American Association for Respiratory Care

Board of Directors Meeting

Embassy Suites Outdoor World
Grapevine, TX

April 12-13, 2013

Index

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and FinanceCommittee Meetings – April 11, 2013
Board of Directors Meeting – April 12-13, 2013

Thursday, April 11

4:00-7:00 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 12

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

8:00 am Call to Order
Announcements/Introductions
Approval of Minutes pg. 9
E-motion Acceptance pg. 65

General Reports pg. 67
- President pg.68
- Past President pg.69
- Executive Director Report pg. 70 (R) (A)

9:00 am Bill Sims, Salmon, Sims, & Thomas - Auditor's Report

9:30 am Lawrence M. Wolfish, Wolfish & Newman, P.C.
Board Member Fiduciary Responsibility & Conflict of Interest

10:00 am Board of Directors Orientaion

11:00 am BREAK

11:15 am CoARC report presented by Tom Smalling pg. 94 (A)

General Reports con't.
- Government & Regulatory Affairs pg. 95 (A)
- House of Delegates pg. 107
- Board of Medical Advisors pg. 108
- Presidents Council pg. 111

Standing Committee Reports pg. 116
- Audit Subcommittee pg. 117
- Bylaws Committee pg. 118
- Elections Committee pg. 119
- Executive Committee pg. 120
- Finance Committee pg. 121
- Judicial Committee pg. 122
- Program Committee pg. 123 (R)
- Strategic Planning Committee pg. 125

12:00 pm **LUNCH BREAK (Daedalus Board Meeting)**

1:30 pm **RECONVENE**

Specialty Section Reports pg. 126
- Adult Acute Care pg. 127
- Continuing Care-Rehabilitation pg. 128 (R)
- Diagnostics pg. 129
- Education pg. 130
- Home Care pg. 131
- Long Term Care pg. 132
- Management pg. 133
- Neonatal-Pediatrics pg. 134
- Sleep pg. 135
- Surface to Air Transport pg. 136

3:00 pm **BREAK**

3:15 pm Special Committee Reports pg. 137
- Benchmarking Committee pg. 138
- Billing Code Committee pg. 139
- Federal Govt Affairs pg. 140 (A)
- Fellowship Committee pg. 141
- International Committee pg. 142
- Membership Committee pg. 144 (R) (A)
- Position Statement Committee pg. 146 (R)
- Social Media Committee pg. 156
- State Govt Affairs pg. 157

4:15 pm Nominations for Life & Honorary Membership

5:00 pm **RECESS**

Saturday April 13

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

8:00 am Call to Order

Special Representatives pg. 158
- AMA CPT Health Care Professional Advisory Committee pg. 159
- American Association of Cardiovascular & Pulmonary Rehab pg. 160
- American Heart Association pg. 161 (R)
- American Society for Testing and Materials (ASTM) pg. 163
- Chartered Affiliate Consultant pg. 164
- Comm. on Accreditation of Medical Transport Systems pg. 165
- Extracorporeal Life Support Organization (ELSO) pg. 166
- International Council for Respiratory Care (ICRC) pg. 167
- The Joint Commission (TJC) pg. 168
- National Asthma Education & Prevention Program pg. 171
- National Coalition for Health Professional Ed. In Genetics pg. 173
- National Sleep Awareness Roundtable pg. 174
- Neonatal Resuscitation Program pg. 175

9:30 am BREAK

9:45 am Roundtable Reports pg. 176
- Asthma Disease pg. 177
- Consumer (see Executive Director report pg. 70)
- Disaster Response pg. 179
- Geriatrics pg. 180
- Hyberbaric pg. 181
- Informatics pg. 182
- International Medical Mission pg. 183
- Military pg. 184
- Neurorespiratory pg. 185
- Research pg. 186
- Simulation pg. 187
- Tobacco Free Lifestyle pg. 188

11:00 am Ad Hoc Committee Reports pg. 189
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 190
- Ad Hoc Committee on Officer Status/US Uniformed Services pg. 191
- Ad Hoc Committee on Leadership Institutes pg. 192
- Ad Hoc Committee on 2015 & Beyond pg. 193
- Ad Hoc Committee to Recommend Bylaws Changes pg. 194
- Ad Hoc Committee to Reduce Hospital Readmissions pg. 208
- Ad Hoc Committee for Cont'd Development of Education Competition pg. 211

12:00 pm LUNCH BREAK

1:30 pm RECONVENE

1:30 pm Other Reports pg. 212

National Board for Respiratory Care (NBRC) pg. 213
American Respiratory Care Foundation (ARCF) pg. 217 (R)

2:00 pm **UNFINISHED BUSINESS pg. 218**

NEW BUSINESS pg. 219

Policy Review

- BOD.025 – BOD - Conventions and Meetings pg. 220
- BA.002 – BOMA - Member Organizations pg. 231
- CA.005 – Chartered Affiliate– Chartered Affiliate Travel Grant pg. 232
- CT.006 – Committees – Committee Travel Expenses pg. 234
- FM.015 – Fiscal Management – Approval of Budget pg. 235
- FM.021 – Fiscal Management – Old Outstanding Checks pg. 236

White Paper Review

- Guidance Document on Scope of Practice pg. 237
- RRT Credential pg. 238

3:00 pm ARCF Achievement Award Nominations pg. 241

Bird pg. 242
Hudson pg. 245
Petty/ Invacare pg. 250
Mike West pg. 253

ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(as of March 28, 2013)

AARC Board of Directors Meeting

April 12-13, 2013 • Grapevine, TX

Executive Office

Recommendation 13-1-1.1 "That up to $3,000 be allocated to convert AARC historical materials into appropriate formats compatible with current technology."

Recommendation 13-1-1.2 "That the AARC Board of Directors endorse the attached document Clinical Practice Guidelines for Quality Palliative Care" (see attachment "NCP Guidelines")

Program Committee

Recommendation 13-1-15.1 "That the AARC Board of Directors approve San Antonio, TX as the host city for AARC Congress 2016."

Continuing Care Rehabilitation Section

Recommendation 13-1-51.1 "That the AARC coordinate a meeting with CMS with support of our sister pulmonary organizations: AACVPR/ACCP/ATS/NAMDRC to ask CMS to allow listed COPD lung transplant patients to have additional PR sessions beyond the once in a lifetime benefit."

Recommendation 13-1-51.2 "That the AARC investigate through a special task force the development of a national post pulmonary rehabilitation disease management program in collaboration with a nationally recognized community exercise organization, such as the YMCA, including applying for national research funding."

Membership Committee

Recommendation 13-1-24.1 "That the President approve the creation of The Student Membership Retention Sub-Committee and that the Board of Directors approve the following members to serve and the goals/objectives of the sub-committee as well:

Co-Chair – Janelle Gardiner
Co-Chair – Emily Zyla
Member – Fred Goglia
Member – Aaron Light
Member – Melanie Harper McDonough
Member – Kerry McNiven."

Position Statement Committee

Recommendation 13-1-26.1 "That the AARC Board of Directors approve and publish the revised position statement on 'Cultural Diversity'."

Recommendation 13-1-26.2 "That the AARC Board of Directors approve and publish the revised position statement on 'Telehealth in Respiratory Therapy'."

Recommendation 13-1-26.3 "That the AARC Board of Directors approve and publish the recently reviewed 'Respiratory Therapy Protocols' position statement with no changes."

Recommendation 13-1-26.4 "That the AARC Board of Directors approve and publish the recently reviewed 'Home Respiratory Care Services' position statement with no changes."

Recommendation 13-1-26.5 "That the AARC Board of Directors Approve and publish the newly developed position statement 'Development of Baccalaureate and Graduate Education Degrees'."

Recommendation 13-1-26.6 "That the AARC Board of Directors Approve and publish the totally revised position statement 'Concurrent Therapy'."

American Heart Association

Recommendation 13-1-64.1 "That we communicate the AHA clarification via appropriate channels."

American Respiratory Care Foundation

Recommendation 13-1-82.1 "That the AARC consider returning fundraising for the AARC International Fellows back to the ARCF."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

New Orleans, LA • November 8, 2012

Minutes

Attendance

Karen Stewart, MSc, RRT, FAARC, President
George Gaebler, MSEd, RRT, FAARC, President-Elect
Toni Rodriguez, EdD, RRT, FAARC, Past President
Susan Rinaldo-Gallo, MEd, RRT, FAARC, VP/Internal Affairs
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
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
Joe Sorbello, MSEd, RRT
Greg Spratt, BS, RRT, CPFT
Cynthia White, BA, RRT-NPS, AE-C

Absent

Lori Conklin, MD, BOMA Chair

Consultants

Margaret Traband, MEd, RRT, FAARC, President's Council President
Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Bill Lamb, BS, RRT, CPFT, FAARC, Past Speaker

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Sam Giordano, MBA, RRT, FAARC, Consultant
Doug Laher, RRT, MBA, Associate Executive Director/Meetings and Conventions
Tim Myers, MBA, RRT-NPS, Associate Exec Director/Brands Management
Steve Nelson, RRT, FAARC, Associate Executive Director/IT
Cheryl West, Government Affairs Directors
Anne Marie Hummel, Regulatory Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Assistant

CALL TO ORDER

President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:00am CST, Thursday, November 8, 2012. 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.

Members stated their disclosures as follows:

Cynthia White – Advisory Boards, Aerogen, Discovery Labs
Fred Hill – Bylaws Chair, Alabama Society for Respiratory Care
Greg Spratt – Director of Clinical Marketing, Oridion/Covidien
Bill Lamb – National Clinical Manager, Ohio Medical Corp; Member, Corporate Council, National Patient Safety Foundation
Lynda Goodfellow –Consultant/Advisor, Teleflex Medical

APPROVAL OF MINUTES

Colleen Schabacker moved to approve the minutes of the July 16, 2012 meeting of the AARC Board of Directors with an amendment - Fred Hill, Alabama State Board of Respiratory Therapy.
Motion Carried

Colleen Schabacker moved to approve the minutes of the July 17, 2012 meeting of the AARC Board of Directors.
Motion Carried

E-MOTION RATIFICATION

Joe Sorbello moved to ratify the E-Motions discussed over the Board AARConnect since July 2012 as follows:

E12-3-81.1 **"**To ratify the appointment of Robert Joyner to the NBRC Board of Trustees".
Motion carried

E12-3-15a.1 "To ratify the appointment of Richard Zahodnic to the Sputum Bowl Committee".
Motion carried

E12-3-9.1 "That the AARC BOD approve the amended bylaws of the Pennsylvania Society for Respiratory Care".
Motion carried

E12-3-1.1"To ratify the appointment of Dr. Toni Rodriguez to the Elections, Finance, Judicial, Program, Strategic Planning and Membership Committees, and as the BOD Liaison to the

International Medical Mission Roundtable".
Motion carried

E12-3-40.1 "To ratify the appointment of Lois Rowland, MS, RRT-NPS, FAARC as Chair of the Neurorespiratory Roundtable."
Motion carried

GENERAL REPORTS

President
President Stewart thanked the Board for their support over the past two years.

Executive Director/Office
Susan Rinaldo Gallo moved to accept Recommendation 12-3-1.1 "That the AARC Board of Directors officially endorse the Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit as requested by the Society of Critical Care Medicine."
Motion carried

Tom Kallstrom gave highlights of the Executive Office written report. Frank Salvatore challenged the Board to donate to the Disaster Relief fund. The Board thanked Bill Dubbs, who is retiring at the end of 2012, for his many years of service.

Government & Regulatory Affairs
State Government Affairs
Director of Government Affairs, Cheryl West, provided an update on state legislative and regulatory issues.

Federal Government Affairs
Cheryl West provided an update on our legislative issues pending before Congress.

President's Council
Margaret Traband gave comments on her written report.

STANDING COMMITTEES REPORTS

Bylaws Committee
Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.1 "That the AARC BOD accept and approve the Bylaws of the Alabama Society for Respiratory Care."
Motion carried
Fred Hill abstained from voting.

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.2 "That the AARC BOD accept and approve the Bylaws of the Iowa Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.3 "That the AARC BOD accept and approve the Bylaws of the Maine Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.4 "That the AARC BOD accept and approve the Bylaws of the Mississippi Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.5 "That the AARC BOD accept and approve the Bylaws of the Nebraska Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.7 "That the AARC BOD accept and approve the Bylaws of the Rhode Island Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.6 "That the AARC BOD accept and approve the Bylaws of the Puerto Rico Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.8 "That the AARC BOD accept and approve the Bylaws of the South Carolina Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.9 "That the AARC BOD accept and approve the Bylaws of the Tennessee Society for Respiratory Care."
Motion carried
Colleen Schabacker abstained from voting.

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.10 "That the AARC BOD accept and approve the Bylaws of the Utah Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.11 "That the AARC BOD accept and approve the Bylaws of the Wyoming Society for Respiratory Care."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-9.12 "That the AARC BOD find the Texas Society for Respiratory Care in violation of Chartered Affiliate Policy CA.007."

Colleen Schabacker moved to refer to President-elect.

Susan Rinaldo Gallo moved to make a friendly amendment to include a targeted date for the Texas Society for Respiratory Care to revise their bylaws. Susan Rinaldo Gallo withdrew her motion.

Colleen Schabacker withdrew her motion to refer.
Original motion carried

Frank Salvatore moved to accept Recommendation 12-3-9.13 "That the AARC BOD appoint an ad hoc committee to address the current imbalance in the 5-yr review cycle."

Linda Van Scoder moved to refer back to Bylaws Committee to establish a calendar to present at the April 2013 Board meeting.
Motion carried

Elections Committee
Susan Rinaldo Gallo moved to accept Recommendation 12-3-10.1 "That the following statement be added to Policy CT.003 (Elections Committee – Nomination Process) 'The Committee's goal will be to have a minimum of two qualified members for each elected position'." (See Attachment "A")
Motion carried

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

Finance Committee
FM 12-3-12.1 Linda Van Scoder moved to approve the capital purchases from July – September 2012 in the amount of $6,597.79.
Motion carried

Susan Rinaldo Gallo moved to accept the Standing Committee reports as presented.
Motion carried

SPECIALTY SECTION REPORTS

Adult Acute Care Section
Susan Rinaldo Gallo moved to accept Recommendation 12-3-50.1 "That the BOD evaluate the feasibility of creating a Critical Care Clinic Fellowship syllabus and in conjunction with large academic centers, implement such a fellowship."

Frank Salvatore moved to refer to Executive Office.
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-3-50.2 "That the BOD evaluate the feasibility of creating and supporting a monthly critical care teleconference and potentially offering continuing education credits for participants."

Colleen Schabacker moved to refer to Executive Office for feasibility.
Motion carried

Continuing Care Rehabilitation Section
Susan Rinaldo Gallo moved to accept Recommendation 12-3-51.1 "That the AARC pursue a more formal partnership with the AACVPR which has been recommended in the AACVPR report."

Colleen Schabacker moved to refer to Executive Office for investigation and follow-up.
Motion carried

Karen Stewart added a friendly amendment to receive a follow up by the April 2013 Board meeting. Colleen Schabacker and Camden McLaughlin agreed to the friendly amendment.
Motion to refer as amended carried

Education Section
Susan Rinaldo Gallo moved to accept Recommendation 12-3-53.1 "That the Preceptor Training Program as developed by the Preceptor Training Subcommittee of the Education Section be accepted, at least in concept, as the AARC's Preceptor Training Program."

Linda Van Scoder moved to refer to Executive Office to explore and report back at the April 2013 Board meeting.
Motion carried

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

RECESS
President Stewart recessed the meeting of the AARC Board of Directors at 9:40am CST Thursday, November 8, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 10:00am CST Thursday, November 8, 2012.

SPECIAL COMMITTEE REPORTS

Membership Committee
Frank Salvatore informed the Board of a new membership recruitment campaign that he will announce at the Joint Session meeting.

Position Statement Committee
FM 12-3-26.1 Colleen Schabacker moved to approve the white paper on "Best Practices in Respiratory Care Productivity and Staffing".

Linda Van Scoder moved to postpone voting on this motion until Friday, November 9, 2012.
Motion carried

FM 12-3-26.2 Colleen Schabacker moved to bring back the Concurrent Therapy paper for revision by the Position Statement Committee to redevelop and submit a draft by April 2013 and final by July 2013.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

American Heart Association
Colleen Schabacker moved to accept Recommendation 12-3-64.1 "That the AARC Executive Office pursue the AHA's intent to limit the ability to issue cards for respiratory therapists who are seeking advance life support provider or instructor status enforced by some regional offices."
Motion carried

Colleen Schabacker moved to accept the Special Representatives Reports as submitted.
Motion carried

ROUNDTABLE REPORTS

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

AD HOC COMMITTEE REPORTS

Ad Hoc Committee to Recommend Bylaws Changes
Denise Johnson moved to accept Recommendation 12-3-30.1 "Review and accept proposed changes to AARC Bylaws as presented." (See Attachment "B")

Linda Van Scoder moved to refer back to the Ad Hoc Committee to Recommend Bylaws Changes to bring back a clean copy at the April 2013 Board meeting.
Motion carried

LUNCH RECESS
President Stewart recessed the meeting of the AARC Board of Directors at 11:30am CST Thursday, November 8, 2012.

JOINT SESSION

Speaker-elect, John Steinmetz, convened Joint Session at 1:34pm CST, Thursday, November 8, 2012. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

Commission on Accreditation of Respiratory Care - CoARC
Dr. Kathy Rye, CoARC President-elect, gave highlights of the written report.

Elections Committee Report
Jim Lanoha, Elections Committee Chair, announced the 2013 election results.

Vice President Internal Affairs – Brian Walsh
Vice President External Affairs – Colleen Schabacker
Secretary/Treasurer – Frank Salvatore
Director-at-Large – Sherri Tooley
Director-at-Large – Gary Wickman
Homecare Section – Kimberly Wiles
Neonatal/Pediatrics – Natalie Napolitano
Sleep Section – Russell Rozensky

Government Affairs
Cheryl West commented on current state affairs. Anne Marie Hummel and Miriam O'Day gave comments on the Government and Regulatory Affairs report. Sam Giordano gave an update on Medicare Part B Initiative.

Karen Stewart and Karen Schell presented Sam Giordano with a retirement gift from the Board of Directors and House of Delegates.

International Committee Report
John Hiser gave highlights of his written report.

This year there were 23 International Fellowship applications from 18 different countries and 7 new countries and 20 City Hosts applied. There were 7 International Fellows selected and 2 alternates:

China – Ling Liu – Honolulu, HI and Oakland, CA (Kaiser)
China – Manling Liu – Portland, OR and Oakland, CA (Katy)
Ecuador – Raul Castro Garcia – Charleston, SC and Winston-Salem, NC
Ghana – Audrey Forson – Emporia, KS and Salt Lake City, UT
Haiti – Job Joseph – Charlottesville, VA and Washington, DC
India – Anitha Nileshwar – Brooklyn, NY and Baltimore, MD
Turkey – Sanihe Ugurlu – Cincinnati, OH and Baltimore, MD

Alternates:
Argentina – Marina Busico
Columbia – Lsybeth Yamylle Roldan Valencia

John Hiser reported that the House of Delegates has donated over $35,000 to the International Fellows Program in the past 6 years.

MEMBERSHIP
Frank Salvatore presented the new membership recruitment campaign that will run from November 1, 2012 through October 31, 2013.

EXECUTIVE SESSION
Linda Van Scoder moved to go into Executive Session to discuss the current 2012 and proposed 2013 budget with the AARC Board of Directors and House of Delegates at 3:10pm CST, Thursday, November 8, 2012.
Motion carried

Denise Johnson moved to come out of Executive Session.
Motion carried

Executive Session ended at 3:30pm CST, Thursday, November 8, 2012.

Colleen Schabacker moved to approve the 2013 budget.
Motion carried

RECESS
President Karen Stewart recessed the meeting of the AARC Board of Directors at 3:31pm CST, Thursday, November 8, 2012.

Meeting minutes approved by AARC Board of Directors as attested to by:

_____ _____
Frank Salvatore, MBA, RRT, FAARC Date
AARC Secretary/Treasurer

Attachment “A”

Policy No. CT.003 – Elections Committee – Nomination Process

American Association for Respiratory Care
Policy Statement

Policy No.: CT.003

SECTION: Committees

SUBJECT: **Elections Committee – Nominations Process**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 8, 2012

DATE REVISED: December 4, 2012

REFERENCES: AARC Bylaws, CT.005, and Delegate Handbook

Policy Statement:
The process used to prepare a slate of candidates for Association offices and to conduct elections shall be in accordance with the following revision from AARC's July 2011 BOD meeting.

Policy Amplification:

1. An official nomination form must be submitted for each nominee.

2. Each nominee shall be notified of the location on-line where they can find the requirements of the Elections Committee in order to continue in the elections process with full instructions and the submission deadline date.

3. All candidates shall submit information (e.g., answers to questions. **Biographical form**) required of all nominees with a defined date of return to the Executive Office for preparation and publication in the appropriate publication to provide the general membership with additional information about the candidates.

4. An AARC Officer or Director shall not hold a paid or voluntary position of authority for or in any AARC Chartered Affiliate during his/her term of office as an AARC Officer or Director. Candidates holding such positions must submit in writing a plan for resolution of any conflict of interest prior to Election Committee consideration of candidates.

5. Questions will be derived from HOD/BOD input, and organized/compiled by the Elections Committee. Nominees will respond via mail, e-mail or fax to the Executive Office according to established timelines.

6. The administrator/supervisor of each nominated individual must submit written certifying support for the candidate's nomination and time commitment for AARC responsibilities.

7. The Elections Committee members, under the guidance of the Committee chair, will review the compiled data, assess qualifications, rank, etc. Once the data is compiled, it will be sent to each committee member, followed by a telephone conference, and the committee will decide upon a slate of candidates.

8. All nominated individuals shall be notified in writing the outcome of their nomination.

9. All deliberations within the Elections Committee for preparation of the slate of candidates shall be performed in Executive Session and may not be discussed beyond the committee. Any committee member breaching confidentiality of the aforementioned deliberations shall be referred to the AARC Judicial Committee for appropriate action.

10. The Elections Committee Chair shall submit the elections slate in writing to the Board of Directors and the House of Delegates no later than June 1. This deadline for submission of nominees may be extended as necessary.

11. Voting will be by an online process with the order of candidate names randomly listed.

12. The Elections Committee Chair shall receive and review the layouts of the general election ballots and the biographical forms.

13. The Elections Committee shall forward a roster of all nominees for the AARC Board of Directors to the President and/or President-elect which would include all personal contact information for these individuals (i.e., e-mail, work address, work phone, etc.) for consideration in the committee appointment process.

14. Past speakers of the House of Delegates are eligible for nomination for Association officer positions to include Secretary-Treasurer, Vice President for Internal Affairs, Vice President for External Affairs and President-elect, provided that they will have completed their full term of office as speaker-elect, speaker and immediate past speaker sometime prior to the year for which they would serve as an Association officer.

15. Write-in candidates for Directors and Officers of the Board of Directors of the AARC must meet the minimum eligibility requirements for the office for which they have received votes.

16. The Elections Committee shall have the ability to extend the established nomination period by 20 days if a full slate of candidates for each position has not been obtained.

17. The Committee's goal will be to have a minimum of two qualified members for each elected position.

DEFINITIONS:

ATTACHMENTS: Biographical Form Guidelines (See Appendix)

Attachment “B”

AARC Bylaws (*revisions from Nov 2012 BOD meeting included)*

AARC Bylaws

ARTICLE I - NAME

This organization shall be known as the American Association for Respiratory Care, incorporated under the General Not-For-Profit Corporation Act of the State of Illinois, hereinafter referred to as the Association.

ARTICLE II - OBJECT

SECTION 1. PURPOSE

AARC Vision/Mission Statement

The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist.

The Association is formed to:

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

SECTION 2. INTENT

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

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

d. The Association shall not commit any act which shall constitute the unauthorized practice of medicine under the laws of the State of Illinois or any other state.

ARTICLE III - MEMBERSHIP

SECTION 1. CLASSES

The membership of the Association shall include three classes: Active Member, Associate Member, and Special Member.

SECTION 2. ACTIVE MEMBER

An individual is eligible for Active Membership if he/she lives in the United States or its territories or was an Active Member prior to moving outside its borders or territories, and meets ONE of the following criteria: (1) is legally credentialed as a respiratory care professional if he/she is employed in a state or territory that maintains a legal credential for respiratory care professionals OR (2) is a graduate of an educational program in respiratory care accredited by an AARC- recognized agency, OR (3) holds a credential issued by an AARC-recognized agency. An individual who was an AARC Active Member in good standing on December 8, 1994, will continue as such, providing his/her membership remains in good standing. Active Members in good standing shall be entitled to all the rights and privileges of membership of the Association including: the rights to hold office, hold committee chairs, and vote.

SECTION 3. ASSOCIATE MEMBER

Individuals will be classified as Associate Members if they hold a position related to respiratory care but do not meet the requirements to become Active Members. Associate Members shall have all the rights and privileges of membership except that they shall not be entitled to hold office, vote, or serve as a director, chair of any standing committee or specialty section of the Association. There shall be the following subclasses of Associate Membership:

a. Foreign Member – Individuals will be classified as foreign members if they meet all the requirements for Associate Membership and they are citizens of or reside in any country other than the United States of America.

b. Student Member – Individuals will be classified as Student Members if they meet all the requirements for Associate Membership and are enrolled in an educational program in

respiratory care accredited by, or in the process of seeking accreditation from, an AARC-recognized agency.

c. Foreign Student Member – Individuals will be classified as Foreign Student Members if they meet all the requirements for a Foreign Member and are enrolled in an educational program in respiratory care which is accredited or is seeking accreditation by an appropriate governmental or professional accrediting agency.

d. Physician Member – Individuals will be classified as Physician Members if they meet all the requirements for Associate membership and are duly licensed as doctors of medicine or osteopathy.

e. Industrial Member – Individuals will be classified as Industrial Members if they meet all the requirements for Associate Membership and their primary occupation or business or a majority of their business time is directly or indirectly devoted to the manufacture, sale, or distribution of equipment or products which are directly or indirectly used in the area of respiratory care.

SECTION 4. SPECIAL MEMBER

a. Life Member – Life Members shall be members who have rendered outstanding service to the Association as Active Members. Life Members shall have all the rights and privileges of active membership of the Association. Life Members shall be exempt from the payment of dues. Hereinafter all references to Active Members shall refer to both Active and Life Members of the Association.

b. Honorary Members – Honorary Members shall be persons who have rendered distinguished service to the field of respiratory care. Honorary Members shall have all the rights and privileges of Associate Membership of the Association. Honorary Members shall be exempt from the payment of dues.

c. General Member – General Members shall be individuals who have an interest in respiratory care and who do not qualify for other membership classifications. General Members shall have all the rights and privileges of Associate Membership in the Association.

SECTION 5. PREREQUISITES
FOR MEMBERSHIP

Applicants for membership shall meet all the qualifications of the class of membership for which they apply. As a condition of membership, all Members shall be bound by the Articles of Incorporation, Bylaws, standing rules, code of ethics, and other rules, regulations, policies, and procedures adopted from time to time by the Association.

SECTION 6. APPLICATION
FOR MEMBERSHIP

a. Applicants for membership shall submit their completed official application to the Executive Office of the Association.

b. The names and addresses of applicants accepted by The Executive Office shall be submitted for publication.

c. Any member or members may object to approval of an applicant for membership by filing written objection with the Executive Office within (30) calendar days after publication of

the applicant's name. If an objection is received, the Executive Office shall promptly notify the President, Judicial Committee Chair, the applicant, and the Chartered Affiliates-President. Whenever there is an objection, the Judicial Committee shall reevaluate the application and make a decision regarding admission.

SECTION 7. SPECIALTY SECTIONS

a. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. Specialty Sections with a minimum of 1000 active members may be considered for a seat on the Board.
b. The active members of each Specialty Section shall elect a Chair-elect every third year. Elections shall be staggered such that a maximum of one third (1/3) of section chairs-elect shall be elected each year.

SECTION 8. PAYMENT OF DUES

Each member of the Association, except Life Members and Honorary Members, shall pay dues in such amounts and in such manner as may be established annually by the Board of Directors.

SECTION 9. ETHICS

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

ARTICLE IV - OFFICERS

SECTION 1. OFFICERS

a. The Officers of the Association shall consist of the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, Secretary-Treasurer, and in alternate years President-Elect, and shall be elected in accordance with the provisions of Article XII, Section 2 (b).
b. Officers of the Association shall not concurrently be members of national respiratory care credentialing or accreditation bodies, chartered affiliate staff or voting members of their Board of Directors.

SECTION 2. TERM OF OFFICE

a. The term of office for the President-elect shall be one (1) year. The term of office for the President, Immediate Past President, Vice President for Internal Affairs, Vice President for

External Affairs, and Secretary-Treasurer shall be two (2) years. The term shall begin immediately following the Annual Business Meeting.

b. The President-elect shall complete immediate successive full terms for the offices of President-elect, President, and Immediate Past President before being eligible to serve a successive term in any elected office.

SECTION 3. VACANCIES IN OFFICE

a. In the event of a vacancy in the office of President, the Immediate Past President shall resume the duties but not the office of President until a special election can be held to fill the office.

b. In the event of a vacancy in the office of President-elect due to resignation or inability to perform duties, the Vice President for Internal Affairs shall assume the duties, but not the office, of the President-elect and shall also continue to serve as Vice President for Internal Affairs until a special election is held to fill the office of President-elect.

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

d. In the event of a vacancy in the office of immediate Past President, the most recent Past President will assume the office of Immediate Past President. If that person is unable or unwilling to serve, the office shall be filled by the appointment of a qualified individual by the Board of Directors. Individuals so appointed shall serve the remainder of the term.

SECTION 4. DUTIES OF OFFICERS

a. President – The President shall be the Chief Executive Officer of the Association. The President shall preside at the Annual Business Meeting and all meetings of the Board of Directors; prepare an agenda for the Annual Business meeting and submit it to the membership not fewer than thirty (30) calendar days prior to such a meeting in accordance with Article VI of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) calendar days prior to such meeting; appoint standing and special committees subject to approval of the Board of Directors; be an ex-officio member of all committees except the Elections Committee; and present to the Board of Directors and membership an annual report of the Association.

b. President-elect – The President-elect, if sitting, shall perform duties as assigned by the President or Board of Directors.

c. Vice President for Internal Affairs – The Vice President for Internal Affairs shall serve as a liaison to the committees and groups of the Association as designated by the President and perform such other duties as shall be assigned by the President or the Board of Directors. The Vice President for Internal Affairs shall assume the duties of the President-elect in the event of the President-elect's absence, resignation, or disability, but will also carry out the duties of the office of the Vice President for Internal Affairs.

d. Vice President for External Affairs – The Vice President for External Affairs shall serve as a liaison to committees and groups as designated by the President, and perform such other duties as shall be assigned by the President or the Board of Directors.

e. Secretary-Treasurer – The Secretary Treasurer shall see that full and accurate accounts are kept; see that the Executive Office submits monthly financial statements to the Board of Directors, House of Delegates Officers, and the Finance Committee within a reasonable period of time after the monthly closing of the books, make a complete written yearly report at the Annual Business Meeting; keep complete and accurate minutes of meetings of the Board of Directors, Executive Committee, Finance Committee, the Annual Business Meeting, and any other meeting as directed by the President; and perform such other duties as shall be assigned by the President or the Board of Directors. At the expense of the Association, the Secretary-Treasurer shall be bonded in an amount determined by the Board of Directors.

f. Immediate Past President – The Immediate Past President, shall advise and consult with the President, serve as a member of the Bylaws Committee, serve as a liaison to the Board of Medical Advisors and perform such other duties as shall be assigned by the President or the Board of Directors. If the office of President becomes vacant, the Immediate Past President will resume the duties of President until a special election can be held.

ARTICLE V - BOARD OF DIRECTORS

SECTION 1. COMPOSITION AND POWERS

a. The executive government of the Association shall be vested in a board of at least seventeen (17) and no more than eighteen (18) Active Members consisting of at least five (5) Officers, and twelve (12) Directors-at-Large, and/or Section Chairs serving as a Director. So long as the number of Section Chairs serving as Directors is at least six (6), the number of at-Large Directors shall be equal to the number of Section Chairs serving as Directors. If the number of Section Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of twelve (12) director seats on the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the Presidents Council, and the Chair of the Board of Medical Advisors shall serve as non-voting members. Directors shall be elected in accordance with the provisions of Article XII, Section 2 (b).

b. Members of the Board of Directors shall not concurrently be members of national respiratory care credentialing or national respiratory care accreditation bodies, chartered affiliate staff or voting members of their Board of Directors.

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

SECTION 2. TERM OF OFFICE

Up to one-third (1/3) of the at-Large Directors shall be elected each year, and the term of office for all Directors shall begin following the Annual Business Meeting and shall be three (3) years.

SECTION 3. DUTIES

The Board of Directors shall:

a. Supervise all the business and activities of the Association within the limitation of these Bylaws.
b. Employ a business counsel to be identified as the Executive Director, who shall manage the Executive Office from which the business of the Association is conducted.
c. Govern the activities of the Executive Director.
d. Grant charters to affiliates which meet the requirements for affiliation upon recommendation of the Chartered Affiliates Committee; and have the power to revoke charters.
e. Adopt and rescind standing rules, regulations, policies, and procedures of the Association.
f. After consideration of the budget, determine for the following year the amount of membership dues, remunerations, stipends, and other related matters.
g. Furnish the elections committee with the names of qualified candidates for AARC Officers.
h. Perform such other duties as may be appropriate for the management of the Association.

SECTION 4. VACANCIES

a. Any vacancy that occurs in the office of an at-Large Director shall be filled by appointment by the Board of Directors.
b. An appointed at-Large Director shall serve until the next scheduled election, or until a successor is elected.
c. Any vacancy that occurs in the office of Section Chair serving as a Director shall be filled by the Chair-elect of that Specialty Section, if one is serving at that time. The ascending Chair-elect shall serve the unexpired term of the Chair and his or her own three (3) year term. If there is no Chair-elect, that Specialty Section will hold a special election of a Chair, who will serve the unexpired term and his or her own three (3) year term.
d. If no Chair-elect is serving at the time of vacancy, the vacancy shall be filled by appointment, of a member of that Specialty Section, by the Board of Directors. An appointed Section Director shall serve until the next scheduled election, or until a successor is elected.
e. The Board of Directors shall have the power to declare an office or seat on the Board of Directors vacant by a two-thirds (2/3) vote upon refusal, neglect or inability of any officer or director to perform their duties, or for any conduct deemed prejudicial to the Association. Written notice shall be given to the member that the office has been declared vacant.

SECTION 5. MEETINGS

a. The Board of Directors shall meet immediately preceding and immediately following the annual Business Meeting of the Association and shall hold not fewer than two (2) regular and separate meetings during the course of the year.
b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Association shall require, or upon written request by the majority of the Board of Directors filed with the President and the Executive Director of the Association.
c. Meetings of the Board of Directors may be in person, by telephone or video conferencing or other electronic means as shall be determined by the Board of Directors.
d. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

SECTION 6. VOTE OF MEMBERSHIP

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

ARTICLE VI - ANNUAL
BUSINESS MEETING

SECTION 1. DATE AND PLACE

a. The Association shall hold an Annual Business Meeting each calendar year. Additional meetings may be held as required to fulfill the objectives of the Association.
b. The date and place of the Annual Business Meeting and additional meetings shall be decided in advance by the Board of Directors. In the event of a major emergency, the Board of Directors may cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by alternate means provided the material is distributed in the same words to the membership.

SECTION 2. PURPOSE

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

SECTION 3. NOTIFICATION

Written notice of the time and place of the Annual Business Meeting shall be sent to all members of the Association not less than five (5) nor more than forty (40) calendar days prior to the meeting. An agenda for the Annual Business Meeting shall be sent to all members not fewer than thirty (30) calendar days prior to the Annual Business Meeting.

ARTICLE VII - HOUSE OF DELEGATES

SECTION 1. COMPOSITION

a The House of Delegates shall be composed of from one (1) to three (3) delegates from each Chartered Affiliate of the Association They shall be hereinafter referred to as the Delegation.

b. A Speaker shall be elected by and from the House to chair House meetings. The House shall elect such other officers and be responsible for such organizational practices as it may otherwise require.

SECTION 2. PURPOSE

The House of Delegates shall serve as a representative body of the general membership and the representative body of the Chartered Affiliates of the Association. It shall participate in the establishment of the goals and objectives for the Association and participate in the governance of the Association.

SECTION 3. DUTIES

a. The House of Delegates shall adopt such rules, regulations, policies, and procedures with respect to the House as it may deem necessary or appropriate, and all Delegates shall be bound thereby.
b. The House Speaker may appoint members to the House Committees, subject to the approval of the House of Delegates. In the event of vacancies occurring in any House Committee, the Speaker may appoint members to fill such vacancies, subject to the approval of the House of Delegates.
c. Each Delegate shall:
1. Attend all meetings of the House of Delegates and report the activities to the respective Chartered Affiliate.
2. Attend the Annual Business Meeting of the Association as the representative of the Active Members of the Association within their respective Chartered Affiliate.
3. Furnish the Elections Committee with the names of qualified members for nomination as Director-at-Large.
4. At the direction of their respective Chartered Affiliate, present proposed amendments to the Bylaws Committee.
5. Perform such other duties of office as may be necessary or required.

