American Association for Respiratory Care

Board of Directors Meeting

Hilton Santa Fe Golf Resort & Spa at Buffalo Thunder
Santa Fe, NM

July 16-17, 2012

Index

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – July 15, 2012
Board of Directors Meeting – July 16-17, 2012

Sunday, July 15

3:00-7:00 pm Executive Committee Meeting (Committee Members only) **Executive 5th Floor Hospitality Room**

7:00-8:00 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) **Pueblo Ballroom 3 B-C**

Monday, July 16

8:00 am-5:00 pm **AARC Board of Directors Meeting – Pueblo Ballroom 3 B-C**

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Disclosures/Conflict of Interest Statements
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12:00-1:30 pm Lunch Break (Daedalus Board Meeting)

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3:30 pm BREAK

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5:00 pm RECESS

Tuesday, July 17

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

8:00 am Call to Order

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- National Coalition for Health Professional Ed. In Genetics pg. 150
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10:00 am BREAK

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12:00 – 1:30 pm LUNCH BREAK

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2:00 pm **UNFINISHED BUSINESS pg. 193**

2:30pm **NEW BUSINESS pg. 194**
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4:30 pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(as of June 28, 2012)

AARC Board of Directors Meeting

July 16-17, 2012 • Santa Fe, NM

Board of Medical Advisors

Recommendation 12-2-7.1 "That the AARC Board of Directors form an Ad Hoc Committee to place information on the different schools on their website specifically giving benchmarks, such as, but not limited to, first time pass rates and job placement and possibly faculty strengths and weaknesses with input from CoARC and NBRC. "

Bylaws Committee

Recommendation 12-2-9.1 "That the AARC BOD accept and approve the Respiratory Care Society of Washington bylaws."

Recommendation 12-2-9.2 "That the AARC BOD accept and approve the Nevada Society for Respiratory Care bylaws."

Recommendation 12-2-9.3 "That the AARC BOD accept and approve the Minnesota Society for Respiratory Care bylaws."

Recommendation 12-2-9.4 "That the AARC BOD accept and approve the Virginia Society for Respiratory Care bylaws."

Elections Committee

Recommendation 12-2-10.1 "That the AARC Board provide guidance in the form of a policy statement on the number of candidates that can be placed on the ballot for each position."

Program Committee

Recommendation 12-2-15.1 "That the AARC Board of Directors authorize $10,340 to be spent above budget for the travel-related expenses of the 2012 Sputum Bowl Committee to attend AARC Congress 2012."

Education Section

Recommendation 12-2-53.1 "That the AARC please consider a modification to the AARC web page regarding baccalaureate (and masters) degree education at http://www.aarc.org/education/accredited_programs/ to read:

'The AARC provides a link to the Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) website that maintains a separate list of programs that offer an associate degree in respiratory therapy with a ***baccalaureate degree option****. This list also contains some additional information about* ***all programs offering a baccalaureate or masters degree*** *in respiratory therapy as the first professional degree. The list of accredited programs on the CoARC website is updated continuously as accreditation decisions are made. Therefore, the current accreditation status of these programs should always be checked on the CoARC website."*

Position Statement Committee

Recommendation 12-2-26.1 "Approve and publish the revised position statement on "AARC Statement of Ethics and Professional Conduct". This statement is submitted for your review as Attachment #1. Text to be deleted appears with strikethrough and text to be added appears with underline."

Committee on Accreditation of Air Medical Transport Systems

Recommendation 12-2-66.1 "That the travel funding allowance for the AARC representative to the Commission on Accreditation of Medical Transport Services (CAMTS) be increased from the current level of $2000 a year to $2500 a year."

Extracorporeal Life Support Organization (ELSO)

Recommendation 12-2-69.1 "Request AARC financial assistance of $2,500 for registration fees and expenses to be able to attend one of the two Extracorporeal Life Support Organization (ELSO) meetings."

Geriatrics

Recommendation 12-2-48.1 "That the Geriatrics Roundtable be expanded to include Palliative Care."

Ad Hoc Committee on 2015 & Beyond

Recommendation 12-2-32.1 "That the AARC BOD accept the competencies needed by graduate respiratory therapists as recommended in the publication 'Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond' by Thomas A Barnes EdD RRT FAARC, David D. Gale PhD, Robert M Kacmarek PhD RRT FAARC, and Woody V Kageler MD MBA; Published -Respir Care 2010;55(5):601–616. © 2009 Daedalus Enterprises."

Recommendation 12-2-32.2 "That the AARC explore strategies that would enable respiratory therapists to acquire these competencies."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

Grapevine, Texas, April 20, 2012

Minutes

Attendance

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

House Officers

Karen Schell, RRT-NPS, RPFT, RPSGT, Speaker
John Steinmetz, MBA, RRT, Speaker-Elect
Rick Weaver, RRT-NPS, RPFT, Secretary
Ross Havens, MS, RRT, Treasurer

Consultants

Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Margaret Traband, MEd, RRT, FAARC, President's Council President

Guests

Larry Wolfish, Legal Counsel
Eileen Keller, Salmon, Sims, Thomas
James Nash, Salmon, Sims, Thomas
Tom Smalling, CoARC Executive Director
Kathy Rye, CoARC President-elect

Absent (Excused)

Bill Cohagen, BA, RRT, RCP, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC, HOD Past Speaker
Mike Runge, BSRT, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Joe Sorbello, MEd, RRT

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, MBA, RRT, FAARC, Chief Operating Officer
Doug Laher, MBA, RRT, Associate Executive Director

Ray Masferrer, RRT, FAARC, Managing Editor, RESPIRATORY CARE
Sherry Milligan, MBA, Associate Executive Director
Cheryl West, State Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Tony Lovio, CPA, Controller
April Lynch, ARCF Coordinator/Administrative Assistant
Russell Leighton, IT
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:00a.m. CDT, Friday, April 20, 2012. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

DISCLOSURE

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

WELCOME AND INTRODUCTIONS

Members introduced themselves and stated their disclosures as follows:

Tim Myers – Advisory Board for Draeger and Discovery Labs
Linda Van Scoder – CoBGRTE
Lynda Goodfellow – Teleflex Medical, Mediserve Consulting
Fred Hill – Chair, Alabama State Board of Respiratory Therapy
Karen Schell – Masimo Advisory Board
Greg Spratt – Employed by Oridion Capnography
Cyndi White – Masimo Advisory Board

APPROVAL OF MINUTES

George Gaebler moved "To approve the minutes of the November 3, 2011 meeting of the AARC Board of Directors."
Motion Carried

George Gaebler moved "To approve the minutes of the November 4, 2011 meeting of the AARC Board of Directors."
Motion Carried

George Gaebler moved "To approve the minutes of the November 8, 2011 meeting of the AARC Board of Directors."
Motion Carried

E-MOTION RATIFICATION

Karen Stewart moved "To ratify the E-Motions discussed over the Board AARConnect since November 2011 as follows:

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

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

12-1-15.1 "That the AARC Board of Directors approves the membership of the 2012 Sputum Bowl Committee as recommended by the Program Committee:

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

* *New Committee Member*"

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

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

Denise Johnson moved to ratify the E-Motions
Motion Carried

GENERAL REPORTS

President
President Stewart discussed her report.

Executive Director/Office
Sam Giordano and Tom Kallstrom gave an overview of the written Executive Office report.

The Membership Committee has initiated a campaign that will focus on non-member managers and show them the benefits of membership and provide them the tools to assist them in managing their department.

The IT upgrade that the Board approved in 2011 is generally on schedule and, in most areas, under budget.

The Executive Office is currently working on several projects including Safety Checklist for Oxygen Monitoring, COPD Toolkit, Peak Performance USA, Drive4COPD, Office Spirometry, and High Flow Heated Humidity Research Study.

The Hospital Care Collaborative (HCC) Committee, which The AARC is a founding member of, met in Washington, DC in April 2012. The HCC's mission is collaboration of the healthcare team which leads to improved systems and processes.

In January 2012 an invited group of speakers presented an Asthma/COPD/aerosol device workshop in Riyadh, Saudi Arabia. In March 2012 the same group traveled to Dubai to speak at the Gulf Thoracic Society meeting.

A list of Professors Rounds and Webcasts topics for 2012 was presented to the Board.

LEGAL COUNSEL
Larry Wolfish gave an overview of Board member fiduciary responsibilities.

President Stewart handed the gavel over to Past President Tim Myers at 8:45am CDT, Friday, April 20, 2012.

AUDITORS REPORT
Audited financial statements were distributed to the Board. Eileen Keller and James Nash with Salmon Sims Thomas discussed the audited financial statements.

RECESS
Past President Tim Myers recessed the meeting of the AARC Board of Directors at 9:10am CDT Friday, April 20, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors 9:28am CDT Friday, April 20, 2012.

STATE GOVERNMENT AFFAIRS
Cheryl West provided an update on recent legislative and regulatory issues impacting the profession. Challenges continue for our state societies to address onerous provisions imbedded in polysomnography licensure legislation. She also discussed the efforts in the state of Michigan to rescind respiratory therapy licensure and the efforts of the MSRC to prevent this from occurring. She complimented all the state societies on their quick, organized and thorough response to these challenges.

GOVERNMENT & REGULATORY AFFAIRS
Anne Marie Hummel provided an update on federal regulations and rules that impact the profession, with an emphasis on the current low payment rate for Medicare outpatient pulmonary rehab services. She detailed the response AARC has made, including the development of a Tool Kit for RTs to use to assist in eventually increasing reimbursement for this benefit.

HOUSE OF DELEGATES
Karen Schell gave an overview of her written report.

PRESIDENT'S COUNCIL
Margaret Traband gave an overview of her written report. Dr. Bruce Rubin has been selected as the 2012 Jimmy A. Young Medal Winner.

BOARD OF MEDICAL ADVISORS (BOMA)

Dr. Lori Conklin (2012 BOMA Chair-elect) may be taking over Dr. Marcus's position as Chair due to his sudden death on April 9, 2012.

STANDING COMMITTEES REPORTS

Audit Subcommittee

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

Linda Van Scoder moved to refer to the President to develop a process for reviewing compensation.

Motion Carried

Bylaws Committee

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-9.1** "That the AARC BOD accepts and approves the Alaska Society for Respiratory Care Bylaws"

Motion carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-9.2** "That the AARC BOD accepts and approves the Michigan Society for Respiratory Care Bylaws"

Motion carried

Finance Committee

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-1.3** "That up to $350,000 is allocated from reserves for an AARC corporation's websites upgrade."

Motion Carried

Program Committee

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

Motion Carried

Colleen Schabacker moved "To accept the Standing Committee reports as presented."

Motion Carried

COMMISSION ON ACCREDITATION for RESPIRATORY CARE (CoARC)

CoARC Executive Director Tom Smalling and President-elect Kathy Rye gave highlights of their written report to the Board. On behalf of the Board, President Stewart thanked Tom Smalling and CoARC for their response to 2015 Recommendations.

LEGISLATIVE AFFAIRS
Miriam O'Day recapped the efforts on Capitol Hill, including the successful 2012 AARC Hill Lobby Day, our Virtual Lobby Week, and where the AARC stands in advancing our legislation, HR 941.

George Gaebler moved "To accept the General Reports as presented."
Motion Carried

SPECIALTY SECTION REPORTS

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

Colleen Schabacker moved to refer to the Executive Office for further development and planning. A preliminary report will be given by the Executive Office at the Summer Forum.
Motion Carried

Continuing Care Rehabilitation
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-51.1** "That the AARC issue a consensus statement that recognizes the EPR-3 as the standard for asthma management"

George Gaebler moved to accept for information only.
Motion Carried

Diagnostics
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-52.1** "Offer a six month trial membership to the Diagnostics Section for AARC members"
Motion Defeated
Tim Myers suggested that Susan Rinaldo Gallo contact Matt O'Brien and explain why it was defeated.

Home Care
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-54.1** "Create pilot studies for RT-led programs for reducing readmissions"

Susan Rinaldo Gallo moved to refer to the Executive Office to help gain assistance from the Research Roundtable to help develop an RFP to be able to present back at Summer Forum.
Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-54-2** "Survey section members for potentially combining home care and long-term care specialty sections"

Linda Van Scoder moved to refer back to the Homecare Section to follow the survey process.
Motion Carried

RECESS
Karen Stewart called a recess of the AARC Board of Directors at 12:00pm CDT, Friday, April 20, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors 1:40pm CDT Friday, April 20, 2012.

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

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

Motion Defeated

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

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

Motion Defeated

FM 12-1-26.1 Linda Van Scoder moved that the Position Statement Committee be charged to develop a statement on best practices in respiratory care productivity assessment and analysis.
Motion Carried

Surface and Air Transport

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

Motion Ruled Out of Order

The AARC must receive a request from an organization before it can appoint a liaison. We have not received a request from the AAP.

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

Motion Carried

SPECIAL COMMITTEE REPORTS

Membership Committee

Tim Myers discussed the new pilot project that involves working with the House of Delegates and state societies to find managers of existing facilities who are not AARC members to entice them to sign up for AARC membership and show them the benefits.

Position Statement

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-26.1** "Approve and publish the newly developed position statement on "Respiratory Therapists in the Emergency Department."

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-26.2** "Approve and publish the revised position statement on "Respiratory Therapists Education."

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-26.3** "Approve and publish the revised position statement on "Continuing Education."

Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-26.4** "Approve and publish the revised position statement on "Licensure of Respiratory Care Personnel."

Motion Carried

(See Attachment "A" for all position statements listed above.)

RECESS

President Karen Stewart recessed the meeting of the AARC Board of Directors at 3:06p.m. CDT, Friday, April 20, 2011.

RECONVENE

President-elect George Gaebler reconvened the meeting of the AARC Board of Directors 3:21pm CDT Friday, April 20, 2012.

SPECIAL REPRESENTATIVES REPORTS

Extracorporeal Life Support Organization (ELSO)

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

Linda Van Scoder moved to refer to the president contingent upon the report (intent/goal of ELSO Steering Committee) received back from Vice-President of External Affairs
Motion carried

Susan Rinaldo Gallo moved to accept the Special Representatives reports as presented.
Motion Carried

ROUNDTABLE REPORTS

Tobacco Free Lifestyle
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-41.1** "That the BOD discuss how a day-long workshop on tobacco treatment skills could be offered during the AARC Congress or as a pre-event"

Colleen Schabacker moved to accept for information only.
Motion Carried

Camden McLaughlin moved "To accept the Roundtable reports as presented."
Motion Carried

AD HOC COMMITTEE REPORTS

Ad Hoc Committee to Recommend Bylaws Changes
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-30.1** "That the amended revision to the policy on Bylaws Conflicts (Policy No.CA.007) be approved by the BOD." (See Attachment "B")
Motion Carried
(Regarding #5 of Policy No. CA.007 "put on probation" was changed to "suspended")

Ad Hoc Committee on Section Membership
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-33.1** "That the AARC ask each Section Chair to review the 'Section' description and update to better describe the focus of the section."

Lynda Goodfellow moved to accept for information only.
Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-33.2** "That the AARC investigate offering some form of CEU through the bulletins as a benefit of section membership."

Denise Johnson moved to accept for information only.
Motion Carried

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

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

Susan Rinaldo Gallo moved to refer to the Executive Office.
Motion Carried

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

Lynda Goodlfellow moved to refer to the Sleep Section to review pros and cons and report at the Summer Forum Board meeting about the implementation.
Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-33.6** "That the AARC investigate the feasibility of offering a membership fee for multiple sections."

Lynda Goodfellow moved to accept for information only.
Motion Carried

Ad Hoc Committee to Reduce Hospital Readmissions
Susan Rinaldo Gallo moved to accept **Recommendation 12-1-34.1** "Proposes a project to select and fund 3-5 pilot studies exploring the benefits of different models of RT-led programs for reducing hospital readmissions in COPD."

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

RECESS
President Stewart called a recess of the AARC Board of Directors meeting at 4:25pm CDT on Saturday, April 21, 2012.

Attachment “A”

Position Statements:

Respiratory Therapists in the Emergency Department
Respiratory Therapists Education
Continuing Education
Licensure of Respiratory Care Personnel

American Association for Respiratory Care

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

Position Statement

Respiratory Therapists in the Emergency Department

Patients are at risk for unanticipated injury or illness requiring emergency services. This is why Emergency Departments rely on Respiratory Therapists for their expertise in a wide range of cardiopulmonary treatment modalities. The Respiratory Therapist's skills in assessment, airway management, resuscitation, patient education and mechanical ventilation are essential for optimizing care of the compromised patient.

To provide the quality of care our patients deserve while reducing the risk of liability in health care institutions, the AARC recommends the use of qualified Respiratory Therapists trained in patient management and complex respiratory care modalities to provide safe and effective treatment for the highest risk patients with cardiopulmonary compromise in all Emergency Department settings.

Effective 04/2012

American Association for Respiratory Care

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

Position Statement

Respiratory Therapist Education

It is the position of the American Association for Respiratory Care (AARC) that in order to prepare entry level respiratory therapists for clinical practice and to prepare clinical leaders for services requiring complex, cognitive abilities and complex patient management skills:

- The minimum education required to practice respiratory care is completion of an associate degree in respiratory care.
- Programs for the education of respiratory therapists, managers, researchers, faculty, and professional leaders should be accredited by a body recognized by government, and through a rigorous and ongoing process which assures the quality of their programming.
- Respiratory therapists completing such education, advanced training, and/or experience should be eligible for credentialing to reflect their didactic preparation and clinical skills required for practice in the respective area of specialization. Credentialing should be encouraged in related areas of specialization to include Neonatal/Pediatric Care, Adult Critical Care, Sleep Disorders, Pulmonary Function Testing and others which may be added as the field evolves.

The AARC also encourages the development of accredited, advanced degree programs in Respiratory Care at the bachelor's, masters and doctoral levels; and encourages therapists to pursue such higher education as a means of expanding career opportunities and advancing the Respiratory Care profession.

Effective: 1998
Revised: 03/2009
Revised 04/2012

American Association for Respiratory Care

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

Position Statement

Continuing Education

It is critical for all health care practitioners to participate in continuing education in order to enhance their knowledge, improve their clinical practice and meet state licensure and national credentialing requirements. Participation in continuing education, whether mandatory or voluntary, offers the potential to be one of the most powerful tools to ensure safe, efficient, and quality patient care. The American Association for Respiratory Care (AARC) recognizes the value of, and need for, participation in continuing education and recommends that practitioners participate in educational activities 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

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 3/90
Revised 3/00
Revised 12/06
Revised 07/09
Revised 04/12

Attachment “B”

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

American Association for Respiratory Care
Policy Statement

Policy No.: CA.007

SECTION: Chartered Affiliates

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

EFFECTIVE DATE: November 3, 2011

DATE REVIEWED: ~~November 4, 2011~~ April 2012

DATE REVISED: April 2012

REFERENCES:

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

Policy Amplification:

1. Affiliate bylaws will only be reviewed for compliance with AARC Bylaws. Errors in grammar, spelling or internal inconsistencies will be the responsibility of the Chartered Affiliate. The Bylaws Committee may make recommendations regarding grammar, spelling, or internal inconsistencies but will not delay the approval process over such issues.
    a. All Affiliate Bylaws shall be submitted to the AARC Bylaws Committee every 5 years for review and approval. The AARC Bylaws Committee will request in writing that the Chartered Affiliate submit the affiliate bylaws so that they can be reviewed.
    b. The Affiliates have six months to respond to the Bylaws Committee request for review.
    c. If an Affiliate does not respond with submission of the bylaws, the Bylaws Committee will notify the Chartered Affiliate in writing that they are in conflict with the Chartered Affiliates Policy.
    d. Failure to submit Bylaws or respond with a plan for submission within 45 days shall start the process in section 5 below.

2. Affiliate Bylaws will be considered in conflict with the AARC Bylaws and/or policy if non-AARC members are allowed to vote and/or hold a voting position on the Affiliate's Board of Directors.

3. Affiliate Bylaws will be considered in conflict with AARC Bylaws and/or policy if Active members of the AARC are not automatically Active members of the Chartered Affiliate.

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

5. The Affiliate will have their Affiliate Charter ~~put on probation~~ suspended until the Chartered Affiliate makes changes to their bylaws to bring them into compliance with AARC Bylaws.
    a. The charter affiliate shall lose their voting powers in the House of Delegates until the Bylaws are revised and accepted by the AARC Board of Directors.
    b. If after a period of one year the Affiliates Bylaws are still not in compliance, the AARC Board will take action by withholding Affiliate revenue sharing starting at one quarter of revenue sharing every six months.

c. This would be a three year process whereby revenue would dwindle to zero after three years of non-compliance.
d. The AARC Board of Directors would then revoke the charter of the affiliate.

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

DEFINITIONS:
ATTACHMENTS: AARC Bylaws

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 21, 2012- Grapevine, TX

Minutes

Attendance

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

House Officers

Karen Schell, RRT-NPS, RPFT, RPSGT, Speaker
John Steinmetz, Speaker-Elect
Rick Weaver, RRT-NPS, RPFT, Secretary
Ross Havens, MS, RRT, Treasurer

Consultants

Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Margaret Traband, MEd, RRT, FAARC, President's Council President

Absent (Excused)

Bill Cohagen, BA, RRT, RCP, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC, HOD Past Speaker
Mike Runge, BSRT, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Joe Sorbello, MEd, RRT

Staff

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

CALL TO ORDER

President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:35a.m. CDT, April 21, 2012. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

Education Section Report

Recommendation 12-1-53.1 "That the AARC please consider a modification to the AARC webpage regarding baccalaureate (and masters) degree education at http://www.aarc.org/education/accredited_programs/ to read:

> 'The AARC provides a link to the Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) website that maintains a separate list of programs that offer an associate degree in respiratory therapy with a **baccalaureate degree option**. This list also contains some additional information about **all programs offering a baccalaureate or masters degree** in respiratory therapy as the first professional degree. The list of accredited programs on the CoARC website is updated continuously as accreditation decisions are made. Therefore, the current accreditation status of these programs should always be checked on the CoARC website.'"

The recommendation was tabled due to the lateness of the report. Executive Committee will discuss at another time and send out as E-Motion if needed.

Susan Rinaldo Gallo moved to accept the Specialty Section reports.
Motion Carried

FM 12-1-84.1 George Gaebler moved to create a policy to deal with AARC Governance concerning interlocking Board members with other organizations.
Motion Carried

FM 12-1-1.1 Linda Van Scoder moved to direct the Executive Office to place a link to the AARC Policy & Procedure Manual in the member resources section of the AARC website.
Motion Carried

OTHER REPORTS (NBRC, ARCF)

President Stewart will contact the NBRC to request their response to 2015.

George Gaebler moved to accept the NBRC and ARCF reports.
Motion carried

NEW BUSINESS

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-84.1** "That the AARC's white paper on Concurrent Therapy be temporarily pulled from the website for revision."
Motion Carried

FM 12-1-1.2 Colleen Schabacker moved to expand the charge of reviewing policies to include white papers and other AARC Statements to the Executive Office.
Motion Carried

SpirXpert Website

Tom Kallstrom spoke about www.SpirXpert.com and stated the owner would like to turn it over to the AARC.

American Organization of Nurse Executives (AONE)
AARC was invited to participate in their upcoming meeting to be held on June 4 in Washington, DC. President Stewart will identify one or two individuals to attend and represent the AARC.

National Coalition of Black Lung Diseases
This organization would like to collaborate with AARC during the annual Hill Day/PAC.

RECESS
Karen Stewart called a recess of the AARC Board of Directors at 10:11am CDT, Saturday, April 21, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors 10:31am CDT Saturday, April 21, 2012.

Haiti Proposal
The Board discussed the proposal prepared by Natalie Napolitano and Dan Rowley. Numerous requests have been submitted from many countries needing assistance. The ICRC or ARCF may be a better avenue for finding funding.

FM 12-1-84.2 Tim Myers moved that the AARC write a letter of support back to the petitioners of the Haiti proposal for the pilot program based on the condition that they develop goals and outcomes and get a review from the ICRC on its efficacy and strategic implications.
Motion Carried
President Stewart will prepare a letter to send to Natalie Napolitano and Dan Rowley.

