American Association for Respiratory Care

Board of Directors Meeting

Renaissance Orlando at SeaWorld
Orlando, FL

July 18-19, 2013

Index

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – July 17, 2013
Board of Directors Meeting – July 18-19, 2013

Wednesday, July 17

4:00-7:00 pm Executive Committee Meeting (Committee Members only) *[Executive Boardroom]*

7:00-8:00 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) *[Atlantis]*

Thursday, July 18

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

8:00 am Call to Order
Announcements/Introductions
Disclosures/Conflict of Interest Statements
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1:30 pm Reconvene – JOINT SESSION

3:30 pm Break

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Billing Code Committee pg. 135
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5:00 pm RECESS

Friday, July 19

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

8:00 am Call to Order

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- American Association of Cardiovascular & Pulmonary Rehab pg. 156
- American Heart Association pg. 157
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- Chartered Affiliate Consultant pg. 159
- Comm. on Accreditation of Medical Transport Systems pg. 160
- Extracorporeal Life Support Organization (ELSO) pg. 161
- International Council for Respiratory Care (ICRC) pg. 162
- The Joint Commission (TJC) pg. 163
- National Asthma Education & Prevention Program pg. 166
- National Coalition for Health Professional Ed. In Genetics pg. 167
- National Sleep Awareness Roundtable pg. 168
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10:00 am BREAK

10:15 am Roundtable Reports pg. 170
- Asthma Disease pg. 171 (R)
- Consumer (see Executive Director report pg. 40)
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- Geriatrics pg. 174
- Hyberbaric pg. 175
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- Research pg. 181
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10:45 am Ad Hoc Committee Reports pg. 184
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 185 (R)
- Ad Hoc Committee on Officer Status/US Uniformed Services pg. 186
- Ad Hoc Committee on Leadership Institutes pg. 187
- Ad Hoc Committee on 2015 & Beyond pg. 188
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12:00 pm Lunch Break

1:30 pm Reconvene

1:30 pm Other Reports pg. 191

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NEW BUSINESS pg. 199

Policy Review

- BOD.025 – BOD - Conventions and Meetings pg. 200
- CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges pg. 216
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3:30pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(as of July 3, 2013)

AARC Board of Directors Meeting

July 18-19, 2013 • Orlando, FL

Executive Office

Recommendation 13-2-1.1 "That an Ad Hoc Committee be appointed to recommend the content to be included in exhibits for the proposed virtual museum."

Recommendation 13-2-1.2 "That resources be allocated to conduct and record interviews with Past Presidents, key physicians, and other leaders in the profession."

Recommendation 13-2-1.3 "That the BOD approve the purchase of a new phone system to replace the current one that is over six years old."

Recommendation 13-2-1.4 "That the AARC BOD approve the addition of Merrill Lynch as an investment advisor."

Recommendation 13-2-1.5 "That the AARC BOD approve opening a brokerage account with the Bank of Texas."

Bylaws Committee

Recommendation 13-2-9.1 "That the AARC BOD accepts and approves the Georgia Society for Respiratory Care Bylaws."

Recommendation 13-2-9.2 "That the AARC BOD accepts and approves the North Dakota Society for Respiratory Care Bylaws."

Recommendation 13-2-9.3 "That the AARC BOD accepts and approves the New York State Society for Respiratory Care Bylaws."

Elections Committee

Recommendation 13-2-10.1 "Amend the Election Committee Policy by adding the following to item 5: 'The Committee will develop a question for the Section Chair nominees that would be specific to the role, with input from the AARC President, focusing on the charges set forth for the particular section. The question will be generic for all Section Chair nominees.'."

Recommendation 13-2-10.2 "Amend the Election Committee Policy by adding the following: '18. The Executive Office will provide updated section membership numbers and election grid to the Elections Committee, reflecting December 31st membership.'."

Adult Acute Care Section

Recommendation 13-2-50.1 "That the AARC BOD consider creating an 'Acute/Critical Care Workshop' to be presented at Summer Forum."

Recommendation 13-2-50.2 "That the AARC BOD look into the feasibility of creating a 'Back to Basics' education curriculum much like the ACCS Prep Course."

Recommendation 13-2-50.3 "That the AARC BOD appoint members to look into the best approach to organize the AARConnect archives into easily accessible and partitioned areas to include, but not limited to, protocols, policies, and clinically relevant articles."

Recommendation 13-2-50.4 "That the AARC BOD, in conjunction with possibly the Research Roundtable, develop a way that budding researchers can tap into the vast knowledge and resources available to the AARC to assist them with their research design, data analysis, and presentation."

Recommendation 13-2-50.5 "That the AARC BOD look into the possibility of developing a committee or such group that would look into ways of ensuring that non-traditional clinical responsibilities and opportunities are being fully supported."

Position Statement Committee

Recommendation 13-2-26.1 "Approve and publish the position statement on 'Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care' with no revisions."

Recommendation 13-2-26.2 "Approve and publish the revised position statement on 'Home Respiratory Care Services'."

Recommendation 13-2-26.3 "Approve and publish the position statement on 'Respiratory Care Scope of Practice'."

Recommendation 13-2-26.4 "Approve and publish the position statement 'Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists' with no revisions."

Social Media Committee

Recommendation 13-2-19.1 "That the AARC BOD approve the Mission Statement & Guidelines documents as listed in the 'Other' section of the written report."

Recommendation 13-2-19.2 "That the AARC BOD approve the structural approach described in the 'Report' section of the written report, providing any suggestions at this point."

American Society for Testing and Materials (ASTM)

Recommendation 13-2-65.1 "That the AARC BOD direct the Executive Office to investigate the potential of hosting F29 should AAMI be voted down on July 1, and report back to the BOD their recommendations."

Asthma Disease Management Roundtable

Recommendation 13-2-42.1 "Reconsider stance on AARC Congress presenter registration to include full complimentary registration."

Recommendation 13-2-42.2 "If not already available, consider developing formal AARC sponsored smoking cessation counselor training for RTs. If already available, consider a media blitz to raise awareness so interested RTs can enroll."

Recommendation 13-2-42.3 “Develop tools that will help RTs gain the support of local Executive Leadership (e.g. CEOs, CMOs).”

Recommendation 13-2-42.4 “Provide an educational session (Webcast?) on motivational interviewing/behavioral change strategies.”

Ad Hoc Committee on Cultural Diversity

Recommendation 13-2-29.1 “That the AARC promote the Cultural Diversity in Care Management Committee Mentoring Program in the AARC News.”

