



American Association for Respiratory Care

Board of Directors Meeting

Embassy Suites Outdoor World
Grapevine, TX

April 8-9, 2011

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AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – April 7, 2011
Board of Directors Meeting – April 8-9, 2011

Thursday, April 7

4:00 – 7:00 pm Executive Committee Meeting (Committee Members only)
7:00 – 8:00 pm AARC Finance Committee Meeting (BOD and HOD members
welcome)

Friday, April 8

8:00am-5:00pm **AARC Board of Directors Meeting**

8:00 am Call to Order
Announcements/Introductions
Disclosures/Conflict of Interest Statements
Swearing in of Officers/Directors
Approval of Minutes pg. 7
E-motion Acceptance pg. 98

General Reports pg. 100
 President
 Past President
 Executive Director Report pg. 105 (R)
 Technology Refresh pg. 127

9:00 am Auditor's Report
9:30 am Lawrence M. Wolfish, Wolfish & Newman, P.C.
 - Board Member Fiduciary Responsibility & Conflict of Interest
10:30 am Frank Sloan – AARC Investment

11:00 am BREAK

11:15 am CoARC report presented by Tom Smalling pg. 167 (**AARCConnect**)
CoARC Proposed Bylaw Amendments (**AARCConnect**)

General Reports con't.
 Government & Regulatory Affairs pg. 168
 House of Delegates pg. 181
 Board of Medical Advisors pg. 182 (R)
 Presidents Council pg. 190

Standing Committee Reports pg. 196
 Bylaws Committee pg. 197 (R)
 Elections Committee pg. 198
 Executive Committee pg. 199
 Finance Committee pg. 200

- 12:00 pm Lunch Break (Daedalus Board Meeting)**
- 1:30 pm Reconvene**
- 1:30 pm Standing Committee Reports con't.
 Audit Subcommittee pg.201 (R)
 Judicial Committee pg. 205
 Program Committee pg. 206 (R)
 Strategic Planning Committee pg. 209
- Specialty Section Reports pg. 210
 Adult Acute Care pg. 211
 Continuing Care-Rehabilitation pg. 213
 Diagnostics pg. 214
 Education pg. 216
 Home Care pg. 217
 Long Term Care pg. 219
 Management pg. 220 (R)
 Neonatal-Pediatrics pg. 222 (R)
 Sleep pg. 224 (R)
 Surface and Air Transport pg. 226
- 3:00 pm BREAK**
- 3:15 pm Special Committee Reports pg. 228
 Benchmarking Committee pg. 229
 Billing Code Committee pg. 230
 Clinical Practice Guidelines Steering Committee pg. 232 (R)
 Fellowship Committee pg. 233
 Federal Govt Affairs pg. 234
 International Committee pg. 239
 Membership Committee pg. 241
 Position Statement Committee pg. 243 (R)
 Public Relations Action Team pg. 251
 State Govt Affairs pg. 252
- 4:15 pm Nominations for Life & Honorary Membership
- 5:00 pm RECESS**

Saturday April 9

8:00am-5:00pm

Board of Directors Meeting

8:00 am

Call to Order

Special Representatives pg. 253

AAAAI pg. 254

AMA CPT Health Care Professional Advisory Committee pg. 255

American Association of Cardiovascular & Pulmonary Rehab pg. 257

American Association of Critical Care Nurses pg. 258

American Heart Association pg. 259

American Society for Testing and Materials (ASTM) pg. 260

Chartered Affiliate Consultant pg. 261

Comm. on Accreditation of Medical Transport Systems pg. 262

Extracorporeal Life Support Organization (ELSO) pg. 263

International Council for Respiratory Care (ICRC) pg. 264

The Joint Commission (TJC) pg. 266

National Asthma Education & Prevention Program pg. 270

9:30 am

BREAK

10:00 am

Special Representatives con't.

National Coalition for Health Professional Ed. In Genetics pg. 271

Neonatal Resuscitation Program pg. 272

National Sleep Awareness Roundtable pg. 274

Simulation Alliance pg. 275

10:30 am

Roundtable Reports pg. 276

Asthma Disease pg. 277

Consumer (see Executive Director report pg. 105)

Disaster Response pg. 279

Geriatrics pg. 280

Hyberbaric pg. 281

Informatics pg. 283

International Medical Mission pg. 284

Military pg. 285

Neurorespiratory pg. 287

Research pg. 288

Simulation pg. 289

Tobacco Free Lifestyle pg. 290

11:00 am

Ad Hoc Committee Reports pg. 291

Ad Hoc Committee on Cultural Diversity in Patient Care pg. 292

Ad Hoc Committee on Officer Status/US Uniformed Services(see Military Roundtable report pg. 285)

Ad Hoc Committee on Oxygen in the Home pg. 294

Ad Hoc Committee on Leadership Institutes pg. 295

Ad Hoc Committee on 2015 & Beyond pg. 298

Ad Hoc Committee to Review Age Membership Discount pg. 299

12:00 – 1:30 pm LUNCH BREAK

1:30 pm Other Reports pg. 301
 National Board for Respiratory Care (NBRC) pg. 302
 American Respiratory Care Foundation (ARCF) pg. 305

2:30 pm BREAK

2:45 pm UNFINISHED BUSINESS pg. 307
Clinical Practice Guidelines Committee Appointments
(CVs on pdf)
Policy Review

NEW BUSINESS pg. 308
Ratification of Appointments
Policy Review
NYDART pg. 309
International Committee Additional Charges pg. 310

4:30 pm ARCF Achievement Award Nominations pg. 311
 Bird
 Hudson
 Invacare

ANNOUNCEMENTS

TREASURER’S MOTION

ADJOURNMENT

(R) = Recommendation

Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting
December 4, 2010
Las Vegas, Nevada

Minutes

Attendance

Tim Myers, BS, RRT-NPS, President
Karen Stewart, MS, RRT, FAARC, President-elect
Toni Rodriguez, EdD, RRT, Past President
George Gaebler, MEd, RRT, FAARC, VP/Internal 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
Cheryl Hoerr, MBA, RRT, FAARC
Denise Johnson, BS, RRT
Robert McCoy, RRT, FAARC
Doug McIntyre, MS, RRT, FAARC
Cam McLaughlin, BS, RRT, FAARC
James Taylor, PhD, RRT
Brian Walsh, RRT-NPS, RPFT

Guests

Laure Jaeger
Cindy White
Andrea Williamson

Consultant

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

Absent

Cliff Boehm, MD, RRT, BOMA Chair (Excused)
Joseph Lewarski, BS, RRT, FAARC, VP/External Affairs (Excused)
Frank Salvatore, MBA, RRT, FAARC (Excused)
Tony Stigall, MBA, RRT, RPSGT (Excused)

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, AE-C, FAARC, Chief Operating Officer
Ray Masferrer, RRT, FAARC, Associate Executive Director
Steve Nelson, RRT, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, 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 8:05 a.m. PST, Sunday December 4, 2010. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

WELCOME-INTRODUCTIONS- DISCLOSURES

President Myers asked members to introduce themselves and state their disclosures as follows:

Lynda Goodfellow – Teleflex Medical Consultant

APPROVAL OF MINUTES

George Gaebler moved “To accept the minutes of the July 19, 2010 meeting of the AARC Board of Directors as amended.”

Motion Carried

George Gaebler moved “To accept the minutes of the July 20, 2010 meeting of the AARC Board of Directors.”

Motion Carried

E-MOTION RATIFICATION

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

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.”

Motion Carried

PRESIDENT’S REPORT

President Tim Myers highlighted his written report stating that 2010 marked the highest recorded increase in membership. Sections are gaining in membership as well. Four Roundtables have been added. The law called SRG (Sustainable Growth Rate) has the result of decreasing overall reimbursement payments to physicians who see Medicare patients. The SGR for 2011 was to be over 23%, thus Congress had to provide the “Doc Fix” to prevent the reduction. There is some movement on Medicare Part B concerning the “Doc Fix.” International activities continue to increase and a new Saudi affiliate will

be brought before the Board for a vote at this meeting. The 2015 and Beyond project continues to create interest. Networking with other organizations has been a positive experience for the Association.

PRESIDENT-ELECT REPORT

President-elect Karen Stewart reported that she completed work on the 2011 Committee assignments, and looks forward to beginning her Presidency in 2011.

EXECUTIVE OFFICE REPORT

Executive Director Sam Giordano reported that positioning resources for patients with pulmonary disorders has presented a challenge. The National Ventilator Survey manuscript was completed. A meeting is in the works to go to Washington DC to discuss a population survey to initiate a new project. He also wants to propose a training program regarding the strategic stockpile. The COPD Coalition, state coalitions and patient organizations elected to hold its meeting in Las Vegas in conjunction with AARC's meeting and AARC provided them with space and an in kind grant to promote this activity.

Chief Operating Officer Tom Kallstrom stated that 4 new corporate partners will join us next year. Winners of the Drive4COPD screener contest are as follows:

Pennsylvania

1. Highest Number of Drive4COPD Screeners submitted

West Virginia

1. Highest number of Drive4COPD screeners in relation to AARC Members
2. Highest number of Drive4COPD screeners in relation to the number of people over 35 in the state

Due to the success of Drive4COPD, we've committed to this campaign for another 2 years. The beta VAP workshops were successful. Three cities were chosen to present the VAP workshop this spring. The new aerosol booklets will be an online education piece. Over 2,000 downloads were performed in the first week it was released.

Associate Executive Director Steve Nelson stated AARC has 100,000 copies of a new stop smoking brochure aimed at patients and sponsored by Pfizer.

Sam Giordano stated that our focus has expanded from Europe to the Middle East as the Saudis want to obtain Western teachings and staffing in the area of respiratory care. They invited AARC to help them devise an education system. Officials also want to talk with the NBRC about a credentialing system in Saudi Arabia. Their financial resources

are greater than in any other part of the world. More conferences are planned in which AARC will play a prominent role which will attract Egyptian, Kuwaiti and Emirate interests as well. The Saudis have expressed a high degree of interest in AARC's science journal *RESPIRATORY CARE*.

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:30 a.m. PST, Saturday December 4, 2010.

RECONVENE

President Tim Myers reconvened the meeting of the AARC Board of Directors at 9:50 a.m. PST Saturday December 4, 2010.

EXECUTIVE OFFICE REPORT CONTINUED

Sam Giordano briefed the Board on the history of the 2015 and Beyond Project entailing the three conferences conducted thus far and noting the key players involved and the visionary planning that went into the project to protect the integrity of the project.

George Gaebler moved to accept **Recommendation 10-3-1.1** "That the 2015 and Beyond 'Transition Plan Attributes' be approved by the Board of Directors."

Toni Rodriguez moved to amend **Recommendation 10-3-1.1** "To consider approving the 'Transition Plan Attributes' with the exception of the following:

- Assure that emerging conference recommendations must be supported by a plurality of the stakeholders in attendance.

George Gaebler moved "To table **Recommendation 10-3-1.1**."

Motion to Table Carried

VICE PRESIDENT FOR EXTERNAL AFFAIRS

George Gaebler stated there were some glitches in the electronic reporting system that need to be resolved before the next meeting.

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 10:50 a.m. PST Saturday, December 4, 2010.

RECONVENE

President Tim Myers reconvened the meeting of the AARC Board of Directors at 11:10 a.m. PST, Saturday, December 4, 2010.

STANDING COMMITTEE REPORTS

BYLAWS COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 10-3-9.1** “That the AARC Board of Directors accept and approve the Oregon Society for Respiratory Care Bylaws.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-9.2** “That the AARC Board of Directors accept and approve the Maryland Society for Respiratory Care Bylaws.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-9.3** “That the AARC Board of Directors accept and approve the North Dakota Society for Respiratory Care Bylaws.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-9.4** “That the AARC Board of Directors accept and approve the Idaho Society for Respiratory Care Bylaws.”

Motion Carried

EXECUTIVE COMMITTEE REPORT

President Tim Myers reported that the Executive Committee discussed recommendations and the 2015 and Beyond project. They also touched upon financial proforma (stocks and bonds) noting that investments are favorable at this time. The Committee discussed the strategic plan.

FINANCE COMMITTEE REPORT

President Tim Myers stated that revenues and expenses were discussed. There were no recommendations with financial impact.

SPECIALTY SECTION REPORTS

SURFACE TO AIR TRANSPORT SECTION

George Gaebler moved to accept **Recommendation 10-3-59.1** “That the AARC BOD consider the feasibility of creating a position statement in regard to state reciprocity for transport RTs.”

Linda Van Scoder moved “To refer **Recommendation 10-3-59.1** to President-elect Karen Stewart to have the Surface to Air Transport Section further research.”

Motion to Refer Carried

ROUNDTABLES

ASTHMA DISEASE ROUNDTABLE REPORT

George Gaebler moved to accept **FM 10-3-42.1** “That the Asthma Disease Management Roundtable start a page on Facebook.”

Linda Van Scoder moved “To refer **FM 10-3-42.1** back to the Asthma Disease Management Roundtable for clarification.”

Motion to Refer Carried

NEURORESPIRATORY ROUNDTABLE REPORT

George Gaebler moved to accept **FM 10-3-40.1** “That the AARC 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.”

George Gaebler moved “To accept **FM 10-3-40.1** for information only.”

Motion Carried

TOBACCO FREE LIFESTYLE ROUNDTABLE REPORT

George Gaebler moved to accept **Recommendation 10-3-41.1** “That the AARC BOD approve a resolution from the AARC that members regularly ‘Ask and Advise’ their patients about tobacco use.”

George Gaebler moved “To accept **Recommendation 10-3-41.1** for information only.”

Motion Carried

ACCEPTANCE OF ROUNDTABLE REPORTS

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

Motion Carried

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 12:00 p.m. PST, Saturday December 4, 2010.

JOINT SESSION

President Tim Myers convened the meeting of the AARC Board of Directors at 1:45 p.m. PST, Saturday December 4, 2010. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

EXECUTIVE SESSION

President Tim Myers convened Executive Session at 1:50 p.m. PST, Saturday, December 4, 2010.

JOINT SESSION RECONVENED

President Tim Myers reconvened the meeting of the AARC Board of Directors at 2:10 p.m. PST, Saturday, December 4, 2010.

AMERICAN RESPIRATORY CARE FOUNDATION REPORT

President Tim Myers reported in Chair Michael Amato’s absence. He reminded members that the ARCF is their Foundation and urged them to make donations which will be placed in an unrestricted account.

ELECTIONS COMMITTEE REPORT

Elections Committee Chair John Steinmetz briefly reported on the following 2011 elections which were certified November 8, 2010 :

Secretary-Treasurer	Michael Tracy	844	37%
	Linda Van Scoder	1434	63%
VP/External Affairs	George Gaebler	1220	54%
	Robert McCoy	1036	46%
VP/Internal Affairs	Michael Hewitt	904	39%
	Susan Rinaldo Gallo	1392	60%

Directors at Large	Fred Hill	867	16%
	Denise Johnson	1294	23%
	John Lindsey	803	14%
	Cam McLaughlin	947	17%
	Albert Moss	783	14%
	Gary Wickman	846	15%
Specialty Sections			
Adult Acute Care	Keith Lamb	242	98%
Diagnostics	Matthew O'Brien	77	57%
	James Sullivan	58	43%
Education	Joseph Sorbello	229	73%
	Keith Terry	79	25%
Management	Roger Berg	162	37%
	Bill Cohagen	272	62%
Neonatal-Pediatric	Tiffany Mabe	98	43%
	Cynthia White	129	57%

STATE GOVERNMENT AFFAIRS REPORT

State Government Affairs Director Cheryl West reported that most of the state legislators have adjourned for the year but will return in January. We anticipate at least 3 states where sleep personnel licensure law efforts will be undertaken (KY, CT, AZ).

REGULATORY GOVERNMENT AFFAIRS REPORT

Director of Regulatory Affairs Anne Marie Hummel reported that competitive bidding will become effective January 1st with an appeal unlikely. She stated that the FDA Strategic Plan is investigating what cigarette packaging will look like in the future and they believe 50% of the packaging will be devoted to graphic results of smoking. She discussed ventilator allocation and ethics involved in the event of a shortage such as who makes the decision as to who receives a ventilator and who doesn't. It is believed that triage teams will be assigned to make such decisions.

FEDERAL GOVERNMENT AFFAIRS REPORT

Federal Government Affairs Director Miriam O'Day reported that tobacco legislation is targeting menthol cigarettes which usually becomes a starter cigarette for young people. The House passed an extension of health benefits and we expect a great deal of gridlock in the near future. Healthy People 2020 has money available to address pulmonary rehab,

asthma, COPD, etc. \$115 billion is needed to implement healthcare reform. The RT initiative will have a technical language amendment and will be reintroduced this spring in both the House and Senate.

JOINT SESSION ADJOURNED

President Tim Myers adjourned the Joint Session of the AARC Board of Directors at 2:45 p.m. PST, Saturday December 4, 2010.

RECONVENE REGULAR SESSION

President Tim Myers reconvened the meeting of the AARC Board of Directors at 3:05 p.m. PST, Saturday December 4, 2010.

BYLAWS COMMITTEE CONTINUED

Bill Lamb posed the question previously about what happens if bylaws aren't approved by the Board. He met with AARC's corporate counsel and reported that the BOD has authority to revoke bylaws. There is no current policy that addresses this issue. Therefore, the Bylaws Committee put forth the following recommendation:

George Gaebler moved to accept **Recommendation 10-3-9.5** "That the AARC Board of Directors develop a policy that defines actions that may be taken when a state affiliate's bylaws are in conflict with the AARC Bylaws and are therefore not approved or accepted by the AARC Board of Directors."

Jim Taylor moved "To refer **Recommendation 10-3-9.5** to President-elect Karen Stewart to either consider as a Bylaws charge or to develop an ad hoc committee to address the recommendation."

Motion to Refer Carried

ACCEPTANCE OF STANDING COMMITTEE REPORTS

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

Motion Carried

EXECUTIVE OFFICE REPORT CONTINUED

Karen Stewart moved "To bring **Recommendation 10-3-1.1** back to the table."

Motion Carried

Toni Rodriguez moved “To accept **Recommendation 10-3-1.1** as amended.” (See Page 5)

Amended Motion Carried

George Gaebler moved to accept **Recommendation 10-3-1.2** “That the AARC Board of Directors after reviewing recommendations generated in Conference III identify additional research, additional communication needs, legal issues, including but not limited to legal credentialing, feasibility and other potential impact brought about by implementation of the recommendations.”

Motion Carried Unanimously

Toni Rodriguez moved “To refer **Recommendation 10-3-1.2** to the President-elect.”

Motion to Refer Carried Unanimously

George Gaebler moved to accept **Recommendation 10-3-1.3** “That if the ‘Transition Plan Attributes’ are approved by the Board, that it conduct a crosswalk of Conference III recommendations with the attributes.”

Motion Carried Unanimously

George Gaebler moved to accept **Recommendation 10-3-1.4** “That the AARC’s Board of Directors use the next year to conduct a briefing/listening tour to provide key stakeholder groups with an opportunity to better understand the project and allow AARC to gain additional input before it takes action on recommendations.”

Motion Carried Unanimously

HOUSE OF DELEGATES REPORT

Brian Walsh moved to accept **HR 87-10-07** “Resolved 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.”

Motion Carried

Toni Rodriguez moved to accept **HR 36-10-08** “Resolved that the AARC consider writing a position paper to assist state affiliates to work toward a provision in licensure language to allow for temporary license reciprocity for RTs transporting patients via an air or ground ambulance service.”

Linda Van Scoder moved “To accept **HR 36-10-08** for information only as a similar recommendation was submitted by the Surface to Air Transport Section at this meeting.”

Motion Carried

Toni Rodriguez moved to accept **HR 43-10-09** “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.”

Brian Walsh moved “To refer **HR 43-10-09** to President-elect Karen Stewart to investigate criteria surrounding this issue.”

Motion to Refer Defeated

George Gaebler moved “To refer **HR 43-10-09** back to the House of Delegates to develop language.”

George Gaebler moved “To withdraw **HR 43-10-09**.”

Motion to Withdraw Carried

Original Motion Defeated

ACCEPTANCE OF GENERAL REPORTS

George Gaebler moved “To accept the General Reports as presented.”

Motion Carried

Secretary-Treasurer Linda Van Scoder moved “To recess the meeting of the AARC Board of Directors.”

Motion Carried

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 5:15 p.m. PST, Saturday December 4, 2010.

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

Minutes

Attendance

Tim Myers, BS, RRT-NPS, President
Karen Stewart, MS, RRT, FAARC, President-elect
Toni Rodriguez, EdD, RRT, Past President
George Gaebler, MEd, RRT, FAARC, VP/Internal Affairs
Joseph Lewarski, BS, RRT, FAARC, VP/External 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
Robert McCoy, RRT, FAARC
Doug McIntyre, MS, RRT, FAARC
Cam McLaughlin, BS, RRT, FAARC
Tony Stigall, MBA, RRT, RPSGT
James Taylor, PhD, RRT
Brian Walsh, RRT-NPS, RPFT

Guests

Michael Runge
Andrea Williams

Consultant

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

Absent

Cliff Boehm, MD, RRT, BOMA Chair (Excused)
Frank Salvatore, MBA, RRT, FAARC (Excused)

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, AE-C, FAARC, Chief Operating Officer
Ray Masferrer, RRT, FAARC, Associate Executive Director
Steve Nelson, RRT, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, 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-elect Karen Stewart called the meeting of the AARC Board of Directors to order at 8:00 a.m. PST, Sunday December 5, 2010. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

President-elect Karen Stewart called for any disclosures to be declared by members. None were noted.

SPECIAL COMMITTEE REPORTS

CLINICAL PRACTICE GUIDELINES COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 10-3-19.1** “That 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.”

Linda Van Scoder moved “To accept **Recommendation 10-3-19.1** for information only.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-19.2** “That the President has appointed Arzu Ari as a new member of the Committee effective Spring, 2010. Steven Sittig and Keith Hirst are filling the two vacancies listed on Recommendation 10-3-19.1 and the Committee requests their official appointment by the President.”

George Gaebler moved “To refer **Recommendation 10-3-19.2** to President-elect Karen Stewart.”

Motion to Refer Carried

George Gaebler moved to accept **Recommendation 10-3-19.3** “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.”

George Gaebler moved “To refer **Recommendation 10-3-19.3** to President-elect Karen Stewart.”

Motion to Refer Carried

AARC FELLOWSHIP COMMITTEE REPORT

George Gaebler moved to accept **Recommendation 10-3-20.1** “That the attached policy describing the activities of the AARC Fellowship selection Committee be approved and incorporated per established guidelines.”

George Gaebler moved “To amend **Recommendation 10-3-20.1** to change language from ‘are expected’ to ‘must’ under the Rules section of the policy.” (See ATTACHMENT “A”)

Motion to Amend Carried

Amended Motion Carried

POSITION STATEMENT COMMITTEE

George Gaebler moved “To accept **FM 10-3-26.6** that the following definitions brought forth by the Position Statement Committee be accepted (See ATTACHMENT “C”):

Respiratory Care: Umbrella term that identifies a distinct subject area and health care profession within medicine; a subject area in medicine that includes all aspects of the care of patients with respiratory disease; used to identify the services provided by respiratory therapists and other health care practitioners such as physicians, nurses, physical therapists, managers, educators, etc.

Respiratory Therapy: Term that describes a specific component of the area of medicine known as respiratory care; typically used to refer to the procedures, treatments, and technology-based work.

Respiratory Therapists: Term that identifies the professional practitioners who are credentialed as Registered and/or Certified Respiratory Therapists and who practice in the area of medicine known as respiratory care.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-26.1** “Approve and publish the position statement entitled ‘Administration of Sedative and Analgesic Medications by Respiratory Therapists’.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-26.2** “Approve and publish the position statement entitled ‘Pre-Hospital Ventilator Management Competency’.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-26.3** “Approve and publish the position statement entitled ‘Respiratory Care Scope of Practice’.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-26.4** “Approve and publish the position statement entitled ‘Telehealth and Respiratory Care’.”

Motion Carried

George Gaebler moved to accept **Recommendation 10-3-26.5** “Approve the Position Statement Review Schedule.”

Motion Carried

COMMITTEE REPORTS

AD HOC COMMITTEE TO REVIEW THE INTERNATIONAL FELLOWSHIP PROGRAM

Vice President for External Affairs Joe Lewarski reported on the Committee’s findings. Although members feel the selection process is a good one, there are differing opinions on who should be selected. The Ad Hoc committee suggested retooling their goals and objectives as well as modifying the financial aspects of the Committee.

AD HOC COMMITTEE ON MASS CASUALTY

George Gaebler moved to accept **Recommendation 10-3-30.1** “Continually update statements on Mass Casualty respiratory failure and ventilator issues as new data emerges.”

George Gaebler moved “To accept **Recommendation 10-3-30.1** for information only.”

Motion Carried

ACCEPTANCE OF SPECIAL COMMITTEE REPORTS

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

Motion Carried

RECESS

President-elect Karen Stewart recessed the meeting of the AARC Board of Directors at 9:40 a.m. PST, Saturday December 5, 2010.

RECONVENE

President-elect Karen Stewart reconvened the meeting of the AARC Board of Directors at 10:05 a.m. PST, Saturday December 5, 2010.

ORGANIZATIONAL REPRESENTATIVE REPORTS

AMERICAN ASSOCIATION FOR CARDIOVASCULAR AND PULMONARY REHAB REPORT

George Gaebler moved to accept **Recommendation 10-3- 62.1** “Continue the liaison position of the Continuing Care Rehab Section chair as representative to AACVPR Professional Liaison Committee.”

Toni Rodriguez moved “To refer **Recommendation 10-3-62.1** to the President-elect.”

Motion to Refer Carried

CHARTERED AFFILIATE CONSULTANT REPORT

Joe Lewarski moved to accept **Recommendation 10-3-67.1** “That the AARC consider a previous recommendation from Toni Rodriguez to utilize the chartered affiliate consultant in a series of webcasts 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.”

Toni Rodriguez moved “To refer **Recommendation 10-3-67.1** to the President-elect.”

Motion to Refer Carried

ACCEPTANCE OF ORGANIZATIONAL REPRESENTATIVE REPORTS

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

Motion Carried

UNFINISHED BUSINESS

There was no unfinished business.

POLICY REVIEW

Policy No FM.016 – Travel Expense Reimbursement

George Gaebler moved “To table **Policy No FM.016.**”

Motion To Table Carried

Policy No. BOD.023 – Board of Directors Listserv

George Gaebler moved “To amend **Policy No BOD.023** and change #6 of the ‘Guidelines for the Board of Directors E-Voting’ policy from ‘5 business days’ to ‘3-5 business days’ under the Guidelines section.” (See ATTACHMENT “B”)

Motion to Amend Carried

Amended Motion Carried

RECESS

President-elect Karen Stewart recessed the meeting of the AARC Board of Directors at 10:45 a.m. PST, Saturday, December 5, 2010.

RECONVENE

President Tim Myers reconvened the meeting of the AARC Board of Directors at 11:05 a.m. PST, Saturday, December 5, 2010.

NEW BUSINESS

ONCOLOGY ROUNDTABLE

President Tim Myers engaged members in discussion regarding the Oncology Roundtable proposal. President-elect Karen Stewart advised that she would like to review current roundtables for 2011 and if it is determined that some are not active, they will be

dissolved or restructured. Tom Kallstrom stated that the Executive Office can take a look at overall activity of roundtables and report back to her.

AGE DISCOUNT MEMBERSHIP

President Tim Myers appointed an Ad Hoc Committee on Age Discount Membership comprised of 6 individuals; 2 from the House of Delegates, two from the Board of Directors and two at large members as follows:

Chair – Tom Lamphere – member at large
James Taylor – member at large
Connie Paladenech - HOD
Russ Woodruff - HOD
Doug McIntyre - BOD
Denise Johnson - BOD

George Gaebler moved “To accept **FM 10-3-37.1** to ratify the presidential appointment of the Ad Hoc Committee on Age Discount Membership.”

Motion Carried

SLEEP DISCUSSION

Tony Stigall engaged members in discussion regarding sleep issues.

ELECTION COMMITTEE REPORT

It was reported that the newly elected HOD Officers are:

Speaker elect	Karen Schell
Secretary	Sheri Tooley Peters
Treasurer	Bill Pupanek

SAUDI ARABIAN AFFILIATE

George Gaebler moved to accept **FM 10-3-23.1** “That the AARC BOD grant a charter to the Saudi Society for Respiratory Care as an International Affiliate.”

Motion Carried Unanimously

TREASURER’S MOTION

Linda Van Scoder moved to accept “That the expenses incurred at this meeting be reimbursed according to AARC Policy.”

Motion Carried

Secretary Linda Van Scoder 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 11:40 a.m. PST, Saturday December 5, 2010.

ATTACHMENT “A”

AARC Fellowship Selection Committee Policy CT.009

American Association for Respiratory Care

Policy Statement

Page 1 of 2
Policy No.: CT.009

SECTION: **Committees**

SUBJECT: AARC Fellowship Selection Committee

EFFECTIVE DATE: January 1, 2011

DATE REVIEWED: December 2010

DATE REVISED: December 2010

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~~ must 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.

ATTACHMENT “B”

Board of Directors Listserv - Policy No. BOD.023

American Association for Respiratory Care Policy Statement

Page 1 of 2
Policy No.: BOD.023

SECTION: Board of Directors

SUBJECT: **Board of Directors Listserv**

EFFECTIVE DATE: February 1, 2004

DATE REVIEWED: December, 2010

DATE REVISED: December, 2010

REFERENCES: AARC Bylaws

Policy Statement:

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

Policy Amplification:

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

DEFINITIONS:

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

American Association for Respiratory Care Policy Statement

Page 2 of 2
Policy No.: BOD.023

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 3-5 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:

ATTACHMENT “C”

Position Statements:

Administration of Sedative and Analgesic Medications by Respiratory Therapists
Pre-Hospital Ventilator Management Competency
Respiratory Care Scope of Practice
Telehealth and Respiratory Care

and

Position Statement Review Schedule

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 organizations) 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

Revised 12/10

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 patients 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

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

December 9, 2010

Las Vegas, Nevada

Minutes

Attendance

Karen Stewart, MSc, RRT, FAARC, President
Tim Myers, BS, RRT-NPS, Past President
George Gaebler, MEd, RRT, FAARC, VP/External Affairs
Susan Rinaldo Gallo, MEd, RRT, FAARC, V/P Internal Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary-Treasurer
Bill Cohagen, BA, RRT, FAARC
Debbie Fox, MBA, RRT-NPS
Lynda Goodfellow, EdD, RRT, FAARC
Michael Hewitt, RRT-NPS, FAARC, FCCM
Fred Hill, MA, RRT-NPS
Denise Johnson, BS, RRT
Tom Lamphere, RRT, RPFT
Doug McIntyre, MS, RRT, FAARC
Cam McLaughlin, BS, RRT, FAARC
Greg Spratt, BS, RRT, CPFT
Tony Stigall, MBA, RRT, RPSGT
Cindy White, RRT, NPS, AE-C

Guests

Consultant

Dianne Lewis, MS, RRT, FAARC, President's Council President
Colleen Schabacker, BA, RRT, FAARC, Parliamentarian

Absent

Frank Salvatore, MBA, RRT, FAARC (Excused)
Joe Sokolowski, MD, BOMA Chair (Excused)

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, AE-C, FAARC, Chief Operating Officer
Ray Masferrer, RRT, FAARC, Associate Executive Director
Steve Nelson, RRT, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, 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 Karen Stewart called the meeting of the AARC Board of Directors to order at 9:00 a.m. PST, Thursday December 9, 2010. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

INTRODUCTIONS AND DISCLOSURES

President Karen Stewart asked members to introduce themselves and then called for members to present their disclosures.

Bill Cohagen – Arizona Licensure Board
Colleen Schabacker – Tennessee Society
Karen Stewart – Medicare Advisory Committee

2011 GOALS AND OBJECTIVES

President Karen Stewart reviewed with members the 2011 goals and objectives. (See ATTACHMENT “A”)

ELECTION COMMITTEE NOMINATION

Debbie Fox moved “To nominate Denise Johnson to a two-year term on the Election Committee.”

Motion Carried

PRESIDENTIAL APPOINTMENTS OF ROUNDTABLE LIAISONS

President Karen Stewart appointed the following Board members as Roundtable Liaisons:

International Medical Mission Roundtable – Tim Myers
Simulation Roundtable – Mike Hewitt
Informatics Roundtable – Susan Rinaldo Gallo
Military Roundtable – Lynda Goodfellow
Neurorespiratory Roundtable – Bill Cohagen
Disaster Roundtable – Debbie Fox

APPROVAL OF 2011 APPOINTMENTS, GOALS AND OBJECTIVES

Tim Myers moved “To approve the 2011 appointments, goals and objectives (with the exception of the Clinical Practice Guideline Committee membership).”

Motion Carried

NEW BUSINESS

Linda Van Scoder moved “To appoint Toni Rodriguez and Tim Myers as Trustees to the American Respiratory Care Foundation (ARCF).”

Motion Carried – 1 Abstention (Tim Myers)

NEXT MEETING DATE

President Karen Stewart advised members the next meeting of the AARC Board of Directors will be held in Grapevine, TX, April 7 - 9, 2011.

TREASURER’S MOTION

Linda Van Scoder moved to accept “That the expenses incurred at this meeting be reimbursed according to AARC policy.”

Motion Carried

Linda Van Scoder moved “To adjourn the meeting of the AARC Board of Directors.”

Motion Carried

ADJOURNMENT

President Karen Stewart adjourned the meeting of the AARC Board of Directors at 10:10 a.m. PST, Thursday, December 9, 2010.

ATTACHMENT “A”

2011 Goals and Committees

AARC

2011

Goals & Committees

Committees

Sections

Roundtables &

Special Representatives

Karen J. Stewart, MSc, RRT, FAARC, President

AARC Presidential Goals – 2011

1. Continue to promote the patient and their family's needs by being the advocate for those patients with respiratory disorders.
2. Continue to develop and execute strategies that will increase membership and participation in the AARC both nationally and internationally.
3. Promote patient access to respiratory therapists as medically necessary in all care settings through appropriate vehicles at local, regional and national venues.
4. Continue to advance our international respiratory community presence through activities designed to address issues affecting educational, medical and professional trends in the global respiratory care community and to advance advocacy for the patient.
5. Evaluate the transitional needs to meet the competencies necessary to develop the "Respiratory Therapist for 2015 and Beyond" based on the expected needs of respiratory care patients, the profession and the evolving health care system.
6. Promote the access of high quality continuing education to development and enhance the skill base of current practitioners to meet the future needs of our profession.
7. Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.
8. Expand efforts to obtain research funding.
9. Increase and enhance activities to increase public awareness of respiratory therapists and their role in the treatment of respiratory disorders.

Standing Committees Index

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Standing Committees & Objectives

Bylaws Committee

Objectives:

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

Chair:

Gary Wickman, BA RRT
26554 Old Day Creek
Sedro Woolley WA 98284
425/261-3838
Gary.wickman@providence.org

Chair-elect:

Rick Weaver
Memorial Health System
1400 E Boulder St
Colorado Springs, CO 80909
719/365-5247
rtpftguy@msn.com

2011 Past President:

Tim Myers, BS, RRT -NPS

Members:

Bill Lamb, BS, RRT, CPFT, FAARC
Doug McIntyre, RRT
Jim Lanoha, RRT

AARC Liaison: 2011 VP/Internal Affairs: Susan Rinaldo-Gallo, MEd, RRT, FAARC

AARC Staff: Sherry Milligan/Tina Sawyer

Elections Committee

Objectives:

1. Screen candidates nominated for Director, Officer and Section positions.
2. Report the slate of nominees to the Board of Directors and House of Delegates by June 1, 2011.
3. The Elections Committee shall forward a roster of all nominees for the AARC Board of Directors to the current President, which would include all personal contact information for those individuals (i.e., e-mail, work address, work phone, etc.) for consideration in the committee appointment process.

Chair:

Suzanne Bollig, BHS, RRT, RPSGT
Sleep Disorders Center
2500 Canterbury Dr, Ste 108
Hays KS 67601
785/623-5376
suzanne.bollig@haysmed.com

Chair-elect:

Jim Lanoha, RRT
10885 Olinde Ln
Ventress, LA 70783-3115
225/638-5080
lanoharentals@charter.net

Members:

Debbie Fox, MBA, RRT-NPS (1-yr term)
Denise Johnson, BS, RRT (2-yr term)
Ross Havens (HOD)

AARC Staff: Sherry Milligan/Beth Binkley

Executive Committee

Objectives:

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

Chair:

Karen J. Stewart, MSc, RRT, FAARC
Charleston Area Medical Center
Associate Administrator, Neuro, Trauma and Emergency Services
501 Morris Street
Charleston, WV 25301
office 304-388-3744
pager 304-330-3744
work cell 304-550-2045 private cell 304-545-3386
fax 304-388-3604

Members:

Tim Myers BS, RRT-NPS (**2011 Past President**)
George Gaebler, MEd, RRT FAARC – (**2011 VP External Affairs**)
Susan Rinaldo-Gallo, MEd, RRT, FAARC – (**2011 VP Internal Affairs**)
Linda Van Scoder, EdD RRT FAARC – (**2011 Sec/Treas**)

AARC Staff: Sam P. Giordano, MBA RRT FAARC

Finance Committee

Objectives:

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

Chair:

Karen J. Stewart, MSc, RRT, FAARC
Charleston Area Medical Center
Associate Administrator, Neuro, Trauma and Emergency Services
501 Morris Street
Charleston, WV 25301
office 304-388-3744
pager 304-330-3744
work cell 304-550-2045 private cell 304-545-3386
fax 304-388-3604
karen.stewart@camc.org

Members:

Karen Schell, MHSc, RRT-NPS, RPFT (**2011 HOD Speaker-elect**)
Bill Pupanek, RRT (**2011 HOD Treasurer**)
Tim Myers BS, RRT-NPS (**2011 Past President**)
George Gaebler, MEd, RRT, FAARC – (**2011 VP External Affairs**)
Susan Rinaldo-Gallo, MEd, RRT, FAARC – (**2011 VP Internal Affairs**)
Linda Van Scoder, EdD RRT FAARC – (**2011 Sec/Treas**)

AARC Staff: Tony Lovio

Audit Subcommittee

Objectives:

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

Chair:

2011 HOD Speaker-elect

Karen Schell, MHSc, RRT-NPS, RPFT

Newman Regional Health

2612 Lincoln St

Emporia KS 66801-5814

H – 620-343-8624

W – 620-341-7760

ksschell@newmanrh.org

Members:

Susan Rinaldo-Gallo, MEd, RRT, FAARC– (2011 VP Internal Affairs)

Bill Pupanek (2011 HOD Treasurer)

Linda Van Scoder, EdD RRT FAARC(2011 Secretary/Treasurer)

AARC Staff: Tony Lovio

Judicial Committee

Objectives:

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

Chair:

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

Members:

Patricia Ann Doorley MS RRT FAARC
Donald Holt BS RRT CPFT
Susan Rinaldo-Gallo MEd RRT
Tim Myers BS RRT-NPS
Linda A Smith BS RRT

AARC Staff: Sam Giordano

Program Committee

Objectives:

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

Chair:

Cheryl Hoerr, MBA, RRT
300B W Christy Dr
Rolla MO 65401
573/458-7642
choerr@pcrmc.com

Members:

Ira M Cheifetz MD FCCM FAARC
Patrick Dunne MEd RRT FAARC
Bill Galvin MEd RRT CPFT
Garry Kauffman MHS RRT FAARC
Dean Hess PhD, RRT FAARC (consultant)
Michael Gentile RRT FAARC
Tim Myers BS, RRT-NPS

AARC Staff: Doug Laher

Strategic Planning Committee

Objectives:

1. Review the Strategic Plan of the Association and make recommendations to the Board for any needed revisions or adjustments in the plan at the Spring 2011-2012 Board of Directors Meeting.
2. Recommend to the Board of Directors the future direction of the Association and the profession of Respiratory Care.

