American Association for Respiratory Care

Board of Directors Meeting

Embassy Suites Outdoor World
Grapevine, TX April 24-25, 2015

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – April 23, 2015
Board of Directors Meeting – April 24-25, 2015

Thursday, April 23

3:30-5:00pm Executive Committee Meeting (Committee Members only) **Su Vino Room**
6:00-7:00pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) **Preston Trail Ballroom**

Friday, April 24

7:30am Board Orientation (Mandatory for all new Board members, House Officers, and Executive Committee)

8:00am-5:00pm **Board of Directors Meeting – Preston Trail Ballroom**

8:00am Call to Order
Announcements/Introductions
Approval of Minutes pg. 10
E-motion Acceptance pg. 37

General Reports pg. 38
- President pg.39 (R)
- Past President pg. 44
- Executive Director Report pg. 45 (R)

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

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

9:30am John Barrett and Nancy Bello – Merrill Lynch –Investment Report

10:00am CoARC report presented by Tom Smalling and Kathy Rye pg. 80(A)

NBRC report pg. 81

12:00pm LUNCH BREAK (Daedalus Board Meeting)

1:30pm RECONVENE

1:30pm General Reports con't.
- House of Delegates pg. 85
- Board of Medical Advisors pg. 88
- President's Council pg. 93

Standing Committee Reports pg. 98
- Audit Subcommittee pg. 99 (R)

Bylaws Committee pg. 100 (R) (A)
Elections Committee pg. 104
Executive Committee pg. 105
Finance Committee pg. 106
Judicial Committee pg. 107
Program Committee pg. 108
Strategic Planning Committee pg. 110

Specialty Section Reports pg. 111
Adult Acute Care pg. 112 (R)
Continuing Care-Rehabilitation pg.114
Diagnostics pg. 115
Education pg. 118
Home Care pg. 120
Long Term Care pg. 121
Management pg. 122
Neonatal-Pediatrics pg. 124
Sleep pg. 125
Surface to Air Transport pg. 126

3:00pm BREAK

3:15pm Special Committee Reports pg. 127
Benchmarking Committee pg. 128
Billing Code Committee pg. 129
Federal Govt Affairs pg. 130
Fellowship Committee pg. 131
International Committee pg. 132
Membership Committee pg. 134
Position Statement Committee pg. 137 (R)
State Govt Affairs pg. 144
Virtual Museum Committee pg. 145

4:15pm Nominations for Life & Honorary Membership
(see pg. 97 for criteria)

Nominations for Legends of Respiratory Care
(see pg. 212 for criteria)

5:00pm RECESS

Saturday April 25

8:00 am-5:00 pm **Board of Directors Meeting** – **Preston Trail Ballroom**

8:00am Call to Order

Special Representatives pg. 146
- AMA CPT Health Care Professional Advisory Committee pg. 147
- American Association of Cardiovascular & Pulmonary Rehab pg. 150
- American Heart Association pg. 151 (R)
- American Society for Testing and Materials (ASTM) pg. 152
- Chartered Affiliate Consultant pg. 153
- Comm. on Accreditation of Medical Transport Systems pg. 154
- Extracorporeal Life Support Organization (ELSO) pg. 155
- International Council for Respiratory Care (ICRC) pg. 156 (A)
- The Joint Commission (TJC) pg. 158
- National Asthma Education & Prevention Program pg. 161
- Neonatal Resuscitation Program pg. 162

9:30am BREAK

9:45am Roundtable Reports pg. 163

10:00am Ad Hoc Committee Reports pg. 165
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 166 (R)
- Ad Hoc Committee on RTs and Disease Management pg. 168
- Ad Hoc Committee on Revisions to AARC Bylaws pg. 169
- Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education pg. 173

General Reports con't.
- Government & Regulatory Affairs pg. 174

12:00 pm LUNCH BREAK

1:30 pm RECONVENE

1:30 pm ARCF Report pg. 186

2:00 pm **UNFINISHED BUSINESS** pg. 189
2015 & Beyond recommendations (A)

NEW BUSINESS pg. 190
Policy Review

- FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities pg. 191
- MP.002- Membership – Membership Challenge Policy pg. 195

3:00 pm ARCF Achievement Award Nominations pg. 197
Bird pg. 198
Hudson pg. 201
Petty/Invacare pg. 206
Mike West pg. 209

ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of April 13, 2015)

AARC Board of Directors Meeting

April 24-25, 2015 • Grapevine, TX

President

Recommendation 15-1-4.1 "That the AARC Board of Directors approves the creation of the Joint Taskforce on a White Paper Regarding – Safe Initiation and Management of Mechanical Ventilation."

Recommendation 15-1-4.2 "That the AARC Board of Directors approves the objectives and membership of the Ad Hoc Committee on Advanced RT Practices, Credentialing and Education."

Recommendation 15-1-4.3 "That the AARC Board of Directors approves the membership additions to the American Respiratory Care Foundation: Anthony L. DeWitt, Mark A. Valentine, Christianna Vance, and Tonya Armer Winders."

Recommendation 15-1-4.4 "That the AARC Board of Directors ratifies the appointment of Peter Allen, BSRC, RRT-NPS-SDS, RPSGT, RST as the interim chair of the Sleep Section."

Executive Office

Recommendation 15-1-1.1 "That the Board of Directors authorize up to $379,660 for Technology Refresh 2015, which will provide an updated system capable of providing the support necessary to manage the needs of the association for the next five years."

Audit Subcommittee

Recommendation 15-1-13.1 "That, as per policies FM.002 and FM.018 and having served the AARC for several years in good standing with complete, accurate, and acceptable results, continue to retain the services of Salmon Sims Thomas & Associates, LLC for independent auditing services."

Recommendation 15-1-13.2 "That the Board of Directors accept the auditor's report as presented."

Bylaws Committee

Recommendation 15-1-9.1 "That the AARC Board of Directors accept and approve the Indiana Society for Respiratory Care Bylaws."

Recommendation 15-1-9.2 "That the AARC Board of Directors accept and approve the Pennsylvania Society for Respiratory Care Bylaws."

Recommendation 15-1-9.3 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article II, Section 1.
The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist."

Recommendation 15-1-9.4 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article III, Section 7(a).

a. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. A seat on the Board of Directors, up to a maximum of six seats, were granted to those Specialty Sections ~~consisting of at least~~ with a minimum of 1000 active members as defined in the policies and procedures of the Association ~~to be considered for a seat on the Board~~."

Recommendation 15-1-9.5 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article IV, Section 1(b).
b. Officers of the Association shall not concurrently be members of the national respiratory care credentialing or accreditation bodies or chartered affiliate staff or voting members of their Board of Directors."

Recommendation 15-1-9.6 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article IV, Section 4(c and d).
c. Vice President for Internal Affairs - The Vice President for Internal Affairs shall serve as a liaison to the ~~Chartered Affiliates, Specialty Sections, and~~ committees and groups of the Association as designated by the President and perform such other duties as shall be assigned by the President or the Board of Directors. The Vice President for Internal Affairs shall assume the duties of the President-elect in the event of the President-elect's absence, resignation, or disability, but will also carry out the duties of the office of the Vice President for Internal Affairs.

d. Vice President for External Affairs – The Vice President for External Affairs shall serve as a liaison to ~~the sponsors of the Association and to other organizations and associations with which the Association has a relationship~~ committees and groups as designated by the President, and perform such other duties as shall be assigned by the President or the Board of Directors."

Recommendation 15-1-9.7 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

a. The executive government of the Association shall be vested in a board of ~~at least~~ no more than ~~seventeen~~ eighteen (~~17~~ 18) Active Members consisting of at least five (5) Officers, ~~at least six~~ and twelve (~~6~~ 12) Directors-at-Large, and/or ~~a~~ Section Chairs serving as a Director from ~~each~~ Specialty Sections ~~of at least~~ with a minimum of 1000 active members of the Association ~~to be~~ that were considered for a seat on the Board of Directors as defined in the policies and procedures of the Association. So as long as the number of Section Chairs serving as Directors is at least six (6), the number of at-Large Directors shall be equal to the number of Section Chairs serving as Directors. If the number of Sections Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of

b. ~~seventeen~~ twelve (~~17~~ 12) ~~members~~ Directors on ~~of~~ the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the President's Council and the Chair of the Board of Medical Advisors shall serve as non-voting members. Directors shall be elected in accordance with the provisions of Article XII, Section 2 (b).

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

Recommendation 15-1-9.8 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article VIII, Section 3 (b)
b. The Board of Directors of the Association and all its committees and specialty sections may consult with the Board of Medical Advisors in regard to medical issues. ~~The Board of Medical Advisors must approve all matters regarding medical policy.~~ The Board of Medical Advisors shall assist the appropriate committees and specialty sections regarding medical and educational issues."

Recommendation 15-1-9.9 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article VIII, Section 4
An annual meeting of the Board of Medical Advisors shall be held at the time and place of the Annual Meeting of the Association~~, and other meetings shall be held at such times and places as shall be determined necessary by the Board of Medical Advisors~~."

Recommendation 15-1-9.10 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article XI, Section 4
~~**SECTION 4. INTERNATIONAL AFFILIATE DUTIES**~~
~~A copy of the minutes of every meeting of the governing body and other business meetings of the International Affiliate shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meetings.~~"

Recommendation 15-1-9.11 "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article XII, Section 2 (b) items 1&2

1. The committee shall be composed of five (5) Active Members; three (3) elected by the House of Delegates and ~~two~~ one (1) elected by the Board of Directors and the seated Past President. The Chair shall be selected by the House of Delegates.

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

Adult Acute Care

Recommendation 15-1-50.1 "That the Board explore methods to support respiratory care practitioner formed research groups, such as CARTER (**C**onsortium to **A**dvance **R**espiratory **T**herapy through **E**xcellence in **R**esearch)."

Position Statement Committee

Recommendation 15-1-26.1 "Approve and publish the revised Position Statement 'Ethics and Professional Conduct'."

Recommendation 15-1-26.2 "Approve and publish the Position Statement 'Licensure of Respiratory Care Personnel' with no revisions."

Recommendation 15-1-26.3 "Approve and publish the Position Statement 'AARC Statement of Continuing Education' with no revisions."

Recommendation 15-1-26.4 "Be it resolved the AARC develop and publish a new Position Statement regarding respiratory therapists inserting and maintaining arterial lines."

Recommendation 15-1-26.5 "Be it resolved the AARC develop and publish a new Position Statement regarding respiratory therapists inserting and maintaining vascular lines."

American Heart Association

Recommendation 15-1-64.1 "That Keith Lamb replace Brian Walsh as AARC Liaison to the AHA."

Ad Hoc Committee on Cultural Diversity in Patient Care

Recommendation 15-1-29.1 "That the AARC continue with the program of Developing and Mentoring AARC members with the purpose of increasing the Diversity of the BOD and HOD."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

December 7, 2014 • Las Vegas, NV

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Frank Salvatore, MBA, RRT, FAARC, President-elect
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
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
Lynda Goodfellow, EdD, RRT, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC
Natalie Napolitano, MPH, RRT-NPS, FAARC
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS
Kim Wiles, BS, RRT, CPFT
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
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
Peter Papadakos, MD, BOMA Chair
John Steinmetz, MBA, RRT, Past Speaker
Ellen Becker, PhD, RRT-NPS, FAARC (sitting in for Joe Sorbello)

Excused

Joe Sorbello, MSEd, RRT

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director/CEO
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 8:11am PST, Sunday, December 7, 2014. Secretary/Treasurer Linda Van Scoder 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:

Lynda Goodfellow – NACEB Board member CoBGRTE Consortium member
Ellen Becker – CoBGRTE member, Board member for Association for Asthma Educators, Board member for Chicago Asthma
Bill Lamb – Ohio Medical, Advisory Committees Univ of Missouri, St. Louis Community College
Gary Wickman - CoBGRTE
Sheri Tooley – Chair Advisory Committee Genesee Community College
Kim Wiles – Member of Advisory Board for IUP West School of Respiratory Care
Cyndi White – Vapotherm Advisory Board, Aerogen key opinion leader, speaker for Aerogen and Philips
Brian Walsh – Aerogen, Draeger, Maquet, NIH, Vapotherm
Natalie Napolitano – Aerogen, Nihon-Kohden, Draeger
Keith Lamb – Masimo, GE, Sunovian
Karen Schell – Member of FDA Pulmonary Advisory Committee
Linda Van Scoder – Member of Indiana Society for Respiratory Care, CoBGRTE

APPROVAL OF MINUTES

Colleen Schabacker moved "To approve the minutes of the July 18, 2014 meeting of the AARC Board of Directors."
Motion carried

Lynda Goodfellow moved "To approve the minutes of the July 19, 2014 meeting of the AARC Board of Directors."
Motion carried

E-MOTION ACCEPTANCE

Brian Walsh moved to ratify the E-motions.
Motion carried

STANDING COMMITTEES REPORTS

Bylaws Committee

Brian Walsh moved to accept Recommendation 14-3-9.1 "That the AARC Board of Directors find that the Florida Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Karen Stewart moved to table for further clarification.
Motion to table carried

Brian Walsh moved to accept Recommendation 14-3-9.2 "That the AARC Board of Directors find that the Arkansas Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."
Motion carried

Program Committee
Brian Walsh moved to accept Recommendation 14-3-15.1 "That the city of Indianapolis be selected as the host city for AARC Congress 2017."
Motion carried
Linda Van Scoder abstained.

SPECIALTY SECTION REPORTS

Education Section
Brian Walsh moved to accept Recommendation 14-3-53.1 "That Edwin Coombs, MA, RRT-NPS, ACCS, Director of Marketing, Respiratory Care Systems of North America, Drager Medical and Drager Medical be formally recognized and thanked by the Board of Directors for their proposed give away of 5 refurbished Drager Evita XL mechanical ventilators to 5 RT education programs."

Brian Walsh moved to accept for information only.
Motion carried

Brian Walsh moved to accept Recommendation 14-3-53.2 "That the President-Elect charge the Education Section and Education Section Chair-Elect with developing more programming directed at hospital educators and all therapists whose position requires some type of educational process."

Colleen Schabacker moved to refer to President-elect.
Motion carried

Sleep Section
Brian Walsh moved to accept Recommendation 14-3-58.1 "That the AARC Board of Directors approve to begin a marketing campaign to solicit more Section members by offering the section membership at half the regular price for new members."

Frank Salvatore moved to refer to Executive Office to review financial feasibility and to review for all sections and report back by Summer Forum 2015.
Motion carried

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

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 9:03am PST Sunday, December 7, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 9:18am PST Sunday, December 7, 2014.

SPECIAL COMMITTEE REPORTS

Fellowship Committee
Brian Walsh moved to accept Recommendation 14-3-20.1 "That the revised Policy/Procedure (CT.009) governing the activities/processes of the FAARC Selection Committee be approved."
Motion carried
(See Attachment "A" for revised policy)

Position Statement Committee
Brian Walsh moved to accept Recommendation 14-3-26.1 "Approve and publish the revised Position Statement 'Ethics and Professional Conduct'."
Motion carried

Brian Walsh moved to accept Recommendation 14-3-26.2 "Approve and publish the revised Position Statement 'Electronic Cigarette' and place links to additional educational resources on the AARC website."
Motion carried
(See Attachment "B" for revised position statements)

Brian Walsh moved to accept the Special Committee reports as presented.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

American Heart Association
Colleen Schabacker moved to accept Recommendation 14-3-64.1 "That the AARC support the use of the attached reporting tool by the AHA liaison as requested by the AHA."
Motion carried

Colleen Schabacker moved to accept Recommendation 14-3-64.2 "That the AARC provides a communication blitz, offers a webcast and reserves a block of time at the 2015 Congress in support of the AHA and their new 2015 guidelines."

Linda Van Scoder moved to refer to Program Committee.
Motion carried

Commission on Accreditation of Medical Transport Systems (CAMTS)
Colleen Schabacker moved to accept Recommendation 14-3-66.1 "To increase the CAMTS budget to $2,500 for 2016."

Linda Van Scoder moved to refer to President-elect to review for 2016 budget.
Motion carried

National Sleep Awareness Roundtable
Colleen Schabacker moved to accept Recommendation 14-3-75.1 **"**That the Board end the special representative appointment to the National Sleep Awareness Roundtable, effective 2015."
Motion carried

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

ROUNDTABLE REPORTS

Asthma Disease Management Roundtable
Brian Walsh moved to accept Recommendation 14-3-42.1 "Create a Disease Management Roundtable that would combine all disease specific roundtables together."

Linda Van Scoder moved to refer to President-elect to investigate roundtable structure.
Motion carried

Disaster Response Roundtable
Brian Walsh moved to accept Recommendation 14-3-39.1 "That the Disaster Response Roundtable continue as a separate entity within the committee structure of AARC."

Linda Van Scoder moved to refer to President-elect to investigate roundtable structure.
Motion carried

FM 14-3-43.1 Brian Walsh moved to dissolve the Hyperbaric Roundtable.
Motion carried

Neurorespiratory Roundtable
Brian Walsh moved to accept Recommendation 14-3-40.1 "Do not dissolve the Neurorespiratory Roundtable or combine with another existing group. Allow it to continue it as its own entity."

Linda Van Scoder moved to refer to President-elect to investigate roundtable structure.
Motion carried

Simulation Roundtable
Brian Walsh moved to accept Recommendation 14-3-38.1 "Continue the Simulation Roundtable as a community for Respiratory Care Professionals at various levels of simulation integration in their teaching, assessment, research and patient safety initiatives."

Linda Van Scoder moved to refer to President-elect to investigate roundtable structure.
Motion carried

Colleen Schabacker moved to accept the Roundtable reports as presented.
Motion Carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 10:32am PST Sunday, December 7, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 10:51am PST Sunday, December 7, 2014.

LEGISLATIVE REPORTS
Cheryl West and Anne Marie Hummel provided a detailed explanation on the 2015 AARC legislative initiative which will be directed at gaining Congressional co-sponsors for the Medicare Telehealth Parity Act. The bill specifically includes RTs and RT services as well as telehealth coverage for COPD patients. An update on the CDC nebulizer cleaning rules was also provided.

EXECUTIVE SESSION
Colleen Schabacker moved to go into Executive Session at 11:25am PST, Sunday, December 7, 2014.
Motion carried

Executive Session ended at 12:10pm PST, Sunday, December 7, 2014.

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 12:15pm PST Sunday, December 7, 2014.

JOINT SESSION
Joint Session was called to order at 1:35pm PST on Sunday, December 7, 2014. Secretary/Treasurer, Linda Van Scoder, called roll and declared a quorum.

Jakki Grimball presented the 2014 election results:

Vice President for Internal Affairs:	Lynda Goodfellow, EdD, RRT, AE-C
Vice President for External Affairs:	Cynthia White, MSc, RRT-NPS, AE-C, FAARC
Secretary/Treasurer:	Karen Schell, DHSc, RRT-NPS, RRT-SDS, RPFT, RPSGT, AE-C, CTTS
Directors-at-Large:	Timothy Op't Holt, EdD, RRT, AE-C Lisa Trujillo, DHSc, RRT

Cheryl West and Anne Marie Hummel 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, gave an update on the membership campaign.

Sherry Milligan showed a preview of the new AARC website that will be live by the end of 2014.

EXECUTIVE SESSION
Linda Van Scoder moved to go into Executive Session at 3:02pm PST.
Motion carried

Bill Cohagen moved to come out of Executive Session ended at 3:18pm PST.
Motion carried

President Gaebler adjourned the Joint Session at 3:23pm PST.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 3:43pm PST Sunday, December 7, 2014.

Sheri Tooley moved to approve the 2015 budget.
Motion carried

BYLAWS COMMITTEE
Bill Cohagen moved to untable Recommendation 14-3-9.1 "That the AARC Board of Directors find that the Florida Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Motion carried
Brian Walsh moved to accept Recommendation 14-3-9.1 "That the AARC Board of Directors find that the Florida Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."
Motion carried

FM 14-3-9.1 Karen Stewart moved to review the acid test policy for Affiliate Bylaws and report back in April 2015.
Motion carried

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

GENERAL REPORTS

Executive Director/Office
Tom Kallstrom gave highlights of his written report.

Bill Lamb moved to accept Recommendation 14-3-1.1 "That the AARC Board of Directors approve the revised 401k restatement as presented."
Motion carried

FM 14-3-80.1 Frank Salvatore moved that the BOD endorse the CoARC 2015 standards.
Motion carried

FM 14-3-81.1 Frank Salvatore moved that the BOD request that the NBRC begin work on creating the Advanced Practice Respiratory Therapist (APRT) credential in an expedited timeframe.
Motion carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 5:25pm PST Sunday, December 7, 2014.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

Policy
CT.009 Committees – AARC Fellowship Selection Committee

American Association for Respiratory Care
Policy Statement

SECTION: **Committees**

SUBJECT: **AARC Fellowship Selection Committee**

EFFECTIVE DATE: January 1, 2011

DATE REVIEWED: December 2014

DATE REVISED: December 2014

REFERENCES:

Policy Statement: The AARC Fellowship Program was established to recognize active or associate members who have made profound and sustained contributions to the art and science of respiratory care and to the AARC.

Policy Amplification: This policy sets forth the eligibility requirements, criteria for nomination, the selection process and rules governing the AARC Fellowship Program.

Eligibility:

- Be an active or associate member of the AARC in good standing for at least ten consecutive years prior to the deadline for receipt of nominations.
- Possess the RRT credential issued by the NBRC or, be a licensed physician with a respiratory care-related specialty.
- Current members of the AARC Board of Directors or the House of Delegates are not eligible.

Criteria:

- Must be nominated by a Fellow of the AARC with membership in good standing.
- Must have demonstrated national prominent leadership, influence and achievement in clinical practice, education or science.
- Must possess documented evidence of significant contribution to the respiratory care profession and to the AARC.

Rules:

- All nominations for Fellow, and associated supporting documents, must be submitted online through the AARC website.

- Upon receipt of a nomination, the Executive Office will confirm that each nominee satisfies the minimum criteria for 10 consecutive years of AARC membership, and that each nominator continues to maintain eligibility to submit nominations for Fellow.

- For those nominees not meeting the 10-year requirement, the nominator will be so informed and the nomination not accepted. Nominators not eligible to submit nominations will likewise be notified.

- Deadline for receipt of nominations and all supporting documentation will be the last working day of August of the calendar year in which the nomination is to be considered. Nominations not received by the established date will not be accepted.

- The Fellowship Selection Committee, consisting of a Chair and four current Fellows appointed by the AARC President, will evaluate nominations annually.

- During the first week of September, Selection Committee members will be provided an electronic folder containing all accepted nominations and supporting documents in alphabetical order. Committee members will also receive a ballot to indicate which nominees they consider worthy of induction as a Fellow. Completed ballots will be returned to the Chair for final tabulation.

- Committee members are expected to evaluate each nominee independently and make their determination based upon the contributions of the respective nominee to the profession, and most importantly, to the AARC. Committee members are discouraged from collaborating with one another during the selection process.

- Nominees receiving an affirmative vote from all five committee members will be inducted as a Fellow of the AARC.

- Nominees selected for induction will be formally notified upon completion of the selection process, with their nominators receiving a blind copy of the congratulatory letter.

- An overriding goal of the Selection Committee is to minimize any embarrassment or discomfort to members not selected for induction. Therefore, for those nominees not selected, a letter so stating will only be sent to the nominators.

- Once the final tabulation is completed, the results of the balloting for induction shall remain confidential and will not be subject to outside review or discussion.

- New Fellows will be inducted during the Awards Ceremony held in conjunction with the annual AARC International Respiratory Congress.

- Newly inducted Fellows will receive a pin, a certificate suitable for framing and will have their names added to the list of Fellows on the AARC website.

- Upon induction, Fellows are expected to maintain their AARC membership in good standing.

Attachment “B”

Position Statements
AARC Statement of Ethics and Professional Conduct
Electronic Cigarette

AARC Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapists shall:

- Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.
- Promote and practice evidence-based medicine.
- Seek continuing education opportunities to improve and maintain their professional competence and document their participation accurately.
- Perform only those procedures or functions in which they are individually competent and which are within their scope of accepted and responsible practice.
- Respect and protect the legal and personal rights of patients, including the right to privacy, informed consent, and refusal of treatment.
- Divulge no protected information regarding any patient or family unless disclosure is required for the responsible performance of duty as authorized by the patient and/or family, or required by law.
- Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.
- Promote disease prevention and wellness.
- Refuse to participate in illegal or unethical acts.
- Refuse to conceal, and will report, the illegal, unethical, fraudulent, or incompetent acts of others.
- Follow sound scientific procedures and ethical principles in research.
- Comply with state or federal laws which govern and relate to their practice.
- Avoid any form of conduct that is fraudulent or creates a conflict of interest, and shall follow the principles of ethical business behavior.
- Promote health care delivery through improvement of the access, efficacy, and cost of patient care.
- Encourage and promote appropriate stewardship of resources.
- Work to achieve and maintain respectful, functional, and beneficial relationships with all health professionals.

Effective 12/94
Revised 12/07, 07/09, 07/12
Reviewed 12/14

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 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. The effects of nicotine on the body are known to be harmful and this does not change when ingested in a smokeless route. Additional safety concerns are emerging concerning ingestion of the Liquid Nicotine Solution (LNS) by young children as poison control centers report a continual increase in calls as e-cigarettes become more popular.

Effective 4/2014
Revised 12/2014

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

December 8, 2014- Las Vegas, NV

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Frank Salvatore, MBA, RRT, FAARC, President-elect
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
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, MBA, RRT, RCP, FAARC
Lynda Goodfellow, EdD, RRT, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC
Doug McIntyre, MS, RRT, FAARC
Natalie Napolitano, MPH, RRT-NPS, FAARC
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC
Cynthia White, MSc, RRT-NPS, FAARC
Gary Wickman, BA, RRT, FAARC
Kim Wiles, BS, RRT, CPFT

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
John Steinmetz, MBA, RRT, Past Speaker
Peter Papadakos, MD, BOMA Chair
Ellen Becker, PhD, RRT-NPS, FAARC (sitting in for Joe Sorbello)

Excused

Joe Sorbello, MEd, RRT
Keith Lamb, RRT

Guests

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

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director/CEO
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
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
President George Gaebler called the meeting of the AARC Board of Directors to order at 8:07am PST, Monday, December 8, 2014. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

GENERAL REPORTS
BOARD OF MEDICAL ADVISORS (BOMA)
Dr. Peter Papadakos, Chair of BOMA, gave an update of the recent activities of BOMA. Several new doctors have joined BOMA this year.

Mary Hart and one of her students were introduced to the Board.

Dr. Papadakos informed the Board he was on the Canadian Society Board and would like to offer a $1,000 poster prize for a student to attend AARC Congress next year. President Gaebler thanked Dr. Papadakos for his generous offer.

HOUSE OF DELEGATES
Deb Skees updated the Board on the recent activities of the House of Delegates. She informed the Board that HOD Resolution 78-14-8 was passed.