SECTION 4. MEETING

The House of Delegates shall meet preceding the Annual Business Meeting of the Association and at such other times as called by its Speaker or by the majority vote of the House of Delegates.

SECTION 5. ELECTION OF
DELEGATES

a. The Delegation shall be elected by the Active Members of the Association within their respective Chartered Affiliates.
b. Only Active Members in good standing of the Association who are not on the Board of Directors of the Association shall be eligible to be members of a delegation.
c. The Chartered Affiliate shall have the power to declare any position of the Delegation vacant upon refusal, neglect or inability of the Delegate to perform the duties of office, or for any

other conduct deemed prejudicial to the Chartered Affiliate of the Association. Written notice shall be given to that Delegate and the Speaker of the House of Delegates that the office has been declared vacant.

SECTION 6. VOTING

a. Each delegation shall have one (1) vote for each Active Member within their Chartered Affiliate as submitted by the Executive Office and certified by the House of Delegates Credentials Committee.
b. The House Speaker shall appoint the members of the House Credentials Committee from the House. This Committee shall certify the Delegation and number of votes each Delegation may cast.

SECTION 7. QUORUM

A majority of the credentialed Delegations shall constitute a quorum at any meeting of the House of Delegates.

ARTICLE VIII - BOARD
OF MEDICAL ADVISORS

SECTION 1. COMPOSITION

The Board of Medical Advisors of the Association shall consist of no less than twelve (12) individual members. Representation shall be maintained from each member organization, as defined by the Association Board of Directors policy. Members of the Board of Medical Advisors shall not concurrently be members of national respiratory care credentialing or accreditation bodies. Appointees to the Board of Medical Advisors must be physicians who have an identifiable role in clinical, organizational, educational or investigative respiratory care. Members of the Board of Medical Advisors must be members of the Association during their term.

SECTION 2. TERM OF OFFICE

Each member shall be appointed by the sponsoring member organization in such a manner that no more than one-fourth of the members of the Board of Medical Advisors shall be replaced in any year. Any vacancy that occurs on the Board of Medical Advisors should be filled by an appointment from the member organization. Terms shall commence immediately following the Annual Business Meeting.

SECTION 3. DUTIES

a. The Board of Medical Advisors shall elect their own officers and be responsible for such organizational policies and procedures as they may require.

b. The Board of Directors of the Association and all of its committees and specialty sections may consult with the Board of Medical Advisors in regard to medical issues. The Board of Medical Advisors shall assist the appropriate committees and specialty sections regarding medical and educational issues.

c. The Chair of the Board of Medical Advisors shall be a non-voting member of the Board of Directors.

SECTION 4. MEETINGS

An annual meeting of the Board of Medical Advisors shall be held at the time and place of the Annual Meeting of the Association, and other meetings shall be held at such times and places as shall be determined necessary by the Board of Medical Advisors.

ARTICLE IX - PRESIDENTS COUNCIL

a. The Presidents Council shall be composed of Past Presidents of the Association who have been elected to membership by the Council.
b. The Presidents Council shall serve as an advisory body to the Board of Directors and perform other duties assigned by the Board of Directors.
c. The Presidents Council shall elect a Chair from its membership to serve a one-year term beginning immediately following the Annual Business Meeting.
d. The Chair of the Presidents Council shall serve as a non-voting member of the Board of Directors and preside at meetings of the Presidents Council.
e. The Presidents Council shall meet annually following the Annual Business meeting of the Association.
f. The Presidents Council may appoint committees as necessary to complete its duties.
g. In the event of a vacancy in the Chair, the vacancy shall be filled according to the procedure defined by the Association.

ARTICLE X - CHARTERED
AFFILIATES

SECTION 1. REQUIREMENTS

Twenty (20) or more Active members in good standing of the Association meeting the requirements for affiliation may become a Chartered Affiliate of the Association upon the affirmative recommendation of the Chartered Affiliates Committee and approval by the Board of Directors of the Association. Active Members of Chartered Affiliates must be Active Members of the Association. The minimum geographical boundaries of an applicant for a Chartered Affiliate of the Association shall encompass one or more entire states, territories, possessions, or protectorates of the United States. The District of Columbia shall be considered an entire state for this section.

SECTION 2. ADMISSION PROCEDURE

The formal application for a charter shall be sent to the Executive Office of the Association and shall consist of a list of officers, membership, minutes of the organizational meeting, the Bylaws, and a letter requesting approval of the proposed medical advisor or advisors.

SECTION 3. MEDICAL ADVISOR

Each Chartered Affiliate shall have one (1) or more medical advisors whose name(s) shall be submitted to the Board of Medical Advisors.

SECTION 4. DUTIES

A copy of the minutes of every meeting of the governing body and other business meetings of the Chartered Affiliates shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meeting.

SECTION 5. SUSPENSION OR
REVOCATION OF A CHARTER

a. The Board of Directors of the Association may suspend or revoke the charter of any affiliate with due and sufficient cause or upon the failure of an affiliate to maintain a membership of at least twenty (20) Active Members in good standing of the Association.
b. Action for the suspension or revocation of the charter of any affiliate shall follow approved Association policy and procedure.

ARTICLE XI - INTERNATIONAL
AFFILIATES

SECTION 1. REQUIREMENTS

Twenty (20) or more Foreign Members in good standing of the Association meeting the requirements for affiliation may become an International Affiliate of the Association upon the affirmative recommendation of the Chartered Affiliates Committee, and approval by the Board of Directors of the Association.

SECTION 2. INTERNATIONAL
AFFILIATE ADMISSION PROCEDURE

The formal application for International Affiliate status shall be sent to the Executive Office of the Association and shall consist of a list of officers, membership, minutes of the organizational meeting, the Bylaws, and a letter requesting approval of the proposed medical advisor or advisors.
SECTION 3. INTERNATIONAL
AFFILIATE MEDICAL ADVISOR

Each International Affiliate shall have one (1) or more medical advisors whose name(s) shall be submitted to the Board of Medical Advisors.

SECTION 4. INTERNATIONAL
AFFILIATE DUTIES

A copy of the minutes of every meeting of the governing body and other business meetings of the International Affiliate shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meeting.

SECTION 5. SUSPENSION OR
REVOCATION OF INTERNATIONAL AFFILIATE STATUS

a. The Board of Directors of the Association may suspend or revoke the International Affiliate status with due and sufficient cause or upon the failure of an affiliate to maintain a membership of at least twenty (20) Foreign Members.
b. Action for the suspension or revocation of International Affiliate status shall follow approved Association policy and procedure.

ARTICLE XII - COMMITTEES

SECTION 1. STANDING COMMITTEES

a The standing committees of the Association shall be: Bylaws, Elections, Executive, Finance, Judicial, Program and Strategic Planning. The Chair and members of standing committees, not otherwise designated in these Bylaws or Association Policy and Procedure, shall be appointed by the President, subject to the approval of the Board of Directors. With the exception of the Elections and Bylaws Committees, committee terms shall be for two (2) years. The Chartered Affiliates Committee, as referred to in these Bylaws, shall be a standing committee of the House of Delegates.
b. Decisions of standing committees, except as specified in Article XII, Section 2 (a) (3), may be appealed to the Board of Directors. A two-thirds (2/3) vote of the Board of Directors shall be required to sustain an appeal.

SECTION 2. COMPOSITION AND DUTIES OF COMMITTEES

a. Bylaws Committee
1. The committee shall be composed of the Immediate Past President and four (4) additional Active Members of the Association elected by the House of Delegates. The House elect members shall serve two year terms. These terms shall be staggered, with two (2) members being elected each year. The Chair shall be the senior House elect member, who, between the two senior members, received the greatest number of votes cast by the House.
2. Proposed amendments to the Bylaws may be originated by the Bylaws Committee or submitted to the Bylaws Committee only by the Board of Directors, House of Delegates, or Chartered Affiliates. The committee shall review the amendments proposed by any of the foregoing bodies and shall submit its recommendations to the proponent. Upon receipt of such recommendations, the proponent may, but shall not be obliged to, withdraw the proposed amendments from further consideration. Any proposed amendments that are not withdrawn by

the proponent and any proposed amendments which are originated by the Bylaws Committee shall be delivered to the House of Delegates and the Board of Directors, with the committee's recommendations for same, at least sixty (60) calendar days prior to the date on which voting begins.

3. In the event of a problem with the interpretation of the Bylaws, the question shall be referred to the Bylaws Committee. Either the Board of Directors or the House of Delegates may refer a Bylaws interpretation matter to the committee by a two-thirds (2/3) affirmative vote. The decision of the committee shall be final.

b. Elections Committee

1. The committee shall be composed of six (6) Active Members; three (3) elected by the House of Delegates and two elected by the Board of Directors and the Immediate Past President. The Chair shall be selected by the House of Delegates.

2. The term of office for each member, except the Immediate Past President shall be three (3) years. The election of the members shall be staggered, so that no more than 50% of the membership changes each year.

3. The committee shall screen candidates nominated for Director, Officer, and Specialty Section Chair-Elect positions. Nominations for at-Large Directors shall be submitted to the committee only by the House of Delegates. Nominations for Section Chair-elect shall be submitted to the committee only by members of that Specialty Section. Nominations for Officers shall be submitted to the committee only by the Board of Directors.

4. The Chair of the committee shall report the slate of nominees to the Board of Directors and House of Delegates no later than June 1. The final slate of candidates shall be submitted to the Board of Directors and the House of Delegates before submission to the general membership.

5. The committee shall be responsible for preparing, distributing, receiving, and verifying all ballots. At least sixty (60) days prior to the Annual Business Meeting, ballots setting forth the slate of candidates shall be made available to Active Members of the Association in good standing. Only Active Members of a Specialty Section may vote for the Chair-elect of the Specialty Section. Provisions shall be made on the ballot for write-in votes for each office to be filled. Voting will close no less than thirty (30) calendar days prior to the Annual Business Meeting. Ballots shall be counted no less than twenty-one (21) calendar days prior to the Annual Business Meeting. The deadline date and time shall be clearly indicated on the ballot.

6. Association elections shall be determined by a plurality of the votes cast. A tie vote shall be decided by lot.

c. Executive Committee

1. The Executive Committee of the Board of Directors shall be composed of the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, Secretary-Treasurer, and in alternate years, the President-Elect.

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

d. Finance Committee

1. The Finance Committee is composed of the Executive Committee of the Board of Directors and the House of Delegates Treasurer and Speaker-elect. The committee shall be

chaired by the President. The committee shall submit for approval the annual budget to the House of Delegates and the Board of Directors.

2. The Audit Subcommittee shall consist of the Speaker-elect, who shall be the chair, the House of Delegates Treasurer, and one member of the Executive Committee appointed by the President. The Secretary-Treasurer shall be a non-voting member. The subcommittee is responsible for monitoring the financial affairs of the Association in cooperation with external independent auditors.

e. Judicial Committee

1. The committee shall consist of not fewer than four (4) Active Members.

2. The committee shall review membership challenges, or complaints against any member charged with any violation of the Association's Articles of Incorporation, Bylaws, standing rules, code of ethics, or other rules, regulations, policies, or procedures adopted, or for any conduct deemed detrimental to the Association. Such complaints must be filed with the Chair of the Judicial Committee. The committee shall conduct a review in accordance with established policies and procedures. Such policies and procedures shall be available to any member upon request.

3. If the committee determines in its sole discretion that the complaint warrants further action, a written statement of the charges shall be prepared with benefit of legal counsel if deemed advisable, and the matter shall be resolved according to established policies and procedures.

4. The member shall have the right to appeal the decision of the committee to the Board of Directors. There shall be no appeal from the decision of the Board of Directors.

f. Program Committee

1. The committee shall consist of not fewer than four (4) Active Members.

2. The committee shall prepare the program for the Annual Business meeting and all other programs, as directed by the President.

g. Strategic Planning Committee

1. The committee shall consist of not fewer than five (5) members. The chair shall be the Immediate Past President.

2. The committee shall make recommendations to the Board of Directors about the direction of the Association and the profession of Respiratory Care.

SECTION 3. COMMITTEE CHAIR'S DUTIES

a. The Chair shall perform those duties as specified by the President and the Board of Directors to carry out the objectives of the Association.

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

c. Members of any membership class, as well as non-members, may be appointed as consultants to committees. The President shall request recommendations regarding physician consultants from the Chair of the Board of Medical Advisors.

SECTION 4. SPECIAL COMMITTEES AND OTHER APPOINTMENTS

a. Special committees may be appointed by the President, subject to the approval of the Board of Directors.
b. Representatives of the Association to such external organizations as may be required shall be appointed by the President, with the approval of the Board of Directors.

SECTION 5. VACANCIES ON
COMMITTEES

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

ARTICLE XIII - FISCAL
YEAR AND BUDGET

a. The fiscal year of the Association shall begin on January 1 and end on December 31.
b. The annual budget proposed by the Finance Committee, shall be approved by the House of Delegates and Board of Directors before implementation.

ARTICLE XIV - PARLIAMENTARY AUTHORITY

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

ARTICLE XV - AMENDMENT

These Bylaws may be amended in accordance with Article XII, Section 2 (a) 2, if an amendment receives an affirmative majority vote of the Board of Directors and also receives an affirmative majority vote of the House of Delegates. The amendment must then be submitted to the membership for comments and input within forty-five (45) days of the first affirmative vote. After which the Board of Directors and the House of Delegates will have a second reading and vote. If the amendment receives an affirmative vote of two-thirds (2/3) of the Board of Directors and also receives an affirmative vote of two-thirds (2/3) of the House of Delegates, then it shall be adopted.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

New Orleans, LA • November 9, 2012

Minutes

Attendance

Karen Stewart, MSc, RRT, FAARC, President
George Gaebler, MSEd, RRT, FAARC, President-Elect
Toni Rodriguez, EdD, RRT, FAARC, Past President
Susan Rinaldo-Gallo, MEd, RRT, FAARC, VP Internal Affairs
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
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
Joe Sorbello, MSEd, RRT
Greg Spratt, BS, RRT, CPFT
Cynthia White, BA, RRT-NPS, AE-C

Excused

Lori Conklin MD, BOMA Chair

Consultants

Bill Lamb, BS, RRT, CPFT, FAARC, Past Speaker
Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Margaret Traband, MEd, RRT, FAARC, President's Council President

Guests

John Hiser, MEd, RRT, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Sam Giordano, MBA, RRT, FAARC, Consultant
Tim Myers, MBA, RRT-NPS, Associate Exec Director/Brands Management
Miriam O'Day, Legislative Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director/IT
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Kris Kuykendall, Executive Assistant

CALL TO ORDER

President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:30am CST, Friday, November 9, 2012. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

Ad Hoc Committee on 2015 & Beyond

Denise Johnson moved to accept Recommendation 12-3-32.1 "The 2015 ad hoc committee recommends increased access to baccalaureate degrees (either Bachelors Science Respiratory-Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the workforce, be readily available to access by established articulation or transfer agreements by 2015."

Lynda Goodfellow made a friendly amendment to replace "BSRT" with "Bachelor's degree from an accredited school of higher education in a health science field."

Fred Hill moved to refer amended motion to President-elect for further work and implementation.

Amended motion carried

Colleen Schabacker moved to accept Recommendation 12-3-32.2 "The 2015 ad hoc committee recommends the acquisition of the competencies approved at the July 2012 BOD meeting by segregating those required at entry level and those that can be acquired after entering practice by 2015."

Fred Hill moved to refer to President-elect for implementation.

Motion carried

Denise Johnson moved to accept Recommendation 12-3-32.3 "The 2015 ad hoc committee recommends that the AARC BOD recruit stakeholders who understand the issues, recognize the barriers, and are motivated to make the 2015 and Beyond efforts successful."

Linda Van Scoder moved to refer to President-elect.

Motion carried

President Stewart led a discussion regarding the document entitled "Suggested BOD Actions to Address Conference Recommendations from Transitioning the Respiratory Therapy Workforce for 2015 and Beyond". (See Attachment "A")

FM 12-3-32.1 Frank Salvatore moved to accept the suggested action on recommendation #1 from the 3rd conference "That this conference recommendation not be considered by the AARC Board of Directors for implementation until CoARC data indicates an adequate number of future baccalaureate graduates are available to satisfy future workforce demand as required by the following transition plan attributes:

- Maintain an adequate respiratory therapist workforce throughout the transition.
- Address unintended consequences such as respiratory therapist shortages."

Motion carried

FM 12-3-32.2 Bill Cohagen moved "That the AARC have a goal of 75% of respiratory therapists with a baccalaureate degree or higher by 2020."

Linda Van Scoder moved to amend the goal to 80%.
Motion defeated

Bill Cohagen amended the original motion to "That the AARC have an aspirational goal of a 25% increase of respiratory therapists with a baccalaureate degree or higher by 2020."
Motion carried

RECESS
President Stewart recessed the meeting of the AARC Board of Directors at 10:22am CST Friday, November 9, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 10:40am CST Friday, November 9, 2012.

FM 12-3-32.3 Frank Salvatore moved to accept the suggested action on recommendation #2 from the 3rd conference. "That action on this conference recommendation be postponed by the AARC Board of Directors until the impact of the NBRC's new consolidated written examination to be implemented in 2015 is evaluated."
Motion carried

FM 12-3-32.4 Linda Van Scoder moved to accept the suggested action on recommendation #3 from the 3rd conference. "That action on this conference recommendation be postponed by the AARC Board of Directors until there is objective evidence the CRT credential no longer adequately documents minimal entry level competency required to prevent patient harm as required by the following transition plan attributes:

- Require competency documentation options for new graduates.
- Support a process of competency documentation for the existing workforce.
- Assure that credentialing and licensure recommendations evolve with changes in practice.
- Address implications of changes in licensing, credentialing and accreditation."

Motion carried

FM 12-3-32.5 Frank Salvatore moved to accept the suggested action on recommendation #4 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president."
Motion carried

FM 12-3-32.6 Bill Cohagen moved to accept the suggested action on recommendation #5 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president."
Motion carried

FM 12-3-32.7 Mike Runge moved to accept the suggested action on recommendation #6 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president to appoint an ad hoc committee of experts to work with the CoARC to develop models of consortia and cooperative agreements for associate degree programs that wish to align with bachelor degree granting institutions by a date to be established by the president**.**"
Motion carried

FM 12-3-32.8 Linda Van Scoder moved to accept the suggested action on recommendation #7 from the 3rd conference "That the AARC Executive Office conduct a survey of CoARC accredited associate degree granting programs to identify those without existing bridges to baccalaureate programs ascertain their future plans about establishing these bridges and identify any perceived barriers. The results of the survey are to be reported in July 2013."
Motion carried

FM 12-3-32.9 Joe Sorbello moved to accept the suggested action on recommendation #8 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president."
Motion carried

FM 12-3-80.1 Joe Sorbello moved to ask CoARC to put a 5 year moratorium on all new associate degree respiratory therapy programs.
Motion carried (11 yes and 6 no)

Joe Sorbello moved to reconsider the motion.
Motion carried with two-thirds majority

Original motion defeated

RECESS
President-elect George Gaebler recessed the meeting of the AARC Board of Directors at 11:55am CST Friday, November 9, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 1:40pm CST Friday, November 9, 2012.

Linda Van Scoder moved to accept the Ad Hoc Committee reports as presented.
Motion carried

HOD Resolutions

HOD Resolution 06-12-03 "Be it resolved that the AARC investigate starting a public membership for patients and other interested parties."

Frank Salvatore moved to refer to Executive Office to look at the feasibility and report back in April 2013.
Motion carried

HOD Resolution 13-12-04 "That the AARC investigate the formation of an apprenticeship Program in partnership with the ARCF, for Respiratory Therapists who would like to learn from established researchers."

Frank Salvatore moved to refer to Executive Office to investigate and report back in April 2013.
Motion carried

Linda Van Scoder moved to accept the General Reports as presented.
Motion carried

FM 12-3-26.1 Bill Cohagen moved to accept, with edits and revisions, the White Paper on "Best Practices in Respiratory Care Productivity and Staffing". (See Attachment "B")
Motion carried

Denise Johnson moved to accept Special Committee Reports as presented.
Motion carried

OTHER REPORTS

ARCF and NBRC reports were reviewed.

Linda Van Scoder moved to accept the agency updates as submitted.
Motion carried

Unfinished Business
There was no unfinished business.

New Business
White Paper Review

FM 12-3-26.3 Frank Salvatore moved to refer the white paper entitled, "Development of Baccalaureate and Graduate Education Degrees" to the Position Statement Committee.
Motion carried

FM 12-3-26.4 Frank Salvatore moved to retire the white paper entitled, "Guidance Document on SARS" and place in the archives.
Motion carried

POLICY REVIEW

Policy No. BOD.015 – Board of Directors – AARC Stationery, Business Cards
Frank Salvatore moved to accept with new reviewed date.
Motion carried

Policy No. BOD.016 – Board of Directors Votes on HOD Recommendations
Frank Salvatore moved to accept with new reviewed date.
Motion carried

Policy CT.004 – Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations
Colleen Schabacker moved to accept with new reviewed date.
Motion carried

See Attachment "C" for all revised polices listed above.

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 2:25pm CST, Friday November 9, 2012.

Meeting minutes approved by AARC Board of Directors as attested to by:

_____ _____

Frank Salvatore, MBA, RRT, FAARC Date
AARC Secretary/Treasurer

Attachment “A”

Suggested BOD Actions to Address Conference Recommendations from transitioning the Respiratory Therapy Workforce for 2015 & Beyond

Suggested BOD Actions to Address Conference Recommendations from Transitioning the Respiratory Therapy Workforce for 2015 and Beyond

Transition Plan Attributes

The transition plan must:

1. Maintain an adequate respiratory therapist workforce throughout the transition.
2. Address unintended consequences such as respiratory therapist shortages.
3. Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc.)
4. Require competency documentation options for new graduates.
5. Support a process of competency documentation for the existing workforce.
6. Assure that credentialing and licensure recommendations evolve with changes in practice.
7. Address implications of changes in licensing, credentialing and accreditation.
8. Establish practical timelines for recommended actions.
9. Reflect the outcomes of the previous two 2015 and Beyond conferences
10. Identify the agencies most appropriate to implement identified elements.

Recommendations of the third conference publication:

1. That the AARC request CoARC to change by 7/1/12 accreditation standard 1.01 to read as follows:

    - 1.01 the sponsoring institution must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education (USDE) and must be authorized under applicable law or other acceptable authority to award graduates of the program a baccalaureate or graduate degree at the completion of the program.

      Programs accredited prior to 2013 that do not currently offer a baccalaureate or graduate degree must transition to conferring a baccalaureate or graduate degree, which should be awarded by the sponsoring institution, upon all RT students who matriculate into the program after 2020.

Suggested Action: That this conference recommendation not be considered by the AARC Board of Directors for implementation until CoARC data indicates an adequate number of future baccalaureate graduates are available to satisfy future workforce demand as required by the following transition plan attributes:

- **Maintain an adequate respiratory therapist workforce throughout the transition.**
- **Address unintended consequences such as respiratory therapist shortages.**

- That the AARC recommends to the NBRC on July 1, 2011, that the CRT examination be retired after 2014; And, that the AARC recommends to the NBRC on July 1, 2011 that the multiple choice examination components (CRT and RRT written) for the RRT should be combined after 2014.

Suggested Action: That action on this conference recommendation be postponed until the impact of the NBRC's new consolidated written examination to be implemented in 2015 is evaluated.

2. That the AARC establish on July 1, 2011, a commission to assist state regulatory boards transition to a RRT requirement for licensure as a respiratory therapist.

Suggested Action: That action on this conference recommendation be postponed until there is objective evidence the CRT credential no longer adequately documents minimal entry level competency required to prevent patient harm as required by the following transition plan attributes:.

- **Require competency documentation options for new graduates.**
- **Support a process of competency documentation for the existing workforce.**
- **Assure that credentialing and licensure recommendations evolve with changes in practice.**
- **Address implications of changes in licensing, credentialing and accreditation.**

3. That the AARC Executive Office request that the AARC Board of Directors ask the appropriate existing sections to develop standards to assess competency of RTs in the workforce relative to job assignments of the RT.
    a. Standards should address the variety of work sites that employ RTs.
    b. Standards should address RT knowledge, skills and attributes relative to the tasks being evaluated.

Suggested Action: Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president.

4. That AARC encourage clinical department's educators, and state affiliates continuing education venues to use clinical simulation as a major tactic for increasing competency levels for the current workforce.

Suggested Action: Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president.

5. That the AARC, in cooperation with the CoARC, consider development of consortia and cooperative models for associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.

Suggested Action: Refer this conference recommendation to the AARC 2013 president to appoint an ad hoc committee of experts to work with the CoARC to develop models of consortia and cooperative agreements for associate degree programs that wish to align with bachelor degree granting institutions by a date to be established by the president.

6. That the AARC provide budgetary resources to assist associate degree programs with the transition to baccalaureate level respiratory therapist education.

Suggested Action: Conduct a survey of CoARC accredited associate degree granting programs to identify those without existing bridges to baccalaureate programs ascertain their future plans about establishing these bridges and identify any perceived barriers. The results of the survey are to be reported in July 2013.

7. That the AARC BOD explores development and promotion of career ladder education options for the member of the existing workforce to obtain advances competencies and the baccalaureate degree.

Suggested Action: Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president.

Recommendations of the 2015 & Beyond Ad Hoc Committee

Recommendation 1

Education by Degree Focus - The 2015 ad hoc committee recommends increased access to baccalaureate degrees (either Bachelors Science Respiratory Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the workforce, be readily available to access by established articulation or transfer agreements by 2015.

Justification: The AARC clearly supports all associate-degree programs that are accredited by the CoARC. However, in order to maintain an adequate therapist workforce and avoid

unintended consequences of a shortage of respiratory therapists, multiple options and flexibility are required. Working with CoARC, model affiliation agreements between AS programs and BS programs are needed with mentoring assistance provided in the articulation process. Lastly, distance learning opportunities that provide flexibility for working therapists and the acceptance of experiential work experience should be thoroughly explored. This recommendation addresses recommendations 6 & 8 of the third conference.

Recommendation 2

Competency Level Focus –The 2015 ad hoc committee recommends the acquisition of the competencies approved at the July 2012 BOD meeting by segregating those required at entry level and those that can be acquired after entering practice by 2015.

Justification: If the competencies required at entry- level are identified, then the CoARC can incorporate them into their future standards which will assure that they are included into the curriculum of accredited programs. As these skills find their way into the workplace, the NBRC will eventually detect this through their job analysis and incorporate them into their credentialing examinations. This can be accomplished by the development of standardized curricula that incorporates the teaching of knowledge, skills and attributes (KSA's) necessary to acquire the competencies that can be acquired after entering practice. The content can be delivered through continuing education programs developed by the AARC; CoARC accredited respiratory therapy education programs, and other institutions that deliver education. In traditional courses, participants can gain the needed KSAs and competency documentation. Nontraditional programs can be used to deliver the educational content while the skill development and competency documentation can be conducted in laboratories of accredited respiratory programs or skills labs located in the facilities, or systems (high-fidelity), where therapists are employed. This recommendation addresses recommendations 4, 5 & 8 of the third conference.

Recommendation 3

Project Leadership Focus - The 2015 ad hoc committee recommends that the AARC BOD recruit stakeholders who understand the issues, recognize the barriers, and are motivated to make the 2015 and Beyond efforts successful.

Justification: Representation from CoARC accredited associate degree programs that have and don't have an articulation agreements as well as representatives from baccalaureate and masters (BSRT and MSRT) degree programs are urged to participate in order to successfully overcome barriers to higher education. Other professionals needed to guide the process are a distance learning specialist, representatives from CoARC and the NBRC, respiratory therapy employers from both the hospital and home care settings. As specific tasks are defined, additional volunteers will likely be required. This recommendation addresses recommendations 4,5,6 & 8 of the third conference.

Conclusion: It is essential that the AARC plan for the future and take steps to assure that we are prepared to assume the duties and responsibilities that may be required of the respiratory therapist in the years to come. By accepting these recommendations, the BOD is sending the message that you agree with the findings of the third conference supporting the need for more bachelor degree level therapists and the requirement that the transition plan conforms to the transition plan attributes.

Attachment “B”

White Paper – Best Practices in Respiratory Care Productivity and Staffing

AARC White Paper

November 8, 2012

BEST PRACTICES IN RESPIRATORY CARE PRODUCTIVITY AND STAFFING

This paper provides guidance and considerations in the application of the AARC Position Statement: **Best Practices in Respiratory Care Productivity and Staffing** adopted by the AARC Board of Directors in July 2012.[1]

Background and purpose

The provision of safe respiratory care is largely dependent on staffing adequate numbers of competent respiratory therapists (RTs). Understaffing puts at risk the welfare and safety of patients and may not allow care consistent with national guidelines and community practice. On the other hand, respiratory services represent a significant expense in the provision of health care and overstaffing respiratory therapists is neither productive nor efficient.

The 2012 AARC Position Paper regarding Respiratory Care Productivity and Staffing was approved and published to address growing concerns that inappropriate measures were being applied to determine the number of RT staff needed at a given institution. *This White Paper is intended to provide additional guidance to AARC members and to health care institutions and other providers to ensure that respiratory care productivity and staffing levels are provided within acceptable standards of practice recognized by the profession and that patient safety is protected.*

Considerations for rendering respiratory care

Medicare Hospital Conditions of Participation state that there must be adequate numbers of respiratory therapists[2], and other personnel who meet the qualifications specified by the medical staff, consistent with state law. Medicare Hospital Conditions of Participation further require hospitals that provide respiratory care services to meet the needs of their patients in accordance with acceptable standards of practice. “Acceptable standards of practice” as noted in the Hospital Interpretive Guidelines for State Surveyors include compliance with applicable standards that are “set forth in Federal or State laws, regulations or guidelines, as well as standards and recommendations promoted by nationally recognized professional organizations (e.g., American Association for Respiratory Care, American Medical Association, American Thoracic Society, etc.).”[2]

The documentation of competency in delivering respiratory care services may be assured by applicable state licensing boards and/or the attainment of respiratory

therapy credentials awarded by the National Board for Respiratory Care (NBRC). All respiratory therapists employed by the hospital to deliver bedside respiratory care services must be legally recognized by state licensing laws, where applicable, as competent to provide respiratory care services. For states that do not require licensure,

a CRT or an RRT credential from the NBRC should be required to assure documented competency and assure patient safety

The metrics described in this paper apply to the provision of care in which the RT provides direct oversight of care one patient at a time. Having therapists provide therapy to multiple patients simultaneously may be considered as a mechanism to reduce labor expenses. This practice denies patients the direct supervision of a respiratory therapist for the duration of treatment, thus diminishing quality and potentially placing the patient at risk. Medications delivered by aerosol and other interventions provided by respiratory therapists are noted to have serious side effects that require rapid recognition and corrective action, which can only be achieved by direct observation of the patient. The practice of providing therapy to multiple patients simultaneously diminishes the respiratory therapist's time needed to observe the patient's tolerance and compliance with the medication and to provide patient education. More to the point of this paper, when multiple patients are treated simultaneously, the time standard for the treatment is no longer valid because it is based on the assumption that the therapist remains at the bedside of each patient throughout the patient's therapy. Therefore, performing simultaneous treatments leads to reporting productivity values that are erroneously high.

Situation analysis and considerations

From a financial perspective, the over-estimation of staffing requirements leads to unnecessary and avoidable labor expenses. In contrast, understaffing may reduce salary cost in the short term, while producing more expense and lost revenue in the long run. Fiscally, there is much to be gained by staffing appropriately. Threats to revenue can result if prescribed treatments are not delivered and billed. Healthcare reforms associated with value based purchasing will affect reimbursement payments from Medicare based on both clinical outcomes and patient satisfaction. Thus, each institution should be financially motivated to assure adequate staffing for patients to receive appropriate care and avoid lengthy hospital stays or unnecessary readmissions. Further, missed and delayed treatments increase institutional liability.

Understaffing negatively affects respiratory therapists' morale because of inadequate time to provide needed assessments and care.[3] Low morale may result in increased staff turnover. These are compelling reasons to ensure adequate staffing in the provision of respiratory care.

Any metric, model, or system that is used to define respiratory staffing levels within institutions should recognize and account for all the activities required of a Respiratory Care Department in that institution. These activities vary greatly among institutions, and therefore must be determined on a case-by-case basis and approved by the medical staff and administration in individual hospitals.

Failure to account for all medically necessary interventions, or use of inaccurate metrics of workload, may lead to underestimation of staffing requirements. For instance: An exclusive focus on Current Procedural Terminology (CPT) codes (or other standards

based only on billable activities) can lead to the omission of a large number of non-billed activities from the estimated respiratory care workload. Similarly, relying on internal measures, such as Total Patient Days, Average Daily Census, Adjusted Discharges per Patient Day, and Nursing hours per patient day (which do not accurately reflect respiratory therapist workload intensity), can lead to the omission of important and necessary tasks that contribute to workload and thus provide erroneous estimates of required staffing.

The majority of clinical procedures conducted by respiratory therapists have not been assigned a CPT code. CPT codes describe procedures and services provided by physicians and other health care professionals who bill for reimbursement. However, relatively few have been assigned to procedures and activities provided by respiratory therapists. Examples of activities without CPT codes include but are not limited to:

- Airway Management Procedures
- Assessment/Screening Patients for Obstructive Sleep Apnea
- Assessment/Screening of Patients for Treatment
- Assessment/Screening of Patients for Invasive and Non-Invasive Ventilation
- Assessment/Screening of Patients for VAP
- Assessment/Screening of Patients for Weaning
- Cardio Version Monitoring of the Patient
- Continuous Oximeter
- Disease Management
- End Tidal CO2 Monitoring
- Endotracheal Tube Extubation
- Endotracheal Tube Repositioning and Securing
- Heliox Administration and Monitoring
- Incentive Spirometry
- Inpatient Sleep Apnea Monitoring
- Lung Recruitment Maneuvers
- Management of Patient Monitoring Devices
- Moderate Sedation Monitoring
- Nitric Oxide Administration
- Oxygen Administration and Monitoring

- Patient and Family Education, most instances
- Patient Transports Requiring Mechanical Ventilation or Airway Maintenance
- Rapid Response Calls
- Respiratory Care Consultations
- Spontaneous Breathing Trials
- Tracheotomy Management

In addition, there are additional activities required to support the safe and effective delivery of care that consume therapist time. Many of these support activities are required by regulatory agencies. These activities must also be accounted for and include but not limited to:

Calibration of Equipment
Cleaning and Stocking of Equipment
Clinical Instruction of Students
Cylinder Inventory Management
Department and Medical Center Meetings
In-service Attendance
Maintenance of Equipment
Patient Care Report/Handoff
Patient Care Rounds
Performance Improvement Activities
Quality Control of Devices and Procedures
Staff Education and Training

Recommendations for using metrics to determine staffing levels

- Workload metrics used to predict staffing levels must include all clinical and support activities that respiratory therapists perform, as stated in the AARC position statement. An organization must account for all activities that are driven by physician orders or medical staff approved protocols. If there is an obligation to perform the procedure, it must be used in determining required staff, regardless of eligibility for CMS payment. Clinical support activities should be included, such as labor law mandated paid breaks, shift report, participation in required training, or the need to safety test equipment.

- Because of varying time requirements for different respiratory care procedures, systems to determine staffing should be based upon statistically valid activity time standards for all the services provided by a department. Because of the significant variability in the nature and types of care rendered in treating patients in need of respiratory services, unweighted metrics such as patient days, billable procedures with CPT codes, total procedures, etc., should not be used to determine respiratory therapist staffing levels.[4]

- Relative value units (RVUs) have been adopted by CMS for physician reimbursement, and provide another mechanism to weight specific procedures.[5] An

RVU-based staffing program must be used with a department staffing plan that provides the ability to flex direct patient care staff based upon service needs. The assessment of work demand (by shift, by day or by hour), based on specific procedure volume and the associated RVU, should be used to drive staffing decisions in which staff can be added or reduced to match demand. Peer-reviewed, evidence-based research indicates that a daily, RVU-based, flex staffing system can meet staffing requirements for patient needs and reduce costs by approximately $250,000 per year (5 full-time equivalents, FTEs) in a 400-bed hospital.[6]

- When constructing a staffing system, the need for "core staffing" or "minimal staffing" should be determined. This means that some staff is always available to immediately respond to emergency situations such as cardiopulmonary arrest or attendance at high-risk neonatal deliveries. Core-staffing requires consideration and some level of exclusion from being managed through a flex staffing model.

- The literature documents that unscheduled respiratory care activities, such as emergency department procedures, patient transports, rapid response calls, etc., may account for up to 40% of the workload. Staffing should be provided for unscheduled procedures based upon historical data and work rate. Failure to include unscheduled procedures in staffing projections, or failure to recognize peak workrates during the day, result in drastic mismatching between work demand and labor supply.[7]

- Adequate fixed time should be budgeted for operation and support of the Respiratory Care Department for required activities such as mandatory education, department meetings, competency assessment, performance improvement projects, research, and patient safety initiatives. Fixed time should not be included in variable flexed staffing estimates.[8]

- Staffing adjustments, driven by any workload estimation system or benchmarking analyses must include a mechanism to assess the effects of staffing on patient outcomes. Monitoring outcomes like length of stay, COPD readmissions, missed therapy, delays in treatment, and other complications provide data to validate adjustments in staffing. Such monitoring may also minimize risk and improve the ability to provide quality and safe care.

