American Association for Respiratory Care

Board of Directors Meeting

Embassy Suites Outdoor World
Grapevine, TX April 11-12, 2014

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AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – April 10, 2014
Board of Directors Meeting – April 11-12, 2014

Thursday, April 10

4:00-7:00 pm Executive Committee Meeting (Committee Members only) **Su Vino Room**
7:00-8:00 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) **Pheasant Ridge 1 & 2**

Friday, April 11

8:00 am-5:00 pm **Board of Directors Meeting** – **Pheasant Ridge 1&2**

8:00 am Call to Order
Announcements/Introductions
Approval of Minutes pg. 10
E-motion Acceptance pg. 35

General Reports pg. 36
President pg.37
Past President pg. 38
Executive Director Report pg. 39

8:45 am Bill Sims - Salmon, Sims, & Thomas - Auditor's Report

9:15 am Lawrence M. Wolfish - Wolfish & Newman, P.C.
Board Member Fiduciary Responsibility & Conflict of Interest

9:30 am John Barrett – Merrill Lynch – via phone – Investment Report

10:00 am CoARC report presented by Tom Smalling and Kathy Rye pg. 67(A)
NBRC report presented by Gary Smith and Carl Haas pg. 68

11:00 am BREAK

11:15 am Board Discussion about CoARC and NBRC

12:00 pm LUNCH BREAK (Daedalus Board Meeting)

1:30 pm RECONVENE

1:30 pm Board of Directors Orientation

2:00 pm General Reports con't.
Government & Regulatory Affairs pg. 72
House of Delegates pg. 82 (R)
Board of Medical Advisors pg. 84
President's Council pg. 85 (R)

Standing Committee Reports pg. 90

- Audit Subcommittee pg. 91 (R)
- Bylaws Committee pg. 93 (R) (A)
- Elections Committee pg. 94
- Executive Committee pg. 95
- Finance Committee pg. 96
- Judicial Committee pg. 97
- Program Committee pg. 98 (R)
- Strategic Planning Committee pg. 105

Specialty Section Reports pg. 106

- Adult Acute Care pg. 107
- Continuing Care-Rehabilitation pg.108
- Diagnostics pg. 109
- Education pg. 110 (A)
- Home Care pg. 111 (R)
- Long Term Care pg. 113
- Management pg. 114
- Neonatal-Pediatrics pg. 115
- Sleep pg. 116
- Surface to Air Transport pg. 117 (R)

3:00 pm BREAK

3:15 pm Special Committee Reports pg. 118

- Benchmarking Committee pg. 119
- Billing Code Committee pg. 120
- Federal Govt Affairs pg. 121
- Fellowship Committee pg. 122
- International Committee pg. 123
- Membership Committee pg. 125 (R)
- Position Statement Committee pg. 128 (R)
- Social Media Committee pg. 139
- State Govt Affairs pg. 140 (R)

4:15 pm Nominations for Life & Honorary Membership

(see pg. 89 for criteria)

5:00 pm RECESS

Saturday April 12

8:00 am-5:00 pm **Board of Directors Meeting – Delaney (2nd Floor)**

8:00 am Call to Order

Special Representatives pg. 142

- AMA CPT Health Care Professional Advisory Committee pg. 143
- American Association of Cardiovascular & Pulmonary Rehab pg. 144
- American Heart Association pg. 148
- American Society for Testing and Materials (ASTM) pg. 149 (R)
- Chartered Affiliate Consultant pg. 151
- Comm. on Accreditation of Medical Transport Systems pg. 152
- Extracorporeal Life Support Organization (ELSO) pg. 153 (R)
- International Council for Respiratory Care (ICRC) pg. 155
- The Joint Commission (TJC) pg. 157
- National Asthma Education & Prevention Program pg. 161
- National Coalition for Health Professional Ed. In Genetics pg. 162
- National Sleep Awareness Roundtable pg. 163
- Neonatal Resuscitation Program pg. 164

9:30 am BREAK

9:45 am Roundtable Reports pg. 165

- Asthma Disease pg. 166
- Consumer (see Executive Director report pg. 39)
- Disaster Response pg. 168
- Geriatrics pg. 169
- Hyberbaric pg. 170
- Informatics pg. 171
- International Medical Mission pg. 172 (R)
- Military pg. 175
- Neurorespiratory pg. 176 (R)
- Palliative Care pg. 177
- Research pg. 178
- Simulation pg. 179
- Tobacco Free Lifestyle pg. 180

11:00 am Ad Hoc Committee Reports pg. 181

- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 182
- Ad Hoc Committee on Officer Status/US Uniformed Services pg. 183
- Ad Hoc Committee on Leadership Institute pg. 184 (R)
- Ad Hoc Committee on 2015 & Beyond pg. 186
- Ad Hoc Committee to Reduce Hospital Readmissions pg. 190
- Ad Hoc Committee on Virtual Museum Development pg. 191 (R)

12:00 pm LUNCH BREAK

1:30 pm RECONVENE

1:30 pm ARCF Report pg. 193

2:00 pm **UNFINISHED BUSINESS** pg. 195

NEW BUSINESS pg. 196

Policy Review

- BOD.024 – BOD – AARC Disaster Relief Fund pg. 197
- RT.001 – Roundtables – Roundtables pg. 199
- CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges (A)
- FM.001 – Fiscal Management – Accounting Systems pg. 201
- FM.005 – Fiscal Management – Independent Auditors and Audit Subcommittee pg. 202
- FM.018 – Fiscal Management – Audit and Oversight Standards pg. 203

3:00 pm ARCF Achievement Award Nominations pg. 205

Bird pg. 206
Hudson pg. 209
Petty/ Invacare pg. 214
Mike West pg. 217

ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of March 28, 2014)

AARC Board of Directors Meeting

April 11-12, 2014 • Grapevine, TX

House of Delegates

Recommendation 14-1-6.1 "That the AARC Board of Directors, jointly with the House of Delegates, develop a Bylaws Taskforce, not to exceed 4 members, or Subcommittee (members to be appointed by the President of BOD and Speaker of HOD) with a charge to revise or formalize the bylaws conflict resolution process (article XV). The revised procedure will be brought back to the BOD & HOD during the Fall 2014 meeting for approval."

Presidents Council

Recommendation 14-1-8.1 "That complimentary registration for the AARC educational meetings be offered to AARC Life Members."

Audit Subcommittee

Recommendation 14-1-13.1 "That the Board of Directors accept the auditor's report as presented."

Bylaws Committee

Recommendation 14-1-9.1 "That the AARC Board of Directors accept and approve the Texas Society Bylaws."

Recommendation 14-1-9.2 "That the AARC Board of Directors accept and approve the Massachusetts Society Bylaws."

Recommendation 14-1-9.3 "That the AARC Board of Directors accept and approve the Arizona Society Bylaws."

Recommendation 14-1-9.4 "That the AARC Board of Directors accept and approve the Wisconsin Society Bylaws."

Program Committee

Recommendation 14-1-15.1 "That the AARC Board of Directors ratify the Chair and members of the 2014 Sputum Bowl Committee as noted below:

Chair – Sherry Whiteman
Member – Kelli Chronister
Member – Tom Lamphere
Member – Diane Oldfather
Member – David Panzlau
Member – Rick Zahodnic
Member – Jim Ciolek."

Home Care Section

Recommendation 14-1-54.1 "That the AARC Board of Directors investigate the feasibility of a post-acute care certification program for RTs."

Surface to Air Transport Section

Recommendation 14-1-59.1 "That the AARC consider drafting a position statement regarding interstate transport to alleviate the need for multiple licenses."

Membership Committee

Recommendation 14-1-24.1 "That the AARC Board of Directors approve our AARC Membership campaign incentive program."

Position Statement Committee

Recommendation 14-1-26.1 "Approve and publish the revised Position Statement 'Definition of Respiratory Care'."

Recommendation 14-1-26.2 "Approve and publish the revised Position Statement 'Health Promotion and Disease Prevention'."

Recommendation 14-1-26.3 "Approve and published the revised Position Statement 'Tobacco and Health'."

Recommendation 14-1-26.4 "Approve and publish the revised Position Statement 'Pulmonary Rehabilitation'."

Recommendation 14-1-26.5 "Approve to retire the Position Statement 'Inhaled Medication Administration Schedules'."

Recommendation 14-1-26.6 "Approve and publish the new Position Statement 'Electronic Cigarette'."

State Government Affairs

Recommendation 14-1-22.1 "That the AARC Board of Directors approve the Michigan State Society for Respiratory Care's application for the $10,000 grant/loan."

American Society for Testing and Materials (ASTM)

Recommendation 14-1-65.1 "That the Executive Director investigate the possibility of appointing a member of the Executive Office to attend and participate in the appropriate standards organizations to further the development and improvement in standards that impact the respiratory profession."

Extracorporeal Life Support Organization (ELSO)

Recommendation 14-1-69.1 "Request AARC financial assistance, not to exceed $2,400, to attend the 25th Anniversary Extracorporeal Life Support Organization (ELSO) conference in Ann Arbor, Michigan September 15-18, 2014."

International Medical Mission Roundtable

Recommendation 14-1-44.1 “That the ICRC consider adding the IMMR Chairperson as a council member in order to support collaboration between both international groups.”

Recommendation 14-1-44.2 “That the AARC provide a table for the IMMR in the vendor area or outside the main hall at the AARC International Congress for the purpose of sharing mission opportunities and to increase IMMR membership and awareness.”

Recommendation 14-1-44.3 “That the AARC allow the IMMR one page in the AARC International Congress Program to increase awareness of the IMMR and encourage involvement.”

Recommendation 14-1-44.4 “That the AARC add an open forum section to the AARC International Congress that focuses on international mission work, volunteerism and global research.”

Neurorespiratory Roundtable

Recommendation 14-1-40.1 “That Neurorespiratory topics at the 2014 AARC Congress be scheduled in a group at a time to allow the roundtable members to meet following the grouped presentation.”

Recommendation 14-1-40.2 “That a sample of Neurorespiratory topics and speakers which have been accepted for the Congress be shared with the roundtable before the formal agenda is posted to assist in generating interest in attending.”

Ad Hoc Committee on Leadership Institute

Recommendation 14-1-35.1 “That the AARC BOD terminate the Ad-Hoc Committee: AARC Leadership Institute.”

Ad Hoc Committee on Virtual Museum Development

Recommendation 14-1-28.1 “That travel expenses be allocated to send a member of the ‘Legends’ team of the Ad Hoc Committee on Virtual Museum Development to interview Dr. Forrest M. Bird and obtain photographs of equipment and key information from the Bird Museum for inclusion in the AARC’s Virtual Museum.”

Recommendation 14-1-28.2 “That the Executive Office be charged with developing a plan to digitize past serial publications.”

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

November 14, 2013 • Anaheim, CA

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Karen Stewart, MSc, RRT, FAARC, Past-President
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Brian Walsh, MBA, RRT-NPS, RPFT, FAARC, VP Internal Affairs
Frank Salvatore, MBA, 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
Joe Sorbello, MEd, RRT
Greg Spratt, BS, RRT, CPFT
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC
Cynthia White, MSc, RRT-NPS, FAARC
Gary Wickman, BA, RRT, FAARC

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS Past Speaker
Lori Conklin, MD, BOMA Chair

Guests

Natalie Napolitano, MPH, RRT-NPS, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director
Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Regulatory Affairs Director
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President George Gaebler called the meeting of the AARC Board of Directors to order at 8:00am PST, Thursday, November 14, 2013. Secretary/Treasurer Frank Salvatore called the roll and declared a quorum.

DISCLOSURE
President George Gaebler reminded members of the importance of disclosure and potential for conflict of interest.

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

Greg Spratt – employed by Covidien and industry advisor
Cyndi White – consultant for Discovery Labs and Vapotherm
Brian Walsh – consultant for Draeger, Covidien and Vapotherm

APPROVAL OF MINUTES
Karen Stewart moved "To approve the minutes of the July 18, 2013 meeting of the AARC Board of Directors."
Motion carried

Karen Stewart moved "To approve the minutes of the July 19, 2013 meeting of the AARC Board of Directors."
Motion carried

Karen Stewart moved to approve **E13-3-9.3** "That the AARC Board of Directors approve the Bylaws amendments as revised by the Ad Hoc Committee to Recommend Bylaws Changes and approved by the Bylaws Committee."
Motion carried

GENERAL REPORTS

President
President Gaebler gave highlights of his written report. There will be many opportunities for Board members to give talks at state meetings in 2014.

The membership campaign helped save approximately 1,900 members. The Bylaws Ad Hoc Committee will be reformulated to make a few changes. President Gaebler also gave an update of recent CoARC and NBRC activities.

Executive Director/Office
Tom Kallstrom gave an overview of the written Executive Office report. The Alpha-1 study will be printed in Respiratory Care Journal.

Tom informed the Board that the Executive Office has saved over $30k in expenses and will be saving $19k in real estate taxes.

Tim Myers gave an update on digital advertising and the relationship with Multiview. The Buyers Guide is now produced by Multiview as well. Benchmarking has had a decrease of about 18% over the past year. Products from Respiratory Care Week cleared about $31k. The redesign of the AARC website is coming along and should roll out by the end of the year. The ARCF Fundraiser will be held Friday night and 234 tickets have been sold in advance.

Steve Nelson gave an update of grants and the AARC website.

Doug Laher gave an update of changes at this year's Congress. Lectures will be 30 minutes and will start and end at the same time. There will be a closing ceremony featuring Bob Eubanks.

Shawna Strickland gave an update on the Education Department. Learning Management Systems (LMS) will give a presentation today.

Referral from July 2013 Board of Directors Meeting:
FM.017 – Fiscal Management – Presidential Stipend
Karen Stewart moved to approve the reviewed date of this policy.
Motion carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 9:45am PST Thursday, November 14, 2013.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 10:10am PST Thursday, November 14, 2013.

HOUSE OF DELEGATES
Karen Schell updated the Board on the recent activities of the House of Delegates.

BOARD OF MEDICAL ADVISORS (BOMA)
Dr. Lori Conklin, Chair of BOMA, gave an update of the recent activities of BOMA. Tom Kallstrom thanked Dr. Conklin for stepping into her position sooner than expected.

STANDING COMMITTEES REPORTS

Bylaws Committee
Brian Walsh moved to accept Recommendation 13-3-9.1 "That the AARC Board of Directors accept and approve the Texas Society Bylaws."

Brian Walsh moved refer back to the Bylaws Committee because the Texas Society Bylaws do not meet the acid test requirements.
Motion carried

Brian Walsh moved to accept Recommendation 13-3-9.2 "That the AARC Board of Directors accept and approve the California Society Bylaws."
Motion carried

Finance Committee
FM 13-3-12.1 Karen Stewart moved to approve the purchase of the laptop for Asha Desai in the amount of $1,176.07
Motion carried

FM 13-3-12.2 Doug McIntyre moved to approve the convention programming enhancements for registration in the amount of $14,636.31.
Motion carried

FM 13-3-12.3 Bill Cohagen moved to approve the replacement for the Executive Office conference room projector in the amount of $898.35.
Motion carried

FM 13-3-12.4 Doug McIntyre moved to approve the purchase of a desk for Shawna Strickland in the amount of $832.44.
Motion carried

FM 13-3-12.5 Karen Stewart moved to approve the expense for the Clinical Practice Guidelines related to airway clearance (CPGs) in the amount of $114,000.
Motion carried

Tony DeWitt will be appointed as the new Judicial Committee Chair to replace Patricia Blakely.

Brian Walsh moved "To accept the Standing Committee reports as presented."
Motion carried

SPECIALTY SECTION REPORTS

Continuing Care Rehabilitation Section
Brian Walsh moved to accept Recommendation 13-3-51.1 "To update the Pulmonary Rehabilitation Facility/Program Locator on the AARC Website."

Bill Cohagen moved to accept for information only.
Motion carried

Brian Walsh moved to accept Recommendation 13-3-51.2 "Have a link for Pulmonary Rehabilitation Program Locator on the Front page of the AARC Website – to click and go directly to the site."

Bill Cohagen moved to accept for information only.
Motion carried

Brian Walsh moved to accept Recommendation 13-3-51.3 "That a task force be immediately organized for a Grant Submission for a National Pulmonary Rehabilitation Disease Management/Maintenance Exercise Program."

Brian Walsh moved to refer to Executive Office.
Motion carried

Diagnostics Section
Brian Walsh moved to accept Recommendation 13-3-52.1 "Provide complimentary AARC Congress registration for each recipient of section Specialty Practitioners of the Year."

Frank Salvatore moved to refer to Executive Office for cost analysis and report back in April 2014.
Motion carried

Management Section
Brian Walsh moved to accept Recommendation 13-3-55.1 "With the assistance of AARC Board staff, create and conduct a survey to the Section Membership to investigate the drop of membership."

Colleen Schabacker moved to make a friendly amendment "To conduct a survey to all sections to investigate the drop in membership and report back in April 2014."

Karen Stewart moved to make a friendly amendment to refer to Executive Office.
Motion carried

Brian Walsh moved to accept the Specialty Section reports as presented.
Motion carried

SPECIAL COMMITTEE REPORTS

Position Statement Committee
Brian Walsh moved to accept Recommendation 13-3-26.1 "That the AARC Board of Directors approve and publish the revised White Paper 'Guidance Document on Scope of Practice'."
Motion carried

Brian Walsh moved to accept Recommendation 13-3-26.2 "That the AARC Board of Directors approve and publish the revised 'AARC White Paper on RRT credential'."
Motion carried

(See Attachment "A" for revised position statements)

Social Media Committee
Brian Walsh moved to accept Recommendation 13-3-19.1 "That the AARC BOD accepts the changes made to the current AARC Connect Code of Conduct."
Motion carried

SPECIAL REPRESENTATIVES REPORTS

American Heart Association
Colleen Schabacker moved to accept Recommendation 13-3-64.1 "That the Executive Office reach out to the leadership of AHA to determine if an AARC representative is needed."

Brian Walsh moved to make a friendly amendment to "an additional".
Motion carried

Commission on Accreditation of Medical Transport Systems (CAMTS)
Colleen Schabacker moved to accept Recommendation 13-3-66.1 "To increase travel support stipend from the current level of $2,000 a year for the three yearly meeting to $2,500 which would match the stipend level supported by CAMTS."

Frank Salvatore moved to refer back to CAMTS for more information.
Motion carried

Colleen Schabacker moved to accept the Special Representatives reports as presented.
Motion carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 11:37am PST Thursday, November 14, 2013.

JOINT SESSION
Joint Session was called to order at 1:30pm PST on Thursday, November 14, 2013.
Secretary/Treasurer, Frank Salvatore, called roll and declared a quorum.

International Committee Chair, John Hiser, presented the International Committee report.

Ross Havens presented the 2013 election results:

President-Elect:	Frank Salvatore
Director at Large:	Bill Lamb Karen Schell Cynthia White
Adult Acute Care Section Chair-Elect:	Keith Lamb
Diagnostics Section Chair-Elect:	Katrina Hynes
Education Section Chair-Elect:	Ellen Becker
Management Section Chair-Elect:	Cheryl Hoerr

Bylaws Chair, Terry Gilmore, presented the Bylaws report.

Cheryl West, Anne Marie Hummel, and Miriam O'Day gave highlights of the written State and Federal Government Regulatory Affairs report and provided updates on HR 2619.

Gary Wickman, co-Chair of the Membership Committee, reported that 166 members did not renew their AARC memberships on 2013. That number could have been higher had it not been for the membership campaign. Listed below are the winners of the membership contest:

Largest raw number increase:
1st place – Pennsylvania
2nd place – Florida
3rd place – California

Largest percentage increase:
1st place – Nevada
2nd place – New Mexico
3rd place – Mississippi

Secretary/Treasurer Frank Salvatore presented the Finance Committee report.

Frank Salvatore moved to go into Executive Session at 2:57pm PST.
Motion carried

Executive Session ended at 3:10pm PST.

President Gaebler adjourned the Joint Session at 3:15pm PST, Thursday, November 14, 2013.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 3:30pm PST Thursday, November 14, 2013.

Denise Johnson moved to accept the General Reports as presented.
Motion carried

Bill Cohagen moved to accept the Special Committee reports as presented.
Motion carried

ROUNDTABLE REPORTS

Military Roundtable
Brian Walsh moved to accept Recommendation 13-3-45.1 "That the AARC BOD encourage the AARC state delegates and officials of other state level respiratory care societies to follow the lead from the Texas Society of Respiratory Care (TSRC) and offer similar memberships and registrations to conferences, convention and other meetings at a reduced rate or complimentary to members of the armed forces."

Brian Walsh moved to amend the motion to read "That the AARC BOD encourage the AARC state affiliates to offer reduce rate or complimentary registrations to conferences for active members of the armed forces."

Karen Stewart moved to refer to speaker-elect of House of Delegates.
Motion carried

Tobacco Free Lifestyle
Brian Walsh moved to accept Recommendation 13-3-41.1 "That the AARC urge membership to take a leadership role in their respective workplaces to update work environment safety policies to address e-cigarettes."

Karen Stewart moved to refer to Position Statement Committee to include e-cigarettes in the Tobacco-free Lifestyle position statement and include in April 2014 report.
Motion carried

Brian Walsh moved to accept the Roundtable reports as presented.
Motion Carried

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on 2015 & Beyond
Brian Walsh moved to accept Recommendation 13-3-32.1 "That the AARC BOD approve the combining of the two committees: *Ad-Hoc Committee on 2015 and Beyond* and *Ad-Hoc Workgroup on Strategies for 2015* into one committee to be named Ad-Hoc Committee on 2015 and Beyond."

President Gaebler informed the Board of Directors that this has already been done and needs to be ratified. Brian Walsh moved to ratify the change.
Motion carried

Brian Walsh moved to accept Recommendation 13-3-32.2 "The AARC BOD approve the revised charges for the Ad-Hoc Committee on 2015 and Beyond."

President Gaebler informed the Board that this will be done on Tuesday, November 19th at the new Board of Directors meeting.

Brian Walsh moved to accept the Ad Hoc Committee reports as presented.
Motion Carried

NEW BUSINESS

POLICY REVIEW

Policy No. BA.001 – *BOMA – Medical Advisors*
Karen Stewart moved to accept as amended with date change.
Motion carried

Policy No.BA.003– *BOMA – Policies and Procedures*
Karen Stewart moved to accept as amended with date change.
Motion carried

Policy No. CT.002 – *Committees – Medical Advisors*
Karen Stewart moved to accept as amended with date change.
Motion carried

(See Attachment "B" for all amended policies)

RECESS
President Gaebler called a recess of the AARC Board of Directors meeting at 3:50pm PST on Thursday, November 14, 2013.

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

_____________________________ ___________________

Linda Van Scoder Date
AARC Secretary/Treasurer

Attachment “A”

Position Statements:
Guidance Document on Scope of Practice
White Paper on RRT Credential

Guidance Document on Scope of Practice

The American Association for Respiratory Care (AARC) is aware that a credentialing examination is required by law in states that have a respiratory care practice act.

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.

The 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). The 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. The 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
Revised 11/2013

www.nbrc.org
www.brpt.gov

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 care 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 care 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, moderate 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 care 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.

According to the AARC's latest Human Resources Survey, 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.-

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 ventilator 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
Revised Nov 2013

Attachment “B”

Policies:
BA.001 – Board of Medical Advisors – Medical Advisors
BA.003 – Board of Medical Advisors – Policies and Procedures
CT.002 – Committees - Medical Advisors

American Association for Respiratory Care
Policy Statement

Policy No.: BA.001

SECTION: Board of Medical Advisors

SUBJECT: **Medical Advisors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2013

DATE REVISED:

REFERENCES:

Policy Statement:
Upon the President's request, the Chairperson of the Board of Medical Advisors (BOMA) shall identify Medical Advisors for Committees, Specialty Sections, and other appropriate Association Groups.

Policy Amplification:

1. Medical Advisors shall be limited to:

   A. Members of the Board of Medical Advisors
   B. Physicians approved by the Board of Medical Advisors

2. Medical Advisors so identified shall be appointed by the President, subject to ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: BA.003

SECTION: Board of Medical Advisors

SUBJECT: **Policies and Procedures**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2013

DATE REVISED:

REFERENCES:

Policy Statement:
Policies and procedures adopted by the Board of Medical Advisors shall not be in conflict with Association policies and procedures.

Policy Amplification:

1. The Chairperson of the Board of Medical Advisors shall present policies and procedures being considered by the Board of Medical Advisors to the President.

2. The President shall, in collaboration with the Chairperson of the Board of Medical Advisors, present such policies and procedures to the Board of Directors as appropriate.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CT.002

SECTION: Committees

SUBJECT: **Medical Advisors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2013

DATE REVISED: March, 2009

REFERENCES:

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

Policy Amplification:

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

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

DEFINITIONS:

ATTACHMENTS:

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

November 15, 2013- Anaheim, CA

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Karen Stewart, MSc, RRT, FAARC, Past-President
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Brian Walsh, MBA, RRT-NPS, RPFT, FAARC, VP Internal Affairs
Frank Salvatore, MBA, 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
Joe Sorbello, MEd, RRT
Greg Spratt, BS, RRT, CPFT
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC
Cynthia White, BA, MSc, RRT-NPS, AE-C
Gary Wickman, BA, RRT, FAARC

Consultants

Mike Runge, BS, RRT, FAARC, Parliamentarian
Lori Conklin, MD, BOMA Chair
Dianne Lewis, MS, RRT, FAARC, President's Council President
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS, Past Speaker

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director
Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Director of Regulatory Affairs
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President George Gaebler called the meeting of the AARC Board of Directors to order at 8:31am PST, Friday, November 15, 2013. Secretary-Treasurer Frank Salvatore called the roll and declared a quorum.

HOD RESOLUTIONS

Karen Stewart moved to accept **Resolution 77-13-14** "Be it resolved that the AARC Board of Directors approve an annual recognition award to be entitled, The Bill Lamb Volunteer Award, presented at the national Congress which recognizes a respiratory therapist who has demonstrated exemplary service as a volunteer."

Motion carried

Karen Stewart moved to accept **Resolution 36-13-15** "Be it resolved that the AARC Board of Directors continue to collaborate with the CoARC, CoBGRTE and the NBRC to develop a strategic plan, complete with timetable, to develop Graduate Level Educational Programs equivalent to PA's CNP's, CRNA's and Anesthesia Assistants and develop a strategic plan to help the State Affiliates obtain the appropriate licensure for these Advanced Practice Respiratory Therapists in each of the States and Territories within the United States of America."

Karen Stewart moved to accepted for information only, already being done.

Motion carried

Karen Stewart moved to accept **Resolution 19-13-16** "Be it resolved that the AARC continue to communicate with the CoARC and request that the new accreditation Standards require all new programs seeking initial accreditation to grant, at minimum, the baccalaureate degree to its graduates, with the proviso that existing fully accredited associate degree programs may continue to function as long as they meet CoARC accreditation Standards and actively develop articulation mechanisms whereby graduates can pursue baccalaureate degrees relevant to the respiratory care profession."

Fred Hill moved to accept for information only.

Motion carried

Karen Stewart moved to accept **Resolution 35-13-17** "Be it resolved that the AARC Board of Directors continue to collaborate with the CoARC, the CoBGRTE and the NBRC to develop a strategic transitional plan, complete with timetable, to require the minimum entry-level educational preparation of respiratory therapy program graduates to be the baccalaureate degree level. The strategic plan is to include model curricula to assist existing associate degree programs in formulating articulation strategies with baccalaureate degree granting institutions."

Karen Stewart moved to accept for information only.

Motion carried

Karen Stewart moved to accept **Resolution 32-13-18** "Be it resolved that the AARC Board of Directors and Executive Office continue to collaborate with the Chartered State Affiliates and the NBRC to develop a strategic transitional plan, complete with timetable, to require minimum entry-level for respiratory therapist licensure to be the RRT credential."

Frank Salvatore moved to accept for information only.
Motion carried

RECESS
George Gaebler called a recess of the AARC Board of Directors at 9:37am PST, Friday, November 15, 2013.

RECONVENE
President Gaebler reconvened the meeting of the AARC Board of Directors 9:52am PST Friday, November 15, 2013.

FM 13-3-12.6 Karen Stewart moved to accept the 2014 budget.
Motion carried

OTHER REPORTS (ARCF, CoARC, NBRC)
Tom Kallstrom gave updates of ARCF. Quarterly conference calls have been taking place instead of one meeting a year. An ARCF Fundraiser Committee has been created to make the Fundraiser profitable. The 52nd Journal Conference Aerosol Delivery in Respiratory Care, chaired by Arzu Ari and Bruce Rubin, will take place on June 6, 2014 will be the 52nd Journal Conference.

Brian Walsh moved to accept the ARCF, CoARC, and NBRC reports.
Motion carried

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS
Brian Walsh made a motion **FM 13-3-1.1** "That the AARC Executive Office explore developing relationships with organization such as, but not limited to, CLSI, ISO, NIH-NHLBI, ASTM and FDA."
Motion carried

Rationale: Many of these organizations regulate or establish standards for devices, drugs, and research that directly affect respiratory therapist and the patients they treat, yet there is little involvement from our community.

President Gaebler thanked the Board members who are transitioning off.

Treasurers Motion
Frank Salvatore moved “That expenses incurred at this meeting be reimbursed according to AARC policy.”
Motion Carried

MOTION TO ADJOURN
George Gaebler moved “To adjourn the meeting of the AARC Board of Directors.”
Motion Carried

ADJOURNMENT
President George Gaebler adjourned the meeting of the AARC Board of Directors at 10:30am PST, Friday, November 19, 2013.