Linda Van Scoder moved to accept HR 78-14-8 "Resolve that the AARC Executive Office with the help of the Past Speaker update the HOD Resolutions tracking grid on the Delegates Home page within 60 days after the last HOD meeting. Updates are to be posted within 60 days anytime there is a change in status made by either the BOD, HOD or EO for all open HOD originated resolutions."
Motion carried

Karen Schell moved "To accept the General reports as presented."
Motion carried

Sherry Milligan informed the Board of a new member level, named "Senior Member", for age 65 or older and retired or who do not want CRCE credits for only $25/year, digital membership only. Members may receive a print membership for an additional $23. Lifetime membership is also being offered for retired members for a one-time fee of $200, digital only, no CRCE.

There is also a new program for early renewal for students. Students will be billed 6 months before they graduate offering a deep discount of only $70 for a 2 year membership.

An auto-pay option is also being investigated with the ability to divide membership fee into 3 payments.

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 8:55am PST Monday, December 8, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 9:14am PST Monday, December 8, 2014.

OTHER REPORTS (ARCF, CoARC, NBRC)
Tom Smalling and Kathy Rye from CoARC gave highlights of the written CoARC report. CoARC declined the AARC's request to place a moratorium on accreditation of new associate degree respiratory care programs. Kathy Rye stated that with implementation of the new TMC exam CoARC is beginning to collect data for RRT pass rates.

Linda Van Scoder moved to accept the ARCF, CoARC, and NBRC reports.
Motion carried

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on 2015 & Beyond
Brian Walsh moved to accept Recommendation 14-3-32.1 "That the AARC BOD review and discuss the Issue Brief on Clinical Simulation as prepared by sub-committee #2, found under Appendix A of the final AARC 2015 report."

Lynda Goodfellow moved to refer to President-elect.
Motion carried

Brian Walsh moved to accept Recommendation 14-3-32.2 "That the AARC BOD review and approve the Model Articulation Agreement developed by sub-committee #3 found under Appendix C of the final AARC 2015 report."
Motion carried

Brian Walsh moved to accept Recommendation 14-3-32.3 "That the AARC BOD review and approve the Clinical Ladder Tool Kit developed by sub-committee #4 found under Appendix D of the AARC 2015 final report."

Linda Van Scoder moved to refer to President-elect.
Motion carried

Ad Hoc Committee on Virtual Museum Development
Brian Walsh moved to accept Recommendation 14-3-28.1 "That the policy for the Legends of Respiratory Care Recognition Program be approved."
Motion carried

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

NEW BUSINESS

FM 14-3-1.1 Brian Walsh moved that the AARC create an electronic conflicts of interest system that is updated yearly, and published with each Board Book.

Linda Van Scoder moved to refer to President-elect.
Motion carried

POLICY REVIEW

Policy No. RT.001 – *Roundtables - Roundtables*
Bill Cohagen moved to accept as amended.
Motion carried

Policy No. FM.016 – *Fiscal Management – Travel Expense Reimbursement*
Karen Stewart moved to accept as amended with date change and add $50 per diem and remove "telephone" and replace with "Internet".
Motion carried

Policy No.FM.022 – *Fiscal Management – Capital Purchase Approval*
Colleen Schabacker moved to accept as amended with date change and change $500 to $2,500.
Motion carried

(See Attachment "A" for all amended policies)

RECESS

George Gaebler recessed the meeting of the AARC Board of Directors at 11:10am PST Monday, December 8, 2014.

RECONVENE

George Gaebler reconvened the meeting of the AARC Board of Directors at 11:18am PST Monday, December 8, 2014.

UNFINISHED BUSINESS

FRCSC Presentation
Jerome Sullivan and Hassan Alorainy gave a presentation regarding FRCSC (Fundamental Respiratory Care Support Course).

FM 14-3-1.2 Frank Salvatore moved to refer the FRCSC plan to Executive Office to review and
report back at April 2015 BOD meeting.
Motion carried

Treasurers Motion
Linda Van Scoder moved “That expenses incurred at this meeting be reimbursed according to AARC policy.”
Motion carried

Bill Cohagen 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 12:03pm PST, Monday, December, 8, 2014.

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

_____ _____

Karen Schell Date
AARC Secretary

Attachment “A”

Policy
RT.001 – Roundtables - Roundtables
FM.016 – Fiscal Management – Travel Expense Reimbursement
FM.022 – Fiscal Management – Capital Purchase Approval

American Association for Respiratory Care
Policy Statement

Policy No.: RT.001

SECTION: Roundtables

SUBJECT: **Roundtables**

EFFECTIVE DATE: August 22, 2001

DATE REVIEWED: December 2014

DATE REVISED: December 2014

REFERENCES:

Policy Statement:

1. Roundtables are informally organized members of the AARC focused on specific topics of common interest.

2. A minimum of 25 members may propose a Roundtable by completing the attached *Roundtable Proposal Form* and submitting it to the AARC Executive Office.

3. The AARC 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 within AARConnect community (listserv) will be established.
   b. All AARC members will be contacted and informed of the new Roundtable.
   c. The AARC President will appoint a section chair or BOD member liaison to monitor the activities of the roundtable and report as needed to the Board.

5. The Board of Directors may elect to dissolve a Roundtable at any time. In such case, the 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. Examples of dissolvent include, but are not limited to:
   a. If the Roundtable has three consecutive months with no posts the AARC Board liaison will be notified of the lack of communication.
   b. If the Roundtable is no longer serving the original purpose for development.
   c. If the Roundtable grows large enough to become a section.

6. Through the Board liaison, the Roundtable is charged to:
   a. Promote and advance the interests of the Roundtable among its members;
   b. Work with the Board 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 bylaws criteria for becoming an AARC Specialty Section.

American Association for Respiratory Care
Policy Statement

Policy No.: FM.016

SECTION:	Fiscal Management
SUBJECT:	**Travel Expense Reimbursement**
EFFECTIVE DATE:	December 14, 1999
DATE REVIEWED:	~~April 2012~~ December 2014
DATE REVISED:	~~April 2012~~ December 2014
REFERENCES:	TR: 0397- 1997

Policy Statement:
Expenses incurred for all official Association travel shall be reported, recorded, and reimbursed in accordance with Association policy.

Policy Amplification:

1. Association policy for Travel Expense Reimbursement shall apply to all Association employees and authorized Association members.

    A. Travel expense reimbursement shall not be provided for representatives to external organizations unless approved in advance by the President with subsequent review by the Finance Committee and ratification by the Board of Directors.

2. All persons requesting reimbursement for expenses incurred for Association business shall report those expenses:

    A. Using an approved Expense Voucher with valid receipts attached
    B. Within thirty (30) days of when expenses are incurred

3. Reimbursement for travel shall be as follows, with the provision of valid receipts:

    A. Travel arranged through High Point Travel three weeks in advance of departure date.
    OR
    Round-trip, coach class airfare or lowest day airfare available. Because the AARC strives to get the lowest airfares in order to maximize our travel dollars, all air travel must be booked no later than three weeks from the anticipated date of departure. Please forward airline travel itineraries to the AARC Executive Office before booking your flight.
    B. Airport parking and ground transportation
    C. Other methods of transportation (rail, automobile, bus, road tolls, parking), singularly or in any combination, shall be reimbursed at a total rate not to exceed the lowest day airfare available.
    D. Automobile travel shall be paid at the current Internal Revenue Service (IRS) rate that is in effect at the time of the annual budget process (usually October of each year).

4. Reimbursement for lodging shall be as follows, with the provision of valid receipts:

    A. Lowest possible rate for those nights required for Association business.

5. Reimbursement for registration fees shall be as follows, with the provision of valid receipts:

    A. When necessary, advertised registration or admittance fees to programs attended on Association business shall be reimbursed at the fee stated on the program announcement.

6. Per diem shall be ~~$40~~ $50 (effective ~~1/1/09~~ 1/1/2015) per day for those days required for Association business:

    A. Per diem is meant and expected to cover expenses other than actual travel and lodging (e.g. meals, ~~phone calls~~ Internet)
    B. Personal expenses incurred while on official Association travel (e.g., entertainment, ~~telephone~~ Internet, or laundry) shall not be eligible for reimbursement from the Association, other than coverage with per diem.

7. Advance payment of per diem shall be made in compliance with Association travel reporting requirements and only with advance written approval from:

    A. The President for the voluntary sector of the Association
    B. The Executive Director for Association employees
    C. Exceptions to the above requirements for advance per diem shall be:
        1. Regularly scheduled Board of Directors' meetings
        2. Regularly scheduled Executive and Finance Committee meetings
        3. Travel for official Association representation to external organizations

8. International travel shall be reimbursed at actual expense, with receipts required for any expense of $25.00 or more, to include the following:
    A. Business class airfare
    B. Ground transportation
    C. Lodging
    D. Meals
    E. ~~Telephone~~ Internet and facsimile

9. Expenses incurred by the President incidental to executing the duties and responsibilities of that office shall be:
    A. Paid by the Association

B. Monitored by the Finance Committee
C. Subject to review by the independent auditors

10. All individuals traveling at Association expense shall notify the Executive Office in advance of the intended travel.

    A. The Executive Office may act as the Association's travel agent and schedule advance transportation and lodging.
    B. The Executive Office may direct individuals to purchase tickets on their own.
    C. The Executive Office may review and approve the travel plans made by the individuals

11. All public transportation (e.g., airfare, bus fare) not purchased through the Association's designated travel agency shall be reimbursed at a fee up to, but not exceeding, the fee that would have been charged by the Association's travel agency.

12. Board meeting expenses

    A. Travel, lodging and meal expenses for the Spring and Summer meetings will be reimbursed for all officers and directors using the criteria established above.
    B. At the Fall meeting held in conjunction with the annual AARC convention, the following special policies will apply to directors that are either incoming or outgoing that year:
        i. Incoming director required to attend New board meeting only (usually last day of convention)
            1. Airfare reimbursed according to the policy point 3 above.
            2. Lodging and per diem reimbursed according to the policy points 4 & 5 above, respectively, for two nights only.
        ii. Outgoing directors
            1. Airfare reimbursed according to the policy point 3 above.
            2. Lodging and per diem reimbursed according to the policy points 4 & 5 above, respectively, for up to a maximum of four nights.
    C. Convention registration---While all directors and officers are encouraged to seek payment for such from their employer, the AARC will pay for such registration as follows:
        i. Current and outgoing directors---full registration
        ii. Incoming directors—not entitled to registration reimbursement.

DEFINITIONS: "Valid receipt" includes original receipts from the travel/other provider. Reproductions of receipts shall not be accepted.

American Association for Respiratory Care
Policy Statement

Policy No.: FM 022

SECTION: **Fiscal Management**

SUBJECT: **Capital Purchase Approval**

EFFECTIVE DATE: July 2007

DATE REVIEWED: December 2014

DATE REVISED: December 2014

REFERENCES:

Policy Statement

Capital expenditures are those spent on asset items exceeding $2,500 and providing value for a year or more. In purchasing such, the following approval procedures shall be in effect:

- Any capital expenditure for $5,000 or less may be purchased with the express approval of the AARC Executive Director. Such must be subsequently ratified by the AARC Board at the next available meeting.
- Any capital expenditure for more than $5,000 must be presented to and approved by the AARC Board BEFORE funds are committed. Purchases cannot be split to avoid this approval level process.
- Capital purchases exceeding $5,000 (but not more than $20,000) that are required due to emergency circumstances (i.e. air conditioning units) may be purchased with the approval of the AARC Executive Director and concurrence by the AARC President. Such also must be subsequently ratified by the AARC Board at the next available meeting.

E-Motions

(Since Last Board Meeting in December 2014)

E15-1-15.1 "That the AARC Board of Directors ratify the Chair and members of the 2015 Sputum Bowl Committee as noted:

2015 Sputum Bowl Committee
Chair: Sherry Whiteman (MO)

Committee Members: Tom Lamphere, Diane Oldfather, Renee Wunderley, and Rick Zahodnic."

Results – February 12, 2015
Yes – 12
No – 0
Abstain – 1
Did Not Vote – 4

General Reports

President Report

Submitted by Frank Salvatore– Spring 2015

Recommendations

That the AARC Board of Directors approves the creation of the Joint Taskforce on a White Paper Regarding – Safe Initiation and Management of Mechanical Ventilation. (See document below)

That the AARC Board of Directors approves the objectives and membership of the Ad Hoc Committee on Advanced RT Practices, Credentialing and Education. (See document below)

That the AARC Board of Directors approves the membership additions to the American Respiratory Care Foundation: Anthony L. DeWitt, Mark A. Valentine, Christianna Vance, and Tonya Armer Winders.

That the AARC Board of Directors ratifies the appointment of Peter Allen, BSRC, RRT-NPS-SDS, RPSGT, RST as the interim chair of the Sleep Section.

Report

The following is an accounting of my activities done prior to and around the April 2015 Board meeting:

1. February 20, 2015 – Spoke at NYSSRC Albany Teaching Day – Albany, NY.
2. March 16-17, 2015 – Attended the First Pulmonary Disease Educator Course – Washington, DC.
3. March 17-18, 2015 – Participated in the AARC PACT Hill Day – Washington, DC.
4. March 26-27, 2015 –Attended COPD Foundation's Readmission Summit 2015 – Washington, DC
5. April 8-10, 2015 – Spoke at LSRC Conference – Baton Rouge, LA.
6. April 23-25, 2015 – AARC Board Meeting – Dallas, TX.
7. April 25-26, 2015 – AARC Corporate Partners Meeting, Dallas, TX.

The following are the items that were given to me at the December 2014 board meeting:

1. **FM 14-3-9.1** - Karen Stewart moved to review the acid test policy for Affiliate Bylaws and report back in April 2015. (President Salvatore to appoint person/group.)

   I initially appointed a group to look at this and during the information gathering phase contacted the FSRC President Kelley Jenkins. She reported to me that AARC members are automatically FSRC members without having to pay additional dues. She also reported that AARC member receive ballots when there are elections. The FSRC will not hold elections if there isn't more than one person running for Officer/Board positions. She did tell me that they do send out ballots for Delegate, but since John Wilgis went into the Speaker Track, they appointed the current Delegate and the first

election for Delegate is coming up. So it looks like there have been no ballots for at least 2-3 years. **Update 4/6/15** – I've been told ballots were sent out and in fact there are positions with only one name appearing for the office.

I don't see where the acid-test is failing us at this point and the information we may have created the above motion was more policy/procedure related and I don't believe the AARC has grounds to dictate policy/procedure of a separate organization.

2. **FM 14-3-1.1** – The AARC create an electronic conflict of interest system that is updated yearly, and published with each Board Book.

   Will work to see if we can get this done for the April meeting, if not, it will be in place for the July meeting.

3. Recommendations given to the President-elect in December 2014:
   a. **14-3-42.1** – Create a Disease Management Roundtable that would combine all disease specific roundtables together.
   I am recommending that we change the name of the Asthma Disease Management Roundtable to the Pulmonary Disease Management Roundtable. There are no other roundtables at this time that would be an appropriate move to roll them into this new roundtable.

   b. **14-3-38.1, 14-3-39.1 and 14-3-40.1** – Roundtable requests to remain as their own entity.

   No action on combining these roundtables, there will be a little more scrutiny on the activity levels. I'd like to see us move these roundtables into the AARConnect community if they aren't already there to allow them to maximize participant activity.

   c. **14-3-66.1** – Increase the CAMTS budget to $2,500 for 2016.

   Will work with the AARC CFO so that he can have it in the 2016 budget for us.

   d. **14-3-32.1 and 14-3-32.3** – The AARC BOD review and discuss/approve the Issue Brief on Clinical Simulation and the Clinical Ladder Tool Kit created by the Ad Hoc Committee on 2015 and beyond.

   I'd like this Board to review the documents associated with the recommendation and will plan to make this a part of the Unfinished Business/breakout sessions for the April 2015 Meeting.

The following are highlights of communications that have come up since my installation:

1. Letter written to the Commonwealth of Massachusetts' Board of Respiratory Care (MBRC) responding to their survey on CPAP/BiPAP administration related to their current regulations under the MA Respiratory Care Licensure Law. (January 2015)

2. As per the direction of the AARC Board in December, a letter thanking Ed Coombs, Marketing Director for Drager medical for donating five refurbished Drager Evita XL ventilators to five RT educational programs. (January 2015)
3. Letter written to CMS submitting comments on the proposed rule that addresses changes to Medicare's Shared Savings Program: Accountable Care Organizations. (February 2015)
4. Letter to urge Oregon Legislative Committee reviewing SB 2305 (Polysomnography Licensure Law) to dismiss the bill from further consideration or legislative action. (February 2015)
5. Letter to the Association for the Advancement of Medical Instrumentation Foundation (AAMI) signing onto a consensus statement on continuous monitoring of patients on opioids. (February 2015)
6. Letter to CoARC consenting to the proposed Accreditation Standards for the Advanced Practice Programs in Respiratory Care. (February 2015)
7. Letter written to Congressman Mike Thompson strongly supporting the reintroduction of the Medicare Telehealth Parity Act in the 114th Congress. (February 2015)
8. Letter written to CMS submitting comments on the subject advance notice of Methodological Changes for Calendar Year 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter. (March 2015)
9. Letter to the National Consortium for Health and Science Education (NCHSE) supporting the standards for high school educational health science curriculum. (March 2015)

Other Communication to the Board:

1. The executive committee was asked to do some work over the past few months; I decided that a full board action in a compressed time would not allow for the timely needs of the actions required. These will be discussed more in the Executive Committee report.

I will create an addendum document to this if issues/communication arises from the date this report was due.

Joint Taskforce on a White Paper Regarding – Safe Initiation and Management of Mechanical Ventilation

Subject to AARC BOD Approval in April 2015

Background:
During a University Hospital System Coalition (UHC) steering committee meeting, UHC members were discussing patient safety and the common problem of non-RT staff making ventilator changes and adjustments that lead to major patient safety issues. They published a document in 2014 (pages 2-6) addressing this issue. In researching that document, they found a document from the North Carolina Board for Respiratory Care (pages 7-8) addressing the issue as well.

Current Plan:
The UHC group decided it would be beneficial to not only write a document on who can make changes but also regarding equipment setup and pre-use checks and initial patient setups. While the UHC is committed to this project and will go forward, they are seeking to develop a document to benefit all respiratory therapists, not just UHC members. They feel that the AARC has a wider reach and more national acceptability / respectability and the white paper could have a broader impact if published by or, at the least, endorsed by the AARC.

After talking with the UHC group, it was decided that a Joint Taskforce on the creation of a white paper regarding the safe initiation and management of mechanical ventilation would be set-up.

Objectives:
1. To provide guidelines for initiation and management of mechanical ventilation to improve patient care and safety.
2. To provide guidelines for the minimal training and competencies needed to effectively manage patients of mechanical ventilation.
3. To highlight the need for in depth knowledge required to safely initiate and manage patients on mechanical ventilation including adjusting appropriate alarm settings with each adjustment. To emphasize the benefit that RT brings to the interdisciplinary team regarding ventilation and its effect on patient outcomes.
4. To establish that the Respiratory Therapist is the best qualified individuals to be trained and deemed competent as new technology arises.
5. To establish importance of interdisciplinary communication on patient outcomes.
6. To set guidelines to ensure that there is timely and accurate documentation of initiation and subsequent adjustments and there effect on the patient.
7. To highlight the need for written or electronically signed physician orders for each adjustment unless covered under established protocol.

Committee Members:

Representing the AARC:	**Representing University Heath System Coalition (UHC)**:
Dario Rodriquez – Co-Chair	Lisa Stampor – Co-Chair
Peter Papadakos, MD	Joy Hargett
Richard Branson	Tim Godwin

AARC Executive Office Liaison: Shawna Strickland

Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education

Committee Approved - December 2014; Objectives and Membership Pending AARC Board Approval – April 2015

Objectives:

1. CoARC – Develop application and accreditation documents for APRT Standards
    a. Validate if a needs assessment was done to create the CoARC standards (if it was done, share it with the group) and if not, do a survey of the current needs assessment.
2. General - Identify an institution (or institutions) to be pilot programs and provide funding through ARCF or other source (this should also tie into #3 since it would obviously not be prudent to start a pilot program in a state where there's no chance at all of having licensure to support it).
3. General - Licensure - identify states where passage of APRT licensure would have the greatest chance of success
4. AARC - Reimbursement issues
    a. The APRT workgroup supported an 'incident to' approach versus an 'independent practice' approach
    b. Direct billing versus salary from physician/facility
        i. One suggestion - 75% of physician fee schedule should be competitive with AA/CRNA, ANP, CNM, and PA
        ii. Level of supervision (general/direct/indirect)
5. NBRC – Develop the credential for the APRT.

Committee:

AARC Representatives:

Ellen Becker
Chuck Menders
John Wilgis
AARC Executive Office Liaison: Shawna Strickland

CoARC Representatives:

Dr. Kevin O'Neil
Dr. Shane Keene
Dr. George Burton
CoARC Executive Office Liaison: Tom Smalling

NBRC Representatives:

Robert Balk, MD, FCCP
Kerry George, MEd, RRT, RRT-ACCS, FAARC
Robert Joyner, PhD, RRT, RRT-ACCS, FAARC
NBRC Executive Office Liaison: Gary Smith, RRT (Hon)

Past President Report

Submitted by George Gaebler– Spring 2015

Verbal report to be given at the Spring meeting

Executive Office

Submitted by Tom Kallstrom – Spring 2015

Recommendations

That the Board of Directors authorize up to $379,660 for Technology Refresh 2015, which will provide an updated system capable of providing the support necessary to manage the needs of the association for the next five years.

This plan will be implemented in phases and be completed by the end of 2019.

Rationale: The existing IT infrastructure is a result of a multi-year project launched in 2004. We have received Board approval in 5 year intervals to meet existing business continuity and member support requirements and to address the ever-increasing need to add services.

The last cycle allowed us to remove 14 physical servers and replace them with 3 servers running virtual server software. We also virtualized the desktops to create a common image that could be deployed in minutes, rather than days.

The next cycle will allow further expansion of the existing servers to meet the increasing demands for storage. Many of our offerings include video files that rapidly consume space. In addition, we will continue to move towards a paperless office, which will add to storage requirements.

Licensing of desktops has changed. What we learned from virtual desktops will allow us to deploy a mix of virtual and physical desktops as appropriate for our business needs to optimize cost.

This request does not include upgrades to our association management software, iMIS. The need for upgrades is dependent on the software manufacturer and does not follow a schedule. We went through 2 major and 2 minor upgrades in the past 5 years. We are at a stable version now and only anticipate minor upgrades over the next 2-3 years. As in the past, we will bring requests for upgrades to the board for separate approvals.

Report

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 in December.

<u>Membership</u>
At the end of March our membership count was > 49,500.

<u>Revenue Sharing/Co-Marketing</u>
As of April 1st there have been 46 states (40 in 2014) that have signed their co-marketing and revenue sharing agreements which is an all-time record.

MEETINGS & CONVENTIONS

AARC Congress 2014, held in Las Vegas, was very successful for the Association in meeting the education needs of our members and in exceeding our financial budget. Content was outstanding and the Open Forums delivered another strong year with more than 300 original research posters presented in 16 Open Forums over 4 days. New Open Forum formats allowed presenters the opportunity to present their original research in the traditional method, as well as poster only presentations in the Exhibit Hall, and the top 6 posters were highlighted in a stand-alone session in which they could present their research via Powerpoint Presentation.

The Keynote Address delivered by Michael Ramsey MD was well received and delivered a much needed message to our members regarding the importance of patient safety and the role of the respiratory therapist. The closing ceremony also had rave reviews and left attendees with a mix of education, entertainment, and emotions across the continuum as DeWitt et al "Put the Profession on Trial".

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 an estimated 30 first time speakers.

AARC Congress 2014 did not host the Speaker Academy, but that will return in 2015. The Speaker Academy is slated to be conducted every other year. As a refresher, the Speaker Academy is an opportunity given to individuals who have never presented at an AARC Congress and provide them with an "audition" for an opportunity to present at the following year's Congress.

2015 AARC Program Committee Meeting

The AARC Program Committee met in January/February to create the Program for the AARC Summer Forum and Congress. In excess of 800 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 Summer Forum, as well as Congress. We are now in the process of contacting individuals who submitted proposals indicating our acceptance or rejection of their proposals.

2015 AARC Summer Forum

2015 Summer Forum will be held July 13-15 in Phoenix, AZ. The meeting will be held at the Marriott JW Desert Ridge Hotel & Spa. While Phoenix is not the most desired destination in mid-July, it does offer us incredible room rates at a property we would otherwise be unable to secure during other months of the year. This year's rate of $125 makes Phoenix more palatable and serves as a nice enticement for meeting attendees.

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 "Focus on the Future: Respiratory Therapy Program Administration". This pre-course provides direction and hands on experience in identifying components of an academic program plan, evaluating outcomes measures, determining expectations for academic achievement, and succession planning for respiratory therapy education programs. This course will be held in close collaboration with the CoARC and NBRC.
There will be a nominal fee associated with this course.

AARC Congress 2015
Progress is well underway for the logistical planning for AARC Congress 2015 to be held in Tampa, FL Nov. 7-10, 2015. The program is well balanced and representative of all specialty sections, roundtables and content categories required for re-credentialing. Formatting for the Congress agenda will remain very similar to 2013-2014 regarding session length (35 minutes) and unopposed exhibit hours (8 hours).

The AARC Congress Facebook fan page will continue to be used to generate and maximize excitement surrounding the meeting throughout the entire year.
https://www.facebook.com/aarc.congress

The AARC will continue its utilization of our electronic and digital portal for exhibitors to more easily engage with the association while better enabling them to participate in our meeting. On this site exhibitors will be able to electronically select booth space, pay for booth space, and create an online 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 brings AARC practices more current with existing practices taking place in the meetings and conventions industry. The Exhibitor Prospectus and Rules & Regulations will have already been published on the AARC website at the time of this meeting. It is difficult to compare advance exhibitor registration to previous years as the AARC (for the first time ever) sold 2015 booth space at last year's meeting in Las Vegas. While very labor intensive, this turned out to be very advantageous for both the AARC and our exhibitors. In turn, this allows the AARC Exhibits Coordinator to be more productive/efficient in the use of her time in Q1-2015 and allows her more opportunity to seek and solicit new exhibitors for the 2015 meeting.

Of note, Draeger Medical Inc. has already committed to the sole sponsorship of the AARC Opening Reception.

Project Update
Fisher & Paykel Humidification Project – At the time of the report, this project has not yet been finalized, however it is anticipated there will be more to report at the Spring AARC BOD meeting.

Synopsis: Fisher & Paykel has approached the AARC in hopes to achieve 2 outcomes: 1) Create a mutually advantageous spend that will allow F&P to move into the ranks of an AARC Corporate Partner; and 2) Provide basic humidification education to respiratory therapy students. Working in close collaboration with F&P, they have professionally produced 5 basic humidification education modules geared towards 2nd year respiratory therapy students. These modules have been vetted by executive office staff and found to be very professional and unbiased. These modules are to be placed in the AARC University for 24/7 on demand access. Length of the 5 modules is roughly one hour in duration for each module. The modules are not eligible for continuing education. A portion of the grant money invested into this project would serve as an incentive for 2nd year RT students to take the 5 modules. F&P has expressed interest in a multi-year agreement that would extend this grant for years into the future.

