American Association for Respiratory Care

Board of Directors Meeting

Embassy Suites Outdoor World
Grapevine, TX

April 20-21, 2012

Index

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and FinanceCommittee Meetings – April 19, 2012
Board of Directors Meeting – April 20-21, 2012

Thursday, April 19

5:30 – 7:00 pm Executive Committee Meeting (Committee Members only)
7:00 – 8:00 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend)

Friday, April 20

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

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9:30 am **BREAK**

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TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of April 5, 2012)

AARC Board of Directors Meeting

April 20-21, 2012 • Grapevine, TX

Executive Office

Recommendation 12-1-1.1 "That the AARC Board of Directors directs the Management Section Chair to initiate a project to encourage respiratory care managers to look for, and seize, opportunities described in the manuscript entitled, 'Creating a Vision for Respiratory Care in 2015 and Beyond' Kacmarek, Durbin, Barnes, Kaegler, Walton, O'Neil RESPIRATORY CARE 2009;54(3):375-389."

Recommendation 12-1-1.2 **"**That the following position statement by the Hospital Care Collaborative (HCC) be reviewed and reaffirmed by the AARC Board of Directors.

Common Principles for Team-Based Care: The Hospital Care Collaborative (HCC)

- The HCC believes that healthcare is a "team sport" with respect and recognition for the knowledge, talent and professionalism of all team members.
- The HCC supports clear delineation of team roles and responsibilities with an emphasis on a collaborative and non-hierarchical model.
- The HCC believes in patient centered care, rather than provider-centered care, and that the healthcare team members should involve the patient/family/caregiver in developing care plans and goals of care.
- The HCC believes that collaboration of the healthcare team can lead to improved systems and processes that provide care more efficiently and result in better patient outcomes. Examples include strategies for implementation, improved workflow and the utilization of evidence-based processes.
- The HCC believes that all members of the team within their licensure and scope of practice have a role to play in establishing organizational policy, and directing and evaluating clinical care.
- The HCC believes that in a system that involves many team members, all health professionals should work to create safe care transitions and handoffs within the hospitalization and post-hospitalization episodes of care.
- The HCC believes that all team members must be as proficient in communications skills as in clinical skills.
- The HCC believes that the appropriate capacity and staffing of the entire team is a requirement for providing the best care."

Audit Subcommittee

Recommendation 12-1-13.1 "That the AARC Board of Directors (BOD) review the discretionary employer contribution percentage amount and determine if this is still within an acceptable limit and consider the development of guidelines for future contributions. An independent benefits consultant might be considered."

Bylaws Committee

Recommendation 12-1-9.1 "That the AARC BOD accepts and approves the Alaska Society for Respiratory Care Bylaws"

Recommendation 12-1-9.2 "That the AARC BOD accepts and approves the Michigan Society for Respiratory Care Bylaws"

Program Committee

Recommendation 12-1-15.1 "That the AARC Board of Directors approve Las Vegas and the Mandalay Bay as the destination and venue for AARC Congress 2014. (Dec 9-12)"

Adult Acute Care Section

Recommendation 12-1-50.1 "That a study guide be developed in anticipation of the new Adult Critical Care Specialty exam due to be available by the NBRC sometime near the end of the summer 2012"

Continuing Care Rehabilitation Section

Recommendation 12-1-51.1 "That the AARC issue a consensus statement that recognizes the EPR-3 as the standard for asthma management"

Diagnostics Section

Recommendation 12-1-52.1 "Offer a six month trial membership to the Diagnostics Section for AARC members"

Home Care Section

Recommendation 12-1-54.1 "Create pilot studies for RT-led programs for reducing readmissions"

Recommendation 12-1-54-2 "Survey section members for potentially combining home care and long-term care specialty sections"

Management Section

Recommendation 12-1-55.1 "That the AARC Board of Directors convenes a consensus conference on 'Patient Safety and Respiratory Care Staffing Levels' with a committee of expert stakeholders to review evidence-based literature and best practice to:

a. Identify research opportunities related to Respiratory Care Department Staffing and Productivity
b. Identify resources for determining safe and effective Respiratory Care Department staffing levels
c. Develop cost-reduction strategies for maintaining safe staffing levels
d. Develop standards for the following items:
    - Measuring Respiratory Care Department staff productivity levels
    - Determining safe and effective Respiratory Care Department staffing requirements
    - Determining the appropriate number of direct reports for Respiratory Care Department directors, managers, and supervisors
    - Determining minimum or core-staffing requirements for Respiratory Care Departments"

Recommendation 12-1-55.2 "That the AARC Board of Directors develop a Position Statement for the promotion of patient safety by maintaining appropriate Respiratory Care Departments' staffing levels, and that within this statement include:

- A position which encourages the inclusion of all procedures performed to determine staffing levels and productivity targets for the safe delivery of Respiratory Care Services
- A position which identifies the metric of Relative Value Units (RVU's) as the standard to determine staffing levels and productivity targets for the safe delivery of Respiratory Care Services
- A position which censures the use of inappropriate, inaccurate, and non-validated data to determine staffing levels and productivity targets, as these create patient safety issues from mathematically impossible workloads and productivity targets for Respiratory Therapists and from the chronic understaffing of Respiratory Care Departments."

Surface to Air Transport Section

Recommendation 12-1-59.1 "That the AARC BOD appoint a member of the Surface and Air Transport Section to be a liason to the American Academy of Pediatrics (AAP) Transport Section."

International Committee

Recommendation 12-1-23.1 "That the AARC Board of Directors approves the revised International Mission/Goals statement and that the statement is added to the International Fellowship Program home page on the AARC web site."

Recommendation 12-1-23.2 "That the AARC Board of Directors approve the AARC International Fellows Effectiveness Survey and that it be programmed and administered by the Executive Office via the Internet using Survey Monkey or a similar Internet tool to survey the new Fellows after their visit and also to survey all pas Fellows if contact information is available."

Recommendation 12-1-23.3 "That the AARC consider funding the creation and production of an International Fellow lapel pin."

Position Statement Committee

Recommendation 12-1-26.1 "Approve and publish the newly developed position statement on "Respiratory Therapists in the Emergency Department."

Recommendation 12-1-26.2 "Approve and publish the revised position statement on "Respiratory Therapists Education."

Recommendation 12-1-26.3 "Approve and publish the revised position statement on "Continuing Education."

Recommendation 12-1-26.4 "Approve and publish the revised position statement on "Licensure of Respiratory Care Personnel."

Extracorporeal Life Support Organization (ELSO)

Recommendation 12-1-69.1 "That the AARC consider providing funds to enable the Extracorporeal Life Support Liaison to attend biannual ELSO Steering Committee Meetings."

Tobacco Free Lifestyle Roundtable

Recommendation 12-1-41.1 "That the BOD discuss how a day-long workshop on tobacco treatment skills could be offered during the AARC Congress or as a pre-event"

Ad Hoc Committee on 2015 & Beyond

Recommendation 12-1-32.1 "That the AARC BOD accept the direction for the future of health care as recommended by the publication 'Creating a Vision for Respiratory Care in 2015 and Beyond' by Robert M Kacmarek PhD RRT FAARC, Charles G Durbin MD FAARC, Thomas A Barnes EdD RRT FAARC, Woody V Kageler MD MBA, John R Walton MBA RRT FAARC, and Edward H O'Neil PhD

Published -Respir Care 2009;54(3):375–389. © 2009 Daedalus Enterprises

Ad Hoc Committee to Recommend Bylaws Changes

Recommendation 12-1-30.1 "That the revision to the policy on Bylaws Conflicts be approved by the BOD."

Ad Hoc Committee on Section Membership

Recommendation 12-1-33.1 "That the AARC ask each Section Chair to review the 'Section' description and update to better describe the focus of the section."

Recommendation 12-1-33.2 "That the AARC investigate offering some form of CEU through the bulletins as a benefit of section membership."

Recommendation 12-1-33.3 "That the AARC consider offering a special incentive to recruit colleagues to join Specialty Sections. Each time you refer a new Regular Member, the AARC will reward you with an appropriate thank you gift."

Recommendation 12-1-33.4 "That the AARC create and post to each section webpage a CRCE Section Calendar that shows all education activities a member can access as a member of that section."

Recommendation 12-1-33.5 "That the AARC aggressively promote the fact that the new SDS specialty exam has been accepted as an alternative to the RPSGT by the AASM."

Recommendation 12-1-33.6 "That the AARC investigate the feasibility of offering a membership fee for multiple sections."

Ad Hoc Committee to Reduce Hospital Readmissions

Recommendation 12-1-34.1 "Proposes a project to select and fund 3-5 pilot studies exploring the benefits of different models of RT-led programs for reducing hospital readmissions in COPD."

New Business

Recommendation 12-1-84.1 "That the AARC's white paper on Concurrent Therapy be temporarily pulled from the website."

Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

November 3, 2011 • Tampa, FL

Minutes

Attendance

Karen Stewart, MS, RRT, FAARC, President
Tim Myers, BS, RRT-NPS, Past President
Susan Rinaldo-Gallo, MEd, RRT, FAARC, VP Internal Affairs
George Gaebler, MSEd, RRT, FAARC, VP External Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
Debbie Fox, MBA, RRT-NPS
Lynda Goodfellow, EdD, RRT, FAARC
Fred Hill, Jr., MA, RRT-NPS
Denise Johnson, MA, RRT
Keith Lamb, RRT
Camden McLaughlin, BS, RRT, FAARC
Doug McIntyre, MS, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Greg Spratt, BS, RRT, CPFT
Cynthia White, BA, RRT-NPS, AE-C

Consultants

Tom Lamphere, RRT, RPFT, Past HOD Speaker
Dianne Lewis, MS, RRT, FAARC, President's Council President
Colleen Schabacker, BA, RRT, FAARC, Parliamentarian

Absent

Joseph Sokolowski, MD, BOMA Chair (Excused)

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, FAARC, Chief Operating Officer
Ray Masferrer, RRT, FAARC, Managing Editor, RESPIRATORY CARE
Steve Nelson, RRT, FAARC, Associate Executive Director
Cheryl West, State Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:01a.m. EDT, Thursday, November 3, 2011. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

DISCLOSURE
President Karen Stewart reminded members of the importance of disclosure and potential for conflict of interest.

WELCOME AND INTRODUCTIONS
Members introduced themselves and stated their disclosures as follows:

Susan Rinaldo-Gallo – Masimo
Fred Hill – Alabama State Board of Respiratory Therapy
Lynda Goodfellow – Teleflex Medical, COBGRTE Steering Committee
Greg Spratt – Director of Clinical Marketing Oridion Capnography
Cynthia White – Masimo/Monaghan
Tim Myers – Dey Labs, Discovery Labs, and Draeger Medical consultant

APPROVAL OF MINUTES
George Gaebler moved "To approve the minutes of the July 21, 2011 meeting of the AARC Board of Directors."
Motion Carried

George Gaebler moved "To approve the minutes of the July 22, 2011 meeting of the AARC Board of Directors."
Motion Carried

E-MOTION RATIFICATION
Lynda Goodfellow moved to ratify the E-Motions discussed over the Board AARConnect since July 2011 as follows:

EM 11-3-53.1 "To ratify the appointments to the Education Section subcommittees:

Bachelor's/Graduate Respiratory Therapy Education (BGRTE):
Chair – Tom Barnes
Vice-Chair for Research – Bob Joyner
Vice-Chair for Communication – David Shelledy
Secretary/Treasurer – Tim Op't Holt
Member at Large – Georgianna Sergakis

Associate Degree Respiratory Education (ADRTE)
Chair – Peggy James
Vice-Chair – Carl Eckrode
Secretary – Charity Bowling
Member at Large – Kerry George
Member at Large – Cindy Fouts"

Motion Carried

GENERAL REPORTS

President

President Stewart gave highlights of her written report.

Executive Director/Office

Sam Giordano gave an overview of the Executive Office written report. Tom Kallstrom discussed the new membership rates that will go into effect in 2012.

President Stewart recalled previous recommendations that were referred to Executive Office.

Recommendation 11-2-6.2 "Resolve that the AARC copy the State Delegates in all routine correspondences to Affiliate Board members including, but not limited to, follow up on revenue sharing checked which have not been cashed."

In house procedures have been developed which will assure that all delegates are copied on routine communications between AARC and Chartered Affiliate presidents. This will include such business items as revenue sharing and check distribution.

Recommendation 11-2-45.1 "We recommend that the AARC create a fund that will allow corporations and individuals to donate money that can be used to support travel to the AARC convention for respiratory therapists in the military services that are active duty."

Executive Office researched and President Stewart will accept for information only and will discuss at HOD meeting.

Recommendation 11-3-1.1 "That AARC's Board of Directors restricts $250,000 of AARC's reserves for the purpose of development of evidence-based clinical practice guidelines."

Mike Runge moved to accept the recommendation.
Motion carried

Government & Regulatory Affairs

Federal Government Affairs

Miriam O'Day, AARC's Director of Legislative Affairs provided an update on the Congressional activities of interest to the RT profession. Congress is entirely focused on budget and debt issues, in particularly the potential actions of the "Super Committee" tasked with finding $1.3 trillion dollars in savings. Because of this near total focus on cost savings efforts, Congressional action on any other legislation, including AARC"s HR 941, the Medicare RT Initiative has been stalled. We will continue our efforts to move our bill forward in 2012; our focus will be on urging our Congressional supporters to assist with a new CBO cost analysis. We will begin to plan for our March 2012 PACT Lobby Day where despite the current climate RTs and pulmonary patients who will once again join us, will continue to advocate for our legislation. The AARC is also supporting S 1350 and HR 2505 the Pulmonary Fibrosis Research Legislation.

Anne Marie Hummel, AARC's Director of Regulatory Affairs discussed the most recent regulatory actions by CMS. Most notably, the final rules that will provide only $37 reimbursement for the pulmonary rehabilitation code… an unsustainable amount. AARC along with its Pulmonary Rehab association partners will meet in December 2011 to develop a

response strategy the organizations can take to CMS to try to amend the new payment. It was also reported that CMS has revised aspects of the Medicare Hospital Conditions of Participation that will decrease paper work requirements for hospitals. Several of the revisions will be advantageous to respiratory departments. AARC has also written to the Department of Veteran's Administration requesting clarification on the license/credential policy it has for employing RTs in the VA system.

State Government Affairs
Cheryl West, AARC"s Director of Government Affairs provided additional details to the State Government Affairs Report. This update included a more detailed discussion on the new ABSM's polysomnography exam and the credential Registered Sleep Technologist-RST. Respiratory Care Licensure Boards are receiving requests by the ABSM to formally rule that those who hold this non accredited credential should be exempt from the respiratory care licensure law, thus be allowed to provide the full scope of practice of the respiratory profession. AARC's response is to recommend that RC Licensure Boards inquire if the new exam has been accredited by an independent accrediting agency, such as the NCCA, as being valid and reliable. In addition, State Societies were urged to make sure their Legislative Committees were fully prepared to address any new challenges and opportunities that will occur once most state legislatures come back into session January 2012. States will continue to look for ways to find budget savings, which may include rescinding professional licensure (MI and VT have tried) or expanding the scope of practice of para-professionals into clinical areas where competency has not been documented.

RECESS
President Stewart recessed the meeting of the AARC Board of Directors at 9:52am EDT, Thursday, November 03, 2011.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 10:24am EDT, Thursday, November 03, 2011.

President's Council
Dianne Lewis referred the Board to review her written report.

STANDING COMMITTEES REPORTS

Bylaws Committee
Recommendation11-3-9.1 "The committee has reviewed the Bylaws submission for Hawaii and recommends that the AARC Board of Directors approves them as submitted."

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-9.2 "The committee has approved the Bylaws submission for Illinois and recommends that the AARC Board of Directors approves them as submitted."

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-9.3 "The committee has approved the Bylaws submission for Missouri and recommends that the AARC Board of Directors approves them as submitted."

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-9.4 "The committee has reviewed the Bylaws submission for Oklahoma and recommends that the AARC Board of Directors approves them as submitted."

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-9.5 "The committee has reviewed the Bylaws submission for New Jersey and recommends that the AARC Board of Directors approves them as submitted."

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-9.6 "The committee has reviewed the Bylaws submission for Vermont/New Hampshire and recommends that the AARC Board of Directors approves them as submitted."

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-9.7 "The committee has reviewed the Bylaws submission for Michigan and does not recommend these Bylaws for approval at this time."

Susan Rinaldo Gallo moved to accept.
Motion carried

Finance Committee
The Board of Directors ratified recent capital purchases by the Executive Office including laptop replacement, consulting fees, and software programs for a total of $28,662.49.

Denise Johnson moved to ratify the purchases by the Executive Office since July 2011.
Motion carried

Mike Runge moved "To accept the Standing Committee reports as presented."
Motion Carried

SPECIALTY SECTION REPORTS

Continuing Care Rehabilitation
Recommendation 11-3-51.1 "Continued liaison work with AACVPR, ACCP and NAMDRC to monitor and discuss with CMS changes in PR reimbursement."

Susan Rinaldo Gallo moved to accept for information only.
Motion carried

Education Section
Lynda Goodfellow gave a brief overview of her written report. President Stewart asked the Board of Directors to read the attachments to Lynda's report so they can be discussed at the meeting on November 4, 2011.

Surface and Air Transport
Recommendation 11-3-59.1 "To evaluate the potential of offering Surface and Air Transport Section membership to the active duty members of the Air Force Critical Care Air Transport Team (CCATT). This would be in keeping with the great support the AARC gives to active military. Their inclusion of the military transport professionals would be a great resource to the section as well as give them exposure to the civilian side of medical transport."

Susan Rinaldo Gallo moved to accept.

Linda Van Scoder moved to amend the recommendation to reflect "To evaluate the potential of offering a Section membership to the active duty members of the Air Force Critical Care Air Transport Team (CCATT)."

Susan Rinaldo Gallo moved to refer to Executive Office. Susan Rinaldo Gallo withdrew her motion to refer.

Linda Van Scoder moved to make a friendly amendment to read as follows: "To offer a Section membership to the active duty members of the Military at no cost."
Amended motion carried

Susan Rinaldo Gallo moved to accept the Specialty Section reports as presented.
Motion carried

SPECIAL COMMITTEE REPORTS

Billing Codes Committee
Recommendation 11-3-18.1 "That the current goals for the Billing Codes Committee be revised/updated as follows:

1. Recommend new AMA CPT respiratory care and pulmonary function related codes as needed and assist with coding proposals
2. Act as repository for current respiratory care and pulmonary function codes.
3. Serve as coding resource for members.
4. Monitor the Billing Codes list serve postings.
5. Review and update the AARC's coding sources such as Coding Resources on aarc.org and the Uniform reporting Manual."

Susan Rinaldo Gallo moved to accept. Linda Van Scoder moved to refer to President Stewart.
Motion to refer carried

Membership Committee
Tom Lamphere distributed his report to the Board of Directors at the meeting and gave an overview.

Position Statement Committee
Recommendation 11-3-26.1 "Approve and publish the revised position statement on 'Competency Requirements for the Provision of Respiratory Therapy Services'." (see Attachment "A")

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-26.2 "Approve and publish the revised position statement on 'Hazardous Materials Exposure'." (see Attachment "A")

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-26.3 "Approve and publish the revised position statement on 'Pre-Hospital Ventilator Management Competency'." (see Attachment "A")

Susan Rinaldo Gallo moved to accept.
Motion carried

Recommendation 11-3-26.4 "Approve the current 'Pulmonary Rehabilitation' with no revisions." (see Attachment "A")

Susan Rinaldo Gallo moved to accept.
Motion carried

George Gaebler moved to refer the inventory, revision, and review process of white papers and guidance documents to the President.
Motion carried

Susan Rinaldo Gallo moved to accept the Special Committee reports as presented except Federal Government Affairs and International Committee reports, which will be presented at the Joint Session.
Motion carried

RECESS
Karen Stewart called a recess of the AARC Board of Directors at 11:37am EDT, Thursday, November 3, 2011.

JOINT SESSION
President Stewart convened Joint Session at 1:38pm EDT, Thursday, November 3, 2011. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

Suzanne Bollig gave an overview of her written report and announced the 2012 election results.

Cheryl West, Anne Marie Hummel, and Miriam O'Day provided a Government Affairs update.

Frank Salvatore discussed Virtual Lobby Day.

John Hiser reported on the recent activities of the International Committee.

EXECUTIVE SESSION

Linda Van Scoder moved to go into Executive Session to discuss the current 2011 and proposed 2012 budget with the AARC Board of Directors and House of Delegates at 2:42pm EDT, Thursday, November 3, 2011.

Motion carried

Executive Session ended at 3:30pm EDT, Thursday, November 3, 2011.

George Gaebler moved to approve the 2012 budget.

Motion carried

Frank Salvatore moved to reconvene Executive Session of the Board of Directors at 3:45pm EDT, Thursday, November 3, 2011.

Motion carried

Executive Session ended at 4:25pm EDT, Thursday, November 3, 2011.

RECESS

President Karen Stewart recessed the meeting of the Board of Directors at 4:28p.m. EDT, Thursday, November 3, 2011.

Attachment “A”

Position Statements:

Competency Requirements for the Provision of Respiratory Care Services
Hazardous Materials Exposure
Pre-Hospital Ventilator Management Competency
Pulmonary Rehabilitation

American Association for Respiratory Care

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

Position Statement

Competency Requirements for the Provision of Respiratory Care Services

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

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

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

The education shall be approved by a national accrediting entity. In the allied health fields, this training includes supervised pre-clinical (didactic and laboratory) and clinical activities, as well as documentation of competence accredited by an independent accrediting entity to be valid and reliable. The qualifications of the faculty providing this training shall be documented and also meet accreditation standards.

AARC, therefore, supports recognition of individuals with competencies from the aforementioned accredited formal education programs for the purpose of providing care which includes a subsection of the respiratory care scope of practice with the caveat that such provision be limited to the elements contained within each credentialing examination's matrix respectively.

Effective 11/98
Revised 12/08, 11/11

American Association for Respiratory Care

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

Position Statement

Hazardous Materials Exposure

The Environmental Protection Agency (EPA) defines a hazardous material as any substance or material in a quantity or form that poses an unreasonable risk to health, safety, and environment when transported. These materials are extremely hazardous to the community during an emergency spill, or release, as a result of their physical or chemical properties.

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

The AARC's Position

- The Respiratory Therapist, as well as all other healthcare professionals, must insure their personal safety before entering ANY hazardous situation.
- Respiratory Therapists must be knowledgeable in treating, reversing, and avoiding the effects of hazardous materials.
- Respiratory therapists must be alert to the potential effects of hazardous materials and be able to provide care to patients when needed.
- Respiratory therapists, while providing care, must assure that they do not become victims, or carriers, of the same entities that have harmed their patients. This can be accomplished through the use of personal protective equipment, isolation and decontamination procedures, and quarantine when recommended by professionals trained in hazardous materials incidents.
- The AARC supports efforts toward an epidemiological approach to the prevention of hazardous material exposure.

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

Effective 5/7/02
Revised 12/08, 11/11

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. To meet the goals of mechanical ventilation and promote positive outcomes, pre-hospital care givers must be trained to understand the age-specific the 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 the indications for changes in the settings on a mechanical ventilator.

The American Association for Respiratory Care promotes the use of standardized terminology to promote understanding of the applications and pre-hospital management of mechanical ventilators. Furthermore, the AARC 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 during the transport of sick and injured patients.

Effective 9/11

Revised 11/11

American Association for Respiratory Care

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

Position Statement

Pulmonary Rehabilitation

A pulmonary rehabilitation program is a physician-supervised, evidence based, multifaceted approach to providing services designed for persons with pulmonary disease and their families. A program includes, but is not limited to, physician prescribed exercise, education and training, psychosocial and outcomes assessment. The goals of this respiratory disease management approach are to improve, or maintain, the patient's highest possible level of independent function and to improve their quality of life. Pulmonary rehabilitation is a multi-disciplinary program and should be included in the overall management of patients with respiratory disease. The respiratory therapist, by virtue of specialized education and expertise, is uniquely qualified to function as the leader of a successful pulmonary rehabilitation program.

Effective 1973
Revised 12/08

Reviewed 11/11

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

November 4, 2011 • Tampa, FL

Minutes

Attendance

Karen Stewart, MSc, RRT, FAARC, President
Tim Myers, BS, RRT-NPS, Past President
Susan Rinaldo-Gallo, MEd, RRT, FAARC, VP/Internal Affairs
George Gaebler, MSEd, RRT, FAARC, VP/External Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary-Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
Debbie Fox, MBA, RRT-NPS
Lynda Goodfellow, EdD, RRT, FAARC
Fred Hill, Jr., MA, RRT-NPS
Denise Johnson, MA, RRT
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Camden McLaughlin, BS, RRT, FAARC
Mike Runge, BS, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Greg Spratt, BS, RRT, CPFT
Cynthia White, BA, RRT-NPS, AE-C

Consultant

Tom Lamphere, RRT, RPFT, HOD Past Speaker
Dianne Lewis, MS, RRT, FAARC, President's Council President
Colleen Schabacker, BA, RRT, FAARC, Parliamentarian

Guest

Deborah Waggoner, RRT (Cultural Diversity)

Absent

Joseph Sokolowski, MD, BOMA Chair (excused)

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, FAARC, Chief Operating Officer
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Cheryl West, MHA, Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:00a.m. EDT, November 4, 2011. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

Bill Cohagen moved to accept the Federal Government Affairs and International Cmte reports that were presented at Joint Session.
Motion carried.

Deborah Waggner from Cultural Diversity group was introduced.

SPECIAL REPRESENTATIVES REPORTS

American Association of Cardiovascular & Pulmonary Rehab
Recommendation 11-3-62.1 "Recommend continued work with AACVPR in regards to monitoring and communicating with CMS changes in PR reimbursement changes."

George Gaebler moved to accept for information only.
Motion carried

American Heart Association
Recommendation 11-3-64.1 "Be it resolved, that the AARC Board of Directors contact the AHA to offer the support of a Respiratory Therapist on the PALS and ACLS subcommittees."

George Gaebler moved to refer back to himself to discuss with Brian Walsh.
Motion carried

George Gaebler moved to accept the Special Representatives Reports as submitted.
Motion Carried

ROUNDTABLE REPORTS

Hyperbaric
Recommendation 11-3-43.1 "Continue to present HBO as an alternative career path to respiratory therapists."

Susan Rinaldo Gallo moved to accept for information only.
Motion carried

Susan Rinaldo Gallo moved to accept the Roundtable Reports as submitted.
Motion carried

House of Delegates
Bill Lamb discussed his House of Delegates report.

Recommendation 11-3-6.1 "That the AARC Board of Directors support non Delegate Committee Members to serve on the House ad hoc committee to redesign the annual educational competition at the International Conference to be offered beginning in 2013 and on the ad hoc committee to plan the transitional "Sputum Bowl" type program for the 2012 International Conference. These additional committee members should include present and or formal program committee members, AARC staff and other creative individuals to help in design of the best possible program to serve our members."

Frank Salvatore moved to accept.
Linda Van Scoder moved to refer to President Stewart for further action.
Motion carried

President Stewart will create the "2013 Ad Hoc Committee for Educational Competition Program". Bill Cohagen will chair this Committee.

Recommendation 11-3-6.2 "That the AARC President & Board of Directors consider forming an AARC Committee and subcommittee to transition the current House Committees into."

Bill Lamb withdrew this recommendation because it was resolved in the first recommendation, Recommendation 11-3-6.1.

House Resolutions
Resolution: 07-11-05 "Be it resolved that the AARC establish a limit to the amount funded to members applying for disaster relief."

Linda Van Scoder moved to refer to President Stewart.
Motion carried

Resolution 05-11-06 "Be it resolved that the AARC BOD strongly consider the addition of the Past Speaker of the AARC HOD as a voting member of the Board of Directors."

This Resolution was reworded by the House of Delegates and is no longer a recommendation to the Board of Directors. It was presented to the Board for information only.

AD HOC COMMITTEE REPORTS

Ad Hoc Committee to Recommend Bylaws Changes
Recommendation 11-3-30.1 "That the BOD accept the policy attached for action to be taken when Chartered Affiliate Bylaws are in conflict with the AARC Bylaws."

George Gaebler moved to accept.
Linda Van Scoder moved to accept as amended. (See attachment "A")
Motion carried

Susan Rinaldo Gallo moved to accept the Ad Hoc Committee Reports as submitted.
Motion carried

RECESS
President Stewart called a recess of the AARC Board of Directors meeting at 9:25am EDT on Friday, November 4, 2011.

RECONVENE
Karen Stewart reconvened the meeting of the AARC Board of Directors at 9:53am EDT on Friday, November 4, 2011.

OTHER REPORTS
ARCF, CoARC, NBRC reports were reviewed

Frank Salvatore moved to accept the agency updates as submitted.
Motion carried

Denise Johnson moved to accept the House of Delegates report.
Motion carried

OLD BUSINESS
There was no old business to discuss.

NEW BUSINESS
Tom Kallstrom reported on the COPD Alliance. The Board asked for more information before making a decision on joining.

POLICY REVIEW

Policy No. BOD.001 – *Board of Directors – Awards*
The policy was updated in March 2010 and does not need to be reconsidered by the Board at this time.

Policy No. BOD.002 – *Board of Directors – Liaisons to Committees, Task Forces, Focus Groups, Panels, and Special Representatives*
Requires a bylaws change – on hold

Policy No. BOD.007 – *Board of Directors – Fiduciary Responsibility*
Frank Salvatore moved to accept with name change from Committee on Accreditation of Respiratory Care to Commission on Accreditation for Respiratory Care.
Motion carried

Policy No. BOD.018 – *Board of Directors – Position Description/Profiles: VP Internal Affairs*

Will wait to amend until bylaws are changed.

Policy No. BOD.026 – *Board of Directors – Open Communication Policy*
Frank Salvatore moved to accept.
Motion carried

(See Attachment "B" for BOD.007 and BOD.026 updated policies.)

Karen Stewart announced the date for the Spring 2012 Board of Directors meeting. The meeting will be held in Grapevine, TX April 20-21.

Treasurers Motion
Linda Van Scoder moved "That expenses incurred at this meeting be reimbursed according to AARC policy."
Motion Carried

MOTION TO ADJOURN
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 10:25am EDT, Friday, November 4, 2011.

Attachment “A”

Chartered Affiliates – Chartered Affiliates Bylaws in Conflict with AARC Bylaws
Policy No.: CA.007

American Association for Respiratory Care
Policy Statement

Policy No.: CA.007

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliate Bylaws in Conflict with AARC Bylaws**

EFFECTIVE DATE: November 3, 2011

DATE REVIEWED: November 4, 2011

DATE REVISED:

Policy Statement:
The Bylaws of the Chartered Affiliates shall not be in conflict with the Bylaws of the AARC.

Policy Amplification:

1. 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. All Affiliate Bylaws shall be submitted to the AARC Bylaws Committee every 5 years for review and approval. Failure to submit Bylaws by 5 years will start the process below in Section 5.

2. 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.

3. Affiliate Bylaws will be considered in conflict if Active members of the **AARC** are not automatically Active members of the **Chartered Affiliate**.

4. If affiliates Bylaws are in conflict with the AARC Bylaws the Bylaws Committee will notify the Affiliate in writing that The Affiliates Bylaws are in conflict with the AARC Bylaws including the reason.

5. The Affiliate will have their Affliliate Charter revoked until the Chartered Affiliate makes changes to their bylaws to bring them into compliance with AARC Bylaws.
    a. The charter affiliate shall lose their voting powers in the House of Delegates until the Bylaws are revised and accepted by the AARC Board of Directors.
    b. If after a period of one year the Affiliates Bylaws are still not in compliance, the AARC
    Board will take action by withholding Affiliate revenue sharing starting at one quarter of revenue sharing every six months.
    c. This would be a three year process whereby revenue would dwindle to zero after three
    years of non-compliance.
    d. The AARC Board of Directors would then revoke the charter of the affiliate.

6. The AARC Bylaws Committee shall notify the AARC Board of Directors of the rejection of affiliate's bylaws so the revocation of the charter can proceed through the Executive Committee.

DEFINITIONS:
ATTACHMENTS: AARC Bylaws

Attachment “B”

Policy No.: BOD.007 – Board of Directors – Fiduciary Responsibility
Policy No.: BOD.026 – Board of Directors – Open Communication Policy

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Fiduciary Responsibility**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2011

DATE REVISED: July 2005

REFERENCES:

Policy Statement
Directors and Officers of the AARC shall retain fiduciary duty to manage the Affairs of the Association so that its property will be used for the purpose for which it has been entrusted.

Policy Amplification:

1. Association Directors and Officers shall be considered "fiduciaries" and therefore have a status similar to that of trustees.

2. Directors and Officers shall act solely for the benefit of members of the Association in scrupulous good faith and candor.

3. Directors of the AARC shall not serve as voting members of the following corporations during the tenure of their directorship: the National Board for Respiratory Care, and Commission on Accreditation of Respiratory Care.

4. The fiduciary standards applicable to Directors and Officers of the AARC shall be as summarized below to provide background for determining conduct to which a Director or Officer should adhere.

A. Duty of Loyalty

The duty of loyalty for an AARC Director or Officer requires that he or she not exploit Association opportunities, or misuse inside information, or cast a vote on a matter in which a Director or Officer has an adverse interest.

B. Doctrine of Corporate Opportunity

Where a business opportunity is in line with the Association's activities, and is one in which the Association has a legitimate interest or expectancy, the opportunity belongs to the Association. A Director or Officer who diverts the opportunity and embraces it as her/his own will be considered a constructive trustee for the benefit of the Association

and holds all of the profits and benefits received there from for the Association.

C. Use of Inside Information

A Director or Officer who acquires special knowledge or information by virtue of his/her fiduciary relationship with the AARC is not free to exploit that knowledge or information for his/her own personal benefit. Just as trustees have no right to retain for themselves the profits yielded by property placed in their possession, but must account to their beneficiaries, and AARC Director or Officer who is entrusted with or obtains potentially valuable information may not appropriate that asset for his/her own use. A Director or Officer may also be held accountable where he/she has disclosed such information to another person who then gains an advantage over members of the general public or the Association and its members.

D. Duty of Care

The duty of care requires that AARC Director and Officers exercise reasonable care and good faith in carrying out their responsibilities. A Director or Officer should exercise the same care and skill which an ordinarily prudent person would exercise under similar circumstances in his or her own personal affairs, by accepting the office, Directors and Officers implicitly undertake to give their best judgment to the AARC, and may be held liable for negligent or unauthorized acts.

In the event that any Director or Officer of the Association should have any direct or indirect interest in or relation with, any individual or corporation which has entered, or proposes to enter, into any transaction with the Association, such Director or Officer must notify the Board of Directors of such interest or relationship, and must thereafter refrain from discussion or voting on the particular transaction in which he or she has such interest. Such a Director or Officer must also refrain from otherwise attempting to exert influence on the Association, its Officers, Board of Directors, or employees to effect its decision to participate or not to participate in such actual or proposed transaction. The types of transactions here considered include, but are not limited to, those involving:

1) the sale, purchase, lease or rental of any property, supplies or other asset(s) between a Director or Officer and the Association.

2) employment or the rendition of services

3) the award of any grant, contract or subcontract, or

4) investment or deposit of any funds of the Association

If and when the particular transaction is discussed in a meeting, the minutes of that meeting must reflect that a disclosure was made by the interested Director or Officer. Furthermore, a Director or Officer must not in any direct or indirect manner compete with the association or secretly act on behalf of creditors.

Any questions not directly answered should be brought before the entire Board of Directors.

5. Each Board member shall complete a "Conflict of Interest" statement as directed by the President.

6. Smoking is prohibited during meetings of the Board of Directors and each Board member shall complete a "Tobacco-Free Policy and Pledge".

DEFINITIONS:

Conflict of Interest:
A conflict of interest is defined as any situation in which a Director or Officer has a direct or indirect outside personal interest which has the potential of being contrary to the best interest of the Association.

Fiduciary Duty:
A fiduciary duty is the highest form of legal duty owned by one person to another.

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

American Association for Respiratory Care
Policy Statement

Policy No.: BOD.026

SECTION: Board of Directors

SUBJECT: **Open Communication Policy**

EFFECTIVE DATE:

DATE REVIEWED: July 2005, November 2011

DATE REVISED: July 2005

REFERENCES: GP.1174 - 1997

Policy Statement:

The general membership will be informed as is reasonably possible regarding both the actions and plans of its chosen leaders.

Policy Amplification:

1. All actions taken by any Board, committee or any other official group of the AARC are considered public information insofar as our membership is concerned with the exception of

   A. Actions taken by in officially declared "Executive Session"
   B. Sensitive areas which may tend to unnecessarily embarrass innocent persons.
   C. Sensitive areas that may lead to legal redress as directed by legal consul.
   D. Information whose public exposure would tend to cause financial or other hardship to the Association.
   E. Information clearly marked as "confidential" by the author

2. The Officers and employees of the Association are charged with making such public information available to the general membership upon request at the earliest possible time and in every reasonable manner.

DEFINITIONS:

ATTACHMENTS:

E-Motions

Since Last Board Meeting in November 2011

12-1-39.1 "Move that the AARC endorse the 2011 Guidelines for Field Triage of Injured Patients."

