists should know related to the following topics suitable for publication in AARC communications or website posting:

- Common respiratory prescription medications used by older adults.
- Immunizations for older adults
- Communicating with the geriatric patient
- Geriatric end of life/palliative care.

With Executive Office, review material on Yourlunghealth.org for relevance and appropriateness for geriatric population

Used AARCConnect to ask for volunteers to help write articles for next year's COA section for the AARC Times. Was successful in getting some "new blood" to author a couple of articles and have increased our membership through "connect". Core members continue to be strong advocates for the Roundtable and our profession.

An early morning meeting is planned for the Roundtable in Las Vegas during the Congress Meeting to discuss the coming year's plan of action!

Hyperbaric Medicine Roundtable Report 2010

1. The Hyperbaric Roundtable has an active discussion group on the AARConnect Social network.
2. We have scheduled a three part presentation on Hyperbaric Medicine and its importance to Respiratory Therapists. It is scheduled 10:40 am thru 12:20 pm on Wednesday Dec. 8 as part of the 56th AARC International Respiratory Congress.
3. We have scheduled a "meet & greet" session for later that same day for all the members of the HBO Roundtable in the Las Vegas Convention Center 5-6:00 pm Rms. N233/N235/N237

Informatics Roundtable

International Medical Mission Roundtable

Reporter: Lisa Trujillo

Last submitted: 2010-11-05 16:34:54.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

Since the development of the **International Medical Mission Roundtable** by the AARC in February 2010, membership has grown to 57 members. The December 2010 issue of the AARC Times will contain an article spotlighting this new roundtable and the international activities of a few current members. We anticipate this article will stimulate additional membership growth. During the AARC International Congress this December 2010, International Medical Mission Roundtable members plan to meet to network, share current member activities, and discuss future possibilities for the roundtable and it''s members.

Military Roundtable

Neurorespiratory Roundtable

Reporter: Lee Guion

Last submitted: 2010-10-30 17:07:03.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

Report: Members of the Neurorespiratory Roundtable have not made the transition to the new Connect social networking format. Prior to this change there were regular postings and helpful responses on the listserv. To date I am the only one to have submitted postings. I do receive e-mails with suggestions and queries to my work e-mail from members. Most of our members access colleagues on line from work. Perhaps the extra steps required to log onto the AARC website and locate the roundtable have made it less friendly when time is in such short supply during the work day.

Recommendations: I am resubmitting my request to the BOD to support roundtable members in our pursuit of an education program and specialty certification in the assessment and care of neuromuscular patients for RCPs within the AARC. Our ultimate and long-range goal is to have questions on the respiratory management of neuromuscular patients on the NBRC exam and see a module taught in CoARC-accredited respiratory therapy programs. There is growing momentum for this. The VA in Tampa has designed and implemented an educational and competency program. RCPs in northern California specializing in the respiratory care of neuromuscular patients are meeting to form a professional organization/support group on December 1st. One of the first items of business will be the creation of standards of care to promote consistency in the assessment and treatment of our patients. We would like a dialogue with the President or President-elect and other members of the BOD and increased support for this small, but growing and significant membership of the AARC.

My 2-year term as chair of the NR Roundtable is drawing to a close. It has been a rewarding experience. I have met in person and on-line some of the most professional and knowledgeable RCPs of my long career. I am nominating Neurorespiratory Roundtable member Norma Rivera, RRT to succeed me. She works at the Shepherd Center in Marietta, GA, the largest rehabilitation center in the U.S. She works with a

neuromuscular patient population not represented by past chairs Louis Boitano and Charles Gutierrez. She is dedicated and enthusiastic. She lectures regionally on the care of patients with respiratory impairment due to neuromuscular disease. Thank you for considering this recommendation. And thank you for the opportunity to serve the AARC.

Research Roundtable

Reporter: John Davies
Last submitted: 2010-10-27 10:51:08.0

Recommendations

Ongoing enrollment of new members

Report

[Nothing new to report]

Simulation Roundtable:

Julianne Perretta

The report currently won't display on the AARC website. Therefore I don't have any charges as listed by the AARC and BOD.

The Simulation Roundtable has been recruiting members via AARC Connect since its creation in August 2010. Discussion and idea sharing has been ongoing via the listserv. Plans for the upcoming calendar year include:

- Ongoing member recruitment
- Recommendations for workshops at the 57th AARC International Congress and 2011 AARC Summer Forum
- Engaging and support of simulation research by members
- Collaboration between AARC and the Society for Simulation in Healthcare to improve the quality of pulmonary and ventilation simulators

Meeting has been proposed at the 56th International Congress. I will not be available but Scoot Woodcox and Joel Brown have offered to assist in the coordination of this meeting as available.

Potential recommendations for the AARC Connect website would include video uploading capabilities

Tobacco Free Lifestyle Roundtable

Reporter: Jonathan Waugh

Last submitted: 2010-10-22 11:17:07.0

Recommendations

That the AARC BOD approve a resolution from the AARC that members regularly "Ask and Advise" their patients about tobacco use.

Rationale: Many clinicians consider asking and advising patients about tobacco use to be the job of a specialist. While assisting someone through the quitting process does take special expertise, any RT professional is capable of asking patients about tobacco use and then advising why it is important to quit (and direct those interested to resources). Hearing this from multiple health care professionals multiple times has a definite cumulative effect which can help move people without interest to being interested in quitting. Likewise, clinicians need to hear from authorities and leaders that they need to be regularly engaged in asking and advising their patients-it is not an activity just for specialists. Our membership needs to know that they can make a meaningful impact in this aspect of patient and community health, and that we are counting on them to be a part of the success.

Report

As with all roundtables, the Tobacco Free Lifestyle roundtable mailing list started afresh with the conversion to AARConnect and we are rebuilding the membership. This new electronic networking tool seems to be working well for the membership and people like the ability to choose to receive a single compilation of messages rather than a new message for each post made.

The working group that created the educational patient guide for tobacco treatment is reviewing the final proof which will soon go to print. We are thinking of how to help the AARC disseminate the copies of the patient guide that will be made available through the grant from Pfizer Inc. I am very pleased to be associated with this project and think it will reflect very well on the AARC with the public and among professional groups. We thank Steve Nelson and the staff of the AARC for their partnership and excellent work on this project.

We remain committed to the idea that all respiratory therapists need to be asking patients about their tobacco use and recommend cessation as a part of their regular patient interaction, just like listening to breath sounds. It is precisely the "repetitive" aspect of asking and advising that helps our patients move toward change. Taking the next step in assisting patients to quit is of course desired but we realize that time and training constraints may vary what our peers are able to do. For the present, we feel it would be a great step forward if everyone in respiratory care were routinely asking and advising their patients on tobacco use. I also think this is a complementary goal for the AARC's Drive4COPD initiative.

Other
As previously recommended by the BOD, we intend to submit another tobacco education proposal for the next AARC International Congress program. Suggestions from the BOD would be most welcome.

Respectfully,
Jonathan Waugh

Special Committees

Benchmarking Committee

Reporter: Richard Ford

Last submitted: 2010-10-08 10:54:14.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

•1. Jan Thalman was unable to continue serving on the committee and resigned in July 2010 and Tom Malinowski will resign from the committee after serving the remainder of 2010. We thank both Jan and Tom for their ongoing contributions over the past 2-3 years.

•2. Marc Mays from Ohio and Cheryl Hoerr from Missouri have accepted appointments to the committee and are committed to serve through 2011.

•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. Members of the committee have been designated to followup with clients based on regions of the country.

•4. A proposal was accepted for presentation by Richard Ford on Productivity and Benchmarking at the 2010 Congress in which AARC Benchmarking will be featured.

•5. Subscribers to AARC Benchmarking have received a monthly status report that includes the number of subscribers, the number of data sets available for each quarter, and recognizes those facilities that have entered there prior quarter data. These efforts, in addition to reminders that are now sent out to subscribers have improved the timeliness of data entry, although this still remains an issue the committee will continue to focus on.

•6. At the time this report Bill Dubbs indicated that we are seeing some improvement in the number of new subscribers, and those renewing. This is likely due to the notifications now in place and the personal follow-up that is provided to assist Directors/Managers in data entry and compare group analysis.

•7. The committee has also recognized the need to again launch education programs to improve user understanding of the value of AARC Benchmarking and how to use the data. It was decided to utilize the AARC Elluminate resources to conduct a series of programs. The topics of this series will be defined by user need and inclusive of no less than 4 presentations through 2011.

•8. Forums exist for user input indicated the AARC should consider International Marketing of this product. This is not a formal recommendation from the Benchmarking Committee, but an idea for the Executive Offer to consider as they see opportunities.

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

Billing Codes

Reporter: Roy Wagner

Last submitted: 2010-11-08 10:03:58.0

Recommendations

No recommendations at this time.

Report

AARC BOD Report

Billing Code Committee
AARC Activity Report
Winter BOD Meeting, 2010

Chair: Roy Wagner, RRT

Recommendation:

No recommendations at this time.

Summation of Committee Charges:

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.

Act as a repository for current respiratory therapy related codes.

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

Action: Ongoing

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

Plan: 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.

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

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

Action: No further action has occurred at the current time on this goal.

The Frequently Asked Billing Questions have been set up on the Web site and appear to be going well. Thanks to the Office Staff and Cheryl West for this effort.

Clinical Practice Guidelines

Reporter: Ruben Restrepo

Last submitted: 2010-11-12 09:32:18.0

Recommendations

[Recommendation #1: The committee has excused Ira Cheifetz and Michael Tracy from their duties as members of the committee per their request effective April and June of 2010, respectively.

Recommendation #2: The president has appointed Arzu Ari as a new member of the committee effective Spring of 2010. Steven Sittig, and Keith Hirst are filling the two vacancies listed on #1 and the committee requests their official appointment by the President.

Recommendation #3: The committee suggests the addition of Leonard Wittnebel, Richard Wettstein, and John Emberger to the committee to expedite the process of reviewing and updating the CPGs.

Report

I. Two CPGs were published in the June''s issue of Respiratory Care. An Editorial explaining the transition from "reference-based" to "evidence-based" CPGs was also part of June''s issue.

A. Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways

B. Providing Patient and Caregiver Training

II. Three (3) CPGs are underwent external review.

A. Capnography Capnometry has been submitted for publication - expected March 2011

B. Humidification during mechanical ventilation - minor editorial changes and expected submission by end of November 2010 - expected publication April 2011

C. Incentive spirometry - awaiting summary from editorial office to work on submission

III. Two (2) CPGs have been revised and updated but awaiting CPG committee''s input before submission to external reviewers by end of Nov 2010:

A. Selection of an aerosol delivery device for neonatal and pediatric patients

B. Discharge Planning for the Respiratory Care Patient

IV. Two (2) are currently undergoing revision and update - expected completion in Winter 2010

A. Sampling for arterial blood gas analysis

B. Transcutaneous blood gas monitoring for neonatal and pediatric patients

V. Five (5) CPGs have been assigned for revision and update - expected drafts in Spring 2011

A. Capillary Blood Gas Sampling for Neonatal and Pediatric Patients

B. In-Hospital Transport of the Mechanically Ventilated Patient

C. Pulse Oximetry

D. Surfactant Replacement Therapy

E. Selection of a Device for Delivery of Aerosol to the Lung Parenchyma

VI. Continue development of appropriate and new clinical practice guidelines in the evidence-based format.

A. EB-CPG on Inhaled Nitric Oxide. Completed and awaiting publication.

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 Committee

Reporter: Frank Salvatore

Last submitted: 2010-11-08 18:09:08.0

Recommendations

None

Charges:

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

    a. Ongoing.

2. Work with PACT coordinators, the HOD and the State Governmental Affairs committee to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care.

    a. Ongoing.

3. Assist in coordination of consumer supporters.

    a. Ongoing.

AARC Fellowship Committee

Reporter: Patrick Dunne

Last submitted: 2010-10-19 10:21:29.0

Recommendations

Fellowship Committee

AARC Activity Report

Winter 2010

Recommendations:

That the attached policy describing the activities of the AARC Fellowship Selection Committee be approved and incorporated per established guidelines.

Justification:

There are four major changes in the Policy compared to what has customarily appeared on the AARC website.

1. Eligibility: We are recommending that the period of required active or associate membership be increased from the current five years to **ten** years. Ten years is more in line with the minimum tenure required for an individual to exhibit the talents, traits, characteristics and accomplishments for someone to be considered for Fellow status.

2. Criteria: We are recommending that, henceforth, all nominations for FAARC can only be made by an AARC Fellow, with AARC membership in good standing. This is a transition to the format originally contemplated when the Fellowship program was launched in 1998. Only now do we have enough Fellows to make this change. This is also the format used by other professional medical associations.

3. Rules: We are recommending that the rules include a new statement that AARC Fellows are expected to maintain their membership in AARC. This expectation was also originally implied, but never formally codified.

4. Rules: We are recommending that the deadline for receipt of all nominations and supporting documentation be changed from August 31 to July 30, and that all mailed documents be postmarked no later than July 26 of the respective year. The change in date is necessitated by the fact that, starting in 2011, the AARC International Respiratory Congress will be held earlier in the year - - late October/early November. Accordingly, the selection process must be accelerated to coincide with the earlier planning of the annual Awards Ceremony. The inclusion of a postmark date is consistent with accepted business practices.

Report

The 2010 Committee reviewed 23 complete nominations received by the August 31 deadline and 14 individuals were selected to be Fellows of the AARC. All individuals selected have been so notified. The 2010 AARC Fellows will be formally inducted in December as part of the Awards Ceremony during the 56th AARC International Respiratory Congress in Las Vegas.

The Committee extends thanks and appreciation to Brenda DeMayo for processing all nomination forms (and supporting documentation), facilitating a timely and user-friendly selection process and dealing with several unexpected contingencies this year.

American Association for Respiratory Care

Policy Statement

SECTION: **Committees**

SUBJECT: AARC Fellowship Selection Committee

EFFECTIVE DATE: January 1, 2011

DATE REVIEWED:

DATE REVISED:

REFERENCES:

Policy Statement: The AARC Fellowship Program was established to recognize active or associate members who have made significant and sustained contributions to the art and science of respiratory care.

Policy Amplification: This policy sets forth the eligibility requirements, criteria for nomination and rules governing the AARC Fellowship Program.

Eligibility:

- Be an active or associate member of the AARC in good standing for at least ten consecutive years prior to the deadline for receipt of nominations.
- Possess the RRT credential issued by the NBRC or, be a licensed physician with a respiratory care-related specialty.
- Current members of the AARC Board of Directors are not eligible.

Criteria:

- Must be nominated by a Fellow of the AARC with membership in good standing.
- Must have demonstrated national prominent leadership, influence and achievement in clinical practice, education or science.

- Must possess documented evidence of significant contribution to the respiratory care profession and to the AARC.

Rules:

- Nominations will be evaluated annually by the Fellowship Selection Committee, consisting of five current Fellows appointed by the AARC President.

- New Fellows will be inducted during the Awards Ceremony held in conjunction with the annual AARC International Respiratory Congress.

- Newly inducted Fellows will receive a pin, a certificate suitable for framing and will have their names added to the list of Fellows on the AARC website.

- Fellows will have the right to identify themselves with letters FAARC after their names.

- All Fellows are expected to maintain their AARC membership after induction.

- Deadline for receipt of nominations and all supporting documentation will be July 30 of the calendar year in which the nomination is to be considered. Nomination packets must therefore be postmarked no later than July 26 of the respective year to ensure receipt in the AARC Executive Offices by the established deadline.

International Committee

Reporter: John Hiser

Last submitted: 2010-10-07 14:08:26.0

Recommendations

[None]

Report

1. Administer the International Fellowship Program.

This year we will welcome 4 new international fellows. We have invited two physicians one each from Peru and Austria and two respiratory therapist one from China and one from Saudi Arabia. Since beginning the program we've brought 135 respiratory care professionals from 54 countries to the US. They have included 68 physicians, 29 physiotherapist, 21 respiratory therapists, 11 nurses and 6 others with various medical backgrounds. They have come to us from every continent except of course Antarctica. The popularity of the program is evidenced by the fact that we've had over 1250 applicants from 130 countries.

I want to thank the AARC Board of Directors and the ARCF Board of Trustee and the ICRC for supporting the international fellowship program and the other international activities of the international committee for the past 21 years.

I also want to personally thank the members of the committee many of which have been involved in the program since its inception.

Thank you.

All charges to the committee were successfully completed.

2010

37 applicants for International Fellows
26 different countries
4 accepted
21 applicants for City Hosts
8 cities accepted

1990 - 2010 Program Totals

21 years
Over 1250 applicants
130 countries
135 Accepted Fellows
54 countries
90 Host Cities

Breakdown by profession/specialty

68 physicians
29 physiotherapists
21 respiratory therapists
11 nurses
6 others

International Fellow Applications by year

2002	38
2003	40
2004	24
2005	18
2006	17
2007	40
2008	46
2009	44
2010	37

City Host Applications by year

2002 Not available
2003 Not available
2004 14
2005 18
2006 13
2007 21
2008 23
2009 13
2010 21

2010 Program Schedule

Event	Date
Arrive in the First City:	Saturday, November 20
First City Rotation: Arrive in Second City:	Monday, November 22- Friday, November 26 Saturday, November 27
Second City Rotation:	Monday, November 29- Friday , December 3
Arrive in Las Vegas, NV:	Saturday, December 4
AARC International Congress:	Monday, December 6- Thursday, December 9
Fellowship Program ends:	Friday, December 10

2010 Program Roster

Adil Al Otaibi	Saudi Arabia	Miami, FL	Charlottesville, VA
Guillermo Carlos Contreras Noglaes	Peru	Tampa, FL	Durham, NC
Hui-Qing Ge	China	Dallas, TX	Denver, CO
Micheline Gmeiner	Austria	Boston, MA	Rochester, MN

Confirmed Sponsors as of November 1, 2010

AARC
AMP/NBRC
DME Train
Marsh Affinity
Pima Medical University

2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International portion of the Congress.