CPG Development

The first EBCPG was published in RESPIRATORY CARE in December 2013. The second EBCPG, Pharmacologic Interventions for Airway Clearance in Hospitalized Patients, has been accepted for publication in RESPIRATORY CARE for September 2014. Funding opportunities and areas of interest for future EBCPGs are being explored.

NBRC Collaboration

The AARC will begin testing the NBRC CRCE information sharing program in mid-March. The IT teams from both organizations are finalizing access points and, once the sharing program has been proven to work, we will recruit a group to beta test the program. After confirmation of the beta test group, the project will be launched to the general membership. Only active members will be able to benefit from this sharing program.

AAMI Collaboration

The AARC has been collaborating with AAMI on several projects for the last year. Executive Office Staff and AARC members Matthew Trojanowski and Russell Cazares participated in an AAMI webinar in March 2014 focused on ventilator alarm safety. This webinar reached over 1,000 RTs and nurses. In September 2014, AAMI hosted the AAMI/FDA Summit on Ventilation Technology in Virginia. Rich Branson and Dario Rodriquez represented the AARC and many other RTs were among the invited participants. In November 2014, Shawna Strickland was invited to participate in the AAMI Foundation HTSI National Coalition to Promote Continuous Monitoring of Patients on Opioids in Chicago. One result of this event was a consensus statement on opioid monitoring, to which President Salvatore signed on with the AARC's support. The AAMI is advancing the ventilator alarm safety initiative with three webinars in 2015: one aimed at the bedside nurse and two aimed at the respiratory therapist. Shawna Strickland and AARC member Jenifer Burke (nurse practitioner at Rush University) will be delivering the "Basic Ventilator Alarms for Nurses" webinar in May. The other two webinars are in development and will be partnered with the AARC for CRCEs for participants.

Professor's Rounds and Current Topics in Respiratory Care

Professor's Rounds have been retired in favor of a new series: Current Topics in Respiratory Care. Current Topics in Respiratory Care utilizes the same basic format as Professor's Rounds – purchase of a series of videos or a single video on DVD for department CRCE – but will be less expensive to produce and, therefore, less expensive to the end user. The 2015 series was

recorded during the AARC Congress 2014 in Las Vegas, NV, and the first DVD was published in February 2015.

Respiratory Care Education Annual

The RCEA received 11 submissions in 2015 for review. First round reviews currently underway. Publication will occur in early September 2015. Dr. Kathy Rye replaced Dr. Arthur Jones on the editorial board in 2015. Dr. Linda Van Scoder has resigned from the editorial board effective after the 2015 publication. Recruitment for a new editorial board member is in progress.

Live Courses in March 2015

Two live courses were delivered in March 2015. The Pulmonary Disease Educator course was held in conjunction with 2015 PACT Day on the Hill. The course was held on March 16 and 17, 2015, and provided a comprehensive discussion of chronic pulmonary diseases and facilitating the development of effective self-management skills. There were 115 registrations for the course. The Adult Critical Care Specialist course was delivered in a new format. A one-day live session was held in Winfield, IL on March 20, 2015. Half of the course material was presented live; those who attend received the other half other course material via an online supplement through AARC U. There were 80 registrations for this course. The Illinois Society for Respiratory Care partnered with the AARC to deliver the course and Dräger Medical, Inc. provided sponsorship.

CDC Strategic National Stockpile Ventilator Workshops

The AARC has been contracted by the CDC to deliver the SNS ventilator workshops at two locations in 2015. The AARC delivered the first SNS ventilator workshop at the Missouri Society for Respiratory Care meeting in April 2015 and the second is scheduled for the Texas Society for Respiratory Care meeting in July 2015. The AARC will pursue continued funding in 2016 to expand the offerings of the workshop.

Pfizer Grant

A full proposal was submitted to Pfizer for the project: “Clinician Training on Tobacco Dependence for Respiratory Therapists.” In late March we received word that we are being awarded the grant. We will produce the course, though the method of production will change depending on funding opportunity. The course will include video-based and text-based learning modules and offer 5 CRCE.

Additions to Education

Several additions to AARC U are in the works for 2014. The Adult Critical Care Specialist course (13.5 cr) and the Caring for the Chronically Critically Ill course (3 cr) were added in January 2015 and the Spirometry course (2 cr) was added in February 2015. In June, we expect to launch the Advanced Pulmonary Function Technology course (4-5 cr). The Congenital Heart Defects course (5 cr), collaboration with Duke Pediatrics, is scheduled for August, and Clinician Training on Tobacco Dependence for Respiratory Therapists (5 cr) is scheduled for October.

2015 Educational Product Sales/Attendance Trends at a glance (as of 3/6/15)

	2015 to date	2014	2013	2012	Comments
Webcasts and JournalCasts	1,503	8,812	7,511	6,289	Per session attendance in 2014: 383
Asthma Educator Prep Course	23	268	203	224	Slightly under budget 2014
COPD Educator Course	163	820	570	420	Well over budget 2014
Ethics	290	1,757	2,361	2,711	Slightly over budget 2014
RT as the VAP Expert	6	115	81	275	At budget 2014
Alpha-1	19	125	98	330	At budget 2014
Exam Prep	11	39	40		Under budget 2014
Leadership Institute	14	89			Slightly under budget 2014
Asthma and the RT	71	172			Launched in July 2014
ACCS Prep Course	17				Launched in January 2015
Spirometry	34				Launched in January 2015

RESPIRATORY CARE Journal

- As announced last September, after December 31, 2014 we stopped accepting submissions of case reports and teaching cases. You may remember the decision was based on the small number of readers accessing case reports as teaching cases, as well as the need to publish more original research without increasing expenses. Since January 1 this year we only received one inquiry asking for consideration of a case report.
- We continue to be concerned and puzzled about the relatively small percentage of members who have activated their online subscription of the Journal. While all members, including students, may activate their online subscription at no additional charge, as of the writing of this report 9,612 members have opted activation and of those, 1,424 had their activation expire.
- In January Dean Hess and Ray Masferrer met with the AARC Program Committee to review the results of the OPEN FORUM at AARC Congress 2014 as well as the plans for the 2015 FORUM. Significant changes were introduced in 2014 and everyone agreed that while the results were good, we need to make some adjustments for continued success of the three formats introduced last year:

- 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.)

Deadline for submissions of abstracts to the 2015 OPEN FORUM is May 1, a month earlier than previous years.

- On June 5-6, 2015 the Journal will be presenting the 54th Journal Conference on Controversies in RESPIRATORY CARE. For some time now we have known Conference papers published in RESPIRATORY CARE are the most widely accessed and cited. We are most grateful to the ARCF for their continued support making presentation and publication of the Conference proceedings possible.

Information Technology (IT)

- We are submitting our next technology refresh plan at this meeting. As stated in the plan, we need to keep current as technology improves and our members and staff demand more services and performance.
- We have been using thin-client technology for the desktops. In most cases this has proven to be a cost effective choice. All desktops are using the same base image so a desktop can be removed and replaced in minutes. Management is greatly simplified with this technology.
- Unfortunately, Microsoft has changed the way that they license thin-clients, which will have an adverse cost impact on us going forward. A PC desktop comes with a perpetual license when you buy it. Thin-clients are now being charged an annual license fee, resulting in higher costs. We are looking at this as we evaluate the replacement desktop.
- The servers still have room for minimal expansion. We will likely max out the capability in the next year. The primary reason for this is that we have allocated space for development and test servers that we did not have before. This reduces the possibility that we will introduce bugs and program errors into production servers.
- The phone system and network upgrades are complete.
- We continue to review the security needs for our systems. The Payment Card Industry (PCI) standards changed this year, so we will need to make changes to accommodate additional requirements. This is primarily policy changes and will not require large investments right now, but as we consider expanded services, we will need to a review our security capacity.

Web services

The new website has been up in extended beta as we continue to transition pages and functions from the old server. The comments fall into 2 distinct camps. Long-term members that

became accustomed to the convoluted paths to resources in the old site dislike the new site. The remainder of the people are adapting to the new site without too much difficulty.

We will continue to adapt the site to the way that people are using it as our members provide more feedback.

Advertising and Marketing

Print advertising has reversed some previous trends and at the time of this report (end of 1st quarter) is slightly ahead of the 2015 budget and 2014 actuals. A renewed interest in print advertising and a "new voice" from the Daedalus sales perspective has reversed the trends at this time.

Digital advertising on aarc.org continues to remain consistent and strong through our partner, Multiview. In fact, almost all of aarc.org and AARConnect advertising positions have been sold out for the remainder of 2015. We are also seeing increase interest and sales through the AARC Respiratory Care Marketplace site. With the redesigned website we are considering other potential opportunities as well as facilitating changes on both the RESPIRATORY CARE JOURNAL and Your Lung Health websites. RESPIRATORY CARE JOURNAL will be ready prior to the end of 2nd quarter and YLH hopefully by year's end.

Other advertising channels through eNewsletters, ePubs and recruitment ads are also part of the digital advertising footprint. Recruitment ads have gotten off to a fantastic start compared to prior years and are a very positive trend for the association as the advertising has a high ROI for the AARC. Changes here can be attributed to a fresh website and the biweekly Career News distribution channel. ENewsletter advertising has gotten off to a slow start compared to 4th quarter of 2014, but is starting to gain renewed interest in March. At this time, we have filled these slots with internal ads that have been good in boosting our educational and product sales.

Corporate Partners

We had a very successful year of revenue and sponsorships from our 2014 Corporate Partners. All current 2014 Corporate Partners will return in 2015 as well with the addition of a 13th partner, ResMed.

2015 Partners: Carefusion, Masimo, Covidien, Monaghan, Philips/Respironics, Drager, Maquet, Teleflex, Boehringer Ingelheim, Forest Pharmaceuticals, Ikaria, Sunovion Pharmaceuticals and ResMed (new).

We have revised the AARC's Corporate Partner program for 2015 to enhance the opportunities, benefits, and relationships with these companies and possibly stimulate increased interests from others. We will be rolling out the new benefits and enhancements to our Partners at the annual meeting.

We will be meeting with the Corporate Partners on Saturday evening and all day Sunday at the conclusion of our BOD meetings here in Dallas. Along with our elected leadership and Executive Office team, we will have presentations by Richard Ford and Garry Kauffman on the ACA's inpact on from the C-Suite and Respiratory Care Department perspectives.

Marketing

We continue to look at new vehicles through social media sites and electronic newsletters to better market the AARC, as well as, its educational and professional products. Many of these venues will also open up additional and new advertising and sponsorship opportunities as well and have gotten off to a strong start in 2015. The ability to better track and monitor our endeavors is proving us critical feedback on the optimal methods to move marketing endeavors forward.

We have seen some excellent interest in our Educational product lines due to the implementation of AARC U, creative pricing, marketing, and bundling of some other product lines. We also redesigned the AARC Store site to optimize its appearance and utility to those who visit us for our variety of products.

We are also looking at "value-added" products through our Membership Affinity program that may my find highly desirable. We have reinvigorated our relationship with Geico Insurance and hope to see a boost in revenues from that program. We also continue our relationship with the malpractice insurance group for our members. Shortly after our Spring Board meeting, we will be launching a new membership credit and reloadable debit card program with VISA. Both of these new programs will provide additional revenue streams on customized AARC and ARCF cards that are acquired and used by our membership.

There are also strategies and discussions at partnering with some other entities to produce, market, or advertise other products that align with our Mission.

Products

Benchmarking continues to see a decline in membership early in 2015 as the economic reigns are tightening for hospitals with approximately 60-65 hospitals (-10-12%) around the US and in Middle East (2). This will be a make or break year for this product. 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 have also installed a new pricing structure in 2015 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. We are also looking at a "view only" option based on a 2-year analysis of our program.

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. 2014 was our third year outsourcing RC Week products to Coleman. We came in right about our budget target in 2014 and realized a similar royalty to last year. And will look to continue, and hopefully, enhance these sales for RC Week in 2015.

We have added a "new" digital publication product into the Daedalus portfolio after a year of market research and discussions with the Daedalus team. The Best of RESPIRATORY CARE ePublication series was launched about 3-4 weeks ago with the proceedings of the 2013 New Horizon Symposium edition. A 2nd and 3rd set have been completed and will likely be available by the time you read this report. There are 3-4 others currently in various development stages. All these are produced in a digital format and available for immediate download with purchase at a cost of < $10 each.

The Executive Office has again started investigation on working with other organizations and groups on co-marketing products that will provide royalties to the AARC. Cambium Inc is our first new partner in 2015 and several others have been identified in brainstorming meetings with the Marketing team.

We have also recently concluded a new product line that collaborates with the respiratory care industry to conduct marketing research through Digital Focus groups. Industry sponsorships for this new product line will continue to grow as the healthcare landscape changes.

We continue to work to acquire sponsorships for our various educational products to offset expenses in 2015. Companies due to financial constraints, regulatory changes and competitive products in the market have not sponsored as many of these as they have in the past. We restructured our sponsorship rates and deliverables for 2014 and will be adding some new opportunities and a Tiered Pricing structure in 2015, as well as, beta testing some new venues and options.

Executive Office Referrals

(from Dec 2014 BOD meeting)

- ***FM 14-3-11.1*** *That the AARC create an electronic conflicts of interest system that is updated yearly, and published with each Board Book.*

Result: The Conflict of Interest form can now be found at www.aarc.org/aarc_bod.

- ***FM 14-3-1.2*** *That the Executive Office review the FRCSC and report back at the April 2015 Board meeting.*

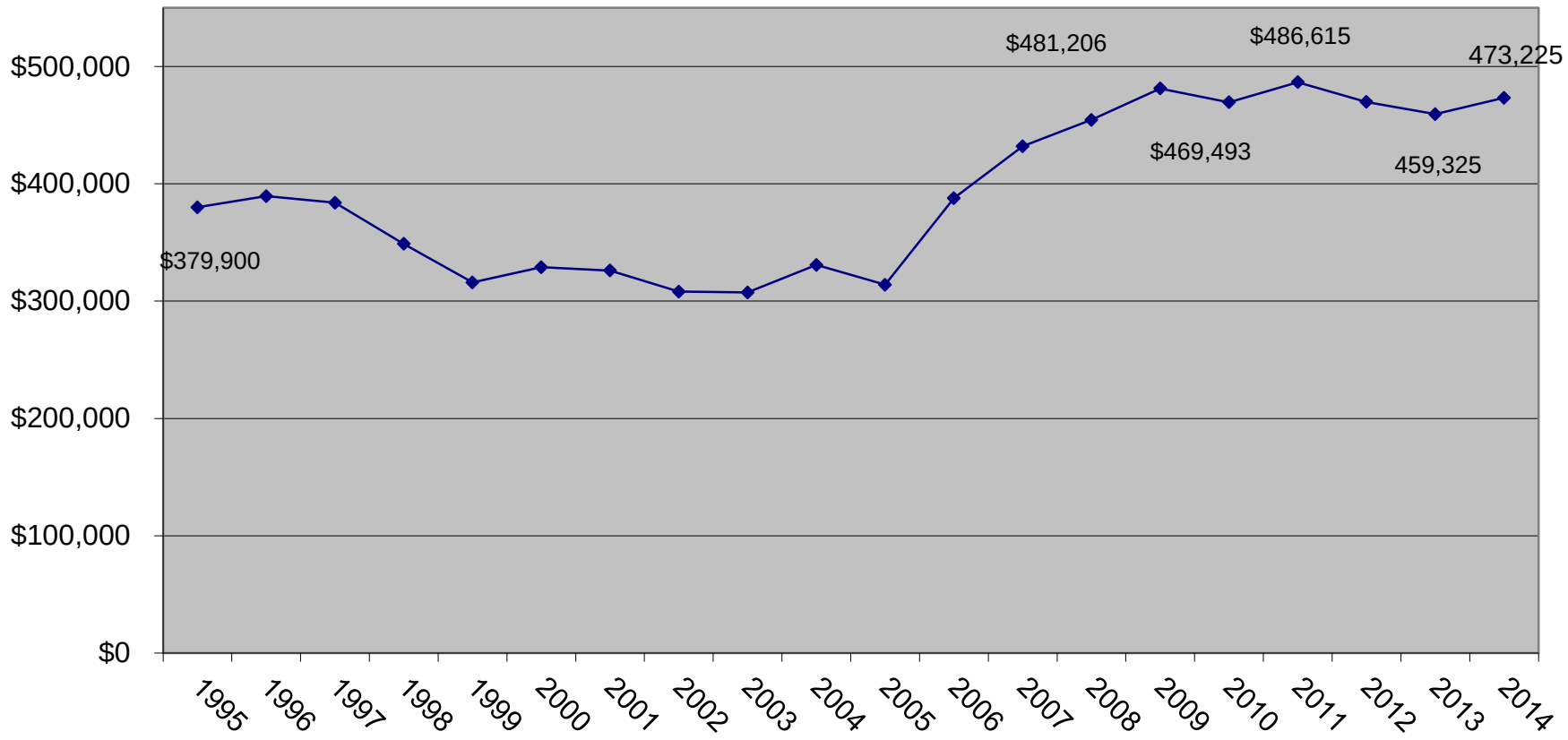
Result: Tom Kallstrom to provide a verbal update.

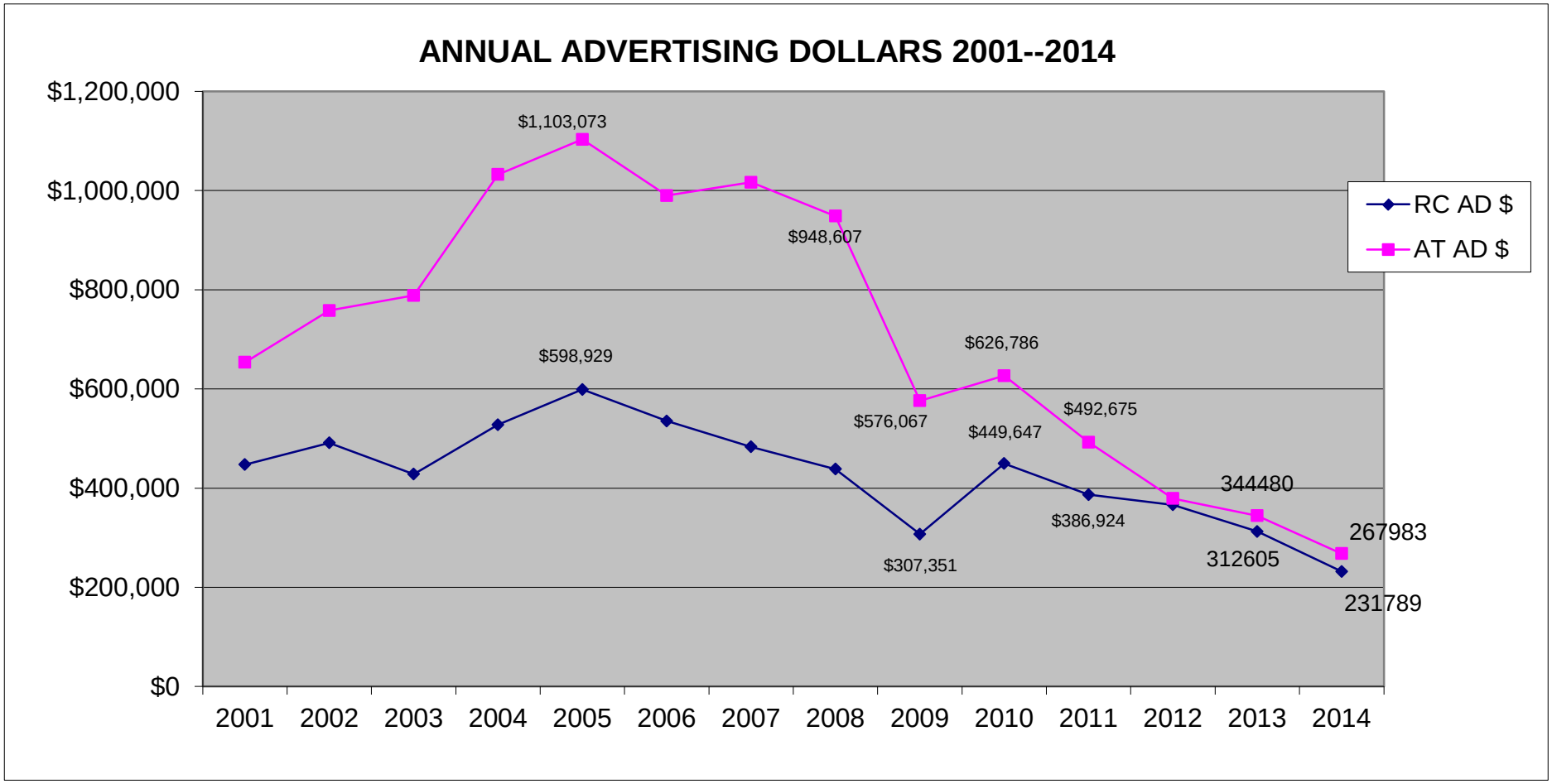
- ***FM 14-3-7.1*** *That one of the open seats for AAP 2015 be filled with a doctor who has an interest in neonatal respiratory care.*

Result: Tom Kallstrom is working on finding the right candidate.


AARC MEMBERSHIP LEVEL-
22 YEAR HISTORY at DEC 31, xxxx
MEMBERS
55,000
45,000
35,000
25,000
35,930
29,574
49,516
51,282
52,088
51,519
51,003
48,754
1993 94 95 96 97 98 99 2000 01 02 03 04 05 06 07 08 09 10 11 12 13 14
YEAR

REVENUE SHARING / SOCIETY GRANT HISTORY
1995-2014




ANNUAL ADVERTISING DOLLARS 2001--2014
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$400,000
$200,000
$0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
RC AD $
AT AD $
$1,103,073
$948,607
$626,786
$598,929
$576,067
$492,675
$449,647
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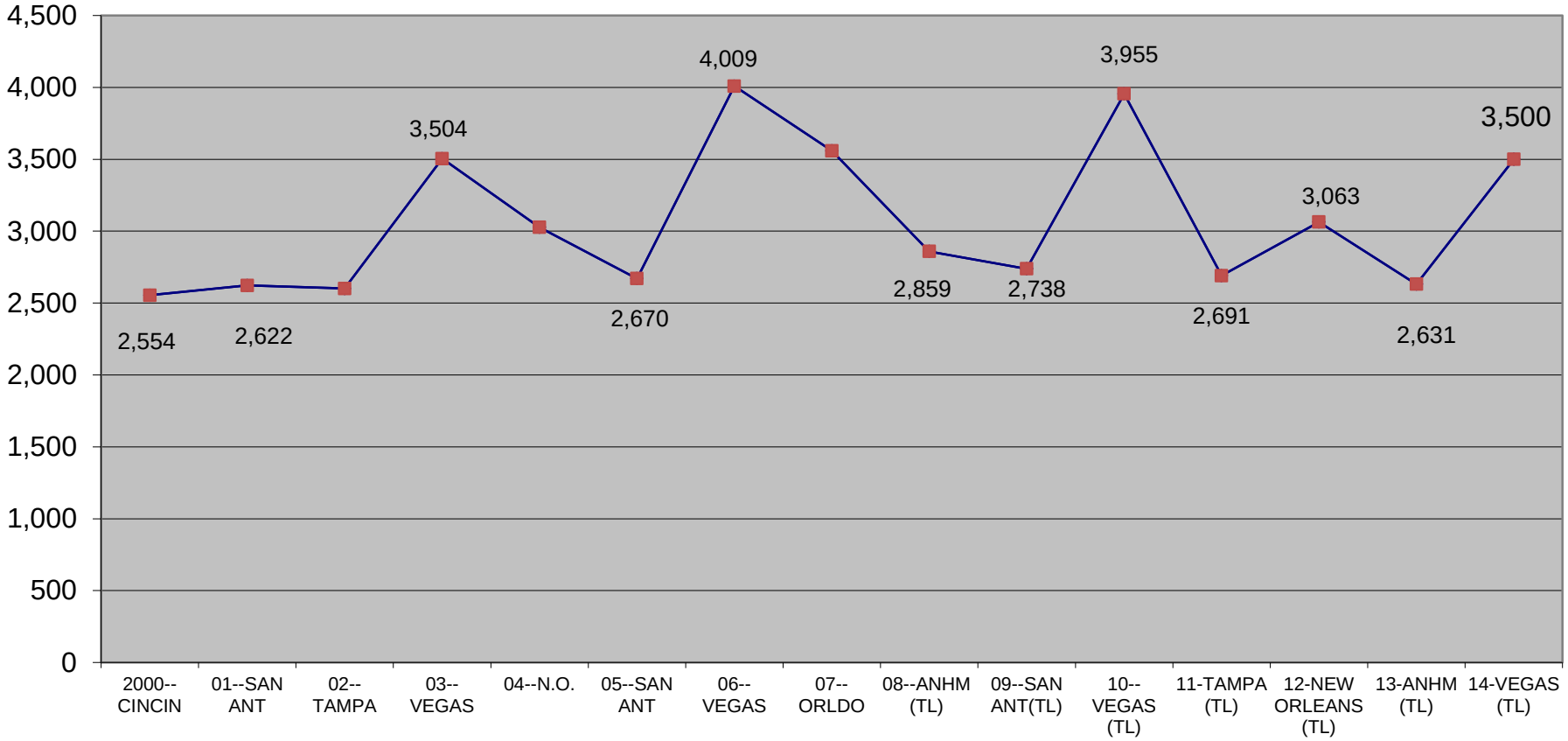
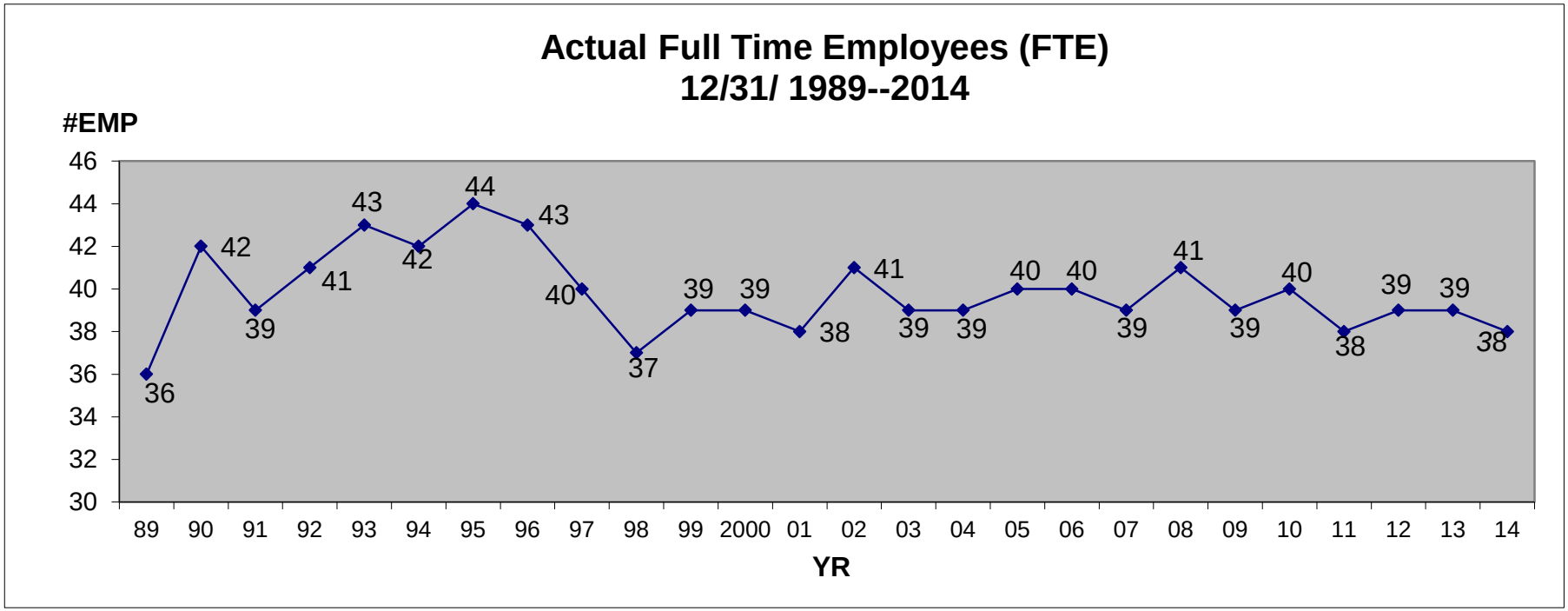
312605
$307,351
231789