Barnes Jewish Hospital Recommendation
Linda Van Scoder moved to accept **Recommendation 12-1-84.2** "That the AARC fund the Advanced Patient Care Coordinator proposal from Barnes-Jewish Hospital Respiratory Therapy department in the sum of $88,020 from the Million Dollar Research Fund."
Motion Carried

POLICY REVIEW
Policy No. BOD.006 – *Executive Session of the Board of Directors*
Colleen Schabacker moved to approve as amended.
Motion Carried

Policy No. CA.002 – *Chartered Affiliate Requirements and Responsibilities*
FM 12-1-6.1 George Gaebler moved to refer to House of Delegates Speaker with assistance from BOD Secretary/Treasurer to develop checklist and revise policy by Summer Forum.
Motion Carried

Policy No. CA.006 – *Chartered Affiliate Consultant*
Linda Van Scoder moved to accept as amended.
Motion Carried

Policy No. CT.005 – *Standing Committees*

Linda Van Scoder moved to accept as amended.
Motion Carried

Policy No. FM.016 – *Travel Expense Reimbursement*
Linda Van Scoder moved to accept as amended.
Motion Carried

(See Attachment "A" for all amended policies)

RECESS
Karen Stewart called a recess of the AARC Board of Directors at 11:45am CDT, Saturday, April 21, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors 3:02pm CDT Saturday, April 21, 2012.

EXECUTIVE SESSION
President Stewart asked that Executive Session convene and staff, as well as non-voting members of the Board were asked to leave at 3:03pm CDT, Saturday, April 21, 2012. The motion was made by Linda Van Scoder.
Motion Carried

Susan Rinaldo Gallo moved to recess Executive Session at 3:23pm CDT, Saturday, April 21, 2012.
Motion Carried

FM 12-1-1.3 Linda Van Scoder moved that Tom Kallstrom be offered the position of AARC Executive Director.
Motion Carried (Unanimous hand vote of all voting members present)

Past President Tim Myers took over the meeting of the Board of Directors at 3:28pm CDT, Saturday, April 21, 2012.

ARCF AWARD NOMINEES
The Board brought forth the following nominees for the ARCF Awards for 2012.

Forest M. Bird Lifetime Scientific Achievement Award
Denise Johnson moved to nominate ***Patrick Dunne*** – Nominated by Lynda Goodfellow
Motion Carried

Charles H. Hudson Award for Cardiopulmonary Public Health
Linda Van Scoder moved to nominate ***Danica Patrick*** **-** Nominated by Colleen Schabacker
Motion Carried

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care
Linda Van Scoder moved to nominate ***Linda Smith–*** Nominated by Tim Myers
Motion Carried

Life Membership Nominations
Linda Van Scoder moved to nominate ***Rick Ford***– Nominated by Karen Stewart

Motion Carried

Honorary Membership Nominations
Colleen Schabacker moved to nominate ***Miriam O'Day*** – Nominated by Doug McIntyre
Motion Carried

Denise Johnson moved to destroy the written ballots.
Motion Carried

Karen Stewart took over the meeting of the Board of Directors at 3:46pm CDT, Saturday, April 21, 2012.

President Stewart announced to the entire group that Tom Kallstrom was offered the position of Executive Director of AARC effective June 1, 2012.

International Committee
John Hiser gave an overview of his written report.

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-23.1** "That the AARC Board of Directors approves the revised International Mission/Goals statement and that the statement is added to the International Fellowship Program home page on the AARC web site." **(As Amended)**
Motion Carried

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

Linda Van Scoder moved to refer back to the International Committee to follow the survey process.
Motion Carried

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-23.3** "That the AARC consider funding the creation and production of an International Fellow lapel pin."

Linda Van Scoder moved to refer to Executive Office for implementation.
Motion Carried

Susan Rinaldo Gallo made a motion to accept the Special Committee reports as reported.
Motion Carried

Ad Hoc Committee on 2015 & Beyond
George Gaebler moved to accept **Recommendation 12-1-32.1** "That the AARC BOD accept the direction for the future of health care as recommended by the publication 'Creating a Vision for Respiratory Care in 2015 and Beyond' by Robert M Kacmarek PhD RRT FAARC, Charles G Durbin MD FAARC, Thomas A Barnes EdD RRT FAARC, Woody V Kageler MD MBA, John R Walton MBA RRT FAARC, and Edward H O'Neil PhD Published-Respir Care 2009; 54(3):375–389. ©2009 Daedalus Enterprises"
Motion Carried

Susan Rinaldo Gallo moved to accept the Ad Hoc Committee reports as submitted.
Motion Carried

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

Susan Rinaldo Gallo moved to accept **Recommendation 12-1-1.2** "That the following position statement by the Hospital Care Collaborative (HCC) be reviewed and reaffirmed by the AARC Board of Directors:

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

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

Motion Carried

FM 12-1-1.4 Tim Myers moved that the AARC Executive Office develop a website dedicated to findings, processes, outcomes and decisions surrounding the AARC's 2015 and Beyond Conference and Project.
Motion Carried

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

MOTION TO ADJOURN
Linda Van Scoder moved "To adjourn the meeting of the AARC Board of Directors."
Motion Carried

ADJOURNMENT
President Karen Stewart adjourned the meeting of the AARC Board of Directors at 4:30pm CDT, Saturday, April 21, 2012.

Attachment “A”

Policy No.BOD.006 - Executive Session of the Board of Directors
Policy No.CA.002 - Chartered Affiliate Requirements and Responsibilities
Policy No.CA.006 – Chartered Affiliate Consultant
Policy No. CT.005 – Standing Committees
Policy No. FM.016 – Travel Expense Reimbursement

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Executive Session of the Board of Directors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~July 2007~~ April 2012

DATE REVISED:

REFERENCES: AARC Bylaws; Robert's Rules of Order

Policy Statement:
All Executive Sessions of the Board of Directors shall be held in strict accordance with Association policy, and Robert's Rules of Order.

Policy Amplification:

1. Executive session shall be an important mechanism for conducting confidential business of the Board of Directors

2. All items discussed in executive session shall be held in strict confidence by all who are in attendance and may not be divulged to individuals other than the Board.

3. The Board of Directors shall review the actions of a member of the Board who is suspected of violating this policy in accordance with the due process provisions of AARC policy.

4. A member of the Board found to be in violation of this policy shall be subject to disciplinary action up to and including removal from office.

   A. The Board shall also file a complaint with the Judicial Committee regarding such member found in violation of this policy.

5. Any executive session information that is germane to the effective functioning of the Board of Directors shall be disseminated to all board members in the most timely fashion possible (e.g. Executive, Budget, and other special committees' business and rough drafts of proposed documents).

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliate Requirements and Responsibilities**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~March, 2009 (was referred to Chart. Affil. Cmte to update by summer 2009)~~ April 2012 (checklist and revisions by HOD Speaker with assistance from BOD Secretary due at Summer Forum 2012)

DATE REVISED: April 2012

REFERENCES:

Policy Statement:
Chartered affiliates shall be responsible for providing necessary formal documentation required for Chartered Affiliate Membership in the AARC.

Policy Amplification:

1. Chartered Affiliates shall be required to provide the following written documentation to the AARC.

    A. Proof of state and federal ~~exempt tax~~ not for profit status.

    B. Proof of Chartered Affiliate Treasurers and other checking account signatories being bonded.

2. The Affiliate Charter shall remain the property of the Association, and replacement or additional copies must be purchased at cost plus handling.

3. It shall be the responsibility of the Chartered Affiliates Committee to solicit and maintain documentation.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CA 006

SECTION: Chartered Affiliate

SUBJECT: **Chartered Affiliate Consultant**

EFFECTIVE DATE: ~~January 1, 2008~~

DATE REVIEWED: ~~December 2007~~ April 2012

DATE REVISED: ~~December 2007~~ April 2012

References:

Policy Statement:

The American Association for Respiratory Care (AARC) has established a mechanism to offer consultation services to its state societies (chartered affiliates).

Policy Amplification:

The role of the consultant is to assist the state societies, in regard to resolution of problems and/or disputes associated with the operation of the state society at the direction of the AARC President.

1. The President may appoint an AARC member volunteer with Board of Director or Executive Committee experience to serve as AARC State Society Consultant. The Consultant serves at the pleasure of the President. The position will be subject to reappointment ~~on a yearly basis~~ every two years.

2. The Consultant's role is strictly voluntary with no pay for services, but state societies requesting a consultation will accept responsibility for any expenses incurred with the AARC matching up to $500 of the total expense.

3. While the consultant may be engaged with state societies on a wide range of topics related to arbitration, the consultant is not empowered to represent the AARC without its written authorization to do so from the AARC President.

4. When the Consultant provides advice in the execution of a consultation it must be clearly stated that the advice is not a position, opinion, recommendation or other form of direction from the AARC, but rather represents the best opinion of the consultant given his/her extensive experience and expertise in this area.

5. If the consultant feels that it is necessary and appropriate for the AARC to undertake a formal recommendation or other action, the consultant will contact the AARC's President and make the appropriate recommendation(s). The President will in turn consider the recommendation(s) and after consideration with appropriate parties take any subsequent action.

6. The consultant will communicate on a regular basis with the AARC's President regarding any activities undertaken in fulfillment of this appointment and will generate a written report after any consultation be copied to the AARC's President and Executive Director within ten days post meeting.

7. The consultant will submit a report that summarizes activities participated in on behalf of the AARC for each BOD meeting.

8. All communications from the consultant to the State Affiliate must be copied to the AARC President and Executive Director.

9. Any brochures, publications and/or e-mails that the consultant desires to send out to the affiliates promoting services provided through the position must first be approved by the AARC President and Executive Director.

10. All requests for services of the consultant must first be submitted to the AARC President. The President will make the decision regarding approval of the consultation and travel grant funding by the AARC Travel Assistance Grant Fund.

11. The Chartered Affiliate Consultant will be required to sign a Letter of Agency which will describe scope and limitations of authority.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Standing Committees**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~March 2008~~ April 2012

DATE REVISED: ~~March 2008~~ April 2012

REFERENCES:

Policy Statement:
The standing committees of the Association shall be the Bylaws, Elections, Executive, Finance, Judicial, Program and Strategic Planning Committees.

Policy Amplification:
1. The Association's standing committees are designated by the Association's Bylaws and only may be changed by initiation of a Bylaws change as designated in the Association's Bylaws in Article XII, sec 2.2.

2. Committee chairs and committee members of standing committees, not otherwise designated in the Association's Bylaws and/or policy shall be appointed by the President and subject to the approval of the Board of Directors.

3. Committee terms of appointment shall be for ~~one (1)~~ two (2) years with the exception of the Elections ~~and Bylaws~~ Committees~~,~~ which is a three (3) year term.

    ~~A. Elections committee terms shall be for two (2) years.~~
    ~~B. Bylaws committee terms shall be for two (2) years.~~

4. Decisions of the standing committees of the Association, except as specified in Article XII, Section 2 (a) (3), may be appealed to the Board of Directors.

    A. A two-thirds (2/3) vote of the Board of Directors shall be required to sustain an appeal.

DEFINITIONS:
ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Travel Expense Reimbursement**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~July 2011~~ April 2012

DATE REVISED: ~~December 2008~~ April 2012

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 (effective 1/1/09) 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)
   B. Personal expenses incurred while on official Association travel (e.g., entertainment, telephone, 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 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 ~~three~~ 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

E-Motions

Since Last Board Meeting in April 2012

12-2-15.1 Susan Rinaldo Gallo moved "That the AARC Board of Directors approve the Marriott Renaissance at SeaWorld (Orlando, FL) as the venue and destination for the 2013 AARC Summer Forum."

Results – June 14, 2012
Yes – 16
No – 0
Abstain - 0
Did not vote – 1

The motion carried

General Reports

President Report

Work continues with the project 2015 and Beyond. At the December BOD meeting the Board voted to accept the proceeding of the first conference, Creating a Vision for Respiratory Care in 2015 and Beyond. The approval of this document allows the AARC to follow a course of action which will enable the association to further planning and design programs for the future. The work is far from finished; the committee continues to obtain information need for the next set of recommendations for which action will be taken.

Work continues on the Respiratory Care Medicare initiative. Somewhat disappointed the AARC was not successful in getting the bill restored by the CBO. Lobby day in Washington DC was successful with record numbers of visits on the hill. Efforts now are being made to reword the bill with more emphasis on the disease management aspect of care. It is hopeful that this action will create a new look and perhaps new scoring from CBO. The effort remains a high priority for the association.

I recently attended a meeting in Washington with the AHA and their organization, the American Organization of Nurse Executives. The meeting was convened to address workforce needs... This new group, Allied Health Professions Workforce Planning Meeting, is an effort to bring a wide variety of health professions together as a multi-disciplinary group to understand and consider workforce needs and how care may be delivered in the future. Attending the meeting were representatives from physical therapy, nutrition and dietetics, radiological technologists, clinical pathology, occupational therapy, health care human resources, and health system pharmacists. The group identified 3 areas to start the work and has agreed that there is a need for this level of collaboration.

The AARC continues to identify educational opportunities for its members. The leadership program is still in development stages and other new programs. Education requests continue from the Middle East and two programs were delivered early in the year.

Respectfully submitted

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

Executive Office Report

Submitted by Thomas Kallstrom MBA, RRT, FAARC Executive Director
The following are highlights from the Executive Office since the spring meeting in Dallas in April.

Membership

Since January of this year our membership efforts with the Membership Committee chaired by Frank Salvatore have focused on managers. We have been able to identify hospitals where a manager or director is not a member. In early June the membership committee sent directed messages to managers who are not members to join the AARC with an offer of complimentary management section membership while describing the many benefits of AARC to the operation of their department. We will be prepared to provide you with an update on this initiative in Santa Fe.

At last report (June 28th) our membership numbers are at 50,861. This compares to 51,054 a year ago (June 30, 2011). As happens every year at this time we see a drop in our numbers in late spring due to student membership adjustments. This tends to reverse itself in August when student members engage with the AARC. We have kicked off the web student program for this scholastic year with a letter to all program directors and faculty names are being submitted.

July is the first month that we will be offering our new membership rates. There are three membership rates (all of which are full memberships). The change allows members the choice of how to receive the two publications (AARC Times and Respiratory Care Journal). The incentive for our members is that they can actually get the same benefits and publications at a lower membership rate.

Digital only $78.00/annually
Receive one publication $84.50/annually
Receive both publications $90.00/annually

All members automatically have access to both publications on-line regardless of which option they decide upon. Again this change will not change the revenue sharing agreement. The AARC will continue to provide the affiliates with $12.50 for each active and associate member. We are also upgrading our web platform so that the member will be able to take advantage of features that are not available in the print medium.

In 2013 the AARC will begin the “Senior Discount Membership”. Members will retain their current member

category (Active, Associate, etc) and retain the rights of that membership type. To be eligible the member must be 65 or older with 20 years of consecutive AARC membership. A 10% discount will be given for any dues tier. Membership will be made aware of this change later in 2012.

Co-Marketing Opportunities with our State Affiliates

There are 33 affiliates who have signed revenue sharing agreements and 32 who have opted for co-marketing agreement with the AARC. This program allows the affiliates more financial support in addition to the revenue sharing program. We will be rolling out more co-marketing opportunities for the Affiliates this year.

Professional Advocacy

American Hospital Association

As noted at the spring board meeting the AARC was invited to participate in a meeting hosted by American Organization of Nursing Executives and the Human Resources Section of the American Hospital Association in Washington, DC. Many hospital-based professional organizations were in attendance. President Stewart and I represented the AARC. The purpose of the meeting was to discuss current needs and future projections for each organization in the provision of health care. This invitation was significant because it was the first time we were asked to the AHA to sit at the table for such a meeting. It was the 90's when the AHA actually was working to phase out our profession.

One of the first initiatives will be for all hospital-based health care professions to share with their organizations, consumers, and patients a clear message that the provision of care in the hospital is provided by a health care team who all recognize and respect what each discipline provides to our patients.

The theme of this meeting is consistent with the AARC vision, noting that the AARC is also a member of the Hospital Care Collaborative, the direction of which the Board of Directors reaffirmed at their meeting this spring.

Other health care organizations represented at this meeting were:

- American Society of Clinical Pathology
- Academy of Nutrition and Dietetics
- American Occupational Therapy Association
- American Society of Health-System Pharmacists
- American Society of Radiologic Technologists
- American Physical Therapy Association

- American Organization of Nursing Executives

Adventures of an Oxy-phile 2

The book authored by Dr. Petty and associates was audio recorded at a professional sounds studio. Patrick Dunne is the narrator. The AARC will make these available for download from YLH and AARC.org. This is a unique way to spotlight his last book, which will be a treasure to many that knew him and knew of his work.

Drive4COPD

The Drive campaign has been officially turned over to the COPD Foundation. The AARC will play a more significant role this year and moving forward. In fact the AARC is a major partner in this new effort. As was presented at the spring BOD meeting we have received grant money from COPD Foundation for the purpose of filling a new position with the Drive. This position will be a COPD Coordinator. Her/his role will be to coordinate public Drive events as well as to expand the current venues. The position was posted on the AARC Job Site and interviews are being conducted. We will be working closer with the American Legion, VFW, and Am Vets organizations moving forward.

Peak Performance USA (PPUSA)

AARC's National Asthma Education and Prevention Program (NAEPP) representative, Natalie Napolitano has promoted PPUSA to the NAEPP coordinating committee members and asked that they share information about the program to their perspective members and constituents. NAEPP leadership fully supports PPUSA. We continue to promote in AARC communication vehicles including our web site, News Now, and AARConnect. PPUSA has reached an estimated 45,978 children with asthma. It has been implemented in 885 schools in 34 states.

HOSA

HOSA's 2012 Annual National Leadership Conference was held June 20-22, 2012 in Orlando, FL. Members and students from the Valencia College in Orlando FL staffed our booth and represented the AARC at this meeting. A report will be posted on AARC website soon.

Tobacco Cessation Booklet

Our second grant for the Tobacco Cessation booklet was received and an additional 200,000 copies printed. We are reviewing our options for distribution to assure that all members have access to a reasonable number for free, and can then purchase additional copies. We expect the program to become self-sustaining, based on the initial response.

Joint Commission Field Reviews

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

- Clinical Alarm Management Environmental Assessment (03-26-12)
- Proposed revisions to the Disease-Specific Care (DSC) Certification Program Standards (4-27-12)

Meetings and Conventions

AARC Congress 2012

Logistical planning for AARC Congress 2012 is progressing as scheduled:

- 150 (+) speakers
- ~ 275 unique presentations
- Several first time speakers to the AARC Congress have been invited to present; creating a portal for new talent into the AARC.
- All specialty sections are represented in the Congress program with representation from most roundtables.
- Two pre-course offerings are scheduled one day prior to the Congress
    - Patient Safety
    - Post-graduate mechanical ventilation course

Summer Forum 2012

- A full 2.5 day Program has been created to address educational needs of educators and managers.
- There is a continued emphasis on creating course offerings for hospital-based educators (an untapped demographic for the Summer Forum)
- Two post-graduate course offerings have been scheduled.
    - Pre-course: "Building a Simulation Toolbox"
    - Post-course: "Getting the Best Return on Your Investment: Maximizing Patient Education"
- A smartphone application is offered in conjunction with the meeting. It will include a schedule, course descriptions, and add sessions to your personal calendar, speaker bios, and ability to rate speakers.
- Pre-registered attendance is on schedule to meet budget.

Summer Forum 2013

- Summer Forum 2013 will be held in Orlando, FL at the Marriott Renaissance: Orlando at SeaWorld.
- This property is located adjacent to, and within walking distance to, Orlando SeaWorld.
- The last Summer Forum held in Orlando drew record attendance and we anticipate that trend to continue in 2013.
- Orlando is a prime vacation destination with multiple options for recreation and entertainment. We anticipate many attendees will travel with family.

Projects Update

COPD Toolkit

The COPD Toolkit is completed and has been submitted for legal review. At the time of this submission, all supporting documents have been approved with anticipated approval of flip chart at the time of this meeting.

Beta test is tentatively scheduled to include 20 hospitals, each using the Toolkit on 100 COPD patients per hospital. Participating hospitals have been identified. Data will be collected from patients to identify whether or not teaching via the materials provided were effective, and if so, to what degree. Estimated Completion Date: Fall 2012

Patient Safety Checklists

The Patient Safety Checklist project is now complete. Phase One (Oxygenation and Patient Transport) was completed in February, with Phase Two (Respiratory and ICU Recidivism) was completed in June.

Three patient safety checklists are now available for download off of the AARC website (http://www.aarc.org/resources/safety_checklist/). Both Phase One and Phase Two rollouts to membership included a story on the website, an article in the AARC Times, and a webcast. These checklists will reinforce the importance of the respiratory therapist as members of the team in promoting patient safety.

Hospital-to-Home

The Hospital-to-Home initiative continues to move forward in educating hospital-based RTs on issues facing patients as they transition into the home environment. This includes best practices, equipment in the home, disease management and patient education, and discharge planning. The end goal is to create improved relationships between hospital-based RTs, homecare RTs, and the patient. Educational webcasts are scheduled to take place in August.

High Flow Heated Humidity

Identifying that there are knowledge gaps, a lack of evidence, and potential misuse of this technology, this project is designed to encourage RTs using this therapeutic modality to engage in research so that adequate evidence is available to draft a white paper/clinical practice guidelines. An IRB template that participating RTs can use to submit to their respective hospital IRB has been completed and submitted to Midland IRB for review.

RTs will be encouraged to use this template and submit a research application to their own IRB. Once approved, the research study would collect evidence on the clinical effectiveness and safety of this technology. Once adequate data is collected, the AARC could draft a clinical practice guideline/white paper on the proper use of this technology.

Target completion date:

- IRB template: July 2012.
- Rollout to Membership: September 2012
- Data collection: ongoing.

Office Spirometry

We have been asked to extend our clinical trial Spirometry QA program through Feb 2013. It was scheduled to expire in August. Our train-the-trainer program has been well received and produced good results. We have trained about 160 health care professionals to provide training in primary care offices. They have conducted training for over 100 people, with 38 out of 39 successfully passing the online test.

Adult Critical Care Exam

The Executive Office is working with Keith Lamb, RRT and chair of the Adult Acute Care Specialty Section to provide support in his Committee's recommendation to assist RTs who take the new Critical Care Exam, which will be available in July.

Benchmarking

As of June 1, there were 139 facilities participating in the benchmarking service. The volume of users is 108% of budgeted revenue. Our persistent monthly follow-up continues to yield a higher percentage of subscribers with current data. Members of the benchmarking committee continue to personally contact new subscribers within one week after they have gained access to the system and offer personal assistance to facilities that are within 4 months of their expiration date and have not entered at least one quarter of data. We continue to encourage subscriber engagement by holding monthly teleconferences.

Education

Professors Rounds

9 topics and speakers (including one bonus program) constitute the 2012 Professor's Rounds series. All production dates have been completed except for the last two, which will be completed by the end of July. Following that we will begin planning the 2013 series.

Web Casts

By the end of June we will have conducted 10 webcasts. We have dates for 6 more and have commitments for 2 more at this time but dates for those have not yet been established. We continue to attract a large number of participants. (see below)

CRCE

CRCE accreditation revenue is at 130% of budget. The on-line CRCE application process has been completed and will be ready for implementation this summer. Final stages of testing are being completed at this time. It will be live in August.

Course Registrations

Since Jan 1, 2012

All Webcasts	2143
All Archives	786
EPA Courses	
Triggers	2495
Allergy Skin	1426
Asthma Educator	151
COPD Educator	248
Ethics	1578
VAP	226
Alpha 1	266

2015 and Beyond

As per the BODs direction a 2015 and Beyond placement on our web site (aarc.org) was added. In the first week after it was put on the web site there were over 11,000 views. This will be housed permanently on our

main page so that anyone who wishes to learn about this project as well as to get current updates will have access.

AARC Research Fund

The BOD approved $88,020 to fund a research proposal from Barnes Hospital for a respiratory therapist to serve as an advanced patient care coordinator for patients discharged from the hospital with COPD/asthma. Their role would be to oversee the discharge of the patient to insure that respiratory treatments and medications are appropriately prescribed for outpatient therapy, that adequate follow-up occurs post discharge in a medical clinic, that outpatient access to medications is available, and that other social services are involved as needed. They will also monitor study patients to assure adherence to COPD/asthma management guidelines during their inpatient stay. The desired outcome would be to reduce readmissions to the hospital and visits to the emergency department while at the same time documenting the value of the respiratory therapist in this critical role. A payment schedule has linked acceptable periodic performance reports to payments has been agreed upon. The study began on June 1 and the first report is due September 12, 2012.