Results – December 1, 2011
Yes – 14
No – 0
Abstain - 0
Did Not Vote – 3
The motion carried

12-1-81.1 "Move that the Board ratify President Stewart's appointment of Sue Meade and Todd Bocklage to the NBRC."

Results – December 10, 2011
Yes – 14
No – 0
Abstain - 0
Did Not Vote – 3
The motion carried

12-1-15-1 "That the AARC Board of Directors approves the membership of the 2012 Sputum Bowl Committee as recommended by the Program Committee:

Co-Chair: Deb Hendrickson (WI)
Co-Chair: Garry Kauffman* (NC) - *Program Committee Liaison*
Kelli Chronister* (OH)
Jim Ciolek (TX)
Tony Dietz (NC)
Ashley Dulle* (LA)
Bill Galvin* (PA) *Program Committee Special Representative*
Thomas Hill (GA)
Tom Lamphere (PA)
Diane Oldfather* (MO)
David Panzlau* (MI)
Sherry Whiteman* (MO)

* *New Committee Member*"

Results – February 7, 2012
Yes – 12
No – 2
Abstain – 1
Did Not Vote – 2
The motion carried

12-1-47.1 "Move to approve the appointment of Jim Fielder as Chair of the Informatics Roundtable."

Results – February 15, 2012
Yes – 16
No – 0
Abstain - 0
Did Not Vote - 1
The motion carried

12-1-24.1 "Move to approve the appointment of Sarah Varekojis as a member of the Membership Committee."

Results –February 15, 2012
Yes – 16
No – 0
Abstain – 1
Did Not Vote - 0
The motion carried

General Reports

President Report

Past President Report

Spring 2012 AARC Executive Office Report

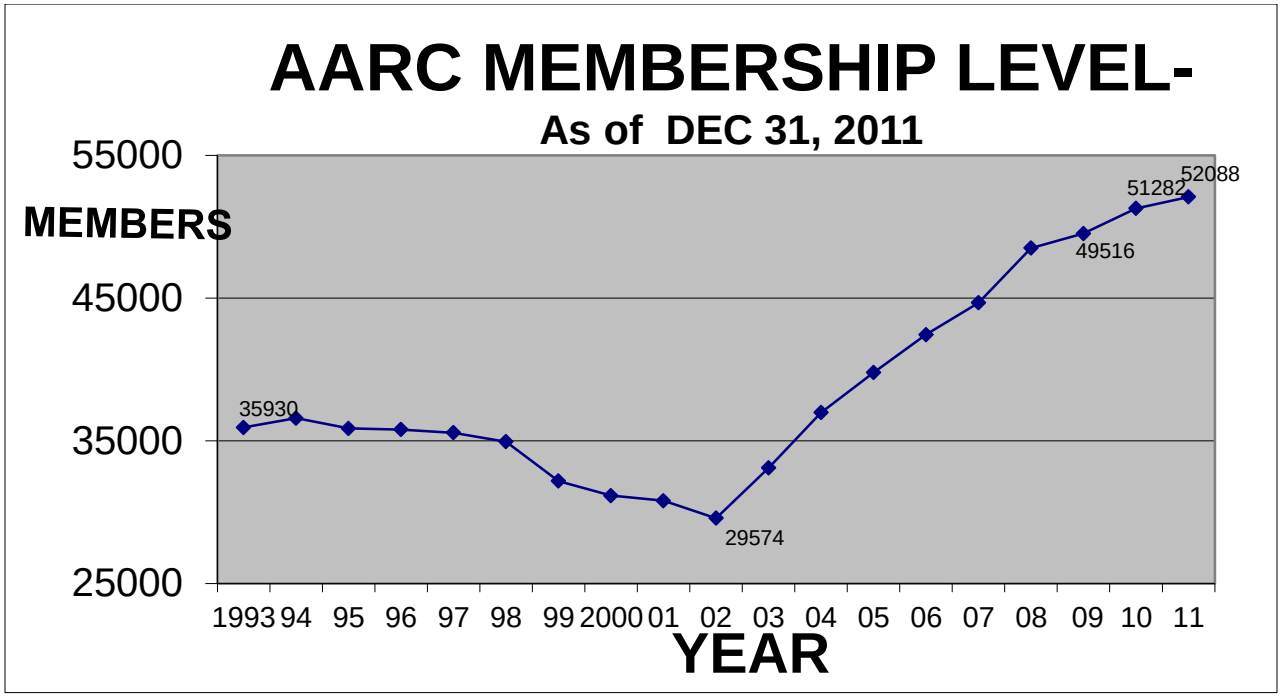
Sam P. Giordano, MBA, RRT, FAARC
Chief Executive Officer/Executive Director

Membership

Membership Campaign

The membership committee has initiated a membership campaign that will focus on managers in hospitals. Identifying the manager/directors who are not members was the first step. This was largely accomplished with the help of the HOD and affiliate leadership under their direction of the membership committee. The plan is to introduce to non-member manager/directors the benefits AARC membership offer them professionally as well as to provide the tools to assist them in managing their department.

Current membership count is 52,530 members. This compares with 52,400 the same time last year ago.



Meetings & Conventions

AARC Congress 2011 (Tampa) – AARC Congress 2011 held in Tampa was a very successful for the Association. In total, more than 5,400 attendees, exhibitors, and patient advocates were in attendance. Despite challenging economic climate, strong attendance suggests our members continue to find value in our meeting; despite the fact many fail to receive supportive funding through their employers.

The AARC continues to differentiate itself from other competing meetings through our exhibitors and speakers. The 2011 meeting hosted international speakers from Italy and the UK, as well as representation from government agencies in the exhibit hall. We were also fortunate to host speakers from CMS and Blue Cross during a Congress pre-course.

2012 AARC Program Committee Meeting - The AARC Program Committee met in January to create the Program for Summer Forum 2012 and AARC Congress 2012. More than 800 individual lecture proposals were submitted for consideration.

The 3-day meeting concluded with a full Program developed for both meetings, and were inclusive of pre/post-course meetings for SF, as well as 2 pre-courses for Congress.

Summer Forum 2012 - Summer Forum 2012 will be held July 13-15, 2012 in Santa Fe, NM. The meeting will be held at the Hilton Santa Fe Golf Resort & Spa at Buffalo Thunder. This is both a new location and meeting venue for Summer Forum. Preliminary feedback has been strong and we anticipate attendance to meet or exceed budget. Many thanks to the Education and Management specialty sections who contributed to the Program.

As in 2011, the primary demographics for those who attend will also include hospital-based educators. This is a relatively untapped market and one who we believe will attend if programmatic content is supportive of their needs.

Pre/post-graduate courses have been scheduled for Summer Forum 2012. We believe both courses will target all demographics in attendance. The first post graduate course is titled; "Building a Simulation Toolbox", and second titled; "Getting the Best Return on Your Investment: Maximizing Patient Education". There will be a nominal registration fee for each event.

AARC Congress 2012 (New Orleans) - Progress is well underway for the AARC Congress 2012 to be held in New Orleans, LA, November 10-13. 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.

IT Update

The IT upgrade remains generally on schedule, and in most areas under budget. There were some unexpected problems in the database and accounting upgrades due to old, custom software. In the process, we have eliminated most of the old programs. The attached table shows current status.

As you can note, we have not yet started on the network, firewall, document management or video production. The expected completion dates for workstation upgrade, Q2 2012: network and firewall, Q4 2102; and document and video, 2013.

AARC Upgrade

Area	Budget	Spent	Savings	Pending	Est cost
Server	82677	55537	8277	7700	7700
Network	52200	0		52200	
Workstations	78735	19744	-1736	57300	50000
Firewall	13000	0		13000	

Member database	14550	22600	-8050	0	
Accounting SW	13200	22000	-8800	2500	2500
Document mgmt	80000	0			
Video production	35000	0			
Total	369362	119881	-10309		

DAED Upgrade

Area	Budget	Spent	Savings	Pending	Est cost
Workstations	30579	11122	8277	11800	9800

Communications

	Jan	**Feb**
Sections		
Adult Care	1224	1357
CCR	8	42
Diagnostics	97	75
Education	75	74
Home Care	31	11
Long Term Care	7	1
Management	354	357
Neo/Peds	109	175
Sleep	8	23
Transport	47	59
Adult Acute Care		
Journal Club	131	62
Leadership		
Book Club	1	25
Roundtables		
Asthma	1	3
Disaster Response	3	5
Geriatrics	0	0
Hyperbarics	0	1
Informatics	4	0
International	2	0
Military	0	0
Neurorespiratory	1	0
Research	4	2
Simulation	3	9
Tobacco Free	4	6

Social Networking

AARC Facebook: Approximately 4,600 visits per week

Linked In: 2,800 are linked in and approximately 50 new members join every week

Electronic Communication
Top ten sites accessed Jan-Feb, 2012
Index (206,561)
Ethics Course (120,803)
Education Index (68,053)
On –Line courses (59,509)
Member Services (31,444)
Resources (26,705)
Transcript (19,350)
Exam Central (25,743)

Projects

Safety Checklist for Oxygen Monitoring - Phase 1 of the safety checklist is complete. This includes an oxygenation checklist for neonates/newborns, pediatric, and adult patients for in-hospital transports. This includes the checklist itself, as well as an explanatory article in the AARC Times, and archived webcast. All 3 checklists are available for FREE (members and non members) download off of the AARC website.

Phase 2 is underway. This project will also be a safety checklist, but will target ICU patients preparing for discharge to a step-down floor. The checklist will act as a triage-scoring tool to identify respiratory patients who are at high risk for recidivism. Target completion date for phase 2 (including AT article and webcast): Summer 2012.

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. Once beta-test is complete, a final version will be made available for member. Once approved, toolkits will be distributed for beta-test. Target completion date: April 2012. Data collection: Ongoing

Peak Performance USA (PPUSA)
As of April 1, 2012 PPUSA has reached an estimated 45,043 children with asthma. It has been implemented in 187 schools in 32 states. Over 30,000 people and over 182,000 visits have viewed the PPUSA webpage since its launch two years ago.

Drive4COPD
The Drive4COPD collaboration has entered its third year. We continue to urge members to liaison with local businesses, as was the campaign in 2011. In 2012 we find that the VFW has expressed an interest in having respiratory therapists present a lung education/screener event. In May we will be beta testing our first VFW iDrive4COPD event in Dell City, VA. We are also negotiating a contract with COPD

Foundation for the next three years in their public campaign. Part of this agreement will be that the AARC will secure all respiratory therapists for all public events.

Office Spirometry

The Office Spirometry education and competency achievement program continues to grow. In Feb, we trained over 150 Clinical Science Consultants from a pharmaceutical company in a train-the-trainer program. Our goal is to assure that physician's offices that do spirometry have a trained and competent clinician doing the test. There has been interested expressed in the Middle East for the educational component of this offering. Thoracic Society of Australian and New Zealand (TSANZ) are already in the system.

High Flow Heated Humidity Research Study

Identifying that there are knowledge gaps, a lack of evidence, and potential misuse of this technology, this project is designed to encourage RTs using this therapeutic modality to engage in research so that adequate evidence is available to draft a white paper/clinical practice guidelines.

Step 1 of the project is to create a generic IRB template that participating RTs can use to submit to their respective hospital IRB. Once approved, the research study would collect evidence on the clinical effectiveness and safety of this technology. Researchers would be expected to report their findings to the AARC for review. Once adequate data is collected, the AARC would draft a clinical practice guideline/white paper on the proper use of this technology. Target completion date: IRB template – April 2012. Data collection: ongoing.

Respiratory Care Journal

Contents of the Journal continue to improve both, in quality and quantity. Since our last report, the publication has performed as follows:

- The Journal now mails by the 1st of the month
- Extended the monthly deadline for online participation in CRCE Through the Journal
- Proceedings from Journal Conferences now published in one issue instead of two
- Two Journal Conferences will be presented this year, one in April on *Oxygen* and the other in September on *Adult Mechanical Ventilation in Acute Care: Issues and Controversies*
- Assumed responsibility for overseeing the development of the AARC's evidence-based CPGs
- "Quick Look" added to the second page of every original article
- Our host partner, IngentaConnect, now hosts old issues, back to January 2003
- Fast Track (ePub ahead of printing) now fully implemented whereas articles are posted online within 10-14 days of acceptance

- RESPIRATORY CARE ranks in the top 100 of more than 10,000 titles hosted by IngentaConnect for number of full-text downloads

Online Access of RESPIRATORY CARE since January 2011, when IngentaConnect began hosting the Journal:

	Full-Texts Downloads	Abstracts Viewed
January - June 2011	11004	30428
July 2011	2977	8310
August 2011	2514	7127
September 2011	3688	10648
October 2011	4789	15991
November 2011	4758	19659
December 2011	4306	15071
January 2012	5220	16970
February 2012	5798	16905

Who accesses RESPIRATORY CARE online? Of 5798 full-text downloads in February 2012:

- 1695 were from AARC members through the signed linking authorization
- 26 articles were purchased via PPV

Evidence-based CPGs

In 2012 the development of evidence-based CPGs was assigned to the Journal RESPIRATORY CARE and its Editorial Board. The Journal began working on this project with everyone agreeing that the development of evidence-based CPGs is entirely different to what the AARC has done until now; that we all must go through a steep learning curve if we are to write evidence-based CPGs; and that we will need to use experts to help us learn and to guide us through the process.

We then identified airway clearance as the first evidence-based CPG to be written and individuals AARC members were asked to develop and to write this CPG. Following a call by the working group we began having preliminary conversations with all Evidence-based Practice Centers (EPC) we though could lead us through the process, the "experts" in writing evidence-based CPGs.

Initial Findings: What have we learned?

- Preliminary analysis on an airway clearance CPG using our working group criteria to be included (pharmacologic and non-pharmacologic, mechanically ventilated and non-mechanically ventilated, acute and chronic, all ages) is exceptionally large. The EPCs admit that until they do the preliminary literature search, they won't have an accurate grasp on the project size but anticipate that the number of articles will be on the high side (our own PubMed search for "airway clearance"––without actually going through and choosing most relevant articles––yields 2,134 results).

- The development of an evidence-based CPG in accord with today's recognized standards and using an EPC will be expensive. A less expensive way may be using a methodologist from an EPC. This however, provides the least quantity of service and requires more extensive labor from our working group.

- We now have a good grasp of the process we need to undertake and how to do it, either using an EPC or a methodologist from an EPC.

- It would take at least a year or longer to develop a CPG.

What's next?

- We anticipate selecting an EPC by May 1st at the latest. This selection will be based on the level of assistance provided in telephone conversations, level of interested displayed, the most beneficial services to our group considering the scope of our project, and our research of their track records.

- We will then meet face to face with the selected EPC for more extensive and specific discussions and to cost the project.

- Soon thereafter we should be ready make recommendations on how to proceed.

Benchmarking System

As of March there were 144 facilities participating in the benchmarking service. Members of the benchmarking committee continue to personally contact new subscribers within one week after they have gained access to the system and offer personal assistance to facilities that are within 4 months of their expiration date and have not entered at least one quarter of data. We continue to encourage subscriber engagement by holding monthly teleconferences.

Professors Rounds/Webcasts (see below)

9 topics and speakers (including one bonus program) constitute the 2012 Professor's Rounds series. All production dates have been set and 4 will be

completed by the end of March. All are scheduled for production before the end of July. By the end of March we will have conducted 5 webcasts. We have dates for 6 more and have commitments for 5 more at this time but dates for those have not yet been established. We continue to attract a large number of live participants (now averaging over 350) to our live webcasts.

Joint Commission (JC) Field Reviews
The AARC continues to participate in the Joint Commission Standards Field Review process. The volume of standards so far this year is substantially less than in previous years. Since the last board report we responded to these reviews relevant to respiratory therapy:

- Field Review on the Proposed National Patient Safety Goal on Overuse 12-6-11
- Patient Flow in the Emergency Department Field -12-20-11

VAP Course
The VAP course was released at the end of January. There have been 200 RTs who have taken the course in the first 60 days.

Alpha one Course
The Alpha one course was released in early February. Over 250 have taken the course. We are working closely with the Alpha One Foundation and Alpha One Association in an effort to make sure that all practicing respiratory therapists view this course and take the exam. As part of outcomes measurement we will be contacting those who took the course and received CRCE to determine if they had an impact on identifying patients with Alpha One.

Uniform Reporting Manual
Developing the survey instrument is beta tested by the members of the expert panel who are providing favorable reports on its functionality and the instructions that I have written for the processes of login, facility selection and survey completion. We expect to complete beta testing and have the survey ready for release by April 1. As a reminder, this enhanced URM that will focus on acute care hospitals and diagnostic laboratories (PFT, blood gases, echo/non-invasive cardiology, and sleep) and pulmonary rehabilitation. While the survey process is on much of the content (except the actual time standards of course) can be written. When the statistical analysis of the time standards is completed they can be inserted. This will allow the availability of the manual in the summer of 2012 prior to the Summer Forum.

<u>Affiliation with other associations and agencies</u>
ACCP COPD Protocol
The development of the COPD protocol has been completed. Next step will be to beta test the protocols. There are three protocols (emergency room, in patient, and post discharge). The AARC has had a representative to all three protocols. This will be

especially important in the coming years as the Affordable Healthcare Act starts to penalize hospitals the experience readmissions for COPD. They will also be penalizing hospitals for readmissions for pneumonia and CHF.

Hospital Care Collaborative
The Hospital Care Collaborative (HCC) committee met in Washington (the day before Hill Day). The AARC is a founding member of this group. HCC's mission is essentially collaboration of the healthcare team which leads to improved systems and processes that provide care more efficiently and result in better patient outcomes (see attached minutes from the March meeting).

Saudi Thoracic Society
In January an invited group of speakers presented an Asthma/COPD/aerosol device workshop in Riyadh, Saudi Arabia. This conference was well attended and resulted positive feedback to the association.

Gulf Thoracic Society (GTS)
In March the same team traveled to Dubai where they where speakers at the GTS meeting. In addition to this an Asthma/COPD/aerosol device workshop was held. We also had a booth, as was the case last year and there was a great deal of interest in AARC membership, online education, and the RC Journal. A regional membership meeting was held with RTs from the region. This provided us with much needed feedback. As a result a regional live webcast will be presented this spring to members in the Middle East. Its purpose will be to let them learn more about the AARC and to communicate live with AARC leadership. Dean Hess was invited to participate in an Editors-in Chief discussion with the Editors of Thorax, Annals of Thoracic Medicine, and Journal of Bronchology & Interventional Pulmonary (see below).

We also had the opportunity to meet with representatives of the UAE Ministry of Health to talk about our education, training and continuing education documentation. Our discussions were encouraging and we are awaiting more details from the Ministry.

CDC

CDC approached the AARC in March to solicit comments about a VAP definition protocol, which will likely be released the first quarter of 2013. Teams of experts from the respiratory care community were on the call and offered opinion. In order to make sure all respiratory therapists are made aware of this change we have asked (and it has been confirmed) that the lead physician from the CDC working group will make a presentation at the 2012 Congress. We have also been invited to be an official member of the VAP Surveillance Definition Working Group along with representatives from CCSC, IDSA, SHEA, APIC, CSTE, and HICPAC. Dean Hess has been selected to be our representative.

Summary

We hope that the foregoing information proves useful. If you have any questions regarding any of the foregoing, or, if we have failed to report on an activity you are interested in, please contact me at your earliest convenience. I do want to add that I hope to submit an addendum report in addition to the foregoing. The addendum

will deal specifically with a recommendation to upgrade our Internet capabilities so that the Association can take full advantage of smart phone, iPad, and other apps that are becoming so popular with our members. At this time, I do not have all the numbers relating to the cost of the upgrade but hope to get them to you in time for the Board's consideration when it meets later this month.

Recommendation:
That the AARC Board of Directors directs the Management Section Chair to initiate a project to encourage respiratory care managers to look for, and seize, opportunities described in the manuscript entitled, "Creating a Vision for Respiratory Care in 2015 and Beyond" Kazmarek, Durbin, Barnes, Kaegler, Walton, O'Neil Respiratory Care 2009;54(3):375-389.

Justification:
While the Association has and continues to work towards evolving the profession along the lines of our nation's health reform initiatives, it is imperative that respiratory therapists, especially those employed in hospitals, seize opportunities that have been described in the previously mentioned manuscript. Enhancements to our scope of practice need to be driven by the needs of our employers and our patients. As with most cutting edge procedures, we have incorporated into our scope of practice over the past several years. Such opportunities are led by managers and RTs who are willing to look for opportunities, to expand their scope, and improve their value to employers. Encouragement from the AARC can go a long way towards encouraging our members to step forward and seize these legitimate opportunities when they present themselves. This action is consistent with our profession's philosophy of being change agents.

Recommendation:
That the following position statement by the Hospital Care Collaborative (HCC) be reviewed and reaffirmed by the AARC Board of Directors.

Justification: This is a strongly held position by all collaborating partners that each organization annually reaffirms and distributes to their affiliates.

Common Principles for Team-Based Care: The Hospital Care Collaborative (HCC)

- The HCC believes that healthcare is a "team sport" with respect and recognition for the knowledge, talent and professionalism of all team members.
- The HCC supports clear delineation of team roles and responsibilities with an emphasis on a collaborative and non-hierarchical model.

- The HCC believes in patient centered care, rather than provider-centered care, and that the healthcare team members should involve the patient/family/caregiver in developing care plans and goals of care.
- The HCC believes that collaboration of the healthcare team can lead to improved systems and processes that provide care more efficiently and result in better patient outcomes. Examples include strategies for implementation, improved workflow and the utilization of evidence-based processes.
- The HCC believes that all members of the team within their licensure and scope of practice have a role to play in establishing organizational policy, and directing and evaluating clinical care.
- The HCC believes that in a system that involves many team members, all health professionals should work to create safe care transitions and handoffs within the hospitalization and post-hospitalization episodes of care.
- The HCC believes that all team members must be as proficient in communications skills as in clinical skills.
- The HCC believes that the appropriate capacity and staffing of the entire team is a requirement for providing the best care.

Attachment

Hospital Care Collaborative
March 5, 2012
ASHP Headquarters, Bethesda, MD

In attendance: Ramon Lavandero, Sam Giordano, Tom Kallstrom, Doug Scheckelhoff, Paul Abramowitz, Larry Wellikson, Carol Frazier Maxwell, Bona Benjamin

Summary of discussion regarding the future of the HCC:

There was agreement that discussion and information sharing at HCC has been helpful to all parties. One important aspect of the meetings has been that they have always been high level, with CEO and/or presidential officer level engagement. Core premises when HCC was formed: (1) the 6 specialties represented make up the core workforce caring for patients in the hospital, and there needed to be a forum to know more about each other. As the healthcare system is evolving, there was a need to work together collectively. Many of the involved organizations have had individual projects and initiatives with each other, but by pulling together all the organizations, it brought the opportunity to bring even more value; (2) we should pick a problem that impacts all organizations – and team work was the one chosen. There has been discussion of the HCC developing an aggressive advocacy agenda (beyond payment and licensure), but advocacy resources from each organization are focused on their own issues. It was concluded that the HCC functions better as a "League of Nations" as opposed to an advocacy organization or coalition.

There was a consensus that meeting face-to-face once or twice per year was valuable and should be continued. A conference call between face-to-face meetings could help structure the agenda of the meetings and determine the relative urgency and timing.

Issues surrounding workforce, teamwork, team-based care, continue to be important issues for hospitals, and the role of teams will only grow in importance as health care delivery and payment models evolve. Effective teams will be critical in this transition.

Another important aspect of team-based care has been the recognition that participation of each team member is important to improving outcome. The *Common Principles for Team Based Care* (Appendix I) document is as relevant in 2012 as it was when it was developed in 2009.

Organizations involved need to consider how the goals of HCC intersect with their own strategic goals. There is reasonably good alignment with those around the table, and agreement on principles is easy, but the challenge is when it comes to resources.

Other organizational alliance models were described. One successful example was given of an alliance that is open to any organization who wishes to join, governed by a steering group (vs. a Board of Directors), and their focus has been on discussion and agreement to common principles. Then each organization decides how they will implement the principles with their constituency and resources. They have intentionally not tried to come up with a joint initiative – because their individual size, scope, and resources all differ so much. Each organization needs to decide where these collaborations fit with other priorities.

The potential for HCC to focus more on statements and principles was discussed, and it was acknowledged that coming around a big initiative (such as a conference) might be difficult since it would compete for individual organizational resources. Maintaining a good working relationship between the organizations will allow the HCC to mobilize quickly should the environment require assertive action.

There was discussion of what other organizations might be invited to be a part of HCC. But as other provider organizations were discussed, it was concluded that their roles differ from those already involved, and would likely not add greatly to the discussion.

It was suggested that the HCC consider developing principles on other areas of focus, using a process similar to that used to develop the *Common Principles for Team Based Care*. Ideas included patient safety, hospital acquired infections, communications, and readmissions.

There was a suggestion that individual organizations should communicate their involvement in HCC to their members. The collaboration is important, and members would appreciate knowing that the dialogue is occurring.

The idea of developing presentations that could occur at individual organizations annual meeting was discussed. The format could include representatives from other organizations describing effective teamwork and collaboration, or HCC principles could be incorporated into (and highlighted) in regular educational programs. Examples of presentations suggested included focusing on the role of TBC in VTE, preventing readmissions, heart failure, others. It could be a good opportunity to have teams share what they do. We would want to make sure that the program is something attendees could get excited about, and would want to come to.

The idea of the HCC identifying best practices for team based care and promoting those practices was also discussed. If there was a call for best practices, it might be a way to recognize and showcase those organizations that are doing team based care well and highlight the key elements of their teams that make them successful. This idea should be discussed further on the next conference call.

The minutes will be summarized and distributed, along with a proposed structure

and next steps. The next call will be targeted for mid to late June. Carol volunteered to schedule the June call.

The meeting was adjourned.

Prepared by: Doug Scheckelhoff/ASHP

DRAFT
HCC Meeting Structure

Spring meeting: March

Summer conference call: June

Fall meeting: October

Winter conference call: January

Rotation:

Hosts of in-person meetings:	Scheduler/host of conference calls:
2012: ASHP (March) SHM (October)	2012: SSWLHC (June)
2013: CMSA (March) AACN (October)	2013: AARC (January) ASHP (June)
2014: SSWLC (March) AARC (October)	2014: SHM (January) CMSA (June)

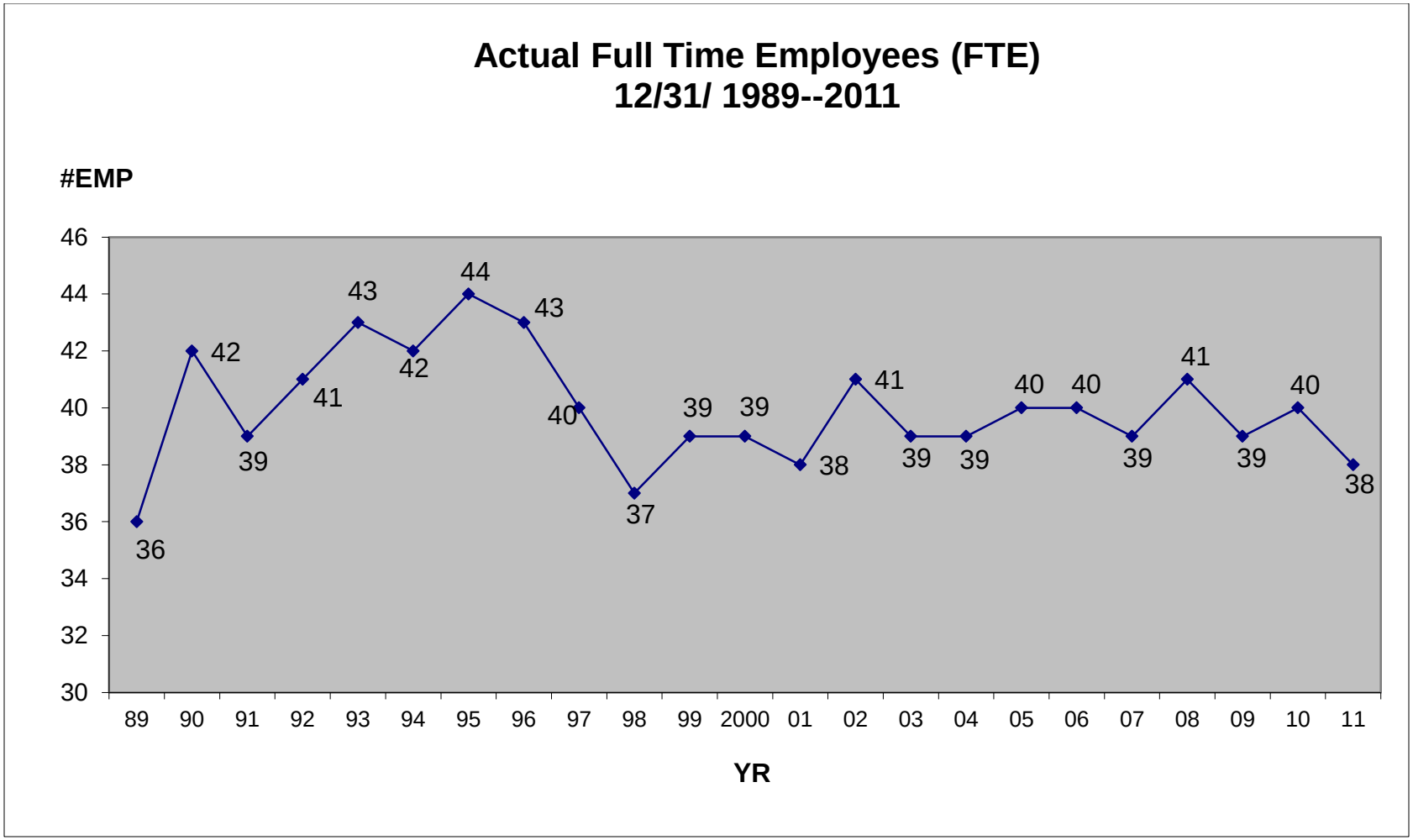
The HCC believes that the all team members are accountable for their individual performance as a healthcare provider as well as the performance of the entire team. While this may be defined by statute or regulation, this also relies on the clinical judgment of each member of the team.

The HCC understands that in order to improve quality of care, standards and measurement of performance are important. The HCC believes that the measurement should be of the outcomes of the team rather than of any individual member of the team.

The HCC believes that in order to provide the best care possible appropriate information must be readily available to all team members, at the right point of decision-making, and in a format that allows for ongoing updating and communication to the team.

The HCC believes the current undergraduate and postgraduate professional education of team members is inadequate to promote true team functions. The HCC calls on the training institutions for health professionals to adopt new curricula and experiential models that foster the competencies and the culture that support team-based care. The HCC also calls on the professional associations to likewise function in a team-based manner and develop creative approaches to "teaching" the professionals they represent, as well as modeling for other healthcare professionals, the skills to be a functioning member of a healthcare team. Professional associations should foster research that demonstrates the effectiveness of team-provided care.

The HCC recognizes that today's hospital cultures do not foster true teams of healthcare professionals. The HCC calls on all stakeholders (e.g. payers, providers, administrators, patients) to work together to create a new hospital culture that nurtures and rewards high performing teams.