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 12, 2013 • Grapevine, TX

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Karen Stewart, MSc, RRT, FAARC, Past-President
Brian Walsh, MBA, RRT-NPS, RPFT, FAARC, VP Internal Affairs
Frank Salvatore, MBA, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
Lynda Goodfellow, EdD, RRT, FAARC
Fred Hill, Jr., MA, RRT-NPS
Denise Johnson, MA, RRT
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Camden McLaughlin, BS, RRT, FAARC
Joe Sorbello, MEd, RRT
Greg Spratt, BS, RRT, CPFT
Sheri Tooley, RRT-NPS, CPFT, AE-C
Cynthia White, BA, RRT-NPS, AE-C
Gary Wickman, BA, RRT, FAARC

House Officers

John Steinmetz, MBA, RRT, Speaker
Deb Skees, BS, RRT, CPFT, Speaker-Elect
Terri Miller, MEd, RRT, CPFT, Secretary
Ross Havens, MS, RRT, Treasurer

Consultants

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

Guests

Larry Wolfish, Legal Counsel
Bill Sims, Salmon, Sims, Thomas
Tom Smalling, CoARC Executive Director

Absent (Excused)

Colleen Schabacker, BA, RRT, FAARC, VP External Affairs

Staff

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

Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Regulatory Affairs Director
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
President George Gaebler called the meeting of the AARC Board of Directors to order at 8:05am CDT, Friday, April 12, 2013. Secretary/Treasurer Frank Salvatore called the roll and declared a quorum.

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

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

Greg Spratt – employed by Covidien

APPROVAL OF MINUTES
Joe Sorbello moved "To approve the minutes of the November 8, 2012 meeting of the AARC Board of Directors."
Motion carried

Bill Cohagen moved "To approve the minutes of the November 9, 2012 meeting of the AARC Board of Directors."
Motion carried

Karen Stewart moved "To approve the minutes of the November 13, 2012 meeting of the AARC Board of Directors."
Motion carried

E-MOTION RATIFICATION
Denise Johnson moved "To ratify the E-Motions discussed over the Board AARConnect since November 2012 as follows:

E13-1-49.1 Brian Walsh moved that the AARC Board of Directors authorize the formation of the Palliative Care Roundtable.
Motion carried

E13-1-10.1 Vote for one Board member to serve a 3 year term on the Elections Committee, the nominees are Karen Stewart and Bill Cohagen.

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

E13-1-15a.1 Colleen Schabacker moved that the AARC Board of Directors approves the membership of the 2013 Sputum Bowl Committee as recommended by

the Program Committee: Chair – Sherry Whiteman (MO), Members – Kelli Chronister (OH), Tom Lamphere (PA), Diane Oldfather (MO), David Panzlau (MI), Rick Zahodnic (MI).
Motion carried

E13-1-39.1 Brian Walsh moved to approve Charlie Friderici as the Chair of the Disaster Response Roundtable.
Motion carried

E13.1-81.1 Colleen Schabacker moved to approve the appointment of Hyacinth Johnson as a replacement for Sue Meade to the NBRC Board of Directors.
Motion carried

E13-1-10.2 Brian Walsh moved to approve Karen Stewart as the Elections Committee representative from the Board of Directors.
Motion carried

Denise Johnson moved to ratify the E-Motions
Motion carried

GENERAL REPORTS

Executive Director/Office

Tom Kallstrom gave an overview of the written Executive Office report. Tom introduced Shawna Strickland as Bill Dubbs' replacement as Associate Executive Director/Education. Associate Executive Directors Doug Laher, Shawna Strickland, Tim Myers, Steve Nelson, and Sherry Milligan, commented on their current and ongoing projects from their respective departments.

AUDITORS REPORT

Audited financial statements were distributed to the Board. Bill Sims of Salmon, Sims, Thomas discussed the audited financial statements.

Bill Cohagen moved to accept **Recommendation 13-1-13.1**"That the Board of Directors accept the audit report as presented."
Motion carried

LEGAL COUNSEL

Larry Wolfish gave an overview of Board member fiduciary responsibilities and answered questions from Board members.

INVESTMENT REPORT

Frank Sloan, from Sloan and Associates, gave an overview of the current investments of the Association.

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 9:58am CDT Friday, April 12, 2013.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors 10:12am CDT Friday, April 12, 2013.

EXECUTIVE SESSION
Karen Stewart moved to go into Executive Session at 10:20am CDT on Friday, April 12, 2013.
Motion carried

Brian Walsh moved to come out of Executive Session at 11:45am CDT on Friday, April 12, 2013.
Motion carried

COMMISSION ON ACCREDITATION for RESPIRATORY CARE (CoARC)
CoARC Executive Director Tom Smalling presented his report and answered questions. He also gave highlights of the "2012 Report on Accreditation in Respiratory Care Education".

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 12:18pm CDT Friday, April 12, 2013.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors 1:45pm CDT Friday, April 12, 2013.

Board Orientation
George Gaebler reminded the Board of basic rules of the Board meeting, i.e., proper way to make motions, proper attire.

PRESIDENT'S REPORT
George Gaebler gave highlights of his report that was distributed at the meeting.

FINANCE COMMITTEE
Bill Cohagen moved to accept **Recommendation 13-1-1.1** "That up to $3,000 be allocated to convert AARC historical materials into appropriate formats compatible with current technology."
Secretary/Treasurer, Frank Salvatore, stated that the Finance Committee recommended that this motion be approved.
Motion carried

Joe Sorbello moved to accept **FM 13-1-12.1** "That the AARC Board of Directors approve the capital purchase (January-March 2013) of the INFORMZ email system of $7,306.88 plus the first year email block for a total of $15,155."

Secretary/Treasurer, Frank Salvatore, reported that the Finance Committee recommended the Board approve it.
Motion carried

Karen Stewart moved to accept **Recommendation 13-1-1.2** "That the AARC Board of Directors endorse the attached document Clinical Practice Guidelines for Quality Palliative Care" (see attachment "NCP Guidelines").
Motion carried pending adding "respiratory therapist" in the Foreword

President Gaebler announced that Helen Sorenson will Chair the new Palliative Care Committee.

STATE GOVERNMENT AFFAIRS
Cheryl West provided an update on recent legislative and regulatory issues impacting the profession. IN and MI Societies have worked diligently to defeat efforts by their respective states to de-license the RT profession. IN issue has been resolved, RT licensure kept, MI Licensure still in flux.

GOVERNMENT & REGULATORY AFFAIRS
Anne Marie Hummel provided an update on federal regulations and rules that impact the profession. Tom Kallstrom, Tim Myers, Anne Marie Hummel and Dr. Kent Christopher recently attended the Pulmonary Medicine Summit in Washington, DC. Anne Marie gave an explanation of the changes to our Medicare Part B Initiative, titled the Medicare Respiratory Therapist Access Act

HOUSE OF DELEGATES
John Steinmetz gave an overview of his written report.
BOARD OF MEDICAL ADVISORS (BOMA)
Dr. Lori Conklin informed the Board of a virtual BOMA meeting on April 27th.