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

______________________________ ____________________

Linda Van Scoder Date
AARC Secretary/Treasurer

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

December 7, 2013 • Webcast

Minutes

Present
George Gaebler, MSEd, RRT, FAARC, President
Karen Stewart, MSc, RRT, FAARC, Past President
Frank Salvatore, MBA, RRT, FAARC, President-elect
Colleen Schabacher, BA, RRT, FAARC, VP External Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Lynda Goodfellow, EdD, RRT, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Natalie Napolitano, MPH, RRT-NPS, FAARC
Karen Schell, DHSc, RRT-NPS, RPFT, AE-C, CTTS
Joseph Sorbello, MSEd, RT, RRT
Kimberly Wiles, BS, RRT, CPFT
Cynthia White, BA, RRT-NPS, AE-C
Gary Wickman, BA, RRT, FAARC

Absent
Brian Walsh, MBA, RRT-NPS, FAARC, VP Internal Affairs
Bill Cohagen, BA, RRT, RCP, FAARC
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC

Consultants to the Board of Directors
Present
Peter Papadakos, MD
Mike Runge, BSRT, RRT, FAARC

Absent
Dianne Lewis, MS, RRT, FAARC
John Steinmetz, MBA, RRT

Guests
AARC Executive Office:
Tom Kallstrom, MBA, RRT, FAARC, Executive Director/CEO
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Sherry Milligan, MBA, Associate Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Steve Nelson, MS, RRT-FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director

NBRC:
Kerry George, RRT, MEd, FAARC, NBRC President

Carl Haas, MS, RRT, FAARC, NBRC President-elect
Gary Smith, BS, RRT, FAARC, NBRC Executive Director
Lori Tinkler, MBA, NBRC COO

CoARC:
Kathy Rye, EdD, RRT, FAARC, CoARC President
Tom Smalling, PhD, RRT, RPFT, RPSGT, FAARC, CoARC Executive Director

CALL TO ORDER
President Gaebler called the meeting to order at 9:02 CST on Saturday, December 7, 2013.

DISCUSSION
Kerry George and Gary Smith presented the NBRC's concerns about CoARC Policy 13. The NBRC intends to change its rules so that BSRT program students will no longer be permitted to take NBRC exams before they receive their degree. This policy change passed the NBRC on first reading and is scheduled for a second reading and vote next week. Mr. George and Mr. Smith answered questions from the Board.

Kathy Rye and Tom Smalling reviewed CoARC's concerns about Policy 13 and possible remedies for those concerns. Their concerns and suggested remedies were sent to AARC Board members prior to the meeting. CoARC has voted to continue Policy 13 if the concerns can be remedied. Dr. Rye and Dr. Smalling answered questions from the Board

President Gaebler excused the NBRC and CoARC representatives at 10:00am CST. AARC Executive Office staff were invited to remain on the meeting.

EXECUTIVE SESSION
Bill Lamb moved to go into Executive Session.
Motion carried

The Board of Directors came out of Executive Session at 10:36am CST.

FM 13-4-84.1 Joe Sorbello moved "To request the NBRC to postpone its December vote on Policy 13 (Special Certificate of Completion for CRT/RRT Eligibility) in order to allow a committee to be formed to address the issues."
Motion Carried by a unanimous vote

FM 13-4-84.2 Karen Stewart moved "That an Ad Hoc committee be formed to address Policy 13 (Special Certificate of Completion for CRT/RRT Eligibility) issues. Representation on the committee is to come from CoARC, NBRC, and AARC, with no more than two committee members coming from each group. The committee is to report back to the AARC Board of Directors at its April 2014 meeting, with in-person representation from the NBRC and CoARC at that meeting."
Motion carried by a unanimous vote

ADJOURNMENT
Frank Salvatore moved to adjourn the meeting at 10:53am CST.
Motion carried

E-Motions

(Since Last Board Meeting in November 2013)

None

General Reports

President Report

Verbal report

Past President Report

Submitted by Karen Stewart – Spring 2014

Nothing to report

Executive Office

Submitted by Tom Kallstrom – Spring 2014

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

Membership

As of the second week in March the member count is 50,500 members. Interestingly there are over 700 less students as compared to a year ago with active members being about the same as in 2013. We will have a more specific number by the time of the Board meeting as well as a membership committee report.

Revenue Sharing/Co-Marketing

As of March 10th there have been 40 states (40 in 2013) that have signed their co-marketing and revenue sharing agreements. The state affiliates have been notified of this a number of times but this will be discussed at the affiliate leadership workshop in April. In 2014 new co-marketing opportunities for the affiliates include Exam Prep and Leadership Institute.

MEETINGS & CONVENTIONS

AARC Congress 2013

AARC Congress 2013, held in Anaheim, was a successful meeting for the Association in meeting the education needs of our members. Content was outstanding, and the Open Forums delivered another strong year with more than 300 original research posters presented in 19 Open Forums over 4 days. The Keynote Address delivered by Steven Jencks MD was outstanding and delivered a much-needed message to our members. The Closing Ceremony also had rave reviews and left attendees with a mix of education and entertainment to close out the show.

In lieu of a challenging economic climate, limited travel and education budgets from employers, and the overall impact of the Affordable Care Act, communicating value of attendance at future meetings must continue to be a primary focus moving forward.

The Program Committee continued to provide a diverse faculty for the meeting that included a balanced mix of experienced presenters, international faculty, as well as 46 first-time speakers.

Back by popular demand, AARC Congress 2013 hosted the Speaker Academy, where individuals who have never presented at an AARC Congress could “audition” for an

opportunity to present at AARC Congress 2014 in Las Vegas. Roughly 30 individuals submitted proposals to participate and 16 were invited to present a 10-minute, abbreviated presentation of their proposed talk. Of those 16, 8 were invited to present at AARC Congress 2014. This continues to be a key mechanism to identify and cultivate new talent within the Association. AARC Congress hosts the Speaker Academy every other year.

Complimentary video recordings of most all sessions were provided to registered attendees and served as a value-added bonus to reinforce value of attendance. This was funded through an unrestricted educational grant from Draeger Medical Inc.

2014 AARC Program Committee Meeting

The AARC Program Committee met in February to create the Program for the AARC Summer Forum and Congress. Nearly 1,000 individual lecture proposals were submitted for consideration.

The 2-1/2 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 individuals who submitted proposals indicating our acceptance or rejection of their proposals.

2014 AARC Summer Forum

The 2014 AARC Summer Forum will be held July 15-17 in Marco Island, FL. The meeting will be held at the Marco Island Marriott Resort & Spa (a favorite venue of many SF attendees). Marco Island has traditionally drawn strong attendance for AARC Summer Meetings in the past and we anticipate this trend to continue.

Primary demographics for those who attend this meeting will include department directors, managers and supervisors, hospital-based educators, program directors and directors of clinical education.

A post-graduate pre-course has been scheduled for the AARC Summer Forum titled; "*How Viable Is Your Respiratory Care Program? Assessing Quality and Sustainability of RC Education"*. This will be geared towards Program Directors and will focus on the business and financial side of operating a successful RT program. There will be a nominal fee associated with this course.

AARC Congress 2014

Progress is well underway for the logistical planning for AARC Congress 2014 to be held in Las Vegas, NV Dec. 9-12, 2014. The program is well balanced and representative of all specialty sections and roundtables. Formatting for the Congress agenda will remain very similar to 2013 regarding session length (35 minutes in 2014 v. 30 minutes in 2013) and

unopposed exhibit hours (8 hours in 2013 and 2014).

There are 2 new exciting changes to share regarding AARC Congress 2014:

- An AARC Congress Facebook fan page has been created to generate and maximize excitement surrounding the meeting throughout the entire year. https://www.facebook.com/aarc.congress
- The AARC has launched a new, completely electronic and digital portal for exhibitors to more easily engage with the association to participate in our meeting. On this site, exhibitors will be able to electronically select booth space, pay for booth space and create an on-line exhibitor e-booth which attendees (who will be invited to visit the site later in the year) will be able to peruse to learn more about participating companies and the products and services they provide to the respiratory community. This technology will bring AARC practices more current with existing practices taking place in the meetings and conventions community.

The Exhibitor Prospectus and Rules & Regulations have already been published on the website. Thus far, booth revenue for AARC Congress 2014 is well ahead of 2013 and 2014 budget. This primarily is a result of offering advance booth purchases for AARC Congress 2014 while we were at our meeting in Anaheim.

Several sponsorships that have traditionally been sold by Goldsbury & Associates for AARC Congress have been brought in-house for 2014. This will save the Association advertising commission previously paid to G&A. The Sponsorship Prospectus has already been published on the website and requests for sponsorships have already started to trickle in. Of note, Draeger Medical Inc. has already committed to the sole sponsorship of the AARC Opening Reception.

Project Update

Nutritional Resource Guide

The nutritional resource guide for respiratory therapists is complete. Product launch and distribution occurred in conjunction with AARC Congress 2013 in Anaheim. The resource guide was funded through an unrestricted educational grant from GE. As of the time of this report, 1,149 RTs have read the guide, taken the post-test and earned 3.0 CRCE.

Anticipated Completion Date: Done

COPD Best Practices

Participation in this AARConnect user community currently sits at 277 members. Thus far, 10

“COPD Best Practices” have been posted to the Library. The Executive Office has made concerted efforts to keep members focused on the purpose of this community by posting journal articles and manuscripts on pertinent topics devoted to management of the COPD patient and reducing unplanned hospital readmissions.

Anticipated Completion Date: Ongoing

Steven Jencks Moderated Discussion

In an effort to maintain momentum regarding our messaging about pending penalties for COPD readmission, the AARC has leveraged its relationship with Dr. Steven Jencks (2013 keynote presenter) to offer additional resources and content to managers and RTs looking for information to better manage the COPD patient and mitigate unplanned readmissions.

Dr. Jencks, in addition to Becky Anderson from Fargo, ND, will travel to Dallas in mid-April to record a moderated discussion (ala Professor’s Rounds) on this topic. The focus will be on providing RTs with practical tips, recommendations, and tools to address this issue within their own institutions. Becky Anderson will provide a “how to” guide to set up a successful COPD disease management program.

We intend to not only market this product internally (free to AARC members…no CRCE credit), but also to non-members (fee-based registration), doctors, nurses and hospital administrators through external advertising. At the time of this report, the course is funded through an unrestricted educational grant from BI, and Monaghan. We hope to seek additional funding partners as well.

Completion Date: Recording April 2014. Distribution: Spring 2014

Education

Adult Critical Care Course (ACCS)

The first ACCS course was held in September 2013. The topics and faculty were well received. Approximately 15% of attendees who qualify to challenge the NBRC ACCS exam have earned the credential at this time. A second course is planned for Summer 2014 and the course is anticipated to be online in early 2015. From there we expect to take the course on line.

Leadership Institute

The Leadership Institute was launched in early 2014. Consisting of 3 tracks (management, research, and education), the Leadership Institute was designed to provide real-world education for respiratory therapists who wish to expand their breadth and depth of knowledge

beyond the clinical realm. In February 2014, Dräger sponsored a scholarship competition to support the tuition for 9 RTs. We continue to promote this new program to both new and veteran RTs.

Learning Management System/AARC University

In early 2014, the AARC signed with Peach New Media for the Freestone LMS product. This platform will consolidate all educational items available from the AARC into one platform. It allows the consumer to search, purchase, watch, read, test, and earn credit in one location. The anticipated launch is in mid-April 2014.

Clinical PEP: Practices of Effective Precepting

The Clinical PEP: Practices of Effective Precepting was released in August 2013. So, far the course has been well received. At this time, the AARC has sold over 100 units (roughly 23% of accredited programs have purchased). The plan for 2014 is to update some of the videos so that the content remains dynamic and relevant to educators and preceptors.

Professor's Rounds

The 2014 Professor's Rounds will be the 25th Anniversary Edition. Topics include:

- ACA and the RT
- Managing the Difficult Airway
- ECMO
- Pediatric Emergencies
- Non-invasive Ventilation
- Mechanical Ventilation Waveform Analysis
- Non-invasive Monitoring in the ICU
- COPD Disease Management.

Webcasts

Webcasts and JournalCasts continue to be popular educational features. Average attendance in 2013 for a webcast was 441. For 2014, 11 webcasts and 10 JournalCasts are planned.

Respiratory Care Education Annual

The 2013 edition was the first online-only edition of the Respiratory Care Education Annual. The 2014 Editorial board consists of Dennis Wissing (editor), Helen Sorenson (associate editor), Will Beachy, David Chang, Arthur Jones, and Linda Van Scoder. Paul Matthews and Lynda Goodfellow resigned in early 2013; Doug Gardenhire and Kathy Myers Moss joined

the editorial board in their places.

Human Resources Survey (HRS)

The AARC is working with AMP to deploy the 2014 HRS in the spring. The anticipated completion date is November 2014 with a reporting of the major findings at the AARC Congress 2014 in Las Vegas, NV.

2014 Additions to Education

Several additions to the educational offerings are planned for 2014. A 3 CRCE asthma course and a 3 CRCE guide to the treatment of tobacco dependency are planned for late spring. Future content development will focus on materials that relate to specialty credentials and state licensure needs.

CPG Development

The first evidence based clinical practice guideline (EBCPG) was published in RESPIRATORY CARE in December 2013. Work began on the follow-up of that guideline, Pharmacologic Interventions for Airway Clearance in Hospitalized Patients, in January 2014. Submission for publication of the second EBCPG is expected by December 2014. The group is exploring funding opportunities and areas of interest for future EBCPGs.

Advocacy

Recruiting for the Profession

There are two major events for recruiting this year:

- HOSA, an annual event in which the AARC participates The HOSA event will be held in Orland, Florida, in June. Jamy Chulak, RRT, is coordinating volunteers for that event.
- USA Science & Engineering Festival (USA SEF). USA SEF will be held in Washington, DC, in April. Carolyn Williams, RRT, is coordinating volunteers for that event.

DRIVE4COPD

In 2013, AARC members successfully screened 14,639 people for their risk for COPD. Many involved in the campaign did during Respiratory Care week in October, while others had events throughout the year. There were a total of 138 members who participated in over 160 events in almost every state. Members also participated in events that where organized by the AARC/COPD Foundation.

For 2014, the AARC has focused its efforts on four states, and a multinational corporation. Throughout 2014, members will once again be participating in screening events but this time efforts are being focused on PespiCo. In 2013 the AARC participated in 4 onsite screening events, and to date in 2014 this has expanded to over 15 sites. These sites span across the country, and are being held primarily in the first quarter of 2014. This has been a good change for screening, and many of the sites are interested in other diseases like OSA and Asthma. Ideally in 2015 there should be efforts to increasing the screening sites from the 15 this year to 30 in 2015. More should be planned to increase the services required and less focus on the DRIVE4COPD.

The remainder of 2014 will yield another screening competition, this one putting each respiratory department against each other. Details are still be worked out, but this competition will commence at Summer Forum and run through the end of November with the winner being reviled at the AARC International Convention in Las Vegas this December. The goal is year will to utilize the digital screener in place of the paper screener. This will allow us better analysis of the data and better research from the completed screeners.

Publications

RESPIRATORY CARE Journal

Overview

- Every month we continue to receive more manuscripts than the month before, a trend than has been going on for more than 5 years now. The benefits are tremendous in that the Journal is now well recognized as a place for publishing your original research. This has required us to be much tougher on the acceptance process and to publish some manuscripts online only.

- As reported during your last meeting, all the 2013 matrixes point to perhaps the most significant 12 months in the 57 years of the Journal. We want to continue growing, offering more to our readers, increase our prestige as an elite medical journal, etc.

- The Journal Seattle operation was shut down last December 31 and the 2 staff positions there were eliminated at that time. Some of the work done there was outsourced to a division of Cenveo, the long-time printer of the Journal, and the remaining staff absorbed the rest. We went from 2 full-time positions (80 hours/week) and 3 part-timers (total for all 44 hours/week) to 1 full-time (40 hours/week) and 4 part-timers (total for all 52 hours/week). For comparison purpose, the last time we checked the ACCP's Chest Journal, they list more than 20 people as working on their publication. We feel the changes will make our Journal a better publication and reduce production costs.

- At the end of 2013 we added a Portuguese podcast to the English, Spanish and Mandarin podcasts we have been offering for a few years now. The podcasts offer subscribers a narration of the Editor's Commentary published every month in the Journal and they briefly describe each article in that particular issue.

- In 2013 the AARC began offering the RESPIRATORY CARE JournalCasts. The webcasts are designed for the monthly Editor's Choice paper to be presented, critically evaluated, and discussed by a therapist and AARC member with expertise on the subject matter; the podcasts are free of charge to AARC members and approved for CRCE. The following podcasts have been presented since our last November report:

    - *The Impact of Hospital-Wide Use of a Tapered Cuff Endotracheal Tube on VAP Incidence.* Presenter: Steven Holets BS RRT, Rochester MN
    - *Role of a Respiratory Therapist in Improving Adherence with Positive Airway Pressure Treatment in a Pediatric Sleep Apnea Clinic.* Presenter: Teresa Volsko MHHS RRT FAARC, Akron OH
    - *Pulmonary Function Test Quality in the Elderly: A Comparison with Young Adults.* Presenter: Gregg Ruppel MEd RRT RPFT FAARC, St. Louis MO
    - *Frequency Oscillatory Ventilation versus Synchronized Intermittent Mandatory Ventilation plus Pressure Support in Preterm Infants with Severe Respiratory Distress Syndrome.* Presenter: Jeanette Asselin MS RRT, Oakland CA
    - *Scintigraphic Assessment of Radioaerosol Pulmonary Deposition through Acapella Device.* Presenter: Brian K Walsh MBA RRT-NPS RPFT FAARC, Boston MA

- This time of the year the Journal staff becomes heavily involved in promoting, receiving, and selecting the OPEN FORUM abstracts to be presented at AARC Congress 2014. As announced at last year's Congress in Anaheim, in 2014 the OPEN FORUM will be significantly different from previous years. In 2014 accepted abstracts will be presented in one of three formats, as determined by the review process:
    - **Editors' Choice** – Authors of this select group of abstracts will prepare a poster for prominent display during the first two days of the Congress. On the third day of the Congress each Editors' Choice presenter will give a 10-minute slide presentation, followed by 10-minute of audience questions and discussion.
    - **Poster Discussions** – Authors will prepare a poster of their work to be presented in a session grouped by topic. A brief oral presentation (no slides) and audience questions and discussion will allow presenters to expand on the work feature on the poster. The majority of accepted abstracts fall into this category.
    - **Posters** – Authors will prepare a poster to be displayed during Exhibit Hall hours on an assigned day. The presenter is required to be present between 12:00 noon and 1:00 pm to discuss their work. (Note: At the time of submission you may choose for your abstract to be considered as a Poster *only*.)

IT

- The email system is in the final process of being upgraded and should be complete by the end of March. This upgrade will include access to an online calendar for all users that will help internally with scheduling.

- The new phone system will be installed over the weekend of Mar 28. This will replace the outdated system that no longer has support available. Enhancements will include automatic redirecting of calls, and integration with the calendar system to show a person's availability.

- Our internet connection is being upgraded from copper wire to fiber. This enhancement will allow us to increase our bandwidth almost 8x. This allows us to use a single line for our internet and phone service now and will remove the cost of phone trunks.

- We have been working diligently with our website designer, AXZM, on modernizing and streamlining our web presence for AARC in the coming months. We have finalized branding concepts and are currently in the process of developing the layout of the site. An aggressive timeline has been established to develop and implement the new websites (AARC, ARCF and YLH) in 2014. The aarc.org website design is about 50% completed as we meet.

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 with only two months of sales date, advertising is slightly behind target for both Resp Care Journal and *AARCTimes* as has been the trend of the last several years. This comes despite efforts to create a flexible portfolio of opportunities. We are seeing a slight increase in Digital Advertisements on our e-newsletter products and our Recruitment Advertisements in 2014.

We continue to develop and grow our platforms in the digital advertising environments. Our agreements with a digital advertising firm, Multiview Inc (Las Colinas, TX), to procure digital advertising for our various digital and on-line platforms has provided a new royalty stream that is well into its first year. We are developing new opportunities for advertisement banners and towers with them as they have done a nice job selling out our space on AARC.org. We will also in the near future begin selling advertising in a digit format on other platforms through Multiview.

We also successfully launch our new “Online Buyer’s Guide” right after Summer Forum 2013. The new platform and product is hosted by Multiview Inc. and is “AARC Respiratory Care Marketplace” and can be found on both aarc.org and YourLungHealth.org. This new platform has open additional royalty advertisement that is 5-6 times greater than when we hosted our own labor-intensive platform.

Corporate Partners

We had a very successful year of revenue and sponsorships from our 2013 Corporate Partners. As in other years, we saw some Corporate Partners lose their status in 2014 and the addition of some new Partners.

2013 Partners: Carefusion, Masimo, Covidien, Monaghan, Philips/Respironics, Drager, GE Healthcare, Maquet, Teleflex, Boehringer Ingelheim, Tri-Anum/Sarnova, and Forest

Pharmaceuticals.

2014 Partners: Carefusion, Masimo, Covidien, Monaghan, Philips/Respironics, Draeger, Maquet, Teleflex, Boehringer Ingelheim, Forest Pharmaceuticals, Ikaria (new) and Sunovion Pharmaceuticals (new).

GE Healthcare and Sarnova will not be a partner in 2014 due to some corporate changes and different strategies. There are 2-3 other companies looking to step up to the program in 2015 possibly. At the same time we welcome Ikaria and Sunovion Pharmaceuticals.

We will be meeting with the Corporate Partners on Monday evening and all day Tuesday at the conclusion of our BOD meetings here in Dallas. Along with our elected leadership and Executive Office team, and in keeping with our vision of preparing the respiratory therapist as a leader in hospital and outpatient based disease management we will have Dr. Stephen Jencks and Becky Anderson, RRT provide a presentation to the Partners on Readmissions and the ACA's Impact on the Respiratory Care Department.

Marketing
We continue to look at new vehicles through social media sites and electronic newsletter to better market the AARC, as well as, its educational and other products. Many of these venues will also open up additional and new advertising and sponsorship opportunities as well.

Products
Benchmarking has seen a slight decline in membership in 2013 as the economic reigns are tightening for hospitals with approximately 100 hospitals (-25%) around the US and in Middle East (3). The Benchmark Committee is currently conducting an assessment of the program, possible upgrades and a potential new product line to insure it is a current and valued tool to its participants. We are also revised the pricing structure for 2014 to insure that has a good ROI for both the AARC and its participants that has led to an uptick in renewals and a few new clients.

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. 2013 was our second year outsourcing RC Week products to Coleman. We came in right about our budget target in 2014 and realized a higher royalty than in year one. We have already begun work on the 2014 campaign.

We continue to work to acquire sponsorships for our various educational products to offset expenses in 2014. In 2013, we acquired 5 sponsors for Professor's Rounds. Webcast sponsorship acquisition was not as successful in 2013. We restructured our sponsorship rates and deliverables for 2014. We also introduced a new product in this area with Webcast specific for Editor's Choice publications in Respiratory Care, which have been met with great satisfaction and participation. We have also received approval on our US Trademark for this series for 2014….AARC RESPIRATORY CARE *JournalCast*.

As we continually review our product offerings, we revised and updated 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 were in need of a good refresh. These new brochures and IQ cards were released last October just in time for RC Week events. We hope to see an increase in sales in 2014 with a younger, more modern look of the brochures.

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.

Roundtable/Section Communication

In late January we did an analysis of communication with roundtables. They are available at this meeting. Below is a summary over a 12-month period ending in January 2014.

Round Tables

Asthma (Eileen Censullo)
44 postings (3 from chair and 15 from co-chair)

Geriatric (Mary Hart)
12 postings (3 from chair)

Hyperbaric (Cliff Boehm as of January but now is vacant)
5 postings (zero from chair)

Informatics (Jim Fielder)
7 postings (1 from chair)

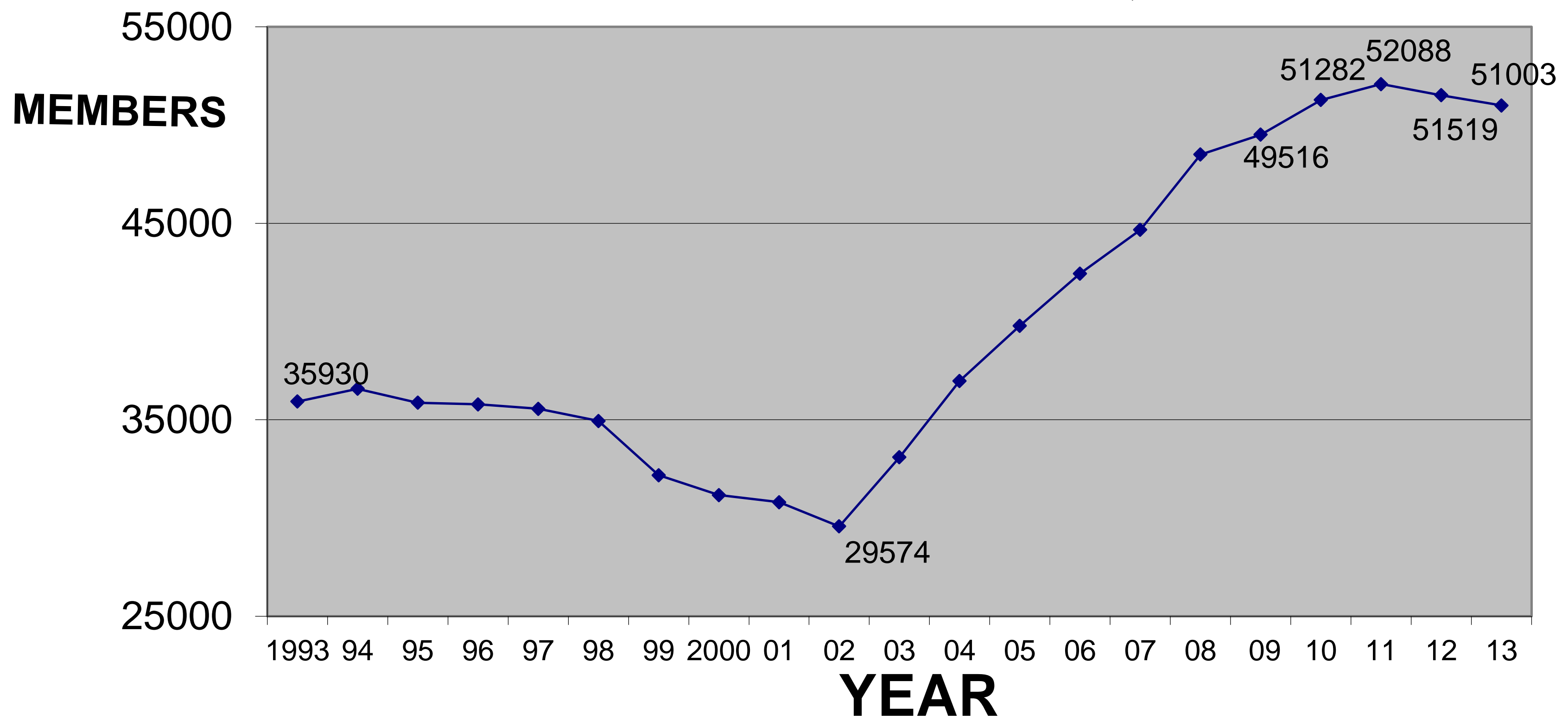
International Missions (Lisa Trijullo)
21 postings (8 from chair)

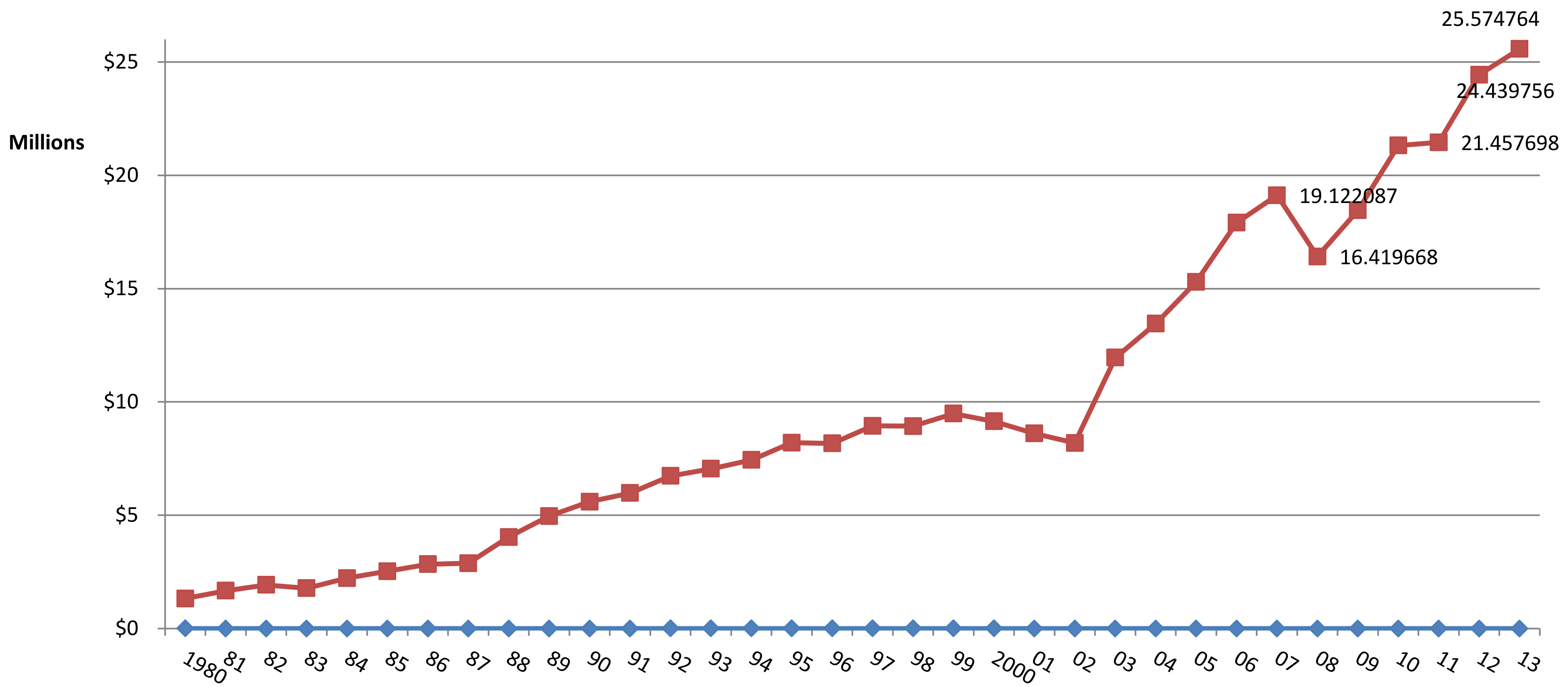
Military (Harry Roman)
21 postings (15 from chair)