The committee continues to work with the ICRC to help coordinate and help prepare the presentations given by the fellows to the council.

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

We continue to work on improving communication and on targeted activities.
The International Fellows List serve continues to show activity and continues to be valued by our past fellows.

4. Coordinate and serve as clearinghouse for all international activities and requests.
We continue to receive requests for assistance with educational programs, seminars, educational materials, requests for information and help with promoting respiratory care in other areas of the world.

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

We continue to correspond with other medical associations, societies and practitioners. AARC representatives attended the ERS again this year. Several contacts were made with those interested in the fellowship program, international membership and potential contributors to *Respiratory Care*. We also visited with 10 of our past international fellows who were attending the meeting.

The international activities of the AARC continue to be of great interest to both the ARCF and to our AARC Corporate Partners. Updates on our activities were provided to both groups at their meetings in February and April respectively.

I want to thank Kris Kuykendall and Steve Nelson for all of their hard work.

The International Committee:

Vice Chairs
Debra Lierl, MEd, RRT, FAARC, Vice Chair for International Fellows
Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations

Committee members:
Michael Amato, BA, Chair ARCF
Jerome Sullivan, PhD, RRT, FAARC, President ICRC
Arzu Ari, PhD, MS, MPH, RRT,
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

Attachments

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

- BOD 12 2010 Int. Comm.pdf

Membership Committee

Reporter: Thomas Lamphere

Last submitted: 2010-11-08 21:48:32.0

Recommendations

1. Begin a membership campaign beginning in February, 2011 and ending April 20, 2011 (see charge #3 in this report for justification).

REPORT

Charges:

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

No action on this charge this quarter. As previously reported, three short webcasts focusing on "How To Increase Membership" were recorded earlier in 2010. 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.

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

A membership campaign was recommended as part of the summer report what would have taken place from August until November 1, 2010. This recommendation was not upheld due to the start of the Drive4COPD initiative and was tabled until 2011. The focus of the campaign will be on getting the AARC affiliates to actively recruit new members during these months. There will be two enticements utilized during this campaign aimed at the affiliates including:

- □□ □□A minimum threshold of new members will be determined for each state that will be communicated to the affiliate leadership prior to the start of the

membership campaign. State that meet the threshold will receive 2 free registrations to the AARC International Congress to use as they wish (i.e. for use by Board member, raffle off, give to a good member recruiter, etc..)

- The state with the highest total number of new members during the campaign will receive free membership dues for all voting members of the affiliate's Board of Directors and Membership Committee Chair.

- In addition, as an inducement to joining during this campaign, the AARC will offer a $10 coupon for the AARC Store (minimum purchase $25) the new members.

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

No activity.

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

The AARC Executive Office will obtain data for the proposed membership campaign for both 2009 and 2010. This will provide historical data with which to compare the data from the 2011 campaign.

My thanks to Sherry Milligan and Asha Desai in the AARC Executive Office. These ladies are the true "membership committee" and are the backbone of the committee!

Position Statement Committee

Reporter: Patricia Doorley

Last submitted: 2010-11-08 17:25:12.0

Recommendations

Recommendation # 1:

Approve and publish the position statement entitled "Administration of Sedative and Analgesic Medications by Respiratory Therapists". 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: The revisions recommended for this statement update the document to reflect the current language used in clinical practice and to identify that CoARC is the current accreditation body for Respiratory Therapy educational programs.

Recommendation # 2:

Approve and publish the position statement entitled "Pre-Hospital Ventilator Management Competency". This statement is submitted for your review as Attachment # 2. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: The revisions recommended for this statement more clearly identify the basic components of the training and education related to mechanical ventilation that must be completed by the pre-hospital provider and that the content of the curriculum must be based on the type of transport and patient population served.

Recommendation # 3:

Approve and publish the position statement entitled "Respiratory Care Scope of Practice". This statement is submitted for your review as Attachment # 3. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: The revision recommended for this statement removes language that presents a limit to the practice of respiratory therapists. This request was brought to the Position Statement Committee by a member whose facility has requested that Respiratory Therapists administer an anesthetic gas to patients with asthma.

Recommendation # 4:

Approve and publish the position statement entitled "Telehealth and Respiratory Therapy". This statement is submitted for your review as Attachment # 4. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: The revisions recommended for this statement update the language to reflect the expansion of electronic communication from just the internet to multiple forms of information technology and also to incorporate the concepts of the use of best practice and the promotion of wellness.

Recommendation # 5:

Approve the Position Statement Review Schedule presented as Attachment # 5.

Justification: There are currently twenty two (22) AARC position statements. The schedule submitted for consideration of, and approval by, the BOD will assure that each of the current statements will be scheduled for review on a 3 year schedule.

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.

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

During 2010, the Committee''s goal is to complete the review of the nine (9) position statements listed below. Action on each statement to this point in 2010 is listed following the statement title as is the name of the Committee member spearheading the review.

- Administration of Sedative and Analgesic Medications by Respiratory Therapists - Recommended changes submitted to BOD with this report (11/10) -- Linda Van Scoder
- Cultural Diversity - Statement reviewed and no changes were suggested; review date has been updated to 07/10 - Pat Doorley
- Health Promotion and Disease Prevention - Review completed; complete re-write of the statement recommended, but unable to get it completed -- Pat Doorley
- Home Respiratory Care Services - Recommended changes submitted and approved by BOD at the 07/10 BOD Meeting - Pat Doorley
- Pre-Hospital Mechanical Ventilator Competency - Recommended changes submitted to BOD with this report (11/10) -- Nick Widder
- Respiratory Care Scope of Practice - Recommended changes submitted to BOD with this report (11/10) -- Michael Hewitt
- Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists - Review completed and no revisions are recommended; statement review date will need to be updated to 12/10 - Nick Widder
- Respiratory Therapy Protocols - Review completed and no revisions are recommended; statement review date will need to be updated to 12/10 - Michael Hewitt

- Telehealth - Recommended changes submitted to BOD with this report (11/10) - Kathleen Deakins

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 # 5) has been revised to reflect the BOD actions through July 2010 and is submitted for BOD review and approval in Recommendation # 5.

4. Develop definitions for ''respiratory care'', ''respiratory therapy'', and ''respiratory therapist, and bring back to the December (2010) meeting.

This charge was received from the BOD at the July 2010 meeting. The work on this charge is currently incomplete. An effort will be made to provide the BOD with information to review related to this charge prior to the December 2010 BOD meeting.

Attachments

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

- Position Statement Committee Attachments 1110.docx
- AARC Position Statement Review Schedule 110810.xls

American Association for Respiratory Care

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

Position Statement

Administration of Sedative and Analgesic Medications by Respiratory Therapists

The American Association for Respiratory Care (AARC) recognizes the fact that Respiratory Therapists are called upon to assist physicians with the administration of sedative and analgesic medications during diagnostic and therapeutic procedures and patient transportation.

"Sedation" and "analgesia" describe a physical state in which the patient is able to tolerate unpleasant procedures, while maintaining adequate cardiorespiratory function, and the ability to respond purposefully to verbal commands and tactile stimulation. This is commonly referred to as moderate sedation/analgesia or conscious sedation. The AARC believes that Respiratory Therapists working under qualified medical supervision can assist physicians during diagnostic and therapeutic procedures and patient transportation, and help to minimize risks by administering prescribed medications and closely monitoring the patient.

The AARC recognizes and acknowledges the following:

- The American Society of Anesthesiologists (ASA) has published the document "Practice Guidelines for Sedation and Analgesia by Non-anesthesiologists." Reference: Anesthesiology, 2002; 96: 1004-1017
- The purpose of the ASA document is to allow clinicians to provide their patients with the benefits of sedation and analgesia while minimizing associated risks

- The ASA Guidelines should be followed by all Respiratory Therapists called upon to provide this service
- The clinicians and their facilities have the ultimate responsibility for selecting patients, procedures, medications, and equipment
- Respiratory care education programs approved by the Commission ~~on the Accreditation of Allied Health Education Programs/Committee~~ on Accreditation for Respiratory Care (or ~~their~~ its successor organization~~s~~) provide appropriate pharmacologic and technologic training to enable Respiratory Therapists to safely administer sedatives and analgesics by following the ASA Guidelines.

Following successful completion of a specialized education and competency assessment program the Respiratory Therapists must:

- Be knowledgeable about the techniques, medications, side effects, monitoring devices, response or untoward effects of medications, and documentation for any specific procedure
- Meet qualifications to be certified as competent, in accordance with her/his facility's and Respiratory Care Department's policies, to administer sedatives and analgesics under qualified medical direction
- The AARC affirms that Respiratory Therapists who have successfully completed a specialized education and competency assessment program on sedation and analgesia based on the ASA's Guidelines, and who have been certified as competent by the appropriate medical director and department head or governing body, should be permitted to provide the service in accordance with ASA's Guidelines, facility policies, procedures, protocols, and service operations, as well as with Joint Commission and state requirements and policies.

Effective 12/97
Revised 07/07

<u>Revised 12/10</u>

American Association for Respiratory Care

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

Position Statement

Pre-Hospital Ventilator Management Competency

It is the position of the American Association for Respiratory Care that all persons involved in the setup, initiation, application, and maintenance of mechanical ventilators in the pre-hospital setting be formally trained in both the clinical and disease-specific applications of mechanical ventilation. Pre-hospital ~~care-givers~~ providers must be trained to understand the age-specific interactions that application of positive airway pressure has on the cardio-pulmonary system, as well as the mechanisms available for the monitoring of these interactions. The pre-hospital provider must ~~also~~ be familiar with proper assessment of the airway and ventilation, safe and effective ventilator parameters, and the indications for changes in the settings of the mechanical ventilator. Finally, the pre-hospital provider must be familiar with ventilator alarms, the proper setting of alarm parameters, and strategies used to respond to ventilator alarms and malfunctions.

It should be noted that the training and education for pre-hospital providers regarding mechanical ventilation must be tailored to the type of transport. Providers conducting inter-facility transports, and those conducting the transport of special patient populations, will require significantly more didactic and clinical hours than providers who primarily provide ventilation to support patients from their time of arrival at the scene of an accident, or illness, until the handoff of care in an emergency department.

Further, the American Association for Respiratory Care recommends that all pre-hospital providers of mechanical ventilation be required to demonstrate competence, at regular intervals, in the use and manipulation of all mechanical ventilators used by their service ~~pre-hospital provider~~ during the transport of sick and injured patients.

Effective 12/07

Revised 12/10

American Association for Respiratory Care

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

Position Statement

Respiratory Care Scope of Practice

Respiratory Therapists are health care professionals whose responsibilities include the diagnostic evaluation, management, education, rehabilitation and care of patients with deficiencies and abnormalities of the cardiopulmonary system. The scope of practice includes the application of technology and the use of treatment protocols across all care sites including, but not limited to, the hospital, clinic, physician's office, rehabilitation facility, skilled nursing facility and the patient's home.

The practice of respiratory care encompasses activities in diagnostic evaluation, therapy, and education of the patient, family and public. These activities are supported by education, research and administration. Diagnostic activities include but are not limited to:

1. Obtaining and analyzing physiological specimens
2. Interpreting physiological data
3. Performing tests and studies of the cardiopulmonary system
4. Performing neurophysiological studies
5. Performing sleep disorder studies

Therapy includes but is not limited to the application and monitoring of:

1. Medical gases ~~(excluding anesthetic gases)~~ and environmental control systems
2. Mechanical ventilator support

3. Artificial airway care
4. Bronchopulmonary hygiene
5. Pharmacological agents related to respiratory care procedures
6. Cardiopulmonary rehabilitation
7. Hemodynamic cardiovascular support

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

Effective 8/87
Revised 12/07

Revised 12/10

American Association for Respiratory Care

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

Position Statement

Telehealth and Respiratory Therapy

Telehealth, also known as telemedicine or telepractice, refers to the use of electronic communication technologies and ~~the internet~~ information technology to allow health care providers in one location to offer services and provide consultations to patients and health care providers at another location. Services can include patient assessment, ~~and~~ education and promotion of best practice, diagnostic evaluation, sleep testing, monitoring, disease management, disease prevention, health and wellness promotion, and rehabilitation as well as specific patient consultations.

The American Association for Respiratory Care (AARC) supports efforts to promote, provide, and evaluate patient~~s~~ access to respiratory therapy services via telehealth. Furthermore, the AARC supports the recognition of respiratory therapists as providers of telehealth services under Medicare, Medicaid, commercial and other health insurance programs.

Effective 03/01
Revised 07/07

Revised 12/10

The <u>Position Statement Review Schedule</u> will be a handout at the meeting.

Public Relations Action Team

Reporter: Linda Smith

Last submitted: 2010-11-03 10:49:45.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

Over the last year the PRAT Committee contacted the Affiliate Presidents asking them for their help in distributing four separate press releases. The timely topics were Asthma in May, Air Quality in the heat of the summer, Preventing Respiratory Infections in time for the beginning of school, and Raising Awareness of COPD to coincide with COPD Month. Some of these releases were picked up by local papers.

There were no requests for review of information.

In September, Tom Kallstrom and I met with Reverend Anthony Evans, the director of the National Black Church Health Initiative. The focus of the meeting was to discuss how the AARC can assist his organization with the COPD Demonstration Project. Initial groundwork was laid. This continues to be a work in progress.

I wish to thank my committee for their attention to task. I also wish to thank President Myers for his willingness to allow me to chair the PRAT Committee this past year.

State Government Affairs Committee Report

Tom McCarthy, Chair
December 2010

Our Committee is tasked with providing assistance to state societies and the Executive Office on legislation and regulations that can be opportunities or challenges to the profession.

However, the Committee continues to focus on state licensure efforts by sleep disorder personnel and the impact such efforts will have on the practice of respiratory care. With the increase in the number of states that have passed sleep personnel licensure we are now also scrutinizing the accompanying regulations as these can have just as much of an impact on the respiratory profession as legislation does (See State Government Affairs Report from Cheryl West and review the issue in Maryland).

We have also been monitoring the effect of the newly created Certified Polysomnography Technician credential by the Board of Registered Polysomnographic Technologists (BRPT).

The new credential will simply require a candidate to be a high school graduate, hold a BCLS card and have completed basic self study courses sponsored by the American Academy of Sleep Medicine. Twelve weeks of working in a sleep entity is what is required to take the exam to earn the credential.

State Societies must monitor efforts to insert the unrestricted CPSGT credential in state legislation or regulations. Without practice parameters placed on the holder of a CPSGT credential, these individuals will be legally permitted to provide the full and extensive range of clinical services and procedures that is now asserted to be “polysomnography”.

We will be monitoring and evaluating this new credential and legislative and regulatory initiatives to determine the impact these changes will have on our patients with sleep disorders as well as the profession of respiratory care.
No Recommendations

Ad Hoc Committees

Cultural Diversity in Care Management Committee

AARC Activities Report
Fall 2010

Chair: **Joseph R. Huff** **Liaison:** **George Gabler**

Recommendation: None

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 the Fall Meeting. Erika Abmas will attend the Meeting on Sunday. Erika attended the Fall 09 meeting in San Antonio.

Mr. John Wilgis attended the 2010 Summer House of Delegates and Board of Directors Meeting. Mr. Wilgis will be attending the Fall 2010 Meeting as the Alternate Delegate.

The committee is still hoping to have a candidate from Nevada attend the Meeting. Information will be forward to the Board when available.

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

Status: Ongoing.

VP External Affairs Report

Ad Hoc Committee to Review the International Fellowship Program

December 2010 – Joe Lewarski

The AARC Board of Directors Passed Recommendation 10-2-23.1:
"That AARC establish an ad hoc committee to conduct a review to re-examine the structure, effectiveness, objectives and goals of the International Fellowship Program with conclusions and recommendations due in December 2010 to the AARC BOD and in February 2011 to the ARCF Board of Trustees."

Ad-Hoc Committee Members:

- Chair – Joseph Lewarski, BS, RRT, FAARC, Ad-Hoc Chair
- John D. Hiser, MEd, RRT, FAARC, International Committee Chair
- Debra Lierl, MEd, RRT, FAARC, Vice Chair for International Fellows
- Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations
- Michael Amato, MBA, Chair ARCF
- Jerome Sullivan, PhD, RRT, FAARC, President ICRC

Goals and Objectives of the Ad-Hoc Committee:
To conduct a review to re-examine the International Fellowship Program:

- Goals and objectives (Mission and Vision)
- The committee's structure (infrastructure, number of members, COI, etc…)
- Effectiveness
    - Financing (Revenue stream and Expense)
    - Selection Process: Fellows and Host Cities
    - Receptions and Congress Functions
    - Outcomes (based on Goals and Objectives)

Report Summary:
The committee met via phone on October 26, 2010 for approximately 1.5 hours. All members of the ad-hoc committee were in attendance. The committee discussed in order, the three primary and the four secondary issues (as noted above in the goals & objectives of the committee) that have been raised by the AARC BOD. To assist with the

project, the committee reviewed two documents prepared by John Hiser that provided detailed information and background on the International programs entitled “We are on a Mission” and “International Fellowship Program” along with two documents from Hassan Alorainy (International Fellowship & Just my Thoughts) that detail his personal concerns and suggestions regarding the Fellow selection process. All of these documents are included as attachments to this report. The following is the summary of the discussion and any recommendations:

Goals & Objectives

The committee reviewed the AARC mission statement, along with the goals of the International Fellowship Program (IFP). The committee agrees that the global mission of the AARC to “promote communication and fellowship among respiratory care professionals in the United States and their counterparts world though cooperation, dialogue and education exchanges” is still highly relevant and applicable today. The world is now smaller than ever and globalization is a standard within most modern businesses and professional organizations. In reviewing the goals of the Fellowship program, it was agreed that the primary goals are still relevant and applicable but may benefit from a more thorough review by the entire International Committee (IC). Therefore this Ad-Hoc committee recommends the AARC BOD direct the IC to review their current goals and determine if they need to be updated and/or modified.