IT update

All upgrades are progressing as per agreed upon timetable. The desktop replacement will start in July. There have been no additional expenses since the spring board meeting. The users have a small device on the desktop that does nothing more than manage the display and keyboard. There is no local operating system or disk or memory. Instead, all of these functions are performed on a server in the data center. This has the advantage of not needing to upgrade or replace desktop hardware as often, since there are no parts to fail.

All programs are run from the virtual server, so operating system and software upgrades can be applied to all desktops with one instruction. It also helps with software management, since no programs can be loaded on the local desktop. It will reduce the possibility of introducing viruses from unauthorized software.

The server virtualization is nearly complete. The 14 physical servers have been reduced to 2. We have also reduced the heat load in the server room to the point that it can run for a reasonable time to safely shut down the servers in case of a power failure. Remembering last summer's rolling blackouts in the region, the battery backups and reduced heat load should keep us from shutting down the servers if we see the same problems this summer.

Communications Update

We continue to monitor communications between our roundtables and section members. Attachment #1

indicates that some groups are more engaged then others. The Roundtable members are using this communication tool far less then section members.

Membership Analysis

We have attached the latest membership numbers from other medical organizations as we do annually. See Attachment #2

Attachment #1

AARConnect Messages from 1/1/2012 to 6/21/2012

Specialty Sections

Discussion	New Threads	Reply to Discussion	Total Messages
Adult Acute Care	0158	0371	0529
Continuing Care/Rehab	0076	0120	0196
Diagnostics	0089	0239	0328
Education	0106	0244	0350
Home-Care	0027	0045	0072
Long-Term Care	0025	0031	0056
Management	0467	1227	1694
Neonatal-Pediatrics	0214	0438	0752
Sleep	0036	0030	0066
Surface & Air Transport	0086	0303	0389

Roundtables

Discussion	New Threads	Reply to Discussion	Total Messages
Asthma Disease Management	0005	0007	0012
Disaster Response	0009	0001	0010
Geriatrics	0000	0000	0000
Hyperbarics	0001	0000	0001
Informatics	0005	0001	0006
International Medical Missions	0002	0002	0004
Military	0009	0010	0019
Neurorespiratory	0007	0008	0015
Research	0005	0004	0009

Simulation	0005	0011	0016
Tobacco-Free Lifestyle	0014	0009	0023

Other Communities

Discussion	New Threads	Reply to Discussion	Total Messages
Leadership Book Club	0037	0045	0082
Bylaws	0023	0099	0122
Coding	0029	0052	0081
Resolutions Committee	0012	0023	0035
Board of Directors	0033	0102	0135
House of Delegates	0037	0009	0046
Help Line	0244	0490	0734

Attachment #2

Organization	National	Student	Retired	No. of members	No. in profession	Salary
American Physical Therapy Assoc	$295	$90	$220	75,000	198,600	$76,310
American Occupational Therapy Assoc	$225	$75	$112	40,000	108,800	$72,320
American Speech, Language, and Hearing Assoc	$225			150,000	123,200 (speech therapists only)	$69,920
American Academy of Physician Assistants	$275	$75	$75	43,000	83,600	$86,410
American Society of Radiologic Technologists	$105	$30	$53	132,000	219,900	$54,340
American Assoc of Critical Care Nurses	$78	$52	$52	80,000	500,000	
American Assoc of Sleep Technologists	$100	$50		4,200		

American Assoc for Respiratory Care	$78	$50		49,000	145,000	$54,280
American Nurses Assoc	$183					

Summary

I am happy to expand on the information provided in this report in Santa Fe. We look forward to a productive meeting.

State Government Affairs Activity Report
July 2012

Cheryl A. West, MHA
Director Government Affairs

A significant number of state legislatures have adjourned for the year, although several legislatures, such as Michigan, New York and California remain in session year round. The tentative economic recovery has not mitigated the budgetary pressures on state finances. Unlike the federal government, states must balance their budgets every year. Thus, states continue to search for new revenue sources (raising licensure fees and tobacco excise taxes, increased state higher education tuition as examples); revising Medicaid payments (ex. moving towards competitive bid payments for DME); diverting tobacco prevention and cessation funds to other state health programs and amending eligibility requirements for state services.

Legislation

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

The bills listed below highlight key legislation that are of particular interest for the respiratory therapy profession. Please note, because of the volume of activity from the many states that pass legislation raising tobacco taxes or restricting smoking in public places I have not included these bills in this report. Although there are two bills that are "interesting": **Arizona** legislation that will classify electronic cigarettes as tobacco products, and a bill in **West Virginia** that would prohibit employers from discriminating against smokers… just FYI.

Michigan Government Recommends Repeal of MI RT Licensure

Nearly a year ago, Michigan Governor Rick Snyder rather quietly tasked staff from the Office of Regulatory Reinvention to review and make recommendations that, in the name of "over-regulation" would present a list of professions that this panel recommends to be "de-licensed", i.e. removing the state from oversight and regulation. The final report from the Commission included respiratory therapy as one of the 18 professions recommended to be "de-licensed". (Also on the list of health professions slated to be "de-licensed" are occupational therapists, speech therapists and dieticians/nutritionists). According to the Deputy Commissioner of the Office of Regulatory Reinvention these professions were selected because "We found that there were at least 18 occupations that did not require regulation. These regulations provide little or no significant protection to the public".

The rationale given in the Report to "de-license" MI RTs is that the NBRC credential is sufficient to "provide employers of the qualifications of the respiratory therapists."

To put it mildly the Michigan Society for Respiratory Care –MSRC (see attachment 1), the AARC (see attachment 2) and the NBRC (see attachment 3) adamantly oppose this recommendation. The MSRC has organized an all out coordinated response to this initiative. The Governor has the discretion to remove any profession that is on the recommendation list. For those professions not removed by the Governor and thus remain on the list, the set of recommendations will be sent to the Michigan legislature for debate and decision. Therefore, the MSRC's first plan of attack is to approach the Governor with the rationale why it is imperative to remove RTs from the list. If the Governor fails to act on the persuasive arguments, the MSRC's considerable efforts will turn to the legislature where an all out lobbying effort by MI RTs will get under weigh.

I want to take a moment to commend the MSRC's exceptionally well coordinated, organized and strategically planned response to this threat not only to the RT profession, but one if implemented will jeopardize the health and safety of Michigan patients. As this report is written the outcome of this situation is very fluid and I will provide an update at the July meeting.

RT Licensure Legislation

Iowa- legislation was enacted that permits "qualified health care providers*"* defined in this bill as physician assistants and advanced nurse practitioners to write RT orders (in addition of course to physicians).

Nebraska enacted a similar bill, but permits NPs and PAs, and CRNAs to write RT orders.

Missouri – again similar legislation as in Iowa and Nebraska, but bill would only extend RT order authority to advanced practice nurse.

Comment: These 3 legislative initiatives result from the relaxing of Medicare Hospital Conditions of Participation for RC Services. These new rules permit RTs to take orders from a select set of non physician practitioners (termed by CMS as "qualified health care providers") without the need of a physician co-signature. However, one of the stipulations by CMS for this more lenient policy is that this must be "in accordance with state laws".

If RT licensure laws permit RTs to take orders only from physicians, then this less restrictive Medicare policy cannot be implemented. Therefore, the intent of these bills in MO, NE and IA, (where the original RT licensure law language permits only physicians to write RT orders) is to revise the laws in order to meet the requirements of CMS's more flexible policy on RT orders. **Washington State** enacted a similar revision to the RT practice act in 2011.

Ohio expands the authority of CRNAs to direct a list other professionals including RTs to administer drugs.

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

Louisiana – (**enacted**) Legislation addressing paramedic regulatory personnel requirements was introduced. The actual paramedic revisions had no impact on the RT profession. However, what was noticed when reviewing the legislation was that current law (not undergoing any revisions) had explicitly listed the health care professionals permitted to ride as ambulance transport personnel. Respiratory therapists were not listed in the law. Recognizing that if some "entity" was to raise the legal issue of whether RTs could be part of transport teams (no as they are not listed in the law); the LSRC inserted a provision into the law that now legally allows for RTs to be part of a transport team, thus averting any future questions or disruption of transport teams.

Florida- a staffing bill focused on medically fragile children under 21who are in need of skilled care. The bill specifically requires 5 hours a day of skilled care which must be provided by a list of health care professionals including RTs.

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

Oklahoma will raise RT license fee from $75 to $100. Also, a bill requiring RTs to maintain a valid NBRC credential for license renewal was introduced. This NBRC credential bill did not move forward but it is of interest that this requirement is under consideration.

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

Generic Health Profession Licensure Legislation that Includes Respiratory Therapists

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

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

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

Other Legislation of Interest to the Profession of Respiratory Therapy

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

Connecticut legislation was originally introduced to establish a small 5 site Medicaid pilot program to provide skilled home care for vent dependent patients with the services to be provided only by LPNs and RNs. The CSRC contacted state legislators with their concerns over the omission of RTs and the bill was amended to remove nurses and insert RTs (and advanced nurse practitioners). This bill has been enacted.

New Jersey a bill requiring oxygen providers to provide notice to the local fire department or company whenever they stop supplying or delivering oxygen or an oxygen delivery system to a particular patient and the O2 system has been removed from the residence.

Florida (adopted), Hawaii (adopted), Illinois, Kansas (adopted), New Jersey, New Mexico (adopted), Mississippi (adopted) and Utah- - a variety of legislation that focuses specifically on COPD, requesting more study on the causes of COPD and/or developing strategies for prevention and management of COPD or recognizing the efforts of the state COPD Coalition (**North Carolina**-adopted).

Alabama (adopted) , Georgia (adopted) Florida, Illinois, Indiana, Iowa (adopted), Louisiana (adopted), South Dakota (adopted) all have legislation that either designates a COPD Day or a COPD Month

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

Respiratory Related Rules/Regulations

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

Florida- tweaks how to account for continuing education credits for license renewal.

Iowa and Delaware also make technical changes to continuing ed credits.

Louisiana makes long anticipated and expected changes to RT regs, however these changes were not unexpected by the LSRC

Nevada- amends RT license expiration, technical change

Tennessee is changing the fee for RT license

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

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

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

Concerns or Challenges from Other Occupations

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

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

Washington State- legislation was introduced to expand the scope of practice for unlicensed medical assistants, including providing "respiratory testing", which among other points of contention, is not defined.

Iowa- legislation that would create a new provider category termed "direct care professional". These individuals would care for patients in the home and community settings. Limited definitions of what would be required in terms of education, scope or competency testing. However, one point was clear- this new category would not be required to be licensed.

Sleep Disorder or Polysomnography State Legislative Activities

Maryland
As noted in previous State Update Reports, the Maryland Polysomnography licensure law, was enacted (2006) prior to the availability of A Step, the American Academy of Sleep Medicine-AASM(sleep physicians)- 80 hour OJT training course. The MD Polysom licensure law requires polysom personnel to be graduates of CAAHEP accredited education programs. Being unable to meet this education standard, mandatory licensure for polysoms has been delayed by the legislature several times (now slated for October 2013).

The original law did not include a specific exemption for RTs, but rather a general exemption for other licensed health professionals who are practicing within their own scope of practice. About 2 years ago, a statement from the MD Polysomnography Licensure Board and confirmed by MD State Attorney General, that if the RT were

to provide any service or procedure listed in the Polysomnography scope of practice (task specific) but not specifically listed within the RT scope of practice (purposefully general) the RT would require a polysom license.

The MD/DC Society engaged a lobbyist to advance a bill that would provide an exemption for the RTs from the requirements of the Polysom licensure law.

A panel of RTs testified in at a February hearing in support of a RT exemption. The panel included Dr. Cliff Boehm (BOMA rep and Maryland physician – and RT). The bill was passed by the legislature and signed into law by the Governor.

In the meantime, the Sleep Society had its own bill going through the legislature that would add the A Step 80 hour OJT training course as an acceptable "education" pathway, comparable to an accredited CAAHEP accredited education program in polysomnography. This separate bill was passed and signed into law.

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

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

With the refusal to accept the RT exemption provision, the ISRC leadership expressed its concerns to legislators and testified at a legislative hearing stating that without the RT exemption the society regretfully had no choice but to oppose the bill. The ISRC launched a statewide RT grassroots campaign with information and requests that went out to all IA RTs asking them to contact their own legislators and oppose the polysom licensure legislation. As a result of these efforts, the ISRC lobbyist has reported that the polysom licensure legislation was killed in committee (at least for this year).

Again, it should be noted that the leadership of the Iowa Society and the Iowa RTs were exceptional well organized and committed to addressing this issue and resolving it in a such a way as to protect the integrity of the respiratory therapy legal and long standing scope of practice.

Delaware
In mid April the all too familiar "standard" polysomnography licensure bill was introduced. Chief among the concerns of the Delaware Society was the absence of an explicit exemption for RTs. Fearing that what occurred in Maryland, (a general exemption, not an explicit one for RTs) the Delaware Society has taken its' concerns to the Delaware Sleep Society. At this writing a constructive dialog has occurred, with the Sleep Society offering to amend their bill to include an unambiguous exemption for the RTs. The DSRC leadership should be commended for its rapid and thorough response in addressing this legislation and thus far the positive interaction with the DE Sleep Society.

New Hampshire and Louisiana- both state legislatures had technical changes to the current polysom licensure laws (NH polysoms are licensed under the RT Licensure Bd). Originally neither bill revisions had any impact on the RT profession. However, in **Louisiana,** unknown special interests inserted unacceptable revisions into the otherwise benign technical change legislation. The LSRC was able, through intense negotiations with the

legislators to revoke the newly inserted changes and then include wording that would permit RTs to supervise RT students going through a polysom rotation.

I will provide a verbal update at the Summer Meeting.

Federal Government Affairs
Activity Report – July 2012

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

The Congress

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

Certain of the "must pass" legislation such as payroll tax extension, unemployment insurance continuation, and the "doc fix" have already been extended through the rest of 2012. However, by the early fall or in a post-election Lame Duck session, these issues, specifically the "doc fix", will once again be on the agenda and will have to be addressed before January 1 2013, thus necessitating some action on the part of Congress.

Legislation

The Medicare Respiratory Therapy Initiative

The AARC's Congressional advocacy efforts remain focused on legislation that will expand patient access to respiratory therapists in the physician's office. We have pushed this effort via legislation, HR 941, the Medicare Respiratory Therapy Initiative.

However, our greatest challenge in moving our bill forward has been score or cost analysis by the Congressional Budget Office (CBO). There have been several versions by CBO as to what this cost will be to the Medicare Program over the next 10 years.

We are in the process of revising the language of the bill to tighten up the provisions, while keeping the intent of HR 941.

We are currently in discussions with Senator Crapo's office to have Legislative Counsel draft new bill language based on specifications AARC has provided to his staff that can be introduced as new legislation and therefore garner a new CBO estimate.

The intent of this new tact is the same as HR 941, that is, to create greater patient access to respiratory therapists in the physician's office. As you know, ACCP, ATS and NAMRC have already gone on written record in supporting the Medicare Initiative and we expect their continued support with the revised bill language.

AARC Hill Lobby Day

Over a dozen years ago the AARC organized a group of politically active RTs, called the Political Advocacy Action Team (PACT) representatives who are appointed by their state societies to act as coordinators when state or federal political action is required.

A key component to moving our legislative agenda through the Congressional process has been the RTs who come to DC once a year to lobby their Congressional delegations.
For this, our 13th year, AARC respiratory therapists were joined by pulmonary patients from the Alpha 1 Foundation, the COPD Foundation, the Alpha 1 Association and a new partner -- the Pulmonary Hypertension Association. We had over 350 scheduled Capitol Hill Office visits. This number of scheduled meetings is the highest number we have ever achieved and it is a great accomplishment. This year we had 136 RTs from 46 states and the District of Columbia advocating for our legislative agenda.

Our lobby day also generated three Congressional Offices to respond to the request from the visiting RTs to contact the CBO and inquire about the high score for HR 941. We provided additional data for these offices to present to CBO for a recalculation of the cost. Unfortunately, in spite of the additional data, CBO stands by their original score.

Virtual Lobby Week

The AARC launched another successful Virtual Lobby Week at the end of February. This event is where we generate nationwide support from RTs, patients and caregivers to email their members of Congress in support of our legislative agenda. We scheduled this event, with much fanfare, just prior to our Hill Day. We generated over 12,500 emails that supported our RT legislation and showed support from "back home' before the PACT RTs met with their Congressional delegations.

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

Veterans Affairs Bill on COPD

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

NIH to Take Over COPD Plan from CDC

The Senate included language in their appropriations bill that directs the NIH, NHLBI to convene a planning meeting with the goal of producing a National Action Plan for COPD. This is a strategic shift from the previous request that this activity be undertaken by the Centers for Disease Control and Prevention. COPD advocates working with the US COPD Coalition felt that we stood a better chance of having this activity take place under the auspices of the NIH due to significant budget cuts at the CDC. All meetings have been suspended after a GSA meeting in that took place in Las Vegas was reported to have cost tax payers close to a million dollars. The NIH was planning to convene a two day conference but has now reported that if a meeting takes place prior to the end of the fiscal year, which is September 30, 2012, it will be with internal government participants only. We may have to go another round with the government to get this meeting and important agenda item accomplished.

Technical Change to Medicare Outpatient Pulmonary Rehabilitation Benefit

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

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

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

Legislative Actions on Competitive Bidding

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

In March 2011, a new repeal bill was introduced by Reps Jason Altmire (D-PA) and Glenn Thompson (R-PA). This time the bill language included a "pay for" by rescinding $20 billion in unobligated balances of all discretionary appropriations. However, it does not appear that the second attempt at appeal is moving forward.

With competitive bid implemented in 9 areas of the country and poised to expand to 91 areas by July 2013, AAHomecare is promoting an alternative proposal to preserve more of the HME industry, save the government money and provide better service to Medicare beneficiaries. They are waiting for CBO to score the legislation in hopes of showing that it will yield the same Medicare savings as the current competitive bidding model. A recent Congressional hearing with CMS and industry staff did not yield a consensus on whether the program should be expanded, modified or replaced.

Coalition Activities

The AARC continues its practice of participating in a number of Coalitions of like-minded associations and organizations to advance particular legislation and/or regulations. In previous years our participation with certain Coalitions was focused on urging greater funding for health and/disease research to promoting issues that will enhance the clinical support of patients with particular illnesses.

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

Friends of Cancer Research

AARC signed onto a joint letter to Congress requesting that legislation be passed that would designate as a "Breakthrough Product" drugs and biologicals that show benefits in early trail phases thus speeding up the FDA approval process.

Air Quality Control Coalition

AARC joined a loose coalition that supports clean air initiatives. AARC signed onto a letter to Congress opposing Senate Resolution 37 which would employ the Congressional Review Act to reverse the U.S. Environmental Protection Agency's (EPA) Mercury and Air Toxics Standards for Power Plants.

Asthma Control Funding in the CDC

Organized jointly by the American Lung Association and the Asthma and Allergy Foundation of America, the AARC is one of the many organizations to participate in efforts to enhance asthma education, management and

control AARC signed on to a joint letter requesting that the CDC maintain its current funding for asthma control initiatives.

Tobacco Partners

The AARC continues its long-time relationship with the many organizations who participate in the Tobacco Partners Coalition (a Coalition organized and supported by the American Heart Association, the American Lung Association and the American Cancer Society). AARC has signed on to a letter to the House and Senate Appropriations Committees requesting that the Committees continue to support FDA funding of the Centers for Tobacco Products(CP) at the full authorized level and reject any efforts to weaken CTP's authority.

Regulations and Other Issues of Interest

Updates to the Medicare physician fee schedule and inpatient and outpatient prospective payment systems, which are the primary vehicles for policies affecting the pulmonary community, are generally proposed in the spring and finalized in early, fall. Several regulations have been published recently that are of interest.

Proposed FY 2013 Update to Inpatient PPS

The proposed rules to update the annual prospective payment rates for acute and long-term care hospitals (LTCH) were announced on April 24. Key among the provisions is the Hospital Readmission Reduction Program established by the Accountable Care Act which kicks in for discharges on or after October 1, 2012, CMS is required to reduce payments to hospitals with readmissions in excess of an expected level for three selected conditions: heart attack, heart failure and pneumonia (AMI/HF/PN). The payment reduction amounts to a 1% reduction to the hospital's base operating DRG payments. CMS estimates that this will result in an overall 0.3 percent decrease in payments to hospitals, or approximately $300 million.

To provide a broader assessment of a hospital's quality of care, especially for hospitals with too few AMI/HF/PN readmissions, CMS is also proposing for FY 2015 a Hospital-Wide Readmission (HWR) measure as part of the Hospital Inpatient Quality Reporting Initiative (HIQR). This new measure assesses unplanned, all-cause readmissions for any eligible condition within 30 days of hospital discharge. The focus will be on readmissions for acute diagnoses or complications of care. COPD is one such diagnosis in this category.

The Value-Based Purchasing Program (VBP) proposes to add a Medicare "spending per beneficiary" measure that would include all Part A and Part B payments from 3 days prior to an inpatient hospital admission through 30 days post discharge with certain exclusions. Final rules for the overall program were published last year but are not effective until October 1, 2012. As reported earlier, hospitals will receive an incentive payment if they improve performance in 5 specific measures. (NOTE: The measures, which overlap those reported under the Hospital Quality Reporting, include pneumonia).

Although two new conditions are proposed in tracking health-care associated infections, ventilator-associated pneumonia (VAP) is not one of them. However, CMS recognizes that VAP is costly and that 10% - 20% of patients receiving greater than 48 hours of ventilation will develop VAP. Consequently, a ventilator care-bundle process measure consisting of four components is being proposed for LTCHs since ventilator patients are a large segment of the LTCH patient population.

Hospital Conditions of Participation – Burden Reduction

Final regulations that revise various sections of the Hospital Conditions of Participation were published recently by CMS. The changes are aimed at cutting burdensome red tape for hospitals to give them more flexibility to improve patient care while lowering costs. Proposed changes were reported to the Board at its last meeting. Some of the final changes, namely those dealing with protocols, could improve access to respiratory therapists as some hospitals prior to the change restricted protocols to rapid response teams only.

Among the noteworthy changes are 1) encouraging use of nationally recognized, evidence-based pre-printed and electronic standing orders, order sets and protocols that ensure consistency and quality of care provided to all patients; 2) permitting orders for drugs and biologicals to be prepared and administered on the orders of a practitioner other than a doctor in accordance with hospital policy and state law; 3) allowing the option of a single nursing plan of care or a comprehensive interdisciplinary plan that includes nursing and other disciplines such as respiratory care; 4) eliminating the 48-hour timeframe for authentication of verbal orders, deferring instead to applicable State laws; and 5) permitting either the ordering practitioner or a practitioner who is responsible for the care of the patient and authorized to write orders to date, time and authenticate the medical record.

FDA to Consider a New Paradigm for Drugs

The FDA held a public hearing on March 22 to hear presentations and comments on a new paradigm under consideration whereby FDA would approve certain drugs for over-the-counter use that would otherwise require a prescription as long as conditions of safe use are met. Since future proposed rules are incumbent on what is presented at the hearing, it is unclear at this time what specific policies will be proposed. Under consideration are rescue medications, such as inhalers for asthma patients or epinephrine for allergic reactions. Also being considered are medications for certain diseases or conditions that are currently only available by prescription or certain classes of drugs based on a review by FDA of each New Drug Application. Pharmacists would see an increased role in the process.

AARC has expressed concerns about the potential impact on asthma and COPD patients, noting that there are nationally accepted peer-reviewed guidelines for the coordinated management of these diseases. We caution FDA that a shift in the paradigm must be weighed against the negative consequences of removing the input and clinical intervention of health care professionals in the care regimen of these respiratory patients.

Medical Device Tax

The Accountable Care Act requires manufacturers of medical devices to pay a 2.3% tax at the time of sale in order to offset the costs of implementing health care reform measures. The sales tax is aimed at large purchases that are used primarily in a medical institution or office or by a medical professional. Exempt from the sales tax are eyeglasses, contact lenses, hearing aids, and items that are generally purchased by the general public at retail for individual use (i.e., the retail exemption). Certain safe harbor rules allow for additional exemptions.

When the IRS/Treasury published proposed rules in early February, they listed Anesthesiology Devices classified by the FDA as meeting the sales tax criteria. Although there is no argument that a number of items in this device classification meet the device tax criteria, the category also includes oxygen concentrators and portable oxygen systems, as well as nebulizers and other respiratory devices and accessories designed for home use which should be exempt. To demonstrate that these devices should be exempt requires the manufacturer to go through a lengthy "facts and circumstances" test in which a final decision can be made.