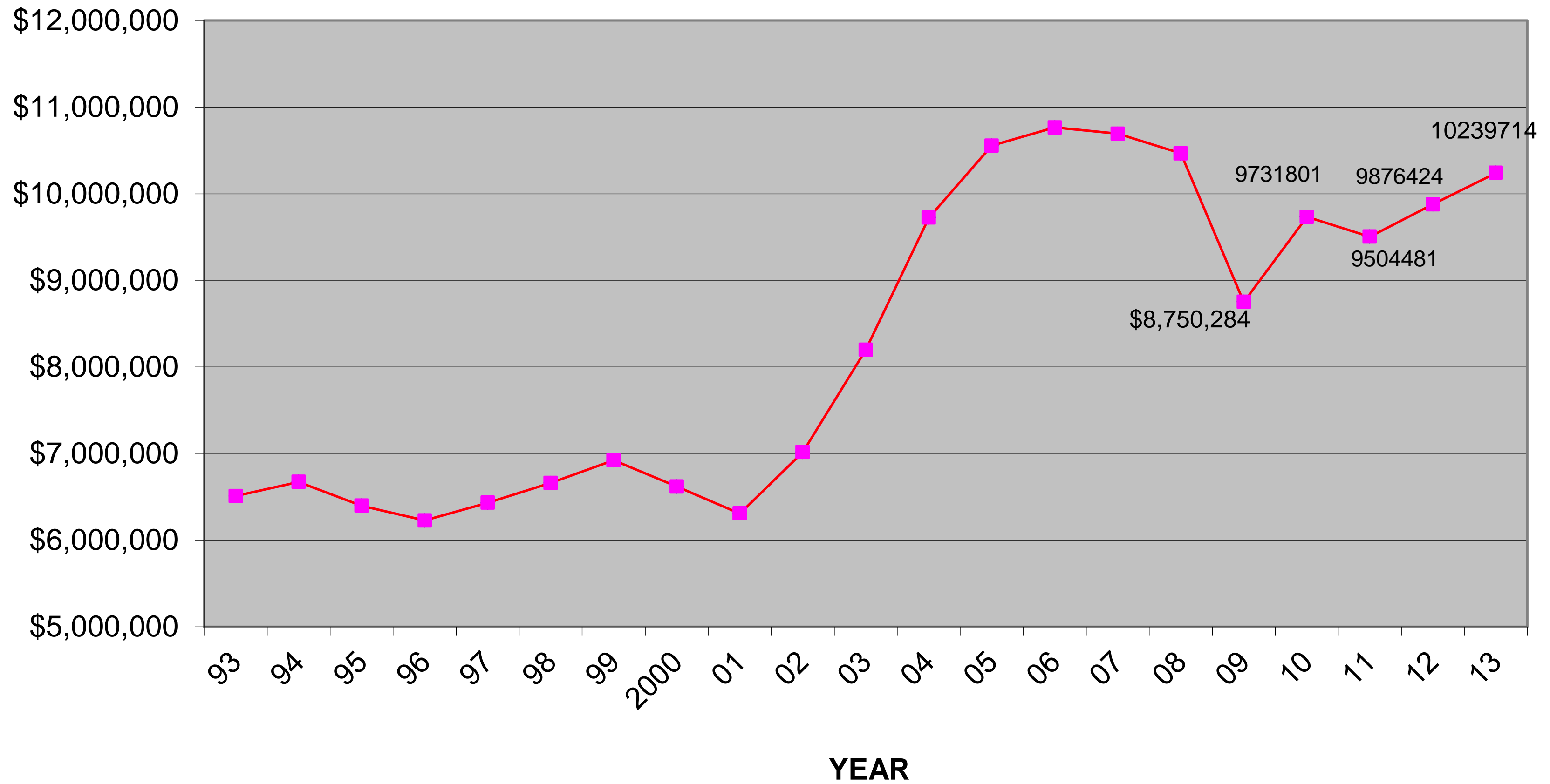
Neurorespiratory (Lois Rowland in 2014 and Lee Guillon in 2013)
41 postings (17 from chair)

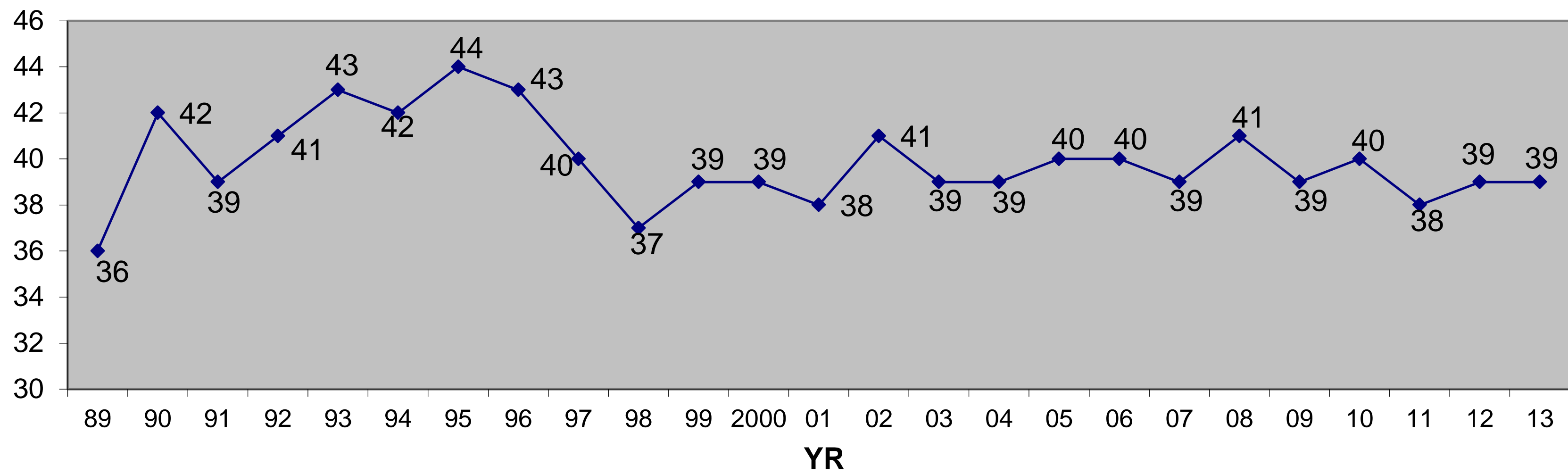
Palliative Care (Helen Sorenson)
29 postings (7 from chair)

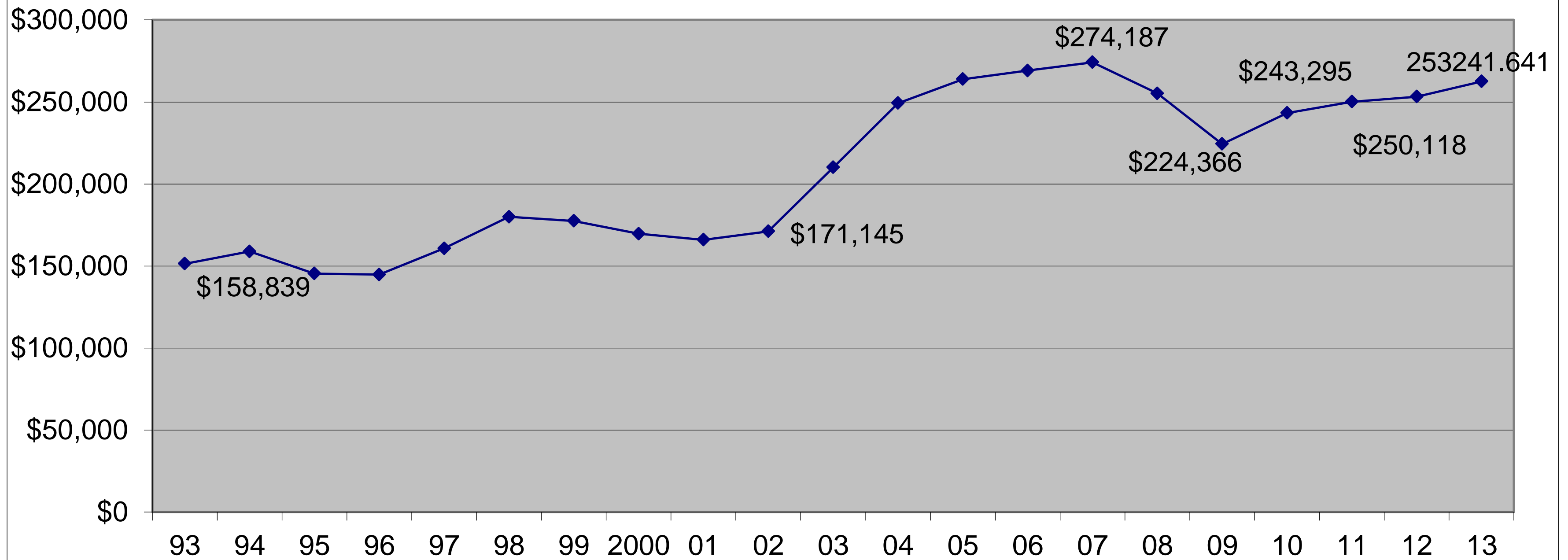
Research (John Davies)
12 postings (6 from chair)


AARC MEMBERSHIP LEVEL-
21 YEAR HISTORY at DEC 31, 2013
55000
45000
35000
25000
MEMBERS
35930
29574
49516
51282
52088
51519
51003
1993 94 95 96 97 98 99 2000 01 02 03 04 05 06 07 08 09 10 11 12 13
YEAR

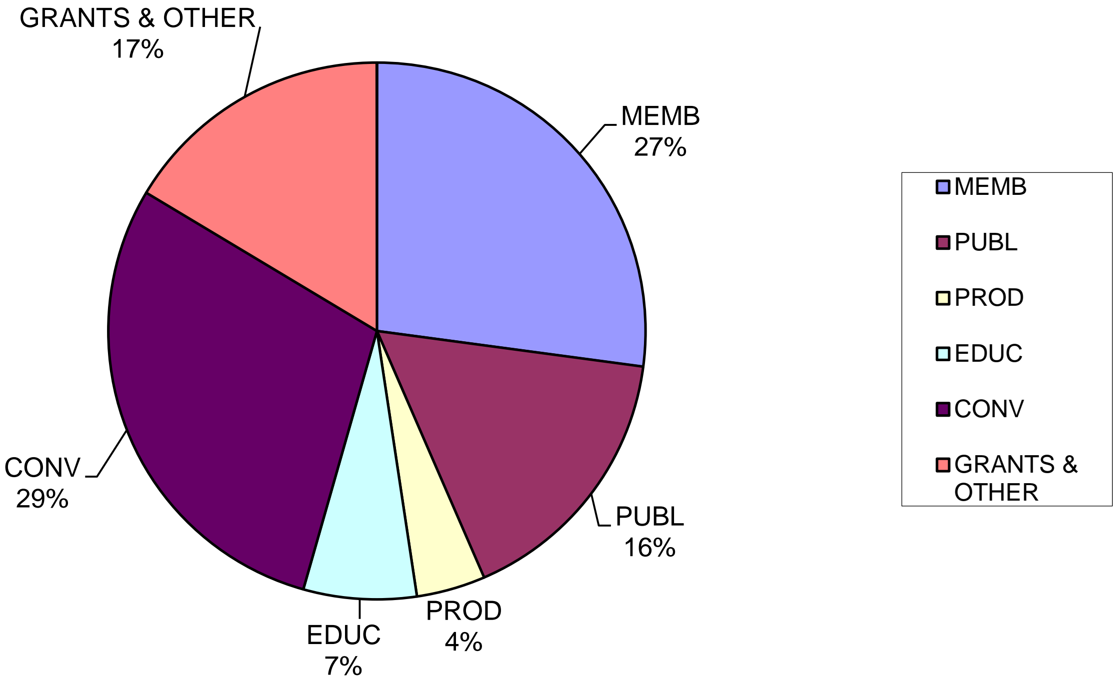

TOTAL AARC ASSETS AT DEC 31
Millions
$25
$20
$15
$10
$5
$0
25.574764
24.439756
21.457698
19.122087
16.419668
1980
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
2000
01
02
03
04
05
06
07
08
09
10
11
12
13

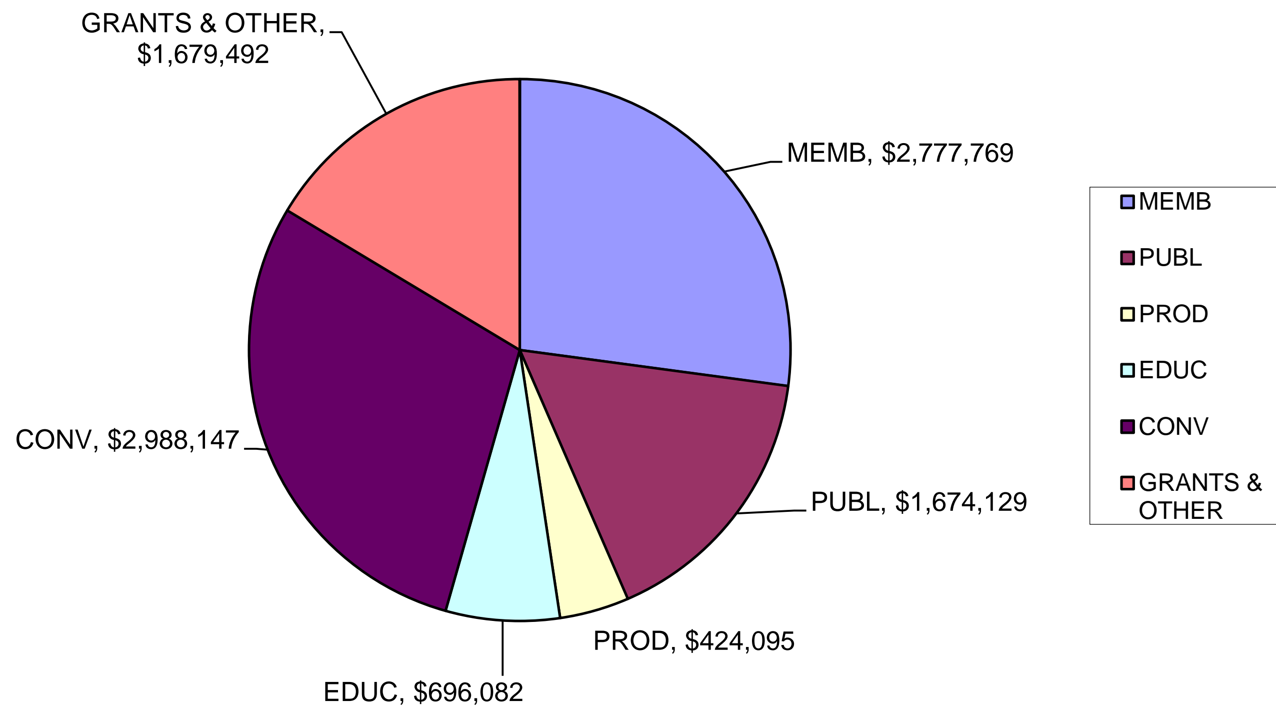

ANNUAL AARC OPERATING REVENUES
INCLUDES GRANTS // EXCLUDES INVESTMENT ACTIVITY
$12,000,000
$11,000,000
$10,000,000
$9,000,000
$8,000,000
$7,000,000
$6,000,000
$5,000,000
10239714
9731801
9876424
9504481
$8,750,284
93
94
95
96
97
98
99
2000
01
02
03
04
05
06
07
08
09
10
11
12
13
YEAR

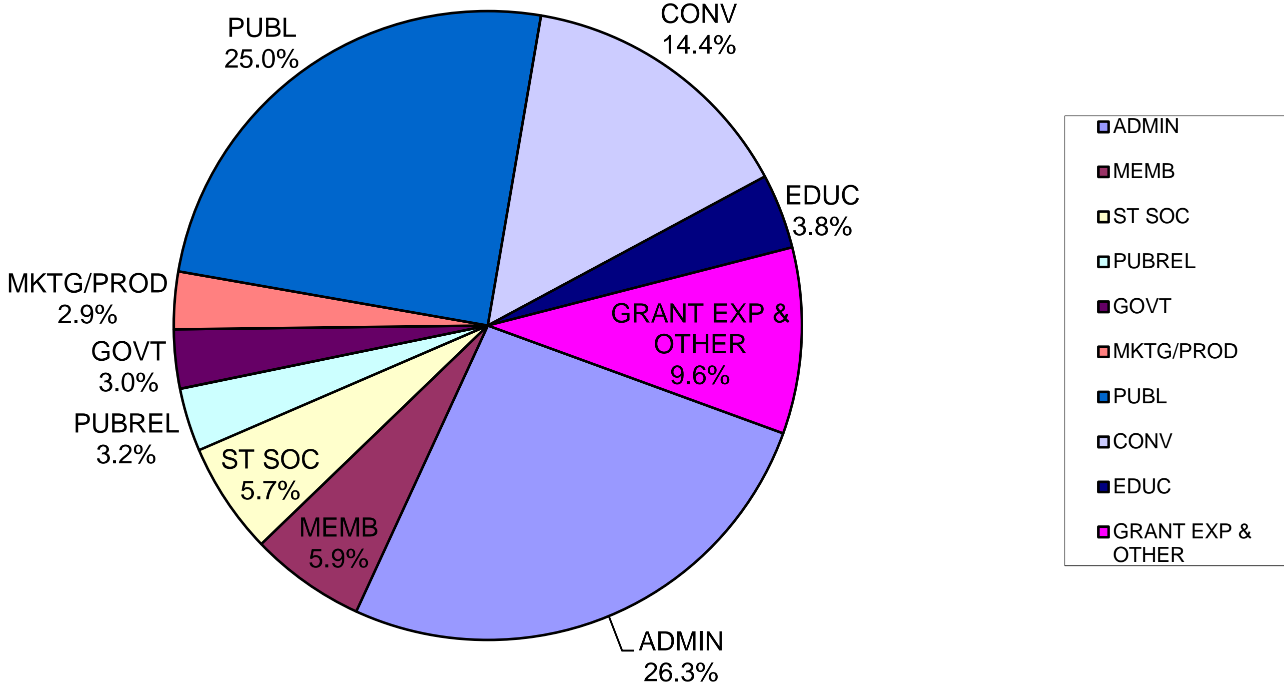

Actual Full Time Employees (FTE)
12/31/ 1989--2013
#EMP
46
44
42
40
38
36
34
32
30
36
42
39
41
43
42
44
43
40
37
39
39
38
41
39
39
40
40
39
41
39
40
38
39
39
89
90
91
92
93
94
95
96
97
98
99
2000
01
02
03
04
05
06
07
08
09
10
11
12
13
YR

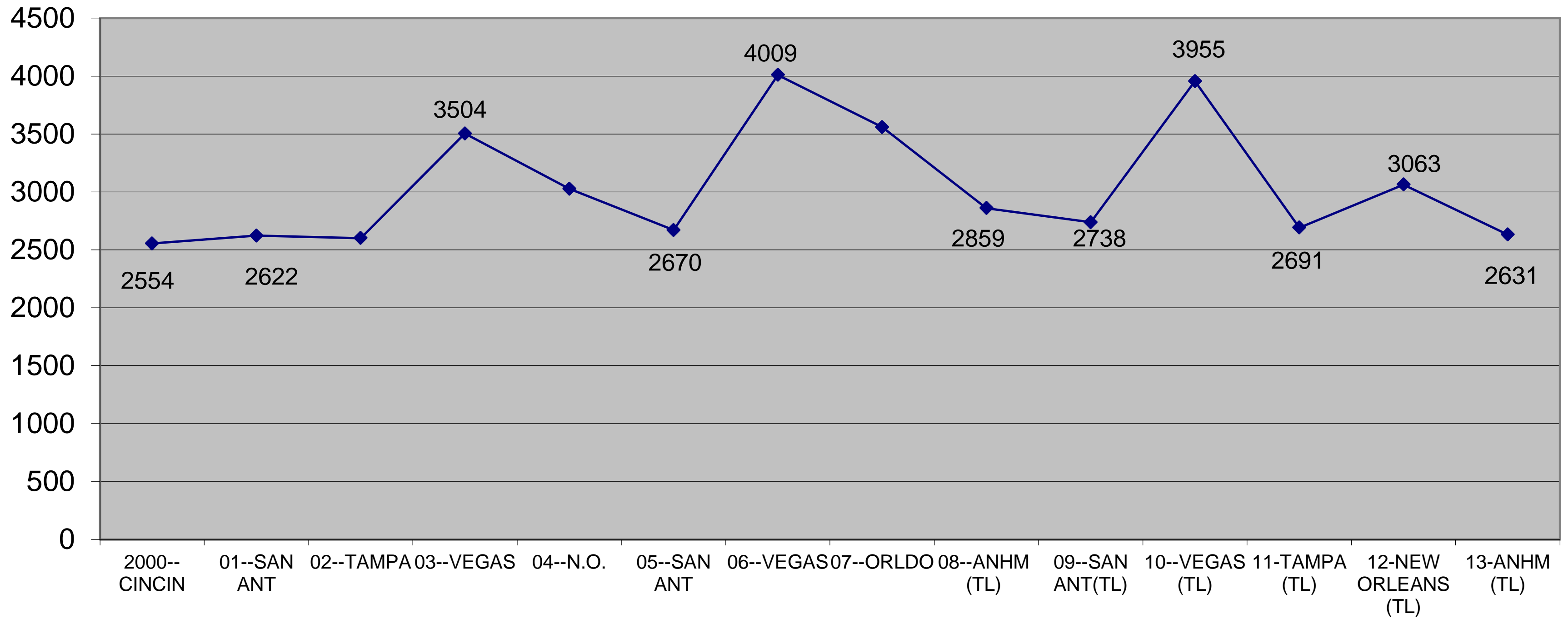

REVENUES per FTE
(w/o investment activity) 12/31/1993-2013
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
$158,839
$171,145
$274,187
$224,366
$243,295
$250,118
253241.641
93
94
95
96
97
98
99
2000
01
02
03
04
05
06
07
08
09
10
11
12
13

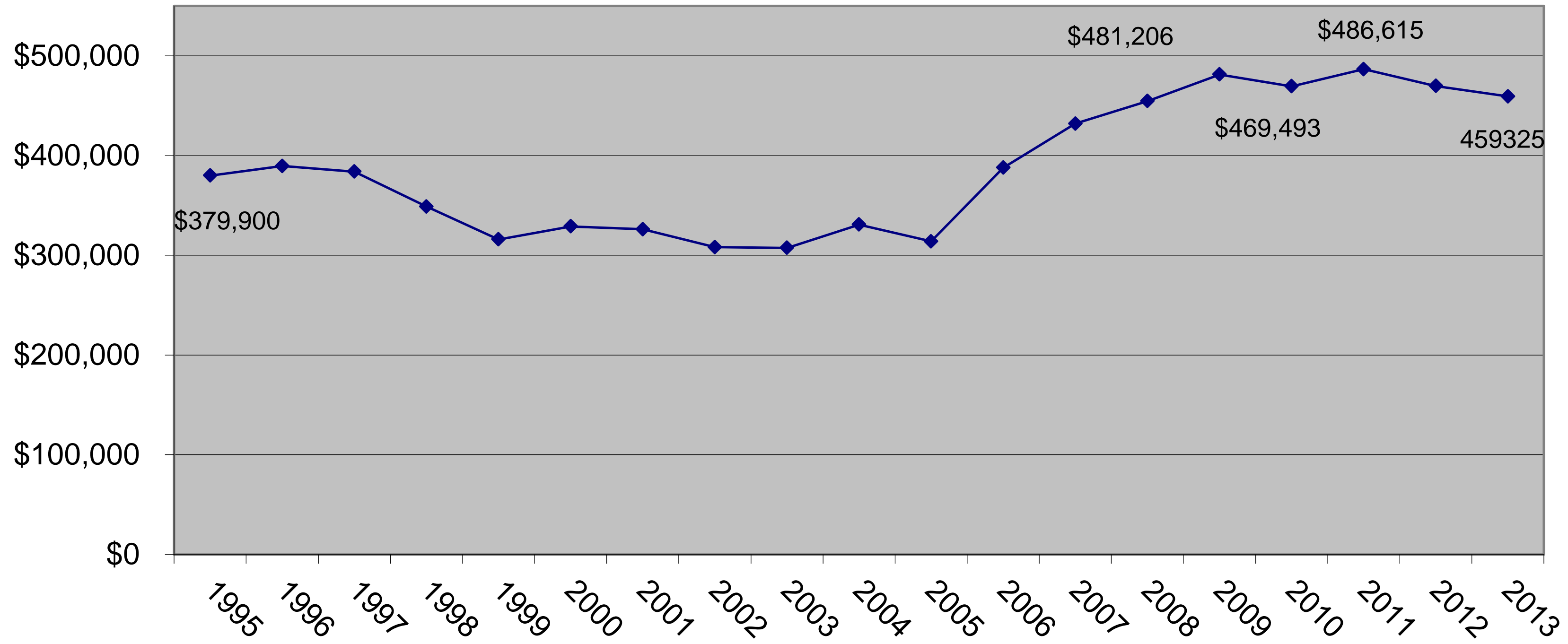
AARC 2013 REVENUE MIX - %'s
(Ignores ALL Investment Activity)

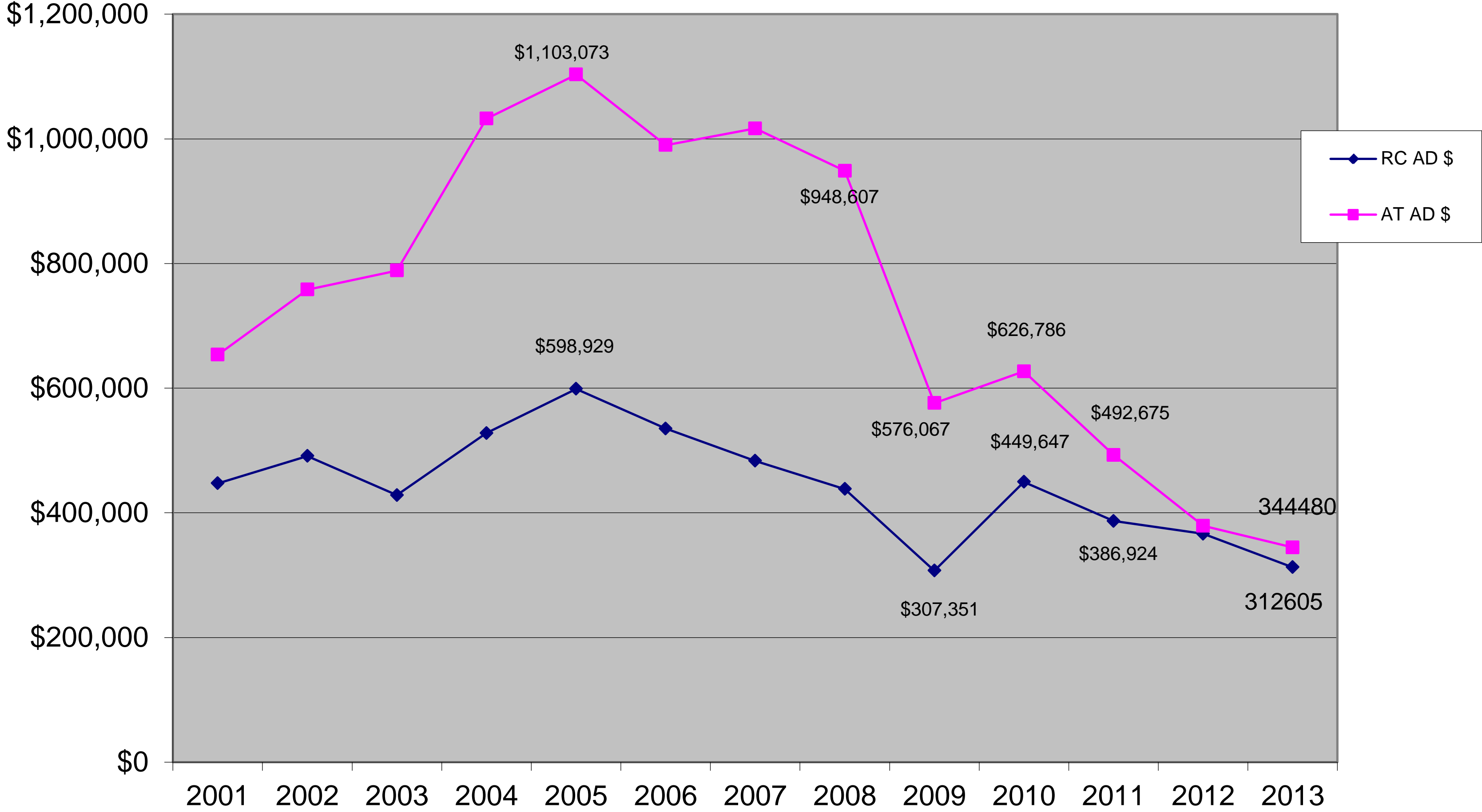



AARC 2013 REVENUE MIX - $$$
(Ignores ALL Investment Activity)
GRANTS & OTHER, $1,679,492
MEMB, $2,777,769
CONV, $2,988,147
PUBL, $1,674,129
PROD, $424,095
EDUC, $696,082
MEMB
PUBL
PROD
EDUC
CONV
GRANTS & OTHER


AARC 2013 EXPENSE MIX BY DEPT.
(%'s)
PUBL
25.0%
CONV
14.4%
EDUC
3.8%
GRANT EXP &
OTHER
9.6%
ADMIN
26.3%
MEMB
5.9%
ST SOC
5.7%
PUBREL
3.2%
GOVT
3.0%
MKTG/PROD
2.9%
ADMIN
MEMB
ST SOC
PUBREL
GOVT
MKTG/PROD
PUBL
CONV
EDUC
GRANT EXP &
OTHER


CONVENTION ATTENDANCE 2000-2013
(Source--Ray M. R&V or TL stats)
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2554
2622
3504
4009
2670
2859
2738
3955
2691
3063
2631
2000--CINCIN
01--SAN ANT
02--TAMPA
03--VEGAS
04--N.O.
05--SAN ANT
06--VEGAS
07--ORLDO
08--ANHM (TL)
09--SAN ANT(TL)
10--VEGAS (TL)
11-TAMPA (TL)
12-NEW ORLEANS (TL)
13-ANHM (TL)


REVENUE SHARING / SOCIETY GRANT HISTORY
1995-2013
$500,000
$400,000
$300,000
$200,000
$100,000
$0
$379,900
$481,206
$469,493
$486,615
459325
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013


ANNUAL ADVERTISING DOLLARS 2001--2013
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
$1,103,073
$948,607
$598,929
$626,786
$576,067
$492,675
$449,647
344480
$386,924
$307,351
312605
RC AD $
AT AD $

Executive Office Referrals

(from Nov 2013 BOD meeting)

- ***FM 13-3-1.1*** *Brian Walsh moved that the AARC Executive Office explore developing relationships with organization such as, but not limited to, CLSI, ISO, NIH-NHLBI, ASTM and FDA.*

Result: The Executive Office has been working closer with AANMA (Tom Kallstrom is now a Board member), COPD Foundation, Alpha 1 Foundation, Alpha 1 Association, and AACVPR, just to name a few. As of this Board meeting, Tom Kallstrom will have attended two NAMDRC meetings. We are focused on working closer with organizations that support our Bill, HR 2619.