Committee Structure

The IC is comprised of a diverse set of fourteen members. The ad-hoc committee believes the current size of the IC is adequate and necessary to accommodate the ever-changing size of the fellows supported. In reviewing the costs incurred to support this fourteen member committee, it was agreed that such is relatively minor and would not be altered significantly if the group number was reduced.

Financing, Selection Process & Congress/Receptions

These were by far the most sensitive areas discussed by the ad-hoc committee. They are quite complex because it involves activities and financial support from the AARC, the ICRC and the ARCF. There are clearly sensitive issues regarding which organizations incur expenses and what is the disposition of the income and/or losses. The 2009 financials were most concerning because the overall program operated essentially break-even. This was the result of the 2009 International reception operating at a loss (approximately $5k) and the Fellowship program operating near break-even (approximately $6K favorable). When comparing 2008 vs. 2009, there is about a $36k negative swing, most of which is explained by the loss of a significant volume of revenue for both the reception and fellowships. This is weighted in the lack of outside sponsorships and funding, which accounts for most of the difference year over year. The ad-hoc committee is concerned this is not a one-time event but potentially a trend, with future funding becoming scarcer. There is significant manufacture consolidation and many organizations have pulled back on donations and non-essential spending.

Pharma and medical device manufacturers are facing new and significant tax laws that will bleed even more money away from philanthropy.

The discussions about finance are intermingled with the fellow selection process and spending for the AARC Congress and International Reception.

- **Reception**: the ad-hoc committee has asked to postpone discussion around the reception as the IC and the ARCF are developing and implementing new strategies to solicit funding for the reception and to raise funds to support fellow activities. Members of the IC are aware of the strong financial concerns and believe they are taking appropriate steps to mitigate the issues. The IC is asking for additional time to implement the changes and measure the effectiveness.
- **Selection Process**: this was also a highly sensitive area of discussion, with some strong opinions in regard to the current process used to select Fellows and the need to re-evaluate and potentially change the process. Both the current process for selecting Fellows and the number of Fellows were discussed in great detail. Clearly, future finances will direct the number of Fellows, as the cost of the fellowships consumes the majority of the annual spend. Although the ad-hoc committee agreed the mechanics of the current selection process is adequate, there are differences in the selection philosophies. It is the ad-hoc committee recommendation that we direct the IC to review the current selection process and determine if it is still relevant and appropriate considering the current market environment. Ideally, the IC would benefit from an objective, measurable, outcomes based selection process.

Outcomes
The IC has a recognized set of high level goals, which more or less better define the mission and provide the general direction for IC and Fellow activities. The ad-hoc committee discussed the IC may benefit from developing some short-term (1-2 year) and longer term (5 year) measurable objectives. These objectives should be deliverable within the time frame allotted and be in keeping with the President's agenda and the overall mission and goals of the AARC. The ad-hoc committee recommends the IC develop some short-term and long term measurable objectives that align with the higher level goals of the organization.

Summary
The ad-hoc committee has met and acted on the charges from the AARC BOD and will await further direction from the BOD.

International Fellowship Program

The International Fellowship Program is a collaborative effort of the American Association for Respiratory Care (AARC), the American Respiratory Care Foundation (ARCF) and the International Council for Respiratory Care. It is sponsored by the ARCF administered by the AARC and supported by the ICRC.

International Fellowship Program Information

The Mission

The *Mission Statement of the American Association for Respiratory Care in Regard to International Activities* states that the American Association for Respiratory Care (AARC) seeks to "promote communication and fellowship among respiratory care professionals in the United States and their counterparts worldwide"…through "cooperation, dialogue, and educational exchanges." In keeping with this mission, the AARC is offering "**International Fellowships in Respiratory Care**." This important project is sponsored by the American Respiratory Care Foundation. The Fellowships have been established to assist health care professionals in visits to the United States to observe the practice of respiratory care as it is performed in a variety of settings, and visit the educational programs that teach it. The goals of the Fellowship program are to:

- promote the exchange, development, and coordination of the art, science and application of respiratory care.
- allow for meaningful interaction and cooperation among multi-national colleagues in an apolitical, humanitarian context.
- enhance the awareness and understanding of the profession of respiratory care and its role on the health care team.
- provide encouragement and assistance to those countries seeking to establish the profession of respiratory care.

Who Can Apply

Health care professionals from outside the United States who have:

- exhibited a profound interest in respiratory care.
- expressed a long-term commitment to the advancement of respiratory care.
- indicated a genuine interest in establishing respiratory care as an allied health profession.
- demonstrated proficiency in written and conversational English.

Fellowship Itinerary

- one travel day to the United States

- one rest day prior to beginning the Fellowship
- visits to two cities in the United States for a stay of approximately five to six days in each city. During the stay in each city, planned activities will include:
    - observation of the practice of respiratory care in large and small hospitals.
    - visits to formal educational programs of respiratory care at colleges and universities.
    - visits to alternate care sites where respiratory care is being provided, such as home care organizations, rehabilitation centers, skilled nursing facilities, hospices, specialty laboratories, etc.
- Attendance at the AARC International Respiratory Congress in Las Vegas, NV December 6-9, 2010.

Award Includes:

- Expenses incurred within the United States related to the planned site visits and the AARC National Convention, which will include lodging, food allowance, and local ground transportation.
- Paid registration at the International Respiratory Congress in las Vegas, NV
- Fellowship is limited to eighteen (18) days of lodging
- Fellowship is limited to eighteen (18) days of food allowance

Selected Fellows will be responsible for obtaining or providing funding for the following:

- All air travel expenses and arrangements to and from their country and within the United States
- Health insurance coverage for hospitalization, laboratory tests, and physician's charges that may be incurred due to illness or injury while in the United States
- All personal travel and expenses such as visiting friends and sightseeing

If you are interested in applying to be a Fellow, please complete the **online application form.**
Applications are accepted January 1 - June 1.

Feel free to contact us:

AARC
International Fellowships/City Host Program
9425 N MacArthur Blvd Suite 100
Irving, TX 75063
972-243-2272 (Phone) 972-484-2720 (Fax)
Email:kuykendall@aarc.org

AARC Vision/Mission Statement

The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist.

International Goals

1. Continue to advance our international presence through activities designed to address issues affecting educational, medical, and professional trends in the global respiratory care community. (from President Myers 2009/2010 Goals)

International Committee Charges

The 2009 – 2010 charges for the International Committee are as follows:
1. Administer the International Fellowship Program.
2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International portion 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.

Overview

This year marks the 21st year that the AARC has brought respiratory professionals from around the world to come to the US in order to see how we deliver respiratory care and also to share our knowledge as they share theirs. During that time we have brought 135 fellows to our country. They have included 67 physicians, 29 physiotherapist, 31respiratory therapist, 11 nurses and 6 others with various medical backgrounds. They have come to us from every continent except of course Antarctica. They represent 22% (54 of 245) of the countries that make up this small world we now live in. They have been involved in a unique educational experience that very few people get the opportunity to participate in. The fact that the AARC and the ARCF have been able to provide that experience for our international guests and for our city hosts has been a great source of pride for everyone who has been fortunate enough to participate in this wonderful program.

2010
37 applicants for International Fellows
26 different countries
4 accepted
21 applicants for City Hosts
8 cities accepted

1990 – 2010 Program Totals

- 21 years
- Over 1250 applicants
    - 130 countries
- 135 Accepted Fellows
    - 54 countries
- 90 Host Cities

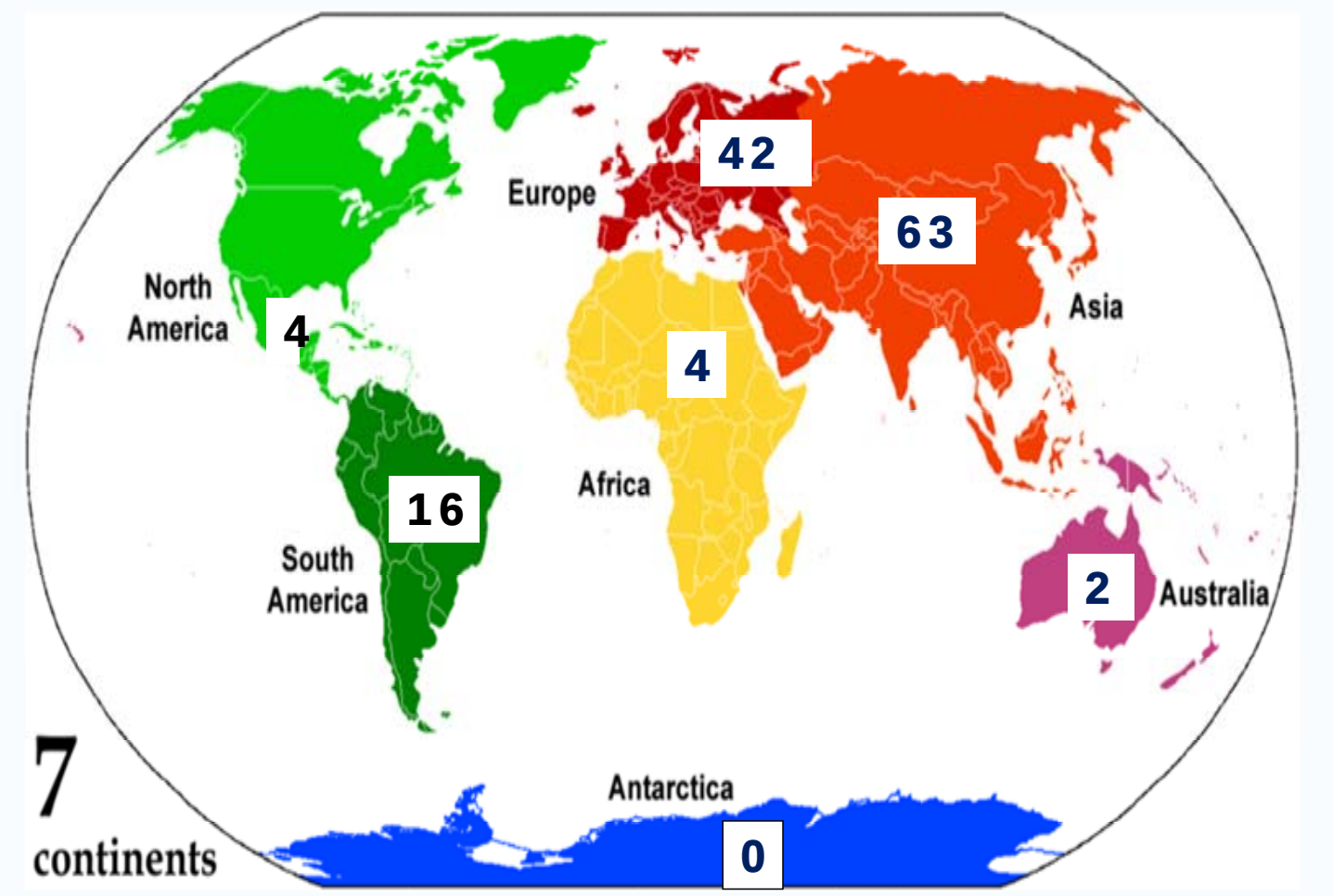
International Fellow Applications by year

- 2002 38
- 2003 40
- 2004 24
- 2005 18
- 2006 17
- 2007 40
- 2008 46
- 2009 44
- 2010 37

City Host Applications by year

- 2002 Not available
- 2003 Not available
- 2004 14
- 2005 18
- 2006 13
- 2007 21
- 2008 23
- 2009 13
- 2010 21

International Fellows
By Continent



As of December 2009

International Fellows
By Country

As of December 2009

International Committee Structure

The International Committee is made up of fourteen members. It consists of the chair, two vice chairs, one for the international fellowship program and one for international affairs, the president of the ICRC and the chair of the ARCF. It is a very diverse group with a wide variety of international exposure and experience. Five of the members are also members of the ICRC, three are trustees of the ARCF, five were born outside the US, three work outside the US, two spend several months each year assisting with respiratory care education in India and Turkey, three are past presidents of the AARC, six

are educators, two are managers, two are physicians, three are researchers, two are industry executives and all of them are passionate about the mission of the program. Seven of the members have over 10 years experience on the committee and the other seven have served for at least four years.

International Committee Members

Chair
John D. Hiser, MEd, RRT, FAARC
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, MBA, Chair ARCF
Jerome Sullivan, PhD, RRT, FAARC, President ICRC
Arzu Ari, PhD, MS, MPH
John Davies, MA RRT FAARC
ViJay Desphande, MS, RRT, FAARC
Hector Leon Garza, MD, FAARC
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

Fellows Selection Process

At least 3 weeks prior to the scheduled summer committee meeting the applications for fellows and host will be posted on AARConnect. Members will be sent log on information. An applicant information spreadsheet, committee member worksheets and benchmarking worksheets will also be sent to committee members via AARConnnect.

The applicant information spreadsheet and committee member worksheet including answers to the yes/no questions on the application will be completed by the executive office before being sent to the committee members. Committee members will review the applications using the committee member worksheet and benchmark worksheets as tools to assist in rank ordering the applicants.

The committee member will rank order the top 9 applicants with 1 being their first choice and 9 being last choice.

Committee members will email their choices to Debbie Lierl with a copy to John Hiser at least 5 days prior to the committee meeting.

Once the committee member's choices are received an applicant ranking spreadsheet will be completed. The spreadsheet is programmed to automatically rank order each applicant. Applicants will receive the score assigned by each committee member (1 through 9). Applicants not receiving a 1 through 9 will receive a score of 10. The

applicant with the lowest overall score will be rank ordered as the top choice while the applicant with the highest overall score will be rank ordered the last choice.

During the committee meeting the spreadsheet will be presented indicating the results of the committee members ranking of the candidates. Each committee member will then be given the opportunity to discuss their choices. **An applicant's ranking can be changed based upon the discussions and upon consensus of the committee members present. Final selection will be made by the committee members present.**

Committee members are encouraged to use International Committee Community on AARConnect to discuss, ask questions or endorse a particular candidate for fellow or host city during the review period. These discussions on AARConnect should only be shared with members of the committee and should not include your final selections, only discussions of individual candidates. Members should also feel free to contact other members by phone to discuss a particular candidate.

Selection of Hosts will be completed once the selection of Fellows is completed. The benchmarking tool may be used by the committee members to aid in their selection of hosts. Please make sure you have reviewed all the host applications prior to the meeting and rank them, your city host ranking does not have to be sent prior to the meeting.

Dear Committee,
You will soon be sent instruction on how to access the fellow and host applications via AARConnect. An applicant information spreadsheet along with the committee member worksheet and benchmarking worksheet will also be sent to you via the list serve.

A detailed description of how the tools may be used to help assist you in your choices is attached to this message. It will also be included on the disk.

The committee member worksheet contains all of the applicant's answers to the yes/no questions on the application. These were completed by the executive office as the applications were received. The benchmarking worksheets allow you to actually assign a score to each applicant based upon important aspects that are felt to reflect the quality of the applicant. Hopefully both of these new tools will aid you in your selections. The choice of using the benchmarking tool is optional until we see how it works.

Committee members are encouraged to use the International Committee List Serve to discuss, ask questions or endorse a particular fellow or host city during the review period. These discussions on the list serve should only be shared with members of the committee. Members should also feel free to contact other members by phone to discuss their selections.

Please rank order the applicants for fellows from 1 to 9 with one being your first choice and 9 being your last choice. Whether you will be attending the meeting or not it is

extremely important that you email your choices to Debbie Lierl with a copy to me by Tuesday, July 13th.

Take care,
John

John D. Hiser, MEd, RRT, FAARC
Chair AARC International Committee
2005 AARC President
Tarrant County College
828 Harwood Road
Hurst, Texas 76054-3219
817-515-6574 (Office)
817-371-3182 (Cell)
Skype: John.Hiser

BENCHMARKS FOR FELLOWS

	LEVEL 1: Exceeds Standards "0 Point"	LEVEL 2: Meets Standards "1 Point"	LEVEL 3: Does not Meet Standards "2 Points"
Previous Application	Applied >1	Applied once	None
Years of Experience	>5 years	1 to 4 years	<1 year
Known Reference	>1 reference	1 reference	No reference
Position	A pioneer at a powerful position	Serves as a physician, RT or nurse at a health care institution	Unemployed and/or unqualified due to his/her degree
Collaboration with the AARC	Considerable	Some	None
Contributions to the Profession in His/Her Home Country	Considerable *	Some *	None *
Quality of Statement and Interest in the Fellowship Program	Well written statement with excellent language, organization, and content.	Good statement in terms of language, organization, and content.	Poor statement due to several grammatical errors, poor organization, and unclear content

* Contributions to the profession can be evaluated based on the applicant's CV. Conference organization, publication, and voluntary work are a few items that can be used for this benchmark.