Chair:

2011 - Past President

Tim Myers BS, RRT-NPS
Rainbow Babies & Childrens
11100 Euclid Ave Mail Stop 6043
Cleveland OH
44106
(216) 844-7429
Timothy.Myers@UHhospitals.org

Members:

2011 Speaker-elect

Karen Schell, MHSc, RRT-NPS, RPFT

2011 - Past HOD Speaker

Thomas Lamphere

2011 VP Internal Affairs

Susan Rinaldo-Gallo, MEd, RRT, FAARC

2011 VP External Affairs

George Gaebler, MEd, RRT FAARC

2011 Secretary/Treasurer

Linda Van Scoder, EdD RRT FAARC

AARC Staff: Sam Giordano

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2011 Specialty Section Charges

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the Program Committee by deadlines in Jan 2011
2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings. Documentation of such a meeting shall be reported in the April 2011 Board Report
3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
4. Identify, cultivate, and mentor new section leadership.
5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section's web page and provide timely responses to requests for information from AARC members.
6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2011 Board Report and updated for each Board report.

Adult Acute Care Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:

Keith D. Lamb, RCP, RRT
Respiratory Therapist 2
Christiana Care Health System
4755 Ogletown-Stanton Rd
Newark, DE 19718
302/733-3563
lambrrt@gmail.com

Medical Advisor: Russell Acevedo

AARC Staff: Sherry Milligan

Continuing Care Rehabilitation Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:

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

Medical Advisor: Phillip Marcus

AARC Staff: Sherry Milligan

Diagnostics Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.
2. Work with the CPG Committee to review, revise and update Diagnostic specific CPG's with report of activity and plan due for Board report April 2011.

Chair:

Matthew J. O'Brien, BA, RRT, RPFT
600 Highland Ave
ES/520
Madison WI 53792-0001
608/263-7001
Mobrien@uwealth.org

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

AARC Staff: Sherry Milligan

Education Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:

Lynda T. Goodfellow, EdD, RRT, FAARC
RRT
School of Health Professions
University
Georgia State University
P.O. Box 4019
Atlanta, GA 30269-1352
(404) 413-1223 Fax (404) 413-1230
ltgoodfellow@gsu.edu

Chair-elect:

Joseph G. Sorbello, MSED,
SUNY Upstate Medical
750 E Adams St
Syracuse, NY 13210
315/464-5580
sorbelloj@upstate.edu

Medical Advisor: Richard Sheldon MD

AARC Staff: Bill Dubbs

Home Care Section

Additional Charges:

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

Chair:

Gregg Spratt, BS, RRT, CPFT
3144 Country Rd 193
Philadelphia MO 63463
573/439-5804
gspratt@marktwain.net

Medical Advisor: Kent Christopher MD

AARC Staff: Sherry Milligan

Long Term Care Section

Additional Charge:

1. Implement the Specialty Section Charges as listed.

Chair:

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

Medical Advisor: Terence Carey MD

AARC Staff: Sherry Milligan

Management Section

Additional Charges:

1. Review and update the SWAP SHOP so that resources are current and reflect recent changes in CPG and Standards. The process will be conducted by the review committee and will conclude with a “new call” for resources for posting with a plan to be presented in the April 2011 Board Report.

Chair:

Bill Cohagen, BA, RRT, RCP, FAARC
13122 N 21st Lane
Phoenix AZ 85029
623/207-3134
Azrrt980@aol.com

Medical Advisor: Woody Kageler, MD

AARC Staff: Bill Dubbs

Neonatal-Pediatrics Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:

Cynthia C. White, BA, RRT-NPS, AE-C, FAARC
240 Hannahs Way
Crittenden KY 41030
859/462-4565
Cynthia.white@cchmc.org

Medical Advisor: Ira Cheifetz, MD

AARC Staff: Sherry Milligan

Sleep Specialty Section

Additional Charges:

1. Implement the Specialty Section Charges as listed.

Chair:

Tony Stigall RRT
Business Manager
Space Coast Sleep Disorders Ctr
640 Classic Ct Ste 106
Melbourne FL 32940-8279
Ph: 321/255-9901 Fax: 321/255-9902
Tony.stigall@spacecoastsleep.com

Medical Advisor: Paul Selecky MD

AARC Staff: Sherry Milligan

Surface & Air Transport Section

Additional Charge:

1. Implement the Specialty Section Charges as listed.
2. Identify workgroup within the section to address the issue of reciprocity for transport across state lines.

Chair:

Steven E. Sittig, RRT-NPS, FAARC
Mayo Clinic
Pediatric Specialist
3702 Halling Pl SW
Rochester MN 55902-1664
W – 507/255-5696 507/287-9794 Fax
sittig.steven@mayo.edu

Medical Advisor: Robert Aranson, MD

AARC Staff: Sherry Milligan

Special Committees Index

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Benchmarking Committee

Objectives:

1. Investigate, through client feedback, what other outcomes are important to compare and the feasibility of incorporating them in the program.
2. For each committee member to serve as an AARC Benchmarking expert to assist in providing existing and potential clients with direct assistance regarding data entry and results interpretation.
3. To provide proposals at both the 2011 AARC Summer Forum and International Congress on the value and use of Benchmarking and Best Practice.
4. To advise the AARC in the development of programs to retain the existing client base and attract new users.

Chair:

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

Members:

Robert Chatburn RRT-NPS
Stan Holland RRT
Cheryl Hoerr, MBA, RRT, FAARC
Marc Mays, MS, RRT

AARC Staff: Bill Dubbs, MEd, RRT, FAARC

Billing Codes Committee

Objectives:

1. Be proactive in the development of needed AMA CPT respiratory therapy related codes.
2. Act as a repository for current respiratory therapy related codes
3. Act as a resource for members needing information and guidance related to billing codes.
4. Develop a primer on the process of developing or modifying codes to include: definitions, development/review process, types and categories, reporting services using CPT codes and submitting suggestions for changes to CPT codes.

Chair:

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

Members:

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

Medical Advisor:

AARC Staff: Cheryl West

Clinical Practice Guidelines

Objectives:

1. Continue to review and revise existing clinical practice guidelines that are greater than 5 years from their publication date.
2. Continue to update and revise the existing clinical practice guidelines from expert opinion to an evidence-based format, as appropriate.
3. Develop appropriate and new clinical practice guidelines, as dictated by current standards of practice, in the evidence-based format.

Chair:

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

Members:

Medical Advisor:

AARC Staff:

Fellowship Committee

Objectives:

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

Chair:

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

Members:

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

AARC Staff: Tom Kallstrom

Federal Government Affairs Committee

Objectives:

1. Continue implementation of a 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts.
2. Work with PACT coordinators, the HOD and the State Governmental Affairs committee to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care.

Ongoing Objectives:

1. Assist in coordination of consumer supporters

Chair:

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

Members:

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

AARC Staff: Cheryl West

International Committee

Objectives:

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

Chair:

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

Members:

Deborah Lierl, MEd, RRT, **Vice Chair/Int'l Fellows**
Hassan Alorainy BS RRT, **Vice Chair/Int'l Relations**
Michael Amato MBA
Arzu Ari PhD, MS, MPH
Yvonne Lamme RRT MEd
Hector Leon MD
Vijay Deshpande MS RRT
Bruce Rubin MD
Daniel Rowley BS RRT-NPS RPFT
Jerome Sullivan MS RRT
Michael Runge BS RRT
Theodore Witek Dr.PH, FAARC
John Davies RRT
Ivan Bustamante, RRT

AARC Staff: Steve Nelson

Membership Committee

Objectives:

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

Chair:

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

Members:

Suzanne Bollig RRT
Joe Horn BS RRT
Garry Kauffman RRT
John Priest, RRT –NPS - new appointment
Debbie Markese RRT
Nicholas Widder RRT
Emily Zyla BS RRT
Hassan Alorainy, FAARC

AARC Staff: Asha Desai

Political Action Committee

Objectives:

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

Chair:

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

Members:

Patricia Blakely RRT
Carrie Bourassa RRT
Colleen Schabacker BA RRT
Tom Striplin MEd RRT RPFT
Frank Salvatore RRT
Joe Huff RRT
Lynn Lenz BS RRT

AARC Staff: Cheryl West

Position Statement Committee

Objectives:

1. Draft all proposed AARC position statements and submit them for approval to the Board of Directors. Solicit comments and suggestions from all communities of interest as appropriate.
2. Review, revise or delete as appropriate using the established three-year schedule of all current AARC position statements subject to Board approval.
3. Revise the Position Statement Review Schedule table annually in order to assure that each position statement is evaluated on a three-year cycle.

Chair:

Colleen Schabacker, BA, RRT, FAARC
Cookeville Regional Medical Center
1 Medical Center Blvd
Cookeville, TN 38501
931/783-2165
CSchabacker@crmchealth.org

Members:

Kathleen Deakins BS, RRT-NPS
Deryl Gulliford, RRT, MHA, DHA, JDH (RT Program Director, Northwest Oklahoma Respiratory Consortium – derly@pdi.net)
Linda VanScoder EdD RRT
Nicholas Widder RRT

AAARC Staff: Doug Laher

Public Relations Action Team (PRAT)

Objectives:

1. Each member will agree to do interviews (radio) and provide information for the written press release that corresponds to the interview topic.
2. Continue to assist Your Lung Health (AARC's consumer website) with reading and editing clinical stories, messages, etc for the website. These will be assigned through the EO on a PRN basis.
3. Communicate with each State Affiliate encouraging the establishment of a public relations committee.
4. Update the current Public Relations material and develop a mechanism to make the PR “tools” more easily available to the State Affiliates.

Chair:

Trudy Watson, BS, RRT, FAARC
3304 44th Street Ct
Moline, IL
309.764.3983
tjwatson@mchsi.com

Members:

Jerry Edens BS MEd RRT
Kathy Rye EdD RRT
Frank Freihaut RRT AE-C
Ken Thigpen BS RRT

AARC Staff: Sam Giordano, MBA, RRT, FAARC

State Government Affairs Committee

Objectives:

1. Assist the State Societies with legislative and regulatory challenges and opportunities as these arise.
2. Work with Federal Governmental Affairs Committee and the HOD to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care.
3. Assign each committee member a region of the country to serve as the key contact person for the states within that region.

Chair:

Tom McCarthy RRT
2761 Overlook Ct
Manchester MD 21102-1717
443/340-0960
Jeremiah.mccarthy@comcast.net

Members:

Claude Dockter RRT
Joseph Goss BS, RRT-NPS, AE-C
Ken Duet MA RRT
Pat Munzer MS RRT
Jeffrey Gonzalez RRT NPS
Dan Perrine RRT

AARC Staff: Cheryl West

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AMA CPT Health Care Professional Advisory Committee

Susan Rinaldo Gallo, MEd, RRT
Respiratory Care Services
Duke University Health System
Rm 7451
Durham, NC 27710
(919) 681-5691 phone
gallo003@mc.duke.edu

American Association of Cardiovascular & Pulmonary Rehab

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

American Association of Critical Care Nurses

Karen Gregory, MEd, RRT, FAARC
13404 Sliver Eagle Trail
Edmond OK 73013-7434
405/235-0040 Wk
kgregory07@yahoo.com

American Heart Association

Brian Walsh, RRT-NPS, RPFT
Children's Medical Center
Resp Care Dept
1935 Medical District Drive
Dallas TX 75235
214/533-4170 – W
brian.walsh@childrens.com

Alternate:

Christine Slocum, RRT, RPFT, AE-C
Samaritan Medical Center
830 Washington St
Watertown, NY 13601
315/785-4163
cslocum65@live.com

American Society for Testing and Materials (ASTM)

Bob McCoy BS RRT
Valley Inspired Products
12529 Everest Trail
Apple Valley MN 55124
Ph: (952) 891-2330 952/431-1483 Fax
bmccoy@inspiredrc.com

Chartered Affiliate Consultant

Garry Kauffman RRT
291 Dogwood Trl
Elizabethtown PA 17022-9447
717/544-7149 Hospital
717/544-5846 Fax
gwkauffm@lancastergeneral.org

Commission on Accreditation of Medical Transport Systems

Steven Sittig, RRT, P/P Specialist
3702 Halling Pl SW
Rochester MN 55902-1664
(507) 255-5696
(507) 287-9794 Fax
sittig.steven@mayo.edu

Extracorporeal Life Support Organization (ELSO)

Donna Taylor, RRT-NPS
2083 Wimpole Ct
Roanoke TX 76262
214/ 456-9445 214/456-2148 Fax
donna.taylor@childrens.com

International Council for Respiratory Care (ICRC)

Governor – United States

Jerome Sullivan, MS, RRT, FAARC
College of Health & Human Services
University of Toledo
2801 W Bancroft St
Toledo OH 43606
(419) 530-5451
(419) 530-5540
jerome.sullivan@utoledo.edu

ICRC Governor at Large

Patrick Dunne, MEd, RRT, FAARC
Healthcare Product ions
Sunny Hills Station
PO Box 5767
Fullerton CA 92838-9998
(714) 870-4440
(714) 870-0124
pjdunne@sbcglobal.net

The Joint Commission (TJC)

Home Care PTAC:

Dianne Lewis, MS RRT FAARC
4820 Teak Wood Dr
Naples FL 34119-2502
239/353-0974
dlewis53@gmail.com

Lab PTAC:

Frank Sandusky RRT
Mgr/Respiratory Care Svcs
Fairview Hospital
18101 Lorain Ave
Cleveland OH 44111-9989
216/476-7822
frank.sandusky@fairviewhospital.org

The Joint Commission (TJC) continued

Alternate:

Bob McCoy, RRT, FAARC
15112 Galaxie Ave
Apple Valley, MN 55124
952/891-2330
bmccoy@inspiredrc.com

Alternate:

M. Darnetta Clinkscale MBA RRT
Patient Care Director/Resp Care Svc
MS 90-52-388
Barnes Jewish Hospital Plaza
St. Louis MO 63110
314/362-1276 W
314/362-3782 Fax
mdb3455@bjc.org

Ambulatory Care PTAC

Suzanne Bollig BHS RRT RPSGT
Sleep Center
2500 Canterbury Dr Suite 108
Hays KS 67601
785/623-5376 785/623-5377 Fax
Suzanne.bollig@haysmed.com

Medicare Coverage Advisory Committee

Karen Stewart MS RRT FAARC
516 Wyoming St
Charleston WV 25302-2032
(304) 388-3744 Fax (304) 388-3604
karen.stewart@camc.org

National Asthma Education & Prevention Program

Natalie Napolitano, MPH, RRT-NPS
Inova Fairfax Hospital
4402 N. Pershing Dr #2
Arlington VA 22203
703/402-8359
natalie.napolitano@inova.org

National Coalition for Health Professional Education in Genetics (NCHPEG)

Linda Van Scoder, EdD, RRT, FAARC
Director, Respiratory Therapy Program
Indiana Respiratory Therapy Education Consortium
1701 N. Senate Blvd
Indianapolis IN 46202
(317) 962-8475 Ph (317) 962-2102 Fax
lvanscoder@iuhealth.org

Neonatal Resuscitation Program

John Gallagher, RRT-NPS
Rainbow Babies & Children's Hospital
11100 Euclid Ave Room B1D RBC 5005
Cleveland, OH 44106
(216) 844-0179 Ph 216/844-8598 Fax
john.gallagher@uhhospitals.org

National Sleep Awareness Roundtable (NSART)

Michael W. Runge, BS, RRT
St. Alexius Medical Center
900 E. Broadway
Bismarck, ND 58506
(701) 530-8558 Fax (701) 530-8557
mrunge@primecare.org

Simulation Alliance

Rob Chatburn, RRT-NPS FAARC
1603 Maple
Cleveland Heights OH 44121-1725
W - 216/445-1424 216/844-5246 Fax
chatbur@ccf.org

Special Representatives to CoARC

CHAIR:

David Bowton MD, FCCP, FCCM (ATS)

Wake Forest Univ Sch of Medicine
Medical Center Blvd
Winston-Salem NC 27157-1009
W – 336/716-2593
dbowton@wfubmc.edu

Chair-elect

Stephen Mikles EdS RRT
Program Dir, Resp Care
St. Petersburg College
7200 66th Street N
Pinellas Park FL 33781
(727) 341-3627 Ph (727) 341-3744
mikles.steve@spcollege.edu

Tammy Miller CPFT, RRT, MEd
Program Director, Respiratory Care
Southwest GA Technical College
15689 US Highway 19 North
Thomasville, GA 31792
(229) 225-5094 Ph (229) 225-5289
tmiller@southwestgatech.edu

Gary C. White, MEd, RRT, RPFT
10405 E Ferret Dr

Kathy Boggs-Rye EdD, RRT
Univ. of Arkansas for Medical Science

Spokane Valley WA 99206
509/891-6473
gcwhite1@earthlink.net

4301 W. Markham St. 704 (14b/nlr)
Little Rock, AR 72205
(501) 257-2343 Ph (501) 257-2349
ryekathyj@uams.edu

Sherif Afifi MD FCCM FCCP (ASA)
Northwestern University
251 E Huron St Feinberg 8-336 A
Chicago IL 60611
W – 312/926-2537
F – 312/926-4949
s-afifi@northwestern.edu

Becki Evans MS RRT
Allied Health Svcs
Tulsa Community College
909 S Boston
Tulsa OK 74119
W – 206/890-6565
F – 206/420-7993
BEvans@tulsacc.edu

Allen Gustin Jr MD FCCP (ASA)
University of Washington Sch of Med
2800 Elliott Ave #1016
Seattle WA 98121
W – 206/890-6565
F – 206/420-7993
Allen.gustinmd@gmail.com

Ronald Allison MD (ATS)
Univ of South Alabama Med Ctr
2451 Fillinghim St Suite 10-G
Mobile AL 36617
W 251-471-7914
F – 251-471-7889
rallison@pol.net

Joseph Coyle, MD (ACCP)
Univ North Carolina at Charlotte
Dept of Kinesiology
9201 University City Blvd
Charlotte NC 28223
W – 704/687-2881
coylejpc@bellsouth.net

Thomas Hill PhD RRT FAARC
109 Indigo Ln
Athens GA 30606
W – 708-369-4046
F – 706-208-9939
tvhill6@bellsouth.net

Ralph Kendall MD FCCP (ACCP)
19 High Meadow Rd
Hadley MA 01035
W – 413/549-1954
F – 413/549-1954
Vkendall1954@charter.net

Diane Klepper, MD
6517 Meadow Hills NE
Albuquerque NM 87111
W – 505/272-4751
dklepper@salud.unm.edu

Diane Flatland MS RRT
Alvin Community College
3110 Mustang Rd
Resp Therapy Dept
Alvin, TX 77511-4807
281/756-3658
dflatland@alvincollege.edu

Shelley Mishoe PhD RRT FAARC
Medical College of Georgia
Allied Health Sciences AA-2028
Augusta GA 30912-0850
W – 706/721-2621
F – 706/721-0495
smishoe@mail.mcg.edu

Bradley Leidich MEd RRT FAARC
Allied Health Director
Harrisburg Area Comm College
One HACC Drive
Harrisburg PA 17110
W - 717/780-2315
F – 717/780-1165
baleidic@hacc.edu

Bonner Smith JD
5220 80th Street
Lubbock TX 79424
W – 806/794-0000
F – 806/794-0149
bsklklaw@llano.net

Jolene Miller MEd, RRT
Dean School of Health Sciences
Ivy Tech Community College-Lafayette
3101 S Creasy Ln
Lafayette IN 47905
W – 765/269-5204
F – 765-269-5248
jomiller@ivytech.edu

CoARC Executive Office Staff

Tom Smalling, PhD, RRT, RPFT, RPSGT, FAARC
Executive Director
817/283-2835 Ext 101
tom@coarc.com

Jana Anderson
Director of Office Operations

Lisa Collard
Assistant to Executive Director

Bonnie Marrs
Site Visit Coordinator/Accreditation Services Assistant

Shelley Christensen
Receptionist/Administrative Assistant

CoARC Executive Office
1248 Harwood Rd
Bedford TX 76021-4244
817/283-2835
Fax – 817/354-8519
www.coarc.com

Special Representatives to NBRC

Special Representatives to the National Board for Respiratory Care (NBRC)

Sherry L. Barnhart RRT
35 "G" Street
Cabot AR 72023
501/364-3576 Office
501/364-3533 Fax
501/941-1244 Home
barnhartsl@archildrens.org

Susan B. Blonshine RRT RPFT FAARC
TechEd Consultants
1012 Pelican
Mason MI 48854
Phone/Fax (517) 676-7018
sblonshine@techedconsultants.com

Katherine Fedor RRT NPS CPFT
Cleveland Childrens Hosp
9500 Euclid Ave DM56
Cleveland OH 44106
Fax
216/444-8279
fedork@ccf.org

Kerry George MEd RRT FAARC
DMACC #9
2006 S Ankeny Blvd
Ankeny IA 50023
(515) 964-6298
(515) 964-6327 Fax
kegeorge@dmacc.edu

Teresa Volsko BS RRT FAARC
Youngstown St Univ
1 University Plaza
Youngstown OH 44555
(330) 342-7445
(330) 342-4744 Fax

Peter Betit RRT FAARC
Children's Hospital
300 Longwood Ave
Boston MA 02115
(617)355-6118 Fax (617) 738-0338

Suzanne Bollig RRT RPSGT
Sleep Disorders Ctr/Neurodiag
2500 Canterbury Dr #108
Hays KS 67601-2247
785/623-5376 785/623-5377 Fax
suzanne.bollig@haysmed.com

Pam Bortner
3014 Redington Woods Rd
Toledo OH 42615-2124
419/291-4460 419/534-2698
p.bortner@buckeye-express.com

Carl Haas
628 Fountain St
Ann Arbor MI 48103-3267
313/936-5234
734/936-5228 Fax
chaas@med.umich.edu

Mark Siobal BS RRT
Clinical Specialist/Resp Care Svcs
1001 Potrero Ave
San Francisco General Hosp
UCSF Dept of Anesthesia
415/206-5044
415/206-5735 Fax

James Harvey MS RPFT (NSPT)
PO Box 370165
Montara CA 94037
650/723-1891 (office)
650/724-3227 (fax)
650/728-3665 (home)
Ja_harvey@yahoo.com

Gregg Ruppel MEd RRT RPFT
FAARC
Pulmonary Function Laboratory
St Louis Univ Hospital
PO Box 15350
St. Louis MO 63110
314/577-8812 W 314/577-8808 F
Gregg.ruppel@tenethealth.com

Terry Livengood CRT RPFT (NSPT)
Western Maryland Health System
600 Memorial Ave
Cumberland MD 21502
301/723-3742 (office)
301/733-4348 (fax)
814/662-2458 (home)
tlivengood@wmhs.com

David Vines, RRT, MHS
2070 W Weisbrook Rd
Wheaton IL 60189-1506
312/942-7120
312/942-2100 F
David_Vines@rush.edu

Linda A Napoli
649 Mount Laurel Rd
Mount Laurel NJ 08054-9555
215/590-1704 W 215/590-4414 F
napoli@email.chop.edu

National Board for Respiratory Care
18000 W 105th Street
Olathe, KS 66061
913/895-4702

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Asthma Disease Roundtable

Objectives:

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

Chair:

Eileen M. Censullo, BS, RRT
DSG, Inc
325 Technology Drive
Malvern, PA 19355
484/913-0210 Ext 136 (610) 853-2575 Fax
ecensullo@dsg-us.com

BOD Liaison: Lynda Goodfellow, EdD, RRT, FAARC

Consumer Roundtable

Objectives:

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

Chair:

Sam Giordano MBA RRT FAARC
AARC
9425 N MacArthur Blvd Ste 100
Irving TX 75063
972/243-2272 Ph 972/484-2720 Fax
giordano@aacr.org

Disaster Response Roundtable

Objectives:

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

Chair:

Steven Sittig RRT
3702 Halling Pl SW
Rochester MN 55902-1664
507/255-5696
507/287-9794 Fax
sittig.steven@mayo.edu

BOD Liaison: Debbie Fox, MBA, RRT-NPS

Neurorespiratory Roundtable

Objectives:

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

Chair:

Lee Guion, MA, RRT
143 Stillings Ave
San Francisco, CA 94131-2823
415-350-5292
415-30-5292 fax
GuionL@aol.com

BOD Liaison: Bill Cohagen, BA, RRT, FAARC

Tobacco Free Lifestyles Roundtable

Objectives:

1. Conduct a survey to assess the needs and potential vision of AARC members of the Tobacco Free Lifestyle Roundtable.
2. Review and revise the smoking cessation resources on the AARC Website.
3. Increase the Tobacco Free Lifestyle roundtable membership to section status in 2011.

Chair:

Jonathan Waugh PhD RRT RPFT
Assoc Professor/Director of Clinical Ed
University of Alabama at Birmingham
RMSB 486-Respiratory Therapy Program
1705 University Blvd
Birmingham AL 35294
205/934-7638 Ph 205/975-7302 Fax
waughj@uab.edu

BOD Liaison: Denise Johnson

Military Roundtable

Objectives:

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

Chair:

David Vines MHS RRT
2070 W Weisbrook Rd
Wheaton IL 60189-1506
312/942-7120
630/868-3832 Fax
David_vines@rush.edu

BOD Liaison: Lynda Goodfellow, EdD, RRT, FAARC

Research Roundtable

Objectives:

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

Chair:

John Davies
207 Woodstar Dr
Cary NC 27513
919/681-4602
davie007@mc.duke.edu

BOD Liaison: Frank Salvatore, BS RRT FAARC

Hyperbaric Roundtable

Objectives:

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

Chair: Cliff Boehm, MD

8289 Elko Dr.
Ellicott City, MD 21043-7223
(410) 521-2200
(410) 328-3138 Fax
cliffboehm@hotmail.com

BOD Liaison: George Gaebler MSED RRT

Staff Liaison: Bill Dubbs

Informatics Roundtable

Objectives:

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

Chair:

Garry Kauffman RRT
Director of Strategic Implementation
Lancaster General
291 Dogwood Dr
Elizabethtown PA 17022-9447
717/544-7149
717/544-5846 Fax
gwkrrt@comcast.net

BOD Liaison: Susan Rinaldo-Gallo, MEd, RRT, FAARC

Staff Liaison: Steve Nelson

Geriatric Roundtable

Objectives:

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

Geriatric Roundtable continued

Chair: Mary Hart, BS RRT AE-C

Baylor University Med Ctr
4004 Worth St #300
Martha Foster Lung Care Ctr
Dallas TX 75246-1607
Ph: 214/820-9774 Fax: 214/820-9799
mary.hart@baylorhealth.edu

BOD Liaison: Debbie Fox, MBA, RRT-NPS

International Medical Mission Roundtable

Chair:

Lisa Trujillo, MS, RRT
Director of Clinical Education
Weber State University
4095 S 1000 W
Riverdale UT 84405-2677
801/626-6834
801/626-7075 Fax
ltrujillo@weber.edu

Purpose:

To provide a forum where AARC members who are interested in the many aspects of international respiratory care, medical education and humanitarian efforts throughout the world can collaborate, share experiences and develop new ideas.

Goals:

1. Provide AARC members a forum where they can network with other members with similar interests in delivering respiratory care, medical education and humanitarian aid to countries throughout the world
2. Foster the development of international collaborative research possibilities that stretch beyond our borders.
3. Establish a forum where AARC members involved in international work can showcase their projects, view others accomplishments and learn from each other's experiences.

BOD Liaison: Tim Myers, BSRT, RRT-NPS

Simulation Roundtable

Chair:

Julianne S. Perretta MEd, RRT-NPS
Simulation Educator
Johns Hopkins Medicine Simulation Center
1053 Pebble Ct.
Eldersburg MD 21784
443/287-2092
jstick11@jhmi.edu

Purpose: To develop a network of respiratory therapists interested in the sharing of simulation ideas and curricula as well as to provide a place to collaborate on future simulation research and training for the respiratory community.

Objectives:

1. Guide future formalized training for respiratory care practitioners using patient simulation.
2. Aid the AARC in bringing formalized recommendations to the Simulation Alliance Task Force regarding the simulation needs of the respiratory community.
3. Promote a forum for asking questions regarding simulation curriculum development and utilization, and the sharing of simulation ideas, lessons learned, and curriculum.
4. Provide a place to collaborate for multi-centered simulation research and training for respiratory care practitioners.

BOD Liaison: TBD

Staff Liaison: Tom Kallstrom

Ad Hoc Committee Index

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Ad Hoc Committee on Cultural Diversity in Patient Care

Objectives:

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

Chair

Joseph Huff, BS, RRT
6711 Basswood Dr
Bedford Heights OH 44146
216/587-8111 440/439-6962 Fax
Jgh578@aol.com

Members:

Dorothy Clark MEd RRT
Mary V Simmons MPH RRT
Erika Abmas RRT/RCP
Kandy T Woods MPH RRT
Carolyn O'Daniel EdD RRT
Ricardo Valdez CRT
Mikki Thompson RRT
Linda Van Scoder EdD RRT

AARC Staff: TBD

Ad Hoc Committee on Officer Status in the US Uniformed Services

Objective:

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

Co -Chairs:

Tsgt. Scott Woodcox Sr., MPH
8926 Wolff Vis
Converse TX 78109-1944
210/240-8478
scott.woodcox@yahoo.com

Members:

William Bernhard MD
MSgt Ray Machacon
Robert May MD
Fred Sharf RRT
AllenWentworth MEd RRT

AARC Staff: Sam Giordano, MBA, RRT, FAARC

Ad Hoc Committee on AARC Leadership Institutes

Objectives: To develop a management, research and educational leadership institute.

Vision Statement: The Learning Institutes 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.

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

Chair:

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

Steering Committee Members:

Sam Giordano MBA RRT FAARC
Tim Myers BS RRT-NPS

Education Institute Chair: Linda Van Scoder, EdD, RRT

Research Institute Chair: Robert Chatburn, RRT-NPS, FAARC

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

Ad Hoc Committee on Home Oxygen

Chairs:

Bob McCoy RRT FAARC
Valley Inspired Products
15112 Galaxie Ave
Apple Valley MN 55124-6985
952/891-2330
bmccoy@inspiredrc.com

Kent Christopher ND FAARC
Assoc Clin Professor of Medicine
Univ of Colorado Health Sciences
9086 E Colorado Cir
Denver CO 80231
303/337-8080
drkchristopher@comcast.net

Members:

Dr. Nick Hill
Brian Carlin

Ad Hoc Committee on 2015 & Beyond

Objectives:

1. Review the attributes and compare to the recommendations for areas that required additional definition.
Identify gaps and identify other information that will be necessary to act on the recommendations.
2. Identify groups of organizations and interested parties that would be necessary to obtain feedback regarding the recommendations and the attributes.
3. Identify a mechanism to obtain additional feedback from members and managers of respiratory care
4. Develop a time line of activity the needs to occur and a time line for BOD action.

Chair: Karen Stewart, MSc, RRT, FAARC

Members:

George Gaebler
Lynda Goodfellow
Toni Rodriguez
Patricia Doorley
John Hiser
Dianne Lewis
Tim Myers
Denise Johnson
Karen Schell
Margaret Traband

Staff Liaison: Sam Giordano/Tom Kallstrom/Bill Dubbs

Ad Hoc Committee to Review Age Membership Discount

Objectives:

- Review and benchmark other organizations process for age membership discounts
- Work with the Executive Office to identify a program for AARC, include impact on revenue and revenue sharing
- Propose a program to the AARC BOD by the summer BOD meeting

Chair: Tom Lamphere – At Large

Members:

Denise Johnson - BOD
Doug McIntyre - BOD
Russ Woodruff - HOD
Connie Paladenech - HOD
James Taylor – At Large

Staff Liaison: Sherry Milligan

Ad Hoc Committee to Review the AARC International Fellowship Program

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
 - Financing (Revenue stream and expense)
 - Selection Process (Fellows & Host cities)
 - Receptions and Congress Functions
 - Outcomes (based on Goals and Objectives)

Chair:

Joe Lewarski
Invacare Corporation
38683 Taylor Pkwy
Vice President/GM, Respiratory Group
North Ridgeville OH 44035-6200
(440) 329-6891
jlewarski@invacare.com

Members:

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)

Staff Liaison: Steve Nelson

E-Motions

Since Last Board Meeting in December 2010

11-1-49.1

“That the AARC Board of Directors approve the proposal for the Oncology Roundtable.”

Results -December 27, 2010

Yes – 15

No – 0

Abstain – 0

The motion carried

Per Policy No.: RT 001, Executive Office sent survey to members on February 11, 2011 to determine interest. The results were 26 members showed interest. (see attached)

Page: Oncology Roundtable

1. An Oncology Roundtable is being proposed with the following purpose: "To discuss the challenges that cancer patients face in their respiratory care." Is this a Roundtable you might have an interest in joining?

	answered question	24
	skipped question	2
		Response Percent Response Count
Yes		95.8% 23
No		4.2% 1

2. Would you like to be contacted if an Oncology Roundtable forms? If yes, please provide your member number and email address:

	answered question	26
	skipped question	0
		Response Percent Response Count
AARC Member Number:		96.2% 25
Email:		100.0% 26

General Reports

President Report

Past President Report

VP Internal Affairs

Reporter: Susan Rinaldo Gallo

Last submitted: 2011-03-15 09:25:33.0

Recommendations

➔ No recommendations

Report

There has been little activity in the first quarter of 2011. I suspect this will change as the year progresses. The electronic report approval process went smoothly. Of the 60 reports VPI approves 66% were submitted by March 15th (four days after the deadline).

VP – External Affairs

Spring 2011 AARC Executive Office Report

Sam P. Giordano, MBA, RRT, FAARC
Chief Executive Officer/Executive Director

The following represents an overview of the operations of the AARC since our last report. I am happy to provide you with further information on this or any other AARC related activities that may not be in this report.

Membership

We are well on our way to reaching our goal for 2011. We continue to reach new milestones as our membership grows. Domestically each month our membership is growing at a rate of 4%. Of special note is our international members whose numbers are growing at a rate of 15%. Currently there are now over 850 members outside of the United States.

The Membership committee convened in January and to date has developed a plan for the year see "membership campaign". This plan will address areas that the committee determined were areas of opportunity. A dashboard was also developed that will assist us in measuring impact of our interventions in relation to our goals throughout the year (see attachment #1)

Membership Campaign

Looking closer at the patterns, our members show when it comes to renewal we have found that it is critical that our message gets out to them quickly. After 90 days after expiration less than 2% of active members actually renew. The critical window is two months before they are set to expire through 90 days past it. Most members renew at the time of the second notice.

The membership campaign was launched in early January. In order to measure effectiveness of our efforts the executive office developed a dashboard report (see attached) that will be used moving forward. In addition to this the following changes been agreed upon and or initiated as part of the membership campaign.

- An email with a link to a video message from the AARC president will welcome (must be renewed every two years)
- Another email with link to a video message from the president will thank renewing members.
- The renewal letters were updated in order to detail the work and accomplishments of the AARC in 2010
- We have found a way for us to identify members who have lapsed but have attempted to get engage with the AARC. (E-Lance). Once they are identified we will send an email informing them of their expired status and how to renew their membership.
- We have reinstated the telemarketing program through Comnet. This is a

company that calls members after a 3-month lapse. To date they have recaptured 169 members. We will continue to monitor the effectiveness of this.

Student Membership Plan

We intend to have a plan that covers all segments of the AARC membership, but because we have a large group of members – our students – lapsing in May, we have concentrated efforts in that area for the first part of the year. The practicing members will be the next starting in April. A full review of the plan is provided under the Membership Committee Report.

Meetings and Conventions

2010 Congress (Las Vegas) – The 2010 Congress held in Las Vegas was a great success for the Association. In total, more than 5,800 attendees, exhibitors, and patient advocates were in attendance. In lieu of a poor economic climate, strong attendance in 2010 suggests our members continue to find value in our meeting; despite the fact many fail to receive supportive funding through their employers.

2011 Program Committee Meeting – Chaired by Cheryl Hoerr, RRT, and the AARC Program Committee convened in Irving, TX February 10-12, 2011. Despite a November meeting date in 2011, the Program Committee received a near record number of proposals – all of which were reviewed by the committee. Special thanks go out to all section chairs and specialty section liaisons on the Program Committee for their advance preparation in ensuring all sections were well represented with content that was timely, evidence-based, and of high interest to section members.

All feedback from exhibitors and attendees on the 2010 Congress was reviewed as well as discussion from all committee members on their perceptions of the meeting. Several programmatic changes were made to the 2011 meeting as a result and can be found in the report from the Program Committee chair.