- *Recommendation 13-3-51.3 "That a task force be immediately organized for a Grant Submission for a National Pulmonary Rehabilitation Disease Management/Maintenance Exercise Program."*

Brian Walsh moved to refer to Executive Office.
Motion carried

Result: As a result of conversations with Gerilynn Connors, she will develop a proposal with Shawna Strickland's assistance.

- *Brian Walsh moved to accept Recommendation 13-3-52.1 "Provide complimentary AARC Congress registration for each recipient of section Specialty Practitioners of the Year."*

Frank Salvatore moved to refer to Executive Office for cost analysis and report back in April 2014.
Motion carried

Result: **$4,190** ($419 on-site registration x 10 specialty sections)

- *Brian Walsh moved to accept Recommendation 13-3-55.1 "With the assistance of AARC Board staff, create and conduct a survey to the Section Membership to investigate the drop of membership."*

Colleen Schabacker moved to make a friendly amendment "To conduct a survey to all sections to investigate the drop in membership and report back in April 2014."

Karen Stewart moved to make a friendly amendment to refer to Executive Office.
Motion carried

Result: See "Survey Summary Report" below

- *Colleen Schabacker moved to accept* Recommendation 13-3-64.1 *"That the Executive Office reach out to the leadership of AHA to determine if an AARC representative is needed."*

Brian Walsh moved to make a friendly amendment to "an additional".
Motion carried

Result: A letter was sent to AHA CEO, Nancy Brown, asking if she would like an additional AARC representative, no response yet. (see letter sent below)

Survey Summary Report

In further discussion about this referral, we know that some Sections have developed a Section-specific survey. Section chairs can develop a survey and run it through the Executive Committee as our survey policy defines. However, because a drop in membership affects our entire base, these highlights from surveys we conduct on an ongoing basis with our membership may provide some insights.

- There are some misconceptions and inaccuracies about what members believe of the AARC.
- Online continuing education offerings are of most value to our members.
- People want job help
- They say they want "value" but then continue to cite things that we currently offer as things they want.

Highlights of the Six-Month Surveys
These surveys are sent to members in their 6th month of membership, not only to solicit their input, but also to serve as a form of education to them about what is available from AARC.

1. Most say they join because of professionalism is important to them. Secondly it's because their instructor recommended it

Professionalism – 46.4%
Instructor Recommended – 33.9%

2. They say the service or benefit most important to them is:

Free online continuing education – 37.1%
Respiratory Care Journal – 18.0%
AARC Web Site – 14.3%

3. 55% say they belong to be a better care provider to their patient.

4. 73% have no plans to attend one of our meetings.

5. 30.3% do not know that we have webcasts and other courses online.

Of the comments coming through, we can categorize them loosely as saying to:

- continue having online continuing education
- help them find a job
- have lower dues
- raise the profile of respiratory therapists

Highlights of the Sixteen-Month Survey
We also circulate a survey in an individual's 16th month of membership.

1. 87.9% feel they receive value from their AARC membership.

2. Of the services and benefits they've used in the last year, we see:

78.6% - read AARCTimes
73.7% - read RESPIRATORY CARE
28.6% - signed up for an online course
16.1% - signed up for a webcast
15.1% - was a Facebook fan of AARC's

3. 93.3% would recommend AARC to another respiratory therapist.

4. 57% participated in a state society activity within the last year.

Exit Survey

This was sent in late 2013 to members who had lapsed between six and 24 months previously.

1. They joined for the following reasons (they could choose more than one)

67.9 – to stay current in the profession
54.2 – to get online continuing education
53.8 – to demonstrate professional pride
32.3 – to support the work in Washington DC
25.9 – to network with other RTs

2. They chose not to renew for the following reasons

26.4 – didn't get enough value for dues paid
26.3 – I forgot
19.0 – retired
11.5 – unable to participate actively
10.3 – was dissatisfied with AARC

Why don't you see value?

- Simply can't afford it (no job, underemployed, family situations)
- Continuing education too expensive.
- Something is wrong in the wider world and AARC is not helping with it.

Why dissatisfied?

- Dues are too expensive
- I don't know what you offer
- Something's happening out there in the world/my hospital and you aren't helping

Misinformation

In reviewing all of the surveys, these "themes" of misinformation were identified. These were thoughts expressed by several individuals throughout the surveys.

- You don’t offer free continuing education.
- You can’t opt out of receiving magazines.
- You never send magazines any more.
- Why don’t you have a membership that’s affordable (say around $80)
- You don’t ever tell us what you offer.
- I pay the NBRC already. Why should I pay you?

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

March 19, 2014

Nancy Brown, CEO
American Heart Association
7272 Greenville Ave
Dallas, TX 75231

Dear Nancy,

Allow me to introduce myself. My name is Tom Kallstrom and I am the CEO/Executive Director of the American Association for Respiratory Care (AARC). I wanted to bring to your attention a request from our last Board of Directors meeting, which was held last November.

Currently, Brian Walsh, RRT, FAARC, is the AARC's sole representative to the American Heart Association and served the BLS Subcommittee for the past 4 years. At our last Board of Directors meeting we were informed that the overall structure of these meetings has changed to "systems of care" in order to better meet the mission, vision, and goals of the AHA. We were also informed that there is no longer a BLS subcommittee in which we were asked to provide representation. Mr. Walsh has chosen, with the support of the AHA leadership, to participate in inpatient system of care (ISOC) as that is where most respiratory therapists serve. Due to the wide variety of work and value that respiratory therapists offer, we feel that there are other areas within the American Heart Association where respiratory therapists may be of assistance; including pediatrics, patient education, instruction, and Emergency Medical Service (EMS or out of hospital system of care).

We believe our patient centric missions are in alignment with each other and overlap in several areas (i.e. smoking cessation training). If there is a desire for an additional Registered Respiratory Therapist to work with Brian Walsh to represent the AARC, I would be happy to bring this back to our Board of Directors for consideration.

We are located in the Dallas area and I would be happy to meet with you should you like to explore this further. Please contact me at 972-243-2272 or Kallstrom@aarc.org should you wish to discuss this request further.

Thank you,

Thomas J. Kallstrom, MBA, RRT, FAARC
CEO/Executive Director

CoARC Report

Submitted by Tom Smalling – Spring 2014

See Attachment:

"CoARC Update to AARC 4 14"

Date: March 11, 2014

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

From: Carl F. Haas, MLS, RRT, CPFT, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you my first update on activities of the NBRC as President. Since the last report, the Board of Trustees and its committees met in December 2013. The Board of Trustees will hold its spring meeting April 27- May 3 in Kansas City to conduct examination development activities and discuss business related items pertinent to the credentialing system. For the fifteenth consecutive year (since implementing computer based testing) the NBRC has been able to provide quality credentialing programs to the respiratory therapy profession with no increase in the testing fees for candidates. The following information summarizes the current status of significant changes to several examinations and major activities in which the Board and staff are currently involved.

Credentialing System Evolves

Therapist Multiple-Choice Examination

We are in the final stages of development of the new Therapist Multiple-Choice Examination. In late April, examination committee members and invited outside representatives will conduct the passing point study to determine the low and high cut-scores for this new examination, which allow one exam to be used to establish competence at the CRT level and eligibility to sit for the clinical simulation examination, respectively. The new examination will be implemented in January 2015. Details regarding admissions policies, how/when to apply, etc. can be found on the NBRC's website.

Clinical Simulation Examination

The committee continues to work on problems for the new simulation examination which will be introduced in January 2015. The new format will contain twice as many (20) shorter questions and allow the committee advantages such as more efficient problem updates. Dr. Robert Shaw,

NBRC's psychometrician and Assistant Executive Director will present more details about the new simulation examination and the value of the Clinical Simulation Examination to the RRT credential at the Summer Forum in Marco Island.

Pulmonary Function Technology Examination

A study of the examinations for the CPFT and RPFT programs revealed a very similar result as had been observed when the same kind of assessment was made for CRT and RRT programs three years ago. Among tasks that the 2006 CPFT and RPFT job analyses had found were critical to assess in examinations, more than 95% of those tasks were critical for both the CPFT and RPFT programs. In other words, the vast majority of content that was critical to assess RPFT competencies were also critical to assess CPFT competencies. NBRC trustees interpreted this result as evidence of sufficient convergence between what had been more strongly distinct roles for persons holding the CPFT and RPFT credentials in the past.

A job analysis study of pulmonary function technologists was repeated in 2013. Before the study began, the NBRC decided to transition to a conceptual model for the examination program that was the same as the model under which the new Therapist Multiple-Choice Examination was developed. The model assumes that candidates for CPFT and RPFT credentials in the future will be assessed over the same body of content. The two credentials will be differentiated based on the expectation that RPFTs will be more proficient than CPFTs while performing within the body of content. This new examination will be introduced in June 2015.

CE Collaboration

The NBRC Board authorized the staff to engage in further discussions with AARC staff to determine whether AARC CRCE data could be transmitted directly into the NBRC's online recertification database for AARC members who choose to participate. We expect discussions to continue in 2014 with a possible rollout in mid-late 2015.

2014 Officers Elected

The following individuals have been elected to a one-year term beginning January 1, 2014:

President:	Carl F. Haas, MLS, RRT, CPFT, FAARC
Vice President:	Alan L. Plummer, MD, FCCP, FAARC
Secretary:	Linda A. Napoli, MBA, RRT, RRT-NPS, RPFT

Treasurer:	Robert A. Balk, MD, FCCP
At-Large Member:	Susan B. Blonshine, BS, RRT, RPFT, AE-C, FAARC
At-Large Member:	Robert L. Joyner, PhD, RRT, FAARC
At-Large Member:	Stephen A. Stayer, MD

2013 Examination and Annual Renewal Participation

For 2013, we received over 41,000 applications across all examination programs, up from 2012 numbers. We also processed a record number of active status renewals in 2013 totaling over 51,000. 2014 annual renewal notices were mailed to credentialed practitioners in early October and credentialed practitioners were encouraged to renew their status by December 31. To date, we have received 38,291 active status renewals for 2014.

Examination Statistics – January 1 – December 31, 2013

The NBRC administered just shy of 40,000 examinations in 2013. Pass rate statistics for the respective examinations follow:

Examination	***Pass Rate***	
CRT Examination – 12,609 examinations		
	Entry Level	Advanced
First-time Candidates	66.7%	81.5%
Repeat Candidates	14.6%	26.6%
Therapist Written Examination – 12,870 examinations		
First-time Candidates	68.6%	
Repeat Candidates	34.0%	
Clinical Simulation Examination – 11,996 examinations		
First-time Candidates	62.7%	
Repeat Candidates	49.1%	
Adult Critical Care Examination – 315 candidates		
First-time Candidates	87.7%	
Repeat Candidates	47.4%	
Neonatal/Pediatric Examination – 927 examinations		
First-time Candidates	71.1%	
Repeat Candidates	45.1%	

Sleep Disorders Specialty Examination – 56 examinations

First-time Candidates	91.3%
Repeat Candidates	66.7%

CPFT Examination – 381 examinations

First-time Candidates	67.8%
Repeat Candidates	54.3%

RPFT Examination – 90 examinations

First-time Candidates	56.5%
Repeat Candidates	46.4%

Your Questions Invited

I look forward to working with you during my term as President. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and each 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.

State Government Affairs Activity Report

BOD April 2014
Cheryl A. West, MHA
Director Government Affairs

Introduction

The majority of legislatures have been back in session for several months. The usual path most legislatures follow is to introduce a great many bills in the beginning of the year, and only as the session progresses does it become apparent which bills will actually move through the legislative process.

Because 2014 is an election year, where most if not all state legislators' seats will be up for election or reelection, legislation that might appeal to particular constituencies may receive greater attention and action than perhaps these same bills would receive in off election years.

Respiratory Therapy Licensure

Michigan RT License Repeal Efforts

As you recall over the past two years, the **Michigan** state government focused on efforts to move towards de-licensing the 18 professions (including RT). As noted previously, it will require the Michigan legislature to enact any de-licensing law. In the fall of 2013 a bill to de-license respiratory therapists, SB 514, was introduced at the end of September.

The MI RT de-licensing bill was introduced by a legislator who is "friend" of the respiratory therapy profession. This legislator understands the important patient safety and quality issues of keeping MI RTs licensed. The logical question to ask is: why, if this legislator is considered a "friend" if he introduced a RT license repeal bill? The answer is that this repeal bill is now that legislator's bill; no other legislator would break protocol and introduce another RT license repeal bill. The friendly legislator can now (and is now) "holding" the bill, that is not moving it forward. And from updates from the MSRC leadership, this is exactly what the legislator is going to do for the rest of the year.

Introducing the RT license repeal bill and having the friendly legislator "hold" the bill is a very cleaver maneuver, especially given the MI legislature seems determined to de-license those 18 professions. This is yet another example of the focus and effort the MSRC leadership with unwavering support from MI RTs is undertaking to protect RT licensure at all costs. The effort, time and financial output that the MSRC has expended over the past 2 years has tapped into the Society's resources. The MSRC has submitted an application for the AARC grant/loan program to help offset the costs that they have incurred in fighting this long battle to maintain MI RT licensure.

Colorado RT Licensure Sunset

The Colorado State Society leadership is very much aware of the spreading climate demonstrated by state legislatures to not so quickly and in a pro forma fashion simply

reauthorize every state licensure board. The CO RT license is up for Sunset this year and the CO Society has been proactive in answering questions the state licensing agency has posed. They are very much aware that they must actively monitor and provide information, asked or unasked to assure that the CO RT license will be continued.

California Bill Requiring the RRT Credential for a RT License
Legislation has been introduced in **CA** that on January 1, 2015 "new" RTs applying for a CA respiratory care license will have to possess the RRT credential in order to qualify for the license. Those holding CRT credentials only prior to that date would be grandfathered in. This legislation mirrors the revisions made in Ohio regarding new license credential requirements, also due to be implemented January 1, 2015.

Other State Related Issues of Interest
Texas Law Limiting Total Program Hours for Community Colleges.
Texas passed a law in 2013 that would prevent educational programs provided at state supported community colleges to exceed a total of 60 hours. With much pressure from the community college supporters the final law included a provision that offered a waiver process to this new limitation. The AARC was asked, and we agreed to write a letter to the Texas Higher Education Coordinating Board asking that Texas respiratory therapy education programs be granted a waiver to exceed the 60 hour program limit.

Massachusetts Respiratory Care License Board
The AARC was made aware of a situation regarding the MA RC Licensure Board which is a seven member Board with four vacant seats at the time this issue was brought to the AARC's attention. Four individuals had applied and been vetted to fill the vacant Board seats. All that was required for them to be seated was Massachusetts Governor, Duval Patrick sign a letter confirming the appointments to the MA RC Board. MA law requires state Boards be open meetings with a quorum present. With no quorum of the MA RC Licensure Board, no business such as reviewing requests for RT licensure reactivation or reinstatement can be conducted. The AARC sent a letter to Governor Patrick urging him to post haste confirm the appointments of the waiting Board applicants in order for the mandated business of the MA RC Licensure Board to take place. Within a week of sending the letter, two of the awaiting appointees were confirmed by the Governor. The MA RC Licensure Board now has a quorum in place and held its first meeting nearly immediately.

Legislation
Note, legislation introduced is never guaranteed to be enacted into law. Those bills that have been enacted are designated as such.

Legislation that Includes RTs
In order to establish conformity among rules and requirements for licensed professions, states will often pass legislation that effects numerous professions. The bills noted below would all include RT.

OK and OR have bills to expedite the licensure process and requirements for military veterans or to accept the training from the military as equivalent to civilian training.

VT has legislation that requires health care professionals to provide more transparency regarding their qualifications when advertising to the public.

IA for the third year/legislative session a bill has been introduced that would license polysoms creating a joint licensure board with RTs. The initial version of the polysom licensing bill provided an exemption for RTs. However, sleep interests then inserted a number of amendments to their own bill, including one that removed the RT exemption. The Iowa Society has worked diligently to re-insert the RT exemption. However citing the concern that without regulation and mandated qualifications the sleep arena is susceptible to fraud, abuse and incompetent care, the legislature has been insistent that those providing sleep services have specific qualifications. The one positive point in this situation is that there will now be a combined RT Sleep Licensure Board, with RTs holding the majority of seats.

WV you may recall that in 2013 a bill to permit un-licensed personnel to provide vent and trach care (deemed a "health maintenance task") in a patients home with no oversight was vigorously pushed by the legislature. The bill was also vigorously opposed by the WV Society for Respiratory Care. A compromise was reached and a new bill has been introduced and soon will be enacted that while still permitting trach and vent care for the homebound patient, those who do provide this service must meet training and competency standards as developed and monitored by the WV RT Society. The WVSRC is mentioned throughout the bill.

OH has a bill that reaffirms that during declared emergencies a list of licensed health professionals (including RTs) may administer medications via protocols.

NM has a health profession malpractice bill which limits liability. The list of professions covered under this legislation include RTs.

Other Legislation of Interest

KS introduced a House Resolution that would create a Kansas plan for comprehensive treatment of COPD. A similar Resolution was introduced last year. Karen Schell from the KSRC leadership recently offered testimony before the House Committee in support of enacting this Resolution. The House Committee took a step forward by passing the Resolution out of Committee, and while no funding is attached it is clearly a step in the right direction.

AL, HI & **KY** have bills that would require any HME to have a physical location in the state if the HME intends to do business in the state. **OR** has passed a bill that requires Oregon Health Authority to contract with community-based organizations to operate pilot project to provide used durable medical equipment to medical assistance recipients

Asthma, Schools, and Nebulizers

MS & NJ have bills dealing with nebulizers, kids and asthma in schools. **NY** has legislation that addresses the use of nebulizers in schools including who can administer, who can have access to the nebs and how much to stockpile. **NM** has a number of bills that address asthma including one supporting the stockpiling of asthma meds in schools. **FL** has legislation that addresses who may provide assistance with a nebulizer treatment (and other med admin) in an assisted living facility, and what precisely an aide may or may not do (no titration of O2 for example,). **MS** has a number of bills addressing the monitoring of incidence of asthma. **NM** will require the state to develop guidelines for the use of albuterol in schools.

Tobacco Legislation
Many states introduce legislation to raise taxes on tobacco products or to prohibit smoking in a variety of places. These bills are too numerous to mention. However, there are a couple of interesting bills: **CA** would make it a state policy that by 2030 everyone in CA would have a right to have a 100% smoke free home. **MD** has a bill that would let rental, condo and home owners associations set no smoking policies- it is unclear if this would cover individual units. **WV** would prohibit smoking in a car when children are present.

It is worth noting that a number of states have legislation that would regulate or tax electronic cigarettes and/or vaporizing devices. These include**: AZ, CT DE, HI, IA, KY, MN, MO, NJ, NM, NY, OR, OK, & UT, Note VA's** bill only urges the federal government to regulate e-cigarettes. **OK** also has a bill that would prohibit the state from taxing nicotine vaporizing devices.

Expansion of Scope of Practice Other Professions
As noted in previous Reports over the last 2 years there has been a noticeable increase in the number of bills that expand the scope of practice for a variety of licensed or regulated professions or disciplines. Also noted, this increase may be due in part in anticipation of the increased demand (triggered by the ACA and/or Medicaid expansion) for the clinical services of health care professionals that may not be able to be met or for budgetary purposes, that is permitting less costly personnel to provide clinical services previously only provided by more 'expensive' clinicians. This trend is particularly noticeable for nurse practitioners (NPs) and physician assistants (PAs) and to some extent pharmacists. For the PAs and especially NPs the focus is to increase the autonomy from the physician.

The following states have NP/PA legislation

CT, FL & OH, have bills that would provide more autonomy for PAs. Bills in **KS** & **ID** expand the authority of NPs. And **OR, & WV** has legislation that addresses expansion for both PAs and NPs. **WV** has a slightly different expansion bill that expands the prescriptive authority of NPs and eliminates their formal "collaborative" agreement with physicians.

VT has a more specific RT related bill that among other areas of expansion would permit CRNAs to supervise and RTs (VT already allows NPS)

On the flip side there is a bill in **KY** that would do just the opposite, i.e. require physicians to confirm their collaborative agreement with NPs (which is most likely a push back bill from the physician community). **NJ** also has a bill that appears to prevent PAs from gaining more autonomy.

DC, FL, MN & **NM,** have bills to require nurse staffing ratios. **WV** has a Senate Resolution that would study the issue.

There are a number of bills that expand the scope of practice for pharmacists. **GA, MS, & OH** would permit pharmacists to administer immunizations.

GA has introduced a bill was is very similar to one from 2013 that would establish a pilot project to assess the need for and effectiveness of using protocol technicians in areas of GA

which do not have access to a hospital …the scope of these protocol technicians would include doing undefined "respiratory rates".

DC has enacted a bill also introduced in 2013 that creates licensed trauma technician. The scope of practice includes. "..Identify respiratory emergencies and perform critical interventions with oxygen therapy equipment, including bag valve masks…"

Respiratory Related Rules/Regulations
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. For the most part in this early part of 2014 there have been few administrative changes in RT related rules and regs.

Specific RT related Rule/Reg Changes
OH makes changes to continuing ed requirements and ethical and professional conduct revisions.

IA issued regs that removes language that attempts to describe clinical continuing education; reiterates the definition of "respiratory care as a practice" and provides clarification regarding what is considered the practice of respiratory therapy.

WY revises refund fees, fees for duplicate and wallet RT licenses.

IN issued regs that clarified that medically necessary therapies (PT, OT, ST) and respiratory therapy would be covered under Medicaid for those under the age of 21.

OK establishes new rules concerning ventilator-dependency and tracheostomy care and regulations for ventilator-dependent individuals. The rule clarifies coverage for nursing home admission for ventilator-dependent and tracheostomy care services for resident in a nursing home facility.

I will provide a verbal update at the April BOD Meeting.

Federal Government Affairs Activity Report April 2014

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

The Congress

The second session of the 113th Congress began this January with partisan politics still dictating the national legislative agenda. Adding to this mix is the upcoming 2014 Congressional elections where the entire 435 Member House of Representatives and one-third of the Senate are up for election or re-election. With the "eyes" of the politicians, be they current or would-be members of Congress trained on both the spring primaries and November national elections, most political watchdogs predict only a limited amount of legislative activity will occur in 2014. While AARC and all other health advocacy organizations cannot control the more macro machinations of Congress, AARC will, as we must, keep our legislation and the needs of pulmonary patients and the respiratory therapy profession in the minds of members of Congress and their staff.

Legislation

HR 2619 - The Medicare Respiratory Therapist Access Act

As you know, our legislation 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 specific chronic lung diseases. As of March 30th we had 20 co-sponsors for our bill. As this Report is due prior to our Capitol Hill Lobby Day, we hope that because of the efforts of our PACT representatives and their meetings with their members of Congress we will have added additional new co-sponsors and secured Senate support. An update on the Capitol Hill Lobby Day and any new developments on HR 2619 will be provided at the April Board Meeting.

Throughout early 2014 Miriam O'Day has continued to meet with Congressional members and staff seeking support for our legislation. We also have engaged our state society and PACT leadership to encourage meetings when their Members are back in their home state. Miriam then follows up with additional meetings in Washington, D.C. with those Members of Congress who have met with respiratory therapists.

Tom and Sam have traveled to Washington for a series of Congressional appointments with Committee staff and Members of Congress. Due to unusual extreme weather conditions in Washington, this "face-to-face" series was changed to a series of teleconferences with Congressional staff. We continue to use PAC funds to influence the process and have attended fundraisers for Congressman Pitts, Andrews, Lewis and Senator Udall.

AARC Capitol Hill Lobby Day

As this Report's submission deadline is prior to our 16th annual Capitol Hill Lobby Day (April 1), a detailed recap will be provided at the meeting. However, here is some preliminary information. As this Report is written, one month prior to the event we have already scheduled well over 100 meetings with Members of Congress. As of this writing we have just over 100 respiratory therapists 44 states and DC, and 20 RT students from regional RT education programs (many of whom will assist with our Drive for COPD event on the Hill also taking place on April 1). Tom has reached out to corporate supporters and patient organizations that we have not partnered with in the recent past to try to increase their participation at our PACT meeting. We will have a few local patients who will be at the meeting sponsored by the COPD Foundation.

Virtual Lobby Week

As part of the run-up to our Hill Day, we launch our Virtual Lobby Week with its own unique set of webpages at http://www.aarc.org/advocacy/lobby_week_exp/. The goal of VL Week is to have as many emails going to the Hill as possible in support of our PACT reps efforts to generate support for our legislative agenda. We prep for this week by creating a very high profile on our website (Big Button), the lead story on Your Lung Health website, through emails to all members, and through News Now stories all with links to the "send your email" site, which is our Capitol Connection page (http://capwiz.com/aarc/issues/). Final response numbers from VL Week will be provided at the Board Meeting.

HR 1717 - The Medicare DMEPOS Market Pricing Program (MPP) Act of 2013

The alternative to competitive bidding is still active in this session of Congress but will probably not move forward. You will recall that it sets up an auction-type program that is designed to be more transparent and offer bids in smaller areas. As of February 21, 2014 it had 169 sponsors (123R – 46D). AARC supports the legislation as noted previously.

HR 3890/S 1932 – Better Care, Lower Cost Act of 2014

These companion bills introduced in mid-January, 2014 represent a bi-partisan approach to improving care coordination introduced by Senators Wyden [D-OR] and Isakson [R-LA] and Representatives Paulsen [R-MN] and Welch [D-VT]. The legislation would establish Better Care Programs (BCPs) along the lines of Accountable Care Organizations (ACOs); however, unlike ACOs, the BCPs would focus specifically on targeting chronically ill beneficiaries, allowing physician groups to be more involved in the care assessment and treatment of those with multiple chronic conditions. The programs are supposed to fill the gap in areas where there are no ACOs and improve access in rural areas.

While there is no specific mandate as to the conditions to be covered, Senator Wyden's website provides data on heart disease, diabetes and COPD. BCPs will be paid under a new model designed to move away from fee-for-service care and improve long-term cost containment based on a capitated rate per beneficiary. Each enrollee would have an individualized plan of care tailored to their specific needs and unique conditions. Qualified BCPs would be expected to develop strategies that prevent, delay, or minimize the progression or disability associated with chronic conditions.

Although these bills may offer additional opportunities for respiratory therapists if enacted, the patients treated in BCPs would be limited due to the number of providers who qualify

or are approved as BCPs, unlike our legislative bill, HR 2619 which covers all physician practices under Medicare's fee-for-service program.

HR 4015 and S 2000 – SGR Repeal and Medicare Provider Payment Modernization Act of 2014 – aka "Doc Fix"

The SGR formula determines the annual payment update to physicians based on Medicare fee schedule amounts. Without taking action, the rates are expected to drop by about 24 percent in April 2014. Congressional lawmakers have come to a bi-partisan agreement with identical bills on how to permanently fix the SGR based on new payment systems over the next several years. CBO estimates that enacting the bills would increase direct spending by about $138 billion over the period 2014-2024, assuming enactment this spring. This estimate is relative to the CBO's February 2014 baseline projections of spending under current law. Nearly all of the estimated increase in spending would stem from the specified updates to rates for services paid in the physician fee schedule.