Sample Committee Member Worksheet

1	Family	Given	Prof.	Ranking	New	Previously			Official	US	Interest	Position	Followup	Known
2	Name	Name	Title	1 - 10	Country	Applied	Passport	Visa	Letter	Training	Est. RT	Est. RT	Report	Reference
3	Greenfield	Rodrigo	RT											
4	Garcia	Angelica	RT											
5	Serendero	Jose	PT											
6	Adasme	Rodrigo	PT											
7	Taculod	Juval	RT											
8	Wang	Qixing	RT											
9	Luo	Zujin	RT											
10	Izquierdo	Giovane	RT											
11	Taylor	Ronald	RT											
12	Ng	Fiona	RN											
13	Gopal	Bharat	MD											
14	John	Lejo Issac	MD											
15	Joseph	Saumy	RT											

Sample Applicant Information Spread Sheet

Country	Family Name	Given Name	Prof. Title/Dept.	Employer	City	Email
Brazil	Greenfield	Rodrigo	RT	Hospital Erasto Gaertner	Curitiba	rodrigog(
Chile	Garcia	Angelica	RT			amagaba
Chile	Serendero	Jose	PT	Hospital de Niños Roberto del Rio	Santiago	jmlander
Chile	Adasme	Rodrigo	PT	Teveuci Ltda/Clinical Hosp Pont Cath Univ	Santiago	radasme
China	Taculod	Juval	RT	Tan Tock Seng Hospital	Singapore	juveltacu
China	Wang	Qixing	RT	Shanghai Tenth People's Hosp/Tongji	Shanghai	wangqixi
China	Luo	Zujin	RT	Beijing Chaoyang Hospital	Beijing	rrtluozuji
Colombia	Izquierdo	Giovane	RT	Hospital Occidente de Kennedy	Bogota	giovaner
England	Taylor	Ronald	RT	Watford General Hospital	Watford	ron.taylo
Hong Kong	Ng	Fiona	RN	Queen Elizabeth Hospital	Kowloon	ngyyfiona
India	Gopal	Bharat	Physician	Metro Hospitals	New Delhi	drbharat
India	John	Lejo Issac	Physician	Palana Institute of Medical Sciences	Kannadi	dr_lejois
India	Joseph	Saumy	Asst Prof/RT	Manipal College of Allied Hlth Sciences	Udupi	saumyjo
India	Patel	Raxit	BS Medicine/Surg	T. B. Hospital	Vijapur	raxit.449
India	Peters	Amit	PT	MPM Hospital	Jagdalpur	onpc_jdp
India	Rao	Dadi	RT	Yashoda Hospitals/Kalkapet Branch	Hyderabad	srinivas_

Finances

INTERNATIONAL ACTIVITY

AARC	**2009**	**2008**	
INTERNATIONAL DEPT EXPENSE (1650-XXXX)			
MEETING	916	3,304	INTL COMMITTEE
TRAVEL			
MEETING FUNCTION--CONV	7,648	5,124	INTL COUNCIL
MEETING A/V		1,731	INTL COUNCIL
FELLOWSHIPS	10,000	6,000	SPONSORSHIP
OTHER		243	
	18,564	16,402	

INCL. ONLY DIRECT INTERNATIONAL EXPENSES IN AARC (EXCL. ERS AND SIMILAR TRIPS)

ARCF

ARCF INTERNATIONAL FUND ACTIVITY	**2009**	**2008**
INTL RECEPTION		

	REVENUE	11,400	(1)	26,300	(1)
	EXPENSE	(16,233)	San Ant.	(23,788)	Anaheim
		(4,833)		2,512	

FELLOWSHIPS

	REVENUE	36,065	(2)	59,263	(2)
	EXPENSE	(29,901)		(24,509)	
		6,164		34,754	

INCOME DETAIL>>>				
(1)--	NBRC>>>	10,000		25,000
	ALL OTHER	1,400		1,300
		11,400		26,300

(2)	AARC	10,000	AARC	6,000
	NBRC	5,000	NBRC	5,000
	MARSH	7,000	PALL CORP.	10,000
	STATES	9,200	GARY SMITH	5,000
			UN. TOLEDO	5,000
	DME	4,865	RESPIRONICS	5,000
		36,065	MALLINCKRODT	5,000
			MO SOCIETY	1,000
			MA SOCIETY	5,000
			GA SOCIETY	1,000
			AFFILIATES	920
			STATES	4,700
			INDIVIDUALS	1,200
			OTHER	4,443
				59,263

For 2008 & 2009

- **The international committee cost the AARC $4,220.**
- The international council meeting, including lunch and AV equipment cost the AARC $14,503.
- The AARC donated $16000 to the ARCF for sponsoring international fellows.
- **Total AARC expense was $34,966 for the ICRC and the International Committee and Sponsorships.**
- The international reception cost the ARCF $40,021. They took in $37,700 in donations for an overall cost of $2,321 spread out over 2 years.
- The ARCF spent $54,410 on fellows. They took in $95,328 in donations for a net income of $40, 918.
- **Total ARCF expense for the reception and fellows was $94,431 with a total income $133,028 resulting in a net income of $38,597.**
- **AARC spent 35 K. ARCF brought in 39 K more than it cost for fellows.**

INTERNATIONAL COUNCIL FOR RESPIRATORY CARE

The Council, comprised of governors from various countries, is a diverse group of worldwide health professionals forms the International Council for Respiratory Care, addressing issues affecting educational, medical and professional trends in the global respiratory care community.

There are twenty five member countries. Members of the council include the president, 5 executive committee members, one assistant to the council president, 18 council members by country, 4 at large council members, 3 governors' emeriti and two honorary deceased members. Of the 22 Governors 10 (45%) are past AARC international fellows.

Member Countries		
Argentina	Guatemala*	Singapore
Brazil	India	South Korea
Canada	Italy	Spain

China*	Japan	Taiwan
Chile	Mexico	Turkey
Colombia	Philippines	UAE
Costa Rica	Russia	United Kingdom
Finland	Saudi Arabia	USA
France		

** Candidate status*

Council members

President

Jerome M Sullivan, PhD, RRT, FAARC

Council President, Executive Committee Member

Professor Emeritus, College of Health Science & Human Service, University of Toledo

Toledo, OH USA

Executive Committee

Chia-Chen Chu, MS, SCRT, FAARC **(Past Fellow)**

Governor for Taiwan, ROC

Instructor/Technical Director, Respiratory Therapy, China Medical University/China Medical University Hospital

Tai-Chung City, Taiwan

Hector G. Leon, MD, FAARC

Governor for Mexico

Presidente del Consejo LatinoAmericano Certificación Profesional en Terapía Respiratoria, Respiratory Therapy Private Clinic

Mexico City, Mexico DF

Hassan S. Alorainy BSrc, RRT, FAARC

Governor for Saudi Arabia

Senior Clinical Respiratory Specialist

King Faisal Specialist Hospital and Research Centre

Riyadh, Saudi Arabia

Kazunao Watanabe, MD

Governor for Japan

Surgeon-in-Chief & Head, Shonan Kamakura General Hospital & Day Surgery Center

Kanagawa, Japan

Patrick J. Dunne, MEd, RRT, FAARC

Governor for the United States of America

HealthCare Productions

Fullerton, CA

Assistant to the Council President

Brian N Oka, RRT-NPS, FAARC

Clinical Sales Specialist, Holden Hospital Supply, Inc.

Honolulu, HI

Council Members By Country

Daniel Arellano, PT (Past Fellow)

Governor for Chile

The Latin American Certification Board

for Respiratory Care

Santiago, Chile

Arzu Ari, PhD, MS, MPH

Governor for Turkey

Istanbul, Turkey

Arvind Bhome, MD (Past Fellow)

Governor for India

Physician, Seth Ramdas Hospital & Research Center

Pune, India

Brendan Cooper, BSc, MSc, PhD, CBiol, MIBiol

Governor for United Kingdom

University Hospital Birmingham

Birmingham, United Kingdom

Patrick J. Dunne, MEd, RRT, FAARC

Governor for the United States of America

HealthCare Productions

Fullerton, CA

Gerardo Nicolas Ferrero, PT **(Past Fellow)**

Governor for Argentina

Clinical Consultant, Hospital Maria Ferrer

Buenos Aires, Argentina

Marcela Hamrick, RRT, BSA

Governor for Columbia

Manager Respiratory Care, Shriners Hospitals for Children

St. Louis, MO

Ruben Restrepo, MD, RRT, FAARC

Governor for Columbia

Associate Professor, UT Health Science Center

San Antonio, TX

Ray Hubble

Governor for Canada

President, Canadian Society for Respiratory Therapy

Jose Landeros, PT, CRT **(Past Fellow)**

Governor for Chile

Robertodel Rio Children's Hospital

Santiago, Chile

Kook-Hyun Lee, MD, PhD **(Past Fellow)**

Governor for South Korea

Professor, Seoul National University College of Medicine

Seoul, Korea

Christiane Menard

Governor for Canada

Executive Director, Canadian Sociery for Respiratory Therapy

Daniel McPhee

Governor for Canada

President, Canadian Society for Respiratory Therapy

Tetsuo Miyagawa, PhD, RRT, RPT, RCET **(Past Fellow)**

Governor for Japan

Associate Professor, Showa University School of Nursing & Rehab

Yokohama, Japan

Gustavo Adolfo Olguin, PT, CRT **(Past Fellow)**

Governor for Argentina

Director, The Latin American Board for Professional Certification in Respiratory Therapy

Buenos Aires, Argentina

Yorleny Vargas Prado, MS, RRT **(Past Fellow)**

Governor for Costa Rica

Respiratory Care Director, Santa Paula University

Curridabath, Costa Rica

Mohankumar Thekkinkattil, MBBS, MD, DPPR **(Past Fellow)**

Governor for India

Physician, Ramakrishna Institute of Paramedical Sciences

Coimbatore, India

Sergio Zuffo, PT

Governor for Italy

Physiotherapist, Ospedale Pediatrico Meyer

Firenze, Italy

Council Members At-Large

Michael T. Amato, MBA

Governor-At-Large

Senior Vice President, Special Accounts and Professional Relations, Monaghan Medical Corp

Syracuse NY

Derek L Glinsman, RRT, FAARC

Governor-At-Large

International Market Development Manager,

Philips Respironics Inc

Loveland CO

Bill Y Kashiwazaki

Governor-At-Large

President, Pacific Commercial Inc

Forest Hills NY

David Lu

Governor-At-Large

Respiratory Care Association of ROC

Taipei, Taiwan, ROC

GOVERNORS EMERITAE

Graeme A'Court
SINGAPORE

Pierre Emery
Versailles, Paris, FRANCE

Airton Stingelin Crespo, MD, FCCP **(Past Fellow)**
Rio de Janeiro, BRAZIL

Taisto Hakkinen
Vanajantie, Hameenlinna, FINLAND

DECEASED

Abundio Leon Valedrrabano, MD
Governor-At-Large
Mexico City, MEXICO

Toshihiko Koga, MD **(Past Fellow)**
Governor for Japan
Tokyo, JAPAN

ICRC MISSION STATEMENT

The International Council for Respiratory Care (ICRC) is dedicated to advancing the safe, effective and ethical practice of respiratory care worldwide through the following initiatives:

- Promoting the art, science, clinical practice and educational foundation required for the attainment of high quality respiratory care outcomes in all nations;
- Developing and disseminating evidence-based standards of care according to the special needs and resources of individual nations;
- Facilitating interaction among and between the allied health professions, nursing, the medical specialties, hospitals and clinics, service companies and industry;
- Encouraging the creation and growth of related respiratory care organizations in individual nations, and
- Providing educational resources for patients, caregivers and the general public in respiratory health promotion, disease prevention and rehabilitation as appropriate in individual nations.

Time lines

- It took 13 years (1947 to 1960) before we had our first registered therapist.
- It took 16 years (1947 to 1962) before The Board of Schools of Inhalation Therapy Technicians was formed in Chicago.
- It took 23 years (1947 to 1970) before The Board of Schools of Inhalation Therapy Technicians becomes the Joint Review Committee for Respiratory Therapy Education (JRCRTE).
- It took 30 years (1980 to 2010) to get legal recognition in 49 states. We still have one to go.
- It took 63 years (1947 to 2010) to go from 59 members to 50,000.

Change takes time.

We Are On a Mission!

The Mission Statement of the AARC regarding our international activities states that we are to "promote communication and fellowship among respiratory care professionals in

the United States and their counterparts worldwide"…through "cooperation, dialogue, and educational exchanges."

In keeping with this mission 21 years ago the AARC gave birth to the International Fellowship Program. This important project is sponsored by the American Respiratory Care Foundation (ARCF), supported by the International Council for Respiratory Care (ICRC) and administered by the AARC. Many of us consider it a rite of passage when someone reaches the age of 21. It's a time when a young man or woman is considered to have come of age, a time when they are considered an adult. It's also a time when parents look at the prior accomplishments of their children and dream about where they will be and what they will accomplish in the future.
But, should we be proud parents? Have we accomplished enough in the last 21 years? What do we need to do to accomplish more in the future? Are we fulfilling our mission?

Since 1947 our profession has grown from a handful of RN's, LVN's, former military corpsmen and medics, orderlies and other on-the-job trained individuals to an organized profession of over 150,000 credentialed therapists who graduate from nationally accredited programs with credentials that result from successfully completing job related validated exams and work in states that require legal recognition to practice. It took years of hard work by thousands of dedicated volunteers to come to where we are today. We had our successes and our failures along the way but we never stopped our efforts to make it better.

Thanks at least in part to the international efforts of the AARC the respiratory therapy profession outside the US is now on its way to achieving some of the same successes that we achieved here at home. Respiratory therapy is now known in over 50 countries where it was never heard of in the past. There are now 70 formal respiratory therapy programs in 8 countries outside the US. Master degree programs designed for nurses and physiotherapists are being developed in Asia, Europe and South America. Voluntary credentialing through the Latin American Board for Profession Certification in Respiratory Therapy (LABPCRT) using reliable criterion referenced, job related examinations is being taken advantage of in 11 countries. Mandatory credentialing along with legal recognition by the government exists in Canada, Panama, Philippines and Taiwan. Organized efforts to legalize the profession are ongoing in places like China, India, Peru, and the United Arab Emirates. At least 10 countries now have professional associations whose members are practicing respiratory therapists. Similar associations for physio-respiratory therapists exist throughout Europe and South America. We now have AARC International Affiliates in Italy, Mexico and United Arab Emirates. Educational programs approved by the ICRC International Education Recognition System are being offered. The AARC international fellow's list serve allows fellows to share information on a daily basis. Past fellows are working to translate educational materials to their countries languages. AARC CPGs have been translated to Chinese, Japanese, and Spanish. *A Guide to Aerosol Delivery Devices* has been translated to Arabic, Chinese and Spanish and is in the process of being translated to French, Italian and Turkish. *The Clinicians Guide to PAP Adherence* is being translated to Arabic. *AARCTimes* and *Respiratory Care* articles appear regularly in Italian and Japanese

publications. *Respiratory Care* journal podcasts and international news are provided on a monthly basis in both Chinese and Spanish by past fellows and current ICRC members Chia Chen Chu and Gustavo Olguin.
Since beginning the program we've brought 135 respiratory care professionals from 54 countries to the US. They have included 68 physicians, 29 physiotherapist, 21 respiratory therapists, 11 nurses and 6 others with various medical backgrounds. They have come to us from every continent except of course Antarctica. The popularity of the program is evidenced by the fact that we've had over 1250 applicants from 130 countries.

International Membership has grown from one member in 1961 to 500 in 2010. Our first international member was Dr. Abundio León, father of Dr. Hector León Garza a pioneer in our initial international efforts and charter member of the ICRC who continued his father's dream of introducing our profession to Mexico and other parts of Latin America.

The ICRC which first proposed the formation of the fellowship program to the AARC now has 22 Governors from 25 countries. Over 50% of the Governors are past fellows. Several ICRC members are the same leaders who first encouraged the AARC to globalize respiratory care. People like Jerome Sullivan, Patrick Dunne, Dr. Hector León Garza and Sensei Toshihiko Koga honorary member in memoriam of the ICRC and past fellow who worked to introduce our profession to Asia. All of these successes and many more are outlined in over 100 articles published in *AARCTimes* over the last two decades. Videotaped testimonials from 26 of the most recent fellows can be found on the ICRC web site at www.irccouncil.org/newsite/fellowship/index.cfm. So should we be proud? Are we fulfilling our Mission? The logical answer is a definite Yes. But are we doing enough? Can we do it better? Should we change our strategies? This last July the International Committee made a recommendation to the AARC Board of Directors that an ad-hoc committee composed of representatives from the AARC, the ARCF and the ICRC; the proud parents of the international fellowship program; and asked that a detailed review of the effectiveness of the program be completed before the board met again this December. This request was made so that we could study our past accomplishments and consider what we need to do in the future in order achieve our mission.

Where do we go from here? I'm not clairvoyant and I don't have a crystal ball but there is no doubt in my mind the AARC will continue its international efforts and I have no doubt that we will continue to succeed. Should we change our strategies? Maybe! Can we improve? Of course we can. We are on a Mission!

International Fellows by Country & Continent

- North America 3/4
  - Costa Rica
  - Mexico (2)
  - Panama
- South America 6/17
  - Argentina (5)
  - Brazil (4)
  - Chile (2)
  - Paraguay
  - Peru (3)
  - Venezuela (2)
- Africa 3/4
  - Cameroon
  - South Africa
  - Nigeria (2)
- Australia/Oceania 1/2
  - Australia (2)
- Antarctica → 0/0

- Asia 16/65
  - Bangladesh
  - China (11)
  - India (12)
  - Israel (3)
  - Japan (8)
  - Korea, South (2)
  - Malaysia (4)
  - Oman
  - Philippines (5)
  - Russia (3)
  - Saudi Arabia (2)
  - Taiwan (5)
  - Thailand (3)
  - Turkey (3)
  - UAE
  - Vietnam

- Europe 24/43
  - Austria (4)
  - Belarus
  - Denmark (2)
  - Finland
  - France (3)
  - Georgia
  - Germany
  - Holland
  - Hungary
  - Ireland
  - Italy (4)
  - Lithuania
  - Malta
  - Norway
  - Poland (2)
  - Portugal (3)
  - Romania
  - Serbia
  - Slovak Republic
  - Slovenia (4)
  - Spain (2)
  - Switzerland (2)
  - United Kingdom (2)
  - Uzbekistan
  - Yugoslavia

ICRC Member Countries

Argentina	Guatemala*	Singapore
Brazil	India	South Korea
Canada	Italy	Spain
China*	Japan	Taiwan
Chile	Mexico	Turkey
Colombia	Philippines	UAE
Costa Rica	Russia	United Kingdom
Finland	Saudi Arabia	USA
France		

** Candidate status*

Professional Associations

Argentine Society in Respiratory Care
Asociacion Mexicana De Terapia Respiratori
Association for Respiratory Care of Respiratory Insuff
Association of Respiratory Care Practitioners in the
Canadian Society of Respiratory Therapi
Emirates Association of Respiratory Care Pract
European Respiratory Care Association
Indian Association for Respiratory Thera
Japanese Respiratory Care Network
Korean Association for Respiratory Car
Panamanian Association for Respiratory C
Taiwan Society for Respiratory Therapy
Saudi Society for Respiratory Care

Legal Recognition with Mandatory Credentialing

Canada
Panama
Philippines
Taiwan

Voluntary Credentialing

South America

Argentina
Chile
Columbia
Peru
Venezuela

North America

Costa Rica
Ecuador
Guatemala
Mexico
Panama

Europe

Spain

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Respiratory Care." This important project is spons
Foundation. The Fellowships have been established to
the United States to observe the practice of respirato
settings, and visit the educational programs that teach i

The Goals of the International Fellowship Program:

- promote the exchange, development, and coordination of the art, science and application of respiratory care.