CONVENTION ATTENDANCE 2000-2014
(Source-- R&V or TL stats)




Actual Full Time Employees (FTE)
12/31/ 1989--2014
#EMP
46
44
42
40
38
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39
41
43
42
44
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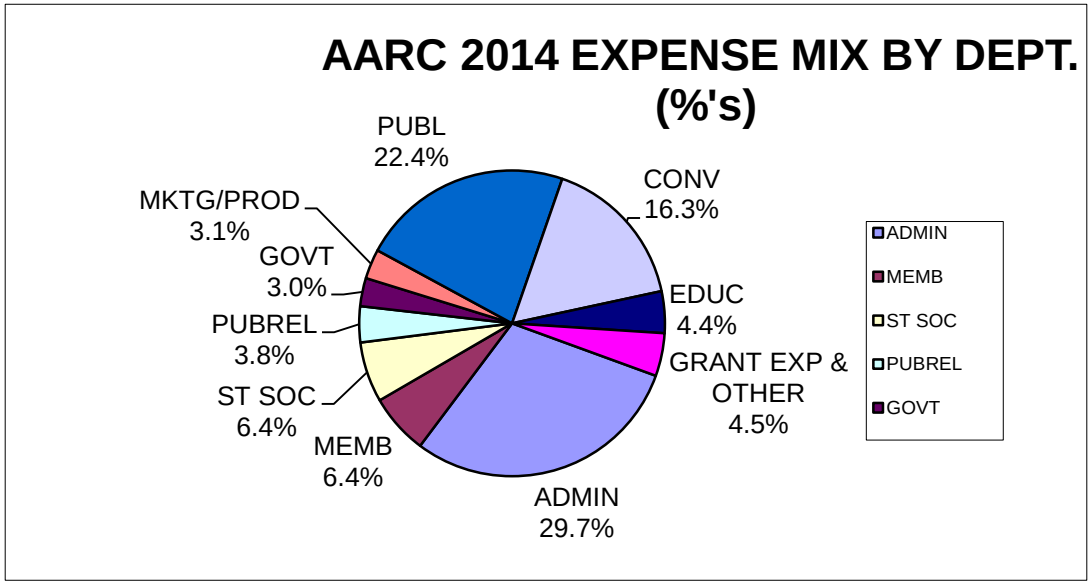
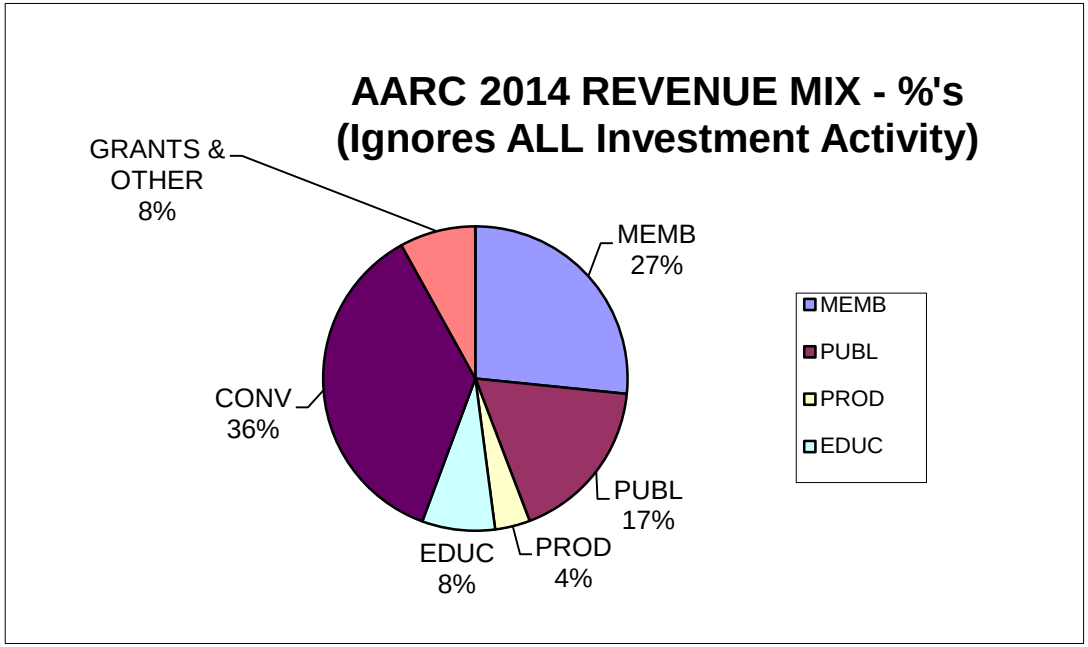

AARC 2014 EXPENSE MIX BY DEPT. (%'s)
PUBL 22.4%
CONV 16.3%
MKTG/PROD 3.1%
GOVT 3.0%
EDUC 4.4%
PUBREL 3.8%
GRANT EXP & OTHER 4.5%
ST SOC 6.4%
MEMB 6.4%
ADMIN 29.7%
ADMIN
MEMB
ST SOC
PUBREL
GOVT


AARC 2014 REVENUE MIX - %'s (Ignores ALL Investment Activity)
GRANTS & OTHER 8%
MEMB 27%
CONV 36%
PUBL 17%
EDUC 8%
PROD 4%
MEMB
PUBL
PROD
EDUC

American Association for Respiratory Care

5-Year
Information Technology
Strategic Plan

Steve Nelson, MS, RRT, FAARC
Associate Executive Director

Grady Peters
Information Technology Coordinator

Table of Contents

SECTION 1: EXECUTIVE SUMMARY

INTRODUCTION

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

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

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

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

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

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

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

CONTENTS SUMMARY

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

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

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

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

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

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

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

Section 8, Business Alarm, Security, and Surveillance System

Section 9, Document Imaging and Paperless Workplace, discusses the effort to become a reduced paper or paperless environment.

Section 10, Video Production Facility, discusses the vision to provide video teleconferencing services to the desktop and beyond.

Section 11, Overall Budget Plan

Section 12, Evaluation and Assessing New Technology, discusses AARC plans for assessing new technology.

SECTION 2: VISION AND GOALS

INTRODUCTION

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

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

DESIGN STANDARDS AND METHODOLOGY

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

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

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

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

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

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

CURRENT ENVIRONMENT

AARC currently has 4 Servers and 40 workstations deployed locally. There are ~20 virtual servers on the local area network (LAN). Some are connected to the Internet, as appropriate. The local servers are connected to a gigabit switch, along with switching technology to support our phone system. Connectivity to the Internet is achieved through AT&T Optical with a Palo Alto firewall.

SECTION 3: GUIDING PRINCIPLES

REFRESH STRATEGY POLICY

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

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

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

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

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

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

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

Impact of refresh clients: While the IT department is always looking for ways to make the refresh less intrusive on clients, the refresh is still a process that can take up to 4 hours depending on the client specific software that needs to be reinstalled onto the refreshed computer.
As a part of the communication process before a refresh takes place, an IT department staff member will contact the client and give them guidelines on how to minimize the impact of having their computer refreshed.

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

SOFTWARE COPYRIGHT POLICY

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

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

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

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

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

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

Legal purchase and use would normally imply the following:

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

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

* No unauthorized copies are made.

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

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

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

DESKTOP SOFTWARE STANDARDS

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

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

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

1. Desktop Supported Workstations:

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

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

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

Adobe Acrobat Professional - Document formatting and publishing

Adobe Dreamweaver - Web page designer

Adobe Illustrator - Artwork designer
Adobe Photoshop - Picture editor

AVG Anti-Virus - Virus and spam detection
Crystal Reports - Report design

Flash Professional - Video designer

FRx 6.7 - Accounting management database viewer

Great Plains - Accounting management database

iMIS 20 - Membership management database

iMIS TaskCentre - Automated task designer

Macromedia Contribute - Web page editor

Reinvented Software Feeder - RSS feed and Podcast publisher

Smart Draw - Architecture designer

Visual Studio - SQL report designer

WinZip - File compression

2. Server Supported:

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

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

Windows Server Datacenter 2008 R2 - Server operating system

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

F-Secure Anti-Virus for Windows Server - Virus & Spy Protection - Virus and spam detection
LISTSERV - Electronic mailing list
Macromedia ColdFusion - Web applications developer
Microsoft Exchange Server - Company Email and Calendar
WebTrends - Analytic and web tracking
Windows SQL Server - Database management
WIN-PAK/Other - Alarm system

SECTION 4: DATA CENTER INFRASTRUCTURE

VISION

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

servers will help the organization’s strategic approach to IT consolidation and building the datacenter of tomorrow.

GOAL AND STRATEGY TO OBTAIN GOAL

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

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

TARGET STATE
The Items here can only be viewed as recommendations based on current perceived business requirements. Because of past growth there is a need to expand our storage capabilities for our virtual servers, Windows and Mac computers. Current storage is rapidly being used by the addition of new servers being added and data accumulation by our users. We need to purchase twelve 600GB SAS drives to ensure adequate space for the increased workload. Server Technology is always changing and it would be difficult to predict what will be in the road ahead. I would suggest we upgrade from Gen7 to Gen8 DL380, DL560 and Gen8 Blade Servers, of course by the time we plan to purchase the Servers Gen8 might not be the latest.

Targeted benefits include:

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

RECOMMENDATIONS AND ROADMAP

The following roadmap shows the path to obtain the vision:

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

BUDGET TO IMPLEMENT

HP ProLiant DL560 Gen8 - Xeon E5-4650 2.7 GHz - 64 GB - 0 GB	*$12,000*
HP ProLiant DL380p Gen8 - Xeon E5-2690v2 3 GHz - 32 GB - 0 GB	*$9,600*
HP ProLiant BL460c Gen8 Blade Server	*$8,700*
HP ProLiant Memory Upgrades to 512GB each server 48 x 16 GB	*$19,200*
HP TFT7600 G2 - KVM console - 17.3	*$1,800*
HP Dual Port Enterprise - hard drive - 600 GB - SAS-2 (12)	*$6,600*
HP Modular Smart Array P2000 G3 SAS Dual Controller SFF Bundle	*$26,600*
Unitrends Backup Appliance	*$24,000*
SUBTOTAL	$108,500

SECTION 5: NETWORK INFRASTRUCTURE

CURRENT STATE
Two Adtran switches have been installed and connections from these switches back to the datacenter are via fiber optic cable.

Connection to the Internet has been upgraded to Fiber Optic cable.

As more video is sent to the desktop for conferencing, we will need to increase the internal bandwidth by adding additional switches

BUDGET TO IMPLEMENT

Additional Ethernet switches (2)	*$6,000*
Network cabling	*$8,000*
SUBTOTAL	*$14,000*

SECTION 6: WORKSTATION HARDWARE AND SOFTWARE

VISION

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

GOALS AND STRATEGY TO OBTAIN VISION

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

End-User Computing

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

Our Strategies

Implement and deploy collaboration software tools to support centralized storage, VPN for remote access, and end-user device management.

CURRENT STATE

The AARC currently has 40 Windows Desktop Computers, four IMACs and five Mac laptop computers. The lifecycle on a standard desktop is three years.

RECOMMENDATIONS
Several power-users will be moved from virtual terminals to Windows Based PC's. These users tend to encounter problems on a regular basis with computer lockups and slow running applications. There are additional computers that are at the end of their lifecycle and need to be replaced

BUDGET TO IMPLEMENT

HP EliteBook 8xxxp Notebook Intel Core i7	Qty7	$9,100
HP TouchSmart All-in-One Desktop PC	Qty6	$8,600
HP Pavilion Desktop PC	Qty15	$8,500
AeroHive Branch Routers	Qty5	$1,800
Apple iMAC 27inch	Qty3	$8,000
Apple iMAC 21inch	Qty5	$7,500

Apple MacBookPro 15inch	Qty5	$11,000
HP Desktop computers	Qty9	$7,200
Video\Monitor replacement or upgrade	Qty10	$2,000
Software(Microsoft, Adobe and Other)		$39,300
	SUBTOTAL	$103,000

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

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

VISION

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

GOALS AND STRATEGY TO OBTAIN VISION

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

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

CURRENT STATE
We have a Palo Alto PA-500 firewall that is located between our network and the outside internet.
The AARC currently utilizes a Barracuda 300 Spam/Virus Firewall as the filter for incoming email traffic.

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

RECOMMENDATIONS AND ROADMAP

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

Palo Alto PA-2050 Firewall
The Palo Alto Networks' next-generation firewall, PA-2000 Series, manages network traffic flows using dedicated processing and memory for networking, security, threat prevention, URL filtering and management. This next-generation firewall's high speed backplane smoothes the pathway between processors and the separation of data and control plane ensures that management access is always available, regardless of the traffic load. We need to ensure that our network is secure from outside threats.

Barracuda 400 Series Spam/Virus Filter
The upgraded series of Barracuda filters will provide additional protection for our email system. As threats continue to multiply, it is critical to have a filter capable of meeting the challenge. This series includes automated updates to virus and threat signatures.

BENEFITS AND IMPACT IF NOT IMPLEMENTED

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

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

BUDGET TO IMPLEMENT

Barracuda Spam/Virus firewall 400	$5,200
Palo Alto PA-2050 Firewall	$15,200
SUBTOTAL	$20,400

SECTION 8: BUSINESS ALARM, SECURITY, AND SURVEILLANCE SYSTEM

We need to upgrade our Security system to include video surveillance. We need a system that will not only control access to our building, but will also provide us with real time video of everyone who enters and leaves. We need to have a camera located at every entrance. Video Surveillance helps to serve as a deterrent to crime.

BUDGET TO IMPLEMENT

Alarm system	*$6,500*
Surveillance system	*$7,500*
Access control system	*$4,200*
	$18,200

SECTION 9: DOCUMENT IMAGING AND PAPERLESS WORKPLACE

VISION

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

FUTURE STATE

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

RECOMMENDATIONS AND ROADMAP

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

BENEFITS

Benefits of a paperless environment are:

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

BUDGET TO IMPLEMENT

QTY	DESCRIPTION	UNIT PRICE	EXTENDED PRICE
001	IntellChief Base System	$24,050	$24,050
001	Workflow Base Server License 10 Users	$7,190	$7,190
001	IntellChief Annual Maintenance (Yrly)	$5,936	$29,680
001	Installation and Training	$7,400	$7,400
001	Implementation	$11,840	$11,840
001	Neat scanning system	$400	$400
		SUBTOTAL	$80,560

SECTION 10: VIDEO PRODUCTION FACILITY

VISION

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

GOALS AND STRATEGY TO OBTAIN VISION

The primary goal is to enable users to host video teleconferencing calls from a local computer while sitting in their office space. Also, there is a need for a general meeting room with video conferencing capability to allow multiple personnel to attend.

CURRENT STATE

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

FUTURE STATE

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

RECOMMENDATIONS AND ROADMAP

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

BENEFITS AND IMPACT IF NOT IMPLEMENTED

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

BUDGET TO IMPLEMENT

QTY	DESCRIPTION	UNIT PRICE	EXTENDED PRICE
001	Installation and Equipment	$35,000	$35,000
		SUBTOTAL	$35,000

SECTION 11: OVERALL BUDGET PLAN

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

BUDGET TO IMPLEMENT

	Total
Section 4: Datacenter Infrastructure	$108,500
Section 5: Network Infrastructure	$14,000
Section 6: Workstation Hardware and Software	$103,000
Section 7: Information Security, Firewall and Spam/Virus Protection	$20,400
Section 8: Business Alarm, Security, and Surveillance System	$18,200
Section 9: Document Imaging and Paperless Workplace	$80,560
Section 10: Video Production Facility	$35,000
Overall Cost	$379,660

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

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

Second, the technologies described in this plan are at various stages of maturity, and the accuracy of the budget estimates reflects that. Some, like the

technology plans proposed for security, reflect ongoing efforts that have already begun. Plans may change as new and better technologies appear, but the estimates provided for proposed changes are fairly accurate.

SECTION 12: EVALUATION AND ASSESSING NEW TECHNOLOGY

VISION

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

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

GOAL AND STRATEGY TO OBTAIN VISION

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

TARGET STATE

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

BENEFITS

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

BUDGET TO IMPLEMENT

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

CoARC Report

Submitted by Tom Smalling – Spring 2015

See Attachments:

“CoARC Update 4.15”

“2014 CoARC Report on Accreditation 3.21.15”

Date: March 27, 2015

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

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

Subject: NBRC Report

I appreciate the opportunity to provide you this update on activities of the NBRC. Since the last meeting, the Board of Trustees and its committees met in November 2014 to conduct examination development activities and discuss business related items pertinent to the credentialing system. 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

On January 15, 2015, the new Therapist Multiple-Choice and Clinical Simulation Examinations were launched in the computer-based testing network. To date, we have administered 1,649 Clinical Simulation Examinations and 2,397 Therapist Multiple-Choice tests. We are seeing pass rates similar to that of the previous CRT and Written Examinations, but our number of candidates tested is still relatively low. Graduation season will soon be upon us and we will provide pass rate information in our next report to the AARC Board.

Pulmonary Function Technology Examination Committee

We are in the final stages of QA for the new PFT Examination. The committee will conduct a cut-score study at its April 2015 meeting and this new examination will be introduced in June 2015, using two cut scores, the lower score used to identify those attaining the CPFT and the higher the RPFT credential.

Specialty Examination for Sleep Disorders Testing and Therapeutic Intervention

In April 2014, the committee for the Sleep Disorders and Therapeutic Intervention Specialty Examination began the process of conducting a repeat job analysis for this program. This is the second job analysis to be conducted for this specialty program since it was introduced in 2008. The study is expected to be completed in 2015 and new test specifications will be introduced in 2016.

Collaboration with AARC

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. Staff of both organizations have been working together on the logistics of this plan and we anticipate a roll-out in mid-late 2015.

Continuing Competency Program

In 2015, the NBRC will reconvene a Recertification Commission to take an in-depth look at the NBRC's current Continuing Competency Program (CCP). Much is changing in the world of continuing competence, and to ensure that our program meets the intent of our accreditation with the National Commission for Certifying Agencies (NCCA), we feel it is time to review our program that has now been in place for 13 years. Stakeholders from related organizations will be invited to participate when the Recertification Commission convenes later this year.

Advanced Practice Respiratory Therapist

In concert with the AARC and CoARC, the NBRC will be appointing representatives to serve on an Ad Hoc Committee on the Advanced Practice RT to work on issues related to the education, credentialing, and practice of these therapists. In anticipation of an eventual credentialing examination for these therapists, the NBRC is working with trademark counsel to protect, through intent to use, the terms APRT and RRT-AP.

2014 Examination and Annual Renewal Participation

For 2014, the NBRC administered 42,299 tests across all examination programs compared to approximately 40,000 in 2013. Active status renewals continues to increase and 2014 was no exception. 53,157 credentialed practitioners paid their active status fee for 2014; this exceeded the number of active status renewals received in 2013. Renewal notices for 2015 were mailed in early October. To date, 43,925 credentialed practitioners have renewed their active status with the NBRC for 2015.

Thus far in 2015, we have received approximately 5,500 applications across all examination programs. This is lower than 2014 as we expected with the implementation of the new TMC Examination.

Examination Statistics – January 1 –December 31, 2014

The NBRC administered over 42,200 examinations in 2014. Pass rate statistics for the respective examinations follow:

Examination	***Pass Rate***
CRT Examination – 12,363 examinations	
• First-time Candidates	81.6%
• Repeat Candidates	27.2%
Therapist Written Examination – 14,295 examinations	
• First-time Candidates	66.7%
• Repeat Candidates	34.2%
Clinical Simulation Examination – 13,230 examinations	
• First-time Candidates	61.4%
• Repeat Candidates	49.7%
Adult Critical Care Examination – 726 candidates	
• First-time Candidates	81.8%
• Repeat Candidates	50.5%
Neonatal/Pediatric Examination – 1,106 examinations	
• First-time Candidates	69.7%
• Repeat Candidates	47.1%
Sleep Disorders Specialty Examination – 80 examinations	
• First-time Candidates	94.5%
• Repeat Candidates	57.1%
CPFT Examination – 388 examinations	
• First-time Candidates	73.4%
• Repeat Candidates	38.2%
RPFT Examination – 111 examinations	
• First-time Candidates	58.3%
• Repeat Candidates	51.3%

Based on the success rate of candidates, the NBRC awarded the following numbers of credentials to respiratory care practitioners in 2014:

CRT – 7,709

RRT – 7, 268

RRT-ACCS – 565

CRT-NPS and/or RRT-NPS – 704

CRT-SDS and/or RRT-SDS – 73

CPFT – 246

RPFT – 62

Your Questions Invited

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

House of Delegates Report

John Wilgis – Spring 2015

Recommendations

None

Report

- Worked with the Executive Office, House Officers, House Committee Co-Chairs and Delegates to confirm committee rosters, objectives, goals, strategies and charges and committee calendar dates.
- Developed House objectives, goals, strategies and charges document and committee calendar and disseminated documents to the House via AARConnect.
- Began monthly conference calls with House Officers to share information and in support of House objectives, goals, strategies and charges. Call summaries available on request.
- Held quarterly conference call with House Committee Co-Chairs to share information and in support of House objectives, goals, strategies and charges. Call summaries available on request.
- Participated in 2P/3S conference call with AARC leadership and liaisons.
- Worked to confirm financial information sharing and audit sub-committee process and expectations provided to House Speaker-Elect Grimball and Treasurer Merriman.
- Conducted outreach to House AdHoc Committee on Advancing the Profession about consolidating committee's work into a Joint Committee with the Board.

Other

2015 HOUSE COMMITTEE OBJECTIVES, GOALS, STRATEGIES AND CHARGES

Objective 1: Strengthen the position of the House of Delegates' through action, communication and collaboration with the AARC and its Board of Directors.

- **Goal 1.1 -** Provide routine and relevant information regarding House of Delegates activities and actions to the AARC Executive Office, the Board of Directors and other Committees and groups.
- **Goal 1.2** – Working with the AARC, the Board of Directors, the AARC Bylaws Committee and the House Bylaws Committee determine the necessary revisions to the AARC Bylaws and present them to the House and AARC membership for implementation on or before January 1, 2016.
- **Goal 1.3** – Refine the House Policy Manual and Delegate Guide into clear, concise and effective procedural and guidance documents for use by House officers, Committees and Affiliate representatives by December 31, 2015.

Objective 2: Support the stated goals of AARC President Frank Salvatore.

- **Goal 2.1** – Through the work of the Affiliate Best Practice, Chartered Affiliate / Special Recognition, Progress and Transition, Student Mentorship and Connections on Professional Volunteerism Committees (and others as appropriate), demonstrate at least 1 positive example per committee endorsing President Salvatore's goals to the AARC, its members and partner organizations by December 31, 2015.

Objective 3: Provide tools, resources and assistance to House officers, committee chairs and their members, and affiliate representatives that improve the effectiveness and efficiency of House activities and achievements.

- **Goal 3.1** – As developed by Past-Speaker Skees, finalize transition documents into a toolkit for House officers and committee chairs outlining specific duties, responsibilities and key schedule dates by July 31, 2015.
- **Goal 3.2** - Working with the Orientation and Policy and Guide Committees (and others as appropriate) refine the House Delegates guide into a useful tool that provides accurate, consolidated and significant information for affiliate representatives by December 31, 2015.
- **Goal 3.3** - Working with the AARC Executive Office, re-design the House web page to serve as a working repository of useful and historical information for all House members by December 31, 2015.

Objective 4: Promote engaged student involvement with House meetings, activity and delegations.

- **Goal 4.1** – Determine a mechanism to have international students attend and participate in a House of Delegates meeting by December 31, 2015.
- **Goal 4.2** - Working with the Student Mentorship and Policy Committee (and others as appropriate), establish a clearly defined program for student support and participation in House meeting and activities as indicated in the House and Board approved resolution #57-14-1 "Resolved that the AARC create a financial assistance budget of $2000 per year to support Respiratory Care Students attending the House of Delegates meeting."

Objective 5: Develop innovative processes that advance the work of the House and establish durable practices driving continual improvement.

- **Goal 5.1** - Establish an ad hoc committee by March 1, 2015 to explore methods and actions the House can take to support the implementation of the AARC Strategic Plan for 2015-2020.
- **Goal 5.2** - Refine the parliamentary process to support the business of the House in an efficient and effective manner by July 31, 2015.

HOD COMMITTEE CHARGES

1. Update the Committee Action Plan before and after each House meeting, and as needed / required, and submit it to the Secretary.
2. Review and update committee schedule deadlines. In cooperation with the Secretary and House Liaison.
3. Using AARConnect, coordinate Committee meetings and schedule work assignments as defined in the Committee Action Plan.

4. Submit a Committee report with recommendations to be included in the Delegate's book for each House meeting in 2015.
5. Present a brief overview of the Committee's purpose for new Delegates during the Orientation Session of each House meeting in 2015.
6. Identify transition plans (as needed) with recommendation for replacement of any outgoing co-chair(s).
7. Provide an update of Committee membership to the Secretary at the winter meeting for 2016.
8. Perform other duties as assigned by the Speaker.

I would like to thank the Executive Office, Board of Directors, and House leaders who have assisted me over the past several months. Their contributions are invaluable!