2011 Summer Forum – The 2011 Summer Forum has been scheduled for July 18-20, 2011 in Vail, CO. This year's meeting pattern is slightly different than in years past with a Monday – Wednesday meeting schedule.

This year's pre/post courses were developed with a broader audience in mind. With the hopes of not only attracting the program educators and department managers, this year's courses titled; "Beyond the Preceptor" (pre-forum) and "Competency College" (post-forum) were created with the intent to attract hospital-based department educators as well. The pre/post courses will be FREE of charge to all Summer Forum registrants as a value-added benefit, and will also

be made available to non-Summer Forum registrants at a nominal fee.

2011 Congress (Tampa) – Progress is well underway for the 2011 Congress to be held in Tampa, FL November 5-8. The program is well balanced and representative of all specialty sections and roundtables. The exhibitor prospectus is currently posted on the AARC website with several exhibitors already committing to both booth rentals and sponsorships.

Education

Asthma Prep Course

The Asthma Prep Course continues to register attendees at the same pace we had in 2010. To date 100 have registered in the first two months of 2011. We are starting to see repeat registrants because of the need to renew certification every seven years.

The Asthma Prep Course was presented live in Dubai in mid-March. This was a landmark meeting because it was the first time an AARC course had been presented outside of the United States. The program was delivered to sold out standing room only audience. Response to the program was very positive and as a result we have been invited back next year to present the Asthma Prep Course as well as the COPD Educator Course at the Gulf Thoracic Society Meeting in March 2012.

COPD Educator Course

The COPD Educator Course, which was launched in 2010, continues to receive continued positive response. To date there are 125 who have registered in the first two months of 2011. Both the Asthma Prep Course and the COPD Educator Course are available for co-marketing from the state affiliates who have indicated a desire to do so and who have signed the revenue sharing agreement for 2011.

Publications

RESPIRATORY CARE JOURNAL

Submissions and Manuscript Flow – Original Research submissions in 2010 were up 44% over 2009; Case Reports were up almost 50%. The Journal's increased visibility through PubMed and Web of Science, as well as the ease of online submission, may be the source of the increase in unsolicited papers. About 50% of all new submissions are coming from outside the United States, mostly from China, Brazil, Italy, Taiwan, and Turkey. The acceptance rate is about 50% for original research and about 40% for case reports. Despite that the Journal is becoming more selective, we remain committed to helping first-time authors. We anticipate the 2010 volume will be another successful year in the quality of materials published.

The 2010 Impact Factor (a measure of the frequency with which the "average article" has been cited in indexed journals in a given period of time; that is, the number of times articles published over a two-year period divided by the number

of articles, reviews, proceedings or notes) – The Journal was listed in the 2009 *Journal Citation Report* with its first Impact Factor (IF) of 1.52. That value remained essentially unchanged in 2010, at 1.524. The Journal is ranked 18 out of 22 in the Critical Care category and 32 out of 43 in the Respiratory System category. Our self-citation rate is 24%. The top 10 journals that cited RESPIRATORY CARE were: *Intensive Care Medicine*, *Critical Care Medicine*, *Critical Care*, *Respiratory Medicine*, *Chest*, *COPD*, *Respiration*, *Seminars in Respiratory and Critical Care*, *Expert Opinion in Drug Delivery*, and *European Respiratory Journal*. Conference and symposium papers (reviews) continue to be the most cited Journal papers - thus, the need to continue to focus on these features. Some journals have stopped publishing Case Reports because they are seldom, if ever, cited and thus tend to lower the IF. We cannot over emphasize the IF importance, but we will continue to balance this against the two distinguishing features of the Journal: its unique subject matter and also its important role of educating its readers.

Conflict of Interest Disclosure – The need for transparency in reporting conflicts of interest of authors and the relationships between investigators and funding sources has never been greater and is essential to help maintain confidence and trust in the scientific integrity of medical research articles. Our policy now requires that in industry-sponsored studies, the data collection and data management must be conducted independently of the study sponsors.

Digital Object Identifier (DOI) – DOI is another requirement for the Journal and its digital activities. DOI is a permanent digital identifier given to an object. Its most common application is identifying electronic documents. A DOI is not dependent on the object's location and, in this way, is similar to a [Uniform Resource Name \(URN\)](#) or [Persistent Uniform Resource Locator \(PURL\)](#) but differs from an ordinary [Uniform Resource Locator \(URL\)](#). The International DOI Foundation (IDF) defines DOI name as "a digital identifier for any object of intellectual property"; it explains that the DOI is used for "persistently identifying a piece of intellectual property on a digital network and associating it with related current data in a structured extensible way." DOI is a registered trademark of the IDF. A typical use of a DOI is to give a scholarly paper or article a unique identifying number that anyone can use to obtain information about the publication's location on a digital network. We now have DOIs with all articles published in RESPIRATORY CARE.

Goggle Analytics - The number of Journal web site visits is about 1,000 per day. The number of podcast downloads through December 31, 2010 was 22,578 English, 15,312 Spanish, and 318 Mandarin. CPGs, symposia, and conference papers continue to be the most accessed content.

The Journal Website – In February we took another big leap forward in the digital age. Thanks to an updated website, AARC members and subscribers can now read RESPIRATORY CARE papers in an online “DigiMag” format, an HTML format with cross-

linking to references, and via a new “ePub ahead of print” feature.

- The new DigiMag format allows you to turn the pages of the Journal much as you would turn the pages of the print edition of the publication, making it easy to read RESPIRATORY CARE on your computer screen in a format identical to the one you’re accustomed to seeing in the print edition.
- The new HTML format with cross-linking to references is especially designed for folks who want instant access to the papers cited in Journal articles. With this format, each of the references is actually a hypertext link that will take you right to the articles being referenced.
- The addition of “ePub ahead of print” papers gives you the chance to read the latest research accepted for publication by the Journal months before it appears in the print edition, ensuring a rapid dissemination of the most recent scientific evidence in the field. Available in PDF format, these papers are generally up on the website within a couple of weeks of acceptance.

CRCE Through the Journal – Starting with the January 2010 issue, CRCE Through the Journal became a monthly feature offered for free to AARC members only. Between the 5th and the last day of the month, members can answer ten true or false questions covering articles identified as CRCE-approved in that month’s journal, get seven of the ten right, and they will earn one non-traditional CRCE contact hour – all at no charge to members. There’s even a “second chance” option on our online exam site, as long as they do it before the last day of the month – so if they don’t get seven correct the first go around, they can try again. Members can take advantage of the program every month – earning up to 12 CRCE contact hours for the year -- or just in the months when it fits their schedule, making it easy to earn extra CRCEs whenever it’s most convenient for them.

Journal Conferences – Late in March the Journal, under the auspices of the American Respiratory Care Foundation, will present the 48th Journal Conference on *Pulmonary Function Testing*. The next conference will address the chronically critically ill respiratory patient and it will be presented in September 2011. As mentioned above, proceedings from the journal conferences continue to be the most cited articles in our publication.

Projects and Activities

A Guide to Aerosol Delivery Devices for Physicians, Nurses, and Pharmacists

The AARC is preparing for the release of its 3rd Aerosol Delivery Guide. Following the successful release of Guides for RTs, and patients, the 3rd version’s targeted demographic will be physicians, nurses, and pharmacists. Final draft of the document is complete and has already been sent to an expert panel of reviewers. After consultation from the reviewers, it was determined that

the document may be too lengthy. As such, a 10-12 page executive summary will be constructed as an addendum to the full document. Target completion date: Spring 2011

Safety Checklist for Oxygen Monitoring

Funded through an unrestricted grant, the AARC is creating oxygen monitoring safety checklist to be used by RTs and other hospital caregivers during patient “hand-off”; or for when patients with oxygen monitoring needs move from one level of care to another. This safety checklist will be an evidence-based resource that will evolve from a systematic review currently in progress. Target completion date: Summer 2011

COPD Toolkit

Funded through an unrestricted grant, the AARC is developing a COPD Toolkit to be used by RTs for patients with COPD. This toolkit will be inclusive of educational resources. Constructed as an adjunct resource for RTs, the toolkit will be of benefit to COPD patients the moment they are admitted to the hospital. Designed to identify knowledge gaps by the patient, the toolkit allows the RT to educate to those deficiencies through the use of tools within the kit. Devices, flip-chart pictures, and COPD-specific medical information written at a 6th grade-reading level will prepare the patient to better manage their disease once they leave the hospital. This toolkit will be intended for use throughout the patient’s entire hospitalization. A group of 20 hospitals will be used as a beta-testing group, each utilizing the toolkit with 100 patients. Once beta-test is complete, a determination will be made whether or not to launch the toolkit as an AARC educational product. Target completion date: Summer – Fall 2011

Hospital to Home

Charged by the AARC Board of Directors, Executive Office staff are working in conjunction with the AARC Homecare Specialty Section and the AARC Management Specialty Section to better educate both homecare and hospital-based RTs on the challenges, and barriers of creating seamless respiratory care as the patient transitions from the hospital to the home. This project was launched at the 2010 AARC Congress in which a joint session of homecare and management RTs gathered to discuss the breadth and scope of the project as well as generate some preliminary dialogue. The session was well attended with members actively engaged. Many participants volunteered to participate with the project. Led by Bob McCoy, Gregg Spratt, and Cheryl Hoerr, a survey is currently being constructed which will be sent out to RTs working within these venues to more clearly identify what issues interfere with seamless respiratory care. Dedicated educational offerings have been tentatively approved by the AARC Program Committee to be included into the 2011 Congress. Target completion date: Ongoing.

Best Practice Ventilator Protocols

Funded through an educational grant, the AARC is working to create a resource available to AARC members that share ventilator protocol best practices. Solicitations to members have been made through the AARC website asking them to submit ventilator protocols used within their facility. All protocols must be authorized for use and to be shared by the department's medical director, and must include documented evidence suggesting improved outcomes. Once submitted, an expert team of reviewers (Dean Hess, Rich Branson, and Rich Kallet) will review the protocols for appropriateness and to ensure they are evidence-based. Once approved, all accepted protocols will be included into the "best practice" document. Target completion date: Summer 2011

Benchmarking System

As of March 10 there were 137 facilities participating in the benchmarking service. 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 continue to personally contacting new subscribers within one week after they have gained access to the system. This contact gets them started by making sure they know how to access and use the system. Additionally, members of the committee offer personal assistance to facilities that are within 4 months of their expiration date and have not entered at least one quarter of data.

32 University Hospital Consortium (UHC) hospitals signed up for the free trial subscription in December. The 14 of those facilities that entered at least one quarter of data by February 28th will continue to have complimentary access to the system through June 31, 2011. Those 14 facilities can now extend their subscription for the same discounted rate we offer all subscribers who enter at least one quarter of data during their subscription period. So far 1 UHC facility has extended their subscription to June 2012. This is not discouraging news as they have until June 30, 2011 to access the system. To promote subscriber engagement the committee has decided to hold monthly teleconferences via Elluminate. The format will include a section to address identified issues and an "open mike" discussion.

Professors Rounds and Webcasts (see attachment #2)

Most all of the Professors Rounds are recorded by summer. We have recorded four out of the eight by the time we meet in Dallas. We continue to see record numbers of Webcast attendees. The most recent presentation on March 24 had over 420 sites logged on for the live presentation.

Joint Commission (JC) Field Reviews

The AARC continues to participate in the Joint Commission Standards Field Review process. So far this year we responded to these 3 reviews relevant to respiratory therapy:

Long term care credentialing and privileging (1-17-11)
NPSGs (VAP and CAUTI (01-27-11)
Performance Expectations for ORYX Accountability Measures (2-22-11)

Later this year we will be asked for names to nominate for PTAC representatives to JC. This is a four year commitment.

Uniform Reporting manual

The development of the 2011 URM that will focus on acute care hospitals, diagnostic laboratories (PFT, blood gases, non-invasive cardiology, sleep) pulmonary rehabilitation and hyperbaric medicine remains a work in progress. The expert panel has been completed their first priority which is to identify activities and procedures to be included in the survey of cohorts that will eventually provide us with time standards. We will now focus on the design and execution of the surveys that will provide us with valid time standards that we can publish. Due to other priorities the completion of this project will not likely occur until sometime this fall.

CRCE Update

CRCE accreditation activity been heavy and is consistent and revenue for January is on budget. Much attention has been focused on the development and review of the web-based accreditation program that finally has taken traction after years of fits and starts. ATS has been developing the application screens and functionality. These are about 95% completed and have been thoroughly tested by us. We are scheduled to begin testing the application review process within the week. At this time we are optimistic that we will be able to begin beta testing within 2 months and envision 2011 as being the last year that we will accept hardcopy applications.

Advocacy and Public Awareness

DRIVE4COPD

Thanks large in part to all AARC members, the DRIVE4COPD was successfully able to screen more than one million Americans for COPD with the DRIVE4COPD pop-screener. The AARC and its members contributed more screeners than any other partnering organization. As a result, the DRIVE4COPD campaign was named PR Week's Health Campaign of the Year. Special thanks

go out to all AARC members who contributed to “The Drive”. Also new to 2011, the AARC will look to identify ways in which RT and RT students from across the country can become more involved in the campaign. The AARC is also reviewing other suggestions from the DRIVE4COPD on additional ways in which the AARC can contribute to the campaign. Target completion date: Ongoing

Peak Performance USA (PPUSA)

As of today PPUSA has reached an estimated 41,874 children with asthma. It has been implemented in 806 schools in 34 states. Its webpage has been by 30,485 people with 181,621page views since launch. This includes 3,922 visits to the page to learn more about respiratory therapists. The program is supported by ads and stories in AARC Times, emails to groups and individuals, an AARConnect community, and public relations.

Public Relations

So far in the first quarter there have been 6 press releases and 6 published interview from AARC Executive Office staff and volunteers (see below).

HME News (Greg Sprat)

Washington Square News (Tom Kallstrom)

Bridges.com (Tom Kallstrom)

Chicago Tribune (Karen Stewart)

Curaspan.com (Gene Gant)

Lifescrpt.com (Tom Kallstrom)

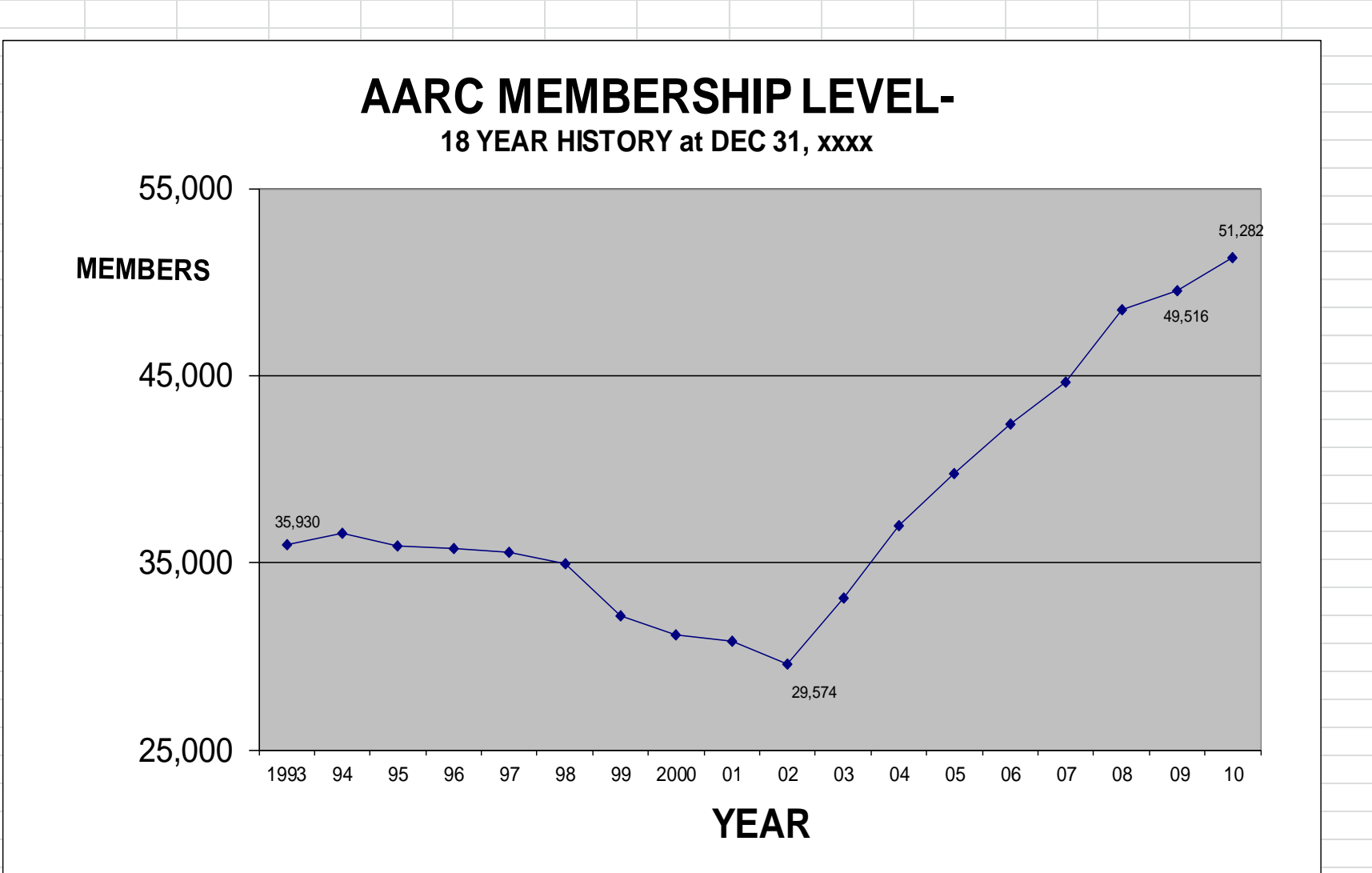
Recommendation: That the Board of Directors authorize up to \$372,000 for our IT Upgrade Initiative 2011, which will provide an updated system capable of providing the support necessary to manage the needs of the association for the next five years. This plan will be implemented in phases and be completed by end of end 2015. This Upgrade will allow us to expand IT platform and capabilities. An IT Upgrade Initiative will reduce the cost of desktop support, improve our business continuity, and provide better member access to our increasing online offerings (see attached IT Upgrade Initiative 2011 proposal).

Rational: The existing IT infrastructure is a result of a multi-year project launched in 2004. We received Board approval in 2006. This included a designed server infrastructure, desk top computers, updated software packages, updated networking and security monitoring. During this time the servers were upgraded

to manage AARC's increased internet exposure coming from enhanced educational opportunities. The networking was upgraded to improve the protection from external hacks and provide better access to increasing multimedia offerings.

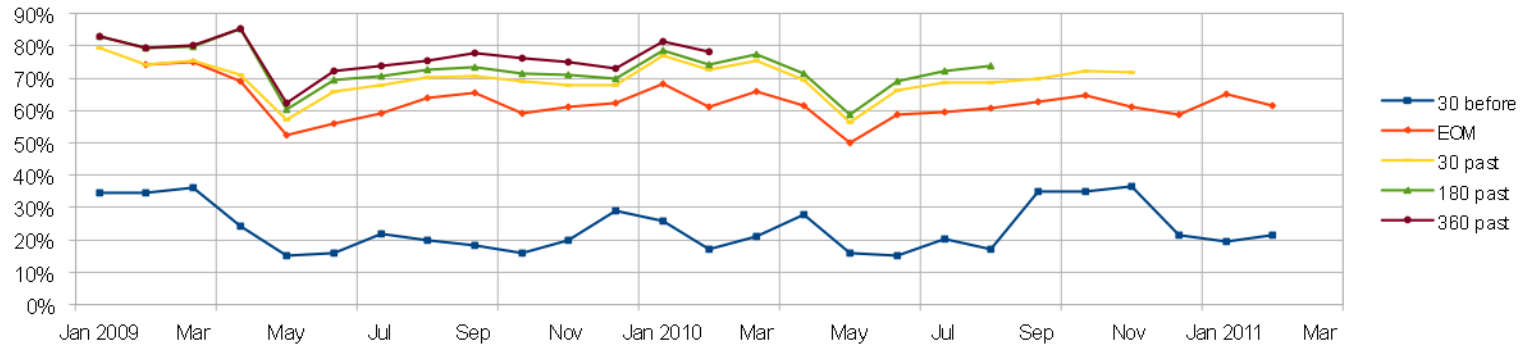
Since that time, the equipment has become outdated and has impacted the reliability of the current system. The current hardware is more susceptible to crashes. We are also unable to upgrade our software to current versions which causes us not to have the support for critical functions (accounting). The cost to maintain old computers approaches the replacement cost, therefore we have self-maintained them at a savings of approximately \$15,000/yr for the last 2 years. We are running out of storage space due to the greater number of multimedia webcasts and courses that we are serving. This upgrade increases our processing capabilities, allows us to reduce the number of physical servers from 14 in the last request, to 2, decreases maintenance costs, as well as heat load in the data center. Heat load has been a considerable issue causing us to have several unplanned outages. The requested servers will be scalable to meet our anticipated needs over the next five years. Changes to the firewall will also allow us to prevent system compromises.

Attachment 1

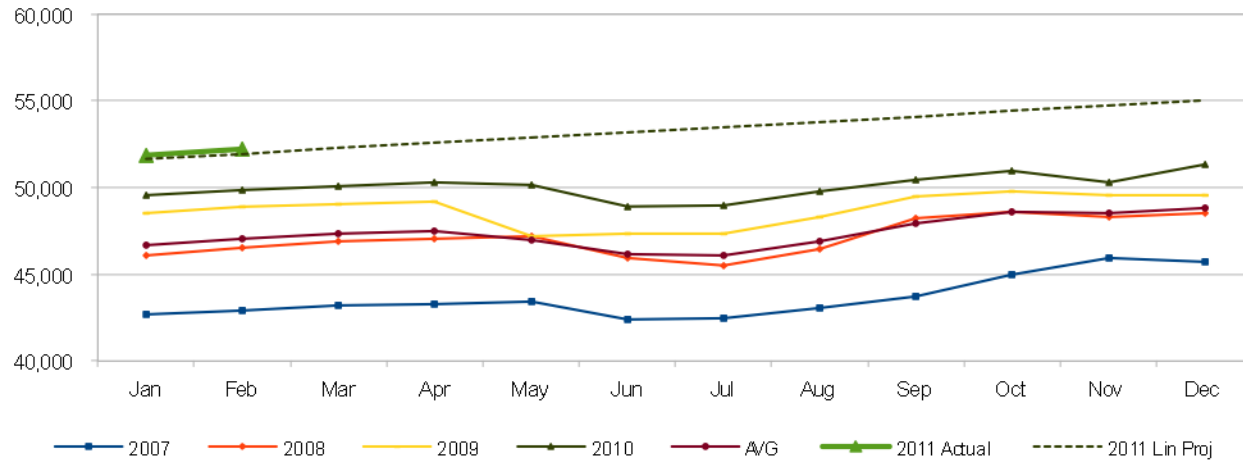


MEMBER COMPOUNDED GROWTH RATE OF 7.2% SINCE BOTTOMING OUT IN 2002

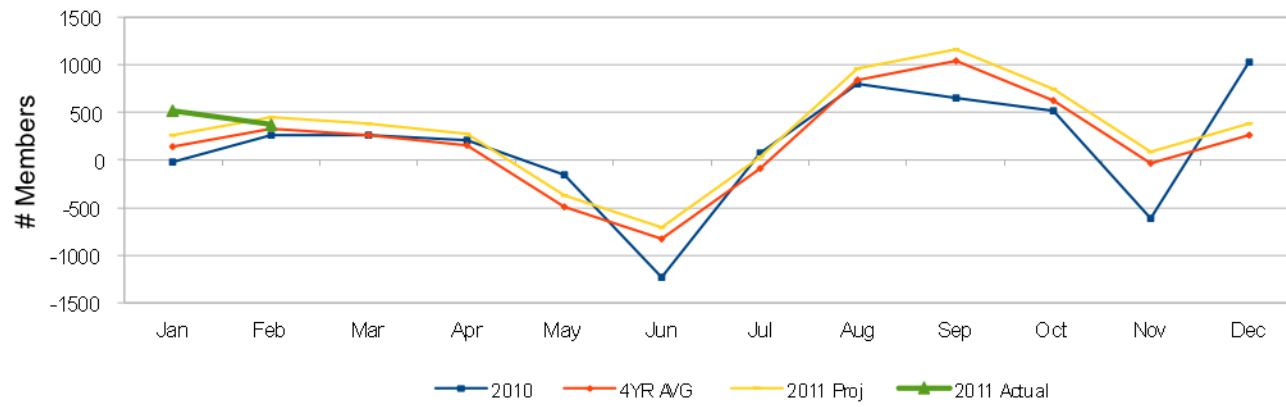
Renewal Rate



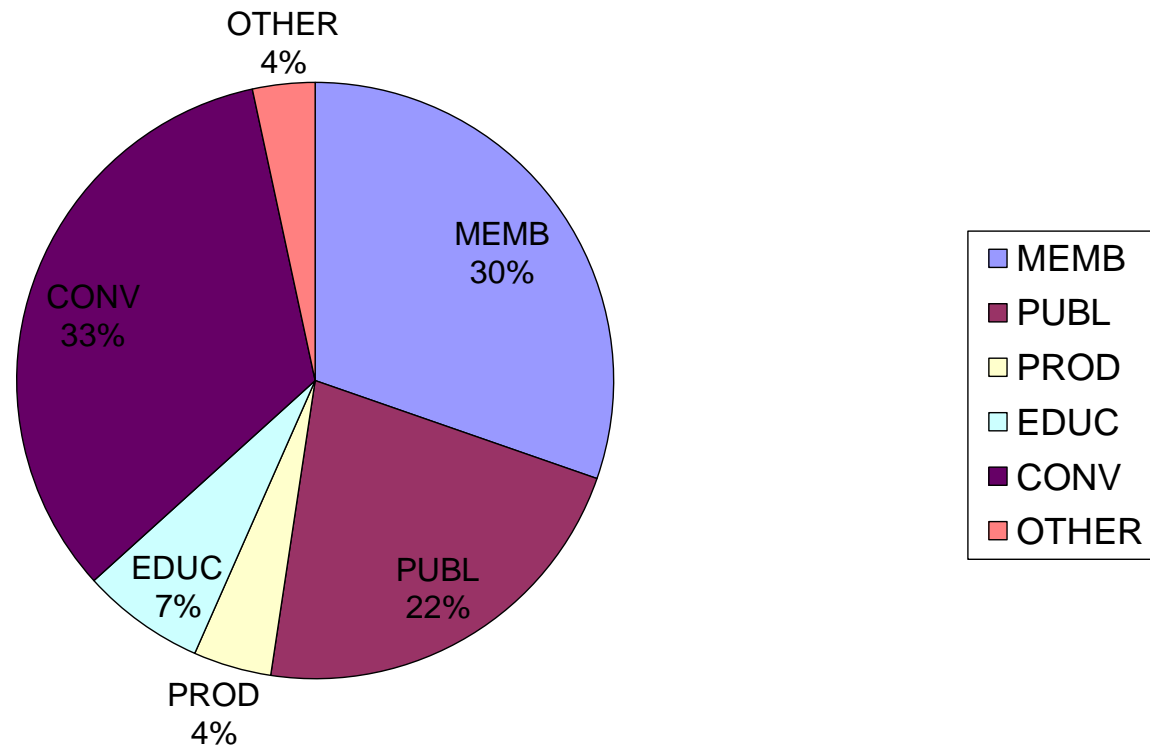
Members



Net Change

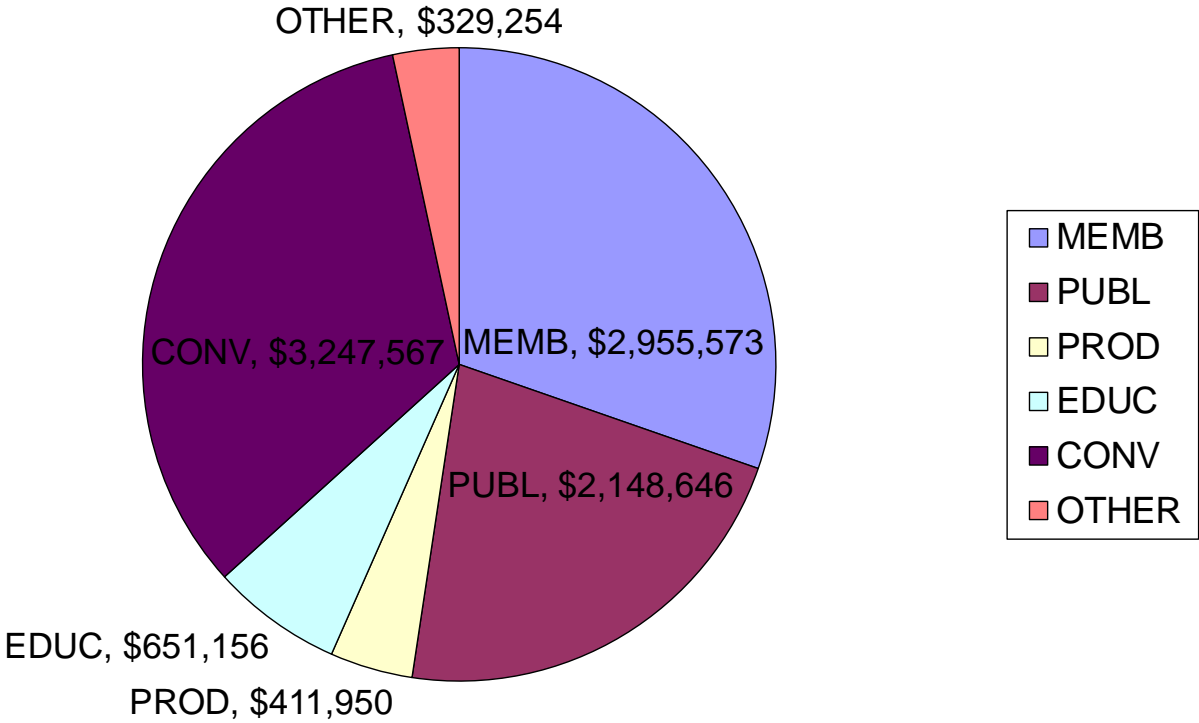


AARC 2010 REVENUE MIX - %'s (Ignores ALL Investment Activity)

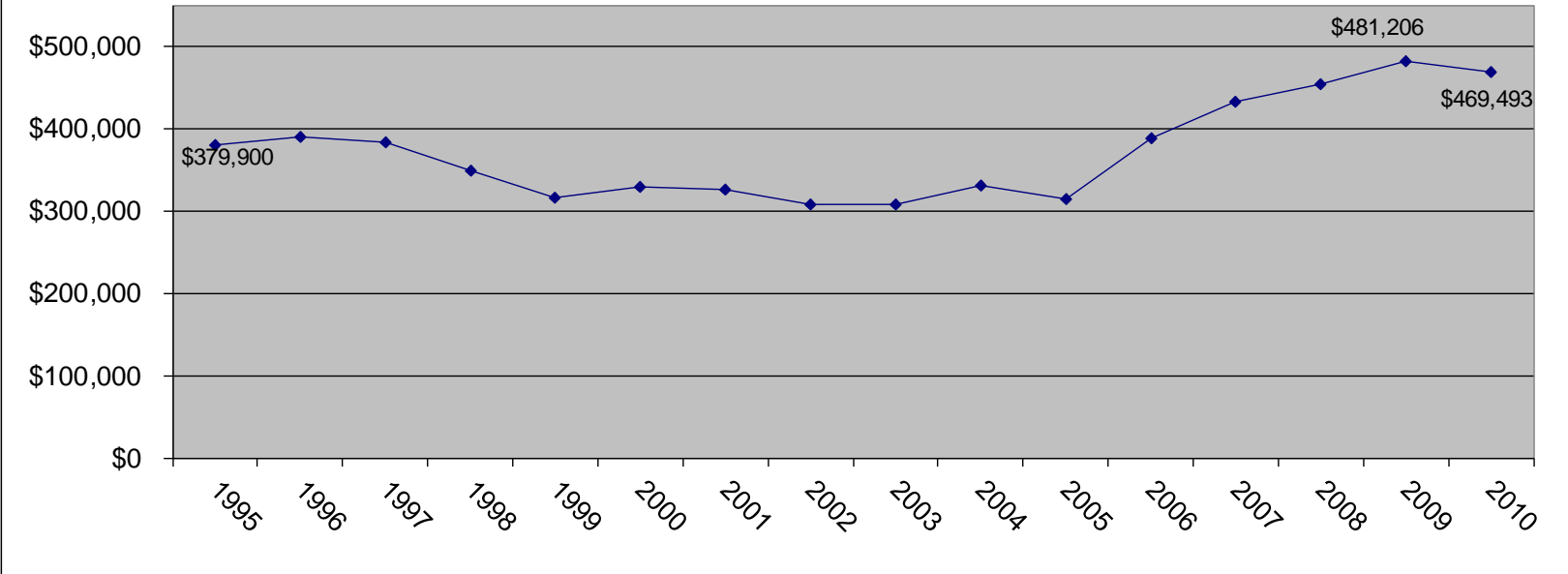


AS A PERCENTAGE, CONVENTION UP; MEMB AND PUBL DOWN FROM 2009

**AARC 2010 REVENUE MIX - \$\$\$
(Ignores ALL Investment Activity)**



REVENUE SHARING / SOCIETY GRANT HISTORY 1995-2010



TRACKS WITH DUES REVENUE

Attachment # 2

2011 Professors Rounds/Webcasts

Program Title/Sponsor	Professor/ Moderator	Description
Tracheostomy: Current Practice/Smith Covidien	Alexander White, 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	Rob DiBlasi RRT-NPS, FAARC/Ira	This presentation will identify clinical circumstances that favor the use of NIV to support ventilation and explore the evidence

<p>Patients: Do We Really Want to Intubate</p>	<p>Cheifetz MD, FAARC / Tom Kallstrom, MBA, RRT FAARC</p>	<p>supporting the use of non-invasive ventilation in neonatal and pediatric patients</p>
<p>The Role of Safety Checklists in Healthcare: Bother or Necessity?</p>	<p>Timothy McDonald MD, JD/ Sam Giordano, MBA, RRT, FAARC</p>	<p>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.</p>
<p>Minimizing VAP in 2011- How Respiratory Therapists Can Contribute.</p>	<p>Marcos I. Restrepo, MD/ Tom Kallstrom, MBA, RRT, FAARC</p>	<p>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.</p>

2011 Webcasts

Topic	Presenter	Description
Helping COPD Patients Achieve a Better Quality of Life by Improving Medication Adherence	Edward Regis McFadden, Jr., MD	This presentation will review common reasons for low medication adherence and review actions that can be taken to improve patient compliance.
Improving Patient Safety by Addressing Disruptive Behavior	David Gourley, MHA, RRT, FAARC	This presentation will define and review the impact of disruptive behavior occurring within and between disciplines, review relevant TJC standards, and discuss Code of Conduct expectations.
Dealing with Difficult People	Scott Reistad RRT,CPFT	This presentation will identify common disciplinary issues and provide strategies for effectively addressing the problems created by them.
Contributing to the Success of the Organization-What Respiratory Therapists Must Do	Lynn LeBouef, CEO Tomball Hospital	This presentation will describe the challenges facing today's hospitals and discuss the skills and attitudes required of respiratory therapists to contribute to the success of their organization.
Developing a Successful Asthma Disease Management Program	Mike Shoemaker, RRT-NPS, AE-C	This presentation will describe the essential components of a successful asthma disease management program including personnel, facilities, outcome measures, accessing the target population and others.
Defending Your Respiratory Therapy License	Antony L DeWitt JD RRT FAARC	This presentation will identify the common causes of licensure board disciplinary action and explain how respiratory therapists can remain in compliance with the laws of their state.
Traveling with Oxygen-	Joseph S Lewarski RRT FAARC	This presentation will provide an overview of current FAA regulations for using personal oxygen equipment inflight. Pre-travel arrangements oxygen patients must make to ensure TSA clearance, prompt boarding and a safe air travel experience will also be discussed.
PFT: Back to Basics	Gregg L Ruppel MEd RRT RPFT FAARC	Pulmonary function testing provides valuable data that is used to assist in the diagnosis of a variety of diseases and formulate treatment plans. This presentation provides an overview of the current practices and standards.

Topic	Presenter	Description
State of the Art in LTOT: What Does the Science Say?	Brian Carlin, MD	This presentation will review current science behind the use of supplemental oxygen therapy, examine the perceived gaps in the science and discuss how to resolve the potential impact.
Screening for COPD	Steve Nelson MS RRT FAARC	This presentation will review the value of routine public spirometry screening and examine whether self-reported risk factors and peak expiratory flow rate can be used to better determine who would benefit from spirometry and additional testing.
Is America Prepared for Mass Respiratory Public Health Emergencies?	Richard Branson	Using information from the national ventilator survey coordinated by the AARC, this presentation will address the ventilator support resources currently available in our nation to support ventilator dependent children and adults
Respiratory Care of the Morbidly Obese Patient	John D Davies MA RRT FAARC	This presentation will examine the impact of obesity on the respiratory system and review strategies to effectively ventilate the obese patient
High-Flow Oxygen Therapy: Is it Here to Stay?	Timothy R Myers RRT- NPS	This presentation will review the medical literature related to high flow oxygen therapy and discuss the recent trends in the application of this increasingly popular respiratory support strategy.
Setting the Ventilator for Maximum Patient Comfort	Richard H Kallet MS RRT FAARC	This presentation addresses patient-ventilator synchrony in the context of the patient's experience with mechanical ventilation during acute illness. The available evidence will be reviewed and the application at the bedside will be discussed.
Understanding Sleep Apnea	Antonio Stigall MBA RRT RPSGT	This presentation will review the types of sleep-disordered breathing and discuss prevalence and symptoms associated with each condition. Surgical and non-surgical treatment modalities will be discussed.