The AARC sent comments to IRS recommending that Anesthesiology Devices be removed from the non-exempt list and a new safe harbor for retail exemption be established for all devices in that category, including oxygen concentrators, portable oxygen systems and other respiratory care devices and accessories, that are specifically designed for and intended to be used in the home by individual consumers who are not medical professionals. Individual home medical equipment companies, AAHomecare and NAMDRC submitted similar comments. A hearing by the IRS regarding these provisions was held on May 16. Final rules have yet to be published.

Conclusion

The AARC will continue our efforts on Capitol Hill to advance our legislative agenda. We believe our increased efforts to partner with patient organizations and other like-minded associations will provide forward momentum in achieving our goals. We will also maintain our vigilance on the regulatory side responding to both challenges and opportunities.

HOD Report

Reporter: Karen Schell
Last submitted: 2012-06-18 14:45:13.0

Recommendations

No Recommendations

Report

The Agenda for the HOD meeting in Santa Fe is being finalized for the Agenda Book by the deadline.

The Speaker of the HOD has been in contact with the AARC office through conference calls to communicate updates with the AARConnect, committee work, and specific questions.

The HOD Officers have been working closely with committees assigned to complete goals set by the Speaker in preparation for the Summer meeting in Santa Fe.

Committees have been communicating and working on their goals through the AARConnect and are preparing reports for the Summer meeting on their progress. The Speaker has notified the committee of time allotted during the meeting in Santa Fe for committee work on the Agenda. Awards, Delegate Assistance, and Ad Hoc committee on Policy and Procedures are finalizing their reports. The new version of the policy and procedure and delegate handbook will go to house members for review prior to the meeting in July for approval during the meeting.

The Past Speaker and the AARC office are working on finalizing the credentials and conflict of interest statement for the meeting.

The orientation committee is working on contacting all new members to prepare them for their term in the HOD.

Tom Kallstrom, CEO, AARC will be giving one of the Best Practices presentations on "Budget 101" to prepare HOD member for the joint meeting scheduled with the AARC BOD. Three other best practice presentations are scheduled during the meeting.

The Speaker of the House is working with HOD officers to act on the BOD directive to review Policy No. CA. 002 *Chartered Affiliate Requirements and Responsibilities* and recommend a checklist and revised policy for the HOD members to review and give input prior to returning to the BOD as a final document recommendation during the Summer meeting.

The Speaker of the House will be preparing a summary of survey sent to HOD for review and place on the agenda on "how we are doing".

Respectfully submitted,

Karen Schell

Speaker of the HOD, 2012

Board of Medical Advisors Report

TO: AARC Board of Directors
FROM: Lori D. Conklin, M.D. Chairman of the Board of Medical Advisors to the ASA Respiratory Care Committee
DATE: June 22, 2012
RE: Summer BOMA Meeting held in Dallas, Texas

Please find the minutes of this past summer meeting of the Board of Medical Advisors to the ASA Respiratory Care Committee below.

First, let me begin by saying, I assumed the position of BOMA Chairman following the unexpected death of our current Chairman, Dr. Philip Marcus. Second, let me offer my apologies for not attending this meeting. With Dr. Marcus' unanticipated passing, I had already made vacation plans with my daughter to travel into Yellowstone's Backcountry during the time of this meeting. I am already making plans to attend next year's meeting. Finally, I would like to highlight one area of discussion regarding the format for our summer BOMA meeting. This year we will be participating in online webinars as a possible format change for the June BOMA meeting. A "test run" will take place in August or September. It has come to our attention that time constraints and travel budgets require more creative meeting formats and integration/utilization of internet technology can assist in alleviating some of the issues surrounding business travel in today's economy.

RECCOMENDATION

Finally, BOMA recommends that the AARC Board of Directors form an Ad Hoc Committee to place information on the different schools on their website specifically giving benchmarks, such as, but not limited to, first time pass rates and job placement and possibly faculty strengths and weaknesses with input from CoARC and NBRC.

I hope you all have a fantastic meeting in Santa Fe. It is a beautiful and very relaxing venue.

Sincerely,

Lori D. Conklin, M.D.
BOMA Chairman
Associate Professor of Anesthesiology
University of Virginia Health Care System

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Medical Advisors Meeting
June 9, 2012

Minutes

Attendance

Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
Steven Boas, MD (AAP)
Cliff Boehm, MD, RRT (ASA)
Terence Carey, MD (ACAAI)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Kent Christopher, MD, RRT, FCCP (ACCP)
Lori Conklin, MD (ASA), **Chair**
Thomas Fuhrman, MD (ASA)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
Col. Michael Morris, USA, RET
Peter Papadakos, MD, FCCM, (SCCM)
Christopher Randolph, MD (AAAAI)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)

Guests

Kerry George, NBRC President
Gary Smith, NBRC Executive Director
Tom Smalling, CoARC Executive Director

Excused

William Bernhard, MD (ASA)
Bradley Chipps, MD (ACAAI)
Brett Gerstenhaber, MD (ATS)
Barrett Kitch, MD (ATS)
Harold Manning, MD, FCCP (ACCP)
Joseph W. Sokolowski, MD, FACP, FCCP (ATS)

Consultant

Tim Myers, MBA, RRT-NPS, AARC Past-President, BOMA Liaison
Sam Giordano, MBA, RRT, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Anne Marie Hummel, Director of Regulatory Affairs
Doug Laher, MBA, RRT, Associate Executive Director
Steve Nelson, RRT, FAARC, Associate Executive Director
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
Chairman Conklin called the meeting of the AARC Board of Medical Advisors to order at 8:06a.m. CDT, Saturday June 9, 2012.

BOMA Liaison Tim Myers swore in Dr. Lori Conklin as new Chair of BOMA.

INTRODUCTIONS
Chairman Conklin asked members to introduce themselves.

APPROVAL OF MINUTES
Dr. Randolph moved "To accept the minutes of the November 6, 2011 meeting of the AARC Board of Medical Advisors."
Motion Carried

CHAIRMAN'S REPORT
Dr. Conklin gave highlights of her written report. Dr. Boehm's term will expire at the end of 2012 and Dr. David Kelley has been appointed as the new ASA representative.

NATIONAL BOARD FOR RESPIRATORY CARE
NBRC President Kerry George presented highlights of his written report. A discussion followed regarding the new NBRC Written Credentialing Exam for CRT/RRT.

CoARC (Commission on Accreditation for Respiratory Care) REPORT
Tom Smalling, Executive Director of CoARC, updated BOMA on CoARC's recent activities. Tom commented on Dr. Sheldon's concern on the excessive number of respiratory therapy schools.

Dr. Carey moved to recommend to the AARC Board of Directors "to form an Ad Hoc Committee to place information on the different schools on their website specifically giving benchmarks, such as, but not limited to, first time pass rates and job placement and possibly faculty strengths and weaknesses with input from CoARC and NBRC."
Motion Carried

PRESIDENT'S REPORT
Tim Myers gave highlights of AARC President Karen Stewart's written report.

RECESS
Chairman Conklin recessed the meeting of the AARC Board of Medical Advisors at 10:13a.m. CDT, Saturday, June 9, 2012.

RECONVENE
Chairman Conklin reconvened the meeting of the AARC Board of Medical Advisors at10:32a.m. CDT, Saturday, June 9, 2012.

EXECUTIVE DIRECTOR REPORT

Tom Kallstrom gave highlights of the Executive Office report. Tom informed the members of BOMA that Tim Myers will be joining the AARC effective July 9, 2012. A link to the online Aerosol Delivery Device Guide and the new Safety Checklist will be sent via email to all BOMA members.

Sam Giordano commented on evidence-based clinical practice guidelines. The development will be done under the auspices of our science journal, RESPIRATORY CARE.

Doug Laher informed the Board that Summer Forum that will be held in July in Santa Fe, NM. The next BOMA meeting will take place on Sunday, November 11, 2012, in New Orleans, with a reception the night before.

Tom Kallstrom led a discussion regarding attendance at the BOMA Summer Meeting and the possibility of using current technology to conduct a meeting as opposed to an in-person meeting. Dr. Carey requests that there continue to be two meetings per year in some fashion.

Dr. Randolph moved "that BOMA offer a web-based meeting after AARC Summer Forum Meeting with the topic 'BOD Update'".

Motion Carried

LEGISLATIVE AFFAIRS REPORT

Director of Regulatory Affairs, Anne Marie Hummel, reviewed the written reports.

RECESS

Chairman Conklin recessed the meeting of the AARC Board of Medical Advisors at 11:53a.m. CDT, Saturday, June 9, 2012.

RECONVENE

Chairman Conklin reconvened the meeting of the AARC Board of Medical Advisors at 12:28p.m. CDT, Saturday, June 9, 2012.

MEDICAL ADVISOR REPORTS

Some BOMA Members gave updates on their sponsoring organizations.

SPECIALTY SECTION REPORTS

The Specialty Section Reports were reviewed.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Patient Safety and Respiratory Care Staffing Standards Position Statement

Dr. Cheifetz offered comments on the position statement from North Carolina. He requests that BOMA offer a position statement or comments.

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

ADJOURNMENT
Dr. Conklin adjourned the meeting of the AARC Board of Medical Advisors at 1:10p.m. CDT, Saturday, June 9, 2012.

President`s Council

Submitted by Margaret Traband

Recommendations

No Recommendations

Report:

We have received the Life and Honorary nominations and CVs from the BOD. We will receive the nominations from the HOD after their summer meeting.

Other

No other business

Standing Committee Reports

Audit Sub-Committee

Submitted by John Steinmetz

Recommendations

No Recommendations at this time

Report

There has been no committee activity since the April 2012, BOD meeting in Grapevine, TX.

Bylaws

Reporter: Rick Weaver

Last submitted: 2012-06-18 15:25:17.0

Recommendations

Recommend the AARC BOD accept and approve the Respiratory Care Society of Washington bylaws.

Recommend the AARC BOD accept and approve the Nevada Society for Respiratory Care bylaws.

Recommend the AARC BOD accept and approve the Minnesota Society for Respiratory Care bylaws.

Recommend the AARC BOD accept and approve the Virginia Society for Respiratory Care bylaws.

- Note: The VSRC struck language in the Associate member section regarding voting and holding office. Although unconventional, they defined in their officer sections and in their voting section that only Active members can hold office and that only Active members are sent ballots.

Report

The Bylaws Committee reviewed the bylaws submitted by Washington State, Nevada, Virginia, and Minnesota and has found that they meet the criteria for approval.

The Bylaws Committee reviewed the bylaws submitted by Puerto Rico and has found they are not ready for submission. Committee members will meet with the Puerto Rico delegates at the HOD meeting.

Attachments

- RCSW Cover Letter-042212.docx - SEE BELOW, Page 82
- RCSW Proposed Bylaws .docx - ATTACHMENT
- Nevada Bylaws Cover Letter 2012.docx – SEE BELOW, Page 83
- NSRC Bylaws-revisions 2012.docx - ATTACHMENT
- VSRC Letter to AARC Bylaws 061512.doc – SEE BELOW, Page 85
- VSRC BYLAWS Proposed Changes 061512.docx - ATTACHMENT
- MSRC Bylaws Cover Letter1.doc – SEE BELOW, Page 87
- MSRC proposed bylaws-final version.docx - ATTACHMENT

AARC BOD: 22 Apr 2012

Please find attached the updated RCSW bylaws. We made the following changes (*see in red/blue print on document*):

1. Made the President position a 2 year term

2. Set term limits on Chapter presidents to 2 years

3. Changed wording with active members voting for chapter presidents.

If you have any questions, please don't hesitate to contact me.

****

Greg Carter BS, RRT
2012 RCSW President
Program Director - Respiratory Program
Tacoma Community College
Phone: (253) 566 - 5231
Cell: (253) 227-5329
Pager: (253) 383 - 0317
Email: gcarter@tacomacc.edu

June 14, 2012

To: AARC Bylaws Committee

The Nevada Society for Respiratory Care is submitting revised Bylaws for approval. The changes that have been made to reflect what we aspire to put into place.

The major changes we have made are as follows:

In Article II – Membership

1. Added Student Member and a classification description of Student member

In Article III – Nominations and Elections

1. Added electronic mail as an option for sending out nominations
2. Changed the date for when nominations and ballots will be sent out to the members to coincide more closely to our fiscal year (January 1 – December 31).
3. Changed the return deadline date that the ballots must be postmarked.
4. Added how the elections shall be determined by a plurality of votes cast. A tie vote shall be decided by lot.
5. Added a clause allowing the Board of Directors to appoint someone to office if unable to solicit any nominee for any position(s).
6. Changed the date for announcement of the election results.

In Article IV – Officers

1. Split the Secretary/Treasurer position into two separate positions; delineated the duties
2. Changed the term length for the office of President, Secretary and Treasurer.
3. Defined the date of when the term of office begins; ie. odd numbered or even numbered years
4. Changed the timeframe for submitting the agenda to the membership (from 30 days to 7 days)

In Article V – Board of Directors

1. Added clause about officer voting rights; what constitutes a quorum
2. Added option for conducting an electronic or phone vote
3. Defined the date of when the term of office begins
4. Added Electronic Mail Vote to the Section 5 heading

In Article VI – Society Delegation to the House of Delegates

1. Defined the date and year (odd numbered) that term of office begins.

In Article VII – Committees

1. Added Executive Committee and description of executive committee

In Article VIII – Medical Advisor

1. Added to be appointed by the Board of Directors;
2. Added the duty for Medical Director to provide a one (1) hour educational presentation at least once per year

In Article X – Amendment

1. Added option of electronic vote for amendments
2. Added statement for minimal frequency to review Bylaws.

Respectfully submitted,

Bonnie Weaver
2011-2012 NSRC President
bon_weaver@yahoo.com
702 301-8421

June 15, 2012

AARC Bylaws Chair
AARC Executive Office
Attention: Tina Sawyer
9425 N. MacArthur Blvd.
Suite 100
Irving Texas 75063

RE: Virginia Society for Respiratory Care
Proposed Bylaws Revisions

Dear AARC Bylaws Committee Chair:

At the April 20, 2012 meeting of the Virginia Society for Respiratory Care (VSRC) Board of Directors (BOD), the VSRC Bylaws Committee Chair provided the members of the BOD with proposed revisions to the VSRC's Bylaws (dated April 13, 2008). This review was conducted to address the Chartered Affiliate directive for all AARC Chartered Affiliates to complete a review of their Bylaws every 5 years.

Attached please find a copy of the VSRC Bylaws that include the proposed revisions for your consideration. All additions appear as **underlined and bold text** and all deletions appear as ~~strikeout text~~.

Unless specifically addressed below, the proposed changes were made to address formatting, grammatical, or writing style issues and were not made to change or alter the intent of the Bylaws.

- Article II, Section 1. a. – This change is proposed to expand the list of specialties encompassed by the profession of Respiratory Care.
- Article II, Section 1. C. – This change is proposed to specifically include non-governmental organizations, such as not-for-profit organizations.
- Article III, Section 3. – This change is proposed to align the definition of Associate Member to that found in the AARC Bylaws and not allow for Associate Members to chair a standing committee.
- Article III, Section 4.a. – This change is proposed to clarify that Society Life Members do not have the right/privilege to hold office, serve as a committee chair or vote unless they are an Active Member of the AARC.
- Article IV, Section 3. d. 3. – This change is proposed to define the duties of the Vice President and align the stated duties with those of other officers..
- Article IV, Section 6. d. – This change is proposed to eliminate the need for written or printed notice in an effort to remove all references to a specific format

for notice and allowing for the use of electronic and other media for the delivery of this notice.

- Article IV, Section 7. B – This change is proposed to specifically include all members of the VSRC Executive BOD, except the Past President, in the group of members that cannot serve as a member of the VSRC and AARC BOD simultaneously.
- Article V, Section 3 -- This change is proposed to eliminate the need for written notice in an effort to remove all references to a specific format for notice and allowing for the use of electronic and other media for the delivery of this notice.
- Article VI, Section 2 – This change is proposed so that issues related to termination of all appointed members of the VSRC BOD – Medical Director, Committee Chairs, and Special Representatives -- can all be addressed in the same manner within the VSRC's Standing Rules.
- Article VII, Section 1. a. 12 – This change is proposed to change the name of this standing committee to one that reflects its actual function.
- Article VII, Section 2. c. – This change is proposed to more clearly state the current role of the Education Committee which is strictly focused on the issues impacting the formal education of Respiratory Therapists within the Commonwealth of Virginia and the role of the student member in the VSRC.
- Article VII, Section 2. k. and l. – These two changes were proposed to reflect the transformation of the Publications Committee to the Media Committee. The responsibility for printed publications was transferred to the Public and Professional Relations Committee and then the duties of the Media Committee are stated.
- Article IX, Section 1 – This change is proposed to align the language with the appointment of this member of the BOD with that of other appointees – the Medical Director, Chairs of Standing Committees, and Special Representatives.

Please let me know if you have any questions or require additional information about the proposed revisions. I can be reached via e-mail at pad2a@virginia.edu or via phone at 434.924.1933. Thank you for your consideration.

Sincerely,

Patricia Ann Doorley, MS, RRT, FAARC
Chair, VSRC Bylaws Committee

Enclosure: Virginia Society for Respiratory Care Bylaws, April 2008

To: AARC Bylaws Committee
From: Minnesota Society for Respiratory Care
Re: Revisions to the MSRC Bylaws
Date April 24, 2012

Attached you will find the revised Minnesota Society for Respiratory Care bylaws. We used strike through and bold/yellow highlight for the changes.
Our main changes include:

- electronic voting,
- committee details clean up,
- grammar and language usage clean up,
- terms of officer changes to be implemented in the future.

Please let me know if you need anything else.
Thanks so much.
Denise Johnson, MSRC Bylaws Chair

Elections Committee

Reporter: Jim Lanoha
Last submitted: 2012-06-17 20:50:21.0

Recommendations

That the AARC Board provide guidance in the form of a policy statement on the number of candidates that can be placed on the ballot for each position.

Justification: In the past, instructions from the Board recommended that only two names be placed in nomination for each office, but the Committee felt strongly that, in the case of Director at Large, three candidates possessed equally strong qualifications, and should be brought forward to the ballot. Tim Myers reviewed both the AARC Bylaws and Policy Manual, and found nothing that limited the number of nominees to two. The Committee would like some guidance from the Board, in the form of a Policy statement and clarification, if the number of candidates brought forward is to be limited to two.

Report

On behalf of the Elections Committee I am pleased to present you with the slate of candidates for the AARC elections ballot.

Vice President of Internal Affairs
Bill Lamb
Brian Walsh

Vice President of External Affairs
Patricia Blakely
Colleen Schabacker

Secretary/Treasurer
Frank Salvatore
James Taylor

Director at Large
Curt Merriman
Sheri Tooley
Gary Wickman

Home Care Section Chair
Kimberly Wiles

Neonatal/Pediatrics Section Chair
Kathleen Deakins
Natalie Napolitano

Sleep Section Chair
Craig Johnson
Russell Rozensky

The committee is working with the executive office to make some changes in the way that the online nominations form works so that it is easier for the committee to review the candidates on that system. Also we have requested that all committee members receive candidate names as they are posted to the online system; currently it is just the chair of the committee who is notified.

Other

It has been a privilege to serve the AARC on this Committee and I would like to commend all Committee Members for the due diligence and time they devoted to the task at hand. Committee members include Ross Havens, Jacklyn Grimball**,** Doug McIntyre, and Tim Myers and I would recommend them for future projects requiring teamwork, thoughtful consideration, and hard decision-making.

Executive Committee

(Karen Stewart)

Finance Committee

(Karen Stewart)

Judicial Committee

Reporter: Patricia Blakely

Last submitted: 2012-06-15 12:18:40.0

Recommendations

No recommendations

Report

The Chair received one (1) inquiry from an AARC member on a potential Judicial Committee complaint. Chair contacted the member and reviewed the committee's policy and procedure for submitting a formal complaint. The member has not contacted the Chair again and no formal complaint has been received as of the time of this report.

Other

No additional information to report to the BOD

Program Committee

Submitted by Cheryl Hoerr
June 21, 2012

Recommendation

Recommendation:

That the AARC Board of Directors authorize $10,340 to be spent above budget for the travel-related expenses of the 2012 Sputum Bowl Committee to attend AARC Congress 2012.

Justification: The AARC BOD ratified the appointment of 12 individuals to serve on the 2012 Sputum Bowl Committee (SBC). The expansion of the committee (from 5 members in 2011 to 12 members in 2012) occurred as part of a succession plan for the SBC that allows for a simultaneous transition of new SBC members with the evolution of a new competition in 2012 and beyond.

Prior to 2012, the SBC included 5 members. Each member fully contributed to the planning and operation of the competition. As such, the AARC paid travel expenses (air, per diem, lodging) for each member to the AARC Congress. These dollars are budgeted each year.

Because the 2012 budget for the AARC was approved by the Board of Directors at the 2011 Fall meeting in Tampa, FL and the ratification of the new SBC did not take place until the Spring 2012 meeting, there is a shortfall of dollars in the budget to fully compensate all 12 SBC members to attend AARC Congress 2012.

Report

1. Prepare the Annual Meeting Program, Summer Forum, and other approved seminars and conferences.
   Status: The Summer Forum program has been published both in print and online. The Summer Form will take place July 13 – 15 in Santa Fe, NM. Updated marketing efforts have included blogs and postings on AARC Connect as well as video postings by past participants and invited presenters.

   The 58th AARC International Respiratory Convention & Exhibition Program is being finalized and information on early registration for the Congress was published in the May issue of the Times and has also been posted online. The Congress will take place November 10 – 13 in New Orleans, LA. There will be approximately ~250 sessions on current respiratory topics and 20 Open Forum symposia.

The Program Committee sincerely thanks the BOD and membership for all of their support and contributions.

2. Recommend sites for future meetings to the Board of Directors for approval.
   Status: The Program Committee previously submitted the following recommendation BOD for an e-vote: That the AARC Board of Directors approve the Marriott Renaissance at SeaWorld (Orlando, FL) as the venue and destination for the 2013 AARC Summer Forum. It is likely 2 on-site recommendations will be submitted to the BOD on behalf of the Program Committee for Summer Forum meeting sites in 2014 and 2015.

3. Solicit programmatic input from all Specialty Sections and Roundtable chairs.
   Status: As stated in previous report; no new information.

4. Develop and design the program for AARC Congress to address the needs of the membership regardless of area of practice or location.
   Status: Member feedback has been incorporated into the Summer Forum Program by including presentations on building a Simulation Toolbox in the Pre-Forum session and Maximizing Patient Education in the Post-Forum session. The Program Committee has also minimized session overlaps between the education and management tracks, which will facilitate movement of conference participants between specialty track sessions without compromising earned CRCE credit.

   Once again the Program Committee incorporated member feedback by minimizing session start/stop time overlap to facilitate the earning of CRCEs. Membership feedback regarding consistent room assignments for specialty section lectures will continue to be incorporated into the Congress program. The Program will also feature ~ 50 new invited lecturers as a way of encouraging greater participation from our membership.

   A broad offering of topics presented by a wide variety of practitioners are included in the agenda for both the Summer Forum and Congress.

Other

Sputum Bowl Sub-Committee Report:
Status: Marketing of the 2012 Sputum Bowl continues on plan with exposure in print, on the web and through the AARC Connect. The sub-committee has used several other discussion threads for promotion of the event.

Updates to the competition have been approved and the ZIP! Workgroup will be executing the implementation of the following:

Risk-Reward
During each match throughout the competition, teams may "buzz" in at any time after the moderator begins reading a question. Once the entire question has been read, the moderator will indicate the end of the question by illuminating a light that both teams can see.
If a team buzzes in after the light is illuminated:

- The team is awarded one point if they answer correctly.
- If the team answers incorrectly, no points are awarded or deducted and the question will be re-read for the opposing team who may then answer the question. If the opposing team answers correctly, they receive one point.
- No "penalty" points are assessed to either team for an incorrect answer.

If a team buzzes in prior to the illumination of the light:

- If the question is answered correctly, the team is awarded one point.
- If the question is answered incorrectly, the team that buzzed in prior to the end of the question will lose one point and the question will be re-read for the opposing team who may then answer the question. If the opposing team answers correctly, they receive one point but do not lose any points if they answer incorrectly.