Recommendations for using metrics for benchmarking

- Workload metrics used to predict staffing levels should be distinguished from *metrics used for benchmarking productivity*. Workload metrics used for benchmarking (i.e., the process of comparing performance among different departments for the purposes of identifying best practices) are often based on data that are easily captured through billing systems. Metrics based on such data reflect only a portion of the total workload. However, if properly selected to

represent the majority of the workload common to different departments, they are appropriate for the purpose of ranking productivity levels.

- Metrics are useful for benchmarking productivity only if they can be demonstrated to reflect the same activities in the departments being compared. Benchmarking metrics based on data representing partial departmental workloads are not appropriate for determining staffing levels (see above).

- Productivity metrics for which the source is undisclosed (common practice among external consultants) or including an arbitrary number of procedures is inappropriate and unacceptable. This type of data degrades the utility of the measures in proportion to the degree of mismatched activities among benchmarking group members.

Summary

The AARC urges organizations that offer Respiratory Care Services to work closely with Respiratory Care Department directors/managers and respiratory therapists to develop comprehensive and realistic metrics, staffing models, and benchmarks which are evidence-based and data-driven. Metrics used for staffing must capture the full range of activities required of respiratory therapists in order to ensure consistent, safe, cost-effective, and high quality care. Metrics used for comparing productivity among different departments may be based on a restricted range of activities provided that such activities are common to all the departments in the compare group.

Understaffing respiratory care services places patients at risk for unsafe incidents, missed treatments, and delays in medication delivery, as well as increases the liability risk for hospitals. On the other hand, appropriate staffing levels help assure that a consistent standard of respiratory care is provided throughout the hospital. Adequate staffing levels decrease the potential for error and harm by providing respiratory therapists adequate time to perform required functions and can contribute to greater levels of patient satisfaction.

Patient harm directly related to inadequate staffing must be reported to the appropriate state and federal regulatory agencies.

References

1. American Association for Respiratory Care Position Statement: Best Practices in Respiratory Care Productivity and Staffing 2012.

   (http://www.aarc.org/resources/position_statements/productivity_and_staffing.html)

1. 42 C.F.R. § 482.57 Condition of Participation: Respiratory Care Services.

2. Schwnezer K and Wang L. Assessing Moral Distress in Respiratory Care practitioners. Crit Care Med. 2006, Dec; 34 (12) : 2967-73.

3. Grady D, Smith T, and Collar L. A Comparison of Metrics for a Respiratory Care Department in an 800-Bed Medical Center. Respiratory Care, 2011 Oct; 56(10): 1703.

4. Dummit L. Relative Value Units. National Health Policy Forum. The George Washington University. www.nhpf.org, February 12, 2009, 1-5.

5. Grady D. and Smith T. Healthcare Cost Reductions Using a Daily, RVU-Based, Flex-Staffing System for a Respiratory Care Department. Respiratory Care, 2011 Oct; 56(10): 1703.

6. Chatburn RL, Gole S, Schenk, P, Hoisington E, and Stoller. Respiratory Care Work Assignment Based on Work Rate Instead of Work Load. Resp Care. 2011, Nov; 56(11): 1785-1790.

7. American Association for Respiratory Care. Uniform Reporting Manual. 5th Ed. Dallas, Tx, Daedalus publishers, 2012.

Attachment “C”

Policy No.BOD.015 – AARC Stationery, Business Cards
Policy No.BOD.016 – Board of Directors Votes on House of Delegates Recommendations
Policy No.CT.004 – Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **AARC Stationery, Business Cards**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2012

DATE REVISED:

REFERENCES: AARC Bylaws

Policy Statement:
Only authorized personnel shall use Association stationery and receive Association business cards.

Policy Amplification:

1. Officers and directors may be supplied with business cards indicating their position with the AARC, and their business title and contact information subject to approval of the President.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Board of Directors Votes on House of Delegates Recommendations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2012

DATE REVISED: July 2008

REFERENCES:

Policy Statement:
Resolutions brought by the House of Delegates to the Board of Directors shall be submitted, considered, and voted upon in an appropriate and timely manner.

Policy Amplification:

1. All resolutions from the House of Delegates shall be presented to the Board of Directors by the Immediate Past Speaker and/or a designee identified by the Speaker of the House of Delegates and approved by the President.

2. For a HOD resolution to be acted upon by the Board during the same meeting at which it is considered by the House, it shall be submitted in written form including the House-assigned resolution number by 12:00 noon on the final day of the Board of Directors' Meeting.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2012

DATE REVISED: July 2005

REFERENCES: AARC Bylaws, CT.001, CT.002, CT.003 and CT.004

Policy Statement:
Special Committees or Representatives to External Organizations may be appointed by the President to carry out specific activities, subject to ratification by the Board of Directors.

Policy Amplification:

1. The President may appoint a Special Committee, Task Force, Focus Group or Panel to complete specific charges related to the needs of the Association or the profession.

2. The Executive Director, Board of Directors, Board of Medical Advisors, House of Delegates, Chartered Affiliates, Specialty Sections or member may request that the President appoint a Special Committee, Task Force, Focus Group or Panel to perform specific charges.

3. In the event of vacancies occurring in Special Committees, Task Forces, Focus Groups or Panels, the President may appoint members to fill such vacancies, subject to ratification by the Board of Directors.

4. Representatives of the Association to such external organizations as may be required shall be appointed by the President, subject to ratification by the Board of Directors.

5. In the event of vacancies occurring in any representative position to external organizations, the President may appoint members to fill such vacancies, subject to ratification by the Board of Directors.

6. Trustees of the CoARC, ARCF and NBRC :

A. Shall not serve as voting members of more than one of the above identified organizations during any single term of appointment.
B. Presents and communicates the positions, policies and concerns of the AARC.
C. Desired qualifications include:

1) AARC Member for five (5) years.
2) Knowledge of AARC bylaws, positions, policies and philosophies.
3) One year previous experience at the AARC level, e.g., Board of Directors, House of delegates, special representative, committee chair or member.
4) Ability to communicate effectively.
5) For CoARC: Previous management/supervisory experience as faculty of a CoARC accredited respiratory care program.

DEFINITIONS:

ATTACHMENTS:

E-Motions

(Since Last Board Meeting in November 2012)

13-1-49.1 "That the AARC Board of Directors authorize the formation of the Palliative Care Roundtable."

Results – January 15, 2013
Yes – 15
No – 0
Abstain - 0
Did Not Vote – 2
The motion carried

13-1-10.1 Voting for one Board member to serve a three-year term on the Elections Committee. The nominees are: Karen Stewart and Bill Cohagen

Results – December 10, 2011
Total number of votes - 12
Abstain - 3
Did Not Vote – 2

Bill Cohagen is the Board representative for 3 years to the Elections Committee.

13-1-15a.1 "That the AARC Board of Director4s approves the membership of the 2013 Sputum Bowl Committee as recommended by the Program Committee:

Chair – Sherry Whiteman (MO)
Members – Kelli Chronister (OH), Tom Lamphere (PA), Diane Oldfather (MO), David Panzlau (MI), Rick Zahodnic (MI)."

Results – February 18, 2013
Yes – 15
No – 0
Abstain – 0
Did Not Vote – 2
The motion carried

13-1-39.1 Brian Walsh moved "to approve Charlie Friderici as the Chair of the Disaster Response Roundtable."

Yes = 17
No = 0
Did not vote = 0
Motion carried

13-1-81.1 Colleen Schabacker moved “to approve the appointment of Hyacinth Johnson as a replacement for Sue Meade to the NBRC Board of Directors.”

Yes =
Motion carried

General Reports

President Report

Past President Report

Submitted by Karen Stewart – Spring 2013

Nothing to report

Executive Office

Submitted by Tom Kallstrom – Spring 2013

Welcome back to Dallas and we hope to have a productive meeting. I wanted to update you on some of the work that the AARC Executive Office has been up to since we last met.

In January we welcomed our newest staff member Dr. Shawna Strickland who replaced retiring Bill Dubbs. Fortunately for the AARC she has hit the ground running. The leadership team at the executive office is also in the process of identifying areas of opportunities that will make the operations here in Irving more streamlined. As this becomes clearer we will share with the Board our changes.

Membership

As of the third week in March the member count is above 52,000 members. We will have a more specific number by the time of the Board meeting. The Membership committee's campaign has completed its first quarter (Dec. 2012-Feb. 2013). See Frank Salvatore's report for specifics. This year's campaign will run until the Congress where state affiliate winners will be announced.

Revenue Sharing/Co-Marketing

As of March 22nd there have been 32 states that have signed their co-marketing and revenue sharing agreements. One last reminder was sent out on March 22nd and I will report the current number at the Board meeting.

2015 and Beyond

As per direction from the Board of Directors a survey was distributed to the 423 identified program directors of CoARC approved respiratory care educational programs. During the two-week survey period (2/21/13-3/8/13), 223 program directors responded to the survey (52.7% response rate). See attachment

MEETINGS & CONVENTIONS

AARC Congress 2012 (New Orleans)

AARC Congress 2012 held in New Orleans was very successful for the Association. In total, more than 5,900 attendees, exhibitors, and patient advocates were in attendance. Despite a challenging economic climate in which fewer employers are providing financial assistance, strong attendance suggests our members continue to find value in our meeting.

The Program Committee continued to provide a diverse faculty for the meeting that included a balanced mix of seasoned, federal and international presenters as well as nearly 50 first-time speakers. For the first time ever, complimentary audio/video recordings were provided to all attendees as an added BONUS for their registration. This is a great value added feature that has been well received by those who attended the Congress.

2013 AARC Program Committee Meeting
The AARC Program Committee met in January to create the Program for AARC Summer Forum and AARC Congress 2013. Close to 800 individual lecture proposals were submitted for consideration.

The 3-day meeting concluded with a full Program developed for both meetings, and was inclusive of a pre-course(s) for SF, as well as Congress. We are now in the process of contacting potential speakers as well as developing post-graduate programing for both the Congress and Summer Forum.

AARC Summer Forum
The 2013 AARC Summer Forum will be held July 15-17 in Orlando, FL. The meeting will be held at the Renaissance Orlando at SeaWorld. Orlando traditionally has seen good attendance numbers for Summer Forum, and we anticipate that this new location in such close proximity to SeaWorld will continue that trend.

As in 2011-2012, the primary demographics for those who attend will also include hospital-based educators. This is a demographic that we have seen stronger support from and we believe will continue to attend if programmatic content is supportive of their needs.

A post-graduate course has been scheduled for AARC Summer Forum titled "*Clinical Preceptor and Inter-Rater Reliability Workshop: Clinical PEP (Practices of Effective Preceptors)".* There will be a nominal fee to attend this course.

AARC Congress 2013 (Anaheim)
Progress is well underway for the AARC Congress 2013 to be held in Anaheim, CA, Nov. 16-19, 2013. The program is well balanced and representative of all specialty sections and roundtables. Several formatting changes have been made to this year's Congress that will better meet the needs of our exhibitors and attendees. The exhibitor prospectus has been posted on the AARC website with several exhibitors have already committed to both booth rentals and sponsorships.

Corporate Partners
We are set to meet with our 2013 Corporate Partners immediately after the Spring BOD meeting has concluded. At the Corporate Partner meeting, our 11 Partners will hear AARC executive office staff provide an update on the state of the respiratory profession, AARC projects and meetings, and AARC legislative affairs. We will have two featured clinical presentations for the meeting, Dr. Russell Acevedo, FAARC, of Crouse Hospital in Syracuse, NY, speaking on: Lung Partner Project and Keith Lamb, RRT-ACCS will speak on the Future of the Critical Care RT.

2013 Partners: Carefusion, Masimo, Covidien, Monaghan, Philips/Respironics, Drager, GE Healthcare, Maquet, Teleflex, Boehringer Ingelheim, and Forest Pharmaceuticals.

Three companies have expressed interest in achieving Corporate Partner status in 2013 that would make them Partners in 2014. We have had good discussions with those companies and

will work to jointly achieve this status with them.

Website Project

We conducted a series of screenings and interviews in search of a company to assist us in the upgrade and reconstruction of new websites for AARC, YLH and ARCF. We have settled on a vendor and will begin work on modernizing and streamlining our web presence in the coming months. An aggressive timeline has been established to develop and implement the new websites before October.

PROJECTS UPDATE

COPD Toolkit

The COPD Toolkit is complete and received legal approval from its sponsor in late 2012. The project is now in its Beta-testing phase with roughly 15 hospitals evaluating the toolkit for effectiveness in teaching patients about their disease and in better self management strategies. This beta-test will conclude in May and data will be analyzed, after which, the Executive Office will determine next steps. Potential options include, but are not limited to a more robust, multi-centered study, or to commercially release the product to members via the AARC Store.

Completion Timeline: Data Collection – June 1, 2013

Humidified Heated High Flow Nasal Cannula Research Protocol

The research protocol is complete. A template of an IRB application specific to this technology was vetted through an independent 3rd party and released to AARC members. The IRB template is customizable depending upon the unique needs or study design of any researcher. This project was developed with the intent to promote research specific to this technology (robust scientific evidence is currently lacking). Members have been encouraged to present findings at the AARC Open Forum and subsequently publish their data as a manuscript to RESPIRATORY CARE.

Completion Timeline: Completed

ACCS Prep Course

Faculty (all RTs possessing the credential) has been identified for the course with content that mimics the ACCS matrix provided by the NBRC. Fourteen different content areas have been identified and faculty has been assigned accordingly.

1-2 courses will be hosted to determined member demand and refine presentations. Assuming demand is strong, AARC intends to take the course to studio for professional recording, of which will be added to our educational digital portfolio.

Completion Timeline: Live Courses – Dec. 31, 2013
Studio Recordings: 2014

Nutrition Resource Guide
An unrestricted educational grant has been received to develop an educational resource guide for the respiratory therapist regarding the importance of nutrition and the impact (or lack thereof) it has on the cardiopulmonary patient. This document will have a similar look and feel as that of the Aerosol Delivery Guide for Respiratory Therapists.

Faculty has been identified with project objectives communicated and agreed upon.

Completion Timeline: AARC Congress 2013

Guide of Aerosol Delivery Devices
We received a grant from Phillips to write a third edition to the RT Guide as well as a second edition for the guide for physicians, nurses and pharmacists, as well as the patient guide. All three guides have been edited and are now available for members.

Clinical Practice Guidelines
Evidence-based CPG for airway clearance: non-pharmacologic interventions is ongoing. The committee is working with the Evidence Practice Center at Vanderbilt University in Nashville, TN. Phase 1 (systematic review) is complete and we are in the midst of phase 2 (grading the evidence and writing the recommendations). Once the recommendations are completed, the CPG will be submitted to the RESPIRATORY CARE Journal for publication. The majority of the existing committee may be committed to the next evidence-based CPG, which will focus on airway clearance: pharmacologic interventions. It is expected that the next CPG will take less time though the cost will be comparable to the first. Cost is based on amount of evidence for the review, time commitment of the EPC staff, and amount of responsibility from the EPC versus the committee.

Advocacy
Adult Ventilator Associated Events (VAE)
As you know the AARC has been an active participant in the CDC's Ventilator Associated Event Subcommittee. Dr. Dean Hess is our representative to the adult portion of this. The CDC working group has prepared a paper that is currently under review at Critical Care Medicine. They have asked us if there is a desire to publish the paper in Respiratory Care journal in an effort to increase exposure to this important change in practice.

Pediatric VAE Group Update.
This group was formed several months after the Adult VAE group and is currently still in discussions. Some of which include:

- The group recently voted whether to conduct surveillance by unit or by age of patient. They are consulting the adult group to confirm that adult patients in a pediatric unit would follow pediatric surveillance measures and adult ICU's with pediatric patients would be able to include pediatric patients in their adult measures or be dropped.
- Discussion is currently on what types of diagnostic tests they will use for evaluation in the definition, protected brush specimen etc.
- There is consideration regarding writing a white paper about this process with an emphasis on what research needs to be done to confirm if we are on the right track for

choosing the right method for surveillance.

CMS

In mid March the AARC collaborated with leadership of NAMDRC and ACCP in a meeting at CMS. The purpose of which was to discuss our concern regarding the recently published Local Coverage Determination for Tracheostomy Care Supplies. In this CMS has changed its coverage from 29-day changes to 90-day changes of tracheostomy tubes. Kathy Deakins, RRT FAARC and Anne Marie Hummel were present at this meeting. CMS asked for more information before a decision to reverse this could be made. We will continue to work with the other associations to get this reversed.

AACVPR

At the AARC Boards direction we were asked to contact the American Association of Cardiovascular and Pulmonary Rehabilitation. In February a conference call was arranged with their leadership. The call was as expect in that they would like to have a closer relationship with the AARC due to our aligned interests in pulmonary rehab. Moving forward we agreed to establish a speaker swap for an upcoming meeting included in this will be complementary booth exchanges at our Congress and at their annual meeting. We will also be sharing links with AACVPR. There was also interest in working with us as we plan for an upcoming Diagnostics section webcast. At some point in the future we will also work with them to get input for a future AARC Times article.

Spirometry Training

Since our fall Board meeting, we have concluded two different grants. The BI grant to train their Clinical Science Consultants to teach Office Spirometry expired at the end of the 2012. We were successful in getting the grant extended for 2013 and are implementing the training update for CSC's as well as developing material for the Office Spirometry renewal process for the candidates.

The Spirometry Quality Assurance program for the Forest clinical trial ended on Feb 28, 2013. We have been asked by Forest to respond to a request to provide similar services for a new grant. This grant is projected to run 3 years and have about 5 times more participating sites. It is projected to start in May 2013. We are in the process of responding.

DRIVE4COPD

Jason Moury, RRT is the AARC's Drive4COPD Campaign Coordinator. This was made possible by a grant from COPD Foundation. He started in this position in December 2012 and has been very active in reinvigorating our Adopt a Company Campaign. In the first two months of 2013 there were three Drive4COPD events. At each of those events we have screened people for their risk of COPD utilizing the DRIVE4COPD material. Over 3,000 have been screened

Some of the Drive4COPD's recent activity include:

- Identification of the top 10 states that would benefit most from the Adopt-A-Company campaign. (Arkansas, Kentucky, Maine, Mississippi, Nevada, Ohio,

Oklahoma, Vermont, West Virginia, and Wyoming). These states were identified based on the data from the most recent Behavioral Risk Factor Surveillance System (BRFSS) and the mortality rates published from the CDC.

- Developed new Adopt-A-Company material for the members to use when adopting companies. This includes new updated letter templates for management, flyers, brochures, COPD fact sheets, and media inquiry templates.
- Working with Executive Office to develop a new Adopt-A-Company website for members to go to when adopting a company. Website went live on March 15th.
- Developed new prizes for participating members of the AARC who adopt companies between March and November in 2013. Grand prize includes (2) VIP access tickets to the Daytona 500 and the DRIVE4COPD 300 races in February 2014. There are other prizes of free COPD Educator courses from the AARC that will be given to members who screen a predetermined amount of employees through the Adopt-A-Company initiative.
- Actively trying to recruit members from the various societies to appoint at least one person from each to be the state's Crew Chief. This person has two primary roles, first is to be a local resource if a fellow member has questions about the DRIVE4COPD. Second, they are to recruit other members to participate in the DRIVE4COPD.

Products

Benchmarking continues to maintain its foothold in approximately 130-140 hospitals around the US and in Saudi Arabia (3). The Benchmark Committee is currently conducting an assessment of the program and possible upgrades to ensure it is a current and valued tool to its participants. We are also reviewing the pricing structure for 2014 to ensure that has a good ROI for both the AARC and its participants.

As you are aware, in 2012 we outsourced our Respiratory Care Week products to a third-party supplier, Jim Coleman Ltd that handle all products and the necessary shipping. We reviewed the program's successes, weaknesses and opportunities and will continue this outsourcing in 2013 with some minor revisions.

As we gather for the Spring BOD meeting in Dallas, we are set to release updated versions of all 3 of our Aerosol Guides (RT, Non-RT Clinicians and Patient). These revised guides will again be release in a limited print format, download versions as pdfs and as an ePub for the Aerosol Guide that will be viewable on digital readers. In conjunction to the aerosol guide releases, we are exploring a relationship with a software developer and a group of clinicians on a joint venture in this arena for interactive software and apps.

We continue to work to acquire sponsorships for our various educational products to offset expenses. At the time of this report, we have acquired 4 sponsors with Professor's Rounds and are close to finalizing sponsors for 3 others. Webcast sponsorship acquisition is moving a little slower at this time. We have also introduced a new product in this area with Webcast specific for Editor's Choice publications in Respiratory Care with the first being completed in March with over 300 participants. We have applied for a branded trademark for these and should hear back on our application for a trademark by the Summer BOD meeting.

As we continue to review our product offerings, we have engaged in the review, revision and update on our patient, disease and professional brochures that we have sold for many years with great success for health fairs, RC Week and other community events. The current items have been used for approximately 6 years and are in need of a good refresh. We expect to have the updates available by early fall.

We continue to work with our project consultants on our Competency videos and assessment program. We currently have 5 specific competency videos with accompanying check-off lists available for hospitals and education programs. We have also received interests in these products from some nursing organizations.

We are also currently conducting an overall review of our educational products both online and print for their clinical relevance and pricing, as well as potential for new product development. As part of this review, we are also exploring the opportunities for packaging of products and licensing agreements to increase our flexibility to offer these products to a wider audience in an affordable manner.

Finally, we are looking at a variety of new product lines for Daedalus that will coincide with the mission and vision of the Respiratory Care Journal. The previous mentioned Editor's Choice webcast are an example and other products will include a line of products that are published in an ePub format for digital readers.

Publications

RESPIRATORY CARE Journal

We continue receiving manuscript submissions at a record pace. In 2012 we received 150 submissions more than in 2011 and 310 more than in 2008. There are days now when we get 5-7 submissions and some of us are old enough to remember when we would 5 submissions in 6 months.

Since our last report the Journal successfully launched a new website hosted by HighWire at Stanford University. With features including a more robust search engine, enhanced linking capabilities, more frequent ePub articles, and the ability to download figures as PowerPoint slides, the site is as good as it gets and comparable to the sites of all medical journals available on the Internet. You can find the information you need faster and more easily than ever before, and fitted for desktop computers, laptops, and tablets.

In January we launched the mobile-optimized site for all smartphones, followed by the launching of the app for iPad, iPhone and iPod on March 1. The mobile site and the app offer AARC members and subscribers just about all the features available in the new website, including access to archived issues, weekly ePub of articles accepted for publication but not to appear in the Journal until a few months later, podcasts, abstracts, and view complete full text articles in HTML or as a PDF. The app also allows for full download of the entire issue in about 10-15 seconds…you can now carry and read the Journal even when you don't have an Internet connection.

In summary, the Journal is well entrenched in today's technical world and it should continue to get better, help improve patient care, and offer more useful information to AARC members and subscribers.

As mentioned in previous reports, we continue to be disappointed with the small number of members that take advantage of "CRCE Through The Journal." To offer this service is tedious and time consuming and in our opinion, no worth the valuable staff time needed to get it done. Shawna Strickland is working hard at trying to get better results. Any thoughts on what may done to have members more interested on the program or stop offering it would be highly appreciated.

IT

The technology refresh is continuing. We will be signing a contract for the website re-design. This will require us to do a lot of content review to make sure that any content that gets moved to the new website is still accurate. As one would imagine, there is a lot of data that has been put on the site since the first version went up in 1995. We will be recruiting RTs to do content reviews to make sure all of the information is still relevant and correct.

We have completed the desktop virtualization portion. The majority of the staff is now on a virtual desktop. The exceptions are a few Mac users. As you can see from the attached summary, we continue to stay under budget on our updates. The reason is that much of the technology we specified has come down in price.

We are on target to complete the required PCI compliance assessment by our processing bank's August 31 deadline. The biggest remaining items are isolating guest and BYOD (bring your own device) connections to a separate network, and code review of webpages. The webpage code review is an automated process that will be run after the new website is in place. It is part of the penetration testing that we have been doing for the last 2 years to find potential vulnerabilities in our webpages. We have already addressed most of the vulnerabilities found in the tests.

Advertising and Marketing

Advertising

Advertising continues to be in a state of flux with many changes in the industry and with our advertising base. At the time of this report, advertising is slightly ahead of target for Resp Care Journal and behind target for *AARCTimes* on the print side. This comes despite efforts to create a flexible portfolio of opportunities.

We continue to develop and grow our platforms in the digital advertising environments. With the new Highwire platform for the Journal, we have introduced a portion of our digital advertising opportunities on the new platform and will introduce more in the future.

We have signed 3 sets of agreements with a digital advertising firm, Multiview (Las Colinas,

TX), to procure digital advertising for our various digital and on-line platforms. Multiview has been in the digital advertising arena for over 15 years and works with over 1400 associations. In addition, we will also be utilizing Multiview's on-line platform to host our Consumer and Buyer's Guides. The final agreement will focus on digital newsletters and advertising and will be used to introduce some new product lines.

Marketing

We have purchased a software package, *Informz*, which integrates with our IMIS membership database to provide a broad-based set of marketing and business intelligence tools to assist us in analyzing our marketing endeavors. The package includes software for: e-mails, digital advertising monitoring for emails, on-line surveys and voting modules.

With the implementation of the *Informz* software packages, we will also be developing some new digital product lines from both an e-mail and digital advertising standpoint.

I look forward to meeting with you and should you have any questions after reading this please be sure to give me a call. I can expand on any of the information that has been provided to you either before or at the Board meeting.

Recommendations

Recommendation: That up to $3,000 be allocated to convert AARC historical materials into appropriate formats compatible with current technology (see concept paper below).

Justification: Over the past 65+ years, the AARC has accumulated photographs and materials with historical relevance to the profession and our Association. The historical materials are in a variety of formats such as VHS tapes, cassette tapes, paper documents, and photographic prints.

Recommendation: That the AARC Board of Directors endorse the attached document Clinical Practice Guidelines for Quality Palliative Care (see attached).

Justification: The AARC was approached to offer comment and to endorse the Clinical Practice Guidelines for Quality Palliative Care from the National Consensus Project for Quality Palliative Care. Upon review we found it to be well written and all encompassing. However it neglected to mention the role of the respiratory therapist in a variety of areas. After a call they agreed with our concern and resubmitted for our endorsement the attached. As you can see the role of the respiratory therapist has been included as part of the palliative care team.

Concept Paper for a Respiratory Care Museum

Last year the American Association for Respiratory Care observed its 65th anniversary. As our community, as well as our profession, ages, it becomes all the more imperative that we begin the development of a museum for the respiratory care community. Fortunately, we still have many pioneers still alive, and due to the efforts of AARC's historians we have video and audio taped interviews of persons identified as pioneers in our field but have passed on. Moreover, as the profession, the Association, and the community ages we tend to accumulate a large number of historical documents concerning the evolution of respiratory care clinical interventions, thought leaders, and pioneers who envisioned the profession long before we earned the right to call ourselves professionals. The foregoing factors, along with the veritable explosion in the respiratory related technological sector, provide us with an opportunity to organize virtually all items of historical relevance to the profession and the community in order to preserve our history and reignite pride in our profession and create a worldwide open access route to our historical materials through the museum.

Web-Based Museum

We propose that the museum be web-based thus affording all internet users access to the museum. This will then allow access to the museum contents by researchers, students, respiratory therapists, and physicians to view firsthand the initiatives to improve respiratory care interventions by educating providers, leveraging technology, and establishing the infrastructure necessary to continue such efforts beyond our first 65 years.

Museum Organization

Given the limitations of this concept paper, we offer the following as examples of what the virtual museum will contain and how it will be organized.

We will use a system of "rooms" or "halls" focusing on a specific theme. For example, we can have a hall that focuses on our infrastructure. In it, we will find documents, photos, audio and video relating to the inception, formation, and evolution of the interrelationships between AARC, NBRC, CoARC, etc.

We will have another "hall" that may focus on the evolution of aerosol drug delivery from the pre-Colombian "smoke blowing" etching all of the way to the 21st Century and beyond. Other halls will be dedicated to the evolution of ventilatory support, technology, education, etc.

We also hope to have a special track to guide laymen through our museum. This track can then be used to promote recruitment into the profession by our educators and even high school guidance counselors.

Currently, AARC has thousands of documents and memorabilia. We need to convert these materials to a digital format as soon as possible in order to preserve them. This is an important first step that we must take in order to provide us with the time to organize the design, implementation, and administration of the museum.

As an aside, I think it is fair to say that we've had disappointing results when attempting to

solicit contributions from AARC's membership. Many of us have opined from speaking with members that simply do not relate to the many important projects and activities undertaken by ARCF unless it involves someone they know personally. I, therefore, propose that ARCF's Trustees consider adopting the Respiratory Care Museum for the purpose of solicitation of contributions from AARC members. I would estimate the cost to organize and establish the museum at an operational level would be approximately $50,000. I would also estimate the ongoing upkeep and maintenance expense and web hosting to be approximately $5,000 - $10,000 per year depending on the volume of new items reviewed and added to the museum on an annual basis. The foregoing costs are just estimates since we currently do not have universal agreement on museum concept or its organization. If the Trustees want to become involved with the museum as a funding source, we need to decide it at this meeting. We can then report our action to the AARC Board of Directors at its next meeting in April. If the Trustees vote in the affirmative, we can then recommend to the AARC Board of Directors that it establish a committee in collaboration with NBRC and CoARC to undertake completion of the final organization of the museum and cost out all activities necessary to make the museum operational, hosting it with its own URL but using AARC's IT resources.

Summary
I would like to add that we suggest putting a bit of a different twist on any solicitation efforts for the museum. Since fundraising amongst AARC members has been problematic, we propose that we set a goal (i.e. $50,000), describe the purpose of the fund, and then organize in collaboration with our sister organizations a solicitation effort with the caveat that we cannot begin to undertake the project until we have reached at least a 50% funding level ($25,000). This approach will keep the topic before our members and allow us to leverage communication networks within our State Societies, as well as sister agencies such as CoARC and NBRC. By putting the funding before the project, we create a sense of urgency. Indeed, we may return to the old days and put up a classic thermometer to show the level our funding has progressed toward the goal. This approach is different than any we've tried before and may lead to larger contributions from the general AARC membership, albeit restricted to the purpose of the museum.

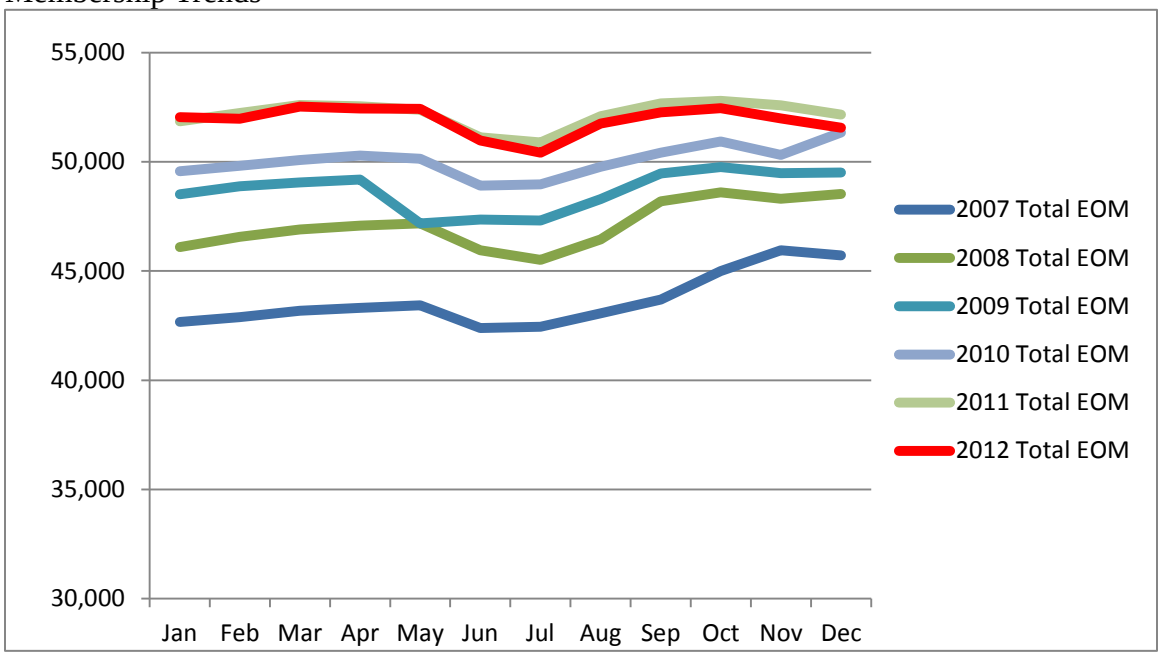
I have been collaborating with Trudy Watson, who is AARC's Historian, as well as Bob Weilacher, who is AARC's Past Historian. We are all in agreement with the foregoing concept description of the museum. If you have any questions, please feel free to contact me straight away.

2013 Professors Rounds and Webcasts

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

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

Membership Trends

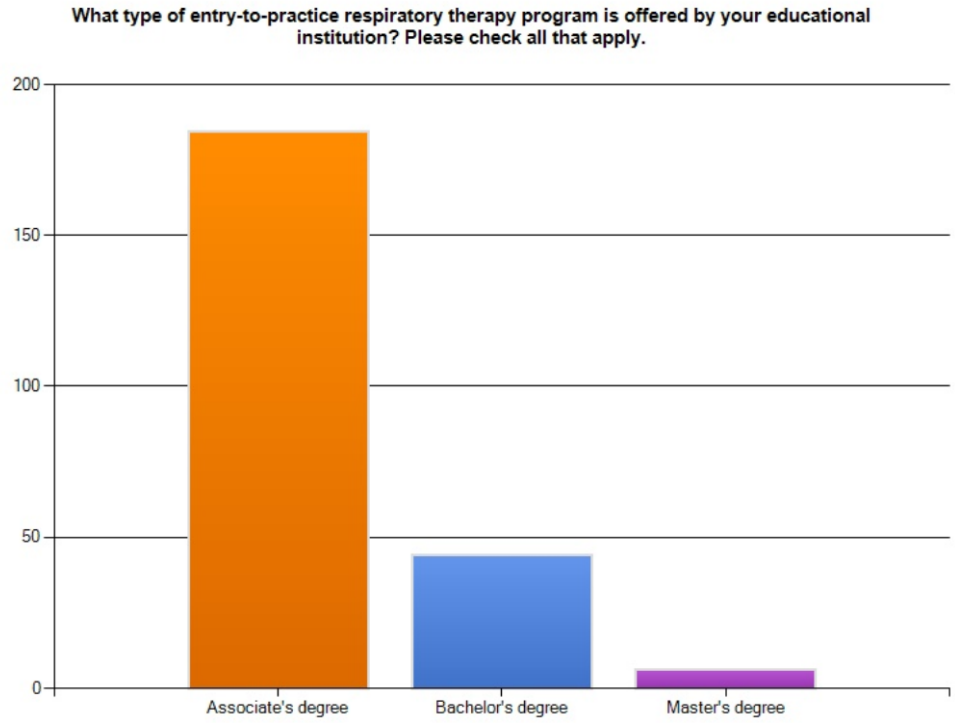


American Association for Respiratory Care
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.aarc.org, E-mail: info@aarc.org

DATE: 3/7/13
TO: AARC Board of Directors
FROM: AARC Executive Office
RE: Survey of CoARC approved respiratory care educational programs for the identification of academic resources

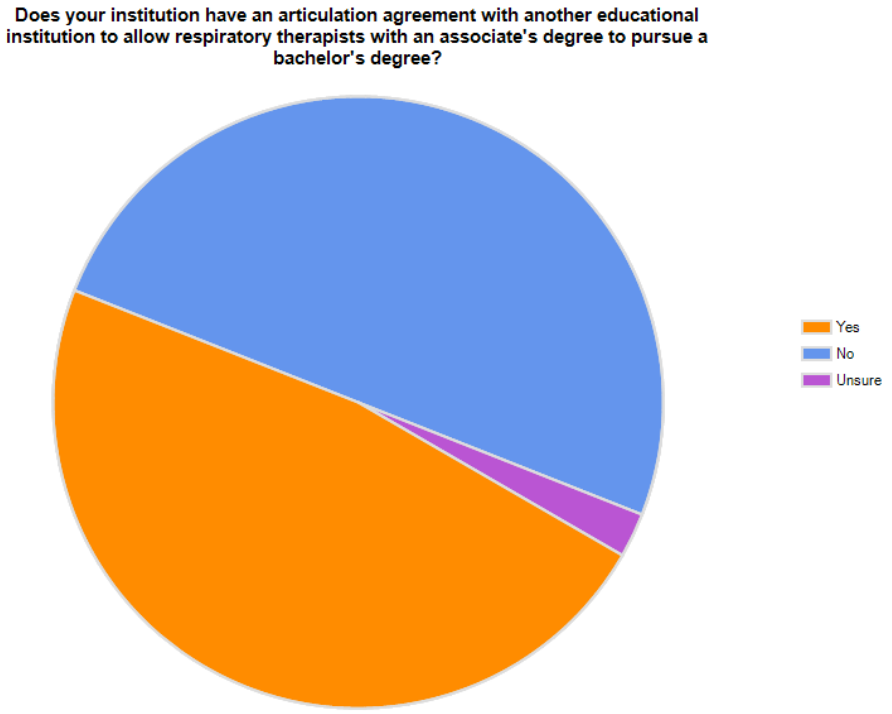
At the direction of the AARC Board of Directors, a survey was generated and distributed to the 423 identified program directors of CoARC approved respiratory care educational programs. During the two-week survey period (2/21/13-3/8/13), 223 program directors responded to the survey (52.7% response rate). The questions and responses are detailed in this report.