Board of Medical Advisors Report

Submitted by Steven Boas, MD – Spring 2015

Recommendations

None

Report

There has been little activity with BOMA since the December meeting. Below are the preliminary minutes that should be approved on our next conference call that is scheduled for June 27th.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Medical Advisors Meeting

December 10, 2014 – Las Vegas, NV

Minutes

Attendance
Peter Papadakos, MD, FCCM, FAARC (SCCM), Chair
Steven Boas, MD, Chair-elect (AAP)
Terence Carey, MD (ACAAI)
Kevin Murphy, MD (ACAAI)
Russell Acevedo, MD, FCCP (ACCP)
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Kent Christopher, MD, RRT, FCCP (NAMDRC)
Harold Manning, MD, FCCP (ACCP)
Lori Conklin, MD (ASA), Past Chair
Thomas Fuhrman, MD (ASA)
Neil MacIntyre, MD (ATS)
Allen Dozor, MD (ATS)
Col. Michael Morris, MD, FACP, FCCP, USA RET
Ravi Tripathi, MD (ASA)

Excused
Robert Brown, MD (ATS)
David Kelley, MD, RRT-NPS, CRT (ASA)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
George Gaebler, AARC Past President, BOMA Liaison

Guests
Tom Smalling, PhD, RRT, RPFT, RPSGT, FAARC,
Kathy Rye, EdD, RRT, FAARC
Lori Tinkler, MBA
Carl Haas, MS, RRT, FAARC

Staff
Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Cheryl West, MPH, Director of Government Affairs
Anne Marie Hummel, Legislative Affairs
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
Chairman Papadakos called the meeting of the AARC Board of Medical Advisors to order at 10:08am PST, Wednesday, December 10, 2014.

INTRODUCTIONS
Chairman Papadakos asked members to disclose any conflicts of interest.

Michael Morris – paid speaker for Spiriva
Peter Papadakos – NY State Board of Professions
Russell Acevedo – Sunovian Advisory Board

APPROVAL OF MINUTES
Russell Acevedo moved to accept the minutes of the May 31, 2014 meeting of the AARC Board of Medical Advisors.
Motion carried

NATIONAL BOARD FOR RESPIRATORY CARE
Lori Tinkler and Carl Haas gave highlights of their written report. The NBRC administered over 32,500 examinations in 2014 and pass rates have remained the same. 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. Look for this new process to roll-out in mid-late 2015.

CoARC (Commission on Accreditation for Respiratory Care) Report
Brad Leidich, Kathy Rye, and Tom Smalling gave highlights of their written report. 86% of accredited programs are at associate degree level. Kathy Rye invited BOMA members to become site visitors.

CHAIRMAN'S REPORT
Dr. Papadakos thanked the BOMA members for working on the ACCP letter.

AARC PRESIDENT'S REPORT
Frank Salvatore presented the Board of Medical Advisors with his goals for 2015-2016. Awareness will be the forefront and he wishes to advance the science of respiratory care, especially by moving the APRT credential forward. He asked for the support of BOMA to advocate for our profession and patients. President Salvatore also informed BOMA that bill HR2619 would be put on the shelf for now.

Tom Kallstrom told BOMA about the new membership tiers for senior and student members. Tim Myers explained the student membership discount. Dr. Fuhrman suggested that when people register for the NBRC exam there should be a link to AARC for a discounted membership.

Shawna Strickland informed BOMA about webinars, webcasts, and other educational opportunities available that she oversees and invited BOMA to be more involved as content experts.

FRCSC (Fundamental Respiratory Care Support Course)
Tom Kallstrom told BOMA about the program Jerome Sullivan and Hassan Alorainy presented to the BOD on Monday.

Dr. Chiefetz, Program Committee Chair and BOMA member, told BOMA that the Committee would really like for more BOMA members to be speakers, review proposals, submit ideas and general topics thru the website. January 8th is the deadline for proposals and the Program Committee meets on January 29th in Dallas. Many BOMA members were enthusiastic and said they would submit ideas before the deadline.

RECESS
Dr. Papadakos recessed the meeting of the Board of Medical Advisors at 11:30am PST Wednesday, December 10, 2014.

RECONVENE
Dr. Papadakos reconvened the meeting of the Board of Medical Advisors at 11:56am PST Wednesday, December 10, 2014.

EXECUTIVE DIRECTOR REPORT
Tom Kallstrom thanked Dr. Papadakos for his leadership over the past year and thanked BOMA for the CHEST rebuttal articles. Tom also discussed the AARC Strategic Plan.

FM 14-3-7.1 Dr. Aranson moved that, due to the fact that AARC members have expressed a growing interest, one of the open seats from American Academy of Pediatrics (AAP) should be filled with a doctor who has an interest in neonatal respiratory care.
Motion carried

Dr. Christopher moved that the AARC Executive Office investigate.
Motion carried

RECESS
Dr. Papadakos recessed the meeting of the Board of Medical Advisors at 12:52pm PST Wednesday, December 10, 2014.

RECONVENE
Dr. Papadakos reconvened the meeting of the Board of Medical Advisors at 1:00pm PST Wednesday, December 10, 2014.

LEGISLATIVE AFFAIRS REPORT
Cheryl West provided updates on state legislative initiatives including those states exploring the RRT credential only for licensure. Anne Marie Hummel discussed the advantages of AARC pursing Congressional support in 2015 for the Medicare Telehealth Parity Act, which currently includes specific RT provisions.

MEDICAL ADVISOR REPORTS
Dr. Christopher stated that the NAMDRC meeting will take place in Scottsdale, AZ March 10-11, 2015.

SPECIALTY SECTION REPORTS
The Specialty Section Reports were reviewed.

OTHER REPORTS
Tom Kallstrom reviewed the ARCF written report. ARCF partnered with American Airlines for a special promotional announcement that was played in first class cabins during the months of November and December. The ARCF held its second annual Fundraiser on Monday night and approximately 325 guests attended.

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS
There was no new business.

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

ADJOURNMENT
Dr. Papadakos adjourned the meeting of the AARC Board of Medical Advisors at 1:52pm PST, Wednesday, December 10, 2014.

President`s Council

Submitted by Dianne Lewis – Spring 2015

Recommendations

None

Report

This year's Jimmy A Young Medalist is Bill Galvin MEd, RRT, FAARC. I think most of you are familiar with Bill and/or have had the opportunity to work with him in various positions within the AARC. He is very deserving of this award. Also, at this meeting we will be taking nominations for Life and Honorary membership from the BOD. Below is a list of previous winners and the criteria for each.

At the last Council meeting, I appointed a committee to look at our policies for Life and Honorary nominations and voting. The purpose of the review is to put in writing how it is done and to fill in gaps that are needed.

AARC Life and Honorary Memberships

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

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

YEAR	LIFE	*HONORARY*
2003	Margaret F. Traband J. Michael Thompson	Cheryl A. West
2004	David C. Shelledy Karen J. Stewart	Patricia A. Lee
2005	Janet Boehm Richard Branson	Jill Eicher
2006	John Hiser Lucy Kester	Marsha Cathcart
2007	Doug MacIntyre Joseph L. Rau	Kent Christopher
2008	Susan Rinaldo Gallo Michael W. Runge	John W. Walsh
2009	Vijay M. Deshpande	Dale L. Griffiths
2010	William H Dubbs Toni Rodriguez	None awarded
2011	Patricia A. Doorley	Foster M. “Duke” Johns III
2012	Richard M. Ford Timothy R. Myers	Miriam A. O’Day
2013	Linda Van Scoder	Kathy Blackmon
2014	Debra J. Fox	Edna Fiore

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 Jakki Grimball – Spring 2015

Recommendations

That, as per policies FM.002 and FM.018 and having served the AARC for several years in good standing with complete, accurate, and acceptable results, continue to retain the services of Salmon Sims Thomas & Associates, LLC for independent auditing services.

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

Report

The Audit Sub-Committee met via phone conference on Wednesday, April 1, 2015 to review the findings of the Auditor, Salmon Sims Thomas & Associates, LLC.

The auditors and the Committee members introduced themselves prior to the audit review. The auditors and the Committee reviewed the consolidated financial statements and independent auditors report for fiscal years 2013 and 2014 and found the records to be in compliance with general accepted accounting principles for the United States.

The auditor's report provided details of assets and liabilities as well as each statement included in the report. They were very complementary of the quality of the AARC financial statements. 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. The decrease in membership revenue was discussed. Tony pointed out approximately 70% of members are now digital which led to the drop in revenue. However, it was pointed out the increase in digital membership led to a decreased in expenses for the cost of postage and printing. The auditor's report included no recommendations for change or improvement.

There was discussion about Grants income and expenses which started in 2013. Explanation of each grant was provided. Grants income and expenses are starting to level off.

Other

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 John Wilgis and Deb Skees who helped me understand my role in this process as I am a new member of the committee.

Members: Karen Schell (KS), Curt Merriman (MN), John Walton (IL) and Jakki Grimball (SC)
Liaisons: Tony Lovio (TX).

Bylaws Committee

Submitted by: Troy Whittaker - Spring 2015

Recommendations

- That the AARC Board of Directors accept and approve the Indiana Society for Respiratory Care Bylaws. (see attachment "bylaws-indiana-aarc…..")

- That the AARC Board of Directors accept and approve the Pennsylvania Society for Respiratory Care Bylaws. (see attachment "2014 PSRC…..")

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article II, Section 1.

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

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article III, Section 7(a).

b. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. A seat on the Board of Directors, up to a maximum of six seats, were granted to those Specialty Sections ~~consisting of at least~~ with a minimum of 1000 active members as defined in the policies and procedures of the Association ~~to be considered for a seat on the Board~~.

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article IV, Section 1(b).

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

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article IV, Section 4(c and d).

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

d. Vice President for External Affairs – The Vice President for External Affairs shall serve as a liaison to ~~the sponsors of the Association and to other organizations and associations with which the Association has a relationship~~ committees and groups as designated by the President, and perform such other duties as shall be assigned by the President or the Board of Directors.

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

c. The executive government of the Association shall be vested in a board of ~~at least~~ no more than ~~seventeen~~ eighteen (~~17~~ 18) Active Members consisting of at least five (5) Officers, ~~at least six~~ and twelve (~~6~~ 12) Directors-at-Large, and/or ~~a~~ Section Chairs serving as a Director from ~~each~~ Specialty Sections ~~of at least~~ with a minimum of 1000 active members of the Association ~~to be~~ that were considered for a seat on the Board of Directors as defined in the policies and procedures of the Association. So as long as the number of Section Chairs serving as Directors is at least six (6), the number of at-Large Directors shall be equal to the number of Section Chairs serving as Directors. If the number of Sections Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of

d. ~~seventeen~~ twelve (~~17~~ 12) ~~members~~ Directors on ~~of~~ the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the President's Council and the Chair of the Board of Medical Advisors shall serve as non-voting members. Directors shall be elected in accordance with the provisions of Article XII, Section 2 (b).

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

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article VIII, Section 3 (b)

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

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article VIII, Section 4

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

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article XI, Section 4

~~**SECTION 4. INTERNATIONAL AFFILIATE DUTIES**~~

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

- That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article XII, Section 2 (b) items 1&2

3. The committee shall be composed of five (5) Active Members; three (3) elected by the House of Delegates and ~~two~~ <u>one (1)</u> elected by the Board of Directors <u>and the seated Past President</u>. The Chair shall be selected by the House of Delegates.

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

Report

Both the Indiana and Pennsylvania Societies Bylaws changes meet the established criteria and were approved as drafted and submitted by those affiliates.

The Ad Hoc Committee requested a conference call with the Bylaws Committee to discuss their proposed changes to the AARC Bylaws. Subsequently, our two committees had a conference call on March 11, 2015. After discussing the proposed changes, some edits were made to those initial recommended changes. The final draft was revised and resubmitted by the Ad hoc Committee on March 13, 2015 and were subsequently approved by the Bylaws Committee.

Throughout this review and approval process, the AARC Bylaws Committee has considered the implications of all Bylaws changes to both the respective Affiliates and the AARC and has determined that these changes are appropriate and are not in conflict. Potential conflicts with affiliates Bylaws changes were considered and were determined to be consistent with the AARC Bylaws and established requirements. Otherwise, these changes would not have been approved by the AARC Bylaws Committee and would not have been recommended to the AARC Board of Directors for approval. In addition to our collaborative review, the Ad hoc Committee has consulted legal counsel regarding their recommended changes.

Analysis is currently underway to determine which other state affiliates Bylaws are due for review this year. Once that list is compiled, each of those affiliates will be contacted and informed.

Other

I would like to than the AARC Bylaws Committee members for their input and involvement in this process.

Elections Committee

Submitted by: Jim Lanoha - Spring 2015

Recommendation

None

Report

On behalf of the AARC Elections Committee, I am pleased to present the slate of candidates for the 2015 election.

President-Elect:
Brian Walsh
Sheri Tooley

Director-at-Large:
John Lindsey
Raymond Pisani
Carl Hinkson
Thomas Malinowski
Doug McIntyre
Debra Skees
Gary Wickman
Pattie Stefans

Sleep Chair:
Marilyn Barclay
Jessica Schweller

Home Care Chair:
Zachary Gantt
Debra Schuessler

Neonatal/Pediatrics Chair:
Steve Sittig
Bradley Kuch

I would like to thank the members of the Committee for their hard work and diligence in considering this year's nominees. Committee members include Mary Roth, Dan Rowley, John Hiser and George Gaebler. I would like to give special thanks to Tim Myers, Sherry Milligan and Beth Binkley at the Executive office for their guidance and assistance

Executive Committee

Submitted by: Frank Salvatore - Spring 2015

Executive Committee Actions Needing Board Ratification:

1. **The AARC BOD ratifies the Executive Committee vote consenting to the CoARC Accreditation Standards for Advanced Practice Programs in Respiratory Care**.
    a. Justification – due to the time sensitive nature of the CoARC approval request, it was decided to have the Executive Committee review and decide on the action to take regarding the standards. The Executive Committee found the standards to be acceptable and voted to Consent to the Standards. Per the AARC by-laws the Board must ratify this action at the next meeting.

Executive Committee Action – Notification Only:

1. **The Executive Committee voted to approve funding for AARC Executive Office building repairs**.
    a. Although the Board must ratify this action, we're moving it to the finance committee report/recommendations. This is just notification that the vote originated with the executive committee. *NO ACTION REQUIRED UNDER THIS REPORT*.

Objective:

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

Survey Proposals Reviewed:

1. Cappiello Survey – 2/12/15 – Approved
2. Rojas Survey – 2/25/15 – Not Approved
3. Miller Survey – 2/27/15 – Approved
4. Seal Survey – 3/3/15 – Approved
5. Wiles Survey – 3/3/15 – Approved
6. Knigge Survey – 3/16/15 – Approved
7. Chatburn Survey – 3/30/15 - Approved

Notes:

1. The Executive Committee will meet on Thursday, April 23, 2015 in Dallas to review the agenda and prepare for the Board Meeting.

Finance Committee Report

Verbal report

Judicial Committee

Submitted by Anthony Dewitt – Spring 2015

Recommendations

None

Report

- During this reporting period only one case has been referred to the committee. Unfortunately, because the matter had not run its course at the hospital where the events took place, the committee chair was unable to continue dialogue with the reporter.
- The Committee Chair is an attorney, and an attorney has an ethical duty not to have “ex parte” communications with a represented party. There is no hospital I know of that does not have counsel. The reporting individual did not have clearance from her hospital counsel to talk to me.
- I asked her to get that clearance and come back to me when she had the consent of the hospital’s attorney.
- To do otherwise would place the reporter at risk for discipline by her facility.

I will continue to monitor email traffic for a case that requires a hearing.

Program Committee

Submitted by Ira Cheifetz – Spring 2015

Recommendations

None

Report

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

Status: The committee met in Dallas on Jan. 29 – Feb. 1, 2015 to review in excess of 800 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 2014 meeting in Las Vegas, the length of presentations will remain at 35 minutes. The committee would like to express our gratitude to all the individuals (and groups) who 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. An active search is underway for locations for 2016 and beyond. A recommendation for site selection will likely be forthcoming shortly after the 2015 AARC Spring BOD Meeting, and voting may be requested via eVote. The next open year for Congress is 2018. The Executive Office is currently evaluating destinations for this meeting, and a recommendation for this meeting will likely be brought to the BOD later in the year.

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 that 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. In addition, Dr. Strickland made a point of keeping the Program Committee abreast of the amount of content by "content category" during the meeting. This was especially helpful to ensure that we offer a well-balanced program that includes sufficient content (i.e., CRCE) in the various content categories for re-credentialing.

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 and hot topics as well as reviewing membership feedback from previous meetings. As a result of these conversations, several changes will be made to AARC Congress 2015, including, but not limited to marketing the meeting, programming, exhibitors, and exhibit hall.

5. Misc.

- During the meeting, a video tutorial was created by Mr. Garry Kauffman for those who will be moderating sessions at future AARC meetings. It was widely discussed that there was minimal education and expectations provided to moderators creating inconsistencies from moderator to moderator.
- As such, a "how to" video was created with tips and recommendations on how to serve as a professional moderator.
- The Program Committee discussed at length member's response to rejected proposals and the "rejection letter" they receive. As such, a 60-second video message was created by the entire committee to better communicate the message and better explain why proposals might be rejected. A link to this video was included with each rejection letter.
- Crystal Maldonado created a video tutorial for AARC members (and others) on best practices in submitting AARC Congress/Summer Forum lecture proposals. Many times, proposals are rejected because of poorly written submissions. This video is designed to better explain the submission process, provide members a better understanding of the process, and maximize their chance for acceptance. This video will be used to educate members during the 2016 Call for Proposals.

Strategic Planning Committee

Submitted by George Gaebler – Spring 2015

Verbal report

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Spring 2015

Recommendations

That the Board explore methods to support respiratory care practitioner formed research groups, such as CARTER (**C**onsortium to **A**dvance **R**espiratory **T**herapy through **E**xcellence in **R**esearch).

(See below report for details about CARTER)

- That a committee is appointed to develop strategies to help develop and support groups like CARTER.
- That the development of a "fund" or "endowment" be considered. This endowment could potentially receive monies from corporate partners and then these monies could be applied for by groups like CARTER to help support their research efforts. These funds could be used to fund many aspects of research projects including:

    - FTE's to help provide for protected time to researchers
    - Equipment
    - Administrative support
    - Statistical analysis support

- We (CARTER) believe that these efforts fit nicely within the spirit of Objective #3 of the **AARC's Strategic Plan listed below.**

Objective 3
Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.

Description
Demonstrate the value of the respiratory therapist in providing respiratory care by supporting, conducting, and publishing research information. Research should compare the value of the respiratory therapist to others who may provide respiratory care services. Information generated should consider the needs of employers, legislators, regulators, other health professionals, and patients. Research efforts will, when appropriate and possible, be conducted in collaboration with other health care stakeholders.

Strategies
1. Financially support research that seeks to advance the science and practice of respiratory care provided across all care sites.

2. Publish scientific information that advances the science and practice of respiratory care.

3. Work collaboratively with other health professions to conduct research to demonstrate the value of allied health professionals.

4. Demonstrate the effectiveness of the respiratory therapist in health promotion and disease prevention.

Report

The Adult Acute Care Section members continue to be active in all areas of Acute and Critical Care.

The Section continues to:

- Publish a quarterly bulletin with quality articles written by new authors
- Publish a Monthly News letter
- Monthly Image and Discussion
- Monthly Journal Club Article and Discussion
- Monthly Case Report and Discussion

Four of the acute care section members have developed a consortium between their medical centers and have named it **CARTER. C**onsortium to **A**dvance **R**espiratory **T**herapy through **E**xcellence in **R**esearch.

The group consists of:

- Iowa Methodist Medical Center (Des Moines - Keith Lamb)
- Harborview Medical Center (Seattle – Carl Hinkson)
- Rush University Medical Center (Chicago – Brady Scott)
- University of Virginia Medical Center (Charlottesville – Dan Rowley)

This group, which represents several adult critical care centers across the country, has come together in an effort to develop a research infrastructure to conduct respiratory care research. This consortium has a long term goal of creating a sustainable program for training new respiratory care researchers and conducting quality research.

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Spring 2015

No report submitted as of April 13th.

Diagnostics Section

Submitted by Katrina Hynes – Spring 2015

Recommendations

None

Report

2015 Diagnostic Section Charges

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the deadline in Jan 2015.
    a. *47 lecture proposals were submitted by the Diagnostic Specialty Section membership for this year's conference. The Section Chair provided feedback to Thomas Lamphere, AARC Program Committee, by rating the lecture topic relevance and quality of the speaker to assist in the selection process. Any specific lecture requests made by the Section membership during the 2014 Diagnostic Section Annual Meeting held at the AARC International Congress were communicated.*

2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings. Documentation of such a meeting shall be reported in the April 2015 Board Report.
    a. *Section Bulletin – the 2015 Spring Bulletin has been completed and is awaiting publication. Quarterly Bulletin deadlines: Winter Issue: December 1; Spring Issue: March 1; Summer Issue: June 1; Fall Issue: September 1.*
    b. *Section Specific web cast/chat – continued efforts are being made by the Section Chair to identify a topic and lecturer. Any progress made or outcomes will be reported to the Board of Directors in the second quarter report.*
    c. *1-2 web-based Section meetings – further investigation and communication is being made by the Chair with the AARC to better understand the expectations of this charge as well as the resources to be utilized. Any progress made or outcomes will be reported to the Board of Directors in the second quarter report.*

3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
    a. *As a manager of the Mayo Clinic Pulmonary Function Laboratory, the largest Pulmonary Function Laboratory in the world, I routinely receive numerous calls regarding best practice and standard operating procedures. During these communications I take advantage of the opportunity to promote and advocate the value of the AARC membership as a tool to share knowledge, professional growth and development, and keep abreast of up-to-date technology, standards and guidelines.*
    b. *As a team, the Section Chair and Bulletin Editor are relentless in seeking out new talents through AARConnect List Serve interactions, or via warm-chatter during the International Congress, to author quarterly Section Bulletin articles. These efforts*

engage our membership and encourage future professional interactions.

4. Identify, cultivate, and mentor new section leadership.
    a. *Professional growth and development is a high priority of the Diagnostic Section. Motivated and driven members are identified via electronic or interpersonal interactions within professional settings. As the Chair, I meet with individuals to discuss their professional experience and aspirations and establish goals to aid them in becoming more active within the AARC organization and/or Diagnostic Section; getting their name out there into the Respiratory Care community and sharing their knowledge.*
    b. *Contribution to the Section Bulletin is strongly encouraged by all members and mentorship is provided by the Chair and Bulletin Editor as support.*
    c. *It is important to the Diagnostic Section to have a strong presence at the Annual International Congress, therefore up-and-coming leaders in the field are sought out and encouraged to submit RFPs. As the Chair, I give guidance on potential lecture topics, how to compose a lecture power point and encouragement to inexperienced speakers who aspire to stand at the podium.*

5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section's web page and provide timely responses to requests for information from AARC members.
    a. *Professional communication and follow-up is ongoing.*
    b. *Refinement of information on the Diagnostic Section web page is addressed as an "action item" at the bottom of this report.*

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2015 Board Report and updated for each Board report.
    a. *The review of all material posted in the AARC Connect library and swap shops will be reviewed annually and reported in the 1st quarter Board of Directors Report. For 2015, the review will occur in the 2nd quarter and be reported in the 2nd quarter Board of Directors Report.*

7. Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendations as to what should be done with that section.
    a. *No recommendations are being made at this time.*

Other

Section Bulletin Revision:

1. Within the Section Bulletin body, "Notes from the Editor" has been replaced with "Technologist's Comments" by Mr. Jeffrey Haynes as an avenue to offer insight, observations and opinions. It encourages inter-professional communication and knowledge sharing of the Section membership.

Action Item:

1. Upon review of the resources and links provided on the Diagnostic Section web page, major errors/updates were identified. The following will be updated by the Chair and communicated to the appropriate AARC personnel for upload to the site: About the Chair, Diagnostic Section Resource List, Online Resources (URLs). The update will be reported in the 2nd quarter Board of Directors Report.

Diagnostic Professionals Representation:

1. Mr. Carl Mottram RRT FAARC, Director of the Pulmonary Function Laboratories and Associate Professor of Medicine at the Mayo Clinic was elected as Treasurer and Executive Committee Member of the Board for the Clinical and Laboratory Standards Institute.
2. Mr. Jack Wanger MS RRT, Independent Consult continues to serve on the ATS Pulmonary Function Standards Committee and is currently working on their updated guideline on Bronchoprovocation Testing.

Education Section

Submitted by Ellen Becker– Spring 2015

Recommendations

None

Report

At the December Education Section Meeting at AARC Congress 2014, Drager gave away 5 ventilators. The recipients were:

- Western Technical College-Wisconsin (Lynn Lenz)
- University of Arkansas for Medical Sciences (Erna Boone)
- Grossmont College-California (Peggy Wells)
- Highline College-Washington (Michele Pedicone)
- The Ohio State University (Georgianna Sergakis)

An Education Book Club was implemented as an alternative to the quarterly bulletin for the Education Section as a mechanism to improve value. Less than 10% of the membership downloaded the bulletins and the average viewing time of the bulletins was 45 seconds. The Book Club was initiated by Gayle Carr which started the week of March 2, 2015. Ten additional members volunteered to be chapter leaders. The volunteers came from clinical and academic (associate and baccalaureate degree) backgrounds. One member was someone who had not posted frequently in the education section previously. After an Education Section member expressed concerns about the frequent postings, the Book Club was moved to a separate community.

An Education Section Spring Meeting was held via webinar on March 31, 2015. The content of the meeting addressed the concerns members expressed through a survey. The meeting resources were shared with the section members who could not attend through weblinks for both the presentation and the archived webcast.

Proposals for 127 Education Section programs were reviewed for the 2015 Summer Forum and International Congress. The selected topics related to themes educators addressed in the survey sent prior to the Spring Education Section Meeting as well as frequent postings on the listserve.

Education Section membership has 1107 members.

The Electronic Swap Shop and AARC Connect Library will have contents reviewed according to the following schedule:

- May: Engage section membership in updating topics for the Electronic Swap Shop
- June/July: Solicit volunteers to conduct the review for the Swap Shop and AARC Connect library online and at Summer Forum
- August: Complete reviews

Other

Conduct an evaluation of the value of the Education Section Book Club as an alternative to producing quarterly bulletins.

Reach out to respiratory care program directors/directors of clinical education who are not represented in the Education Section membership.

Home Care Section

Submitted by Kim Wiles – Spring 2015

Recommendations

None

Report

1. Home Care Competency Survey Completed

2. Results will be shared with BOD once results are assimilated

3. Conference call meeting will be scheduled with Homecare membership to discuss results and next steps in homecare competencies

4. Worked closely with Dr. Christopher and Dr. Carlin on homecare lecture submissions for Congress 2015

5. Two homecare related articles in AARC times

6. Pelican trial launch-tentative launch 3.30.15. Recruiting membership to help with recruitment

7. Recruitment of 2 members to run for section chair elect

8. The hot topic for our section members is non-invasive ventilation. Section members seeking guidance on non-invasive ventilation in the home (i.e. CPG). I have had members contact me as well as some discussions on Connect.

Long Term Care

Submitted by Lorraine Bertuola – Spring 2015

No report submitted as of April 13th.