The Time Keeper will be the sole arbiter of whether a team buzzes in before the question is completed and light is illuminated. If unsure, the Time Keeper will ask the Judges, with the majority vote of the judges being the final decision. The moderator will then read the question in its entirety to the opposing team, with play progressing as usual. During the last two minutes of each game, the "Penalty Phase" will begin. During this time, a team that buzzes in either before or after the question is fully read loses a point for an incorrect answer and the opposing team is given a chance to answer the question without the risk of losing a point for an incorrect answer.

Ask an Expert

- During each match throughout the preliminary rounds, teams each team will be given one opportunity to "Ask an Expert" during the round. The option to use or not use this feature is completely up to the team members.
- Play begins and continues following normal sputum bowl rules. At any point in the match, if a team "buzzes" in to answer a question and they realize they do not know the answer or are unsure of the answer, they may opt to "Ask an Expert".
- The request to use this option must be made within the normal 10 seconds of time given to begin answering the question. The request can be made by ANY team member and once it is made and recognized by the moderator, cannot be withdrawn.
- Upon electing to "Ask an Expert", the moderator will stop the clock and the team calls their designated expert to assist. The expert should sit in the front row so s/he can quickly join their team.
- The moderator will then repeat the question for the expert who then has 10 seconds to give whatever they believe to be the answer. Upon giving their answer, the clock is restarted and the team has 10 seconds to either accept the answer or provide their own answer.
- If the team correctly answers the question, a point is awarded. If the team incorrectly answers the question, the opposing team is given 10 seconds to

correctly answer the question. However, the question will NOT be re-read for the opposing team as it will have already been re-read.

- Any "penalty" that may be in effect when the "Ask an Expert" option is utilized remains in effect (i.e. penalty phase, etc.).

Call the Posse

- 5 minutes before the start of each match, the sputum bowl committee will select the members of the posse for the following match.
- The posse will consist of 5 members of the audience, chosen at random by members of the Sputum Bowl Committee.
- The posse will sit at a table near the front of the stage and be available to either participating team during the match.
- Any time during the match if a team buzzes in and is unsure of an answer, they may Call the Posse.
    - The posse will then have 10 seconds to come up with an answer.
    - The team can choose to either accept the posse's answer or come up with another answer.
    - No extra time will be given to a team that does not accept the posse's answer.
- Each team may only Ask the Posse one time.
- At the end of each match, a new posse will be chosen for the following game.
- The Posse will only be used on Finals night.

Audience Participation Game

This new element will allow the audience to participate and play between the Student and Practitioner matches. Audience members will have an opportunity to utilize an audience response system (ARS) or Smart Phone technology to interact in a Sputum Bowl like game. The expectation is that this will increase attendance as well as fun during Finals night.

- The first 250 attendees at the SB Finals night will have an opportunity to play a game that has some strong similarities to SB.
- Each participant will sign in and be issued a uniquely numbered clicker for ARS (not necessary for Smartphone)
- There will be a total of 20 multiple choice questions contained in a PowerPoint (PPT) presentation. These questions will be answered utilizing ARS or SmartPhones.
- A PPT slide will announce the category then the next slide will display the question.
- A moderator will read the question and then begin a 10 second count down timer.
- The system assigns points based upon who answered the question correctly and who answered it first.

- After the 10 second timer runs down - the percentage for each answer selected will be displayed along with an indicator for the correct answer. This will provide immediate feedback to the audience.
- A leader board will be displayed after every fifth question. This will show who the top 5 participants are in the contest.
- Following the last question, the top 5 players will be displayed. The moderator will ask them to come up, introduce themselves, and receive a prize.

Strategic Planning Committee

Reporter: Timothy Myers

Last submitted: 2012-06-18 09:35:55.0

Recommendations

None

Report

As the AARC''s Executive Office goes through transition with Executive personnel and the AARC''s 2015 and Beyond Ad-Hoc Committee continues to move through its due diligence process, Strategic Planning continues in a temporary holding pattern awaiting further clarification on movement in these two critical areas.

Joint Session
Board of Directors
House of Delegates

Opening Remarks
Roll Call
Various Agencies and other Committees
- AARC Election Committee
- Government Affairs

AARC Secretary-Treasurer Financial Update
American Respiratory Care Foundation

Specialty Section Reports

Adult Acute Care Section

Reporter: Keith Lamb

Last submitted: 2012-06-17 12:05:23.0

The section continues to provide support and activities as outlined below.

1) Continue to assist AARC Staff in the development of the ACCS study guide.

2) Maintain an international presence with recent travel to Prague, Czech Republic. Will also travel to Shanghai China in August.

3) Continue to maintain our monthly journal club.

4) Continue to maintain our monthly SKYPE conference call during which we discuss the journal club article as well as a recent clinical case study.

5) We are actively working on choosing our SPOY for this year.

6) We continue to publish our quarterly bulletin which has become an excellent vehicle for young unpublished practitioners to get their feet wet.

7) Our section has approximately 1888 members as of this morning. Our Journal Club has 240 members.

No Recommendations at this time.

Respectfully Submitted,

Keith D. Lamb

Chair, Adult Acute Care Section

AARC

Continuing Care-Rehabilitation Section

Reporter: Debra Koehl

Last submitted: 2012-06-18 08:14:59.0

Report

1. Completed pulmonary rehabilitation section of URM reporting manual.
    a. Recruited members to trial system
    b. Encouraged section members to participate
2. Provided webcast to members along with Gerilynn Connors on the Medicare changes with G0424.
    a. Encouraged use of the "Pulmonary Rehabilitation Toolkit" that was developed through a multidisciplinary effort of the AARC, AACVPR, ATS, NAMDRC and ACCP.
3. Worked with AARC office and Anne Marie Hummel to assure that the pulmonary rehabilitation toolkit was available to all members of the AARC.
    a. Thanks to Sherry Milligan, the toolkit was placed on the website with a very fun logo!
4. Reviewed submissions for AARC Congress for 2012 and provided feedback to Cheryl Hoerr.
5. Continued to monitor AARConnect and provide feedback to members as necessary.

Other

- Thanks to Anne Marie Hummel, Sherry Milligan and Bill Dubbs for their efforts in all of the activities mentioned above.

- I will be representing the AARC at the AACVPR annual conference in September in Orlando Florida.

- I will be speaking at the Michigan Society for Respiratory Care on pulmonary rehabilitation reimbursement and the PR Toolkit in October.

Diagnostics Section

Reporter: Matthew O'Brien
Last submitted: 2012-06-17 15:04:48.0

Recommendations

No recommendations

Report

Charges:

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

•· Multiple proposals were submitted for the upcoming 2012 Congress. We have 11 Diagnostics presentations over 3 days.

•2. In cooperation with the Executive Office Staff, plan and produce four section bulletins, at least one Section Specific thematic Web cast/chat and 1-2 Web-based section meetings.

•· Our new bulletin editor is Lisa Becker, she is doing a great job at helping new contributors in polishing bulletin articles. Weaver, Debbie Bunch and myself.

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

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

•· Ongoing, will offer spirometry specific PPTs focused at improving Spiro quality via AARConnect.

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

•· Ongoing

•5. Enhance communication with and from section membership through the section Listserv and provide timely responses for requests for information.

•· Ongoing

•6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance.

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

Education Section

Submitted by Joe Sorbello

Recommendations

I have nothing new to report at this time. It is a very good beginning for the future of the profession that the Board did approve a motion to accept the direction for the future of health care as recommended by the first report entitled "Creating a Vision for Respiratory Care in 2015 and Beyond" as published in the March 2009 issue of *Respiratory Care*. I look forward to the next steps in discussing the second and third reports as published in the journal in May 2010 and May 2011, respectively.

Modification and Motion
I'm requesting that the AARC please consider a modification to the AARC web page regarding baccalaureate (and masters) degree education at
http://www.aarc.org/education/accredited_programs/ to read:

"The AARC provides a link to the Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) website that maintains a separate list of programs that offer an associate degree in respiratory therapy with a ***baccalaureate degree option****. This list also contains some additional information about* ***all programs offering a baccalaureate or masters degree*** *in respiratory therapy as the first professional degree. The list of accredited programs on the CoARC website is updated continuously as accreditation decisions are made. Therefore, the current accreditation status of these programs should always be checked on the CoARC website."*

CoBGRTE maintains a update list of all baccalaureate and masters degree programs and revises this list continually rather than annually as is the present practice by AARC. I'm asking that very little change be made except that the CoBGRTE name be added, the following links' names remain the same but the destination URL be as follows:

"baccalureate degree option" URL to http://cobgrte.org/asrttobsrtprograms.html
and

"all programs offering a baccalaureate or masters degree" URL to :
http://cobgrte.org/bsrtmsrtentry.html

I'm hoping that the Board of Directors would agree that the continual growth of our profession is both inevitable and good for the profession and the patient. With the anticipation that at least some parts of the "2015 and Beyond" project and subsequent recommendations will and need to go forward, I believe this to be a logical and good initial step in accomplishing the same.

I put this forward as a motion to approve by the Board.

Discussion and Direction

There is no doubt that the discussions of "2015 and Beyond" have been the source of much angst in the RC education community. I anticipate that both advocacy groups will be conducting their own research which will assist the Board in weighing the various issues at hand.

I look to the Board for direction on where to head next with the chairmanships of the 2 subcommittees representing associate degree and baccalaureate/graduate that are still occupied by Peggy James and Tom Barnes, respectively.

Respectfully Submitted,

Joe

Joseph G. Sorbello, MSEd, RT, RRT
Chair, Education Specialty Section

Home Care Section

Reporter: Greg Spratt
Last submitted: 2012-06-15 14:59:04.0

Recommendations

None

Report:

Political Issues:

DMEPOS Competitive Bidding Program Round 1 Recompete Announced

CMS announced plans to recompete the supplier contracts awarded in the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 1 Rebid contract period for all product categories except mail order diabetic supplies expires on Dec 31, 2013. The Round 1 Recompete product categories are:

•· Respiratory Equipment and Related Supplies and Accessories - includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and related supplies and accessories; and standard nebulizers

•· Standard Mobility Equipment and Related Accessories

•· General Home Equipment and Related Supplies and Accessories

•· Enteral Nutrients, Equipment and Supplies

•· Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories

•· External Infusion Pumps and Supplies

CMS is conducting the Round 1 Recompete in the same competitive bidding areas (CBAs) as the Round 1 Rebid. To ensure that suppliers have ample time to prepare for the competition, CMS has announced the following next steps for the program:

Spring 2012

•· CMS begins pre-bidding supplier awareness program

Summer 2012

•· CMS announces bidding schedule

•· CMS begins bidder education program

•· Bidder registration period to obtain user ID and password begins

Fall 2012

•· Bidding begins

Round 2 Bidding

The bid window for Round 2 closed at 9 p.m. EST on March 30. Providers across the country submitted bids for nine product categories in 91 areas.

HC Section Highlights

Since the last meeting we have produced two quarterly newsletters. The March edition was guest edited by Kim Wiles and featured articles on creating value in the home care therapist and coaching patients to self- manage. The June issue is guest edited by Rebecca Olson and features articles on audits, setting patient goals, and EPAP therapy.

Membership

Membership continues to hover around 900. We continue to make appeals for encouraging friends and peers to join through the newsletter.

Patient Survey

I am working with Nicholas Macmillan to develop a survey of home care patients to better understand their perspectives on the care being delivered to them. The BREATHE (Basic Respiratory Evaluation and Assessment at Home) survey has been developed and passed to Linda VanScoder for consideration.

Follow Up on Previous Recommendations:

Hospital to Home Project:

At the last BOD meeting, a recommendation was made to "Create pilot studies for RT-led programs for reducing readmissions. This was referred to the Executive Office to help gain assistance from the Research Roundtable to help develop an RFP to be able to present back at the Summer Forum. Tom Kallstrom and I had a call on May 11th with John Davies to discuss and John was to discuss with the Research Roundtable and return ideas. As of the time of this writing, I have not received an update from John.

Combining Sections Survey

At the last BOD meeting, a recommendation was made to "Survey section members for potentially combining home care and long-term care specialty sections." I have drafted a survey that has been forwarded to Linda VanScoder for consideration.

Other: None

Long Term Care Section Report

Gene Gantt

Report

Over the last several years the LTC Section has discussed the need for a special accreditation for long term ventilator units in post acute arenas of care.. As a result of these conversations HQAA has began the process of developing such an accreditation. HQAA used the AARC Position Statement on **Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care and the LTC Quality Respiratory Care Recognition** as basic elements of the accreditation. It is our hope that this accreditation can be finalized and formally announced by the AARC International Conference in November 2012.

This move has support of the membership and several members have been involved in the design of the program.

This accreditation will provide consumers an additional stamp of approval for quality care and will go a long way with managed care payers in recognizing the need for Respiratory Therapists in the care of LT ventilated patients.

Gene Gantt RRT
Chair LTC Section .

Management Section

Reporter: Bill Cohagen

Last submitted: 2012-06-05 12:59:18.0

Recommendations

None

Report

At the posting of this our membership is 1858 managers. We have been busy with the following;

- The expert/mentor program has been completed and is available on the AARC Section site. Thanks to Lisa Tyler for all of her hard work on this project.
- The updates to the Management TJC guidelines are almost complete with the help of several managers who volunteered to review and update.
- We continue to work on increasing membership.
- We have started working on the recommendation form the spring meeting to help managers in working with productivity standards, staffing matrixes, and competencies in alignment with the AARC 2015 plan.
- The Journal Club is growing and very popular.
- The search for the 2012 Management SPOY is underway.
- We are already planning the 2013 Summer Forum and will review the feedback from this year's forum in order to provide a great program.
- The quarterly Newsletter has enough material to have issues through the first quarter of 2013 thanks to Roger Berg and his editing efforts.

Neonatal-Pediatrics Section

Reporter: Cynthia White

Last submitted: 2012-06-19 14:18:34.0

Recommendations

No Recommendations

Report

- Neonatal pediatric list serve remains active
- Assisted with and Recruited articles for quarterly bulletin publication
- Recruiting for 2012 SPOY
- Will serve as reviewer for Neonatal Pediatric Abstract Submissions
- Working to get Journal Club up and Running in July 2012 to model adult acute care section
- Helped recruit Neonatal Pediatric community members for Haiti Mission trip

Sleep Section

Reporter: Mike Runge

Last submitted: 2012-06-08 11:12:35.0

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 your Specialty Section's members. Proposals must be received by the Program Committee by deadlines in Jan 2012

-Completed

2. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the Program Committee by deadlines in Jan 2012

-Completed

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

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

4. Identify, cultivate, and mentor new section leadership

-Chair Elect candidates submitted to the Elections Committee.

5. Enhance communication with and from section membership through the section list serve, review and refinement of information for your section'\'s web page and provide timely responses to requests for information from AARC members.

-Have identified key people to assist in monitoring the list serve to assist members.

6. Review all materials posted in the AARC connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be report in the April 2012 Board Report and updated for each Board report.

-In progress.

- **Other**

Recommendation 12-1-33.5 "That the AARC aggressively promote the fact that the new SDS specialty exam has been accepted as an alternative to the RPSGT by the AASM." **Was referred to the Sleep Section to review pros and cons and report at the Summer Forum Board meeting about the implementation.**

•· Upon discussion and consulting with multiple key members of the Sleep Sections, we came to the conclusion that it would be a good idea to promote the SDS specialty exam as an alternative to the RPSGT by the AASM.

Surface to Air Transport Section

Reporter: Steven Sittig

Last submitted: 2012-06-12 20:26:57.0

Recommendations

None at this time

Report

The Surface and Air Transport section has published all Newsletters and bulletins on time with quality content. The list serve is active as well. The Chair elect has been networking with transport RT's across the country as has the current chair promoting AARC and transport section membership.

Since my last report I have been assisting transport section members with issues on medication administration and scope of practice. spring CAMTS Board meeting in Nashville, I was invited to Vanderbilt Children's to offer advice and assistance as they were starting a new pediatric critical care transport team staffed with an RN and RT. i also was invited to present a one hour lecture on Ground and Air Transport as a specialty area as they prepare for their career. I was able to meet with 50 students as well as meet the education staff.

Special Committee Reports

Benchmarking Committee

Reporter: Richard Ford

Last submitted: 2012-06-01 17:06:31.0

Recommendations

NONE

Report

• The Benchmarking Committee Team continued the provision of monthly webinars offered to subscribers. Topics in the past three months included:

a. Using Filters to Compare in March by Chuck Menders

b. Real Life Uses for Benchmarking Data in April by Cheryl Hoerr

c. Sharing Data with Staff in May by Stan Holland

• The AARC launched "Achieving Best Practice -- Beginning the Journey" a campaign to promote AARC Benchmarking, inclusive of easy access through the AARC home page and a mailing to member managers. Emails were sent out to over 2300 individuals in which over 650 navigated to the link. Considerations are being made to continue the campaign, inclusive of follow-up with individuals who have allowed their subscription to expire.

• Proposals on benchmarking related topics have been submitted for 2012 programs for both Summer Forum and Congress. Accepted for the Summer Forum is "Staffing RC- How Many Needed" and for the Congress both "Managing Cost" and "Performance Management". Each of these topics will include an overview and benefits with AARC Benchmarking.

• An article authored by Rick is scheduled to be published in the August issue of AARC Times on based on the lecture given at the 2011 conference on Resuscitating Respiratory Services - Best Practice. This article will highlight the benefits of AARC Benchmarking.

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

• The AARC has utilized the Benchmarking client base to promote participation in the Uniform Reporting Manual Survey.

• As of June 1 there are 144 active subscribers.

Billing Codes

Submitted by Susan Rinaldo Gallo

June 15, 2012

Activities

1. Communication of Code Changes – this is ongoing.

2. Monitoring the Billing Codes list serve
   I monitor the list serve along with committee member Karen Boyer. Many coding questions are asked on other list serves, mainly the Help line and Management. These are more difficult to monitor.

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

Federal Government Affairs Committee

Reporter: Frank Salvatore
Last submitted: 2012-06-18 07:32:51.0

Recommendations

NONE

Report

Objectives:

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

•2. Work with PACT coordinators, the HOD and the State Governmental Affairs committee to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care. [Ongoing]

Ongoing Objectives:

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

Other

I want to thank the members of the Federal Government Affairs committee for their work. I also would like to thank Cheryl West for all her hard work keeping this committee in the loop on the progress being made in Washington.

Fellowship Selection Committee Report

Recommendations

There are no recommendations at this time.

Report

The Chair continues to raise awareness of the changes to the FAARC nomination process that became effective in 2011. The primary vehicle has been to post such information on FAARC Connect. July 27 is the deadline for receipt of nominations for FAARC for 2012. In August, the Selection Committee will then commence review of all nominations received by the established deadline, with the final list of 2012 Fellows completed by the end of August.

Other

There is nothing else to report at this time.

International Committee

Recommendations: None

Report

1. Administer the International Fellowship Program.

   As of today June 7, 2012 we have 22 applicants for International Fellows and 20 applicants for City Hosts. The deadline for applications to be received was June 1st. We are in the process of pulling all of the applicant information together and will be ready to send it to the committee for review by June 21st. The committee will meet on Wednesday, July 15th during the Summer Forum. I'll be sharing the final selection of fellows and hosts with the BOD and HOD at your July meetings.

   22 applicants
   17 different countries
   9 applicants from countries without past fellows
   (Nigeria, Syria, Haiti, Ecuador, Botswana, Morocco, Ghana, Columbia, Belize)

   Sponsors to Date
   AARC
   AMP/NBRC
   Aspirant Education
   Care Fusion (new)
   Draeger Medical
   Marsh Affinity Group
   Philips/Respironics
   PIMA Medical

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

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

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

   We continue to be on the look-out for other educational materials that may be translated in the future.
   The International Fellows List serve continues to show a considerable amount of activity and continues to be valued by our past fellows.

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

   We continue to receive requests for assistance with educational programs, seminars, educational materials, requests for information and help with promoting

respiratory care in other areas of the world.

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

   We are corresponding with other medical associations and societies periodically throughout the year.

Additional Charges to the Committee:

1. **The AARC BOD direct the International Committee to review their current goals and determine if they need to be updated and/or modified.**

   The BOD approved the revised International Mission Statement and Goals at the April BOD meeting in Dallas. The statement has been presented to the ARCF and ICRC Executive Committee for their input. It is my understanding that the ARCF had some minor recommendations for edits to the document.
   Pending minor edits from the ARCF and ICRC this charge is completed.

2. **Direct the International Committee to review the current selection process and determine if it is still relevant and appropriate considering the current market environment.**

   Surveys and discussions indicated that virtually all members agree the current selection process is effective and should not be changed. Individual members discussed their philosophy regarding the selection of fellows. It was felt that a new version of the application may help to better identify individuals who will be successful in achieving the goals of the program. The new application was approved by the committee late last year and implemented January 1, 2012.
   This charge is completed.

3. **That the International Committee develop some short-term and long term measurable objectives that align with the higher level goals of the organization.**

   At the April BOD meeting the International Fellows Effectiveness Survey developed by the committee was referred to the survey approval committee which approved it shortly thereafter. The survey has been programmed into Survey Monkey and has been sent to all past fellows that we have contact information for. All new fellows will receive the survey in the future.
   This charge is completed.

Respectfully submitted,

John D. Hiser, MEd, RRT, FAARC
Chair International Committee

I want to thank Kris Kuykendall and April Lynch for all of their hard work. I also want to thank

the members of the committee.

Vice Chairs

Debra Lierl, MEd, RRT, FAARC, Vice Chair for International Fellows
Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations

Committee members:
Michael Amato, BA,
Arzu Ari, PhD, MS, MPH
Ivan Bustamante, RRT
John Davies, MA RRT FAARC
ViJay Desphande, MS, RRT, FAARC
Hector Leon Garza, MD, FAARC
Derek Glinsman, RRT, FAARC
Yvonne Lamme, MEd, RRT
Dan Rowley, BS, RRT-NPS, RPFT
Bruce Rubin, MD, FAARC
Michael Runge, BS, RRT
Jerome Sullivan, PhD, RRT, FAARC

Membership Committee

Reporter: Frank Salvatore
Last submitted: 2012-06-18 07:28:27.0

Recommendations

NO RECOMMENDATIONS AT THIS TIME

Charges:

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

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

• Identify and evaluate methods to recruit respiratory therapy students as ACTIVE members of the AARC. [ON-GOING]

• Develop a scientific, data-driven process to implement and measure the effectiveness of current and new recruitment strategies. [ON-GOING]

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

Report

Recruitment Campaign #1 for 2012:

The BOD discussed the plans and approved our proceeding forward with the following plan:

• Target department leaders who are not members of the AARC for membership.

• Create a campaign that is directed toward leadership to show them the value of AARC membership and how it may help them lead better.

• Campaign begins around the 3rd full week of June 2012 and goes through July 31, 2012.

• We have created a mailer that will be directed to about 600+ department leaders.

• Mailer will point the prospective member to a special web page that will be set-up and go live when the mailer goes out.

• Offer a money back guarantee for joining. We will be giving them a 30 day money back guarantee. The new member must contact AARC within 30-days to get membership cancelled.

• We will be giving all new leaders who sign up for membership during this campaign a free membership in the Management Specialty Section.

• The Membership Committee will track the following and report back to the BOD and HOD, at the time of this printing, we don't have the statistics, but I hope to have some to give you at the July meetings:

• Number of mailers sent out.

• Number of hits on our special web page.

• Number of memberships created by these target leaders during this special recruitment campaign.

• Number of memberships cancelled within 30 days.

Recruitment Campaign #2 for 2012:

At the time of the submission of this report, the second campaign is still in development. Along with some statistics from campaign #1, I hope to present to the BOD and HOD information on this campaign and get any approvals needed to proceed forward with this campaign in late summer or early fall 2012.

Other

I want to thank the members of the Membership Committee. They hit the ground running and had to make many contacts with their states. I'd also like to thank Tom Kallstrom, Sherry Milligan and Doug Laher for all their work and guidance they have given on our first recruitment campaign.

Position Statement Committee

Reporter: Colleen Schabacker
Last submitted: 2012-06-11 11:28:28.0

Recommendations

Recommendation # 1:

Approve and publish the revised position statement on "AARC Statement of Ethics and Professional Conduct". This statement is submitted for your review as Attachment #1. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: Cleaned up some of the verbiage, and added evidence-based medicine.

Report

Charges:
•1. Draft all proposed AARC position statements and submit them for approval to the Board of Directors. Solicit comments and suggestions from all communities of interest as appropriate.