Surgeon General's 50th Anniversary Smoking and Health Report

The AARC was contacted by Senator Blumenthal's (D-CT) office to request our support for the Senators Resolution – S. Res 330 that recognized the 50th anniversary of the first Surgeon General's report on Smoking and Health. This report was the very first report to link the negative consequences of smoking to health and launched efforts that are ongoing today to regulate tobacco and advocate for tobacco use prevention and cessation. Because of our long-time association with tobacco prevention efforts, AARC was proud to be on the list of associations contacted by Senator Blumenthal's staff.

Following our support of the Senate Resolution, Miriam O'Day sought their leadership for our bill in a face-to-face meeting with the Senator's health staff. Our efforts were shared with the Connecticut State Respiratory Society. To date they have not agreed to sponsor the introduction of the bill.

Regulations and Other Issues of Interest

Chronic Care Management Services

In the last Board report, we mentioned new care coordination services aimed at physician practices that would allow them to treat patients with multiple chronic conditions (MCC) and bill separately for care that occurs outside of a face-to-face visit. These services also offer new opportunities for RTs to work in the physician practice setting.

To recap, CMS proposed new chronic care management services (CCM) beginning calendar year 2015 that are intended for patients with 2 or more chronic conditions lasting at least 12 months or until death, or put the patient at risk for acute exacerbation, decomposition or functional decline. The episode of care is for a 90-day period. Final rules were published on December 10, 2013.

The scope of services include 1) patient access to a health care professional 24 hours a day, 7 days a week; 2) continuity of care with a designated practitioner or care team member; 3) management and assessment, including oversight of patient self-management of medications; 4) management of care transitions including referrals to other clinicians and coordination with home and community-based services; and 5) opportunities to communicate through means other than the telephone. Because not all physicians have the

capability to fully furnish the required scope of services, CMS plans to issue separate rulemaking on proposed standards that must be met in order to provide the services.

Nebulizer Cleaning and State Surveyor Worksheets

We have been around and around with CMS and CDC on this issue and yet, it is still not resolved. To refresh your memory, this started when surveyors used worksheets as part of a pilot project that suggested cleaning nebulizers "with sterile water (or tap water followed by isopropyl alcohol)". As late as December last year, CMS was still reviewing final language we had provided months earlier. So the board is aware, we proposed the following language: "Jet nebulizers for single patient use are replaced per hospital policy. Between treatments on the same patient, they are rinsed with sterile water, or sterile saline, and air-dried**."** A separate note would be added to address mesh nebulizers and nebulizer/drug combination systems.

The problem stems from the fact that the AARC CPG uses the words "clean and rinse" and CMS does not want to use our proposed language because it doesn't match the CPG language exactly. We have tried on several occasions to explain that "clean and rinse" are redundant and the common practice in hospitals nationwide is to combine cleaning and rinsing into a single step by rinsing with sterile water. Thus, the language we are proposing is consistent with our guidelines.

As of February 21, CMS' latest response was "CMS cannot make changes to national guidelines, but only enforce what is written. We will continue to discuss this issue internally and get back to you." We have suggested a conference call but will have to wait and see if that is acceptable to them. And the saga continues…..

National Correct Coding Initiative (NCCI) Edits Impact Inhalation Treatments

There has been a lot of discussion on several of the section list serves recently regarding changes CMS made with respect to billing for inhalation treatments effective January 1, 2014 as part of the NCCI. The NCCI was developed by CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment for Part B claims.

The issue stems from the fact that the CMS guidance differs from that of the AMA CPT® Manual. To be clear, these changes only impact separately billable codes under Part B for physicians and hospital outpatient departments. They do not impact inpatient services. The gist of the change is that CMS will only allow one treatment to be reported during a single patient encounter regardless of the number of separate inhalation treatments that are administered. The AMA guidance allows for the subsequent treatments to be billed after the initial treatment using a modifier.

CMS is within its authority to make these changes, which sometimes are viewed as cost saving measures. Nonetheless, we have advised that billing or financial departments should contact the local Medicare contractor that pays their claims if they have any questions. For issues like these, it is best that AARC not make judgment calls. CMS has defined an "encounter" in manual instructions; however, it is up to the contractor to interpret the guidance when paying claims.

Reclassification of Certain Items of DME

At the beginning of the year, CMS announced it would reclassify certain items of DME in the Inexpensive & Routinely Purchased (IN) category to Capped Rental (CR). For respiratory equipment, these include: High Frequency Chest Wall Oscillation Devices (HFCWO) and Nebulizers and Related Drugs. The reason for this change is to reconcile inconsistences in definitions between the two categories. Routinely purchased means equipment purchased on a national basis at least 75 percent of the time. Expensive items costing more than $150 had been classified as routinely purchased. The effective date is April 1, 2014.

CMS Seeks Public Input on Next Phase of Competitive Bidding

By 2016, CMS is required as part of the Affordable Care Act to use information from the competitive bidding program to adjust the fee schedule amount for what it pays for DME in non-competitive bidding areas. An advanced notice of proposed rulemaking was published on February 26, 2014 asking for public input on the issue. Further, CMS is also seeking public input on changes to the competitive bidding program as it moves toward nationwide implementation.

CMS acknowledges that the claims processing system and edits needed to count rental months, prevent duplicate payments for thousands of separately coded items, and track utilization of ongoing replacements of supplies and accessories is complicated. To determine whether they should come up with a more simplified payment structure for competitive bidding, CMS is seeking input on specific issues and questions; for example, whether lump sum purchases and capped rental payment rules are still needed and whether beneficiaries need to own expensive equipment. Other questions to which CMS wants input are spelled out in the regulations. We will be reviewing the questions to determine what, if any, response should be submitted by AARC.

Conclusion

The AARC will continue to aggressively pursue both our legislative and regulatory agendas. We will continue to take advantage of opportunities and oppose challenges. We will provide an update at the April meeting.

HOD Report

Submitted by Deb Skees – Spring 2014

Recommendations

That the AARC Board of Directors, jointly with the House of Delegates, develop a Bylaws Taskforce, not to exceed 4 members, or Subcommittee (members to be appointed by the President of BOD and Speaker of HOD) with a charge to revise or formalize the bylaws conflict resolution process (article XV). The revised procedure will be brought back to the BOD & HOD during the Fall 2014 meeting for approval.

Justification:

- Recently, the proposed Bylaws changes were avoidably delayed because of a communication gap in the current process.
- Bylaw change recommendations that are initiated in the HOD or BOD and referred to the Bylaws Committee are at times at risk for misinterpretation so that language and revisions may not sufficiently express the proposed change.
- The HOD would be better prepared to offer an informed vote if the rationale for the change and language used is communicated through an agreed upon process.
- An Electronic vote on Bylaw changes for HOD and BOD does not promote the significance of the desired Bylaws changes.

Report

1. 2014 Speaker goals were submitted for review and approval by the delegations and are as follows:
    - Improve tools that facilitate hand-off and transitions for officers and committee chairs/co-chairs (See #7).
    - Continue the refining and review progress on the HOD Policy and Procedure manual (ongoing).
    - Investigate, develop and implement an archival system to record rationale for creation, revision and discontinuation of HOD policies and procedures.
    - Continue to promote student involvement to cultivate future professional participation and evaluate outcomes of student strategies.
    - Increase efficiency and productivity of HOD meetings (See #8).
    - Investigate and execute a guidance document for the HOD role in AARC Bylaw amendments to more efficiently collaborate with the BOD for desired changes (See recommendation above).
    - Clarify the expectations and establish the infrastructure to support chartered affiliates in meeting AARC documentation requirements (See #7).
    - Continue to identify opportunities to strengthen HOD communication and contributions with the BOD to advance the interests of the chartered affiliates and profession.

2. Committees and co-chairs have been assigned with respective charges.

3. Two HOD officer conference calls took place to review upcoming strategies.

4. House officers participated in the 3P/HOD conference calls.

5. A special ad hoc committee was appointed and charged to address previously proposed Bylaw changes and any additional HOD recommendations for Bylaws changes. The expected outcome will be to provide proactive recommendations to the BOD ad hoc committee.

6. The Resolutions Committee revised the current resolution submission template to encourage clarity, completeness and due diligence for resolutions submitted by the delegations.

7. The Credentialing Committee with the support of the Executive Office updated the credentialing forms to collect and validate that necessary legal obligations are documented as specified in the HOD and Chartered Affiliate Policy Manuals.

8. Elections committee is creating a "position description" for offices and committees to clarify expectations of the role and time commitment to assist nominees with consideration of acceptance.

9. Kudos to Rick Weaver, HOD Parliamentarian who is in the process of becoming a registered Parliamentarian. He has been very helpful in reviewing the current HOD Rules and comparing to Robert's Rules of Order (11th Edition) to identify any opportunities for meeting efficiencies. A plan has been developed to educate the delegates on identified aspects that would be executed in the upcoming year: webcast, orientation session and email topics.

10. The Committee for Connections on Professional Volunteerism has been connected with the International Roundtable to identify mutual opportunities to spotlight volunteerism projects.

Board of Medical Advisors Report

Submitted by Peter Papadakos, MD – Spring 2014

Recommendations

None

Report

1. During our fall meeting at the Congress we:

   a. Fully supported the activities of the organization to get support for the Bill before Congress MR2619. Dr.'s Fuhrman and Aranson contributed an article to Chest in support of the Bill. BOMA also wrote a letter to the editor to clarify several errors in a counterpoint published in *Chest* against the Bill. The letter was accepted and will be published again thanks to Drs. Fuhrman and Aranson in taking the lead on developing the letter with full support of BOMA that was submitted by Dr. Papadakos as Chair of BOMA.

   b. Also discussed at length by BOMA members were the actions of COARC Policy 13. The majority of the BOMA membership support that students be able to become certified prior to graduation. This policy will also be discussed during our spring meeting.

   c. BOMA is contacting parent organizations for replacements to several inactive members. We await formal nominations and will welcome more active participation.

   d. We actively encourage BOMA members to actively participate in the annual meeting as faculty and attend chapter and sub-specialty meetings.

   e. We look forward to our annual spring meeting.

President`s Council

Submitted by Dianne Lewis – Spring 2014

Recommendation

That complimentary registration for the AARC educational meetings be offered to AARC Life Members.

Justification: Life members are currently offered registration to the AARC International Congress only. The recommendation would have minimal budgetary impact since only a small number of Life members attend the Summer Forum and other educational meetings.

Report

The Presidents Council is proud to announce the 2014 Jimmy A. Young medalist is Charles G. Durbin Jr. MD, FAARC   He is an outstanding choice and deserving of this great award.

It is time to receive Life and Honorary member nominations. Kathy Blackmon and I will be screening the candidates to ensure they meet criteria. If they do not they will not be placed on the ballot. With that in mind I will have the criteria and list of previous winners included with my report.

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

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	
2013	Linda Van Scoder	Kathy Blackmon

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 (cannot vote or hold office).]

Standing Committee Reports

Audit Sub-Committee

Submitted by John Wilgis – Spring 2014

Recommendations

That the Board of Directors accept the auditor's report as presented.

Report

The Audit Sub-Committee met via phone conference on Monday, March 17, 2014 to review the findings of the Auditor, Salmon Sims Thomas & Associates, LLC. The committee was provided all relevant AARC policies that impact their work, the 2012 Audit Sub-Committee report for reference and the audit report reflecting fiscal years 2013 and 2012. The committee reviewed the consolidated financial statements and independent auditors report for fiscal years 2013 and 2012 and found the records to be in compliance with general accepted accounting principles for the United States.

Tony Lovio, AARC Controller, provided an overview of the committee's process and responsibilities and made general introductions of the members of Salmon Sims Thomas & Associates, LLC.

The auditor's report noted very few journal entry adjustments and was very complementary of the quality of the AARC financial statements. The auditor's report included no recommendations for change or improvement.

The committee asked whether notation 8: Employee Benefits Plan describing discretionary employer contribution percentage to the employee benefit package, is a required part of the audit or was it included in the report because the auditors thought there was something out of line that needed to be brought to the committee's attention? The Auditor's response was this is a required part of the audit. There was discussion about the decreased amount of revenues and support from membership dues. The AARC changed its dues structure in 2012 and more members appear to be using the on-line features of member renewal. It was also noted that the virtual environment may be impacting other areas like education materials and publications and advertising as more members use the Internet in their daily lives. There was discussion about Grants income and expenses which is a new endeavor by the association. Explanation of each grant was provided and questions related to unrestricted grant funds and administration fees were addressed. Grants income is expected through 2015. The auditors also provided an explanation of temporarily restricted funds versus unrestricted funds as a means of accounting for funds that have not or cannot be spent to date.

There was follow-up discussion from last year's recommendation for improvement for the AARC to have more separation and internal controls for the reconciliation process of the AARC bank account. The AARC has implemented a process for the review of bank reconciliation after it has been prepared by the AARC Controller and this process has been in place for approximately 14 months.

Committee Members:

I want to thank the committee for their participation in this review and report. I also want to thank Tony Lovio and the staff of Salmon Sims Thomas, LLC for their participation and open discussion and explanation of the committee's questions. I also want to thank the leadership who helped me understand my role in this process as I am a new member of the committee.

Members: Frank Salvatore (CT), Keith Siegel (ME), Linda Van Scoder (IN), Brian Walsh (MA), John Walton (IL) and John Wilgis (FL).

Liaisons: Tony Lovio (TX).

Bylaws Committee

Submitted by: Tom Cahill - Spring 2014

Recommendations

- That the AARC Board of Directors accept and approve the Texas Society Bylaws. (see attachment "TSRC Bylaws 2014.")
- That the AARC Board of Directors accept and approve the Massachusetts Society Bylaws. (see attachment "Massachusetts bylaws 2013 clean copy.")
- That the AARC Board of Directors accept and approve the Arizona Society Bylaws. (see attachment Bylaws of the Arizona Society for Respiratory Care 1.24.14.")
- That the AARC Board of Directors accept and approve the Wisconsin Society Bylaws. (see attachment "WSRC Bylaws 2014.")

Report

- The Bylaws Committee has met its charges so far this year. At this time there are no pending resolutions or bylaws changes for review.
- The Bylaws Committee has review the above 4 sets of bylaws and recommends the AARC Board of Directors accept and approve those states bylaws listed above.
- We have not received bylaws from Connecticut or Louisiana as of yet, but have received an e-mail from Louisiana that they hope to be ready so we can make the summer Board of Directors meeting.
- There is a large bottle neck of bylaws due for review in 2016 and 2017; as time permits I will be contacting states from that list to see if they may be ready to submit their reviews early to help ease the bottle neck in those years.

Other

I would like to thank the members of my committee: John Jarosz, Albert Moss, Troy Whittaker, Brian Kendall, and Karen Stewart. A special thanks to Sherry Milligan at the AARC office for her help.

Elections Committee

Submitted by: Jakki Grimball - Spring 2014

Recommendation

None

Report

1. Candidate Questions. Questions for nominees will be solicited from the BOD, HOD and Committee members. The Committee will formulate 3 questions for nominees, and the questions will submitted to the executive Office by April 3.

2. Nominations. Nominees are being solicited from the BOD, HOD and appropriate Section members for VP Internal Affairs, VP External Affairs, Secretary-Treasurer, Director (2), Long Term Care Section, Rehab Section and Transport Section. The nomination deadline is April 1. Nominees will be asked to complete a Nominee Profile Form and answer Nominee Questions; the deadline for completion will be May 1.

3. The Committee conference call to consider all nominees is being scheduled for the week of May 8. The final slate of candidates will be selected at that meeting and forwarded to the BOD

Other

Many thanks to Sherry Milligan, Beth Binkley, Jim Lanoha, Dan Rowley, Tim Myers, Karen Stewart, Doug McIntyre and Tim Myers.

Executive Committee

Verbal report

Finance Committee Report

Verbal report

Judicial Committee

Submitted by Anthony Dewitt – Spring 2014

Recommendations

None

Report

This is my first report as chair of the Judicial Committee. I have only recently reviewed the policy and procedure and suggested some modifications to Mr. Kallstrom. Beyond doing this and agreeing to serve the association in this capacity, I have taken no action in any official capacity. I regret the short nature of this report. In the future the committee will:

- Meet and review the procedures for membership discipline

- Forward any recommendations to the Board.

Program Committee

Submitted by Ira Cheifetz – Spring 2014

Recommendations

That the AARC Board of Directors ratify the chair and members of the 2014 Sputum Bowl Committee as noted.

2014 Sputum Bowl Committee

Chair:
Sherry Whiteman (MO) Whiteman-S@mssu.edu

Committee Members:
Kelli Chronister (OH) ckelli@uakron.edu
Tom Lamphere (PA) ExecutiveDirector@psrc.net
Diane Oldfather (MO) DOldfather@rolla.k12.mo.us
David Panzlau (MI) david.panzlau@mcc.edu
Rick Zahodnic (MI) zahodnicr@macomb.edu
Jim Ciolek (TX) james.ciolek@tccd.edu

Justification: A succession plan in 2012 included the mentoring of Sherry Whiteman to become the next chair of the SB committee. She excelled in that role and embraced the new SB format in 2013.

All other members as recommended for the 2014 committee also served in 2013; each possessing their own unique skill set and delineated responsibilities. This team is open and receptive to new ideas of improving the Sputum Bowl and has made recommendations to the Program Committee on how they might improve the competition based on outcomes, feedback and observations from the 2013 competition.

The Sputum Bowl committee is aware of and understands that funding for travel and lodging is limited to that of 5 people to work on the Sputum Bowl competition. As they did in 2013, the committee is prepared to mitigate costs by sharing rooms and self-absorbing other costs so that total expenditures are less than or equal to what these costs would otherwise be for 5 individuals. As a point of reference, the Sputum Bowl included 5 individuals prior to 2012 and the travel budget was set accordingly. The committee understands that expanding the number of committee members from 5-7 does not equate to additional funding for overall travel **(in exchange for their work on the competition over 3 days of the meeting).**

Report

1. Prepare the AARC Congress Program, Summer Forum, and other approved seminars and conferences.

Status: The committee met in Dallas, TX on Feb. 6-8, 2014 to review nearly **1,000** individual lecture proposals submitted in ten different specialty areas and roundtables for presentation at the Summer Forum and Congress. Crystal Maldonado from the Executive Office has already begun communicating with those who submitted proposals informing them of the Program Committee's decision to accept or reject their proposal. Based on member feedback and after in-depth analysis from the 2013 meeting in Anaheim, the length of presentations at both meetings will be slightly modified from 30 minutes to 35 minutes. Speakers will be clearly informed that content and delivery should not exceed 30 minutes, with each presentation requiring a 5 minute Q&A. This will hopefully address concerns over "rushed" presentations with little or no time available for questions from the audience. 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: Summer Forum has been secured through 2015. A search for locations for 2016 and beyond will take place next Spring.
   The next open year for AARC Congress is 2017. The Executive Office is currently evaluating destinations for this meeting. Doug Laher; Associate Executive Director will likely engage the Board in discussion regarding potential destinations but is not likely to bring forth an official recommendation for the Spring meeting. An e-vote may be requested in late Spring/early Summer with a recommendation for the 2017 meeting destination.

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 and Roundtables. 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 2014; including, but not limited to marketing the meeting, programming, exhibitors, and exhibit hall.

Sputum Bowl Sub-Committee Report:

Upon ratification from the Board and as directed by AARC Program Committee Chair Ira Cheifetz, the 2014 Sputum Bowl Committee, chaired by Sherry Whiteman, has been assembled to start the work of delivering the 2014 Sputum Bowl with continued effort to

enhance the competition for the competitors and attendees. 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 2012/2013 competition received positive feedback from both competitors and audience members however it has yielded minimal improvement in attendance during the "Finals Night" event on the 3rd evening of the Congress.

It was discussed at great length during the Program Committee meeting as to an appropriate course of action should Covidien elect to pull its sponsorship of the event. With new leadership in place and hints that Covidien may not feel the sponsorship delivers an ROI to justify the sponsorship, it was unanimously agreed that the competition should continue, albeit without the grand event (Finals Night) on the 3rd evening of the meeting. The competition would run its course from beginning to end (and crown a champion) in a meeting room at the convention center. This would minimize substantial costs, but would still allow for a hosted competition. Tom Lamphere, Program Committee member and member of the SB sub-committee felt this was a very reasonable compromise and one that the SB committee, competitors and fans of the competition would support.

Below is the report from Sherry Whiteman (2013 chair of the Sputum Bowl sub - committee):

<u>Pre-Game Analysis</u>

Rules Changes:

1. Additional Category: Patient Assessment
2. Change of Category to Acute/Critical Care
3. Addition of Bonus Phase to game play
4. Use of game brackets for pairings/game play determinations

Other Changes:

1. Use of Twitter to share game information and build a following/excitement. Prior to Anaheim, we had 13 followers.

State Survey:

A survey was sent out to all state affiliates asking how their game is played, if they fund a team or teams for Nationals, when they play, and what they would like to see changed at the National level. 16 total surveys and answers were returned to the committee. Of the respondents, 63% said they sponsor at least one team to come to nationals. Many described a financial cause as the reason for not sponsoring teams, as well as dwindling participation at the state level. The majority of respondents replied favorably to the Sputum Bowl at the state and national level, mentioning good participation and the funding of teams. Lack of participation in the survey is likely the result of time constraints on both states polled and committee members sending the poll. Respondents to the survey include: Mississippi, Colorado, Missouri, Maryland/DC, Pennsylvania, Virginia, Tennessee, Wyoming, West Virginia, Michigan, Connecticut, California, Arizona, Alabama, and Washington.

Preliminaries Analysis

Basic Information:

In September, 18 student teams and 12 national teams were registered for the event. As Anaheim drew closer, teams began cancelling. It is my understanding that there was some confusion about whether a team could play or not because they had won the previous year. Going into Anaheim, we had 11 national teams and 17 student teams committed to play. One team from each division did not present themselves to play, leaving final numbers at 10 national teams and 16 student teams. The divisions were as follows:

National Teams
California
Colorado
Maryland/DC
Michigan
Minnesota
Missouri
Nebraska
North Carolina (no show)
Pennsylvania
Virginia
Wisconsin

Student Teams
Arizona
Arkansas
California
Colorado
Iowa
Louisiana
Maryland/DC
Michigan
Minnesota
Missouri
Nevada
New Mexico (no show)
North Carolina
Ohio
Pennsylvania
Texas
Wisconsin

Non-Game-Play Elements:

1. Twitter

Twitter was used throughout the competition as a means of updating players and non-players on the outcomes of each game as they were happening. We gained 11 followers, a few of which were players. Use of Twitter allowed me to make a personal connection with those following me that I hope will foster continued participation; however, I anticipated a larger gain in followers and do not feel that it was worth the time spent updating the feed.

2. LIVE Update of Game Brackets Online

Game brackets were updated live online as teams played. This feature was a HUGE success. Teams and non-players both at the conference and at home used this feature to track team progress throughout the competition. There were many positive comments about the use of technology and social media to update the game, particularly regarding the online brackets.

3. Use of Technology

During preliminaries, we tried to utilize technology as much as possible to connect with players and non-players alike. Team captains were given the option to cast their vote for the Fred Helmholz Sportsmanship Award via text message. We also utilized the text polling capabilities during the preliminary rounds to ask the audience what they thought of this year's Sputum Bowl. The responses were very favorable toward the use of social media/technology and rules changes.

Game-Play Elements:

1. Bonus Phase Rule

The Bonus Phase (teams can score 2 pts for correct answer at end of match) was added as a means to keep the game moving and add some surprise to the game. Overall, this rule was well received and made the game exciting. It kept the game interesting throughout and led to a few very close matches.

2. Bracketing for Game Pairings

The original method for game pairings was time consuming and very confusing. Use of a double elimination bracket made pairings run very smoothly and allowed the games to progress quickly through rounds. Many people were unfamiliar with using game brackets, but learned quickly how to read them.

3. Other Notes

We believe the overall spirit of fun at this year's competition was the best we've seen. There were many people who popped in to check on their teams and we were again able to make a connection with those not directly involved in Sputum Bowl.

<u>Finals Night Analysis</u>

1. Audience Participation Game

   Use of PollEverywhere was implemented for the audience participation game. The game was divided into several small sections of 4 questions each. One question was a toss out to a random person in the audience, who if they answered correctly they immediately won a small prize. The remaining questions were posed to the entire audience. Responses were texted in and tabulated to determine the top 5

respondents at the end of the night. Mixed feedback was received regarding the audience response game – people either loved it or felt it slowed everything down.

2. Half-Time Entertainment

   Comedian Keith Alberstadt performed. His performance was well-received. There were a few comments that perhaps he went a little long, but otherwise everyone loved him.

3. Participation/Attendance

   Overall, participation and attendance at the beginning of the Finals night was excellent; however attendance dropped considerably as teams began to be eliminated. Teams dressed up in theme colors with the committee and filled the tables up front.

Recommendations for Next Year

1. Continue game rules as they are – make only minor changes that won't effect game outcomes (update question categories completely, update references, decrease amount of time allowed to protest, etc).

2. Continue using double elimination brackets – improve their use by placing a "how-to" video on YouTube or AARC.org to teach players how to read the brackets and add appendix to Rules book.

3. Continue use of the online game brackets – improve the template by adding game times to the bracket so everyone can follow along more easily.

4. Discontinue use of a separate Twitter feed for the Sputum Bowl – consider utilization of the AARC Twitter account OR a different social media platform.

5. Eliminate the REQUIREMENT that each team must submit questions to participate – allow the submission to be optional

6. Extend the deadline to allow teams to register – it has been mentioned that states cannot participate because they do not have their state meeting prior to the competition deadline.

7. Allow open registration to teams AFTER the state affiliate deadline. These teams will be dubbed "Renegades." This will allow teams that did not win at state to compete at nationals. Allowing renegade teams may also increase the overall number of participants. We would likely limit this to a certain number of teams overall per state (2-3).

8. Continue with the audience participation game; however, implement it into a "poll the audience" style instead of awarding prizes. This is only a minor possibility because our questions are not multiple-choice, so we would have to experiment to see if we could figure this part out.

9. Utilize AARConnect for team registration and question upload – Missouri uses a very simple site for this for the State Bowl and it works well.

10. Continue Finals night on Monday night, being in the Keynote room as we did in 2013. This brings a sense of wonder and enthusiasm to the competition that we believe helps make it an "event". However, IF NECESSARY, we are more than willing to keep the Finals competition in the same room as preliminaries. We all prefer there be some bowl rather than no bowl.

11. Implement a mentorship program. This program would be two-fold:

    1) Identify other professionals that might eventually be interested in being part of the Sputum Bowl committee. Invite them to be a part of a few meetings (observationally) and invite them to assist with the Bowl at the National level. Persons in this program would not be considered a part of the committee and would not receive funding to attend the conference. It would be purely voluntary.

    2) Identify states that have not been participating or that have asked for assistance in putting together a Bowl in their state. Committee members would put together a "package" of things to assist the states with hosting a Bowl (question banks, rules, etc). Each state in the program would be assigned to a committee member that would be there to mentor the state as they put together and run the competition.

Conclusion:

The 2013 National Sputum Bowl Competition went very well despite a limited number of teams. Overall, the changes introduced this year were well received and many brought a much needed update to the Sputum Bowl. The Sputum Bowl Committee believes there is still room for improvement and is dedicated to finding ways to improve the Sputum Bowl on all fronts. Your continued support is greatly appreciated and we are very thankful for the opportunity to run the 2013 National Sputum Bowl.

Strategic Planning Committee

Submitted by Karen Stewart – Spring 2014

Nothing to report – waiting on information from 2015

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Spring 2014

Recommendations

None

Report

The section of adult acute care continues to participate in local, state national and international clinical care, education and research.

The section continues to publish monthly newsletters, and informational bulletins. These bulletins serve as a springboard for younger less experienced writers to test their skills at writing short and informative articles.

We also continue to hold our monthly journal club discussions, rhythm of the month and interactive case reports. We also discuss a monthly clinical image.

The section conducted a large section "needs assessment" survey and will share the results with the BOD when all of the information has been assimilated.

I have nothing else to report at this time and have no recommendations to discuss with the board members.

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Spring 2014

Recommendations

None

Report

1. Pulmonary Hypertension Association is an affiliated organization to AARC

**Member of the Practice Committee in the PH Professional Network, attended scheduled conference calls with input to suggested practice direction

** **OPEN** - A 2014 Goal is to develop a guideline on pulmonary rehabilitation for the PH Patient and ask AARC & AACVPR to be a part of the review committee to give support

**International Pulmonary Hypertension Conference June 2014: Invited and accepted to be a panelist/speaker for the Medically Led Session Pulmonary & Cardiac Rehabilitation. Saturday June 21 and Sunday June 22nd

2. Section Newsletters – submitted notes from Chair

3. Liaison to AACVPR – see submitted report for Liaison

4. Phone and e-mail communication with AARC members regarding questions on billing codes and documentation.

5. Working with AARC Executive Office to restructure the PR locator webpage by removing the database and linking to the AACVPR pulmonary rehabilitation program locator webpage.

6. Working with AARC Executive Office to explore the feasibility of applying for a PCORI grant to develop a National Pulmonary Rehabilitation Disease Management/Maintenance Exercise Program in conjunction with other pertinent stakeholders.

Diagnostics Section

Submitted by Matthew O'Brien – Spring 2014

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.

•· Multiple 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.