Actual Full Time Employees (FTE)
12/31/ 1989--2011
#EMP
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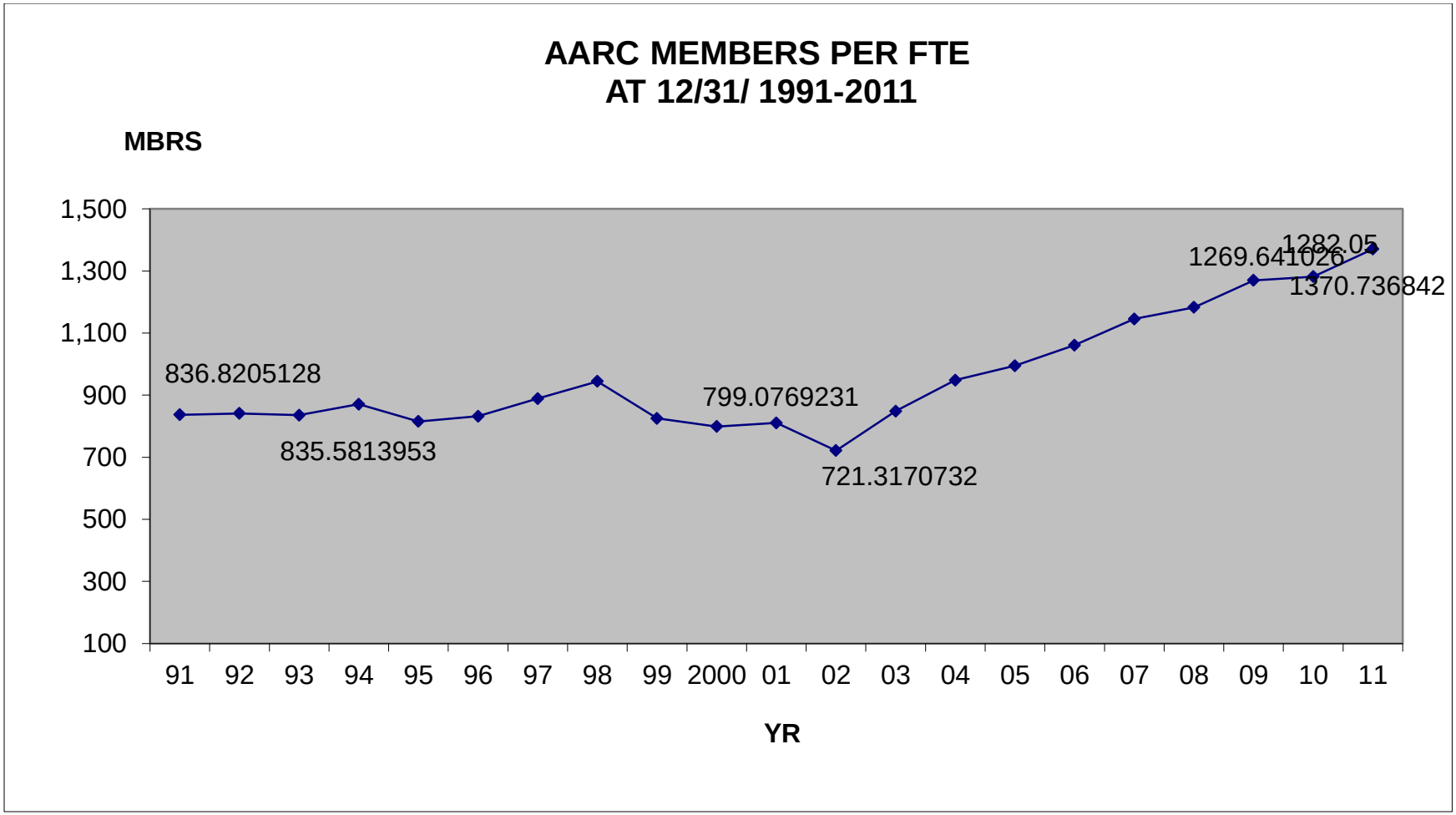
AARC MEMBERS PER FTE
AT 12/31/ 1991-2011
MBRS
1,500
1,300
1,100
900
700
500
300
100
836.8205128
835.5813953
799.0769231
721.3170732
1269.641026
1282.05
1370.736842
91
92
93
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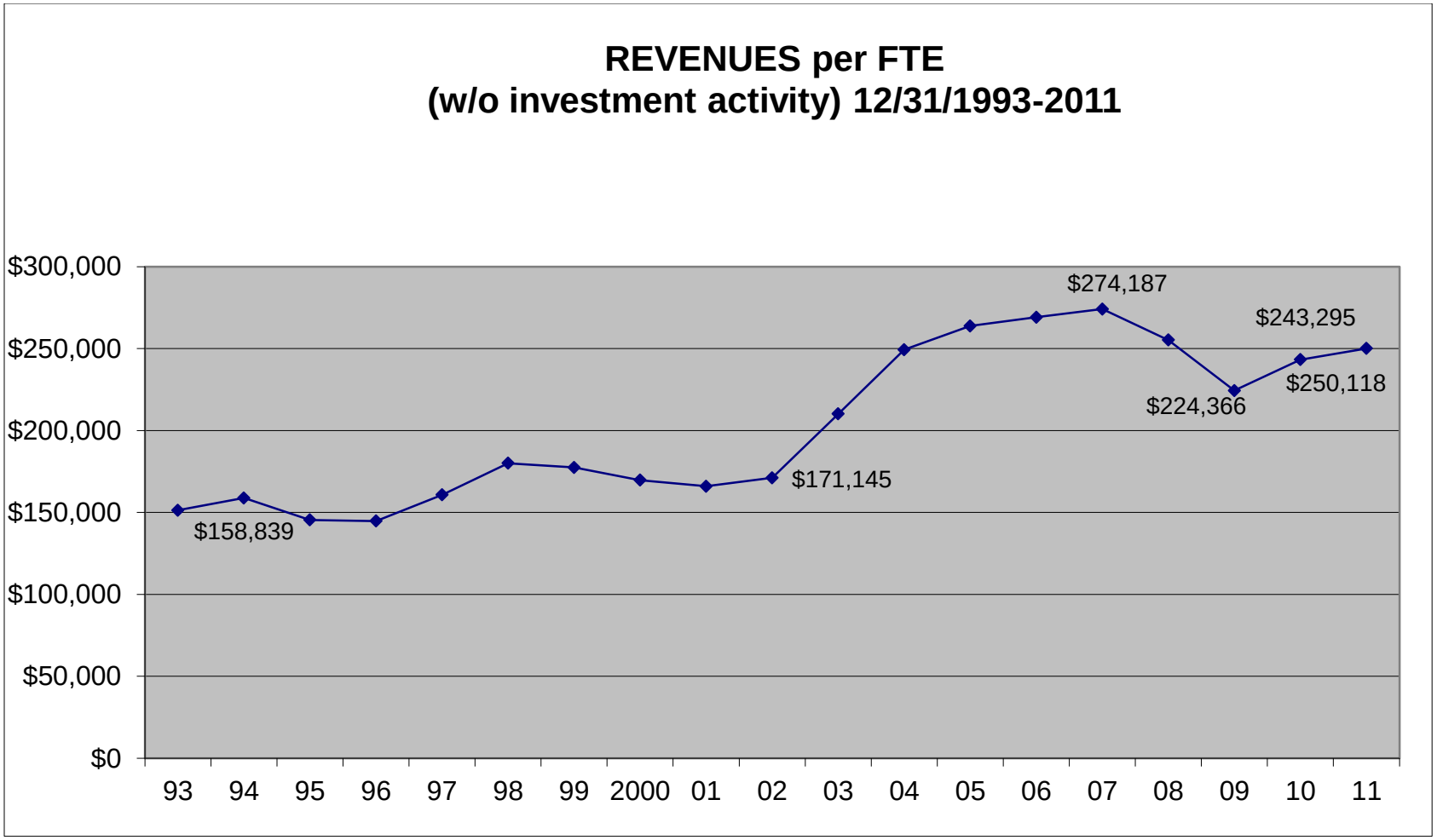
REVENUES per FTE
(w/o investment activity) 12/31/1993-2011
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
93
94
95
96
97
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2000
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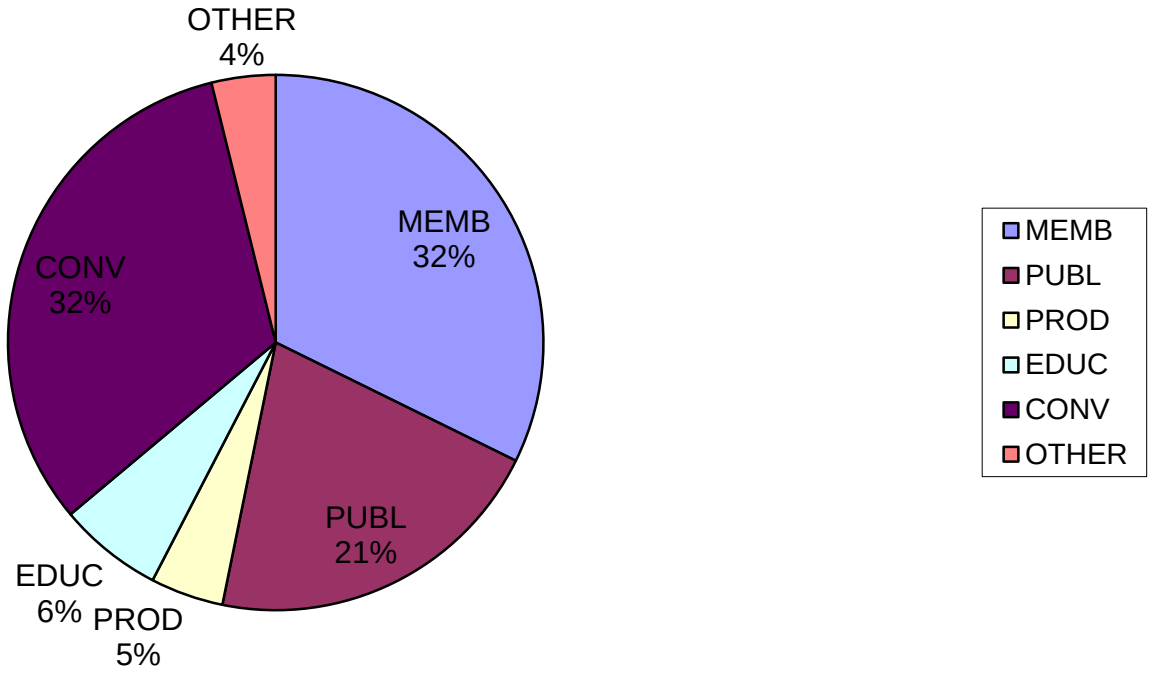
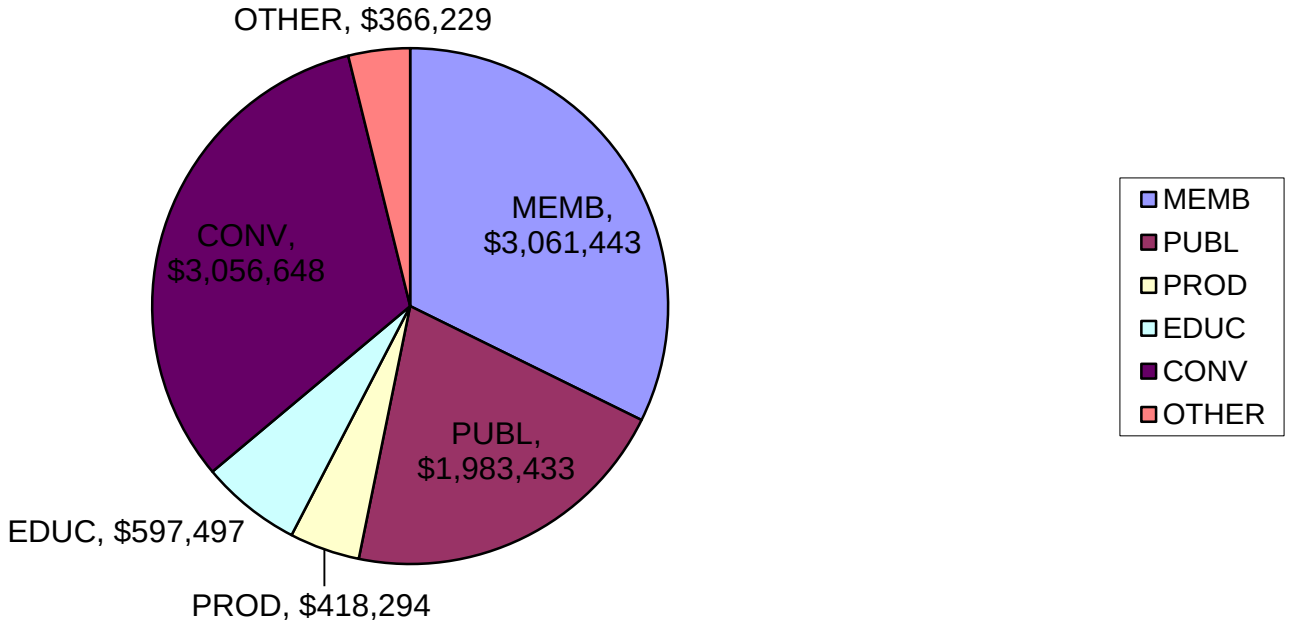
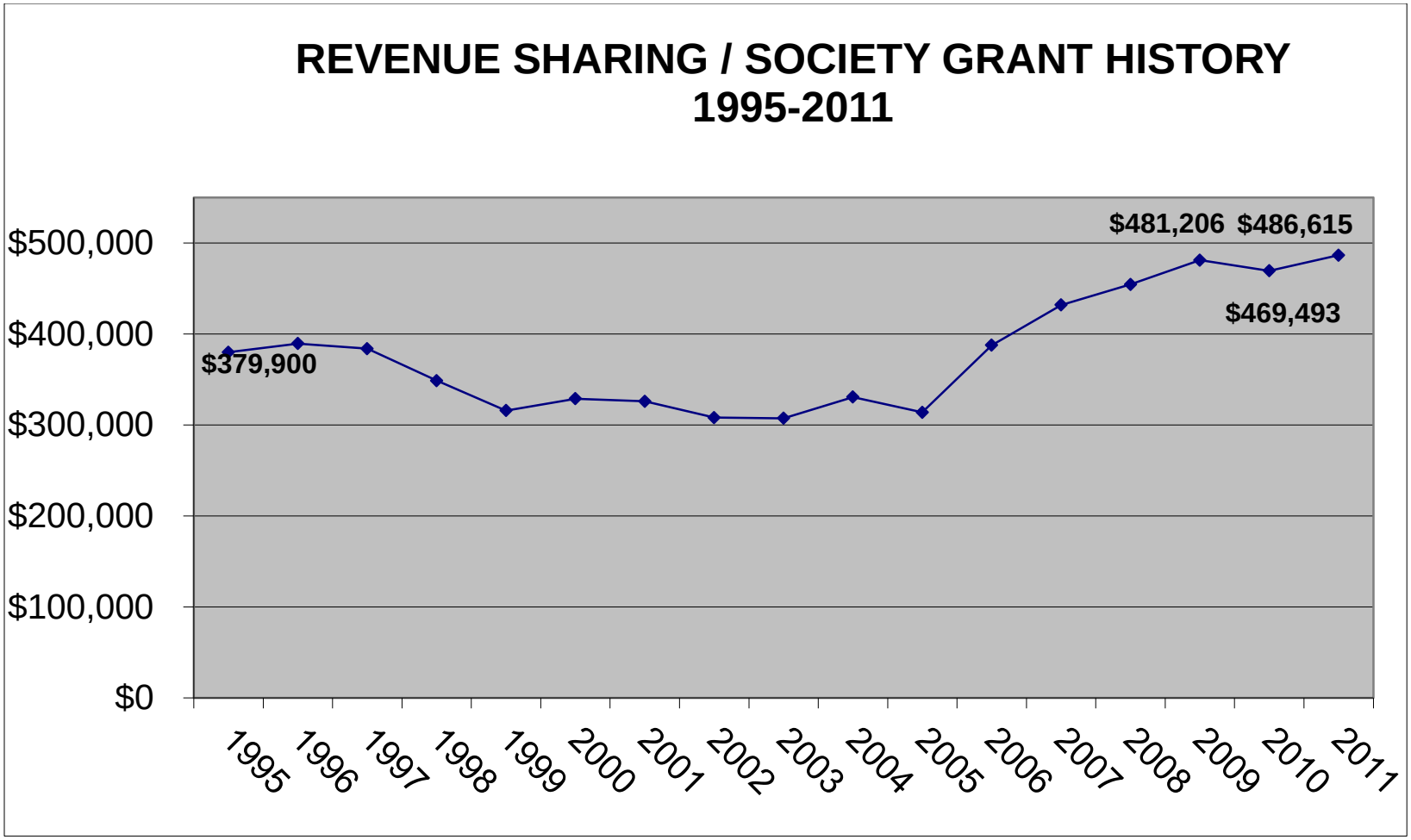
$158,839
$171,145
$274,187
$224,366
$243,295
$250,118

AARC 2011 REVENUE MIX - %'s
(Ignores ALL Investment Activity)



AARC 2011 REVENUE MIX - $$$
(Ignores ALL Investment Activity)




REVENUE SHARING / SOCIETY GRANT HISTORY
1995-2011
$500,000
$400,000
$300,000
$200,000
$100,000
$0
$379,900
$481,206
$486,615
$469,493
1995
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2010
2011

2012 AARC Professor's Rounds Topics and Professors

Production Date	**Program Title**/Sponsor	**Professor**/ Moderator	Description
Jan 6 Friday **#1 April**	The Mandate to Reduce Hospital Readmissions- How Respiratory Therapists Can Help Sponsor: Monaghan	**John R. Walton MBA RRT FAARC** Sam Giordano, MBA RRT FAARC	This presentation will review the financial impact of readmissions from COPD, CHF and pneumonia, and explain the forces driving the increasing focus on reducing readmissions. Specific actions that can be taken by respiratory therapists to improve quality reduce readmissions, and control costs will be discussed.
February 10 Friday **#2 May**	Medical-Legal Implications of the Changing Healthcare System for Respiratory Therapists	**Anthony L DeWitt, JD RRT FAARC** Douglas S. Laher, MBA RRT	With the implementation of the Affordable Care Act, new medical-legal issues will emerge and present challenges for healthcare administrators and respiratory therapists. This presentation will review these issues and provide advice to address them. .
March 20 Tuesday **#3 June**	Reducing Cost while Adding Value- Critical Roles for Respiratory Therapists Sponsor: Draeger	**Rick Ford, BS RRT FAARC** Douglas S. Laher, MBA RRT	The focus of this presentation is on reducing the total cost of care while insuring safety and quality in delivering respiratory services. Strategies presented include reducing misallocation in inpatients through the application of CPGs, use of protocols, and application of tools to efficiently manage personnel. Emerging performance and risk-based reimbursement programs including the preventable admissions of respiratory patients, effective discharge of patients with chronic pulmonary disease and health promotion provide new opportunities for RTs to play a valued role in reducing the cost of inpatient care.
March 26 Monday **BONUS**	Effectively Treating Tobacco Dependence: We Can Move the Mountain	**Michael Fiore, MD MPH MBA** Sam Giordano, MBA RRT FAARC	New and effective treatments for tobacco dependence exist and respiratory therapists are in an unequaled position to deliver these treatments. Current findings have documented that these new treatments can assist both smokers willing to make a quit attempt now and those not yet ready to quit but willing to reduce their smoking. RTs are already on the front line dealing with outcomes of tobacco dependence. New tobacco dependence treatments position them to now assume the key role of preventing these adverse pulmonary and other outcomes from tobacco use.
May 7 Monday #8 November	Improving Patient Safety- How Respiratory Therapists Can Contribute	**Karen Frush, MD** Ira Cheifetz, MD	This presentation will review the history of the current focus on patient safety, cite examples of positive economic and clinical outcomes resulting from patient safety initiatives and discuss how respiratory therapists can become change agents to improve overall patient safety in their workplace

May 29 Tuesday **#4 July**	Managing the Chronically Ill Pediatric Respiratory Patient	**Bruce K Rubin, MD MEngr MBA FAARC** Timothy R. Myers, BS RRT-NPS	This presentation will focus on management of chronic pediatric respiratory diseases including cystic fibrosis, asthma, neuromuscular, and long-term ventilator-dependent patients in acute care, pulmonary clinics and the home. Best practices supporting delivery of respiratory services to these patients, and the skills and knowledge required of RTs to achieve the best outcomes, will be discussed.
May 30 Wednesday **#5 August**	Educating Patients with Chronic Respiratory Disease – RTs Make the Difference	**Timothy R. Myers, BS RRT-NPS** Tom Kallstrom, MBA RRT FAARC	This presentation will identify how RTs can effectively provide educational interventions while providing therapy or conducting diagnostic testing for patients that have asthma, cystic fibrosis or COPD in both the inpatient and outpatient setting. The focus of these teachable moments is to enhance quality of life, assess the efficacy of treatments, and minimize the frequency of exacerbations or daily morbidity
July 24 Tuesday **#6 September**	Palliative and End-of-Life Care: What Respiratory Therapists Need to Know	**J.Randall Curtis, MD MPH** Dean Hess, PhD RRT FAARC	This presentation will provide an overview of palliative and end-of-life care for two patient populations: patients with chronic respiratory disease and patients with acute respiratory failure and critical illness. Areas of knowledge and skill needed by the respiratory therapists in caring for these patients and identifying key palliative care resources within the workplace and community will be covered.
July 25 Wednesday **#7 October**	Get 'Em Movin' - Early Mobility for Ventilator-Dependent Patients Sponsor: CareFusion	**Eddy Fan, MD FRCPC** Dean Hess, PhD RRT FAARC	This presentation will review a growing body of evidence that mobility of ventilator dependent patients in ICUs leads to quicker liberation from mechanical ventilation. Strategies for developing an effective mobility interdisciplinary team and a review of the technology involved will be discussed.

2012 Webcast Topics and Presenters

Date	Section	Topic	CRCE category/ Sponsor	Presenter	Description
Jan 18 Wed 1:00	Adult Acute Care	Advanced Modes of Mechanical Ventilation	Adult Acute Care	Rich Branson, MSc, RRT, FAARC	New modes of mechanical ventilation are frequently added to ventilators without evidence of improved outcomes or efficacy. This webcast will review the newest modes of ventilation with respect to physiologic and clinical outcomes. Proposed advantages will be compared to proven advantages. Cost and complexity of each new technique will also be reviewed.
Feb 2 Wed 1:00	Mgt	Reducing Hospital Readmissions: Evidence and Conjecture		Cheryl A Hoerr MBA RRT CPFT FAARC	Data regarding readmissions to acute care hospitals and the financial impact avoidable readmissions have on the hospital's bottom line will be examined. Proven strategies and action plans focused on creating untraditional roles for the RT to help solve this problem will also be discussed.
Feb 22 Wed 1:00	Neo-Peds	Pediatric Non Invasive Ventilation	Neo Peds	Tom Cahill, BHS, RCP, RRT-NPS	This presentation will discuss the specific challenges that occur in the pediatric population for the successful application of noninvasive ventilation. Disease states that typically require NIV will be reviewed along with an assessment of those which respond favorably to non-invasive approach. The technologic equipment and interface challenges of NIV for infants and children will be discussed.
Mar 15 Thurs 1:00 Cent		Checklists for Safer Intra-hospital Transport of Oxygenated Patients	Patient Safety	Patrick Dunne, MEd, RRT, FAARC	When patients at risk for oxygen desaturation are transported within the hospital, continual monitoring with pulse oximetry is essential. Should the patient also require supplemental oxygen during transport, the monitoring process becomes even more important. Safety checklists are now available to ensure patient status, the pulse oximeter and the supplemental oxygen delivery device are properly assessed for optimum performance prior to transport.

Mar 28 Wed 1:00	CC/Rehab	Strategies for Addressing The New Pulmonary Rehabilitation Reimbursement Reductions		Gerilynn Connors, BS RRT FAARC /Debbie Koehl MS, RRT-NPS, AE-C	In January 2012 Medicare drastically cut the reimbursement for Pulmonary Rehabilitation G0424 billing code. The presenters will explain why this has occurred and will provide step by step instruction on how you can educate your finance department on the combination of services involved in G0424 to gain appropriate reimbursement for your facility.
April 9 Mon 1 Central		Projected Healthcare Employment-What is in the Future for Respiratory Therapists?		Steve Collier PhD	With healthcare employment projected to grow in the future, but stagnant at present, what does that mean for respiratory therapy? The new Bureau of Labor Statistics projections for 2010-2020 will be reviewed and placed within the context of recent AARC reports on respiratory care and its workforce in 2015 and beyond.
May 2 Wed 1:00 Central		Pulse Oximetry: Advances in Technology		Tim Myers, MBA, RRT-NPS	Waiting for a response
May 23 Wed 1:00 CDT	Sleep	Home Sleep Apnea Testing		Suzanne Bollig , BHS, RRT-SDS, RPSGT, R. EEG T., FAARC	This presentation will provide an overview of home sleep apnea testing to include associated clinical challenges, practical applications, and its role in the diagnosis and treatment of sleep apnea.
June 6 Wed 1:00 CDT		The Role of Checklists in Reducing Critical Care Readmissions	Patient Safety	Charlie Durbin, MD FAARC	In this presentation, common causes for readmission will be identified and the impact of readmission on patient mortality and hospital costs will be explored. . Objective determination of readiness for ICU discharge is an evolving area of interest that may impact this problem. Dr. Durbin will discuss a novel data collection and scoring form developed by the AARC to be used at ICU discharge to identify patients at risk for readmission. Strategies directed at this high-risk group should reduce the readmission rate

					and improve survival
June 20 Wed 1:00 CDT		Ventilator Graphics Made Easy		Felix Kushid	Description to be provided
July 11 Wed 1:00 CDT	Diagnostic	Cardiopulmonary Exercise Testing: Performing a Quality VO2 Max Assessment.		Carl Mottram, BA, RRT, FAARC	This presentation will review a how the respiratory therapist can influence the test quality of a cardiopulmonary exercise test (CPET) using the path of workflow QA model.
TBD	Education			Awaiting response from Joe Sorbello	
Aug 1 Wed 1:00 CDT	Long Term Care	New Value-Added Roles for RTs in Long Term Acute Care Hospitals		Garry Kauffman MPA, FACHE, RRT FAARC	This presentation will provide a review of operations and CMS admission criteria for LTACHs, review the discharge process, and describe the role of the RT in facilitating a smooth transition for the patient from the STACH to the LTACH and the LTACH to the next level of care. Challenges for LTACHs, including financial penalties for discharge/admission between LTACHs and STACHs will be discussed.
Aug 14 Tues 1:00 CDT		The Future of the Respiratory Therapist in Homecare (Competitive Bidding, Reimbursement)		Joe Lewarski	Now, more than any other time in the history of homecare, the role and value of the home respiratory therapist is being questioned The home medical equipment and health care business is changing at a rapid pace. National competitive bidding, new health care policies, audit pressures and continued reimbursement pressures have placed significant strain on many providers. This presentation examines the potential future role of the home RT.
Sep 26 Wed 1:00 CDT	Transport	Advances in Transport Mechanical Ventilation		Joe Hylton, BSRT, RRT-NPS, FAARC	Mechanical ventilation requirements in the critical care transport arena have progressed significantly. Patient-ventilator interactions, ventilator induced lung injury and lung protective approaches are now commonly encountered by transport teams. Technological advances are now allowing highly skilled respiratory therapists to bring the ICU to the bedside in transport, maintaining a high level of specialized critical care.

		NON SECTION WEBCASTS			
TBD		NDMS, DMAT, MAC-ST, etc.		Lewis Rubinson, MD, PhD	Waiting for a response
Dec 12 Wed 1:00 CDT		How Quality Care Impacts Payment - What You Need to Know		Ann Marie Hummel	This presentation is designed to bring you up-to-date on some of the most important aspects of the new Medicare programs linked to quality, discuss how providers will be impacted by the changes, and examine the role respiratory therapists can play in patient care.

CoARC Report

See Attachments:

“CoARC Update to AARC Board 4.12”
“Response to AARC on 2015 Recommendations 3.24.12”
“2011 CoARC Report on Accreditation 3.24.12”
“Cirriculum Survey Summary _02162012”

State Government Affairs Activity Report

April 2012
Cheryl A. West, MHA
Director Government Affairs

Most state legislatures reconvened in January. States continue to struggle with a weak economy and the continuing pressure to find other sources of revenue to meet the responsibilities of providing both services and mandated benefits to its citizens. In light of budgetary pressures, expansion of existing state health services, which could include respiratory therapy, continues to be a very difficult endeavor. One pattern of legislation that is clearly continuing is to raise state revenue through a variety of methods. These range from raising taxes, such as tobacco taxes, increasing fees, such as licensing fees (example professional licenses including RTs) or increasing the cost of state provide services or "products" (tuition at state supported colleges, as a noteworthy example) all aimed at bringing more revenue into the state coffers.

Legislation

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

The bills listed below highlight key legislation. FYI, many states, too numerous to mention, introduce and often pass legislation that limits smoking in public places or raises taxes on tobacco. This year has been no exception.

RT Licensure Legislation

Iowa- legislation that would permit physician assistants and advanced nurse practitioners to write RT orders (in addition to physicians). A further amendment to this bill changes the terminology to "qualified health care provider*"* and then defines them as NPs and PAs. This is in keeping with the recent CMS Medicare HCOPS changes which also references "qualified health care provider*"*

Missouri- similar legislation as in Iowa, but this bill would only extend RT order authority to advanced practice nurse

Comment: both of these bills arise from the relaxing of Medicare Hospital Conditions of Participation for RC Services, where RTs may take orders from a select set of non physician practitioners without the need of a physician co-signature. However, one of the stipulations by CMS for this more lenient policy is that this must be "in accordance with state laws". If RT licensure laws permit RTs to take orders only from physicians, then this less restrictive Medicare policy cannot be implemented. Therefore, the legislation in MO and IA, (where current RT Licensure law only permits the RT to accept orders from physicians) is an effort to change the law in order to meet the requirements of CMS's more flexible policy on RT orders

Arizona, Idaho, Mississippi and Wisconsin -technical corrections to RT licensure law

Arizona- a bill that initially amended the RT Licensure Law to require the RT Licensure Board to issue a temporary license to all applying RTs (removed *may* and inserted *shall*) was subsequently revised back to 'may".. This "fix" came about due to the rapid response of the ASRC

California- a bill that would fine up to $100,000 and 1 year in jail if someone impersonates a licensed RCP or buys or sells a RCP license

Oklahoma will raise RT license fee from $75 to $100. Also, FYI a bill that would require RTs to maintain a valid NBRC credential for license renewal (although OSRC lobbyists state this bill is dead for this session)

Oregon will raise RT license fees an additional $50 to $100

Generic Health Profession Licensure Legislation that Includes Respiratory Therapists

Colorado, **Nebraska, Ohio, and Oregon-** these states have legislation that would permit in some way those in the military or the spouses of those in the military to more easily obtain a health professional license. In essence, the education or testing requirements for licensure, in some fashion would be waved for these individuals and their experience accepted in lieu of formal education and testing

Florida- a bill requiring all licensed health professionals to wear name badges with showing professional credentials when providing health services

Oklahoma- revises several provisions of various health profession licensure laws, including RTs. The intent is to consolidate disciplinary violations under one "roof" for most licensed health professions

Other Legislation of Interest to the Profession of Respiratory Therapy

Kentucky- a bill that would require DME Suppliers whose "principle place of business" is outside of KY and who provide DME services and equipment within KY (i.e. crossing state lines) to have a physical office in KY

California, Connecticut, Florida, Georgia, Mississippi, New Hampshire, New York, Pennsylvania, Washington State, West Virginia (enacted) Wisconsin - would require pulse oximetry testing (among other tests) for newborns. **Colorado** would study the need for pulse ox for newborns

Connecticut a bill that would establish a Medicaid pilot program to provide home care for vent dependent patients with care provided only by LPNs and RNs. CSRC has reached out to legislators to request RTs be included as providers of vent care

New Jersey- legislation that would establish a School Asthma Protocol Task Force. **NJ** also has two Good Sam bills protecting against liability for licensed health professionals providing services in an emergency

Florida, Hawaii, Illinois, Kansas, New Jersey, New Mexico, Mississippi and Utah- - have legislation that focuses on COPD, requesting more study on the causes of COPD and developing strategies for prevention and management

Alabama, Florida, Indiana and Iowa have legislation that either designates a COPD Day or a COPD Month

New York- a bill permitting nebulizers on school grounds. Another **NY** bill requires when teaching CPR in high school, the instructors must include the training on the proper use of nebulizers and these instructors must in turn be certified by a nationally recognized entity in the use of nebulizers. Another **NY** bill would require an asthma action plan for pupils who are permitted to use asthma meds on school grounds

Virginia- hospital and "other health care facilities" would have to report on certain health conditions including the incidence of asthma

Respiratory Related 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

Florida- tweaks how to account for continuing education credits for license renewal. **Iowa and Delaware** also make technical changes to continuing ed credits.

Louisiana makes long anticipated changes to RT regs but nothing major

Nevada- amends RT license expiration, technical change

Alabama- will increase reimbursement for nursing facilities that care for vent or trach patients.

Maryland- decreases Maryland Medicaid reimbursement for oxygen and related respiratory equipment from 98 percent to 90 percent of Medicaid's reimbursement rate. Also requires providers of oxygen and related respiratory equipment to document face-to-face encounters with Medicaid recipients within 6 months prior to ordering oxygen services, supplies, and equipment

Oklahoma- removes the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) because CMNs are no longer used for authorization decisions

Concerns or Challenges from Other Occupations

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

States continue to introduce legislation that expands the role of paraprofessionals.

Washington State- there is legislation that the Washington RC Society is actively engaged in efforts to amend. This legislation would expand the scope of practice for unlicensed medical assistants, including providing "respiratory testing", which among other points of contention, is not defined. Also in **Washington State** current law permits nurses to delegate various services to certified nursing assistants. New legislation would permit nurses to delegate these same services to home health aides, with no reference to whether these home health aides have to be certified or meet any training or competency standards.

West Virginia- over the past 2 years WV has enacted laws that expand the role of unlicensed medication assistants employed in nursing homes. This year there are proposed revisions under what conditions these personnel may administer the approved meds.

Iowa- legislation that would create a new provider category termed "direct care professional" that would care for patients in the home and community settings. All very undefined. No set education, scope or competency testing, one point was clear this new category would not be required to be licensed. This goes to the overall point which is states are looking for ways to expand care provided by less costly paraprofessionals.

Mississippi has legislation that creates an "emergency medical technician-paramedic critical care" designation. The bill describes what these individuals may provide such as "advanced care". MS current law also permits EMTs and paramedics to provide services both pre-hospital and inter-hospital care.

Sleep Disorder or Polysomnography State Legislative Activities

Maryland
As noted in other Board Update Reports, the Maryland Polysomnography licensure law, was enacted prior to the availability of the American Academy of Sleep Medicine-AASM- the sleep physicians- 80 hour OJT training course. The MD Polysom licensure law requires polysom personnel to be graduates of CAAHEP accredited education programs. Being unable to meet this education standard, mandatory licensure has been delayed (for years) by the legislature several times.

The original law did not include a specific exemption for RTs, but rather a general exemption for other licensed health professionals who are practicing within their own scope of practice. It was the opinion of the Polysomnography Licensure Board, confirmed by States Attorney General, that if the RT were to provide any service or procedure listed in the Polysomnography scope of practice (task specific) but not specifically listed within the RT scope of practice the RT would require a polysom license.

Both the Sleep Community and the MD/DC Respiratory Care Society supported a delay in the 2011 implementation date. The legislature extended the deadline until 2013. And while mandatory licensure for sleep personnel was delayed until 2013, so too was the requirement that RTs providing sleep services under their own license will have to obtain a polysom license.

The MD/DC Society has engaged a lobbyist to advance a bill that would provide an exemption (somewhat convoluted but an exemption nevertheless) for the RTs. The Maryland Board of Physicians has weighed in requesting that RTs providing sleep must hold, at a minimum, the SDS credential. The MD/DC Society is opposing this recommendation.

A panel of RTs testified in at a February hearing in support of an RT exemption. The panel included Dr. Cliff Boehm (BOMA rep and MD physician – and former RT). The legislative situation in Maryland is very fluid, and I will provide the most up to date information at the BOD meeting.

Iowa
The "standard" polysom licensure bill was introduced in this legislative session in Iowa. The bill contained objectionable provisions that we have seen in all recent polysom licensure legislation, including no explicit exemption for RTs; insertion of the AASM's OJT A Step course as comparable to CAAHEP accredited polysom education programs; and a provision that would provide a backdoor giving the Polysom Licensure Board the authority to accept the American Academy of Sleep Medicine's (AASM) non accredited test for the Registered Sleep Technologist as a measure of clinical competency.

The Iowa Society for Respiratory Care has had an open dialog with the IA Sleep Society, and a number of the concerns (education and testing) had been, more or less, satisfactorily addressed. However, the key issue of an explicit RT exemption was rejected by the IA Sleep Society.

The ISRC leadership both expressed its concerns to legislators as well as testified at a legislative hearing. The ISRC launched a statewide RT grassroots campaign with information and requests that went out to all IA RTs asking them to contact their own legislators and oppose the polysom licensure legislation. As a result of these efforts, the ISRC lobbyist has reported that the polysom licensure legislation was killed in committee (at least for this year).

New Hampshire and Louisiana- both states legislatures have technical changes to the current polysom licensure laws. None having any impact on the RT profession. The Louisiana Society is requesting that RTs be included in the revision that addresses supervision of polysom students.

I will provide a verbal update at the Spring Board Meeting.

Federal Government Affairs
Activity Report – April 2012

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

The Congress

The second session of the 112th Congress was convened in mid-January. For the most part, we can continue to expect debate on legislation to continue to be along Party Lines. As the date for the country's general election draws closer there is no reason to expect cooperation among Democrats and Republicans for the reminder of this short legislative year.

Certain of the "must pass" legislation such as payroll tax extension, unemployment insurance continuation, and the "doc fix" have already been extended through the rest of 2012. However, by the early fall or in a post election Lame Duck session these issues, specifically the "doc fix" will once again be on the agenda for 2013 and that may provide vehicle(s) for other legislation to be attached to these must pass bills.

We will continue to look for legislative opportunities to advance our Medicare Pt. B RT Initiative legislation.

Legislation

The Medicare Respiratory Therapy Initiative

The AARC's advocacy efforts remain focused the Medicare Respiratory Therapy Initiative (HR 941). We should all be aware that the sponsor of our bill, Congressman Mike Ross (D-AR) will not run for re-election this fall as many speculate he is seeking the Governorship of Arkansas during the upcoming November election.

AARC continues to face the challenge presented by the Congressional Budget Office (CBO) and the inaccurate score (i.e. cost) that our bill received during the hectic time of the 2010 health care reform debate. That score came to well over $1 billion. We have consistently maintained that this score could not possibly be that high, given the intentional limitations we put into the provisions. However, that "cost number' remains "out there", resulting in a hesitation for members of Congress (again given the climate) to embrace our bill.

Because of the intense partisan pressures and focus on the budget and the deficit finding a sponsor for our bill in the Senate has been extremely difficult.

The AARC PACT descended on Washington in early March and was joined by four patient advocacy groups that included: Alpha-1 Foundation; Alpha-1 Association; COPD Foundation and Pulmonary Hypertension Association. With about 200 participants this is one of our biggest lobby days yet. PACT members and their patient partners garnered additional support in the form of co-sponsors on the House side for HR 941. The lobby day has also generated numerous inquiries about the CBO score which we continue to leverage with Congressional Committee Staff to keep the pressure on for a new score or a justification of the past score. Many have indicated that there may be a vehicle for HR 941 if the CBO score is revised.

With all of the additional participants the AARC learned quite a bit about what it means to be in partnership with individuals who face health challenges. Miriam continues to follow-up with offices that are offering enquiries and with PACT members who are moving our agenda forward.

New Data Analysis Commissioned by AARC in Support of HR 941

In order to provide a credible response to the CBO cost estimate and to provide incentive for Members of Congress to support our bill or insist on a CBO re-score, the AARC commissioned a new independent analysis (Dobson/DaVanzo & Associates) of Medicare allowed charges and services between 2005 and 2010 for 21 respiratory codes expected to be used in the physician office/practice setting by qualified RTs if the bill were enacted.

According to the analysis, in 2010 there were 4,416,774 allowed physician services and **$131,581,286** allowed charges for respiratory services generally furnished in a physician's office/practice. The analysis shows the costs of services rose less than 10 percent between 2005 and 2010.

The survey data and Medicare analysis clearly suggest that the CBO estimate is vastly overstated and out of line with the intent of our Initiative. This was the key lobby point of the AARC annual Washington, D.C. Hill Lobby Day.

This new data provides the rationale for AARC members to ask their members of Congress to insist that CBO both provide the respiratory community with an clear explanation of the assumptions it used to calculate the over $1 billion dollar cost of our bill and redo the score for our bill.

Virtual Lobby Week

The AARC launched another successful Virtual Lobby Week at the end of February. We scheduled this event, with much fanfare, just prior to our Hill Day. We generated over 12,000 emails that supported our RT legislation and showed support from "back home' before the PACT RTs met with their Congressional delegations.
This year we included a "Countdown Clock to VL Week" on our main page to promote the upcoming event. We also enhanced the posting of Hill Day Photos taken by RTs and the Tweets 5 RT PACT reps agreed to post as they went about the Lobby Day.

As you know we have always had on Capitol Connection a draft email specifically for pulmonary patients to use to reach out to their Members of Congress. At the request of the Alpha 1 Association we developed a specific email message for Alpha 1 patients to send to the Hill in support of our Medicare RT legislation.

We also coordinated our launch of VL Week with the Alpha 1 Association, the COPD Foundation and the Pulmonary Hypertension Association. These important patient associations also geared up their members to use the AARC's Capitol Connection to email in their support of our Pt. B Initiative.

AARC Hill Lobby Day

For the 13th year AARC respiratory therapists and pulmonary patients from the Alpha 1 Foundation, the COPD Foundation, the Alpha 1 Association and new partner the Pulmonary Hypertension Association jointly went on over 350 scheduled Capitol Hill visits. This number of scheduled meetings is the highest number we have ever achieved and it is a great accomplishment. This year we had 136 RTs from 46 states and the District of Columbia advocating for our legislation. As always, we are grateful to both the dedicated respiratory therapists

who took time away from home to come and support their profession and the state respiratory societies who provided the funding for the RTs to travel to the Hill Day.

Moreover, as mentioned above, we had the largest contingent of patient advocates (32) and patient association (15) staff attend the PACT Monday Briefing, Tuesday Hill Day and Tuesday Evening Reception and Debriefing. Patient participation in voicing their support for the RT Initiative is very important in our efforts to advance our Pt. B RT Initiative. We are grateful to the patient advocates and the sponsoring organizations.