Topic	Presenter	Description
Capnography Monitoring for Non-Intubated Patients: Does it Improve Safety?	Jonathan Waugh, PhD, RRT,RPFT, FAARC	This presentation will review the evidence supporting and discuss the increasing use of non-invasive capnography in patient monitoring in critical and noncritical settings including sedation, pain management, etc.
Pediatric Airway Clearance and Maintenance – What Does the Future Hold?	Brian Walsh, MBA, RRT-NPS, FAARC	This presentation will review the differences between pediatric and adult anatomy in reference to airway clearance techniques. Supporting evidence for proper airway maintenance techniques will also be discussed.
Blood Gas Case Studies: What else do you need to know?	Bill Malley MS, RRT, CPFT, FAARC	This presentation will use unusual case studies to focus on the importance of evaluating additional point of care information and general laboratory tests and the importance of utilizing basic electrolyte information in decision making to establish a respiratory care diagnosis and treatment plan.

Other Activities

The AARC remains a strong partner of the US COPD Coalition. I currently am a member of the Coalitions' Executive Committee and serve as its treasurer. The next meeting of the Coalition is scheduled to be held in conjunction with the ATS meeting next month. The Coalition is currently planning a special conference on COPD to be convened in early December of this year. I am part of the planning committee and my area of responsibility is workshops. We plan on having special workshops with regard to pulmonary rehab, aerosol delivery devices and long term oxygen therapy.

International Business Development

As you know, last month AARC participated in this year's Gulf Thoracic Congress. This is the first time in our history that we offered the Asthma Educator Prep Course outside of the United States. Our goal went beyond educating attendees. We also positioned AARC's brand thru recognition of our co-sponsorship of the meeting and hosting an exhibit during the three days of the meeting. Exhibit traffic was strong with many physicians from all over the region expressing interest in our science journal, Respiratory Care, our continuing education products and international membership in AARC.

We met with the Gulf Thoracic Congress organizing committee and have been asked to provide an even broader array of post graduate courses. AARC's post graduate course was the best attended this year. Moreover, because of the efforts we made last year, in which we encouraged a respiratory track, our speakers participated in the program's regular lectures, in addition to their post graduate assignments. Many of our members in the region attended and were happy to see AARC on the ground in the Middle East.

Summary

As you have seen from the forgoing, AARC is off to a great start in 2011 after concluded a fantastic year in 2010. I hope that the forgoing information satisfies your needs but since we only represent the highlights of our activities, I realize we could have left something out of importance to you. Please feel free to contact me directly at your earliest convenience if there is an item of information that was not covered in this report that you would like to learn about. Of course, if you have any questions regarding any of the forgoing, I will be happy to answer them at your convenience. We look forward to seeing you in Dallas soon.

American Association for Respiratory Care

5-Year
Information Technology
Strategic Plan



Steve Nelson, MS, RRT, FAARC

Executive Associate Director

Russell Leighton, AA, A+, NET+

Information Technology Coordinator

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SECTION 1: EXECUTIVE SUMMARY

INTRODUCTION

The American Association for Respiratory Care (AARC) is a professional membership association for respiratory care professionals and allied health specialists interested in cardiopulmonary care.

AARC, a non-profit organization, is the leading national and international professional association for respiratory care.

AARC is primarily in the adult education business, where they are the publishers of several journals, magazines, and newsletters.

AARC membership base consists of approximately 50,000 members and subscribers throughout the world.

This document describes the current state of the AARC technology infrastructure, while outlining a robust and innovative vision designed to meet the instructional needs of our members over the next five years. The ultimate goal is to build an evolutionary roadmap of cost-justifiable projects to support the AARC in its effort to strengthen and enhance its core application and hardware infrastructure to provide quality services to enhance all aspects of teaching and learning.

This document tries to be consistent with the premise of the five basic goals of the AARC. These goals are as follows:

- I. Financial
 - a. New revenue generation
 - b. Reduce costs
 - c. Increase profit margin
- II. Operational
 - a. Improve efficiency
 - b. Reduce product time to market
 - c. Enhance product of quality/service
- III. Market
 - a. Increase market awareness
 - b. Obtain greater market share
 - c. Add competitive advantages
- IV. Customer
 - a. Improve satisfaction

- b. Increase retention
 - c. Obtain greater customer loyalty
- V. Staff
 - a. Increase staff satisfaction
 - b. Improve organizational culture
 - c. Improve staff retention

CONTENTS SUMMARY

Following the Executive Summary (Section 1), this document includes twelve additional sections.

Section 2, Vision and Goals, describes the trends that underlie the technology proposals found in this Strategic Plan.

Section 3, Guiding Principles, focuses on the guiding principles of the AARC transformation represented by the five-year plan.

Section 4, Data Center Infrastructure, describes ongoing plans for the Data Center, and the cost savings that can be realized through its implementation.

Section 5, Network Infrastructure, includes future directions in desktop/mobile services and support structure. It also describes key changes in technology implementation over the next five years.

Section 6, Workstation Hardware and Software, focuses on various efforts to enhance the AARC environment using technology by implementing a virtual desktop environment.

Section 7, Information Security, Firewall and Spam/Virus Protection, describes the efforts to ensure that everyone can access the information needed, but to limit access to only those who should have it.

Section 8, Membership Management System (IMIS), describes the database management software utilized for membership information.

Section 9, Accounting Software (Great Plains), describes the mid-market business accounting software package used by the accounting department.

Section 10, Document Imaging and Paperless Workplace, discusses the effort to become a reduced paper or paperless environment.

Section 11, Video Production Facility, discusses the vision to provide video teleconferencing services to the desktop and beyond.

Section 12, Budget information, is provided in many of the sections of this Strategic Plan, describing the budgets required to implement each of the new technologies. These budget estimates are synthesized in Section 13, the Overall Budget Plan.

Section 13, Evaluation and Assessing New Technology, discusses AARC plans for assessing new technology.

SECTION 2: VISION AND GOALS

INTRODUCTION

In recent years, the American Association for Respiratory Care (AARC) has made great strides in assessing its operational effectiveness. Through this process of self-examination and improvement, technologies have been adapted and enhanced to provide an infrastructure for members and staff, while providing additional services, and improving operational efficiency.

Technology continues to change at a rapid pace, and today's AARC network is much different from the network that existed just a few years ago. We see a trend toward usage of a wider range of technology devices. Five years ago, members primarily used wired, desktop computers to access the internet and other member resources. Now, members are going online with many different mobile devices, including laptops, tablets, handheld devices, and eBook readers. We expect this trend to continue and accelerate. One of AARC's goals is to ensure that the range of devices work well within the enterprise network architecture.

DESIGN STANDARDS AND METHODOLOGY

Although this strategic plan focuses on technical innovation at the AARC, it should be understood that there is a long, complex process between the conception of such technological advances and their implementation. Between the process of defining the technology for a new service and the implementation of that technology at the AARC, the AARC provides a comprehensive, effective means for its realization.

In brief, each technological undertaking at the AARC consists of four main phases: planning, design, implementation, and post-implementation and support.

First, there is the planning phase, when the idea or service is formulated. Project Management plays an important role here, as it does throughout the project. Project Management ensures, among other things, effective resource management, and the timely completion of the AARC project implementation. Project Management is involved from the moment planning begins.

During the design phase, the proposed solution must adhere to the rigors of technical standards, which have previously been put in place by the AARC.

With regard to implementation, the project must also adhere to the framework for solution integration; that is, there is a process in place for integrators to build out the necessary physical and logical framework that will support the technology. These elements should help to provide the necessary structure for the project.

The rigorous process described above must be able to be replicated at the AARC, as well as being extensible within the AARC; it must also be expertly deployed, and thoroughly and consistently supported by the AARC and/or its vendors.

CURRENT ENVIRONMENT

AARC currently has 11 Servers and 44 workstations deployed locally. There are 11 servers on the local area network (LAN) connected to the Internet. The 11 local (LAN) servers are connected to a gigabit switch. Connectivity to the Internet is achieved through a 6MB ATM line connected into a Cisco router. From there the router connects into a Fortigate 200A Firewall that provides security for the network.

SECTION 3: GUIDING PRINCIPLES

REFRESH STRATEGY POLICY

Purpose: All computer updates are governed by a "Refresh Policy". This policy states that if the American Association for Respiratory Care (AARC) is financially able, it will replace each desktop and laptop computer every three (3) years and servers every five (5) years. The Information Systems Technology (IT) department will provide the AARC with a refresh list. The IT department will then work the AARC, where these computers are located, to determine the best time to replace the computers.

Value: The AARC provides all full-time staff with AARC owned computers. In order to maintain pace with technology change (the fastest personal computer (PC) that is available today, is more than 3 times the speed of the fastest PC available just 1 year ago), and to manage acceptable support levels, these computers need to be upgraded in a cyclic fashion in order to maintain their business value and functionality. These upgrades are described as the "computer refresh".

A refresh is a business value and support decision made in conjunction with management and the IT department.

As the IT department is accountable for all hardware purchases for the AARC, it has the ability to maintain a master inventory and aging list of all computers.

Standards: The industry standard which the AARC has adopted are that every desktop configuration is considered for refresh every 3 years from purchase and servers every 5 years from purchase. This is a significant financial commitment and thus it is critical that all stakeholders (clients, management and IT) consider this process critically as good financial stewards. As hardware capability frequently exceeds software requirements over the life of a computer, the IT department does not provide "trickle down" or "computer swapping" services.

When the IT department technician comes to do the refresh, they will deliver a computer that already has the standard programs installed. The technician will transfer any data from the current computer to the refreshed computer, install any other departmentally required software, and setup/configure the new computer.

A follow-up will be made with the client 1 week after refresh to ensure that the client is satisfied with the transition.

Impact of refresh clients: While the IT department is always looking for ways to make the refresh less intrusive on clients, the refresh is still a

process that can take up to 4 hours depending on the client specific software that needs to be reinstalled onto the refreshed computer. As a part of the communication process before a refresh takes place, an IT department staff member will contact the client and give them guidelines on how to minimize the impact of having their computer refreshed.

All computers purchased through the refresh process are owned by the AARC and under the trustee of the IT department.

SOFTWARE COPYRIGHT POLICY

Purpose: The Information Systems Technology (IT) department will purchase and maintain legal computer software licenses for any computer software purchased by the American Association for Respiratory Care (AARC).

Scope: This policy applies to all AARC employees and addresses issues of software purchasing, requirements, and licensing.

General Information: AARC has a large investment in computer hardware and software. The technical ease with which software can be copied or installed multiple times does not negate that such actions often are in violation of applicable copyright laws and/or the license agreements with the manufacturers governing the original purchase of the software. Moreover, regardless of the legalities, unauthorized copying is unethical. It is simply another form of stealing someone else's property.

Software manufacturers and distributors often monitor the compliance of their customers through a formal audit process. In addition, manufacturers have taken legal action to enforce their software agreements and copyrights.

The consequences to an organization such as the AARC being involved in a "software piracy" charge would be detrimental to our core values, image, and credibility. In addition, the financial implications of settling charges such as these could be crippling and would definitely not represent good stewardship of resources entrusted to us.

Policy: All computer software packages should be legally purchased and used. This includes software installed on computer hardware purchased by the AARC, in addition to computer hardware utilized on the premises.

Legal purchase and use would normally imply the following:

- * The original media and manuals are of original distribution from the vendor, and are available on the premises that the software is being utilized.

- * The software is being used in accordance with the license agreement under which it is purchased.

* No unauthorized copies are made.

* The software is not installed on more than the authorized number of systems.

* Software installed on a server in a client/server architecture has an appropriate multiple user license.

Responsibility: The IT department is accountable for the monitoring and correct implementation of this policy. Questions or points of clarification should be referred to the same.

DESKTOP SOFTWARE STANDARDS

Purpose: The Information Systems Technology (IT) department provides various levels of support and training for software applications depending on the needs of the user. Software applications are not limited to software installed on client computers, servers, or presented to users as web based applications.

General Information: The IT department will maintain a published list of department specific software packages. If a user or department installs software and/or hardware, and it interferes with the computer's operation and institutional support is required, the IT department will remove the non-standard products and return the system to its original state. During this refresh to a standard level of performance, the IT department will concentrate on preventing any loss of personal data, but no guarantees can be made.

The following is a tier-based design for installed software at the American Association for Respiratory Care (AARC).

1. Desktop Supported Workstations:

Tier 1 - Enterprise-wide, standard software application packages for AARC owned computers. This is a basic or "standard image" installed on all computers regardless of location and discipline. Software applications provided in this tier are:

Microsoft Office Professional 2010 for PC or 2011 for MAC - Word Processing

Tier 2 - Enterprise-wide software applications that are supported like Tier 1 software applications, but are not included in the "standard image" and are not installed on all computers. Software applications provided in this tier are:

Adobe Acrobat Professional - Document formatting and publishing

Adobe Dreamweaver - Web page designer

Adobe Illustrator - Artwork designer

Adobe Photoshop - Picture editor

AVG Anti-Virus - Virus and spam detection

Crystal Reports - Report design

Flash Professional - Video designer

FRx 6.7 - Accounting management database viewer

Great Plains - Accounting management database

iMIS 15.1.3 - Membership management database

iMIS TaskCentre - Automated task designer

Kaseya - Remote desktop

Macromedia Contribute - Web page editor

Reinvented Software Feeder - RSS feed and Podcast publisher

Smart Draw - Architecture designer

Visual Studio - SQL report designer

WinZip - File compression

2. Server Supported:

Tier 1 - Enterprise-wide, standard software application packages for AARC owned servers. This is a basic or "standard image" installed on all servers regardless of location and discipline. Software applications provided in this tier are:

Kaspersky Anti-Virus 2011 for Windows Servers - Virus and spam detection

Windows Server Datacenter 2008 R2 - Server operating system

Tier 2 - Enterprise-wide software applications that are supported like Tier 1 software applications, but are not included in the "standard image" and are not installed on all servers software applications provided in this tier are:

F-Secure Anti-Virus for Windows Server - Virus & Spy Protection - Virus and spam detection

LISTSERV - Electronic mailing list

Macromedia ColdFusion - Web applications developer

Microsoft Exchange Server - Company Email and Calendar

WebTrends - Analytic and web tracking

Windows SQL Server - Database management

WIN-PAK - Alarm system

SECTION 4: DATA CENTER INFRASTRUCTURE

VISION

The long-term vision for the AARC datacenter is to transform its current IT operation into a utility and customer-oriented service model. We will tailor our solutions strategically, according to the AARC business needs, and set the direction for developing a standardized platform. The platform will leverage traditional infrastructure. This platform will allow applications and infrastructure components to converge into product-service offerings, two of which are unified storage and enterprise servers. Unified storage and enterprise servers will help the organization's strategic approach to IT consolidation and building the datacenter of tomorrow.

GOAL AND STRATEGY TO OBTAIN GOAL

There is a high demand for storage and servers, which are usually associated with projects for implementing new applications. Storing and sharing data on a secured storage platform is vital to the organization's intellectual capital growth and business dynamics.

Virtualization is becoming the de facto standard for implementing services in the datacenter - from virtual servers, desktops to applications. Virtualization provides better utilization of compute resources. Most servers operate at about 15-20% capacity. Virtualization can raise utilization to over 80%, reducing the need for additional servers, electrical cooling, and maintenance. Virtualization, which manages storage, memory and computing power for their high-availability needs, ultimately reduce the overall physical server hardware footprint in the datacenter. We can easily relocate the entire datacenter when virtualized to a strategically assigned disaster recovery site. With virtualization forming the basis of the unified storage and enterprise server architecture, we will enable a dynamic datacenter infrastructure with high capability in terms of availability and the ability to perform "storage thin provisioning" - incrementally increasing storage capacity on-demand or as business grows. Virtualization and unified storage are the foundation for resiliency and a greener datacenter.

CURRENT STATE

The AARCSQL01 server, running Microsoft Windows Server 2003 and Microsoft SQL 2005, hosts two critical databases. One is the iMIS database, our membership management database. The second is the Great Plains accounting database.

The MAIL01 server, running Microsoft Windows Server 2003 and Microsoft Exchange 2003 software, hosts all of the email. Users on the local network receive/send their email using Microsoft Outlook clients using SMTP protocols. Users also have the capability of access their email through Webmail using POP3 protocols.

The AARCWEB01 server, running Microsoft Windows Server 2003, is the primary web server hosting all websites.

The AARNAS01 server, running Microsoft Windows Server 2003, is the iMIS application server, and the backup server, running Veritas Backup Exec 2010. The backup device is a High-Rely drive set.

The AARCFILERSERVER server, running Microsoft Windows Server 2003, is the primary file storage server and Virus Protection server. Antivirus detection/prevention within the environment is Kaspersky Anti-Virus. Kaspersky Anti-Virus Administration, installed on this server, manages virus definitions for all Windows Workstations and servers attached to the AARC domain.

The EPA01 server, running Microsoft Windows Server 2003, is for hosting the www.epapartnershiparcf.org website. This is a secure SSL server utilizing RSA secure user login for authentication. This server also hosts the secure logon to e-series for iMIS.

The MAIL server, running Microsoft Windows Server 2003 and L-SOFT LISTSERV software, is a list server for several distribution groups. Some of these distribution groups contain as many as 30,000 names.

The AARCGHOST server, running Microsoft Windows Server 2003, is the secondary DNS server and primary DHCP server.

The AARC01 server, running Microsoft Windows Server 2003, is the Primary DNS server and Active Directory/Policy server.

The AARC02 server, running Microsoft Windows Server 2003, is running the Kaseya program. This program provides remote access and patch management to the servers and workstations from home or an internal desktop.

Additionally, there is an older MAC server that is used for file share and backup for the Macintosh workstations.

AARC has three primary battery backup (UPS) setups. Two APC SmartUPS 5000 with extra runtime batteries for the servers and one UPS SmartUPS 1500 for the switches.

CURRENT CHALLENGES

The most critical problem that we currently face is running out of storage. We often advise users to delete or move existing data from the network shares, in an effort to free-up disk space. Inadequate network data storage affects the overall end-user experience and impedes business productivity.

The servers and workstations are at the end of their projected lifespan. There has been one major server failure and three workstation failures so far. As the technology gets older the failures become increased.

TARGET STATE

The end-state is a reduction in the number of physical servers in the datacenter with terabytes of centrally managed storage. The reduced computer infrastructure will create a private cloud computer environment that can be leveraged by all AARC entities.

Targeted benefits include:

- Increased overall storage capacity
- Centralized storage management
- Efficient utilization of storage
- Reduce server hardware footprint
- Reduce server hardware heat and energy consumption
- Reduce the amount of time to backup and recovery of data

RECOMMENDATIONS AND ROADMAP

The following roadmap shows the path to obtain the vision:

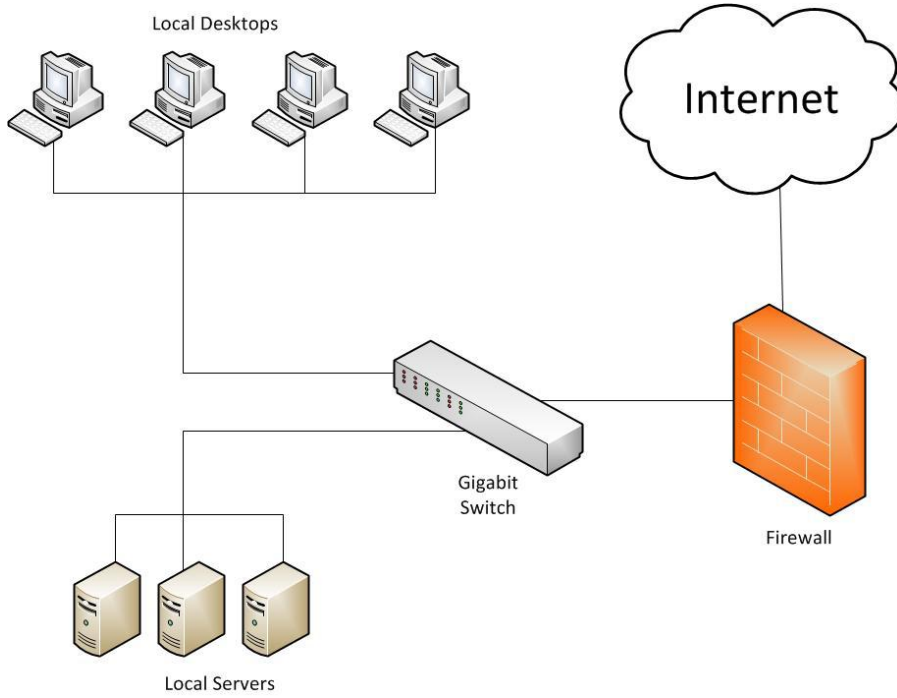
- Build a unified storage platform to meet existing and future needs.
- Build an enterprise server infrastructure to support the applications with scalability and extensibility.
- Implement the tools to efficiently and effectively manage the environment.
- Develop sets of policies, processes, and procedures governing the storage and servers in the datacenter.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

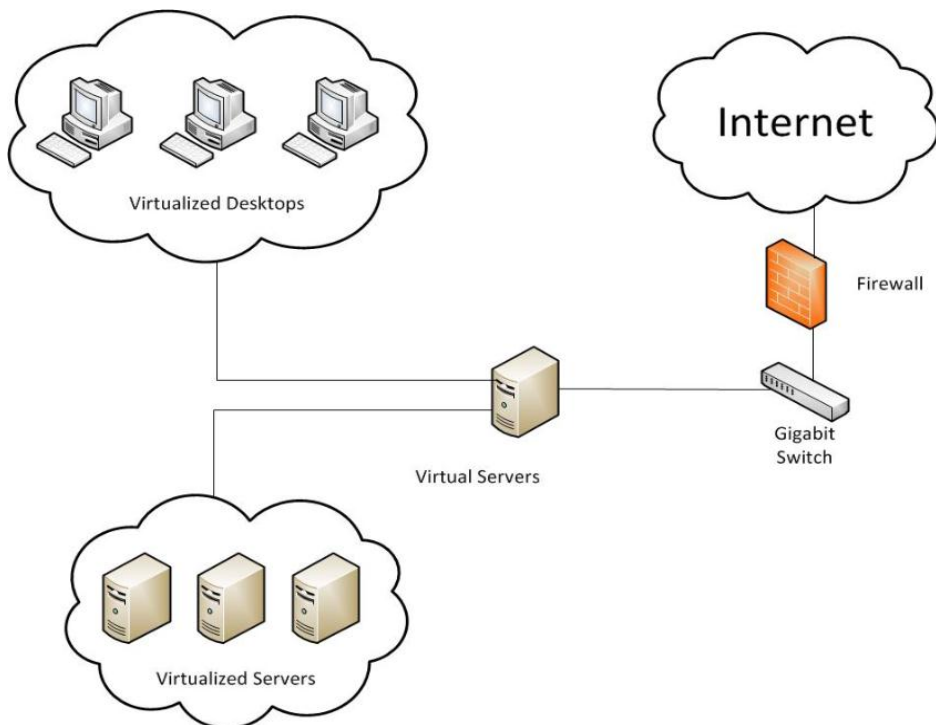
Implementing Unified Storage and using Enterprise Servers for the AARC will realize several organizational goals: from server application to desktop virtualization, including the idea of on-demand computing, it will transform our datacenter into a more dynamic and resilient environment. Additionally, by exploiting emerging market trends, AARC will immediately realize long-term reductions in deployment and administrative costs.

If not implemented, the datacenter will continue to operate as is without efficiency and resiliency. We will continue to have servers with lack of storage space. This also prevents us from moving towards the development of a sustainable and dynamic datacenter. Without the right foundation, we will operate inefficiently, and we are unlikely to lower total cost of ownership due to ever-growing demand for storage and servers.

Current AARC Network



Proposed AARC Network



BUDGET TO IMPLEMENT

<u>QTY</u>	<u>Description</u>	<u>Unit Price</u>	<u>Extended Price</u>
002	HP DL380 G7X5660 12GB PERF SERVER	\$7,282	\$14,564
012	HP 4GB 2RX4 PC3-10600R-9 MEMORY KIT	\$246	\$2,952
004	HP 146GB 6G PLUG SAS 10K SFF DP HARD DISK DRIVE	\$260	\$1,040
004	HP NC375T PCIE 4PT GIGABIT SERVER NIC CARD	\$506	\$2024
004	HP 6' 1.83M 10A C13-UL US POWER CORD	\$18	\$72
002	HPE 3YR 24X7X4 DL380 SUPPORT	\$837	\$1,674
001	HP P2000 C4 FC/ISCSI DUAL CONT SFF BACKPLANE SERVER	\$14,166	\$14,166
001	HPE 3YR 24X7X4 MSA 2000 G3 SUPPORT	\$2,077	\$2,077
008	HP 300GB 6G PLUG SAS 10K SFF DP HARD DISK DRIVE	\$553	\$4,424
002	NETGEAR 24PT GIG L2 MNGD SWITCH	\$600	\$1,200
008	BELKON 10FTCAT5E RJ45 PATCH CABLE	\$7	\$56
001	VMWARE VSPHERE 4ESS PLUS BND 3H SERVER VIRTUALIZATION SOFTWARE	\$3,228	\$3,228
001	VMWARE VSPHERE ESS PLUS BND 1Y SUPPORT	\$908	\$908
004	MS MBL WIN SRV DC 2008 RS 1CPU DATACENTER SERVER LICENSE	\$2,395	\$9,580
035	MS MBL WIN SRV UCAL 2008 WINDOWS 7 WORKSTATION LICENSE	\$30	\$1,050
010	MS MBL REMOTE DT SVC UCAL 2008 R2 REMOTE SERVER LICENSE	\$85	\$850
001	AVL COLDFUSION STD 9 2CPU L1	\$1,162	\$1,162
002	MS MS SQL SQL SRV STD 2008 R2 1CPU	\$7,000	\$14,000
001	MS MBL EXCH SRV STD 2010	\$700	\$700
075	MS MBL EXCHG STD UCAL 2010	\$64	\$4,800
002	APC Smart-UPS 2200VA	\$1,075	\$2,150
			SUBTOTAL \$82,677

SECTION 5: NETWORK INFRASTRUCTURE

VISION

The vision of the network infrastructure is to provide high-speed Internet and shared resource access to the entire building to meet the needs of the next generation of computing in real time.

GOAL AND STRATEGY TO OBTAIN VISION

The ultimate goal is to increase network connectivity and provide internet and access to storage facilities within the AARC network. Updating internal network wiring and strategically placing switches around the building that shorten the length of Cat5 cable required will greatly speed up access.

CURRENT STATE

The AARC currently has every network drop run from each office back to the datacenter and into different patch panels. This is an inefficient model because of the length of each cable run throughout the building. Half of the building is also currently not being utilized by AARC staff and has old network cabling installed.

TARGET STATE

The goal is to install four network switches in the best location and have all network drops run to these switches depending on their location. The switches would then connect back to the datacenter via fiber optic cable. This is a more efficient model because of the reliability of fiber optic cable and avoids the loss of signal when using Cat5 cable in great lengths.

RECOMMENDATIONS AND ROADMAP

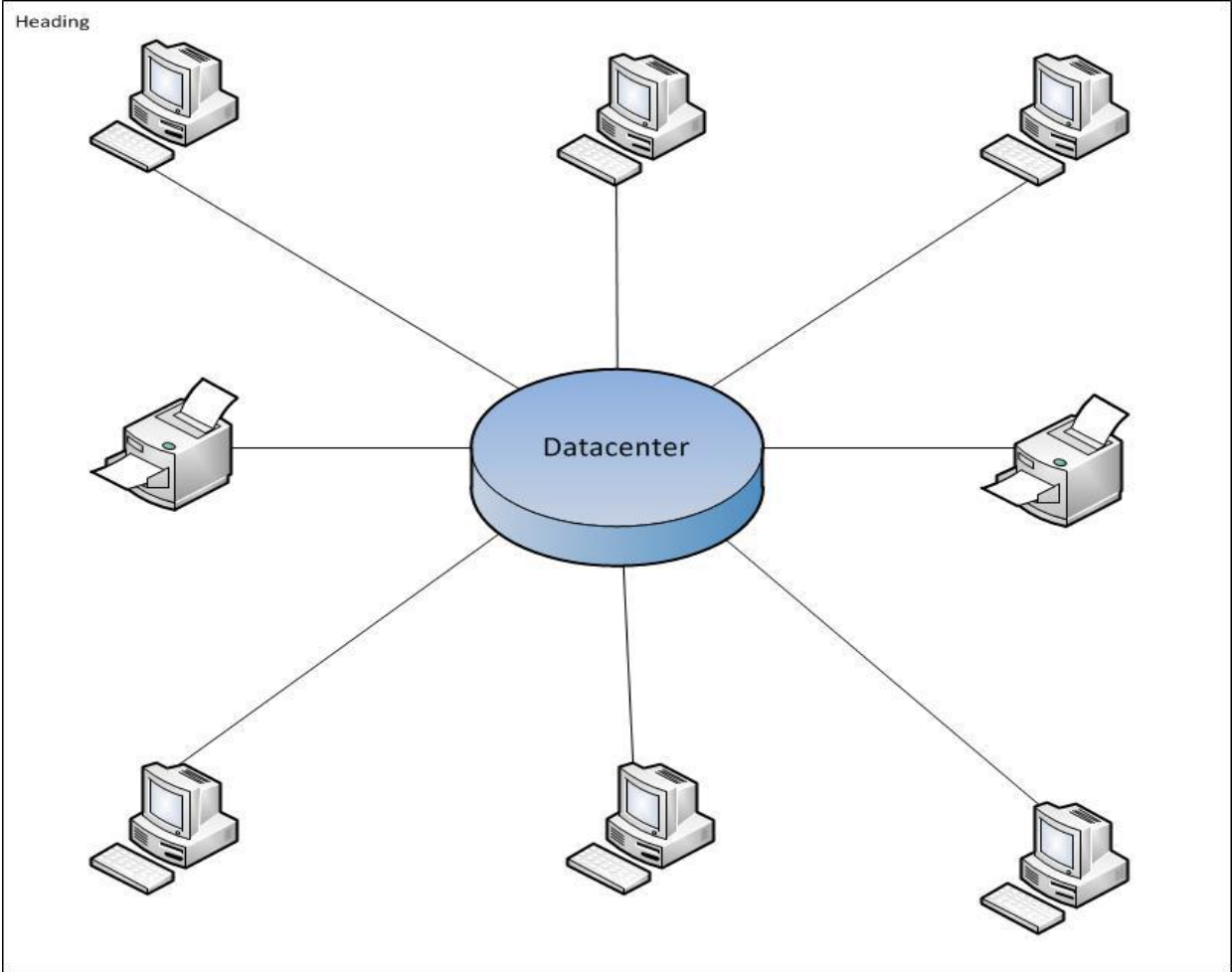
It is recommended that the AARC utilize new technology and internal wiring design to implement a high speed internal local area network with increased speed capability between the datacenter and local workstations.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

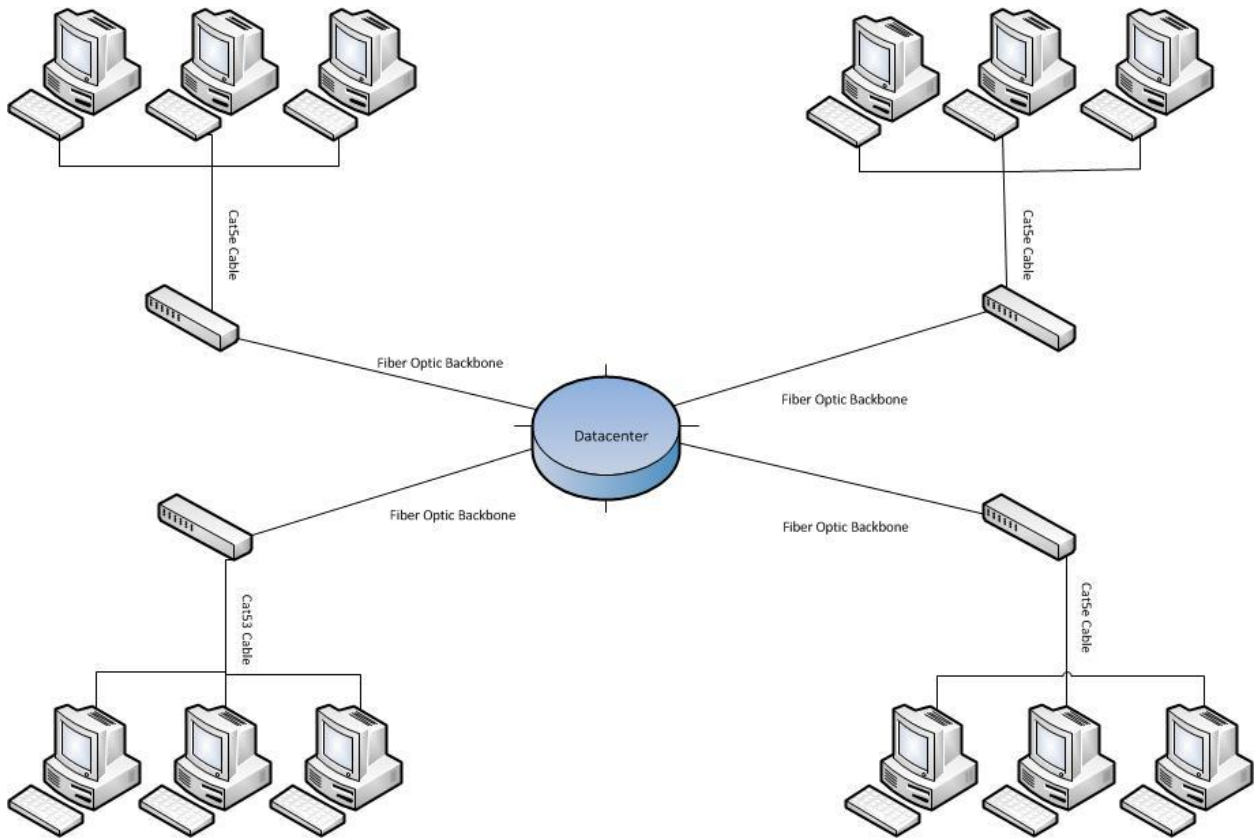
The benefits of updating the internal wiring are as follows:

- Faster access to shared resources. As Cat5 cable lengths get longer the capacity for lost signal strength and data becomes increasingly larger.
- Better access to unused space. As the AARC expands into the other side of the building the wiring will have to be updated. Currently the internal wiring on that side of the building is not connected.

Currently all workstations are connected to the datacenter with individual runs of cable. The longest run is approximately 200ft. The maximum recommended length is 328ft. As the cable gets longer the signal gets fainter and network access speed diminishes.



Under the vision for the new network infrastructure, there will be four switches clustered throughout the building. Each workstation will have a cable run to the nearest switch. The longest estimated run would be 30ft. The switches will have a fiber optic backbone that runs to the datacenter into the gigabit switch. This network design will ensure signal strength is retained meaning faster network access and less data corruption.



BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
001	Building wiring Cat6 and Fiber	\$20,000	\$20,000
004	Netgear 24PT switch and rack	\$1,000	\$4,000
001	Labor and supplies	\$11,000	\$11,000
001	T-1 upgrade to OC3	\$15,000	\$15,000
001	Monthly OC3 line charge	\$2,200	Note 1

			SUBTOTAL \$50,000

Note 1 - The current monthly cost for four T-1 lines is \$1,600. Upgrading to OC3 will add a \$600 increase monthly.

SECTION 6: WORKSTATION HARDWARE AND SOFTWARE

VISION

We all know that technology keeps on changing, and so do user needs. Workstations are likely to become obsolete after three years. It costs the AARC more to support antiquated hardware after three years than it would to upgrade to newer equipment. The initial purchase price of a PC is only a small portion of the total cost of ownership (between 10 and 20 percent). This is far outweighed by administrative support and disposal costs. Delaying a refresh plan can significantly increase support costs. The idea here is to reduce the overall costs in computer purchases and support.

GOALS AND STRATEGY TO OBTAIN VISION

Our goal is to incorporate 21st century technologies at the AARC to support the administrative requirements.

End-User Computing

- Deploy software applications on demand and remove when no longer needed with minimum effort.
- Provide virtualized desktops with access from anywhere.
- Provide centralized support to staff members by managing their end-user platforms remotely as much as possible.

Our Strategies

- Implement and deploy collaboration software tools to support centralized storage, VPN for remote access, end-user device management, thin-clients with virtual desktops.
- Develop processes and procedures governing the Virtual Desktop environment for ease of management and application deployment, including platform standardization.

CURRENT STATE

The AARC currently has 35 Windows Desktop Computers running Windows XP Professional, six PowerPC MAC Desktop computers, and three Powerbook MAC Laptop computers. All machines were purchased in 2006. The lifecycle on a standard desktop is three years.

Most software is outdated. Currently only four systems in the building are capable of reading the current MS Office file formats and other systems have had issues with new graphic formats.

FUTURE STATE

Providing a dynamic computing environment, where Operating Systems are no longer bound to their physical hardware is optimal. Using thin-client systems with Virtual Desktops is the future end-state for all end-user computing, especially in today's economies. Thin-client devices are much cheaper than their overly-powered relative that is more costly to maintain.

RECOMMENDATIONS AND ROADMAP

Providing access to the latest collaboration and work environment will assure our staff is well trained with today's relevant technologies.

- Implement an enterprise Desktop Management solution
- Implement Virtual Desktops with Thin-Client devices.
- Upgrade all software to current editions to take advantage of the newest features.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

The benefits of implementing End-User computing for the 21st century are:

- Reduction in energy consumption.
- Secured and managed end-points.
- Reduction in software licensing costs.
- Enhanced end-user experience.
- Centrally deploy OS patches on time.
- Increased security.
- Improved data integrity by storing desktop images in a single location

If not implemented, the current configuration will continue to impede the process for taking AARC to the 21st century. This also prevents us from moving towards the development of a sustainable computing environment. Without the right foundation, we will continue to operate inefficiently, and we are unlikely to lower total cost of ownership due to ever growing demand for storage and computer processor power.

BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
050	HP T5545 VIA EDEN 512MB TC	\$299	\$14,950
005	VMWARE VIEW 4 PRM ADD 10P	\$1,212	\$6,060
005	VMWARE VIEW 4 PRM ADD 1Y	\$390	\$1,950
003	APPLE IMAC 27" 3.20 2X2GB	\$1,684	\$4,902
005	APPLE MacBookPro 15" 2.53	\$2,198	\$10,990
002	Dell Precision 15-inch, Core i7	\$1,678	\$3,356
002	Dell Vostro All-in-one Desktop	\$698	\$1,396
050	Microsoft Office 2010	\$480	\$24,000
010	Adobe Acrobat Professional X	\$449	\$4,490
003	Adobe Photoshop CS5	\$710	\$2,130
002	Adobe Dreamweaver CS5	\$384	\$768
001	Adobe Flash Professional CS5	\$672	\$672
009	Microsoft Office 2011 for MAC	\$352	\$3,168
002	PARALLELS DESKTOP F/MAC	\$75	\$150
001	Visual Studio 2010 Professional	\$549	\$549
002	Microsoft Windows 7 Professional	\$307	\$614
001	Three-year graphic software refresh	Note 1	\$1,445

			SUBTOTAL \$81,590

NOTE 1 - The current five year plan will upgrade all existing software to its current version. Because graphic design software changes rapidly there is a software refresh included at the three year mark. This refresh will require that upgrades be purchased for graphic design software only to keep it current.