- allow for meaningful interaction and cooperation among multi-national colleagues in an apolitical, humanitarian context.
- enhance the awareness and understanding of the profession of respiratory care and its role on the health care team.
- provide encouragement and assistance to those countries seeking to establish the profession of respiratory care.

Selection Criteria of the International Fellows:

- exhibited a profound interest in respiratory care.
- expressed a long-term commitment to the advancement of respiratory care.
- indicated a genuine interest in establishing respiratory care as an allied health profession.
- demonstrated proficiency in written and conversational English.

Important Questions: Throughout, the many years of International Fellowship:

1. How many past iFellows have actually done anything to develop the Art and Science of Respiratory Care in there own countries.
2. How many iFellows maintained any form of professional communication with the AARC/ICRC?. How many are AARC members?
3. How many past iFellows came back to the AARC Congress?, how many are financially capable of coming on their own?
4. How many past iFellows have done any activities to enhance the awareness and understanding of the profession of respiratory care and its role on the health care team?
5. How many past iFellows made any efforts to establish **Real Model** Respiratory Care as an allied health profession?
6. How many past iFellows in a position to organize a Respiratory/ Pulmonary or Critical Care Conference or a meeting in their own countries. Or done so?
7. How many past iFellows actually met the selection criteria?

From a direct answer to the above questions, we could easily assess how successful we were in meeting the selection criteria and achieving the genuine objectives/goals of the International Fellowship.

Introduction:

I have always believed in inviting **CAREFULLY-SELECTED** people for the fellowship, people who can make difference in their own countries, people who are in a position to help achieve our goals. As you know, the US Respiratory Care model/ true Respiratory Therapist is "*currently*" highly respected/ appreciated by **PHYSICIANS** groups in health care systems around the world. "*Where influence/ power lay*". Therefore, I think we should specifically seek every possible opportunity to invite people who are in position (political, financial, or eminence) such as physicians, to help us achieve our ultimate goal "*….to promote the safe, effective and ethical practice of respiratory care worldwide through the promotion of the art, science, clinical practice and educational foundation required for the attainment of high quality respiratory care profession.*"

Increasing ties with physician groups in general at the international level would be much-much more beneficial to our cause than any other health care providers. Unlike the way it is the US health care system, in many counties around the world, the physician usually has a supreme authority with little (less than optimum) input from others in the bed side. (This is either by

design or due to lack of strong educational background, thus lack of knowledge, competence and confidence), in many cases the non-physicians are basically task oriented (Doers only). little or no power!!. Therefore, even if they like/admire/ believe in our profession, they have no or less than optimum power in their own countries to be able to introduce the right model of Respiratory Care Profession.

Why not start high up with prominent names in International Respiratory/ Pulmonary/Critical Care Medicine such as Physicians in charge of: ERS, Asia pacific Asian Pacific Society of Respirology, The European Society of Intensive Care, Asia-Pacific Association of Critical Care Medicine, World Federation of Critical Care Medicine, or for that matter any director of an ICU of well know hospital in any part of the world. Why not, a president of a well known college or a university, a government official in high position in the health care system, a government official in high position in the education system, an influential figure in health care such as CEO of health care company/system or an individual with strong interest in education and/or health care. I do understand that those people are usually very busy people and may not be able to come to our Congress for two weeks, but why not reconsider the length, itinerary, and structure of the iFellowship for those people.

Those are the people who are more likely to make a difference; they are usually more capable socially, politically and financially to host us or come back again to our Congress and be an effective member of the AARC International /ICRC and helping us achieve our goals.

This is not to say or believe that non-physicians are not important. But, our experience with Physicians International Fellows has proven to give us great results. Our experience with others has not been always effective or positive. In fact some of them want to have shortcuts to our well-established professionalism and remarkable status immediately, therefore they are trying to make some kind of short courses and call themselves Respiratory Therapist, rather than starting the profession as it should be with the appropriate standard curriculum and licensure.

In my opinion, I perceive some of them as impediment to our efforts of globalization of the **RIGHT MODEL** of Respiratory Care. The Respiratory Therapists are very admired and respected by physicians groups around the world for their knowledge and expertise. Therefore we need to take advantage of this unique opportunity to reach out and grow internationally.

Selection Criteria: *Fellows by invitation not by application:*

1. One or two fellows per year.
2. President of a well established Society/ Association in the area of Respiratory/ Pulmonary/Critical Care Medicine.
3. Prominent name in International Respiratory/ Pulmonary/Critical Care Medicine.
4. A president of a well known college or a university.
5. A government official in high position in the health care system who have the authority to introduce our profession to the educational system or at least could influence the officials to establish the Respiratory Care as a profession/discipline in universities, colleges, hospitals or clinics…etc.
6. An influential figure in health care such as CEO of health care company/system.
7. An individual with strong interest in education and/or health care.
8. Director of an ICU of well know hospital in any part of the world.

Itinerary Program:

Typically, those people would have limited time; therefore it may be appropriate to limit the fellowship to 4-5 days, one or two days before the AARC International Congress.

1. Observation of the practice of respiratory care at a tertiary care hospital.
2. Visits to formal educational programs of respiratory care at a university.
3. Visits to alternate care sites where respiratory care is being provided, such as home care organizations, rehabilitation centers, skilled nursing facilities, hospices.
4. Visits to Respiratory Care equipment/ supplies factory or company.
5. AARC International Respiratory Congress.
6. Guided/ escorted visit to the AARC International Respiratory Congress Exhibit Hall.
7. Recognition at ICRC Meeting and Reception.

Main Goal:

1. To make very possible effort to impress (influence/ convince) these fellows on the importance of quality Respiratory Care, so that when they go home, we will expect that they will do something in favor of introducing the profession to their counties.
2. Buy their interest through presentations and lectures on our profession, both the educational system/credentialing, and the clinical scope of practice.
3. Arrangement for meetings with renowned people of our profession, also well-known associates of our profession, especially physicians, and maybe CEO of famous suppliers or manufacturers

Follow-up:

1. Maybe make them an honorary member of the AARC and keep in touch with them, make every people effort to continuously communicate with them and keep them updated on our activities, and wisely ask and encourage them on the progress of the profession in their countries and offering our help.
2. If they are officials of well established Society/ Association in the area of Respiratory/ Pulmonary/Critical Care Medicine, make every possible effort to be present at their meetings as Speakers or Exhibitors. Or in the future provide our course the FRCS.

3. Delegate (sponsored by a company) a prominent name in Respiratory Care to visit the country of our fellow to spend a day or two as a guest of our Ex- Fellow and give presentations on clinical of PR type lectures about the profession and or education process, give advisory/ guidance, or may simply do clinical rotation.
4. Invitation to come back to attend our congress.

Benefits:

I am a true believer that there are countless benefits for globalizing the Profession of Respiratory Care, including but not limited to:

1. More jobs for Respiratory Therapists internationally.
2. Jobs for the educators all over the world.
3. Wider market for respiratory care equipment and supplies.
4. Wider market for Respiratory Care texts books.
5. Opportunity for the credentialing and accreditation bodies of our profession to expand.
6. Increase of international students which may positively affect the RC schools.
7. Most important, enhance the provision of quality patient care throughout the world.

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God Welling, more success in globalizing our profession.

Thank you,

Respectfully yours,

Hassan S. Alorainy BSrc, RRT, FAARC
Executive Committee Member, International Council for Respiratory Care (ICRC)
Vice-Chairman, International Committee, American Association for Respiratory Care (AARC)
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halorainy@gmail.com

Simply My Thoughts!
Hassan Alorainy

I am not sure if we had this discussion on this issue before or not, but I wanted to let you know that I have always believed in inviting **CAREFULLY-SELECTED** people for the fellowship, people who can make difference in their own countries, people who are in a position to help achieve our goals. As you know, the US Respiratory Care model is "*currently*" highly respected/ appreciated by **PHYSICIANS** groups in health care systems around the world. "*Where influence/ power lay*". Therefore, I think we should specifically seek every possible opportunity to invite people who are in position (political, financial, or eminence) such as physicians, to help us achieve our ultimate goal "*….to promote the safe, effective and ethical practice of respiratory care worldwide through the promotion of the art, science, clinical practice and educational foundation required for the attainment of high quality respiratory care.*"

Increasing ties with physician groups in general at the international level would be much-much more beneficial to our cause than any other health care providers. Unlike the way it is the US health care system, in many counties around the world, the physician usually has a supreme authority with little (less than optimum) input from others in the bed side. (This is either by design or due to lack of strong educational background, thus lack of knowledge, competence and confidence), in many cases the non physicians are basically task oriented (Doers only), little or no power!!. Therefore, even if they like/admire/ believe in our profession, they have no power in their own countries to be able to introduce the profession of Respiratory Care.

Why not start high up with prominent names in International Respiratory/ Pulmonary/Critical Care Medicine such as Physicians in charge of: ERS, Asia pacific Asian Pacific Society of Respirology, The European Society of Intensive Care, Asia-Pacific Association of Critical Care Medicine, Critical Care Society of Southern Africa or for that matter any director of an ICU of well know hospital in part of the world, manger of a well know hospital. Why not, a president of a well known college or a university, a government official in high position in the health care system, a government official in high position in the education system, an influential figure in

health care such as CEO of health care company/system or an individual with strong interest in education and/or health care. I do understand that those people are usually very busy people and may not be able to come to the USA for two weeks, but why not reconsider the length, itinerary, and structure of the iFellowship.

Those are the people who are more likely to make a difference; they are usually more capable socially, politically and financially to host us or come back again to the AARC International Congress and be an effective member of the ICRC. How many past International fellow were able to come back to the AARC? , and how many of them have been effective in doing something for the Respiratory Care Profession.

This is not to say or believe that nurses or physical therapist are not important. But, our experience with Physicians International Fellows has proven to give us great results, e.g Dr. Hector Leon Garza, Dr. Koga, and Dr. Antonio Esquinas. Our experience with Physical Therapists has not been positive e.g ERCA. I feel that they want to have shortcuts to our well-established professionalism and remarkable status immediately, therefore they are trying to make some kind of post PT courses and call themselves Respiratory Therapist, rather than starting the profession as it should be with the appropriate standard curriculum. In my humble opinion, I see them as impediment to our efforts of globalization of the **RIGHT MODEL** of Respiratory Care. *I mean Respiratory Care as it exists in North America… Yes, I heard and understand that, you, I mean the Americans, are little sensitive about not imposing the Respiratory Care model to other nations, but I think we should not look at it as an American way of life, we should look at it as an international vocation/ profession that is well established in the USA, Canada, Saudi Arabia and Taiwan. Therefore, I do not think we should compromise in the educational requirements for someone to be titled Respiratory Therapist. A person who does Chest Physiotherapy is not Respiratory Therapist. What scare me the most is when I see PTs, Technologist or Nurses who have a crash course on minimal aspects of our profession such as chest physiotherapy or BiPAP being called Respiratory Therapists.*

In conclusion:

1. I think we should think high, we need to deal with physicians. They are the most influential /powerful socially, politically and financially in the world. They are more capable to help us achieve our goals. The Respiratory Therapists are very admired and respected by physicians groups around the world for their knowledge and expertise. Therefore we need to continue our work and deal with them.
2. I feel, continuing with Nurses and PTs may not get us anywhere.

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The idea of the Fellowship Program is excellent, but I think we should rethink the selection criteria and the goals:

The selection criteria and the goal:

To carefully look and search for a person with great influence in their own countries, example:
A government official in high position on health care system who have the authority to introduce our profession to the health care organizations or at least can influence the officials to introduce the Respiratory Care as a discipline to Hospitals,, Clinics,, etc.

A government official in high position on education system who have the authority to introduce our profession to the educational organizations or at least can influence the officials to establish the Respiratory Care as a profession as discipline in universities and colleges, etc.
An influential figure on health care who can influence the officials to introduce the profession, e.g CEO of health care company/system.. Rich person who have strong interest in education and or health care.

Plans and Schedule:
Select around four (4) fellows from deferent countries each year may be enough: Typically, those people would have limited time, therefore it maybe necessary to limit the fellowship to 4 days the days during the AARC International Congress only. This will require a one dedicated person for each fellow. The idea/goal is to make very possible effort to impress (influence/ convince) these Fellows so that when they go home, we will expect that they will do something in favor of introducing the profession to their counties. Selling our profession can be accomplished through presentations and lectures on our profession both the educational system/credentialing, and the clinical scope of practice of our profession.
Arrangements for meetings with well-known associates of our profession, specifically physicians, renowned individuals of our profession, and CEOs of famous suppliers or manufacturers. May be visits to hospitals, Respiratory Schools, or Respiratory Care equipment/ supplies factories?

Follow-up:
We should keep in touch with these fellows and make very people effort to continuously communicate with them and keep them updated on our activities, and wisely asking them on the progress of the profession in their countries and offering our help.

Example of ideas: If someone (a Respiratory Care Practitioner) is going to Europe, India or somewhere in South America in their own vacation, they may be welling to volunteer to spend a day or two as a guest of our Ex-Fellow and help out by giving presentation lectures whither it is clinical of PR type lectures about the profession and or education process or even advisory or may simply be helping out clinically)

I am a true believer that there are countless benefits for globalizing the Profession of Respiratory Care: First, We are in the globalization age, the world in getting closer and closer. When our profession is internationally recognized there will be more jobs for American graduates internationally, jobs for the educators all over the world, more people know about respiratory care supplies and equipment thus more market for manufactures, more sales of Respiratory Care textbooks, also opportunity for the credentialing and accreditation bodies of our profession to expand,,, and maybe more international students studying in the USA which may positively affect the RC schools financially.

Maybe this is overkill nonetheless it is a thought!

If I can be any help to further address or expand on any of these issue please let me know, I realize these ideas require time, efforts and maybe money but I am welling to make every effort to help the ARCF and AARC/ICRC fulfill its mission.

****
**

Finally let me tell you about this little interesting true story that was told to Jerome, Sam and I during one of our meeting in Saudi last year:
One Medical Organization in the UK invited one very rich man from our part of the world as a gust for their conference. They made an extravaganza about his presence and offered him an honorary membership or fellowship and treated him very well. He in return, built a Research Center for them and donated (£5 million sterling pounds) as a research grant and. The amount was peanuts for him.

The moral of the story is that there are many rich people around the world who have excess money that they do not know what to do with it. Simple thought brought in millions of money to the organization.
****
**
Thank you

Ad Hoc Committee on Mass Casualty

Reporter: Richard Branson

Last submitted: 2010-11-02 07:13:19.0

Recommendations

Continually to up date statements on Mass casualty respiratory failure and ventilator issues as new data emerges.

Report

The group most recently assisted with the ventilator survey project. The next topic to be addressed is the expansion of respiratory care services in a disaster using other personnel to assist respiratory therapists. The personnel and duties need to be addressed.

Ad Hoc Committee on Officer Status

Ad Hoc Committee on Oxygen in the Home

Reporter: Kent Christopher MD, Robert McCoy
Last Submitted: 2010-10-20

Recommendation: None

Report:

The Ad Hoc Committee on Oxygen in the Home has finished its preliminary literature search. A Reference list has been compiled and we are in the process of obtaining actual articles and reviewing them. The next step is to collate them into a summary of the literature on Home Oxygen therapy. Other members of this Committee are Brian Carlin, Nick Hill, and Patrick Dunne.

Ad Hoc Committee on Protocol Implementation

Ad Hoc Committee on Pinnacle Award

Reporter: Jerry Edens

Last submitted: 2010-11-08 15:38:51.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

No new activity. Nothing else to report.

Ad-Hoc Committee: AARC Learning Institute

Fall 2010

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.

Summary of Activities Summer 2010:

1. A phone conference call was conducted on May 10th of the entire committee to review the RFP criteria based upon the project budget. Suggestions were based upon the Core Curriculum only since it will be the first phase of the project to be completed. The criteria was submitted to the Executive Office for review and/or revision before formulating the final RFP. It is hoped that the RFP will be completed and go by the end of the summer. The proposed RFP Criteria are found under Attachment C.

2. Individuals were contacted and asked to participate in the panel of experts for review of the Leadership Institute course competencies. Each individual willing to participate was asked to return a Confidentiality Agreement due to the sensitive nature of the material. A list of the experts willing to participate can be found under Attachment D.

3. Surveys were completed and sent to the AARC Executive Committee for approval. The participating experts were sent the appropriate survey links and asked to complete their review of the competencies by June 23th. Correspondence related to the survey process can be found under Attachment E. The committee would like to thank all the very busy top professionals who willingly gave of their time to participate in the competency review.

Summary of Activities Fall 2010:

1. The competency review was completed and all competencies which were scored by 50% or more of the evaluators as worth of inclusion were kept in the curriculum. The final course competencies have now been determined for the Core, Education, Management and Research Curriculums.