Our patient partners have continued to support the request for CBO review and co-sponsorship of HR 941. In addition, they have made requests for additional funding for the National Institutes of Health, and co-sponsorship of the pulmonary hypertension legislation HR 1810 which calls for a national education program. Patient partners encouraged their members to join the COPD Congressional Caucus.

Veterans Affairs Bill on COPD

HR 168, which is the legislation directing the Secretary of Veteran's Affairs to improve prevention, diagnosis and treatment for COPD, is still active. As reported in the past this bill was introduced by Congressman Cliff Stearns and John Lewis and has no known opposition.

NIH to Take Over COPD Plan from CDC

The Senate included language in their appropriations bill that directs the NIH, NHLBI to convene a planning meeting with the goal of producing a National Action Plan for COPD. This is a strategic shift from the previous request that this activity be undertaken by the Centers for Disease Control and Prevention. COPD advocates working with the US COPD Coalition felt that we stood a better chance of having this activity take place under the auspices of the NIH due to significant budget cuts at the CDC.

Technical Change to Medicare Outpatient Pulmonary Rehabilitation Benefit

When CMS wrote regulations to provide the details for implementation of the new Medicare outpatient pulmonary rehabilitation benefit, it held strictly to the wording of the statute passed by Congress which requires the programs to be physician supervised (applies to cardiac programs as well).

Senators Schumer (D-NY) and Crapo (R-ID) have introduced S 2057, a no-cost technical amendment that would permit physician assistants, nurse practitioners, and clinical nurse specialists to supervise pulmonary rehab (and cardiac programs). This is consistent with other Medicare outpatient therapeutic supervisory requirements.

The legislation is being supported by all of the physician professional associations that practice pulmonary care and the AARC.

HME Legislation - HR 1041- Fairness in Medicare Bidding Act

When the Home Medical Equipment (HME) industry first introduced legislation to repeal the competitive bidding program (HR 3790), it had considerable support from 259 co-sponsors but never made it out of committee or picked up a Senate companion bill. It also had been offered without an offset to the $20 billion cost to repeal estimated by CBO.

In March 2011, a new repeal bill was introduced by Reps Jason Altmire (D-PA) and Glenn Thompson (R-PA).

This time the bill language included a "pay for" by rescinding $20 billion in unobligated balances of all discretionary appropriations. However, it does not appear that the second attempt at appeal is moving forward.

With competitive bid implemented in 9 areas of the country and poised to expand to 91 areas by July 2013, an alternative to competitive is now being proposed on the Hill by AAHomecare. According to AAHomecare, the new concept, called the Market Pricing Program (MPP), "preserves more of the HME industry, saves the government money and provides better service to Medicare beneficiaries." They had hoped to have the legislation attached to the "doc fix" but efforts were unsuccessful.

S. 1461 – Traditional Cigar Manufacturing and Small Business Job Preservation Act

With the 2009 passage of the Family Smoking Prevention and Tobacco Control Act (PL 111-31), Congress gave broad authority to FDA over the manufacture, sale and marketing of all tobacco products, including cigars. The tobacco industry, however, has taken exception to the regulation of certain types of cigar products with the introduction of
S 1461. This bill would exempt certain cigar products that are flavored and most popular among youth. The AARC signed onto a joint letter organized by the Tobacco Partners that was distributed to all members of Congress opposing S 1461.

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 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.
As was the case in 2011, Congress is again focused on cutting funding for domestic programs. And as in 2011, most Coalitions are again focused on simply maintaining current budgets and limiting potential cuts to the programs of interest.

Asthma Control Funding in the CDC
Organized jointly by the American Lung Association and the Asthma and Allergy Foundation of America, the AARC is one of the many organizations to participate in efforts to enhance asthma education, management and control AARC signed on to a joint letter requesting that the CDC maintain it's current FY2010 funding for asthma control initiatives.

Tobacco Partners
The AARC continues its long-time relationship with the many organizations who participate in the Tobacco Partners Coalition (a Coalition organized and supported by the American Heart Association, the American Lung Association and the American Cancer Society).

Regulations and Other Issues of Interest

The majority of final regulations that have any impact or interest to the respiratory profession and AARC members in particular are generally published in the spring and fall of each year.

In our November 2011 update we provided information on a number of on-going activities that involve improvements in hospital quality of care, innovation and care coordination, and quality measures that the Medicare program will focus on in FY 2012 and future years. The regulations that had the most impact were the final payment rules for hospital outpatient services which severely cut the payment rate for pulmonary rehabilitation programs.

Outpatient Pulmonary Rehabilitation

It goes without saying that the drastic reduction in payment for hospital outpatient pulmonary rehabilitation programs from $68 to $37 per session beginning January 1, 2012, was a blow to all involved in this important aspect of caring for patients with COPD. When the final rules were published, however, it became apparent that the problem was with the hospitals, not with CMS. At issue is the hospitals' oversight in accounting for the ancillary services and components that make up the cost of running a PR program that were previously billed separately when they set the charge for the new single code. This action results in under-representing the cost of providing the services and can led to a significant adverse impact on future payments.

AARC, together with other pulmonary organizations, has determined the only course of action to improve hospital claims reporting is to educate hospitals on the issue. A multi-society PR Toolkit has been developed as a resource tool and several AARC members of our Continuing Care/Rehabilitation have volunteered to serve as contacts to assist hospitals in determining the appropriate charge for their individual programs. These RTs were also instrumental in contributing to the development of the Toolkit.

The Toolkit will be beta-tested with a diverse group of between 10-15 PR program directors to evaluate its level of understanding and usefulness. The formal launch of the education initiative should be underway by the time of the spring Board meeting. If all goes according to plan, the earliest we could hope to see a real improvement in the payment rate will be January 1, 2014. Unfortunately, there is no short-term solution.

Quality Reporting Measures

CMS made several changes to some of the proposed quality measures that impact COPD patients when final rules were published. This does not mean services will be discontinued; it simply means certain measures do not have to be reported to CMS.

Effective Jan. 1, 2012, CMS is no longer going to require hospitals to report tobacco-cessation counseling as part of the Hospital Quality Reporting System. The reasons are twofold: one is to reduce the hospital reporting burden, and the other is that hospital performance has been uniformly high nationwide with little variability among hospitals. The CMS action, however, does not preclude hospitals from continuing to improve their own performance on the measure.

CMS originally proposed 65 quality measures in five categories that Accountable Care Organizations must meet in order to participate in the program but narrowed it down to 33 in the final rule based on many comments they received about the burden and complexity of the original program design. Certain COPD quality measures (including spirometry evaluation and bronchodilator therapy) were among the proposed measures that did not make the final cut due to CMS' desire to offer a simpler and more streamlined set of standards to encourage ACO participation. One COPD measure that was retained, however, is aimed at reducing avoidable admissions and is outcome focused. A separate measure for tobacco cessation was also retained which is important for all patients.

The final quality measures as part of the voluntary Physician Quality Reporting System for FY 2012l include individual and/or group measures for COPD (including spirometry evaluation and bronchodilator therapy), asthma, tobacco cessation and sleep apnea. A pulmonary rehabilitation group measure was recommended for inclusion as well, but it lacked the number of measures needed to qualify and did not make the final list. However, CMS noted it was interested in including a PR measures group in the future.

Hospital Conditions of Participation

At the winter Board meeting a verbal report was given regarding proposed changes to certain Hospital Conditions of Participation (COPs). Changes include 1) allowing use of standing orders, order sets and protocols for the preparation and administration of drugs and biologicals as long as they meet certain requirements; 2) permitting a practitioner other than the ordering practitioner to authenticate orders in the medical record as long as he/she is also the one responsible for the patient's care and 3) incorporating the nursing plan of care into a comprehensive interdisciplinary plan that includes other disciplines such as respiratory care. The 48-hour timeframe for authentication of verbal orders would also be eliminated absent a state law mandating another timeframe.

CMS also revised its interpretive guidelines in November 2011 to bring them up-to-date with final rules that were published in 2008 dealing with who could write orders for rehabilitation and respiratory care services. We reported in previous board reports that CMS expanded the types of practitioners who could write respiratory care orders to include practitioners other than a medical doctor or doctor of osteopathy as long as they met certain criteria. When the final guidelines came out, however, they were more restrictive than the regulations and caused confusion among the hospital community. Some respiratory therapists thought rehabilitation orders included pulmonary rehab. They do not. A written order for rehabilitation services in this context refers to PT, OT and speech. CMS has since withdrawn the original transmittal and amended the guidelines to be consistent with the regulations.

Competitive Bidding

Registration for Round 2 of the Medicare Competitive Bidding Program is complete and the deadline to submit bids is March 30, 2012. Round 2 expands the program to 91 metropolitan statistical areas. Full implementation is scheduled for July 1, 2013**.** CMS will update Senate staff members on Rounds 1 and 2 in a meeting scheduled for March 14, 2012.

Conclusion

The AARC will continue our efforts on Capitol Hill to advance our legislative agenda. We believe our increased efforts to partner with patient organizations and other like minded associations will provide forward momentum in achieving our goals. 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: Karen Schell

Last submitted: 2012-03-22 10:05:49.0

Recommendations

[No Recommendations at this time]

Report

Agenda for the summer House of Delegates meeting in Santa Fe is being developed and will be finalized by deadline for the Agenda Book.

Speaker of House of Delegates has worked closely with the AARC office, (Tina Sawyer and Sherry Milligan) to update the HOD roster with new delegates and current photographs, the HOD AARConnect, HOD AARConnect Committees, and are currently up to date until affiliate elections are completed. As the results of the elections come in, names will be forwarded to the AARC office for quick update. Thank you to the AARC staff for their assistance in getting this updated quickly after the winter meeting.

House officers have been assigned as liaisons for specific committee and are in communication with said committees to assist in meeting goals set by the speaker.

All committees have been communicating via the AARConnect and moving forward with specific goals assigned. All have been updated with current members and committee chairs are communicating regularly with the Speaker as work continues. We are very pleased with the enthusiasm of committees and their progress on goals.

Notices have been sent out for Delegates Assistance, Outstanding Affiliate Contributor, Life Membership, Summit Award, and Resolutions by respective committees in preparation for the summer meeting.

A survey is going out soon to Delegates from Speaker for "how we are doing" follow-up from survey done last fall prior to the winter meeting and to improve summer meeting and HOD processes.

ADHOC Committee on policies has been hard at work revising the Delegate Handbook and updating policies. All committees have been working with this committee to improve processes and have clear instructions for the future.

Four presentations are ready to go by the Best Practices Committee for the summer meeting. The Past Speaker of HOD is updating the tracking template of Resolutions for completeness and is credentialing new delegates for the summer meeting.

Board of Medical Advisors Report

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Medical Advisors Meeting
November 6, 2011 • Tampa, FL

Minutes

Attendance
Joseph W. Sokolowski, MD, FACP, FCCP (ATS) **Chair**
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
Richard Sheldon, MD, FACP, FCCP, FACP (ATS)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)
William Bernhard, MD (ASA)
Steven Boas, MD (AAP)
Cliff Boehm, MD, RRT, (ASA)
Terence Carey, MD (ACAAI)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Lori Conklin, MD (ASA)
Brett Gerstenhaber, MD (ATS)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
Barrett Kitch, MD (ATS)
Harold Manning, MD, FCCP (ACCP)
Phillip Marcus, MD, MPH, FCCP, FACP (NAMDRC) **Chair-elect**
Peter Papadakos, MD, FCCM, (SCCM)

Guests
Gregg Ruppel, NBRC President
Gary Smith, NBRC Executive Director
Lori Tinkler, NBRC
David Bowton, CoARC President
Tom Smalling, CoARC Executive Director
Karen Stewart, AARC President

Absent
Bradley Chipps, MD (ACAAI)
Kent Christopher, MD, RRT, FCCP (ACCP)
Robin Elwood, MD (ASA)
Col. Michael Morris, USA, RET
Christopher Randolph, MD (AAAAI)

Consultant
Tim Myers, BS, RRT-NPS, AARC Past-President, BOMA Liaison

Staff
Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, Chief Operating Officer
Cheryl West, MHA, Director of Government Affairs
Miriam O'Day, Federal Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
Chairman Sokolowski called the meeting of the AARC Board of Medical Advisors to order at 10:02 a.m. EST, Sunday November 6, 2011.

INTRODUCTIONS
Chairman Sokolowski asked members to introduce themselves. Dr. Sokolowski called roll and declared a quorum.

APPROVAL OF MINUTES
Dr. William Bernhard moved "To accept the minutes of the June 4, 2011 meeting of the AARC Board of Medical Advisors."
Motion Carried

CoARC (Commission on Accreditation for Respiratory Care) REPORT
David Bowton and Tom Smalling gave highlights of their written report. A discussion arose with CoARC regarding proprietary schools and the standards they set and the lack of jobs when students graduate. This discussion was tabled and Dr. Kageler and Dr. Sheldon were asked to create a recommendation to the AARC BOD later in this meeting.

As of October 2011 there are 396 programs offering an Associate's degree, 53 a Baccalaureate and 2 a Master's. CoARC will undergo a site review by the Council on Higher Education Accreditation (CHEA) after a self-evaluation process this year. In March 2011 CoARC established Ad-Hoc committees on International Accreditation and Master's Degree Accreditation. As of December 2011 the web site of CoARC will present 3 year aggregate program data on both CRT and RRT credentialing success, attrition, job placement and total numbers for program enrollees and graduates. The attrition threshold was recently changed from 30 to 40%. Beginning with 2010 as the reporting year CoARC will collect graduate and employer data on the overall "satisfaction rating" of respiratory therapy programs.

NBRC (National Board for Respiratory Care) REPORT
NBRC president, Greg Ruppel gave highlights of the written report. The American Academy of Sleep Medicine (AASM) has modified their accreditation standards for Sleep Disorder Centers to recognize the CRT-SDS and RRT-SDS credentials. The Board of Respiratory Therapy in Ohio has adopted a workgroup recommendation that the RRT become the minimum requirement for licensure in the future. The NBRC opposes this change. An Adult Critical Care Exam will be available mid-2012. Licensure examinations are be developed for Saudi Arabia

An active discussion by BOMA members ensued following these presentations by CoARC and NBRC relevant to the standards for proprietary versus non-proprietary programs. Competition for clinical sites by these programs has posed an increasing problem. It is recommended that a needs assessment be accomplished before the establishment of new programs with the utilization of affirmation forms reflecting a lack of impact on existing local programs.
AARC Executive Office REPORT
Tom Kallstrom gave highlights of the AARC Executive Office report. Two new courses that will begin being offered in January 2012 are Alpha 1 and VAP Workshop. The Aerosol Delivery Device book will be translated into its 5th language – Italian.

PRESIDENT'S REPORT

AARC President Karen Stewart gave an overview of her written report.

The AARC Disaster Relief Fund assisted over 45 members and their membership fees were waived for one year. President Stewart is considering raising the cap to $1,000 from $500.

The current Clinical Practice Guidelines are out of date and the AARC will use restricted funds up to $250k to create evidence based guidelines.

The AARC Bylaws are being updated and should be complete by April 2012.

LEGISLATIVE AFFAIRS REPORT

Federal Government Affairs

Miriam O'Day, AARC's Director of Legislative Affairs provided an update on the Congressional activities of interest to the RT profession. Congress is entirely focused on budget and debt issues, in particularly the potential actions of the "Super Committee" tasked with finding $1.3 trillion dollars in savings. Because of this near total focus on cost savings efforts, Congressional action on any other legislation, including AARC"s HR 941, the Medicare RT Initiative has been stalled. We will continue our efforts to move our bill forward in 2012; our focus will be on urging our Congressional supporters to assist with a new CBO cost analysis. We will begin to plan for our March 2012 PACT Lobby Day where despite the current climate RTs and pulmonary patients who will once again join us, will continue to advocate for our legislation. The AARC is also supporting S 1350 and HR 2505 the Pulmonary Fibrosis Research Legislation.

Anne Marie Hummel, AARC's Director of Regulatory Affairs discussed the most recent regulatory actions by CMS. Most notably, the final rules that will provide only $37 reimbursement for the pulmonary rehabilitation code… an unsustainable amount. AARC along with its Pulmonary Rehab association partners will meet in December 2011 to develop a response strategy the organizations can take to CMS to try to amend the new payment. It was also reported that CMS has revised aspects of the Medicare Hospital Conditions of Participation that will decrease paper work requirements for hospitals. Several of the revisions will be advantageous to respiratory departments. AARC has also written to the Department of Veteran's Administration requesting clarification on the license/credential policy it has for employing RTs in the VA system.

State Government Affairs

Cheryl West, AARC"s Director of Government Affairs provided additional details to the State Government Affairs Report. This update included a more detailed discussion on the new ABSM's polysomnography exam and credential the Registered Sleep Technologist-RST. Respiratory Care Licensure Boards are receiving requests by the ABSM to formally rule that those who hold this non accredited credential should be exempt from the respiratory care licensure law, thus be allowed to provide the full scope of practice of the respiratory profession. AARC's response is to recommend that RC Licensure Boards inquire if the new exam has been accredited by an independent accrediting agency, such as the NCCA, as being valid and reliable. In addition, State Societies were urged to make sure their Legislative Committees were fully prepared to address any new challenges and opportunities that will occur once most state legislatures come back into session January 2012. States will continue to look for ways to find budget savings, which may include rescinding professional licensure (MI and VT have tried) or

expanding the scope of practice of para-professionals into clinical areas where competency has not been documented.

RECESS
Chairman Sokolowski recessed the meeting of the AARC Board of Medical Advisors at 12:31pm EST, Sunday, November 6, 2011.

RECONVENE
Chairman Sokolowski reconvened the meeting of the AARC Board of Medical Advisors at 1:06pm EST, Sunday, November 6, 2011.

MEDICAL ADVISOR REPORTS
Members gave brief overviews of their respective organizations.

SPECIALTY SECTION REPORTS
The Specialty Section Reports were reviewed.

Education Section Report
Dr. Paul Selecky moved that the "AARC President appoint a representative of BOMA to the Ad Hoc Committee on 2015". Dr. Richard Sheldon was suggested. This recommendation will be presented at the New BOD meeting on Tuesday, November 8, 2011.
Motion carried

OTHER REPORTS
ARCF and International Committee reports were reviewed.

Dr. Sokolowski thanked Sam Giordano and the AARC for their assistance with the Haiti earthquakes. There currently are no respiratory therapists in Haiti and Dr. Sokolowski and a team of volunteers RTs are going there next month to educate.

Dr. Sokolowski suggested that the term of the BOMA Chair should be extended to two years. Dr. Bernhard moved to accept. This suggestion requires a Bylaws change.
Motion carried

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS
Dr. Aranson asked for a response from BOMA regarding the rescinding of the RT licensure CE requirement in Maine. Dr. Sheldon moved to "resolve that BOMA support continuing education for maintenance of licensure for respiratory therapists in all states."
Motion carried

Dr. Aranson moved "that the BOD consider smoke free properties/venue for future annual meetings."
Motion carried

Drs. Kageler and Sheldon will work together and report on a potential resolution regarding proprietary vs. non-proprietary schools.

MOTION TO ADJOURN
Dr. Phil Marcus moved "To adjourn the meeting of the AARC Board of Medical Advisors."
Motion Carried

ADJOURNMENT
Dr. Sokolowski adjourned the meeting of the AARC Board of Medical Advisors at 2:42pm EST, Sunday, November 6, 2011.

President`s Council

Sumbitted by Margaret Traband
4/1/2012

Recommendations

No Recommendations

Report

The President's Council Meeting occurred on Sunday, November 6, 2011 in Tampa, Florida

- The 2011 Award Winners were introduced
- Reports were given from
    - The 2011 AARC President Karen Stewart
    - The 2011 AARC House of Delegates Speaker Bill Lamb
    - International Guests Yuan Yue-hau and Dr. Xiangyu Zahng, Governors for China
    - The 2011 Chair of Commission on Accreditation for Respiratory Care David Bowton
    - The 2011 NBRC President Gregg L. Ruppel

The President's Council selected Dr. Bruce Rubin the 2012 Jimmy A. Young Medal Winner. Dr. Bruce Rubin has made many contributions to the AARC and related organizations such as the ARCF, BOMA ICRC to name a few. The results were announced to the Council on February 9, 2012. Margaret Traband notified the award winner.

Standing Committee Reports

Audit Sub-Committee

Reporter: John Steinmetz
Last submitted: 2012-03-30 09:20:06.0

Recommendations
The Audit-Sub Committee recommends that the AARC Board of Directors (BOD) review the discretionary employer contribution percentage amount and determine if this is still within an acceptable limit and consider the development of guidelines for future contributions. An independent benefits consultant might be considered.

Report
The AARC Audit-Sub Committee met via phone conference on Thursday, March 8, 2012. The committee reviewed the Consolidated Financial Statements and Independent Auditors'' Report dated December 31, 2011 and 2010 and found the records to be in compliance with accounting principles generally accepted in the U.S.

The committee discussed the auditors'' remarks in Note 7: Employee Benefit Plan. The plan requires a 3% contribution to employee compensation; however, the Organization may make discretionary contributions above the 3% minimum. Actual contribution for 2011 and 2010 total 8% of eligible employees'' base salary and were approximately $212,600 and $222,000, respectively. It was unclear to the Audit Sub-Committee, what the decision process is for discretionary contribution, what guidelines exist regarding amount of discretionary contribution, and how this compares to other similar organizations.

After the phone conference, additional information was received from Bill Sims of the Auditors (see below). Bill presents a historical perspective of the current discretionary contribution. It appears that it has been 10 years since the BOD critically reviewed the discretionary contribution amount and that no guidelines exist.

E-mail from Bill Sims, Auditor:

Good morning John,

I trust you had a good weekend and your Monday is going well so far.

Tony Lovio contacted me this morning after learning late last week that there was a discussion and then a proposal by the Audit committee regarding the compensation discussion we had after he dropped off the phone call a couple of weeks ago. He called me asking about that discussion, and I told him my recollection was that the discussion was about overall compensation of AARC people relative to other nonprofits. I also told him that with the change in ED/President, that it might make sense to look at it. I also remember asking if there was a compensation committee that was charged with overall review of the compensation and benefits for staff.

Tony then went on to tell me that the proposal concerned having a plan consultant look at the benefit plan, and he asked me if that was my take-away from that part of the meeting; I told him what I described above.

However, given his understanding, he pulled together the information below on the history of the retirement plan contribution.

The history of the 8% contribution is as follows:

- *The 8% goes back as far as SEPT 1985 (based on the employee manual at that time which specifically mentions it). I could not find exactly when the pension / retirement went into place but it was approximately in the 1982-85 timeframe that it occurred. I do know it was a different type of plan and NOT a 401K*

- *In April 1997, when Wells Fargo was replaced by Alliance Trust for a short time as the trustee, the BOD did have a resolution adopting / ratifying the money purchase (pension) plan at that time and within it was a specific 8% Employer contribution reference--thus, the BOD approved / ratified the 8% at that time.*

- *When we went to the 401K plan, it was simply adopted and approved by the BOD in July 1997. However, this plan did not call out a specific figure for an employer contribution. I suspect the 8% simply carried forward and was built into the budget process each year since which was then approved by the BOD.*

- *The 3% safe harbor / XX % discretionary employer contribution split (of the current, although not specified, 8%) came about 1/1/2003 and was approved by the BOD as an overall plan update/ restatement in October 2002.*

- *The 8% has been built into the budget each year (for at least the last 15 years, probably longer) and has been approved by the BOD each year as part of the normal budget process ever since.*

John, you guys can make any recommendation you choose, but I wanted to reach out to you to see if my understanding was incorrect, or if you and/or the committee had gone on beyond that discussion to where you are now regarding the plan consultant. And I wanted to reach out and make sure I talked with you prior to what Tony said was the proposal going out today.

I'm out of my office today, but I'd be happy to talk with you if you so choose. My cell number is 214.912.8979.

Thanks.

Bill Sims, CPA
Salmon Sims Thomas
972.341.9545 888.332.4829

Other

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

Bylaws

Reporter: Rick Weaver

Last submitted: 2012-03-23 14:57:25.0

Recommendations

- Recommend that the AARC BOD accept and approve the Alaska Society for Respiratory Care Bylaws.
- Recommend that the AARC BOD accept and approve the Michigan Society for Respiratory Care Bylaws.

Report

They Bylaws Committee has reviewed the bylaws submitted by the Alaska and Michigan Societies for Respiratory Care and found that they meet the criteria for approval.

Alaska Society for Respiratory Care
PO Box 773485
Eagle River, Alaska 99577-3485

AARC Board of Directors,

The Alaska Society Board of Directors submits with this cover letter changes to the Bylaws of the Alaska Society for Respiratory Care (ASRC). The reasons for the changes include:

1. We clarified our voting process; including electronic voting.
2. We clarified our purpose; to not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Alaska.
3. We clarified committee membership; consisting of two members.
4. We clarified how office vacancies would be filled.
5. We clarified date and place of our annual business meeting.
6. Office terms were changed prior to this revision.

Thank You for your consideration of these issues.

Sincerely,

Janine Forrest
Vicki Faciance
Bylaws Committee for the ASRC

Liz Collins, President ASRC

BYLAWS OF THE ALASKA SOCIETY OF THE

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

ARTICLE I

NAME

This organization shall be known as the ALASKA SOCIETY FOR RESPIRATORY CARE (ASRC) (hereinafter referred to as the Society), a chartered affiliate of the American Association for Respiratory Care (hereinafter referred to as the Association).

ARTICLE II

Affiliation

The ALASKA SOCIETY FOR RESPIRATORY CARE (ASRC) shall be a chartered affiliate of the American Association for Respiratory Care and shall abide by the rules and regulations of the Association as promulgated from time to time.

ARTICLE III

Boundaries

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

ARTICLE IV

Object

Section 1. Purpose

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

b. To advance the science, technology, ethics, and art of respiratory care through regional institutes, meetings, lectures, and the preparation and distribution of a newsletter and other materials.

c. To facilitate cooperation between respiratory care personnel and the medical profession, hospitals, service companies, industry, and other agencies within the region interested in respiratory care; except that this Society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Alaska. ~~except that this Society shall not commit any act which~~

~~shall constitute unauthorized practice of medicine under the laws of the State of Illinois in which the parent Association is incorporated, or any other state~~.

d. To participate in public education on health promotion and disease prevention within the state of Alaska.

Section 2. Intent

a. No part of the net earnings of the Society shall inure to the benefit of any private member or individual.

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

ARTICLE V

Membership

Section 1. Classes

The membership of this Society shall include four (4) classes: Active Member, Associate Member, Special Member, and State Associate Member.

Section 2. Eligibility and Classification

a. Each applicant for membership shall meet qualifications of ethical practice and suitable moral standards as determined by the membership committee.

b. An individual is eligible to be an Active Member of this Society if he/she is an Active Member of the American Association for Respiratory Care, provided his/her place of employment is within the defined boundaries of this Society. Active Members have all the rights and privileges of membership including: the rights to hold office, vote, serve as committee chairs, and serve on committees.

c. An individual is eligible to be an Associate Member of this Society if he/she is presently employed within the field of Respiratory Care or a related field and is an Associate Member of the American Association for Respiratory Care. Associate Members shall have all the rights of membership except that they shall not be entitled to hold office, vote, or chair committees.

d. An individual is eligible to be a Special Member of this Society is he/she is an Honorary, Life, or General member of the American Association for Respiratory Care. Life Members have all the rights and privileges of Active Members. Honorary and General Members have all the rights and privileges of Associate Members.

e. State Associate members are individuals interested in the delivery of respiratory care in the state of Alaska. They may opt to join the Society, but not the Association. Such individuals will be subject to the payment of dues and will have all the rights of Associate membership in the Society, except they will not be permitted to vote. They may serve on state committees, though not as Chairman.

Section 3. Eligibility for Membership

Association members in good standing who are employed within the geographical boundaries of the State of Alaska are members of the Society and do not need to go through an additional application process. Individuals interested in respiratory care in Alaska may apply to the ASRC for State Associate Membership. State Associate Members may be assessed membership dues to be suggested by the Board of Directors subject to approval by the general membership.

Section 4. Annual Renewal

Members are eligible for renewal of their Society membership as long as they remain members in good standing of the Association. State Associate Members must renew their membership annually and pay the applicable dues.

ARTICLE VI

Offices

Section 1. Officers

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

Section 2. Directors

There shall be four (4) Directors. Two (2) Directors will be elected each election year and others as necessary to fill existing vacancies.

Section 3. Term of Office

a. The term of office for officers shall be for two (2) years. The term shall begin January 1 of the year following the election.

b. The term of office for Directors shall begin January 1 of the year following the election and shall be for four (4) years.

Section 4. Vacancies of Office

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

b. In the event of a vacancy in the office of the Vice-President, the Secretary shall assume the duties, but not the office, of Vice-President as well as his own until the next meeting of the Board of Directors, at which time the Board shall elect a qualified member to fill the vacancy.

c. In the event of vacancy in the offices of Secretary or Treasurer, the Board will meet and appoint a replacement.

Section 5. Duties of Officers

a. President

The President shall preside at the annual business meeting and all meetings of the Board of Directors; prepare an agenda for all business meetings and each meeting of the Board of Directors; appoint standing and special committees, subject to approval by the Board of Directors; be an ex-officio member of all committees except the Nominations and Elections committee; and present to the Board of Directors and membership an annual report of the Society's activities.

b. President-Elect

The President-Elect shall become acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability; he/she shall perform such other duties as shall be assigned by the President or the Board of Directors. The President-Elect shall be a member of the Society's Delegation in the House of Delegates.

c. Vice-President

The Vice-President shall assume the duties and office of the President-Elect in the event of the President-Elect's absence, resignation, or disability, and will also

continue to carry out the office of the Vice-President. The Vice-President shall be a member of the Society's Delegation in the House of Delegates.

d. Treasurer

The Treasurer shall have charge of all the funds and securities of the Society; disbursing funds as authorized by the Board of Directors and/or in accordance with the adopted budget; and depositing funds as the Board of Directors may designate. He/she shall see that full, accurate accounts are kept, make a written quarterly financial report to the Board of Directors, and a complete written yearly report at the annual business meeting. All other duties, and issues such as bonding and endorsement of checks, will be specified in the policies and procedures of the Society. At the expense of the Society, he/she shall be bonded in an amount determined by the Board of Directors.

e. Secretary

The Secretary shall keep minutes of all meetings of the Society and the Board of Directors and shall submit a copy of the minutes of each meeting to the governing body of the Society and to the Executive Office of the Association as specified in the policies of the Society and the Association. Committee chairs will be responsible for keeping their own minutes and must submit those minutes to the Secretary for the record. The Secretary shall handle the general correspondence and perform all duties as from time to time shall be assigned by the President or Board of Directors.

ARTICLE VII

Nominations and Elections

Section 1. Nominations and Elections Committee

The Chairman shall report the slate of nominees to the Board of Directors at least sixty (60) days prior to the annual business meeting or scheduled election for review. The final slate of nominees shall be approved by the Board of Directors prior to the ballots being sent to members.

Section 2. Nominations

The Nominations and Elections Committee shall place in nomination the names of candidates for the offices of President-Elect, Vice-President, Secretary, and Treasurer, and for each of the Board of Directors positions to be elected. Only Active Members in good standing and Life Members shall be eligible for nomination. The Nominations and Elections Committee shall provide a pertinent biographical sketch of each nominee's professional activities and services to the organization, all of which shall be a part of the ballot.

Section 3. Ballot

a. The Nominations and Elections Committee's slate and biographical sketches shall be sent to every Active member in good standing and eligible to vote at least thirty (30) days prior to the annual business meeting or scheduled election.

b. The Board of Directors shall specify how the vote is to be conducted at least sixty (60) days prior to the election. Elections may be conducted by mail, electronic vote, or in person. See the ASRC Procedure Manual for election process.

c. The Nominations and Elections Committee shall consist of at least three (3) impartial members. Any member of the committee who wishes to run for office must resign membership on the committee.

d. It is the duty of the committee to tally the votes and announce the results in a written report to the membership.

e. Only Active Members in good standing and Life Members may vote in Society Elections. It is the duty of the Committee to check each member's voting eligibility prior to sending out ballots.

Section 4. Committee Membership

a. The committee shall consist of at least two (2) members.

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

c. The duties of the committee are outlined in the ASRC Procedure Manual.

ARTICLE VIII

Board of Directors

Section 1. Composition and Powers

a. The executive government of this Society shall be vested in a Board of nine (9) Active or Life members consisting of the President, President-Elect, Vice-President, Treasurer, Secretary, and four (4) Directors.

b. The President shall be chairman and presiding officer of the Board of Directors. The President shall invite such individuals to the meetings of the Board as he/she shall deem necessary with the privilege of voice, but not vote.

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

Written notice shall be given to the member that the office has been declared vacant.

d. A person may hold only one office on the Board of Directors.

e. The Immediate Past-President shall be invited to attend all meetings of the Board of Directors, with the right of voice but not vote.

Section 2. Duties

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

b. Adopt and rescind standing rules of the Society.

c. Determine payments, salaries, fund-raising activities, and other related matters, after consideration of the budget.

Section 3. Vacancies

a. Any vacancy that occurs on the Board of Directors shall be filled by a qualified member appointed by the Board of Directors. Individuals so appointed shall serve until the next regular election.

b. Upon vacancy in the office of President, an elected President-Elect shall serve until the next scheduled election and then automatically succeed to the Presidency.

Section 4. Meetings

a. The Board of Directors shall meet immediately preceding and immediately following the annual business meeting of the Society and shall not hold fewer than two (2) regular and separate meetings during the calendar year. Such meetings may be in person, by teleconference, or by other equivalent technology, as long as there is a quorum.

b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society shall require, or upon written request of five (5) members of the Board of Directors.

c. A majority of the Board of Directors, five (5), shall constitute a quorum at any meeting of the Board. No official Society business may be conducted at a meeting without a quorum.

Section 5. Mail Vote

If the Board of Directors feels it necessary to present any business to the membership prior to the next scheduled meeting, they may instruct the Nominations and Elections Committee to conduct a vote of the membership by mail or other equivalent technology, subject to the Society's Bylaws and policies. The question(s) presented in the vote, except for amendments to the Bylaws, will be decided by a majority of the votes received. Details for conducting the vote will be specified in the policies and procedures of the Society. The procedure for amending the Bylaws is governed by Article XVIII of this document.

Section 6. Executive Committee

The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Vice-President, Secretary, and Treasurer. The Immediate Past-President shall also be a member of the Executive Committee, with the privilege of voice but not vote. The committee shall have the power to act for the Board of Directors between meetings of the Board of Directors and such action shall be subject to ratification of the Board at its next meeting.

ARTICLE IX

Meetings

Section 1. Date and Place

a. The Society shall hold an annual business meeting at a date and time to be determined by the Board, but no later than November 15th of each year; additional meetings may be held as required to fulfill the objectives of the Society.

b. The Program Committee will present recommendations for the place of the annual meeting to the Board of Directors. The Board of Directors will choose the place by their first meeting of the calendar year. In the event of a major emergency, the Board of Directors may cancel the scheduled meeting, set a new date and place, if feasible, or conduct the business of the meeting by teleconference, mail or other equivalent technology, provided the material is sent in the same words to all voting members.

Section 2. Purpose

a. The annual business meeting shall be for the purpose of conducting Society business, including committee reports, election results, and other business deemed necessary by the membership.

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

Section 3. Notification

Notice of the time and place of the annual business meeting shall be sent to all members of the Society not fewer than sixty (60) days prior to the meeting. An agenda for the annual business meeting shall be sent to all members not fewer than thirty (30) days prior to the annual business meeting.

Section 4. Quorum

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

ARTICLE X

Society Delegates to the AARC House of Delegates

Section 1. Election

The Society's Delegation shall consist of the President-Elect and the Vice-President.

Section 2. Term of Office

The term of office for Delegates shall be concurrent with their term as President-Elect or Vice-President.

ARTICLE XI

Committees

Section 1. Standing Committees

The President may appoint the members of standing committees as needed. Members so appointed by the President will be ratified by the Board at the next scheduled meeting.

a. Nominations and Elections

b. Program

c. Budget and Audit

d. Judicial

Section 2. Special Committees and Other Appointments

Special Committees may be appointed by the President. Such committees must have a designated purpose and an identified expiration date. A committee may continue

beyond its expiration date upon notice the purpose has not been met and then only with approval by the Board of Directors.

Section 3. Committee Chairman's Duties

a. The President shall appoint the chairman of each committee.

b. The Chairman of each committee shall confer promptly with the members of his committee on work assignments.

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

d. Non-members or physician members may be appointed as consultants to the committees.

e. Each standing committee Chairman requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee thirty (30) days prior to the annual business meeting.

Section 4. Committee Duties of the Board of Directors

a. Serve as the Budget and Audit Committee.

1) This committee shall be composed of the Executive Officers and the Board of Directors.

2) They shall propose and approve an annual budget. The membership will receive a copy of the budget within thirty (30) days of the meeting.

b. Serve as the Judicial Committee.

1) This committee shall consist of the Executive Officers and the Board of Directors.

2) This committee shall review formal written complaints against any individual Society member charged with any violation of the Society's Bylaws or otherwise with any conduct deemed detrimental to the Society. Complaints or inquiries may be referred to this Committee by the Judicial Committee of the Association.