SECTION 7: INFORMATION SECURITY, FIREWALL AND SPAM/VIRUS PROTECTION

VISION

The AARC's information security vision is of an environment in which the right people within the community have the right access to the right data, when and where they need it.

GOALS AND STRATEGY TO OBTAIN VISION

This vision may seem somewhat unusual for security organization. Too often, the focus of security is to act as a technology "cop", playing whack-a-mole with specific technical threats, with the end result of "protecting" information by preventing access to it. This model is counterproductive, and runs contrary to the very purpose of information technology, which is to facilitate the creation of value from information. The AARC's information security strategy was conceived with this in mind, and its focus is on providing users with the greatest possible access to the information they need without placing that information at excessive risk.

Payment Card Industry (PCI) is fast becoming widely recognized around the globe. The AARC is defined as a merchant and is directly involved in the processing, storage, and transmission of transaction data and must provide security and encryption so that the data is not misused. This requires the installation of PCI hardware, proof of compliance, and annual audits of the PCI program.

CURRENT STATE

The AARC currently utilizes a Fortigate 200A Firewall as the gateway between the Internet and the AARC.ORG domain.

The AARC currently utilizes a Barracuda 300 Spam/Virus Firewall as the filter for incoming email traffic.

FUTURE STATE

As the uses of technology evolves, so too has the associated risks. The value of making data available to the right people is unquestionable, but the value of such data to the "wrong" people has increased considerably as well. The future goal is to place a state-of-the-art firewall and spam/virus firewall in place that provides in-depth reporting services and IP tracking.

The AARC needs to be PCI compliant to continue taking online credit card transactions and eliminate the risk of credit card data being fraudulently obtained and used illegally.

RECOMMENDATIONS AND ROADMAP

The AARC's information security vision is achieved through four core security functions: identity and access management; vulnerability management; policy and compliance management; and awareness and education. Each of the four core security functions addresses a fundamental prerequisite for meeting the vision of ensuring that the right people have the right access to the right data. Identity and Access Management is concerned with identifying who the "right people" are, and what the "right access" is. Vulnerability Management deals with the converse of the vision - ensuring that no one gets access that he or she is not supposed to have. Policy and Compliance Management codifies security processes into formal policies and ensures that information is accessed and stored in ways that comply with federal, state, and city mandates. Finally, Awareness and Education is dedicated to ensuring that the user community understands and respects each of the other core security functions.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

The technological advances experienced in recent times and expected in the next five years open up tremendous opportunities for improving the ways in which the AARC communicates and provides to its members. Information is king, and whether it is being used to analyze membership data, it is only of value if it can be accessed when it is needed. The proliferation of technologies enabling this access has made it easier than ever to get data to the right people, but this advance has not come without liabilities. Data that is easily accessed by the "right" people can often be accessed just as easily by the "wrong" people, with potentially disastrous consequences.

Information security is no longer about stopping annoying viruses; it is about protecting membership information from real harm, and must be treated as seriously as the security of the physical environment. The AARC's information security strategy, through protections proactive and reactive, administrative and technical, and physical and virtual, ensures that our members and staff can safely navigate the dangers of cyberspace well into the next decade.

BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
001	Barracuda Spam/Virus firewall 400	\$4,000	\$4,000
001	Barracuda SSL/VPN 380	\$2,000	\$2,000
001	Fortigate 310B Firewall	\$6,995	\$6,995
-----			SUBTOTAL \$12,995

SECTION 8: MEMBERSHIP MANAGEMENT SYSTEM (IMIS)

VISION

Advanced Solutions International (ASI) iMIS 15 is the latest version of iMIS, which is upgradeable, web-based software for organizations. The iMIS 15 uses advanced technology including Microsoft's .NET development platform. iMIS has the ability to help with data collection, including managing member, donor and customer information. The iMIS 15 is a multi-module system which can help with relationship management, marketing, communication, and commerce.

GOALS AND STRATEGY TO OBTAIN VISION

Improve stability of iMIS to create a platform for improved communications and interoperability. To obtain better reporting and data-mining capabilities to allow AARC to make informed decisions from the data they have.

CURRENT STATE

The AARC is currently running version 10.6. This version requires software be loaded on the local user's computer to access the database.

FUTURE STATE

Version 15.1.3 is available and has the following enhancements:

- Expanded support for an array of new operating systems and web applications.
- New web content management features, including support for a new design template based on Universal Design concepts, which makes it easy to transform web content for use in mobile devices.
- Better reporting integrated with SQL 2008 Reporting Services and Crystal Reports.

RECOMMENDATIONS AND ROADMAP

Recommend upgrading iMIS to the latest version to take advantage of upgrades, web-based programming and quality.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

The AARC currently has version 10.6 installed. This antiquated version is a desktop based program that requires the product be installed locally on the user's computer. iMIS 15 is web-based and is installed on a network server that has better processor power, memory and space.

BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
001	Consulting and installation	\$12,300	\$12,300
001	Training	\$2,250	\$2,250
-----			SUBTOTAL \$14,550

SECTION 9: ACCOUNTING SOFTWARE (GREAT PLAINS)

VISION

Microsoft Dynamics GP is a mid-market business accounting software package. It uses either Microsoft SQL Server 2005 or 2008 to store data. It is one of four accounting packages acquired by Microsoft that now share the Microsoft Dynamics Business Solutions brand.

GOALS AND STRATEGY TO OBTAIN VISION

Improve stability of Great Plains to create a platform for improved communications and interoperability. To obtain better reporting and data-mining capabilities to allow AARC to make informed decisions from the data they have.

CURRENT STATE

The AARC is currently running version 9.0. Support from Microsoft for version 9.0 expired February 11, 2011.

FUTURE STATE

Microsoft Dynamics GP delivers built-in, flexible functionality that provides business value now and into the future. With Microsoft Dynamics GP you can:

- Simplify your business with a single solution that connects financials, manufacturing, supply chain, sales and marketing, project management, human resources, and services information.
- Improve productivity with familiar, easy-to-use tools such as Microsoft Office that make it easy to communicate and collaborate effectively.
- Go beyond basic reporting and extend insight across your entire organization with easy to use, out-of-the-box reporting capabilities and sophisticated analysis tools that help you gain deep insight into your business performance.
- Role-specific dashboards help set priorities and simplify access to the information your people need to make confident decisions.
- Choose from flexible deployment options and implement quickly using our rapid implementation tools, and customize your system to meet your current business needs knowing that you can easily adapt to changing demands by adding functionality, custom applications, and online business capabilities.
- Adapt quickly without complicated and costly development time, and easily connect to external applications and data sources.
- Realize fast, yet long-term ROI with consistent product releases that keep pace with Microsoft technology innovations, and robust support and training.

RECOMMENDATIONS AND ROADMAP

Recommend upgrading to the latest version of Great Plains. The software is already purchased as part of the AARC's yearly maintenance plan. Cost associated is for Anchor Business Service to upgrade the software.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

The current version of Great Plains installed is no longer supported by Microsoft. Because of the lack of support there will be no updates to the software or debugging.

BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
001	Upgrade cost 80hrs at \$165hr	\$165	\$13,200

			SUBTOTAL \$13,200

SECTION 10: DOCUMENT IMAGING AND PAPERLESS WORKPLACE

VISION

A paperless office is a work environment in which the use of paper is eliminated or greatly reduced. It is argued that "going paperless" can save money, boost productivity, save space, make electronic documentation and information sharing easier and minimize environmental damage. With recent laws that require businesses to exercise due diligence in managing and storing documents with personally identifiable information, paperless office systems are now more critical. In reducing the amount of paper used, processes and systems are employed to further that objective and convert all forms of documentation to digital form.

GOALS AND STRATEGY TO OBTAIN VISION

As awareness of identity theft and data breaches become more widespread, new laws and regulation were enacted requiring companies that manage or store personally identifiable information to take due care with those documents. Paperless office systems are easier to secure than traditional filing cabinets, and can track individual accesses to each document.

CURRENT STATE

The AARC currently has one Xerox 4110 model Copier that has the capability to email. All documentation must be manually loaded into the copier and the printout is then sent to email addresses the user specifies. This is the only way to create electronic documentation from paper form at the AARC.

FUTURE STATE

As Payment Card Industries (PCI) compliance becomes integrated into everyday workflow at the AARC the requirements for document security will have an impact. We will need to purchase some tools to help us meet those requirements.

RECOMMENDATIONS AND ROADMAP

We will need to purchase digital scanning software and associated equipment to fulfill this requirement.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

Benefits of a paperless environment are:

- Reduced costs and quicker access to information.
- Document security and easy information sharing.

BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
001	IntellChief Base System	\$24,050	\$24,050
001	Workflow Base Server License 10 Users	\$7,190	\$7,190
001	IntellChief Annual Maintenance (Yrly)	\$5,936	\$29,680
001	Installation and Training	\$7,400	\$7,400
001	Implementation	\$11,840	\$11,840
-----			SUBTOTAL \$80,160

SECTION 11: VIDEO PRODUCTION FACILITY

VISION

The vision is to provide video teleconferencing services to the desktop and design a video teleconferencing setup for the executive conference room.

GOALS AND STRATEGY TO OBTAIN VISION

The primary goal is to enable users to host video teleconferencing calls from a local computer while sitting in their office space. Also, there is a need for a general meeting room with video conferencing capability to allow multiple personnel to attend without being short on space.

CURRENT STATE

Currently the AARC is utilizing Skype messenger with a low budget webcam and headset. Video is choppy at best depending on the internet connection and sound is of a low quality. There is no video teleconferencing equipment for the executive conference room.

FUTURE STATE

The concept is to update staff members that require video teleconferencing with upgraded webcams with superior sound systems. The executive conference room will be updated with a web camera with panoramic view and the capability to move and zoom in on certain items. A surround sound speaker system and high quality microphone setup will be utilized for audio.

RECOMMENDATIONS AND ROADMAP

Recommend updating members computers requiring teleconference access with new technology. Also recommend installing a teleconference system in the executive conference room.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

Video teleconferencing within the executive conference room will provide staff members with the opportunity to host a conference with multiple members in one location. This will allow them to share ideas and questions while together instead of waiting for responses to email or phone calls.

BUDGET TO IMPLEMENT

<u>QTY</u>	<u>DESCRIPTION</u>	<u>UNIT PRICE</u>	<u>EXTENDED PRICE</u>
001	Installation and Equipment	\$35,000	\$35,000

			SUBTOTAL \$35,000

SECTION 12: OVERALL BUDGET PLAN

The matrix below summarizes the budget estimates provided in the technology sections in this Strategic Plan.

BUDGET TO IMPLEMENT

Section	Total
Section 4: Datacenter Infrastructure	\$83,677
Section 5: Network Infrastructure	\$50,000
Section 6: Workstation Hardware and Software	\$81,590
Section 7: Information Security, Firewall and Spam/Virus Protection	\$12,995
Section 8: Membership Management System (iMIS)	\$14,550
Section 9: Accounting Software (Great Plains)	\$13,200
Section 10: Document Imaging and Paperless Workplace	\$80,160
Section 11: Video Production Facility	\$35,000
Overall Cost	\$371,172

These are summary results; detailed breakdowns of these figures appear in the individual sections.

The numbers provided here need to be viewed as guidelines/high level estimates rather than as precise budgets. There are two reasons for this:

First, technology changes rapidly. Over the course of the five year horizon of this Strategic Technology Plan, new technologies will emerge that will be incorporated into AARC's plans. Their inclusion will change the budget requirements.

Second, the technologies described in this plan are at various stages of maturity, and the accuracy of the budget estimates reflects that. Some, like the technology plans proposed for security, reflect ongoing efforts that have already begun. Plans may change as new and better technologies appear, but the estimates provided for proposed changes are fairly accurate.

TIMELINE TO IMPLEMENT

	Year 1	Year 2	Year 3	Year 4	Year 5
Datacenter Infrastructure	100%				
Network Infrastructure		30%	70%		
Desktop Hardware	30%	70%			
Desktop Software	10%	90%			
Information Security		100%			
Member Management System	100%				
Accounting Software	10%				
Document Imaging/Paperless			100%		
Video Production Facility				100%	
Graphic Software Refresh				100%	

SECTION 13: EVALUATION AND ASSESSING NEW TECHNOLOGY

VISION

AARC typically works with several vendors before introducing any new technology. The process may include multiple iterations, starting with a test of AARC's proof of concept lab, followed by a piloting of new products and testing performance against a specific check-list of tasks.

The evaluation process that takes place prior to technology deployment is both rigorous and well-defined. The same cannot be said for technology evaluation once the technology is deployed in the field.

GOAL AND STRATEGY TO OBTAIN VISION

AARC's goal is to incorporate member evaluation as an integral component of every new technology roll-out. A requirement to include member evaluation would be part of each new RFP (Request for Proposal). The methodology for evaluation would vary from product to product, and be developed jointly by vendor and AARC staff.

CURRENT STATE

Currently, our understanding of how effective technology is after it is deployed is largely anecdotal. AARC staff often works with members, answering questions about technology, and in the course of this interaction gets a better understanding of how the technology is used by members. But there is no formal process to evaluate technology and address problems. Some technologies are rarely used after they have been deployed. An evaluative process as the technology is rolled out, might allow AARC to address aspects of the technology that later prove to be problematic.

TARGET STATE

The target state is an environment in which every technology is periodically evaluated by members, and these evaluations are used to accelerate, improve or curtail the deployment of the technology. It is in the AARC's best interest to ensure that technology that users' value, and that improves membership, is widely deployed.

RECOMMENDATIONS AND ROADMAP

Such a process starts with meetings between vendor and AARC staff to identify the desired goals. Understanding what members hope to gain from the new technology is a necessary step for deciding if the technology introduction is successful. Once the criteria for success are understood, vendor and AARC staff should agree on a methodology for evaluation. This will vary by

technology. In some cases, the methodology may require the use of an evaluation form or questionnaire that will be completed periodically by members using the technology. In others cases, it may require nothing more than monitoring the network to quantify variables such as bandwidth utilization.

The periodic review of these results by AARC staff, along with follow-up meetings, can allow technology deployment to follow a number of different paths, each of which is valuable. One might be to accelerate deployment of technology that quickly proves to be very valuable, making the technology available to a larger base of users. A second is to work with the vendor to incorporate new features that members realize would enhance the utility of the technology. Another is to identify problems or limitations of the technology that went undiscovered during the initial testing. The technology environment found in AARC is so diverse, that technology that often works well for one member will perform poorly for another. Sometimes, only experience with the technology in diverse settings can reveal what these problems are. Finally, one possible outcome is to realize that the technology is not accomplishing what it was intended to do, and that plans for deployment should be curtailed. This will be crucial information for the AARC.

This Quality Assurance process, completed at regular intervals after technology deployment, should be an integral component of all AARC's technology plans. Only by being open to all possible outcomes, will new technology be deployed in a optimal way at the AARC.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

Incorporating member evaluations in the technology deployment process will ensure that the AARC is deploying technology and applications that best meet member needs. It allows the AARC to expand the role of the most useful technologies, and curtail the deployment of technologies and applications that are not embraced by the member community. Only by canvassing members to understand how they use technology can the AARC be sure that its investment in technology is well-spent. If this is not done, the AARC risks investing in technologies that are inefficient and not widely used.

BUDGET TO IMPLEMENT

The budget for member technology evaluations will be incorporated into vendor pricing as part of the RFP process.

Auditor Report

Legal Counsel Report

Investment Report

CoARC Report

The CoARC report is available on AARConnect as “CoARC update”.

The CoARC proposed Bylaws Ammendments are available on AARConnect as “AARC-Bylaws Ammendment Notice”, “CoARC Bylaws BRD Approved 3-5-2011 w changes”, and “CoARC Bylaws BRD Approved 3-5-11 clean”.



State Government Affairs Activity Report April 2011

*Cheryl A. West, MHA
Director Government Affairs*

The majority of legislatures have been back in session for several months. The November 2010 elections changed the make up of Congress in Washington, D.C., but re-ordered the configuration of state governorships and legislatures as well. Republicans now control 26 Governors offices and in 20 states, Republicans control both Houses of the legislature. In 18 other states the Chambers are split between the Democrats and Republicans majorities. In only 11 states do the Democrats hold both Chambers. (FYI Nebraska has a single Chamber legislature). The change from one party to another will no doubt influence the type of policies and legislation a state will put forth.

As difficult as the last two years have been for states to work within dire financial conditions, 2011 could see even more pressure on the states. Most economists predict the financial viability of city and municipal governments to meet local budgets, pay on bond notes and provide public services will be sorely tested, something that has not directly happened to these entities over the last two years. Whether this is viewed as a trickle up or trickle down event probably does not matter as the impact on hospitals, other employment sites and overall legislative agendas will be impacted.

As noted in the December 2010 State Update Report, in order to raise revenues states will continue to raise fees on state services, which may include respiratory therapy licensing fees.

As you are aware, the Affordable Care Act (ACA) (aka Health Care Reform) law included numerous changes and enhancements to state Medicaid programs, mostly funded by federal tax dollars. As you also recall one of the first acts that new Republican controlled U.S. House of Representatives was to vote to repeal the ACA. While symbolic in nature (the controlling majority in the Senate did not support) what will not be a “gesture” is the House declining to provide legislation that will fund these initiatives via the appropriations process. Therefore, while states are poised to begin new Medicaid initiatives over the next 18 months, the money to underwrite the new programs may simply not be there.

State Legislation

As stated in every State Update Report, while there can be 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, the majority of this legislation is often not enacted. .

RT Licensure Legislation

Hawaii – Hawaii was the 49th state in addition to Puerto Rico and the District of Columbia to gain licensure for the profession of respiratory care. As the implementing regulations are written, the Hawaii Society continues its dialog with the state agency that oversees professional licensure in an effort to lower the proposed licensing fees. The state agency is insistent that the over the first 3 years of licensure that the fees paid by RTs must recoup the start up costs. During the legislative process, in order to enact RT licensure the state insisted it would require \$136,000 in start up costs. A figure that was unsupported, but nevertheless is now in the law. The HSRC continues its negotiations with the licensing agency to mitigate the financial impact on the RT as licensure is implemented.

Alaska- The leadership of the Alaska Society is beginning the organizational process of moving towards licensure legislation. The ASRC recognizes that this is a long process one that requires much up front work prior to the introduction of any legislation. Alaska faces unique issues, particularly dealing with the impact that regulating respiratory therapy might have on those who currently provide RT services in the remote and tribal regions of the state. Any legislation will likely have to make accommodations that will address these situations. Any legislation will probably include more exemptions then other state RT licensure laws.

Virginia- enacted a law that would provide a “transport” exemption. That is a health care professional (the law covers more professions then just the RTs) coming into VA would not need to have a VA license if coming into the state is for the purpose of transporting a patient to a VA health care facility. This became an issue last year for RTs transporting patients to and from other states, in particular NC. State agencies opined that because there was no transport exemption crossing state lines required RTs to obtain a license from the “visiting” state. Last fall the ever active NC RC Licensure Board issued a ruling (no legislation required) that would permit a “transport” exemption. VA has now “returned the favor”.

Washington State- Last year the WSRC supported legislation that would permit RTs to accept orders from other non physician practitioners (in addition to physicians) including PAs and NPs. This less restrictive language would permit the more efficient carrying our of RT services when physicians were unavailable. While the legislation was not enacted last year, the bill was re-introduced this year and is near final passage.

Other Legislation of Interest to the Profession of Respiratory Therapy

Florida & Illinois- bills that would increase payments to nursing homes for patients who are “technologically and respiratory dependent”

Indiana- a bill that would more formalize the licensure requirement that licensed health care professionals undergo a criminal background check including fingerprinting.

Hawaii- a bill that would recognize RTs among the providers of palliative care

Michigan- a bill that would define a “in home service agency” (one of those new demo programs created by the ACA) with a list of covered services, including RT.

Mississippi a bill that would set up a pilot program to manage patients with COPD

Montana- a bill that would enhance state licensing authority to verify out of state licenses, includes RT

New Jersey- a bill that would clarify health care professionals protection from liability when providing volunteer and/or emergency care, includes RTs

New York a bill that would set up asthma management programs in public schools. Another NY bill would require insurance companies to offer smoking cessation programs

North Dakota a bill that would permit at its discretion the state licensing agency to require background checks

Oregon- a bill that revises the licensure renewal requirements for health care professionals, includes RTs. Oregon also has a bill to license DME providers and includes an option to have a respiratory therapist as a member of the licensing board.

Texas- a bill that would include COPD as a condition that could be” treated” via telemedicine.

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. Thus far this year there have been limited revisions, however we anticipate more to come as the year progresses. Some regulatory changes of interest:

Maryland- finalized the increase in licensure fees for the RT as proposed in 2010. Also MD has regs that make RT disciplinary provisions more consistent with other professions.

Nevada- revises the RT licensure renewal date and application for licensure.

Other Legislation of Interest

Hospital Acquired Infections

Following in the federal footsteps, states are more frequently at least introducing legislation (not necessarily passing it, due to opposition from the hospital industry) that would reduce Medicaid and other state payments to hospitals with a high incidence of acquired infections. Most legislation specifically includes ventilator acquired pneumonia (VAP). Some states take a smaller step, i.e. no reduction in reimbursement but try to enact legislation to requires a hospital to track and report on these events.

Oklahoma- a bill that would not pay hospitals for acquired conditions, including VAP

Hawaii- a bill that hospitals must report both medical errors and hospital acquired infections

Kentucky- a bill stating that hospitals must increase their efforts to prevent acquired infections, includes VAP

Mississippi & Utah a bill that would require hospitals to track acquired infections includes, VAP

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.

Medication Aides

West Virginia has reintroduced a bill from last year that would expand the venues where an unlicensed medication aide may administer meds. The 2011 version has more specific provisions on the nurse supervision of these aides than the previous 2010 legislation.

Perfusion Licensure

Florida, Georgia, Kansas, Maryland and New York all have bills that would license perfusionists.

Sleep Disorder/Polysomnography State Activities

A major rift has developed between the alliance of the American Academy of Sleep Medicine- AASM- the sleep physicians who run sleep testing facilities and the Board of Polysomnographic Technologists-BRPT- the testing and credentialing arm for polysomnographic personnel.

The AASM has publically stated that the organization will develop its own competency exam with, presumably awarding a new credential to be available November 2011.

In a letter to the BRPT the American Board of Sleep Testing (ABST a testing entity executive managed by the AASM) has stated that the passing scores for the RPSGT competency exam are set too high, that “sleep physicians who are medical directors of sleep centers have expressed concern that certification by the BRPT does not ensure professional readiness” and that “the BRPT examination does not test the basic knowledge necessary to perform sleep studies.”

This new AASM proposed test for competency has raised a sharp response from the BRPT which strenuously opposes the AASM’s efforts. The back and forth communications are laid out on the BRPT website <http://www.brpt.org/default.asp?contentID=153>

I speculate the following:

Nearly all polysom state licensure laws have the requirement that sleep personnel must, at some point, take and pass the BRPT exam in order to obtain or maintain their sleep license. The BRPST , Registered Polysomnographic Technologist (RPSGT) exam, like the NBRC exam for RTs becomes the “state licensing test”.

As more and more states move forward with licensure laws, the BRPT exam requirement provision is always included in the language. All sleep personnel must take the BRPT exam to get a license. While the licensure laws may permit years to go by before the sleep personnel (the “trainee”) has to take the BRPT exam, eventually they all will have to pass the exam, in order to obtain a license to practice. Without the license the sleep personnel will no longer be able to provide sleep disorder services as defined in the very sweeping and all encompassing scope of practice which is standard in all the state sleep practice acts.

Again, I surmise that sleep physicians directing and owning sleep entities are finding that the individuals that they employ to provide sleep services are not able to pass the BRPT exam, and thus, in the states that require polysom licensure, these individuals cannot get a license and therefore must cease providing sleep services.

Say what one will about the AASM, it can never be criticized as not being forward thinking. Getting ahead of the curve by creating some less rigorous test that would qualify as a state licensure exam is forward thinking. I would anticipate any new state legislation for polysom licensure will include a provision that would somehow permit the impending AASM exam to also serve as a qualifying state licensure test. Keep in mind, the AASM provides financial, staff support and “advice” to state sleep societies. I believe the AASM will “advise” the state sleep societies to put forth legislation (or even amend the current laws) that will insert the AASM test.

Maryland

As reported in the December State Update Report the situation still remains the same, that is RTs providing any sleep services set forth in the polysom scope of practice that are not specified in the RT scope of practice will have to obtain a polysom license by October 1, 2011. This interpretation of the law is by a written opinion of the Maryland Polysomnography Licensure Board, with concurrence from MD Respiratory Care Board and the Maryland Board of Physicians.

As you recall the Maryland polysom licensure law did not include a specific exemption for the licensed respiratory therapist.

The only recourse is to have a legislative change.

Another twist in the Maryland polysom situation is that the sleep interests have introduced legislation to amend the polysom licensure law regarding educational requirements for polysom licensure. Maryland licensure was enacted in 2006, prior to the onset of efforts to insert the 2 week A Step training course as an “educational” pathway (as is now being done in other state polysom licensure laws and pending legislation). MD polysom licensure law requires sleep personnel to be graduates of CAAHEP accredited education programs. Because the sleep

personnel were unable to meet the original CAAHEP deadline, the implementation date was legislatively extended (twice) with the latest deadline set for October 2011.

The sleep interests have evidently decided that their personnel in their profession still cannot meet this deadline and in lieu of yet another bill to extend the CAAHEP deadline further, have introduced legislation that would simply gut the CAAHEP requirement and insert A Step as an additional option.

The MD/DC Society is adamantly opposed to this change and are working with the legislators to defeat this effort. At the same time we believe they will also work to insert a clear RT exemption thus avoiding the October 1, 2011 deadline.

Oregon

A polysom licensure bill has been introduced. The bill contains unacceptable provisions, including one that is similar to the MD provision that will open up the RT to having to obtain an additional polysom license in order to continue to provide the same services they currently legally provide under their own license. There is no explicit RT exemption. Another provision requires the RT to take an *accredited* exam (that's not new nor an issue) however, within this same sentence, the polysoms only have to take "an exam" (see comments above on new AASM test).

The Oregon Society for Respiratory Care is responding in opposition.

Connecticut-

Throughout 2010, the CSRC and the CT Sleep Society had positive dialog during the development of the draft language for sleep licensure legislation. A specific RT exemption was included in the last version of the draft legislative provisions. It does not appear at this time that 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 sought input from all concerned parties and has developed proposed regulations that appear to be equitable and fair. The regs should go final by summer.

New York

The same bill that has circulated in the NY legislature for the past 5 years that would license polysoms has once again been introduced. The bill would exempt RTs. However at some future date the bill would require that the polysoms be graduates with an *associate degree*. I believe this provision which has been in all previous bills is the chief reason that the bill has not moved forward.

I will provide a verbal update at the April meeting.



Federal Government Affairs Activity Report – April 2011

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

The Congress

The 112th Congress was convened in mid January. As you know, the Republicans now control the House of Representatives and the Democrats maintain a slim majority in the Senate. A clear statement to the American people has been for Congress to publically espouse that the focus of its agenda must be on economic recovery measures and reducing the federal deficit. Attempting to reduce the federal deficit, will either entail reducing the current budget and/or raising revenue, and these thorny issues will drive most legislation. Fiscal year 2011 began for the federal government in October 2010, and at the date of this report, Congress has yet to pass a budget or appropriate funds to the federal agencies. The country continues to run on continuing resolutions (CR) which means that there is no expansion in federal programs which are running at fiscal year 2010 levels.

As we noted in the December Report, with Republicans now in charge of the House, one area of focus will turn more towards revising or eliminating certain provisions of the Affordable Care Act (ACA) aka the Health Care Reform law passed in March 2010. While a vote to repeal the law succeeded in the House it did not pass the Senate. A key strategy for taking away the viability of the new law is to refuse to fund the specific new provisions. And this will dovetail back into the reducing the deficit agenda.

As this report is written it is too early to state definitively the precise course the Congress will be taking this session.

Legislation

The Medicare Respiratory Therapy Initiative

The AARC's advocacy efforts remain focused the Medicare Respiratory Therapy Initiative. During the current session of Congress – the 112th – the bill has now been introduced by Congressman Mike Ross (D-AR) and has been issued the number HR 941.

As you know as a result of the November 2010 elections, Senate, Blanche Lincoln (D-AR), our champion and primary sponsor of the RT Initiative lost her seat to Republican Congressman John Boozman. Looking for a primary Democratic sponsor in the Senate has been a focus of our efforts. Senator Mike Crapo (R-ID) has restated his commitment and plans to introduce a Senate Companion to House bill HR 941.

AARC continues to face the challenge presented by the Congressional Budget Office (CBO) and the score that it received in the last session of Congress. We will continue to work with the Members who currently support this initiative to have the score re-evaluated and seek an explanation from CBO on the assumptions it used to arrive at the unsupported high score. Once we have ascertained the reasons why, we will determine if changes to the bill's language are warranted to reduce the cost.

In the last session of Congress the House bill had 36 co-sponsors. 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 drumbeat 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 add our bill's provisions onto "must pass" legislation.

Virtual Lobby Week

Building on the success of last years Virtual Lobby Day, we took this important communication effort with Capitol Hill and went one step farther, by hosting a *Virtual Lobby Week*. We scheduled this event right before the annual March PACT Hill Lobby Day. The intent was to flood members of Congress with emails of support for our RT Medicare Initiative right before our PACT reps and patient volunteers went to the Hill.

This "get out the voice of support" was very successful with over 8,000 messages sent to Capitol Hill and our PACT representatives reported back that numerous Hill staff were well aware of our issue and the support from "back home" all due to the effort made via the Virtual Lobby Week.

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's public policy working group recently convened a teleconference to discuss the CDC strategy. The CDC budget has been significantly reduced, specifically in the Chronic Disease Division, and the ALA reported that the Asthma program has been decimated. The Coalition has decided to target the NIH, NHLBI as the leading agency to convene a COPD consensus conference to prepare a National Action Plan. The draft legislation will then be adjusted to reflect this change.

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 168. 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 VA and other veterans' organizations outside of government supported the bill.

HME Legislative legislation:

Repeal of Medicare DMEPOS Competitive Acquisition Program

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

During the last session of Congress, the HME industry organized strong legislative efforts to repeal onerous laws that imposed new regulations on HME providers. There was a bill to repeal the Competitive Bid Program, which had much support in the House, but no companion bill in the Senate. The repeal bill was not enacted. For this new session of Congress, the Competitive Bid repeal bill was introduced in mid March, HR 1041. The Competitive Bid Program was implemented in 9 MSAs this past January 1.

Also in the last session of Congress, a bill to repeal the Medicare 36 month cap on home oxygen and oxygen equipment rental had much less Hill support and therefore it too was not enacted. At this time a repeal bill for the 36 month cap has not been re-introduced and the cap remains in place.

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. In previous years our participation with certain specific coalitions was focused on urging greater funding for health and/disease research to promoting issues that will enhance the clinical support of patients with particular illnesses.

This year as noted in the introduction the efforts to reduce the deficit by cutting discretionary spending has refocused the efforts of many of these coalitions to attempt to maintain current funding rather than to seek increases in funding and to of course fight efforts to reduce program funding.

Coalition for Biomedical Research

The AARC was one of 65 organizations to sign onto a Coalition letter that urged the House and Senate Appropriations Committees to continue to fund the FDA's medical research program under the umbrella of the FDA's Reagan-Udall Foundation.

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. Many PACT reps have for years taken personal time to assist their profession and come to DC to

advocate for the profession and the patients we serve. Their efforts and the financial support from their state societies are deeply appreciated by the AARC.

Our 12th annual PACT DC Hill Day was again very successful, with 119 respiratory therapists from 42 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 our Respiratory Therapy Initiative. As we did last year, PACT reps were joined by nearly 20 members of either the Alpha-1 Association or the COPD Foundation. Their presence put a face to why it is so important for patients to have better access to respiratory therapists.

Regulations and Other Issues of Interest

As a new year starts, typically there are only a few regulatory activities that may have an impact on the respiratory therapy profession, since most of the regulations we follow (e.g., physician fee schedule, inpatient and outpatient hospital prospective payment system updates) are published in late fall of the preceding year. However, some of the most recent noteworthy activities are reported below.

Outpatient Pulmonary Rehabilitation (PR)

The final calendar year (CY) 2011 rules on payment updates for pulmonary rehabilitation (PR) services in both the hospital outpatient and physician office settings were reported in the December Board report. As a recap, the biggest change had to do with “direct” physician supervision requirements and the fact that CMS will no longer require the physician to be either within 250 yards of the main building as part of the definition of “on campus” or in the provider based department if the building is “off campus.” The physician will, however, still have to be “immediately” available. Non-enforcement of this provision has been extended until CY 2012 in Critical Access Hospitals and hospitals in rural areas with beds of 100 or less.

An issue that continues to linger is CMS’ strict interpretation of the statute that, for purposes of “direct” supervision, only a MD/DO can supervise pulmonary and/or cardiac rehab programs. For all other therapeutic outpatient services, non-physician practitioners such as nurse practitioners and physician assistants can supervise if it is within their scope of practice. The AACVPR tried unsuccessfully last year to get legislation passed that would expand the supervision requirement to non-physician practitioners. We understand they are continuing to try for a “technical amendment” to the statute to clarify this issue and will be lobbying for the change the week before our PACT meets with Congressional leaders.

Competitive Bidding

As reported earlier, the competitive bidding program for durable medical equipment went into effect January 1, 2011 in 9 metropolitan bidding areas. Four million beneficiaries are currently impacted by the program. Round 2 is expected to begin later this year which will expand the program to 91 metropolitan areas in accordance with changes made by the Affordable Care Act.

CMS recently reported that they have a wide array of resources to deal with any concerns, including a complaint and inquiry process for beneficiaries, caregivers, doctors, referral agents and suppliers to report any problems associated with implementation. In addition, CMS has hired an independent contractor, Abt and Associates, to meet with stakeholders regarding the program. At Abt's request, the AARC provided input for their report.

In a recent press release, CMS reported that they had received only a handful of beneficiary complaints which were resolved quickly and that most inquiries were of a routine nature involving selecting a supplier. The HME industry, however, reports continued problems and flaws in the program, although they admitted that the complaints were "trickling in" (100 as of January 26) and were not the "flood" of complaints that had been expected. An industry task force has been established to find alternative payment mechanisms to the current competitive bidding structure or other avenues to stop the program altogether.

CDC Reports on Surge Capacity during Mass Casualties and Terrorist Bombings

At the end of 2010, AARC was alerted to two reports on CDC's website that deal with surge capacity for terrorist bombings and preparedness and response to a mass casualty resulting from use of explosives by terrorists. These reports contained serious omissions in the area of respiratory care medicine, especially with respect to the need for oxygen therapy and ventilator use during such events. AARC expressed concern that if the guidelines were not revised to address these omissions hospitals using the guidelines might not be able to meet the needs of their patients. We also provided the results of AARC's ventilator study and stressed the need to have a respiratory therapist on their expert panel when considering future updates.

Dr. Richard Hunt, Director of CDC's Division of Injury Response, acknowledged that our comments were very helpful and agreed that there were gaps related to respiratory therapy that should be addressed. He also noted that he had recently given a presentation on the topic of the reports to the NY Downstate Association for Respiratory Therapists where the discussion focused on the need to better address respiratory therapy. He stated that our comments reinforced and provided greater specificity to that discussion and indicated CDC would definitely work toward incorporating our comments into future iterations. AARC offered to work with CDC in any way it deemed appropriate.

Activities Related to Hospital-Acquired Infections

Agency for Healthcare Research and Quality (AHRQ) recently announced the results of a quality improvement initiative whereby rates of pneumonia were dramatically reduced by more than 70 percent in patients on ventilators in Michigan intensive care units. The rate was sustained for the duration of the study's follow-up, a period of 2-1/2 years.

The results are part of a nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP) model for reducing hospital-acquired infections. The CUSP grant program administered by AHRQ is part of the Secretary of Health and Human Services' action plan to prevent HAIs. The model is based on CDC guidelines. To date AHRQ has awarded \$34 million in grant money to expand the fight against HAIs. John Hopkins and Baystate Medical Center are the only two grants currently targeting ventilator-associated pneumonia (VAP).

The Centers for Medicare and Medicaid Services (CMS) recently proposed regulations to prohibit Federal Medicaid payments to states for any amounts expended for providing medical assistance for healthcare-acquired conditions (HCAC), including infections. These rules when finalized will implement provisions of the Affordable Care Act. According to CMS, 29 states do not have HCAC-related nonpayment policies.

These provisions follow along the lines of Medicare payment restrictions mandated by earlier laws which are contained in CMS' inpatient hospital prospective payment regulations. To date, there are no respiratory-related conditions, including VAP, that are on Medicare's list of HCACs for which payment to hospitals would be prohibited. However, VAP remains as part of the HHS Secretary's action plan to reduce preventable infections as noted above.

Surgeon General's Prevention Plan

Yet another prevention plan has been established within the Department of Health and Human Services. This latest one is the Surgeon General's National Prevention Strategy. It is a broad-based strategic plan aimed at moving the focus on health care from sickness and disease to wellness and prevention. The plan identifies 10 targeted directions related to the environment, health disparities, quality clinical preventive services, and tobacco-free living among others. It is part of a component of the Affordable Care Act that calls for the establishment of a National Prevention Council and an Advisory Group on prevention and health promotion.

AARC submitted comments supporting the plan, highlighting those goals that address COPD and asthma management and the role respiratory therapists play in caring for patients with respiratory diseases.