2. A Plenary Session was presented on July 17, 2010 at the AARC Sumer Forum entitled: "Continuing Professional Development: The AARC Leadership Institute". The presenter was Linda Van Scoder, EdD, RRT, FAARC, who did an excellent job.

3. RFPs for the Core Curriculum courses have been completed and are now available on the AARC Web site at: http://www.aarc.org/headlines/10/11/leadership_institute/ . Project Time line is as follows:

   RFP announcement – Nov 1, 2010
   Letter of Intent – Nov 15, 2010
   Informational webcast – Nov 22, 2010
   Response to webcast questions – Nov 29, 2010
   RFP closure date – Dec 31, 2010
   Contract sent to accepted authors – Jan 31, 2011
   Contract acceptance – Feb 15, 2011

   The committee would like to thank the Executive Office on all the work that they expended to make this possible.

4. The committee conducted a conference call on October 29 to review the activities of the summer, give final approval of the RFP and to decide on a process of evaluation for the applications. The last half hour of the meeting was devoted to laying out the Institute Presentation to be delivered on Tuesday at the International Congress.

1:00 pm – 1:45 pm

The AARC Leadership Institute: Preparing Tomorrow's Leaders Today

Toni L Rodriguez EdD RRT, Phoenix AZ and
Linda I Van Scoder EdD RRT FAARC, Indianapolis IN

Robert L Chatburn MHHS RRT-NPS FAARC, Cleveland OH
and Richard M Ford RRT FAARC, San Diego CA

The Leadership Institute program is comprised of a core curriculum that each participant must complete comprised of topics related to a basic skill set any practitioner would need to advance professionally (ie: communication, leadership, basic finance, computer skills etc). After completion of the core curriculum, individuals can complete any or all of 3 separate tracks: Management, Education and/or Research. Upon completion of the Core and a Track, the individual will be awarded a certificate of completion. The main goal of the Fast Track program is to make accessible to any RT anywhere the skills and mentorship required to advance as a professional in their work environment. The topics for the three tracks were chosen because they are key to the advancement of our profession, and the AARC is committed to growing our own future leaders.

I would like to thank my committee members and the Executive Office staff for all they have done this year to keep this project on track and moving forward.

Committee Members:
Chair: Rodriguez, Toni Ed.D, RRT
Member: Chatburn, Robert (Research Institute Chair) MHHS, 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%
Automony 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%
Automony 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%
Automony 69%
Respect 86%

Asked if this was offered would they promote its use it they said
Yes - 95%

Attachment C

Proposed RFP for Leadership Institute: Core Curriculum

Suggested RFP Format:

- A separate RFP for each module in the Core Curriculum (5 RFPs)
- Description for each module;
    - Target Audience: Each participant in the Institute must initially complete the Core Curriculum before entering a specialty track. The Core is composed of topics related to the basic skill set any practitioner would need to advance professionally (i.e.: communication, leadership, basic finance, computer skills etc). The audience for the Core Curriculum is any

Respiratory Care Practitioner who wants to acquire the general education skill set essential to advancement at any level of the profession.

- Content per module: (Competencies can be obtained upon request)

1. **CCC 101 Introduction to Communication:**
   Course Description: Theory and practice of communication skills in public, small groups and interpersonal setting.
   7 Competencies
2. **CCC 102 Health Information Management and Informatics:**
   Course Description: The use of technology to support and sustain information management within the healthcare environment.
   7 Competencies
3. **CCC 103 Financial Planning and Budgeting Principles:**
   Course Description: Fundamental theory of accounting principles and procedures as they relate to healthcare.
   5 Competencies
4. **CCC 104 Small Group Problem Solving and Decision Making**
   Course Description: An organized approach to problem solving, decision making and small group management.
   8 competencies
5. **CCC 105 Basic Management Skills**
   Course Description: The functions of management, specific roles and responsibilities of the supervisor and the application of leadership principles in addressing on-the-job situations and handling work related conflicts.
   7 Competencies

- Deliverables:
  - Each module when tested shall not exceed 9 hours for completion by the learner.
  - Each module shall be delivered as a stand-alone product.
  - Each module will be composed of separate lessons to cover each competency.
  - It will be the responsibility of the developer to identify all the course content and arrange in power point format in a manner that is effective, engaging, interactive and designed to reinforce learning by various learning styles.

        - Development of the lessons may require the production of new graphics, art work animation, photos and video. Industry Standard Visual Literacy Guidelines are to be followed as well as ADA and SCORM compliance.
        - Any previously designed/developed graphics, art work, animation, photos, text and or copy used in the development of a lesson must be cited and copyright release obtained by the developer.
        - Scenario-based activities are required to illustrate process and improve retention of material.
    - Lessons will be designed to provide self-paced, instructor independent e-learning.
        - Content should be written in standard English language
        - Geared to an adult reading level
        - Inter culturally appropriate
    - Assessment strategies must be designed to align with the lesson objectives.
        - Learner performance should be assessed and feedback provided through out each lesson as well as assessment on the overall module.
    - Technical Requirements**:** (Obtain from AARC IT)
        - Accessibility
        - Web Browser Support
        - Software Compatibility
        - Hardware Compatibility
- The AARC shall receive all electronic and written materials that were developed in completion of the RFP.
- The presentation of the final online materials shall be totally at the discretion of the AARC based upon corporate image requirement and guidelines.
- Intellectual property and copyright shall be the sole property of the AARC in partial and final completion.
    - Developers will receive credit as the module/lesson author.
- Time Line
    - **Develop a time line for completion**
    - Penalty:
        - A 15% penalty will be assessed for every calendar week the project is late.
- Payment:
    - 25% at the signing of the contract
    - 25% after all terns and requirement of the contract have been met.
    - 50% after successful completion and validation by the AARC.
- Selection Criteria:
    - Submit CV of the developer
    - Outline of course objectives to be achieved for each lesson of the module

    - Submit an example of an e-learning lesson previously developed.
- Submission deadline **Develop a submission deadline**

ATTACHMENT D

Management:
Doug Laher RRT MBA, RRT
Fairview Hosptial

Ken Thigpen, BS, RRT, FAARC,

St. Dominic Hospital

Stan Holland MS RRT

Rockingham Memorial Hospital

John Salyer, MBA, FAARC

Seattle Children Medical Center

Roger L. Berg, BS, RCP, RRT-NPS
Ridgecrest Regional Hospital

Education:
Lynda Goodfellow, EdD, RRT
Georgia State University

Gina Buldra, BS, RRT
Eastern New Mexico University

Peggy Watts, RRT
Barnes Jewish Hospital

Barry Grenier, RRT-NPS
Children's Hospital Boston

Debbie Lierl RRT, FAARC
Cincinnati Technical & Community College

Research:

Mike Gentile, RRT
Duke University Medical Center

Alex Adams, MPH, RRT
Health Partners

Ray Sibberson, MS, RRT
University of Akron

Terry Volsko, RRT, FAARC
Youngstown State University

ATTACHMENT E:

Thanks for your willingness to provide input on the relevance of the competencies developed for use in the AARC Leadership Institute, Management Track.
You will first be asked to evaluate the Core Competencies. Each participant must initially complete the Core Curriculum before entering a specialty track. The Core is composed of topics related to the basic skill set any practitioner would need to advance professionally (i.e.: communication, leadership, basic finance, computer skills etc). Next you will be asked to evaluate the competencies specific to the Management Track. Finally please give you're your over all opinion of the Core and Track competencies. Please indicate any competencies that you feel are missing and should be added.

The evaluation scale will be as follows:

Competency	Include	Exclude	Modify

Comments:

If you select "modify" please indicate how the competency should be modified in the space provided for **comment below each competency.**

Organizational Representatives

AMA CPT Health Care Professional Adv Comm

Reporter: Susan Rinaldo Gallo

Last submitted: 2010-11-08 10:51:48.0

Recommendations

Report

The long awaited response from the CPT Assistant editorial board concerning the use of HFCWO has been published (cpt Assistant, Sept 2010, vol 20:9). This is in response to our request for clarification of use of codes 94667 (Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial demonstration and/or evaluation) and 94668 (subsequent). Specifically we asked if these could be used to cover HFCWO (ie the Vest). The response is confusing and needs further definition (attached).

Summary of the response:

1. It *cannot* be used for HFCWO (i.e., Vest)

It is questionable if this can be used for the initial instructional session of HFCWO. RC managers need to check with their Medicare Administrative Contractors (MACs) for the final decision.

The article further states:
(Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device) can be used to cover the use of flow-operated inhaler devices such as Acapella. This is an additional use of this code which we did not have previously (good news).

2. Also Intrapulmonary Percussive Ventilation (IPV) can be coded as 94640 (Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device). I would add that Metaneb can be coded with 94640 as well.

3. I attended the annual HCPAC and CPT Editorial Panel meeting October 14-16, 2010. The RUC/CPT Relative Assessment Workgroup (RAW) is in the process of evaluating all CPT codes. This group looked at codes that were reported together more than 75% of the time (codes that are reported alone less than 25% of the time). The RAW had asked the specialty organization/s to make recommendations on combining codes.

A. The PFT codes fell into that category:
94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94260 Thoracic gas volume
94350 Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time
94360 Determination of resistance to airflow, oscillatory or plethysmographic methods
94370 Determination of airway closing volume, single breath tests
94720 Carbon monoxide diffusion capacity (eg, single breath, steady state) (DLCO)
94725 Membrane diffusion capacity

The ACCP and ATS were asked to revise the codes by combing several. The ACCP/ATS proposal presented at the meeting was to combine all these codes into one "super code". This was not well received and another proposal will be forthcoming.

The RAW will be evaluating codes that are have a high volume and low RVU. Our treatment codes may be in this group.

B. Revision to the language for ECMO codes 33960 Prolonged ECMO initial 24 hours and 33961 Prolonged subsequent day, 24 hours was proposed by the CPTAMA staff. The intent of these codes will not change.

C. Non CPT issues presented at the meeting were:
a. Conversion from ICD-9 to ICD-10 codes
b. Home Medical Model
c. Facilities/providers requesting Medicare reimbursement will need to meet new standards. Providers will need to meet additional quality measure s to qualify for Medicare reimbursement under "Meaningful Use" standards. These include: increase security standards (HIPPA), use of Computerized Physician Order Entry, the ability to E prescribe, EHR, automatic alerts of drug, drug interactions, and clinical support application/assistance.

Feel free to contact me for more information.

The information on the CPT HCPAC and the role of the representatives is listed below for the benefit of new BOD members.
Currently, the CPT HCPAC is comprised of three CPT Editorial Panel members (the CPT Editorial Panel chair and two elected representatives of the CPT HCPAC as further described herein) and seventeen representatives each representing one of the following organizations:

American Nurses Association
American Physical Therapy Association
American Speech-Language-Hearing Association
National Association of Social Workers
American Occupational Therapy Association
American Psychological Association
American Optometric Association
American Chiropractic Association
American Podiatric Medical Association
American Dietetic Association
American Academy of Physician Assistants
American Association of Naturopathic Physicians
American Association for Respiratory Care
American Massage Therapy Association
National Athletic Trainers'' Association
National Society of Genetic Counselors
Pharmacist Services Technical Advisory Coalition

Role and Functions

CPT HCPAC advisors have the following roles and functions in the CPT editorial process:

1. HCPAC members are encouraged to attend all CPT Editorial meetings as well as the annual advisor meeting (in October).

2. Preparing CPT code applications submitted by their organization or assisting/collaborating with other specialty organizations on applications.

3. Commenting on other applications, in advance of the CPT Editorial meeting.

4. Serving on CPT work groups related to the maintenance of the CPT code set.

5. Serving as liaison with the related national health care professional organizations.

6. Serving as an educational resource to their organization and other parties.

Other: Attachment

Coding Attachment 11-10.pdf

American Academy of Cardiovascular & Pulmonary Rehabilitation

November 8, 2010

Debbie Koehl

Recommendations

Recommendation #1 Continue liaison position of the Continuing Care Rehab Section chair as representative to AACVPR Professional Liaison Committee.

Report

- Attended AACVPR Annual meeting in Milwaukee, WI on October 7-9, 2010.
- Attended Professional Liaison committee meeting.
    - 4th Edition of Pulmonary Rehabilitation Guideline manual has been released.
    - NQF now has 2 performance measures for pulmonary patients, 6 minute walk and the Quality of Life tool, CGRQ.
    - PR registry project being developed.
        - Data dictionary
        - Data input
        - Trying to keep affordable
        - Benchmarking and data comparision
    - Liaison reports
        - ACCP is working on COPD Alliance to educate primary care providers.
        - ATS/ERS guidelines being redone.
        - Reported to group about work being done by the AARC URM project in regards to pulmonary rehabilitation. Need to gain AACVPR support when we survey PR programs.
        - APTA is concerned about PT's not being as involved in PR since new regs have been released.

Other

- Anne Marie Hummel and Cheryl West have continued to be important in our relationship with AACVPR in regards to legislative updates and concerns.
    - Recently have assisted in the support of HR 6376.

American Association of Critical Care Nurses

Submitted 11/9/2010

Karen Gregory

There is nothing to report at this time. Before this summer, I hope to have a meeting with the American Association of Critical Care Nurses.

It is an honor to serve on this committee. Thank you so very much.

Karen

American Heart Association

Amer Society for Testing and Materials

Reporter: Robert McCoy

Last submitted: 2010-11-04 15:51:26.0

Recommendations

none

Report

There have been no US meetings with the ASTM since the summer BOD meeting. A meeting was held in England on new oxygen conserving device standards. The process has started to address limitations in the current standard and will be similar to the efforts currently underway with NAMDRC.

I will continue to network within the specialty sections to identify standards under review or development to allow interested therapist the opportunity to provide input.

Chartered Affiliate Consultant

Reporter: Garry Kauffman

Last submitted: 2010-10-07 12:52:03.0

Recommendations

Recommendation

As a follow up to a suggestion made by then AARC President Rodriguez, in collaboration with Sam Giordano and Tom Kallstrom, I'd like to suggest that we consider Toni's recommendation to utilize the chartered affiliate consultant in a series of web casts aimed at improving the chartered affiliate leadership capabilities, with the potential of archiving the webcasts to serve as orientation and training for future chartered affiliate leadership. If approved, it would be my pleasure to participate.

Report

I have been in contact with several chartered affiliates via phone with regard to providing thoughts on questions posed by them to improve their operations (e.g. business planning, educational offerings, membership recruitment/retention, and BOD performance. On behalf of the Kansas BOD, Karen Schell asked me if I could work with their board during the last quarter of this and I have agreed, pending official submission of the request from the Kansas BOD and approval by President Myers.

Respectfully submitted October 7, 2010
Garry W. Kauffman, MPA, FACHE, RRT, FAARC

Clinical Laboratory Standards Institute

Reporter: Susan Blonshine

Last submitted: 2010-11-05 16:03:04.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

1. CLSI has published a new report which provides guidance on Methicillin-Resistant Staphylococcus Aureus (MRSA) Surveillance.

2. The Joint Commission and CLSI have partnered to provide education on Point of Care Testing and accreditation. The webinars highlight topics such as how the Joint Commission accredits clinical laboratories for point-of-care-testing (POCT) and POCT challenges for end users.

3. Delegate voting is open on POCT11-A2, Pulse Oximetry; Approved Guideline--Second Edition until December 6, 2010. Any comments on the document would be appreciated prior to the voting deadline.

4. GP26-A4, Quality Management System: A Model for Laboratory Services; Approved Guideline-Fourth Edition is in the delegate voting process.

5. Recently approved documents:
POCT07-A *Quality Management: Approaches to Reducing Errors at the Point of Care; Approved Guideline*

The guidance provided in the document to avoid POCT errors is extremely beneficial to quality coordinators as well as testing personnel. POCT07-A allows for a comprehensive and global look at a quality program.

Clinical Laboratory Institute POCT

Reporter: George Gaebler

Last submitted: 2010-11-08 09:28:40.0

Recommendations

No Recommendations at this time

Report

The CSLI POCT subcommittee published a guideline for Qualith Management approaches for reducing errors at the point of care. It is an approved guideline. To purchase the guideline CSLI members must pay $60. I would say the AARC guidelines are quite a benefit to members.

No other activity wil Respiratory Care implications during the reporting period.

Committee on Accreditation of Air Medical Transport System

Reporter: Steven Sittig

Last submitted: 2010-11-01 02:23:33.0

Recommendations

NONE AT THIS TIME

Report

The Commission on Accreditation of Medical Transport Services (CAMTS) held it''d final board meeting in Ft Lauderdale October 7th-9th. This year marks the 20th anniversary of CAMTS and a formal celebration was held the evening of October 9th after our three day meeting. During this meeting the updated 8th edition of the CAMTS standards were reviewed and released at the Air Medical Conference the following week in Ft Lauderdale. This recent edition of the standards has the most prominent mention of RT''s as medical transport staff. Recognition of advanced credentials such as RRT, NPS and C-NPT are now included in the matrix of advanced credentials. Prior to the edition no advanced credentials were listed for RT''s. It is hoped once the NBRC exam for Critical Care is released that this advanced credential will also be included

Attachments

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

- ExecutiveSummaryOctober20101.rtf
- ExecutiveSummaryOctober20102.rtf

camts
Commission on Accreditation of Medical Transport Systems

Executive Summary - CAMTS Board Meeting

October 7-9, 2010 – Ft Lauderdale, FL

The Board of Directors met for three days prior to the AMTC in Ft Lauderdale. Dr. Richard Orr, Vice-Chair, presided until Dr. Ralph Rogers arrived as Chair over a very busy meeting. There were 17 accreditation deliberations by the full Board. In addition, there were also 30 progress reports reviewed by the Executive Committee.

NEW MEMBER ORGANIZATION

Mr. Tom Judge and Eveline Bisson, representing ACCT – Association of Critical Care Transport – answered questions from the Board and continued a presentation provided by Dr. Suzanne Wedel at the July Board meeting. The Board voted to accept ACCT as a new member organization. Dr. Wedel will be the representative to the CAMTS Board.