3) If the Committee determines the complaint justifies an investigation, a written copy of the charges shall be prepared with benefit of legal counsel if deemed advisable.

4) A statement of charges shall then be served upon the member and an opportunity given the member to be heard before the Committee.

5) After careful review of the results of the hearing conducted with the benefit of legal counsel, when the Chairman of the Committee deems it necessary or advisable, the Committee may recommend to the Board of Directors to expel or suspend such a member. A complete report shall be forwarded including copies of all documents to the Chairman of the Judicial Committee of the Association, after a final decision by two-thirds (2/3) vote has been made by the Society's Board of Directors.

ARTICLE XII

Duties of Committees

Section 1. Program Committee

a. This Committee shall consist of at least two (2) members and be so constructed as to provide experienced members for program planning.

b. The Medical Advisor(s) or his designate shall be consultant to this committee.

c. The Committee shall be responsible for procuring and maintaining educational materials for the Society.

d. The Committee shall encourage and assist regions in their efforts to conduct educational programs.

e. The Committee shall concern itself with continuing education programs and special education projects of the Society.

f. The Chairman of the Program Committee shall receive all proposed Society educational programs for review and approval.

ARTICLE XIII

Society Medical Advisor

The Society shall have at least one (1) Medical Advisor, and shall conform to Article IX, Section 3 of the Association Bylaws concerning chartered affiliate Medical Advisors.

ARTICLE XIV

Fiscal Year

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

ARTICLE XV

Dues and Assessments

The Society shall have the right to assess membership dues as established by the Board.

ARTICLE XVI

Ethics

If the conduct of any Society member shall appear, by report of the Society or the Association's Judicial Committee, to be in willful violation of the Bylaws or standing rules of this Society or prejudicial to this Society's interests, as defined in the Association's Code of Ethics, the Board of Directors may, by a two-thirds (2/3) vote of its entire membership, suspend or expel such a member. Within thirty (30) days after receipt of notice of expulsion, the expelled member shall have the right to appeal the decision to the Board of Directors. If such appeal is made, the Board, at its next meeting shall uphold, reverse, or modify the action of the Committee. All such suspension or expulsion actions shall be reported immediately to the Association's Judicial Committee.

ARTICLE XVII

Parliamentary Procedure

The rules contained in *Robert's Rules of Order, Revised* shall be utilized as a reference whenever they are not in conflict with the Bylaws of the Society or of the Association.

ARTICLE XVIII

Amendments

To amend these Bylaws, all eligible voting members of the ASRC must be given a copy of the proposed change(s) sixty (60) days prior to the scheduled vote. The vote may be by mail or other equivalent technology, so long as provisions are made to allow all eligible members the opportunity to vote. Amendments are considered approved if they get a two-thirds (2/3) majority of the votes received. All amendments must be approved by the Association's Bylaws Committee and shall become effective upon ratification by the Association's Board of Directors.

Michigan Society for Respiratory Care
1000 W. St. Joseph Hwy., Suite 200
Lansing, MI 48915
tel: 866-989-MSRC (6772)
fax: 517-485-9408
Email: info@michiganrc.org
Website: www.michiganrc.org

Breathing life into your career

February 21, 2012

To: The AARC BOD
Re: Michigan Bylaws amendments
,

The Michigan Society for Respiratory Care (MSRC) has completed the revision of its bylaws with the following changes:

1. The statement that the MSRC has the authority to assess dues.

2. The MSRC has eliminated Article III.G. Chartered Affiliate Member.

3. Clarified that to be a life member of the MSRC you must be an active or life member of the AARC. Life members have to meet the same eligibility criteria as active members.

The MSRC looks forward to your review of these bylaws and feels that we have done our due diligence to assure that our bylaws are acceptable to the AARC. The MSRC looks forward to implementing our revised bylaws. Please me know if you have any questions.

Sincerely,

Albert W Mosr

MSRC Bylaws Chair

BYLAWS OF THE MICHIGAN SOCIETY FOR RESPIRATORY CARE (MSRC) A CHARTERED AFFILIATE OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

AS ADOPTED DECEMBER 1972
AND AMENDED JUNE 15, 1980
AND AMENDED JUNE 28, 1985
AND AMENDED NOVEMBER 16, 1990
AND AMENDED DECEMBER 5, 1991
AND AMENDED FEBRUARY 5, 1993
AND AMENDED JULY 23, 1996
AND AMENDED DECEMBER 3, 2004
AND AMENDED ___ ___ ___

ARTICLE I -NAME

This organization shall be known as the Michigan Society for Respiratory Care. It is incorporated under Public Act No. 327 of 1931 of the State of Michigan. It is a Chartered Affiliate of the American Association for Respiratory Care, hereinafter referred to as the AARC, which is incorporated under the General Not for Profit Corporation Act of the State of Illinois.

ARTICLE II -OBJECT

Section A -Purpose

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

2 To advance the science, technology, ethics and art of Respiratory Care, through meetings, lectures and the preparation and distribution of Society publications and other materials.

3 To facilitate cooperation between respiratory care personnel and the medical profession, hospitals, service companies, industry and other agencies within the State interested in respiratory care; except that this Society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Michigan, the state in which the parent Society is incorporated, or any other state.

4 To ensure strict adherence to the principles of the Code of Ethics of the AARC.

5 To promote education of the general public on pulmonary health promotion and disease prevention.

Section B -Intent

1 No part of the net earnings of this Society shall inure to the benefit of any private member or individual, nor shall the Society perform particular services for individual members thereof, other than those usually and customarily performed by similar organizations.

2 Contributions of any kind, except as otherwise defined in this document, may be made only to such charitable or other organizations which operate from tax exempt contributions under the appropriate sections of the Internal Revenue Code. Such contributions must be authorized by a majority vote at any meeting of the House of Representatives.

ARTICLE III -MEMBERSHIP

The MSRC has the authority to assess annual dues.

Section A -Classification

The membership of this Association shall include the following classes: Active Member, Associate Member, Student Member, Life Member, and Honorary Member. The area included within the boundaries of this Society shall be the boundaries of the State of Michigan.

Section B -Active Member

An individual is eligible to be an Active Member of the MSRC if the member meets the following criteria

1. Is currently an Active or Life Member of the AARC.

2. Resides or works in the state of Michigan or has designated Michigan as their affiliate of choice to the AARC,

3. AND meets one of the following criteria:

    a. Currently licensed by the State of Michigan as a respiratory therapist, OR

    b. Holds a credential issued by the National Board for Respiratory Care, Inc. or its successors

Active members in good standing shall be entitled to all the rights and privileges of membership of the Society including: the rights to hold office, be a committee chair, and vote.

Section C -Associate Member

An individual will be classified as an Associate Member of the MSRC if the member wishes to be a member of the MSRC but does not qualify for Active Membership. Associate Members shall have all the rights and privileges of the Society except they shall not be entitled to hold office, vote, or serve as a chair of any standing committee of the Society.

This Membership classification would include, but is not limited to,

1 an individual who has the qualifications for Active Membership in the AARC but is not currently a member;

2 an individual who qualifies, but not necessarily is, an Associate Member of the AARC.

Section D -Student Member

An individual will be classified as a Student Member of the MSRC if the member is enrolled in a CoARC (Commission on Accreditation for Respiratory Care accredited educational program in respiratory care or in a an educational program in respiratory care in the process of seeking CoARC (Committee on Accreditation of Respiratory Care) accreditation. Student Members shall have all the rights and privileges of the Society except they shall not be entitled to hold office, vote, or serve as a chair of any standing committee of the Society.

Section E -Life Member

1. Life Members shall be members who have rendered outstanding service to the MSRC or the AARC. Life membership may be conferred by a majority affirmative vote of the House of Representatives.

2. Life members of the AARC will automatically have life membership conferred upon them as long as they meet the following criteria:

    a. Reside or work in the state of Michigan or have designated Michigan as their affiliate of choice to the AARC,

    b. AND meet one of the following criteria:

        1) Currently licensed by the State of Michigan as a respiratory therapist, OR

        2) Hold a credential issued by the National Board for Respiratory Care, Inc. or its successors

3. Life Members who are also Active Members of the AARC or those members that are Life Members because they are AARC Life Members shall have all the rights and privileges of membership of the Society, including the right to hold office, serve as committee chair, and vote. Life Members shall be exempt from the payment of any dues.

Section F -Honorary Member

Honorary Members shall be individuals who have rendered distinguished service to the field of Respiratory Care. Honorary membership may be conferred by a majority affirmative vote of the House of Representatives. Honorary members shall have all the rights and privileges of membership of the Society, except that they shall not be entitled to hold office, serve as committee chair, and vote. Honorary Members shall be exempt from the payment of dues for a period as determined by the House of Representatives.

Section G -Application for Membership

1 An applicant for membership shall submit a completed official application to the MSRC office. The MSRC office staff will follow the Membership Application Process as outlined in the MSRC policy and procedure manual.

2. Annual Registration, Dues, and Assessments

    a. Each member who attains Society membership may renew membership in the Society by demonstrating continuing eligibility for such.

    b. Annual dues, or special assessments for the members of the Society, as well as policies and procedures regarding payment of such, are established by the MSRC House of Representatives.

    c. A requirement for maintaining good standing in each membership category is to be current with any dues and assessments required by the MSRC membership policy.

Section H Membership Renewal

Membership Renewal will follow the policies as outlined in the MSRC Policy and Procedure Manual.

Section I -Membership Specialty Sections

Specialty Sections representing particular areas of interest within respiratory care shall be made available to all MSRC members. Specialty sections may be added or deleted by a majority vote of the House of Representatives.

Section J -Dues and Assessments

The amount for dues and dues cycle for each category of membership shall be recommended by the MSRC membership committee and follow the policies as outlined in the MSRC Policy and Procedure Manual. Changes in these policies require approval by the House of Representatives

Section K -Suspension or Expulsion from Membership

If the conduct of any Active member shall appear, by the report of the Society's or AARC's Judicial Committee, to be in willful violation of the Bylaws, or standing rules of this Society or that of the AARC, or prejudicial to this Society's interest as defined in the AARC's Code of Ethics, the individual's name will be submitted to the AARC Judicial Committee for further action. If the conduct of any Associate, Student, Life or Honorary member shall appear, by the report of the Society's or AARC's Judicial Committee, to be in willful violation of the Bylaws, or standing rules of this Society or that of the AARC, or prejudicial to this Society's interest as defined in the AARC's Code of Ethics, the House of Representatives may, by two-thirds (2/3) vote of its entire membership, suspend or expel such a member. A motion to reconsider the suspension or expulsion of a member may be made at the next regular meeting of the House of Representatives. All such suspension or expulsion actions shall be reported immediately to the AARC Judicial Committee.

ARTICLE IV -OFFICERS

Section A -Officers

The officers shall be President, President-Elect, Immediate Past President, Treasurer, Secretary, and AARC Delegates. The officers of this Society shall be members at large of the House of Representatives with full voting privileges.

Section B -Nominations and Election of Officers

1. The tabulation of all ballots and election of all officers and Medical Advisors shall be done as outlined in the MSRC Policy and procedure manual

Section C -Term of Office

The term of office shall begin January 1 of the fiscal year following the election. The incumbent officers shall remain in office until such date and until their respective successors assume office.

Section D -Succession

No officer may serve more than two (2) consecutive terms in the same office. The President, President-Elect, and Past President shall not consecutively serve more than one (1) term in the same office.

Section E -Duties of Officers

1 President -The President shall be the Chief Executive Officer of the Society; shall serve as Speaker of the House of Representatives; preside at all general Society meetings; appoint chairs of all standing committees subject to House approval; be an ex-officio member of all committees except the Nominations and Elections Committee; present an annual report to the House and general membership; direct and administer the business of the Society as its Chief Executive Officer; The term of office shall be as outlined in the MSRC Policy and Procedure Manual.

2 President-Elect -The President-Elect shall become the President pro tem and shall assume the duties of the President in the event of the President's absence, resignation or disability; be an ex-officio member of all Committees; the term of office shall be as outlined in the MSRC Policy and Procedure Manual after which President-Elect will assume the responsibilities and duties of the President as described in Article IV, Section E, Subsection 1 of these MSRC Bylaws.

3 Immediate Past President -The Immediate Past President shall serve a term as outlined in the MSRC Policy and Procedure Manual immediately following the term as President and shall carry out duties as directed by the House of Representatives.

4 Treasurer -The Treasurer shall account for the monies of the Society and disburse funds in accordance with the budget approved by the House of Representatives; be responsible for the continuing record of all income and disbursements; prepare and submit in writing, an annual report of the finances of the Society for the preceding year to the House of Representatives within thirty (30) days of the end of fiscal year; be an ex-officio member of the Budget Committee. The term of office shall be as outlined in the MSRC Policy and Procedure Manual.

5 Secretary -The Secretary shall keep the minutes of the meetings of House of Representatives; attest to the signatures of the officers of this Society and, in general, perform all duties assigned by the President; submit a copy of the minutes of every meeting of the House and other business of the Society to the members of the House and the Director of Membership Services of the AARC within ten (10) days following the meeting. The term of office shall be as outlined in the MSRC Policy and Procedure Manual.

6 AARC Delegates -The Delegates shall represent the MSRC in the AARC House Delegates according to the instructions given to them by a quorum of the House of Representatives of the MSRC; shall attend all meetings of the MSRC House of Representatives; and will perform other duties as assigned by the MSRC House of Representatives. The terms of office of the AARC Delegate shall be four years with one delegate being elected every two years.

7 In addition to the foregoing specific duties, the duties of the officers shall be such as stated in Robert's Rules of Order Newly Revised except when in conflict with the Bylaws of the AARC or MSRC.

Section F -Vacancies in Office

The House of Representatives shall fill any vacancy that occurs in an officer's position for the unexpired term of said vacancy, unless a specified provision is made in these Bylaws in such an event. Vacancies may occur due to resignation, assumed resignation, impeachment, or other reasons. Details on filling officer position vacancies can be found in the MSRC Policy and Procedure Manual.

ARTICLE V -HOUSE OF REPRESENTATIVES

Section A -Composition and Power

1. The government of this Society shall be vested in the House of Representatives. The president shall serve as Speaker of the House of Representatives. The House Rules shall govern the organization and operation of the House of Representatives, provided they are not in conflict with these Bylaws or with the Bylaws of the AARC.

2. The Number of House of Representative districts and boundaries of each House of Representative district shall be determined by the House of Representatives.

    a. Additional districts or changes in boundaries of existing districts may be established on petition of Active MSRC Members within affected areas and as approved the House of Representatives. Districts may be combined and the total number of districts reduced on petition of Active MSRC Members within affected areas and as approved by the House of Representatives.

Section B -Nomination and Election of Representatives

1. The tabulation of all ballots and election of all Representatives shall be done as outlined in the MSRC Policy and Procedure manual

Section C –Representation ratio and Term of Office

1. The requirements for the ratio of representatives per member in each district, numbers of alternates, and term of office is outlined in the MSRC policy and procedure manual.

Section D -Duties

1. Duties of Representatives and Alternate Representatives shall be to represent their constituency to the best of their ability. Alternate representatives shall have full voting privileges in the absence of the elected Representatives. If an elected district representative is also an elected Membership Section Chair, the alternate district representative will assume voting privileges if present.

Section E -Membership Section Representation

1 Each Membership Section Chair shall be a member at large of the House of Representatives with full voting privileges.

2 The Chair-elect shall be elected by the Active MSRC Members of the individual sections and shall serve a two-year term as Chair-elect and a two-year term as Chair.

3 If the Chair is not present at any House of Representatives meeting, the Chair-elect if present, will assume voting privileges.

Section F -Medical Advisors

1 There shall be at least two (2) Medical Advisors elected each election year for a term of one year, the exact number to be determined annually by the House of Representatives.

2 The Medical Advisors shall have only such powers as are granted to them in these Bylaws.

3 A Medical Advisor should attend the meetings of the House of Representatives as a non-voting member.

Section G - Vacancies in the House of Delegates.

Any vacancy that occurs in a House member's position shall be filled by appointment by the President with approval of a majority of the House of Representatives for the unexpired term of said vacancy. Vacancies may occur due to resignation, assumed resignation, impeachment, or other reasons. Details on filling a vacancy in the House of Representatives can be found in the MSRC Policy and Procedure Manual.

ARTICLE VI -MEETINGS

Section A -Regular Meetings

1. The House of Representatives shall meet on a regular schedule as approved by the House of Representatives. Details on the meeting schedule can be found in the MSRC Policy and Procedure Manual

Section B -Special Meetings

1. Additional meetings of the House of Representatives may be called by the President or at the request of a majority of the total membership of that body.

Section C -Annual Business Meetings

1 Not less than sixty (60) days prior to the Annual Business Meeting, written notice of the time and place of Meeting shall be sent to all members of the Society.

2 The purpose of this meeting is to report to the general membership the activities of the MSRC government.

Section D -Quorums

1. Quorum at a regularly called meeting is 12 voting members of whom 3 are officers as listed in Article IV, Section A of these bylaws. Any Specially Called Meetings requires 50% of those eligible (by the Bylaws) to vote be present.

ARTICLE VII -COMMITTEES

Section A –Permanent Standing Committees

The following are Permanent Standing Committees and shall not be changed without a change in Bylaws

a. Audit Committee
b. Bylaws and House Rules Committee
c. Professional Development Committee
d. Industrial Relations Committee
e. Judicial Committee
f. Legislative Committee
g. Membership Committee
h. Nominations and Elections Committee
i. Program Committee

The Chair of each of these Standing Committees shall be appointed by the President, with House approval by simple majority vote, to serve a term one (1) year. All Chairs must be Active members of the Society. They need not be members of the House of Representatives. Duties and composition of each of the Permanent Standing committees are as follows:

1. Audit Committee

    a. The Committee shall be composed of at least three members whose duty it shall be to ensure, by at least quarterly review of the accounts, that the Treasurer does not exceed the budget in any account, without approval of the House of Representatives.

2. Bylaws and House Rules Committee

    a. The Committee shall be composed of the Clerk Parliamentarian (as defined in the Standing Rules of Order) and three other individuals whose duty it shall be to review and properly prepare all proposed amendments to these Bylaws and House Rules.

3. Professional Development Committee

    a. The Committee shall be composed of at least three individuals whose duty it shall be to design and plan the educational activities of the Society. In addition the Committee shall administer funds designated for education and research, and for procuring and maintaining educational materials for the MSRC.

4. Industrial Relations Committee

    a. The Committee shall be composed of at least three members, with the Program Committee Chairperson acting as an ex-officio member. The duty of the committee shall be to solicit exhibit hall booth sales, sponsorships and outside support funding for the Annual MSRC Convention and other programs and activities in conjunction with the President and respective chairpersons of committees and membership sections. The Committee will also coordinate exhibit hall set-up and operation, ensuring compliance with appropriate regulations.

5. Judicial Committee

    a. The Committee shall be composed of three members. The Committee shall have the duty of reviewing formal, written complaints against any individual charged with any violation of the Society's Bylaws, AARC Code of Ethics, or otherwise with any conduct deemed detrimental to the Society or the AARC and any written requests for impeachment. All complaints regarding MSRC Active or Life Members are to be directed to the AARC Judicial Committee for resolution. All complaints regarding all other MSRC members are to be handled by the MSRC Judicial Committee.

    b. If the Committee determines that the complaint justifies an investigation, a written copy of the charges shall be prepared with benefit of legal counsel if deemed advisable. A statement of charges shall then be served upon the member and an opportunity given that member to be heard before the Committee.

    c. After careful review of the results of the hearing conducted with benefit of legal counsel, when the Chairperson of the committee deems counsel to be necessary or desirable, the Committee may, by two-thirds (2/3) vote of its entire membership, recommend expulsion to the MSRC House of Representatives. Counsel shall be retained only to advise the MSRC and not for purpose of representing the individual whose membership is being reviewed.

6. Legislative Committee

    a. The Committee will be composed of three members and shall have the duty of concerning itself with legislation and government regulations pertaining to health care or the profession of respiratory care. The Committee shall participate with State government agencies as needed and prepare statements of the Society's position with regard to legislation or regulations subject to approval of the House of Representatives.

7. Membership Committee

    a. The Committee shall be composed of at least three members whose duty it shall be to monitor a roster of members, bill and collect dues and forward monies to the Treasurer. They shall issue certificates of membership annually.

8. Nominations and Elections Committee

    a. The Committee shall be composed of at least three members whose duty it shall be to present each year the slate of nominees to the House of Representatives at least ninety (90) days prior to the election. The Committee will sent ballots to all eligible members of the MSRC and/or AARC as described in Article IV, Section B and Article V, Section B of these Bylaws. The Committee will further tabulate ballots and announce Election Results as noted in Article IV, Section B and Article V, Section B of these Bylaws.

9. Program Committee

    a. The Committee shall be composed of at least five members whose duty it shall be to plan, implement and coordinate the Annual Society Educational Program.

The House of Representatives may create, combine, or disband non-permanent standing committees as necessary to manage the society's business. Approval to create, combine or disband a non-permanent standing committee requires a 2/3 majority vote of the House of Representatives. Non-permanent Standing Committee are committees that generally are expected to continue for a period of several years. The list Duties and composition of non-permanent standing committees can be found in the policy and procedure manual.

10. Other special committees may be created and/or chairs appointed by the President with House of

Representatives approval. Duties of these committees will be as designated by the President. Other Permanent standing committees may be created by revision of these Bylaws.

11. All committee members must be MSRC members (Active, Associate, Affiliate or Student).

Section B -Membership Sections

Membership sections shall be established or dissolved by approval of two-thirds of the MSRC House of Representatives present and voting at any regular or specially called meeting. The Chair shall be nominated and elected by those MSRC members who have designated themselves members of the respective Membership Sections. The Chair of these sections shall be Active Members of the MSRC and members-at-large of the House of Representatives with full privileges.

Chairs of these Membership sections shall submit a written report to the President and Secretary prior to each meeting of the House of Representatives. Each membership section requiring operating expenses shall submit a budget for the fiscal year to the Budget and Audit Committee.

ARTICLE VIII -PARLIAMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Society in all cases to which they are applicable and in which they are not inconsistent with these bylaws, the bylaws of the AARC and any special rules of order the Society may adopt.

ARTICLE IX –Type of Policies

The MSRC has the following types of policies.

1. Governance and House Rules

   A. These policies are policies that had historically been in the Michigan Society for Respiratory Care (MSRC) bylaws and/or described the composition of the House of Delegates, voting functions and other MSRC governance issues.

   B. Since these Governance and House Rules policies had been the historical foundation for the organization, changes in these governance functions should be considered carefully. These Governance and House Rules policies may be amended at any regular or specially called meeting of the MSRC House of Representatives, by approval of two-thirds of those members present and voting. The two-thirds affirmative vote must be repeated at a separate meeting held at least 30 days after the first, provided that prior notice of all proposed changes to all members of the Society has been made.

2. Operational Policies and Procedures. These policies describe the roles and functions of MSRC committees and the volunteers that serve on these committees. Changes in these policies will require simple majority vote of the MSRC House of Representatives.

ARTICLE X -AMENDMENT OF BYLAWS

These Bylaws may be amended at any regular or specially called meeting of the MSRC House of Representatives, by approval of two-thirds of those members present and voting. The two-thirds affirmative vote must be repeated at a separate meeting held at least 30 days after the first, provided that prior notice of all proposed changes to all members of the Society has been made. All amendments to these Bylaws shall be submitted to the AARC for adjudication as provided in its Bylaws. The Bylaws or amendments thereof, do not become effective until ratified by the Board of Directors of the AARC.

Elections Committee

Reporter: Jim Lanoha

Last submitted: 2012-03-23 09:42:34.0

Recommendations

No recommendations at this time.

Report

- BOD and HOD members were solicited for ideas for candidate questions with deadline of 2-15-12
- Committee members voted on 2012 Candidate questions and submitted to EO 3-08-12
- AARC On-line Nomination process activated 1-31-12 with BOD, HOD, and appropriate sections solicited for nominations (VP of Internal Affairs, VP External Affairs, and Secretary/Treasurer, Director X 1, Chair-elects for Neonatal-Pediatrics, Sleep, and Home Care.)
- Committee conference call scheduled for 4-25-12 to review nominations and determine final slate of candidates

Executive Committee Report

Finance Committee Report

Judicial Committee

Reporter: Patricia Blakely

Last submitted: 2012-03-20 07:05:50.0

Recommendations

No recommendations at this time.

Report

The Committee has not received any "Formal Complaints" as of the date of the report.

Program Committee

Program Committee
AARC Activity Report
Spring, 2012

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

Recommendations: That the AARC Board of Directors approve Las Vegas and the Mandalay Bay as the destination and venue for AARC Congress 2014. (Dec. 9-12, 2014)

Justification: In 1997, the AARC Board of Directors passed a motion "That Las Vegas, Nevada be identified as the site for the AARC's Annual Meeting on a rotation basis of every three years." The last AARC Congress held in Las Vegas, NV was in Dec. 2010.

The Program Committee feels a change in venue is warranted. The hotel formerly known as the "Las Vegas Hilton" recently lost its Hilton franchise tag and is currently named the "Las Vegas Hotel & Casino". While the property is convenient to the Las Vegas Convention Center, the Executive Office routinely receives complaints from attendees and exhibitors regarding the poor quality of the property, guest rooms in disrepair, with low ceilings and poor ventilation in the casino that increase exposure to second hand smoke. The Las Vegas Convention Center is less than ideal because of limitations on meeting room space and storage.

At the urging of the Program Committee, the Executive Office staff was asked to investigate feasibility of other venues in Las Vegas. It was identified that the only other properties in Las Vegas large enough to accommodate the AARC Congress are the Mandalay Bay, and the Venetian. Both properties were thoroughly investigated with the Mandalay Bay being identified as the best option for the AARC. This property would serve as both the HQ hotel and the convention center. Mandalay Bay has in excess of 4,500 guest rooms and does have the capability of housing all Congress attendees.

Oct/Nov meeting dates were explored for 2014, however space was not available. As such, a December meeting date in 2014 was explored and space is currently being held for the meeting.

Program Committee Report:

1. Prepare the Annual Meeting Program, Summer Forum, and other approved seminars and conferences.
   Status: The committee met in Dallas, TX on Jan. 26 – 28, 2012 to review nearly 800 individual lecture proposals submitted in eleven different categories for presentation at the Summer Forum and/or the Congress. Authors of proposals that were not accepted by the committee have already been notified. Communications for authors of proposals that have been accepted for presentation are currently taking place. The structure of the final program will be based upon the number of acceptances received; we anticipate approximately 40 presentations at the Summer Forum and 275 at the Congress.

Keeping with our commitment to infuse new talent into the Association, roughly 50 first time presenters have been invited to speak at Congress. The committee would like to express our gratitude to all the individuals and groups that submitted proposals and to those who support our many programs and activities.

2. Recommend sites for future meetings to the Board of Directors for approval.
   Status: In addition to solidifying the location for AARC Congress 2014, and with direction from the Program Committee, the Executive Office is also investigating locations for future Summer Forums (2013-2015) as well as AARC Congress 2016.

3. Solicit programmatic input from all Specialty Sections and Roundtable chairs.
   Status: Proposals for the Summer Forum and the Congress were received from all Specialty and Roundtable Sections. Each specialty section was appointed a liaison from the Program Committee and this liaison worked closely with the Section Chairs to review the submitted proposals and ensure a well-rounded representation of section interests are included in our programs. Most Section Chairs were very involved in this process this year and are to be commended for their initiative and effort.

4. Develop and design the program for the annual AARC 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 to discussing industry priorities and reviewing membership feedback from previous meetings. The committee focused on membership dissatisfaction with overlapping start/stop times for presentations, which interfered with earning CRCEs. The committee explored the possibility of starting/stopping all sessions at the same time to eliminate overlap, but found it impossible to implement for the entire Congress program without negatively impacting program quality. However, attendees at the 2012 Congress will find a significantly larger number of educational sessions do not overlap. A broad offering of topics presented by a wide variety of practitioners are included in the agenda for both the Summer Forum and Congress.

Sputum Bowl Sub-Committee Report:

As directed by AARC Program Committee Chair Cheryl Hoerr, the 2012 Sputum Bowl Committee; co-chaired by Deb Hendrickson and Garry Kauffman, assembled this year's committee to start the work of delivering the 2012 Sputum Bowl with several enhancements. While the specifics of the changes aren't finalized at the time of this report, the committee's intent is to create a much more engaging and energetic Sputum Bowl. The enhancements and modifications for this year's event are being accomplished in direct response to members, participants, and audience feedback.

Four (4) workgroups have been created from this year's committee to allow those new to the committee to more quickly get up to speed.

The work groups are as follows:

- Project timeline and contest operations

- Marketing
- Questions
- Contest Enhancements

The full committee and the workgroups are actively engaged on a daily basis to deliver a ‘new and improved’ Sputum Bowl that will meet the request of our various stakeholders.

Respectfully submitted,

Deb Hendrickson and Garry Kauffman

Strategic Planning Committee

Reporter: Timothy Myers

Last submitted: 2012-03-22 22:10:09.0

Recommendations

None at this time

Report

Due to transitioning of AARC leadership and ongoing work on the 2015 project, committee goals are in a holding pattern. We envision sometime after the Spring BOD meeting, both these major endeavors will have some resolution and timelines established that will allow this committee to begin its planning for the next 3-5 years.

Specialty Section Reports

Adult Acute Care Section

Reporter: Keith Lamb

Last submitted: 2012-03-20 20:59:10.0

Recommendations

Recommendation:

The Adult Acute Care Section recommends that a study guide be developed in anticipation of the new Adult Critical Care Specialty exam due to be available by the NBRC sometime near the end of the summer 2012.

It is our understanding that there is not one available, and there are no plans by any other organization to develop one.

There is a matrix made available by the NBRC along with a practice exam. These could be used to develop a table of contents by which the remainder of the study guide could be developed. There is also now a self – assessment examination that can be purchased by individuals.

Although these “practice exams” can be helpful, it is believed by the section that there is a real need for a study guide to assist RCP’s in preparing for this rigorous test.

The study guide could be as simple as an “electronic” version listing various resources on each topic. It could be as complicated as a printed text with chapters on each topic.

As far as cost is concerned, it is difficult to anticipate. It would depend on how involved we decided to make it.

Steps that I would take if this project moves forward:

1) Develop a Committee to oversee this project

2) Develop TOC using matrix and practice test

3) Contact experts on each topic (within the AARC) to develop chapters/resources on each topic

4) Coordinate these resources and develop final study guide

Report

The section continues to improve on its clinical resource offerings to its members in the way of our Journal Club, and interactive case studies. Thus far we have held two skype video journal club discussions which have both gone very well. We are planning on continuing this effort as appropriate.

We continue to publish our quarterly bulletin allowing new writers to gain experience.

The section continues to assist other sections, committees and roundtables as asked and appropriate.

Respectfully Submitted,

Keith

Keith D. Lamb

Chair, Adult Acute Care Section

Continuing Care-Rehabilitation Section

Reporter: Debra Koehl

Last submitted: 2012-03-23 07:21:13.0

Recommendations

It has been requested by a member of the MSRC that the AARC issue a consensus statement that recognizes the EPR-3 as the standard for asthma management.

- Jan Fields from the MSRC contacted me to ask if the AARC had such a position statement.
- She stated that the MSRC was looking to write such a document.
- I agreed to bring this matter to the AARC BOD for continued discussion and support.
- EPR-3 is the standard of care for asthmatics, AARC support of this document would be practical.
- The EPR-3 report is the Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma. It is issued by the National Asthma Education and Prevention Program. The report can be found at: http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf

Report

The following items have either been completed or are currently happening in our section:

- Submissions to the program committee occured.
    - I am very appreciative of the communication Cheryl Hoerr provided to me during the process.
- Uniform Reporting Manual project
    - Continued work on the PR section of that manual with Bill Dubbs
    - Tested it and engaged some additional member of our section to look at prior to release.
- Pulmonary Rehabilitation Toolkit project with AACVPR, AACP, NAMDRC and ATS
    - Joint project of these organizations to address the recent decrease in reimbursement from CMS for PR.
    - CMS clearly stated that the bundled code G0424 was most likely not calculated correctly by hospitals for reflect proper costs.

- Respiratory Toolkit document was developed and piloted.
    - Committee felt that massive re-education was needed to correct reimbursement problem.
- Worked with Anne Marie Hummel and incoming section chair Gerilynn Connors on this committee.
- A webcast will occur on March 28th to discuss this project.
- AARC has also posted many supporting documents and a "Toolkit" button for members.
- We will also alert other sections about this document as well
    - targeting Management Section, Long Term Care and the Coding Roundtable
- Many thanks to Anne Marie for her tireless support and words of wisdom with this project.

Diagnostics Section

Reporter: Matthew O'Brien

Last submitted: 2012-03-23 13:38:00.0

Recommendations

Allow us to offer a 6 month trial membership to the Diagnostics Section for AARC members.

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.

•· Proposals were submitted for the 2012 Congress.

•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.

•· Our new bulletin editor is Lisa Becker, she is new to this role but has support from Rick Weaver, Debbie Bunch and myself.

•· A diagnostic specific webinar has been planned for 2012. Carl Mottram will present on "Pulmonary Exercise Testing".

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

•· Ongoing, we are recruiting members and with the goal being the 1000 member mark.

•· Recommendation: **Offer a 6 month trial membership to the Diagnostics Section for AARC members.**

•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.

•· Ongoing monitoring of sites during the first week of each month.

Education Section

Home Care Section

Reporter: Greg Spratt

Last submitted: 2012-03-22 08:35:05.0

Recommendations

1. **Proposal to Create Pilot Studies for RT-Led Programs for Reducing Readmissions**

The Hospital to Home Committee proposes a project to select and fund 3-5 pilot studies exploring the benefits of different models of RT-led programs for reducing hospital readmissions in COPD. Pilot studies would be evaluated and selected based on the criteria designated by the committee. (Attachment A following)

2. **Proposal to Survey Section Members for Potentially Combining Home Care and Long-Term Care Specialty Sections**

I propose a survey of the memberships of the Home Care and Long-Term Care sections to understand their attitudes toward the potential of a combined section for the purpose of better meeting our mutual objectives. Based on the results of that survey, we would proceed forward or not based on the response received. (Detail following)

Report:

Political Issues:

DMEPOS Competitive Bidding Program Moves Forward with Round 2

The Centers for Medicare & Medicaid Services (CMS) continues to move forward with Round 2 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program.

The Round 2 product categories include:

- **Oxygen, oxygen equipment, and supplies**
- Standard (Power and Manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies

- **Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories**
- Hospital beds and related accessories
- Walkers and related accessories
- Negative Pressure Wound Therapy pumps and related supplies and accessories
- Support surfaces (Group 2 mattresses and overlays)

The timeline for Round 2 is as follows:

•· **1/30/2012 -** CMS opens 60-day bid window for Round 2 and National Mail-order Competitions

•· **2/9/2012 -** Registration closes

•· **2/29/2012 -** Covered Document Review Date for bidders to submit financial documents

•· **3/30/2012 -** 60-day bid window closes

•· **Fall 2012* -** CMS announces single payment amounts, begins contracting process

•· **Spring 2013* -** CMS announces contract suppliers, begins contract supplier education campaign

•· **Spring 2013* -** CMS begins supplier, referral agent, and beneficiary education campaign

•· **July 1, 2013* -** Implementation of Medicare DMEPOS Competitive Bidding Program Round 2 and National Mail-order Competition contracts and prices

HC Section Highlights

Membership was solicited for submissions of topics for the 2012 AARC Congress. Solicitation was done primarily through AARC Connect and the Qtly Newsletter. A number of topics were submitted and I have made my suggestions to Patrick Dunne for inclusion in the program.

Since the last meeting we have released two quarterly newsletters. The December edition was guest edited by Bob McCoy and focused on a review of the AARC Congress. The March edition was edited by Kim Wiles and featured articles on creating value in the home care therapist and coaching patients to self- manage.

Membership

Membership continues to slowly decline and is presently at ~900. In the newsletters we have included articles on the importance of increasing membership by each member soliciting one friend to join. A joint call with representative section members discussed other potential projects to increase membership which we continue to research.

Based on a number of changes to healthcare structure and reimbursement, post-acute respiratory care continues to undergo a significant evolution. The care of the post-acute respiratory patient may now reach across multiple "places of service" even for a single patient. While the site of care may differ, the modalities, objectives, and strategies for care are quite similar.

•- Continue the healing process

•- Promote adherence to the prescribed plan of care

•- Educate the patient and caregivers for self-care

•- Adjust therapy based on patient response to maximize management of a chronic process per accepted treatment standards

•- Prevent readmissions to acute care

•- Assure continuity of care in the post-acute setting

As such, we believe that it is time to adjust the sections to respond to the changes in the healthcare system and the challenges those changes present.

Objectives of Combining Sections

•- Improve the continuity of post-acute care across ''place of service'' borders

•- Develop combined strategies to improve care and meet mutual objectives (see above)

•- Improve communication between care givers in the post-acute arena

•- Educate members of combined strategies for meeting objectives

•- Create a stronger voice both within the AARC and external to the AARC for key initiatives of post-acute respiratory care (e.g., recognition of the role of the post-acute respiratory therapist and need for appropriate reimbursement)

Proposition

We propose a survey of the memberships of the Home Care and Long-Term Care sections to understand their attitudes toward the potential of a combined section for the purpose of better meeting our mutual objectives.