1. Please provide your demographic information.
   Programs from 45 states with CoARC approved programs participated. *N* = 218
2. What type of entry-to-practice respiratory therapy program is offered by your educational institution?
   Participants had the opportunity to choose more than one option as some programs offer more than one option for earning a degree in respiratory therapy. *N = 222*
   184 Associate's degrees
   44 Bachelor's degrees
   6 Master's degrees

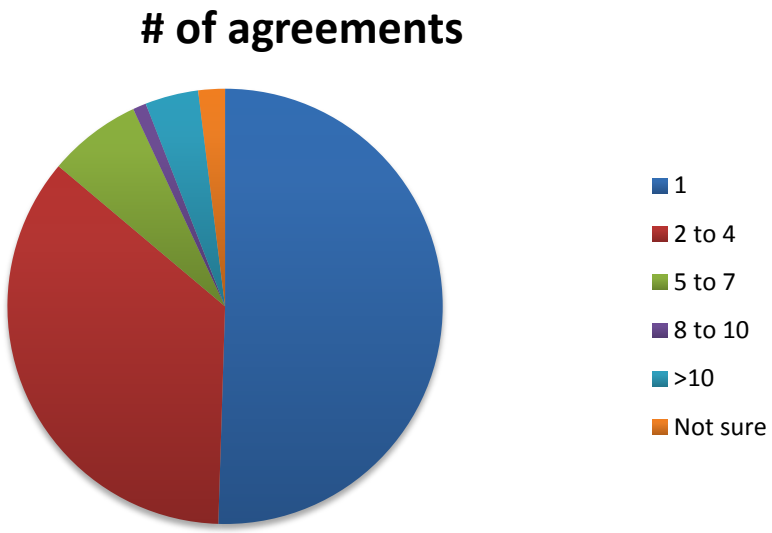


3. Does your institution have an articulation agreement with anot

4. Her educational institution to allow respiratory therapists with an associate's degree to pursue a bachelor's degree?
   N = 212
   101 Programs have at least one articulation agreement in place (47.6% of respondents)
   106 Programs do not have an articulation agreement in place (50% of respondents)
   5 Respondents were unsure if their respective program(s) have an articulation agreement in place (2.4%)

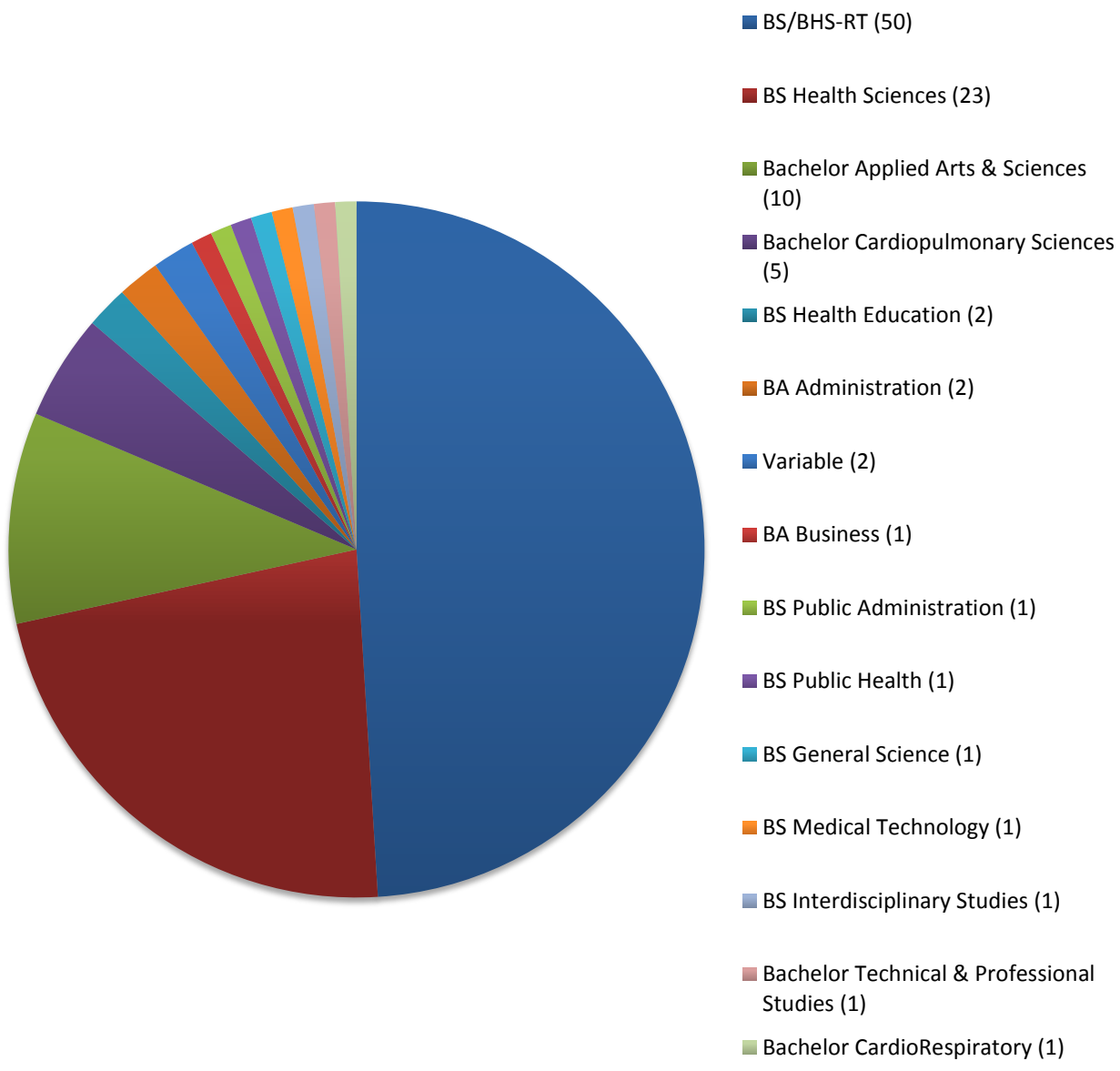


5. If you answered yes to the previous question, how many articulation agreements does your educational institution currently have in place?
   N = 101 (of the 106 respondents to "yes" in question #3)

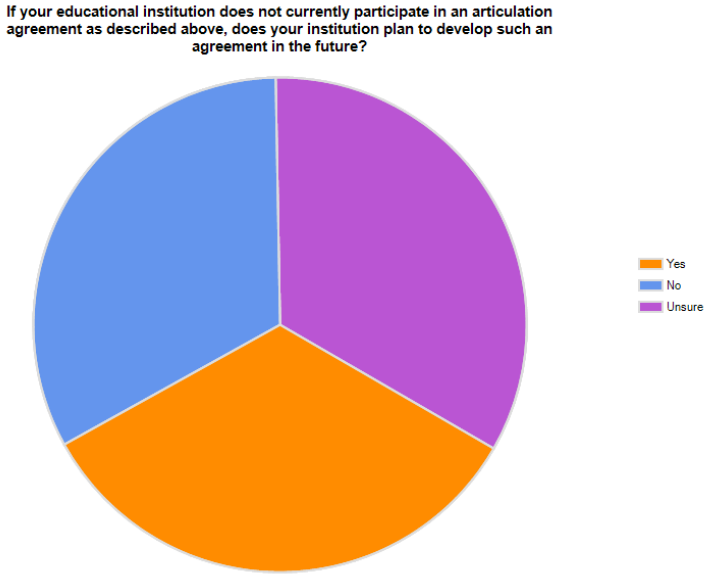


6. If your institution does participate in an articulation agreement as described above, in what major is the bachelor degree?
   N = 102

Bachelor Degree Majors



7. If your educational institution does not currently participate in an articulation agreement as described above, does your institution plan to develop such an agreement?
   N = 116 (Several written responses from those programs that already offer a BS or participate in an articulation agreement)



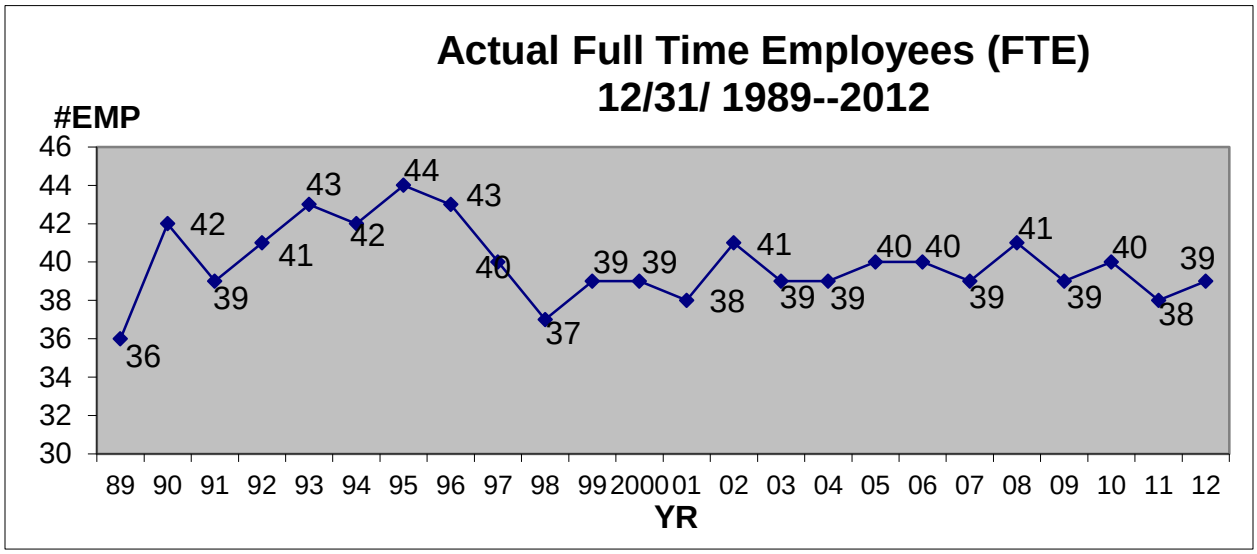
8. If your educational institution currently participates in or is currently developing an articulation agreement as described above, what, if any, barriers has your institution encountered?
   a. Does not fit the students' needs
   b. Cost of tuition
   c. Geographical location of the BS program (too far away)
   d. Communication (between AS and BS programs)
   e. Clinical access
   f. Academic council policy
   g. Length of time for the agreement process
   h. BS time requirement (of students) too demanding for working RT
   i. Quality (of BS program)
   j. Number of courses that will transfer to the BS program
   k. Types of courses that will transfer to the BS program (results in students re-taking courses)
   l. Time
   m. State legislature
   n. General education course difference between AAS and AS (AAS graduates need to take more general education courses to qualify for BS degree)
   o. No in-state options
   p. CoARC restrictions
   q. Lack of interest or willingness of BS program to participate
   r. Proprietary college courses do not transfer to universities (difference between regional accreditation and national accreditation)
   s. No salary incentive for RT to have BS over AAS
   t. Timing
   u. Funding for process
   v. Managers do not place a value on the BS
   w. Lack of interest from graduate to pursue higher degree

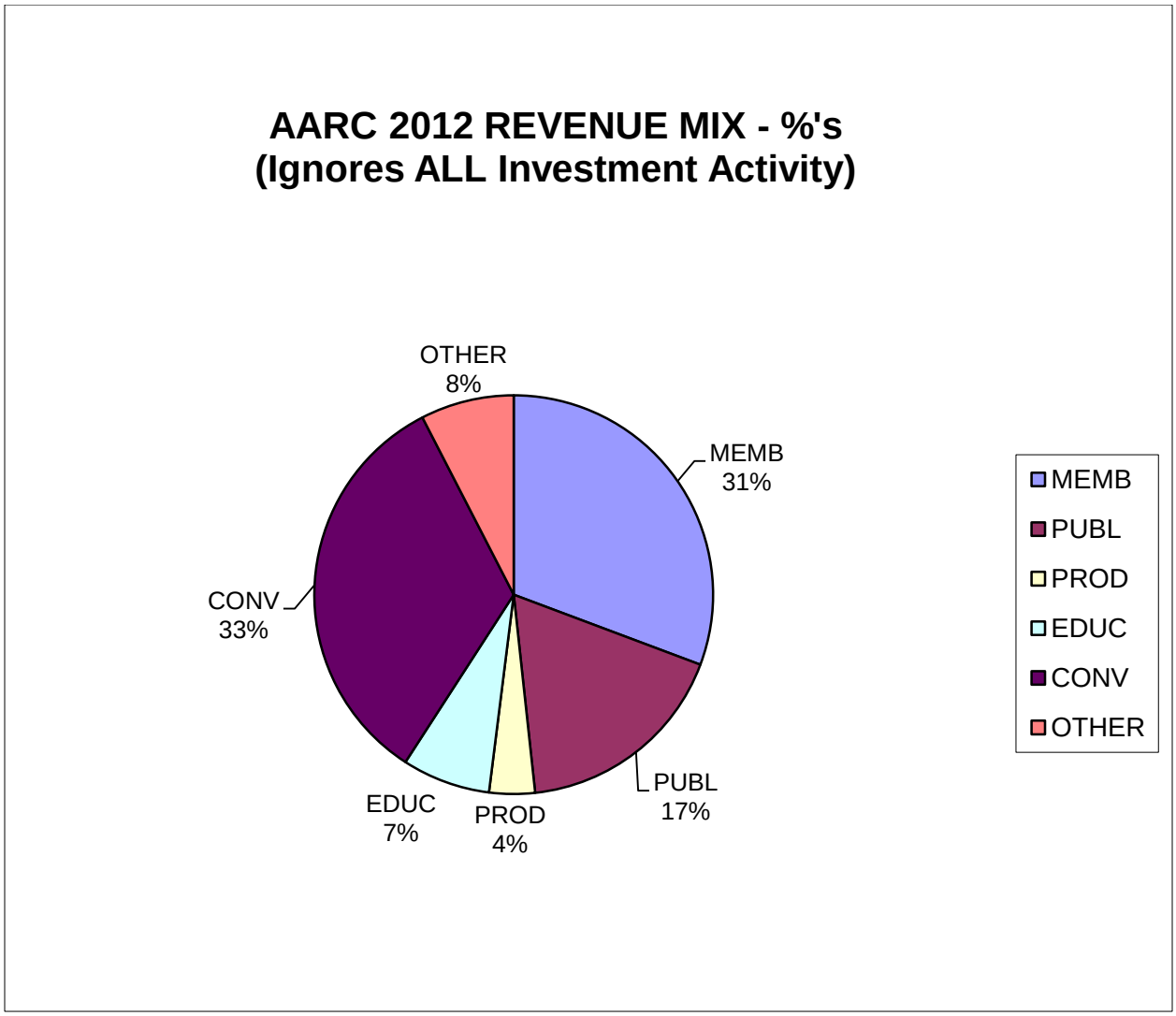
Recommendations:

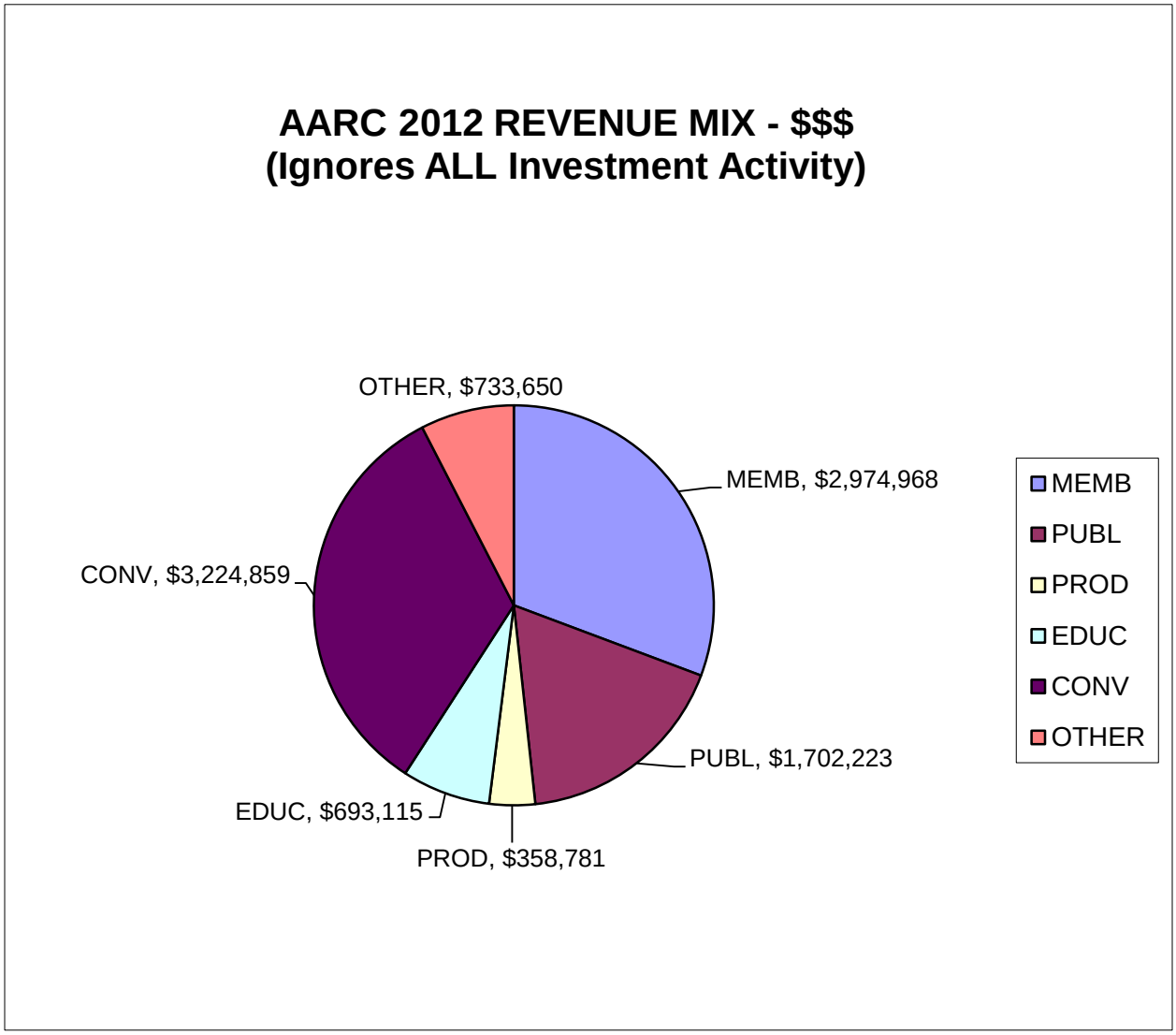
- Construct follow-up survey: Identify more targeted questions toward the resources necessary to encourage more articulation agreements (funding for release time, templates, etc).
- Recruit “best practices” from well-implemented articulation agreements (AS and BS perspective, templates, tips, etc)
- Release data from current survey to the program directors

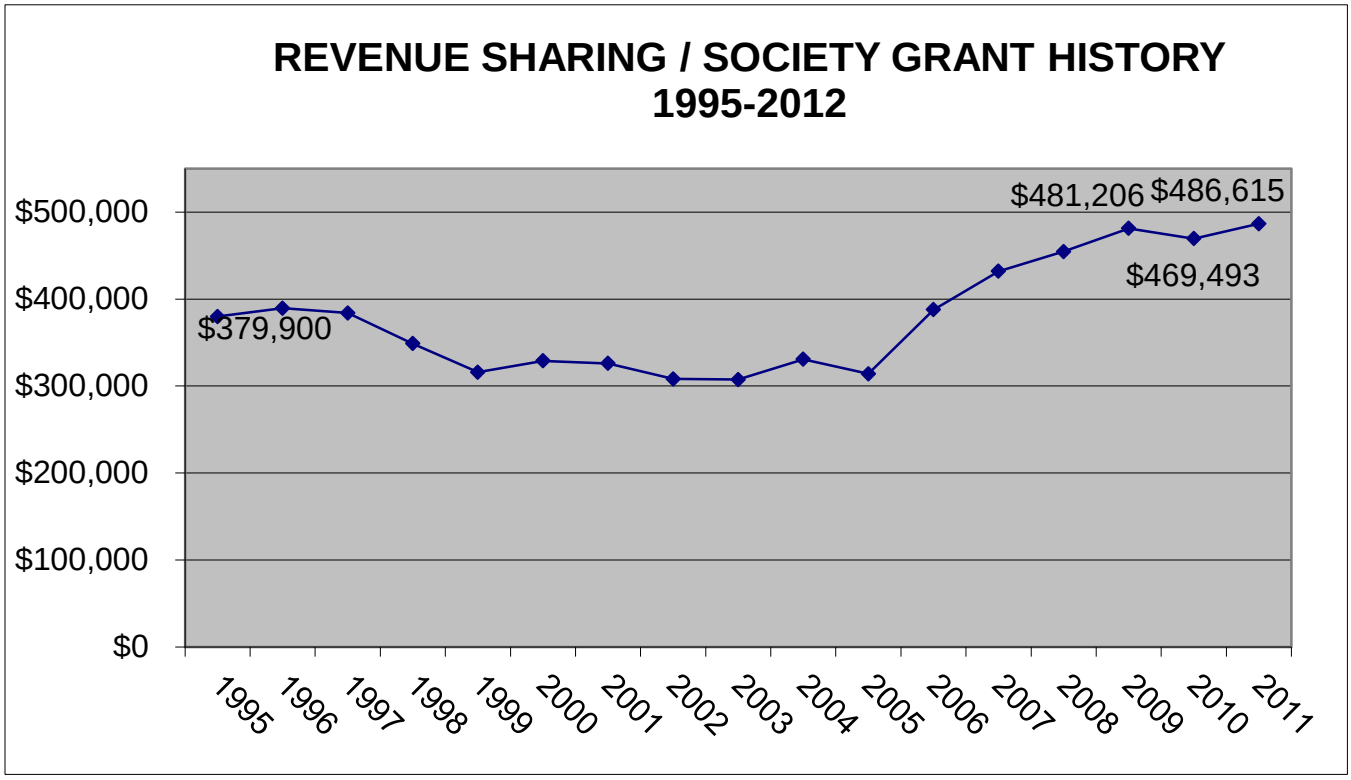
Respectfully submitted,
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC
Associate Executive Director
American Association for Respiratory Care


AARC MEMBERSHIP LEVEL-
20 YEAR HISTORY at DEC 31, xxxx
MEMBERS
55000
45000
35000
25000
35930
29574
49516
51282
52088
51519
1993
94
95
96
97
98
99
2000
01
02
03
04
05
06
07
08
09
10
11
12
YEAR


Actual Full Time Employees (FTE)
12/31/ 1989--2012
#EMP
46
44
42
40
38
36
34
32
30
36
42
39
41
43
42
44
43
40
37
39
39
38
41
39
39
40
40
39
41
39
40
38
39
89 90 91 92 93 94 95 96 97 98 99 2000 01 02 03 04 05 06 07 08 09 10 11 12
YR


AARC 2012 REVENUE MIX - %'s
(Ignores ALL Investment Activity)
OTHER
8%
MEMB
31%
CONV
33%
PUBL
17%
EDUC
7%
PROD
4%
MEMB
PUBL
PROD
EDUC
CONV
OTHER


AARC 2012 REVENUE MIX - $$$
(Ignores ALL Investment Activity)
OTHER, $733,650
MEMB, $2,974,968
CONV, $3,224,859
PUBL, $1,702,223
EDUC, $693,115
PROD, $358,781
MEMB
PUBL
PROD
EDUC
CONV
OTHER


REVENUE SHARING / SOCIETY GRANT HISTORY
1995-2012
$500,000
$400,000
$300,000
$200,000
$100,000
$0
$379,900
$481,206
$486,615
$469,493
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011

CoARC Report

Submitted by Tom Smalling – Spring 2013

See Attachments:

"CoARC Update to AARC 4.13"
"2012 CoARC Report on Accreditation 3 23 13"

State Government Affairs
Activity Report – April 2013

BOD April 2013
Cheryl A. West, MHA
Director Government Affairs

Introduction

Most state legislatures came back into session in early January. The budgetary issues facing the states over the last several years are still the foremost agenda items that must be dealt with, even with the signs of a slow economic recovery. The re-election of President Obama settled the question whether or not the provisions Affordable Care Act (ACA) aka Obama Care, ruled Constitutional by the Supreme Court last year would continue to be implemented. The key and most controversial provision which was the focus of the High Courts' ruling was the requirement that nearly all Americans have health insurance starting in 2014. A key component for this mandate is to assure that health insurance "packages" will be available for employers and individuals to select from. The list of available insurance choices that meet general mandated criteria are called Health Exchanges.

State governments can choose to develop their own Exchange network, develop an Exchange in partnership with the Federal government or opt to let the Federal government create in its entirety an Exchange for their state. There have been many bills in many legislatures that advocate all three positions. Regardless, the Exchanges are due to be up and running by October 1, 2013 when businesses and/or individuals are supposed to be able to select a health insurance program.

Another key issue that state legislatures are addressing is whether to accept yet another provision of the ACA, that is the expansion of Medicaid eligibility. The Supreme Court decision did rule that this was an option, not a mandate for the states. Under this now optional provision, the federal government will pick up 100% the cost of the Medicaid expansion for the first 3 years and thereafter 90% of the costs.

Respiratory Therapy Licensure

Last year saw two serious efforts to repeal state licensure for the RT profession: **Michigan and Indiana.**

As noted in previous Board Reports, this state effort was not solely directed at the RT profession, but included numerous other licensed professions that were under scrutiny and debate.

In **Indiana** the final decision from the state agency was to continue RT licensure.

Until mid-March of this year the de-licensure issue in **Michigan** had not moved forward over the past 6 months. Most believed that the Michigan Governor's report that listed 18 professions to be "de-licensed" including RT remained quiet due to the impending November 2012 elections.

Most speculated that the potential backlash politicians running for office would face from impacted professionals prevented the process from moving forward in the legislature.

However, now with the elections over this issue has been placed on the legislative front burner. Preliminary hearings in key committees included an "expert" who represents a Libertarian organization, opposed to licensure, the rationale being it infringes on individuals rights and access to employment. The mere fact this individual was invited to speak before legislative committee members foreshadows the intentions of certain legislators to proceed with the de-licensing recommendations of the Governor's report.

The MSRC leadership has been in contact with the AARC, keeping us apprised of the situation. AARC has offered to help in any way we can and the MSRC has assured us that when they need us they will be the first to call on us. We are fortunate that the MSRC leadership and designated RTs continue to be fully engaged (including a very good lobbyist under contract) as they were last year when the de-licensing issue first arose. I will provide an update on this fluid situation at the Board meeting.

California and Colorado-
Most states insert a "Sunset" provision into many of their licensure laws. Most Sunset laws require review every five to seven years, to determine and assess if the requirements of licensure have met the intent of the law, i.e. to protect the health and safety of the public. If it is determined that licensure has met the mandate then licensure of that particular profession would be legislated to continue. This is usually a pro forma process. However, given the regulation climate in many states, nothing should be taken for granted.

RT licensure in CA (2013) and CO (2014) are due for Sunset review. There certainly may be other states where RT licensure is up for Sunset, however these are the 2 states that I have been notified about by the state societies. Because it is common knowledge among state society leadership of what recently transpired in MI and IN, the CO Society in particular is proactively developing the rationale for RT licensure continuation. The Colorado Society should be commended for being farsighted and preparing for all eventualities.

As part of the CA RT Sunset review process, the CA Department of Consumer Affairs (DCA) has been tasked with reviewing how well the CA RC Licensure Board has fulfilled its statutory responsibilities. The DCA conducted 2 separate telephone interviews with myself and Tim Myers to gather AARC's opinion on how well the CRCB has met its goals and responsibilities. The short answer: we think the RC Board has done a very fine job indeed and expressed those opinions to the staff of the DCA. Legislation was introduced in late February to extend the CA RC Licensure Board for another 5 years.

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

Because of the volume of activity from states that introduce and pass legislation to raise tobacco taxes or restrict smoking in public places I have not included these types of bills in this report.

Specific RT Licensure Legislation

North Dakota (enacted) a bill that will eliminate the temporary RT license and raise licensure fees to $100 for the RRT license and $90 for the CRT license (ND has duel level licensure). Note that the ND Licensure Board has not issued a temporary license to any applicant in over 6 years, so this particular revision is viewed as more of a "clean up" provision. The bill would also permit NPs and PAs to write RT orders, which is in line with the 2010 revised Medicare Hospital Conditions of Participation (HCOPs).

Arizona a bill to allow the RC Licensure Board to hire its own Executive Director and other staff as needed.

Iowa a bill that would permit **RNs** and PAs to write RT orders. Note: this is not in keeping with the revised Medicare HCOPs, where only Advanced Practice Nurses, NPs or PAs will be permitted to write the RT order without a physician's co-signature. Medicare will not permit RNs to write RT orders. The ISRC has been monitoring this legislation, and the ISRC"s lobbyist states that the legislator who sponsored the bill is not viewed by fellow legislators as a prominent "mover" of health legislation, and the expectation is the bill will die.

Illinois a bill that amends the RT Act to permit advanced practice nurses to write RT orders without having to have a "collaborative agreement" with a physician. (Medicare rules require NPs and advanced practice nurses to have such an agreement).

Oklahoma a bill that clarifies that CoARC is an acceptable RT education program accreditor. Also deletes the outdated reference to CAAHEP.

General Licensure Legislation that Includes RT

Many bills are introduced each year that encompass numerous licensed professions. The intent, one would assume, is to synchronize specific requirements most notably in the disciplinary and sanction area. The bills listed below all specifically include RT.

Colorado has a bill that would require licensed practitioners who are applying or renewing, or reinstating their license to disclose specified information about their practice history and this would be publically available. **North Dakota** has a similar bill termed "transparency" as does **Vermont**.

Maryland has a bill that revises disciplinary criteria for numerous boards, including RT and would assure the licensure fees would cover the costs of RT rehabilitation, which is interesting.

Nebraska has a bill that requires more specific direction in the display of credentials and advertising for professions. **Nebraska** also has a bill that would permit spouses of veterans and spouses of active military personnel to "use" the training and experience gained in other jurisdictions to meet NE licensure/credentialing requirements.

Ohio has a bill that would require licensed health professionals to wear a badge with name and picture on it when providing care to patients. The bill also prohibits licensed professionals form making false claims or advertising in the solicitations of clients.

Oregon has a bill requiring licensees to document participation in continuing education opportunities relating to cultural competency approved by Oregon Health Authority. **Oregon** has

another bill that would tighten the rules regarding the disclosure of licensee personal information.

Washington State has a bill that addresses mandatory overtime of clinical professionals, including RTs at health care facilities.

Other Legislation of Interest to the RT Profession

Kansas has a bill directing the Secretary of Health and Environment to create a state plan for comprehensive treatment of chronic obstructive pulmonary disease. On behalf of the Kansas Society respiratory therapists Suzanne Bollig and Karen Schell attended the legislative hearing where both Ms. Schell and Ms. Bollig spoke in support of the bill.

Arkansas, Florida, Illinois, Iowa, New York, Massachusetts, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas all have bills that would require among other tests to be performed on newborns a pulse oximetry test. **Utah** has a bill that revises the current mandated pulse ox testing and would replace the mandate with a pilot program to determine the efficacy of pulse ox testing. **Nebraska** has a more general bill to require newborn testing, without mentioning pulse ox. **Delaware** and **West Virginia** which previously enacted this requirement are now at the rule writing stage for implementation.

New York has again re-introduced numerous asthma related bills previously considered in other legislative sessions (but not enacted). Several bills require reporting on the incidence of asthma, and one bill requires schools develop action plans for their students with asthma. Another bill would require all teachers to be trained in identifying and responding to asthma emergencies. **New York** has also reintroduced legislation that requires certification for those in public schools who will administer nebulizers to the students.

Texas has a bill that would expand Medicaid to require increased services, including RT, under the Home and Community Based Waiver program.

Illinois, Michigan (adopted), New Jersey, North Dakota, Oregon, and South Dakota have introduced legislation (House/Senate Resolutions) that would adopt a COPD Awareness Week or Month.

<u>Respiratory Related Rules/Regulations</u>

A change in the rules and regulations for respiratory therapy may have just as much impact on how respiratory therapists are permitted to practice as does amending the licensure laws for RT.

Thus far in 2013, there have been just a few new rule/reg changes. However, that can change quickly and without warning.

Iowa has revised the rule that adds *certifications* to the list of acceptable continuing education requirements that can be used towards licensure renewal.

Idaho polysomnography personnel are licensed (legal reference is to issue a "permit" to practice polysom) under the RC Licensure Board. The RC Board issued this revision to the polysom rules: "Enhances the guidance of polysomnographic trainees via direct on-site supervision.

Prohibits polysomnographic technicians from applying for temporary permits as polysomnographic trainees."

Washington State a rule change that allows the Department (Health) to establish a methodology for ventilator and tracheostomy payments for nursing facility clients.

Ohio after many months of deliberation, the OH Respiratory Care Licensure Board has put forth proposed rules that will, beginning in January 1, 2015, require any new RT licensees to hold the RRT credential. The current CRT only RTs will be grandfathered in until 2015. The AARC expressed its concerns that the impact of this rule change on available RT manpower was not fully analyzed, nor was evidence put forward that established patient harm or poor quality care was rendered by CRT only RTs.

North Carolina in 2012 the NC Respiratory Care Licensure Board provided notice to the AARC that it was intending to seek legislative changes to the RT licensure law. The key change would be to require on January 1, 2015 and thereafter a bachelor degree in RT (as well as the RRT credential) in order to be licensed as a *respiratory care practitioner* (RCP). For those with an associate degree, whether or not they hold the CRT only or the RRT credential, these RTs would be licensed as *respiratory therapists* and under the supervision of the licensed RCP when providing certain, as yet undefined RT procedures.

The AARC has similar concerns with the proposal as we have with the Ohio regulatory change, that is; the proposed requirement of a bachelor degree/RRT and the supervision of the associate degree CRT/RRT will, we believe, result in the constriction of available RT manpower. Moreover, there is a dearth of bachelor level RTs programs in the country and only 1 bachelor *completion* program in NC (not CoARC accredited as CoARC does not accredit completion programs). It should also be noted that there are other proposed legislative changes in the NC draft bill that are very positive including: assuring that RT scope of practice includes assessment, more explicit wording of what would constitute tasks that could be performed by non-licensed personnel; a clear transport exemption for RTs, and a more tightly worded exemption language for federally employed RTs.

Sleep Disorder or Polysomnography State Legislative Activities

With the start of new state legislative sessions, there have been several bills introduced to license polysomnographic personnel.

Iowa a bill similar to the 2012 sleep licensure bill was re-introduced in January. The Iowa Society RT leadership working with the society's new lobbyist met several times with the Iowa Sleep Society to try to work out issues the RT profession has had with certain provisions of the legislation. The chief concern is the (again) refusal by the sleep interests to include an explicit RT exemption. In early February, the ISRC testified at a legislative hearing and was disturbed at the misinformation that their sleep counterparts stated to the legislators, (which was quickly corrected by the ISRC). At this writing, there have been assurances by legislators on the Committees of jurisdiction that this legislation will not move out of the Committees.

Indiana a sleep licensure bill was introduced without including the non-negotiable RT exemption. The Indiana Society leadership has been fully engaged on this issue and has lobbied legislators pointing out their concerns with the legislation. Given the Indiana government's focus on de-licensing professions, the effort to create a new license for a very limited number of

polysoms in the state has met with a lukewarm response. The legislature's final action on the bill was to send it to "Summer Study" where the merits of the bill will be reviewed and considered after the legislature has adjourned for the year.

New Hampshire the original (1990's) RT licensure law contained a provision that permitted the RT Licensure Board to regulate polysomnography personnel. For many years the Board saw no need to act on the regulatory authority due to the limited number of sleep personnel in the state. In 2012 the RT Bd. did move to establish a detailed set of polysom practice regulations, which were then implemented. Because the rules were very detailed, it was thought that sending the provisions through the legislative process was warranted. A bill has been introduced to do just that.

Maryland as you recall, last year the MD/DC Society undertook the arduous task of legislating a RT exemption into the previously enacted polysom licensure law. This effort was launched when the opinions of the MD Polysomnography and the Respiratory Care Licensure Boards both determined that licensed RTs would not be exempt from having to obtain a Polysom license if they provided any of the tasks listed in the polysom scope of practice that were not similarly listed in the RT scope of practice The Attorney General of the state concurred with the opinions of the two licensure boards. (Note this is precisely why asking for an explicit RT exemption in any polysom licensure legislation is so critical).