•· Katrina Hynes has done a great job with the section bulletin and became "chair elect" in November 2013. Our new bulletin editor is Jeff Haynes, RRT, RPFT.

•· We are still in the planning stages for the two diagnostic specific webinars for 2014. 1. What is your Cardiopulmonary Exercise Testing IQ? 2. BioQC for the Pulmonary Lab

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

•· Ongoing, We are close to our goal in adding new members in an effort to reach the 1000 member count.

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

•· Ongoing, transitioning responsibilities of Chair to Katrina Hynes.

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

Submitted by Joe Sorbello – Spring 2014

Recommendations

None

Report

In concert with Dr. Shawna Strickland, we developed a very short survey using Survey Monkey that was sent out to the Education Section via AARC Connect in the first week of March to measure interest in a live, online Education Section meeting in late March (see attachment "Education Section Survey Spring 21014") Based on the survey results, Shawna suggested and I agreed that Wednesday March 26 at 10 a.m. ET would be a good date and time for the meeting. The Meeting Agenda has not yet been established. I will report the results of the meeting to the Board at our April meeting. I want to thank Shawna again for her professionalism and excellent work ethic!

Other

I have received several copies of letters written by both BS/MS program faculty and students addressed to CoARC asking for the re-instatement of Policy 13. I have not, however, seen any letters addressed to the NBRC which is the key to this issue and discussion. Hopefully, this obvious letter-writing campaign spearheaded by CoBGRTE will be a major factor in at least creating more dialogue amongst and between the AARC, NBRC and CoARC.

Home Care Section

Submitted by Kim Wiles – Spring 2014

Recommendations

Investigate the feasibility of a post-acute care certification program for RTs.

Justification: Education is limited in the RT programs and very few standards and post-acute care competencies exist for RTs. With healthcare reform and transition of care from acute to post-acute care settings, new models are emerging that involve RT's going into the post-acute care setting. Specific education/competencies need to be identified and a formalized education/certification program developed to guide care.

- Target audience-RTs employed in any of the following post-acute care settings:
    - Hospital RT involved in discharge planning
    - Durable Medical Equipment Company
    - Home Health Agency
    - Physician office
    - Long term acute care facilities
    - Skilled nursing facilities
    - Students

- Desired outcomes
    - Improved patient care in the post-acute care setting
    - Improvement in readmission rates
    - Credibility and private payer recognition related to respiratory services

- Potential curriculum may include, but not limited to;
    - Assessment-environmental and physical
    - Behavior modification and psychological approach to care
    - Problem identification and resolution
    - Training and educational skills needed for caregivers and patients
    - Diagnostics
    - Therapy options and limitations
    - Medication management
    - Long term oxygen therapy
    - Home monitoring
    - Ventilator management, invasive and non-invasive
    - Sleep disorder identification, treatment and management

Report

- Two section bulletins produced since last meeting, with one new author in the Spring Bulletin.

- Several homecare section members recruited at Congress to help with articles in attempt to get new members involved.

- Recruited members for lecture and symposia submission for post-acute care topics and transition of care topics

- Webinar scheduled on Home Oxygen in August 2014

- Reviewing clinical practice guidelines with some members as they relate to homecare and potential revisions/additions will be presented to Shawna

Long Term Care

Submitted by Lorraine Bertuola – Spring 2014

Recommendations

None

Report

- Survey Members to determine a need for Benchmarking in Long-Term Care Ventilator Units
- Discussed Benchmarking at our section meeting at the Congress with a favorable response
- Develop an Uniform Reporting Manual for Long-Term Care
- Develop Quality Outcomes for Benchmarking

Management Section

Submitted by: Bill Cohagen – Spring 2014

Recommendations

None

Report

- At the writing of this the membership is at 1621 which is about the same as the end of 2013.
- After reviewing the 2013 SF and Congress proposals the Management Section agenda has been set.
- The Section Book Club is continuing to gain speed and members.
- The Mentor program has been a success.
- The Quarterly newsletter has several submissions already for 2014.
- The search for the 2014 SPOY will soon to commence.
- Mentoring for the Chair-elect is going very well.

Other

LinkedIn has a new group that has taken the unplanned extubation benchmarking process to fruition.

Neonatal-Pediatrics Section

Submitted by Natalie Napolitano – Spring 2014

Recommendations

None

Report

1 newsletter published and the 2nd at the editor.

Worked with AANMA to communicate offer free 1 year membership for NeoPeds Members

There were a few concerns that were brought to my attention at the Neo/Peds committee meeting that I am researching and will bring to the boards attention if they require recommendations or actions from the BOD.

Sleep Section

Spring 2014

No chairperson

Surface to Air Transport Section

Submitted by Billy Hutchison – Spring 2014

Recommendation

That the AARC consider drafting a position statement regarding interstate transport to alleviate the need for multiple licenses.

Justification: There are Transport Therapists that are being required to carry two to four different state licenses and only in another state other than their home state for minutes and up to a few hours. I feel we need to possibly appoint a committee to study this recommendation and want to thank all of you in advance for your support.

Report

We have some exciting things happening within our group this year. We have a group of outstanding Transport Therapists assisting us in gathering data to present a Scope of Practice for Respiratory Therapists involved in the medical transport world. I would like to recognize and thank Tabatha Dragonberry, Alex Brendel, Steve Sittig, Wade Scoles, and Joe Hylton for their hard work and diligence in getting this project going. We have had a survey completed and gathering data that we hope to have compiled later this spring. We also announced a challenge to each member to invite a friend to join our section. I feel our list serve and the AARC as a whole has so much to offer and I am confident we can grow as a section. Our quarterly newsletter has continued to deliver great topics and articles and we are encouraged to see more people involved in submitting articles. I am also pleased to say that we have had 10 excellent proposals submitted for the 2014 Congress. In these proposals, we have several new lecturers submitting which is always exciting. We have had a good year with great discussions and great participation. My goal for the remainder of the year is to encourage new membership.

Special Committee Reports

Benchmarking Committee

Submitted by: Rick Ford – Spring 2014

Recommendations

None

Report

1. The Benchmarking Committee conducted a February conference call to assess committee status and priorities for 2014.

2. Rob Chatburn, who has been engaged with the early development in 2005 announced he would no longer serve on the committee secondary to competing priorities. We thank Rob for being instrumental in the design of the program and his support of user clients over 8 years.

3. The committee is currently seeking nominations/volunteers from the Benchmarking users community to replace Rob's vacant spot and is considering an additional member as President Elect Salvatore is currently serving on this committee and may need to direct his time and energy elsewhere as he starts his term as AARC President.

4. We are also seeking to transition the Chair of AARC Benchmarking from myself to Chuck Menders. The request has been submitted to President Gaebler at the time of this report for review and hopeful appointment. Rick will continue his service as a member of the committee.

5. The committee has identified elements of AARC Benchmarking that should be updated in 2014. Those elements include:

- Alignment with time standards and definitions included in the 5th Edition URM
- Refinement of metric terminology and measures to be consistent with terms considered universal in reporting performance
- Consider the capture and reporting of key outcome metrics, such as unplanned extubations, VAE %, etc.
- Revise the department profile, designed back in 2005 to incorporate department structure and concerns encountered in 2014 and beyond

For each of these initiatives a committee member is serving to oversee. These changes will require funding to accomplish and such expenses will be identified by July 2014.

6. Membership in AARC Benchmarking has declined from approx 140 to 120 in the recent year. The AARC Executive Office has approved a new pricing structure to make the program more affordable. The lower cost, with additional marketing, the updates described, as well as improved collaboration with the management section are hoped to retain existing and recruit new members.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Spring 2014

Recommendations

None

Report

There has been some changes that involve Respiratory Care in Medicare reimbursement (January 1, 2014 NCCI edits). The short version is that Medicare will no longer reimburse more than one inhalation treatment (MDI, Neb, DPI, IPPB), CPT 94640, per encounter, for Part B patients. If a therapist is giving one neb treatment and one MDI treatment to a patient at the encounter, Medicare will only reimburse for one treatment. And we should only bill for one treatment.

A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

The biggest impact of this change is most likely related to treatments given in the Emergency Room. This was just one of the January 1st NCCI, Part B changes. Labs services were also affected. Reimbursement will be denied for any lab tests done on the same date as other services such as x-rays.

As you can imagine, there was much discussion on the list serve about this change. I tried to assure members that this change was one of many made by CMS. And that this does not affect inpatients.

Federal Government Affairs Committee

Submitted by Frank Salvatore – Spring 2014

Recommendations

None

Report

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]**

Other

Since this report is due prior to the AARC PACT Hill day, I will update the board regarding this committees work and final results from the Virtual Lobby week through supplemental literature and/or a verbal update at the board meeting.

Fellowship Committee

Submitted by: Patrick Dunne – Spring 2014

Recommendations

None

Report

The work of the Fellowship Selection Committee does not begin in earnest until the actual selection process commences later in the year. Please note that the deadline for receipt of online nominations for 2014 Fellow is Friday, August 29. 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.

International Committee Report

Submitted by John Hiser – Spring 2014

Recommendations

None

Report

1. **Administer the International Fellowship Program.**

As you already know the fellowship program continued to be successful in 2013. 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
Daniel Van Hise, RRT, NPS

Membership Committee

Submitted by Gary Wickman – Spring 2014

Recommendations

Approve our AARC Membership campaign incentive program.

Justification: The incentive will be monetary, either a onetime bonus or possibly an increase in revenue sharing. However this will not happen until we hit first our overall goal and then the Affiliate hits their individual goal. Since our overall goal to reach 50,000 active members is a stretch and may take a couple of years to accomplish, we may set an interim level where we pay something and then the overall goal. In this way we hope to keep Affiliates engaged in the process. So, the interim overall goal may be 46,000 active members. The Affiliate goals we are looking at would be a percentage increase of your active members to licensed members. We are considering the following Affiliate goals to qualify for the incentive:

- Affiliates with less that 25% active members to licensed members would need to increase membership by 15%
- Affiliates with 25% to 49% active members to licensed members would need to increase membership by 10%
- Affiliates with 50% or more active members to licensed members would need to increase membership by 5%
- In order for any pay out to occur, we would need to reach our overall interim goal of 46,000 active members. This would mean that the Executive Office Staff would have to keep track of those Affiliates who make their individual goals so we would know who would get the incentive. They say they can do this if the incentive is a onetime bonus.
- We would then start the incentive again with the overall goal of 50,000 and the same Affiliate individual incentives. We think in this way, reaching that 50,000 is achievable and the goals are a stretch but can be accomplished and by having an interim goal, we can keep the Affiliates engaged.
- Tom and I will come to the April board meeting with the details to include the financials so we can discuss and vote on the recommendation.

Report

Objectives

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

The Membership Committee has been busy so far this year. Frank, Sherry and I met with the Affiliate membership chairs during the International Congress to gain better insight on the issues they have in recruiting and what support they might need going forward. We also have met by teleconference with the Executive Staff in December, January and February to go over our ideas for strategy for the 2014-2015 Membership Campaign. We have developed a strategy that involves having the committee meet regularly, at least bi-monthly by teleconference to review how we are doing, identify any areas that need more support and to review and revise the resources we supply the Affiliates for recruitment. Our first meeting was in February where we reviewed the current membership statistics and trends, new media projects that Sherry and the Executive Staff have worked on, past exit surveys to see what we could learn that would help going forward, our "Visit Project" that we will unveil to the Affiliate Presidents at the President's Leadership workshop in Dallas after the Board meeting and possible incentives to the members and to the Affiliates for this campaign. We will also hold Affiliate Membership Chair teleconferences at least three times over the year besides meeting with the Presidents in April. In this way we want to engage the committee, Executive Staff, Affiliate Membership Chairs and the Affiliate President's and give them tasks to accomplish so we can stay on track to attain our goal. Sherry and I also held a Student Teleconference in December in which all Programs were invited to attend to discuss the benefits of becoming an Active Member after graduation. The Student retention Subcommittee sent out a survey to the Program Faculty and is now reviewing the data to learn what we can do to engage the students to become active members. They are also preparing another survey directed at the students to get the same information from them. Our plan is to hold 3 more of those over the next year to stay engaged with the group as well and to work with the Student Retention subcommittee to help develop the message based on the input they receive from their surveys to Program Faculty and students. Sherry and I have mapped out monthly activities for the whole year and they involve the committee, the Executive Staff and Affiliate Membership Chairs with the meetings and task associated with each group.
After much discussion and planning with the Executive Staff and Frank, we have set our goal for the next two to three years to get to 50,000 Active members. We had 41,452 active members as of 12/31/2013. That is about 25% of the total licensed RCPs. When we get to 50,000 active members, we will be at about 31% of licensed RCPs as members. With the engagement plan we have developed, we think this is a stretch but it is doable. I have articulated some of the details we have accomplished in the bullets that follow:

1) Sherry has developed some new media projects better targeted to our potential members to include:
    a. New You Tube video where members say in rhyme why AARC is worth the time
    b. A new Infographic that outlines the best benefits of membership
    c. Animation video that will also go through the benefits of AARC membership
    d. Develop a student newsletter that can be sent out each month

2) "Visit Project" Pilot. Each of the committee members have committed to making at least one visit to one of the hospitals or educational programs in their state to pitch AARC membership during the month of March. Sherry and I have put together a power point presentation as a resource for the visit. We also have a survey that we will complete with each visit to get us some much needed information to include numbers of staff versus members and to facilitate a discussion about what draws them to membership and what are barriers. We will then meet at the end of March to go over the results, discuss the resources and make any changes before the President's Leadership workshop in April.

3) Affiliate engagement with the "Visit Project". We are launching this campaign at the President's Leadership workshop in Dallas after the Board meeting. We will be assigning the task for each Affiliate to make at least five visits by their membership chairs or other board members to an assortment of hospitals and educational programs in their state by the end of the year. We will provide them with the resources to make a successful visit. We are also assigning the committee members Affiliates to support and to track with periodic communication to help keep each Affiliate on track.

4) Incentives. We have decided to continue the membership incentives to give IPads and Kindle Fires away to renewing and new members again this year. The first ones will be awarded during April. We have had much discussion about incentivizing the Affiliates, is there benefit, what would be an incentive that we can afford and that would work? The last time we had a major bump in membership was when we raised the revenue sharing. We also want to make sure that whatever we use as an incentive, that each Affiliate had some "skin in the game" before they realized any benefit. We will come with a recommendation to the April Board meeting that will include an individual Affiliate goal and an overall goal to reach before any kind of incentive will be paid out. I am working with Tom to develop that recommendation and will have it detailed for you in April.

Other

Thanks to the members of this committee for being so engaged in the work, Sheri Tooley, Garry Kauffman, Miki Thompson, Sarah Varekojis, Karen Schell, Ray Pisani, John Priest, Tom Lamphere, Janelle Gardiner, Jeff Davis and John Stienmetz. I would also like to thank the Student Retention Subcommittee for their work. I also want to thank the Executive Office staff who have been thoroughly engaged as well, Sherry Milligan, Asha Desai, Tom Kallstrom, Doug Laher, Tim Myers.

Position Statement Committee

Submitted by Colleen Schabacker – Spring 2014

Recommendations

Approve and publish the revised Position Statement "Definition of Respiratory Care". This paper is submitted for your review as attachment #1. Text to be added appears with underline.

Justification: Since respiratory therapists are now working in clinics, we thought we should include it in the Position Statement.

Approve and publish the revised Position Statement "Health Promotion and Disease Prevention". This paper is submitted for your review as attachment #2. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: Made some changes to help promote higher education.

Approve and published the revised Position Statement "Tobacco and Health". This paper is submitted for your review as attachment #3. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: Change "when **applied** to the mucous membrane" to "when **exposed"**. Applied is more related to practical purpose, application, or treatment related.

Approve and publish the revised Position Statement "Pulmonary Rehabilitation". This paper is submitted for your review as attachment #4. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: We added a statement about helping to decrease hospital readmissions.

Approve to retire the Position Statement "Inhaled Medication Administration Schedules". This paper is submitted for your review as attachment #5.

Justification: CMS completely rewrote the section of State Operations Manual and Interpretive Guidelines for Hospitals with respect to Preparation and Administration of Drugs. Given that the issue of administration schedules is no longer an issue and the rules have been made clear, this statement needs to be retired.

Approve and publish the new Position Statement "Electronic Cigarette". This paper is submitted for your review as attachment #6.

Justification: This new Position Statement states the AARC is no supportive of the use of the electronic cigarette (e-cigarette) due to the lack of evidence supporting its use and the lack of regulation as to the amount of nicotine and the other ingredients used.

Report

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. We currently wrote a Position Statement regarding the electronic cigarette. We will present it at this Board meeting for approval.

2. Review, revise or delete as appropriate using the established three-year schedule of all current AARC position statements subject to the Board approval.
    a. During 2014, the Committee's goal is to complete the review/revision of the eight (8) position statements listed below:
    i. Competency Requirements for the Provision of Respiratory Therapy Services
    ii. Definition of Respiratory Care
    iii. Health Promotion and Disease Prevention
    iv. Inhaled Medication Administration Schedules
    v. Pre-Hospital Mechanical Ventilator Competency
    vi. Pulmonary Rehabilitation
    vii. Tobacco and Health
    viii. Verbal Orders

3. Revise the Position Statement Review Schedule table annually in order to assure that each position statement is evaluated on a three-year cycle.
    a. This schedule has been updated and presented for the Board's approval. See attachment #7.

Other

A special thank you to my team members Kathleen Deakins, Deryl Gulliford, Linda VanScoder, Jim Allen and Tony Ruppert. I would also like to thank Ann Marie for her input on the "Inhaled Medication Administration Schedules" position statement.

Attachment #1

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

Position Statement

Definition of Respiratory Care

Respiratory Care is the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health. Respiratory Therapists employ scientific principles to identify, treat and prevent acute or chronic dysfunction of the cardiopulmonary system. Knowledge and understanding of the scientific principles underlying cardiopulmonary physiology and pathophysiology, as well as biomedical engineering and technology, enable respiratory therapists to provide patient care services effectively.

As a health care profession, Respiratory Care is practiced under medical direction across the health care continuum. Critical thinking, patient/environment assessment skills, and evidence-based clinical practice guidelines enable respiratory therapists to develop and implement effective care plans, patient-driven protocols, disease-based clinical pathways, and disease management programs. A variety of venues serve as the practice site for this health care profession including, but not limited to:

- acute care hospitals
- sleep disorder centers and diagnostic laboratories
- long term acute care facilities
- rehabilitation, research and skilled nursing facilities
- patients' homes
- patient transport systems
- physician offices <u>and clinics</u>
- convalescent and retirement centers
- educational institutions
- medical equipment companies and suppliers
- wellness centers

Effective 12/99
Revised 12/06
Revised 07/09
Revised 7/12

Attachment #2

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

Position Statement

Health Promotion and Disease Prevention

The AARC acknowledges that professional respiratory therapists (RTs) in both the civilian and uniformed/military services are integral members of the health care team around the world. They serve in acute care hospitals, long term acute care hospitals (LTACH), long-term facilities, home care settings, pulmonary function laboratories, pulmonology practices and clinics, rehabilitation programs, critical care transport, managed care organizations and a ~~diversity~~ multitude of other environments where respiratory care is practiced.

The AARC recognizes that the highest quality professional education and training of the respiratory therapist is required to inhance ~~the best method of instilling~~ the ability to improve the patient's quality and longevity of life through their practices. ~~Such~~ ~~k~~Knowledge and skills must be incorporated into formal ~~education and training of RTs in~~ Commission on Accreditation for Respiratory Care (CoARC) accredited education and learning programs~~,~~ for the RT. ~~and must emphasize~~ Training initiatives place an emphasis on expanding roles for RTs including, but not limited to: ~~in~~ Disease Management, Health Coaching, Case Management, Clinical Consulting, Patient Education, COPD Education and Asthma Education. ~~in particular.~~ ~~Advanced formal education, to~~ Higher education attained at the baccalaureate level and beyond, permits RTs to participate ~~at a higher~~ in advanced and ~~more~~ independent ~~level~~ roles in health promotion and disease prevention.

The AARC recognizes the RT’s responsibility to take a leadership role in pulmonary disease teaching, smoking cessation programs, second-hand smoke awareness, pulmonary screening for the public, air pollution awareness, allergy and sulfite warnings. RTs must also demonstrate initiative in research in those and other areas where efforts could promote improved health and disease prevention. Furthermore, the RT is in a unique position to provide leadership in determining health promotion and disease prevention activities for students, faculty, practitioners, patients, and the general public, in both civilian and uniformed service environments.

The AARC recognizes the need to:

1. Provide and promote consumer education related to the prevention and control of pulmonary disease;

2. Establish a strong working relationship with other health agencies, educational institutions, Federal and state government, businesses, military and other community organizations for better understanding and prevention of pulmonary disease:

3. Work with CoARC and training programs to prepare practitioners for crucial expanding roles in Disease Management, Health Coaching, Case Management, Clinical Consulting and COPD/ASTHMA Patient Education;

4. Encourage RTs ~~across the country~~ to advance their education to the baccalaureate level and beyond, thereby enhancing their ability to perform in higher level professional roles;

5. Promote the application of Evidence-Based Medicine in all aspects of health promotion and disease prevention;

6. Monitor all such activities for appropriateness and effectiveness

Furthermore, the AARC supports efforts to develop personal and professional wellness models and action plans ~~on~~ related to health promotion and disease prevention. The AARC seeks to inspire RTs to demonstrate their ~~standing as experts~~ expertise in pulmonary disease etiology, pathology and treatment, and to lead the way nationally in health promotion and pulmonary education.

Effective 1985
Revised 2000
Revised 2005
Revised 2011

Attachment #3

American Association for Respiratory Care

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

Position Statement

Tobacco and Health

The American Association for Respiratory Care (AARC) is a professional organization dedicated to the protection of health through public education and the provision of the highest standards of respiratory care. By virtue of their education and health care experience, respiratory therapists are professionals who have a clear understanding of the nature of cardiopulmonary disease and are in a position to act as advocates for healthy hearts and lungs. The AARC is an advocate for both tobacco cessation and tobacco prevention programs.

The AARC recognizes its responsibility to the public by taking a strong position against cigarette smoking and the use of tobacco in any form, and the inhalation of any toxic substance. In view of the evidence, which confirms the health-threatening consequences of using these products in both active and passive forms, the AARC is committed to the elimination of smoking and the use of any tobacco products and the inhalation of any toxic substance.

The AARC acknowledges and supports the rights of non-smokers and pledges continuing sponsorship and support of initiatives, programs, and legislation to reduce and eliminate smoking. The AARC extends its concern beyond the smoking of tobacco to the use of smokeless tobacco. These products are linked to diseases of not only the heart and lungs, but also to the gastrointestinal tract, mouth, and nose. There is also evidence that these products, when ~~applied~~ exposed to the mucous membranes, diffuse into the circulation and can also cause ill effects in remote organs of the body.

Effective: 1991

Revised: 07/11

Attachment #4

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

Position Statement

Pulmonary Rehabilitation

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

Effective 1973
Revised 12/08
Reviewed 11/2011

Attachment #5

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

Position Statement

Inhaled Medication Administration Schedules

Inhaled medication administration incorporates a unique methodology and has a recognized time standard between nine and twenty minutes depending on the delivery device used for administration. It is the position of the AARC that medical facilities need to establish written policies and procedures for the safe and timely administration of inhaled medications that are appropriate for the facility and approved by the medical staff. These policies may differ from standard medication administration schedules and time frames, but must be implemented so that medications are administered as prescribed—i.e. Q 1 hour, QID 4 X per day, BID 2 X per day, etc. If a facility establishes an alternative schedule for the safe and effective delivery of inhaled medications, the AARC recommends that the inhaled medication delivery schedule window not exceed 60 minutes before or after the scheduled medication delivery due time for medications prescribed at an interval greater than or equal to four hours.

Effective 8/08
Revised 7/2011

Attachment #6

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

Position Statement

Electronic Cigarette

In line with its mission as a patient advocate and in order to ensure patient safety, The American Association for Respiratory Care (AARC) opposes the use of the electronic cigarette (e-cigarette). Even though the concept of using the E-cigarettes for smoking cessation is attractive, they have not been fully studied and the use among middle school children is increasing year after year. There is no evidence as to the amount of nicotine or other potentially harmful chemicals being inhaled during use or if there are any benefits associated with using these products.

Position Statement Review Schedule Attachment #7

Originally Proposed 02/20/2007;
Last approved by BOD 12/2009; 12/2/2010, 4/2013, 1/2013
Last Update: 11/08/2010, 03/04/2011, 3/2014

Statement Title	Original Statement Date	Most Recent Review or Revision	Schedule Review for 2014	Schedule Review 2015	Schedule Review 2016	Schedule Review for 2017	Schedule Review for 2018
AARC Statement of Ethics and Professional Conduct	1994	2012		1			1
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2013			1		
Competency Requirements for the Provision of Respiratory Therapy Services	1998	2011	1			1	
Continuing Education	1990	2012		1			1
Cultural Diversity	1994	2013			1		
Definition of Respiratory Care	1987	2012	1			1	
Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	2009	2013			1		
Hazardous Materials Exposure	2002	2011	1			1	
Health Promotion and Disease Prevention	1985	2011	1			1	
Home Respiratory Care Services	2000	2013			1		
Inhaled Medication Administration Schedules	2008	2011	1			1	

Licensure of Respiratory Care Personnel	1990	2012		1			1
Pre-Hospital Mechanical Ventilator Competency	2007	2011	1			1	
Pulmonary Rehabilitation	1973	2011	1			1	
Respiratory Care Scope of Practice	1987	2013			1		
Respiratory Therapist Education	1998	2012		1			1
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2013			1		
Respiratory Therapy Protocols	2001	2013			1		
Telehealth	2001	2013			1		
Tobacco and Health	1991	2011	1			1	
Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child, or Adult Patient	2009	2012		1			1
Best Practices in Respiratory Care Productivity and Staffing	2012	2012		1			
Verbal Orders	1990	2011	1			1	
Development of Baccalaureate and Graduate Education Degrees	2013				1		
Electronic Cigarette	2014		1			1	
			10	**7**	**9**	**1**	**7**

Social Media Committee

Submitted by: Brian Cayko - Spring 2014

Recommendations

None

Report

Nothing to report

State Government Affairs Committee

Submitted by: John W. Lindsey - Spring 2014

Recommendation

That the AARC Board of Directors approve the Michigan State Society for Respiratory Care's application for the $10,000 grant/loan.

Justification: The MSRC has for over two years fought the concerted effort by the State of Michigan Administration to de-license respiratory therapists. The Society has engaged a well-connected health lobby firm in this effort and the Society has expended many of their financial resources to underwrite this effort including the costs incurred by the RTs in their active engagement at the State Capitol and with legislators. The final decision on grant approval and grant amount rests with the AARC Board of Directors.

Report

This is another legislative year, plus, 2014 is an election year, so a lot of legislative seats along with governorships will be up for election or re-election. There is one big election in Arkansas, where incumbent Senator Mark Pryor is being challenged by Congressman Tom Cotton. Former Congressman Mike Ross who sponsored AARC's previous Hill legislation is running for Governor. If elected we AR RTS hope we will have a "Friend" in the Governor's Office.

In Iowa, it looks like the Polysomnography Licensure Law may not pass. The current version does not include a RT exemption.

The AARC has responded to the Kentucky situation with a letter to the CEO of Kentucky One Health. This raised the interest of on Kentucky Television Station and they actually interview AARC Executive Director-Tom Kallstrom and AARC Associate Executive Director-Tim Meyers. This was in response to the layoffs of respiratory therapist in Kentucky Free Standing Emergency facilities. Our other state societies are, as expected, very concerned with the Kentucky situation, but thankfully, the AARC has pushed back.

In Arkansas, the Private Option has been renewed after several votes from the House of Representatives. It passed in the Senate on its first try.

In Michigan, a bill has been introduced to de-license respiratory therapists, but through the efforts of the Michigan Society for Respiratory Care (MSRC) the bill at this moment is on hold. The MSRC has applied for assistance under the AARC's Grant/Loan Program (60% grant 40% no interest loan, repayable over 2 years). This long standing AARC program financially helps state societies in their efforts to gain (in previous years) or maintain (the current iteration) RT licensure. An extensive application process is required by any state applying for consideration of the grant/loan.

The State Government Affairs Committee must review the application and vote to approve or decline- simple majority of the seven -member Committee. A majority of the AARC State Government Affairs Committee has voted to recommend that AARC approves the MSRC application for the grant/loan.

Ms. Cheryl West will be giving you much more detailed report. Once again, my many thanks to Ms. West and the outstanding job that she does.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Spring 2014

Recommendations

None

Report

I attend the February AMA/ CPT meeting in Phoenix.

Changes in the ECMO ECLS codes were proposed.

The current codes that RC departments use when providing ECMO are: 33960- Prolonged extracorporeal circulation for cardiopulmonary insufficiency, initial day and 33961 each subsequent day.

In the past few years ECMO services have expanded greatly. When the original codes were created the patient population was primarily neonatal. Now ECMO is used for all age groups, in treatment of a wide variety of indications. Many different physician specialties are involved (i.e. neonatologists, pulmonologists, thoracic surgeons, cardiologist, critical care physician and others). There are now two types of ECMO; veno - arterial and veno -venous. The new code proposals include codes for insertion of catheters, the types and locations of the catheters, repositioning of catheters and the age range of the patients.

Two maintenance codes were also proposed; 1. Daily management of Veno - Arterial ECMO and 2. Daily management of Veno- Venous ECMO. These would replace to the current codes 33960 and 33961. I assume that RC departments will be able to use these daily management codes. After consultation with Ann Marie, I wrote to the AMA to assure that non - physicians will be able use these new maintenance codes.