- A draft of the proposed AARC position statement "Respiratory Therapists in the Emergency Department" was approved at the April Board meeting.
- A sub-committee is working on a draft of the newly proposed "Best Practices in Respiratory Care Productivity, Assessment and Analysis" position statement. The members are Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Linda VanScoder and Bill Dubbs from the AARC. We held a conference call in May, where it was determined Rick would write an introductory paragraph and Rob, Dan and Rick will create an outline for the statement. Another conference call is scheduled for June 19, 2012. Once we have a good start on a draft, I will send it out to the rest of the committee members for their feedback. I should have more to report at the July meeting.

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

- During 2012, the Committee’s goal is to complete the review of the four (4) position statements listed below. Action on each statement to this point is listed following the statement title as is the name of the Committee member spearheading the review.
- 1) Respiratory Therapy Education - Deryl Gulliford - presented revisions at April BOD meeting
- •2) Licensure of Respiratory Care - Kathy Deakins - presented revisions at April BOD meeting
- •3) Continuing Education - Jim Allen - presented revisions at April BOD meeting
- •4) Ethics and Professional Conduct - Linda VanScoder - presented revisions at the July BOD meeting

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

- Presented at the April BOD meeting.

Other

A special thank you to committee members Kathleen Deakins, Deryl Gulliford, Jim Allen and Nick Widder. A special thanks Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Bill Dubbs and Linda VanScoder for their work so far on the new "Best Practices in Respiratory Care Productivity, Assessment and Analysis". (see Attachment #2 below)

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 of evidence-based medicine.
- Seek continuing educational 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
Revised 07/09

Revised 07/12

American Association for Respiratory Care
Position Statement

Best Practices in Respiratory Care Productivity and Staffing

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

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

Because of varying time required to perform different Respiratory Care procedures, systems to determine staffing should be based upon statistically valid activity time standards for all the services provided by a department. Because of the significant variability in the nature and types of care rendered in treating patients in need of respiratory services, unweighted metrics such as patient days, etc., should not be used to determine respiratory therapist staffing levels.

Use of unweighted metrics of workload may lead to the determination of inaccurate staffing requirements. An exclusive focus on CPT coded procedures to determine staffing levels or other standards based only on billable activities can lead to the omission of a significant number of non-billed activities from the estimated respiratory care workload and result in underestimating the number of staff needed.

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

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

Public Relations Action Team

Reporter: Trudy Watson
Last submitted: 2012-06-18 09:06:37.0

Recommendations

No recommendations at this time.

Report

The Public Relations Action team has not received any requests for action during this reporting period.

1. Each member will agree to do interviews (radio) and provide information for the written press release that corresponds to the interview topic.

- No requests for radio interviews have been received.

2. Continue to assist **Your Lung Health** with reading and editing, clinical stories, messages, etc. for the website. These will be assigned through the EO on a PRN basis.

- No requests to assist with **Your Lung Health** activities have been received.

3. Communicate with each State Affiliate encouraging the establishment of a public relations committee.

- The Presidents of the Chartered Affiliates were contacted in 2011 regarding this charge.

4. Update the current Public Relations material and develop a mechanism to make the PR “tool” more easily available to the State Affiliates.

- To date, the EO has not requested that any PR materials be updated.

Respectfully submitted,
Trudy Watson

State Government Affairs Committee Report

Tom McCarthy RRT, Chair
June 2012

Senate Bill 350, in Maryland provides "*that a licensed respiratory care practitioner has the right to practice respiratory care within the scope of practice of the respiratory care practitioner's license, including practicing respiratory care in a sleep laboratory*". The bill passed and will become law once signed by the Governor.

The other legislative initiative in Maryland that is of concern to the Respiratory community is Senate Bill776. Essentially, the language in SB 776 would allow individuals who may, or may not, be graduates of an accredited education program and who may, or may not, have passed a Nationally Accredited Credentialing Board competency examination to be licensed in the State to practice Polysomnography with patients. The concern with this language is that, by default, these individuals will be practicing Respiratory care as well. The legislation passed and will become law.

By becoming law, SB776 will allow the Maryland Board of Physicians to approve educational programs such as ASTEP that are not accredited by a National Educational Accreditation Board. Further, the legislation will also allow the Maryland Board of Physicians to approve a certification exam that is not accredited by a Nationally Accredited Credentialing Board.

Issues that remain ongoing in States such as Michigan are being monitored.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Reporter: Susan Rinaldo Gallo

Last submitted: 2012-06-01 11:21:36.0

Recommendations

No recommendations at this time.

Report

Code revision proposal from the May 18, 2012 meeting

Well it looked like the revised proposal was going well and then it fell apart. The conundrum that exists is that the AMA wants to grant codes for outpatient use only. However, RT departments need CPT codes that can be used for inpatients tracking. These inpatient CPT codes are not submitted for payment due to DRGs and not listed on the hospital bills yet they are very important for internal productivity measurements.

The only way the AMA was going to allow the current codes for Chest Wall Manipulation to be revised was to put a limit on the number of times per day it could be used (e.g. twice per day). Once or twice a day would be acceptable for clinic or outpatient use. Since we currently use these codes many times a day for inpatient tracking/productivity a limit of 1 or 2 a day was unacceptable. Therefore we chose to bring the proposal back. I doubt we can think of a way around this situation.

This only emphasizes the need for RC departments to use RVUs and NOT CPT codes for productivity measurements. Anyway, the ATS, ACCP and AARC worked very hard and invested time and resources into changing this code. We also had a CPT consultant from Hill-Rom working with us. Henceforth, it is doubtful that new CPT code proposals for inpatient procedures will be successful unless physician work (ie PFTs) is included.

As a reminder, this is the revision we were attempting to make:

- CPT code **94667**: Manipulation chest wall, such as cupping, percussing, vibration **and oscillation** to facilitate lung function; initial demonstration and/or evaluation

- CPT code **94668**: Manipulation chest wall, such as cupping, percussing, vibration **and oscillation** to facilitate lung function; subsequent

American Association of Cardiovascular & Pulmonary Rehab

Reporter: Debra Koehl

Last submitted: 2012-06-18 08:15:18.0

Recommendations

None at this time

Report

- Worked with the AACVPR as AARC representative along with Anne Marie Hummel in the developed and review of the Pulmonary Rehabilitation Toolkit. This addressed the reduction in payment for Medicare PR code G0424.
    - Societies involved included AARC, AACVPR, ATS, NAMDRC and ACCP.
- Assisted in the development of the AACVPR pulmonary rehabilitation educational track at their annual meeting.
- Continue as a member of the Professional Liaison Committee of the AACVPR.

Other

- Will attend and report back from the AACVPR annual meeting in September.

American Heart Association

Submitted by Brian Walsh

Nothing to report

Amer Soc for Testing and Materials

Reporter: Robert McCoy

Last submitted: 2012-06-15 14:27:24.0

Recommendations

Nothing to report

R McCoy

Chartered Affiliate Consultant

Reporter: Garry Kauffman
Last submitted: 2012-05-25 12:31:18.0

Recommendations: None at this time

Report:

I did not conduct any on-site sessions with chartered affiliate leadership during this time period. I have kept in contact with those chartered affiliates with whom I have provided strategic and operational guidance to ensure that they are implementing their agreed-upon plans and to offer ongoing support with their business plans and operations. The Virginia Society leadership requested me to work with them and I submitted for AARC Presidential approval. Karen approved and I have scheduled this for Friday-Saturday June 22-23, 2012.

On behalf of the Indiana Society, Cheri Bates has requested my services and we are in the process of selecting dates in August for the strategic/operational planning session.

Respectfully submitted,

Garry W. Kauffman, MPA, FACHE, RRT, FAARC

Committee on Accreditation of Air Medical Transport System

Reporter: Steven Sittig

Last submitted: 2012-06-12 20:35:33.0

Recommendations

- Recommendation: That the travel funding allowance for the AARC representative to the Commission on Accreditation of Medical Transport Services (CAMTS) be increased from the current level of $2000 a year to $2500 a year.
- Justification: Airfare and Hotel costs have increased significantly especially over the past year. Up to this point I have rarely accessed this travel allowance but will be starting with the summer board meeting in Vancouver BC this July. This funding has not been increased for about 5 years.

Report

- The CAMTS board is currently working to publish the 9th edition of the CAMTS Standards. The public comment period is still open on the proposed changes. I was able to better include transport RT's into areas of certifications and clinical experience, in line with other transport staff.
- The CAMTS Board meeting in April for the spring meeting in Nashville for deliberations on program accreditations as well as general business items.
- I have also been elected to the CAMTS Executive Committee in the office of secretary. To my knowledge this is the first time the AARC representative has been elected by the entire board to the position.

Extracorporeal Life Support Organization

Submitted by Donna Taylor, RRT-NPS

Recommendations

Request AARC financial assistance of $2,500 for registration fees and expenses to be able to attend one of the two Extracorporeal Life Support Organization (ELSO) meetings.

The ELSO Steering Committee of which I am the Respiratory Care Representative meets bi annually to discuss direction of ELSO, upcoming meetings, review ELSO grant applications to be awarded, review and revise bylaws and continue to discuss process for establishing ECMO certification. The ELSO Registry and its content is discussed each meeting. Revisions to the Registry as well as other devices/therapies desiring to be included in the Registry are discussed. Other temporary extracorporeal devices (Impella, Abiomed, CentriMag, tandem heart, etc) may one day be a part of this registry. Each meeting, I am allotted time on the Steering Committee agenda to present/discuss issues related to Respiratory Therapists as ECMO Specialist. As ECMO evolves and changes, prompting staffing model changes I feel it is important for Respiratory Therapist to continue to be part of extracorporeal life support management.

Report

The first **Euro ESLO** meeting was held this year in Rome in May. Plans are underway for next year's Euro ELSO meeting in Stockholm. ELSO has become a referenced, worldwide association.

ELSO has established a new website that will be much more comprehensive and interactive allowing members to share experiences. I will serve as one of the initial moderators of this forum.

There is currently much discussion among the steering committee about incorporating "single care giver" models in the teaching that is currently sponsored by ELSO in their classes. This model in Europe and Australia has existed for some time, partly due to the lack of Respiratory Therapists in these countries and partly due to their ability to have had much improved equipment and disposable equipment that did not need to be FDA approved. If this staffing model is adopted by ELSO, it could potentially impact RRTs and Perfusionists in the ECMO community.

Other

I continue to serve as a resource for ECMO centers who want to incorporate RRTs into their staffing model and for new ECMO centers just establishing their center. Our hospital has just been awarded the ELSO ECMO Center of Excellence Award. We have held this distinction since 2010 and will be granted this for now another 2 years when we reapply

International Council for Respiratory Care Report

Submitted by Jerome Sullivan

BOARD OF DIRECTORS REPORT

NO RECOMMENDATIONS AT THIS TIME

I. Fundamental Respiratory Care Support Course (FRCSC)

Key Requirements for RC Training Program Out Side USA

The ICRC has been involved in discussions on several occasions regarding the potential development of a flexible RC educational program for health care practitioners with little or no RC experience living outside the USA. This has been a stated goal of the ICRC since 2004. Members of the ICRC Executive Committee including the President are continuing to try to identify and secure funding for the FRCSC which has a broad application potential. Listed below please find elements which the ICRC feels are essential to develop a sustaining program of this type.

The key elements a FRCSC educational program should include:

1) Copyright to AARC/ICRC
2) Generic & modular in format for any country or local where deemed appropriate. Ability to customize as to need with regard to both length of program & level of instructional intensity & even partnerships with local degree granting programs

3) "Lion's Share" of budget devoted to Curriculum development & compensation for peer reviewed experts to develop format, content & evaluation instruments
4) Six months to 1 year for content development (divided into Phase I & II) - depending on funding

Fundamental Respiratory Care Support (FRCS) Course

Executive Summary

A four-day comprehensive Respiratory Care course intended for implementation outside of the United States for health care providers not experienced in respiratory care. The course will be offered under the auspices of the ICRC and the AARC. The FSRC Course is composed of two parts: the ***Basic*** component which can be completed as a stand-alone course of instruction however, the ***Basic*** component is a pre-requisite for the ***Advanced*** course.

Course Purpose: The primary purpose of the course is to enhance the care of respiratory patients around the world. Secondarily, the provision of the course may help alleviate shortages and provide increased opportunity to recruit and train RT's outside the USA.

Fundamental Respiratory Care Support – Basic: A two day course consisting of lecture demonstrations and practice *Skill* stations to expose health care providers not experienced in respiratory care to the knowledge and skills required to provide basic Respiratory Care for patients in non-acute situations until a Respiratory Care Specialist becomes available or until transfer to appropriate facility.

Fundamental Respiratory Care Support – Advanced: A two day course consisting of lecture demonstrations and practice *Skill* stations to expose health care providers not experienced in respiratory care to the knowledge and skills required to provide advanced Respiratory Care for patients in acute situations until a Respiratory Care Specialist becomes available or until transfer to appropriate facility.

Overall Course Design:

Although a complete FRCS course is normally given in four days, it is possible to complete the first section (Fundamental Respiratory Care Support - ***Basic***) as a stand-alone course in two days. However, the ***Basic*** component is a prerequisite for the Fundamental Respiratory Care Support – ***Advanced*** component.

Course Goals & Objectives:

• Appropriate assessment of needs for the respiratory compromised patient.
• Selection of appropriate Respiratory Therapies and or modalities.
• Selection and appropriate application/ administration of various Respiratory Care equipment and supplies.
• Selection of appropriate course of action.
• Selection of appropriate diagnostic tests.
• Identification and appropriate response to significant changes in respiratory status.
• Recognition and initiation of appropriate intervention for acute/serious respiratory conditions.
• Determine the need for expert consultation and/or need to transfer patients.

Disclaimer:

Participants must be aware that the course is not intended to provide them with comprehensive expertise in the care of respiratory compromised patients, but to provide some knowledge and skills to assist them in providing care for patients until an expert respiratory clinician becomes available or until transfer to an appropriate facility. The emphasis will be on the benefits of new knowledge and limited exposure to selected skills. The ICRC and AARC will issue a combined logo **"*Certificate of Completion*"** for the FRCS courses. Neither the ICRC nor the AARC, nor FRCS instructors certify competency or any level of knowledge or skill following completion of the course. In order to assure the quality and integrity of the standardized FRCS curriculum, the program must be presented according to the standardized electronic textbook, CD-ROM, and *Skill* station lesson plans.

Target Audience: The FRCS Course is intended for implementation outside of the United States for health care providers not experienced in respiratory care and may include:

1. Physicians with possible exception of Intensivist, Anesthesiologist, ER physicians …

2. Nurses
3. Emergency medical technicians
4. Long Term Facility clinical staff
5. Pre-hospital providers with lengthy patient transfer
6. Physician assistants
7. Residents in training
8. Respiratory Care Students
9. Respiratory Care practitioners who would like to take refresher course

FRCS Deliverables: The Project Core Committee working with designated content experts will develop the project curriculum, supporting materials and delivery mechanisms in two phases.

Phase I - FRCS Electronic Textbook: Curriculum developed and available via electronic media delivery systems (e.g. DVD, PowerPoint presentations). Hard copy text could be produced in Phase II if volume of pre-publication orders warrents.

• *Basic* Section
• *Advanced* Section
• *Appendices* Section
• *Skill Stations* Section
• Evaluation & Testing Section

Phase II – Supporting materials & internet access

• *Skill Station* workbook & check-off sheets
• FRCS Administrator's Guidebook
• FRCS "Train the Trainer" course & Instructor Syllabus
• Online access to curricular elements

***Beta* testing of FRCS Course:** After finalization of the curriculum, and other Phase I elements it has been suggested that the prototype and first course be offered in a *Beta* testing format in the Kingdom of Saudi Arabia.

FRCS Instructor Criteria: May include RRT credentialed respiratory care practitioners, Intensivist physician, Pulmonolgist, Anesthesiologist, and critical care nurse practitioners

An FRCS Instructor must:

- be experienced in respiratory critical care
- demonstrate an understanding of the FRCS lecture components and proficiency with the *Skill Stations.*
- Successfully complete an FRCS course, both ***Basic*** and ***Advanced***
- complete a review of the FRCS instructor syllabus with a **Certified FRCS Instructor**

• receive the recommendation for instructor status after two teaching experiences in FRCS courses under the supervision of the FRCS Director or a **Certified FRCS Instructor.**
• be a member in good standing of AARC.
• teach in an instructor/provider course at least once every 2 years to maintain instructor status
• A minimum of two FRCS Instructors must be present for each course.
• The FRCS Director will issue **FRCS Instructor Certificates**, and maintain records on each instructor.
• Additional instructor qualifications may apply for physicians, respiratory care practitioners & other health care providers located outside the USA who do not hold US credentials.

II. Review & Revision of AARC International Mission Statement:

The ICRC Executive Committee is still in the process of formally drafting language to suggest for the revision of the Mission Statement. Finalized suggestions were not complete at the time of submission of this report.

Joint Commission - Ambulatory PTAC

Reporter: Suzanne Bollig

Last submitted: 2012-06-18 16:15:09.0

Recommendations

None at this time.

Report

The Ambulatory Care Professional and Technical Advisory Committee (PTAC) held a conference call on April 10, 2012 to report an update on activities related to alarm management.

Key Points

1. At the November 2011 SSP Committee meeting, staff reported that alarm management was identified as an important safety issue.

2. Staff developed a draft National Patient Safety Goal (NPSG) that contained a proactive risk assessment approach for managing alarms in order to prevent adverse events. There were concerns that the NPSG did not provide enough guidance for organizations.

3. Staff plans to conduct a field assessment over the next few months to obtain information on current practices in the field, knowledge gaps, special issues, etc. Based on the survey findings, the staff will identify method(s) to address the issue. This may include development of an accreditation requirement, field education, or communication through a Sentinel Event Alert. Findings will be presented in the fall 2012.

The next conference call is scheduled for July 12, 2012.

Respectfully submitted,

Suzanne Bollig

Joint Commission - Home Care PTAC

Reporter: Joseph Lewarski

Last submitted: 2012-05-30 12:20:35.0

Recommendations

No recommendations

FOR INFORMATION ONLY

There have been no activities or meetings of the HomeCare PTAC since the last report.

Joint Commission - Lab PTAC

Reporter: Franklyn Sandusky

Last submitted: 2012-06-14 09:14:54.0

Recommendations

NONE

Report

LAB PTAC Committee Meeting May 4th, 2012

We received and update on Board of Commissioners'' Meetings Schedule.

They value the improving transparency between CMS and their accredited organizations and the public.

CMS is developing a system to post field survey results on the Internet. Check the website at www.data.medicare.gov for more information.

The quality measures task force, developed within CMS to help align and prioritize the measures across the organization to avoid duplication and conflict among developing and implementing measures.

There are six measurement domains; they try to build measures around coordinated care, population heath, efficiency and cost, safety, person and caregiver experiences, and outcomes and critical care. Additional information was about the statement of work they do within CMS

LAB PTAC

- The Laboratory PTAC is asked to review and discuss a proposed revision to Standard

WT.04.01.01, EP 4, which addresses quality control checks for instrument-based waived testing. This standard seems to imply that instrument-based waived tests had different QC requirements

than those that were non-instrument based. The question was asked as to why two different standards.

Thirteen expert panels were convened in August of 2011, representing both general and specialized laboratory disciplines. They revisited issues left over from a previous standard cycle and reviewed the laboratory accreditation manual for content and accuracy and they introduced new emerging issues for standards development. Highly ranked recommendations were moved into standards development.

Draft standards were sent back to the expert panels for final review and approval. Proposed changes in standard were review with questions for clarification.

Other standards dealt with documentation of policies and procedures. Respiratory ABG labs should be in compliance with these revised standards.

- Proposed Standard QSA.02.01.02 which would change the standard to comply with current edition of Clinical and Laboratory Standards Institute (CLSI) document EP23-A.
- CMS is planning to use the principles in EP23 to create an alternative quality control that is called IQCP.
- The IQCP is still in development and details have not been worked out.
- CMS is not ready to approve it because the IQCP is not fully developed.
- CMS suggests postponing EP23 until IQCP is completed.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano

Recommendations

None at this time

Report

Have been working with Dale Griffiths in AARC office to solicit endorsement and recommendations for further dissemination of the Peak Performance USA program from the NAEPP School Subcommittee. A summary of the program will be sent out to the group in a few weeks for them to recommend and disseminate to their groups and to give us feedback on how to cast a wider net to get schools to participate with the program.

NHLBI NAEPP does not make official endorsements of programs but is willing to assist with "getting the word out" and recommending the program. I will pass on any information I receive to Dale and the BOD.

Next in person Steering Committee meeting will be in September or October.

Natl Coalition/Hlth Pro Edu - Genetics

Reporter: Linda Van Scoder

Last submitted: 2012-05-29 09:14:40.0

Recommendations

No Recommendations

Report

There is nothing new to report. I continue to monitor the weekly Genetic Alliance bulletins.

National Sleep Awareness Roundtable

Reporter: Mike Runge
Last submitted: 2012-06-08 11:20:49.0

Recommendations

None

Report

I have not attended the National Sleep Awareness Roundtable so I have no updates at this time.

Neonatal Resuscitation Program

Reporter: John Gallagher
Last submitted: 2012-06-13 15:20:35.0

Recommendations

No recommendations at this time.

Report

The NRP Steering Committee Meeting held its strategic planning meeting on March 5 - 6, 2012 in Elk Grove Village. Dr. Tom Bigda-Peyton facilitated the meeting. Tom is an educator and researcher whose areas of expertise include adult learning, safety across high-consequence industries, and health system transition and transformation. The group developed an ambitious process of evolving NRP into a learner-directed program that will move toward episodic and just-in-time educational interventions with more of a QI focus. The new model will require a complete restructuring of the current instructor implementation model, including retiring the titles of the current instructors and moving toward a facilitation model. The development of a small group of highly-skilled resource individuals for defined areas will support facilitators. Additionally, the group will be stepping up efforts to create research consortiums and new opportunities to elevate the levels of science in the NRP algorithm.

In April NRP volunteers and staff implemented a pilot course of NRP through the American Heart Association International Training Centers in Hong Kong. The course trained 24 initial instructor candidates as regional trainers. AAP Staff have disseminated a Program Administration Manual to our counterparts to aid in the implementation and maintenance of NRP in Hong Kong.

The Helping Babies Breathe® initiative has entered a strong implementation phase, with over 40,000 individuals being trained in at least 34 countries. USAID is supporting implementation in 24 of these developing countries. Learning materials have been or are in the process of being translated into Arabic, Bangla, Cambodian, Dari, French, Mongolian, Pashto, Portuguese, Spanish, Swahili, and Thai.

An NRP Seminar is scheduled for Friday, October 19, 2012, in New Orleans, LA, in conjunction with the NCE and NRPSC meeting (Oct 17-18). Steven Ringer, MD, PhD and Kimberly Ernst, MD, MSMI will Co-chair the program.

Plenary sessions include:

•· Reflections on the 25th Anniversary

•· The Business of NRP

•· The "C" in CPR: Evidence on Epinephrine and Chest Compressions

•· Research Grant Presentations

Breakout sessions include:

•· Case Based Discussions

•· Hands-on Simulation

•· Debriefing After Difficult Resuscitations in the Real World

Roundtable Reports

Asthma Disease Mgmt Roundtable

Reporter: Eileen Censullo

Recommendations

NONE

Report

List Serve activity has been very good this half of the year.

Working with the Executive Office to hold a roundtable meeting at our Congress with AARC representation and to have a webinar for roundtable members prior to the Congress so that we can meet and answer any questions or concerns.

Consumer Roundtable

(See Executive Director Report)

Disaster Response Roundtable

Reporter: Steven Sittig

Last submitted: 2012-06-12 20:55:17.0

Recommendations

None at this time

Report

The Disaster Response Roundtable once again submitted numerous lecture proposals for the upcoming AARC Congress that were accepted for presentation. We are also planning a scheduled roundtable meeting while in New Orleans.

We are also actively working with Dr Lewis Rubinson to increase the presence of RT's with federal disaster response programs.

Other

Geriatrics Roundtable

Reporter: Mary Hart
Last submitted: 2012-06-18 23:14:11.0

Recommendations

Expand the Geriatric Roundtable to include Palliative Care. Several AARC members have expressed the need and will support such a change. This will not only meet the needs of some current members but will help provide a service for future members. Palliative Care is one of the growing areas of health care that we as healthcare providers need further education. The AARC would be providing a service to members/ community that is not well understood, there is a great need for and will certainly have an impact on health care in the near future.

Report

Membership has continued to support the charge for this committee to write and review articles for the AARC Times Coming of Age Section.