While meeting fierce resistance from the sleep community the RTs were successful in inserting a limited exemption which allows RTs who provided polysom services prior to December 31, 2012 to provide those sleep services under their own license. However, a recent requested opinion from the Attorney General also stated that those RTs licensed after January 1, 2013 should they provide polysom services would have to have a polysom license to do so. This is the first and only state that requires this additional license of the RTs.

I will provide verbal updates at the April Meeting.

Federal Government Affairs Activity Report – April 2013

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

The Congress

The 113th Congress convened in January amidst continued partisan politics. While the initial Fiscal Cliff issue was temporarily "resolved" on New Year's Day, deep political and philosophical divisions exist between Democrats and Republicans and factions within their own parties over debt, taxes, domestic and defense budgets and entitlement programs (Medicare in particular). Also at risk is the country's investment in medical research through the National Institutes of Health and public health through the Centers for Disease Control and Prevention. We can expect Congress to continue to enact "stop-gap" measures such as Continuing Resolutions that take us through the end of fiscal year 2013 (e.g., September 30). This is primarily because solutions offered by Republicans are untenable to Democrats and vice versa.

How these larger issues will be addressed will impact not only how our legislative agenda moves forward, but nearly all other legislation supported by our communities of interest.

Legislation

The Medicare Respiratory Therapist Access Act

During the 112th Congress, we lobbied the Hill to enact legislation (HR 941) that would have amended Medicare Part B to permit greater patient access to RTs employed in a physician's office. Qualified RTs would have worked under the general supervision of the physician; that is in Medicare terminology, the physician would not have to be on site when the RT provided services.

We were unable to move HR 941 forward due to an unsupportable cost estimate from the Congressional Budget Office (CBO). The AARC commissioned and provided additional independent cost analysis to CBO through our Congressional champions. Unfortunately the CBO stayed firmly with their cost estimate which placed our legislation on the shelf.

With the federal deficit and increased tax revenues at the forefront of current Congressional debates, AARC recognized that to be successful in having new legislation introduced for 2013 we needed to adapt our approach. After extensive discussions with AARC leadership our approach has changed to do the following:

1) Tailor our initiative to define a discrete set of services in order to secure a better CBO estimate; and,
2) Present an initiative that was more in line with the current emphasis on disease management and reducing preventable hospital readmissions.

This new initiative is designed to provide coverage of pulmonary self-management and education services when furnished in a physician practice by qualified respiratory therapists to Medicare beneficiaries who have been diagnosed with certain chronic lung diseases. A copy of the draft language and a more detailed explanation of the new initiative can be found in the attachments to this report.

- **Attachment #1** is the draft legislative language.

- **Attachment #2** is the one page background paper describing the legislation, which was provided to members of Congress and their staff during the March PACT Meeting.

- **Attachment #3** is the Frequently Asked Questions (FAQs) document. This gives a clear explanation of the differences between the Medicare Respiratory Therapist Access Act and the previous legislation. It also provides more in-depth information and details of our new legislative initiative.

AARC has commissioned Dobson/DaVanzo, the firm we used last year to do an analysis of the Medicare Part B files, for an outside cost estimate on the newly redrafted initiative.

AARC Capitol Hill Lobby Day

AARC in partnership with 44 state societies held its 13th Capitol Hill Lobby Day. Once again we were privileged to also partner with patient advocates from the COPD Foundation. There were 119 respiratory therapists who came to DC to represent their state and advocate for the Medicare Respiratory Therapist Access Act. We had 15 patient partners hosted by the COPD Foundation and several of state societies who underwrote the additional participation of sending a patient to accompany their PACT rep(s).

Carolyn Williams a PACT rep from D.C. has continued her tradition of bringing her RT students to the Monday briefing and up to the Hill for the Tuesday meetings. We commend her efforts to expand the student's awareness of one of the many projects the AARC is involved in that enhances their soon-to-be profession of respiratory therapy. Overall we welcomed nearly 30 student RTs to our PACT Hill Day.

This year in tandem with our Hill Day, the AARC also hosted a Drive4COPD event at the Capitol Visitors Center on Capitol Hill. Local volunteer RTs, not involved in Hill Day (and some of Carolyn's students) oversaw a screening event which dove tailed well with our advocacy efforts going on that day.

Virtual Lobby Week

As part of the lead up to our Hill Lobby Day, the AARC also sets in motion our Virtual Lobby Week just prior to the RTs and our patient partners coming to Washington, DC. This event generates nationwide support from RTs, patients and caregivers who email their members of Congress in support of our legislative initiative. We had over 20,000 emails sent to Congressional leaders and greatly appreciate the efforts of Frank Salvatore for keeping the competitive spirit going between state societies by ranking their activity.

S 382 - Technical Change to Medicare Outpatient Pulmonary Rehabilitation Benefit - Update

On February 26, 2013, Senators Schumer (D-NY) and Crapo (R-ID) introduced S 382, a no-cost technical amendment that would permit physician assistants, nurse practitioners, and

clinical nurse specialists to supervise pulmonary and cardiac rehabilitation programs consistent with other Medicare outpatient therapeutic supervisory requirements. Because the original legislation enacting these programs stated they must be "physician" supervised, CMS took the term literally which prohibited other qualified non-practitioners from providing direct supervision. This is a reintroduction of a bill introduced in the 112th Congress. Senator Grassley (R-IA) has also signed on. AARC and other pulmonary multi-societies/associations support this change.

HR 27 – Small Supplier Fairness in Bidding Competition Act of 2013

This is the bill to repeal competitive bidding and was introduced by Congresswoman Nydia Velazquiz (D NY) in January 2013 as the first repeal bill of the 113th Congress. She is a ranking member of the House Small Business Committee. It is a straight repeal with no alternatives or "pay for". According to the HME industry newsletter ***HomeCare,*** it has no co-sponsors and is not expected to gain any momentum. It has been referred to the Committees on Energy and Commerce, Ways and Means, Judiciary and Small Business.

Market Pricing Program - Alternative to Competitive Bidding

The home medical equipment industry was on the Hill February 26 and 27 in support of its "Save Patient Access" Fly-in. Congressional leaders were briefed on what is wrong with the current competitive bidding program, the problems it has caused, and how it will "ruin the DME marketplace."

During the last Congress, the industry was successful in getting a bill introduced as an alternative to competitive bidding known as the Market Pricing Program. As mentioned in previous Board reports, the alternative is designed to achieve an accurate market place, make the bids binding, increase transparency in the bidding process, and make the bid areas smaller. While there was considerable support for the bill, time ran out in the 112th Congress and it has yet to be re-introduced in the 113th Congress. The industry feels that Congressional leaders must end the current competitive bidding program first, but plans to work on advancing their alternative in the interim. They admit, however, they have run out of ways to pay for it.

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. The efforts now focus on urging Congress not to cut funding for specific programs rather than asking for increased budgets.

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). Recently we have been involved in activities regarding regulation of cigars.

The AARC signed on to a joint letter to the Secretary of Housing and Urban development supporting the Department's efforts to encourage broader smoke-free policies in multi- family housing units. We also signed onto a letter to Congress that opposes legislation that would exempt certain small cigars, especially those that are flavored, from FDA regulation under the Family Smoking Prevention and Tobacco Control Act. Recently HR 792 has been introduced to

exempt traditional and premium cigars wrapped in 100% leaf tobacco. AARC has added its name along with other organizations opposing this legislation which is a re-introduction of a bill brought forth in the 112th Congress.

Appeals to decisions by the 6th Circuit and DC Circuit courts regarding the warning labels FDA intended to add to cigarette packages this past June will be heard during the latter part of March. Depending on the outcomes, the issue may be referred to the Supreme Court. You will recall that AARC, working with our Tobacco Free Lifestyle Roundtable, submitted comments to FDA on which pictures and label warnings we thought would be most effective.

Regulations and Other Issues of Interest

To date, there have been few regulations published by CMS since our last report that are of interest to the profession that have not already been reported. Programs such as value based purchasing and the hospital readmissions reduction program have been underway since last fall. There is no new information to report on pulmonary rehabilitation programs.

Proposed updates to the hospital inpatient and outpatient prospective payment rules and the physician fee schedule will not be out until around May. Most health-related regulations have been issued to implement the Affordable Care Act and are aimed at the establishment of state health insurance exchanges and definitions of benefits.

Competitive Bidding

On January 31, 2013, CMS announced the prices for Round 2 of competitive bid. You will recall that the number of metropolitan areas goes from 9 to 91 markets, which is a significant increase in those affected by the program. Unless Congress takes action, the program is on course to go nationwide by 2016.

This second round results in substantial cuts to previous payment amounts. Or as CMS puts it - results in substantial savings. The average cuts/savings is 45% compared to the current fee schedule amounts. Diabetes testing strips takes the biggest hit at a 72%. Payment for oxygen equipment and supplies results in a 41% cut, while CPAP devices get hit with a 47% reduction.

Here is an example of what the change means in dollars: Currently, stationary oxygen equipment (e.g., oxygen concentrators) is paid based on a fee schedule amount of $177.36 per month including the beneficiary 20% co-pay. Over the course of a 36-month rental period, the supplier is paid $6,385, of which the beneficiary pays $1,277. When the new prices go into effect July 1, 2013, the average allowed amount for stationary oxygen will be reduced to $93. Under the new scenario, the supplier will be paid $3,351 and the beneficiary will pay $670 over the 3-year period. According to Medicare, the program saves $2,428 and the beneficiary saves $607.

CMS reports that 14,654 contract offers will be made to 867 Round 2 bidders. The winning suppliers have 3,109 locations to serve Medicare beneficiaries in the competitive bidding areas. The winners are to be announced in the spring.

Trach Replacement Schedule – DME MAC Local Coverage Policy

In August last year, the regional DME MACs revised a number of local policies to include what they considered to be a standard replacement schedule for various DME items. For trach tubes, the schedule was one replacement every 90 days. Finding this unacceptable, NAMDRC, ATS,

ACCP and AARC met with CMS on March 5 after efforts to get the policy revised at the local level failed.

The accepted practice of care, FDA testing standards, and manufacturer package inserts all support replacement at least once every 30 days. A recent "Clinical Consensus Statement on Tracheostomy Care" from the American Academy of Otolaryngology – Head and Neck Surgery, however, noted that there was a lack of consensus on routine trach replacement. [NOTE: The report was provided to Board members at the November 2012 meeting]. Considering the Consensus Panel to be experts on the topic, CMS put the burden on our medical societies to provide evidence-based studies that would support a minimum 30-day schedule. Unfortunately, because no two patients are alike and their need for tube replacement varies depending on their medical need, there are no studies that agree on a standard replacement schedule.

Dr. Ron Mitchell, lead physician on the AAO-HNS study, and Kathy Deakins, AARC Fellow who was a panel expert, participated in the meeting with CMS via phone. [Note: Kathy and the report were also featured in the October 11, 2012 News Now @ AARC]. Dr. Mitchell presented compelling arguments as to why the move by CMS will drive costs much higher in the long term, noting that the 90 day replacement schedule goes against the goal of the Consensus Report which is to increase quality and reduce complications. CMS asked Dr. Mitchell to follow-up with his panel members to address the 90 day replacement issue specifically since it was not part of the original survey. Depending on the outcome, we are uncertain at this time whether CMS will take action to correct the situation.

State Surveyor Worksheets – Cleaning of Nebulizers

As reported in the November Executive Office Board report, AARC has been working with CMS and CDC for some time over the proper standard for cleaning nebulizers with respect to surveyors' worksheets that are part of a pilot project designed in part to improve patient safety with respect to infection control. This topic has been discussed on several of AARC's section listservs.

One standard that surveyors had been using up until November 2012 as part of the Respiratory Therapy/Ventilator worksheets called for "rinsing nebulizers with sterile water (or with tap water followed by isopropyl alcohol)." AARC provided written comments as to why this presented significant patient safety issues and lacked any scientific evidence, discussed the issues via conference call, and provided CMS/CDC staff with the AARC's clinical practice guidelines. Yet, the agencies have still not made a final determination on the wording of the standard. The November 2012 version has a placeholder for this standard and notes that it is "under revision."

CMS has assured AARC that we will be able to review the final draft language before it is implemented. In the interim, the pilot project is non-punitive in nature and no citations will be issued to hospitals or Plans of Correction required unless an Immediate Jeopardy situation is identified. The worksheet standards are expected to be finalized some time during FY 2013.

SSA Regulations to Revise Criteria for Evaluating Respiratory System Disorders

On February 4, 2013, the Social Security Administration issued a proposed rule to revise the criteria they use to evaluate claims involving respiratory disorders in adults and children. The revisions reflect program experience, advances in medical knowledge, and comments they

received from medical experts at an outreach policy conference. The agency has contacted AARC specifically for comment.

Some revisions are technical in nature, but for the most part, SSA is looking to determine how to define a certain disorder and how to evaluate it. Examples of some of the disorders include chronic respiratory disorders, asthma, cystic fibrosis, bronchiectasis, chronic pulmonary hypertension due to any cause, lung transplantation, respiratory failure, and chronic pulmonary insufficiency. AARC is reviewing the proposal and plans to submit comments by the April 5, 2013 deadline.

Conclusion

Regardless of the "atmosphere" in Congress, the AARC will continue our efforts on Capitol Hill to advance our legislative agenda. We will also maintain our vigilance on the regulatory side responding to both challenges and opportunities.

Attachments

HOD Report

Submitted by John Steinmetz – Spring 2013

Recommendations

1. None at this time

Charges

Preside at all meetings of the House: ***Ongoing***

Prepare an agenda for each meeting and submit to each delegation: ***Ongoing***

Summer meeting: June 14, 2013

Winter meeting: October 11, 2013

Appoint a Parliamentarian: ***Completed***

Appoint the chairs and members of the House standing and special committees: ***Partially Completed and Ongoing***

Chairs and standing members appointed.

Invite persons other than delegates to participate in House activities: ***Ongoing***

Be an ex-officio member of all House committees except the Elections Committee: ***Ongoing***

Serve as Chair of the House Executive Committee: ***Ongoing***

Perform other duties that may authorize: ***Ongoing***

Report

Update on Speaker Goals:

Goal #1 – Committees

Chairs, delegate members, and liaisons (HOD officers) have been assigned. Some committees are undermanned due to term expiration of delegates. New members are being assigned.

• Committee chairs and officers have been working through AARConnect to achieve specific goals

• Policies revisions are being updated to reflect current practices

• Big list update continues for delegations to report back to their affiliates

• Continue to work with BOD to facilitate communication – Tom Kallstrom, Speaker and staff hold monthly phone calls, HOD officers attending BOD meetings 18

Goal #2 – Engaging and involving HOD members

• Regular communication through AARConnect with members

• Overseeing communication of committee work through AARConnect

• Work with executive office to improve accuracy of AARConnect HOD communities to improve communication

Goal # 3 – Volunteering

• Develop and promote activities through the AD HOC Committee

Goal # 4 - Mentoring

• Develop and promote student and professional volunteering through appropriate committees

Goal # 5 – Communication

• Promote the HOD work and members through the AARConnect, AARC Times, web page and give opportunity for feedback

Board of Medical Advisors Report

No report submitted as of March 28 – minutes from the BOMA Congress meeting are below.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Medical Advisors Meeting

November 11, 2012 – New Orleans, LA

Minutes

Attendance

Lori Conklin, MD (ASA), Chair
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
William Bernhard, MD (ASA)
Steven Boas, MD (AAP)
Cliff Boehm, MD, RRT (ASA)
Terence Carey, MD (ACAAI)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Kent Christopher, MD, RRT, FCCP (ACCP)

Thomas Fuhrman, MD (ASA)
Col. Michael Morris, USA, RET
Peter Papadakos, MD, FCCM, (SCCM)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)
Richard Sheldon, MD, FAARC (ATS)
Joseph W. Sokolowski, MD, FACP, FCCP (ATS)

Guests

Kerry George, NBRC President
Gary Smith, NBRC Executive Director
Lori Tinkler, NBRC COO
Tom Smalling, CoARC Executive Director
Steven Mikles, CoARC President

Excused

Bradley Chipps, MD (ACAAI)
Barrett Kitch, MD (ATS)
Harold Manning, MD, FCCP (ACCP)
Christopher Randolph, MD (AAAAI)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)

Consultant

George Gaebler, AARC President
Karen Stewart, Past President, BOMA Liaison

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Anne Marie Hummel, Director of Regulatory Affairs
Cheryl West, Director of Government Affairs
Miriam O'Day, Federal Government Affairs Director
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
Chairman Conklin called the meeting of the AARC Board of Medical Advisors to order at 10:00am CST, Sunday, November 11, 2012.

INTRODUCTIONS
Chairman Conklin asked members to introduce themselves.

APPROVAL OF MINUTES
Dr. William Bernhard moved to accept the minutes of the June 9, 2012 meeting of the AARC Board of Medical Advisors.
Motion Carried

CHAIRMAN'S REPORT
Dr. Conklin gave highlights of her written report.

PRESIDENT'S REPORT
Karen Stewart gave updates on 2015 & Beyond.

CoARC (Commission on Accreditation for Respiratory Care) REPORT
Dr. Steven Mikles, President of CoARC and Tom Smalling, Executive Director of CoARC, updated BOMA on CoARC's recent activities and discussed the excessive number of proprietary respiratory care schools.

NATIONAL BOARD FOR RESPIRATORY CARE
NBRC President Kerry George presented highlights of his written report.

LEGISLATIVE AFFAIRS REPORT
Cheryl West gave an update of State Affairs. Director of Regulatory Affairs, Anne Marie Hummel, gave a report. Miriam O'Day updated the Board on Federal Government Affairs and asked BOMA for support.

RECESS
Chairman Conklin recessed the meeting of the AARC Board of Medical Advisors at 11:55am CST, Sunday, November 11, 2012.

RECONVENE
Chairman Conklin reconvened the meeting of the AARC Board of Medical Advisors at 12:40pm CST, Sunday, November 11, 2012.

EXECUTIVE DIRECTOR REPORT
Tom Kallstrom gave highlights of the Executive Office report.

MEDICAL ADVISOR REPORTS
Some BOMA Members gave updates on their sponsoring organizations.

SPECIALTY SECTION REPORTS
The Specialty Section Reports were reviewed. Dr. Selecky reminded BOMA the importance of being more involved with the Specialty Sections as BOMA liaisons.

OTHER REPORTS
ARCF and International Committee reports were reviewed.

UNFINISHED BUSINESS
There was no unfinished business.

Dr. Conklin discussed a virtual meeting and not being able to select a date. BOMA members selected April 27, 2013 at 9am CDT for a virtual meeting. This will take place of a face to face meeting in June 2013.

NEW BUSINESS
There was no new business.

MOTION TO ADJOURN
Dr. Christopher moved to adjourn the meeting of the AARC Board of Medical Advisors.
Motion Carried

ADJOURNMENT
Dr. Conklin adjourned the meeting of the AARC Board of Medical Advisors at 1:35pm CST, Sunday, November 11, 2012.

President`s Council

Submitted by Dianne Lewis – Spring 2013

Recommendations

None

Report

It is with great pleasure that I announce the 2013 Jimmy A Young Medal recipient is Kerry George, MEd, RRT, FAARC. Kerry has served the profession in many capacities, not only as AARC President, but he currently chairs the NBRC.

At this meeting, the BOD will need to nominate individuals for Life and Honorary membership. I have included a list of past winners and the criteria for each.

AARC Life and Honorary Memberships

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

YEAR	LIFE	*HONORARY*
1985	James S. Allen	Walter J. O'Donohue, MD
	Houston R. Anderson	
	Thomas A. Barnes	
	Julie S. Ely	
	David H. Eubanks	
	Glen N. Gee	
	Gary L. Gerard	
	Sam P. Giordano	
	Robert L. Knosp	
	Lillian Van Buskirk	
	John R. Walton	
	Robert R. Weilacher	
	George A. West	
1986	Richard W. Beckham	Hugh Matthewson, MD
	Paul Powers	
1987	Jeri E. Eiserman	John Hodgkin, MD
	Edward A. Scully	
1988	Michael Gillespie	Irvin Ziment, MD
	Melvin G. Martin	
1989	Gerald K. Dolan	Roger Bone, MD
	Ray Masferrer	
1990	Paul J. Matthews, Jr	Alan Plummer, MD
1991	Larry R. Ellis	Alfred Sofer, MD
	Jerome M. Sullivan	
1992	Patrick J. Dunne	David J. Pierson, MD
	Phil Kittredge	
1993	Bob Demers	Richard L. Sheldon, MD
	Bernard P. Gilles	
1994	Philip R. Cooper	Forest Bird, MD, PhD, ScD
	Dianne L. Lewis	
1995	Deborah L. Cullen	Neil R. McIntyre, MD
	Patricia A. Wise	
1996	Jim Fenstermaker	Steven K Bryant, MBA
	Trudy J. Watson	
1997	Charlie G. Brooks, Jr.	Charles Durbin, MD
	Pat Brougher	
1998	Kerry E. George	Barry A. Shapiro, MD
	W. Furman Norris	
1999	Dean R. Hess	James K, Stoller, MD
	Cynthia J. Molle	
2000	Jerry Bridgers	Michael T. Amato
	Dianne Kimball	
2001	Robert Fluck	William Bernhard, MD
	Garry W. Kauffman	
2002	Susan B. Blonshine	Sherry Milligan
	William Galvin	
	Carl Wiezalis	

YEAR	LIFE	*HONORARY*
2003	Margaret F. Traband	Cheryl A. West
	J. Michael Thompson	
2004	David C. Shelledy	Patricia A. Lee
	Karen J. Stewart	
2005	Janet Boehm	Jill Eicher
	Richard Branson	
2006	John Hiser	Marsha Cathcart
	Lucy Kester	
2007	Doug MacIntyre	Kent Christopher
	Joseph L. Rau	
2008	Susan Rinaldo Gallo	John W. Walsh
	Michael W. Runge	
2009	Vijay M. Deshpande	Dale L. Griffiths
2010	William H Dubbs	None awarded
	Toni Rodriguez	
2011	Patricia A. Doorley	Foster M. “Duke” Johns III
2012	Richard M. Ford	Miriam A. O’Day
	Timothy R. Myers	

CRITERIA

Candidates for AARC Life Membership

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

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

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

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

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

Candidates for AARC Honorary Membership

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

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

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

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

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

Standing Committee Reports

Audit Sub-Committee

No report submitted as of March 28, 2013

Bylaws Committee

No report submitted as of March 28, 2013

Elections Committee

Submitted by: Ross Havens - Spring 2013

Recommendations: None at this time.

However, the Committee has several issues it will be discussing at its telephone conference call in April, and may have recommendations to bring forward after that call.

Report:

1. Candidate Questions. Questions for nominees were solicited from the BOD, HOD and Committee members. The Committee formulated 3 questions for nominees, and these were submitted to the executive Office on February 27.
2. Nominations. The Committee solicited nominees from the BOD, HOD and appropriate Section members for President-Elect, Director (3), Adult Acute Care Section, Diagnostic Section, Education Section and Management Section. The nomination deadline was extended to March 15. Nominees will be asked to complete a Nominee Profile Form and answer Nominee Questions; the deadline for completion will be April 1.
3. The Committee conference call to consider all nominees is being scheduled for the week of April 15-19. The final slate of candidates will be selected at that meeting and forwarded to the BOD.

I would like to thank the members of the Committee for their hard work; Jakki Grimball, Bill Cohagen, Jim Lanoha and Doug McIntyre.

Executive Committee

Finance Committee Report

Judicial Committee

Submitted by Patricia Blakely – Spring 2013

Recommendations

There are no committee recommendations at this time

Report

The committee has not received any inquiries or formal complaints from any members as of March 07, 2013

Other

No other information to report to the BOD at this time.

Program Committee

Submitted by Cheryl Hoerr - Spring, 2013

Recommendation

That the AARC Board of Directors approve San Antonio, TX as the host city for AARC Congress 2016.

Justification

Future host cities for AARC Congress -
2013: Anaheim
2014: Las Vegas
2015: Tampa
2016 & Beyond: Open

San Antonio has been part of the Congress rotation for several years and has consistently drawn strong attendance figures. The last time AARC Congress was hosted in San Antonio was 2009; meaning 7 years will have passed by the 2016 meeting.

Report

1. Prepare the AARC Congress Program, Summer Forum, and other approved seminars and conferences.
   Status: The committee met in Dallas, TX on Jan. 31 – Feb 2, 2013 to review over 700 individual lecture proposals submitted in eleven different specialty areas and roundtables for presentation at the Summer Forum and/or Congress. Authors of proposals that were not accepted by the committee will be notified no later than May. Communications for authors of proposals that have been accepted for presentation are currently taking place. Based on member feedback, the length of presentations at both meetings has been shortened to expedite learning, facilitate additional networking opportunities and to allow for expanded exhibit hall hours. 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: Both Summer Forum and Congress destinations have been secured through 2015. The Executive Office has evaluated destinations for the 2016 AARC Congress and contract negotiations are in progress. Assuming those negotiations are successfully concluded before the BOD meeting, an on-site recommendation will then be made asking the Board to approve the chosen location of the 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 Sections. For the first time ever, members could also submit proposals on behalf of a Roundtable. Each specialty section/roundtable 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 and are to be commended for their initiative and effort; however we continue to struggle with

select section chairs that do not participate. This increases the difficulty of assembling a relevant meeting for our members.

4. Develop and design the program for AARC Congress to address the needs of the membership regardless of area of practice or location.
   Status: A broad offering of topics presented by new and experienced presenters are included in the agenda for both the Summer Forum and Congress.

   The Program Committee dedicated a significant amount of time to discussing industry priorities, hot topics and reviewing membership feedback from previous meetings. As a result of these conversations, several changes will be made to AARC Congress 2013; including, but not limited to changes in programming and the exhibit hall.

Sputum Bowl Sub-Committee Report:

As directed by AARC Program Committee Chair Cheryl Hoerr, the 2013 Sputum Bowl Committee, chaired by Sherry Whiteman, has been assembled to start the work of delivering the 2013 Sputum Bowl while maintaining and expanding the enhancements put in place at the 2012 competition. The Committee's intent is to continue to provide an updated, engaging and energetic Sputum Bowl. The enhancements and modifications put in place for the 2012 competition received much positive feedback from both competitors and audience members and should contribute to increase participation in 2013.

Strategic Planning Committee

Submitted by Karen Stewart – Spring 2013

Nothing to report

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Spring 2013

Recommendations

NONE

Report

1) The section continues to publish a quarterly bulletin, using this medium as a spring-board for younger less experienced writers in many instances
2) The section continues to publish its newsletter, passing along to its members the latest in evidence based practice.
3) We continue to publicize our Journal Club and have recently moved to a new format that allows us to have many more "inactive" participants. These participants can "chat" but not participate verbally. We have recorded our first discussion and archived it.
4) Section leadership continues to participate in national and international lectures, education and humanitarian efforts.
5) We continue to have an active AARConnect discussion group.
6) We sent our first screencast recently which was well received. Our plans are to send one quarterly and as needed when major announcements are appropriate.

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Spring 2013

Recommendations

1. The CMS National Coverage Policy for PR for COPD is once in a lifetime benefit (36 up to 72 sessions). The COPD Medicare patient accepted for Lung Transplant must do Pulmonary Rehabilitation (PR) pre and post Lung Transplant BUT the current CMS NCD does NOT allow this reimbursement. **I ask for AARC to coordinate a meeting with CMS with support of our sister pulmonary organizations; AACVPR/ACCP/ATS/NAMDRC to ask CMS to allow Listed COPD Lung Transplant patients to have additional PR sessions beyond the once in a life time benefit.**

2. Comprehensive Pulmonary Rehabilitation (PR) includes long term adherence through disease management, exercise maintenance programs that are self-pay, not covered by insurance. The challenge of all PR programs is facility space for such a patient self-pay program. **I ask AARC to investigate through a special task force the development of a National Post Pulmonary Rehabilitation Disease Management Program in collaboration with a Nationally Recognized Community Exercise Organization, such as the YMCA including applying for national research funding.** The literature supports the need for post PR program Disease Management/Exercise programs to improve compliance, retain post program outcomes and for the COPD PR graduate could also impact rehospitalization. AARC has the leadership and expertise to develop a National Post Pulmonary Rehabilitation Disease Management program that can impact pulmonary patient outcomes and quality of life.

Report

1. submitted topics/speakers for the AARC 2013 International meeting
2. Newsletter contribution

Other

none

Diagnostics Section

Submitted by Matthew O'Brien – Spring 2013

Recommendations - None

Report

Charges:

•1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of the Diagnostic Specialty Section.

•· Over 28 presentations were submitted for the Diagnostics Section. The next step is to put a call out to encourage more participation submitting Open Forum posters that highlight what our members are currently researching.

•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.

•· Lisa Becker did a great job with the bulletin however decided to step down because she is transitioning out of Respiratory Care. Our new bulletin editor is Katrina Hynes who works at the Mayo Clinic Pulmonary Lab. Her first bulletin will publish shortly.

•· We are still in the planning stages for a diagnostic specific webinar for 2013.

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

•· Ongoing, I am offering a state level- diagnostic membership meeting at the Washington State RC meeting in April. We hope to add several new members in our effort to reach the 1000 member count.

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

•· Nominations for the Chair- Elect position have been made and the election will occur this fall.

•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 site

Education Section

No report submitted as of March 28, 2013

Home Care Section

Submitted by Greg Spratt – Spring 2013

Recommendations:

None

Report:

POC Survey

I have been working with Sam Giordano, Patrick Dunne, Joe Lewarski, and Bob McCoy to develop and distribute a manufacturers'' survey on portable oxygen concentrators. The intent is to gather basic specifications on these devices and publish to allow both clinicians and patients access to this information along with guidance on how to use this information when deciding on which device will best meet a specific patient''s needs. We are in final edits of the paper to be published.

HC Section Highlights

Since the last meeting we have produced two quarterly newsletters, one after the Congress and the Spring edition is in edits.

Membership

We had a very successful membership drive during the AARC Congress based on HC Section ''scholarships'' provided by several of the home care equipment manufacturers including Breathe Technologies, Chart, Covidien/Oridion, Drive, Fisher and Paykel, Invacare, Precision Medical, and Respironics. Membership went from a low of ~820 to over 1,000 by the end of the year, allowing the HC Section to retain its membership for the next 3 years.

Home Patient Survey

I continue to work with Nicholas Macmillan (a past HC Section Chair) to assimilate results of a survey of home care patients to better understand their perspectives on the care being delivered to them. The BREATHE (Basic Respiratory Evaluation and Assessment at Home) survey was developed, approved, and distributed through the AARC and other organizations. The survey was made available to patients via Home Care Section members and patient advocacy groups (viewable at www.yourlunghealth.com) and the results have been posted by Tom in the BOD Library.

Other: None

Long Term Care

No report submitted as of March 28, 2013

Management Section

Submitted by: Bill Cohagen – Spring 2013

Recommendations

None

Report

At the time of writing this report the membership is at 1783 members.
Projects include;

- Completion of TJC standards for Respiratory Care Departments.
- Review and updates on the "Expert' list.
- Creation of the Management Section Program for both the 2013 Summer Forum and the 2013 International Congress.
- Start of the process for amassing candidates for the ARRC's Management Section Chair.

The AARC Connect list continues to be one of the busiest and most useful section tools.
The book club continues to grow.
There is continued alignment with the AARC's 2015 plan.
The Hospital to Home initiative is making slow progress, but continues their work.
The Bulletin has a amassed a large amount of articles for 2013 editions.

Other

New projects;

Working to mentor and train new leaders in respiratory care.
Developing a guide to assist in succession planning.
Creating a link for managers to expand the education (Bachelors and Masters Programs).

Neonatal-Pediatrics Section

Submitted by Cynthia White – Spring 2013

Recommendations

NONE

Report

- Section membership remains strong at >2000
- Shared screencast with members to update on section activities
- Recruited members for lecture and symposia submissions for Neonatal and Pediatric Topics at Congress 2013
- Shared information on new online Respiratory Care Journal site and iphone app with members
- List serve has remained active with much activity and discussion
- Worked to engage members with journal club discussions surrounding HFOV
- Winter bulletin published online with spring bulletin under construction
- Section chair elect and other neonatal pediatric section members attended DC PACT meeting

Sleep Section

Submitted by Russell Rozensky – Spring 2013

Recommendations

Report

Nothing to report to date. Would like to work with the Executive Office on the following:

Update the Section chair with information and the intro I have (Russell Rozensky)

Update the committee section (possible remove some sections) and add links for nominations and possible new committees

Need to "update ***links*** (Please correct the CoARC link and NAME, It is commission ***not*** committee)

Add a swap shop page with some power points and word documents I have for educational purposes

Update resources page (take Tom Smalling off as his email is not valid, use mine)

Add a section about the sleep section practitioner of the year nomination

Review/correct the nomination form for sleep section practitioner of the year

Do an email blast to all in section (about nomination for sleep section practitioner of the year, about possible consultant panel, follow the template of the educational and/management sections)

Maybe add a job openings page for sleep or teaching in sleep

Add a resource directory with contacts to help with technical issues (email blast to see who might want to help in this area)

On the bottom of the online reporting page, Mike Runge is listed. Should It be Russell Rozensky??

- Announcement of NYS Poly Bill becoming fully effective Feb 2014 to sleep section members, and see about email blast to all AARC members

Other

Will contact Steve Nelson (sorry if I spelled his name wrong) about possible changes to website.

Would like to follow-up with Debbie Bunch and Suzanne Bollig for specific ideas on new topics.

Surface to Air Transport Section

Submitted by Billy Hutchinson – Spring 2013

Recommendations: None at this time

Section Report

1. Section membership is steady despite the current economic times. We are looking at new methods of getting the word out about AARC and section membership to increase membership. . By promoting our list serve and the opportunities to interact with great clinicians to make us all better clinicians.

2. Our list serve is very active with extremely relevant content and great participation. There is a lot of information shared with a great emphasis on Specialty Teams.

3. The Quarterly Bulletin has been published on time with relevant content with and strong support for our members. We are working hard on getting more members submitting and sharing each quarter.

We feel for the low cost of membership in our section, so much is gained. There is tremendous support through our bulletin and our list serve.

4. For the upcoming 2013 AARC Congress this fall, we as a section had a larger number of submissions with some great relevant topics. As section chair, I was very encouraged with the quantity and quality of the submissions. We are awaiting the decision of the program committee as to which submissions were selected.

Special Committee Reports

Benchmarking Committee

No report submitted as of March 28, 2013

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Spring 2013

1. Monitoring the Billing Codes list serve
   Ongoing, committee member Karen Boyer assists with this.

2. Cheryl, Ann Marie and I have updated the Coding Resources on AARC.org. We also worked on the coding section of the Medicare R T Access Act.

3. About 50% of the coding questions are posted on the Management or Help Line list serves. Activity on the Billing codes list serve is light. Good question continue to be discussed on all three lists.

4. I continue to field questions that members send me through AARC Connect.

Federal Government Affairs Committee

Submitted by Frank Salvatore – Spring 2013

Recommendations

NO RECOMMENDATIONS

Objectives:

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

Ongoing Objectives:

1. Assist in coordination of consumer supporters **[Ongoing]**

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 2012 with Cheryl West sending out the details of the meeting in March of 2013. We began working on the details of the VLW in late January/early February. The VLW went live on March 1, 2013 and ran through March 14, 2013. The numbers of messages sent to Washington DC during this VLW not only exceeded but smashed through the numbers sent in ALL of 2012. There were 21,030 messages sent during the VLW. Florida, Michigan, Pennsylvania and North Carolina societies led the pack with well over 1000 messages sent with Florida and Michigan sending over 3,000 messages during the VLW. Overall, there was a good response, we saw over 6,100 individual activists send messages with RTs sending over 4,300 and students being the next highest with slightly less than 1,000 individuals. (See attached spreadsheet for some specifics regarding this year's statistics and some historical perspective)

The committee will continue to push the state societies to keep messages coming into Washington DC via Capitol Connection. We will be putting out regular 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.

Fellowship Committee

Submitted by: Patrick Dunne – Spring 2013

Recommendations

There are no recommendations at this time.

Report

The work of the Fellowship Selection Committee does not begin in earnest until the actual selection process commences later in the year.

However, as Committee Chair, I have recently had discussions with several key thought leaders of the Association suggesting it may be time to set a limit on the number of new FAARC inductees each year. The reasoning is that having an unlimited number of new inductees each year may be diluting the stature of the recognition. The current selection process does not have a limit. For example, in 2012 the Committee received 42 nominations of which 32 were selected under the existing rules (e.g. garnering 4 or 5 accept votes from the 5 person committee). Should it be determined to indeed set a limit, the next question is how many each year – at this point, 10 seems to be the most favored. In the coming weeks I will be working with the members of the Selection Committee to address this issue and to develop a proposed alternative to the current selection process in time for the Summer BOD Meeting. It would be my intent that any changes to the process become effective this year.

Finally, please note that the deadline for receipt of nominations for 2013 Fellow is August 30. In September the Selection Committee will then commence review of all nominations received by the established deadline. The selection process will be completed by the end of September with notification letters being sent shortly thereafter.

Other

There is nothing else to report at this time.

International Committee Report

Submitted by John Hiser – Spring 2013

Recommendation 1: None

Report

1. Administer the International Fellowship Program.

As you already know the fellowship program continued to be successful in 2012. 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 deadline for application is June 1st.

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.