PRESIDENT'S COUNCIL
Dianne Lewis gave an overview of her written report. Kerry George has been selected as the 2013 Jimmy A. Young Medal Winner.

Karen Stewart moved to accept the General Reports as presented.
Motion carried

STANDING COMMITTEES REPORTS

Program Committee
Karen Stewart moved to accept **Recommendation 13-1-15.1** "That the AARC Board of Directors approve San Antonio, TX as the host city for AARC Congress 2016."
Motion carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 3:40pm CDT Friday, April 12, 2013.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors 3:52pm CDT Friday, April 12, 2013.

Frank Salvatore moved "To accept the Standing Committee reports as presented."
Motion carried

SPECIALTY SECTION REPORTS

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

Karen Stewart moved to refer back to section for more information.
Motion carried

Karen Stewart moved to accept **Recommendation 13-1-51.2** "That the AARC investigate through a special task force the development of a national post pulmonary rehabilitation disease management program in collaboration with a nationally recognized community exercise organization, such as the YMCA, including applying for national research funding."
Karen Stewart moved to refer back to section for more information.
Motion carried

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

SPECIAL COMMITTEE REPORTS

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

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

The President appoints these members and, therefore, the recommendation is out of order.
Motion made by Karen Stewart to refer to the President.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

American Heart Association

Brian Walsh moved to accept **Recommendation 13-1-64.1** "That we communicate the AHA clarification via appropriate channels."

Accepted FIO

Karen Stewart moved to accept the Special Representatives reports as presented.

Motion carried

RECESS

President Gaebler called a recess of the AARC Board of Directors meeting at 4:50pm CDT on Friday, April 12, 2013.

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

_____ _____

Frank Salvatore Date
AARC Secretary/Treasurer

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 13, 2013 • Grapevine, TX

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Karen Stewart, MSc, RRT, FAARC, Past-President
Brian Walsh, MBA, RRT-NPS, RPFT, FAARC, VP Internal Affairs
Frank Salvatore, MBA, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
Lynda Goodfellow, EdD, RRT, FAARC
Fred Hill, Jr., MA, RRT-NPS
Denise Johnson, MA, RRT
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Camden McLaughlin, BS, RRT, FAARC
Joe Sorbello, MEd, RRT
Greg Spratt, BS, RRT, CPFT
Sheri Tooley, RRT-NPS, CPFT, AE-C
Cynthia White, BA, RRT-NPS, AE-C
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John Steinmetz, MBA, RRT, Speaker
Deb Skees, BS, RRT, CPFT, Speaker-Elect
Terri Miller, MEd, RRT, CPFT, Secretary
Ross Havens, MS, RRT, Treasurer

Consultants

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

Absent (Excused)

Colleen Schabacker, BA, RRT, FAARC, VP External Affairs

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director
Sherry Milligan, MBA, Associate Executive Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
President George Gaebler called the meeting of the AARC Board of Directors to order at 8:31am CDT, April 13, 2013. Secretary-Treasurer Frank Salvatore called the roll and declared a quorum.

Position Statement Committee
Karen Stewart moved to accept Recommendation 13-1-26.1 "That the AARC Board of Directors approve and publish the revised position statement on 'Cultural Diversity'."
Motion carried

Karen Stewart moved to accept Recommendation 13-1-26.2 "That the AARC Board of Directors approve and publish the revised position statement on 'Telehealth in Respiratory Therapy'."
Motion carried

Karen Stewart moved to accept Recommendation 13-1-26.3 "That the AARC Board of Directors approve and publish the recently reviewed 'Respiratory Therapy Protocols' position statement with no changes."
Motion carried

Karen Stewart moved to accept Recommendation 13-1-26.4 "That the AARC Board of Directors approve and publish the recently reviewed 'Home Respiratory Care Services' position statement with no changes."
Greg Spratt stated that changes had been made to this Position Statement.
Moved to refer back to Position Statement Committee to check changes and vote thru an e-vote.
Motion to refer carried

Karen Stewart moved to accept Recommendation 13-1-26.5 "That the AARC Board of Directors approve and publish the newly developed position statement 'Development of Baccalaureate and Graduate Education Degrees'."
Motion carried

Karen Stewart moved to accept Recommendation 13-1-26.6 "That the AARC Board of Directors approve and publish the totally revised position statement 'Concurrent Therapy'."
Motion defeated

FM 13-1-26.7 Frank Salvatore moved to retire the Concurrent Therapy Position Statement.
Motion carried

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

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

ROUNDTABLE REPORTS

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

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on Cultural Diversity in Patient Care
FM 13-1-29.1 Brian Walsh moved that the Executive Office develop a method to collect diversity information of its members.
Motion carried

Ad Hoc Committee to Recommend Bylaws Changes
FM 13-1-30.1 Karen Stewart moved to approve Bylaws changes as presented and move forward to Bylaws process for approval.
Motion carried

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

RECESS
George Gaebler called a recess of the AARC Board of Directors at 9:30am CDT, Saturday, April 13, 2013.

RECONVENE
President Gaebler reconvened the meeting of the AARC Board of Directors 9:46am CDT Saturday, April 13, 2013.

OTHER REPORTS (NBRC, ARCF)
American Respiratory Care Foundation
Karen Stewart moved to accept Recommendation 13-1-82.1 "That the AARC consider returning fundraising for the AARC International Fellows back to the ARCF."

Fred Hill moved to make a friendly amendment to remove the word "consider" and change "returning" to "return".
Motion carried

Tom Kallstrom gave highlights of the ARCF report.

Frank Salvatore moved to accept the NBRC and ARCF reports.
Motion carried

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS
FM 13-1-1.3 Frank Salvatore moved that the AARC ensure the members of the Executive Committee and Board have access to the Internet while at meetings.

Friendly amendment to add House Officers.
Frank Salvatore moved to refer to Executive Office for investigation and report back at the July 2013 Board meeting.