Membership is preparing presentations for the Congress Meeting that will include a section on Palliative Care (Thank You)

The information below is being provided by our roundtable members:

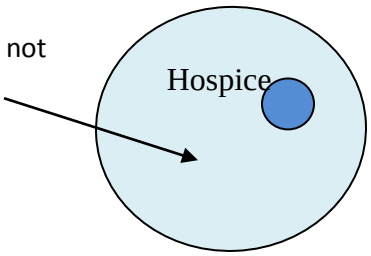
The AARC has always been good at responding to the needs of therapists and educators. One current need, that is becoming more imperative every year, is the need to educate first our faculty, and then our students on the importance of palliative care. While palliative care is by no means specific to any one age group, the majority of the time, palliative care is ordered on our older adults at the end-of-life.

Healthcare professionals are quite good at providing palliative care to cancer patients, but not so much to individuals with COPD. Respiratory therapists can lead the way in promoting palliative care to COPD patients, understanding that our emphysema patients are five times (5X) more likely to develop lung cancer than the generally population, and that the distressing symptoms at end of-life for those with COPD cause a downhill spiral of events that hastens death. Yes, research has demonstrated that good palliative care extends life!!

A Geriatric/Palliative Care Roundtable makes sense. This will be a way for faculty/administrators to share information, gather new information and ideas, and find ways to implement interventions that will ultimately help both the patient and the healthcare system. The ultimate goal of such a resource could be to generate and support clinical competencies in palliative care for the profession of respiratory care.

Additionally, there needs to be a clear understanding on the difference between palliative care and hospice. Hospice is an organization that supports individuals and families at the end of life. Palliative care is management of distressing symptoms and should begin the same day that a diagnosis of a terminal disease is given.

Hospice may be ordered and palliative care will continue, but even if hospice is not ordered, or indicated yet, palliative (comfort) care is needed. Palliative care



Hyperbaric Roundtable

Reporter: Clifford Boehm

Last submitted: 2012-06-15 10:15:36.0

Recommendations

NONE

Nothing to report

Informatics Roundtable

Jim Fielder

International Medical Mission Roundtable

Reporter: Lisa Trujillo

Last submitted: 2012-06-25 15:16:13.0

Recommendations

Report

The International Medical Mission Roundtable currently has 66 members

Recent discussions include the development of a Respiratory Therapy program in Haiti and the need for Respiratory Therapy supplies for projects in Liberia.

Military Roundtable

Submitted by Harry Roman
May 24, 2012

Nothing new to report

Neurorespiratory Roundtable

Reporter: Lee Guion

Last submitted: 2012-06-05 22:48:43.0

Recommendations

None

Report

Posts have slowed in the past quarter. Multiple abstracts for Mini-symposium for 2012 not accepted. Some resubmitted to Open Forum.

Other

Will be chairing a meeting of roundtable members at the 2012 Congress and will plan focus for the coming year.

Research Roundtable

Reporter: John Davies

Last submitted: 2012-06-18 14:08:14.0

Recommendations

NONE

Report

- Activity in the roundtable still remains low.
- However, a new initiative has been brought to the group for recommendations and suggestions - the hospital to home pilot study proposal. This has been presented to the group but with little feedback. Continued follow-up of this project will take place

Simulation Roundtable

Reporter: Julianne Perretta
Last submitted: 2012-06-18 13:24:50.0

Recommendations

•· None

Report

The Summer Forum 2012 will be providing a 4 hour pre-conference session on simulation entitled "Building a Simulation Toolbox." The content was inspired by feedback from the Simulation Roundtable meeting at the International Congress in 2012.

I have recently received feedback regarding several outstanding items to the BOD from last quarter's meeting, and will be able to take action on those items in the following quarter. These include

•· having a simulation webcast on the AARC site

•· inviting an international guest speaker to the roundtable's listserv

•· providing Roundtable members with access to simulation videos-this is not a closed issue as yet. Potential solutions include posting the videos to the roundtable site (not ideal), granting access to the AARC YouTube account for upload, or other solutions such as Vimeo. Kris will assist in communications with Steve (?) regarding an ideal solution to sharing simulation videos.

Tobacco Free Lifestyle Roundtable

Reporter: Jonathan Waugh
Last submitted: 2012-06-19 14:41:56.0

Recommendations

- None at this time.

Report

- Update on the "Clinician Guide for Tobacco Cessation," a joint effort between the TFL Roundtable in and the AARC executive office. Co-chairs are Georgianna Sergakis and Rita Mangold are hoping the typically slower hospital pace during the summer will help the work group make faster progress on the guide. This is a companion text to the patient guide on tobacco cessation. The patient guide is a print publication but the clinician guide is planned to be an electronic publication.
- A number of TFL members have contributed to publications this past year or were "in the news" in various ways. Please officially communicate to our ACCP partner that their tobacco education resources were used by RT students working with elementary school children to teach them about tobacco risks, promoting lung health, and how to encourage their family and friends to quit tobacco (RC Currents, AARC Times, June 2012).
- Steve Nelson reports that Pfizer has provided additional funding for a second printing of the patient tobacco guide (this time 200,000 copies). We are working on a method for distribution to those who request to ensure proper dissemination.
- The TFL stands ready to assist with educational programs and curricula for tobacco-related training.

Other

- We were pleased to see that AARC TFL members are leading the way with providing their expertise at a pre-conference tobacco treatment training workshop prior to the FOCUS conference.
- Susan Gallo posted the following information of reimbursement that needs to be widely broadcast to the AARC membership. On May 22, the Centers for Medicare & Medicaid Services announced that, effective July 1, the supervision level for the following codes

will change from direct supervision to general supervision. 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes 99407 intensive, greater than 10 minutes

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Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Care Management Committee

Cultural Diversity in Care Management Committee
AARC Activities Report
Summer 2012

Chair: **Joseph R. Huff** **Liaison:** **Susan Gallo**

Recommendation: None

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

Status: **Larry Garland will be attending the HOD/BOD at this year Summer Meeting. Resume is attached. Mr. Garland expressed interest in attending to how the Board and HOD function. We are very grateful of Mr. Garland's wanting to participate in the mentoring program.**

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 Comm on Officer Status in the US Uniformed Services

Submitted by Scott Woodcox
June 21, 2012

Nothing to report at this time.

Ad Hoc Committee on Home Oxygen

Per Kent Christopher, Tom Kallstrom will provide update in the Executive Director report.

Ad Hoc Committee on AARC Leadership Institute

Reporter: Toni Rodriguez
Last submitted: 2012-06-19 01:13:40.0

Original Charge: That this Ad Hoc Committee develop a Management, Research and Educational leadership Institute.

Vision Statement
The Learning Institute will be the first AARC sanctioned program designed to provide advanced training to ensure the future continuity of leadership, discovery, and education within the profession of Respiratory Care.

Mission Statement
The mission of the Learning Institute is:
To foster leadership talent
To teach the skills of academic leadership
To advance the science of respiratory care

Summary of Activities Spring 2012

- Discussion over the current lack of progress.
  - Problem of recruiting authors for Core Curriculum Modules was attributed to: 1) Content areas are not in line with our membership's areas of expertise and 2) the money offered to complete a module was too low.
  - Possible suggestions to overcome current stumbling blocks and move forward:
    - Have participants provide proof of attainment of Core Course objectives from another appropriate venue. We would then only provide the specialty tracks. It was agreed that this would not be the best option given the extra time and cost to program participants.
    - Subsume the core competencies in a more generalist form into each specialty track. Specialty content experts authoring a module would be better able to speak to core concepts in context. It was agreed that this would be the best solution and the committee chair was charged with presenting a model for accomplishing this. See Appendix A. Each committee member volunteered to rewrite the original track competencies to incorporate the newly developed general core competencies.
  - The committee agreed that we should proceed with development of a model script for the purpose of answering some of the questions raised at the end of the final 2011 committee report. Rob Chatburn volunteered to work out the Research Track. A meeting between Rob, Toni and Tom identified the following points:

Conclusions used for developing the original RFP:

- 5 modules in the Core Track/ 34 competencies to be covered
- Total of 45 contact hours for the entire core
- 9 hours of instruction per module
- 9:1 ratio for instructional development of a module = 81 hours of development time per module or 405 hours of instructional development for the entire track.

- 81 hours X $30.00 per hour = $2430.00 per module
- RFP amount $2500.00 to be paid per module

New consideration used in developing a new proposal for development:

1) Based upon anecdotal data reported in the December 2011 committee report $65 - $150.00 per hour, based upon developer background and experience, was the standard range for content development. In addition consultation fees can be as much as $200.00 per hour. Given this data and even factoring in the desire to contribute as a volunteer, $30.00 per hour was an unrealistic amount to pay for the development of instructional content.
2) Content authors would not be working on the project full time since they will most likely have a full time job. Rob indicated that upon his current commitments the most time he would be able to expend on the project is 10 hours per week. Using this time frame as an example, 432 hours of instructional content would require 43 weeks to complete or approximately 9 months.

Based upon this information the following conclusions were arrived at:
The original concept behind the institute was to provide continuing education for our members to prepare them for career advancement and/or make them more value as employees. The core was generalist skills and the three tracks were chosen because they are pillars of the profession essential to its continued growth. The time span of 45 hours was chosen based upon a desire to eventually have the courses accepted for credit by a traditional education program (i.e.: 2 or 4 year institution). 45 hours correlates with 3 credit hours in a traditional education environment (15 hrs = 1 credit). The three tracks plus the core would equal 12 credits in a traditional education environment.
Currently the project is at a standstill. We could not entice our own membership to author the Core modules at $30.00 per hour and an outside company intimated that it would cost "mid six figures" to produce the five modules. In addition, if membership could be recruited to produce course content it would be on a part time basis. Given Rob's guesstimate of 10 hr per week to work on the project, it would take almost a year to get the instructional material for a track completed.
Given this information we may need to rethink our approach. Going back to our original premise, the concept was to provide continuing education. Continuing education is by definition training received post formal education to maintain or improve job skills. Continuing education is usually awarded CEU's over credits. According to Wikipedia one CEU is generally 10 hours of participation. Even considering the reference source we have greatly exceed traditional CEU standards with our desire to one day to align with a traditional education institution. It may be advisable to reduce the number of hours in each track in line with providing general knowledge instead of producing and expert.. The goal would be for enlightenment that could peak someone's interest in pursuing more in depth education in a subject area. For the sake of discussion we considered the following based upon a rate of pay for development at $100.00/ hr which is the minimum amount Rob would consider to author the Research Track.

Example A: Research Track: Based on 3 credit format.

- 6 modules in research track/ 30 competencies

- Total of 45 - 50 contact hours for the entire track
- 8 hours (round up from 7.5 hrs) of instruction per module.
- 9:1 ratio for instructional development of a module = 72 hours of development per module or 432 hours of instructional development for the entire track.
- 432 hours X $100.00/hr =$43,200.00 cost for development of the Research track.
- 432 hours/10 hr per week = 43 weeks or 10 months to complete.

Example B: Research Track: Based upon a continuing education model

- 6 modules in research track/30 competencies
- Total of 15 contact hours for the entire track
- 2.5 hours of instruction per module
- 9:1 ratio for instructional development of a module = 22.5 hours of development per module or 135 hours of instructional development for the entire track.
- 135 hours X $100.00/hr = $13,500.00 cost for development of the Research Track
- 135 hours/10 hr per week = 13.5 weeks or 3.5 months to complete.

A conference call of the entire committee was held on February 17th. At that time the committee voted to move forward based upon "Example B". On March 9th a subcommittee of Rob, Toni, Tom and Steve met to further discuss the possible layout of the online modules. Based upon this discussion Rob was charged with development of one lesson to be presented to the subcommittee by the end of March. This lesson will then be used as a platform for furthering the discussion on instructional design.

Summary of Activities Summer 2012

A Leadership Committee meeting was held on May 10 to view the sample lesson developed by Rob Chatburn. The committee was pleased with results. The amount of information provided was appropriate with the integration of terms, web links and reference throughout the lesson. There was also an index along the side of each page so that participants could easily navigate sub-topics within the lesson (See Appendix B). Rob thanks again for giving our vision a face. The committee voted to approve a contract with Rob to complete the Research Track. Tom Kallstrom suggested that we could speed up the development process by working on all three tracts simultaneously. The Committee agreed. Toni Rodriguez said she is interested in writing the Education Track and Rick Ford and the Executive office agreed to seek out possible writers for the Management Track. The committee set a goal of having something to demo at the International Congress this fall.

Committee Members:

Chair: Rodriguez, Toni Ed.D, RRT; Members: Chatburn, Robert (Research Institute Chair) MHHS, RRT-NPS, FAARC; Ford, Richard (Management Institute Chair) RRT, FAARC; Myers, Timothy BS, RRT-NPS; Van Scoder, Linda (Education Institute Chair) EdD, RRT, FAARC, John Walton MBA, RRT FAARC

Staff Liaisons: Tom Kallstrom, RRT FAARC,

Appendix A:

CCC 101 Introduction to Human Communication:

Course Description: Theory and practice of communication skills in public, small groups and interpersonal setting to include: interpersonal and inter-organizational communication, barriers to communication, impact of diversity on communication, non-verbal communication and conflict resolution.

Competencies:

1. Describe the process of interpersonal communication in terms of models and principles.
2. Describe the nature and function of communication on all levels within organizations.
3. Identify the components of listening and common barriers to the process.
4. Identify and explain the elements of nonverbal communication.
5. Identify strategies for conflict resolution within small groups.
6. Explain the impact of cultural and gender variables on interpersonal communication.
7. Prepare and demonstrate the effective delivery of a verbal presentation to a small group.

Suggested General Communication Competency:

Demonstrate the ability to listen to others and communicate in an effective manner.

CCC102 Health Information Management and Informatics:

Course Description: The use of technology to support and sustain information management within the healthcare environment to include: basic word processing, spreadsheet, database, statistical and desktop presentation applications as well as the application, care and management of Personal Health Records.

Competencies - Basic Computer and Health Information Literacy Skills

Pre-Requsites

*Demonstrate proficiency in the Windows operating environment.
*Resolve minor technical problems associated with use of computers.
*Demonstrate use of email, addressing, forwarding, attachments, and netiquette.
*Create and name or rename subdirectories and folders.
*Demonstrate how to save work to a computer file, and printing and copy a file.
*Create and edit a formatted document using tables and graphs
*Demonstrate use of the essential aspects of file organization, information storage (such as disk or flash drive), protection from data loss, and basic computer skills.

Competencies:

1. Demonstrate Internet/intranet communication and topic search skills
2. Use basic word processing, spreadsheet, database, and desktop presentation applications as applicable to your work.
3. Use statistical analysis packages.
3. Differentiate between the types and content of patient health records (such as paper-based, electronic health records, and personal health records).
4. Know the architecture and data standards of health information systems.
5. Demonstrate an understanding of the relationship of telemedicine and its application to all care settings.
6. Identify legal and regulatory requirements related to the use of personal health information and apply policies and procedures for access and disclosure.

Suggested General Health Information Competency:

Use health record data collection tools such as input screens, document templates and adhere to health record documentation requirements of external agencies and organizations.

CCC 103 Financial Planning and Budgeting Principles:
Course Description: Fundamental theory of accounting principles and procedures as they relate to healthcare to include: generally accepted accounting principles, income statements, balance sheets, cost/benefit/ratio analysis, and strategic financial planning.
Competencies:

1. Demonstrate generally accepted accounting principles (GAAP).
2. Explains income statement, balance sheet and cash flow
3. Prepare a simplified balance sheet and income statement.
4. Demonstrate knowledge of ratio analysis, cost-benefit analysis and cost-effectiveness analysis
5. Demonstrate knowledge of strategic planning, strategic financial planning, operational planning and capital budgeting.

Suggested General Financial Management Competency:
Organize, direct and control the financial activities related to project design and implementation

CCC 104 Small Group Problem Solving and Decision Making
Course Description: An organized approach to problem solving, decision making and small group management to include: group facilitation, conducting meetings, team building, intervention strategies and monitoring group progress.
Competencies:

1. Define the role of the facilitator, team leader and team members.
2. Discuss the impact of group dynamics in facilitating small group communication.
3. Explain how listening and speaking skills facilitate communication. Identify methods for identifying and defining problems
4. Select a problem and develop a solution based upon established problem solving protocol to include: study design, data analysis, selection of best solution, action plan analysis , implementation and follow up.
5. Define the steps in effective team building
6. Identify effective conflict management and intervention techniques.
7. Discuss strategies to be used in conducting effective meetings.
8. Identify ways to monitor group progress.

Suggested General Small Group Problem Solving Competency:
Demonstrate the ability to effectively manage and guide group efforts by providing appropriate feedback and prevent, manage, and/or resolve conflict.

CCC 105 Basic Management Skills
Course Description: The functions of management, specific roles and responsibilities of the supervisor and the application of leadership principles in addressing on-the-job situations and handling work related conflicts.

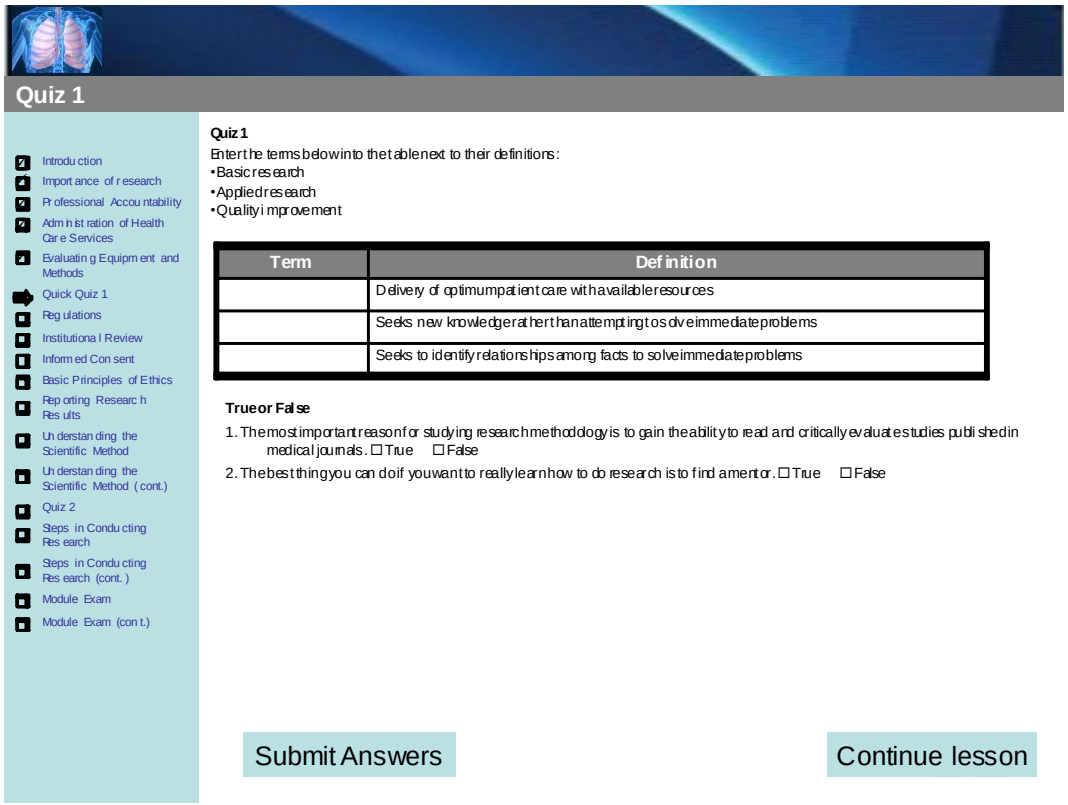
Competencies:

1. Demonstrate an understanding of what it is to manage and to lead in the role of a successful department manager.
2. Describe the roles, functions of management and the responsibilities of supervisors and how they impact effective relationships in the workplace.
3. Examine different leadership styles, explaining the advantages and disadvantages of each.
4. Explain how to be successful in communicating with others based on their leadership style.
5. Demonstrate an understanding of the characteristics of effective leaders, how to identify mentors, and gain from the example of others.
6. Evaluate how to motivate others and coach them to improved performance
7. Demonstrate an appreciation for teams, the importance of prioritizing conflicting demands, achieving desired outcomes and accountability for the achievement of outcomes.

Suggested General Management Competency:

Demonstrate the ability to support, promote, and ensure alignment with an organization's vision and values while ensure the effective, efficient, and sustainable use of resources and assets.

Appendix B:



Evaluating New Equipment and Methods

Validating Manufacturer's Claims

To meet the changing needs of health care, medical equipment manufacturers introduce to the market new diagnostic and support instruments. Because of the relatively short product life cycle in the market of technical equipment, new products are introduced frequently. But new does not necessarily mean better. At times, the development of new technology outpaces the need for that technology. When this happens, product marketers have not done their job in accurately assessing demand. Medical professionals must then take the lead in assuring that they are not left in the position of trying to invent ways to use new equipment. Rather, new equipment should satisfy a well-established need. Although manufacturers often engage in extensive testing and market research, the final burden of proof as to a product's ultimate function and benefit falls to the end user, us.

Rather than accept on faith that a new technology will do exactly what its manufacturer claims, we should validate claims and conduct comparison tests with existing equipment. We should ask questions such as: What is the chance of nosocomial infection with this equipment? Does this equipment work equally well on a patient with chronic obstructive pulmonary disease (COPD) as it does on one with a flail chest? How accurate are the pressure manometers, spirometers, and gas analyzers provided? Empirical observations often indicate a need for a new piece of equipment or procedure. But to insure safe and effective application, its final implementation must rest on sound scientific judgment.

Click to see a real-world example

Ad Hoc Committee on 2015 & Beyond

Submitted by Lynda Goodfellow and John Hiser

Recommendation 1: That the AARC BOD accept the competencies needed by graduate respiratory therapists as recommended in the publication " Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond" by Thomas A Barnes EdD RRT FAARC, David D. Gale PhD, Robert M Kacmarek PhD RRT FAARC, and Woody V Kageler MD MBA; Published -Respir Care 2010;55(5):601–616. © 2009 Daedalus Enterprises"

Justification: It is essential that the AARC plan for the future and that steps are taken to assure that the organization is prepared to take on the duties and responsibilities that may be required of the respiratory therapist in the years to come. By accepting this recommendation, the BOD is sending the message that you agree with the findings of the second conference and that the respiratory therapist of the future may be asked and expected to perform these competencies. Endorsement will provide the AARC with direction to continue to develop projects and recommendations to complete the 2015 Ad Hoc Committee charges. A copy of conference #2 manuscript is attached.

Recommendation 2:
That the AARC explore strategies that would enable respiratory therapists to acquire these competencies.

Justification: In order to ensure that all competencies are acquired, various strategies should be investigated. These strategies should address the needs of the existing and entry workforce of the future.

Committee Objectives:

1. Review the attributes and compare to the recommendations for areas that required additional definition.
   Complete

2. Identify gaps and identify other information that will be necessary to act on the recommendations.

   - Committee members were asked once again in April to submit any comments regarding the gap analysis.
   - Surveys originally sent in 2010 to associate degree program educators; hospital directors and ASAHP members were reformulated to seek additional information. Results will be presented at the July BOD meeting.

3. Identify groups of organizations and interested parties that would be necessary to obtain feedback regarding the recommendations and the attributes.

   Feedback from CoARC and from NBRC has been received and reviewed.

4. Identify a mechanism to obtain additional feedback from members and mangers of respiratory care.

5. Develop a time line of activity the needs to occur and a time line for BOD action.

The following timeline was accepted in directing the committees activities:

April BOD Meeting

Complete the Gap Analysis revision - complete

Present the two recommendations to the BOD – three recommendations were acted upon by the Bod in April (see attached).

Review responses from NBRC and CoARC- to be provided at the July BOD meeting

Send an update of progress to AARC members following the BOD meeting - Complete

July BOD Meeting

Report results of any surveys conducted to in response to information needs identified during and after the April BOD meeting.

November BOD Meeting

a. Present final 2015 and Beyond recommendations to the BOD

b. Send an update of progress to AARC members following the BOD meeting

Other activities since the April BOD meeting:

1. A membership update was created and distributed to the membership on May 31, 2012. It is attached to this report for review.
2. A link was posted to the AARC home webpage to provide information to the membership

The co-chairs would like to thank President Stewart once again for her leadership in this effort and also thank her for the trust she has placed in us to carry on this initiative. Also thanks to the members and a big thank you to Bill Dubbs for all of his work.