New Value-Based Purchasing Hospital Program to Promote High-Quality Care

CMS has issued proposed regulations to establish a new hospital value-based purchasing program to reward hospitals for providing high quality, safe care for patients. Under the program, hospitals would receive higher payments if they perform well on certain quality measures based on clinical process and patient experience. It is not set to begin until FY 2013. The initial set of measures CMS proposes to adopt is a subset of the measures already established under the Medicare Hospital Inpatient Quality Reporting Program. Pneumonia is the only respiratory-related condition on the proposed list with measure indicators that include flu and pneumonia vaccinations. When finalized, value-based purchasing will become a permanent part of the inpatient prospective payment system affecting more than 3,000 acute care hospitals.

FDA Tobacco Updates

With valuable input from our Tobacco-Free Lifestyle Roundtable, AARC submitted comments to FDA at the end of 2010 on the graphic warning labels which are required by law to be displayed on 50% of future cigarette packages. FDA must publish final rules by June 22, 2011. Manufacturers will be required to change their packaging no later than 15 months after publication.

Over the next six months, FDA plans to issue proposed rules that will address public health issues associated with cigar use and would deem cigars to be subject to the Tobacco Control Act. Also on the agenda are final regulations restricting the sale and distribution of cigarettes and smokeless tobacco to individuals under the age of 18. The Tobacco Products Scientific Advisory Committee is currently developing a report and recommendations on the impact of the use of menthol cigarettes on the public health.

Safe Practices for the Delivery of Medications

The Institute for Safe Medication Practices (ISMP) recently announced new draft guidelines for the timely administration of scheduled medications. These new guidelines are the result of ISMP's awareness of AARC's position statement and problems with CMS' 30-minute rule (e.g., scheduled medications must be delivered within 30 minutes before or after the scheduled due time), and a ISMP survey in which approximately 18,000 nurses expressed grave concerns about safety issues associated with compliance of CMS' current guidelines. The ISMP guidelines are based on the Institute's expertise on medication safety, review of available literature on risks associated with early and delayed administration of maintenance doses, survey feedback and advice from an expert clinical advisory group from more than 20-diverse clinicians and academics.

AARC submitted comments supporting the draft guidelines. For example, it is recommended that scheduled non-time-critical medications (daily, weekly, or monthly) be administered plus or minus 2 hours from the scheduled time. For scheduled medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h), the recommended timeframe is plus or minus 1 hour from the scheduled time.

ISMP is working closely with CMS on this issue and if CMS accepts the final guidelines and makes changes to its State Operations Manual, it is recommended that the Board review the necessity of keeping our position statement. However, we do not expect any changes to take place in the immediate future.

Conclusion

The AARC will continue to adapt to the new normal on Capitol Hill in order to advance our agenda. We will also maintain our vigilance on the regulatory side responding to both challenges and opportunities.

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

HOD Report

Reporter: Billy Lamb

Last submitted: 2011-03-10 16:28:03.0

Recommendations



None at this time.

Report

- House Leadership is planning its activities for the summer meeting in Vail.
- House Committees have begun work; the Publications Committee was eliminated at the meeting in Las Vegas and the Chartered Affiliates and Special Recognition Committees were combined.
- Two Ad-Hoc Committees have been formed for 2011: An Ad-Hoc Committee, "Connections" , on Professional Volunteerism an An Ad-Hoc Committee on Student Membership
- I have spoken with President Karen Stewart and we plan to schedule outside guests (NBRC, ARCF, etc) to present to the AARC BOD and AARC HOD in joint session to avoid duplication, improve efficiencies and as a courtesy to the outside guests.

Board of Medical Advisors Report

Recommendation:

"To recommend revision of the AARC bylaws to create a new category of membership in the AARC designated as 'Physician Member' distinct from the present associate membership."

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Medical Advisors Meeting - December 5, 2010
Las Vegas, Nevada

Minutes

Attendance

Cliff Boehm, MD, RRT, (ASA) **Chair**
Joe Sokolowski, MD, EMT-B FACP, FCCP (ATS)
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
William Bernhard, MD (ASA)
Terence Carey, MD (ACAAI)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Bradley Chipps, MD (ACAAI)
Kent Christopher, MD, RRT, FCCP FAARC (ACCP)
Lori Conklin, MD (ASA)
Robin Elwood, MD (ASA)
Brett Gerstenhaber, MD (ATS)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
Harold Manning, MD, FCCP (ACCP)
Phillip Marcus, MD, MPH, FCCP, FACP (NAMDRRC)
Col. Michael Morris, MC USA-Retired
Peter Papadacos, MD, FCCM, (SCCM)
Christopher Randolph, MD (AAAAI)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRRC)
Richard Sheldon, MD, FACP, FCCP, FAARC (ATS)
Bruce Rubin, MD, MEngr, MBA, FRCPC (ACCP)

Guests

Gary Smith, NBRC Executive Dir
Gregg Ruppel, NBRC President
Tom Smalling, CoARC Executive Dir
Tim Myers, AARC President
Karen Stewart, AARC President-elect
Lori Tinkler, NBRC COO
David Bowton, MD, CoARC Chair
Karen Stewart, AARC President-elect

Absent

Steven Boas, MD (AAP)
Gerald Weinhouse, MD (ATS)

Consultant

Toni Rodriguez, EdD, RRT, BOMA Liaison

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Steve Nelson, MS, RRT, CPFT, FAARC, Associate Executive Director
Bill Dubbs, RRT, MHA, MEd, FAARC
Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Director of Regulatory Affairs
Miriam O'Day, Director of Legislative Affairs
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

Chairman Cliff Boehm called the meeting of the AARC Board of Medical Advisors to order at 12:20 p.m. PST, Sunday December 5, 2010.

INTRODUCTIONS

Chairman Cliff Boehm asked members to introduce themselves.

APPROVAL OF MINUTES

Dr. Randolph moved “To approve the minutes of the June 19, 2010 meeting of the AARC Board of Medical Advisors.”

Motion Carried

PRESIDENT’S REPORT

President Tim Myers thanked BOMA for their expertise in advising AARC. Despite the tough economy the Association did see an increase in membership. AARC Connect, a social media program was implemented in 2010. AARC added 4 roundtables this year with one still pending. International activities are growing. The 2015 and Beyond conferences have concluded but there are still recommendations stemming from those conferences that will be dealt with by the Board of Directors. The Leadership Institute will provide mentorship and education for future leaders of the Association. A pamphlet entitled A Patient’s Guide to Aerosolized Drug Delivery was developed this year and is in great demand. He stated the Association has taken a forward stance on communications with other organizations.

COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE (COARC)

CoARC Chair, Dr. David Bowton highlighted his written report stating all but one of the Level 100 CRT programs has transitioned to Level 200. Those students currently in a Level 100 program must graduate by December 31, 2012. CoARC Accreditation Standards went into effect on June 1, 2010. CoARC will evaluate the success of the program graduates on the CRT exam as the measure of examination-based program outcomes since the majority of states utilize this exam for licensure. The outcomes threshold for attrition will increase from 30 to 40% as of April 15, 2011.

NATIONAL BOARD FOR RESPIRATORY CARE (NBRC)

NBRC President Gregg Ruppel highlighted his written report adding that the NBRC Board approved the RRT-Adult Critical Care Specialty credential designation for those individuals who successfully complete the examination. Applicants for this exam shall be an RRT with at least one year of full-time clinical experience in a critical care setting.

LEGISLATIVE AFFAIRS

Cheryl West, Director of State Government Affairs reported on state legislative and regulatory issues. State legislatures will convene in January and we expect numerous bills to impact respiratory therapy including licensure fee increases as well as other occupations seeking licensure that may have implications for the RT profession.

Anne Marie Hummel, Director of Regulatory Affairs, reported on changes to Medicare's direct physician supervision rule. CMS has removed the physical boundary requirement and beginning in 2011 will only require the physician to be "physically available and interruptable." They also plan to develop a process using an independent technical advisory committee to determine the appropriate supervision level of future outpatient therapeutic services. CMS proposed a new regulation as part of the Affordable Care Act that if finalized will become effective in March 2011. It sets risk levels for Medicare providers and suppliers as part of its fraud and abuse activities which will be an important component of the Medicare program in the coming year. A workgroup reporting to the CDC has developed a draft report that lays out a fair and equitable process for ventilator allocation in the event of a public health emergency/severe flu pandemic. It proposes that the treating physician be taken out of the equation in favor of a triage team comprised at a minimum of a physician, critical care nurse and RT. The FDA rolled out their strategic plan on tobacco control. The public is asked to weigh in on the graphic warning labels that will comprise 50% of the cigarette packaging by 2012. FDA has a separate website to access information on its tobacco activities.

Miriam O'Day reiterated that it's critical to AARC that physicians support the Part B RT initiative bill as we continue our advocacy efforts in Washington DC.

RECESS

Chairman Cliff Boehm recessed the meeting of the Board of Medical Advisors at 1:50 p.m. PST, Sunday, December 5, 2010.

RECONVENE

Chairman Cliff Boehm reconvened the meeting of the Board of Medical Advisors at 2:10 p.m. PST, Sunday December 5, 2010.

EXECUTIVE OFFICE REPORT

Executive Director Sam Giordano thanked members for taking their time to work with AARC.

He stated AARC has a new software system (AARC Connect) that will require BOMA members to be AARC members. Physicians voiced their views on the Physician designation that is now called "associate member." Mr. Giordano suggested members create a recommendation to the BOD for its spring meeting concerning this topic.

Mr. Giordano reported briefly on the 2015 and Beyond project stating that two BOMA members were on the Planning Group of the 2015 project who are currently working on the draft of the manuscript of the 3rd conference. He thanked Dr. Mike Morris and Dr. Woody Kageler for their expertise and participation on this project. There were a series of recommendations which came from the third conference which the Board reviewed during its meeting. There is a need for much more dialogue concerning this project before it can be considered a finished product. The conferences discussed future roles for RTs, competencies, how do we get from here to where we want to be tomorrow, and education.

Tom Kallstrom reported on the Patient's Guide to Aerosol Drug Delivery which is in high demand right now. He encouraged members to share the publication with their hospitals. It's also online at the AARC website and on www.yourlunghealth.com. It will be translated into Spanish in the future. He asked interested members to review it and get back with him regarding their comments. The link to this publication will be sent to BOMA members.

MILITARY REPORT

Dr. Michael Morris reported that beginning in August 2010, the combined Army and Navy RT program is now mandated to complete an online Associate degree through Thomas Edison College to successfully graduate the RT program. With this mandate and completion of the Associates degree, all Army/Navy graduates will now be eligible to take the CRT before they leave the school and move to their first assignment. The merger of all military medical training by BRAC law will be completed in 2012 with the Air Force assuming command of the overall school at Fort Sam Houston, Texas. The Air Force RT program will be co-located at Ft. Sam Houston with the Army/Navy course but will remain a separate program with accreditation from CoARC. The Air Force continues to train cardiopulmonary technicians instead of a designated respiratory therapists and Air Force RT students are required to complete a 3rd phase of on-the-job training prior to completing requirements to be eligible for the CRT.

CALIFORNIA POLYSOMNOGRAPHY

Dr. Brad Chipps advised that in California hospital associated sleep labs there are two issues of concern. One is that the grandfather clause is still being stonewalled and the Medical Board of Quality Assurance is not supporting it. And, secondly, nurses are now doing assessments prior to and after each sleep study as required by the state. They have until 2012 to iron out the difficulties and are working with lobbyists to resolve the situation.

CHAIR REPORT

Chairman Cliff Boehm reported that Dr. Mike Morris became an official member of BOMA this year representing the military perspective. He stated BOMA has had success in conducting business electronically and will continue to do so. With the implementation of AARC Connect, a new computer program utilized by AARC, BOMA members would have to be a member of AARC to gain access to its website. Now it's available to each member of BOMA with an associate member status so they can receive membership cost free. Anyone not a current

member, is asked to join and their account will be activated with AARC Connect which will replace the listserv or e-mail.

Those already using AARC Connect weighed in with comments stating response rate on Connect is not a quick process. With most physicians using their smart phones to quickly respond to communications via e-mail, the Connect program isn't as fast. Conversely, you can see the thread of discussions on Connect. Sam Giordano stated AARC will look into a BOMA listserv or other viable solution.

CME DISCUSSION

Dr. Gerstenhaber suggested that the AARC offer physician approved CME meetings before or after the BOMA meeting. Dr. Rubin advised that CME/CEU online may be more efficient to produce and pay for. Dr. Cheifetz suggested submitting proposals. It was noted that the current process of accreditation is prohibitive to AARC offering CMEs for so few interested. Dr. Papadakos suggested asking sponsoring organizations to share in the cost of this endeavor.

Dr. Gerstenhaber moved **“That AARC provide a cost analysis of giving one day of CME’s for physicians as part of their national meeting, and to look into online ramifications.”**

Motion Carried

HOUSE OF DELEGATES REPORT

Past Speaker Tom Lamphere introduced Bill Lamb the 2011 speaker of the House of Delegates. He described the function of the House of Delegates and that it acts as an advisory group to the Board of Directors and state societies. The HOD supported World COPD Day, World Spirometry Day and the Drive4COPD day. They continually look at ways to keep and recruit new members and increase value of membership. The House developed a Best Practices program whereby states share their successes with each other. Information sharing has been a deliberate component of the House this year. He noted that the Speaker-elect for 2011 will be Karen Schell. The HOD Secretary will be Sheri Tooley Peters and HOD Treasurer will be Bill Pupanek.

Speaker-elect Bill Lamb reported that he will continue to support the goals and objectives of the President as he oversees the House. His emphasis will be on patient care and safety. Most states send 2 delegates to the House as their representatives. He encouraged BOMA to approach him during 2011 on any issues of importance concerning the House.

MEDICAL ADVISOR REPORTS

Homecare Section

Dr. Kent Christopher reported on the Homecare Section stating that the group was looking into collecting references on long term oxygen therapy (LTOT). It was noted that nearly 400

citations were accumulated and the group is now in the process of putting together the PDFs for those citations and will make a report available to the Board of Directors of the AARC and the AARC Executive Office to help make better decisions regarding oxygen therapy in the home for the future.

Surface to Air Section

Dr. Robert Aranson reported on the Surface to Air Section stating that one issue is to give RTs reciprocity in air transport across state lines as Paramedics are apparently trying to fill the role of RTs and managing patients on mechanical ventilation. Steve Sittig chair of the section is asking for the support of BOMA and AARC. Toni Rodriguez reported that there was a referral to the President-elect to put a working group together to address this issue.

Education Section

Dr. Richard Sheldon reported on activities of the Education Section stating the current issue surrounds the 2-yr. program versus the 4-yr. program for RTs. He stated that BOMA is informed of the issue, but it is too early to act on it at this time.

NEW BUSINESS

AAAAI

Dr. Randolph noted that AAAAI should be added to the first page of the BOMA Organizational Document under the “Structure” section which outlines organizational representation.

Palliative Care

Dr. Selecky brought up the topic of the role of respiratory therapists in providing palliative care. Tim Myers and Karen Stewart said they would look into it as part of their activities for the year and determine if it should be on an existing Section or an ad hoc committee. Dr. Selecky supplied them with some names of respiratory therapists already involved in palliative care in their hospitals.

BYLAWS MOTION

Dr. Marcus moved **“To recommend revision of the AARC bylaws to create a new category of membership in the AARC designated as ‘Physician Member’ distinct from the present associate membership.”**

Motion Carried Unanimously

DR. SHELDON HONORED

During AARC’s Annual Business Meeting this year, Dr. Sheldon will be honored for his 23 years on BOMA and for his willing participation and leadership as BOMA Chair.

DR. CHEIFETZ HONORED

Members were advised that Dr. Cheifetz will be the recipient of AARC's Forest M. Bird Lifetime Scientific Achievement Award at this year's AARC International Congress.

2015 AND BEYOND REPORT

Dr. Kageler reported on the 2015 and Beyond project stating that 90% in attendance were in favor of doing away with the CRT exam although that probably won't happen. Some felt the 4-year entry requirement was necessary to be recognized as a professional instead of a technician. Others felt Medicare reimbursement would be hooked onto a bachelors degree which would be another way to be recognized, while others felt academic and educational competencies were difficult to cover adequately in a 2-yr. program.

The Board will address the final report along with the attributes.

WINTER 2011 BOMA MEETING

Dr. Boehm noted that next year's winter BOMA meeting will be held November 6 with the BOMA Reception to be held on November 5th.

SUMMER 2011 BOMA MEETING

There was discussion concerning the 2011 summer meeting in Dallas. It is tentatively scheduled for June 11 but Dr. Boehm advised that an e-vote will be conducted soon to solidify the date.

Dr. Sheldon moved "To adjourn the meeting of the Board of Medical Advisors."

Motion Carried

ADJOURNMENT

Chairman Cliff Boehm adjourned the meeting of the Board of Medical Advisors at 4:45 p.m. PST, Sunday December 5, 2010.

President`s Council

Reporter: Dianne Lewis

Last submitted: 2011-03-06 09:58:18.0

Recommendations

None

Report

The Presidents Council is proud to announce the 2011 Jimmy A. Young medalist is Richard Branson MSc,RRT.FAARC. All of you are familiar with Rich`s work for the profession as well as the AARC. He is an outstanding choice.

It is time to receive Life and Honorary member nominations. The Council this year has requested that Kathy Blackmon and I screen the nominees to ensure they meet criteria.

If they do not they will not be placed on the ballot. With that in mind I will have the criteria included with my report.

CRITERIA

Candidates for AARC Life Membership

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

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

2. Must have served in the AARC in an official capacity, i.e., national officer, Board member, committee chair or member, House of Delegates, etc., for at least seven (7) years, not necessarily consecutively.
3. Must have made an extraordinary contribution to the AARC and its affiliates.
4. Must have been active in affiliate operations and have served in an official capacity at the affiliate level.

Candidates for AARC Honorary Membership

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

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

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

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

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

AARC Life and Honorary Memberships

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

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

<u>YEAR</u>	<u>LIFE</u>	<u>HONORARY</u>
2002	Susan B. Blonshine William Galvin Carl Wiezalis	Sherry Milligan
2003	Margaret F. Traband J. Michael Thompson	Cheryl A. West
2004	David C. Shelledy Karen J. Stewart	Patricia A. Lee
2005	Janet Boehm Richard Branson	Jill Eicher
2006	John Hiser Lucy Kester	Marsha Cathcart
2007	Doug MacIntyre Joseph L. Rau	Kent Christopher
2008	Susan Rinaldo Gallo Michael W. Runge	John W. Walsh
2009	Vijay M. Deshpande	Dale L. Griffiths
2010	William H Dubbs Toni Rodriguez	None awarded

*Standing
Committee
Reports*

Bylaws

Reporter: Gary Wickman

Last submitted: 2011-03-11 19:12:18.0

Recommendations

The committee has reviewed the Bylaws submission for Montana and recommends that the AARC Board of Directors approves them as submitted.

The committee has reviewed the Bylaws submission for Ohio and recommends that the AARC Board of Directors approves them as submitted.

The committee has reviewed the Bylaws submission for North Carolina and recommends that the AARC Board of Directors approves them as submitted.

The committee has reviewed the Bylaws submission for Colorado and recommends that the AARC Board of Directors approves them as submitted.

The committee has reviewed the Bylaws submission for New Mexico and recommends that the AARC Board of Directors approves them as submitted.

Report

The committee has reviewed the master list of Bylaws that are due this year and will work through them this year.

We have also agreed to assign the committee members to specific Affiliates to help communicate the need for their reviews this year and to help them with the process.

The committee also communicated the AARC Board actions of approving Bylaws for Oregon, Maryland, North Dakota and Idaho to the Affiliates respective Presidents and Delegates

Elections Committee

Reporter: Suzanne Bollig

Last submitted: 2011-03-11 15:50:00.0

Recommendations

 **No recommendations at this time.**

Report

- BOD and HOD members were solicited for ideas for candidate questions with deadline of 2-4-11
- Committee members voted on 2011 Candidate questions and submitted to EO 2-18-11
- AARC On-line Nomination process activated 2-18-11 with BOD, HOD, and appropriate sections solicited for nominations (President-elect, Director X 2, Chair-elects for Long Term Care, Continuing Care Rehab., and Transport)
- Committee conference call scheduled for 4-26-11 to review nominations and determine final slate of candidates.

Executive Committee Report

Finance Committee Report

Audit Sub-Committee

Reporter: Karen Schell

Last submitted: 2011-03-14 15:09:06.0

Recommendations

RECOMMENDATION:

That AARC consult with their investment advisors to determine if refining and establishing further investment range categories (e.g. foreign stocks 0-10%, domestic growth stocks 0-25%, etc.) is prudent within the broad overall ranges currently existing in the AARC Investment Policy.

JUSTIFICATION

The current AARC Investment Policy allows for broad investment ranges of 40-60% for fixed income-type investments and 40-70% for equity investments. The recommendation was made due to the constantly changing investment markets and to potentially minimize risk.

Report

The AARC Audit-Sub Committee met via phone conference on Friday, March 11, 2011. The committee reviewed the Consolidated Financial Statements and Independent Auditors' Report dated December 31, 2010 and 2009 and found the records to be in compliance with accounting principles generally accepted in the U.S. Investment range categories were discussed and the committee agreed to submit the above recommendation to the Board of Directors for consideration.

Respectfully submitted, Karen Schell, Speaker-Elect HOD

Other

Thank you to the committee; Susan Rinaldo-Gallo, Linda Van Scoder, William Pupanek, John Walton, Tony Lovio, and Auditors -Salmon Sims Thomas & Associates

AARC
INVESTMENT POLICY AND PROCEDURES
(Revised *December 2007*)
(clean copy)

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

Policy Statement

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

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

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

Investment Guidelines

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

All investments of Association cash shall fall within the following guidelines:

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

- Equity investments
 - Range: 40-670% of entire portfolio; Optimum allocation: 55%
 - Single issues---Any stock EXCEPT those that are:
 - A Penny Stock (i.e. trading for less than \$1 via OTC (pink sheets))
 - Highly speculative, for example:
 - Be trading with unusually high P/E ratios...50-75++ or
 - Have little or no history of any earnings
 - Stock Mutual funds must be:
 - Primarily comprised of the stock issues allowed for above and
 - Judged to be of high quality by considering:
 - S&P or Moody's ratings
 - Past earnings records / future growth
 - Fund manager experience and track record

- No investment in any security that is related to the tobacco industry is permitted
- No one equity security issue shall comprise more than 5% of the total equity portfolio and no one sector shall comprise more than 15% of the total equity portfolio.
- Alternative investments

- No more than 5% of portfolio
 - Options, derivatives, future contracts, REITs
 - Range: no more than 2.5% of entire portfolio
 - Each trade must be approved by AARC CEO
 - Real Estate
 - Range: no more than 2.5% of entire portfolio
 - Each purchase must be approved by AARC CEO

Implementation.

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

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

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

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

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

Judicial Committee

Reporter: Patricia Blakely

Last submitted: 2011-03-10 14:55:35.0

Recommendations

 **No recommendations at this time**

Report

The complaint previously reported is still in preliminary investigation. All accused members have been notified of the complaint and have received a copy of the complaint via certified mail/return receipt requested. All members, with the exception of one, have returned the receipt. As of 3/10/11, no correspondence has been received in the EO from any of the accused members.

The Chair will follow-up with AARC counsel for next steps and will then schedule a telephonic conference call with the committee to review all documents provided by the complainants and accused members as applicable.

No additional complaints have been received by the Chair as of this report.

**Program Committee
AARC Activity Report
Spring, 2011**

Report submitted by: Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Program Committee Chair

Recommendations:

That the Sputum Bowl competition be eliminated from the AARC International Respiratory Congress following the 2011 meeting in Tampa, FL

Justification:

The Program Committee strongly believes that after 34 years, attendees no longer view the Sputum Bowl Finals as a “must see” event at the International Congress. This is displayed through declining attendance over the last several years. Despite many efforts to create more appeal for attendees that include a variety of unique talent acts for halftime entertainment, an open bar, inclusion of student teams, and promotions both before and during the Congress, attendance continues to falter. The committee has engaged in dialogue for many years regarding the discontinuation of the Sputum Bowl, but after great deliberation on the pros, cons, and value-added benefits of the competition, it was decided at the January 2011 meeting that the time has come to bring forth the recommendation to discontinue the event. Additional key points to consider are as follows:

- Many Program Committee members have taken notice that attendance for the Sputum Bowl has been on steady decline for the last several years. It was estimated in 2010 that total attendance for the Sputum Bowl Finals was less than 200 people. This attendance estimate was inclusive of competing teams, volunteers, corporate sponsors, and AARC staff.
- To create the illusion that there are more people in attendance, changes to room configurations have been made that include the use of fewer chairs, and utilizing a smaller overall footprint in the ballroom.
- All Sputum Bowl teams are invited to the Sputum Bowl Finals to be publicly recognized as participants in the competition. In 2010, it was estimated that fewer than 40% of all teams were in attendance at the start of the event.
- Other competing corporate events contribute to low attendance.
- Despite corporate sponsorship in the amount of \$40,000, the Sputum Bowl operates at a deficit each year. In 2010, the Sputum Bowl operated at a \$30,000 loss in direct costs to the Association. This does not include indirect costs (staff time, promotions, website creation and maintenance etc).
- Opportunity costs:

- It should be noted that many chartered affiliates provide financial support to their respective teams. Elimination of the Sputum Bowl would allow for those funds to be spent elsewhere.
- If eliminated, sponsorship dollars can be reinvested back into the Congress to provide value-added benefits to attendees

Report:

1. Prepare the Annual Meeting Program, Summer Forum, and other approved seminars and conferences.

Status: The committee met in Dallas, TX on Feb. 10 – 12, 2011 to review more than 800 individual lecture proposals submitted for presentation at the Summer Forum and Congress. Broad offerings of topics presented by a wide variety of practitioners are included in the agenda for both the Summer Forum and Congress.

Authors of proposals that were accepted for Summer Forum have already been contacted. Authors of proposals that have been accepted for presentation at Congress will receive an invitation to speak no later than May 31, 2011. All other speaker not accepted for presentation will also be contacted no later than the May 31, 2011 deadline. Preliminary release of Congress program on the website and Advance Program in AARC Times is scheduled for August.

The Congress program was based on the collaborative decisions of the Program Committee. All proposals were reviewed by the Committee and vetted by speaker and topic. Each lecture and symposium was individually approved based on their relevance to the overarching goals of the Program established by the Committee at the onset of the meeting. Due to the extraordinarily large number of submissions, the Committee found itself in the difficult, but envious position of only being able to select the “best of the best” proposals.

The Program Committee would like to express our gratitude to all the individuals and groups that submitted proposals. We are proud to acknowledge that AARC Congress 2011 is a meeting creating by its members, for its members.

2. Recommend sites for future meetings to the Board of Directors for approval.

Status: The AARC Meetings and Conventions Staff are currently evaluating destinations and venues for the following meetings: a) 2012 Summer Forum; b) 2014 Congress; and c) 2106 Congress. There are no recommendations at this time, but will be forthcoming in the near future.

3. Solicit programmatic input from all Specialty Sections and Roundtable chairs.

Status: Proposals for the Summer Forum and Congress were received from Section Chairs, Roundtable Chairs and general membership. Each specialty section was appointed a liaison from the Program Committee. This liaison worked closely with the Section Chairs to review proposals and ensure each section was represented at the

Congress with content that was timely, evidence-based and important to section membership. Section Chairs were very engaged in this process and are to be commended for their initiative and effort.

4. Develop and design the program for the annual congress to address the needs of the membership regardless of area of practice or location.

Status: The Program Committee dedicated a significant amount of time discussing priorities that they felt were paramount to each section and the profession. This list of priorities served as the guide in developing the program. At the conclusion of the meeting, the Committee the list of priorities to ensure each was represented in the Congress Program.

Membership and Committee feedback from the 2010 Congress was discussed. This feedback yielded a Summer Forum program that is more participatory in nature with a focus on mission critical knowledge for both managers and educators. Based on this feedback, a new target demographic of hospital-based clinical instructors was also identified for Summer Forum. The pre/post courses were created specifically with this demographic in mind.

Membership feedback was also discussed as it relates to streamlining room assignments for specialty section lectures at the Congress. It was universally agreed that efforts would be made (contingent on room availability and coordination of start/end times) to keep specialty section lectures in the same room locations throughout the day.

Strategic Planning Committee Report

Reporter: Tim Myers

Submitted: 3/11/11

Recommendations

None

Report

Nothing to report at this time due to pending 2015 Conference and Task Force work

Other

Specialty Section Reports

Adult Acute Care Section

Reporter: Keith Lamb

Last submitted: 2011-03-10 18:45:34.0

Recommendations

Board Report for the Adult Acute Care Section (3/10/2011)

- 1) 1. The section has started off strong this year with three new proposed interactive clinical activities that will be featured on AARC Connect.

To begin with we will initiate an **On-Line Journal Club**. We will choose a current article, post it, and encourage discussion amongst ourselves. Working much like a traditional journal club, each paper will be dissected and looked at for its weaknesses, its strengths, and the best way the presented information can be used in our daily practice. Each paper will then be archived for future reference, and be available for section members indefinitely.

Secondly, we will present a “**quarterly clinical case study**.” Volunteers will present a case study of interest to the section. Incremental installments will be made by the presenter, in “near real time.” Commentary will be encouraged by the section. There are an indefinite number of learning possibilities as those experienced in complicated cases show us the ropes, and we become “virtual experts”. As real case studies, the presenter will receive feedback that can be used to facilitate real live clinical decisions.

Lastly, we will formulate a “**virtual consult service**”, where a list will be created with recognized experts around the country offering their contact information, and area of expertise so that others can easily reach them for clinical advice and experience. This should be extremely useful to those working in smaller facilities where there are not large volumes of complicated patient scenarios, and where resources may be limited.

- 2) 2) We are actively requesting nominations for “specialty practitioner of the year”.
- 3) 3) We are enjoying a membership of approximately 1,776 at the time of writing this report.
- 4) 4) AARC members submitted approximately 89 proposals for the 2011 Congress that were identified as related to Adult Acute Care.

- 5) 5)The section is actively looking for new and motivated RCP's to contribute and become fresh resources. Our spring bulletin showcases three of these new professionals, and their editorials regarding Liquid ventilation, and Phrenic Pacing.

Respectfully Submitted,

Keith D. Lamb, RRT

Chair, Adult Acute Care Section

Continuing Care-Rehabilitation Section

Reporter: Debra Koehl

Last submitted: 2011-03-14 11:03:30.0

Recommendations



No recommendations at this time

Report

At this time I have the following to report:

- Recruited fellow section members to submit topics for the AARC Congress in 2012. After numerous reminders we were able to have numerous submissions to committee. Cheryl Hoerr shared the topics with me and I was able to comment on each of them.
- Winter Bulletin submitted to Debbie Bunch.
- At this time legislative issues for PR are quiet. Anticipate some Local Coverage Policies to be written in the future.
- I was asked and submitted article for AARCTimes on Caring for the Caregiver.
- Continue to monitor AARC Connect for section concerns and questions regarding pulmonary rehabilitation.
- Working with Bill Dubbs on URM in regards to pulmonary rehabilitation.
- Asked members to send article suggestions to Marsha Cathcart for clinical topics for the AARCTimes.

Diagnosics Section

Reporter: Matthew O'Brien

Last submitted: 2011-03-11 18:47:38.0

Recommendations

No recommendations

Report

Charges:

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of the Diagnostic Specialty Section.
 - A total of 40 individual proposals were submitted for consideration. The variety and quality of the potential presentations should enhance the value for all attendees.
2. In cooperation with the Executive Office Staff, plan and produce four section bulletins, at least one Section Specific thematic Web cast/chat and 1-2 Web-based section meetings.
 - Rick Weaver, bulletin editor, does a fantastic job for the section
3. Undertake efforts to demonstrate value of section membership, encouraging membership growth.
 - We plan on a membership drive to be promoted in the summer bulletin.
4. Identify, cultivate, and mentor new section leadership.
 - Ongoing

5. Enhance communication with and from section membership through the section Listserv and provide timely responses for requests for information.

- Ongoing

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2011 Board Report and updated for each Board Report.

- Planning review of sites during the first week of each month.

Other

Nothing to Report

Education Section

Reporter: Lynda Goodfellow

Last submitted: 2011-03-12 16:46:09.0

Recommendations



No recommendations

Report

Nothing to report

Other

Home Care Section

Reporter: Greg Spratt

Last submitted: 2011-03-15 17:01:08.0

Recommendations



None

Reporter: Greg Spratt BS, RRT, CPFT

Submitted: March 15, 2011

REPORT:

Political Issues:

Round 1 of Competitive Bidding was implemented January 1, 2011. HME providers and organizations continue to lobby for repeal. Recently, Pennsylvania Reps. Glenn Thompson, R, and Jason Altmire, D, introduced a new bill, the Fairness in Medicare Bidding Act, in an attempt to resurrect the efforts of a previous bill to repeal the program, H.R. 3790, which was supported by more than 250 representatives. With cost cutting being the theme in Washington, prospects of repeal are not positive as competitive bidding is projected to save \$28 billion over 10 years. It is unknown what impact the competitive bid will have on respiratory therapists in the home, but with average cuts of 32% in reimbursement in Round 1 competitive bid areas (CBA), it is likely that providers will continue to look for ways to cut costs.

Round 2 will expand the number of CBAs from 9 in Round 1 to 100. CMS statements indicate it doesn't have any plans for changes in Round 2. There has been discussion of additional product categories being included in Round 2. The proposed timeline for Round 2 was as follows: CMS planned to announce affected zip codes and product categories last fall; open registration sometime this winter; accept bid this summer; and implement the program Jan. 1, 2013. So far, none of that has happened.

AARC Annual Meeting - HC Section Highlights

While the Home Care Section continues to face challenges on the reimbursement front, I am encouraged by positive indications from our membership. This year's AARC annual meeting was no exception. Home care topics were well represented throughout the program. Sessions were very well attended with active participation. Innovative ideas were presented for maintaining high and even increasing levels of care within new reimbursement paradigms. Home care RTs and topics were well represented in the Open Forum abstracts.

The primary focus of the Home Care Section Meeting was the Hospital to Home project (details below). The Home Care Section meeting was well attended with approximately 100 attendees, with very active participation by members of the AARC Executive Team, including Tom Kallstrom and Doug Laher.

To increase the involvement of members, four specialty teams were formed within the Home Care Section at this year's Home Care Section meeting. Teams for COPD, asthma, OSA, and education/reimbursement will focus on creation of future newsletters and a specialty project in each group. Team leaders are: Kimberly Wiles - COPD, Bob McCoy - Asthma, Rebecca Olson - OSA, and Lou Kaufman - Education/Reimbursement.

Over 20 RTs attending the meeting volunteered their assistance in this effort. Names and contacts were collected, divided based on interest, and passed on to the team leaders.

Hospital to Home Project:

At the direction of the AARC Executive Office, the Home Care and Management sections of the AARC are joining forces in a project called "Hospital to Home". The goal of this project is that hospital and home care Respiratory Therapists will work together to improve the transition of respiratory care from hospital to home with the objectives of:

- Improving patient care and management upon discharge
- Reducing hospital readmissions within 30 days of discharge, then beyond

A joint meeting of the specialty sections at the AARC Congress focused on an open discussion of the best methods of educating clinicians and patients alike in keys to optimizing airway management, ensuring optimal oxygenation, and educating patients on key self management topics. Many suggestions came from those in attendance on best methods.

The next step will include a survey of AARC membership on the barriers and issues encountered in preventing hospital readmissions.

Action items:

A draft survey was developed and distributed to Tom K, Doug L, Bill K, and Bob M for comment and further development. Upon completion, the survey will be posted to the membership. Additional future actions will be based on the response to the survey.

Long Term Care

Management Section

Reporter: Bill Cohagen

Last submitted: 2011-03-10 08:52:08.0

Management Section Report

Recommendations

- Would like to be able to produce and send out one Bulletin to all AARC members who are managers, but not members of the Management Section promoting the section and increase the Section membership.
- Would like to enhance and categorize the Management Section Library in order to have quicker searches for Policies & Procedures, Protocols, Job Descriptions, past discussions, etc.

Report

- Thanks to the help from Garry Kaufman the Management Section lecture series for both the 2011 Summer Forum and the 2011 National Congress have been established.
- Review of the Management Section Library and "Swap Shop" are under way to ensure that all submissions are current and pertinent in order to assist Managers in their needs for meeting the standards of regulatory bodies as wells as their own departments/facilities.
- Section membership as of 03/10/2011 is 1844 members.
- Work is beginning to encourage submissions to the "Best Practices" area on the Management Section site.
- There are currently enough submissions for the Section Bulletin for the next two (2) issues.

- Working on a BOD proposal for a Section Mentoring/Outreach program to help cultivate Managers/Leaders in the profession.

Respectfully Submitted:

Bill Cohagen, RCP, RRT, BA, FAARC

Neonatal-Pediatrics Section

Reporter: Cynthia White

Last submitted: 2011-03-11 15:20:39.0

Recommendations



We recommend that additional vouchers be available for purchase by affiliate societies for an AARC specialty sections

Justification: Many members who renew AARC membership with voucher do not renew specialty section membership separately

Report

- We continue to execute the charges assigned
- Membership has remained >2000 this year, currently at 2053 section members
- A section meeting was held in December 2010 in Las Vegas
- Participation in the list serve on AARC connect was decreased at the end of last year, but is currently active
- Jenni Raake MBA, RRT and Natalie Napolitano MHS, RRT-NPS have come onboard as editors of the bulletin. First time authors have increased, but most articles have required additional editing time.
- We had section representation at the 2011 PACT meeting in Washington
- AARC connect library and swap shop is being reviewed bimonthly to evaluate continued relevance


- Worked with Ira Chiefetz, MD to identify section goals and priorities for neo-peds for the 2011 AARC International Congress

Sleep Section

Reporter: Antonio Stigall

Last submitted: 2011-03-16 17:35:01.0

Recommendations

 **Recommendation:** That the AARC formally request a meeting with the AASM with the primary goal of the discussing recognition of the NBRC SDS credential in the AASM sleep center/lab standards.

Justification: On December 17, 2010, Dr. Nathaniel Watson, President of the AASM stated that the AASM has concerns regarding the BRPT examination does not test the basic knowledge necessary to perform sleep studies. In addition he was quoted saying “If efforts to improve certification rates are not expedited, many sleep technologists will be forced out of their job by legislation that is necessary to protect the profession.”