Management Section

Submitted by: Cheryl Hoerr – Spring 2015

Recommendations

None

Report

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

   Status: More than 120 individual proposals were submitted for the management section. Cheryl Hoerr, Management Section Chair, collaborated closely with Garry Kauffman, Program Committee Management Section Liaison, to evaluate the merits of each proposal and its appropriateness in addressing current healthcare management issues. The program for the Summer Forum has been finalized. The program for the International Respiratory Congress is currently in draft form.

2. Produce four section bulletins, at least one Section-Specific thematic web cast/chat, and 1-2 web-based section meetings.

   Status: The winter bulletin was published on schedule and the spring bulletin is ready and will be released on schedule. A management-themed webcast entitled "Benchmarking and Productivity" is scheduled for April 30th; Tim Myers will be the presenter. A web-based meeting with the management section membership is in the process of being scheduled for early May.

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

   Status: The management section meeting at the International Respiratory Congress in Vegas was extremely well-attended. Discussed challenges facing RT and emphasized the value of the group as a resource during this time of healthcare upheaval. Collaborated closely with Garry Kauffman to ensure timely, insightful topics are on the management agenda for the Summer Forum in Phoenix; the spring newsletter "Notes From the Chair" is focused on emphasizing the value of attendance to managers.

4. Identify, cultivate, and mentor new section leadership

   Status: New attendee introduced herself to Garry Kauffman and I at last SF; she will be management section speaker at this year's Summer Forum. Unfortunately no action has been taken on this charge to date. Would appreciate advice/input from other experienced Board members as to what activities and initiatives would be effective.

5. Enhance communication with and from section membership through list serve, review and refine information for section web page, provide timely responses to requests for information from AARC members.

   Status: Daily review of management section list serve postings and reply as necessary. Have received one request to post a survey; collaborated with Shawna Strickland to determine what

information was required and awaiting further information from survey author. Sam Giordano made a couple of suggestions for postings: calling membership attention to the Feb 2015 RC Journal research study on TDPs and encouraging members to participate in the associated JournalCast on Feb 27; and posting the latest FDA recommendations on Reprocessing Medical Devices. Additional postings included: new ICD-10 coding information related to CPAP/BiPAP documentation and billing, a clarification of the NCCI edit for billing 94640, and an open invitation to all management specialty section members to join the latest Leadership Book Club discussion on Essentialism by Greg McKeown. Based on the number of emails received asking for instructions on how to join the book club we should have picked up at least a dozen new participants. On average there have been 44 conversational threads posted in each of the past four months on the management list serve; the volume was slowest in December and picked up after the New Year. Hot topics included: department dress code, removal of simple O2 masks from clinical areas, TJC, Oxymask, code team structure, protocol orders, O2 cylinder segregation, and nebulizer billing.

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2015 Board Report and updated for each Board report.
   Status: There are currently 664 documents in the Management Specialty Library. Review of ½ of these materials will be complete by July BOD meeting. The second ½ of the review will be completed prior to the November BOD meeting.

7. Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendation as to what should be done with that section
   Status: There are currently 1648 total management specialty section members, of which 1608 are active members. No action necessary for this charge for management specialty section as of this posting.

Other

1. Review and update the SWAP SHOP so that resources are current and reflect recent changes in CPG and Standards. The process will be conducted by the review committee and will conclude with a "new call" for resources posting.
   Status: Reference #6 above.

Neonatal-Pediatrics Section

Submitted by Natalie Napolitano – Spring 2015

Recommendations

None

Report

2016 Congress: Solicited topics through the section and make submissions as requested by the section. I worked with the program committee in grading submitted topics. Began reminding people about abstract submission deadline and offered mentorship for those that would like it. Have a group of individuals willing to be mentors when requests come in so that I am not the only one doing it this year for the section.

Newsletters - put together another newsletter and working with co-editors and a few new members that want to write for the newsletter and become more involved with the section.

Exploring the possibility of a NPS prep course with Shawna as the NPS exam has the lowest pass rate and is one of the oldest specialty exams. The section discussion at the meeting at the congress was that the reduction in neo/peds education in programs is making it harder for people to pass this exam. We are also seeing this in new grad coming to work with children as we have to completely teach them in orientation. This course could be used not only for the exam but also for those who individual to become better neo/peds practitioners.

Sleep Section

Spring 2015

No chairperson

Surface to Air Transport Section

Submitted by Billy Hutchison – Spring 2015

No report submitted as of April 13th.

Special Committee Reports

Benchmarking Committee

Submitted by: Chuck Menders – Spring 2015

Recommendations

None

Report

1. Tom Berlin, Garry Kauffman and Bill Cohagen were added as new members to the benchmarking committee.

2. Geographic regions were redefined and assigned and regional client support has continued by all members of the team to assist new clients and follow up with subscribers.

3. Created a marketing promotional tool for subscriber inquiries.

4. Various elements of AARC Benchmarking software have been identified as needing updating. Committee members have been assigned and continues to work on defining what these needs are, including:

    - 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 and simplify the department profile to allow for quicker data entry.
    - Develop of a benchmarking survey to query members about quality indicators that would add value to the system.

5. User list reports containing user demographics and subscription expiration dates have once again been made available for the committee.

6. Membership in AARC Benchmarking has declined from 80 as of June 1, 2014 to 50 on March 30, 2015, despite a new pricing structure to make the program more affordable for both current and new subscribers.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Spring 2015

Recommendations

None

Report

I continue to monitor the Coding list serve and address the charges assigned.

I am happy to report that there has not been any major controversies or major changes in reimbursement that have caused concern this past quarter.

Federal Government Affairs Committee

Submitted by John Lindsey – Spring 2015

Recommendations

None

Report

One of the on-going goals of the AARC Federal Government Affairs Committee is to "Assist in Coordination of Consumer Supporters".

New Objectives may include:

1. Find ways to resurrect the AARC 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts.
2. Assist the State Societies with legislative and regulatory challenges and opportunities as these arise.
3. Work with PACT coordinators and the HOD to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care.
4. Oversee the virtual lobby week and/or any calls to action that come up over the year.
5. Assign committee members specific states to act as liaisons toward and ensure the members communicate with their liaison state during active committee work periods.

The 17th annual AARC/State Society 2015 DC Hill Lobby Day was held on Wednesday, March 18, 2015 with 144 RT PACT representatives from 44 states and DC met with their House of Representative Members and Senators to discuss support for the Medicare Telehealth Parity legislation that we anticipate will be reintroduced soon. Through the efforts of the AARC via Virtual Lobby Week, efforts from the State Society Leadership and PACT reps, and the Members of this Committee we had nearly 19,500 total Advocacy Messages sent to Congress asking for support of the Parity bill. Of course, we need to keep the momentum going and aim to achieve at least 25,000 messages sent over the next few months. As AARC President Frank Salvatore says, we need to advocate 365 days a year for our profession.

This Committee is also been kept informed of state legislative developments of interest to the RT profession, especially those that impact RT state licensure.

Fellowship Committee

Submitted by: Patrick Dunne – Spring 2015

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 2015 Fellow is Friday, August 28. 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 2015

Recommendations

None

Report

1. Coordinate market and administer the International Fellowship Program.

We are in the process of gearing up for this year. The web site and the online application have been updated. A call for applicants has been posted on the international fellows list serve, the city host list serve, the HOD/Presidents and the BOD list serves, *AARCTimes* and the web site.

2. Collaborate with the Program Committee and the International Respiratory Care Council to plan and present the International functions of the Congress.

The committee continues to work with the ICRC to help coordinate and help prepare the presentations given by the fellows to the council.

3. Strengthen AARC Fellow Alumni connections through communications and targeted activities.

We continue to work on improving communication and on targeted activities.

4. Coordinate and serve as clearinghouse for all international activities and requests.

We continue to receive requests for assistance with educational programs, seminars, educational materials, requests for information and help with promoting respiratory care in other areas of the world.

5. Continue collegial interaction with existing International Affiliates to increase our international visibility and partnerships.

We continue to correspond with other medical associations, societies and practitioners.

I want to thank April Lynch for all of her hard work. I also want to thank the members of the committee.

Vice Chairs
Dan Rowley, MS, RRT-ACCS, NPS, RPFT, FAARC, Vice Chair for International Fellows
Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations

Committee members:
Michael Amato, MBA
Arzu Ari, PhD, RRT, FAARC
John Davies, RRT, MA, RRT, FAARC
ViJay Desphande, MS, RRT, FAARC
Hector Leon Garza, MD, FAARC
Derek Glinsman, RRT
Yvonne Lamme, MHA, RRT
Debra Lierl, MEd, RRT, FAARC
Camden McLaughlin, RRT, BS, FAARC
Natalie Napolitano, MPH, RRT-NPS, FAARC
Bruce Rubin, MD, FAARC
Michael Runge, BS, RRT
Jerome Sullivan, PhD, RRT, FAARC
Daniel Van Hise, RRT, NPS

Membership Committee

Submitted by Gary Wickman – Spring 2015

Recommendation

None

Report

Objectives

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

Report

<u>New Projects</u>

The following programs were launched by the Executive Office with the support of the Membership Committee:

1. Student early recruitment program
    a. We have launched a new program to recruit students into active membership. From 6 months to 3 months prior to graduation, a student can become an active member for $70 for a 2-year membership. From 3 months prior to graduation until graduation a student can become a member for $90 for a 2-year membership. From graduation until1 month post-graduation a student can become an active member for $70 for a 1-year membership. This was communicated to all student members via email and to the Program Directors. To date we have had about 300 new active members, about 10% of the total graduating classes for May, June and July. We will continue to use this tool to recruit students to active members. The Membership committee members are communicating with the Affiliates to ensure this is marketed to all students. The potential is very good. We have about 7,000 student members.
2. Senior member program
    a. The Senior Member program was also launched this spring. When an active member reaches age 65, they will have the opportunity to renew for $25 per year or $200 for lifetime membership. The benefits are limited, they can get some of the free or reduced CRCEs but the AARC will not track these CRCEs for the member. Also,

some of the educational offerings, those from the AARC University, will need to be paid at the nonmember rate. All other benefits of active membership are available. The thought is that most people over 65 will be retired and do not need the CRCEs, but that is not a necessity to get this benefit. This far 31 members have taken advantage of this program.

3. Lapsed member program
    a. This is a "Win back program". This is a new, refreshed campaign to win back lapsed members. We have focused on people who have been lapsed between 3 and 6 months. We were able to recruit 6% of that group back to active membership. We then focused on people who had been lapsed between 7 to 24 months. We were able to recruit back 3% of those people. To date we have brought back 600 members in the last 2 months.
4. Auto renewal program
    a. This will be a program to offer auto renewal much like Netflix or Amazon. People will be able to be auto renewed each year as long as they want to do that. The Executive Office is working through the security to be able to offer this benefit. This should be active later this year.

Data Review

We have been stuck at 39,000 to 40,000 active members for the past couple of years. We ended 2014 at 40,000 active members about 1,500 members less than when we started this campaign. We continue to lose about 100 to 150 senior members per month. Retention rate for 2013 was about 81% and it is 76% for 2014. We did increase our new members in 2014 by over 9,000, which was slightly more than in 2013.

Next Steps

President Salvatore gave us a 2-year goal to reach 50,000 active members. The committee met in March to review the new programs, the data, and develop a plan for next steps. We are gathering more data around total number of educational programs, the number of those programs that are utilizing the free student member benefit. We also want to review the conversion rate of those free student members versus those student members who paid for their membership.

The following are ideas to engage the profession in this campaign:

1. We are scheduling a teleconference for the Charted Affiliate Presidents, Membership Chairs, educational Program Directors and Directors of Clinical Education to review the current data, the new programs that are available to recruit members, and to also go over Best Practices from affiliates who have been successful.
2. We will also review Best Practices from educational programs that do a great job engaging their students in the ARC. This could be by requiring the students to go to the AARC web site for a class project. We will also require students who have the free memberships to log in at the web site to activate their memberships. The goal of this is to market the value of the AARC to potential new active members.
3. We will also continue the "Visit Project". We will focus on educational programs and students while continuing to meet with RCPs in a hospital setting. We still believe that a grass roots effort is needed for this campaign.
4. Other ideas include continuing to hold special forums at the state and local conferences for student members. To continue the mentoring programs in the HOD and the state boards for students.

5. Meet with Affiliate Presidents and Membership Chairs at the Summer Forums and International Congresses in the future to help keep them engaged on this campaign.

There was a lot of discussion and ideas to renew and re-energize this campaign. The Membership Committee will continue to meet every other month to keep the energy and momentum going. We will also stay engaged on AARC Connect in between those meetings. The Chair will also meet individually with all of the members of the committee to ensure that they still will be engaged in this program. We know that achieving President Salvatore's goal is attainable and we are in this campaign for the long haul. The future of our profession is dependent on membership.

Other

I would like to thank the members of my committee and the Executive Office for their help with this campaign.

Position Statement Committee

Submitted by Colleen Schabacker – Spring 2015

Recommendations

Recommendation #1:
Approve and publish the revised Position Statement "Ethics and Professional Conduct". This paper is submitted for your review as attachment #1. Text to be added appears in RED.

Justification: The Board did review revisions at the last December 2014 meeting and the revisions were approved. However, it was brought to my attention the draft of revisions I submitted in that report was the wrong draft and didn't include all revisions. The attached draft is the one approved by the committee and was worked on by members of the HOD.

Recommendation #2:
Approve and publish the Position Statement "Licensure of Respiratory Care Personnel" with no revisions. This paper is submitted for your review as attachment #2.

Justification: It was determined this position statement remains pertinent to the profession.

Recommendation: #3:
Approve and publish the Position Statement "AARC Statement of Continuing Education" with no revisions. This paper is submitted for your review as attachment #3.

Justification: It was determined this position statement remains pertinent to the profession.

Recommendation #4:
Be it resolved the AARC develop and publish a new Position Statement regarding respiratory therapists inserting and maintaining arterial lines.

Justification: Numerous hospitals allow respiratory therapists to insert and maintain arterial lines, however the AARC does not currently have a position on this invasive procedure. For those hospitals not currently performing this procedure look to the AARC for guidance in the form of a Position Statement.

Recommendation #5:
Be it resolved the AARC develop and publish a new Position Statement regarding respiratory therapists inserting and maintaining vascular lines.

Justification: Hospitals in some states allow respiratory therapists to insert and maintain vascular lines, however the AARC does not currently have a position on this invasive procedure. Some states are looking to revise their licensure rules to allow therapists to perform this procedure and they are looking to the AARC for guidance in the form of a Position Statement.

Report

Objectives:

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.

Ongoing

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

Review, revise or delete current AARC Position statements in a more frequent schedule when the science/technology changes dictate (i.e. E-cigarette position statement and continuous changes to regulation and clinical research

Ongoing

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

This schedule has been updated and is attached to this report.

Other Info:

A sincere thank you to the members of this committee for their input: Kathleen Deakins, Deryl Gulliford Linda Van Scoder, Tony Ruppert and Karen Stewart.

Attachment #1

AARC Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapists shall:

☐Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.

☐Promote and practice evidence-based medicine.

☐Seek continuing education opportunities to improve and maintain their professional competence and document their participation accurately.

☐Perform only those procedures or functions in which they are individually competent and which are within their scope of accepted and responsible practice.

☐Respect and protect the legal and personal rights of patients, including the right to privacy, informed consent, and refusal of treatment.

☐Divulge no protected information regarding any patient or family unless disclosure is required for the responsible performance of duty as authorized by the patient and/or family, or required by law.

☐Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.

☐Promote disease prevention and wellness.

☐Refuse to participate in illegal or unethical acts.

☐Refuse to conceal, and will report, the illegal, unethical, fraudulent, or incompetent acts of others.

☐Follow sound scientific procedures and ethical principles in research.

☐Comply with state or federal laws which govern and relate to their practice.

☐Avoid any form of conduct that is fraudulent or creates a conflict of interest, and shall follow the principles of ethical business behavior.

☐Promote health care delivery through improvement of the access, efficacy, and cost of patient care.

☐Encourage and promote appropriate stewardship of resources.

☐Work to achieve and maintain respectful, functional, beneficial relationships and communication with all health professionals. It is the position of the American Association of Respiratory Care that there is no place in a professional practice environment for lateral violence and bullying among respiratory therapists or between healthcare professionals.

Effective 12/94
Revised 12/07
Revised 07/09
Revised 07/12

Attachment #2

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

Position Statement

Licensure of Respiratory Care Personnel

The American Association for Respiratory Care staunchly supports the non-restrictive licensing of respiratory therapists at all levels within the defined scope of practice as a means of protecting the public's health, safety, and welfare by mandating a minimal level of competency in respiratory care modalities. Respiratory Care licensure is not intended to limit, preclude or otherwise interfere with the practice of other persons who are formally trained and licensed and who have documented equivalent competency.

Effective 03/90
Revised 03/00
Revised 12/06
Revised 07/09
Revised 04/12

Attachment #3

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

Position Statement

AARC Statement of Continuing Education

It is critical for all health care practitioners to participate in continuing education in order to enhance their knowledge, improve their clinical practice and meet state licensure and national credentialing requirements. Participation in continuing education, whether mandatory or voluntary, offers the potential to be one of the most powerful tools to ensure safe, efficient, and quality patient care. The American Association for Respiratory Care (AARC) recognizes the value of, and need for, participation in continuing education and recommends that practitioners participate in educational activities on a continual basis. AARC members may utilize the Continuing Respiratory Care Education (CRCE) system as the mechanism for recognition and documentation of such activities. The AARC encourages Respiratory Therapists who have completed the required entry level education to pursue baccalaureate and graduate degrees relevant to their professional pursuits.

The AARC encourages Respiratory Therapists to select continuing education activities relevant to their personal and professional needs. Providers of continuing education activities (which can include clinical institutions, educational institutions, public and private associations or organizations, and proprietary corporations) are encouraged to conduct needs assessments in order to design and develop valuable educational activities that will enable practitioners to meet their professional goals. In addition, providers of continuing education are encouraged to review, evaluate and measure their activities' effectiveness. Providers are also urged to use instructional technology, incorporate multiple learning styles, current research-based learning and assessment theories, and foster critical thinking to promote effective learning.

Effective 1990
Revised: 2000
Revised: 2005
Revised: 2012

Position Statement Review Schedule

Originally Proposed: 02/20/2007
Last Update: 03/2015

Statement Title	Original Statement Date	Most Recent Review/ Revision	Schedule Review 2015	Schedule Review 2016	Schedule Review 2017	Schedule Review 2018
AARC Statement of Ethics and Professional Conduct	1994	2014	X			X
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2007	X			X
Competency Requirements for the Provision of Respiratory Services	1998	2014			X	
Continuing Education	1990	2012	X			X
Cultural Diversity	1994	2013		X		
Definition of Respiratory Care	1987	2014			X	
Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	2009	2013		X		
Hazardous Materials Exposure	2002	2013		X		
Health Promotion and Disease Prevention	1985	2014			X	
Home Respiratory Care Services	2000	2013		X		
Inhaled Medication Administration Schedules	2008	2014			X	
Licensure of Respiratory Care Personnel	1990	2012	X			
Pre-Hospital Mechanical Ventilator Competency	2007	20014			X	
Pulmonary Rehabilitation	1973	2014			X	
Respiratory Care Scope of Practice	1987	2013		X		
Respiratory Therapists Education	1998	2012	X			X
Respiratory Therapist as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2013		X		

Statement Title	Original Statement Date	Most Recent Review/ Revision	Schedule Review For 2015	Schedule Review For 2016	Schedule Review For 2017	Schedule Review for 2018
Respiratory Therapy Protocols	2001	2013		X		
Telehealth	2001	2013		X		
Tobacco and Health	1991	2014			X	
Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child, or Adult Patient	2009	2012	X			
Best Practices in Respiratory Care Productivity and Staffing	2012	2012	X			
Verbal Orders	1990	2014			X	
Development of Baccalaureate and Graduate Education Degrees	2013	2013		X		
Electronic Cigarette	2014	2014	X			

State Government Affairs Committee

Submitted by: Raymond Pisani - Spring 2015

Recommendation

None

Report

Federal and State Government Affairs Committee have been combined with John Lindsey Co-Chair of Federal and Raymond Pisani Co-Chair of State.

Objectives:

1. Find ways to resurrect the AARC 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts.
2. Assist the State Societies with legislative and regulatory challenges and opportunities as these arise.
3. Work with PACT coordinators and the HOD to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care.
4. Oversee the virtual lobby week and/or any calls to action that come up over the year.
5. Assign committee members specific states to act as liaisons toward and ensure the members communicate with their liaison state during active committee work periods.

Ongoing Objectives:

1. Assist in coordination of consumer supporters.

The Government Affairs Committee worked closely with AARC President Frank Salvatore, Committee Co-Chair John Lindsey, the AARC Executive Office including Cheryl West, PACT Representatives, State Affiliate leadership and many others to make the 17th annual AARC/State Society DC Hill Advocacy Day a success. The issue is to gain Congressional support for the Medicare Telehealth Parity Legislation. Virtual Lobby Week achieved over 19,000 messages sent to Congressmen/Senators in Washington D.C. prior to PACT reps coming to DC. More activity will occur over next couple of months and throughout the year on advocating this important legislation.

Government Affairs Committee has been kept up to date of all State Legislation involving RT Profession. There are several states (2015-IL, NM, CO, and 2016 HI) that face RT licensure law sunset. It is important to note that every state society understands that the days of simple licensure extensions are over. Each of the above states have organized a very coordinated response and provided the policymakers with extensive rationale and documentation as to why RT licensure must be continued.

Virtual Museum Committee

Submitted by: Trudy Watson- Spring 2015

Recommendation

None

Report

The Virtual Museum Committee is working on the development of several new galleries to add to the Virtual Museum during this calendar year.

I have discussed ideas with Tom Kallstrom to request vintage photos from the AARC's corporate sponsors to enhance our current galleries and add content to future galleries. We have also sent out requests for photos through the specialty sections.

The Executive Office is currently in the process of developing access for me to the staging museum so content can be added and edited prior to going live with the galleries.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Spring 2015

Recommendations

None

Report

AMA/CPT Meeting, February 2015

The February meeting agenda was packed full of code proposals, 93 in all. Many of these were lab codes and genomic sequencing codes. Laboratory is doing a total revision of their code sets.

Codes related to Respiratory Care were Arterial Pressure Waveform Analysis and Moderate sedation.

9300X1 Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive

Moderate sedation codes were revised and now include the duration of the procedure and patient's age group. Twelve codes were approved. Below are a few examples:

Moderate Sedation

10-22 minutes for < 5years of age

10-22 minutes for 5 years and older

23-37 minutes for the same age group

38-52 minutes for the same age groups

If moderate sedation is less than 10 minutes it is not separately reportable.

Actions taken at this meeting will not be active until January 2016 and should not be published to the general membership.

There was also a code proposal for a Venous Electrode Insertion and Revision Replacement for Sleep Apnea. This was withdrawn.

The AMA Executive committee announced that it is looking into adherence of the "Guidelines for Medical Specialty Societies Coding". I suspect that we will hear about this at the October meeting.

Attendance at this meeting was so high that a second room was opened. Attendees in this room viewed the meeting via video. Many of these attendees were consultants and representatives from industry. AMA/CPT meetings are open to the public, although they pay a registration fee.

New Codes for 2015

Below is a review of some codes that were new January 2015. These are published in the *cpt* Professional Edition 2015.
ECMO/ECLS

A family of new ECMO/ECLS codes was activated in January 2015. The AMA recognized that ECMO has evolved from its original use for neonates to treatment of numerous cardiac and respiratory conditions for patients of all ages. Many medical specialties are involved in the care of ECMO/ECSL patients. There are two different methods of ECMO. One method is veno-arterial (VA) ECMO, which will support the heart and the lungs and requires the insertion of two cannulas which are –one in a large vein and the other in a large artery. The other method is Veno-venous (VV) ECMO. VV ECMO is used to support the lungs and requires one or two cannula(e) which are placed in the vein.

Prior to this revision there were only two ECMO codes:

33960 – Prolonged extracorporeal circulation for Cardiopulmonary insufficiency, initial day, and 33961- subsequent day

The above codes were deleted and replaced by:

33946- ECMO/ ECLS provided by a physician, initiation, veno-venous

33947 – initiation, veno-arterial

33948- daily management, each day, veno-venous and

33949 – daily management, each day, veno-arterial

Respiratory Care departments that provide ECMO can use codes 33948 and 33949. However, these cannot be reported on the same day as 33946 and 33947 are reported. I was happy to see that Respiratory Therapists were mentioned as one of the nonphysician groups who provide "long periods of constant attention" to patients on ECMO/ECLS.

In addition, ECMO/ECLS codes 33951 -33989 were activated. These are related to insertion, reposition, and removal of various ECMO cannulas.

Care Management Services

The title "Complex Chronic Care Coordination" Evaluation and Management Services codes have been changed to "Chronic Management Services". This family of codes was created to recognize and encourage physician practices to provide non- face to face follow up with their patients. The objectives are to increase patient compliance, provide patient education, maintain a plan of care, and therefore reduce office visits and readmissions. Respiratory Therapists are in a group referred to as "clinical staff" and can provide these services under the direction of a physician or other qualified health professionals.

99490 – Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: (too numerous to mention here)

99487 – Complex chronic care management services, with the following required elements:

* Patient has multiple (two or more) chronic conditions …..

* 60 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month

* Many more…

99489 – Each additional 30 minutes of clinical time……

Thank you for the opportunity to serve as your representative!

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors - Spring 2015

No report submitted as of April 13th.

American Heart Association

Submitted by Brian Walsh – Spring 2015

Recommendations

That Keith Lamb replace Brian Walsh as AARC Liaison to the AHA.

Justification: As the AHA prepares to publish the 2015 Guidelines, it the best opportunity for another liaison to step in and begin the process of developing the 2020 Guidelines. I have done this for 7 years and respectfully would like to resign and allow someone else to participate.

Report

Summary:

1. There remains a strong interest within the profession for assisting with the prevention of and quality of inpatient resuscitations, as RTs are part of rapid response and code teams.

2. Presented ILCOR requests for public comment sent by Dr. Montgomery to all list-serves within the AARC. There appeared to be some excitement regarding the request for comment. An educational webcast will be provided to education on the guidelines process. The AHA guidelines will be used as an example to maintain this momentum.

3. The program committee has blocked 2 lecture spots for updates to the new guideline updates at our International Congress in Tampa, Florida – November 7-10th.

American Society for Testing and Materials

Submitted by Thomas Kallstrom – Spring 2015

Nothing to report

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Spring 2015

Recommendations

None

Report

I have remained in contact with and support those chartered affiliates with whom I have worked over the past 5 years to provide ongoing assistance to their business planning and operations. These include New York, Pennsylvania, Virginia, West Virginia, Kansas, Indiana, George, Iowa, New Jersey, and Washington State.

I was asked to facilitate a strategic and operational planning session with the KCRS leadership, which I did January 23-24th. The outcome of that engagement resulted in a revised mission statement, new operating principles, and a new operating plan that addresses three strategic goals and focused initiatives to guide operational improvement.