I want to thank 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
Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations
Dan Rowley, MS, RRT-ACCS, FAARC, Vice Chair for International Fellows
Committee members:
Michael Amato, MBA
Arzu Ari, PhD, MS, MPH, RRT, FAARC
John Davies, MA, RRT, FAARC
ViJay Desphande, MS, RRT, FAARC

Derek Glinsman, RRT, FAARC
Yvonne Lamme, MHA, RRT
Hector Leon Garza, MD, FAARC
Debra Lierl, MEd, RRT, FAARC
Camden McLaughlin, RRT, BS, FAARC
Natalie Napolitano, MPH, RRT-NPS, FAARC
Bruce Rubin, PhD, MD, FAARC
Michael Runge, BSRT, RRT, FAARC
Jerome Sullivan, PhD, RRT, FAARC

Membership Committee

Submitted by Frank Salvatore – Spring 2013

Recommendations

The Membership Committee would like the President to approve the creation of The Student Membership Retention Sub-Committee and ask the Board of Directors to approve the following members to serve and the goals/objectives of the sub-committee as well:

Co-Chair – Janelle Gardiner
Co-Chair – Emily Zyla
Member – Fred Goglia
Member – Aaron Light
Member – Melanie Harper McDonough
Member – Kerry McNiven

Goals and Objectives of the Sub-Committee:

1. Address the needs to enhance and add value to the students membership in the AARC
2. Address strategies and methods to increase student members to continue their membership as "Active" members of the AARC after graduation
3. Present findings and preliminary outcomes of the above objectives to the AARC Board through Membership Committee Chair and report

Charges

Review, as necessary, all current AARC membership recruitment documents and toolkits for revision, addition and/or elimination based on committee evaluation. **[ON-GOING]**

In conjunction with the Executive office, develop a membership recruitment campaign based on survey results for implementation. **[SEE REPORT AREA BELOW]**

Identify and evaluate methods to recruit respiratory therapy students as ACTIVE members of the AARC. **[Upon approval of above recommendation, the sub-committee will be charged with this task]**

Develop a scientific, data-driven process to implement and measure the effectiveness of current and new recruitment strategies. **[SEE REPORT AREA BELOW]**

Develop strategy to entice more member use of AARConnect. **[ON-GOING]**

Report

The 2013 AARC Membership Campaign was officially launched this quarter. The Executive office team with Co-Chairs of this committee met to develop the strategies used to launch this campaign. We developed communication strategies for the membership and made resources available to Chartered Affiliates to develop their own campaigns.

1) The 2013 AARC Membership Campaign includes incentives for both the members and the Affiliates; these were communicated through a launch article with messages

from President Gaebler and Co-Chairs Frank Salvatore and Gary Wickman. Website was launched in early January. Later that month a You Tube video from Frank promoting the AARC Membership Campaign, benefits of membership and incentives for renewing and new members was also posted on the AARC Website.

2) Frank, Gary and Sherry developed and recorded Web Cast for the Chartered Affiliates, their Presidents and Boards as a launch promotion for the campaign.
3) Launched a Membership Website for both members and Chartered Affiliates to use with resources and method to track their progress.
    a. Member section reviews benefits of membership, link to application and identifies incentives for renewing or joining as a new member.
    b. Affiliate section has resources for developing their own membership campaigns, tracks progress of each Affiliate and identifies incentive awards for Affiliates for this campaign. The tracking site allows State Affiliates to see current data on how they are doing in this campaign.
4) The committee awarded the first quarter membership incentive awards to Elizabeth Harvey for renewing her membership and to Deb Sheffield for a new membership. Elizabeth won an IPad and Deb won a Kindle Fire.
5) Next Steps include presenting this information at the upcoming Affiliate President's Workshop, organizing the membership committee to be assigned Affiliates to support during the rest of the campaign, another You Tube video to promote the campaign and to work with the new subcommittee to work to promote this campaign to our students.

Other

We want to thank the members of the Membership Committee. We'd also like to thank Tom Kallstrom, Sherry Milligan, Tim Myers and Doug Laher for all their work and guidance they have given during the first quarter of the year and on our year-long membership campaign.

Position Statement Committee

Submitted by Colleen Schabacker – Spring 2013

Recommendations

Recommendation # 1: Approve and publish the revised position statement on "Cultural Diversity". This statement is submitted for your review as Attachment #1. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: Made some verbiage changes to make this a stronger statement

Recommendation # 2: Approve and publish the revised position statement on "Telehealth in Respiratory Therapy". This statement is submitted for your review as Attachment #2. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: The revisions merely clean up the first paragraph; no content changes.

Recommendation # 3: Approve and publish the recently reviewed "Respiratory Therapy Protocols" position statement with no changes. This statement is submitted for your review as Attachment #3.

Justification: The committee felt it needed no revisions.

Recommendation # 4: Approve and publish the recently reviewed "Home Respiratory Care Services" position statement with no changes. This statement is submitted for your review as Attachment #4

Justification: The committee felt it needed no revisions.

Recommendation # 5: Approve and publish the newly developed position statement "Development of Baccalaureate and Graduate Education Degrees". This statement is submitted for your review as Attachment #5.

Justification: At the November 2012 Board meeting, this committee was given the charge of developing this position statement. Looking into the future and the work being done by "2015 and Beyond" group, this position statement is very timely.

Recommendation # 6: Approve and publish the totally revised position statement "Concurrent Therapy". This statement is submitted for your review as Attachment #6.

Justification: The old position on "Concurrent Therapy" was seriously looked at and deemed in much need of an overhaul. In fact, the group working on this; Rob Chatburn, Rick Ford, Garry Dukes, Linda VanScoder, Susan Rinaldo-Gallo and Dan Grady, decided to start from scratch. The reason for this decision was the fact the old position statement was written using requirements for Skilled Nursing Facilities, not critical care. Within the new statement, there is reference to the "Best Practices in Respiratory Care Productivity and Staffing" position statement, which in return, references the White Paper.

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 "Development of Baccalaureate and Graduate Education Degrees" is being presented at the April Board meeting. A special thanks to Linda VanScoder and Deryl Gulliford for their very timely and excellent submission.
- A draft of the proposed AARC position statement "Concurrent Therapy" is being presented at the April Board meeting. A special thanks Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Bill Dubbs, Shawna Strickland, Anne Marie Hummel, Susan Rinaldo-Gallo and Linda VanScoder for their work on "revamping" the "Concurrent Therapy" position statement.

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

- During 2013, the Committee''s goal is to complete the review of the eight (8) 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.

•§ Administration of Sedatives and Analgesic Medication by Respiratory Therapists - on hold

•§ Cultural Diversity - Kathleen Deakins - to be presented in April

•§ Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care - Colleen

•§ Home Respiratory Care Services - Jim Allen - to be presented in April

•§ Respiratory Care Scope of Practice - Jim Allen

•§ Respiratory Therapy as Extracorporeal Membrane Oxygenation (ECMO) Specialists - Colleen

•§ Respiratory Therapy Protocols - Tony Ruppert - to be presented in April

•§ Telehealth - Kathy Deakins - to be presented in April

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

Other

A special thank you to committee members Kathleen Deakins, Deryl Gulliford, Jim Allen, Linda VanScoder and Tony Ruppert.

Attachment #1

American Association for Respiratory Care

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

Position Statement

Cultural Diversity

The AARC professional community embraces diversity and multi-culturalism in all of its forms and promotes ~~a professional community established with understanding,~~ respect and cultural competence in every facet of its mission. The AARC is enriched by the unique differences found among its diverse members, their patients/clients, and other stakeholders. The AARC values and incorporates ~~encourages and promotes~~ equal opportunity, and promotes the use of ~~a culture where personal~~ personal and cultural backgrounds ~~are utilized effectively~~ to enhance our profession. The AARC accomplishes this by:

- Demonstrating sensitivity to all forms of diversity and multiculturalism including, but not limited to: age, gender and gender identity, race, color and ethnicity, nationality and national origin, ancestry, religious affiliation and creed, sexual orientation, socio-economic status, political affiliation, physical and mental abilities, veteran and active armed service status, job responsibilities and experience, education and training.
- Acknowledging the varied beliefs, attitudes, behaviors and customs of the people that constitute its communities of interest, thereby creating a diverse and multicultural professional environment.
- Promoting an appreciation for communication between, and understanding among, people with different beliefs and backgrounds.
- Accommodating the needs of the physically disabled at events and activities.
- Using multicultural content and gender-neutral references in documents and publications.
- Promoting diversity education and cultural competence in its professional education programs.
- Recruiting candidates from under-represented groups for leadership and mentoring programs.

Effective 12/94
Revised 12/07
Reaffirmed 07/10

Attachment #2

American Association for Respiratory Care

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

Position Statement

Telehealth and Respiratory Therapy

Telehealth is the broad ~~also known as telemedicine or telepractice, refers to the~~ use of electronic ~~interactive~~ synchronous or asynchronous communication ~~technologies~~ technology ~~and the internet~~ to provide ~~allow~~ virtual health care ~~providers~~ services and consultations (telemedicine) for patients or providers residing in separate locations. ~~in one location to offer services and provide consultations to patients and health care providers at another location.~~ Services can include patient assessment and education, diagnostic evaluation, sleep testing, monitoring, disease management, disease prevention, health promotion, and rehabilitation as well as specific patient consultations.

The American Association for Respiratory Care (AARC) supports efforts to provide patients access to respiratory therapy services via telehealth. Furthermore, the AARC supports the recognition of respiratory therapists as providers of telehealth services under Medicare, Medicaid, commercial and other health insurance programs.

Effective 03/01
Revised 07/10

Attachment #3

American Association for Respiratory Care

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

Position Statement

Respiratory Therapy Protocols

Respiratory therapy protocols are used to initiate or modify a patient care plan following a pre-determined and structured set of physician orders. They include instructions or interventions in which the respiratory therapist is allowed to initiate, discontinue, refine, transition, or restart therapy as the patient's medical condition dictates. Protocols are generally written in algorithmic form, are based on scientific evidence, and include guidelines and options at decision points along with clearly stated outcome objectives.

Current medical literature supports the use of respiratory therapy protocols as an effective tool for producing improved patient outcomes and appropriate allocation of services. Based on their demonstrated efficacy, it is the position of the American Association for Respiratory Care that institution-approved protocols should be used by respiratory therapists as the standard of care for providing respiratory therapy services under qualified medical direction.

Effective 05/16/01
Revised 07/07

Attachment #4

American Association for Respiratory Care
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

Position Statement
Home Respiratory Care Services

Home respiratory care is defined as those prescribed respiratory care services provided in a patient's personal residence. Prescribed respiratory care services include, but are not limited to:

- patient assessment and monitoring
- diagnostic and therapeutic modalities and services
- disease management
- patient, family and caregiver education

These services are provided on a physician's written, verbal or telecommunicated order and practiced under appropriate law, regulation, and qualified medical direction or physician supervision. A patient's place of residence may include, but is not limited to: single-family homes, multi-family dwellings, assisted living facilities, retirement communities, and skilled nursing facilities.

The goals of home respiratory care are to:

- achieve the optimum level of patient function through goal setting
- educate patients and their caregivers
- administer diagnostic and therapeutic modalities and services
- conduct disease state management
- promote health

It is the position of the American Association for Respiratory Care (AARC) that the respiratory therapist—by virtue of education, training, and competency testing—is the most competent health care professional to provide prescribed home respiratory care. The complexities of the provision of home respiratory care are such that the public is placed at a significant risk of injury when respiratory care services are provided by unqualified persons, either licensed or unlicensed, rather than by persons with appropriate education, training, credentials, and competency documentation.

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

Effective 12/14/00

Revised 12/07

Revised 07/10

Attachment #5

Position Statement of the American Association for Respiratory Care

Development of Baccalaureate and Graduate Education Degrees

The continually expanding knowledge base of today's respiratory care field requires a more highly educated professional than ever before. The realities of healthcare reform under the Patient Protection and Affordable Care Act place additional importance on higher education as the foundation for professional roles and reimbursement for professional services. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate respiratory therapists achieve formal academic preparation commensurate with an advanced practice role.

American healthcare now requires respiratory professionals who can practice in a diversity of clinical settings, in leadership and educational settings, and who can function at a higher level of independence in clinical decision making for their patients. Professional respiratory therapists must be capable of supporting their patients through the maze of medical services and resources which are now available to them, educating patients regarding pathophysiology, diagnostic, treatment regimens and positive self-care for better outcomes and wellness.

Professional respiratory therapists must also prepare themselves for a broader role in community health, health promotion, health maintenance and coordination across the continuum of their patients' medical care.

It is the position of the American Association for Respiratory Care that practicing respiratory therapists and respiratory therapy students currently in training should be strongly encouraged to seek higher education beyond the associate degree entry-level to the bachelors' level, thereby preparing themselves for greater responsibility and greater independence of function over the decades ahead.

It is the position of the American Association for Respiratory Care that respiratory therapists seeking to practice in advanced clinical settings, in leadership roles, and in professional educator roles be strongly encouraged to seek higher education at the masters or doctoral levels, demonstrating the value of advanced learning in their own organizations.

The profession of Respiratory Care itself, the leadership of respiratory care departments and services, and most importantly the care of our patients will be advanced as our members themselves advance their qualifications through higher academic preparation. Academic institutions which conduct respiratory therapy education should develop bachelors', masters' and doctoral programs at this time to support the need for such higher education within the field of respiratory care.

Attachment #6

American Association for Respiratory Care

Position Statement

Concurrent Therapy

draft 2-11-13

In line with its mission as a patient advocate and in order to ensure patient safety and cost-effective staffing levels in Respiratory Care Departments, the American Association for Respiratory Care has adopted the following position statement:

Concurrent therapy, also known as "treatment stacking", means providing a defined patient treatment that has a standard treatment time based on a 1:1 caregiver-patient ratio to more than one patient at a time. It is the position of the American Association for Respiratory Care that systems used to define respiratory care staffing levels, inclusive of the practice of concurrent therapy, should be in compliance with the AARC Position Statement "Best Practices in Respiratory Care Productivity and Staffing". Concurrent therapy when applied as a staffing reduction measure, without regard for the quality of therapy provided is a practice not supported by the Association.

Managers are advised to audit their operations to determine if therapists are practicing concurrent therapy. If concurrent therapy is practiced, the reasons should be determined. If concurrent therapy is mainly due to inadequate staffing levels to accommodate *average* workload, then the manager should seek to obtain more staff or implement alternative approaches such as protocols, triage, staggered work hours, etc. If concurrent therapy is practiced mainly to accommodate the occasional unavoidable *peak* work load, then appropriate measures should be implemented to assure that each patient is assessed for appropriateness of unsupervised therapy. A written policy should state when and how concurrent therapy may be applied in this context.

The Association also realizes that there is significant variability related to the reasons concurrent therapy may be practiced. Such practices must be determined on a case-by-case basis and approved by the medical staff and administration in individual hospitals. The practice can only be supported when the patients in question have undergone a thorough individual assessment to document that their safety and outcomes will not be compromised by failing to receive one-on-one care.

Position Statement Review Schedule
Originally Proposed 02/20/2007;
Last approved by BOD 12/2009; 12/2/2010
Last Update: 11/08/2010, 03/04/2011

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2013-x)	Schedule Review for 2013	Schedule Review for 2014	Schedule Review 2015	Schedule Review 2016	Schedule Review for 2017
AARC Statement of Ethics and Professional Conduct	1994	2012	1			X		
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2010	3	X			X	
Competency Requirements for the Provision of Respiratory Therapy Services	1998	2011	2		X			X
Continuing Education	1990	2012	1			X		
Cultural Diversity	1994	2010	3	X			X	
Definition of Respiratory Care	1987	2011	2		X			X
Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	2009	2010	3	X			X	
Hazardous Materials Exposure	2002	2011	2		X			X
Health Promotion and Disease Prevention	1985	2011	2		X			X
Home Respiratory Care Services	2000	2010	3	X			X	
Inhaled Medication Administration Schedules	2008	2011	2		X			X

Licensure of Respiratory Care Personnel	1990	2012	1			X		
Pre-Hospital Mechanical Ventilator Competency	2007	2011	2		X			X
Pulmonary Rehabilitation	1973	2011	2		X			X
Respiratory Care Scope of Practice	1987	2010	3	X			X	
Respiratory Therapist Education	1998	2012	1			X		
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2010	3	X			X	
Respiratory Therapy Protocols	2001	2010	3	X			X	
Telehealth	2001	2010	3	X			X	
Tobacco and Health	1991	2011	2		X			X
Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child, or Adult Patient	2009	2012	1			X		
Best Practices in Respiratory Care Productivity and Staffing	2012	2012	1			X		
Verbal Orders	1990	2011	2		X			X
Development of Baccalaureate and Graduate Education Degrees	2013					X		
Concurrent Therapy	2002	2011				X		
				8	**9**	**8**	**8**	**9**

Social Media Committee

Submitted by: Brian Cayko - Spring 2013

Recommendations

No Recommendations to report

Report

The Social Media Committee was established in January 2013.

Members were contacted and ability to serve was discussed.
Committee Charge and Member involvement was outlined.
Conference Call was conducted to review distributed information and to discuss the committee's
Charge further along with the mechanism for establishing & discussing recommendations for the Board.
Current discussions are underway regarding potential recommendations.

Other

Social Media posting & member communication

As to date several members have been very active on social media pursuant to our charge
As to date there has been less than desirable response to my communications from the committee members
I am hopeful that this is due to the busy period we are currently in as well as the "Newness" of adding this committee's responsibilities to daily workloads

State Government Affairs Committee

Submitted by: John W. Lindsey - Spring 2013

I have reached out to the other committee members and we seem to all be on the same page with this committee.

I have also sent an e-mail message to each of the State Affiliate Presidents letting them know that the committee is here and willing to help in any way possible.

Since this is a legislative year, there are many bills being brought before the Senate and House of Representatives in many states. Ms. Cheryl West will be giving you a report on this.

I will point out one thing from my State of Arkansas. Arkansas has passed a 12-week Abortion bill. It was vetoed by the governor, but the veto was over-ridden by the senate and house. The ACLU has already said they would file suit contested the legality of the bill.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Spring 2013

Activities

1. Proposed a code for "Mechanical chest wall oscillation to facilitate lung function, per session". This was the third attempt to obtain this code and it was approved! The proposed language is posted below. Notice that it is option D, it's the fourth revision. It was truly a team effort and could not have been possible without the support of Drs. Steve Peters, and Mike Nelson from the ACCP and Dr. Steve Hoffman, ATS. This new code will appear in the 2014 CPT book and will be active on January 1, 2014.

2. We were able to get this code approved because HFCWO can be performed in clinics and physician offices. The AMA CPT will not approve codes for non physician health care provider's procedures that are exclusively performed in the inpatient world. The reason being that Medicare does not recognize CPT codes for inpatients due to the DRG system. However, once the code is active it can be used by RC departments for internal billing and productivity purposes.

3. Cheryl, Ann Marie and I have updated the Coding Resources on AARC.org

High-Frequency Chest Wall Manipulation

ONSITE OPTION D FINAL Feb 1, 2013

Category I -Pulmonary Diagnostic Testing and Therapies

Chest Wall Manipulation for the mobilization of secretions and improvement in lung function can be performed using manual (94667, 94668) or mechanical (9466X1) methods. Manual techniques include cupping, percussing, and use of a hand-held vibration device. A mechanical technique is the application of an external vest or wrap that delivers mechanical oscillation.

94667 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation

94668 subsequent

9466X1 Mechanical chest wall oscillation to facilitate lung function; each session

Foot note

Here is an excerpt from the minutes of the January – February CPT meeting received 3/313. Its official and I am doing the happy dance!

Tab 21: Mechanical Chest Wall Oscillation
This issue was presented by Stephen Hoffmann, MD, CPT Advisory Representative from the American Thoracic Society; Steve Peters, MD, CPT Advisory Committee representative from the American College of Chest Physicians; and Susan Rinaldo-Gallo, RRT, AARC, CPT HCPAC representative from the American Association for Respiratory Care. The Presenters indicated no disclosable conflicts of interest for this issue.

The Panel accepted with modifications on-site option D of this request to establish Category I code 9466X1 and add new guideline language to identify the application of and training for a device to accomplish mechanical high-frequency chest wall oscillation.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors - Spring 2013

Recommendations

None at this time.

AACVPR activities:

1. Day on Hill was held March 6/7, 2013: asking for a technical correction to amend Public Law 110-275 (MIPPA) to allow non-physician practitioners such as physician assistants, advanced nurse practitioners, and clinical nurse specialists to meet current physician supervision requirements required in pulmonary rehabilitation and cardiac rehabilitation programs.

2. AACVPR Program Certification Expert Panel - providing recommendations to the AACVPR Program Certification Committee. Members of committee are: Trina Limberg RRT;chair, June Schulz RRT, Chris Garvery FNP, MSN and myself

3. Leadership Board Development Committee – I am a member of this committee.

4. Master Fellows Committee – I am a member of this committee

American Heart Association

Submitted by Brian Walsh – Spring 2013

Recommendations

Recommend that we communicate the AHA clarification via appropriate channels.

Report

Tom, Cheryl and I met with the AHA leadership via a conference call to clarify my last report and recommendations presented to the BOD. As a reminder, there was a report from Montana members that the AHA was doing the following:

Issue #1: Montana AHA Regional Office reject RT volunteer application to apply to be ACLS instructor or AHA Regional faculty based on notion RTs scope of practice will not permit the RT to provide all the necessary skills needed.

It was pointed out that nurses and pharmacists who are permitted to apply don't have formal training (esp pharmacists) in advanced airway mgt. yet they can apply.

Issue #2 RTs are being told that after completing the ACLS course they will not receive a cards but just a certificate of course completion.

Issue #3 In AHA Manuals there is no mention of RTs as there is for nurses and pharmacists.

Issue # 4 AHA hasn't applied for AARC approval of continuing ed courses for RTs.

The below is the memo the AHA put out to their training centers.

REMINDER: Clarification on Definition of "Healthcare Provider" in AHA Advanced Courses
We have received several questions about who is eligible to take AHA ACLS and PALS courses, receive ACLS and PALS course completion cards and subsequently, be eligible for consideration for an AHA Regional Faculty position. On pages 44 and 54 of the ACLS and PALS Instructor Manuals, respectively, the target audience for these advanced courses is "any current, active healthcare provider" who practices ACLS or PALS skills in his or her occupation. Below, we have provided additional points to clarify the definition of healthcare providers.

- AHA uses the terminology of "any current, active healthcare provider" to be inclusive of any potential member of a resuscitation team. Also, because the AHA's course materials are translated into up to 12 languages and used in more than 40 countries, the terminology is broad enough to account for the fact that certain professions outside of the US do not require the same level of licensure as is required in the US.

- Examples of "any current, active healthcare provider" include, but are not limited to: physicians, nurses, paramedics, physician assistants, nurse practitioners, advanced practice nurses, dentists, respiratory therapists, pharmacists or any other provider who may be part of a resuscitation team. Therefore, there is no limitation for current, active

healthcare providers to attend AHA advanced courses or to be considered as Instructors for AHA advanced courses.

- Likewise, there is no limitation for any AHA Instructor to apply for Regional Faculty status based on his or her level of licensure. For example, a respiratory therapist who applies to become Regional Faculty will not be denied status solely on the basis of his or her level of licensure.

Other

The AARC and AHA concluded our 12/21 call with 3 follow-up items: send clarification message out in the ECC Beat, send message to AHA field-based volunteers; and forward AARC offer to assist with CEs'. Please see the below updates:

AARC offer to provide CE's for RTs: After we completed our call on 12/21/12, I provided an overview of the call along with the follow-up to a list of AHA staff that needed to be either informed or assisting in delivering outcomes. The person who manages this process from our department . The two parts of her response are below:

o She confirmed that "It is up to the individual training centers to seek credit for other professions for their classroom courses."

o She also explained that we have never received a request to provide CEs for RTs, but she would work with the AHA Professional Education Department to add this as a possible future enhancement. All CEs offered by the AHA is managed centrally through Professional Ed.

· ECC Beat: This message was published and transmitted this past Friday (2/15). Click on ECC Beat to view this online newsletter. Then, scroll down to the TCC Tidbits section. The message is the third topic labeled: REMINDER: Clarification on Definition of "Healthcare Provider" in AHA Advanced Courses. This newsletter covers all 3,300+ Training Centers, plus approximately 5,000 field based volunteers

· Message to volunteers: The above message will be repackaged and sent to all 48 Regional Committee members and transmitted within the next 10 business days. These volunteers are a subset of the 5000 volunteers mentioned above. The goal is to resend the message and increase the chance that the message is received. Lastly, we will include this topic during our Spring planning calls with our Regional Chairpersons (volunteer leadership).

American Society for Testing and Materials

Submitted by Robert McCoy – Spring 2013

Nothing to report

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Spring 2013

Recommendations: None

Report:

I have remained in contact with those chartered affiliates with whom I have worked over the past 5 years to provide ongoing assistance to their business planning and operations.

As I am typing this report, I have been notified by the Georgia Society for Respiratory Care President that they are interested in having me work with their board to develop an operating plan to guide their affiliate. As soon as I receive the official request, I will forward to AARC President George Gaebler for his review and approval.

I appreciate the support of the AARC leadership, AARC Executive Office, and the Chartered affiliate leadership-all of whom demonstrate the commitment, dedication, and passion to make these efforts both rewarding and successful.

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Spring 2013

The CAMTS Board of Directors held an additional board meeting in January via teleconference for additional deliberations and business items. We also discussed the pending levels of care standards after a public comment period. Discussion also centered on the new standards for medical escort services which is a new area of accreditation

The CAMTS BOS is scheduled to meet again in April in Austin Texas prior to the Critical Care Medical Transport Conference. We will be deliberating on 18 reaccreditations, 7 new programs and 3 Progress reports in addition to normal business discussions.

Extracorporeal Life Support Organization

Submitted by Donna Taylor – Spring 2013

No recommendations at this time

Report

The Extracorporeal Life Support Organization (ELSO) Steering Committee on which I serve met February 23rd at the 29th Annual Children's National Medical Center ECMO Symposium in Keystone Colorado. ELSO continues to expand across the globe. In addition to long established centers in the US, Canada and Europe, Asia and Latin America are developing active ECMO centers. Latin America now has the most growth in cases relative to size.

Very important decisions are due to be made this year regarding the future and growth of ELSO as an organization. The organization has grown out of the University of Michigan. Determining how to proceed forward with the important work of the organization—the ELSO Registry, education, printing of ELSO materials, monies collected by the organization for grants and projects—prompted the organization to seek council as to the best course of action to support ELSO. The chairman of the Steering Committee will soon receive the results of a third consultant report to determine if this relationship with the University of Michigan should continue, end or partner with a nonprofit organization to be founded to deal with the growth and increased responsibilities of the ELSO organization.

ELSO is considering revising the ELSO Registry to include more data fields to make the registry more valuable to ECMO research. The ELSO registry was utilized by Berlin heart to get the Berlin heart FDA approved last year in an unprecedented matched pairs trial.

Increasing demand for educational offerings with simulation training for ECMO may require additional personnel and resources from ELSO. The new ELSO website is evolving quickly as well and requiring more resources, time and expertise than available from the steering committee and subcommittee members.

The ELSO guidelines are now being revised and will have additional subjects added. These guidelines will be passed among the steering committee members to review before publishing. The steering committee member responsible for the revisions, Dr. Dan Brodie, is not only the Director of the ECMO Program at Columbia University, but also co-director of the Center for Acute Respiratory Failure and Associate Chief of the Division of Pulmonology, Allergy and Critical Care Medicine. These qualifications should lead to a more robust set of guidelines.

A case study that I submitted for the Keystone conference, "Extubation Of A 6 Year Old On ECMO" was accepted and I was honored to be able to present this case study in an oral presentation at the conference.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Spring 2013

Recommendations

None

Report

I. International Education Recognition System (IERS): Demand for approval of International Respiratory Care Educational programs and seminars continues to grow. Already in 2013 six programs have been approved or are under review. Requests for IERS approval have been received this year from the following:

Tokyo, Japan January - approved
Tokyo, Japan February - approved
Cairo, Egypt March – approved
Jeddah, Saudi Arabia May – under review
Xia Men City, China May – under review
Shanghai, China July - under review

II. "The 7th Congress of the Chinese Society of Critical Care Medicine", May 23 - 27, 2013, Xia Men City, Fujian Province, China. This is a national meeting being sponsored by the CSCCM. This is an historic event in that it is the first time the CSCCM has dedicated a Section of the Congress to Respiratory Care Clinical Practice. Three members of the ICRC Executive Committee have been invited and will participate as faculty in the meeting.

Joint Commission - Ambulatory PTAC

Submitted by Suzanne Bollig – Spring 2013

Recommendations - None at this time.

Report

The Ambulatory Professional and Technical Advisory Committee (PTAC) met by conference call on November 29, 2012. The purpose of the meeting was to review and discuss the results of a field review of proposed standards changes for the Ambulatory accreditation program.

• The majority of recommended changes from the field review was considered minor and primarily was clarification of definitions.

• Standard HR.02.01.03: The organization grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently. Recommended revisions included the definitions of "primary sources" and a listing of acceptable resources. There were no major disagreements within the committee.

• The definition of "discharge" from care was debated among the different representatives and ultimately the original definition and use of the term in the standards was left intact.

Other

The next PTAC Committee conference call is scheduled for Friday, March 15, 2013.

Respectfully submitted,

Suzanne Bollig

Joint Commission - Home Care PTAC

Submitted by Joe Lewarski – Spring 2013

Recommendations - No recommendations at this time

Other

The next scheduled PTAC conference call is March 20, 2013.

Joint Commission - Lab PTAC

Submitted by Franklyn Sandusky – Spring 2013

Recommendations - None

Report

The first Lab PTAC meeting of 2013 is March 21.

There is nothing to report at this time.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Spring 2013

Last meeting was a webinar on February 4th that lasted 3 hours. It appears that this may be the new method for these meetings instead of the 2 day in person meetings.

NHLBI Update: Dr. Gary Gibbons was announced to the group as the new director of NHLBI and that he has a continued commitment to the NAEPP. They are developing a small workgroup of NEAPP members to review and discuss the FDA proposal for Over-The-Counter (OTC) asthma medications. As this is a hot topic for everyone on the NAEPP and their partner organizations, the full NAEPP coordinating committee will receive updated on the activity of this group. The goal is to produce an official opinion or white paper on the topic of OTC asthma medications.

> I had a subsequent call with Rachel Tracy, Acting Coordinator of NAEPP, to inquire about my unanswered question from the webinar for the names of the individuals that will be part of this focus group. The group has not yet been appointed, thus there are no names to give at this time. I offered the support and cooperation of the AARC if they need recommendations for individuals to be part of this group, that if the NAEPP wanted participation from the AARC that individual would not necessarily be me but that the AARC president would recommend the appropriate person for the specific committee and within t the requirements of what they are looking for as participants (i.e. pulmonary physician, extensive researcher in asthma, etc.). *– I will keep the George and Tom informed as new information comes in from this committee prior to the next BOD meeting.*

School subcommittee has 2 new/updated publications that I participated in as an editor: "Asthma & Physical Activity in the Schools" & "Managing Asthma: A Guide for Schools". They documents are available on the NAEPP site for order (or will be soon).

EBR-4: The NHLBI is changing their process for systemic reviews. Once this process if finalized we will be conducting the EBR 4 update of the guidelines. It will not be a full review but will include updates to several topic areas that have new literature or will ass sections that now have enough literature to discuss and give an opinion on. Once the process at NHLBI is finalized there will be a call for suggested participants in the review group and the topics of which will be reviewed. *I will inform you all of this timely information so that we can have opinion on both topics and recommend individuals to be part of the review group.*

Lung Division Update: Dr. Kelly gave an update on the Lung Division activities since the last meeting and specifically a clinical research update form AsthmaNet (network of 9 asthma research centers with NIH grant funded projects). Upcoming research includes the topic of vitamin D in pregnant woman with asthma (and effect on asthma development in their babies), home-based asthma education programs in headstart, and asthma medication use in African-American children.

NACI Update: The 26 NACI funded projects gave their update. As all programs have reached the end of their funding and they are in the publication phase and we should be seeing these

publications soon. The coordinating committee will be updated as the publications are accepted and printed. As a reminder the NACI projects all surround programs to implement the EPR-3 guidelines using various methods and programs as well as the effectiveness of the guidelines in different populations.

President's Task Force on Environmental Health Risk and Safety Risk to Children: Sandra Howard, Senior Environmental Health Advisor to the Office of the Assistant Secretary for Health, introduced key components to improve delivery of the President's Task force related to Asthma.

- Identifying priority issues of Environmental health and safety risks to children that are best addressed through interagency efforts
- Recommending and implementing efforts
- Communicating information to Federal, State and Local decision makers to protect children from risk

The task force priorities include addressing asthma disparities, chemical exposure, and settings (such as home and school). To assist with this an asthma disparities action plan was launched in May of 2012 with the help of more than 80 members of federal, clinical, scientific and lay voluntary groups and community leaders. The r4 key strategies that fall into 3 areas of focus: surveillance/research, policy and public health intervention.

We discussed through question answer 2 of the 4 strategies and possible ways to achieve them.

The next meeting/webinar has not been scheduled as of yet. I will continue communicating with the BOD as timely requests and information occurs so that they can be kept up to date.

Natl Coalition/Health Professional Education In Genetics

Submitted by Linda Van Scoder – Spring 2013

The Genetic Alliance, in partnership with the March of Dimes, put together a letter supporting the continuation of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. We were able to add the AARC''s name to the letter. That charter was set to expire in April, which could have affected government policies on newborn screening.

I will continue to monitor Genetic Alliance communications for opportunities to support our patients' needs.

National Sleep Awareness Roundtable

Submitted by: Anne Marie Hummel - Spring 2013

Recommendations:

➔ **No recommendations**

Report

The National Sleep Awareness Roundtable (NSART) held its spring meeting on February 28, 2012. NSART has been funded under a 5-year grant from the National Sleep Foundation (NSF) and faces a new bidding cycle in September when the current grant runs out. Whether it will continue under the auspices of its current name or become a different entity will not be known until fall. There are currently 30 member organizations that comprise the Roundtable.

Mark Rosekind, a Member of the National Transportation Safety Board gave a presentation on *The Role of Sleep in Transportation Safety*. The Board is responsible for determining the probable cause of accidents involving all modes of transportation and making recommendations to prevent their recurrence. He noted that fatigue accounts for almost 80% of accidents.

CDC updated members on its sleep surveillance activities including its recent Morbidity and Mortality Weekly Report (MMWR) on Drowsy Driving. CDC plans to develop a new sleep module in the BRFSS based on recommendations from NSART members focusing on perceptions about sleep importance/priority, talking with a health provider about sleep and products used to either keep alert or induce sleep.

The National Sleep Foundation presented data from its latest Sleep in America® Poll on Sleep and Exercise. Key findings include the following: 1) exercisers say they sleep better, 2) vigorous exercisers report the best sleep, 3) non-exercisers are the sleepiest and have the highest risk for sleep apnea, 4) less time sitting is associated with better sleep and health. NSF has amended its sleep recommendation for "normal" sleepers to encourage exercise without any caveat to time of day as long as it is not at the expense of sleep. Those with chronic insomnia should continue to restrict late evening and night exercise if it is part of the treatment regimen.

NSART accomplishments include the addition of sleep health as a Healthy People 2020 topic, promoting press releases for national Sleep Awareness Week®, Drowsy Driving Prevention Week® and the Sleep in America® poll; writing a commentary on *Sleep is a Healthy Behavior*, and providing a place for diverse stakeholders in the sleep field to share ideas, information and data.

Neonatal Resuscitation Program

Submitted by John Gallagher – Spring 2013

Recommendations

No recommendations at this time

Report

The NRP Steering Committee met in March at the AAP headquarters in Elk Grove, Illinois. This was their semi-annual meeting which is routinely held there for the Spring session. Later this Fall, the Committee will meet at the site of the AAP national convention in Orlando, Florida. Following the meeting, the committee and its liaisons will host a NRP Current Issues Seminar for NRP providers and instructors.

Current initiatives within the committee are a redesign of the regional trainer role. Among many ideas is one to have a select few trainers (yet to be titled) in zones throughout the United States. Within each zone, the hope would be to have a respiratory therapist identified as lead trainer that could facilitate training in their zone. I suggested that this may also serve well as a feeder system for future liaisons from the AARC to the committee. More details will be provided as the process unfolds.

Also of current debate is whether or not all NRP providers should have to complete all lessons of NRP to satisfy the basic requirement. At this time, instructors have the option of skipping sections related to medication administration if the duty does not fall upon a specific discipline, like RT. I have strongly advocated that all providers should learn all lessons, including medication delivery, as a means of understanding the entire flow of the guidelines. To support this position, I have written an article for the upcoming NRP Instructor Update in which I discuss the background of respiratory care and the many roles of the respiratory therapist. Any further decisions will be shared by this liaison.

No further updates.

Roundtable Reports

Asthma Disease Management

Submitted by: Michael Shoemaker – Spring 2013

Recommendations

We would like to change the name of the roundtable

We will keep you posted with our suggestions

Report

Members of the roundtable met during the Congress for an hour. Suggestions were made to possibly change name of the committee and we will be holding a teleconference to discuss ideas brought up during this meeting.