NCCI Changes

The pulmonary physicians attending the meeting were Dr. Steve Hoffman (ATS) and Dr. Mike Nelson (ACCP). We discussed the NCCI changes for inhalation treatments for Part B (outpatient) services. As you are probably aware, effective January 1, 2014, not more than one inhalation treatment will be reimbursed by CMS, per encounter. The doctors didn't feel this would negatively impact their office practices very much. Dr. Nelson employs several respiratory therapists in his office.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors - Spring 2014

Recommendations

None

Report

Submitted lecture proposals for AARC Congress 2014 with AACVPR/AARC Liaison Goals – worked with Chris Garvey and Trina Limberg on these submissions: Noted in Report I. A. below.

AARC 2014 LECTURE SUBMISSION

Control ID	Title	Suggested Speakers	Suggested Time
1949033	Endurance training, exercise progression and oxygen titration in pulmonary rehaiblitaiton. So your done with the exercisee assessment - NOW WHAT? The Science, Best Practice and Case Studies in Exercise Training Would like this symposium second…	Chris Garvey Trina Limberg Carl Willoughby	50 min 50 min 50 min
1949056	Outcomes in Pulmonary Rehabilitation. The Science, Best Practice and putting it all together in the AACVPR Registry and Program Certification. Would like this symposium third…	Chris Garvey Cathe Pleasant Debbie Koehl Gerilynn Connors	50 min 30 min 30 min 50 min
1949087	Pre Conference Symposium. Pulmonary Rehabilitation 101 through Level 500. Everything you need to know and do to have an Evidence Based, Nationally Recognized Pulmonary Rehabilitation Program (PR).	Connie Paladenech Debbie Koehl Sidnie Hess Scott Cerreta Carl Willoughby Gerilynn Connors	40 min 40 min 40 min 40 min 40 min 40 min

I. **Liaison to AACVPR**

A. **Submitted the suggested lectures for AARC Nationals from the AACVPR & AARC Face-to-Face Partnership Discussion on Thurs. Oct. 3, 2013 2:45 – 3:45 pm as noted below:

From Liaison Minutes 10-03-2013:

Minutes: National Meeting Speaker Swaps is an opportunity for AARC and AACVPR to support speakers at each other's National Conferences. AACVPR is Sept. 3-5, 2014 and AARC will be in Las Vegas, Dec. 9-12, 2014.

Action Item: I submitted via AARC WEBSITE lecture proposals for speakers/topics by November 2013 for AARC Congress 2014

What can AARC/AACVPR do together? Is Rehab 101 needed? Pre-conference 2014 to consider in the future. Present to AARC Program Committee by January this idea

Action Item: I submitted Rehab 101 preconf. Program to AARC program committee: included AACVPR speakers, COPD Foundation speakers plus AARC speakers

B. I am also the current President of the AACVPR Affiliate the Virginia Association of Cardiovascular and Pulmonary Rehabilitation – continuing to deal with 95-100% denials for G0424 Pulmonary rehab. through discussions with MAC 11 Senior Medical Director – Dr. Feliciano (See timeline below)

C. March 21, 2014 submitting information/questions to Palmetto GBA-MAC 11 Medical Director for the Palmetto WEBCAST on Pulmonary Rehab audits/granular errors, etc.

D. Working to educate PR programs on coding and documentation

   a. Feb. 1st Lectured in Virginia at Workshop 10:00am – 1:00 pm
   b. Feb. 19th, Lectured through webcast/conf. call to South Carolina 2:00 pm – 3:00 pm
   c. Feb. 27th , Lectured through webcast/conf. call to West Virginia 3:00 pm – 4:00 pm

E. AACVPR PR Program Certification Expert Panel committee member, chaired by Trina Limberg had committee work during the past few months

F. Member of AACVPR National program committee with speaker/topic review and recommendations – committee conf. call - completed

Timeline

Date	Item	Discussion	Liaison Involvement
2013 Monthly	AACVPR MAC 11 Conf. Calls	Cardiac Rehab audits stop Pulmonary Rehab Audits **ESCALATE with DENIALS**	G. Connors
2013 Nov. 8	AACVPR MAC 11 Committee conf. call with MAC 11 Dr. Feliciano	TOPIC: PR Denial rate and what can be done to change this. Dr. Feliciano asks for a face to face meeting with his team to discuss	G. Connors & Dr. Lamberti IFH PR Med Dir. & NAMDRC BOD member joins call – MD representation vital
2013 Dec. 5	Palmetto GBA Face to Face meeting with AACVPR MAC 11 Committee in Columbia SC	Dr. Ohar Wake Forest PR Med Dir is MD representative joins via phone conference calls entire 3 ½ + hr mtg TOPICS: Granular Errors, SixSigna, Process Improvement, Pulmonary Rehab Supply Chain Committee Dr. Feliciano called our working group	G. Connors at face to face mtg, developed minutes of the meeting for committee with their edits
2013 Dec. 30	VACVPR Newsletter & AACVPR MAC 11 Minutes	Minutes of Palmetto GBA face to face mtg attached to VACVPR Newsletter – the Dec. 5th Mtg minutes and sent to Kathy Delaney	G. Connors state Pres. VACVPR
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2014 January 3	Special VACVPR mailing to members with all 5 attachments Dr. Feliciano sent me of Dec. 5th meeting	Dr. Feliciano's Dec 5th Handouts emailed to VACVPR members and sent to Kathy Delaney	G. Connors
2014 Monthly	AACVPR MAC 11 Conf. Calls	Pulmonary Rehab Audits	Gerilynn Connors VACVPR – Virginia PR Representative
2014 Jan 13	AACVPR,AARC, ATS,NAMDRAC Conf Call	Connors request URGENT National Pulm Society conf. call to discuss MAC 11 PR Denials and Granular Errors	G. Connors & Dr. Lamberti
2014 Jan 28	AACVPR MAC 11 Committee conf. call with MAC 11 Dr. Feliciano	Goal is to decrease to below 50% denial rate in MAC 11 by July, Granular error discussion, goal for Webinar by Palmetto requested Dr. Feliciano asked to speak at VACVPR state meeting April 6th and agrees	G. Connors & Dr. Lamberti on call – MD representation vital

2014 Feb. 26	Connors representing AACVPR MAC 11	Granular errors, need process improvement and I was invited by Dr. Feliciano to provide content material and discussion to	G. Connors

	Committee conf. calls with Dr. Feliciano and his team	the Webcast being planned for March 28th Friday	
March 28, 2014 Tentative Date	Palmetto MAC 11 Webcast with slides from Connors representing AACVPR MAC 11 Committee	In development	G. Connors

American Heart Association

Submitted by Brian Walsh – Spring 2014

Recommendations

None

Report

Will give a verbal report as the AHA meeting is March 31st-Apr 2nd and past the report deadline.

American Society for Testing and Materials

Submitted by Robert McCoy – Spring 2014

Recommendations

That the Executive Director investigate the possibility of appointing a member of the executive office to attend and participate in the appropriate standards organizations to further the development and improvement in standards that impact the respiratory profession.

Report

ASTM International, formerly known as the American Society for Testing and Materials (ASTM), is a globally recognized leader in the development and delivery of international voluntary consensus standards. Today, some 12,000 ASTM standards are used around the world to improve product quality, enhance safety, facilitate market access and trade, and build consumer confidence

ASTM has gone through some changes. The Technical Advisory Group (TAG) which represented ASTM to ISO has moved to AAMI.

AAMI, the Association for the Advancement of Medical Instrumentation, is a nonprofit organization founded in 1967. It is a diverse community of nearly 7,000 healthcare technology professionals united by one important mission—supporting the healthcare community in the development, management, and use of safe and effective medical technology.

AAMI is separate from ASTM and represents the US for respiratory equipment standard to the International Standards Organization (ISO).

ISO (International Organization for Standardization) is the world's largest developer of voluntary International Standards. International Standards give state of the art specifications for products, services and good practice, helping to make industry more efficient and effective. Developed through global consensus, they help to break down barriers to international trade.

Standards are critical to the respiratory profession as the equipment used in the treatment of respiratory disease is developed to meet or comply with established standards. Respiratory therapists need to be involved with standards organizations as their practical application experience can be very valuable to a useful and safe standard.

A volunteer representative to the standards organizations is overwhelming as the time necessary to be effective does not allow for a primary (paying) job.

A staff representative from the AARC executive office would be able to:

- Stay current with standards that are developing in the respiratory profession (Devices)
- Communicate with the membership on issues under development that require an experts input
- Participate in meetings to stay abreast of new or modifying standards
- Identify opportunities for specialty sections to recommend standards to improve product development

- Write updates in the AARCTimes to raise awareness of the critical role a respiratory therapist can have in standards development and new product development

The recommendation from the ASTM representative (Robert McCoy) is to replace the volunteer representative with an appointed executive staff member to represent the AARC to the standards organizations.

Chartered Affiliate Consultant

No report submitted as of March 28, 2014.

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Spring 2014

Recommendations

None

Report

The CAMTS BOD is scheduled to meet March 27th to 29th for the spring meeting prior to the Critical Care Transport Medical Conference, (CCTMC) in Austin Texas. Work continues on the 10th edition of the CAMTS Standards which will include the introduction of Levels of Care accreditation. As of January 28, 2014 there are 162 accredited services.

Extracorporeal Life Support Organization

Submitted by Donna Taylor – Spring 2014

Recommendations

Request AARC financial assistance, not to exceed $2,400, to attend the 25th Anniversary Extracorporeal Life Support Organization (ELSO) conference in Ann Arbor, Michigan September 15-18, 2014.

Justification: The ELSO Steering Committee of which I am the Respiratory Care Liaison meets bi annually to discuss the direction of ELSO, the expanding worldwide scope of the organization, upcoming meetings, review ELSO grant applications to be awarded, review and revise bylaws and continue to discuss processes for establishing ECMO training and requirements for centers of excellence. Each meeting, I am allotted time on the Steering Committee agenda to present and discuss issues related to Respiratory Therapists as ECMO Specialist. As ECMO evolves and changes, prompting staffing model changes I feel it is important for Respiratory Therapist to continue to be part of extracorporeal life support management. I plan to submit an abstract for this conference on our work with our BSI rates and ECMO and a policy we have implemented for ECMO cannula site and care.

Report

I was able to attend the 30th Annual Children's National Health System symposium that occurred in Keystone, Colorado last month. ELSO continues to assist in the establishment of an increasing number of ELSO centers worldwide. The inaugural South and West Asia ELSO meeting occurred in January in India. This conference brought together ECMO centers from South Asia- Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, Sri Lanka and Afghanistan. Attendees from West Asia were from Armenia, Azerbaijan, Bahrain, Egypt, Georgia, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen. Due to State Department advisories, Steering Committee members have not traveled to Iran, however, the invitation has been extended! These disparate groups have come together for training and to promote ethical and safe ECMO practices. The ECMO society of India is well established and wants to maintain their relationship with ELSO. As these centers spring up all over the world now-Ukraine, Russia (St Petersburg and Moscow) and Israel -- ELSO must determine how to establish requirements in order to thoughtfully ratify chapters. The committee decided to allow for provisional ratification with the potential chapter's bylaws and membership be submitted to ELSO within a yet to be determined timeframe.

The Steering Committee Chairman, Dr. Lynch has arranged for a brief article be placed in an upcoming Joint Commission's newsletter. Joint Commission ECMO accreditation for centers has been discussed. The cost of this accreditation to the individual institutions is significant. However, with the growing number of ECMO centers the committee feels that the area of ECMO and ECLS will be of interest to The Joint Commission in the near future.

It is hoped that the recent FDA move to re-classify the ECLS membrane lung from a class III to a class II device with special controls, will open the US market to many of the advanced oxygenators that have been available to the rest of the world for some time. A recent incident this year with the only US available membrane oxygenator's shipments from Germany being held up pending FDA documentation requirements highlighted the precarious position that US centers find

themselves in regarding the lack of options from which we can choose. This ship-hold could have stopped ECMO at many US centers. If centers continued to offer ECMO treatment it would have forced them to use cardiopulmonary bypass oxygenators which would have required more frequent changes, and prone to failure in long term use, thus exposing the sickest patients to increased risks. All members of the ECLO Steering committee including myself signed a letter requesting that the FDA intervene and allow these oxygenators to resume shipment to the US as it is our only option. The oxygenator manufacturer did acknowledge that this plea from ELSO did accelerate the return of their product for use in the United States.

Astounding growth in numbers of centers and in technological advancements poise respiratory therapists to be frontline participates in this therapy. I have had the opportunity to meet with three hospitals, two in the DFW metroplex who are starting new ECMO programs for adults. I have been invited to Wichita Falls, Texas to present an ECMO lecture at their annual two day respiratory therapy conference. This group has made a site visit to our institution and plans for RRTs to be incorporated in their ECMO program.

ECMO use for adults in this area is common now in this area. I have offered our institution and its new SIM center to the ELSO education committee chair as a site for one of the ELSO sponsored Adult Respiratory ECMO training courses for 2015.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Spring 2014

Recommendations

None

Report

1) Mexico: University of Sonora Establishes Formal Respiratory Therapy Certificate Course

Dr. Hector Leon Garza, President of the Latin American Board for Professional Certification in Respiratory Therapy (LABPCRT), and Governor for Mexico to the ICRC, reports that a formal academic program in Respiratory Therapy has recently been established at the University of Sonora in Hermosillo, Sonora. This Certificate Program spans six months, and has been developed by Dr. Celia Delgadillo Ugalde, Chief of Teaching and Research Division, of the distinguished "Dr. Ignacio Chavez" Medical Center and is endorsed by the Department of Medicine and Health Sciences of the University.

According to Dr. Hector Leon Garza, "this is a significant step forward in the professionalization of Respiratory Therapy in Mexico." The program provides a comprehensive curriculum in RT that includes both theoretical concepts and practice in clinical skills. The program prepares graduates in techniques and procedures in the management of respiratory diseases in adults, newborns, and children in both the hospital and outpatient environment. Class size is limited to a maximum of 20 students and prospective students must hold a Paramedic Technician College Degree and must have a minimum of 1 year prior experience in working with respiratory patients. It is a goal that holders of the RT Certificate will qualify to successfully pass the examinations administered by the Latin American Board for Professional Certification in Respiratory Therapy. In addition, there are initial discussions regarding application to the International Education Recognition System (IERS) for international recognition of this high quality program.

2) **China Medical University, Bachelor of Science RT Program:**

First approved by the International Education Recognition System (IERS) in 2011 this RT program has reached another milestone. Taiwan's BS RT Program has satisfied all requirements for Re-Certification by IERS on March 7, 2014 and was awarded Continuing Approval. This high quality program is recognized by the Ministry of Education of the Government of the Republic of China (ROC). Graduates of the program are eligible to take the national license examination. After successfully passing the examination they are designated with the SRRT credential and receive their license to practice from the Ministry of Health and Welfare of the ROC. In the last three years the program has had 147 graduates and for those classes has a 100% placement rate in 19 hospitals throughout Taiwan.

3) **International Medical Mission Roundtable (IMMR):**

At the invitation of Lisa Trujillo, Chair of the IMMR President Jerome M. Sullivan met with the Roundtable at their meeting in Anaheim November 18, 2014. It was a very productive session and a number of items were suggested.

It was discussed that the development of a Fundamental Respiratory Care Support Course (FRCSC) curriculum would be beneficial to RTs who are in a position to introduce respiratory therapy concepts and modalities in developing nations. All agreed that this would be a very beneficial resource and would provide a structured and consistent introduction to the respiratory care profession. Participants welcomed collaboration between the ICRC and the IMMR. Partnering would encourage mutual support and discussion regarding international development of RC. It was recognized that many RTs who are actively providing care in the form of international medical missions are in a unique position to introduce respiratory care, specifically in developing nations and with underserved populations. Collaboration between the IMMR and the ICRC would increase awareness and opportunity in both groups.

Collaboration between the ICRC and the IMMR could include the following: ICRC Newsletter URL link be shared on the IMMR page of the AARConnect. ICRC Logo be added to the IMMR page of the AARConnect. An introduction of the IMMR be sent to the ICRC to be shared in the ICRC International Newsletter. It was discussed that an IMMR representative provide a presentation to the ICRC during a council meeting for the purpose of sharing the work that is currently being done by IMMR members.

4) Tribute to Dr. Louis Sinopoli, EdD, RRT, FAARC**:**

Dr. Sinopoli was a special friend to the international respiratory therapy community and the most recent edition of the ICRC eNewsletter contained the following tribute to his lasting contributions to respiratory care education.

The International Council for Respiratory Care (ICRC) and the entire international respiratory therapy community were deeply saddened to learn of the passing on January 8, 2014 of Dr. Louis Sinopoli. Louis was a steadfast supporter and friend of the international Respiratory Care community and worked tirelessly to enhance the quality of respiratory care education on a global scale. He served as On-line Education Advisor to respiratory colleagues in 30 countries, offering peer review and education advice to individuals and professional societies. In his capacity as Education Advisor to the ICRC he worked to instill a caring philosophy among the member countries and their representatives as he endeavored to help countless individuals to plan, evaluate and improve their educational offerings. He was the architect and principle advocate for the International Education Recognition System (IERS), the voluntary internet review process designed to implement international quality standards for RC education programs. His effort, spanning a decade, has resulted in over 70 formal RC educational programs outside of North America being granted IERS Approval.

Dr. Sinopoli served for many years as the Respiratory Therapy Program Director at El Camino College in California. In 1999 following his eight year tenure on the National Board for Respiratory Care (NBRC) he was awarded the distinguished Robert H. Miller Award for his continuing contributions to RC credentialing. In 2004 the AARC awarded him its highest honor, the Jimmy A. Young Medal. Dr. Sinopoli brought many skills to the international RC education community including his international reputation for pioneering competency-based, criterion-referenced credentialing examinations. However, his most enduring quality to his international colleagues was his ability to reach out, one educator to another, to provide open friendly peer review for the enhancement of RC around the world. Louis was a friend and will be missed by his many international colleagues.

Joint Commission - Ambulatory PTAC

Submitted by Suzanne Bollig – Spring 2014

Recommendations

None

Report

The Ambulatory Care Professional and Technical Advisory Committee (PTAC) held a conference call on October 16, 2013. The agenda included review and discussion of the proposed standards changes for ambulatory care accredited hospitals that provide diagnostic imaging services.

Key Points

1. The PTAC originally reviewed proposed changes on June 20, 2013 and approved a field review consisting of focus group calls with imaging experts and professional associations in order to obtain additional feedback and further refine the proposed standards.

2. The Standards and Survey Procedures Committee (SSP) approved the field review on July 17, 2013. The field review was conducted for six weeks and closed on September 25, 2013. The proposed standards were presented to the SSP Committee for approval in November 2013.

3. The field review identified several questions or concerns from the interested groups surveyed including the possible shortage in the number of available Medical physicists, state requirements for radiology technician certification and registration, and implications for pediatric imaging services.

4. Further investigation and research on identified problem areas or questions will be conducted by staff over the next few months.

Joint Commission - Home Care PTAC

Submitted by Kim Wiles – Spring 2014

Recommendations

None

Report

AARC Attendees: Kimberly S. Wiles, RRT and Jeffrey Karamol, RRT-alternate

Karen Utterback, new Chairman for the homecare PTAC committee and Don Filibeck, new Vice Chairman introduced

Review of Board of Commissioners Meeting-nothing to report. This meeting had not been held as of 3/4/2014

Review of Standards and Survey Procedures Meeting-nothing to report

The majority of the meeting was around the 2015 NPSG: Home care Fires.

Field review was completed. There were 287 responses. Approximately 72% of the responses represented accredited home care agencies, and of these organizations 57% were hospital based. 88% agreed that compliance with the NPSG contributes to the achievement of patient safety and quality of care. Slightly more than 73% agreed that the benefits outweigh the cost of compliance.

Some concerns/questions were raised;

1. Several questioned the intervals for re-evaluation. However others stated that the Joint Commission should establish minimal time frames for re-evaluation rather than leaving it up to the organization.
   Discussion: Time-frame set by The Joint Commission should be minimally once per year and every time a company representative goes into the home.

2. Other concerns were raised as to the documentation requirements and are they appropriate to each element of performance.
   Discussion: A lot of discussion around involving the physician and strengthening the verbiage in the EP to address this. It was discussed that the agency/company should get a physician's signature on a communication form attesting to the communication to the agency/company. This would fall under the Collaboration of Care and ongoing documentation requirement.

   When asked how often this documentation requirement should be, it was suggested initially and if non-compliance is an issue. It was recommended that the verbiage be strengthened to include caregiver or other smokers in the home education and responses.

3. Should the presence of fire extinguishers be added to the safety risk assessment in EP 1.
Discussion: Overall the whole group was in agreement that this should not be included. More of the discussion surrounded around the wording in the EP regarding "functioning smoke detectors". New wording was added under this element of performance to include "Functioning smoke detectors can be verified with the patient or family or by testing the smoke detector, if they are accessible". The overall opinion of the group recommended that the wording should only document the presence. If the patient doesn't know or is unsure, are we obligated to check? There is a potential risk if the employee attempts to check when the detector is out of reach and uses a stool or chair. The other concern is if they document it works and something happens a month later would they be liable? Some suggestions were made to include a few other questions when assessing "functional smoke detectors", which would add and educational element. Questions such as;

    - *Do they work?*
    - *Do you know when they were checked last?*
    - *Do you know when the battery was changed?*

4. No other changes were recommended to improve the clarity of the requirements or the focus on safety.

Joint Commission - Lab PTAC

Submitted by Franklyn Sandusky – Spring 2014

Recommendations

None

Report

The first meeting of the Lab PTAC on March 13, 2014 was cancelled.

There is nothing else to report at this time.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Spring 2014

Recommendations

None

Report

Attended NAEPP Teleconference 1/16/13

Jim Kiley: focused meeting surrounding specific topic on Potential Updates to NAEPP EPR-3

This is a needs assessment to determine if an updated is needed and if so what topics should be addressed (questions):

- Do you think there needs to be an update:
  - Yes – need more guidelines for primary care arena and need to keep guidelines current
  - Since the last guidelines there has been major advances in topics that were not addressed in current guidelines.
  - Series of key issues with assessment of current state of knowledge may be better than an overall review. Specifically concentrate on effective strategies on guideline implementation.
  - Also Update GIP and simplify
  - Need to be able to tweak guidelines to expand into individual disciplines
  - Adherence with drugs, new technology, use of NIV, intermittent therapy, safety with LABA's, environmental factors, management for severe asthma, doubling inhaled steroid dose during exacerbation, biomarkers, workplace in adult asthma, EHR's, objective measures on implementation.
- If a systemic review and update are undertaken:
  - Should it be done in the same way?
  - Even without fundamental change, how can we improve involvement of all NAEPP partners in the process?
  - If we were to use a different model to develop guidelines, what would you suggest?
  - What would be the most appropriate role for your organization?
  - What could your organization contribute?
- If 2-3 professional medical societies would develop the systemic reviews and draft updates (for example taking a different topic) rather than an expert panel convened by NAEPP:
  - What would be the advantages and/or disadvantages?
  - Would your organization support this model? Get involved in implementing the product?
  - Who should coordinate such collaboration?
  - What role would your organization have if it were not one of the "leads"?
- Plans for future NAEPP and NACI activities – an update form Rachel Tracy:
  - Will be ramping up outreach and communication activities. Will start working with a new support contractor. Working on NACI publications to have success stories. There will be an in person face to face meeting soon. Will have 2 more coordinating committee webinars scheduled as well.

Natl Coalition/Health Professional Education In Genetics

Submitted by Linda Van Scoder – Spring 2014

Recommendations

None

Report

Nothing new to report. I will continue to monitor Genetic Alliance communications for opportunities to support patients' needs.

National Sleep Awareness Roundtable

Submitted by: Anne Marie Hummel - Spring 2014

Recommendations

None

Report

The last face-to-face meeting of NSART took place February 2013. Funding for NSART ended August 31, 2013 and the program was to be rebid that fall.

From what I understand, the American Academy of Sleep Medicine (AASM) won the bid, which is interesting since they declined membership in NSART when first approached about it a couple years ago.

Members of NSART have seen nothing officially about the bid outcome, nor has there been anything in writing from AASM about what to expect with the new leadership nor any information about upcoming meetings.

Neonatal Resuscitation Program

Submitted by John Gallagher – Spring 2014

Recommendations

None

Report

The NRP Steering Committee (NRPSC) recently met on March 2-4, 2014 in Elk Grove, IL at the headquarters of the American Academy of Pediatrics. This recent meeting included an extended timeframe beyond normal standards in an effort to review currents drafts of the upcoming 7th edition of the NRP textbook. As AARC liaison, my participation was significant in both pre-work editing and during board room discussions of proposed edits. This committee relies upon our professional expertise in many areas of neonatal resuscitation including airway management, resuscitation devices, and alternative airways.

The NRP Steering Committee also launched an Instructor Development Task Force in early 2014. I ask our fellow AARC member, Rich Wade, to participate in this short-term task force. The NRPSC manager thanks Rich for his active assistance with that group.

The next planned event is a NRPSC meeting in San Diego, CA in October of 2014 to complete all outstanding edits to the 7th edition textbook and resume all other committee work currently underway.

Roundtable Reports

Asthma Disease Management

Submitted by: Eileen Censullo – Spring 2014

Recommendations

None

Report

All Asthma Roundtable members were given free membership to AANMA. Tonya Winders was given access to our roundtable by Tom Kallstrom to allow her to participate in our conversations.

Consumer

See Executive Director Report

Disaster Response

Submitted by Charles Friderici – Spring 2014

Recommendations

None

Report

Membership has remained steady around 80 participants. I am working to increase membership to 100 as a short term goal. Have continued to post various documents and newsletters, with some good response (based on number of downloads)

Geriatrics

No report submitted as of March 28, 2014.

Hyperbaric

Spring 2014

No Chairperson

Informatics

No report submitted as of March 28, 2014.

International Medical Mission

Submitted by Lisa Trujillo – Spring 2014

Recommendations

That the ICRC consider adding the IMMR Chairperson as a council member in order to support collaboration between both international groups.

That the AARC provide a table for the IMMR in the vendor area or outside the main hall at the AARC International Congress for the purpose of sharing mission opportunities and to increase IMMR membership and awareness.

That the AARC allow the IMMR one page in the AARC International Congress Program to increase awareness of the IMMR and encourage involvement.

That the AARC add an open forum section to the AARC International Congress that focuses on international mission work, volunteerism and global research.

Report

Membership is currently at 79.

Goals of the meeting:

- Discuss ways to increase IMMR membership (as of Nov. 2013 – 82 members)
- Discuss ways to support mission groups who are actively providing assistance in other countries
- Explore ways to support RT development in developing nations
- Examine ways to collaborate with the International Council for Respiratory Care

Discussions:

- It was discussed that the development of a Fundamental Respiratory Care Course curriculum would be beneficial to RTs who are in a position to introduce respiratory therapy concepts and modalities in developing nations. All agreed that this would be a very beneficial resource and would provide a structured and consistent introduction to the respiratory care profession. The curriculum would be created with the understanding that many nations are resource poor. Therefore, the curriculum would include, but not be limited to, respiratory modalities that do not require expensive devices. Creation of such a curriculum would include collaboration with the AARC, ICRC and the ARCF, so as to meet all anticipated needs and goals of introducing RC to such nations.
- It was discussed that a "Step-by-Step" document be created that outlines how volunteers can get involved in international medical mission work.

- Pres. Jerome Sullivan, from the ICRC, welcomed collaboration between the ICRC and the IMMR. Partnering would encourage mutual support and discussion regarding international development of RC. It was recognized that many RTs who are actively providing care in

the form of international medical missions are in a unique position to introduce respiratory care, specifically in developing nations and with underserved populations. Collaboration between the IMMR and the ICRC would increase awareness and opportunity in both groups.

- Collaboration between the ICRC and the IMMR would include the following: ICRC Newsletter URL link be shared on the IMMR page of the AARConnect

  ICRC Logo be added to the IMMR page of the AARConnect

  An introduction of the IMMR be sent to the ICRC to be share in the ICRC Newsletter

  Connect to ICRC via ICRC Facebook page

- It was discussed that an IMMR representative provide a presentation to the ICRC during a council meeting for the purpose of sharing the work that is currently being done by IMMR members as well as the goals of the IMMR.
- It was discussed that the ICRC consider adding the chairperson of the IMMR as a council member to further foster collaboration between both groups.
- It was discussed that additional resources are placed on the AARConnect IMMR page that allow for sharing donated supplies. Often supplies are donated to one mission group but are either in excess of the groups need or don't meet the needs of the group. The resources placed on the AARConnect IMMR page would allow groups who have such supplies a means to share them with other groups who may be in need of them.
- It was discussed that IMMR members share their mission and international RT development stories with the AARC Times and the AARConnect blog.
- In order to share the work being done by IMMR members, stimulate membership and recruit volunteers for mission work, it was suggested that the IMMR request the following from the AARC:

  A booth at the AARC International Congress (either in the vendor area or outside of the main hall) that will allow the IMMR to increase membership and share international medical mission opportunities. The booth would be manned by IMMR members throughout the conference.

  A page in the AARC International Congress Program to increase awareness of the IMMR and encourage involvement

  An open forum be added to the AARC International Congress that focuses on international mission work, volunteerism and research

- It was discussed that future IMMR meetings be available for members via dial-in or videoconference.

Update since November meeting:

Arrangements are being made to share posters of mission work with the AARC House of Delegates at the Summer Forum and the AARC International Congress in the fall.
Approval has been received to have a table/booth in the vendor area or outside the main meeting hall where IMMR members can share mission experiences, recruit new IMMR members and offer opportunities for AARC members to get involved in mission trips.