Based on the results of that survey, we would proceed forward or not based on the response received.

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

Actions Completed:

•· A survey of the membership has been completed and a summary was provided back to the BOD at the Summer 2012 meeting.

•· An exploratory committee to draft a proposal for the AARC to fund and select 3-5 pilot studies exploring the benefits of RT-led programs for reducing hospital readmissions due to cardiopulmonary diagnoses of pneumonia, heart failure, and COPD" was presented at the Summer 2011 BOD meeting and approved.

•· President Stewart has formed a committee to create the research proposal. Members include: Keith Lamb, Bill Cohagen, Bob McCoy, Cindy White and Greg Spratt.

•· We have had several calls discussing and met at the 2011 AARC Congress.

Proposal to Board

Based on the feedback received from the membership survey, and the input from the exploratory committee formed by President Stewart:

The Hospital to Home Committee proposes a project to select and fund 3-5 pilot studies exploring the benefits of different models of RT-led programs for reducing hospital readmissions in COPD. Pilot studies would be evaluated and selected based on the criteria designated by the committee (Attachment A).

Attachment A

Hospital to Home Pilot Study Objectives

•1. Study a COPD population

•2. At least 30 patients each (or calculated to be sufficiently powered) in Treatment and Control Arms

•3. Prospective, Randomized, Controlled Design

•4. IRB Approved

•5. Minimum of 1 year follow up data including but not limited to:

•a. Readmissions (COPD-related and not)

•b. Cost data including costs to deliver the program and cost savings from the program

•6. Incorporate standardized RT-directed intervention, (based on literature) that could be applied to large populations, which may include but is not limited to:

•a. Individualized patient needs assessment

•b. Patient / caregiver education

• i. Written and/or web-based materials

• ii. Pre and/or post-discharge

•c. Self-management plans

•7. Potential RT-directed follow up models may include the following (or a combination thereof):

•a. Pre-Discharge Intervention

•b. Visits to Home

•c. Calls to Home

•d. Checklist

•e. Telemedicine (e.g., Smart Phones, tablets, web-based)

•f. RT-Directed Long Term Care Facility Involvement

•g. Novel or Emerging Concepts

•8. Should be submitted in accordance with the ***AARC Research Program Grant Application***

•9. Must be completed as outlined in the proposal

•10. Must be submitted for publication

Other: None

Long Term Care

Management Section

Motions from the AARC Management Section to the AARC Board of Directors
April 20-21, 2012

Motion # 1
The AARC Management Section moves that:
"The AARC Board of Directors convene a consensus conference on 'Patient Safety and Respiratory Care Staffing Levels' with a committee of expert stakeholders to review evidence-based literature and best practice to:

e. Identify research opportunities related to Respiratory Care Department Staffing and Productivity
f. Identify resources for determining safe and effective Respiratory Care Department staffing levels
g. Develop cost-reduction strategies for maintaining safe staffing levels
h. Develop standards for the following items:
    - Measuring Respiratory Care Department staff productivity levels
    - Determining safe and effective Respiratory Care Department staffing requirements
    - Determining the appropriate number of direct reports for Respiratory Care Department directors, managers, and supervisors
    - Determining minimum or core-staffing requirements for Respiratory Care Departments"

JUSTIFICATION
Over the many decades of existence of the Respiratory Care profession, there has been an extraordinary amount of informal discussions as to the appropriate number of respiratory therapists required to meet the needs of a facility. In addition to these ongoing discussions, in various media and forums, presenters have discussed and displayed varied methodologies that they singularly employ: 1) to determine productivity, 2) to project shift requirements for staff, 3) as a flex-staffing models, 4) to determine budgetary FTE needs, 5) to recommend the appropriate number of ventilators assigned to a therapist per shift, and 6) to recommend the appropriate number of treatments to be assigned to a therapist per round or shift. These presentations and discussions have consistently been inconsistent.

Many principles of Respiratory Care are guided by a national consensus opinion, developed from the expertise of the stakeholders. These include standards for educational programs, standards for competency requirement, standards for the credentialing programs, and standards for the safe and effective administration of clinical respiratory procedures. It seems that it is now appropriate to establish a national consensus opinion on some of the principles required to establish appropriate staffing levels that will enable the provision of safe, efficient, and effective care to patients receiving respiratory care.

The Center for Medicare and Medicaid (CMS) require in its Conditions of Participation for Respiratory Care Services that "there must be adequate numbers of Respiratory Therapists and other personnel who meet qualifications specified by Medical Staff, consistent with State law". It would be appropriate for a national organization, representing Respiratory Therapists, to provide guidance to accomplish this objective by the expression of a national consensus opinion.

Motion # 2
The AARC Management Section moves that:
"The AARC Board of Directors develop a Position Statement for the promotion of patient safety by maintaining appropriate Respiratory Care Departments' staffing levels, and that within this statement include:

- A position which encourages the inclusion of all procedures performed to determine staffing levels and productivity targets for the safe delivery of Respiratory Care Services
- A position which identifies the metric of Relative Value Units (RVU's) as the standard to determine staffing levels and productivity targets for the safe delivery of Respiratory Care Services
- A position which censures the use of inappropriate, inaccurate, and non-validated data to determine staffing levels and productivity targets, as these create patient safety issues from mathematically impossible workloads and productivity targets for Respiratory Therapists and from the chronic understaffing of Respiratory Care Departments."

JUSTIFICATION
For years, Respiratory Care Department managers have, for the most part, operated in "individual facility silos" while developing staffing budgets and productivity targets for their Departments. When establishing these budgets and targets, each individual manager may be limited by his/her own skill level and experience when making crucial staffing decisions. Without state or national guidance, these managers have developed internal and individual methods of counting procedures performed by the therapists at their facilities and formulized internal and individual methods for converting the number of counted procedures into a projected number of therapists needed to provide care at their facilities. As a result, inconsistencies in staffing levels exist within Respiratory Care Departments across the United States. These staffing inconsistencies have been derived by using varied methodologies to count Respiratory Care Department volume (daily count, monthly count, historical trending, count all procedures, count "representative" treatments only) and by using varied metrics to project and determine Department staffing levels (Relative Value Units, Total Patient Days, Billable Procedures by CPT Code, Average Daily Census, Total Respiratory Care Procedure Volume, Total Inpatient Days, and Adjusted Discharges per Patient Day). Recent postings in January 2012 on the AARC Management List Serve have provided a small glimpse into this inconsistency, as the managers reported a wide range in their requirements for staffing in the provision of care to the ventilated patient – the range was from 1 therapist per 4 ventilators to 1 therapist to 8 ventilators.

On many occasions, Department managers are presented with opinions that counter their determined number of staff required for the provision of respiratory care services at their facility. Pressure may exist from administrators to reduce staffing or avoid hiring solely on financial parameters of the institution. On other occasions, these managers may be faced with strategies and potentially invalidated data from national benchmarking and productivity consultants with more pressing agendas other than to provide recommendations that assure appropriate staffing levels for the Respiratory Care Departments.

The AARC currently provides information and guidance on Respiratory Care Department staffing and productivity measurement as a resource on its website. A Position Statement on safe Respiratory Care Department staffing levels could provide further definitive guidance on what is considered minimally safe staffing levels. In addition, a position on appropriate methods of measuring safe staffing levels could provide specific guidance on at least two potentially minimally required elements – that effective staffing systems should apply well documented Relative Value Units and that effective staffing systems should account for all expected tasks and activities performed by the therapist.

Neonatal-Pediatrics Section

Reporter: Cynthia White

Last submitted: 2012-03-23 13:06:45.0

Recommendations

No recommendations

Report

- Assisted program committee with lecture proposal recommendations for Congress 2012
- Recruited candidates for section chair elect
- Participated in Hospital to Home Study conference call and planning committee
- assisted with articles for AARC Times
- Assisted with recommendations for Patient Safety Checklists
- Working on development on Neo-Peds Online Journal Club to begin by next BOD meeting

Sleep Section

Reporter: Mike Runge

Last submitted: 2012-03-21 16:21:58.0

Recommendations

No Recommendations at this time.

Report

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

-Completed.

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

-In progress.

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

-Co-chair Ad-hoc Committee and report submitted by Lynda Goodfellow.

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

-Chair Elect candidates submitted to the Elections Committee.

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.

-Have identified key people to assist in monitoring the list serve to assist 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 report in the April 2012 Board Report and updated for each Board report.

-In progress.

Surface to Air Transport Section

Reporter: Steven Sittig

Last submitted: 2012-03-18 20:18:22.0

Recommendations

- Recommendation: That the AARC BOD appoint a member of the Surface and Air Transport Section to be a liason to the American Academy of Pediatrics (AAP) Transport Section.
- I would like to submit Brad Kuch RRT-NPS, FAARC as my nomination.

Justification: Currently there is no representative listed to this organiztion's transport group or to the AAP itself. Brad Kuch has been very actively involved with the AAP for many years dealing with research and transport topics. Brad is the Program Director of Transport at University of Pittsburgh Medical Center. He has a direct working relationship with Dr RIchard Orr who is very active within the AAP as well. The focus of this liason would be to potentially increase transport section membership as well as increase membership to the AARC. It is highly likely that there are RT's within the AAP transport section who are not yet members of the AARC.

Report

The section bulletins continue to be published on time with quality content. Membership continues to slowly increase. I have been working with the executive office to update the Transport section’s webpage to better reflect the large percentage of neonatal and pediatric patient transport RT’’s care for every day. The current verbiage is somewhat vague in what a transport RT is involved in.

The Section list serve on AARConnect has been busy with posts related to transport issues. The section once again submitted approximately 15 lecture proposals for the AARC Congress in New Orleans. I continue to involve Chair Elect Billy Hutchinson in the role of section chair that he will assume at the AARC Congress in November.

I continue to do my transport specialty talk to RT students around the country. I will be speaking twice in Nashville at Tennessee State RT program on the 26th and 27th of March prior to my attendance of the CAMTS BOD meeting. I have also been invited to Vanderbilt Children’s hospital for an afternoon. They are starting a pediatric transport team staffed with an RN and an RT. They are looking for my suggestions as to prepare training and education that may be helpful as well as meet the transport staff and leadership.

Special Committee Reports

Benchmarking Committee

Reporter: Richard Ford
Last submitted: 2012-03-02 15:00:24.0

Recommendations

NONE

Report

•1. The Benchmarking Committee has been engaged in several education forums to inform both potential and existing clients of the features and benefits of the program. These programs include Stan Holland and Rick Ford presentations on staffing, best practice, and benchmarking at the AARC Congress in which features and benefits of AARC Benchmarking were included. Other programs provided by team members included the monthly webinars for existing clients:

•a. Setting up Compare Groups in January by Rob Chatburn

•b. Key to Comparisons-The Profile in February by Rick Ford

•c. Using Filters to Compare in March by Chuck Menders

•2. Proposal on benchmarking related topics were submitted for the 2012 Summer Forum and Congress, with one already accepted for the Summer Forum on "Staffing RC- How Many Needed" by Rick Ford. The presentation will demonstrate the utility of AARC Benchmarking in determining staffing levels.

•3. The regional "Client Support" has continued by all members of the team to assist new clients and followup with subscribers that are late in entering data, or subscriptions are about to expire.

•4. Members of the Benchmarking Committee estimate they commit 4 hours per week of volunteer work. This includes preparation of educational material and the personalized follow-up with clients, as well as committee business. Stan Holland is recognized for his systematic and thorough follow-up to guide clients in getting started and solving issues. Stan is also actively recruiting a large hospital group in his region to purchase several subscriptions to the program.

•5. This year we are using AARC Connect to network with each committee member and now have a document library of resources that aid in supporting clients. As of March 1 a discussion group specifically for Benchmarking Subscribers has been set up through AARC Connect. It is noted that AARC membership is required to access AARC Connect and not all subscribers are members. The committee will continue to assess if this is an issue, with a focus of encouraging all subscribers to also be AARC members in order to use this recently added feature.

•6. Committee members held a teleconference on January 31st to discuss the issues presented in this report as well as the need to refine the program after the release of the new AARC Uniform Reporting Manual.

•7. As of March 1 there are 144 active subscribers.

8. Bill Dubbs has continued to support this team and AARC Benchmarking clients by continuing early notifications to all users in which subscriptions will terminate or in which data has not been entered. Bill also provides a comprehensive monthly e-bulletin that informs clients of recent changes, enhancements, and updates. These bulletins also provide helpfull links to other resources and are much appreciated.

Billing Codes

Submitted by Susan Rinaldo-Gallo
3/21/12

Activities

1. Communication of Code Changes

As you are aware, there were many changes to PFT codes this year. These changes were communicated on the Coding list serve and on the AARC Resources web page under Coding.

2. Monitoring the Billing Codes list serve

There are 188 members and there have been 80 posts.
Many coding questions are asked on other communities, mainly the Help line and Management. These are more difficult to monitor.

3. I have received numerous phone calls and e mails for coding advice.

4. The AARC along with the ACCP and ATS has proposed a coding change to the AMA/CPT. We are requesting a code for HFO (i.e. Vest). See the AMA/CPT report for more information.

Federal Government Affairs Committee

Reporter: Frank Salvatore

Last submitted: 2012-03-23 18:01:51.0

Recommendations

NO RECOMMENDATIONS

Objectives:

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

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.

Assist in coordination of consumer supporters

Report:

The first activity of every year for this committee is the coordination and implementation

of the Virtual Lobby Week (VLW) and PACT Hill day. Planning started late in 2011 with Cheryl West sending out the details of the meeting in March of 2012. We began working on the details of the VLW in late January/early February. The VLW went live on February 27, 2012 and ran through March 8, 2012. The numbers of messages sent to Washington DC during this VLW was almost as many as were sent in ALL of 2011. There were 12,542 messages sent during the VLW. Michigan, Pennsylvania and Maryland/DC societies had over 1000 messages sent with Michigan almost attaining 1,500 messages during the VLW. Overall, there was a good response, but I would be remiss if I didn't point out that we only scrapped the iceberg with the number of letters sent. There still needs to be a better mechanism for state societies to get the messages out. Looking at the attached spreadsheet for the VLW, there are a few states that don't even have the number of activists equal to the number of people that sit on their boards.

Looking at the PACT Hill day, I'm sure these will be duplicated in Cheryl West's report, but we saw 135 RTs from 46 states and DC attend this year's meeting. Over 30 of those attendees were there for their first time. We had 32 patient advocates attend as well. There were 349 visits scheduled this year which was the most ever in the 13 years we have been going to DC!! At the time of this reports creation, 11 new co-sponsors were signed onto HR 941 as a direct result of our hill day. We also have gotten some traction on getting someone to advocate for the

Congressional Budget Office (CBO) to speak with the AARC to allow us to understand how they came up with their fiscal estimates back in 2010.

The committee will continue to push the state societies to keep messages coming into Washington DC via Capitol Connection. We will be putting out monthly reports of totals so that the states can keep track of how they are doing.

Other

I want to thank the members of the Federal Government Affairs committee for their work this first quarter. I also would like to once again point out that we'd be stuck in the pond without paddles if Cheryl West wasn't our AARC leader and advocate. Her coordination of the PACT Hill Day was once again flawless. And to Miriam O'Day and Natalie Napolitano, a hearty hooray for them too!! We are blessed to have such high-powered and tireless people working for our profession.

AARC Federal Government Affairs

2012 VLW Messages Spreadsheet

#	RECIPIENT_STATE	TOTAL_ACTIVISTS	E_MAIL	PRINTED	TOTAL_ADVOCACY_MESSAGES
1	Michigan	381	1468	23	1491
2	Pennsylvania	462	1416	24	1440
3	Maryland	239	1046	5	1051
4	Georgia	243	830	7	837
5	Ohio	252	721	20	741
6	Florida	259	714	1	715
7	Missouri	198	497	11	508
8	North Carolina	150	416	1	417
9	South Carolina	122	359	0	359
10	Connecticut	105	346	1	347
11	Alabama	68	268	0	268
12	Louisiana	84	252	2	254
13	Washington	82	247	4	251
14	Nebraska	75	218	0	218
15	Minnesota	68	218	0	218
16	Wisconsin	69	211	2	213
17	Nevada	66	199	0	199
18	South Dakota	50	179	0	179
19	California	66	170	4	174
20	Virginia	65	169	1	170
21	Indiana	69	157	10	167
22	Kansas	64	157	6	163
23	West Virginia	59	163	0	163
24	Illinois	77	157	1	158
25	Oregon	38	153	0	153
26	Texas	55	134	3	137
27	Hawaii	37	136	0	136
28	Arizona	37	131	0	131
29	Utah	51	130	0	130
30	Colorado	42	115	0	115
31	New York	45	108	1	109
32	Montana	24	102	0	102
33	New Jersey	36	95	0	95
34	Maine	29	80	2	82
35	Kentucky	29	76	6	82
36	Arkansas	28	69	0	69
37	District of Columbia	38	39	27	66
38	Massachusetts	22	59	5	64
39	Oklahoma	20	59	0	59
40	New Mexico	19	46	0	46
41	Iowa	13	41	0	41
42	North Dakota	14	41	0	41
43	Tennessee	16	33	0	33
44	Idaho	13	32	0	32
45	Delaware	11	31	0	31
46	Mississippi	18	30	0	30
47	New Hampshire	11	25	0	25
48	Vermont	4	10	0	10
49	unknown	8	1	8	9
50	Alaska	1	6	0	6
51	US - National	5	5	0	5
52	Rhode Island	1	2	0	2
4038			**12542**		

Fellowship Committee

Reporter: Patrick Dunne

Last submitted: 2012-03-09 14:56:48.0

Recommendations

- There are no recommendations at this time.

Report

The Committee continues to encourage those AARC members who have been recognized as FAARC to nominate qualified individuals for this prestigious honor. Nominations and all supporting documentation must be received in the Executive Office by the end of August, 2012. The Committee will then commence the formal selection process in September.

International Committee Report

Recommendations

Recommendation 1: That the AARC Board of Directors approves the revised International Mission/Goals statement and that the statement is added to the International Fellowship Program home page on the AARC web site.

Justification: The AARC BOD charged the International Committee to review their current goals and determine if they need to be updated and/or modified. After extensive review with input from all members it is felt by the committee that the current International Mission Statement needs to be revised to better reflect all of the international activities the AARC is involved in. The document also needs to be revised to delete the reference to the ARCF as the sponsor for the program. The committee spent most of last year and both committee meetings discussing proposed changes to the Mission/Goals statement. Last November with 12 of 15 members present at our meeting, all of the members present, with the exception of one abstention (Jerome Sullivan) voted to approve the proposed changes to the document. The document has been shared with the Executive Committee of the ICRC and will also be shared with the ARCF BOT at their upcoming meeting.

The *Mission Statement of the American Association for Respiratory Care in Regard to International Activities* states that the American Association for Respiratory Care (AARC) seeks to "promote communication and fellowship among respiratory care professionals in the United States and their counterparts worldwide"…through "cooperation, dialogue, and educational exchanges". ~~In keeping with this mission, the AARC is offering "**International Fellowships in Respiratory Care**." This important project is sponsored by the American Respiratory Care Foundation. The Fellowships have been established to assist health care professionals in visits to the United States to observe the practice of respiratory care as it is performed in a variety of settings, and visit the educational programs that teach it. The goals of the Fellowship program are to:~~ Our International Goals are to:

- promote the exchange, development, and coordination of the art, science and application of respiratory care.
- allow meaningful interaction and cooperation among multi-national colleagues in an apolitical, humanitarian context.
- enhance the awareness and understanding of the profession of respiratory care and its vital role on the health care team.

- provide encouragement and assistance to those countries seeking to establish the profession of respiratory care as an independent profession.
- provide encouragement and assistance to those countries seeking to establish professional associations for respiratory therapists.
- provide encouragement and assistance to those countries seeking to gain legal recognition of the profession of respiratory care.
- provide encouragement and assistance to those seeking to provide and establish seminars, programs and schools in their home country.
- encourage professional and educational organizations to gain recognition of seminars, programs and schools through the ICRC International Education Recognition System (IERS) .
- provide encouragement and assistance to those seeking to establish international affiliates of the AARC in their country.
- provide encouragement and assistance to those seeking to establish Governors representing their country to the ICRC.
- encourage and promote the exchange qualified speakers between the AARC and other professional associations around the world.
- encourage respiratory care professionals to participate in medical mission projects.
- encourage student and faculty exchange programs between respiratory care programs around the world.
- encourage and assist our international colleagues in publishing articles, case studies, or abstracts in *Respiratory Care*, *AARCTimes* or other professional journals from their country.
- encourage the sharing of AARC publications with related foreign publications around the world.
- encourage and assist our international colleagues in providing translations of AARC publications.
- encourage international membership in the AARC.
- select qualified providers of respiratory care who have a desire to develop the respiratory care profession in their country through application to the AARC International Fellowship Program in order to assist in visits to the United States to observe the practice and education of respiratory care professionals in a variety of settings.
- invite highly recognized clinical, educational, political, and industrial health care leaders through the ARCF Visiting Dignitary Program for structured, individualized visits to the United States in order to achieve the globalization of the Respiratory Care profession.

All of these initiatives are wholeheartedly endorsed by the AARC in an effort to ultimately improve the respiratory care of patients throughout the world.

Recommendation 2: That the AARC Board of Directors approve the AARC International Fellows Effectiveness Survey and that it be programmed and administered by the Executive Office via the internet using Survey Monkey or a similar internet tool to survey the new fellows after their visit and also to survey all past fellows if contact information is available.

Justification: The International Committee was charged with developing both short-term and long term measurable objectives that reflect higher level goals of the AARC. The objectives were developed by the committee and implemented into this survey instrument which can be used to evaluate both past and future successes of the international fellowship program. The

survey will also provide useful information regarding the Fellow's perception/satisfaction with AARC resources, the value of international membership and the international congress.

Recommendation 3: That the AARC consider funding the creation and production of an International Fellow lapel pin.

Justification: Six years ago the ARCF created and produced several International Fellow lapel pins. The pins were meant to help identify the fellows while at the International Congress and also identify them as Fellows at other meetings around the world. When first produced the pins were distributed to the new fellows and also to all of the past fellows. They were and still are a valued item by the Fellows. Today they are only given to the new fellows. However since the Foundation is no longer funding the Fellowship program and due to the fact that the pins indicate "ARCF International Fellow", new pins need to be produced.
I will have an example of the pin at the meeting.
Approximate cost would be around $300

AARC International Fellows

Effectiveness Survey

Family Name: _____
Given Name: _____
Country: _____
Year of Fellowship: _____
I am an: (mark as many as apply)
MD _____
RN _____
PT _____
RT _____
Other _____ Please identify your specialty.

1. Have you taken advantage of AARC member resources during your free membership period?
   Yes _____ No _____
2. If Yes, what resources have you found most helpful? Please rank the following from 1 to 12. 1 being the most beneficial and 12 being the least beneficial.
   Respiratory Care Journal _____
   AARC Times _____
   Membership registration rates for the AARC International Congress _____
   News Now Emails _____
   Internet Resources _____
   International News _____
   Position Statements _____
   The Clinicians Guide to PAP Adherence _____
   Clinical Practice Guidelines _____
   Protocol Resources _____
   A Guide to Aerosol Delivery Devices for Respiratory Therapists _____

Webcasts _____
AARConnect _____

3. Did you or will you renew your membership after your free membership expires?
   Yes _____ No _____
4. If No, what benefits or services would encourage you to join the AARC?

_____
_____
_____
_____

5. Have you attended an AARC International Congress since your visit as a Fellow?
   Yes _____ No _____
6. If Yes, how many Congresses have you attended? _____

7. If No, what would have to change in order to encourage you to attend?

_____
_____
_____

8. Does your country have Respiratory Therapy Schools?
   Yes _____ No _____
9. If Yes:
   How many schools are in your country? _____
   Where are they located? Please list the institution and the city.

   _____
   _____
   _____

   How many are hospital based programs? _____
   How many are certificate programs? _____
   How many are college based 2 or 3 year programs? _____
   How many are university based BS programs? _____
   How many are post graduate programs designed for nurses or physiotherapists? _____
10. If No, have you worked to establish respiratory therapy programs?
    Yes _____ No_____
    If Yes, please describe your efforts.

    _____
    _____
    _____
    _____

11. Does your country have Respiratory Therapist
    Yes _____ No _____
12. If yes, how many Respiratory Therapist are in your country? _____

13. If Yes, do the Respiratory Therapists in your country have legal/governmental recognition?
    Yes _____ No _____
14. If No, have you worked to establish recognition in your country?
    Yes _____ No _____
    If Yes, please describe your efforts.

    _____
    _____

_____
_____

15. Does your country have professional associations specifically created for Respiratory Therapists?
    Yes _____ No _____
    If Yes, please provide their names, physical address, email address, and web site address along with the current Presidents name and email information.

    _____
    _____
    _____
    _____

16. If No, have you worked to establish professional associations in your country?
    Yes _____ No _____
    If Yes, please describe your efforts.

    _____
    _____
    _____
    _____

17. Have you published articles, case studies or abstracts in *Respiratory Care, AARCTimes* or other professional journals in your country or others?
    Yes _____ No _____
    If Yes, please list those publications.

    _____
    _____
    _____
    _____

18. Have you provided translations of AARC products?
    Yes _____ No _____
    If Yes, please provide a list of those products and also names of other individuals who worked on the translations.

    _____
    _____
    _____
    _____

19. Have you collaborated with the AARC to publish *Respiratory Care or AARCTimes* articles in publications within your country?
    Yes _____ No _____
    If Yes, please describe the publications and the articles that were published.

    _____
    _____
    _____
    _____

20. Have you attended a meeting of the International Council for Respiratory Care?
    Yes _____ No _____
    If Yes, how many meetings have you attended and in what year and what location?

    _____
    _____
    _____

21. Do you now or have you ever served as a Governor on the International Council for Respiratory Care?
    Yes _____ No _____

22. Does the Professional Association in your country hold AARC International Affiliate status?
    Yes _____ No _____
23. If No, have you worked to establish International Affiliate status?
    Yes _____ No _____
    If Yes, please describe your efforts.
    _____
    _____
    _____
    _____
24. Have you or your colleagues obtained AARC International Education Recognition System (IERS) approval for seminars, programs or schools in your country.
    Yes _____ No _____
    If Yes, please describe your efforts.
    _____
    _____
    _____
    _____
25. Have you made presentations at the AARC Congress or Summer Forum?
    Yes _____ No _____
26. If Yes, please describe your efforts.
    _____
    _____
    _____
    _____
27. Have you used the International Fellows List Serve to communicate with members of the International Committee and other Fellows?
    Yes _____ No _____
28. Have you found the list serve to be helpful?
    Yes _____ No _____
29. How could the list serve change in order to make it more useful?
    Please provide suggested changes.
    _____
    _____
    _____
    _____

Report

1. Administer the International Fellowship Program.

As you already know the fellowship program continued to be successful in 2011. That trend should continue this year. The web site is being updated and invitations for hosts and fellows have been included in *AARCTimes* and on the web site. The online application has been revised to provide more useful information. The application period is January 1 to June 1st each year.

2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International portion of the Congress.

The committee continues to work with the ICRC to help coordinate and help prepare the presentations given by the fellows to the council.

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

The International Fellows List serve continues to be valued by the past fellows.

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

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

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

We are corresponding with other medical associations and societies periodically throughout the year.

6. The AARC BOD direct the International Committee to review their current goals and determine if they need to be updated and/or modified.

The committee began work on charges 6, 7 and 8 last year. All of the members were surveyed regarding their thoughts/opinions about each charge. Results of the surveys were discussed at the International Committee meeting in July. Results of those discussions led to the formation of three working groups. One group worked on revisions to the mission and goals for the international activities of the AARC. One group worked on revisions to the International Fellows application and one group worked on the effectiveness survey instrument. The revised Mission/Goals statement was approved by the committee in Tampa last November and is presented in this report as Recommendation 1. The statement has been shared with ICRC Executive Committee and will be shared with the ARCF BOT at their next meeting.

7. Direct the International Committee to review the current selection process and determine if it is still relevant and appropriate considering the current market environment.

Surveys and discussions indicated that virtually all members agree the current selection process is effective and should not be changed. Individual members discussed their philosophy regarding the selection of fellows. It was felt that a new version of the application may help to better identify individuals who will be successful in achieving the goals of the program. The new application was approved by the committee late last year and implemented January 1, 2012. It is presented below for your information.

8. That the International Committee develop some short-term and long term measurable objectives that align with the higher level goals of the organization.

The AARC International Fellows Effectiveness Survey was unanimously approved by the committee in Tampa last November and is presented in this report as Recommendation 2.

I want to thank Kris Kuykendall and April Lynch of the Executive Office and the committee members for all of their hard work.

The International Committee:
John D. Hiser, MEd, RRT, CPFT, FAARC
Vice Chairs
Debra Lierl, MEd, RRT, FAARC, Vice Chair for International Fellows
Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations
Committee members:
Michael Amato, BA
Arzu Ari, PhD, MS, MPH, RRT
Ivan Bustamante, RRT
John Davies, MA RRT FAARC
ViJay Desphande, MS, RRT, FAARC
Hector Leon Garza, MD, FAARC
Derek Glinsman, RRT, FAARC
Yvonne Lamme, MEd, RRT
Dan Rowley, BS, RRT-NPS, RPFT
Bruce Rubin, MD, FAARC
Michael Runge, BS, RRT
Jerome Sullivan, PhD, RRT, FAARC

Personal Information

First (Given) Name:

Last (Family) Name:

Gender: ○ Male ○ Female

Credentials:

Professional Title:

Home Address:

City:

Postal Code:

Country:

Telephone Number: *(country code - city code - number)*

Email Address:

Professional Information

Your Employer's Name: *(institution, hospital, or university)*

Work Address:

City:

Country:

Work Fax Number: *(country code - city code - number)*

Describe Your Current Position and Job Responsibilities:

Describe Your Experience in Health Care: *(examples: nursing, pulmonary medicine, anesthesia, physiotherapy, critical/intensive care, academics, additional training or experience, etc.)*

What professional groups (physicians, nurses, physiotherapists, or others) currently perform respiratory care procedures in your hospitals and other institutions? This would include procedures such as airway care, aerosol therapy, oxygen therapy, mechanical ventilation, diagnostic testing, etc.

Please explain how health care is administered and funded in your country:

Are you a member of the AARC and/or a respiratory care society within or outside your country?

○ Yes ○ No

Do you have a current passport and are you able to acquire a visa to travel to the United States?

○ Yes ○ No

Have you previously traveled in the United States for professional training or other professional reason?

○ Yes ○ No

Have you attended an international respiratory, thoracic, or lung conference outside your country?

○ Yes ○ No

Educational Information

Highest Diploma/Degree:

Year Received:

University:

General Information

Have you previously applied to be an International Fellow?

○ Yes ○ No

Will you need an official letter of invitation if selected to be International Fellow?

○ Yes ○ No

What are your expectations of your AARC Fellowship if you are chosen?

Upon completion of your Fellowship what are your specific plans and goals to develop and improve respiratory care in your country?

What resources do you have (such as agencies, hospitals, universities, ministry of health, or personnel) that can help you achieve your plans and goals to improve respiratory care?

Will you agree to do a written report and respond to surveys from the committee at 6 months and at 12 months after your fellowship?

○ Yes ○ No

How did you learn about the AARC International Fellowship?

File Attachments

Attach your curriculum vitae (résumé/biographical data) to include a list of any publications you have completed, a letter of recommendation from your institution's director, two general letters of recommendation, and a digital photograph of yourself:

Curriculum Vitae:

Browse...

Director's Letter:

Browse...

First Recommendation Letter:

Browse...

Second Recommendation Letter:

Browse...

Your Photograph:

Browse...

Submit Your Fellowship Application

Membership Committee

Reporter: Frank Salvatore

Last submitted: 2012-03-23 18:02:09.0

Recommendations

NO RECOMMENDATIONS AT THIS TIME

Charges:

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

In conjunction with the Executive office, develop a membership recruitment campaign based on survey results for implementation.

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

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

Develop strategy to entice more member use of AARConnect.

Report

Recruitment Campaign #1 for 2012:

The membership committee got a jump on 2012 by sending out a request at the end of December 2011 to the state societies for them to take lists provided by the AARC and help us determine who the "leader" was in each AHA listed hospital in their state. This project was cumbersome and by the beginning of March we received XX completed lists from the states. The AARC then worked these lists into usable forms and we determined from that work that there were about 600+ department leaders who were not members of the AARC.

Target department leaders who are not members of the AARC for membership.

Create a campaign that is directed toward leadership to show them the value of AARC membership and how it may help them lead better.

Campaign begins around the 3rd full week of April 2012 and goes through May 31, 2012 (depending on how late the mailer goes out, the end date may be pushed into June).

We have created a mailer that will be directed to those 600+ department leaders. The expected mailing of them will be

Mailer will point the prospective member to a special web page that will be set-up and go live when the mailer goes out.

Offer a money back guarantee for joining. We will be giving them a 30 day money back guarantee. The new member must contact AARC within 30-days to get membership cancelled.

We will be giving all new leaders who sign up for membership during this campaign a free membership in the Management Specialty Section.

The Membership Committee will track the following and report back to the BOD and HOD in July:

Number of mailers sent out.

Number of hits on our special web page.

Number of memberships created by these target leaders during this special recruitment campaign.

Number of memberships cancelled within 30 days.

Recruitment Campaign #2 for 2012:

Once campaign #1 gets off the ground, we will be working on the details of our 2nd half of 2012 membership campaign. We will once again use the list worked upon by the state societies to send mailings to "ALL" department leaders (members and non-members) to try to get our recruitment campaign inside of as many institutions as possible. Details will be forthcoming.

Other

I want to thank the members of the Membership Committee. They hit the ground running and had to make many contacts with their states. I'd also like to thank Tom Kallstrom, Sherry Milligan and Doug Laher for all their work and guidance they have given during the first quarter of the year and on our first recruitment campaign.

Position Statement Committee

Reporter: Colleen Schabacker

Last submitted: 2012-03-22 08:27:50.0

Recommendations

Recommendation # 1:

Approve and publish the newly developed position statement on "Respiratory Therapists in the Emergency Department". This statement is Attachment #1.

Justification: This resolution from the HOD was approved by the BOD and referred to this committee. The motion was as follows: "Be it resolved that the AARC formulate and distribute a position statement regarding the rising of free standing emergency rooms (FSER) and the need for Respiratory Therapist to be an integral part of the ER Team". Instead of writing a position about FSERs only, it was felt a position on all emergency department settings was more appropriate.

Recommendation #2:

Approve and publish the revised position statement on "Respiratory Therapists Education". This statement is submitted for your review as Attachment #2. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: Cleaned up some of the verbiage, and made a strong emphasis on furthering one's education.

Recommendation #3:

Approve and publish the revised position statement on "Continuing Education". Text to be deleted appears with strikethrough and text to be added appears with underline. See Attachment #3

Justification: It was felt we needed to add the following statement at the end of this position: Providers of continuing education are encouraged to review, evaluate and measure their activities'' effectiveness. Providers are also urged to use instructional technology, incorporate

multiple learning styles, current research-based learning and assessment theories, and foster critical thinking to promote effective learning."

Recommendation #4:

Approve and publish the revised position statement on "Licensure of Respiratory Care Personnel". Text to be deleted appears with strikethrough and text to be added appears with underline. See Attachment #4

Justification: Added public's "health, safety and welfare".

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.

•· A draft of the proposed AARC position statement "Respiratory Therapists in the Emergency Department" has been proposed.

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

- During 2012, the Committee's goal is to complete the review of the four (4) position statements listed below. Action on each statement to this point is listed following the statement title as is the name of the Committee member spearheading the review.

•1) Respiratory Therapy Education - Deryl Gulliford - presented revisions at April BOD meeting

•2) Licensure of Respiratory Care - Kathy Deakins - presented revisions at April BOD meeting

•3) Continuing Education - Jim Allen - presented revisions at April BOD meeting

•4) Ethics and Professional Conduct - Linda VanScoder - to be presented at the July BOD meeting

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

• The schedule (See Attachment #5) is ongoing.

Other

A special thank you to committee members Kathleen Deakins, Deryl Gulliford, Jim Allen and Nick Widder. A special thanks to committee member Linda VanScoder who always had her finger on the pulse and was always there to help.

Attachment #1

American Association for Respiratory Care

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

Position Statement

Respiratory Therapists in the Emergency Department

Patients are at risk for unanticipated injury or illness requiring emergency services. This is why Emergency Departments rely on Respiratory Therapists for their expertise in a wide range of cardiopulmonary treatment modalities. The Respiratory Therapist's skills in assessment, airway management, resuscitation, patient education and mechanical ventilation are essential for optimizing care of the compromised patient.

To provide the quality of care our patients deserve while reducing the risk of liability in health care institutions, the AARC recommends the use of qualified Respiratory Therapists trained in patient management and complex respiratory care modalities to provide safe and effective treatment for the highest risk patients with cardiopulmonary compromise in all Emergency Department settings.