Details of teleconference to come

- We also submitted 2013 AARC Congress asthma topic ideas for submission and we are waiting to hear if they were approved
- Article ideas were also submitted for asthma topics for future AARC Times.
- Roundtable members will likely be involved in an IRB approved, multi-center study: *A Survey of Asthma Knowledge Across Multiple Disciplines*. Will update with new information as available.

Consumer

See Executive Director Report

Disaster Response

Submitted by Charles Friderici – Spring 2013

Recommendations

None

Report

There has been increased activity in posting documents and downloads in the AARC connect space for the roundtable

We have begun to see some posting and dialogue in the discussion forums of the roundtable.

I will continue to post relevant materials, and engage other members in discussion of these materials.

We have seen a slight increase in the number of members in the roundtable. I will continue to promote it in my AARC connect blog.

I will be reaching out as well to therapists to encourage them to become active with HHS, either in a DMAT, or locally in the medical reserve corps or other similar groups.

Geriatrics

No report submitted as of March 28, 2013

Hyperbaric

Submitted by Cliff Boehm – Spring 2013

Recommendations

No new recommendations

Report

Two items discussed in the AARConnect HBO Roundtable:

Disinfection of ventilator components

reimbursement for a new indication for HBOT: medicare approval for idiopathic sudden sensorineural hearing loss

Other

no new information

Informatics

No report submitted as of March 28, 2013

International Medical Mission

Submitted by Lisa Trujillo – Spring 2013

Recommendations

No new recommendations at this time.

Report

Membership has increased to 74. Following the November Congress IMMR meeting, folders have been created within the roundtable library to allow for sharing information related to (a) donations available for mission trips, (b) education presentations used in community and clinical health education, and (c) available mission trips.

Other

Side note: National involvement in mission trips seems to be growing through exposure to this roundtable, AARC Times articles and AARC Congress presentations on International Missions. My mission trips to Ghana this summer will include 5 out of state RTs.

Military

Submitted by Harry Roman – Spring 2013

Recommendations

None at this time

Report

The Military Roundtable is requesting the AARC BOD to support and to promote the following initiatives:

• H.R. 4057, "The Improving Transparency of Education Opportunities for Veterans Act", signed into law Jan 2013.

This law strengthens the educational benefits afforded to veterans and will give them the best available information available about higher education.

The AARC could attract veterans into pursuing an education and a career as respiratory therapists as they transition from active duty to civilian life.

http://veterans.house.gov/press-release/veterans-bills-become-law

• The VOW to Hire Heroes Act of 2011 also known as the Veterans Retraining Assistance Program (VRAP) was recently passed by Congress to provide assistance for unemployed Veterans.

The VRAP will provide training for programs of education that lead to a high demand occupation including Respiratory Therapy. http://www.benefits.va.gov/VOW/education.htm

Other

The Military Roundtable has been promoting the RC Journal and the AARC Connect to the active duty military RTs through other social media outlets.

Neurorespiratory

Submitted by Lois Rowland Spring 2013

Membership increased to current 125 members with the assistance of Sherry Milligan merging related groups in December 2012. In October, there were 60 Neurorespiratory Roundtable members, yet 87 members in AARConnect with the Neuromuscular identifier.

Ten lectures were submitted from the roundtable for the 2013 AARC International Congress. The proposals are from 4 speakers, 2 of whom are international.

Research

Submitted by John Davies – Spring 2013

Recommendations

None

Report

Membership has increased to 86. Discussions have picked up slightly especially in regards to the recent OSCILLATE and OSCAR Trials. I have spoken to a few key members about their lack of contribution. They cited large workloads at their institutions but said they would try and contribute as the abstract deadline gets closer. I'm hoping to stimulate more discussion with periodic reviews of RC Journal articles.

Simulation

Submitted by Julianne Perratta – Spring 2013

Recommendations

None at this time

Report

Several simulation-based workshops were submitted to the AARC Program Planning Committee, including ones that would incorporate more experiential learning and active simulation during the congress and/or summer forum. Will await to hear the committee's decision

The next quarter goals are to elicit more sharing of programs and ideas using the Roundtable site on AARConnect, and solicit suggestions from Roundtable members for continuing topics in the discussion board and file sharing sections.

Tobacco Free Lifestyle

No report submitted as of March 28, 2013

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Spring 2013

Recommendation

None

Charge

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

Status

Beginning recruiting candidates for the Summer HOD Meeting.

Charge

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

Status

Ongoing

Other

Reviewed the Mission Statement for the Committee

Ad Hoc Committee on Officer Status/US Uniformed Services

No report submitted as of March 28, 2013

Ad Hoc Committee on Leadership Institutes

Submitted by Toni Rodriguez – Spring 2013

Recommendations

None

Report

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 2013

Development of module content continues. A deadline of April 1st has been set for the tracks currently under contract to include Research and Education. We are still seeking developers for the Management Track. Even with this delay we have targeted a roll-out for fall 2013.

Other

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, Shawna Strickland PhD, RRT-NPS, AE-C, FAARC

Ad Hoc Committee on 2015 & Beyond

Submitted by Toni Rodriguez – Spring 2013

Recommendations

None

Report

Committee Co-Chairs are waiting for final confirmation of committee charges and membership. There is no committee activity to report at this time.

Ad Hoc Committee to Recommend Bylaws Changes

Submitted by Denise Johnson – Spring 2013

AARC Bylaws

ARTICLE I - NAME

This organization shall be known as the American Association for Respiratory Care, incorporated under the General Not-For-Profit Corporation Act of the State of Illinois, hereinafter referred to as the Association.

ARTICLE II - OBJECT

SECTION 1. PURPOSE

AARC Vision/Mission Statement

The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist.

The Association is formed to:

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

SECTION 2. INTENT

a. No part of the monies of the Association shall inure to the benefit of any private member or individual, nor shall the Association perform particular services for individual members thereof.
b. The Board of Directors shall provide for the distribution of the funds, income, and property of the Association to charitable, educational, scientific, or religious corporations, organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payee or distributees are exempt from income taxation, and if gifts or transfers to the payee or distributees are then exempt from taxation under the provisions of Sections 501, 2055, and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.
c. In the event of the dissolution of this Association, whether voluntary or involuntary, all of its remaining assets shall be distributed in such a manner as the Board of Directors of this Association shall by majority vote determine to be best calculated to carry out the objectives and purposes for which the Association is

formed. The distribution of the funds, income, and property of this Association upon the dissolution may be made available to any charitable, educational, scientific, or religious corporations, organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payee or distributees are then exempt from income taxation, and if gifts or transfers to the payee or distributee are then exempt from taxation under the provisions of Sections 501, 2055 and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.

d. The Association shall not commit any act which shall constitute the unauthorized practice of medicine under the laws of the State of Illinois or any other state.

ARTICLE III - MEMBERSHIP

SECTION 1. CLASSES

The membership of the Association shall include three classes: Active Member, Associate Member, and Special Member.

SECTION 2. ACTIVE MEMBER

An individual is eligible for Active Membership if he/she lives in the United States or its territories or was an Active Member prior to moving outside its borders or territories, and meets ONE of the following criteria: (1) is legally credentialed as a respiratory care professional if he/she is employed in a state or territory that maintains a legal credential for respiratory care professionals OR (2) is a graduate of an educational program in respiratory care accredited by an AARC- recognized agency, OR (3) holds a credential issued by an AARC-recognized agency. An individual who was an AARC Active Member in good standing on December 8, 1994, will continue as such, providing his/her membership remains in good standing. Active Members in good standing shall be entitled to all the rights and privileges of membership of the Association including: the rights to hold office, hold committee chairs, and vote.

SECTION 3. ASSOCIATE MEMBER

Individuals will be classified as Associate Members if they hold a position related to respiratory care but do not meet the requirements to become Active Members. Associate Members shall have all the rights and privileges of membership except that they shall not be entitled to hold office, vote, or serve as a director, chair of any standing committee or specialty section of the Association. There shall be the following subclasses of Associate Membership:

a. Foreign Member – Individuals will be classified as foreign members if they meet all the requirements for Associate Membership and they are citizens of or reside in any country other than the United States of America.

b. Student Member – Individuals will be classified as Student Members if they meet all the requirements for Associate Membership and are enrolled in an educational program in respiratory care accredited by, or in the process of seeking accreditation from, an AARC-recognized agency.

c. Foreign Student Member – Individuals will be classified as Foreign Student Members if they meet all the requirements for a Foreign Member and are enrolled in an educational program in respiratory care which is accredited or is seeking accreditation by an appropriate governmental or professional accrediting agency.

d. Physician Member – Individuals will be classified as Physician Members if they meet all the requirements for Associate membership and are duly licensed as doctors of medicine or osteopathy.

e. Industrial Member – Individuals will be classified as Industrial Members if they meet all the requirements for Associate Membership and their primary occupation or business or a majority of their

business time is directly or indirectly devoted to the manufacture, sale, or distribution of equipment or products which are directly or indirectly used in the area of respiratory care.

SECTION 4. SPECIAL MEMBER

a. Life Member – Life Members shall be members who have rendered outstanding service to the Association as Active Members. Life Members shall have all the rights and privileges of active membership of the Association. Life Members shall be exempt from the payment of dues. Hereinafter all references to Active Members shall refer to both Active and Life Members of the Association.
b. Honorary Members – Honorary Members shall be persons who have rendered distinguished service to the field of respiratory care. Honorary Members shall have all the rights and privileges of Associate Membership of the Association. Honorary Members shall be exempt from the payment of dues.
c. General Member – General Members shall be individuals who have an interest in respiratory care and who do not qualify for other membership classifications. General Members shall have all the rights and privileges of Associate Membership in the Association.

SECTION 5. PREREQUISITES
FOR MEMBERSHIP

Applicants for membership shall meet all the qualifications of the class of membership for which they apply. As a condition of membership, all Members shall be bound by the Articles of Incorporation, Bylaws, standing rules, code of ethics, and other rules, regulations, policies, and procedures adopted from time to time by the Association.

SECTION 6. APPLICATION
FOR MEMBERSHIP

a. Applicants for membership shall submit their completed official application to the Executive Office of the Association.
b. The names and addresses of applicants accepted by The Executive Office shall be submitted for publication.
c. Any member or members may object to approval of an applicant for membership by filing written objection with the Executive Office within (30) calendar days after publication of the applicant's name. If an objection is received, the Executive Office shall promptly notify the President, Judicial Committee Chair, the applicant, and the Chartered Affiliates-President. Whenever there is an objection, the Judicial Committee shall reevaluate the application and make a decision regarding admission.

SECTION 7. SPECIALTY SECTIONS

a. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. Specialty Sections with a minimum of 1000 active members may be considered for a seat on the Board.
b. The active members of each Specialty Section shall elect a Chair-elect every third year. Elections shall be staggered such that a maximum of one third (1/3) of section chairs-elect shall be elected each year.

SECTION 8. PAYMENT OF DUES

Each member of the Association, except Life Members and Honorary Members, shall pay dues in such amounts and in such manner as may be established annually by the Board of Directors.

SECTION 9. ETHICS

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

ARTICLE IV - OFFICERS

SECTION 1. OFFICERS

a. The Officers of the Association shall consist of the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, Secretary-Treasurer, and in alternate years President-Elect, and shall be elected in accordance with the provisions of Article XII, Section 2 (b).
b. Officers of the Association shall not concurrently be members of national respiratory care credentialing or accreditation bodies, chartered affiliate staff or voting members of their Board of Directors.

SECTION 2. TERM OF OFFICE

a. The term of office for the President-elect shall be one (1) year. The term of office for the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, and Secretary-Treasurer shall be two (2) years. The term shall begin immediately following the Annual Business Meeting.
b. The President-elect shall complete immediate successive full terms for the offices of President-elect, President, and Immediate Past President before being eligible to serve a successive term in any elected office.

SECTION 3. VACANCIES IN OFFICE

a. In the event of a vacancy in the office of President, the Immediate Past President shall resume the duties but not the office of President until a special election can be held to fill the office.
b. In the event of a vacancy in the office of President-elect due to resignation or inability to perform duties, the Vice President for Internal Affairs shall assume the duties, but not the office, of the President-elect and shall also continue to serve as Vice President for Internal Affairs until a special election is held to fill the office of President-elect.
c. Any vacancy in the office of either Vice President or the Secretary-Treasurer shall be filled by the appointment of a qualified individual by the Board of Directors. Individuals so appointed shall serve until the next scheduled election for that office.
d. In the event of a vacancy in the office of immediate Past President, the most recent Past President will assume the office of Immediate Past President. If that person is unable or unwilling to serve, the office shall be filled by the appointment of a qualified individual by the Board of Directors. Individuals so appointed shall serve the remainder of the term.

SECTION 4. DUTIES OF OFFICERS

a. President – The President shall be the Chief Executive Officer of the Association. The President shall preside at the Annual Business Meeting and all meetings of the Board of Directors; prepare an agenda for the Annual Business meeting and submit it to the membership not fewer than thirty (30) calendar days prior

to such a meeting in accordance with Article VI of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) calendar days prior to such meeting; appoint standing and special committees subject to approval of the Board of Directors; be an ex-officio member of all committees except the Elections Committee; and present to the Board of Directors and membership an annual report of the Association.
b. President-elect – The President-elect, if sitting, shall perform duties as assigned by the President or Board of Directors.
c. Vice President for Internal Affairs – The Vice President for Internal Affairs shall serve as a liaison to the committees and groups of the Association as designated by the President and perform such other duties as shall be assigned by the President or the Board of Directors. The Vice President for Internal Affairs shall assume the duties of the President-elect in the event of the President-elect's absence, resignation, or disability, but will also carry out the duties of the office of the Vice President for Internal Affairs.
d. Vice President for External Affairs – The Vice President for External Affairs shall serve as a liaison to committees and groups as designated by the President, and perform such other duties as shall be assigned by the President or the Board of Directors.
e. Secretary-Treasurer – The Secretary Treasurer shall see that full and accurate accounts are kept; see that the Executive Office submits monthly financial statements to the Board of Directors, House of Delegates Officers, and the Finance Committee within a reasonable period of time after the monthly closing of the books, make a complete written yearly report at the Annual Business Meeting; keep complete and accurate minutes of meetings of the Board of Directors, Executive Committee, Finance Committee, the Annual Business Meeting, and any other meeting as directed by the President; and perform such other duties as shall be assigned by the President or the Board of Directors. At the expense of the Association, the Secretary-Treasurer shall be bonded in an amount determined by the Board of Directors.
f. Immediate Past President – The Immediate Past President, shall advise and consult with the President, serve as a member of the Bylaws Committee, serve as a liaison to the Board of Medical Advisors and perform such other duties as shall be assigned by the President or the Board of Directors. If the office of President becomes vacant, the Immediate Past President will resume the duties of President until a special election can be held.

ARTICLE V - BOARD OF DIRECTORS

SECTION 1. COMPOSITION AND POWERS

a. The executive government of the Association shall be vested in a board of at least seventeen (17) and no more than eighteen (18) Active Members consisting of at least five (5) Officers, and twelve (12) Directors-at-Large, and/or Section Chairs serving as a Director. So long as the number of Section Chairs serving as Directors is at least six (6), the number of at-Large Directors shall be equal to the number of Section Chairs serving as Directors. If the number of Section Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of twelve (12) director seats on the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the Presidents Council, and the Chair of the Board of Medical Advisors shall serve as non-voting members. Directors shall be elected in accordance with the provisions of Article XII, Section 2 (b).
b. Members of the Board of Directors shall not concurrently be members of national respiratory care credentialing or national respiratory care accreditation bodies, chartered affiliate staff or voting members of their Board of Directors.
c. The President shall be the Chair and Presiding Officer of the Board of Directors and the Executive Committee. The President shall invite such individuals to the meetings of the Board as deemed necessary, who shall have the privilege of voice but not vote.

SECTION 2. TERM OF OFFICE

Up to one-third (1/3) of the at-Large Directors shall be elected each year, and the term of office for all Directors shall begin following the Annual Business Meeting and shall be three (3) years.

SECTION 3. DUTIES

The Board of Directors shall:
a. Supervise all the business and activities of the Association within the limitation of these Bylaws.
b. Employ a business counsel to be identified as the Executive Director, who shall manage the Executive Office from which the business of the Association is conducted.
c. Govern the activities of the Executive Director.
d. Grant charters to affiliates which meet the requirements for affiliation upon recommendation of the Chartered Affiliates Committee; and have the power to revoke charters.
e. Adopt and rescind standing rules, regulations, policies, and procedures of the Association.
f. After consideration of the budget, determine for the following year the amount of membership dues, remunerations, stipends, and other related matters.
g. Furnish the elections committee with the names of qualified candidates for AARC Officers.
h. Perform such other duties as may be appropriate for the management of the Association.

SECTION 4. VACANCIES

a. Any vacancy that occurs in the office of an at-Large Director shall be filled by appointment by the Board of Directors.
b. An appointed at-Large Director shall serve until the next scheduled election, or until a successor is elected.
c. Any vacancy that occurs in the office of Section Chair serving as a Director shall be filled by the Chair-elect of that Specialty Section, if one is serving at that time. The ascending Chair-elect shall serve the unexpired term of the Chair and his or her own three (3) year term. If there is no Chair-elect, that Specialty Section will hold a special election of a Chair, who will serve the unexpired term and his or her own three (3) year term.
d. If no Chair-elect is serving at the time of vacancy, the vacancy shall be filled by appointment, of a member of that Specialty Section, by the Board of Directors. An appointed Section Director shall serve until the next scheduled election, or until a successor is elected.
e. The Board of Directors shall have the power to declare an office or seat on the Board of Directors vacant by a two-thirds (2/3) vote upon refusal, neglect or inability of any officer or director to perform their duties, or for any conduct deemed prejudicial to the Association. Written notice shall be given to the member that the office has been declared vacant.

SECTION 5. MEETINGS

a. The Board of Directors shall meet immediately preceding and immediately following the annual Business Meeting of the Association and shall hold not fewer than two (2) regular and separate meetings during the course of the year.
b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Association shall require, or upon written request by the majority of the Board of Directors filed with the President and the Executive Director of the Association.
c. Meetings of the Board of Directors may be in person, by telephone or video conferencing or other electronic means as shall be determined by the Board of Directors.
d. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

SECTION 6. VOTE OF MEMBERSHIP

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

ARTICLE VI - ANNUAL
BUSINESS MEETING

SECTION 1. DATE AND PLACE

a. The Association shall hold an Annual Business Meeting each calendar year. Additional meetings may be held as required to fulfill the objectives of the Association.
b. The date and place of the Annual Business Meeting and additional meetings shall be decided in advance by the Board of Directors. In the event of a major emergency, the Board of Directors may cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by alternate means provided the material is distributed in the same words to the membership.

SECTION 2. PURPOSE

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

SECTION 3. NOTIFICATION

Written notice of the time and place of the Annual Business Meeting shall be sent to all members of the Association not less than five (5) nor more than forty (40) calendar days prior to the meeting. An agenda for the Annual Business Meeting shall be sent to all members not fewer than thirty (30) calendar days prior to the Annual Business Meeting.

ARTICLE VII - HOUSE OF DELEGATES

SECTION 1. COMPOSITION

a The House of Delegates shall be composed of from one (1) to three (3) delegates from each Chartered Affiliate of the Association They shall be hereinafter referred to as the Delegation.
b. A Speaker shall be elected by and from the House to chair House meetings. The House shall elect such other officers and be responsible for such organizational practices as it may otherwise require.

SECTION 2. PURPOSE

The House of Delegates shall serve as a representative body of the general membership and the representative body of the Chartered Affiliates of the Association. It shall participate in the establishment of

the goals and objectives for the Association and participate in the governance of the Association.

SECTION 3. DUTIES

a. The House of Delegates shall adopt such rules, regulations, policies, and procedures with respect to the House as it may deem necessary or appropriate, and all Delegates shall be bound thereby.
b. The House Speaker may appoint members to the House Committees, subject to the approval of the House of Delegates. In the event of vacancies occurring in any House Committee, the Speaker may appoint members to fill such vacancies, subject to the approval of the House of Delegates.
c. Each Delegate shall:
1. Attend all meetings of the House of Delegates and report the activities to the respective Chartered Affiliate.
2. Attend the Annual Business Meeting of the Association as the representative of the Active Members of the Association within their respective Chartered Affiliate.
3. Furnish the Elections Committee with the names of qualified members for nomination as Director-at-Large.
4. At the direction of their respective Chartered Affiliate, present proposed amendments to the Bylaws Committee.
5. Perform such other duties of office as may be necessary or required.

SECTION 4. MEETING

The House of Delegates shall meet preceding the Annual Business Meeting of the Association and at such other times as called by its Speaker or by the majority vote of the House of Delegates.

SECTION 5. ELECTION OF
DELEGATES

a. The Delegation shall be elected by the Active Members of the Association within their respective Chartered Affiliates.
b. Only Active Members in good standing of the Association who are not on the Board of Directors of the Association shall be eligible to be members of a delegation.
c. The Chartered Affiliate shall have the power to declare any position of the Delegation vacant upon refusal, neglect or inability of the Delegate to perform the duties of office, or for any other conduct deemed prejudicial to the Chartered Affiliate of the Association. Written notice shall be given to that Delegate and the Speaker of the House of Delegates that the office has been declared vacant.

SECTION 6. VOTING

a. Each delegation shall have one (1) vote for each Active Member within their Chartered Affiliate as submitted by the Executive Office and certified by the House of Delegates Credentials Committee.
b. The House Speaker shall appoint the members of the House Credentials Committee from the House. This Committee shall certify the Delegation and number of votes each Delegation may cast.

SECTION 7. QUORUM

A majority of the credentialed Delegations shall constitute a quorum at any meeting of the House of Delegates.

ARTICLE VIII - BOARD OF MEDICAL ADVISORS

SECTION 1. COMPOSITION

The Board of Medical Advisors of the Association shall consist of no less than twelve (12) individual members. Representation shall be maintained from each member organization, as defined by the Association Board of Directors policy. Members of the Board of Medical Advisors shall not concurrently be members of national respiratory care credentialing or accreditation bodies. Appointees to the Board of Medical Advisors must be physicians who have an identifiable role in clinical, organizational, educational or investigative respiratory care. Members of the Board of Medical Advisors must be members of the Association during their term.

SECTION 2. TERM OF OFFICE

Each member shall be appointed by the sponsoring member organization in such a manner that no more than one-fourth of the members of the Board of Medical Advisors shall be replaced in any year. Any vacancy that occurs on the Board of Medical Advisors should be filled by an appointment from the member organization. Terms shall commence immediately following the Annual Business Meeting.

SECTION 3. DUTIES

a. The Board of Medical Advisors shall elect their own officers and be responsible for such organizational policies and procedures as they may require.
b. The Board of Directors of the Association and all of its committees and specialty sections may consult with the Board of Medical Advisors in regard to medical issues. The Board of Medical Advisors shall assist the appropriate committees and specialty sections regarding medical and educational issues.
c. The Chair of the Board of Medical Advisors shall be a non-voting member of the Board of Directors.

SECTION 4. MEETINGS

An annual meeting of the Board of Medical Advisors shall be held at the time and place of the Annual Meeting of the Association, and other meetings shall be held at such times and places as shall be determined necessary by the Board of Medical Advisors.

ARTICLE IX - PRESIDENTS COUNCIL

a. The Presidents Council shall be composed of Past Presidents of the Association who have been elected to membership by the Council.
b. The Presidents Council shall serve as an advisory body to the Board of Directors and perform other duties assigned by the Board of Directors.
c. The Presidents Council shall elect a Chair from its membership to serve a one-year term beginning immediately following the Annual Business Meeting.
d. The Chair of the Presidents Council shall serve as a non-voting member of the Board of Directors and preside at meetings of the Presidents Council.
e. The Presidents Council shall meet annually following the Annual Business meeting of the Association.
f. The Presidents Council may appoint committees as necessary to complete its duties.
g. In the event of a vacancy in the Chair, the vacancy shall be filled according to the procedure defined by the Association.

ARTICLE X - CHARTERED AFFILIATES

SECTION 1. REQUIREMENTS

Twenty (20) or more Active members in good standing of the Association meeting the requirements for affiliation may become a Chartered Affiliate of the Association upon the affirmative recommendation of the Chartered Affiliates Committee and approval by the Board of Directors of the Association. Active Members of Chartered Affiliates must be Active Members of the Association. The minimum geographical boundaries of an applicant for a Chartered Affiliate of the Association shall encompass one or more entire states, territories, possessions, or protectorates of the United States. The District of Columbia shall be considered an entire state for this section.

SECTION 2. ADMISSION PROCEDURE

The formal application for a charter shall be sent to the Executive Office of the Association and shall consist of a list of officers, membership, minutes of the organizational meeting, the Bylaws, and a letter requesting approval of the proposed medical advisor or advisors.

SECTION 3. MEDICAL ADVISOR

Each Chartered Affiliate shall have one (1) or more medical advisors whose name(s) shall be submitted to the Board of Medical Advisors.

SECTION 4. DUTIES

A copy of the minutes of every meeting of the governing body and other business meetings of the Chartered Affiliates shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meeting.

SECTION 5. SUSPENSION OR REVOCATION OF A CHARTER

a. The Board of Directors of the Association may suspend or revoke the charter of any affiliate with due and sufficient cause or upon the failure of an affiliate to maintain a membership of at least twenty (20) Active Members in good standing of the Association.
b. Action for the suspension or revocation of the charter of any affiliate shall follow approved Association policy and procedure.

ARTICLE XI - INTERNATIONAL AFFILIATES

SECTION 1. REQUIREMENTS

Twenty (20) or more Foreign Members in good standing of the Association meeting the requirements for affiliation may become an International Affiliate of the Association upon the affirmative recommendation of the Chartered Affiliates Committee, and approval by the Board of Directors of the Association.

SECTION 2. INTERNATIONAL
AFFILIATE ADMISSION PROCEDURE

The formal application for International Affiliate status shall be sent to the Executive Office of the Association and shall consist of a list of officers, membership, minutes of the organizational meeting, the Bylaws, and a letter requesting approval of the proposed medical advisor or advisors.

SECTION 3. INTERNATIONAL
AFFILIATE MEDICAL ADVISOR

Each International Affiliate shall have one (1) or more medical advisors whose name(s) shall be submitted to the Board of Medical Advisors.

SECTION 4. INTERNATIONAL
AFFILIATE DUTIES

A copy of the minutes of every meeting of the governing body and other business meetings of the International Affiliate shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meeting.

SECTION 5. SUSPENSION OR
REVOCATION OF INTERNATIONAL AFFILIATE STATUS

a. The Board of Directors of the Association may suspend or revoke the International Affiliate status with due and sufficient cause or upon the failure of an affiliate to maintain a membership of at least twenty (20) Foreign Members.
b. Action for the suspension or revocation of International Affiliate status shall follow approved Association policy and procedure.

ARTICLE XII - COMMITTEES

SECTION 1. STANDING COMMITTEES

a The standing committees of the Association shall be: Bylaws, Elections, Executive, Finance, Judicial, Program and Strategic Planning. The Chair and members of standing committees, not otherwise designated in these Bylaws or Association Policy and Procedure, shall be appointed by the President, subject to the approval of the Board of Directors. With the exception of the Elections and Bylaws Committees, committee terms shall be for two (2) years. The Chartered Affiliates Committee, as referred to in these Bylaws, shall be a standing committee of the House of Delegates.
b. Decisions of standing committees, except as specified in Article XII, Section 2 (a) (3), may be appealed to the Board of Directors. A two-thirds (2/3) vote of the Board of Directors shall be required to sustain an appeal.

SECTION 2. COMPOSITION AND DUTIES OF COMMITTEES

a. Bylaws Committee
1. The committee shall be composed of the Immediate Past President and four (4) additional Active Members of the Association elected by the House of Delegates. The House elect members shall serve two year terms. These terms shall be staggered, with two (2) members being elected each year. The Chair shall be the senior House elect member, who, between the two senior members, received the greatest number of votes cast by the House.

2. Proposed amendments to the Bylaws may be originated by the Bylaws Committee or submitted to the Bylaws Committee only by the Board of Directors, House of Delegates, or Chartered Affiliates. The committee shall review the amendments proposed by any of the foregoing bodies and shall submit its recommendations to the proponent. Upon receipt of such recommendations, the proponent may, but shall not be obliged to, withdraw the proposed amendments from further consideration. Any proposed amendments that are not withdrawn by the proponent and any proposed amendments which are originated by the Bylaws Committee shall be delivered to the House of Delegates and the Board of Directors, with the committee's recommendations for same, at least sixty (60) calendar days prior to the date on which voting begins.
3. In the event of a problem with the interpretation of the Bylaws, the question shall be referred to the Bylaws Committee. Either the Board of Directors or the House of Delegates may refer a Bylaws interpretation matter to the committee by a two-thirds (2/3) affirmative vote. The decision of the committee shall be final.

b. Elections Committee

1. The committee shall be composed of six (6) Active Members; three (3) elected by the House of Delegates and two elected by the Board of Directors and the Immediate Past President. The Chair shall be selected by the House of Delegates.
2. The term of office for each member, except the Immediate Past President shall be three (3) years. The election of the members shall be staggered, so that no more than 50% of the membership changes each year.
3. The committee shall screen candidates nominated for Director, Officer, and Specialty Section Chair-Elect positions. Nominations for at-Large Directors shall be submitted to the committee only by the House of Delegates. Nominations for Section Chair-elect shall be submitted to the committee only by members of that Specialty Section. Nominations for Officers shall be submitted to the committee only by the Board of Directors.
4. The Chair of the committee shall report the slate of nominees to the Board of Directors and House of Delegates no later than June 1. The final slate of candidates shall be submitted to the Board of Directors and the House of Delegates before submission to the general membership.
5. The committee shall be responsible for preparing, distributing, receiving, and verifying all ballots. At least sixty (60) days prior to the Annual Business Meeting, ballots setting forth the slate of candidates shall be made available to Active Members of the Association in good standing. Only Active Members of a Specialty Section may vote for the Chair-elect of the Specialty Section. Provisions shall be made on the ballot for write-in votes for each office to be filled. Voting will close no less than thirty (30) calendar days prior to the Annual Business Meeting. Ballots shall be counted no less than twenty-one (21) calendar days prior to the Annual Business Meeting. The deadline date and time shall be clearly indicated on the ballot.

6. Association elections shall be determined by a plurality of the votes cast. A tie vote shall be decided by lot.

c. Executive Committee

1. The Executive Committee of the Board of Directors shall be composed of the President, Immediate Past President, Vice President for Internal Affairs, Vice
President for External Affairs, Secretary-
Treasurer, and in alternate years, the
President-Elect.
2. The Executive Committee shall have the power to act for the Board of Directors between meetings of the Board and such action shall be subject to ratification by the Board at its next meeting.

d. Finance Committee

1. The Finance Committee is composed of the Executive Committee of the Board of Directors and the House of Delegates Treasurer and Speaker-elect. The committee shall be chaired by the President. The committee shall submit for approval the annual budget to the House of Delegates and the Board of

Directors.
2. The Audit Subcommittee shall consist of the Speaker-elect, who shall be the chair, the House of Delegates Treasurer, and one member of the Executive Committee appointed by the President. The Secretary-Treasurer shall be a non-voting member. The subcommittee is responsible for monitoring the financial affairs of the Association in cooperation with external independent auditors.
e. Judicial Committee
1. The committee shall consist of not fewer than four (4) Active Members.
2. The committee shall review membership challenges, or complaints against any member charged with any violation of the Association's Articles of Incorporation, Bylaws, standing rules, code of ethics, or other rules, regulations, policies, or procedures adopted, or for any conduct deemed detrimental to the Association. Such complaints must be filed with the Chair of the Judicial Committee. The committee shall conduct a review in accordance with established policies and procedures. Such policies and procedures shall be available to any member upon request.
3. If the committee determines in its sole discretion that the complaint warrants further action, a written statement of the charges shall be prepared with benefit of legal counsel if deemed advisable, and the matter shall be resolved according to established policies and procedures.
4. The member shall have the right to appeal the decision of the committee to the Board of Directors. There shall be no appeal from the decision of the Board of Directors.
f. Program Committee
1. The committee shall consist of not fewer than four (4) Active Members.
2. The committee shall prepare the program for the Annual Business meeting and all other programs, as directed by the President.
g. Strategic Planning Committee
1. The committee shall consist of not fewer than five (5) members. The chair shall be the Immediate Past President.
2. The committee shall make recommendations to the Board of Directors about the direction of the Association and the profession of Respiratory Care.

SECTION 3. COMMITTEE CHAIR'S DUTIES

a. The Chair shall perform those duties as specified by the President and the Board of Directors to carry out the objectives of the Association.
b. The Chair of each committee shall confer promptly with the members of that committee on work assignments.
c. Members of any membership class, as well as non-members, may be appointed as consultants to committees. The President shall request recommendations regarding physician consultants from the Chair of the Board of Medical Advisors.

SECTION 4. SPECIAL COMMITTEES AND OTHER APPOINTMENTS

a. Special committees may be appointed by the President, subject to the approval of the Board of Directors.
b. Representatives of the Association to such external organizations as may be required shall be appointed by the President, with the approval of the Board of Directors.

SECTION 5. VACANCIES ON COMMITTEES

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

ARTICLE XIII - FISCAL YEAR AND BUDGET

a. The fiscal year of the Association shall begin on January 1 and end on December 31.
b. The annual budget proposed by the Finance Committee, shall be approved by the House of Delegates and Board of Directors before implementation.

ARTICLE XIV - PARLIAMENTARY AUTHORITY

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

ARTICLE XV - AMENDMENT

These Bylaws may be amended in accordance with Article XII, Section 2 (a) 2, if an amendment receives an affirmative majority vote of the Board of Directors and also receives an affirmative majority vote of the House of Delegates. The amendment must then be submitted to the membership for comments and input within forty-five (45) days of the first affirmative vote. After which the Board of Directors and the House of Delegates will have a second reading and vote. If the amendment receives an affirmative vote of two-thirds (2/3) of the Board of Directors and also receives an affirmative vote of two-thirds (2/3) of the House of Delegates, then it shall be adopted.

Ad Hoc Committee to Reduce Hospital Readmissions

Submitted by Greg Spratt – Spring 2013

Recommendations

None

Report

Nothing New to Report

Other

I did do an article in the Spring HC Section Newsletter on news reports of reductions in readmission rates.

30-Day Readmission Rates Drop
By Greg Spratt BS, RRT, CPFT

According to statistics compiled by the Obama administration, figures released by the Centers for Medicare and Medicaid Services (CMS) show that the national rate of 30-day readmissions for Medicare patients dropped to 17.8% in November 2012 after remaining stuck near 19 percent over the five years that the data has been collected.

Data released at a Senate Finance Committee hearing do not pinpoint a cause for the decline, but Jonathan Blum of CMS argues that the drop "is largely the result" of the health law's provisions, such as penalties for high readmission rates for certain conditions and new initiatives to reduce readmission rates, the *Washington Post* reports.

Under the Hospitals Readmissions Reductions Program, CMS will withhold up to 1% of all reimbursements for hospitals that have high 30-day readmissions for heart attack, heart failure, and pneumonia patients. Penalties will increase to a maximum of 2% starting October 2013 and 3% in October 2014.

While the data does not specifically state the reasons for the reduction in the Medicare readmissions rate, officials stated that the decline occurred as hospitals began focusing more on reducing readmissions, including both financial penalties for poor results and financial incentives for improved results in the health-care law.

For an example of positive re-enforcement, the Accountable Care Act (ACA) funded an initiative to create "hospital engagement networks," (HENs) designed to work with hospitals to improve coordination of patient care. The largest of the HENs has reduced its average 30-day readmission rate among its 450 hospitals from 11.2% in 2010 to 10.2% in September 2012.

On the negative side, in October 2012 Medicare started penalizing 2,217 hospitals that had high readmission rates, levying the maximum fine of a 1% reduction in all Medicare reimbursements on 300 of those hospitals through 2013.

As the three diagnoses involved (i.e., acute myocardial infarction, heart failure, and pneumonia) all involve care from respiratory therapists in both the hospital and home, this creates an exciting new opportunity for RTs to demonstrate their value by involvement in initiatives designed to reduce readmissions. The program is slated to expand to additional diagnoses in fiscal year 2015 (starting October 2014) which will likely include COPD.

The AARC's 'Hospital to Home' initiative was created to educate hospital and home care RTs on methods to decrease readmissions and has included a number of AARC Congress symposia and lectures, membership survey, webinar, and a number of papers presented at the AARC Congress on RT-led initiatives.

Sources:

1. Health law's rules help hospitals cut patient readmission rate. Washington Post. http://www.washingtonpost.com/national/health-science/health-laws-rules-help-hospitals-cut-patient-readmission-rate/2013/02/27/6d1fe3a2-8105-11e2-8074-b26a871b165a_story.html. Accessed March 5, 2013

2. Is Obamacare working? Hospitals finally see drop in readmissions. The Advisory Board Company. http://www.advisory.com/Daily-Briefing/2013/02/28/With-ACA-efforts-hospitals-finally-see-progress-on-readmissions. Access March 5, 2013

Ad Hoc Committee for Continued Development of Education Competition

No report submitted as of March 28, 2013

NBRC
ARCF

MEMORANDUM

Date: March 11, 2013

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

From: Kerry E. George, RRT, MEd, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you an update on the activities of the NBRC. Since the last report the NBRC Board and committees met in early December of 2012 in Tucson, Arizona and continued the work of approving test items and developing examination forms for the computerized testing system. Since that meeting, the examination committees have been very busy with the ongoing activities involved in the development of examination forms and working on many of the changes that will be made to the the examination systems in the coming years. For the fourteenth year (since the implementation of computer based testing) the NBRC has been able to continue to provide very high quality credentialing programs to the respiratory therapy profession with no increase in the testing fees for candidates.