Karen Shell made a trip from Kansas to Utah to deliver donated respiratory and medical supplies. Once it is determined what supplies will be transported to Ghana, a list will be provided of what remains and is available to other mission groups.

Military

No report submitted as of March 28, 2014.

Neurorespiratory

Submitted by Lois Rowland - Spring 2014

Recommendations

That Neurorespiratory topics at the 2014 AARC Congress be scheduled in a group at a time to allow the roundtable members to meet following the grouped presentation. This was the arrangement in 2013 and attendance at the meeting was very good.

That a sample of Neurorespiratory topics and speakers which have been accepted for the Congress be shared with the roundtable before the formal agenda is posted to assist in generating interest in attending.

Report

The Neurorespiratory Roundtable had 117 members in March 2014, reflecting a 0% change since October 2013. In October 2012 there were 60 members.

Interest and contributions have been made from roundtable members to develop a curriculum outline to present this year to the AARC for an online educational program. There is hope that development of a certification for neurorespiratory knowledge will result after establishing a educational offering.

Palliative Care

Submitted by Helen Sorenson – Spring 2014

Recommendations

None

Report

The Palliative Care Roundtable has been stable with over 100 members since its inception. Recent discussions have centered around palliative care training for respiratory therapists, and if CRCEs would be available from existing programs.

Another new discussion centers on dyspnea … in the unconscious and dying patient.

Can unconscious patients experience dyspnea? If so, how should this be assessed? This is an issue that relates to us all (pediatric to geriatric patients)!

A Palliative Care Symposium program proposal has been submitted to the AARC Program Committee for Las Vegas, 2014.

Research

Submitted by John Davies – Spring 2014

Recommendations

None

Report

Discussion level remains low. Attempted to stimulate discussion by posting a few controversial papers. However, the discussion level remained low with few responses. I was contacted by Shawna Strickland about the potential role of the research roundtable in the development of a research mentorship program. I am waiting to hear more details about the research mentorship program.

Simulation

Submitted by Julianne Perretta – Spring 2014

Recommendations

None at this time

Report

Several proposals for simulation topics submitted to AARC Congress and Summer Forum planning committee. Submissions based off of current “hot topics” as observed by AARC Simulation Roundtable Members who were presenting faculty at the recent International Meeting on Simulation in Healthcare.

Tobacco Free Lifestyle

No report submitted as of March 28, 2014.

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Spring 2014

Recommendation

None

Report

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

Status: Had two candidates attend the fall meeting in Anaheim. Lin Zhang and Suzanne Fischetti attended the HOD Meeting.

Golda Crowder from California will attend in the Fall.

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

Status: Ongoing

Ad Hoc Committee on Officer Status/US Uniformed Services

No report submitted as of March 28, 2014.

Ad Hoc Committee on Leadership Institutes

Submitted by Toni Rodriguez – Spring 2014

Recommendations

That the AARC BOD terminate the Ad-Hoc Committee: AARC Leadership Institute.

Justification: The original charge for the committee: "That the Ad Hoc Committee develop a Management, Research and Educational leadership institute" has been completed. The authors (including committee members) are currently involved in the mentoring aspect of the program but are no longer needed as a committee.

Report

The Leadership Institute consists of three tracks to help the respiratory therapist increase his/her knowledge and prepare for advancement in respiratory care management, education, and research. 15 CRCE are awarded per track. The current cost is $225 per track for members; $320 per track for non-members. (Non-member course includes 1-year AARC membership and access to AARC Connect.). The tracks are laid out as follows:

•Education
◦Principles and Methods of Respiratory Therapy Adult Education
◦Developing Respiratory Therapy Courses and Evaluation of Learning
◦Clinical Instruction Techniques for Students and Employees
◦Classroom and Laboratory Instruction Technique
◦Educational Technology
◦Continuing Education

•Management
◦Health Care Infrastructure and Economics
◦Leadership and Your Organization
◦Leadership and Teambuilding
◦Integrated Business Topics for Managers
◦Law and Ethics: Practice and Application
◦Managing Human Capital
◦Finance and Budgeting for Departments
◦Data Driven Performance Improvement

•Research
◦Overview of Respiratory Care Research and Ethics
◦Performing Physical Measurements in Research
◦Developing a Research Study
◦Conducting a Research Study
◦Basic Statistics
◦Reporting Clinical Research Results

We currently have the following enrollment:
Management-20

Education-18
Research-5
This is well above budgeted volumes for 2014.

Dräger sponsored total of nine total Institute scholarships-three in each track. We had over 80 applicants for the 9 scholarships.

In the future the AARC would like to see more interactive pieces to the Institute. They are currently transitioning to a Learning Management System that may make this possible Data is being collected on the initial evaluation of the program.

The Committee Chair would like to thank Shawna Strickland, Rick Ford, Linda Van Scoder and Robert Chatburn for their vision and perseverance in completing this project. I would also like to thank all the professional leaders who took time out of their busy schedules to author the modules.

Ad Hoc Committee on 2015 & Beyond

Submitted by Toni Rodriguez – Spring 2014

Recommendations

None

Report

CHARGE #1

Competency Level Focus –The 2015 ad hoc committee based upon conference document II: "Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond " as approved by the AARC BOD in July 2012, will identify competencies for entry level practice and those that should be acquired after entering practice with suggested mechanisms for competency acquisition.

Committee Members: Claire Aloan, Bill Dubbs, Tim Myers, John Hiser, Woody Kageler, Toni Rodriguez, Lynda Goodfellow

The survey Competencies Needed by the Graduate Respiratory Therapists in 2015 and Beyond was approved by the AARC Executive Committee in early February. Thanks to Kris Kuykendall of the Executive Office who posted the survey for approximately 3 weeks and tabulated the results. The 209 question survey was sent to approximately 8400 members of the Management and Educations sections. 948 practitioners completed the survey giving an 11% return rate. The survey completers identified their position as follows: 52% managers, 37% educators and 11% practitioners. The Survey results have been sent to the committee members for review to determine next steps. A conference call will be arranged for early April. Because of the length of the survey results will be made available upon request.

CHARGE #2:

Explore models that validate the use of clinical simulations as a major tactic for increasing or upgrading the competency level of students and the current workforce for the purpose of 1) establishing the relevance of clinical simulation in the college/university setting as a substitute for actual clinical practice as requires by accreditation agencies 2) developing a "Standards of Quality Clinical Simulation" check list to guide hospital departments, educators and state affiliates in the development and effective use of clinical simulation projects.

Committee Members: Lisa Shultis, Joseph Goss, Denise Johnson, Lynda Goodfellow, Toni Rodriguez

A conference call was conducted on Feb 20th to discuss committee progress. All committee members participated.

It was reported that Wes Granger has resigned from the committee due to personal reasons. Committee members express thanks for his contributions.

Lisa did contact COARC for their position on substitution of clinical simulation for clinical practices and received the following statement from Tom Smalling ,COARC Executive Director :

CoARC does not have any Standard or Accreditation Policy addressing specific time spent in a simulation lab vs. clinical time. Since we have an outcomes-based approach to accreditation, it is up to the program to determine their methods for instruction. The use of simulation technology should only be used to augment the clinical experiences (for example, augmenting a clinical involving airway management with some time in an a simulator lab). CoARC does not address the relationship of high-fidelity patient simulation to clinical patient hours or the ability to substitute the former for the latter. CoARC encourages the use of patient simulation as an adjunct to clinical training, but simulation cannot replace patient contact.

Discussion:

Committee requested that committee chairs contact Shawna Strickland and Pat Doorley on advice related to the production of an official AARC white paper. Toni volunteered to follow up on this. **Done**

Response: Based upon information received from several knowledgeable sources, committee chairs Goodfellow and Rodriguez recommend that the committee produce an" Issue Paper" on the topic of Simulation for the AARC BOD. The Issue Paper would provide essential information and recommendations on the topic without the need for official BOD approval. The BOD could then decide on what to do with the information.

Discussion on the assigned reading material identified two distinct venues for the application of clinical simulation technology: 1) the hospital environment for the maintenance/upgrade of clinical skills and evaluation of current skills and 2) the educational environment to enhance instruction of clinical skills and attitudes. It was decided that any product produced should speak to both venues.

It was decided that we would assume a global perspective in developing the Standards of Quality Clinical Simulation Check List. The Check List will speak to best practices related to pedagogical principles, participant preparation, staff preparation and training, debriefing and equipment. (Assigned: Denise /Toni)

The proposed topics to be covered in the Issue Paper include:

- Value of simulation (Assigned Lynda)
- Variety of simulation (Assigned Lynda)
- Venues for simulation (Clinical, schools etc.) (Assigned Joe/Toni)
- Validity of Simulation (Assigned Lisa)
- Collaboration in simulation (ie: Networking) (Assigned Joe)
- Limitations of simulation (Assigned Joe)
- Integrated learning with simulation (Assigned Lisa)

Committee members will prepare their assignments and email it to other committee members by May 1st. A conference call will be arranged for Mid May.

CHARGE #3:

That the Committee in cooperation with the CoARC, develop models of consortia and cooperative agreements to assist associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.

A. Models should include the methods to overcome barriers to articulation and bridge agreements that arise from different state guidelines that govern college articulation and bridge agreements.
B. Models should include long distance learning that can be used with smart technology and have the ability to fulfill clinical requirements in unique ways that align with clinical education away from the distance classroom.
C. Recommend strategies for implementing parts A & B.

Committee Members: Pat Doorley, Toni Rodriquez, Karen Stewart, Brad Leidich, Lynda Goodfellow, Helen Sorenson

A conference call was conducted on March 6.

- Materials provided by Brad Leidich from CoARC were discussed. Ideas from the survey's comments ranged from the kinds of incentives colleges can offer to have graduates complete the RRT process in a timelier manner after graduation to the need for AS to BS agreements and mentors/champions to assist AS programs with initiation and implementation of Bridge agreements with 4-year colleges/universities.
- With 49% of the survey respondents indicating that they have no plans to start a BS degree, there is a need to articulate with 4-year schools as many (not all) other health care professions currently have advanced degrees; and this is a professional dilemma for the RT profession.
- The committee members agreed that to move bridge programs forward, mechanisms must be market-driven and that managers of respiratory care are key for success. For instance, promotions or pay increases should be tied to the RRT and BS degree via career ladders regardless of years of experience in respiratory care.
- An idea to engage the HOD with their state societies to promote AS to BS completion was discussed. The message for AS graduates is "The BS is the new RRT" in that this equals career advancement. Each delegate can also assist by creating a state list with names/contact information of educators and managers willing to mentor and facilitate an articulation agreement with program directors that may need assistance.
- To close, the discussion of the conference call can be summarized as follows:
    - AS programs need to partner with 4-year colleges with articulation agreements for graduates to continue their RT education
    - Workplace RRT and BS incentives are critical; managers must make a distinction between CRT and RRT roles

- Therapists themselves are to take responsibility for their life-long learning by being a professional who understands the issues of not advancing their credentials and education

Member assignments to prepare for next meeting:

- Brad Leidach will contact the manager of the PSRC regarding articulation agreements
- Pat Doorley will begin a list of talking points that may be used by HOD members when speaking to their state societies regarding AS to BS bridge programs
- Helen Sorenson will ask respondents who provided links to their Bridge agreements to share the agreement with plans to create a standardized template for programs to model.
- Pat Doorley will post to the management section on AARC Connect what are the barriers to t promote BS education and what is needed for change.

CHARGE # 4 :

The committee should assess the validity of career ladders as an education option for upgrading and maintaining the skill set of the existing workforce. The assessment should explore the need for career ladders to facilitate acquisition of advanced competencies and advancement to baccalaureate degree as well as identify how career ladders could be implemented.

Committee Members: Lynda Goodfellow, Dianne Lewis, Karen Schell, Shantelle Graves, Toni Rodriguez

Dr. Goodfellow conducted a literature search for current career ladder programs in nursing and other disciplines. An inquiry was also posted to the Management section on AARC Connect to ask how many managers are offering career ladders in their facility and if they would share examples of their current programs. The Management section was also asked if they are hiring CRTs (CRTs who due to terminal degree/diploma are only eligible for the CRT credential or as new graduates who are registry-eligible with a timeline to become registered). The committee has received a large amount of information and is currently in the process of reviewing the data with the goal of identifying best practices. The committee will conduct a conference call to discussion the retrieved information by the first week of April.

Ad Hoc Committee to Reduce Hospital Readmissions

No report submitted as of March 28, 2014.

Ad Hoc Committee on Virtual Museum Development

Submitted by Trudy Watson – Spring 2014

Recommendations

That travel expenses be allocated to send a member of the "Legends" team of the Ad Hoc Committee on Virtual Museum Development to interview Dr. Forrest M. Bird and obtain photographs of equipment and key information from the Bird Museum for inclusion in the AARC's Virtual Museum.

Justification: Dr. Forrest M. Bird is a true gem who has significantly contributed to the advancement of respiratory care. Dr. Bird is approaching 93 years of age. Due to his long professional association with Dr. Forrest Bird and Dr. Pamela Bird, I suggest that Sam Giordano be designated to travel to Idaho at the earliest opportunity to conduct the interview and gather vital information for the virtual museum.

That the Executive Office be charged with developing a plan to digitize past serial publications.

Justification: Preserving and protecting our historical documents and photos is critical. Currently only a small percentage of *Respiratory Care* journals and *AARCTimes* have been digitized. Should a disaster occur at the Executive Office, a major portion of the Association's history would forever be lost if the *Inhalation Therapy/Respiratory Care* journals, *Bulletins*, *AARTimes/AARCTimes* were damaged or destroyed.

Report

The committee members were divided into teams to work on specific exhibits:

1. Oxygen therapy – Gayle Carr, Karen Schell, Trudy Watson, AARC Liaison:Doug Laher
2. Humidity and aerosol therapy – Debra Skees, Ed Scully, Sheri Tooley, AARC Liaison:Shawna Strickland
3. Mechanical ventilation – Colleen Schabacker, Steve DeGenaro, Trudy Watson substituting for Dianne Lewis, AARC Liaison:Tim Myers
4. History of the agencies (AARC, NBRC, CoARC, and ARCF) - Tom Kallstrom, Tom Smalling, Gary Smith, Sam Giordano, Robert Weilacher,Trudy Watson, AARC Liaison:Tom Kallstrom
5. Legends of respiratory care – Tom Kallstrom, Tom Smalling, Gary Smith, Sam Giordano, Robert Weilacher, Trudy Watson, AARC Liaison: Sherry Milligan

Once the criteria and selection process for the "Legends" exhibit has been determined, we will present it to the NBRC Board, the CoARC Board, and you for your approval.

A preview of the Oxygen Therapy exhibit will be demonstrated at the BOD meeting.

AARC members have generously responded to our requests for photos of specific vintage items. Over 25 members have submitted photos: some shared a single photo while several have submitted 20 or more photos.

The Executive Office staff has truly gone "above and beyond" to offer assistance, advice, and solutions. I'd especially like to acknowledge Asha Desai, our project manager, for her support and patience.

ARCF

American Respiratory Care Foundation

Submitted by Michael T. Amato – Spring 2014

The American Respiratory Care Foundation (ARCF) has been very active since the last Board of Directors meeting in November 2013, with our most recent quarterly call convening on January 31, 2014. The following are highlights of activities currently under taken by ARCF, which are all in addition to administering the extensive array of education recognition awards, fellowships, and grants.

As you are aware, the ARCF hosted its first annual ARCF Fundraiser Reception "A Night at the Museum" during the AARC Congress 2014, which offered attendees the first opportunity to explore the new AARC Virtual Museum. There were over 250 attendees and $36,150 was raised to help support the development of the Virtual Museum. Teleflex was a major benefactor of this event with their purchase of virtual bricks totaling $27,500. Plans have begun for the 2014 ARCF Fundraiser Reception "A Night in the Vineyards" to be held December 8 in Las Vegas, with expectations for it to be a bigger success than the previous reception. I hope that you will make it a point to attend this year's event, as we need the support of our peers to encourage the support from our AARC members.

New for this year, the ARCF will be holding an awareness event and fundraiser raffle during the welcome reception at Summer Forum in Marco Island, Florida. The goals of this event are to bring more awareness to the Foundation while also raising money to support our cause. Promotions for the raffle began in March advertisements. Karen Stevens assisted with the 2013 Fundraiser Reception, and has been contracted to help with the 2014 fundraising activities for the Foundation. We look forward to working with her in this new endeavor.

This June 6-7, ARCF will present the 53rd Journal Conference focusing on the "Aerosol Drug Delivery in Respiratory Care". The preceedings from this Conference will be published in a 2015 issue of RESPIRATORY CARE. As-to-date, Monaghan, Aerogen, and InspiRx have provided funding at the Sponsor level. Grant applications have also been submitted to several companies including Bayer HealthCare, Astrazeneca, Bristol Myers, Forest Pharmaceuticals, and Eli Lilly & Company.

Solicitation for the 2014 ARCF awards has begun. There are two new awards for 2014, which include the Draeger Literary Award for the best published paper on mechanical ventilation and the NBRC/AMP Gary A. Smith Educational Award for Innovation in Education. We are honored to have these two new additions to our awards.

As you may recall, the International Fellowship Program sponsorship was returned to the Foundation this year. Solicitations for sponsorship were sent the end of February. As-to-date, we have had two companies commit to sponsorship, Draeger Medical and Pima Medical Institute. Push for sponsorships will continue.

<u>Summary</u>

The ARCF Trustees have been in frequent communication through quarterly phone conferences as well as two face-to-face meetings last year. We will be holding our first face-to-face meeting of 2014 during Summer Forum this year. I want to thank all of you that gave to the Foundation in 2013 and urge all of you who haven't yet provided your support for the Foundation to consider making a tax-deductible donation. Your support is indispensable to our success. I look forward to presenting this report to you and entertaining any questions you may have while at the Board Meeting.

Unfinished Business

New Business

Policy Review

- BOD.024 – BOD – AARC Disaster Relief Fund
- RT.001 – Roundtables – Roundtables
- CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges (see attachment “CT 007 Judicial Cmte w Dewitt edits”)
- FM.001 – Fiscal Management – Accounting Systems
- FM.005 – Fiscal Management – Independent Auditors and Audit Subcommittee
- FM.018 – Fiscal Management – Audit and Oversight Standards

American Association for Respiratory Care
Policy Statement

Policy No.:BOD.024

SECTION: Board of Directors

SUBJECT: **AARC Disaster Relief Fund**

EFFECTIVE DATE:

DATE REVIEWED: July 22, 2011

DATE REVISED: July 2011

REFERENCES:

Policy Statement*:* The AARC president may activate the Disaster Relief fund for AARC members in the event of a federally declared disaster.

Policy Amplification:

1. In the event of a federally and state declared disaster the President will notify the appropriate State Affiliate President(s) notifying them of Disaster Relief Fund activation.
2. The Executive Office will provide Disaster Relief Forms to the State Affiliate President(s) as well as requesting AARC members.
3. The Application review process will be conducted as follows:

   a. Members of good standing in the AARC prior to the onset of the disaster are eligible for a grant.
   b. The member fills out an application for assistance and sends that form directly to the AARC; where membership status is verified.
   c. The AARC President will send the member's application to the appropriate State Affiliate President for verification that the member is in an affected area and sustained property loss or damage.
   d. The State Affiliate President submits their approval or disproval of the application to the AARC Executive Office in writing. The Executive Office will inform the member of the status of their application (i.e. cut a check or decline the application with documentation of reasons for the action).

4. Members of good standing in the AARC prior to the onset of the disaster are eligible for a grant. Funds will be allocated based on criteria set by the AARC President at the time of the disaster until all designated funds have been expended.

    a. Funding will also include payment of membership dues.

5. The AARC President will authorize a call to all AARC Members for donations to the Disaster Relief Fund at any time it is deemed appropriate and/or necessary.

6. Records relating to the disbursement of Disaster Relief Funds will be available to any AARC member upon written request of their State Affiliate President.

7. The AARC President may consider activating the fund upon request of an affiliate president in the event of a state or local governmentally proclaimed state of emergency or disaster.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: RT.001

SECTION: Roundtables

SUBJECT: **Roundtables**

EFFECTIVE DATE: August 22, 2001

DATE REVIEWED: December 2009

DATE REVISED: December 2009

REFERENCES:

Policy Statement:

1. Roundtables are formally organized members of the AARC focused on significant topics of common interest, and who feel other groups within the organization are not addressing their special interest.

2. A minimum of 10 members may propose a Roundtable by completing the attached *Roundtable Proposal Form* and submitting it to the AARC President.

3. The AARC President will present the *Proposal* at the next meeting of the Board of Directors. If approved by the Board, the Executive Office will communicate this request to the AARC membership using the appropriate methods and solicit their interest.

4. If the Executive Office determines that at least 50 members are interested in joining:
    a. A Roundtable will be formed;
    b. A Listserv will be established;
    c. All AARC members will be contacted and informed of the new Roundtable and the Listserv;
    d. The AARC President will appoint a Roundtable Chair to serve until the time of the AARC Annual Meeting. The incoming AARC President must renew the Chair appointment or appoint a new Chair;
    e. The AARC President will appoint a member of the Board of Directors to monitor the Listserv to contact the Roundtable Chair prior to each meeting of the Board, and to report at each Board meeting on the activities of the Roundtable.

5. The Board of Directors may elect to dissolve a Roundtable at any time. In such case, the Board liaison will post an announcement in the Listserv stating the reason(s) for the dissolution of the Roundtable, and the Listserv will cease 30 days after the announcement.

a. If the Listserv has three consecutive months with no posts the Roundtable Chair and AARC Board liaison will be notified of the lack of communication.

b. The Roundtable Chair will post a query to see if the Roundtable needs to continue or has served its useful life and should be dissolved to its Listserv members.

c. If the Listserv replies indicate a desire to continue, then the 3-month probationary sequence will commence.

d. If the Listserv has no posts during the three-month probationary period, the roundtable shall be dissolved.

6. Through the Board liaison, the Roundtable Chair is automatically charged to:

   a. Promote and advance the interests of the Roundtable among its members;
   b. Work with the Board liaison to advance the interests of the Roundtable through AARC resources other than the Listserv;
   c. Encourage Roundtable members to submit program proposals to the AARC Program Committee;
   d. Determine if the Roundtable growth meets the criteria for the Roundtable becoming an AARC Specialty Section.

American Association for Respiratory Care
Policy Statement

Policy No.: FM.001

SECTION: Fiscal Management

SUBJECT: **Accounting Systems**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2009

DATE REVISED:

REFERENCES:

Policy Statement:
The Board of Directors shall require the application of appropriate accounting systems and internal auditing procedures.

Policy Amplification:

1. The accounting systems and internal auditing procedures shall provide for the timely and accurate assessment of the budgetary and business operations of the Association.

2. Financial statements shall be:

   A. Prepared in compliance with generally accepted accounting principles (GAAP)

   B. Issued in a timely manner to the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: FM.005

SECTION: Fiscal Management

SUBJECT: **Independent Auditors and Audit Subcommittee**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December 2006

DATE REVISED: December 2006

REFERENCES:

Policy Statement:
The Association shall, to the best of its ability, acknowledge and heed the findings and recommendations of its independent auditors and the Audit subcommittee of the Finance Committee.

Policy Amplification:

1. The independent auditor shall:

   A. Report its findings to the Audit subcommittee of the Finance Committee and the Board of Directors on an annual basis

   B. Provide an annual Memorandum of Advisory Comments aimed at improving financial performance and reporting

1. The Board of Directors shall take appropriate action on the recommendations of the Audit subcommittee of the Finance Committee.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: FM.018

SECTION: Fiscal Management

SUBJECT: **Audit and Oversight Standards**

EFFECTIVE DATE: April 1, 2004

DATE REVIEWED: April 23, 2010

DATE REVISED: April 23, 2010

REFERENCES:

Policy Statement:

1. The Board of Directors and the Audit Subcommittee will review financial transactions and auditing procedures of the AARC.

2. The Audit Subcommittee is composed of members from the Executive Committee and officers of the House of Delegates (HOD). AARC staff and management ~~do~~ cannot serve as members.

3. The Board of Directors and HOD officers are not part of management of the AARC nor do they receive any compensation from the AARC.

4. A full independent audit will be conducted annually by an outside auditor.

5. The Audit Subcommittee shall meet with the outside auditors, review the audit and recommend its approval.

6. The Audit Subcommittee should consider retaining the current partner or request obtaining another audit partner to be considered for rotation every five years.

7. The Board of Directors and HOD officers must have a conflict of interest policy with disclosure.

8. The AARC will not provide personal loans for its directors or executives.

9. The AARC must develop and adopt a formal process to deal with complaints from employees and prevent retaliation.

10. The AARC will have a written, mandatory document retention and periodic destruction policy.

Policy Amplification:

1. Orientation of the Board members should include financial training related to the organization.

2. Auditing firms should not be used to provide non-auditing services (except for tax preparation) while the firm is conducting auditing services.

American Association for Respiratory Care
Policy Statement

Policy No.: FM.018

1. A confidential and anonymous mechanism to encourage employees to report any inappropriateness within the entity's financial management should exist.

    a. A member of the executive office staff can report fiscal inappropriateness to the Executive Director of the AARC. He or she can also report this to the President of the Board of Directors.
    b. A member of the Board of Directors can report fiscal inappropriateness to the Executive Director.

2. The document retention policy should include guidelines for handling electronic files and voicemail messages as well as paper documents.

3. Forms 990 or 990-PF should be filed electronically to the IRS, in a timely and accurate manner.

Reference: The Sarbanes-Oxley Act and Implications for Nonprofit Organizations, 2003BroadSource and Independent Sector, www. broadsource.org

DEFINITIONS:

ATTACHMENTS:

ARCF Achievement Awards

Forrest M. Bird
Lifetime Scientific Achievement Award

Dr. Charles H. Hudson Award
for Cardiopulmonary Public Health

Thomas L. Petty, MD Invacare Award for
Excellence in Home Respiratory Care

Mike West, MBA, RRT Patient Education
Achievement Award

Memorandum

DATE: February 2014

TO: George Gaebler, MSEd, RRT,FAARC, AARC President
Carl F. Haas, MLS, RRT, CPFT, FAARC, NBRC President
Kathy Rye, EdD, RRT, FAARC, CoARC President
Peter Papadakos, MD, FAARC, FCCM, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Forrest M. Bird Lifetime Scientific Achievement Award 2014—** ***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, monetary award, coach airfare, one night's lodging, and registration to attend the Awards Ceremony at the AARC Congress 2014.

Previous recipients of this prestigious award have been:

2013 Michael T. Newhouse, MD, FRCP, FACP
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.**

- **Nominees must have authored (or co-authored) at least 25 peer reviewed publications listed on Pubmed.gov that: a) clearly demonstrate the important contributions that the nominee has made to the science of respiratory care; b) provide evidence that the nominee was a principal investigator/author on the work; and c) shows a commitment to scientific process. Previous award recipients have generally been established investigators at either teaching institutions or non-profit organizations and usually have in excess of 150 PubMed citations**

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, 2014.**

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 2014.

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 2014.

Memorandum

DATE:	February 2014
TO:	George Gaebler, MSEd, RRT,FAARC, AARC President Carl F. Haas, MLS, RRT, CPFT, FAARC, NBRC President Kathy Rye, EdD, RRT, FAARC, CoARC President Peter Papadakos, MD, FAARC, FCCM, BOMA Chair
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Dr. Charles H. Hudson Award for Cardiopulmonary Public Health 2014—*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:

- COPD Foundation - 2013
- 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, 2014.**

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, monetary award, coach airfare, one night's lodging, and registration for the AARC Congress 2014.

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, 2014. 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 2014

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

Memorandum

DATE:	February 2014
TO:	George Gaebler, MSEd, RRT, FAARC, AARC President Carl F. Hass, MLS, RRT, CPFT, FAARC, NBRC President
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2014—*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:

- Patricia Blakely, RRT, FAARC - 2013
- 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
- Joseph Lewarski, RRT - 2001
- David A. Gourley, BS, RRT - 2000
- Patrick J. Dunne, MEd, RRT, FAARC - 1999
- Regina D. Marshall, BS, RRT - 1998
- Robert J. Jasensky, RRT - 1997
- Linda Ann Farren, RRT - 1996
- Scott Bartow, MS, RRT - 1995

- Susan Lynn McInturff, RRT - 1994
- Linda Chapman Maxwell - 1993

We are now accepting nominations for this award. Please submit a one-page, typed description of how the nominee embodies excellence in home respiratory care relative to the following criteria:

- Must currently be working in home respiratory care.
- Must be a respiratory care practitioner.
- May not be employed by a manufacturer.
- May be involved in education as well as the management and organization of patient care.
- Should serve as an active patient advocate in home respiratory care, with specific achievements that demonstrate leadership.

In recognition, the recipient will receive an inscribed plaque, monetary award, coach airfare, one night's lodging and registration to the AARC Congress 2014.

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, 2014.

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, 2014. 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 2014.

Memorandum

DATE:	February 2014
TO:	George Gaebler, MSEd, RRT, FAARC, AARC President Carl F. Haas, MLS, RRT, CPFT, FAARC, NBRC President Kathy Rye, EdD, RRT, FAARC, CoARC President Peter Papadakos, MD, FAARC, FCCM, BOMA Chair
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Mike West, MBA, RRT Patient Education Award 2014—** ***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."**

Previous recipients include:

- Bill G. Galvin, MSEd, RRT, CPFT, AE-C, FAARC - 2013
- 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, monetary award, coach airfare, one night's lodging and registration to the AARC Congress 2014.

Please submit nominations to the Executive Office no later than June 1, 2014.

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 AARC Executive Office no later than June 1, and the award will be presented by the ARCF during the Awards Ceremony at the AARC Congress 2014.