Attachment #2

American Association for Respiratory Care

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

Position Statement

Respiratory Therapist Education

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

- The minimum education ~~leading~~ required to ~~entry into the~~ practice ~~of~~ respiratory care is ~~therapy should be~~ ~~successful~~ completion of an associate degree in respiratory care. ~~therapy. educational program.~~
- Programs ~~that educate~~ for the education of respiratory therapists, managers, researchers, faculty, and professional leaders should be accredited ~~through~~ by a body recognized by government, and through a rigorous and ongoing process which assures the quality of their programming. ~~, and a process, which will confirm that the programs meet minimum educational~~ ~~requirements.~~
- Respiratory therapists completing ~~the above-described~~ ~~minimum~~ such education, advanced training, and/or experience should be eligible ~~to pursue and to obtain a~~ for credentialing to reflect their ~~that acknowledges the~~ didactic preparation and ~~related~~ clinical skills required for practice in the respective area of specialization. Credentialing should be encouraged in related areas of specialization to include Neonatal/Pediatric Care, Adult Critical Care, Sleep Disorders, Pulmonary Function Testing and others which may be added as the field evolves.

The AARC also encourages the development of accredited, advanced degree programs in Respiratory Care at the bachelor's, master's and doctoral levels; and encourages therapists

to pursue such higher education as a means of expanding career opportunities and advancing the Respiratory Care profession.

Effective 1998
Revised 03/2009

Attachment #3

American Association for Respiratory Care

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

Position Statement

Continuing Education

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

The AARC encourages Respiratory Therapists to select continuing education activities relevant to their personal and professional needs. Providers of continuing education activities (which can include clinical institutions, educational institutions, public and private associations or organizations, and proprietary corporations) are encouraged to conduct needs assessments in order to design and develop valuable educational activities that will enable practitioners to meet their professional goals. ~~The use of multimedia, multiple instructional techniques, and multiple exposure strategies are also encouraged to improve retention.~~ In addition, providers of continuing education are encouraged to review, evaluate and measure their activities' effectiveness. Providers are also urged to use instructional technology, incorporate multiple learning styles, current research-based learning and assessment theories, and foster critical thinking to promote effective learning.

Effective: 1990
Revised: 2000
Revised: 2005
Revised: 2009
Revised 2012

Attachment #4

American Association for Respiratory Care

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

Position Statement

Licensure of Respiratory Care Personnel

The American Association for Respiratory Care staunchly supports the non-restrictive licensing of respiratory care personnel at all levels within the defined scope of practice as a means of protecting the public by mandating at least minimal levels of competency in respiratory care modalities. Respiratory Care licensure is not intended to limit, preclude or otherwise interfere with the practice of other persons who are formally trained and licensed and who have documented equivalent competency.

Effective 3/90
Revised 3/00
Revised 12/06
Revised 07/09

Attachment #5

Position Statement Review Schedule
Originally Proposed 02/20/2007;
Last approved by BOD 12/2009; 12/2010
Last Update: 11/08/2010, 03/04/11

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2012-X)	Schedule Review for 2012	Schedule Review for 2013	Schedule Review for 2014	Schedule Review 2015
AARC Statement of Ethics and Professional Conduct	1994	2009	3	X			X
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2010	2		X		
Competency Requirements for the Provision of Respiratory Therapy Services	1998	2011	1			X	
Continuing Education	1990	2009	3	X			X
Cultural Diversity	1994	2010	2		X		
Definition of Respiratory Care	1987	2011	2			X	
Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	2009	2010	2		X		
Hazardous Materials Exposure	2002	2011	1			X	
Health Promotion and Disease Prevention	1985	2011	1			X	
Home Respiratory Care Services	2000	2010	2		X		

Inhaled Medication Administration Schedules	2008	2011	1			X	
Licensure of Respiratory Care Personnel	1990	2009	3	X			X
Pre-Hospital Mechanical Ventilator Competency	2007	2011	1			X	
Pulmonary Rehabilitation	1973	2011	1			X	
Respiratory Care Scope of Practice	1987	2010	2		X		
Respiratory Therapist Education	1998	2009	3	X			X
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2010	2		X		
Respiratory Therapy Protocols	2001	2010	2		X		
Telehealth	2001	2010	2		X		
Tobacco and Health	1991	2011	1			X	
Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child, or Adult Patient	2009	2009	3	X			X
Verbal Orders	1990	2011	1			X	
				5	**8**	**9**	**5**

Public Relations Action Team

Reporter: Trudy Watson

Last submitted: 2012-03-22 17:29:19.0

Recommendations

No recommendations at this time.

Report

Status of Charges

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

- To date, no requests for radio interviews have been received.

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

- No requests have been received to assist with **Your Lung Health** activities.

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

- This request was made to the Presidents of the Chartered Affiliates in 2011.

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

- To date, the EO has not requested that PR materials be updated.

State Government Affairs Committee Report

Tom McCarthy, Chair
April 2012

Several pieces of legislation are progressing through legislatures that will affect Respiratory Care Practitioners.

Most notably, Maryland has two major pieces of such legislation. The first, Senate Bill 350, provides "*that a licensed respiratory care practitioner has the right to practice respiratory care within the scope of practice of the respiratory care practitioner's license, including practicing respiratory care in a sleep laboratory*". At this time it appears that this legislation will pass.

The other legislative initiative in Maryland that is of concern to the Respiratory community is Senate Bill 776. Essentially, the language in SB 776 would allow individuals who may, or may not, be graduates of an accredited education program and who may, or may not, have passed a Nationally Accredited Credentialing Board competency examination to be licensed in the State to practice Polysomnography with patients. The concern with this language is that, by default, these individuals will be practicing Respiratory care as well. The Senate version of the bill passed, but the House version (HB 827) was heavily amended before passage. A conference hearing is scheduled for April 4th.

The overall appearance of significant Polysomnography related legislation on an annual basis continues. The AASM recent publication of, "Innovation Care Delivery and Management Program for Patients with OSA" clearly indicates that this trend will continue. In fact, AASM sponsored legislative initiatives may increase since, among other things, the above cited publication calls for Stark Law waivers for sleep physicians. This would, of course, be a Federal matter but there would be ramifications for States with physician self-referral laws.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Reporter: Susan Rinaldo Gallo

Last submitted: 2012-03-29 12:09:32.0

- The AARC, ACCP and ATS proposed a revision of the Chest Wall Manipulation (94667, 94668) codes at the February meeting. We asked that the code description be changed to read (changes in bold):

  •· CPT code **94667**: Manipulation chest wall, such as cupping, percussing, vibration **and oscillation** to facilitate lung function; initial demonstration and/or evaluation

  •· CPT code **94668**: Manipulation chest wall, such as cupping, percussing, vibration **and oscillation** to facilitate lung function; subsequent CPT code

  When presenting code proposals the performance of the procedures in the outpatient clinic and physician office settings must be stressed. Performance of procedures in the inpatient setting will not be considered. Inpatient procedures are covered under DRGs. One of the panel members asked us how the physician''s office obtains the device (Vest), did they purchase it and if so wouldn''t that increase the office expense? I indicated that I was fairly sure that the companies provide the devices free of charge to the physician's office. However I wasn't positive and I was truthful about that. A consultant for the Hill Rom (The Vest Company) was in the audience and she spoke to this stating that the company does supply the machines free of charge. This didn't satisfy the panel; they asked us to return at a future meeting with more information on costs. It is unusual for the AMA CPT to ask about costs, that is the role of the RUC. The AMA's job is to identify legitimate services/procedures for patients. In addition, the February meeting is the last meeting to have codes considered for the following year's CPT publication. It is typically the busiest meeting of the year. There were approximately 80 codes being considered at this meeting. Each code received very little time and many were delayed until the next meeting.

- This code modification proposal was postponed until the May 17th meeting.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Reporter: Debra Koehl

Last submitted: 2012-03-23 08:39:23.0

Recommendations

No current recommendations

Report

The following activities are occurring:

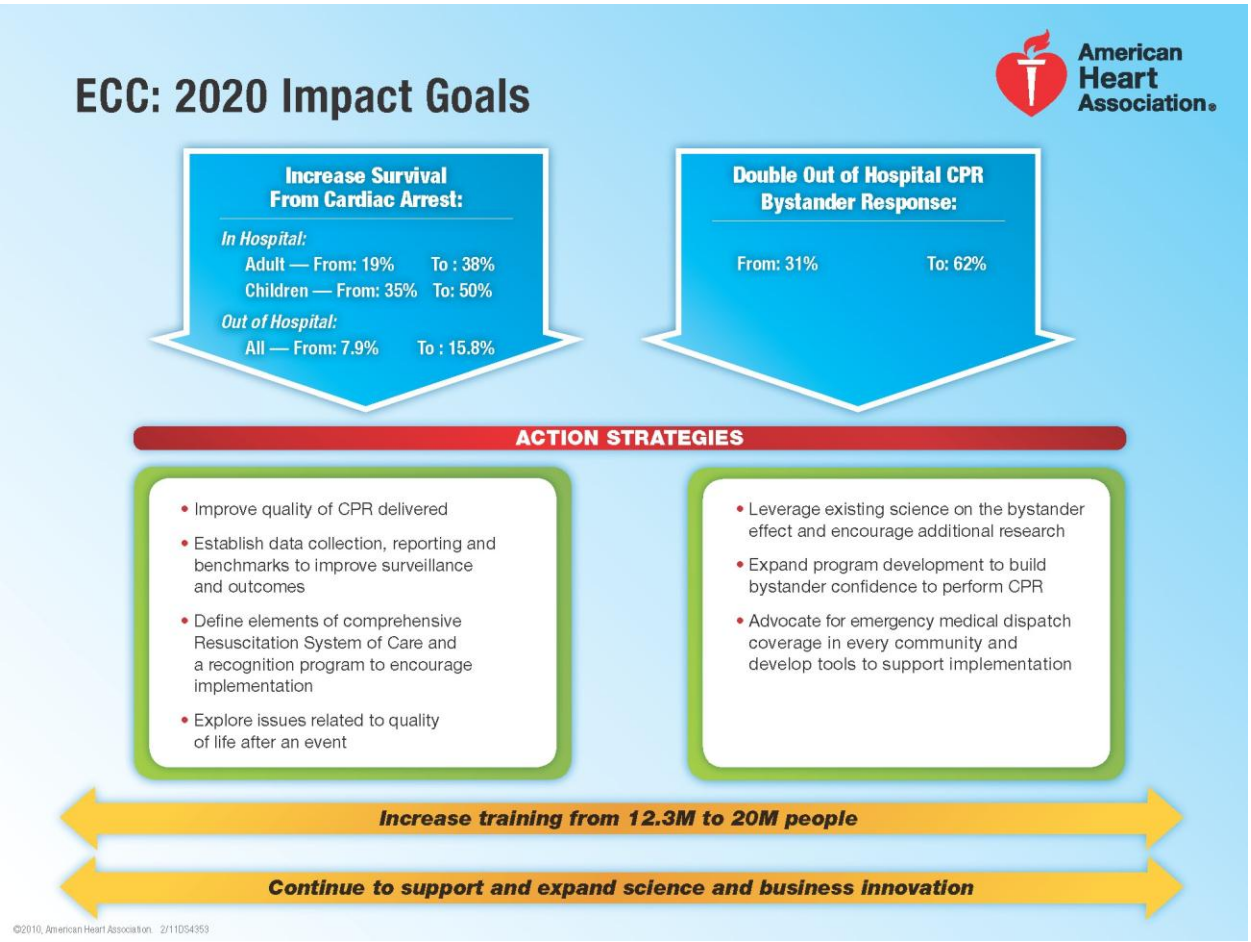
- As part of my AARC responsibilities as well as being the AARC rep to AACVPR we have been hard at work working on the Pulmonary Rehabilitation Toolkit.
    - Full report can be found in the Continuing Care report as well.
    - Goal is to reach as many PR programs in the country to alert them to this educational piece.
    - It is a joint project of AACVPR, AARC, ATS, NAMDRC and ACCP.
- Member of the professional liaison committee
    - committee will meet during the AACVPR conference in Orlando in September 2012
- Member of the pulmonary subcommittee of the Program Committee of the AACVPR
    - worked to establish the pulmonary education side of the AACVPR Conference

American Heart Association

Submitted by Brian Walsh

Report

We continue to develop the 2015 guidelines while trying to achieve the 2020 AHA goals. See below.



Other

In order to try to achieve these lofty goals, the AHA is in the process of piloting service of care (SOC) committees. I have chosen to become a member of the “in-hospital” SOC. As you can imagine this mixes things up a little as this committee will focus on in-patient only, but the entire process from BLS to advance life support regardless of age. We had our first meeting in Dallas last week with the SOC and it was exciting. I feel that the SOC concept will not only help the AHA achieve their goals, but allow me to represent respiratory therapist in a more meaningful way.

Amer Soc for Testing and Materials

Reporter: Robert McCoy

Last submitted: 2012-03-22 15:42:07.0

Recommendations

none

Multiple respiratory related standards are being reviewed and updated by the committees. Most of the ASTM meetings are held out of the country so I have not attended, yet receive updates for review. No action to report on at this time.

Robert McCoy

Chartered Affiliate Consultant

Reporter: Garry Kauffman

Last submitted: 2012-03-21 13:06:53.0

Recommendations

Recommendations: None at this time

Report:

I did not conduct any on-site sessions with chartered affiliate leadership, but I do keep in communication and provide support to leadership with those states with whom I have worked to offer ongoing support with their business plans and operations. I have been requested to work with the Virginia Society leadership and have scheduled this for June 2012.

Respectfully submitted,

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

Committee on Accreditation of Air Medical Transport Systems

Reporter: Steven Sittig

Last submitted: 2012-03-18 19:17:29.0

Recommendations

[No Recommendations at this time

Report

The CAMTS BOD met for an additional business meeting January 26th to 28th in Dallas Tx. In addtion to needed program deliberations the CAMTS Executive Director Eileen Frazer recognized Sam Giordano for his and the AARC''s long time support of CAMTS by giving Sam a CAMTS silver picture frame. COO Tom Kallstrom was also in attendance. During the business meeting I was elected to the CAMTS executive committee in the role as secretary.

The CAMTS Board is scheduled to meet again this month March 28th -31st in Nashville TN in conjunction with the Air Medical Physicians Association meeting.

Extracorporeal Life Support Organization

Reporter: Donna Taylor

Last submitted: 2012-03-26 22:18:53.0

Recommendations

Request that the AARC consider providing funds to enable the Extracorporeal Life Support Liaison to attend biannual ELSO Steering Committee Meetings

ELSO over the last 5 years has experienced much increased notoriety and influence. The expertise and abilities of the Respiratory Therapist are uniquely suited to extracorporeal life support and I continue to champion our involvement in every part of these complex patients' care. Previously, funds were provided for my attendance at one of these conferences. However, the last few years, funding for education and travel has been cut, making my attendance at even one difficult. Below are several of the ELSO Steering Committee's agenda items for this past meeting in Keystone Colorado that highlight the growing influence and scope of ELSO:

- Update on the newly formed EURO-ELSO and the developing involvement and possible addition of similar ELSO chapters in India, Australia, New Zealand, China and Japan
- Expanded presence of ELSO at other medical meetings in presentations and advertising in professional journals to increase awareness and attendance
- ELSO credentialing and proceeding with this endeavor

Report

I continue my duties in promoting the use of respiratory therapists in ECMO therapy. This past quarter I have been consulted by two institutions who are looking at using respiratory therapists. These institutions also now have former physicians who have worked closely at our institution and seen the abilities of RRTs in caring for ECMO patients.

International Council for Respiratory Care

Submitted by Jerome Sullivan – 3/23/12

Recommendations

No recommendations @ this time.

Report

I. March 16, 2012 Meeting With Abu Dhabi Health Authority Leadership: The ICRC was represented J. Sullivan in a meeting arranged for the AARC during the *Gulf* Thoracic 2012 Congress March 14th – 17th in Dubai, United Arab Emirates. The AARC representatives were T. Kallstrom, T. Myers and S. Giordano and the Health Authority of Abu Dhabi was represented by **Hatem Al Ameri, Director of the Health Professionals Licensing Division.** Dr. Al Meri is responsible for the licensing of all health care professionals in the region. He discussed with the group the UAE's need for 1) Credentialing, 2) Assessment of Respiratory Care Practitioners, 3) Continuing Medical Education (CME's), and 4) Quality approval mechanisms for Respiratory Care programs & seminars. These needs were discussed at length and the AARC representatives described how many of these needs could be met by existing and future programs and materials of the AARC. In addition the ICRC's International Education Recognition System (IERS) was described and discussion ensued on how this system might answer the need in Abu Dhabi for quality control of Respiratory Care educational programs.

This was a very positive meeting and the AARC/ICRC suggestions were well received. Contacts for future communications were established and follow up will occur.

II. Proposed Strategic Leadership Group of ICRC: The ICRC Executive Committee and the Council at large are considering a structural change in the strategic organization of the ICRC. The group would consist of Respiratory Care experts from around the world, qualified by experience, credential, and reputation, to provide strategic direction and influence for the activities of the Council. Members of the ICRC Executive Committee would join the proposed ICRC Strategic Leadership Group. This group would meet infrequently but would set the strategic direction and projects of the Council. This new leadership group would represent a structural change for the Council, however, members of the Executive Committee would have full voice and vote and direct representation on the **Strategic Leadership Group.**

III. Development of the Fundamental Respiratory Support Course (FRCSC) & Relationship to Haiti Respiratory Education Proposal: For several years the ICRC has been exploring ways to develop the above referenced FRCSC which would be directed at basic RC training of non-respiratory care givers outside of the United States. The development of this type of course could strategically position and assist the AARC to realize the goal of better patient care on a global scale. A brief description of the FRCSC follows.

Course Purpose:

Fundamental Respiratory Care Support – Basic: A course with didactic instruction and skill stations to expose Non-Respiratory Care professionals outside of the United States to the

knowledge and skills required to provide basic Respiratory Care for patients in non-acute situations until a Respiratory Care Specialist becomes available or until transfer to appropriate facility. The course is intended to be structured so it can be customized to meet the diverse needs and requests of specific countries. The course would be approved by the International Education Recognition System (IERS) and could be developed in a modular fashion advancing from a basic seminar format to a more formal educational offering.

Basic 2-4 day Seminar
Three Month Program
Six Month Program
Nine Month Program
Potential Degree Granting Program Offered by Native Country

The Haiti Respiratory Education Proposal recently submitted by Natalie Napolitano, MPH, RRT-NPS, FAARC and Daniel D. Rowley, B.S. RRT-NPS, RPFT, FAARC may be viewed as an very worthy effort which supports the development of programs such as the FRCSC. Although a single country program and a subset of the broader FRCSC concept the Haiti Project is supported and encouraged by the ICRC (please see attached letter of support). There are a number of charitable groups, foundations, agencies and NGO's which support many types of humanitarian activities and projects in Haiti. These organizations can be approached with the potential of monetary and logistic support for the Haiti Respiratory Education Proposal. Ultimately it would be of strategic importance to the AARC and the ICRC to succeed in developing specific projects such as the one in Haiti and the FRCSC in general.

February 10, 2012

Dear Colleagues:

In my capacity as President of the International Council for Respiratory Care (ICRC), it is my pleasure to provide this letter of support for the Hôpital Sacré Coeur (HSC) Respiratory Care Education Program in Haiti. This project, after much time and effort, has been developed by Natalie Napolitano, MPH, RRT-NPS, FAARC and Daniel D. Rowley, B.S. RRT-NPS, RPFT, FAARC. Natalie and Daniel are well known to the international respiratory care community and are widely respected as clinicians and educators. In essence they plan on delivering a 12 month training program to HSC nurses and physicians on key theoretical and clinical aspects of respiratory care.

They have completed a needs assessment which indicates HSC is prepared to move forward in advancing the care of their patients by providing advanced Respiratory and Critical Care to their patient population. They are developing the curriculum and an evaluation protocol for the training program as well as coordinating the participation of other respiratory therapist and physician instructors from the US. This cannot be accomplished without the assistance and physical presence of Dan and Natalie as well as additional instructors. The project will require funding for developmental, logistical and travel costs. With the support of the AARC BOD this project may qualify for funding by the American Respiratory Care Foundation.

The development of this project by two dedicated Respiratory Therapists represents the best of intentions, and coincides with the patient-centered mission of our Association to forward the art and science of respiratory care. The quality of the proposal deserves our attention, and the humanitarian aspect of the project prompts me to provide my strongest possible recommendation for support. Please let me know if I can be of further help in the process.

Respectfully,

Jerome M. Sullivan, Ph.D., RRT, FAARC
President International Council for Respiratory Care
Professor Emeritus, College of Health Science & Human Service
University of Toledo

Joint Commission - Ambulatory PTAC

Reporter: Suzanne Bollig

Last submitted: 2012-03-21 13:33:18.0

Recommendations

No recommendations.

Report

The Ambulatory Professional and Technical Advisory Committee (PTAC) has had no activity since my last report. The first 2012 meeting is scheduled to take place via conference call on April 10, 2012.

Joint Commission - Home Care PTAC

Reporter: Joseph Lewarski

Last submitted: 2012-03-12 13:10:18.0

Recommendations

There are no recommendations

Report

The Joint Commission PTAC met via telephone conference on January 31, 2012. This was the first call of the year and was attended by Kim Wiles, the PTAC alternate (Lewarski was traveling out of the country). There was nothing of significance to report from this meeting.

Joint Commission - Lab PTAC

Reporter: Franklyn Sandusky

Last submitted: 2012-03-16 08:00:18.0

Report

The LAB PTAC first meeting for 2012 was March 1.

There is nothing to report at this time.

National Asthma Education & Prevention Program

Reporter: Natalie Napolitano

Last submitted: 2012-03-21 13:10:08.0

Recommendations

[Recommendations must be SPECIFICALLY INSERTED here!]

No Report

Natl Coalition/Hlth Pro Edu - Genetics

Reporter: Linda Van Scoder

Last submitted: 2012-03-12 11:58:45.0

Recommendations

No recommendations

Report

Nothing new to report. Will continue to monitor Genetic Alliance communications.

National Sleep Awareness Roundtable

Reporter: Mike Runge

Last submitted: 2012-03-21 16:30:00.0

Recommendations

No Recommendations at this time.

Report

I have not attended the NSA Roundtable meeting. Ann Marie Hummel may have further comments.

Neonatal Resuscitation Program

Reporter: John Gallagher

Last submitted: 2012-03-23 12:49:49.0

Recommendations

No recommendations at this time

Report

The NRP Steering Committee (NRPSC) met on March 5-6, 2012 as part of their semi-annual meeting schedule. Due to illness, I was not able to attend the meeting. However, minutes are being forwarded to me from the Manager of NRP so that I will be able to review them in preparation for a follow-up phone conference of the NRPSC in April 2012.

Current initiatives for the NRPSC include:

- creating the learning methodologies for future iterations of the program
- scenario planning; education and delivery of content in the future
- using learning strategies to generate new patterns of practice
- instructor development moving forward
- fostering continuous learning and innovation
- extending the science of resuscitation

Roundtable Reports

Asthma Disease Mgmt Roundtable

Consumer

See Executive Director Report

Disaster Response Roundtable

Reporter: Steven Sittig

Last submitted: 2012-03-18 19:19:01.0

Recommendations

No Recommendations at this time

Report

This roundtable submitted a number of lecture submissions of interest to this area of Disaster Response for the AARC Congress program. I have not yet heard which lecture proposals were approved. We are also working with Lewis Rubinson to help recruit more RT''s for the government disaster teams. We are also planning on a formal roundtable meeting in New Orleans to better communicate with RT''s who have an interest in Disaster Response.

Geriatrics Roundtable

Hyperbaric Roundtable

Submitted by Dr. Clifford Boehm

Nothing to report

Informatics Roundtable

International Medical Mission Roundtable

Reporter: Lisa Trujillo

Last submitted: 2012-03-27 16:30:22.0

Recommendations

Nothing to report

Military Roundtable

Reporter: David Vines

Last submitted: 2012-02-07 00:00:00.0

Recommendations

None

- Nothing new to report.

Other

Neurorespiratory Roundtable

Reporter: Lee Guion

Last submitted: 2012-03-10 13:22:13.0

With the encouragement and support of our roundtable's BOD representative, we submitted a proposal for a half-day seminar on current topics in ALS for the 2012 AARC Congress to be held in New Orleans. Topics were based on suggestions from members who attended the 2011 Congress and those on AARC Connect.

This is part of a long-range strategy to have members of the AARC become a leaders in the respiratory management of ALS, much as they have with asthma, alpha-1 antitrypsin deficiency and, most recently, COPD.

Over 90% of people with ALS die of respiratory failure and most will require treatment with noninvasive ventilation, secretion mobilization, and lung hyper-expansion therapies. Yet not all multidisciplinary clinics include RCPs. Patients referred to pulmonlogists may not receive the experienced care of RCPs skilled in delivering the above therapies. Our leadership in ALS care is a way of promoting our profession.

We hope the AARC will partner with ALS advocacy organizations ALSA and the ALS division of MDA to publicize this devastating disease, lobby our state and national representatives to expand medical coverage, and increase funding for research into cause and cure. We continue to encourage roundtable members to submit abstracts to the Motor Neuron Disease Association, American Academy of Neurology, and American Academy of Chest Physicians and present our research and best-practice models for respiratory management of the ALS patient.

Research Roundtable

Reporter: John Davies

Last submitted: 2012-03-23 08:59:27.0

Recommendations

- No new recommendations at this time

Report

- Activity has been about the same as in the previous reporting period

Simulation Roundtable

Reporter: Julianne Perretta

Last submitted: 2012-03-23 13:11:16.0

Report

Updates on Simulation within the AARC:

- The Summer Forum 2012 will be providing a 4 hour pre-conference session on simulation entitled "Building a Simulation Toolbox"
- The Roundtable site on the AARConnect will be featuring a monthly "guest speaker". Guest speakers will consist of past simulation presenters at AARC Summer Forums or International Congresses, or abstract presenters from 2011. It will begin with a summary or abstract posting to the listserv, and then be followed up with an asynchronous discussion of the abstract. It will also allow for the guest presenter to share his or her tips and tricks, lessons learned, successes and failures, etc. These will begin in April and continue through July. If successful, I will continue to invite speakers/abstract presenters from 2010 or earlier.

Other

Action Items for the AARC (and/or Board of Directors) from the Simulation Roundtable: Use these

- At the International Meeting for Simulation in Healthcare, I met a Canadian RT who has some innovative simulation curricula for her RT students. I would like to bring her in as one of the guest speakers. Is there a way to get her a "guest login" for AARConnect? She is not an AARC member, because she is not in the US points
- Is there a system for requesting a simulation topic for a webcast through the AARC? Is this an opportunity offered to Roundtables? I had this presented as a suggestion during one of our forum discussions, which I found intriguing, but I’m not sure how to begin to put this forward...
- What is the maximum size for files posted to the AARConnect website? Simulation is a great topic for using video as a training medium. I would like the ability to share videos with the members, but am not sure whether this is allowable. Can I be given a tech support contact or a point person in the webcenter to assist me with this request?

Tobacco Free Lifestyle Roundtable

Reporter: Jonathan Waugh

Last submitted: 2012-03-23 12:25:24.0

Recommendations

• Given that tobacco-dependence treatment is defined as part of the respiratory therapist scope of practice and that the majority of our profession do not have certification for such counseling and self-describe as being insufficiently equipped for it, I request that the BOD discuss how a day-long workshop on tobacco treatment skills could be offered during the AARC Congress or as a pre-event.

Report

• Steve Nelson notified me that a second sponsor has been identified to do a second printing of the AARC patient guide "Why Quit Using Tobacco?" which was written by the Tobacco-Free Lifestyle group.

• Update on the "Clinician Guide for Tobacco Cessation," a joint effort between the TFL Roundtable in and the AARC executive office. Co-chairs are Georgianna Sergakis and Rita Mangold have assigned the content sections to members of the work group. This is a companion text to the aforementioned patient guide on tobacco cessation. The patient guide is a print publication but the clinician guide is planned to be an electronic publication.

• We are hopeful that some of the tobacco-related proposals submitted by TFL members for the 2012 AARC Congress will be accepted.

• A number of TFL members have contributed to publications this past year or were "in the news" in various ways.

• The TFL stands ready to assist with educational programs and curricula for tobacco-related training.

Other

• Last week I presented on tobacco prevention/lung health to 3 classes of students at two elementary schools with the assistance of five our senior RT students. It turned out to be an opportunity to talk about respiratory therapists as well. This could be a good recruiting option for programs and hospitals to use to attract students to the profession (http://www.facebook.com/media/set/?set=a.399394236756975.105513.130875206942214&type=3).

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity

Cultural Diversity in Care Management Committee
AARC Activities Report
Spring 2012

Chair: **Joseph R. Huff** **Liaison:** **Susan Gallo**

Recommendation: None

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

Status: The Committee mentored Deborah Waggoner at the HOD Meeting in November. Deborah is from Miami Florida and had the following comments about her expierence.

Hi, Joe:

I had a REALLY good time, thanks to you. I have learned so much about the working phase of the AARC (sitting in the front and center kept me Wide Awake). Seriously, it was a fantastic learning experience for me. I am thankful that you gave me the opportunity to participate. Yes, we will definitely keep in touch. Thanks again for everything,

Deborah Waggoner RRT, RN, CHT, MS

Respiratory Care Manager

South Miami Hospital

We are working with New Mexico to have candidates attend the Summer Forum.

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

Status: Currently reviewing material for the Web Page. Should be completed by the Summer Board Meeting

Ad Hoc Committee on Officer Status/US Uniformed Services

Ad Hoc Committee on Home Oxygen

Submitted by Dr. Kent Christopher

Nothing new to report

AARC Leadership Institute

Reporter: Toni Rodriguez

Last submitted: 2012-03-23 18:19:19.0

Recommendations

None

Report

AARC BOD Report: Spring 2012

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 2012

Discussion over the current lack of progress.

•o Problem of recruiting authors for Core Curriculum Modules was attributed to: 1) Content areas are not in line with our membership''s areas of expertise and 2) the money offered to complete a module was too low.

•o Possible suggestions to overcome current stumbling blocks and move forward:

•§ Have participants provide proof of attainment of Core Course objectives from another appropriate venue. We would then only provide the specialty tracks. It was agreed that this would not be the best option given the extra time and cost to program participants.

•§ Subsume the core competencies in a more generalist form into each specialty track. Specialty content experts authoring a module would be better able to speak to core concepts in context. It was agreed that this would be the best solution and the committee chair was charged with presenting a model for accomplishing this. See Appendix A. Each committee member volunteered to rewrite the original track competencies to incorporate the newly developed general core competencies.

•o The committee agreed that we should proceed with development of a model script for the purpose of answering some of the questions raised at the end of the final 2011 committee report. Rob Chatburn volunteered to work out the Research Track. A meeting between Rob, Toni and Tom identified the following points:

Conclusions used for developing the original RFP:

•o 5 modules in the Core Track/ 34 competencies to be covered

•o Total of 45 contact hours for the entire core

•o 9 hours of instruction per module

•o 9:1 ratio for instructional development of a module = 81 hours of development time per module or 405 hours of instructional development for the entire track.

•o 81 hours X $30.00 per hour = $2430.00 per module

•o RFP amount $2500.00 to be paid per module

New consideration used in developing a new proposal for development:

•1) Based upon anecdotal data reported in the December 2011 committee report $65 - $150.00 per hour, based upon developer background and experience, was the standard range for content development. In addition consultation fees can be as much as $200.00 per hour. Given this data and even factoring in the desire to contribute as a volunteer, $30.00 per hour was an unrealistic amount to pay for the development of instructional content.

•2) Content authors would not be working on the project full time since they will most likely have a full time job. Rob indicated that upon his current commitments the most time he would be able to expend on the project is 10 hours per week. Using this time frame as an example, 432 hours of instructional content would require 43 weeks to complete or approximately 9 months.

Based upon this information the following conclusions were arrived at:

The original concept behind the institute was to provide continuing education for our members to prepare them for career advancement and/or make them more value as employees. The core was generalist skills and the three tracks were chosen because they are pillars of the profession essential to its continued growth. The time span of 45 hours was chosen based upon a desire to eventually have the courses accepted for credit by a traditional education program (i.e.: 2 or 4 year institution). 45 hours correlates with 3 credit hours in a traditional education environment (15 hrs = 1 credit). The three tracks plus the core would equal 12 credits in a traditional education environment.

Currently the project is at a standstill. We could not entice our own membership to author the Core modules at $30.00 per hour and an outside company intimated that it would cost "mid six figures" to produce the five modules. In addition, if membership could be recruited to produce course content it would be on a part time basis. Given Rob''s guesstimate of 10 hr per week to work on the project, it would take almost a year to get the instructional material for a track completed.

Given this information we may need to rethink our approach. Going back to our original premise, the concept was to provide continuing education. Continuing education is by definition training received post formal education to maintain or improve job skills. Continuing education is usually awarded CEU''s over credits. According to Wikipedia one CEU is generally 10 hours of participation. Even considering the reference source we have greatly exceed traditional CEU standards with our desire to one day to align with a traditional education institution. It may be advisable to reduce the number of hours in each track in line with providing general knowledge instead of producing and expert.. The goal would be for enlightenment that could peak someone''s interest in pursuing more in depth education in a subject area. For the sake of discussion we considered the following based upon a rate of pay for development at $100.00/ hr which is the minimum amount Rob would consider to author the Research Track.

Example A: Research Track: Based on 3 credit format.

•o 6 modules in research track/ 30 competencies

•o Total of 45 - 50 contact hours for the entire track

•o 8 hours (round up from 7.5 hrs) of instruction per module.

•o 9:1 ratio for instructional development of a module = 72 hours of development per module or 432 hours of instructional development for the entire track.

•o 432 hours X $100.00/hr =$43,200.00 cost for development of the Research track.

•o 432 hours/10 hr per week = 43 weeks or 10 months to complete.

Example B: Research Track: Based upon a continuing education model

•o 6 modules in research track/30 competencies

•o Total of 15 contact hours for the entire track

•o 2.5 hours of instruction per module

•o 9:1 ratio for instructional development of a module = 22.5 hours of development per module or 135 hours of instructional development for the entire track.

•o 135 hours X $100.00/hr = $13,500.00 cost for development of the Research Track

•o 135 hours/10 hr per week = 13.5 weeks or 3.5 months to complete.

A conference call of the entire committee was held on February 17th. At that time the committee voted to move forward based upon "Example B". On March 9th a subcommittee of Rob, Toni, Tom and Steve met to further discuss the possible layout of the online modules. Based upon this discussion Rob was charged with development of one lesson to be presented to the subcommittee by the end of March. This lesson will then be used as a platform for furthering the discussion on instructional design.

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, John Walton MBA, RRT FAARC

Staff Liaisons: Tom Kallstrom, RRT FAARC

Appendix A:

CCC 101 Introduction to Human Communication:

Course Description: Theory and practice of communication skills in public, small groups and interpersonal setting to include: interpersonal and inter-organizational communication, barriers to communication, impact of diversity on communication, non-verbal communication and conflict resolution.

Competencies:

1. Describe the process of interpersonal communication in terms of models and principles.

2. Describe the nature and function of communication on all levels within organizations.

3. Identify the components of listening and common barriers to the process.

4. Identify and explain the elements of nonverbal communication.

5. Identify strategies for conflict resolution within small groups.

6. Explain the impact of cultural and gender variables on interpersonal communication.

7. Prepare and demonstrate the effective delivery of a verbal presentation to a small group.

Suggested General Communication Competency:

Demonstrate the ability to listen to others and communicate in an effective manner.

CCC102 Health Information Management and Informatics:

Course Description: The use of technology to support and sustain information management within the healthcare environment to include: basic word processing, spreadsheet, database,

statistical and desktop presentation applications as well as the application, care and management of Personal Health Records.

Competencies - Basic Computer and Health Information Literacy Skills

Pre-Requsites

*Demonstrate proficiency in the Windows operating environment.

*Resolve minor technical problems associated with use of computers.

*Demonstrate use of email, addressing, forwarding, attachments, and netiquette.

*Create and name or rename subdirectories and folders.

*Demonstrate how to save work to a computer file, and printing and copy a file.

*Create and edit a formatted document using tables and graphs

*Demonstrate use of the essential aspects of file organization, information storage (such as disk or flash drive), protection from data loss, and basic computer skills.

Competencies:

1. Demonstrate Internet/intranet communication and topic search skills

2. Use basic word processing, spreadsheet, database, and desktop presentation applications as applicable to your work.

3. Use statistical analysis packages.

3. Differentiate between the types and content of patient health records (such as paper- based, electronic health records, and personal health records).

4. Know the architecture and data standards of health information systems.

5. Demonstrate an understanding of the relationship of telemedicine and its application to all care settings.

6. Identify legal and regulatory requirements related to the use of personal health information and apply policies and procedures for access and disclosure.

Suggested General Health Information Competency:

Use health record data collection tools such as input screens, document templates and adhere to health record documentation requirements of external agencies and organizations.