One week prior to Dr. Watson’s statement listed above, the NBRC received accreditation from the National Commission for Certifying Agencies (NCCA) for the SDS credential.

Report

1. The section submitted over 25 lecture proposals for the 2011 AARC International Respiratory Congress and are awaiting the decision from the program committee on what will be accepted.
2. On December 10, 2010, the NBRC announced that the National Commission for Certifying Agencies (NCCA) granted accreditation to the Sleep Disorders Specialty Examination. The CRT-SDS and RRT-SDS credentials have undergone a rigorous accreditation process that ensures the credentialing program adheres to stringent standards for certification. Despite accreditation by the NCCA for the SDS credential, the American Academy of Sleep Medicine has not officially recognized the SDS credential as a credentialed technologist.
3. On December 17, 2010 a letter was sent from Nathaniel Watson, MD, president of the AASM to the BRPT president, Janice East notifying the BRPT of the AASM’s concern regarding the pass

rate for the RPSGT exam. Furthermore, Dr. Watson stated that sleep physicians who are medical directors of sleep centers have expressed concerns that certification by the BRPT does not ensure professional readiness, resulting in increased costs and time to train technologists whose credentials should indicate otherwise. Another concern is that a majority of qualified sleep technologists employed at sleep centers are unable to obtain necessary credentials to stay in the profession. In an effort to improve certification rates, Dr. Watson informed Ms. East that the AASM will develop a Sleep Technologist Certification Examination to be administered by the ABSM.

4. In a response letter to ABSM president Dr. Watson on January 10, 2011, BRPT president Janice East disputed several references from Dr. Watson all the while stating the ABSM certification examination for sleep technologists has been an unpleasant surprise for the BRPT.

Surface to Air Transport Section

Reporter: Steven Sittig

Last submitted: 2011-03-07 20:38:18.0

Recommendations



NONE AT THIS TIME

Report

The Surface and Air Transport section again submitted numerous lecture proposals for the upcoming congress. I contacted the Neo/Peds Section chair to see if we might work together on proposals of common interest. At this point in time I have not heard back from our program committee representative on the outcome of the submissions.

The Transport section is teaming up with the education, acute care and neo/peds section to update the AARC's IV course first issued by the education section in 1997. We are currently in the research phase and hope to have a completed document by the upcoming AARC Congress or at least a draft available for review.

We are also working with state societies to determine the need for transport RT's to have multiple licenses for neighboring states. I had Sherry Milligan post the Society president's list serve and at this time have approximately 30% return with data. I hope to have completed data for the next AARC BOD meeting and send the report on to President Karen Stewart.

The section is still growing and the bulletins and E bulletins are being published on time with pertinent content. We were also contacted by a transport team looking for data to allow the transport RT's to administer mediations on transport via IV pumps etc. The data provided by the section and the team's state scope of practice was studied by the hospitals administration and the RT's were approved to give additional medications.

The section also appointed a new representative to the Association of Air Medical Services Transport Conference Education Committee. Susan Horne Hill from North Carolina replaced me on this committee. This allowed an RT to be present on this program committee.

Special Committee Reports

Benchmarking Committee

Reporter: Richard Ford

Last submitted: 2011-03-04 13:29:22.0

Recommendations



No recommendations at this time.

- 1. Received confirmation from the AARC BOD supporting Cheryl Hoerr and Marc Mays as members of the AARC Benchmarking Committee, with Rob Chatburn and Stan Holland agreeing to continue serving in 2011.
- 2. On December 6th the Benchmarking Committee held a forum for clients and other interested managers at the 2010 Congress. Activities of the committee over the year were presented as well as enhancements to the service. The session provided the opportunity for questions as well as recommendations for consideration. The session was attended by approximately 20 individuals.
- 3. A special opportunity was offered to RC Departments who are members of the University Healthcare Consortium (UHC) to enroll in the program. From this group of over 70 hospitals, 32 centers expressed an interest in participation in AARC Benchmarking. Of these ,14 had entered data by the February 28th deadline and are eligible to extend their subscription for an additional year at the discounted price we offer all subscribers who have entered data.
- 4. As UHC members signed up for AARC Benchmarking, members of the committee were assigned to personally engage these centers to assist with resolving questions and encourage ongoing participation in the program.
- 5. A web cast was provided on Feb 2 on "Tips and Tricks of Data Entry" for UHC members. It was well received and is archived for future reference.
- 6. Currently there are 128 centers participating in AARC benchmarking. 2011 is getting off to a fine start. 21 new subscribers have joined in January and February. This is the largest number of new subscribers we have ever had during a two month period.

Billing Codes

Reporter: Roy Wagner

Last submitted: 2011-03-11 14:46:42.0

Recommendations

 **No recommendations at this time.**

Report

Summation of Committee Charges:

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

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

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

1. 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

1. 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 development of the Connect and its use in asking questions on this issue has served the members well. Job well done.

1. 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

CPG Steering Committee Activity Report Spring 2011

Chair: Ruben D Restrepo MD RRT FAARC

Staff Liaison: Ray Masferrer

Recommendation #1: The committee requests the official appointment by the President of Steven Sittig, Keith Hirst, Leonard Wittnebel, Richard Wettstein, and John Emberger to the committee to expedite the process of reviewing and updating the CPGs.

Objectives:

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

Report:

1. **One** CPG will be published in the 2011 April's issue of Respiratory Care.
 - a. Capnography Capnometry
2. **Two** (2) CPGs underwent external review and are near completion.
 - a. Humidification during mechanical ventilation – expected submission by end of March 2011
 - b. Incentive spirometry – expected submission by end of March 2011
3. **Three** (3) CPGs have been revised and updated but awaiting CPG committee's input before submission to external reviewers by end of April 2011:
 - a. Selection of an aerosol delivery device
 - b. Discharge planning for the respiratory care patient
 - c. Transcutaneous monitoring
4. **One** (1) is currently undergoing revision and update – expected completion in Summer 2011
 - a. Sampling for arterial blood gas analysis
5. **Four** (4) 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
6. Continue development of appropriate and new clinical practice guidelines in the evidence-based format.
 - a. EB-CPG on **Inhaled Nitric Oxide**. Completed and published.
 - 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.

Fellowship Committee

Reporter: Patrick Dunne

Last submitted: 2011-02-14 18:58:44.0

Recommendations

- There are no Recommendations at this time

Report

The committee continues to solicit nomination for qualified individuals to be considered for induction as a 2011 FAARC. The deadline for receipt of all nominations and supporting documentation is July 31, 2011. The committee will commence the selection process soon thereafter, and have the process completed by August 31, 2011.

Full eligibility criteria as well as official nominating forms for FAARC can be found on the AARC website.

Federal Government Affairs Committee

Reporter: Frank Salvatore

Last submitted: 2011-03-14 18:19:40.0

Recommendations

1. Continue implementation of a 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts.
 - a. **Ongoing - we activated the 435 plan and held our second Virtual Lobby Event in February/March 2011. The Virtual Lobby Week and 435 plan occurred from February 24th and continued through the Legislative Lobby Day on March 8, 2011. See the Excel Spreadsheet #1 for the final statistics by state.**
 - b. **The final tally was 9,047 messages sent by 3,146 individuals. When compared to the 435 activation at the same time last year, we saw 5,926 messages sent by 1,889 individuals.**

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 - The second Excel Spreadsheet takes a look at the number of individuals who sent letters versus the number of licensed individuals in each state (the state license numbers may be slightly dated). Although we continue to increase the number of messages sent at each activation, we are only hitting slightly less than 2% of the licensed therapists in the U.S.**

I would like to thank my committee: Carrie Blacka, Debbie Fox, John Campbell and Jerry Bridgers. I would like to also thank Cheryl West and Miriam O'Day for all their hard work and efforts on behalf of our profession and patients.

Spreadsheet #1

#:	RECIPIENT_STATE	TOTAL_ACTIVISTS	E_MAIL	PRINTED	TOTAL_ADVOCACY_MESSAGES
1	Michigan	259	906	121	1027
2	Illinois	248	633	64	697
3	Pennsylvania	219	552	123	675
4	Ohio	212	465	68	533
5	Florida	121	312	45	357
6	Georgia	116	320	31	351
7	Colorado	89	307	28	335
8	Missouri	130	282	44	326
9	North Carolina	100	269	27	296
10	Minnesota	100	242	51	293
11	Washington	79	209	23	232
12	Connecticut	82	207	20	227
13	New York	74	189	22	211
14	Texas	60	183	20	203
15	Kansas	64	175	27	202
16	Virginia	66	170	27	197
17	Arizona	68	157	32	189
18	Montana	55	173	14	187
19	Oregon	52	145	25	170
20	California	61	141	18	159
21	Utah	58	135	24	159
22	New Jersey	63	133	15	148
23	North Dakota	47	106	29	135
24	Iowa	36	99	18	117
25	Maine	43	104	9	113
26	Massachusetts	45	94	12	106
27	District of Columbia	94	94	8	102
28	Wisconsin	36	86	15	101
29	Maryland	33	91	9	100
30	Nebraska	40	76	24	100
31	Nevada	34	87	10	97
32	South Carolina	34	84	8	92
33	Oklahoma	37	74	14	88
34	Louisiana	23	71	11	82
35	New Mexico	32	65	13	78
36	South Dakota	27	62	16	78
37	Mississippi	22	44	18	62
38	Indiana	24	47	13	60
39	Kentucky	21	48	6	54
40	Delaware	12	38	7	45
41	West Virginia	17	31	12	43
42	Vermont	16	29	8	37
43	Hawaii	12	25	8	33
44	Alabama	20	16	11	27
45	Alaska	13	26	0	26

46	New Hampshire	11	24	1	25
47	Tennessee	7	18	3	21
48	Idaho	14	14	5	19
49	Arkansas	5	11	4	15
50	US - National	11	11	0	11
51	Rhode Island	1	3	0	3
52	unknown	2	0	2	2
53	Virgin Islands	1	1	0	1
		3146	7884	1163	9047
		3123 Unique			

Affiliate	# of Licenses	3/1/11 - 8 AM Report		3/2/11 - 8 AM Report		3/3/11 Report		3/4/11 Report		3/5/11 Report		3/7/11 Report		3/8/11 Report		3/9/11 Report		3/10/11 Report	
		Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.	Individuals/ Activists	% of Licensed Indiv.
Alabama	2,545	0	0.00%	5	0.20%	14	0.55%	15	0.59%	15	0.59%	16	0.63%	18	0.71%	18	0.71%	20	0.79%
Alaska	No Act	0		0		0		5		9		11		12		13		13	
Arizona	3,926	19	0.48%	21	0.53%	35	0.89%	38	0.97%	46	1.17%	50	1.27%	62	1.58%	62	1.58%	68	1.73%
Arkansas	1,900	2	0.11%	2	0.11%	4	0.21%	5	0.26%	5	0.26%	5	0.26%	5	0.26%	5	0.26%	5	0.26%
California	17,902	5	0.03%	11	0.06%	25	0.14%	31	0.17%	46	0.26%	53	0.30%	58	0.32%	58	0.32%	61	0.34%
Colorado	2,305	22	0.95%	34	1.48%	48	2.08%	52	2.26%	58	2.52%	60	2.60%	85	3.69%	86	3.73%	89	3.86%
Connecticut	1,767	34	1.92%	55	3.11%	63	3.57%	64	3.62%	68	3.85%	70	3.96%	81	4.58%	82	4.64%	82	4.64%
Delaware	655	3	0.46%	6	0.92%	7	1.07%	9	1.37%	11	1.68%	12	1.83%	12	1.83%	12	1.83%	12	1.83%
District of Columbia	739	1	0.14%	1	0.14%	1	0.14%	9	1.22%	14	1.89%	87	11.77%	94	12.72%	94	12.72%	94	12.72%
Florida	11,155	24	0.22%	45	0.40%	80	0.72%	91	0.82%	105	0.94%	113	1.01%	120	1.08%	121	1.08%	121	1.08%
Georgia	4,743	12	0.25%	43	0.91%	59	1.24%	82	1.73%	86	1.81%	96	2.02%	107	2.26%	114	2.40%	116	2.45%
Hawaii	No Data	2		3		4		5		5		6		12		12		12	
Idaho	731	2	0.27%	4	0.55%	8	1.09%	9	1.23%	9	1.23%	9	1.23%	11	1.50%	11	1.50%	14	1.92%
Illinois	5,850	37	0.63%	64	1.09%	136	2.32%	163	2.79%	186	3.18%	204	3.49%	240	4.10%	245	4.19%	248	4.24%
Indiana	4,743	6	0.13%	8	0.17%	15	0.32%	19	0.40%	20	0.42%	21	0.44%	23	0.48%	23	0.48%	24	0.51%
Iowa	1,544	13	0.84%	16	1.04%	25	1.62%	31	2.01%	32	2.07%	33	2.14%	35	2.27%	36	2.33%	36	2.33%
Kansas	1,767	28	1.58%	34	1.92%	55	3.11%	58	3.28%	59	3.34%	63	3.57%	63	3.57%	64	3.62%	64	3.62%
Kentucky	3,300	4	0.12%	7	0.21%	9	0.27%	13	0.39%	15	0.45%	15	0.45%	20	0.61%	20	0.61%	21	0.64%
Louisiana	3,436	9	0.26%	11	0.32%	14	0.41%	19	0.55%	21	0.61%	21	0.61%	23	0.67%	23	0.67%	23	0.67%
Maine	656	0	0.00%	5	0.76%	5	0.76%	8	1.22%	9	1.37%	25	3.81%	40	6.10%	41	6.25%	43	6.55%
Maryland	2,589	11	0.42%	12	0.46%	14	0.54%	16	0.62%	28	1.08%	31	1.20%	33	1.27%	33	1.27%	33	1.27%
Massachusetts	3,005	1	0.03%	3	0.10%	14	0.47%	17	0.57%	18	0.60%	25	0.83%	43	1.43%	45	1.50%	45	1.50%
Michigan	4,846	74	1.53%	81	1.67%	137	2.83%	226	4.66%	241	4.97%	251	5.18%	255	5.26%	256	5.28%	259	5.34%
Minnesota	1,725	16	0.93%	23	1.33%	28	1.62%	51	2.96%	77	4.46%	87	5.04%	96	5.57%	99	5.74%	100	5.80%
Mississippi	2,121	1	0.05%	6	0.28%	14	0.66%	16	0.75%	21	0.99%	21	0.99%	22	1.04%	22	1.04%	22	1.04%
Missouri	4,036	27	0.67%	40	0.99%	58	1.44%	76	1.88%	111	2.75%	121	3.00%	126	3.12%	129	3.20%	130	3.22%
Montana	517	14	2.71%	24	4.64%	32	6.19%	41	7.93%	45	8.70%	47	9.09%	51	9.86%	51	9.86%	55	10.64%
Nebraska	1,336	10	0.75%	17	1.27%	19	1.42%	23	1.72%	23	1.72%	23	1.72%	39	2.92%	39	2.92%	40	2.99%
Nevada	1,325	1	0.08%	1	0.08%	22	1.66%	27	2.04%	31	2.34%	32	2.42%	34	2.57%	34	2.57%	34	2.57%
New Hampshire	477	2	0.42%	6	1.26%	8	1.68%	10	2.10%	10	2.10%	11	2.31%	11	2.31%	11	2.31%	11	2.31%
New Jersey	3,344	3	0.09%	4	0.12%	19	0.57%	27	0.81%	28	0.84%	29	0.87%	35	1.05%	36	1.08%	63	1.88%
New Mexico	872	7	0.80%	10	1.15%	17	1.95%	18	2.06%	20	2.29%	30	3.44%	31	3.56%	31	3.56%	32	3.67%
New York	6709	12	0.18%	15	0.22%	44	0.66%	50	0.75%	52	0.78%	54	0.80%	68	1.01%	71	1.06%	74	1.10%
North Carolina	4,405	26	0.59%	47	1.07%	55	1.25%	65	1.48%	73	1.66%	79	1.79%	98	2.22%	99	2.25%	100	2.27%
North Dakota	457	9	1.97%	10	2.19%	17	3.72%	24	5.25%	24	5.25%	27	5.91%	42	9.19%	46	10.07%	47	10.28%
Ohio	7,688	107	1.39%	121	1.57%	154	2.00%	177	2.30%	191	2.48%	196	2.55%	209	2.72%	211	2.74%	212	2.76%
Oklahoma	1,957	0	0.00%	9	0.46%	24	1.23%	31	1.58%	33	1.69%	34	1.74%	37	1.89%	37	1.89%	37	1.89%
Oregon	1,531	12	0.78%	18	1.18%	21	1.37%	39	2.55%	43	2.81%	49	3.20%	51	3.33%	51	3.33%	52	3.40%
Pennsylvania	7199	53	0.74%	97	1.35%	143	1.99%	159	2.21%	177	2.46%	200	2.78%	216	3.00%	217	3.01%	219	3.04%
Puerto Rico	2,007	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rhode Island	531	0	0.00%	0	0.00%	0	0.00%	1	0.19%	1	0.19%	1	0.19%	1	0.19%	1	0.19%	1	0.19%
South Carolina	2,431	14	0.58%	19	0.78%	27	1.11%	31	1.28%	32	1.32%	32	1.32%	34	1.40%	34	1.40%	34	1.40%
South Dakota	450	14	3.11%	18	4.00%	22	4.89%	24	5.33%	24	5.33%	26	5.78%	27	6.00%	27	6.00%	27	6.00%
Tennessee	3673	2	0.05%	2	0.05%	4	0.11%	6	0.16%	6	0.16%	6	0.16%	7	0.19%	7	0.19%	7	0.19%
Texas	12,765	9	0.07%	14	0.11%	33	0.26%	46	0.36%	51	0.40%	55	0.43%	59	0.46%	59	0.46%	60	0.47%
Utah	1,188	4	0.34%	12	1.01%	31	2.61%	38	3.20%	40	3.37%	43	3.62%	54	4.55%	57	4.80%	58	4.88%
Vermont	341	3	0.88%	7	2.05%	8	2.35%	13	3.81%	13	3.81%	15	4.40%	16	4.69%	16	4.69%	16	4.69%
Virgin Islands	N/A	0		0		0		1		1		1		1		1		1	
Virginia	3,504	32	0.91%	43	1.23%	55	1.57%	60	1.71%	62	1.77%	63	1.80%	65	1.86%	65	1.86%	66	1.88%
Washington	2,401	3	0.12%	7	0.29%	11	0.46%	33	1.37%	33	1.37%	66	2.75%	78	3.25%	79	3.29%	79	3.29%
West Virginia	1,534	1	0.07%	2	0.13%	4	0.26%	11	0.72%	12	0.78%	14	0.91%	16	1.04%	16	1.04%	17	1.11%
Wisconsin	2,801	12	0.43%	16	0.57%	24	0.86%	27	0.96%	30	1.07%	31	1.11%	33	1.18%	33	1.18%	36	1.29%
Wyoming	297	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Totals:	159,726	701	0.44%	1,056	0.66%	1,662	1.04%	2,100	1.31%	2,356	1.48%	2,653	1.66%	2,985	1.87%	3,028	1.90%	3,108	1.95%

International Committee

Reporter: John Hiser

Last submitted: 2011-02-23 13:58:50.0

Recommendations

 [None]

Report

1. Coordinate market and administer the International Fellowship Program.

We are in the process of gearing up for this year. The web site and the online application have been updated. A call for applicants has been posted on the international fellows list serve, the city host list serve, the HOD/Presidents and the BOD list serves. Periodically past fellow reports are appearing in the Currents section of AARCTimes.

2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International functions of the Congress.

The committee continues to work with the ICRC to help coordinate and help prepare the presentations given by the fellows to the council.

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

We continue to work on improving communication and on targeted activities.

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

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

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

We continue to correspond with other medical associations, societies and practitioners.

I want to thank Kris Kuykendall for all of her hard work and also thank the Vice Chairs and Committee Members.

Vice Chairs

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

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

Committee members:

Michael Amato, BA, Chair ARCF

Jerome Sullivan, PhD, RRT, FAARC, President ICRC

Arzu Ari, PhD, RRT, MS, MPH, PhD

Ivan Bustamante, RRT

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

Membership Committee

Reporter: Thomas Lamphere

Last submitted: 2011-03-11 14:16:27.0

Recommendations

None at this time.

Report

The Membership Committee & Executive Office staff have been working on a membership plan since mid-January. The focus has been primarily on our students as we have about 2,000 of them graduating this May. A conference call was held that include members of the Executive Office, the Membership Committee Chair and several RT Program Directors from around the country. During the call, the group discussed why we believe our student member to active member conversion percentage is so low and ways to increase the percentage. Possible reasons for the current low conversion rate included:

- 1) Lack of Program Director support for the AARC both personally and in the classroom. The group felt some of this was due to a lack of tools for educators to use to involve their students.
- 2) Lack of exposure from many student members to what the AARC has to offer. This is partly due to the fact that many do not have a reason to go to the AARC website or interact in other ways with the AARC.
- 3) A below average student webpage and/or website. The group felt that although many students do visit the AARC website, there isn't enough information presented in a clear, concise way that appeals specifically to them.

The following plan was then developed to address these issues that involves work both by the AARC Executive Office, Membership Committee and Education Section. The plan includes:

1. Video messages will be created to go to our students, reinforcing the value of the AARC for renewal and new member greetings. (AARC Office)
2. A bigger and better student presence will be created on AARConnect, to allow students to become more involved with the AARC and develop a better affinity with the organization through social networking. (AARC Office)
3. A toolkit will be developed for program directors and educators that will provide ways for educators to actively involve their students in the AARC. (Education Section chair)
4. More emails will be sent specifically to program directors with information they can use for the students. (From AARC Office with Education Section chair support)
5. More emails will be sent specifically targeted to students to remind them of the benefits, services, and resources available to them. (AARC Office)
6. The Membership Committee will gather information from the state societies about their practices in member recruitment. These will be catalogued in a document that will be made accessible to all states. (Membership Committee)
7. The Membership Committee will research and identify tools, other websites, information, etc. that will be helpful to students in their school and as they begin studying for their boards. This information will then be used to guide the upgrade of the student section on the AARC website. (Membership Committee)

Other

Committee Members

Thomas Lamphere – Chair
Hassan Alorainy
Suzanne Bollig
Asha Desai

Joe Horn
Garry Kauffman
Debra Markese
Sherry Milligan

John Priest
Nicholas Widder
Emily Zyla

Position Statement Committee

Reporter: Colleen Schabacker

Last submitted: 2011-03-07 13:01:44.0

Recommendations



Approve and publish policy No.: CT.008 "Position Statement Committee". This policy 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 policy update the document to reflect decisions made by the Board in 2010 to date every Position Statement when reviewed / revised and to include approved definitions to be used when updating all Position Statements.

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 2011, the Committee's goal is to complete the review of the seven (7) 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.
- 1) Competency Requirements for the Provision of Respiratory Therapy Services - to be determined
 - 2) Hazardous Materials Exposure - to be determined
 - 3) Health Promotion and Disease Prevention - Deryl Gulliford
 - 4) Inhaled Medication Administration Schedules - Linda Van Scoder
 - 5) Rehabilitation - Deryl Gulliford
 - 6) Tobacco and Health - Colleen Schabacker
 - 7) Verbal Orders - Colleen Schabacker
 - Health Promotion and Disease Prevention - Review was completed in 2010; complete re-write of the statement recommended, but unable to get it completed
 - o This document will be completed in 2011
 - 3. Revise the Position Statement Review Schedule table annually in order to assure that each position statement is evaluated on a three-year cycle.
 - § The schedule (See Attachment #2) was revised to reflect the BOD actions through 2014 and will be updated as needed.

(Attachment #1)

American Association for Respiratory Care
Policy Statement

Page 1 of 2

Policy No.:CT.008

SECTION: Committees
SUBJECT: **Position Statement Committee**
EFFECTIVE DATE:
DATE REVIEWED: July 2005, April 2011
DATE REVISED: July 2005, April 2011

References: PS.0478

Policy Statement:

AARC position and policy statements shall be created as required and reviewed in a timely manner.

Policy Amplification:

1. The AARC Board of Directors, AARC House of Delegates and/or AARC Board of Medical Examinations may initiate a new position statement.
2. The Position Statement Committee will draft all AARC position Statements and submit them for approval by the Board of Directors after soliciting comments and suggestions from all communities of interest as appropriate.
3. On an ongoing basis the committee will recommend to the Board, review, revise or delete as appropriate, all current AARC position statements in a timely manner. Each Position Statement reviewed/revised, shall be dated upon Board approval of review/revision.
4. The following definitions will be used when writing Position Statements:
 - a. **Respiratory Care:** umbrella term that identifies a distinct subject area and health care profession within medicine; a subject area in medicine that includes all aspects of the care of patients with respiratory disease; used to identify the services provided by Respiratory Therapists and other health care practitioners such as physicians, nurses, physical therapists, managers, educators, etc.
 - b. **Respiratory Therapy:** term that describes a specific component of the area of medicine known as respiratory care; typically used to refer to the procedures, treatments, and technology-based worked

- c. **Respiratory Therapists:** term that identifies the professional practitioners who are credentialed as Registered and/or Certified Respiratory Therapists and who practice in the area of medicine known as respiratory care
5. Position statements adopted by this Association should be available to all members in ~~either~~ electronic ~~or printed~~ form.

DEFINITIONS: respiratory care, respiratory therapy, respiratory therapist

ATTACHMENTS:

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2011-X)	Schedule Review for 2011	Schedule Review for 2012	Schedule Review for 2013	Schedule Review 2014
AARC Statement of Ethics and Professional Conduct	1994	2009	2		X		
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2010	1			X	
Competency Requirements for the Provision of Respiratory Therapy Services	1998	2008	3	X			X
Continuing Education	1990	2009	2		X		
Cultural Diversity	1994	2010	1			X	

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2011-X)	Schedule Review for 2011	Schedule Review for 2012	Schedule Review for 2013	Schedule Review 2014
Definition of Respiratory Care	1987	2009	2		X		
Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	2009	2010	0		X		
Hazardous Materials Exposure	2002	2008	2	X			X
Health Promotion and Disease Prevention	1985	2005	6	Review completed; Complete rewrite of the statement required			X
Home Respiratory Care Services	2000	2010	1			X	

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2011-X)	Schedule Review for 2011	Schedule Review for 2012	Schedule Review for 2013	Schedule Review 2014
Inhaled Medication Administration Schedules	2008	2008	3	X			X
Licensure of Respiratory Care Personnel	1990	2009	2		X		
Pre-Hospital Mechanical Ventilator Competency	2007	2007	3			X	
Pulmonary Rehabilitation	1973	2008	2	X			X
Respiratory Care Scope of Practice	1987	2010	1			X	
Respiratory Therapist Education	1998	2009	2		X		

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2011-X)	Schedule Review for 2011	Schedule Review for 2012	Schedule Review for 2013	Schedule Review 2014
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2010	1			X	
Respiratory Therapy Protocols	2001	2010	1			X	
Telehealth	2001	2010	1			X	
Tobacco and Health	1991	2008	3	X			X
Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child, or Adult Patient	2009	2009	2		X		
Verbal Orders	1990	2008	3	X			X
				7	7	8	7

Public Relations Action Team

Reporter: Trudy Watson

Last submitted: 2011-03-11 14:08:35.0

Recommendations

 **None at this time.**

Report

Due to the short time between receipt of the charges and the Spring BOD meeting report deadline, there has been minimal activity by the committee. To date, we have not received any requests from the Executive Office to update materials or participate in interviews. We will have a more thorough report of our activities for the Summer BOD meeting.

Committee Charges:

1. Each member will agree to do interviews (radio) and provide information for the written press release that corresponds to the interview topic.
2. Continue to assist Your Lung Health (AARC's consumer website) with reading and editing clinical stories, messages, etc for the website. These will be assigned through the EO on a PRN basis.
3. Communicate with each State Affiliate encouraging the establishment of a public relations committee.
4. Update the current Public Relations material and develop a mechanism to make the PR "tools" more easily available to the State Affiliates.

State Government Affairs Committee Report

Tom McCarthy, Chair

April 2011

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.

This quarter was marked by an unusually aggressive and complex collection of Polysomnography legislation in several States. Those legislative initiatives included a continued exclusion of Respiratory Care Practitioners from practicing Polysomnography.

Additionally, language in some of the bills would strike the requirement for accredited education and replace it with non-accredited AASM educational formats that would, among other things, make students ineligible for Federal student aid.

Other language would allow individuals to receive a license after completing a twelve week course and without having passed a competency examination.

In depth reviews and analysis of these legislative initiatives were conducted. Support from the AARC was made available to the State Societies in the affected States.

We will continue to monitor and evaluate these 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.

*Special
Representatives
Reports*

American Academy of Allergy, Asthma & Immunology

AMA CPT Health Care Professional Adv Comm

Reporter: Susan Rinaldo Gallo

Last submitted: 2011-02-24 11:59:26.0

Recommendations

 None

Report

A meeting was held in February which we did not attend. As mentioned previously, the proposal by the ATS and ACCP to revise some of the PFTs codes was presented. This proposal is to bundle codes. Ten codes would be replaced by four new codes. If this is approved the proposal then goes to the RUC in April. Here Relative Values and fees will be assigned to each new code.

Four new codes are:

- 1. Plethysmography for determination of lung volumes
- 2. Gas dilution or washout for determination of lung volumes and when performed, distribution of ventilation and closing volumes
- 3. Airway resistance by impulse oscillometry
- 4. Diffusion capacity

Codes to be deleted are:

- 1. 93720-93722, replaced by Plethysmography
- 2. 94240, 94260, replaced by Plethysmography or Gas dilution or washout
- 3. 94350, replaced by Gas dilution or washout
- 5. 94360, replaced by Plethysmography or Airway resistance by impulse oscillometry
- 4. 94370, replaced by Gas dilution or washout
- 6. 94720, 94720, replaced by Diffusion capacity

Other PFT codes such as spirometry will stay as is.

One other pulmonary code that was proposed is Bronchial Thermoplasty. Bronchial Thermoplasty , radiofrequency ablation of airway smooth muscle, per session.

The minutes from the meeting containing the outcomes will not be available until after this report is due.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Reporter: Debra Koehl

Last submitted: 2011-03-14 09:06:17.0

Recommendations

No recommendations at this time.

Report

At this time I have been working with the AACVPR on the following items:

- Program committee for the AACVPR Conference in October
 - I have been working along with other respiratory therapists to assure that our profession and topics concerning pulmonary patients are well represented on the program committee.
 - I have been asked to present at the AACVPR conference along with Trina Limberg and Lana Hilling.
- Pulmonary Rehabilitation Committee
 - Function as a committee member to comment on issues that arise in regards to pulmonary rehabilitation.
 - Most recent 6 minute walk competency document

American Association of Critical Care Nurses

American Heart Association

Reporter: Brian Walsh

Last submitted: 2011-03-09 10:59:27.0

Recommendations

 None

Report

New guidelines are out and progressing well. Hand only CPR has been a really big hit and will likely improve the odds that someone will at least try to assist. Now the committee has turned their attention to troubleshooting guideline issues and collecting data for the next renewal cycle.

We also reviewed Joint Commission suggested requirement for 2012 regarding time to defibrillation and time to confirmation of ETT placement and submitted recommendation during their public comment period.

Other

Cheers!

Amer Soc for Testing and Materials

Reporter: Robert McCoy

Last submitted: 2011-03-11 16:34:27.0

Recommendations

 None

Report

There have been many reviews of respiratory products related to ASTM standards. I would encourage any specialty section chair to contact me if they have questions or concerns related to an existing standard or the need to improve standards that are already in place.

Of personal interest is the movement on an improved standard for oxygen conserving devices. A meeting will be held in April on a revision to the OCD standard that focuses on labeling of the devices and specifics on oxygen dose per setting.

Robert McCoy BS RRT FAARC

Other

Chartered Affiliate Consultant

Reporter: Garry Kauffman

Last submitted: 2011-03-06 15:39:17.0

Recommendations

None

Report

Thanks to approval by President Stewart, I had the distinct pleasure of working with the Kansas Society leadership in January secondary to the request by Karen Schell. Over the course of an evening and the following day, I lead their team through an interactive process during which they created a new simplified and focused mission statement, core values to guide their deliberations and activities, and a comprehensive action plan to lead their state society. Their enthusiasm and diligence is to be commended, and the outcome of their efforts is already witnessed in various performance domains. I would like to point out to the AARC board members one aspect of their innovation, in that they have utilized the power of AARConnect to serve as a valuable and timely communication tool for their membership.

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).

Respectfully submitted March 6, 2011

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

Committee on Accreditation of Air Medical Transport System

Reporter: Steven Sittig

Last submitted: 2011-03-06 21:14:04.0

Recommendations

 **NONE AT THIS TIME**

Report

The CAMTS BOD will be meeting April 1st - 3rd in Nashville TN in conjunction with the Critical Care Transport Conference and the Air Medical Physicians Association meeting. A formal letter was sent to Sam Gordano the AARC office with a report of the past years activities and thanks for the support that CAMTS has received from the association.

The eighth edition of the CAMTS standards were released in late 2010 and we continue to help provide additional education opportunities

Other

Extracorporeal Life Support Organization

Reporter: Donna Taylor

Last submitted: 2011-03-13 22:15:29.0

Recommendations

 None

Report

The Extracorporeal Life Support Organization (ELSO) continues to pursue a credentialing for ECMO Specialists. Due to the complexity, expense and involvement of nurses, respiratory therapists and perfusionists, the decision to hire a consultant to investigate the full extent of this process was agreed upon by the committee.

Additional opportunities for RRTs with ECMO is anticipated as adult ECMO is again becoming an option for treating ARDs. ELSO is providing Adult ECMO training courses throughout the country.

Other

International Council for Respiratory Care

Reporter: Jerome Sullivan

Last submitted: 2011-03-11 16:01:00.0

Recommendations

 There are no recommendations at this time

Report

I. International Education Recognition System (IERS): Since the AARC International Congress and the ICRC Annual Business Meeting in December 2010 significant progress has been made in IERS with the recognition and pending action of several major seminars and degree programs.

Gulf Thoracic Congress: Major seminar in the Middle East *IERS Recognized*. The Gulf Thoracic sponsored by the Saudi Thoracic Society and the Emirates Allergy & Respiratory Society is scheduled to be held in **Dubai, United Arab Emirates, March 16-18, 2011**. This seminar presents current clinical practice and research in pulmonary medicine and respiratory care. Embedded in the seminar is the widely acclaimed, and *IERS Recognized* AARC Asthma Educator Course. The ICRC will be represented at the meeting and the AARC will have a number of its leaders and clinicians participating as faculty at the congress. Namely, Tom Kallstrom, Sam Giordano, Dean Hess and Tim Myers will serve as faculty for the program.

University of Milan: Post-Master Degree in Italy *IERS Recognized*. The University of Milan and the Italian Association for Respiratory Care, an International Affiliate of the AARC, are sponsoring a Respiratory Physiotherapy Master Degree Course, **March 3, 2011 - February 10,**

2012, Milan Italy. This degree program is fully subscribed and has a waiting list. The entry level for admission to the course is a minimum of a Master Degree in Physiotherapy.

The 5th Intercostal Respiratory Therapy Assembly: Mainland China site of Respiratory Care Congress which is pending review and *IERS Recognition*. The 5th Intercostal Respiratory Therapy Assembly (ICRTA) and International Respiratory and Critical Care Medicine Congress will be held in **July 9-10, 2011** at the Hunan Provincial People's Hospital in **Changsha City, Hunan, China**. Hundreds of respiratory therapists, physicians, nurses, and other healthcare providers and leaders will gather in Changsha City for two full days of educational programming and the opportunity to increase their knowledge in Respiratory Care.

Mexican Institute for Social Security: An advanced Bachelor Technical Degree in Respiratory Therapy is pending review and *IERS Recognition*. Institute de Mexico for Social Security (IMSS), a major university in the Mexican government system, and the Mexican Association for Respiratory Care, an International Affiliate of the AARC, is pending review and *IERS Recognition*. This is significant step forward in providing a model curriculum and structure for Respiratory Therapy Programs at the University level in Mexico.

II. Contacts with ICRC Governors on AARC membership levels : The Council has communicated with the Governors to the ICRC in countries with AARC International Affiliates to assist with ongoing efforts to encourage and maintain AARC membership levels in their organizations. Council has offered it's assistance as threshold AARC membership levels are required for the International Affiliate to retain its active status. Governors have been asked to submit their progress reports on membership to the Council President by June 15, 2011.

Respectfully Submitted,

Jerome M. Sullivan, PhD, RRT, FAARC

President, ICRC

Joint Commission - Ambulatory PTAC

Reporter: Suzanne Bollig

Last submitted: 2011-03-11 15:39:16.0

Recommendations

 No recommendations at this time.

Report

- Michael Hewett resigned as representative to the ambulatory PTAC committee
- A PTAC conference call is scheduled for March 24, 2011

Joint Commission - Home Care PTAC

Reporter: Dianne Lewis

Last submitted: 2011-03-06 09:50:58.0

Recommendations

None

Report

A conference call will be held March 17, 2011 concerning "Influenza Vaccine of Healthcare Workers" in the Home Care Accreditation program. I will give an update at the Spring meeting if there is information important to share.

Other

Joint Commission - Lab PTAC

Reporter: Franklyn Sandusky

Last submitted: 2011-03-09 11:42:12.0

Recommendations

Report

The Joint Commission Laboratory Professional And Technical Advisory Committee met on Thursday, February 24, 2011 .

- This was the First meeting of the year. As such there was a general review of the committee functions.
- Organizational Updates
 - AABB (American Association of Blood Banks)
 - American Association for Clinical Chemistry
 - American Association for Respiratory Care
 - American Association of Bioanalysts
 - American Society for Clinical Laboratory Science
 - American Society for Clinical Pathology
 - American Society for Cytotechnology
 - American Society for Histocompatibility & Immunogenetics

- American Society for Microbiology
 - American Society of Hematology
 - Association for Molecular Pathology
 - At -Large Representative: Informatics
 - Centers for Disease Control & Prevention
 - Centers for Medicare & Medicaid Services
 - Clinical & Laboratory Standards Institute
 - Society for Assisted Reproductive Technology
-
- Lab PTAC meeting will be held on : Thursday, June 2, 2011, Thursday, September 1, 2011, Thursday, December 1, 2011.
 - There was a review of Proposed Standard IC.02.04.01 to Address Influenza Vaccination of Healthcare Workers
 - Respectfully submitted by

Franklyn D. Sandusky

AARC Representative to the Lab PTAC

National Asthma Education & Prevention Program

Reporter: Natalie Napolitano

Last submitted: 2011-03-10 01:23:38.0

Recommendations



No Recommendations at this time

Report

Commented on new Asthma in schools booklet.