2012 was unique for the NBRC in that two respiratory therapist members of the Board of Trustees needed to resign due to personal and employment issues. The AARC Board was very helpful by promptly assisting the NBRC with appointments of individuals to replace those board members.

Therapist Multiple-choice Examination

Members of the committee have been very involved in the activities that need to be completed prior to the implementation of the new examination in 2015. The job analysis has been completed, the Detailed Content Outline is being developed and the procedures and materials for the validation study are being finalized. The NBRC will be inviting therapists to complete a three part process to participate in this important step in the development of the new exam. The NBRC Board has approved a small financial incentive to those individuals who participate in the validation study as thanks for their participation. The committee also continues the ongoing work of developing and approving examination forms for the testing network.

Adult Critical Care and Sleep Disorders Specialty Examinations

The much requested Adult Critical Care Specialty Examination made its debut in July 2012. To date, 255 individuals have attempted this new examination. Since the inception of the Sleep Disorders Specialist Examination in December 2008, 230 individuals have earned the SDS credential. The number of therapist seeking this credential has never been as large as indicated by the data that resulted in the development of this examination system.

Any assistance the AARC can provide in making respiratory therapists aware of the value of these specialty credentials which were reqested by the AARC will be appreciated.

Clinical Simulation Examination Committee

The Clinical Simulation Examination Committee has been working very hard to meet the deadline of January 2015 for the implementation of the changes to this examination program. They have been working very hard to develop the newer, shorter examination problems and have them pretested in the examination system and develop the needed changes to the scoring of the examination.

Ohio Respiratory Care Board

The leaderships of the NBRC and AARC attended a public hearing in Columbus, Ohio on February 13, 2013. Testimony was shared both orally and in written form. Gary Smith also attended and presented testimony at a hearing before the Joint Committee on Agency Rule Review (*JCARR*) on February 18th. The conclusion of this process was that the rule changes to require the Registered Respiratory Therapist credential for persons to be newly licensed in Ohio beginning in 2015 will occur.

NCCA Accreditation

The NBRC received renewal of accreditation of all of its examination programs (except the Adult Critical Care Examination) by the National Commission for Certifying Agencies. This once every five year process required extensive documentation of the processes and procedures employed by the NBRC to ensure a fair, valid and reliable examination system. The NBRC will apply for accreditation of the new Adult Critical Care Specialty Examination in 2013.

Examination Statistics

The NBRC administered nearly 40,000 examinations in 2012. Through February 28, 2013, the NBRC has administered 4,669 credentialing examinations across all programs. Pass/fail statistics for the respective examinations for the period January 1 – February 28, 2013 follow:

Examination	***Pass Rate***	
CRT Examination – 1,497 examinations		
	Entry Level	Advanced
First-time Candidates	88.9%	75.5%
Repeat Candidates	11.8%	26.3%
Therapist Written Examination – 1,566 examinations		
First-time Candidates	64.2%	
Repeat Candidates	32.9%	
Clinical Simulation Examination – 1,386 examinations		
First-time Candidates	59.0%	
Repeat Candidates	45.8%	
Neonatal/Pediatric Examination – 123 examinations		
First-time Candidates	67.4%	
Repeat Candidates	50.0%	
Sleep Disorders Specialty Examination – 9 examinations		
First-time Candidates	71.4%	
Repeat Candidates	50.0%	
Adult Critical Care Specialty Examination – 41 examinations		
First-time candidates	89.5%	
Repeat candidates	66.7%	
CPFT Examination – 38 examinations		
First-time Candidates	60.0%	
Repeat Candidates	61.5%	
RPFT Examination – 9 examinations		
First-time Candidates	50.0%	
Repeat Candidates	100%	

Your Questions Invited

I look forward to continuing to work 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

Submitted by Michael T. Amato – Spring 2013

Recommendation: That the AARC consider returning fundraising for the AARC International Fellows back to the ARCF.
Justification: This will allow for a better mechanism for allowing donations to be considered as tax deductible because of the ARCF's 501C3 status. With the current structure this is not possible. We hope that this will increase the number of sponsorships moving forward.

Report
The Foundation held its annual Trustees meeting in early March. A lot was discussed much of which impacts AARC current and upcoming activities.

In 2012 you may recall that there was a concerted effort to bring to the attention of attendees the ARCF and what it means for members of the AARC. Video was produced and played in the buses that transported attendees at the Congress as well as before all plenary sessions. There was also a plea at the Awards Ceremony. Approximately $1,500 was raised as a result. In addition to this about $3,500 was raised as part of the donations members opted to given when they became members or renewed. Thus a total of $5,000 was raised from the members in all of 2013. Sadly, this equates to less than a dime per member. We will not give up and in an effort to make members more aware there were ARCF featured articles in the AARC Times in 2013 as we did not 2012. There will be another video recording of other AARC luminaries and recipients who will be able to speak to the members of the ARCF and the need to support it. They will be placed on our web site. I also want to thank the AARC for their tireless efforts in assisting the ARCF in making this happen. We could not have done this without their support.

The ARCF Trustees after much deliberation have decided to no longer fund the International Reception as part of their annual fundraiser. We learned that the fundraiser was not as successful as we expected despite our best marketing efforts through the years. There will still be a fundraiser at the Congress in 2013 and we hope it will draw attention to development of the AARC's Virtual Respiratory Care Museum. This ARCF fundraiser will take place on the Friday evening before the start of Congress (November 15, 2013). AARC Historian Trudy Watson and Sam Giordano will be working with the AARC moving forward in this effort.

Moving forward there will only be one Journal Conference each year. In 2013 the ARCF will be presenting the 52nd RESPIRATORY CARE Journal Conference on Adult Artificial Airways and Airways Adjuncts in St. Petersburg, FL on June 14-15.

I would like to thank the AARC Board of Directors for their ongoing support of the ARCF. Please feel free to contact me with any questions you may have regarding this report or the Foundation.

Unfinished Business

New Business

Policy Review

- BOD.025 – BOD - Conventions and Meetings
- BA.002 – BOMA - Member Organizations
- CA.005 – Chartered Affiliate– Chartered Affiliate Travel Grant
- CT.006 – Committees – Committee Travel Expenses
- FM.015 – Fiscal Management – Approval of Budget
- FM.021 – Fiscal Management – Old Outstanding Checks

White Paper Review

- Guidance Document on Scope of Practice
- RRT Credential

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Conventions and Meetings**

EFFECTIVE DATE:

DATE REVIEWED: September 2005

DATE REVISED: September 2005

REFERENCES: CM.000, CM.003 - 1997

Policy Statement:

Policy Amplification:

1. Products not related to respiratory care will not be permitted in the exhibit hall at the annual convention. The determination of non-related products shall be made at the discretion of the Convention Manager.

2. Prizes, awards, drawings, raffles, lotteries, or contests of any kind are expressly prohibited at the AARC convention.

3. Merchandise sale will not be allowed in the registration area. A special association booth will be located in the exhibit hall for sales. A current membership card is required in order to purchase AARC merchandise.

4. Point system for the sale of exhibit space:

    A. A priority closing date will be established approximately two weeks after the mailing of the initial notice of the convention.

    B. Exhibit applications received prior to this closing date will be assigned booth numbers by the point system.

C. Points to be awarded at the rate of one point per single booth for each of the last five years for which records have been kept.

D. Applications received after the closing date will be assigned space on a first-come, first-serve basis.

5. Hospitality Suite Policy: Assignment of suites shall be handled by the Convention Manager subject to the rules and regulations governing same.

A. Suites or other hospitality areas will not be open to the membership whenever any technical or educational session is underway, nor will they be open during exhibit hours.

B. Hospitality areas will only be open from 6:00 p.m. to 11:00 p.m., and if members do not cooperate, exhibitors will be asked to notify the Convention Manager and/or the Executive Director. Spot checks of hospitality areas will be made to insure that members are not present after 11:00 p.m.

C. Only firms or companies which have booth space at the exhibit hall will be allowed to maintain a hospitality suite.

D. Exhibitors must not allow members in hospitality areas who are under the legal drinking age. Exhibitors must enforce this policy, and members will be asked for identification if there is doubt that they are of drinking age.

E. Violators of this policy may, at the discretion of the Board of Directors or its designee, be subject to the loss of booth space privileges for two consecutive years.

F. A letter shall be sent to all exhibiting companies outlining the hospitality suite policy.

6. All persons attending the annual convention must register. No fees will be charged for attendance at constitutionally required sessions, i.e., meetings of the Board of Directors, House of Delegates, or Board of Medical Advisors. Fees will be charged for all other activities, i.e., lectures, general sessions and exhibits.

7. Registration fees are listed in the schedule of fees. Only members who have paid their current annual dues or whose applications are in progress will be admitted at the member rate. All others will pay the non-member rate.

8. Members registering at the meeting who have not registered in advance will be required to present their current membership card in order to register at the member fee. Any person who does not present a current membership card will be required to register at the non-member fee.

9. Refunds will not be given to an individual for fees paid by employer check. Refunds will be made directly to the employer following the meeting, provided a request for a refund is made prior to the meeting.

10 All advance registrations must be prepaid. No invoice will be issued for advance registration. Advance registration will be acknowledged.

11. No checks will be cashed in the registration area.

12. Tickets for meal functions at the convention will not be included in registration fees. Purchase of meal tickets shall be optional.

13. The American Association for Respiratory Care, by action of its House of Delegates and its Board of Directors goes on record as opposing the practice of smoking, and in an effort to discourage smoking in all meetings of its annual convention, shall make this fact known through frequent and appropriate announcements during the course of the various meetings, and through the establishment of no smoking policies in all meeting room.

14. All committees desiring activities during the convention program shall be required to inform the Program Committee prior to starting work on such programs.

15. Tickets for social functions at the annual convention shall be provided at no charge to those persons whose attendance at such functions is mandatory.

16. All students shall be required to pay a registration fee, either at the student membership rate or the non-member rate. A student member is defined as one who is a member of the AARC and presents a current validated membership card attesting to that effect.

17. The purpose of the annual convention shall be identified in the following order of importance: a) to further the education of the members, b) to increase opportunities for fellowship among members, c) to transact the association business, and d) to serve as a source of revenue.

18. Members of the President's Council and their spouses will be registered for the annual convention at no charge; function tickets are included in such registrations.

19. A spouse registration fee shall be set annually and shall require positive identification.

20. Bus service for the annual convention shall be included in the convention budget as a membership service at no charge to the registrants.

21. The Board of Directors shall establish a flat fee for the annual convention registration.

22. Each 10 X 10 exhibit boot shall be allowed six (6) exhibitors to register free of additional charge, and the Executive Director shall be given the discretion of allowing visitors.

23. All physicians, including affiliate medical advisors and registry examiners, but excluding Board of Medical Advisors, will be required to pay fees, either at the member rate or non-member rate. (NOTE: BOMA members will be granted free registration at the annual meeting.

24 Pre-registration of spouses for AARC conventions and meetings is abolished.

25. Chartered affiliates planning to hold meetings within the geographic boundaries of another chartered affiliate should inform the other chartered affiliate during the planning stage as to their attention and should seek their written concurrence. In the event the affiliates cannot agree, the Speaker of the House of Delegates and Chair of the Chartered Affiliates Committee should be contacted for assistance in resolving the conflict.

26. The Chair of the Program Committee will notify the President of the Chartered Affiliates, in writing, of the plans to hold an AARC sponsored seminar, and that this notification be given as far in advance as possible.

27. Deadlines for pre-registrations and cancellations for all AARC meetings will be determined by the Director of Conventions. The deadlines will be announced in the programs for such meetings. A cancellation fee, also to be determined by the Director of Conventions, will be deducted from all cancellations; the fee amount will be announced in the program.

28. Non-member registration fees for all meetings shall be higher than member fees and large enough to encourage non-members to join the association.

29. Participants in the Sputum Bowl shall register for the annual meeting, but shall not be required to pay the registration fee for the meeting unless they wish to attend the convention.

30. Chartered affiliates exhibits at the annual meeting:

    A. Upon written request, each AARC chartered affiliate may be granted, free of charge, one (1) booth space in the exhibit hall at the annual meeting, if space is available.

    B. Affiliates requiring additional space may do so by applying and paying the commercial exhibit fees.

    C. The location of the free booth space will be determined by the Convention Manager in consultation with the Executive Director.

    D. Personnel manning the chartered affiliate exhibits must register for the meeting by paying the appropriate registration fee.

    E. No chartered affiliate may conduct sales, raffles, solicit donations, etc. as part of their exhibit.

    F. The association discourages exhibits outside the exhibit hall. The Executive Director may consider granting such requests if circumstances, as determined by the Executive Director, indicate their appropriateness.

31. Smoking is discouraged at social events held during AARC meetings. Proper announcements should be made prior to and during the event itself. If the event is being presented and/or sponsored by an outside group/company, it will be the responsibility of the group/company, to make sure that this policy is observed at all times.

32. Beginning in 1989, the AARC Executive Office shall plan and conduct a leadership workshop for leaders and potential leaders on the day before each annual convention.

33. Policy to establish guidelines for expenses to be paid to speakers participating in AARC seminars and educational meetings:

A. *Scope:* This policy includes compensation to persons requested to participate in a program. This is to apply as follows:

1) Out of Town Speakers

a) Transportation – Coach airfare, round trip
b) Lodging – Single room rate for each day required to be at the convention site.
c) Per diem - $30 for each day required to be at the convention site, plus one per diem for travel.
d) Registration – No charge. Function tickets not included.
e) Honorarium - $250 for each lecture at the annual meeting and summer forum.

2) Out of Country Speakers

a) Same as #1 above will apply, plus one additional lodging day and one additional per diem.
b) All out of country speakers must be approved, in advance, by the Program Committee before an invitation is issued.

3) *Local Speakers*

a) Same as #1 above with the following exceptions:
i) No transportation will be paid
ii) No lodging will be paid
iii) No per diem for travel will be paid

4) *Special Lectures*

a) Egan Lecture: Up to $500 honorarium plus travel expenses will be paid according to current travel policies.
b) Keynote Address: #'s 1, 2 and 3 above will apply; however, an honorarium will be determined by the Program Committee on an annual and individual basis subject to budget allocation.

5) *Panel Discussions*

a) Speakers will receive a $125 honorarium and complimentary registration only.

6) *OPEN FORUM Speakers*

a) Student members presenting papers will receive complimentary registration. This will be limited to the student presenting the paper (in cases where there is more than one student author.)
b) All other authors presenting papers must pay the appropriate registration fee if they wish to attend the convention.
c) All individuals presenting at the OPEN FORUM who arrive at the meeting with a manuscript ready to submit to RESPIRATORY CARE for consideration would have their registration at the Annual Meeting refunded, up to $2,000, excluding Editorial Board members.

7) *Workshops*

Each instructor will receive a $125 per hour honorarium not to exceed $400 per day and complimentary registration. If per diem and travel expenses are to be reimbursed, they will be reimbursed in accordance with existing policy.

8). Contingencies

a) Honorarium and expenses will not be paid to AARC officials presenting programs dealing with their area of involvement.
b) Honorarium shall not be paid to AARC employees.
c) Special circumstances not covered in these guidelines shall be referred to the Chair of the Program Committee for their consideration and action.

34. Requests for co-sponsorship of international meetings related to respiratory care shall be submitted to the International Council for Respiratory Care to review and recommendation to the Board of Directors.

35. Candidates for officers and directors will be provided lodging and per diem for the meeting at which they take office.

36. AARC will provide complimentary registration for members of the Board of Directors and officers of the House of Delegates under the following conditions:

A. The director or officer is unable to obtain registration for payment from his or her employer.
B. A request is made to the AARC for complimentary registration or reimbursement to the director or officer after he or she has rendered payment for registration to the association.

37. **CRITERIA FOR CO-SPONSORSHIP OF MEETINGS**

A. Co-sponsorship is defined as the AARC actively participating in the preparation, presentation, funding or otherwise accepting responsibility for programs involving other organizations or groups.

B. Co-sponsorship shall not be construed to include anything other than the scientific portion of the program.

C. To be considered for co-sponsorship, the requesting organization should write a letter to the AARC President outlining the nature of the request. The President should solicit the advice of the Program Committee in making the decision whether to recommend or reject co-sponsorship. The following criteria should be considered in making the decision:

1) The AARC should only consider co-sponsorship with organizations sharing the same philosophies of patient care.

2) The written request must be received at least 12 months in advance and prior to the fall or spring meetings of the program Committee. The terms and expectations from AARC shall be outlined.

3) Our section of the program should be developed by the AARC Program Committee in concert with the Program Committee of the requesting organization.

4) The AARC must be apprised of any and all other co-sponsoring organizations.

5) The co-sponsored program must not conflict (by calendar, time or geographic location) with any other official AARC program.

6) Co-sponsorship of a meeting includes content of scientific sessions only and does not imply any staff time or resources.

7) Unless authorized by the Board of Directors, no expense is to be incurred by the AARC.

8) Registration fees, if any, for AARC members should be the same as the other association members and not gust admission fees.

9) If there is net income from the meeting, the AARC should receive an amount proportional to the AARC's input and participation.

10) All organizations applying for co-sponsorship should be considered equally and expected to meet the same criteria.

11) Approval of co-sponsorship should be for a one time only, with reapplication necessary for each successive program.

12) Each program will be evaluated while in progress and in retrospect. This may require funding from the AARC.

13) Evaluation criteria should be the same for co-sponsoring meetings as for all formal AARC meetings.

14) In general, the AARC does not subscribe to outside organizations co-sponsoring sections of our annual convention. The AARC does reserve to contact outside organizations as consultants.

15) Any and all exceptions to this policy shall be at the discretion of the AARC President and the Program Committee.

DEFINITIONS:

ATTACHMENTS

American Association for Respiratory Care
Policy Statement

SECTION: Board of Medical Advisors

SUBJECT: **Member Organizations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2008

DATE REVISED: March 2008

REFERENCES:

Policy Statement:
Physician organizations shall be named to the Board of Medical Advisors by the Board of Directors in concurrence with the Board of Medical Advisors.

Policy Amplification:
1. Physician organizations named to the Board of Medical Advisors shall be:

    A. American College of Chest Physicians (ACCP)
    B. American Thoracic Society (ATS)
    C. American Society of Anesthesiologists (ASA)
    D. American Academy of Pediatrics (AAP)
    E. American College of Asthma, Allergy, and Immunology (ACAAI)
    F. Society for Critical Care Medicine (SCCM)
    G. National Association for Medical Direction of Respiratory Care (NAMDRC)
    H. American Academy of Allergy and Asthma Immunology (AAAAI)

2. The Board of Medical Advisors shall determine the number of appointees invited from each physician organization named above.

3. The Chairperson of the Board of Medical Advisors shall assure compliance with Association Bylaws Article VIII, Section 2, and "Term of Office."

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CA 005

SECTION: Chartered Affiliate

SUBJECT: **Chartered Affiliate Travel Grant**

EFFECTIVE DATE: December 2003

DATE REVIEWED: March 2008

DATE REVISED: July 2007

REFERENCES:

Policy Statement:
The chartered Affiliate Travel Fund is to assist affiliates in paying for the travel expenses of AARC officers or executive office staff invited to affiliate meetings to speak about AARC issues. This travel fund will also assist affiliates in paying for the travel expenses of a designated Chartered Affiliate Consultant when an affiliate requests for such services.

Policy Amplification:
1. A grant will be issued which duplicates funding provided by another sponsor or sponsors.
2. Authority:
    A. The AARC President must approve all Affiliate Travel Fund grants.
    B. The AARC Executive Director must approve any executive office staff travel.
3. Grant request procedure:
    A. The Affiliate President sends a completed request form to the AARC Controller, who will forward a copy to the AARC President.
    B. For grants to assist affiliates in paying for the travel expenses of AARC officers or executive office staff, the AARC President must approve the grant. If the grant is approved, the President will determine the amount of assistance and. send the approved request to the AARC Controller.
    C. For grants to assist the Chartered Affiliate Consultant, the President will consult with the State Affiliate submitting the grant to determine the appropriateness of the request. If the grant is approved, the President will determine the amount of assistance and. send the approved request to the AARC Controller.
    D. All grants will generally be a percentage of total expenses up to a maximum dollar amount. Any other funding received from the other outside parties reduces the total expense to be considered in the grant determination process.

E. The AARC Controller will advise the Affiliate President of the grant amount approved.
F. The affiliate should acknowledge that it is receiving support from the AARC in its printed materials.

4. Responsibility for expenses:
   A. The affiliate will be responsible for paying all travel expenses.
      1. Airfare: The AARC can make flight arrangements, and bill the affiliate.
      2. Ground Transportation: The affiliate must provide any necessary transportation between the airport, hotel, and meeting site, and is responsible for the cost of airport transportation or parking in the officer's or staff member's hometown.
      3. Hotel: The affiliate must provide the hotel room and taxes.
   B. Any expenses paid by the AARC will be billed or deducted from the grant.
   C. Any other non-AARC monies received to defray our speaker's expenses must reduce the amount of expenses ultimately submitted to the AARC under this grant.
5. Payment of the grant:
   A. Copies of paid invoices should be sent to the AARC Controller, who will then issue a check to the affiliate.
6. Expenses (car rental, per diem, airfare, etc.) will be reimbursed in accordance with AARC policy.

DEFINITIONS:

ATTACHMENTS: E: Chartered Affiliate Travel Grant Application

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Committee Travel Expenses**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: May 9, 2004

DATE REVISED:

REFERENCES: FM.016

Policy Statement:
Travel expenses for committee members shall be reported, recorded, and reimbursed in accordance with Association policy.

Policy Amplification:

1. Committee members' travel shall be approved by the Committee Chairperson prior to such travel occurring.

2. Committee Chairpersons may approve travel expenses for their committee members when acting in their official capacity, without advance or written approval from the President, provided that such travel expenses do not exceed those contained in the current committee budget as approved by the Board of Directors.

3. Any travel expenses which are not included in the current committee budget as approved by the Board of Directors shall require advance approval from the President, with subsequent review by the Finance Committee and ratification by the Board of Directors.

4. Committee Chairpersons shall submit a statement of travel expenses for their respective committee as part of their regular reports to the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Approval of Budget**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2005

DATE REVISED: July 2005

REFERENCES:

Policy Statement:
The annual budget for the Association shall be reviewed and approved in a manner consistent with the Bylaws and the Corporate Charter.

Policy Amplification:

1. Annually, at the fall meetings of the Board of Directors and House of Delegates, the Secretary-Treasurer and President-elect shall present the proposed revenue and expense budget for the succeeding fiscal year of the Association.

    A. Following discussion in this forum, both bodies must approve the Budget for its implementation.

2. The Board of Directors and the House of Delegates shall receive and review the budget in Executive Session due to the proprietary nature of the information.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: FM 021

SECTION: **Fiscal Management**

SUBJECT: **Old Outstanding Checks**

EFFECTIVE DATE: July 2007

DATE REVIEWED:

DATE REVISED:

REFERENCES:

Policy Statement

Periodically, but at least twice a year AARC shall perform the following procedure for old outstanding checks:

- Obtain the most recent list of all checks issued but still outstanding (i.e. not cleared the bank) for at least six months.
- Attempt to contact the Payee via mail or email to seek information and possible direction in terms of clearing and / or re-issuing the old check.
- Given better information is received, the original check shall be voided and be re-issued less a reasonable fee (currently, the fee AARC is charged by the bank -$25) for handling the stop payment fee on the original check.
- If the payee is still unreachable after several attempts, records shall be maintained for the outstanding item and it shall disposed of as current law allows.

DEFINITIONS

ATTACHMENTS

Guidance Document on Scope of Practice

The American Association for Respiratory Care (AARC) is aware that a credentialing examination is required by law in the vast majority of states in order to provide respiratory services described in their respective respiratory care practice acts.

The American Association for Respiratory Care (AARC) has received several inquiries regarding its opinion of competency documentation for persons who possess credentials other than Certified Respiratory Therapists (CRT) and Registered Respiratory Therapists (RRT) for the purpose of permitting these individuals to provide part of the scope of practice for respiratory therapists as described in respiratory care practice acts throughout the United States.

AARC believes that to ensure safe and effective care for all consumers requiring respiratory therapy, documentation of the provider's competency to do so must possess the same rigor and validity as the examination processes that CRTs and RRTs must undergo in order to achieve their respective credentials.

The credentialing examinations for CRT and RRT are accredited by the National Organization for Competency Assurance's (NOCA) accrediting arm, the National Commission for Certifying Agencies (NCCA). AARC recognizes that the credentialing examinations for Certified Pulmonary Function Technologist (CPFT), Registered Pulmonary Function Technologist (RPFT), and the Registered Polysomnographic Technologist (RPSGT) have also been accredited by the National Commission for Certifying Agencies (NCCA), assuring that these examinations are valid and reliable measures of competence within the limits of their respective examination matrices. AARC, therefore, supports recognition of individuals with the aforementioned credentials for the purposes of providing care which includes a subsection of the respiratory therapy scope of practice with the caveat that such provision be limited to the elements contained within each credentialing examination's matrix respectively.

5/2003

CRT Examination Matrix

RRT Examination Matrix

CPFT Examination Matrix

RPFT Examination Matrix

RPSGT Examination Matrix

AARC White Paper
On RRT Credential

With several developments over the history of the respiratory therapy profession, the education and credentialing processes have evolved to having two basic credentials for respiratory therapists. The Certified Respiratory Therapist (Entry Level) credential (CRT) has been adopted by most states as the minimum level of competency a therapist must demonstrate to obtain recognition by the government of that state as a licensed (certified or registered) respiratory care practitioner. The Registered Respiratory Therapist (Advanced) credential (RRT) has become the credential for advanced-level respiratory therapists. The selection of the CRT as the demonstrated competence needed for state recognition, coupled with a common lack of differential in responsibility and pay between therapists holding the CRT and RRT credentials, has led to decreased numbers of respiratory therapists obtaining the RRT credential. This paper presents the reasons respiratory therapists should obtain the Registered Respiratory Therapist credential.

Respiratory therapists who complete advanced-level respiratory therapy programs have completed education and training that provides them with knowledge and clinical expertise at a level above those needed by the Entry Level Practitioner. The written and clinical simulation components of the RRT exam are the only examination system that documents attainment of the additional knowledge. A graduate of an advanced-level program who does not complete the examinations to earn the RRT credential has not documented that he or she had actually acquired the knowledge and skills necessary to practice as an advanced-level respiratory therapist. This situation is similar to a physician who completes a residency program in a medical specialty and lists his/her credentials as Board Eligible in Internal Medicine rather than completing certification and listing him/herself as Board Certified, one would correctly question the professional commitment of both the Board Eligible physician and Registry Eligible respiratory therapist. Confusion for consumers and regulators arises when a person completes the training and education but does not complete the credentialing process to demonstrate achievement of the competency.

Possessing the RRT credential exemplifies the dedication of a respiratory therapist to professional excellence. A therapist who achieves the RRT credential has demonstrated a commitment to providing care at the highest possible level. Respiratory therapists are more readily able to achieve autonomy in their practice of respiratory care when they have achieved the RRT credential. Medical Directors of respiratory therapy departments and other medical staff recognize the higher level of knowledge and clinical expertise of the RRT compared to the CRT.

Accordingly, they will be more receptive to therapists utilizing protocols in the care of patients if there is an assurance of the level of knowledge and skill conveyed by possession of the RRT credential. A respiratory therapist with education at the advanced-level who has not achieved the RRT credential has not demonstrated he or she has the patient assessment and evaluation skills necessary for determining the needs of the patient or the knowledge to follow the protocol to determine the appropriate intensity of care needed by the patient. A respiratory therapy department director will more easily make the case that therapists are able to implement care using respiratory therapy protocols if the therapists are credentialed at the highest level available.

The RRT credential is the credential that demonstrates respiratory therapists have parity with other credentialed health care professionals. The Registered Respiratory Therapist will have more credibility with the Registered Nurse, the Registered Dietician, the Registered Physical Therapist and the Registered Occupational Therapist. Each of these professions has a practitioner level below that of the Registered individual. In each case, this lower level practitioner is prohibited from performing evaluations for the purpose of defining the care plan, or altering the plan as a result of evaluating the appropriateness of the current care. The scope of practice for the lower level practitioner may be seen as more analogous to that of the Certified Respiratory Therapist. Respiratory therapists wanting other health care professionals, administrators and governmental regulators to respect their knowledge and skills must document possession of that knowledge and those skills through attainment of the RRT credential.

Possession of the RRT credential will assist respiratory therapists who wish to expand their scope of practice. As respiratory therapists seek to become involved in intubation, conscious sedation, invasive line insertion and monitoring they must be able to demonstrate they possess the knowledge and skills necessary to be able to perform these functions safely and effectively. A respiratory therapy director can build a much stronger case for expansion of the scope of practice to assist an institution to respond to shortages of health professionals when the staff possesses the RRT credential.

Appropriate recognition of the respiratory therapy profession will be more easily accomplished at the federal and state levels when the majority of respiratory therapists have achieved the RRT credential. Third party payers will recognize the higher-level credential (RRT) in contrast to the entry-level therapist (CRT).

Advancement to positions in management, education and supervision are generally limited to those persons holding the RRT credential. For a person to be considered for these types of positions, attainment of the advanced-level credential is considered the minimum necessary demonstration of knowledge and competence.

There is a significant financial incentive to earn the RRT credential. Respiratory therapists who have achieved the RRT credential are often paid at a higher rate than those with the CRT credential. As little as $0.20 / hour amounts to a difference $11,929.42 in additional earnings over a 20 year career. At a difference of $1.00 / hour, this difference over 20 years amounts to $59,647.00 in additional earnings.

Conclusions:

- All respiratory therapists are encouraged to obtain the Registered Respiratory Therapist (RRT) credential. The RRT credential is the standard by which a respiratory therapist demonstrates the achievement of excellence. Evidence-based research documents the value of critical thinking, problem solving and advanced patient assessment skills. Only those respiratory therapists who possess the RRT credential have documented they possess these skills and abilities.
- All respiratory therapists involved in the performance of assessment-based care; problem solving and critical thinking; protocol application; diagnostic critical thinking; respiratory care plan development, implementation and analysis; disease management; mechanical ventilatory support; critical care; and critical care monitoring should possess the Registered Respiratory Therapist credential.
- Employers of respiratory therapists should develop policies and implement methods to recognize and compensate employees who hold the RRT credential. Such methods should include requirements for RRT credential for protocol implementation and assessment, increased pay, additional opportunities for cross training and expanded scope of practice for those with the RRT credential.

July 10, 2003

Back

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

Mike West, MBA, RRT Patient Education
Achievement Award

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE: February 2013

TO: George Gaebler, MSEd, RRT,FAARC, AARC President
Kerry George, MEd, RRT FAARC, NBRC President
Steve Mikles, EdS, RRT, FAARC, CoARC Chair
Lori Conklin, MD, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Forrest M. Bird Lifetime Scientific Achievement Award 2013—*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 an endowment from Dr. Forrest M. Bird, founder of Bird Products Corporation, a developer and manufacturer of respiratory equipment. Dr. Bird has been not only an outstanding innovator of respiratory care equipment, but has inspired and encouraged many investigators to continue the search for methods of improving respiratory care. He is recognized as an international educator and promoter of excellence in respiratory care.

In recognition, the recipient will receive an inscribed plaque, coach airfare, one night's lodging, and registration to attend the Awards Ceremony at the AARC Congress 2013.

Previous recipients of this prestigious award have been:

2012 Patrick Dunne, MEd, RRT, FAARC
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, AARC Board of Medical Advisors, the National Board for Respiratory Care and the Committee on Accreditation for Respiratory Care.

1. Your organization may nominate one candidate.

2. In fairness to your nominee, you must submit a complete current curriculum vitae and biographical summary.

3. We request that you 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, 2013.**

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 an 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, coach airfare, one night's lodging and registration for the AARC Congress 2013.

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 will be presented during the Awards Ceremony at AARC Congress 2013.

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE: February 2013

TO: George Gaebler, MSEd, RRT,FAARC, AARC President
Kerry George, MEd, RRT FAARC, NBRC President
Steve Mikles, EdS, RRT, FAARC, CoARC Chair
Lori Conklin, MD, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Dr. Charles H. Hudson Award for Cardiopulmonary Public Health 2013—*Solicitation of Nominations***

The American Respiratory Care Foundation (ARCF) has initiated this year's selection process for the Dr. Charles H. Hudson Award for Cardiopulmonary Public Health. We are requesting one nomination from each organization.

The purpose of this award is to recognize "**efforts to positively influence the public's awareness of cardiopulmonary health and wellness.**"

Previous recipients include:

- Melaine Giordano, MSc, RN, CPFT - 2012
- 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
- 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, 2013.**

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 an 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, coach airfare, one night's lodging, and registration for the AARC Congress 2013.

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, 2013. Please submit nominations to:

ARCF Executive Office
Attention: April Lynch
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 Congress 2013.

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

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE:	January 2013
TO:	George Gaebler, MSEd, RRT, FAARC, AARC President Kerry George, MEd, RRT, FAARC, NBRC President Steve Mikles, EdS, RRT, FAARC, CoARC Chair
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2013—*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:

- Linda A. Smith, BS,RRT, FAARC - 2012
- 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

- 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, coach airfare, one night's lodging and registration to the AARC Congress 2013.

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.

Nominations should be received by the Executive Office no later than **June 1, 2013.**

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 coach airfare and one night's lodging to attend the Awards Ceremony at the AARC Congress.

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, 2013. Please submit nominations to:

ARCF- Thomas L. Petty, MD Invacare Award
Attention: April Lynch
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 Congress 2013.

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE: February 2013

TO: George Gaebler, MSEd, RRT, FAARC, AARC President
Kerry George, MEd, RRT FAARC, NBRC President
Steve Mikles, EdS, RRT, FAARC, CoARC Chair
Lori Conklin, MD, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Mike West, MBA, RRT Patient Education Award 2013—**
Solicitation of Nominations

This award was established in 2012 with an endowment from Philips Healthcare to recognize **"a Respiratory Therapist who has had a profound impact on patients as established by measurable outcomes as a result of patient education."**

The first recipient was:

- Mike West, MBA, RRT- 2012

We are now accepting nominations for this award. Nominations will be invited from the AARC Board of Medical Advisors, the Board of Directors of the AARC, the Trustees of the ARCF, National Board for Respiratory Care (NBRC) and the Committee on Accreditation for Respiratory Care (CoARC). The nominating group is responsible for submitting the following:

- A complete and current biographical report on their nominee (curriculum vitae). Only *one* nominee (who is *not* a past recipient of the award) is allowed from each group.

- A statement, including data which indicates the basis for the nomination, keeping the principle criterion of "promoting patient education" in mind. They should illustrate the nominee's impact on patient education through novel training and education programs, adherence programs for patients, and improved outcomes of patients gained through education and feedback.

- A brief personal comment on their candidate's interests and activities outside of medicine (i.e. civic, family, hobby).

In recognition, the recipient will receive an inscribed plaque, coach airfare, one night's lodging and registration to the AARC Congress 2013.

Please submit nominations to the Executive Office no later than June 1, 2013.

cc: Board of Directors
ARCF Trustees

Mike West, MBA, RRT Patient Education Achievement Award

Established in 2012, this award is named for Mike West, a Registered Respiratory Therapist, who recognized the importance of educating patients to help them manage chronic pulmonary diseases, and the profound impact such self-management has on patient respiratory quality of life. Mike West made it his quest throughout his career to ensure that patients, caregivers, and industry had the highest understanding of respiratory disease and the best solutions for treating these diseases.

An endowment has been established to recognize excellence in patient education by, American Respiratory Care Foundation's Trustees (ARCF), through a grant from Phillips Healthcare, to recognize a Respiratory Therapist who has had a profound impact on patients as established by measurable outcomes as a result of patient education.

This award includes a plaque, coach airfare, one night's lodging and registration for the AARC Congress.

Nomination Procedure

Nominations will be invited from the AARC Board of Medical Advisors, the Board of Directors of the AARC, the Trustees of the ARCF, National Board for Respiratory Care (NBRC) and the Committee on Accreditation for Respiratory Care (CoARC).

The nominating group is responsible for submitting the following:

1. A complete and current biographical report on their nominee (curriculum vitae). Only *one* nominee (who is *not* a past recipient of the award) is allowed from each group.
2. A statement, including data which indicates the basis for the nomination, keeping the principle criterion of "promoting patient education" in mind. They should illustrate the nominee's impact on patient education through novel training and education programs, adherence programs for patients, and improved outcomes of patients gained through education and feedback.
3. A brief personal comment on their candidate's interests and activities outside of medicine (i.e. civic, family, hobby).

All nominations must be received by the ARCF Executive Office no later than June 1, and the award will be presented by the ARCF during the Awards Ceremony at the AARC Congress 2013.