Motion carried

POLICY REVIEW

Policy No. BOD.025 **–** *Conventions and Meetings*
Karen Stewart moved to refer to Executive Office for review.
Motion Carried

Policy No. BA.002 – *Member Organizations*
Karen Stewart moved to accept as amended.
Motion Carried

Policy No. CA.005 **–** *Chartered Affiliate Travel Grant*
Cam McLaughlin moved to accept as amended.
Motion Carried

Policy No. CT.006 – *Committee Travel Expenses*
Karen Stewart moved to retire the policy.
Motion Carried

Policy No. FM.015 – *Approval of Budget*
Karen Stewart moved to accept as amended.
Motion Carried

Policy No. FM.021 – *Old Outstanding Checks*
Karen Stewart moved to accept as amended.
Motion Carried

(See Attachment "B" for all amended policies)

White Paper review
FM 13-1-26.8 Karen Stewart moved to refer White Papers "Guidance Document on Scope of Practice" and "RRT Credential" to Position Statement Committee.
Motion carried

EXECUTIVE SESSION
Frank Salvatore moved to go into Executive Session at 10:35am CDT on Saturday, April 13, 2013.
Motion carried

Karen Stewart moved to go out of Executive Session at 11:20am CDT on Saturday, April 13, 2013.
Motion carried

ARCF AWARD NOMINEES
The Board brought forth the following nominees for the ARCF Awards for 2013.

Forest M. Bird Lifetime Scientific Achievement Award

Denise Johnson moved to nominate ***Alex Adams*** – Nominated by Lynda Goodfellow
Motion Carried

Charles H. Hudson Award for Cardiopulmonary Public Health
Frank Salvatore moved to nominate ***Danica Patrick*** **-** Nominated by Lynda Goodfellow
Motion Carried

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care
Frank Salvatore moved to nominate ***Patricia Blakely*** **-** Nominated by George Gaebler
Motion Carried

Mike West, MBA, RRT Patient Education Award
Frank Salvatore moved to nominate ***Bill Galvin*** **-** Nominated by Dianne Lewis
Motion Carried

Life Membership Nominations
Frank Salvatore moved to nominate ***Ruth Rinker*** **-** Nominated by Denise Johnson
Motion Carried

Honorary Membership Nominations
Frank Salvatore moved to nominate ***Kathy Blackmon*** – Nominated by Doug McIntyre
Motion Carried

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

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

ADJOURNMENT
President George Gaebler adjourned the meeting of the AARC Board of Directors at 11:26am CDT, Saturday, April 13, 2013.

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

_____ _____

Frank Salvatore Date
AARC Secretary/Treasurer

Attachment “A”

Position Statements:
Cultural Diversity
Telehealth in Respiratory Therapy
Respiratory Therapy Protocols
Development of Baccalaureate and Graduate Education Degrees

American Association for Respiratory Care

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

Position Statement

Cultural Diversity

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

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

Effective 12/94

Revised 12/07

Reaffirmed 07/10, 04/13

American Association for Respiratory Care

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

Position Statement

Telehealth and Respiratory Therapy

Telehealth is the broad use of electronic synchronousor asynchronous communication technology to provide virtual health care services and consultations (telemedicine) for patients or providers residing in separate locations. Services can include patient assessment and education, diagnostic evaluation, sleep testing, monitoring, disease management, disease prevention, health promotion, and rehabilitation as well as specific patient consultations.

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

Effective 03/01
Revised 07/10, 04/13

American Association for Respiratory Care

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

Position Statement

Respiratory Therapy Protocols

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

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

Effective 05/16/01
Revised 07/07
Reviewed 04/13

Position Statement of the American Association for Respiratory Care

Development of Baccalaureate and Graduate Education Degrees

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

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

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

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

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

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

Effective 4/13

Attachment “B”

Policies:
BA.002 – Member Organizations
CA.005 – Chartered Affiliate Travel Grant
CT.006 – Committee Travel Expenses
FM.015 – Approval of Budget
FM.021 – Old Outstanding Checks

American Association for Respiratory Care
Policy Statement

SECTION: Board of Medical Advisors

SUBJECT: **Member Organizations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 2013

DATE REVISED: April 2013

REFERENCES:

Policy Statement:
Physician organizations shall be named to the Board of Medical Advisors by the Board of Directors in concurrence with the Board of Medical Advisors.

Policy Amplification:
1. Physician organizations named to the Board of Medical Advisors shall be:

    A. American College of Chest Physicians (ACCP)
    B. American Thoracic Society (ATS)
    C. American Society of Anesthesiologists (ASA)
    D. American Academy of Pediatrics (AAP)
    E. American College of Asthma, Allergy, and Immunology (ACAAI)
    F. Society for Critical Care Medicine (SCCM)
    G. National Association for Medical Direction of Respiratory Care (NAMDRC)
    ~~H. American Academy of Allergy and Asthma Immunology (AAAAI)~~

2. The Board of Medical Advisors shall determine the number of appointees invited from each physician organization named above.

3. The Chairperson of the Board of Medical Advisors shall assure compliance with Association Bylaws Article VIII, Section 2, and "Term of Office."

DEFINITIONS:

ATTACHMENTS:

SECTION: Chartered Affiliate

SUBJECT: **Chartered Affiliate Travel Grant**

EFFECTIVE DATE: December 2003

DATE REVIEWED: April 2013

DATE REVISED: July 2007

REFERENCES:

Policy Statement:
The chartered Affiliate Travel Fund is to assist affiliates in paying for the travel expenses of AARC officers or executive office staff invited to affiliate meetings to speak about AARC issues. This travel fund will also assist affiliates in paying for the travel expenses of a designated Chartered Affiliate Consultant when an affiliate requests for such services.

Policy Amplification:
1. A grant will be issued which duplicates funding provided by another sponsor or sponsors.
2. Authority:
    A. The AARC President must approve all Affiliate Travel Fund grants.
    B. The AARC Executive Director must approve any executive office staff travel.
3. Grant request procedure:
    A. The Affiliate President sends a completed request form to the AARC Controller, who will forward a copy to the AARC President.
    B. For grants to assist affiliates in paying for the travel expenses of AARC officers or executive office staff, the AARC President must approve the grant. If the grant is approved, the President will determine the amount of assistance and. send the approved request to the AARC Controller.
    C. For grants to assist the Chartered Affiliate Consultant, the President will consult with the State Affiliate submitting the grant to determine the appropriateness of the request. If the grant is approved, the President will determine the amount of assistance and. send the approved request to the AARC Controller.
    D. All grants will generally be a percentage of total expenses up to a maximum dollar amount. Any other funding received from the other outside parties reduces the total expense to be considered in the grant determination process.

E. The AARC Controller will advise the Affiliate President of the grant amount approved.

F. The affiliate should acknowledge that it is receiving support from the AARC in its printed materials.

4. Responsibility for expenses:
   A. The affiliate will be responsible for paying all travel expenses.
      1. Airfare: The AARC can make flight arrangements, and bill the affiliate.
      2. Ground Transportation: The affiliate must provide any necessary transportation between the airport, hotel, and meeting site, and is responsible for the cost of airport transportation or parking in the officer's or staff member's hometown.
      3. Hotel: The affiliate must provide the hotel room and taxes.
   B. Any expenses paid by the AARC will be billed or deducted from the grant.
   C. Any other non-AARC monies received to defray our speaker's expenses must reduce the amount of expenses ultimately submitted to the AARC under this grant.
5. Payment of the grant:
   A. Copies of paid invoices should be sent to the AARC Controller, who will then issue a check to the affiliate.
6. Expenses (car rental, per diem, airfare, etc.) will be reimbursed in accordance with AARC policy.