BUDGET

Mr. Dudley Smith, presented the 1st quarter budget report. There was discussion about changing the fiscal year to calendar year. Ms Frazer will research with the accountant.

EXECUTIVE DIRECTOR REPORT

Safety Culture Surveys

Ms Frazer discussed a formal procedure for the Safety Culture Surveys that are becoming an integral part of the review process. A policy will be developed shortly.

Education Division

Brochures have been created for Just Culture, Threat and Error Management and AMRM.

Mr. Smith gave a report on the National Association of EMS Educators conference last month. Mr. Smith exhibited for CAMTS and this was our first exhibit at this conference. Mr, Smith commented that it was worthwhile and we should probably exhibit again next year.

Ms Frazer gave a update on the pre-conference workshops:

Preparing for Accreditation (55 registered). Faculty is Ms Frazer and Ms Corbett

Just Culture (55 registered). Faculty is Dr. Overton, Mr. Smith, Cpt. Tesmer and Ms Frazer
Threat and Error Management (32 registered). Faculty is Dr. Overton and Cpt. Tesmer

There is a great deal of interest in Just Culture and Threat & Error Management. We ran out of brochures at the booth and will follow up on groups that expressed sponsoring a course or combination of courses. Group rates will be a flat fee of $2000.00 plus travel and expenses and $500.00 for each additional course if programs would like to have two 4 hour sessions.

Aviation Management Working Group (AMWG)– Homeland Security

AMWG is the latest NIMS working groups (total of 10) working with FEMA to develop nation-wide disaster plans. Mr. Smith and Dr. Brunko have been part of the EMS Working Group for the past 3 years. Ms Frazer was invited to be part of the AMWG and is the only air medical representative among Coast Guard, BLM, Northcom, Law enforcement and other govt. agencies. There will be a meeting of all the working groups in November in Atlanta.

Standards Compliance Tool

Ms Frazer demonstrated the tool that will now replace the old PIF. The Part A has also been revised to address some of the issues we have had in the past and to clarify some of the ambiguous questions. Programs undergoing accreditation site visit for the March 2011 meeting have already received the new standards and the new tool.

There will be a presentation at the workshop and we will also have a copy of the compliance tool at the workshop on computer so that people can stop by and get first hand instructions.

20th Anniversary Party

The cocktail party will be held on Saturday, October 9th at the Hilton. Dr. Benson and Mary Gills, former Chairs of the Board will not be able to attend. Cathy Peterson, the AARC representative from 1990-1997 will attend. Former Board members, site surveyors and a representative from accredited programs have been invited to attend. Ms. Frazer will present a short ppt on the history of CAMTS and "Memories and Milestones", the booklet she created to be distributed to all. We also have a banner (created by Sheila Calvert - a CAMTS site surveyor - and her husband David) that gives a chronological history of CAMTS from 1990 – 2000. This banner will be displayed at the party and also at the CAMTS Exhibit booth.

Future Board meetings discussed

The next Board meeting will be in conjunction with the AMPA CCTMC conference

March 31, April 1 and 2, 2011. We also plan to do several workshops prior to this conference. Announcements will be forthcoming on the website.

Summer 2011 Board meeting will be July 14, 15, 16, 2011 at the Hilton Garden Inn in Englewood, CO. Board members were very happy with the accommodations and meeting space and several Board members live in the area.

ACCREDITATION STANDARDS COMMITTEE

The final draft of the 8th Edition Accreditation Standards was published. Board members received a copy and the books and CDs will be available for sale at the booth. All changes are posted on the website as well as rationale for new standards and changes to the standards.

PROCESS COMMITTEE

Several policies were reviewed and revised – mostly wording changes. A new policy manual has been posted on the website.

The Board had long discussions about duty times because several programs that were reviewed had repeated deficiencies in scheduling medical personnel over 24 hour shifts. The Board discussed using this as an eligibility requirement so that after 2012, for example, a program may not be eligible for accreditation if medical personnel are scheduled over 24 hours. A formal policy was not voted on and in the meantime the Board will continue to pursue specific research related to air medical services and fatigue.

Ms Holtschneider and a small committee began to work on a gap analysis tool for education requirements for the following: use of HPS, evaluating ongoing clinical experiences and advanced skills. Plans are to use these tools in the future to access clinical competency in a more consistent and quantitative methodology.

Dr Overton is reported that he continues to work king on a risk scoring tool.

A small Board committee will be working on these projects over the next several months.

QM/SITE SURVEYOR COMMITTEE

Ms Rogers gave a report on site surveyor evaluations from the recent surveys and quality management feedback from Board members on performance and process. All of the Site Surveyor evaluations were positive.

Peggy Calhoun Award David Bump was present at the meeting and was congratulated

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New

(Codes 94667 and 94668)

Codes 94667 and 94668 should be reported as appropriate for the performance of manual chest wall manipulation to mobilize pulmonary secretions and clear the bronchi. Typical patients include those with at least one of the following conditions associated with disease, injury, or immobilization:

- excessive sputum production,
- abnormal breath sounds including decreased or wet bronchi, etc., that suggest secretions in the airway,
- abnormal chest X-ray consistent with atelectasis, mucous plugging, or infiltrates, and/or
- deterioration in arterial blood gas values or oxygen saturation.

Manual mobilization techniques include cupping, percussion, vibration, and postural drainage. The purpose of percussion, also referred to as clapping, and percussors is to intermittently apply kinetic energy to the chest wall and lung by rhythmically striking the thorax with a cupped hand or mechanical device directly over the involved lung segment(s) being drained. Vibration involves the application of a fine tremorous action, which is manually performed by pressing in the direction that the ribs and soft tissue of the chest move during expiration over the draining area.

Chest wall manipulation performed by a qualified provider using mechanical devices is also described by codes 94667 and 94668. These types of external devices include those capable of delivering vibrating pulses (eg, a mechanical percussor such as Fluid Flute) or digital acoustic sound waves (eg, an electroacoustical transducer device such as Frequencer™) to the patient's chest and/or back assisting to move secretions. With these devices the professional is holding them to the patient's thorax and repositioning the device as needed.

Coding Tip

Code 94667 represents the initial delivery of bronchial therapy techniques to a patient as well as demonstration of the techniques in order to train family members or caregivers

continued on page 11

Black Hills Life Flight – Rapid City, SD RW/FW

The next Board meeting will be in Nashville, TN – March 31, April 1 and 2, 2011.

Extracorporeal Life Support Organization

Reporter: Donna Taylor

Last submitted: 2010-11-07 18:21:04.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report

Interest in credentialing ECMO Specialists has arisen over the last year and is being pursued by the Logistics and Education arm of the ELSO steering committee. A task force has been gathered to embark on this process to credential RNs, RRTs as well as perfusioninsts who pass this test. The interest in ECMO for Adults due to H1N1 has also increased the questions I have received regarding RRTs managing extracorporeal circuits over the last year. Adult ECMO courses have been offered regionally for centers new to ECMO. Additionally, the need for neonatal and pediatric training courses was suggested in the last Steering Committee meeting for those wanting to start up ECMO programs of their own. This renewed interest in ECMO will provide additional avenues for RRTs in these institutions.

International Council for Respiratory Care

Reporter: Jerome Sullivan

Last submitted: 2010-11-08 15:40:03.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

Report: The ICRC has been preparing for its annual Meeting in conjunction with the AARC 56th International Congress. Attached please find the complete Agenda for the ICRC Business Meeting.

INTERNATIONAL COUNCIL FOR RESPIRATORY CARE

Business Meeting - Las Vegas Hilton - Pavilion 6

Wednesday, December 8, 2010 - 7:30 a.m. - 4:30 p.m.

AGENDA

•I. **8:00 a.m. -** Welcome, **Jerome M. Sullivan, PhD, RRT, FAARC**, President, ICRC

Recognition of Award Winners - **Hector Leon Garza, M.D., International Achievement Award & Toshihiko Koga, M.D., International Medal**

•II. **8:10 a.m.** -Introduction of All Participants and Guests

•III. Report AARC International Committee - **John D. Hiser, M.Ed., RRT, FAARC & Debbie Lierl, M.Ed., RRT**

•IV. Reports of 4 International Fellows (10 minutes each): Austria, China, Peru and Saudi Arabia

•V. **9:00 a.m. - Special Presentation - Hassan Alorainy, BSRC, RRT, Governor for Saudi Arabia**

"Development of Respiratory Care in the Middle East: A Broader Perspective"

BREAK - 10:00 A.M.

•VI. **10:10 a.m. - -** International Respiratory Care Education Recognition System (IERS) - **Louis Sinopoli, PhD, RRT & Jerome M. Sullivan**

•VII. **10:30 a.m.** - Welcome from AARC - **Karen Stewart, MS, FAARC, President**

•VIII. **10:35 a.m.** - International Perspectives - **Sam Giordano**, **MBA, RRT,** Executive Director, AARC

•IX. **10:45 a.m**. - National Board for Respiratory Care (NBRC)

Gary Smith, BS, FAARC, Executive Director & Homer Rodriguez, RRT, FAARC,

Director, International Affairs

•X. **10:55 a.m.** - Report from Mexico, **Hector Leon Garza, MD, Governor for Mexico**

•XI. **11:10 a.m**. - Report from Turkey, **Arzu Ari, PhD, RRT, Governor for Turkey**

•XII. **11:25 a.m. -** Report from Columbia, **Ruben Restrepo, MD, RRT, FAARC, & Marcela Hamrick, RRT, BSA, Governors for Columbia**

•XIII. 11:40 a.m. - Report from Japan, **Kazunao Watanabe, MD,** & **Tetsuo Miyagawa,PhD, RRT,RPT,RCET, Governors for Japan**

BOX LUNCH BREAK - 12 O''CLOCK P.M.

For further information in Las Vegas, please contact:

Jerome M. Sullivan Las Vegas Hilton Phone: 702-732-5111 702-732-5111

Email: Jerome.Sullivan@utoledo.edu, Cell Phone: 419-276-5583 419-276-5583

•XIV. **1:10 p.m. -** Report of Executive Committee **- Recommendations - Action Items for vote**

•XV. 1:30 p.m. - Report from Taiwan, **Chia-Chen Chu, MS, SRRT, FAARC, Governor for Taiwan**

•XVI. **1:50 p.m. -** Report from Canada**, Christiane Menard, CSRT Exec. Dir. & Michael Lemphers,President**

•XVII. **2:10 p.m. -** Report from Italy, **Sergio Zuffo, PT**, **Governor for Italy**

•XVIII. **2:30 p.m. -** Report from South Korea, **Kook-Hyun Lee**, **MD**, **Governor for South Korea**

•XIX. **2:40 p.m. -** Report from United Arab Emirates, **Noel Tiburcio, PhD, RRT-NPS, Governor for UAE**

•XX. **2:55 p.m. -** Report from Chile , **Jose Landeros PT, RTC Governor for Chile**

•XXI. **3:10 p.m. -** Report from Argentina, **Gerardo Ferrero, PhD, RRT** & **Gustavo Olguin, PT, RTC, MHCA**, **Governors for Argentina**

•XXII. 3:30 p.m. - Report for Costa Rica, **Yorleny Vargas Prado, MS, RRT**

•XXIII. **3:50 p.m. -** Report for Indian Association for Respiratory Care, **Vijay Deshpande, MS, RRT, FAARC**

XXIV. **4:05 p.m.** - Ratification of Governors and Officers

International Affiliate: Additionally the ICRC has been working with the Saudi Association for Respiratory Care in preparation of their application for AARC International Affiliate Status. Hopefully this will be submitted prior to the Las Vegas Meeting.

International Education Recognition System: It is positive that there has been a significant increase in the numbers of approval/recognition requests through the ICRC-IERS System. As you know IERS Recognition attests to the quality of program content and faculty on an international level. Recently IERS has approved two separate programs from Japan and two from Turkey and one from the UAE. The demand is increasing and there are several programs pending review and approval. In this regard, I have placed a discussion of IERS on the Agenda for the Council''s Business Meeting to provide an overview and highlights of those approved programs. Attached please find a power point presentation on the IERS System.

Thank you. Respectfully submitted. Jerome M. Sullivan

For further information in Las Vegas, please contact:

Jerome M. Sullivan Las Vegas Hilton, Phone: 702-732-5111 702-732-5111

Email: Jerome.Sullivan@utoledo.edu, Cell Phone: 419-276-5583 419-276-5583

[Insert report here]

Other

[Insert other information here]

Attachments

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

- Vegas ICRC_IERS.pptx

Joint Commission - Home Care PTAC

Reporter: Dianne Lewis

Last submitted: 2010-11-01 17:56:28.0

Recommendations

None

Report

Nothing to report. A conference call was held in September but I was unable to attend.

Joint Commission - Ambulatory PTAC

Reporter: Michael Hewitt

Last submitted: 2010-11-02 10:29:55.0

Recommendations

Report

The regularly scheduled activity for the Ambulatory PTAC for 2010 has concluded. The final conference call for the year took place on September 9th, 2010. The topics of discussion on that call were:

1) Primary Care Home Initiative. None of the discussion involved issues of significant interest to the AARC or respiratory therapists.

2) Proposed Revision to the Medication Reconciliation National Patient Safety Goal. None of this discussion involved issue of significant interest to the AARC or respiratory therapists.

The activities of this group for 2011 is scheduled to begin at the end of January, 2011.

Medicare Coverage

National Asthma Education & Prevention Program

Reporter: Natalie Napolitano

Last submitted: 2010-11-05 13:54:30.0

Recommendations

None

Report

1) There was an Asthma Outcomes Workshop held in March 2010, supported by the NHLBI, the National Institute of Allergy and Infectious Diseases, the National Institute of Child Health and Human Development, the National Institute of Environmental Health Sciences (NIEHS), the Agency for Healthcare Research and Quality (AHRQ), the Merck Childhood Asthma Network (MCAN), and the Robert Wood Johnson Foundation. The aim of the workshop was to recommend core, supplemental, and emerging outcomes and methods for their measurement to be included in NIH-initiated clinical asthma research. An additional aim was to recommend priorities for future research. NIAID and NHLBI co-chaired a planning committee that suggested seven categories of outcomes: asthma control, biomarkers, exacerbations, health care utilization and costs, physiology, quality of life, and symptoms.

Over the course of about one year, 80 sub-committee members drafted reports corresponding to each of the seven outcome categories. In reviewing outcome measures, committee members found that some existing measures are not valid and/or reliable. For example, quality of life measures focus on the frequency and intensity of symptoms, not the patient's perception of the personal impact of those symptoms. Subsequently, the committee on quality of life concluded that there is no available instrument that adequately and discretely measures quality of life.

Additional experts provided critiques at the March meeting. Other meeting attendees included federal agencies with asthma research programs and members of the pharmaceutical industry.

The report will be published in 2011, perhaps in the Journal of Allergy and Clinical Immunology. Additionally, the Division of Lung Diseases of the NHLBI may convene federal agencies to establish commitments and identify mechanisms for implementing recommendations. The NHLBI also wants to promote use of the outcomes definitions and will beta-test the core measures in funded research prior to making them available.

2) There was discussion focused on developing best practice standards for asthma surveillance. The Council of State and Territorial Epidemiologists (CSTE) is an organization of epidemiologists and affiliate members. Founded in the 1950s, the CSTE''s mission is to use epidemiologic data to guide public health. Tasked with deciding what diseases will be reportable nationally, the CSTE provides technical assistance to partner organizations and federal public health agencies such as the Centers for Disease Control and Prevention (CDC). Asthma surveillance programs provide data that can be used to assess the burden of asthma. Comparable standardized indicators are critical to adequate surveillance. With the current expansion in data sources, an expanded set of asthma surveillance indicators will be critical. In June, CSTE issued a position statement recommending continued development of a comprehensive surveillance system with a standardized set of priority indicators for asthma surveillance. As a next step, CSTE and CDC are forming an Asthma Surveillance Indicator Steering Team. CSTE is looking for expertise in particular indicators.

•} Asthma surveillance programs provide data that can be used to assess the burden of asthma, by detecting sentinel events, monitoring trends over time, and evaluating the effectiveness of asthma public health programs.

•} The development of a standardized set of asthma surveillance indicators will improve the comparability of these data between states, increase epidemiologic capacity in states that are not already conducting asthma surveillance, and guide asthma intervention activities.

3) Committee provided an update on the NCI projects and saught input on various options and ideas for future movement.

4) A plan was discussed to developed in collaboration with multiple federal agencies to conduct a nationally representative survey of healthcare providers in primary care settings. Most of the national data that already exist describe the patient perspective (such as number of patients getting formal asthma education, written asthma action plans, those receiving education, those advised to change their home or work environment). Currently, there is not a national survey that focuses on questions such as what providers know about the guidelines, whether they use them, and which elements they find to be most effective, whether they have the time and resources necessary, whether patients accept recommended care, and what other barriers exist.

The goal of this national survey is to gain insight into clinical decision-making, collect data from asthma visits to assess the use of key practices, and obtain a sufficient sample for comparison across specialties, geographic areas (rural vs. urban), and different patient

populations (children vs. adults), in order to establish baseline data to help gauge the impact of the guidelines. Funding partners for the survey are still being recruited; so far they include the National Institutes of Health (NIH), CDC, Environmental Protection Agency (EPA), AHCQR, and MCAN. Currently the activity has an administrative workgroup (funding agency representatives) and survey content workgroup (funding agencies and volunteer experts).

5) It was outlined how the EPA, through its Communities in Action campaign, is trying to accelerate the adoption of the Expert Panel Report (EPR)-3 guidelines and GIP recommendations and to accelerate the infusion of these at the community level. The idea behind the campaign is to bring together all the assets that are important at the local level. There is an action learning network where community asthma program leaders can share strategies and best practices, lessons learned, and other resources via webinars, discussion forums, and a resource bank for community assets and products. The campaign has engaged 1,200 programs across the country, more than 500 of which engage in the online network.