I was requested to provide these services for the Utah Society, and will be working with their leadership team April 9th and 10th. I will report the outcomes of this engagement in the next report. I have also been requested by AARC CEO and AARC President to discuss these services with the Utah Society leadership. I conducted a conference call with their President and board leadership and have scheduled a strategic and operational planning session with them in June. As above, I'll report on this engagement in the next report.

I appreciate the support of the AARC leadership, AARC Executive Office, and the Chartered affiliate leadership, all of whom demonstrate the dedication and passion to make these efforts both rewarding and successful.

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Spring 2015

Recommendations

None

Report

The CAMTS board is scheduled to meet April 16 thru the 18th with the executive board meeting the evening of the 15th. Work continues on the 10th edition of the CAMTS standards as well as the levels of care. The two remaining meetings for 2015 are scheduled for July in Seattle and October in Long Beach prior to the Air Medical Conference.

Extracorporeal Life Support Organization

Submitted by Donna Taylor – Spring 2015

Recommendations

None

Report

I just recently attended the 31st Annual CNMC Symposium: ECMO and Advanced Therapies for Respiratory Failure meeting in Keystone, Colorado. During the Steering Committee meeting, changes in ELSO's structure were discussed. After several years of such discussions, ELSO is now an incorporated nonprofit that will allow continued growth and development to better meet the ECMO community's needs. It is an exciting time for ECMO growth. Due to the interest and growth of both pediatric and adult ECMO, educational demand is high. A joint ECMO course with the Society of Critical Care Medicine was completed in January with plans for other collaborative education programs with other societies. ELSO is developing additional programs besides the ELSO training courses to meet these demands. An online educational module was approved for piloting. The bylaws of the new ELSO Inc. were reviewed and conditionally approved during this meeting. The ELSO guidelines are being revised and updated, providing a current reference for ECMO candidate selection and management posted on the ELSO website. With the last Steering committee meeting voting bylaws were changed to allow all members voting privileges. I now have the opportunity to vote on important issues for ELSO with the bedside ECMO Specialists interests taken into consideration. Globally ELSO is expanding with chapters reporting in growth and successful training courses recently in Brazil, Mexico and Chile. During my time allotted during the meeting I was able to discuss the calls and emails I receive routinely about incorporating respiratory therapists into ECMO programs and present the value that they can add. The perfusion liaison also echoed my comments encouraging use of respiratory therapists. Perfusionists often are being inundated with adult ECMO cases and struggling to staff this therapy in their institution.

My own institution hosted an ECMO course in March drawing attendees from many parts of the United States. For this course, two ELSO Steering Committee members were invited to speak and participate in the course. One of the speakers was Dr. Heidi Dalton- a noted leader in pediatric critical care and ECMO. I thought the Board would be interested in hearing that Dr. Dalton had recently attended an AARC meeting. During the meeting she witnessed the Sputum Bowl contest.

She was so impressed that for the ELSO course in Atlanta in September, she is creating an ECLS version of this event. I was asked to assist in the development of a contest like the AARC's for ECLS specialists. I certainly will be contacting the experts at the AARC for resources and advice!

International Council for Respiratory Care

Submitted by Jerome Sullivan – Spring 2015

Recommendations

None

Report

I. Japanese Respiratory Care Seminars Part of International Exchange Program: January 2015, Professor Lonny Ashworth, Boise State University, Boise, Idaho USA presented a series of Mechanical Ventilation Seminars in Japan as part of the International Exchange Visit Program for Respiratory Care Professionals (IEVPRCP). The prestigious IEVPRCP was initiated in 1998 by Dr. Toshihiko Koga prior to his untimely passing in 2004. Through the leadership of Dr. Kazunao Watanabe and Dr. Norihiro Kaneko, the workshops continue in their tradition of excellence to provide contemporary respiratory care instruction to health care providers throughout Japan.

The Seminar format included lecture/demonstrations and hands-on workshops emphasizing instruction in the "Mechanical Ventilation of the Adult Patient". The length of the programs ranged from one day for the Basic course, and two-three days in length for the more advanced course. The programs were offered in multiple locations throughout Japan to differing audiences of physicians, nurses, clinical engineers, physical therapists and other co-medical personnel. Venues included; St. Luke's International Hospital, Tokyo, Kameda Medical Center, Kamogawa, Sakaide City Hospital, Sakaide, Kobe City Medical Center, Kobe City, Shonan General Hospital, Ofuna and Tokyo Bay Urayasu Ichikawa Medical Center, Urayasu.

Professor Ashworth reported "the seminars were a great success and very beneficial for the participants, but even more so because in the true spirit of the International Exchange Program, learning was mutual and my team and I learned much in exchange from our Japanese colleagues".

II. International Education Recognition System (IERS): Demand for International Respiratory Educational seminars and programs continue to grow. Since the Annual Meeting in Las Vegas five programs have been approved two more are under review. Of note one of the programs under review is the renewal of the approval of the RC Bachelor Degree Program at Prince Sultan Military College of Health Sciences in AlKhobar, Saudi Arabia. Requests for IERS approval have been received this year from the following:

Istanbul, Turkey	December 2014 - approved
Tokyo, Japan	January 2015 - approved
Dammam, Saudi Arabia	April 2015 – approved
Jeddah, Saudi Arabia	April 2015 – approved
Jeddah, Saudi Arabia	May 2015 – approved
Gemikonagi, Cyprus	June 2015 – under review
AlKhobar, Saudi Arabia	BS Re-approval 2015 - under review

III. ICRC Elects New Governors: The following individuals were unanimously elected to the Council at the Business Meeting in Las Vegas.

Simone Gambazza, PT IRCCS Ca Grande, Milano, Italy - Governor
Lysbeth Roldan Valencia, RT Professor Autonoma Americas University, Medellin, Columbia - Governor
Vijay Desphande, MS, RRT, FAARC Visiting Professor Manipal University, Manipal, India – Governor
Chad Gibbs, BSRC, RRT Pulmonary Diagnostics & Respiratory Therapy, University of Virginia – Council President Assistant

IV. Fundamental Respiratory Care Support Course (FRCSC): The development of the FRCSC continues and the ICRC has gratefully acknowledged the financial contributions made by Teleflex and by Kameda Medical Center to support this project. Currently 25 Lesson Plans for lecture/demonstrations and Skill Stations have been developed in draft form. The purpose of the FRCSC is to provide a standardized fundamental respiratory therapy training program outside of the United States for health care providers. The FRCSC will be based on best practice standards and will be offered following identification of need and upon written invitation by the requesting entity. The course is intended to enhance the care of respiratory patients around the world by training individuals to properly and safely provide respiratory therapy procedures. Attached please find a copy of the presentation made to the AARC Board of Directors. (at the December 2014 meeting). See attachment “AARC BOD FRCSC Dec 2014 Presentation”.

Joint Commission - Ambulatory PTAC

Spring 2015

Currently no representative.

Joint Commission - Home Care PTAC

Submitted by Kim Wiles – Spring 2015

Recommendations

None

Report

A conference call was held on March 3, 2015.

1. Joan Doyle is the new "at large" homecare representative on the Joint Commission board.

2. Integrated Care Certification Program-voluntary certification reviews how well an organization handles information sharing, including hand-offs, IT integration and other integration points with healthcare providers. Currently involves hospitals or critical access hospitals that are integrating with a physician practice(s) network or an accredited ambulatory organization that is integrating with a hospital or critical access hospital. The focus of the program is to provide a pathway for these settings to demonstrate that they can unite to deliver clinically integrated care, treatment, and services with the common goal of improving patient outcomes. This will also be expanded to include home care providers. It is currently in the pilot phase.

3. The Joint Commission is currently in the exploratory phase of a Palliative Care Certification that expands into the home care setting.

Joint Commission - Lab PTAC

Submitted by Darnetta Clinkscale– Spring 2015

Darnetta Clinkscale was named AARC representative in early April, no report to submit at this time.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Spring 2015

Recommendations

None

Report

There have been no meetings or communication from the NAEPP since the last report.

Neonatal Resuscitation Program

Submitted by John Gallagher – Spring 2015

Recommendations

None

Report

The Neonatal Resuscitation Program's Steering Committee (NRPSC) has been actively making the final edits to the 7th edition of the NRP Textbook. These edits reflect updates in literature related to resuscitation science and an overall restructuring of the textbook format. The time commitment for the project has been considerable and has been conducted through face-to-face meetings, web-based meetings, conference calls, emails, and independent work. The result is an update to the NRP guidelines which will be published in Pediatrics in October of 2015 and a revised textbook which will be available in April of 2016.

The most recent meeting of the NRPSC was held in Elk Grove, Illinois at the headquarters of the American Academy of Pediatrics on March 2-4, 2015. The focus was textbook revision, instructor development, and strategic planning. An update of AARC news was provided as part of my liaison report.

The next planned NRPSC meeting is in Washington, D.C. on October 23-25, 2015. The annual NRP Current Issues seminar will also take place at this time and location.

Roundtable Reports

	ROUNDTABLES	Chair	Staff Liaison	BOD
37	Patient Safety	S. Sittig/K. McQueen	T. Kallstrom	B. Lamb
38	Simulation	J. Perretta	T. Kallstrom	S. Tooley
39	Disaster Response	C. Friderici	S. Strickland	L. Goodfellow
40	Neurorespiratory	L. Rowland/G. Faulkner	T. Kallstrom	C. Hoerr
41	Tobacco Free Lifestyle	J. Waugh	S. Strickland	K. Wiles
42	Asthma Disease	N. Napolitano	T. Kallstrom	TBD
43	OPEN			
44	Intl Med Mission	M. Davis	S. Nelson	K. Schell
45	Military	H. Roman/J. Buhain	T. Kallstrom	D. Skees
46	Research	J. Davies	D. Laher	E. Becker
47	Informatics	TBD	S. Nelson	G. Wickman
48	Geriatric	M. Hart	S. Nelson	G. Gaebler
49	Palliative Care	H. Sorenson	S. Strickland	C. Hoerr

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Spring 2015

Recommendation

That the AARC continue with the program of Developing and Mentoring AARC members with the purpose of increasing the Diversity of the BOD and HOD.

Justification: The Mentoring Program was not listed as one of the charges of the committee. This program should be continued because of its positive impact on many AARC Members.

The program has given members of culture a chance to attend the HOD to get a firsthand look at the great work the leadership does for the AARC.

The program has started to generate a great deal of buzz with members. At the Congress last year, several members approached me and other committee members about attending the Fall Meeting. Joel Brown from New Jersey asked to attend the House of Delegate Meeting in Tampa to see what happens at the Leadership Level. Mikki Thompson and I have also talked to Vernon Pertelle about attending the meeting.

This process has introduced many members to the AARC House of Delegate and AARC Board of Directors. They were able to network with the House Members and communicate their thoughts by going to the Mic to participate in the HOD process.

This was a charge given to the Committee by Past President Tim Myers. President Myers wanted to start a Mentoring Program to increase the diversity of the Board. As you all know becoming a member of the Board of Directors take many years.

Finding and mentoring diverse members of the AARC is also a process which will take many years to bring more member of diversity to the leadership level of the AARC. The most important thing is that the members know that the AARC is actively taking the lead to bring more diverse member into the leadership of the AARC.

Report

Charge: Survey State Affiliate Boards, AARC House of Delegates and the AARC Board of Directors to determine the level of diversity. Report to the AARC Board of Directors and House of Delegates at the July 2015 meetings in Phoenix, AZ the level of diversity in each area.

Status: The Committee will develop a questionnaire to survey the State Affiliates Boards, AARC House of Delegate, AARC Board of Director and the Executive Office to determine the level of diversity in the AARC

The Committee will collect the Data and Report the Data to the Level of Diversity to the AARC's Board of Directors and the House of Delegates at the Summer Meeting

The Committee will work with the Executive Office to complete the Charges.
In process

Charge: Develop a program that can be used by the state affiliates and AARC Board to bring diversity in the leadership of the profession.

Status: The Committee will review Data collected from the Survey to Assess the Level of Diversity in the AARC and Develop a Program that can be used by the State Affiliates and AARC Board of Directors.
In process

Charge: Research and compile a comprehensive list of related links and resources on cultural diversity in health care for inclusion on the AARC web site to include but not limited to:
• Info related to specific cultural groups
• Workforce diversity
• Linguistic/communication competence
• Disparities in healthcare
• Case studies in cultural competence
• Cultural Competence

Status: The Committee will collect a list of Resources on Cultural Diversity in health care for inclusion on the AARC's Web Site. The list will be reviewed by the Committee for its accuracy before submission to the AARC.
In process

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 RTs and Disease Management

Submitted by Becky Anderson – Spring 2015

No report submitted as of April 13th.

Ad Hoc Committee on Revisions to AARC Bylaws

Submitted by Mike Runge – Spring 2015

Recommendations

None

Report

The following is a list of the Ad Hoc Committee's Recommendations that have been forwarded to the AARC Bylaws Committee for their action. These recommendations are for your review and are not intended to be acted upon as part of this report.

Recommendation 1:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article II, Section 1.

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

Recommendation 2:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:
Article III, Section 7(a).

c. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. A seat on the Board of Directors, up to a maximum of six seats, were granted to those Specialty Sections ~~consisting of at least~~ with a minimum of 1000 active members as defined in the policies and procedures of the Association ~~to be considered for a seat on the Board~~."

Recommendation 3:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:
Article IV, Section 1(b).

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

Recommendation 4:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article IV, Section 4(c and d).

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

d. Vice President for External Affairs – The Vice President for External Affairs shall serve as a liaison to ~~the sponsors of the Association and to other organizations and associations with which the Association has a relationship~~ committees and groups as designated by the President, and perform such other duties as shall be assigned by the President or the Board of Directors."

Recommendation 5:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

e. The executive government of the Association shall be vested in a board of ~~at least~~ no more than ~~seventeen~~ eighteen (~~17~~ 18) Active Members consisting of at least five (5) Officers, ~~at least six~~ and twelve (~~6~~ 12) Directors-at-Large, and/or ~~a~~ Section Chairs serving as a Director from ~~each~~ Specialty Sections ~~of at least~~ with a minimum of 1000 active members of the Association ~~to be~~ that were considered for a seat on the Board of Directors as defined in the policies and procedures of the Association. So as long as the number of Section Chairs serving as Directors is at least six (6), the number of at-Large Directors shall be equal to the number of Section Chairs serving as Directors. If the number of Sections Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of

f. ~~seventeen~~ twelve (~~17~~ 12) ~~members~~ Directors on ~~of~~ the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the President's Council and the Chair of the Board of Medical Advisors shall serve as non-voting members. Directors shall be elected in accordance with the provisions of Article XII, Section 2 (b).

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

Recommendation 6:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article VIII, Section 3 (b)

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

Recommendation 7:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly:

Article VIII, Section 4

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

Recommendation 8:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":

Article XI, Section 4

~~**SECTION 4. INTERNATIONAL AFFILIATE DUTIES**~~

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

Recommendation 9:

"That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":

Article XII, Section 2 (b) items 1&2

5. The committee shall be composed of five (5) Active Members; three (3) elected by the House of Delegates and ~~two~~ one (1) elected by the Board of Directors and the seated Past President. The Chair shall be selected by the House of Delegates.

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

Conclusion:

At this time, I would like to thank the following committee members on their work and expediting this project: Lori Shoman, Karen Schell, Doug McIntyre, and even Tim Myers!

Thank you!

Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education

Spring 2015

Ratifying goals and members at this Board meeting.

State Government Affairs Activity Report

BOD April 2015
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 clear which bills will actually move through the legislative process to become law.

As a result of the November 2014 elections the make-up of the state legislatures are as follows:

31Republican-controlled legislatures

11Democrat-controlled legislatures

8 Split legislatures

Of those noted above, in 24 states there is both a Republican controlled legislature and a Republican Governor. In 7 states there is a Democrat holding the Office of Governor working with a Democrat controlled legislature.

Because nearly 60% of all state governments are controlled entirely by one party or the other, expect legislation and proposed policies to be quickly enacted with reduced impact from the opposing party.

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 18 professions including RT. As noted previously, it will require the Michigan legislature to enact any de-licensing law. The November 2014 elections brought many new MI legislators, who appear to support de-regulation thus that is still a possibility for many professions, again including RT. Therefore, RT is not off the de-licensing table however as this Report is written no legislation has been introduced. The MSRC has a lobbying firm closely monitoring any potential negative legislation and the MSRC leadership and RTs in MI are ready to respond if it appears that de-licensing appears on the 2015 legislative agenda.

Texas Licensure Repeal Efforts

As you know, the focused efforts by the Texas Society aided by the strong support from the AARC were successful in having the TX Sunset Commission reject a Staff Report recommendation to repeal RT licensure. Indeed, the final decision by the Commissioners was to recommend that RT licensure continue and that it be placed under the umbrella of the TX Medical Board and that a separate RT Licensure Committee be created -which has never existed. This was the first and most critical battle to be won. The next step in this process is that these recommendations must be passed by the state

legislature as a law. In early January a bill was introduced (by a legislator who is a Sunset Commissioner and was active in advocating for RT licensure) is the first step in re-organizing regulatory agencies to accommodate the RT (and other professions) move to a different governing entity. An additional bill introduced in early March actually makes the "changeover" and creates an RT Licensure Advisory Board under the TX Medical Board. Regardless of this positive legislation, the TX RTs are taking nothing for granted and had a State Capitol Hill Day in mid-January, as well as continuing to come to Austin to lock down assurances from legislators that the bills continue on track.

Colorado RT Licensure Sunset

The Colorado State Society was well prepared to provide information and documentation to the state licensing agency that was tasked to review the necessity of continuation of RT licensure in the state, aka Sunset. The Final Report issued in the fall of 2014, strongly came out in support for RT licensure continuation. The process has now moved to the legislature where SB 105, the bill to continue RT licensure has already passed one House and is expected to pass the other. The CSRC has reached out to CO RTs requesting they contact their legislators urging passage. The CSRC has also been participating in all the preliminary legislative committee hearings in order to make sure that the nothing derails the bill that will keep the RT licensure law in place.

Illinois RT Licensure Sunset

The Illinois Respiratory Care Licensure law is also up for Sunset review in 2015. The ISRC continues to be proactive in making sure legislators clearly understand the importance of keeping mandatory licensure. The ISRC has been using their website and social media to rally the RTs in the state to contact their local legislators and press upon them the importance of RT licensure. A bill to continue IL RT licensure was introduced and is working its way through the legislature.

Hawaii RT Licensure Sunset

Although not due for sunset consideration until 2016, Hawaii's Professional and Vocational Licensing Division (PVLD) is wasting no time is doing preliminary work to assess whether RT licensure should be recommended for continuation. The HI Society met with regulators in early February to review the profession and how "well" licensure is being implemented and serving its purpose of protecting the health and safety of the public. The PVLD also submitted a very lengthy survey to AARC seeking its opinion on our assessment for the need to license the profession on a national level.

New Mexico RT Licensure Sunset

The NM Society has also been working with the Legislature to pass legislation to extend RT Licensure until 2021. The RT provisions are included in a catch all bill that includes 10 other professions up for Sunset. As this report is submitted, passing of the legislation to extend RT licensure appears on track. Nevertheless the NM Society is asking RTs in the state to send in letters of support, not taking any chances.

California-as part of the CA RC Society's state legislative 2015 agenda a bill has been introduced that among other provisions would expand the RTs scope of practice by permitting RTs to provide conscious sedation under direct supervision and with training, Moreover the bill would expand the CA RTs scope of practice to include providing care to patients with "deficiencies and abnormalities affecting the heart and cardiovascular system". Please note the standard state licensure RT scope of practice says "*cardiorespiratory*" but not *heart and cardiovascular*.

North Carolina for several years now the society has been advocating a legislative change to the RT licensure law that would require the RRT as the only credential accepted for licensure application. The bill also provides that the provisional i.e. the temporary license can be issued for those with the CRT credential (good for 1 year and can be renewed with specific Bd. approval up to a max of 5 years). There is a grandfather clause for those with the CRT only. The grandfather clause expires October 1, 2016. The bill seems likely to pass.

Massachusetts Respiratory Care License Board and CPAP Regulations
The MA RC Licensure regulations are very clear in the requirement that if CPAP/BiPAP devices are delivered to the home and fitted/adjusted to a patient that this must be done by a licensed respiratory therapist. Home care companies in the state have requested that the current rules be revised and be made less stringent by permitting non licensed, but trained personnel to provide the delivery and set up. The MA RC Licensure Board sent out a survey questionnaire to a wide audience requesting input on a potential change to the current requirements. AARC was specifically requested to answer the survey which we did in detail.

Arizona- a bill supported by the ASRC to repeal the temporary license provision in the law.

Virginia enacted a technical cleanup bill for several professions. RT removed the term respiratory *care* and replaced it with *therapist*.

Telehealth/Medicine Legislation

Because the AARC's federal legislative agenda is now focused on telehealth or telemedicine bill, we are scrutinizing state legislation more closely regarding these areas.

Connecticut has a bill that would expand Medicaid coverage of telemonitoring of patients by home health agencies.

Florida has legislation permitting EMTs to provide telemedicine services.

New York has a bill that expands who may provide telehealth services, does not include RTs, but does include certified asthma educators.

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.

North Dakota has a bill that would help with student loans, the list of eligible professionals included RTs.

Legislation of Interest

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

Indiana

Two very similar bills were introduced in the Indiana House of Representatives. The bills are concerning, (and are being monitored by the IN Society) especially upon more intense analysis. Briefly, the bill would permit outside organizations to petition the Licensure Agency of Indiana to be designated, in essence, as a private regulating entity for individual disciplines. The private organization would be required to show proof to the IN Agency that it had the ability to provide testing, and continuing education, a scope of practice all leading to individuals receiving certification to practice from the private entity. If the criteria were met the state then would "accredit" the outside private entity as offering certification. Individuals within a discipline or occupation would go through the "accredited" entity, be issued a certification that would now be accepted by IN in order to provide services as set forth in the scope of practice as determined by the "accredited entity. While this might be useful for disciplines in non-health related fields, those that are involved in providing clinical services to IN citizens this change is another matter.

An entity could simply create its own scope of practice which the IN Agency might not have the expertise to dissect the components to determine if there is any overreach.

An entity applying to be an accreditor would state it has a competency exam for the discipline. However the key point would be has that exam been deemed valid and reliable by an outside exam accrediting agency?

There is a provision that states this new path would not impact currently licensed professions. A good provision. *However,* given the climate in many states to scrutinize and attempt to roll back licensure including RT (in IN in 2012) I see a slippery slope. If this bill becomes law it is not a stretch of the imagination to envision IN policymakers taking aim at certain currently licensed professions and transferring regulatory duties over to private, albeit, 'accredited" entities. The IN Society has issued its opposition to this bill.

West Virginia- a similar bill to Indiana's was also introduced again the purpose is to consolidate various stand-alone licensing boards, including RT into one state agency. The WVSRC, along with every other professional licensing board is opposing the legislation.

Pennsylvania- has an interesting and extensive bill that is directed at fees on gas wells. However, a final provision focused on air quality and a requirement that research has to be performed to determine the impact this bill has on hospital and emergency room respiratory admissions.

Expansion of Scope of Practice Other Professions

As noted in previous Reports over the last 3 years there has been an increase in the number of bills that expand the scope of practice for a variety of licensed or regulated professions or disciplines, specifically nurse practitioners and physician assistants. Also noted in previous reports, this increase may be due in part to 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 due to shortages or for budgetary purposes. Therefore there is a move towards legally permitting less costly personnel to provide clinical services previously only provided by more 'expensive' clinicians.

Community Paramedics/EMTs

While the focus of this expansion has been on legislation to increase the autonomy and authority of NPs and PAs, this year there has been a noticeable increase in the number of bills that expand the concept of "community paramedic" or in the case of **Minnesota**, which already enacted a community paramedic bill, expands on the law with a bill that would now include advanced EMTs in the concept.

Nebraska has a bill to create the community paramedic permitting this cohort to provide patient monitoring and education for the chronic patient in the non-acute care setting. The Nebraska Society requested the AARC's assistance in reviewing a letter (in opposition) to the bill.

North Dakota has a bill that appears to expand the current law for community paramedics and permit reimbursement for their services. Of note it also appears that current law for this community "provider" isn't limited to paramedics, but includes EMTs and advanced EMTs.

Washington State also appears to have a similar expansion for the non-emergent services of paramedics, although it is less direct in its language. A bill provision states "emergency medical services to develop community assistance referral and education services programs."

Polysomnography

New Hampshire- provisions were included in the original and long standing RT licensure law permitting the RT Licensure Board to regulate the practice of polysomnography. For many years the RT Bd. did not write any specific rules for polysom presumably because there were so few practicing this discipline in the state. In recent years the RT licensure Board has attempted to write regulations, which were opposed by the Sleep Industry. This year a bill has been introduced again presumably by the Sleep Industry that would remove polysoms from regulation by the RT Licensure Board.

Iowa- for the third consecutive year the IA polysoms have introduced a licensure bill. This iteration is somewhat different than in previous bills. For the first time the bill would not create a separate Polysom Licensure Board, but combine into a joint board with the Respiratory Care Board. Of interest, in 2014 the defeat of a far less acceptable polysom licensure bill was assured when the Iowa Hospital Association (IHA) publically opposed the bill very late in the process. However in this session the IHA is far more engaged in this process and is offering amendments to revise the bill to its satisfaction. It would appear that if the IHA amendments are accepted the bill will pass. There is no clear exemption for RTs. With the provision to create a Joint RT Polysom Licensure Board with RTs holding the majority of seats RTs can veto any efforts to impose additional requirements on RTs providing sleep disorder services. The caveat of course is that the RTs on the Board be fully committed to exempting RTs from any further training, testing and licensing.

Georgia- for several years GA has had a complicated pathway for polysoms to provide limited services under the Medical Board. A bill was introduced in March that would repeal this structure and replace it with full licensure. Unlike the process in Iowa the GA Sleep Society and the GA RT Society have worked closely with each other to hammer out provisions that are amenable to both professions. A provision that explicitly exempts RTs is included in the bill.

Oregon a bill that would ease the educational requirements and testing requirements for polysoms to obtain a state license, basically create an OJT pathway to licensure, a pathway that was supposedly closed when the polysom licensure bill was enacted. The OR RT leadership believes this bill has been generated by a large health care provider that wants to hire out of state polysoms. The effort to

re-insert the OJT pathway was first attempted last year by requesting a regulation change. When that effort failed the advocates have now turned to the legislative route. At the request of the OSRC AARC submitted a letter opposing this legislative change.

Maine legislation was introduced to license sleep personnel. The legislation which AARC reviewed and commented on for the ME Society is the now standard template of provisions which we have seen in other states. And because it is the same template, the same flaws are there as well. Most notably in the ME bill there is no explicit RT exemption that would assure RTs that they would not have to obtain a polysom license which would require the RT to pay for additional training, testing, and of course a new licensing fee, all to continue the same services he/she has been providing under their own RT license. *However*, an interesting note is that the Maine Sleep Society was unaware that this particular version of the polysom licensure bill was introduced. The ME Sleep Society's own written version gave the RTs an exemption. ME PACT Rep Keith Siegel met with his counterparts from the ME Sleep Society and they have jointly informed the legislators that revisions of the introduced bill must be amended to both Societies satisfaction. Mr. Siegel also testified at a hearing to emphasize the RTs would support a revised bill that includes an RT exemption.