DEFINITIONS:

ATTACHMENTS: E: Chartered Affiliate Travel Grant Application

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Committee Travel Expenses**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 13, 2013

DATE RETIRED: April 13, 2013

REFERENCES: FM.016

Policy Statement:
Travel expenses for committee members shall be reported, recorded, and reimbursed in accordance with Association policy.

Policy Amplification:

1. Committee members' travel shall be approved by the Committee Chairperson prior to such travel occurring. Refer to Policy No. FM.016

~~2. Committee Chairpersons may approve travel expenses for their committee members when acting in their official capacity, without advance or written approval from the President, provided that such travel expenses do not exceed those contained in the current committee budget as approved by the Board of Directors.~~

3. Any travel expenses which are not included in the current committee budget as approved by the Board of Directors shall require advance approval from the President, with subsequent review by the Finance Committee and ratification by the Board of Directors.

4. Committee Chairpersons shall submit a statement of travel expenses for their respective committee as part of their regular reports to the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Approval of Budget**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 2013

DATE REVISED: July 2005

REFERENCES:

Policy Statement:
The annual budget for the Association shall be reviewed and approved in a manner consistent with the Bylaws and the Corporate Charter.

Policy Amplification:

1. Annually, at the fall meetings of the Board of Directors and House of Delegates, the Secretary-Treasurer and President-elect shall present the proposed revenue and expense budget for the succeeding fiscal year of the Association.

    A. Following discussion in this forum, both bodies must approve the Budget for its implementation.

2. The Board of Directors and the House of Delegates shall receive and review the budget in Executive Session due to the proprietary nature of the information.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: **Fiscal Management**

SUBJECT: ~~**Old**~~ **Outstanding Affiliate Checks**

EFFECTIVE DATE: July 2007

DATE REVIEWED: April 2013

DATE REVISED: April 2013

REFERENCES:

Policy Statement

Periodically, but at least twice a year AARC shall perform the following procedure for old outstanding checks:

- Obtain the most recent list of all checks issued but still outstanding (i.e. not cleared the bank) for at least six months.
- Attempt to contact the Payee via mail or email to seek information and possible direction in terms of clearing and / or re-issuing the old check.
- Given better information is received, the original check shall be voided and be re-issued less a reasonable fee ~~(currently, the fee AARC is charged by the bank - $25)~~ for handling the stop payment fee on the original check.
- If the payee is still unreachable after several attempts, records shall be maintained for the outstanding item and it shall disposed of as current law allows.

DEFINITIONS

ATTACHMENTS

E-Motions

(Since Last Board Meeting in April 2013)

None

General Reports

President Report

Submitted by George Gaebler – Summer 2013

Correspondence and activities since April BOD Meeting:

I have worked with Tom Kallstrom and others from Executive Office to get final legislative language for new Therapist Access Act for Medicare. In all probability there should be a bill dropped in one or both the Senate and House prior to our meeting. We have readdressed the AHA related to the Patient Care Team of Future and new language should be forthcoming shortly. There have been multiple licensure issues in Ohio, North Carolina, and Michigan since the April meeting. We had a well-attended Affiliate Leadership Workshop following the April meeting as well as the AARC Corporate Partners Meeting. Membership in this important group is growing which will be part of the Executive Office Report.

CMS Comments Letter: We will spend some time discussing the special importance of CMS wanting the AARC to be involved with the future of CMS language related to care of our patients in statute and policy.

Canadian Society for Respiratory Therapists: I attended a two day workshop on work toward what the Canadian Society expects their Therapists to be doing for the future regarding practice, education and licensure etc. There was a request to see if the original reciprocity system for licensure could return and I will be looking into this with Tripartite. As you may imagine their system is doing roughly the same work being done for 2015 and Beyond. We provided our information for their consideration. There are many Respiratory Therapists working in Canada as Anesthesia Assistants much like CRNAs do in the U.S. They are following the ventilators on protocols after surgery in place of Anesthesiologists which saves time and money. We have learned some RTs in the US are doing similar work where RT jobs are scarce. We will talk some about this in our meeting.

Karen Schell has exciting news about efforts to start a Respiratory Therapy Program in Ghana where she just traveled last month. I will ask her to share this with the BOD. This is just more evidence of the explosion of International Activities in Respiratory Care.

I have had to address requests from state affiliates to fund via travel grant AARC Speakers that would violate the AARC Policy. These have been requests for Tom Barnes who is soliciting speaker engagements as a spokesperson for 2015 and Beyond. We will be having discussion about the behavior he has exhibited which has been witnessed by Board Members and a House Officer. We will discuss the outcome of Tom Kallstrom and me attending the CoBRTE meeting at our request before this meeting.

Many state Affiliates are taking advantage of the grant system for speakers. Some of the speakers include Tom Kallstrom, Tim Myers, Shawna Strickland, Karen Stewart, and me.

Committee Additions/Changes

International Committee: Dan Van Hise, RRT, Senior Marketing Director from Philips Healthcare. The Committee has had an industry representative for many years. He is a replacement for the previous industry representative.

Membership Committee: Ray Pisani, Louisiana

I have been working on some new charges related to the AARC goals with many updates that I will give in person. We will have an extensive discussion about licensure actions by states and the communications the AARC has been using. In light of Ohio and other states seeking similar changes in practice we feel changes were needed.

We will be having an extensive discussion related to 2015 and Beyond in light of many recent actions occurring in the profession and market.

Tom Kallstrom will giving an update on actions taken related to 2015 and Beyond about the findings about programs status in regards to preparations with transfer agreements and bachelors programs. I have held back on some of the other referral actions because I felt it was very important to have that information before we moved the rest of the activities forward. My activities and experience with the states have lent credence to the slower approach.

Tom Kallstrom will cover many of the action items that have happened since the April Meeting related to other organizations and Executive Office activities. A large increase in communication on many issues has been happening related to the Affordability Care Act (ACT). One special note is the CDC PHEMCE Working group related to ventilator preparedness for a potential Pandemic Flu that possibly may hit later this year. This is a new strain that surfaced late this spring in China with a very high mortality rate. It is another of the animal/avian type mutations that seems to be able to cross to humans.

By the time the meeting occurs we will have done a special proclamation for Stephen Mikles, the CoARC President at the Summer Forum. He has had a courageous battle with cancer for many years. It was considered to be quite important to do this while he is able to be recognized publically for his large contributions to our Profession.