CCC 103 Financial Planning and Budgeting Principles:

Course Description: Fundamental theory of accounting principles and procedures as they relate to healthcare to include: generally accepted accounting principles, income statements, balance sheets, cost/benefit/ratio analysis, and strategic financial planning.

Competencies:

1. Demonstrate generally accepted accounting principles (GAAP).

2. Explains income statement, balance sheet and cash flow

3. Prepare a simplified balance sheet and income statement.

4. Demonstrate knowledge of ratio analysis, cost-benefit analysis and cost-effectiveness analysis

5. Demonstrate knowledge of strategic planning, strategic financial planning, operational planning and capital budgeting.

Suggested General Financial Management Competency:

Organize, direct and control the financial activities related to project design and implementation

CCC 104 Small Group Problem Solving and Decision Making

Course Description: An organized approach to problem solving, decision making and small group management to include: group facilitation, conducting meetings, team building, intervention strategies and monitoring group progress.

Competencies:

1. Define the role of the facilitator, team leader and team members.

2. Discuss the impact of group dynamics in facilitating small group communication.

3. Explain how listening and speaking skills facilitate communication. Identify methods for identifying and defining problems

4. Select a problem and develop a solution based upon established problem solving protocol to include: study design, data analysis, selection of best solution, action plan analysis , implementation and follow up.

5. Define the steps in effective team building

6. Identify effective conflict management and intervention techniques.

7. Discuss strategies to be used in conducting effective meetings.

8. Identify ways to monitor group progress.

Suggested General Small Group Problem Solving Competency:

Demonstrate the ability to effectively manage and guide group efforts by providing appropriate feedback and prevent, manage, and/or resolve conflict.

CCC 105 Basic Management Skills

Course Description: The functions of management, specific roles and responsibilities of the supervisor and the application of leadership principles in addressing on-the-job situations and handling work related conflicts.

Competencies:

•1. Demonstrate an understanding of what it is to manage and to lead in the role of a

successful department manager.

•2. Describe the roles, functions of management and the responsibilities of supervisors and how they impact effective relationships in the workplace.

•3. Examine different leadership styles, explaining the advantages and disadvantages of each.

•4. Explain how to be successful in communicating with others based on their leadership style.

•5. Demonstrate an understanding of the characteristics of effective leaders, how to identify mentors, and gain from the example of others.

•6. Evaluate how to motivate others and coach them to improved performance

•7. Demonstrate an appreciation for teams, the importance of prioritizing conflicting demands, achieving desired outcomes and accountability for the achievement of outcomes.

Suggested General Management Competency:

Demonstrate the ability to support, promote, and ensure alignment with an organization''s vision and values while ensure the effective, efficient, and sustainable use of resources and assets.

Ad Hoc Committee on 2015 & Beyond

Co-Chair: Lynda Goodfellow, EdD, RRT, FAARC & John D. Hiser, MEd, RRT, FAARC

Staff Liaison: Sam Giordano/Tom Kallstrom/Bill Dubbs

Recommendation 1

The 2015 ad hoc committee recommends that the AARC BOD accept the direction for the future of health care as recommended by the publication Creating a Vision for Respiratory Care in 2015 and Beyond by Robert M Kacmarek PhD RRT FAARC, Charles G Durbin MD FAARC, Thomas A Barnes EdD RRT FAARC, Woody V Kageler MD MBA, John R Walton MBA RRT FAARC, and Edward H O'Neil PhD

Published -Respir Care 2009;54(3):375–389. © 2009 Daedalus Enterprises

Justification: It is essential that the AARC plan for the future and that we take steps to assure that we are prepared to take on the duties and responsibilities that may be required of the respiratory therapist in the years to come. By accepting this recommendation the BOD is sending the message that you agree with the findings of the first conference that these may indeed be the types of roles and responsibilities that the respiratory therapist of the future may be asked to perform.

Committee Objectives:

1. Review the attributes and compare to the recommendations for areas that required additional definition.

   The committee reviewed and compared the attributes to the recommendations from the third conference and completed a Gap Analysis which is included with this report.

2. Identify gaps and identify other information that will be necessary to act on the recommendations.

   Gaps were identified and are included in the Gap Analysis.

3. Identify groups of organizations and interested parties that would be necessary to obtain feedback regarding the recommendations and the attributes.

   ASAHP, NN2, NBRC, CoARC, and the Ohio and California licensing boards were contacted in 2011. BOMA representatives were also asked to communicate with their respective organizations. The CoARC response is attached to this report. President Stewart also made presentations at several state society meetings.

4. Identify a mechanism to obtain additional feedback from members and mangers of respiratory care.

Surveys went out last year to Education Program Directors, ASAHP deans, Deans of Educational Institutions with RT programs and Deans of Educational Institutions without RT programs. RT Department directors were also surveyed.

5. Develop a time line of activity the needs to occur and a time line for BOD action.

A teleconference was held on February 28, 2012 4:00 -4:35 CST. The participants included Karen Stewart, Lynda Goodfellow and John Hiser along with AARC Staff members Sam Giordano, Tom Kallstrom and Bill Dubbs. The following timelines were accepted by the group and forwarded to the committee for approval:

Future Directions and Timelines

April BOD Meeting

Complete the Gap Analysis revision

Present the first recommendation to the BOD

Review responses from NBRC and CoARC

Send an update of progress to AARC members following the BOD meeting

July BOD Meeting

Report results of any surveys conducted to in response to information needs identified during and after the April BOD meeting.

November BOD Meeting

a. Present final 2015 and Beyond recommendations to the BOD
b. Send an update of progress to AARC members following the BOD meeting

The co-chairs would like to thank President Stewart for her leadership in this effort and also thank her for the trust she has placed in us to carry on this initiative. Also thanks to the members and a big thank you to Bill Dubbs for all of his work.

Members:
Patricia Doorley
George Gaebler
Denise Johnson
Woody Kageler (BOMA)
Dianne Lewis
Tim Myers
Toni Rodriguez
Karen Schell
Richard Sheldon (BOMA)
Margaret Traband

Ad Hoc Committee to Recommend Bylaws Changes

Reporter: George Gaebler

Last submitted: 2012-03-26 12:52:00.0

Recommendations

The committee made a recommendation to slightly change the policy on Bylaws Conflicts to better reflect the actual steps taken when Chartered Affiliate Bylaws are in conflict with AARC Bylaws. ("That the revision to the policy on Bylaws Conflicts be approved by the BOD.")

Report

The policy changes proposed will be available on the back table at the meeting. The changes only clarify but do not change the intent of the policy we approved at the Dec ember BOD meeting. This was done in concert with the Executive Committee and the AARC Bylaws committee.

Ad Hoc Committee on Section Membership

Co-Chairs: Lynda Goodfellow & Mike Runge

Recommendations:

1. That the AARC ask each Section Chair to review the "Section" description and update to better describe the focus of the section.

Rationale: Section descriptions have not been updated and reviewed. A current description which encompasses changes in practice and technology may be warranted.

2. That the AARC investigate offering some form of CEU through the bulletins as a benefit of section membership

Rationale: Many bulletins are publishing best practices and guidelines which may be appropriate and eligible for continuing education credits.

3. That the AARC consider offering a special incentive to recruit colleagues to join Specialty Sections. Each time you refer a new Regular Member, the AARC will reward you with an appropriate thank you gift.

Rationale: Other organizations are offering small tokens of appreciation to incentivize specialty section membership.

4. That the AARC create and post to each section webpage a CRCE Section Calendar that shows all education activities a member can access as a member of that section.

Rationale: Another venue for posting educational offerings.

5. That the AARC aggressively promote the fact that the new SDS specialty exam has been accepted as an alternative to the RPSGT by the AASM.

Rationale: To create interest in specialty section and showcases AARC role in sleep credentialing.

6. That the AARC investigate the feasibility of offering a membership fee for multiple sections.

Rationale: Currently, it is an additional $10 per section, and perhaps a flat rate for access to all sections, but only be an active member of 2 or 3 sections can be investigated.

Charge for Section:

Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendation as to what should be done with that section.

At the 2011 AARC Congress, section chairs were at the AARC Booth during pre-arranged times. Three questions were provided to facilitate a discussion regarding section membership:

1. Which benefits provides the most value to you as a Specialty Section member?
2. What benefits would you like to see offered as a Specialty Section member in the future?
3. As a Specialty Section member, what issues or concerns do you want to pass along to the Specialty Section Chair and the AARC Board of Directors?

Few responses were received at the AARC Congress but section chairs were asked to post the questions on AARC Connect. Suggestions for improvement included:

- A more detailed description of what each section is about or an update to better describe the focus is needed. For instance, for Transport Section, the types of patients transported may be useful.
- Better involvement of RTs serving in the military
- Offer some form of CEU through the bulletins, maybe ½ CEU for some such level of benefit.
- AARC Connect and the Bulletins are great networking tools and are a great way to express what you may doing in your current work place. It allows others to maybe think outside the box and introduce new ideas to their staff and directors that they may not have thought about.
- The following were specifically mentioned for the sleep section:
    1. Offer a special incentive for to recruit colleagues to join the Sleep Section. Each time you refer a new Regular Member for the 2012 membership year, the AARC will reward you with a coupon for a free AARC webinar or archive CD-ROM (including free shipping and handling). Each member referral also enters you into a Grand Prize Drawing to win a complimentary registration to the general session of the 2013 AARC Annual Meeting. The AAST has a program like this but why reinvent the wheel?

    2. Create a CRCE Calendar that shows all the sleep-related activities a member can access to keep up their RPSGT or SDS credential.

    3. Aggressively promote the fact that the new SDS specialty exam has been accepted as an alternative to the RPSGT by the AASM.

    4. Enhance the information available to section members **(**position papers, core competencies/CPGs, CRCE information, advocacy information, calendar of events, discussion groups).

5. Committees (they need to be reinvigorated – I noticed virtually all of the members of the committees were the same people I appointed when I was chair.)

6. The Resources page is outdated (and still has my name and old email on it). Most people in sleep go to the AAST, BRPT, and AASM websites because they have far more resources available. If there are 1,000 + members and each one were asked to provide just one policy, protocol, etc. that would be a nice resource library.

- A fee for multiple sections. Currently, it is an additional $10 per section, and it would be nice if there were a flat rate for access to all sections, but only be an active member of 2 or 3
- I like the bulletin. It gives younger members the opportunity to publish in a very low stress format. Great experience for them. Great medium for us to communicate
- Continue to attempt to improve on our newer projects (journal club etc.)
- focus on ways to target new therapist's, maybe approach schools with "discounted" section memberships for the first year to get them interested
- address AARC members as often as possible and demonstrate benefits and advantages of becoming section members. Maybe mass e-mailings to help-line, schools, hospitals etc.
- Have section demo/booth at the AARC conferences

Recommendations for consideration were crafted from these comments.

Ad Hoc Committee to Reduce Hospital Readmissions

Reporter: Greg Spratt

Last submitted: 2012-03-22 08:39:24.0

Recommendations

Proposal to Board

Based on the feedback received from the membership survey, and the input from the exploratory committee formed by President Stewart:

The Hospital to Home Committee proposes a project to select and fund 3-5 pilot studies exploring the benefits of different models of RT-led programs for reducing hospital readmissions in COPD. Pilot studies would be evaluated and selected based on the criteria designated by the committee (Attachment A).

Attachment A

Hospital to Home Pilot Study Objectives

1. Study a COPD population

2. At least 30 patients each (or calculated to be sufficiently powered) in Treatment and Control Arms

3 Prospective, Randomized, Controlled Design

4. IRB Approved

5. Minimum of 1 year follow up data including but not limited to:

a. Readmissions (COPD-related and not)

b. Cost data including costs to deliver the program and cost savings from the program

6. Incorporate standardized RT-directed intervention, (based on literature) that could be applied to large populations, which may include but is not limited to:

a. Individualized patient needs assessment

b. Patient / caregiver education

i. Written and/or web-based materials

ii. Pre and/or post-discharge

c. Self-management plans

7. Potential RT-directed follow up models may include the following (or a combination thereof):

a. Pre-Discharge Intervention

b. Visits to Home

c. Calls to Home

d. Checklist

e. Telemedicine (e.g., Smart Phones, tablets, web-based)

f. RT-Directed Long Term Care Facility Involvement

g. Novel or Emerging Concepts

8. Should be submitted in accordance with the ***AARC Research Program Grant Application***

9. Must be completed as outlined in the proposal

10. Must be submitted for publication

Ad Hoc Committee for Continued Development of Education Competition

Reporter: Bill Cohagen

Last submitted: 2012-03-30 14:14:43.0

Report

The group has been put together with to create a competition program for the International Congress for 2013 and beyond that;

- Increases attendee involvement
- Is more modern
- Meets the spirit and intent of the sputum bowl.
- Is more fiducially responsible.

The group had several suggestions tossed around and we are taking the top 2 and drilling down to ensure the requirements are met.

The final recommendation will be sent to the Program Committee by the summer meeting in Santa Fe.

NBRC
ARCF

MEMORANDUM

Date: March 26, 2012

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

From: Kerry E. George, RRT, MEd, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you my first update on activities of the NBRC as President. Since the last report, the Board of Trustees and its committees met in December 2011, and the Adult Critical Care Examination Committee and new members of the Board convened in Kansas City in February 2012. The Board of Trustees will hold its spring meeting April 23-28 in Kansas City to conduct examination development activities and discuss business related items pertinent to the credentialing system. The following details the current status of examinations and significant activities in which the Board and staff are currently involved.

Adult Critical Care Specialty Examination

The much awaited Adult Critical Care Specialty Examination is set to launch on July 17, 2012. Details regarding admission policies, fees, test specifications, practice and self assessment examinations can be found on the NBRC website, www.nbrc.org, under the Examinations tab. Individuals who apply and schedule an examination appointment prior to August 31, 2012 will receive a free self assessment examination.

Ohio Examination Requirements Workgroup

I served as the NBRC representative to the Ohio Examination Requirements Workgroup since early 2011. The workgroup's purpose was to evaluate whether the Ohio Respiratory Care Board should amend OAC 4761-5-01 and related rules to require the candidates for licensure in the state of Ohio to pass the written and clinical simulation portions of the RRT Examination as a condition for initial licensure issuance in the state of Ohio. The Ohio Board has now accepted this workgroup's recommendations and is in the process of drafting amendments to its rules to require the RRT be the minimum credential for initial licensure in the future. As you are likely aware, the NBRC supports the CRT credential as the minimum requirement for licensure and we submitted a minority report opposing the proposed recommendations, as well as made a personal appearance at their February 2012 public hearing. We continue to be involved in a stakeholder group providing input into the rule drafting process.

California Respiratory Care Board Meeting

At the request of the California Respiratory Care Board, we also traveled to their February 2012 board meeting to discuss their interest in elevating the credential requirement for licensure in that state. It is not likely they will be proposing any change to their existing requirements.

Credentialing System Evolves

As a result of extensive, ongoing internal research the NBRC conducts regarding testing and measurement, the Board of Trustees voted at its December 2011 meeting to evaluate implementing significant changes to the respiratory therapy credentialing system beginning in 2015. These changes are coincidental with, and not in response to information arising from the Respiratory Care 2015 and Beyond process. To date, none of the recommendations from the third conference relative to credentialing have been acted upon by the AARC Board of Directors. Changes will include a single multiple choice examination with separate passing points for the CRT credential and eligibility for the Clinical Simulation Examination which will include a larger number of shorter simulation problems. Details regarding these significant changes will be announced during the Jimmy Young Memorial Lecture at the AARC Summer Forum in Santa Fe, New Mexico on July 15, 2012.

2012 Officers Elected

The following individuals have been elected to a one-year term beginning January 1, 2012:

President:	Kerry E. George, RRT, MEd, FAARC
Vice President :	Brian W. Carlin, MD, FCCP, FAARC
Secretary:	Linda A. Napoli, MBA, RRT, RRT-NPS, RPFT
Treasurer:	Alan L. Plummer, MD, FCCP, FAARC
At-Large Member:	Carl Haas, MLS, RRT, AE-C, FAARC
At-Large Member:	Katherine Fedor, RRT, RRT-NPS
At-Large Member:	Dorre Nicholau, MD, PhD

2011 Examination and Annual Renewal Participation

For 2011, we received over 40,500 applications across all examination programs; this represents approximately 3,600 more applications than the previous year. 2012 is shaping up to be right in line with 2011 activity.

For 2011, we processed a record number of active status renewals totaling over 44,000. 2012 annual renewal notices were mailed to credentialed practitioners in early October and credentialed practitioners were encouraged to renew their status by December 31. To date, we have received 38,666 active status renewals.

Examination Statistics – January 1 – December 31, 2011

The NBRC administered just shy of 40,000 examinations in 2011. Pass/fail statistics for the respective examinations follow:

Examination	***Pass Rate***	
CRT Examination – 13,683 examinations		
	Entry Level	Advanced
First-time Candidates	72.6%	78.7%
Repeat Candidates	19.7%	26.8%
Therapist Written Examination – 12,922 examinations		
First-time Candidates	66.6%	
Repeat Candidates	30.4%	
Clinical Simulation Examination – 11,451 examinations		
First-time Candidates	61.4%	
Repeat Candidates	54.5%	
Neonatal/Pediatric Examination – 1178 examinations		
First-time Candidates	73.9%	
Repeat Candidates	44.8%	
Sleep Disorders Specialty Examination – 38 examinations		
First-time Candidates	97.1%	
Repeat Candidates	66.7%	
CPFT Examination – 342 examinations		
First-time Candidates	69.1%	
Repeat Candidates	41.8%	
RPFT Examination – 75 examinations		
First-time Candidates	83.6%	
Repeat Candidates	66.7%	

Your Questions Invited

I look forward to working with you during my term as President. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. 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

ARCF Report to AARC Board of Directors
Spring 2012
Submitted by Michael T, Amato, MBA

The Foundation is planning to hold its annual Trustees meeting in early May. At that time, Trustees will review the Strategic Plan and consider additional projects and activities.

You may recall that as I mentioned in my report to you last Fall, the Foundation was busy soliciting financial support for the RESPIRATORY CARE Journal's conference on Oxygen. I am happy to report that we have been able to identify approximately $50,000 in support of the planning, implementation, publication, and distribution of conference proceedings.

As you may recall, last year the Foundation voted to transfer responsibility for funding International Fellows to the AARC. The Trustees are now in the early consideration stages of developing a special International Fellowship that will target highly placed individuals in other country's healthcare delivery systems. It has been suggested for several years by the ICRC that the Foundation consider developing a special program for "high powered" representatives of foreign governments, especially Ministries of Health who may be invited for special visits to the United States in order to understand the value, education, training, and service delivery models of respiratory therapists in the United States. Please consider this a work in progress. I will provide updates as we move forward.

I want to thank the AARC for allowing us to promote the Foundation to its members through a special article in AARC Times last year. We hope to be able to repeat that effort this year. Individual member solicitations have been somewhat disappointing (less than $6,000). However, the Trustees will continue efforts to make the activities of the Foundation much more relevant to the day-to-day practice of our members.

I also want to thank the Board and the House of Delegates leadership for their support of the International Reception. In 2011, we realized a small net gain after expenses. The future of the reception will be discussed and addressed when the Board meets in May and discussions will revolve around cost benefit since it takes quite a bit of time to plan and execute the reception, especially as it involves our International Council governors and their guests.

On behalf of the Trustees, I want to thank the AARC Board of Directors for their continued support of the Foundation and its goals. Please feel free to contact me with any questions you may have regarding this report or the Foundation.

Unfinished Business

New Business

White Paper on Concurrent Therapy recommendation pg.244 (R)

Policy Review

- BOD.006 – Executive Session of the Board of Directors pg.
- CA.002 – Chartered Affiliate Requirements and Responsibilities
- CA.006 – Chartered Affiliate Consultant
- CT.005 – Standing Committees

Submitted by Susan Rinaldo-Gallo

Recommendation: That the AARC's white paper on Concurrent Therapy be temporarily pulled from the web site.

Justification: The paper needs to be updated as it is 10 years old and some of the references are unobtainable (i.e. JC web references). The CMS citations are from 2001 SNF regulations and there is an implication in our paper that somehow based on these regulations, Medicare prohibits Concurrent Therapy in all sites. This is not true, including the SNF setting, the only provider setting where Medicare does address this concern.

These issues affect the White Paper's credibility.

The paper is attached below.

AARC White Paper on Concurrent Therapy

Introduction

The American Association for Respiratory Care (AARC) has been made aware of the practice of concurrent therapy (sometimes referred to as "stacking") within the context of respiratory care. The following information is made available because there are major concerns of respiratory therapists which center on the issues of patient safety and quality of care.

This paper outlines causes, ramifications and alternatives to providing respiratory therapy concurrently.

The Current Health Care System Places Increased Demands on Health Care Providers

Patients with cardiopulmonary diseases need access to safe, cost-effective care. Respiratory therapists provide care that can improve patient outcomes and reduce morbidity, mortality and costs.

Under the current health care system, increasing demands are placed on providers due to the aging population and a decrease in the supply of health care professionals. Respiratory therapy is impacted by these shortages as well. In 2000, we observed a 5.9% vacancy rate of staff positions for respiratory therapists. This fact, when coupled with the lack of sufficient respiratory therapy graduates to fill these vacancies has resulted in increased workloads for respiratory therapists.[1, 2] In some cases, respiratory therapists feel pressured to provide treatments concurrently (stacking) although it is against their best professional judgment. In providing care, respiratory therapists are bound by ethical and professional principles, and in most cases, state practice acts.[3]

Although today's health care system demands increased efficiency, it is imperative to balance that demand with the need for appropriate, effective and skilled patient care. In order to provide safe, cost-effective care, the respiratory therapy profession must address the issue of concurrent therapy (sometimes referred to as "treatment stacking").

In respiratory therapy, concurrent therapy occurs when one therapist administers treatments utilizing small volume nebulizers, metered dose inhalers, or intermittent positive pressure treatments to multiple patients simultaneously.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) cites concurrent therapy as a problem. According to JCAHO, if concurrent therapy is done, there must be a clear indication for it and a policy and procedure that govern its application. It must be differentiated from treatments given individually. Concurrent treatments, when provided in order to meet the convenience needs of the respiratory therapy staff, is considered inappropriate by JCAHO.[4]

The Federal Government's Response to Concurrent (Stacking) Therapy

In a *Federal Register* notice dated May 10, 2001, related to the Prospective Payment System (PPS) for Skilled Nursing Facilities (SNF), the Centers for Medicare and Medicaid Services (CMS) raised the issue of concurrent therapy. According to CMS, **"concurrent therapy is the practice of one professional therapist treating more than one Medicare beneficiary at a time -- in some cases, many more than one individual at a time. Concurrent therapy is distinguished from group therapy, because all participants in group therapy are working on some common skill development and the ratio of participants to therapists may be no higher than four to one."**[5]

Furthermore, CMS goes on to state **"A beneficiary who is receiving concurrent therapy with one or more beneficiaries likely is not receiving services that relate to those needed by any other participants. Although each beneficiary may be receiving care that is prescribed in his individual plan of treatment, it is not being delivered according to Medicare coverage guidelines: that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare."**[5]

Sources of Concern Regarding Concurrent (Stacking) Therapy

Medical Errors: The appropriate administration of respiratory therapy involves assessing and monitoring the patient. Assessment and monitoring include the need for therapy, administration of medications, the type of medication delivery device, patient education, patient tolerance, patient coordination, and outcomes documentation.[6,7,8] Concurrent therapy may encourage the elimination of one or more of these essential elements and could result in medical errors. According to recent reports by the Institute of Medicine, there are serious problems associated with medical errors, particularly medication errors.[9] These errors are often associated with inadequate staffing levels. Again, an increased demand for efficient care coupled with work force shortages, has resulted in increased workloads. In some instances, such demands far exceed a facility's resources.

Billing Errors: Concurrent therapy can cause billing problems and result in possible fraud. According to Medicare policy for Medicare Part A services (i.e., hospital inpatient services, skilled nursing facility services and intermediate are services), "respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual conditions and need for such services."[5] This language, in addition to the concerns raised by CMS in the May 10, 2001 *Federal Register* notice cited previously

indicate that concurrent therapy associated with respiratory services is not covered under Medicare. Although Medicare payments are made according to a prospective payment system, these payments are based on professional standards and the therapist's time spent in providing patient care.

Alternatives to the Practice of Concurrent (Stacking) Treatments

The American Association for Respiratory Care (AARC) appreciates the fact that even though human resources temporarily may not be adequate to meet the demand for respiratory services, there exist service delivery models and strategies which can close the gap between the demand for services and an institution's ability to meet that demand without jeopardizing patient safety, care quality and cost containment objectives. Brief descriptions of alternatives to concurrent therapy are presented in the following paragraphs.

Protocols

The use of established protocols may help respiratory therapists deliver appropriate and efficient care under conditions of an increased workload. Protocols are based on scientific evidence and include guidelines and options at decision points.[10] The use of protocols can help assure that all treatments have established indicators but also are highly effective in reducing the volume of unnecessary care. Evidence based literature exists supporting the use of protocols to minimize unnecessary treatments[11] and provide self-administration options for patients who demonstrate their ability to do so as documented by the respiratory therapists.[12] Research has shown that there exists a high percentage of misallocated respiratory therapy treatments. Indeed the range of misallocation, according to the scientific literature, goes from a low of 25% to a high of 60% depending on the modality.[13,14] It is important to note that numerous studies have concluded that protocols can reduce the volume of unneeded care, and therefore, contribute to an overall reduction in workload. For patients who require bronchodilator therapy, protocols can be effective in switching patients from small volume nebulizers, to the less time-consuming metered dose inhalers administered via hand held spacer devices. Other technology such as breath-activated nebulizers can be incorporated into protocols to increase efficiency without jeopardizing patient safety or quality of care.

Developing a Formal Procedure to Assess Patients' Needs

The AARC recognizes that not all health care provider organizations are in a position to take advantage of the benefits of patient-driven protocols. The Association recommends that a policy and procedure be developed which governs the application of the practice of concurrent therapy. This policy should include assessment of the appropriateness of the order for respiratory therapy utilizing AARC's Clinical Practice Guidelines (CPGs). Numerous studies have observed that CPGs are an invaluable tool in assessing whether the therapy in question is an appropriate allocation of resources. Moreover, if the therapy is appropriate, frequency of its administration should be evaluated as well.

Assessment of the patient is an indispensable component to this process, with patient safety and quality of care foremost. The patient's cognitive status, understanding of therapeutic goals, coordination and tolerance of the therapy must be considered. Moreover, the patient's attitude

and ability to cooperate with the therapy should be recognized as indispensable to the success of the treatment itself. The incidence of cognitive impairment among older people ranges from 30-50% in acute care hospitals, and 50-80% in skilled nursing facilities.[15] Finally, the proximity of the therapist should be taken into consideration, to assure adequate monitoring for quality and safety purposes.

Self-Administration

There are many instances where patients can be transitioned to a self-treatment program and thus avoid a significant demand for the therapist's time. You are encouraged to investigate this alternative in order to decrease workload for respiratory therapists without compromising care quality and patient safety. Policies and procedures must be developed which govern patient self-administration of respiratory therapy treatments. This process should include a thorough assessment of the patient similar to the one described in the previous alternative. Patients can then be categorized as those who require the services of a respiratory therapist or those, who after appropriate instruction from a respiratory therapist can self-administer their therapy. Patients in the first group would be treated the traditional way, while those in the latter group should be assessed and observed on a daily basis in order to assure that the therapy ordered is still appropriate, the patient's clinical condition has not worsened and the patient can still demonstrate correct technique regarding self-administration of the treatment.

The foregoing alternatives are not intended to be all-inclusive. The recurrent themes contained in each are patient assessment, safety, quality of care, appropriateness of the order, monitoring all aspects of the patient's response to therapy, and organizing a formal policy and procedure to implement the alternative in question.[16]

Conclusions

Patient safety is the primary reason for respiratory therapists not to deliver care via concurrent therapy without a thorough patient assessment. Indiscriminate use of concurrent therapy may lead to declines in quality and may jeopardize patient safety. Aerosolized medications administered during treatments have potential adverse reactions. Recognition of these reactions is not possible if the patient is left unattended and thus a safety hazard exists.

Action should be taken to remedy situations that cause concern for patient safety and appropriateness of care. Possible actions include establishing protocols and other procedures, as well as conferences with managers and supervisors, if necessary. Additional actions may include reporting unsafe practices to appropriate authorities within the hospital or other health care agencies. Concurrent therapy may not only adversely affect quality of care and patient safety, but can lead to a decline in job satisfaction and a loss of trained personnel. Such adverse results further exacerbate the health care work force shortage. Ultimately, it is the ethical and professional responsibility of respiratory therapists to assure their patients receive both safe and effective care of the highest quality.

References

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Approved: June 2002

American Association for Respiratory Care
Policy Statement

Policy No.: BOD.006

SECTION: Board of Directors

SUBJECT: **Executive Session of the Board of Directors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2007

DATE REVISED:

REFERENCES: AARC Bylaws; Robert's Rules of Order

Policy Statement:
All Executive Sessions of the Board of Directors shall be held in strict accordance with Association policy, and Robert's Rules of Order.

Policy Amplification:

1. Executive session shall be an important mechanism for conducting confidential business of the Board of Directors

2. All items discussed in executive session shall be held in strict confidence by all who are in attendance and may not be divulged to individuals other than the Board.

3. The Board of Directors shall review a member of the Board who is suspected of violating this policy in accordance with the due process provisions of AARC policy.

4. A member of the Board found to be in violation of this policy shall be subject to disciplinary action up to and including removal from office.

    A. The Board shall also file a complaint with the Judicial Committee regarding such member found in violation of this policy.

5. Any executive session information that is germane to the effective functioning of the Board of Directors shall be disseminated to all board members in the most timely fashion possible (e.g. Executive, Budget, and other special committees' business and rough drafts of proposed documents).

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliate Requirements and Responsibilities**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March, 2009 (was referred to Chart. Affil. Cmte to update by summer 2009)

DATE REVISED:

REFERENCES:

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

Policy Amplification:

1. Chartered Affiliates shall be required to provide the following written documentation to the AARC.

    A. Proof of state and federal exempt tax status.

    B. Proof of Chartered Affiliate Treasurers and other checking account signatories being bonded.

2. The Affiliate Charter shall remain the property of the Association, and replacement or additional copies must be purchased at cost plus handling.

3. It shall be the responsibility of the Chartered Affiliates Committee to solicit and maintain documentation.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CA 006

SECTION: Chartered Affiliate

SUBJECT: **Chartered Affiliate Consultant**

EFFECTIVE DATE: January 1, 2008

DATE REVIEWED: December 2007

DATE REVISED: December 2007

References:

Policy Statement:

The American Association for Respiratory Care (AARC) has established a mechanism to offer consultation services to its state societies (chartered affiliates).

Policy Amplification:

The role of the consultant is to assist the state societies, in regard to resolution of problems and/or disputes associated with the operation of the state society at the direction of the AARC President.

1. The President may appoint an AARC member volunteer with Board of Director or Executive Committee experience to serve as AARC State Society Consultant. The Consultant serves at the pleasure of the President. The position will be subject to reappointment on a yearly basis.

2. The Consultant's role is strictly voluntary with no pay for services, but state societies requesting a consultation will accept responsibility for any expenses incurred with the AARC matching up to $500 of the total expense.

3. While the consultant may be engaged with state societies on a wide range of topics related to arbitration, the consultant is not empowered to represent the AARC without its written authorization to do so from the AARC President.

4. When the Consultant provides advice in the execution of a consultation it must be clearly stated that the advice is not a position, opinion, recommendation or other form of direction from the AARC, but rather represents the best opinion of the consultant given his/her extensive experience and expertise in this area.

5. If the consultant feels that it is necessary and appropriate for the AARC to undertake a formal recommendation or other action, the consultant will contact the AARC's President and make the appropriate recommendation(s). The President will in turn consider the recommendation(s) and after consideration with appropriate parties take any subsequent action.

6. The consultant will communicate on a regular basis with the AARC's President regarding any activities undertaken in fulfillment of this appointment and will generate a written report after any consultation be copied to the AARC's President and Executive Director within ten days post meeting.

7. The consultant will submit a report that summarizes activities participated in on behalf of the AARC for each BOD meeting.

8. All communications from the consultant to the State Affiliate must be copied to the AARC President and Executive Director.

9. Any brochures, publications and/or e-mails that the consultant desires to send out to the affiliates promoting services provided through the position must first be approved by the AARC President and Executive Director.

10. All requests for services of the consultant must first be submitted to the AARC President. The President will make the decision regarding approval of the consultation and travel grant funding by the AARC Travel Assistance Grant Fund.

11. The Chartered Affiliate Consultant will be required to sign a Letter of Agency which will describe scope and limitations of authority.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CT.005

SECTION: Committees

SUBJECT: **Standing Committees**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2008

DATE REVISED: March 2008

REFERENCES:

Policy Statement:
The standing committees of the Association shall be the Bylaws, Elections, Executive, Finance, Judicial, Program and Strategic Planning Committees.

Policy Amplification:
1. The Association's standing committees are designated by the Association's Bylaws and only may be changed by initiation of a Bylaws change as designated in the Association's Bylaws in Article XII, sec 2.2.

2. Committee chairs and committee members of standing committees, not otherwise designated in the Association's Bylaws and/or policy shall be appointed by the President and subject to the approval of the Board of Directors.

3. Committee terms of appointment shall be for one (1) year with the exception of the Elections and Bylaws Committees.

    A. Elections committee terms shall be for two (2) years.
    ~~B. Bylaws committee terms shall be for two (2) years.~~

4. Decisions of the standing committees of the Association, except as specified in Article XII, Section 2 (a) (3), may be appealed to the Board of Directors.

    A. A two-thirds (2/3) vote of the Board of Directors shall be required to sustain an appeal.

DEFINITIONS:
ATTACHMENTS:

ARCF Achievement Awards

Forrest M. Bird
Lifetime Scientific Acheivement Award

Dr. Charles H. Hudson Award
for Cardiopulmonary Public Health

Thomas L. Petty, MD Invacare Award
for Excellence in Home Respiratory Care

AMERICAN RESPIRATORY CARE FOUNDATION
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Memorandum

DATE: February 2012

TO: Karen J. Stewart, MS, RRT,FAARC, AARC President
Kerry George,MEd,RRT, FAARC, NBRC President
Steve Mikles, EdS, RRT, FAARC, CoARC President

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Forrest M. Bird Lifetime Scientific Achievement Award 2012—Solicitation of Nominations**

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 a $25,000 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:

- 2011 Brian Carlin, MD, FAARC
- 2010 Louise Nett, RN, RRT, FAARC
- 2009 James K. Stoller, MD, MS
- 2008 Bruce K. Rubin, MD, FAARC
- 2007 Robert L. Chatburn, RRT-NPS, FAARC
- 2006 Robert M. Kacmarek, PhD, RRT, FAARC
- 2005 Richard D. Branson, MS, RRT, FAARC
- 2004 Joseph L. Rau, Jr., PhD, RRT, FAARC
- 2003 Robert Kirby, MD
- 2002 Charlie G. Durbin, Jr., MD, FAARC
- 2001 Neil R. MacIntyre, MD, FAARC
- 2000 Martin J. Tobin, MD
- 1999 Dean Hess, PhD, RRT, FAARC
- 1998 Walter O'Donohue, Jr., MD

- 1997 Alan H. Morris, MD
- 1996 David J. Pierson, MD,FAARC
- 1995 Leonard D. Hudson, MD
- 1994 John F. Murray, MD
- 1993 Peter Safar, MD
- 1992 George A. Gregory, MD
- 1991 Edward A. Gaensler, MD
- 1990 John W. Severinghaus, MD
- 1989 Roger C. Bone, MD
- 1988 William F. Miller, MD, FAARC
- 1987 H. Fredrick Helmholz, Jr., MD
- 1986 Thomas L. Petty, MD
- 1985 Claude Lenfant, MD
- 1984 C. Everett Koop, MD, Surgeon General

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, 2012.**

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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Memorandum

DATE: February 2012

TO: Karen J. Stewart, MS, RRT,FAARC, AARC President
Kerry George, MEd, RRT, FAARC, NBRC President
Steve Mikles, EdS, RRT, FAARC, CoARC President

FROM: Michael T. Amato, MBA
ARCF Chair

SUBJECT: **Dr. Charles H. Hudson Award for Cardiopulmonary Public Health 2012—*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.

The purpose of this award is to recognize "**efforts to positively influence the public's awareness of cardiopulmonary health and wellness.**"

Previous recipients include:

- Congressman Mike Ross- 2011
- 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-Kersee - 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
- Dr. Louis Sullivan – 1990
- 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, 2012.**

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, 2012. 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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Memorandum

DATE: February 2012

TO: Karen J. Stewart, MS, RRT,FAARC, AARC President
Kerry George, MEd, RRT, FAARC, NBRC President

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2012—*Solicitation of Nominations***

This award was established in 1992 with a grant from Invacare Corporation to recognize **"outstanding individual achievement in home respiratory care."**

Previous recipients include:

- Brian P. Wilson, RCP, EMT-I – 2011
- 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
- Joesph 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

We are now accepting nominations for this award. 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 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 or less), 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, 2012.

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, 2012. 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.