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

Federal Government Affairs Activity Report
April 2015

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

The Congress

With the Republicans now the majority party in both Houses of Congress the stage has been set for the Obama Administration and Congress to be at loggerheads over numerous policy matters. Factor in the reality that the 2016 Presidential election is well under way and there are the makings for limited legislation to be passed. The one mitigating factor in this is members of Congress are acutely aware that the voters regardless of Party affiliation are highly dissatisfied with the past productivity of Congress to put it mildly. Showing the voters that compromise can be reached and legislation benefiting the American people can be passed may result in more bills being enacted than what "Hill Watchers" are predicting.

As noted in previous reports, AARC and all other advocacy organizations cannot control Congress but we will continue to keep the respiratory profession and the needs of pulmonary patients before Congressional members and their staffs.

Legislation

AARC Legislative Initiative – Medicare Telehealth Parity Act

As noted in the December Report, after assessing the political landscape of the new Congress, AARC leadership decided to turn our 2015 federal legislative agenda to a broader-based bill rather than our previous respiratory therapy-only legislation. Our new path was set when the Medicare Telehealth Parity Act (MTPA) was introduced by Reps. Mike Thompson [D-CA] and Gregg Harper [R-MS] the end of July 2014. Numerous studies recognize telehealth or telemedicine as having the potential to provide cost effective care or management in an alternative manner as well as reduce hospital admissions and readmissions, thus having appeal for both Democrats and Republicans.

The bill expands Medicare coverage of originating sites (i.e., where the beneficiary is located) beyond the current rural professional shortage areas and includes home as a telehealth site. It also adds additional practitioners including respiratory therapists to provide telehealth services within their scope of practice. Moreover, the bill includes coverage of respiratory services and specifically includes COPD as one of the chronic conditions covered under remote patient management services that involve consultations, patient monitoring, patient training, clinical observation, assessment and treatment.

Miriam O'Day has been in contact with Cong. Thompson's staff regularly regarding plans to reintroduce the bill in the 114th Congress. AARC offered some technical changes to make the legislative language consistent and they have incorporated those changes into a revised draft which AARC has reviewed and supports. The bill is expected to be reintroduced by Reps. Thompson and Harper after the Easter Congressional recess.

AARC Capitol Hill Lobby Day

The AARC held its 17th annual Capitol Hill Advocacy Day on March 18th. In addition to 120 respiratory therapists represented by 44 states and the District of Columbia, DC area RT students and patient advocates also joined in to lobby Congress on the importance of the Telehealth Parity bill. Members of the Allergy and Asthma Network and the COPD Foundation also attended our briefing day and supported AARC on Hill Day. The PACT reps scheduled over 300 Hill visits.

Virtual Lobby Week 2015

As we have done in years past, we launched our Virtual Lobby (VL) Week just prior to Hill Day. As you know, VL Week is a critical part of our run-up to Capitol Hill Advocacy Day and is designed to send as many e-mails as possible to the Hill to support our PACT representatives' Hill efforts and our legislative agenda. We had over 19,000 emails from supporters prior to our 2015 Hill Lobby Day.

Other Legislative Initiatives

Family Asthma Act

This bill was introduced by Senators Kristen Gillibrand [D-NY] and Cory Booker [D-NJ] in the last session of Congress and is most likely to be reintroduced sometime during the 114th Congress. It directs the Centers for Disease Control and Prevention (CDC) to expand their collection of information on asthma prevalence and costs, including the number of school and work days missed by patients and parents due to asthma, physician and emergency room visits, and hospitalizations. It also authorizes the National Institutes of Health to award grants for research on factors that worsen asthma and ways to help patients and families prevent and control asthma symptoms.

The Asthma & Allergy Network asked AARC to support this legislation during our March Hill Advocacy Day**.** As noted in the December report, AARC sent letters to both Senate sponsors supporting the legislation and commending them on their recognition that asthma is a widespread chronic, costly disease affecting millions of Americans of all ages.

Ensuring Assess to Clinical Trials of 2015: HR 209 and S 139

This bi-partisan legislation, reintroduced in the 114th Congress in January 2015, allows patients with cystic fibrosis and other rare diseases to participate in and benefit from clinical trials without fear of losing vital benefits. Patients would be able to receive up to $2000 in compensation without it counting towards their income eligibility limits for Supplemental Security Income (SSI) and Medicaid. It would make permanent a law enacted in 2010 and scheduled to sunset in October this year.

The Cystic Fibrosis Foundation asked that we support this bill during our March Hill Day meetings. We provided background information on this bill in the PACT Reps leave-with packets and signed on to a group letter of support.

21st Century Cures Act

This bill is spearheaded by the Chair of the House Energy and Commerce Committee, Fred Upton (R-MI) and Rep. Diana DeGette (D-CO). It has been in the works for the past year and is a multi-faceted, bi-partisan initiative which is still under development. It focuses primarily on accelerating

the discovery, development and delivery of promising new cures for patients. It includes expedited review of breakthrough drugs and devices and enhancement of innovative and biomedical research.

As part of the initiative, there is a telehealth section that gives the Secretary of Health and Human Services authority to develop services to address unmet needs or those that are proven to reduce hospital readmissions as long as the Medicare Chief Actuary certifies that the services will reduce costs or not increase costs. The bill would also promote telehealth as part of bundled payments and demonstration projects.

HR 3306 – Medicare Telehealth Enhancement Act

This bill, sponsored by Rep. Gregg Harper (R-MS), is expected to be reintroduced in the 114th Congress after the Easter recess. Among other things, it would include telehealth and remote patient monitoring services as part of a national pilot program for bundled payments and as supplemental health benefits in Accountable Care Organizations. A similar bill was introduced in the Senate during the last Congress by Senators Thad Cochran [R-MS] and Roger Wicker [R-MS]. It does not contain language that would include respiratory therapists and other health care professionals to be qualified telehealth practitioners.

Telehealth Modernization Act of 2015 – HR 691

This bill was introduced by Rep. Doris Matsui [D-CA] on February 3, 2015 and referred to the House Ways and Means Committee. Rep. Matsui is the only sponsor. The bill calls for a Federal standard for telehealth that would require, among other things, states who have authorized a health care professional to deliver health care to an individual to also authorize that such professional be able to deliver the same care via telehealth. The bill sets out conditions for coverage that states **should** consider and adds definitions of telehealth and health care professionals. With respect to the latter, it would include a physician or practitioner who is authorized under law to deliver such telehealth care in person.

Overview of Various Telehealth Legislative Initiatives

The 21st Century Cures Act appears to be gaining momentum and future drafting is expected to include elements from both the Medicare Telehealth Parity Act and the Telehealth Enhancement Act. The next Cures Act draft to be released for comment in early April is expected to include telehealth language from the Harper "Enhancement" Act that focuses on alternative payment models.

We have been told by Cong. Harper's staff that the ultimate goal is to include RTs and other practitioners in the Cures Act, using the language from the Medicare Telehealth Parity Act. AARC will plan to submit comments to the Committee to support inclusion of RTs and respiratory services in the final draft. We also plan to reach out to other members of the Energy and Commerce Committee who are part of the Telehealth Workgroup to indicate our position as they consider future revisions to the Cures Act and the important role respiratory therapists can play in the telehealth arena in terms of improving patient outcomes and reducing hospital readmissions since it is likely the Medicare Telehealth Parity Act will be incorporated into this initiative.

We will update the Board at the April meeting as we gain further information.

Medicare DMEPOS Competitive Bidding Improvement Act of 2015: HR 284 and S 148

A House bill was circulated in the last Congress and AARC sent a letter of support to its sponsor. The legislation would ban non-binding bids within the competitive bidding program and require providers to prove licensure before they submit bids. Bidders would be required to obtain a bid bond and bonds could be forfeited if the contract is declined at or above the bid price.

The current bi-partisan House and Senate bills were reintroduced in the 114th Congress in January 2015 and voted out of the Ways and Means Committee in late February. The House passed the legislation March 16 and it is now with the Senate Finance Committee, a good sign that there is movement and support. The Congressional Budget Office estimates that enacting HR 284 would increase revenues by about $1 million over the period 2015-2020. Any effect on direct spending would not be significant.

Although there has been no action at the time of this report, we also expect bills to be reintroduced in the 114th Congress that would replace the current competitive bidding program with the Medicare DMEPOS Market Pricing Program and increase the transparency of the Medicare audit process, initiatives that AARC supports.

Medicare Physician Fee Sustainable Growth Rate (SGR) aka "Doc Fix"

As we have reported in past Board updates, the Sustainable Growth Rate (SGR) formula determines the annual payment update to physicians based on the Medicare fee schedule amounts. Legislation to reduce these payments was enacted many years ago but, with the exception of one year, the SGR formula has never been implemented and continues to be postponed. The latest postponement of the rate reduction will expire March 31, 2015. As this Report is written, it is unclear what Congress will do to address the expiring hold on the payment reduction. However, it is assumed Congress will pass another temporary postponement aka the "doc fix" to avoid decreasing physician payments by 21.2% if they can't come to some resolution by the deadline.

In the interim, CMS has notified health care professionals that they must take steps to implement the negative update while at the same time urging Congress to ensure the cuts do not go into effect. Electronic claims are generally not paid sooner than 14 calendar days after receipt and paper claims no sooner than calendar days after receipt.

Regulations and Other Issues of Interest

Regulatory Overview

Physician Fee Schedule and Hospital Outpatient Policies

In our December 2014 report, we notified the Board of changes to the supervision requirements for non-face-to-face transitional care management services and chronic care management services, both of which can now be furnished by clinical staff under the physician's "general supervision", which means the physician does not have to be physically present in the suite. In addition, employment provisions were changed to allow clinical staff to furnish services without having to be a full-time employee of the physician practice. These changes offered additional opportunities for RTs. Last, we provided an update on the payment amount for pulmonary rehabilitation and individual respiratory codes which amounted to a $13.00 increase over the previous year.

Because the proposed annual updates to both the physician fee schedule and hospital outpatient prospective payment regulations don't take place until July each year, there are no updates to these issues at this time. In looking forward, however, it is doubtful we will see any further revisions to the care management services policies that would impact respiratory therapists. At most, there may be further refinements with respect to the chronic care management services policies regarding use of electronic health records. A future update may be available by the Summer Board meeting.

Hospital Inpatient Prospective Payment System (IPPS) and Hospital Readmissions

The proposed annual update to IPPS is generally published in May each year. For the 2015 update, CMS tweaked the readmission measures and related payment methodology to account for additional planned readmissions and revised the calculation of aggregate payments for excess readmissions to include COPD. While there may be further refinements to the Hospital Readmissions Reduction Program in the next update, it is unclear what, if any, impact it will have on the COPD readmissions measure. If applicable, we will report any changes at the Summer Board meeting.

FDA's Proposal to Regulate E-Cigarettes and Other Tobacco Products

As reported in December last year, FDA finally published its proposed rule to "deem" all categories of products that meet the statutory definition of "tobacco product" subject to FDA's regulatory authority, including e-cigarettes and cigars. In submitting comments to FDA, AARC and numerous other organizations that are part of the Tobacco Partners Coalition urged FDA to publish final rules no later than April 25, 2015, which is one year from the date of the proposed rule.

As that date fast approaches, there is no indication that a final rule is imminent. The Campaign for Tobacco Free Kids has launched a petition in an effort to put pressure on the White House and FDA to issue the final rule by that deadline due to the alarming rate of increase in use of e-cigarettes among youth and high school boys smoking cigars at the same rate as cigarettes. AARC has encouraged our members to support this action and sign on to the petition via social media.

Bundling of Certain DME Items under Competitive Bidding

In our last report, we notified the Board that CMS issued a final rule limiting its plans to bundle payments for certain items of DME under competitive bidding to CPAP devices and standard power wheelchairs only. The rationale for this decision is these two categories of items generate the greatest amount of separate payments for accessories and repair compared to other DME items. Decisions regarding whether or not this change in policy will be phased in and when it will be effective have not been announced. We will keep the Board informed as future updates become available.

Rewarding Quality and Value over Volume of Services

As you are aware, CMS has been testing new payment models established by the Affordable Care Cat that are designed to provide better care, smarter spending and healthier individuals. In late January this year, the Secretary of Health and Human Services (HHS) made a historic announcement that set out clear goals and timelines for shifting Medicare payments from volume to value.

The goal is to have 30 percent of traditional, or fee-for-service, Medicare payments tied to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016 and 50 percent of such payments by 2018. Eighty-five percent of traditional payments will be tied to quality or value rather than volume

through programs such as Value-Based Purchasing and the Hospital Readmissions Reduction Program by 2016 and 90 percent by 2018. HHS is also working with private payers, including health plans in the Health Insurance Marketplace and Medicare Advantage plans, as well as Medicaid programs to move in the same direction.

Over time we could see these programs become commonplace which could expand opportunities for respiratory therapists.

Next Generation Accountable Care Organizations (ACO)

On March 11, 2015, CMS announced a new ACO model that encourages greater coordination and closer care relationships between ACO providers and beneficiaries. Plans would take on greater performance risk than ACOs in the current model with the goal of potentially sharing in a greater portion of savings. The new ACO models tie in to the announcement above about rewarding value and quality over volume.

Care coordination and cost saving capabilities would be improved by offering ACOs the opportunity to implement telehealth expansion and post-discharge home visits among other things. Regarding telehealth, the rural component of the originating site requirements would be eliminated and beneficiaries could receive certain telehealth services currently covered from their place of residence.

Between 15 and 20 ACOs are expected to participate. Since ACO models bring together hospitals, physician groups, other health care providers and suppliers to provide high-quality coordinated care, respiratory therapists should have opportunities to be part of this new payment model as well.

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.

ARCF

American Respiratory Care Foundation

Submitted by Michael T. Amato – Spring 2015

Recommendations

None

Report

I am pleased to provide an update on the activities under taken by ARCF since the AARC Board of Directors meeting held last December. The following activities are in addition to day-to-day administration of the extensive array of education recognition awards, fellowships, and grants.

ARCF Fundraising

As you are aware, the ARCF hosted its second annual ARCF Fundraiser Reception "A Night at the Vineyards" during the AARC Congress 2015, which was its first year to have Vapotherm, Inc. as the platinum sponsor. There were over 310 attendees, with representatives from many major AARC and ARCF industry supporters. Representatives from Teleflex were on hand to announce the newly established endowment in Jeri Eiserman's honor, to be awarded for the first time in 2015. Our grand prize for our raffle was a weeklong trip to the Bird Air Lodge donated by Drs. Forrest and Pam Bird, which was awarded to Ani Manougian. Plans are currently underway for an exciting venue for the 2015 reception to be held Friday, November 6, in Tampa, FL. Vapotherm has graciously committed to a $30,000 platinum sponsorship of this year's fundraiser, along with the potential for a multiyear platinum sponsorship commitment.

The Trustees will be holding its annual face-to-face meeting at Phoenix, AZ during AARC Summer Forum. We will be also hosting the second annual fundraising raffle during the Welcome Reception in order to continue in our efforts to create more awareness of our Foundation and its activities. I encourage you to make plans to join us for both of these fundraising events.

Journal Conference

This June 5-6, the ARCF will present the 54th RESPIRATORY CARE Journal Conference entitled "Respiratory Care Controversies III". Conference Co-chairs are Richard Branson, MSc, RRT, FAARC and William Hurford, MD. Solicitation is currently under way for donors and sponsors. This Conference is the third in the controversies series.

ARCF Awards

Solicitation for the 2015 ARCF awards has begun. In the Fellowship awards, there is the addition of the Jeri Eiserman, RRT Professional Education Research Fellowship as well as the reactivation of the Allen & Hansburys/GlaxoSmithKline Fellowship for Asthma Care Management Education Fellowship. Last year was the final awarding year for the Dr. Allen DeVilbiss Literary Award. We look forward to receiving many applications from the most qualified respiratory therapy students. These awards not only help current respiratory students reach their educational goals, but also support current research in respiratory sciences in order to increase practitioner knowledge and improve the quality of life for respiratory patients.

2015 International Fellowship

Solicitation is currently underway for sponsors for the International Fellowship program. We are also currently accepting applications for City Hosts and the Fellowship. Please encourage your international associates to get their applications in before the June 1st deadline. Last year's Fellowship was very successful, with goals to make this year's even better. We would not be able to make this program a success without the support of the International Committee, the Sponsors, the City Hosts, and the AARC Executive Office.

Summary

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 annual face-to-face meeting during Summer Forum this year. I want to thank all of you that gave to the Foundation in 2014 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.

Thank you.

Unfinished Business

Ad Hoc Committee on 2015 & Beyond Recommendations from December 2014:

Recommendation 14-3-32.1 "That the AARC BOD review and discuss the Issue Brief on Clinical Simulation as prepared by sub-committee #2, found under Appendix A of the final AARC 2015 report."

Recommendation 14-3-32.3 "That the AARC BOD review and approve the Clinical Ladder Tool Kit developed by sub-committee #4 found under Appendix D of the AARC 2015 final report."

See Attachments:
"2015 and Beyond Clinical Simulation Issue Brief"
"2015 and Beyond Clinical Ladder Document"

New Business

Policy Review

- FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities
- MP.002 – Membership – Membership Challenge Policy

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Guidelines for the Funding of State Legislative Activities**

EFFECTIVE DATE:

DATE REVIEWED: September 2005

DATE REVISED: September 2005

REFERENCES: FA0486

Policy Statement:

The state society requesting funds must provide the Chair of the AARC Government Affairs Committee (GAC).

Policy Amplification:

1. Requirements of State Societies:

A. The state society requesting funds must provide the Chair of the AARC Government Affairs Committee (GAC) the following:

1) A letter signed by the state society president stating the reason for the request. Requests for funding may be made before the legislative process is initiated, while the legislative process is taking place or after successful passage of the legislative initiative Successful passage, however, will not assure AARC funding.

2) A complete financial statement shall be submitted and shall include the state society's total current assets and liabilities. The current year's budget as approved by the state society's Board of Directors shall also be submitted for review. A financial plan for the requested funds shall also be submitted.

3). A most current draft of the state society's legislation.

4) A written response to include supporting documentary to each statement found in the "Criteria for State Society's Seeking Funding from the AARC for Legislative Initiatives" be submitted under the signatures of the state society's president.

2. Responsibilities of the AARC Government Affairs Committee (GAC)

A. Upon receipt of the state society's request for funding the GAC Chair shall:

1) Distribute the state society's letter of request and supportive information to the members of the GAC who shall:

2). Review the state society's legislation utilizing the AARC Legislation Evaluation Form.

B. Review and evaluate the supportive documentation provided by the state society utilizing the: AARC Funding Recommendation Report".

C. If necessary conduct conference calls with the GAC committee members to discuss the evaluations and generate a consensus option.

D. Request additional information from the state society where it is required.

E. The GAC Chair will tabulate the votes from the committee members, for or against approval. A simple majority carries the vote.

F. Formulate a recommendation for funding and submit the recommendation to the AARC President and Board of Directors.

G. The AARC Board of Directors will have final approval of the grant/loan application and will have the right to determine the final dollar amount to be disbursed.

American Association for Respiratory Care
Policy Statement

3. Methodology for Disbursement of Funds:

A. The GAC Chair's funding recommendation presented to the AARC President and Board shall take into consideration the state society's

1) Total current assets and current liabilities.
2) Expected revenues and disbursements per the state society's budget.
3) The amount of money the state society has spent to date on its legislative effort.
4) Consistency of the state society's legislation with AARC policy, position and standards. The AARC President, AARC Executive Committee, in consultation with the Executive Office, will determine if the proposed legislation or legislative content merits financial support.
5) Preparation for the legislative effort.

B. The GAC Chair recommendation shall be based, whenever possible, on the concept that AARC funding shall match the funds the state society has allocated and/or spent on its legislative effort.

C. Affiliates requesting funding shall only specify the amount required. Funds will be allocated on a 60% grant and a 40% no interest loan basis (e.g., $2,000 requested = $1,200 grant and $800 loan). The maximum request may not exceed $10,000.

D. The disbursement of funds shall:
1) Generally the full amount of the allocation be disbursed to the state society as soon as is practically possible AFTER AARC Board approval and implementation of the contract described in b) below
2) Be contingent upon issuance and acceptance by both parties of a contract, memorandum or agreement stating terms and conditions relating to the allocation of funds. Terms shall include
   i. Repayment of the loan portion of the allocated funds will commence within six months following the initial disbursement of the funds to the society by AARC.

ii. Presentation of invoices by the society to the AARC executive Office (Controller) supporting the Society's expenditures within six months of the AARC's funds disbursement. If invoices are not presented within such six months after AARC disbursement, any "Excess Disbursement" (Defined as monies received by the State Society from AARC which are not supported by invoices presented) must be immediately returned to the AARC and the loan repayment terms will be adjusted accordingly. Extension of this six month period for extenuating circumstances may be granted by the Executive Office.

iii. Provision for loan repayment via Society Revenue Sharing withholding on any loan payment that is delinquent for more than 60 days.

iv. Depending on the circumstances other terms of repayment may be established by the AARC Executive Office and the AARC Controller as well.

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E. It is expected that the aforementioned shall serve as guidelines which will be applied consistently. However, unusual circumstances may require waiver of some elements. When an element is waived, the GAC Chair shall provide reasonable cause for such exception.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Membership

SUBJECT: **Membership Challenge Policy**

EFFECTIVE DATE:

DATE REVIEWED: July 2005

DATE REVISED: July 2005

REFERENCES Bylaws, MP.0791

Policy Statement:

Requests may be received by the Executive Office challenging a member's status.

Policy Amplification:

1. A written request must be received at the AARC Executive Office addressed to the chair of the Judicial Committee. This request must include the following:

    A. Name of the individual being challenged.
    B. Reason challenge id being made.
    C. Signature of individual initiating the challenge.

2. The Chair of the Judicial Committee will decide if the challenge is valid. If valid, a non-confrontational request for information will be sent to the individual being challenged, as well as the section of the Bylaws, highlighting Article III, Section 2, containing the definition of Active Member. This request will attempt to obtain the following information from the individual:

    A. Job description(s) for the past 12 months
    B. Explanation of the percentage of time spent on the job
    C. Medical Director/Spouse name
    D. Request for response within ten (10) business days

American Association for Respiratory Care
Policy Statement

3. The following are the time frames for the challenge process:
   A. Five days to inform the challengee
   B. Ten days for the challengee to return information
   C. Fifteen days to send the information to full committee and vote on a decision at the end of the 15 days.
   D. Notify both parties immediately

4. The decision will be based on a majority vote of the Judicial Committee. Anonymity of both the challengee and the challenger will be kept from the committee and all others involved.

5. Any appeal of the Judicial Committee decision will be forwarded to the AARC Board of Directors.

6. The verification of active status for those nominated for an AARC office will be required before the candidate is placed on the ballot.

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 2015
TO:	Frank R. Salvatore, Jr., RRT, MBA, FAARC, AARC President Carl F. Haas, MLS, RRT, RRT-ACCS, CPFT, FAARC, NBRC President, Kathy Rye, EdD, RRT, FAARC, CoARC President Steven Boas, MD, BOMA Chair
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Forrest M. Bird Lifetime Scientific Achievement Award 2015—** ***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 2015.

Previous recipients of this prestigious award have been:

2014 John J. Marini, MD
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, 2015.**

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 a cash award, 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 2015.

Memorandum

DATE:	February 2015
TO:	Frank R. Salvatore, Jr., RRT, MBA, FAARC, AARC President Carl F. Haas, MLS, RRT, RRT-ACCS, CPFT, FAARC, NBRC President Kathy Rye, EdD, RRT, FAARC, CoARC President Steven Boas, MD, BOMA Chair
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Dr. Charles H. Hudson Award for Cardiopulmonary Public Health 2015—*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:

- Stanton A. Glantz, PhD - 2014
- 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, 2015.**

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 2015.

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, 2015. 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 2015.

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 2015
TO:	Frank R. Salvatore, Jr, RRT, MBA, FAARC, AARC President Carl F. Hass, MLS, RRT, RRT-ACCS, CPFT, FAARC, NBRC President
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2015—*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:

- Angela King, RPFT, RRT-NPS - 2014
- 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 2015.

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, 2015.**

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, 2015. 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 2015.

Memorandum

DATE:	February 2015
TO:	Frank R. Salvatore, Jr., RRT, MBA, FAARC, AARC President Carl F. Haas, MLS, RRT, RRT-ACCS, CPFT, FAARC, NBRC President Kathy Rye, EdD, RRT, FAARC, CoARC President Steven Boas, MD, BOMA Chair
FROM:	Michael T. Amato ARCF Chair
SUBJECT:	**Mike West, MBA, RRT Patient Education Award 2015—*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:

- Timothy Op't Holt, RRT, AE-C, FAARC - 2014
- 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 2015.

Please submit nominations to the Executive Office no later than June 1, 2015.

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 2015.

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 31, 2015

Frank R. Salvatore, Jr., RRT, MBA, FAARC
President
American Association for Respiratory Care (AARC)
9425 N MacArthur Blvd
Irving, TX 75063

Dear Frank,

I am seeking your Board's nominations for the 2015 *Legends of Respiratory Care.*

As you may recall, the criteria for the designation of *Legends of Respiratory Care* includes, but shall not be limited to:

- Recognized professional achievements related to the clinical practice, education, or the science of respiratory care, publication of scientific articles or other activities bringing significant, sustained career recognition.
- Sustained personal service, representation, or advocacy on behalf of the respiratory care profession, and/or individual's creativity or ideas that resulted in historic advancement of the profession or its professional societies.
- Scientific achievements and/or inventions of historical significance which revolutionized, or remarkably enhanced delivery of respiratory care.
- Singularly distinctive individual actions during historic professional events, above and beyond reasonable expectations, that resulted in advancement of respiratory care and/or resolution of a significant crisis or issue facing the profession.
- Other sustained historic achievements as determined by the Boards of the AARC, ARCF, CoARC, and NBRC.

The Boards of the AARC, ARCF, CoARC and NBRC may each nominate up to five (5) individuals who have made a significant historic impact on respiratory care. Nominations must be supported by two-thirds (2/3) majority vote of the agency's board. A brief justification, limited to two (2) typed pages, must be submitted for each nominee. The roster of nominees and supporting justifications must be submitted to Asha Desai (desai@aarc.org) at the AARC Executive Office by **June 1, 2015**.

The recipients of this prestigious designation will be announced at the AARC Congress in November. They will be featured in the *Legends* of *Respiratory Care* gallery of the Virtual Museum along with the 2014 recipients*:* V. Ray Bennett, Dr. Forrest M. Bird, Dr. Donald F. Egan, John H. "Jack Emerson, Sam P. Giordano, Dr. H. Fred Helmholz, Jr., Sister M. Yvonne Jenn, Brother Roland Maher, George A Kneeland, and Dr. Thomas L. Petty.

I look forward to receiving your nominations.

Sincerely,
Trudy Watson, Chair
Virtual Museum Committee