Travel:
April 2013

Dallas, Texas for AARC BOD, State Society Leadership and Corporate Partners Meeting

May 2013
Canadian Society for Respiratory Care: The Respiratory Therapist of the Future

June 2013
New York/New Jersey Managers Educator Conference: Speaker X2

September 2013
South Carolina Society for Respiratory Care Speaker
Pennsylvania Society for Respiratory Care Speaker

October 2013
New York Society for Respiratory Care: Speaker

More are pending. I will ask some you to do some of these because it helps prepare you for your future leadership in the AARC BOD!

Past President Report

Submitted by Karen Stewart – Summer 2013

Nothing to report.

Executive Office

Submitted by Tom Kallstrom, Executive Director – Summer 2013

The following are highlights from the Executive Office since the Spring meeting in Dallas in April.

Membership

Membership, which was 52,517 members at the end of May, has been stable. However, at the beginning of June the number dropped to 49,264. This is in large part due to the annual readjustment of the numbers with electronic student memberships dropping post graduation as well as the monthly adjustment which does track lower at the beginning of each month. We will have an updated report from the membership committee at the Board Meeting. The Membership Committee will also be reporting on the progress of the membership campaign in the second quarter and into the third.

Co-Marketing Opportunities with our State Affiliates

There are 40 affiliates who have signed revenue sharing agreements and 40 who have opted for co-marketing agreement with the AARC. This is a record number. 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

Drive4COPD

The Drive 4COPD Adopt-A-Company program was officially launched at the Spring Affiliates meeting in Dallas and the 2013 Adopt-A-Company initiative was implemented. This includes the recruitment of Crew Chiefs and supporting members of the AARC with shipping, receiving, and processing of the DRIVE4COPD material. In order to let members know of the initiative, new marketing material for the Adopt-A-Company were developed that included recruitment videos that have been sent out to members by email (News Now), on social media (Facebook) and a DRIVE4COPD article was published in the April and June 2013 AARC Times.

In an effort to broaden the reach, a new website for the Adopt-A-Company was developed. In addition, respiratory program directors were sent an invitation for their students to participate in the DRIVE4COPD campaign. We had a great response rate from them, with over 100 schools interested in a Fall event (around Respiratory Care week).

As you can see by Table 1 below, some states have already exceeded their goals and some are just getting started. We urge our states to engage in this campaign. Jason Moury will be at the Board Meeting as well as the House Meeting where he will present an update of the activities of Drive4COPD as well as to challenge the affiliates to join the campaign.

Table 1

State Society	Grand Totals	State Goals	Remaining Screens to Target	% to target screens
AL	2	679	677	0%
AK	0	0	0	0
AZ	1121	1505	384	74%
AR	31	502	471	6%
CA	1119	845	-274	132%
CO	87	475	388	18%
CT	28	630	602	4%
DE	2	381	379	1%
DC	*7*	*0*	*-7*	*(added to MD)*
FL	244	1570	1326	16%
GA	25	660	635	4%
HI	12	150	138	8%
ID	4	150	146	3%
IL	37	694	657	5%
IN	334	336	2	99%
IA	1	1219	1218	0%
KS	26	1548	1522	2%
KY	2	223	221	1%
LA	6	796	790	1%
ME	0	150	150	0%
MD-DC	35	150	115	23%
MA	3	150	147	2%
MI	388	831	443	47%
MN	102	835	733	12%
MS	0	562	562	0%
MO	8	764	756	1%
MT	0	150	150	0%
NE	5	592	587	1%
NV	479	240	-239	200%
NH-VT	3	150	147	2%
NJ	15	150	135	10%
NM	14	1655	1641	1%
NY	25	323	298	8%
NC	344	244	-100	141%
ND	0	328	328	0%
OH	16	721	705	2%
OK	3	150	147	2%
OR	17	150	133	11%
PA	42	3309	3267	1%
RI	1	150	149	1%
SC	51	679	628	8%
SD	2	150	148	1%
TN	6	169	163	4%
TX	289	773	484	37%
UT	50	864	814	6%
VA	17	916	899	2%

WA	19	467	448	4%
WV	92	3836	3744	2%
WI	17	195	178	9%
WY	47	150	103	31%
AARC (International and Territories)	13	0	-13	
Total of all screeners	**5356**	32316	27132	17%
	Events pending in that state			

HOSA
The HOSA annual conference was held in Nashville, TN in June. House of Delegate representative from Tennessee, Susan Parsons (TnSRC), coordinated an AARC booth. She did this with Cory Martin, Dave Johnson, and Christine Hamilton (Nashville-area RT program directors) and students who staffed the booth.

Education

Preceptor Training Course
The AARC will be releasing the Preceptor Course this August. The course was developed by Crystal Dunlevy, Georgiana Sergakis, and Sarah Varekojis from Ohio State University. This AARC-owned course will be introduced as an on-line offering after the Summer Forum.

Leadership Institute
- Anticipated release date: November 2013
- Module content development in progress
- Track chairs:
    - Research: Rob Chatburn
    - Education: Toni Rodriguez
    - Management: Rick Ford

Webcasts
- 17 planned for 2013
- Various content areas addressed (patient safety, neo-peds, AAC, etc)
- Plan for 2014: no more than two (2) scheduled webcasts/Journal webcasts planned per month (not to exceed 24/year of BOTH types of webcasts)

Respiratory Care Education Annual
The Publication of the 2013 issue will be released as an electronic copy in September. We want to thank Dennis Wissing, Helen Sorenson, Will Beachey, David Chang, Arthur Jones, and Linda Van Scoder for their efforts this year.

Continuing Respiratory Care Education
In March all processes were converted to an electronic platform. The process has been expedited. All applications are reviewed within 5 days of payment receipt. Since making this conversion the feedback has been positive.

CPG Development
We redesigned the CPG webpage in May 2013 in order to focus on evidence-based medicine and systematic reviews. We retired older and outdated CPGs in favor of linking to reliable and evidence-based documents from other reputable organizations such as the ACCP and AHA. We are currently in the final stages of developing the non-pharmacologic interventions in airway clearance CPG that we have been working on since last August. The committee is currently writing the first draft of the guidelines and we will submit the guidelines to the RESPIRATORY CARE Journal by September 1, 2013, for its anticipated publication in December 2013. The committee is comprised of Cathy O'Malley, Carl Haas, Gail Drescher, Terry Volsko, Rich Branson, and Bruce Rubin with Shawna Strickland as the committee chair.

We have requested a proposal from Vanderbilt for the other half of the topic: pharmacologic interventions in airway clearance. That committee will convene in October 2013 with an anticipated publication date in 2014.