Centered on communication, patient provider support, system integration, and the GIP messages, the campaign is anchored in the Allies against Asthma report from 2003-2005 that looked at 200 programs across the world that were tracking outcomes. Out of this study emerged set of key drivers that programs were using and that were most associated with getting good health outcomes, including leveraging community assets and tailoring the intervention to fit the situation/patient. The report found that home-based, multi-trigger, multi-component interventions for children and adolescents are a cost-effective method of improving quality of life and productivity; support clinicians'' work with medication management and care coordination; and are an ideal way to operationalize GIP priority messages. NAEPP members are encouraged to leverage this system.

National Coalition/Health Professional Education in Genetics

Reporter: Linda Van Scoder

Last submitted: 2010-11-03 07:37:36.0

Recommendations

None

Report

I represented the AARC at the NCHPEG meeting in Bethesda September 23 & 24. Their new executive director, Joan Scott, was introduced there. I will continue to monitor NCHPEG and Genetic Alliance announcements for opportunities for the AARC to join them in support of our patients and members.

National Sleep Awareness Roundtable

Reporter: Mike Runge

Last submitted: 2010-11-01 08:57:00.0

Recommendations

No recomendations at this time

Report

Nothing to report at this time

Neonatal Resuscitation Program

Reporter: John Gallagher

Last submitted: 2010-11-09 13:10:10.0

Recommendations

There are no recommendations at this time.

Report

The NRP Steering Committee (NRPSC) met on September 29 & 30, 2010 for committee meetings and on October 1, 2010 for the NRP Current Issues Seminar titled "Game Changers". Both the meetings and the seminar took place in San Francisco, California at the site of the 2010 AAP national convention.

The meeting included a review of grant proposals for the NRP Young Investigator Award and the NRP Research Grant. As is typical with this process, the chairperson(s) of the NRPSC assign our liaison the task of reviewing proposals that allow our clinical expertise to be of value to the review process. Our recommendations and votes are included in the decision to award grant money to prospective investigators. Further discussions took place regarding research priorities and future funding allocation.
The remainder of the meeting was largely consumed by a final review of the 6th edition materials for the NRP. Included in this review were textbook modifications, instructor manual and DVD formatting, on-line examination procedures, and webinar planning for product release. Also included in the meeting was a report from liaisons. I presented an update of AARC activities that was current at the time of the meeting.

At the NRP Current Issues Seminar, all of the NRPSC members contributed to the skill development of the attendees. As the AARC liaison, I worked in a break-out session titled "Cutting Edge Gear". In this session, I presented the t-piece resuscitator in a hands-on demonstration which allowed for a Q&A period with the nurses, physicians, and other respiratory therapists in attendance.

In addition to the meetings, I have been called upon to answer occasional questions from NRP providers that pertain to resuscitation equipment or practice. I have also worked to

coordinate with the education specialists at the AAP and the director of education at the AARC.

Finally, it is important to note that the updated recommendations of the NPR have been made available to the public. All of the information, from content to testing, has been made available on the NRP website, www.aap.org/nrp.

Other

The NRPSC is scheduled to meet at the AAP headquarters in Elk Grove, IL in March of 2011. Exact dates are not yet available.

Simulation Alliance

Unfinished Business

- Consideration of House Resolutions
- Policy Review
- NBRC
- CoARC

AARC House of Delegates Resolutions – Dec 2010

House of Delegates Resolution 87-10-07

Resolution Author: Jim Lanoha

E-mail:lanoharentals@charter.net

Phone Number: 225 931 8448

Author's State: LA

Co-Sponsors and Their States: none

Resolution:
Resolve that the AARC revise its disaster relief policy to allow the AARC President to consider activating the fund upon request of an affiliate president in the event of a state or local governmentally proclaimed state of emergency or disaster.

Rationale:
To allow members to apply for assistance when a major event is not proclaimed a Federal Disaster by the US President. As an example the governor of Ohio repeatedly requested that the tornado damage which occurred there be proclaimed a Federal Disaster to allow similar funds to be made available to residents of Ohio. Multiple times this request was denied. Similar politics were seen during the aftermath of Hurricane Katarina

Impact of Resolution:
General Membership, Affiliates, AARC Officers & BOD, Executive Office

Implementation Cost: less than $1000

Ongoing Cost: less than $1000

Relationship to AARC Strategic Plan: Develop human resources, Increase membership

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House of Delegates Resolution 36-10-08

Curt Merriman/Laurie Tomaszewski
E-mail:curt.merriman@comcast.net
Phone Number: 612-760-0904
Author's State: Minnesota
Co-Sponsors and Their States: None

Resolution:
Resolved that the AARC consider writing a position paper to assist state affiliates work towards a provision in licensure language to allow for temporary license reciprocity for RT's transporting patients via an air or ground ambulance service.

Rationale:

Currently RT's have to maintain multiple state licenses if they are involved in the transportation of patients between states via air/ground ambulances. This may limit the RT's ability to perform this vital function because of the financial and logistical burden to maintain the multi state licenses. Ambulance services may opt to not utilize RT's because of this issue and replace with a paramedic whom already has the reciprocity issue resolved.

The temporary licensure status could specify to not exceed 12 hours per transport occurrence and also be limited to the transport of specific patient(s) and not to provide patient care to others while within the state.

Impact of Resolution: General Membership, Affiliates, State/Federal Legislation
Implementation Cost: $200
Ongoing Cost: None
Relationship to AARC Strategic Plan: Develop human resources

House of Delegates Resolution 43-10-09

Resolution Author: Connie Paladenech
E-mail:cpaladen@wfubmc.edu
Phone Number: 336-713-8850
Author's State: North Carolina
Co-Sponsors and Their States: none

Resolution:

It is proposed that additional criteria be added to the Quality Respiratory Care Department recognition. Specifically, the criteria should include criteria for management standards which state that the Respiratory Care Department Director/Manager is a qualified Respiratory Therapist.

Rationale:

In a cost-cutting initiative, some hospitals have chosen to eliminate the Director/Manager of Respiratory Care services and place a non-Respiratory Therapist in the leadership position for the service. An unqualified person in a leadership position responsible for

day-to-day operations, policy development, and competency evaluations places patient safety at risk. It is imperative that the leadership of Respiratory Care services be provided by a qualified Respiratory Therapist.

Impact of Resolution:

General Membership, HOD, Affiliates, AARC Officers & BOD, Executive Office, Patients receiving Respiratory Care Services; Board of Medical Advisors
Implementation Cost: $25.00 - $50.00 to update webpage
Ongoing Cost: None

Relationship to AARC Strategic Plan: Develop art and science of RC, Develop human resources

Policy Review

American Association for Respiratory Care
Policy Statement

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

Guidelines for the Board of Directors E-Voting

1. Motions are posted from the President or Parliamentarian or other designee. Board members wanting to introduce a motion must first contact the President (off the Listserv) to have the motion recognized.

2. The President will then contact one Board member (off the Listserv) to get a second.

3. Once the motion is recognized by the President and seconded by a member (off the Listserv) it will be introduced to the Listserv in a message from the Secretary/Treasurer or Parliamentarian.

4. The motion posted will include the originator of the motion, the individual who seconded the motion, the deadline for discussion and the deadline date for voting. The deadline times will be 12 noon EST.

5. Following the set discussion period, the Secretary/Treasurer will post a message indicating the start of the voting period.

6. The discussion period should be 5 business days. The voting period should be 3-5 business days.

7. Only one motion should be active on the Listserv at any time.

8. The Secretary/Treasurer will report the results via the Listserv. A copy will be sent to the Executive Office and ratified at the next BOD meeting.

9. The originator of the motion will be notified of BOD action by the Secretary-Treasurer via e-mail, and with official notification occurring by mail post BOD ratification at its next meeting.

10. If a motion requires a faster turn-around the President can authorize a shorter time period. This should be considered an exception and used only for urgent issues. The subject line will indicate that a motion is urgent.

DEFINITIONS:
ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: FM.016

SECTION: Fiscal Management

SUBJECT: **Travel Expense Reimbursement**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December, 2008

DATE REVISED: December, 2008

REFERENCES: TR:0397- 1997

Policy Statement:

Expenses incurred for all official Association travel shall be reported, recorded, and reimbursed in accordance with Association policy.

Policy Amplification:

1. Association policy for Travel Expense Reimbursement shall apply to all Association employees and authorized Association members.

    A. Travel expense reimbursement shall not be provided for representatives to external organizations unless approved in advance by the President with subsequent review by the Finance Committee and ratification by the Board of Directors.

2. All persons requesting reimbursement for expenses incurred for Association business shall report those expenses:

    A. Using an approved Expense Voucher with valid receipts attached
    B. Within thirty (30) days of when expenses are incurred

3. Reimbursement for travel shall be as follows, with the provision of valid receipts:

    A. Round-trip, coach class airfare or lowest day airfare available
    B. Airport parking and ground transportation

C. Other methods of transportation (rail, automobile, bus, road tolls, parking), singularly or in any combination, shall be reimbursed at a total rate not to exceed the lowest day airfare available.

D. Automobile travel shall be paid at the rate of $0.45 (effective 1/1/09) per mile

4. Reimbursement for lodging shall be as follows, with the provision of valid receipts:

A. Lowest possible rate for those nights required for Association business.

5. Reimbursement for registration fees shall be as follows, with the provision of valid receipts:

A. When necessary, advertised registration or admittance fees to programs attended on Association business shall be reimbursed at the fee stated on the program announcement.

6. Per diem shall be $40 (effective 1/1/09) per day for those days required for Association business:

A. Per diem is meant and expected to cover expenses other than actual travel and lodging (e.g. meals, phone calls)

B. Personal expenses incurred while on official Association travel (e.g., entertainment, telephone, or laundry) shall not be eligible for reimbursement from the Association, other than coverage with per diem.

7. Advance payment of per diem shall be made in compliance with Association travel reporting requirements and only with advance written approval from:

A. The President for the voluntary sector of the Association

B. The Executive Director for Association employees

C. Exceptions to the above requirements for advance per diem shall be:

1. Regularly scheduled Board of Directors' meetings
2. Regularly scheduled Executive and Finance Committee meetings
3. Travel for official Association representation to external organizations

8. International travel shall be reimbursed at actual expense, with receipts required for any expense of $25.00 or more, to include the following:

A. Business class airfare

B. Ground transportation

C. Lodging

D. Meals

E. Telephone and facsimile

9. Expenses incurred by the President incidental to executing the duties and responsibilities of that office shall be:

A. Paid by the Association

B. Monitored by the Finance Committee

C. Subject to review by the independent auditors

10. All individuals traveling at Association expense shall notify the Executive Office in advance of the intended travel.

    A. The Executive Office may act as the Association's travel agent and schedule advance transportation and lodging.

    B. The Executive Office may direct individuals to contact Association's designated travel agency or purchase tickets on their own.

    C. The Executive Office may review and approve the travel plans made by the individuals

11. All public transportation (e.g., airfare, bus fare) not purchased through the Association's designated travel agency shall be reimbursed at a fee up to, but not exceeding, the fee that would have been charged by the Association's travel agency.

DEFINITIONS:

"Valid receipt" includes original receipts from the travel/other provider. Reproductions of receipts shall not be accepted.

ATTACHMENTS:

NBRC Report

MEMORANDUM

Date: November 16, 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

As I near completion of my first year as President, I appreciate the opportunity to provide you an update on activities of the NBRC. The Board of Trustees met November 8-13 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 Specialty Examination Development Continues

Test development activities continue for the Adult Critical Care Specialty Examination. It was decided at the most recent meeting that the Committee will develop a 50-item free, practice examination and a full-length Self-Assessment Examination. This new examination is scheduled to be implemented by mid-year of 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.

Credential Designation for Adult Critical Care Specialty Examination Approved

The Board approved RRT-ACCS as the credential designation for those individuals who successfully complete the Adult Critical Care Specialty Examination and will be filing a registration on this mark for intent to use accordingly.

Adult Critical Care Specialty Examination Admissions Policy Approved on First Reading

The Board of Trustees considered a recommendation from the Admissions Committee and approved on first reading the following admissions policy for the Adult Critical Care Specialty Examination:

> -Applicants shall be an RRT with at least one year of full-time clinical experience in a critical care setting (i.e. intensive care unit, emergency room, post-anesthesia recovery unit, long-term acute care setting etc.)

The Board will consider this on second reading at its April 2011 meeting where a 2/3 affirmative majority vote is required.

2011 Officers Elected

The following individuals have been elected to a one-year term beginning January 1,

2011:

President - Gregg L. Ruppel, MEd, RRT, RPFT, FAARC (AARC)

- Vice President – Thomas M. Fuhrman, MD, FCCM, FCCP (ASA)
- Secretary – Brian W. Carlin, MD, FCCP, FAARC (ACCP)
- Treasurer – Kerry E. George, MEd, RRT, FAARC (AARC)
- At Large – Peter Betit, RRT, RRT-NPS, FAARC (AARC)
- At-Large – Linda A. Napoli, MBA, RRT, RRT-NPS, RPFT (AARC)
- At-Large – Alan L. Plummer, MD, FCCP, FAARC (ATS)

2010 Examination and Annual Renewal Participation

To date, we have received over 33,000 applications across all examination programs; this is approximately 3,700 applications less than 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.

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 processed a record number of active status renewals totaling over 35,000. 2011 Annual Renewal notices were mailed in early October to all credentialed practitioners.

Examination Statistics – January 1 – November 15, 2010

The NBRC has administered over 32,000 examinations thus far in 2010. Pass/fail statistics for the respective examinations follow:

Examination	***Pass Rate***	
CRT Examination – 12,201 candidates		
	Entry Level	
Advanced		
First-time Candidates	71.5%	79.3%
Repeat Candidates	25.1%	25.0%

Therapist Written Examination – 9,734 candidates

First-time Candidates	65.6%
Repeat Candidates	32.1%

Clinical Simulation Examination – 9,514 candidates

First-time Candidates	57.8%
Repeat Candidates	49.5%

Neonatal/Pediatric Examination – 772 candidates

First-time Candidates	74.7%
Repeat Candidates	50.5%

Sleep Disorders Specialty Examination – 32 candidates

First-time Candidates	93.1%
Repeat Candidates	0.0%

CPFT Examination – 279 candidates

First-time Candidates	60.8%
Repeat Candidates	33.7%

RPFT Examination – 76 candidates

First-time Candidates	82.1%
Repeat Candidates	42.1%

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.

CoARC Report

The CoARC Report will be a handout at the meeting.

New Business

- Oncology Roundtable Proposal
- Announcements
- Treasurer's Motion
- Adjournment

Oncology Roundtable

The Oncology Roundtable Proposal will be a handout at the meeting.

Please use the following policy as a guide when considering the Oncology Roundtable proposal. It is not to be considered under the Policy Review Section.

American Association for Respiratory Care
Policy Statement

SECTION: Roundtables

SUBJECT: **Roundtables**

EFFECTIVE DATE: August 22, 2001

DATE REVIEWED: December 2009

DATE REVISED: December 2009

REFERENCES:

Policy Statement:

1. Roundtables are formally organized members of the AARC focused on significant topics of common interest, and who feel other groups within the organization are not addressing their special interest.

2. A minimum of 10 members may propose a Roundtable by completing the attached *Roundtable Proposal Form* and submitting it to the AARC President.

3. The AARC President will present the *Proposal* at the next meeting of the Board of Directors. If approved by the Board, the Executive Office will communicate this request to the AARC membership using the appropriate methods and solicit their interest.

4. If the Executive Office determines that at least 50 members are interested in joining:
    a. A Roundtable will be formed;
    b. A Listserv will be established;
    c. All AARC members will be contacted and informed of the new Roundtable and the Listserv;
    d. The AARC President will appoint a Roundtable Chair to serve until the time of the AARC Annual Meeting. The incoming AARC President must renew the Chair appointment or appoint a new Chair;
    e. The AARC President will appoint a member of the Board of Directors to monitor the Listserv to contact the Roundtable Chair prior to each meeting of the Board, and to report at each Board meeting on the activities of the Roundtable.

5. The Board of Directors may elect to dissolve a Roundtable at any time. In such case, the Board liaison will post an announcement in the Listserv stating the reason(s) for the dissolution of the Roundtable, and the Listserv will cease 30 days after the announcement.

5a If the Listserv has three consecutive months with no posts the Roundtable Chair and AARC Board liaison will be notified of the lack of communication.

5b The Roundtable Chair will post a query to see if the Roundtable needs to continue or has served its useful life and should be dissolved to its Listserv members.

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

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

6. Through the Board liaison, the Roundtable Chair is automatically charged to:

a. Promote and advance the interests of the Roundtable among its members;
b. Work with the Board liaison to advance the interests of the Roundtable through AARC resources other than the Listserv;
c. Encourage Roundtable members to submit program proposals to the AARC Program Committee;
d. Determine if the Roundtable growth meets the criteria for the Roundtable becoming an AARC Specialty Section.

American Association for Respiratory Care
Roundtable Proposal Form

Please read the *AARC Roundtable Policy* before completing this form.

Definition – *Roundtables are formally organized members of the AARC focused on significant topics of common interest, and who feel other groups within the organization are not addressing their special interest.*

Your Name _____

AARC Member # _____ E-Mail _____

Employer _____

City _____ State _____

Suggested name for proposed Roundtable _____

List reasons you and others feel justify the establishment of the Roundtable:

_____
_____
_____
_____
_____
_____

Before your proposal is submitted, at least 9 other AARC members must concur with you. E-mails to you will be accepted in lieu of their signatures; in such case, attach the e-mails to this form.

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Your Signature _____ Date _____

Please Send via US Mail to: **President, American Association for Respiratory Care**
9425 N. MacArthur Blvd #100
Irving, TX 75063