Members:

Patricia Doorley
Toni Rodriguez
Karen Schell
George Gaebler
Denise Johnson
Tim Myers
Margaret Traband
Richard Sheldon (BOMA)
Dianne Lewis
Woody Kageler (BOMA)

Ad Hoc Committee to Recommend Bylaws Changes

Reporter: George Gaebler

Recommendations: None at this time

Activities: The committee finalized the changes to the Policy on Bylaws revisions and reporting for the chartered affiliates. More changes were clarified after the Spring BOD meeting and the policy is in force.

Conference calls occurred that discussed some of the unusual communications coming out of the Bylaws Committee to the affiliates. Chartered Affiliates had concerns that some of the communications had conflicting messages. We believe these concerns have been resolved.

Ad Hoc Committee on Section Membership

Reporter: Lynda Goodfellow

Last submitted: 2012-06-20 07:29:53.0

Recommendations

No Recommendations

Report

Nothing new to report since April BOD meeting

Other

Ad Hoc Committee to Reduce Hospital Readmissions

Reporter: Greg Spratt
Last submitted: 2012-06-15 15:02:19.0

Recommendations

Recommendations: None

Hospital to Home Project:

At the last BOD meeting, a recommendation was made to "Create pilot studies for RT-led programs for reducing readmissions. This was referred to the Executive Office to help gain assistance from the Research Roundtable to help develop an RFP to be able to present back at the Summer Forum. Tom Kallstrom and I had a call on May 11th with John Davies to discuss and John was to discuss with the Research Roundtable and return ideas. As of the time of this writing, I have not received an update from John.

Ad Hoc Committee for Continued Development of Education Competition

Reporter: Bill Cohagen

Last submitted: 2012-05-28 11:04:53.0

Recommendations

[None

Report

The committee has chosen a few options that been passed onto the current Sputum Bowl Committee. We will now observe the 2012 proceedings in New Orleans to ensure that the changes that were put in place are a success or is there still no participation/audience to continue.

The committee has had some participants who are not truly vested in the project and they have been terminated from the committee.

ARCF
CoARC
NBRC

ARCF Report

MEMORANDUM

To: AARC Board of Directors and House of Delegates

From: Michael Amato, Chairman, ARCF

Date: July 2012

RE: ARCF Report

The American Respiratory Care Foundation has been busy in their intervening months since I last submitted a progress report to you. Please accept the following items of information as highlights of activities currently under active consideration which are all in addition to administering the extensive array of education recognition awards, fellowships, and grants.

A few weeks ago ARCF's Board of Trustees convened its annual meeting and I am delighted to report a host of actions you will find of interest. ARCF's strategic plan has been reviewed and a revised draft was submitted to the Trustees for additional input. That input has been received and we are now finalizing the strategic plan. Not only will it continue to closely parallel the goals and activities of the respiratory care community, but we have also established a strategic planning committee which will review the plan on an annual basis. This will facilitate a regular and frequent review of the plan and its subservient tactical objectives.

We will once again host a fundraising reception at the AARC 2012 International Congress in New Orleans. I want to take this opportunity to thank those of you who donated to the fundraiser and were able to attend the reception. As you may recall, this reception is the only face to face fundraising event undertaken by ARCF. We will once again honor International Fellows, City Hosts, ICRC, and AARC's International Committee. You will all be receiving an invitation to attend. The Trustees have set the minimum donation at $100 per person. For those of you who may not have attended in the past, I encourage you to take advantage of this event. It's a tremendous opportunity to get to know our colleagues from all over the world as well as enjoy some excellent food and beverages. This is a great way to show your support for the profession's philanthropic arm.

As you may recall, the Trustees voted to transfer the International Fellowship program to the AARC last year. I know that many of you want to support our International Fellows and I encourage you to do so. The only difference between this year and years past is donations should now be made directly to the AARC which has established a restricted fund for this purpose. The ARCF will continue to support international activities. Under active consideration at this time are the development of a fundamental respiratory care course that can be replicated and utilized in countries all over the world that do not currently have respiratory therapists or the infrastructure to train respiratory therapists. We are currently exploring ways to fund development of the course.

The Foundation is also considering developing a support plan for international visitors who are highly placed within their country's healthcare system. These individuals may be invited to participate in a brief, but intensive, visit to the United States in order to learn of the advantages of establishing a formal respiratory care delivery system including an educational and credentialing

infrastructure. This project is in its preliminary phase. I will provide you with updates as details become available. The Foundation continues to fund RESPIRATORY CARE Journal Conferences. Last September it funded a Conference focusing on the "Chronically Critically Ill". The preceedings from that special Conference were published in the June issue of the Journal. This past spring the Foundation funded a Conference focusing on all aspects of oxygen delivery and we are now in the midst of soliciting for funds for the next Journal Conference to be convened in September 2012 focusing on Adult Mechanical Ventilation.

As some of you may recall, ARCF applied for, and received, several grants from the Environmental Protection Agency to develop an educational course relating to the identification of indoor asthma triggers. Beginning this year we transferred operation of the course to the AARC. It is currently available online through AARC and continues to be free to AARC members.

As with all charities, funding remains a challenge. Last year we developed, and published, an article for AARC Times describing the work and value of the Foundation. This year we are developing another article and also producing a brief video. We will distribute the video to all of you when it's completed and hope that you will share it so that many more in our community will come to appreciate the benefit of supporting our community's only charitable organization organized for the support of the profession.

During its recent Board meeting, the Trustees discussed at some length the desirability and viability of organizing a scholarship fund to encourage respiratory therapists to expand their skills portfolio in order to play a larger role in critical care units. The Trustees are aware that many of our colleagues leave the profession in order to expand their clinical job responsibilities as physician assistants. The Trustees feel that, given all the changes in healthcare, there may be an opportunity to develop an advanced level respiratory therapist who would have, in addition to the traditional advanced level RT skills portfolio, other skills putting them on equal footing with PAs but without having to leave the profession. Work on this concept is in its earliest phase and I will keep you posted as the idea evolves.

Recently, the Trustees voted to support a research grant which will focus on aerosol delivery to tracheotomized patients. Support of applied research is felt to be of high importance amongst Trustees and grant proposals will continue to be reviewed and funded consistent with the goals of our various research endowments.

We were delighted to be asked to provide input to the AARC's International Mission Statement. The Trustees continue to believe that international activities undertaken by AARC, NBRC, ICRC, and CoARC are extraordinarily important and go a long way towards validating the need for respiratory therapists throughout the world.

<u>Summary</u>
I hope that you find the forgoing items and activities of interest. I want to thank all of you who support the Foundation. Please consider making a tax deductible donation to ARCF. Your support is indispensable to our success.

Thank you

CoARC Report

The CoARC report is availble as an attachment to this book.
“CoARC Update to AARC HODBOD 7.12 handouts”

NBRC Report

MEMORANDUM

Date: June 18, 2012

To: AARC Board of Directors and House of Delegates

From: Kerry E. George, RRT, MEd, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you an update on the activities of the NBRC. Since the last report, the Board of Trustees and its committees met April 23-28, 2012 in Kansas City to conduct examination development activities and discuss business related items pertinent to the credentialing system. Additionally, a group of content experts convened in early June to conduct a cut-score study for the new Adult Critical Care Specialty Examination. The following details the current status of examinations and significant activities in which the Board and staff are currently involved.

Adult Critical Care Specialty Examination

The much awaited Adult Critical Care Specialty Examination is set to launch on July 17, 2012. Registration and scheduling for this examination are now available. Details regarding admission policies, fees, test specifications, practice and self assessment examinations can be found on the NBRC website, www.nbrc.org, under the Examinations tab. Individuals who apply and schedule an examination appointment prior to August 31, 2012 will receive a free self assessment examination.

Ohio Examination Requirements Workgroup

I served as the NBRC representative to the Ohio Examination Requirements Workgroup since early 2011. The workgroup's purpose was to evaluate whether the Ohio Respiratory Care Board should amend OAC 4761-5-01 and related rules to require the candidates for licensure in the state of Ohio to pass the written and clinical simulation portions of the RRT Examination as a condition for initial licensure issuance in the state of Ohio. The Ohio Board has now accepted this workgroup's recommendations and is in the process of drafting amendments to its rules to require the RRT be the minimum credential for initial licensure in the future. As you are likely aware, the NBRC supports

the CRT credential as the minimum requirement for licensure and we submitted a minority report opposing the proposed recommendations, as well as made a personal appearance at their February 2012 public hearing. We continue to be involved in a stakeholder group providing input into the rule drafting process.

California Respiratory Care Board Meeting

At the request of the California Respiratory Care Board, we also traveled to their February 2012 board meeting to discuss their interest in elevating the credential requirement for licensure in that state. It is not likely they will be proposing any change to their existing requirements.

Credentialing System Evolves

As a result of extensive, ongoing internal research the NBRC conducts regarding testing and measurement, the Board of Trustees voted at its December 2011 meeting to evaluate implementing significant changes to the respiratory therapy credentialing system beginning in 2015. These changes are coincidental with, and not in response to information arising from the Respiratory Care 2015 and Beyond process. Changes will include a single multiple choice examination with separate passing points for the CRT credential and eligibility for the Clinical Simulation Examination which will include a larger number of shorter simulation problems. Details regarding these significant changes will be announced during the Jimmy Young Memorial Lecture at the AARC Summer Forum in Santa Fe, New Mexico on July 15, 2012.

Examination Statistics – January 1 – June 15, 2012

The NBRC administered over 18,000 examinations for the period January 1 – June 15, 2012. Pass/fail statistics for the respective examinations follow:

Examination	***Pass Rate***	
CRT Examination – 6,542 examinations		
	Entry Level	Advanced
First-time Candidates	65.6%	82.9%
Repeat Candidates	15.5%	26.1%
Therapist Written Examination – 6,024 examinations		
First-time Candidates	67.6%	
Repeat Candidates	31.6%	
Clinical Simulation Examination – 5,016 examinations		
First-time Candidates	66.5%	
Repeat Candidates	52.6%	

Neonatal/Pediatric Examination – 346 examinations

First-time Candidates	65.6%
Repeat Candidates	46.5%

Sleep Disorders Specialty Examination – 27 examinations

First-time Candidates	88.5%
Repeat Candidates	0%

CPFT Examination – 134 examinations

First-time Candidates	78.5%
Repeat Candidates	32.5%

RPFT Examination – 43 examinations

First-time Candidates	84.2%
Repeat Candidates	40.0%

Your Questions Invited

I look forward to continuing to work with you during my term as President. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and all of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the integrity of the credentialing process.

Unfinished Business

New Business

White Paper Review

- "Respiratory Care Practitioner 2001" pg. 195
- "Evolution and Utilization of Respiratory Services" pg. 197

Policy Review

- BOD.004 – Continuous Quality Improvement Plan pg. 200
- BOD.005 – Oversight of Executive Director pg. 202
- BOD.011 – Parliamentarian pg. 203
- BOD.012 – Approval of Presidential Appointments, Goals, Charges pg. 205
- BOD.013 – Professional Attire pg. 206

Respiratory Care Practitioner 2001

Clinical Duties

1. Be involved in direct patient care.
2. Furnish monitoring for cardiopulmonary and other systems utilizing sophisticated, high-tech devices.
3. Be positioned on the health care delivery team in such a way as to have the responsibility and authority for refining broad or general physicians' orders within the parameters of predesigned protocols.
4. Administer medications via aerosol, parenteral, IV, and IM routes of delivery.
5. Educate other caregivers, patients, and family caregivers on methods of self-administration and other related subjects, such as wellness, equipment maintenance, etc.
6. Assess patients and their progress as it relates to the overall care plan.
7. Render clinical interventions over and above the traditional Scope of Practice, including clinical interventions which rely upon qualified patient evaluators; competence with high-tech equipment; and interventions, both therapeutic and diagnostic, which could readily be mastered by qualified respiratory care practitioners.
8. Perform invasive diagnostic and monitoring procedures.

Characteristics

1. Be a product of a multilevel education system, with entry level residing at the associate and advanced identified at the baccalaureate degree levels.
2. Possess training and education in the following areas:
a. Critical thinking skills
b. Liberal arts
c. Basic sciences
d. Communication skills
e. Affective skills (dependability)
f.Computer science

Attributes

1. Possess an ability to practice in all care settings.
2. Have stamina, both physical and mental.
3. Possess a holistic caregiver's perception.
4. Be compassionate.
5. Have an ability to move back and forth between "high-tech" and "high touch."
6. Be an innovator and a creator.
7. Be efficient and effective.
8. Be able to respond to change, as well as be a change agent.
9. Possess skills as a negotiator.
10. Act as a mentor.
11. Remain professionally dynamic as manifested by a commitment to being a lifelong student.
12. Be compensated commensurate with skill level, responsibility, and authority.
13. Refuse to be captive of paradigms, and be willing to create new ones as needed.

14. Possess an awareness of cultural sensitivity and diversity.

Nonclinical Duties

1. Discharge planning.
2. Teaching, at both primary and secondary levels, within the context of health care delivery.
3.Be responsible for preventive medicine and wellness interventions.
4. Expand involvement within the infrastructure of the health care delivery system.
5. Possess a leadership role in allied health, so as to bring about change in health care practices and health care policy.
6. Expand role in each organization's quality improvement process and data collection in order to improve resource accounting and document efficiency and effectiveness.
7. Expand managerial skill base.
8. Enlarge role in research.
9. Possess a more in-depth familiarity with other allied health procedures and interventions.

Care Settings

1. Possess an ability to render care across the entire health care delivery spectrum, from critical care on one extreme to self-care in the home on the other and all points in between, such as transitional care settings, skilled nursing facilities, and all outpatient venues.

EVOLUTION AND UTILIZATION OF RESPIRATORY SERVICES

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
11030 Ables Lane Dallas, TX 75229
July 1995

Prepared by the Ad-hoc Literature Committee

Since the discovery of insulin, the vaccine, modern technology and advanced pharmacology, Americans experience longer lives. Maintaining life and health is a result of 20th century technology and scientific advancement. In the 1900s, the leading causes of death were influenza, pneumonia, and other infectious diseases (smallpox). In 1990, the five leading DRGs were heart failure and shock, pneumonia and pleurisy, angina pectoris, and cerebrovascular disorders -- all conditions necessitating respiratory care treatments. Many Americans have respiratory disabilities for which they need respiratory care services. Smoking is estimated to be responsible for nearly one-sixth of all deaths annually, including 35% of all cancer deaths, 22% of coronary heart disease, 15% of strokes, and 90% of chronic lung disease.

One in ten Americans, including over seventeen million children, have lung disease. Four percent of the U.S. population has asthma, and the number of cases increased by nearly fifty percent during the 1980s. Fourteen million Americans have chronic obstructive pulmonary disease, and the number of chronic bronchitis and emphysema cases have increased fortyfive percent during the same decade. Occupational lung disease is the number one cause of work-related disease and injury. The reemergence of tuberculosis, along with AIDS-related pulmonary disease and smoking-related chronic obstructive pulmonary disease, are all contributing to the growing population of patients who are in need of respiratory care services.

TECHNOLOGY AND RESPIRATORY CARE SERVICES

Technology, in large measure, drives the clinical practice of respiratory care. In fact, applied technology is the raison d'Ítre for both emergence and the continued manifestation of clinical respiratory therapy, now and into the future. The efficacy of oxygen therapy had been well established by the late 1930s. However, it was an enormously expensive, hard-labor intensive, poorly controlled therapeutic modality, generally reserved for dying patients.

Elaborate oxygen rooms (England) and chambers (U.S.) slowly gave way to "refrigerated" oxygen tents that remained in general use until central air-conditioning became a hospital standard. Three fundamental scientific advances brought about during World War II dictated the transition from oxygen therapy to inhalation therapy: (1) antibiotics, (2) demand breathing valves for combat pilots, and (3) non-rebreathing valves and masks for use by aviators as well. Antibiotics precluded the horrendous mortality associated with overwhelming infections, and in so doing, also greatly expanded thoracic surgical opportunities. The new mechanical technology was effectively adapted to precisely control the inhalation phase of breathing.

A new generation of blood gas analyzers was introduced in 1967. When coupled with the first mechanical adult volume ventilator (respirator) marketed the same year, virtually every component of human respiration could be monitored and controlled. Dramatic consequences resulted: crushed chest victims and adult respiratory distress syndrome patients (as characterized by afflicting some of our soldiers serving Vietnam with "Da Nang Lung") were no longer consigned to a certain death.

Concurrent technological and pharmacological breakthroughs salvaged the lives of "Hyaline Membrane" babies and permitted cystic fibrosis suffers to reach adulthood. Simply put, the transition from inhalation therapy to modern respiratory therapy happened because of the triumph of applied technology over death and disease.

DISABILITY AND RESPIRATORY CARE SERVICES

Modern advances in medical treatment and technology are creating a new population of survivors of severe lung disease. Patients with end-stage lung damage resulting from systemic disease or chemotherapy-induced fibrosis, for instance, may now benefit from single lung transplantation. Surfactant (lipid) therapy for premature infants has not only decreased mortality and morbidity, but has also reduced the cost of care for these infants.

Survival of new groups of patients like lung transplantation patients and surfactant-treated premature infants also contributes to an increasing population in need of respiratory care services. Many patients suffering from acute respiratory failure are able to survive and be discharged from the hospital after receiving mechanical ventilatory support (respirator).

Although respiratory care has played a major role in the care of critically ill patients with pulmonary problems, the value of respiratory care services is not limited to just those situations in which patients are experiencing acute trauma or exacerbations of their illnesses. Pulmonary rehabilitation programs, for example, have been shown to improve exercise tolerance and quality of life for patients with chronic obstructive pulmonary disease.

Rehabilitation interventions such as noninvasive ventilatory support and removal of airway secretions can also prolong the lives and improve the quality of life for people with severe disability and paralytic/restrictive pulmonary conditions.

In ongoing efforts to assure that patients receive appropriate care, the respiratory care profession is developing ways of providing necessary care more efficiently. Implementation of respiratory care assessment-treatment protocols has resulted in cost savings without measurable harm to patient outcomes. As technology and medicine continue to make strides in alleviating respiratory illness afflicting seniors, adults, children and infants, the need for respiratory care will continue to be provided in the hospital, but will need to become increasingly integrated in services provided beyond the institution. Rehabilitation facilities, the home, nursing homes, and physicians' offices will increasingly need respiratory care to help avoid hospitalization.

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American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Continuous Quality Improvement Plan**

EFFECTIVE DATE: December 1999

DATE REVIEWED: December 2009

DATE REVISED: December 2009

REFERENCES:

Policy Statement:
The Board of Directors shall continually evaluate its effectiveness as the governing entity of the Association.

Policy Amplification:

1. As part of this process, the Board of Directors shall review planning, operation and service delivery to assure quality performance of the Association based upon key quality precepts.

Quality Performance

The Board of Directors is responsible for the efficient use of available resources to operationalize the mission statement and attain the strategic objectives of the AARC. Quality performance occurs through the continuous improvement of key processes and activities that contribute to the advancement of the art and science of respiratory care irrespective of venue.

Quality Precepts

- Continuous improvement of every process of planning operation and service delivery.
- Elimination of barriers which have the effect of adding costs through waste reduction and simplification.

- Alignment with outside organizations as partners.
- Management practices that focus on improvement of the systems in which members work.
- Emphasis on continuous process improvement rather than periodic inspection
- Continuous evaluation and improvement of working relationships with related organizations.
- Promotion of member understanding of their jobs and individual roles in providing quality services.
- Creation of a caring organizational environment that is characterized by trust and integrity and strives to drive out fear and frustration for optimal performance; encourages suggestions for improvement and innovation; and promotes sharing of ideas.
- Communication about organizational goals and progress as essential for enlisting effective participation.
- Creation of budgets and performance management each year for monitoring progress internally.
- Improvement in statistical processes and planning, and application of quantitative methods for continued improvement.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Oversight of Executive Director**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2008

DATE REVISED: December, 2007

REFERENCES:

Policy Statement:
The day-to-day functioning and business aspects of the Executive Office shall be the responsibility of the Executive Director.

Policy Amplification:

1. These duties and responsibilities shall not be altered, except by the full Board of Directors.

2. Individual officers or directors shall neither cause nor direct a change in Executive Office operations.

3. The President and Executive Committee will review and approve the employment contract of the Executive Director.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Parliamentarian**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2007

DATE REVISED:

REFERENCES:

Policy Statement:
Consultants appointed by the President may include a Parliamentarian.

Policy Amplification:

1. The Parliamentarian shall

   - sign and submit Conflict of Interest and Tobacco Free Pledge to the President
   - attend regularly scheduled meetings of the Executive and Finance Committees
   - attend Awards Ceremony at the Annual International Respiratory Congress and Annual Business Meeting
   - extend appreciation to key sponsors and exhibitors at the Annual International Respiratory Congress and Annual Business Meeting
   - attend receptions when invited
   - perform other duties as directed by the President

2. Additionally, the Parliamentarian shall:

   - assist the President by ensuring adherence to Robert's Rules of Order during official meetings of the Association
   - coordinate schedules for joint sessions with the House of Delegates' Parliamentarian
   - assist the President and President-elect in coordination of schedules for meetings
   - coordinate, in cooperation with Executive Office staff, on-site support

- provides logistical support for meeting
- assists with Presidential transitions
- assists with orientation of new Board Members

DEFINITIONS:

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

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Approval of Presidential Appointments, Goals, Charges**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2008

DATE REVISED: December, 2007

REFERENCES:

Policy Statement:
All goals, charges, and appointments made by the President shall be approved by the Board of Directors before being considered official.

Policy Amplification:

1. At the Board of Directors meeting following the Annual Meeting of the Association, the President shall submit:

    A. Appointments of individuals to serve on Special Committees, Task Forces, Focus Groups, and Panels, and as representatives to other organizations, as applicable

    B. Goals for the succeeding year

    C. Charges to Special Committees, Task Forces, Focus Groups, Panels, Specialty Sections and representatives, as applicable

2. Any other appointments made by the President during his/her term shall also be submitted to the Board of Directors for approval prior to being considered official.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Professional Attire**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: May 8, 2004, March, 2009

REFERENCES:

Policy Statement:
All Officers, Directors, and guests shall adhere to appropriate attire requirements when attending business meetings and social gatherings.

Policy Amplification:

1. Unless otherwise determined by the President, business attire shall be required for all meetings of the Board, Finance Committee and Executive Committee meetings.

    A. This requirement shall also apply to invited guests.

2. Attire worn to receptions and other social gatherings sponsored by other professional organizations (i.e. NBRC) shall be identified by the sponsoring group, unless otherwise defined by the President.

DEFINITIONS:

ATTACHMENTS:

HOD Resolutions

Resolution:
23-12-01

Resolution Author:
Dan Small/Connie Small

E-mail:
bivent@live.com

Phone Number:
702-807-9322

Author's State:
Nevada

Co-Sponsors and Their States:
none

Resolution:
The AARC develop a position paper deeming the administration of bronchodilators to hospitalized patients for off-label use as Medicare abuse and waste.

Rationale:
Currently in many hospitals in many states across the country where clinical practice guidelines and protocols have not become the standard of practice, respiratory therapists are administering bronchodilators via SVNs in the hospital setting for a wide range of conditions other than airway hyper responsiveness or bronchoconstriction. These other conditions, include, but are not limited to the following: pulmonary contusions, pneumonia, interstitial lung disease, renal failure, congestive heart failure, atelectasis, bronchiolitis, and pneumothorax. According to CMS, abuse is the practice that directly or indirectly results in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Waste is acting with gross negligence or reckless disregard for the truth in a manner that results in any unnecessary costs or unnecessary consumption of healthcare resources. The administration of bronchodilators in the absence of reversible airway disease is a medically unnecessary practice. It fails to meet professionally recognized standards of care. This would be considered Medicare abuse. This results in unnecessary costs and unnecessary consumption of healthcare resources, therefore waste, as per Medicare definition. Bronchodilators are beta agonists that relax smooth muscles in the airways, and are used to prevent or treat bronchospasm in people with reversible airway disease. It is also used to prevent exercise-induced bronchospasm. There is an abundance of medical literature to support the use of bronchodilators for these conditions. There is no evidence to support the off-label use bronchodilators, with the exception of hyperkalemia.

Impact of Resolution:

General Membership, Affiliates, State/Federal Legislation

Implementation Cost:

0

Ongoing Cost:

0

Relationship to AARC Strategic Plan:

Develop art and science of RC

Miscellaneous