Tobacco Cessation
The AARC was invited to submit a comment paper to SCLC/Pfizer in April 2013.
The topic was Smoking Cessation Tools for Inpatient Education. Its intended purpose is to develop a toolkit guide for respiratory therapists to follow while conducting a tobacco intervention referred by the hospitalist or other physician. Should the grant be awarded, we would be awarded $25,000 to complete the project. We have not yet heard back from the funder as of early June.

There will be a Tobacco Cessation workshop at the International Congress this year. We have gathered some of the professions experts as well as Dr. Stephen Schroeder, former President and CEO of the Robert Wood Johnson Foundation to present this workshop.

Finally, all active members of the AARC are eligible to receive fifty complimentary copies of the latest tobacco cessation guide as a member benefit. This guide was created by the AARC's Tobacco-Free Lifestyle Roundtable; the "Why Quit Using Tobacco?" guide can be used in the inpatient or outpatient setting and is intended to augment individualized tobacco cessation counseling delivered by a respiratory therapist. The booklet provides a ten-step plan for becoming tobacco-free, the top five reasons for quitting, an understanding of nicotine and its effects, and an overview of the types of helpful medications. To order the guide, go to: http://www.aarc.org/resources/tobaccocessation/

AARC Congress 2013

Logistical planning for AARC Congress 2013 is progressing as scheduled. Details of the meeting are as follows:

- 150 speakers
- ~ 200 unique presentations representing all Specialty Sections and most roundtables.
- ~ 45 first time speakers have been invited to present at AARC Congress; creating a portal for new talent into the AARC.
- 20 Open Forums
    - One Poster Session dedicated for Industry-sponsored Research
- A new plenary session (Thomas Petty Memorial Lecture) will be added to the Program in 2013.
- For the first time in 2013, each presentation will be identified by content category for seamless CRCE reporting.

- Three pre-course offerings are scheduled one day prior to the Congress
    - Patient Safety
    - Trauma
    - Tobacco Cessation
- All sessions to last 30 minutes in length to better meet the learning needs of attendees
- To better meet demand and the travel needs of attendees, there will only be a ½ day meeting scheduled for Nov. 19 culminating with a closing ceremony. Speaker selection for the closing ceremony is underway.

Project Updates

COPD Toolkit:
Data collection for the toolkit concluded as of June 1, 2013. Roughly 15 hospitals served as beta-sites with more than 200 COPD patients being screened in total. Patient data has been collected and is currently undergoing analysis (scheduled to be complete in early/mid August). Surveys will also be sent to participating sites to gather information from respiratory therapists on their perceived value of the toolkit and its impact with the COPD population. Upon review of data analysis and survey results, next steps will be determined.
Projected Completion Date: August 2013

ACCS Prep Course:
Faculty and agenda for the Adult Critical Care Specialty Exam course have been set. The course is scheduled for Sept. 18-19, 2013 at Harrah's Hotel and Casino in Las Vegas, NV. Marketing and on-line registration for the course has not yet started at the time of this report, but is scheduled to be well underway by the time of the BOD meeting.

Attendance, demand, and attendee feedback will determine next steps, with potential actions including, but not limited to: a) a second live-course; and/or b) professional recording of the course for 24/7 on-demand viewing through the AARC website.
Projected Completion Date: September 2013 (ongoing)

Hospital-to-Home:
Numerous presentations will be delivered at AARC Congress 2013 regarding skills, attributes, and competencies needed by the RT to facilitate a seamless transition of patients being transferred from hospital to home.
Projected Completion Date: Ongoing

Affordable Care Act Best Practice Repository:
A member community has been established on AARConnect to house a repository of best practices developed in response to changes in the Affordable Care Act. Members are encouraged to provide a brief description of their best practice and supporting documentation such as job descriptions, business plans, outcomes, implementation strategies etc. Each submission will be vetted by the Executive Office prior to the posting of the best practice on AARConnect.
Completion Date: Ongoing

Nutrition Guide:
An unrestricted educational grant has been received to develop an educational resource guide for the respiratory therapist regarding the importance of nutrition and the impact it has on the cardiopulmonary patient. This document will have a similar look and feel as that of the Aerosol Delivery Guide for Respiratory Therapists. Faculty has been identified with project objectives communicated and timelines agreed upon. Initial draft of the document will have been received

and sent off for review by the time of the BOD meeting.
Projected Completion Date: AARC Congress 2013

Education

Professors Rounds

- Recording will be complete on July 2, 2013
- 8 topics
    - Professors: Doug Gardenhire, Rich Branson, Shannon Carson, Elliot Dasenbrook, Tim Myers, Bob Kacmarek, Dean Hess and Keith Lamb
    - Moderators: Tom Kallstrom, Tim Myers, Doug Laher, Shawna Strickland, Kathy Deakins, Dean Hess
- 2014 topics in development
- 2014 plan to reduce cost: all moderators are AARC staff (Kallstrom, Myers, Laher, Strickland)

Web Casts

- 17 planned for 2013
- Various content areas addressed (patient safety, neo-peds, AAC, etc)
- Plan for 2014: no more than two (2) scheduled webcasts/Journal webcasts planned per month (not to exceed 24/year of BOTH types of webcasts)

RESPIRATORY CARE Journal Webcasts

- New in 2013
- 7 webcasts planned
- Presenters "break down" that month's editor's pick to help with the utilization of research and increase readership of the Journal
- Coordinating presenters, topics, and webcast logistics

CRCE

	2013 YTD	2012 YTD	% change
Webcasts	**10,452**	**2,143**	**487%**
EPA Triggers	**1,634**	**2,495**	**(35%)**
EPA Allergy	**989**	**1,426**	**(31%)**
Asthma Edu	**95**	**151**	**(37%)**
COPD Edu	**280**	**248**	**12%**
Ethics	**1,220**	**1,578**	**22%**
VAP	**45**	**226**	**(80%)**
Alpha 1	**51**	**266**	**(81%)**

Communications Update

We continue to monitor communications between our roundtables and section members. Attachment #1 indicates that some groups are more engaged than others. The Roundtable members are using this communication tool far less then section members.

Advertising

Advertising continues to be in a state of flux with many changes in the industry and with our

advertising base. At the time of this report, advertising is slightly behind target for both Resp Care Journal and behind target for *AARCTimes* on the print side. This comes despite efforts to create a flexible portfolio of opportunities.

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

We have signed three sets of agreements with a digital advertising firm, Multiview (Las Colinas, TX), to procure digital advertising for our various digital and on-line platforms. Multiview has recently begun to sell digital advertising on aarc.org and AARConnect with great success. We are looking for other placement opportunities on aarc.org for advertisement banners and towers. We will also, in the near future, begin selling advertising in a digital format on other patforms.