Next meeting scheduled for September 11-15th in DC

Other

Natl Coalition/Hlth Pro Edu - Genetics

Reporter: Linda Van Scoder

Last submitted: 2011-03-10 14:26:47.0

Recommendations



No Recommendations

NCHPEG has not met since last fall. I continue to monitor NCHPEG and Genetic Alliance for opportunities for the AARC to engage. I recently made the Executive Office aware of a grant opportunity for the development of a targeted educational program sponsored by NCHPEG.

Neonatal Resuscitation Program

Reporter: John Gallagher

Last submitted: 2011-03-10 23:41:19.0

Recommendations

 **No recommendations at this time.**

Report

The NRP Steering Committee (NRPSC) last met September 29th through October 1st, 2010 in San Francisco, California. The meeting was held at the start of the annual AAP convention. As is customary for the beginning of the Fall meeting, the committee members reviewed grant proposals for the Young Investigator Awards and the NRP Research Grants. As AARC liaison, I was responsible for reviewing proposals that specifically dealt with equipment or processes involving the patient airway, oxygenation, or ventilation. Further discussion regarding grant proposals involved identifying key research objectives that would be influential for NRP as a way of guiding hopeful investigators. This information has been published on the NRP website.

Meeting agenda items also included a final review of 6th edition content for the upcoming textbook release. Questions related to ventilation equipment and processes were directed to the AARC liaison. Edits and debate were also conducted around the instructor DVD and general instructor issues as the new guidelines become active.

Additional DVD edits, question formulation for new online exams, and respiratory specific questions from providers have all been additional tasks performed by our liaison over the past 6 months. It is my impression that our role on this committee is quite valued and continues to impact the direction of the NRPSC. Lastly, I just completed work for an article in the upcoming NRP instructor update that takes a closer look at resuscitation equipment in the style of a Q&A

format. I feel that this article will indirectly highlight the role of a respiratory care professional within NRP and within the NRPSC.

The NRPSC will be meeting on March 21 & 22, 2011 in Elk Grove, Illinois as scheduled. The 6th edition textbook and instructor materials are set to be released shortly thereafter.

Respectfully,

John Gallagher, RRT-NPS

National Sleep Awareness Roundtable

Reporter: Mike Runge

Last submitted: 2011-03-10 09:48:23.0

Recommendations

 [None]

Report

National Sleep Awareness Roundtable has not met at this time.

Simulation Alliance Society

Reporter: Robert Chatburn

Last submitted: 2011-02-25 17:11:06.0

Recommendations

 **Nothing to report**

Roundtable Reports

Asthma Disease Mgmt Roundtable

Reporter: Eileen Censullo

Last submitted: 2011-03-09 10:08:34.0

Recommendations

-  **1. Recommend holding a web ex meeting and phone conference to discuss important items to roundtable members**

Report

- Have written articles each quarter for Allergy and Asthma Magazine Publication
- Have submitted topics for AARC Congress 2011
- Have posted topics of conversation on AARConnect

Other

Consumer

See Executive Director Report

Disaster Response Roundtable

Reporter: Steven Sittig

Last submitted: 2011-03-06 21:08:06.0

Recommendations



None at this time

Report

The disaster roundtable has been working closely with the NDMS and MRC to have them present lectures at the upcoming AARC Congress in Tampa this November. We submitted 4 lecture proposals and a request for a roundtable meeting at the AARC Congress that would be included in all brochures and programs. At this time we have not heard if the proposals were accepted or not. Both the NDMS and MRC are actively trying to recruit RRT's to their respective programs.

Geriatrics Roundtable

Reporter: Mary Hart

Last submitted: 2011-03-14 10:32:00.0

Recommendations



No recommendations at this time

Report

The Geriatrics Roundtable met in Vegas to discuss the upcoming year's submission to the Congress Program and Coming of Age Articles. There was a lengthy discussion about how prepared are the RTs to care for the influx of geriatric patients we will begin seeing with comorbidities in the near future. Members do not believe our profession is prepared in either RT school curriculum or Continuing Education. We have proposed a number of sessions for the 2012 Congress Meeting to address some of the needs. Hopefully the program committee will see the urgency of this specialty education for its members. I also met with Tom Kallstrom and Marsha Cathcart to review the COA 2012 articles, authors and needs from the Roundtable.

Hyperbaric Roundtable

Reporter: Clifford Boehm

Last submitted: 2011-02-15 16:31:25.0

Recommendations

Development of another Hyperbaric Medicine presentation for the 57th International Respiratory Congress to include:

- Expanded description of the indications, contraindications and techniques for the administration of hyperbaric oxygen.
- Further description of the skill set overlap between respiratory therapists and hyperbaric technicians
- Several case presentations.

Report

The Roundtable produced a well attended mini-posium at the 56th International Respiratory Congress this past December, 2010. Three aspects of Hyperbaric Medicine were covered:

- A basic introduction of the field including: indications, contraindications and techniques- Clifford Boehm, MD, RRT
- Impressing upon to the membership why they were uniquely qualified to enter the field- William Gearhart, CHT, DMT, EMT, CFPS
- Educating members regarding hurdles encountered when beginning a hyperbaric medicine department.- Garry Kauffman, MPA, FACHE, RRT, FAARC

Other

- Many aspects surrounding the administration of a department of hyperbaric medicine continue to be discussed in the Hyperbaric Roundtable Community on AARConnect.

Informatics Roundtable

Reporter: Garry Kauffman

Last submitted: 2011-03-06 15:48:59.0

Report

A general session was held at the 2010 AARC International Respiratory Congress, lead by Steve Nelson and myself. While attendance was minimal, the session served to allow brainstorming on what activities the Informatics Roundtable should consider for 2011.

Paramount to this group were two activities:

- 1) Convene a webinar to engage members in creating a list of desired activities and selection of a project for 2011.
- 2) Establishing an ad hoc team to begin the creation of standard terminology.

I am communicating with Steve to schedule the webinar and will be communicating the call for volunteers for the ad hoc project team.

Respectfully submitted March 6, 2011

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

International Medical Mission Roundtable

Reporter: Lisa Trujillo

Last submitted: 2011-03-09 11:24:47.0

Recommendations

No recommendations at this time

Report

At the AARC Congress in December 2010, the International Medical Mission Roundtable met as a group with 19 attendees, including roundtable members and investigating AARC members. We discussed current international activities in which each member is involved and the desire of new participants to get involved. Our liaison, Steve Nelson, was in attendance as well. Our roundtable membership has increased to 59 to date. As the summer months approach, we anticipate greater online discussion as members begin to participate in medical missions throughout the world.

Other

Military Round Table & Ad Hoc Comm on Officer Status in the US Uniformed Services

AARC Activity Report
March, 2011

Representative: David L. Vines, MHS, RRT

Liaison: Sam Giordano

Recommandations: None.

Report:

The military roundtable met at on Tuesday, December 7th during the national convention. We reviewed the current strategy listed below and opened it for discussion. The military members in attendance thought that the strategy (stated below) was still acceptable. They suggested that we send letters asking that all branches of the military require at least the passing of the CRT examination to practice respiratory care in the military. They also thought that the VA hospitals should be included in this request. They feel that the soldiers and veterans both deserve the same level of care provided in civilian hospitals. Action: I will schedule a conference call with Sam and Dario Rodriguez, SMSgt., USAF Superintendent to begin the try to grasp the impact of the groups strong recommendation.

The individuals in attendance were asked to spread the word about the round table and encourage others to join. We discussed AARC Connect and how easy it is to join the roundtable. They suggested that a Facebook page and a link to join the roundtable be created. Action: I will discuss this request in more detail with Sam.

They also requested that we look in the possibility of funding travel for active duty military to the national convention. Perhaps corporate sponsors would be willing to provide an educational grant that would fund travel and hotel for active duty military personnel. Action: I will discuss their request in more detail with Sam.

1. Officer status update- Current Strategy
 - A. We will need to compare the mission for Respiratory Therapist in the Army and Air Force to the respiratory therapist in the civilian world.
 - B. If possible we should conduct a survey to compare the current level of practice in military facilities to the level of practice in comparable civilian facilities. This survey could provide the information needed to do a cost analysis to demonstrate how money could be saved.
 - C. We will need to identify the requirements for warrant officer status in both branches and the number of personnel that currently meets those requirements.
 - D. We will need to agree on some significant leadership positions that should be officer positions. Looking at physician assistants who are warrant officers may provide some information.
 - E. We should highlight some of the leadership positions in the AARC Times.

- F. If the NCOIC position is one that should be a warrant officer, then we should look at the current turnover in these positions.
- G. After collecting this information and identifying positions that should be a warrant officer, we can recommend that the AARC and its members write Senators and Representatives to request that the Surgeon General form Army and Air Force create warrant officer positions.

Neurorespiratory Roundtable

Reporter: Lee Guion

Last submitted: 2011-03-14 08:16:05.0

Recommendations



No recommendations

Report

Communication among roundtable members has essentially ceased since moving to a social networking format.

I have agreed to continue as chair for the 2011 year as the AARC member slated to succeed me had to withdraw at the last minute due to increased professional responsibilities.

Research Roundtable

Reporter: John Davies

Last submitted: 2011-03-15 13:37:55.0

Recommendations

 none

Report

The Research Roundtable now has 72 members. Activity has been a little slow post AARC Congress. However, the Research Roundtable will be highlighted in the May issue of the AARC Times. We expect activity to pick up over the next few months.

Other

Simulation Roundtable

Reporter: Julianne Perretta

Last submitted: 2011-03-14 18:24:16.0

Recommendations

Report

Nothing to report.

Julianne S. Perretta MEd, RRT-NPS

Tobacco Free Lifestyle Roundtable

Reporter: Jonathan Waugh

Last submitted: 2011-03-04 16:15:14.0

Recommendations



No recommendations at this time.

Report

- Membership asked to contribute ideas for funding second printing of patient guide to tobacco treatment.
- Several Tobacco-Free Lifestyle roundtable members quoted in AARC Times article about new Surgeon General's report.
- Work group ready to start on companion tobacco treatment guide for clinicians.

Other

- At most recent AARC Congress, several TFL members volunteered to serve as reviewers for tobacco-related articles and to be webcast presenters.
- No additional items.

*Ad Hoc
Committee
Reports*

Ad Hoc Committee on Cultural Diversity

Reporter: Joseph Huff

Last submitted: 2011-03-13 19:34:11.0

Recommendations

 [None]

Report

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

Status: The Committee will be mentoring a Therapist from Colorado at the Summer Meeting. Speaking with Robert Mitchell, University of Colorado, about attending the House Meeting as the candidate.

The committee will work on an evaluation form so the committee can gauge the success of the Charge.

Other

Ad Hoc Committee on Officer Status/US Uniformed Services

See Military Roundtable Report on page 285

Ad Hoc Committee on Home Oxygen

Reporter: Kent Christopher

Last submitted: 2011-03-14 13:09:35.0

Recommendations

 None

Report

Home oxygen therapy BOD report

Dr. Christopher and Dr. Carlin have identified and compiled a list of LTOT articles that the committee will review for content, application and relevance to current home oxygen therapy practice. Each committee member will review articles and responded to specific questions we are identifying as significant to the science of LTOT and the practical issues that are impacting effective LTOT in the home. Dean Hess has reviewed several of these articles for his presentation at the LTOT conference held in Florida March 31-April 1. Nick Hill is a member of the committee and is the co-director of the LTOT conference so the information shared by Dr. Hess at that meeting will be available for our committee. Review of the articles will begin within a few months and hopefully will be completed by the middle of this year.

AARC Leadership Institute

Reporter: Toni Rodriguez

Last submitted: 2011-03-13 16:51:37.0

Recommendations

 NONE

Report:

AARC BOD Report: Spring 2011

Ad-Hoc Committee: AARC Leadership Institute

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

Vision Statement

The Learning Institute will be the first AARC sanctioned program designed to provide advanced training to ensure the future continuity of leadership, discovery, and education within the profession of Respiratory Care.

Mission Statement The mission of the Learning Institute is:

To foster leadership talent

To teach the skills of academic leadership

To advance the science of respiratory care

Summary of Activities Spring 2011:

RFPs for the Core Curriculum courses was completed and made available on the AARC Web site at: http://www.aarc.org/headlines/10/11/leadership_institute/. The original project time line is as stated below with the time revisions in parentheses:

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 (**January 26, 2011**)

Contract sent to accepted authors - Jan 31, 2011 (**Date remains open**)

Contract acceptance - Feb 15, 2011 (**Date remains open**)

A conference call was conducted on January 26th to review the RFPs submitted. There were only five to consider and of this number only three were selected by the committee to present examples of their work. Since that time two of the candidates have declined leaving us with only one viable candidate who desires to work on only one of the five core modules.

Based upon the outcome of the RFP process, the committee will need to reconsider the original plan for completion of the Core Curriculum. Although it is disappointing that we are not on target to achieve our original timeline, a quality product is our first priority as well as establishing a development process that can be duplicated for the various tracks.

Possible reasons for the less than stellar RFP response will be determined by the committee but certainly the amount put forth as payment for each module will need to be reevaluated.

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; Members: Chatburn, Robert (Research Institute Chair) MHHS, RRT-NPS, FAARC; Ford, Richard (Management Institute Chair) RRT, FAARC; Myers, Timothy BS, RRT-NPS; Van Scoder, Linda (Education Institute Chair) EdD, RRT, FAARC

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

Ad Hoc Committee on 2015 & Beyond

Ad Hoc Committee to Review Age Membership Discount

Reporter: Thomas Lamphere

Last submitted: 2011-03-11 13:50:41.0

Recommendations

No recommendations at this time.

Report

Initial work has just begun. Working with AARC Executive Office to review information collected by them to date. During April and May, committee will benchmark other organizations and put together a proposed program for the AARC. The program will be sent for review of financial impact to the AARC Executive office at the end of May and will re-evaluate program after financial impact is determined prior to submitting a final proposal to the AARC Board at the Summer Board meeting.

Charges

- Review and benchmark other organizations process for age membership discounts.
- Working with the executive office identify a program for AARC. Include impact on revenue and revenue sharing.
- Propose a program to the AARC BOD by the summer BOD meeting.

Committee Members

Tom Lamphere – Chair

Denise Johnson - BOD

Doug McIntyre - BOD

Russ Woodruff - HOD

Connie Paladenech - HOD

James Taylor - At Large

NBRC
ARCF



MEMORANDUM

Date: March 21, 2011

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

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

Subject: NBRC Report

I appreciate the opportunity to provide you an update on activities of the NBRC. The Board of Trustees will meet April 4-9, 2011 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.

Sleep Disorders Specialty Examination Accredited

The NBRC has received accreditation of its Specialty Examination for Sleep Disorders Testing and Therapeutic Intervention from the National Commission for Certifying Agencies (NCCA). In light of the recent announcement by the American Academy of Sleep Medicine (AASM) and American Board of Sleep Medicine (ABSM) that they have decided to develop their own sleep technologist examination which would be in direct competition with the BRPT's RPSGT Examination and the NBRC's SDS Examination, the Board has not yet submitted a request to AASM for equivalency status of the SDS Examination. The Board will be discussing this and our next steps at the April meeting.

Saudi Arabia Request for use of NBRC Examinations

Gary Smith recently traveled to Saudi Arabia along with representatives from the AARC to learn more about the respiratory care profession in this country. Saudi Arabia is

interested in using the NBRC's examinations to credential individuals in that country and the Board will be considering their request at the April meeting.

Adult Critical Care Specialty Examination Admissions Policy

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.

2010 Examination and Annual Renewal Participation

Applications received, candidates tested and renewals processed were very strong in 2010. The NBRC administered over 36,000 examinations in 2010, and more than 36,000 individuals renewed their active status with the NBRC in 2010 by paying the \$25 annual renewal fee. 2011 Annual Renewal notices were mailed in early October to all credentialed practitioners. Thus far, over 35,000 credentialed practitioners have renewed their active status with the NBRC for 2011.

Examination Statistics – January 1 – March 15, 2011

The NBRC has administered nearly 6,000 examinations thus far in 2011. Pass/fail statistics for the respective examinations follow:

<u>Examination</u>	<u>Pass Rate</u>	
<u>CRT Examination</u> – 2,021 candidates		
	<u>Entry Level</u>	<u>Advanced</u>
First-time Candidates	74.6%	71.8%
Repeat Candidates	23.8%	25.6%
<u>Therapist Written Examination</u> – 1,977 candidates		
First-time Candidates	61.6%	
Repeat Candidates	27.1%	

Clinical Simulation Examination – 1,722 candidates

First-time Candidates	56.8%
Repeat Candidates	51.7%

Neonatal/Pediatric Examination – 171 candidates

First-time Candidates	77.2%
Repeat Candidates	38.1%

Sleep Disorders Specialty Examination – 10 candidates

First-time Candidates	100%
Repeat Candidates	N/A

CPFT Examination – 73 candidates

First-time Candidates	72.5%
Repeat Candidates	45.5%

RPFT Examination – 12 candidates

First-time Candidates	85.7%
Repeat Candidates	100%

Your Questions Invited

If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need to be fully informed. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and all of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the integrity of the credentialing process.

American Respiratory Care Foundation

March 16, 2011

The ARCF in 2011 is focusing on applying for more grants to fund specific projects. We have had success in the last year with several projects and have increased this effort as a priority.

Grants and Sponsorships

The foundation utilized the 2010 Pfizer grant of \$44,643 to print and distribute the Tobacco Cessation Guide. The pocket-sized handbook proved to be very popular, and the initial stock of 100,000 was depleted in a mere six weeks, with requests from members at more than 800 hospitals and providers. As the foundation continues to receive numerous requests for the handbook, more monies are currently being sought to print and distribute an additional 200,000 copies. Plans still remain to also create a clinician's guide to help respiratory therapists become better educated about smoking cessation.

The Pulmonary Function Respiratory Care Journal Conference held in March received support from four unrestricted grants. The Sponsor was Pharmaxis, and the Donors were CareFusion, ndd and Talecris.

Plans for a fall Respiratory Care Journal Conference are being solidified on the topic of chronically critically ill respiratory patients. We will start solicitation as soon as the program is finalized and required funding is determined.

Awards and Scholarships

The foundation awards and scholarships were presented in December of 2010. The total cost of the awards, including transportation, lodging and registration totaled \$36,990. Due to a lack of qualified applicants several awards were not given. It is essential that information about the awards is broadcast to all of our members. We ask the AARC leadership on the Board and in the House to help by encouraging qualified people to apply for the awards.

The GSK, Sepracor, and DeVilbiss awards were discontinued in 2011 due to mergers and acquisitions of the originating companies. We are trying to get successor companies to reinvest in the awards.

Financial position

The financial position of the American Respiratory Care Foundation has marginally improved since December 2009. If the unrealized gains were not considered, a positive operating margin of about \$54,181 was achieved for year ending December 2010. However, it should be noted that the unrestricted fund area which covers operating expenses and unfunded grants experienced a loss of \$22,000 for the year.

Although, the foundation continues to address challenges from the effects of a depressed economy, we are continually evaluating our investments to try and optimize revenue in a very uncertain investment environment.


The second annual ARCF Fundraiser and International Reception was held in December of 2010. Paid attendance was much improved over last year, with a moderate increase from the first year's fundraiser. The foundation raised a total amount of \$13,400 after expenses. We remain optimistic that this event will continue to grow as its reputation spreads. The leadership on the Board and House deserves our thanks and recognition for showing their support of this event.

The Foundation funded four International Fellows this year. This program included enthusiastic support from 8 city hosts. The cost of the program continues to be approximately \$5000 per fellow, and the ARCF is required to raise twice that amount each year to continue support of the project. This program is currently under review by the AARC Board.

Finally, we are beginning a member-wide solicitation this year. The program started with an article in the January 2011 AARCTimes. We have modified the new and renewing online membership forms to include a donation page.

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 continue to be optimistic about the future.

Thank you for allowing me the opportunity to continue serving the foundation.

A handwritten signature in black ink, reading "Michael T. Amato". The signature is written in a cursive, flowing style.

Michael T. Amato, MBA, Chair
American Respiratory Care Foundation

Unfinished Business

Clinical Practice Guidelines Appointments (CVs on AARConnect)

Policy Review

New Business

Ratification of Appointments

Policy Review

NYDART

International Committee Additional Charges

Nominations for CoARC Board



**New York Downstate Association For Respiratory Therapists,
Inc.
2 Anchorage Lane, Unit 8 B
Oyster Bay, NY 11771**

Karen Stewart MS, RRT, FAARC
516 Wyoming St Charleston,
WV 25302-2032
karen.stewart@camc.org

Dear Ms. Stewart,

Please allow me to introduce myself and the organization I am involved with as a volunteer. My name is Tom Paolillo RRT-NPS, and I am a proud AARC member since 1979. I am the corresponding secretary for NYDART Inc. which is the acronym for the New York Downstate Association for Respiratory Therapists Inc., a nonprofit 501-C6 organization formed by the former volunteers of the Southeastern Chapter of the NY State Society for Respiratory Care (NYSSRC). The Southeastern Chapter as well as the other 4 Chapters of the State Society were dissolved by the NYSSRC and were replaced by "Regions". The Southeastern Chapter was supposed to be replaced by 2 regions, one representing Long Island and the other representing NY City. It has been over 2 years and the NYSSRC has not yet created these 2 regions.

NYDART has filled the void left by these changes and has continued the forty year tradition of providing quality educational symposiums for RTs in the downstate area. NYDART is now and always will be committed to promoting the AARC. Last year in the fall of 2010, Sam Giordano was the keynote speaker at our Annual Symposium. He addressed over 500 attendees and when he asked the audience if they were AARC members, the entire audience proudly raised their hands. Tom Kallstrom has already agreed to be the keynote speaker for the fall 2011 symposium.

Recently, Felix Khusid RRT, a Board Member of NYDART had a conversation with Sam requesting to investigate the possibility of creating an official affiliation as a "liaison" between NYDART Inc. and the AARC. Sam suggested that I write to you. NYDART would like the AARC to send blast emails to RTs in this area announcing our educational events. The NY State Education Department requires RTs to have 10 continuing education credits per year to maintain their license. NYDART is providing these credits, not the official AARC state affiliate.

Thank you for considering this request.
Sincerely,

Tom Paolillo RRT-NPS

Tom Paolillo RRT-NPS
Corresponding Secretary
NYDART Inc.
info@nydart.org
www.nydart.org

NYDART Inc. Executive Board of Directors

Michael Karol - President
Leon Lebowitz – Vice-President
Sharon Connelly-Merdian – Past President
Sharon Pollard - Secretary
Tom Paolillo – Corresponding Secretary
Valerie Yarczower - Treasurer

International Committee Additional Charges

1. the AARC BOD direct the International Committee to review their current goals and determine if they need to be updated and/or modified
2. direct the International Committee to review the current selection process and determine if it is still relevant and appropriate considering the current market environment
3. that the International Committee develop some short-term and long term measurable objectives that align with the higher level goals of the organization

ARCF Achievement Awards

Forrest M. Bird
Lifetime Scientific Achievement Award

Dr. Charles H. Hudson Award
for Cardiopulmonary Public Health

Thomas L. Petty, MD Invacare Award
for Excellence in Home Respiratory Care



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David J. Pierson, MD,
FAARC

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(972) 243-2272

Fax (972) 484-2720
www.arcfoundation.org

American Respiratory Care Foundation

Memorandum

DATE: March 2011

TO: Karen J. Stewart, MS, RRT,FAARC, AARC President
Gregg L. Ruppel,Med,RRT,RPFT, FAARC, NBRC President
David Bowton, MD, FCCP, FCCM, CoARC Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Forrest M. Bird Lifetime Scientific Achievement Award 2011—
*Solicitation of Nominations***

The American Respiratory Care Foundation Trustees are seeking nominations for the Forrest M. Bird Lifetime Scientific Achievement Award 2011 from your organization.

This award was established in 1983 to acknowledge “outstanding individual scientific contributions in the area of respiratory care of cardiopulmonary disorders.” The annual award is funded by an endowment from Dr. Forrest M. Bird, founder of Bird Products Corporation, a developer and manufacturer of respiratory equipment. Dr. Bird has been not only an outstanding innovator of respiratory care equipment, but has inspired and encouraged many investigators to continue the search for methods of improving respiratory care. He is recognized as an international educator and promoter of excellence in respiratory care.

In recognition, the recipient will receive an inscribed plaque, airfare (coach or less), one night lodging, and per diem to attend the Awards Ceremony at the AARC International Respiratory Congress.

Previous recipients of this prestigious award have been:

2010	Ira M. Cheifetz, MD, FAARC	1996	David J. Pierson, MD,FAARC
2009	James K. Stoller, MD, MS	1995	Leonard D. Hudson, MD
2008	Bruce K. Rubin, MD, FAARC	1994	John F. Murray, MD
2007	Robert L. Chatburn, RRT-NPS, FAARC	1993	Peter Safar, MD
2006	Robert M. Kacmarek, PhD, RRT, FAARC	1992	George A. Gregory, MD
2005	Richard D. Branson, MS, RRT, FAARC	1991	Edward A. Gaensler, MD
2004	Joseph L. Rau, Jr., PhD, RRT, FAARC	1990	John W. Severinghaus, MD
2003	Robert Kirby, MD	1989	Roger C. Bone, MD
2002	Charlie G. Durbin, Jr., MD, FAARC	1988	William F. Miller, MD, FAARC
2001	Neil R. MacIntyre, MD, FAARC	1987	H. Fredrick Helmholz, Jr., MD
2000	Martin J. Tobin, MD	1986	Thomas L. Petty, MD
1999	Dean Hess, PhD, RRT, FAARC	1985	Claude Lenfant, MD
1998	Walter O'Donohue, Jr., MD	1984	C. Everett Koop, MD, Surgeon C
1997	Alan H. Morris, MD		

- **Each year nominations are invited from the AARC Board of Directors, ARCF Board of Trustees, the National Board for Respiratory Care and the Committee on Accreditation for Respiratory Care.**
1. Your organization may consider as many candidates as you choose; however, you must declare one as your nominee.
 2. In fairness to your nominee, you must submit a complete current curriculum vitae and biographical summary.
 3. We wish to simplify the process by asking each group to simply vote as a group for the candidate of your choice and tell us why you have made your choice, keeping the purpose of the award as designated by the donor. Your nominee must have made “**outstanding individual scientific contributions in the area of respiratory care of cardiopulmonary disorders.**” This should include activities in research and education of physicians, therapists and nurses, through publications and lectures.
 4. Each organization must provide a personal statement from their nominee of interests and activities outside of medicine as well as the candidate’s opinion of what their most significant contributions are.
 5. Remember, it is your job to sell your nominee to the selection group.

Any submission that does not meet the criteria of the award will be eliminated. The deadline for receipt of your nomination in the Executive Office is **June 1, 2011.**

cc: AARC Board of Directors
ARCF Trustees

Forrest M. Bird Lifetime Achievement Award

The award was established in 1983 to acknowledge "outstanding individual scientific contributions in the area of respiratory care of cardiopulmonary disorders."

The annual award is funded by a \$25,000 endowment from Dr. Forrest M. Bird, founder of Bird Products Corporation, a manufacturer of respiratory equipment. This award consists of \$2,000 cash, a plaque, airfare, one night lodging and registration for the AARC's International Respiratory Congress.

Nominations are solicited from the AARC Board of Directors, the ARCF Board of Trustees, BOMA, NBRC, and CoARC. The recipient will be selected by September 1, and the award presented by the American Respiratory Care Foundation during the Awards Ceremony at the International Respiratory Congress.



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Fax (972) 484-2720

www.arcfoundation.org

American Respiratory Care Foundation

Memorandum

DATE: March 2011

TO: Karen J. Stewart, MS, RRT,FAARC, AARC President
Gregg L. Ruppel, Med, RRT,RPFT, FAARC, NBRC President
David Bowton, MD, FCCP, FCCM, CoARC Chair

FROM: Michael T. Amato, MBA
ARCF Chair

SUBJECT: **Dr. Charles H. Hudson Award for Cardiopulmonary Public Health 2011—*Solicitation of Nominations***

The American Respiratory Care Foundation (ARCF) has initiated this year's selection process for the Dr. Charles H. Hudson Award for Cardiopulmonary Public Health. We are requesting one nomination from your organization.

The purpose of this award is to recognize “**efforts to positively influence the public's awareness of cardiopulmonary health and wellness.**”

Previous recipients include:

- Not awarded in 2010
- John Kattwinkel, MD - 2009
- Ted and Grace Anne Koppel – 2008
- Senator Michael D. Crapo – 2007
- John W. Walsh - 2006
- Christopher Reeve Foundation - 2005
- Thomas L. Petty, MD, FCCP, FAARC - 2004
- Barbara Rogers – 2003
- National Lung Health Education Program (NLHEP) – 2002
- David Satcher, MD, PhD, Surgeon General of the United States – 2001
- Stephen Wehrmen, RRT, RPFT – 2000
- Mike Moore, Attorney General, State of Mississippi – 1999
- Jackie Joyner-Kersey – 1998
- William W. Burgin, Jr., MD, FACP, FACCP – 1997
- Respiratory Care Dept., Toledo Hospital – 1996
- American Lung Association – 1995
- Allergy & Asthma Network-Mothers of Asthmatics, Inc. – 1994
- Lansing Area Respiratory Care Practitioners – 1993
- Debra Koehl, RRT – 1992

- Louise M. Nett, RN, RRT - 1991
- Senator Frank Lautenberg - 1989
- Congressman Richard Durbin - 1988
- Terry H. duPont, CRT - 1987
- New York Society for Respiratory Care - 1986

The nomination procedure and other details concerning the award are included on the enclosed information sheets. Nominations are due in the Executive Office no later than **June 1, 2011**.

cc: Board of Directors
ARCF Trustees

Dr. Charles H. Hudson Award for Cardiopulmonary Public Health

The purpose of the award is to recognize "efforts to positively influence the public's awareness of cardiopulmonary health and wellness." The award is funded by a \$25,000 endowment from Hudson Respiratory Care Inc. and was established in 1986 in honor of the company's founder, Charles H. Hudson, DDS.

This award consists of a plaque, airfare (coach or less), one night lodging, and registration for the AARC's International Respiratory Congress.

Nomination Procedure:

Please submit a typed letter of one thousand words or less that answers each of the following questions as appropriate for the nominee. Nominees may include individuals, groups or organizations whose primary effort has promoted cardiopulmonary health and wellness.

1. How has the nominee promoted cardiopulmonary health and wellness? Outline and describe major activities, events, research, or public policy the nominee has affected.
2. Describe how public cardiopulmonary health and awareness has been influenced through the efforts of the nominee.
3. Why is the nominee a role model for others in terms of public health?
4. How has the nominee promoted the objectives relative to *Healthy People 2010* (see attachment), the federal agenda for a healthier America?

Please include any supporting documentation and, in case of an individual, a curriculum vitae, if available.

Nominations will be accepted through June 1, 2011. Please submit nominations to:

ARCF Executive Office
9425 N MacArthur Blvd., Suite 100
Irving, TX 75063
(972) 243-2272
(972) 484-2720 FAX

The award will be presented by the American Respiratory Care Foundation during the Awards Ceremony at the AARC's International Respiratory Congress.

Fact Sheet
Healthy People 2010

National Health Promotion and
Disease Prevention Objectives

Healthy People 2010 Goals

- Increase quality and years of healthy life.
- Eliminate health disparities.

The Nation's progress in achieving these goals will be monitored through 467 objectives in 28 focus areas. Many objectives focus on interventions designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Others focus on broader issues, such as improving access to quality health care, strengthening public health services, and improving the availability and dissemination of health-related information. Each objective with baseline data for tracking has a target for specific improvements to be achieved by the year 2010. As data sources are established for those developmental objectives currently without data sources or baseline data (see Data Tracking Volume of Healthy People 2010), targets will be set. Each objective is placed in only one focus area so that there is no duplication of objectives in Healthy People 2010. Each focus area, however, has a list of related objectives in other focus areas, indicating the linkages among the focus areas.

Healthy People 2010 Focus Areas

Access to Quality
Health Services
Arthritis, Osteoporosis, and Chronic Back Conditions
Cancer
Chronic Kidney
Disease
Diabetes
Disability and Secondary Conditions
Educational and Community-Based Programs
Environmental Health
Family Planning
Food Safety
Health Communication
Heart Disease and Stroke
HIV
Immunization and Infectious Diseases
Injury and Violence Prevention
Maternal, Infant, and Child Health
Medical Product Safety

Mental Health and Mental Disorders
Nutrition and Overweight
Occupational Safety and Health
Oral Health
Physical Activity and Fitness
Public Health Infrastructure
Respiratory Diseases
Sexually Transmitted Diseases
Substance Abuse
Tobacco Use
Vision and Hearing

Leading Health Indicators

The Leading Health Indicators, set forth in the publication “Healthy People 2010: Understanding and Improving Health,” reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues. They illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education. In addition, the Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life, and on eliminating health disparities – thus creating healthy people in healthy communities.

The Leading Health Indicators have been developed as a short list of measures that will monitor national success in targeting certain behaviors, environmental factors, and community health interventions that impact on health. The set of Leading Health Indicators addresses physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behaviors, mental health, injury and violence, environmental quality, immunizations, and access to quality health care. By tracking and communicating progress on individual indicators, it will be possible to spotlight both achievements and challenges in improving the Nation’s health. It is hoped that the Leading Health Indicators will allow the public to more easily understand the importance of health promotion and disease prevention, and invite their participation and partnership.

The Office of Disease Prevention and Health Promotion (ODPHP), United States Department of Health and Human Services, is the Coordinator of the Healthy People 2010 Initiative.

Additional information can be accessed online at:

Healthy People 2010
<http://www.health.gov/healthypeople>



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Fax (972) 484-2720
www.arcfoundation.org

American Respiratory Care Foundation

Memorandum

DATE: March 2011

TO: Karen J. Stewart, MS, RRT,FAARC, AARC President
Gregg L. Ruppel,Med,RRT,RPFT, FAARC, NBRC President
David Bowton, MD, FCCP, FCCM, CoARC Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2011—*Solicitation of Nominations***

The American Respiratory Care Foundation Trustees are seeking nominations for the Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2011 from your organization.

This award was established in 1992 with a grant from Invacare Corporation to recognize “**outstanding individual achievement in home respiratory care.**”

Previous recipients include:

- Louise Nett, RN, RRT, FAARC -2010
- John R. Loyer, MS, RRT - 2009
- Nancy T. Martin, BS, RRT – 2008
- Claude Dockter, BS, RRT – 2007
- Robert M. McCoy, RRT, FAARC - 2006
- Vernon Pertelle, MBA, RRT - 2005
- Timothy W. Buckley, RRT, FAARC - 2004
- Gene Andrews, BS, RRT, RCP - 2003
- Robert Fary, RRT – 2002
- Joseph Lewarski, RRT - 2001
- David A. Gourley, BS, RRT - 2000
- Patrick J. Dunne, MEd, RRT, FAARC - 1999
- Regina D. Marshall, BS, RRT - 1998
- Robert J. Jasensky, RRT - 1997
- Linda Ann Farren, RRT - 1996
- Scott Bartow, MS, RRT - 1995
- Susan Lynn McInturff, RRT - 1994
- Linda Chapman Maxwell - 1993

Please submit a one-page, typed description of how the nominee embodies excellence in home respiratory care relative to the following criteria:

- Must currently be working in home respiratory care.
- Must be a credentialed respiratory care practitioner.
- May not be employed by a manufacturer.
- May be involved in education as well as the management and organization of patient care.
- Should serve as an active patient advocate in home respiratory care, with specific achievements that demonstrate leadership.

In recognition, the recipient will receive an inscribed plaque, airfare (coach), one night lodging and registration to the AARC International Respiratory Congress.

Preference will be given to individuals who have participated in volunteer community efforts related to home respiratory care, in addition to meeting the medical needs of their patients.

A curriculum vitae is required and supporting documentation should be included, if available. Please submit nominations to:

Nominations should be received by the Executive Office no later than **June 1, 2011**.

cc: Board of Directors
ARCF Trustees

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care

The award was established in 1992 with a grant from Invacare Corporation to recognize “outstanding individual achievement in home respiratory care”. The annual award includes a cash award of up to \$500 and an engraved crystal sculpture, plus airfare and one night’s lodging to attend the Awards Ceremony at the AARC Annual Convention.

Invacare will make a contribution of a minimum of \$5000 per year until the \$25,000 endowment status is reached. Invacare should be invoiced for this amount each year in March. Until the award reaches endowment status, Invacare will provide the necessary funds to cover the award and travel to the annual meeting. Invacare will also be responsible for providing the crystal sculpture award and having it engraved with the winner’s name.

The ARCF will, through a series of press releases and announcements, inform the trade press, its readers, and of course, the AARC members of the existence of the award and its criteria. These releases will go to all chartered affiliate newsletters, all trade press, selected public press, AARC Board of Directors and House of Delegates, the Board of Medical Advisors and Specialty Sections.

Nomination Procedure:

Please submit a one page typed description of how the nominee embodies excellence in home respiratory care relative to the following criteria:

1. Must currently be working in home respiratory care;
2. Must be a respiratory care practitioner;
3. May not be employed by a manufacturer;
4. May be involved in education, as well as the management and organization of patient care;
5. Should serve as an active patient advocate in home respiratory care, with specific achievements that demonstrate leadership;
6. Preference is given to individuals who have participated in volunteer community efforts related to home respiratory care, in addition to meeting the medical needs of their patients.

A curriculum vitae is required and supporting documentation should be included, if available.

Nominations will be accepted through June 1, 2011. Please submit nominations to:
ARCF-Invacare Award
9425 N MacArthur Blvd, Ste 100
Irving, Texas 75063
(972) 243-2272

The award presented by the American Respiratory Care Foundation during the Awards Ceremony at the AARC Annual Convention.