Corporate Partners

We had a very successful meeting in April with 11 Corporate Partners that received information from AARC Executive Office staff providing updates on the state of the respiratory profession, AARC projects and meetings, and AARC legislative affairs. We had two featured clinical presentations for the meeting, Dr. Russell Acevedo, FAARC, of Crouse Hospital in Syracuse, NY, speaking on Lung Partner Project and Keith Lamb, RRT-ACCS spoke on the Future of the Critical Care RT.

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

Three to five companies have expressed interest in achieving Corporate Partner status in 2013 that would make them Partners in 2014. We have had good discussions with those companies and will work to jointly achieve this status with them.

Website Project

We have settled on a vendor, AXZM, that has begun work on modernizing and streamlining our web presence for AARC, YLH and ARCF in the coming months. We have finalized branding concepts and are currently in the process of developing the layout of the site. An aggressive timeline has been established to develop and implement the new websites before October.

Marketing

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

With the implementation of the *Informz* software packages, we will also be developing some new digital product lines from both an e-mail and digital advertising standpoint with Multiview. Most of you by now have seen the AARCareer News product that we successfully launched in May that highlights career building news and recruitment advertising.

Products

Benchmarking continues to maintain its foothold in approximately 130-140 hospitals around the US and in Saudi Arabia. The Benchmark Committee is currently conducting an assessment of the program and possible upgrades to ensure it is a current and valued tool to its participants. We are

also reviewing the pricing structure for 2014 to ensure that it has a good ROI for both the AARC and its participants.

As you are aware, in 2012 we outsourced our Respiratory Care Week products to a third-party supplier, Jim Coleman Ltd, that handled all products and the necessary shipping. We reviewed the program's successes, weaknesses and opportunities and will continue this outsourcing in 2013 with some minor revisions. We have established a logo and slogan for the 2013 Respiratory Care Week and associated products and will launch it shortly after Summer Forum.

We recently released updated versions of all 3 of our Aerosol Guides (RT, Non-RT Clinicians and Patient). These revised guides will again be released in a limited print format, download versions as pdfs and as an ePub for the Aerosol Guide that will be viewable on digital readers. We also are in the process of re-releasing the Guide to Portable Oxygen Concentrators before the end of June.

We continue to work to acquire sponsorships for our various educational products to offset expenses. At the time of this report, we have acquired 5 sponsors with Professor's Rounds and are close to finalizing sponsors for 2 others. Webcast sponsorship acquisition is moving a little slower at this time. We have also introduced a new product in this area with Webcast specific for Editor's Choice publications in Respiratory Care with the first being completed in March with over 300 participants. We have applied for a branded trademark for these and should hear back on our application for a trademark by the Summer BOD meeting.

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

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

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

RESPIRATORY CARE Journal

Submission of manuscripts continues to be received at record pace. This has resulted in more articles now printed than ever before. To try to maintain control over the number of pages printed while increasing the number of original research articles published, case reports, teaching cases, and letters to the editor now appear online only.

The online Journal hosted by HighWire at Stanford University and adjunct apps are now fully operational, including the Android app approved by the Daedalus Board at their April 2013 meeting. We are now investigating how best to use the extra offerings in the platform to the benefit of our readers and subscribers. At this year's Summer Forum editor Dean Hess will give a presentation on how educators and managers can use the online Journal to benefit students and staff.

With tremendous help from Shawna Strickland and others in the Executive Office, in March we began the Journal Webcasts. The webcasts are a new type of Journal Club at which the Editor's Choice paper in that month issue is presented, critically evaluated, and discussed by an AARC member with expertise on the subject matter. Typically, the presenter will express his/her views on the appropriateness of the research design, the statistics used, correctness of the controls, etc. Format allows for questions and answers from the online audience, and is free to AARC members and approved for CRCE. We are happy to report that as of June, 951 members have participated in the 3 webcasts this year. Poor participation in the CRCE Through the Journal has been of great concern for a few years now, in spite of many attempts to make it more attractive and more accessible to members. Shawna Strickland is trying new ways to promote this service and we hope to see increased participation by the end of the year. Editorial Board member Lynda Goodfellow is now responsible for the monthly preparation of the CRCE questions.

In June 2013 we published the proceedings from the 51st Journal Conference on Adult Mechanical Ventilation in Acute Care: Issues and Controversies. In June 2013 we held the conference on Airway Management and publication should occur in early 2014. Plans are now underway for the next conference to cover the subject of aerosol. The Journal is very grateful to the ARCF for their support of the conferences.

June 1 was the deadline for submission of abstracts of original research for possible presentation at this year's AARC Congress. 399 abstracts were received by the deadline. After they go through the peer review process, we anticipate presenting at least 18 Open Forum sessions at the Congress.

Attachment #1
AARConnect Messages from 1/1/2013 – 6/25/2013
Specialty Sections

Discussion	New Threads	Reply to Discussion	Total Messages
Adult Acute Care	137	303	440
Continuing Care/Rehab	30	51	81
Diagnostics	77	192	269
Education	74	125	199
Home-Care	33	31	64
Long-Term Care	13	18	31
Management	391	962	1353
Neonatal-Pediatrics	172	445	617
Sleep	24	53	77
Surface & Air Transport	37	106	143

Roundtables

Discussion	New Threads	Reply to Discussion	Total Messages
Asthma Disease Management	13	28	41
Disaster Response	16	8	24
Geriatrics	3	6	9
Hyperbarics	1	2	3
Informatics	0	0	0
International Medical Missions	4	0	4

Military	6	2	8
Neurorespiratory	8	3	11
Research	5	9	14
Simulation	2	5	7
Tobacco-Free Lifestyle	13	17	30

Other Communities

Discussion	New Threads	Reply to Discussion	Total Messages
Leadership Book Club	23	49	82
Bylaws	10	23	33
Coding	12	25	33
Resolutions Committee	2	5	7
Board of Directors	35	155	190
House of Delegates	28	12	40
Help Line	183	430	613

Historian's Report (from Trudy Watson, BS, RRT, FAARC)

Tom Kallstrom, Sam Giordano, and I met on May 13-14, 2013 to discuss the layout and general content for the proposed virtual museum.

Proposed exhibits could include, but not be limited to, the evolution of:

- airway clearance
- aerosol delivery
- ventilators
- oxygen therapy
- chronic disease management
- monitoring and testing
- diagnostics
- patient education
- smoking cessation
- protocols
- pandemic/mass casualty, emergency responders, transport
- history of the AARC, NBRC, and CoARC
- international respiratory care and the ICRC
- advancing the science of respiratory care –research and publications
- milestones by decade
- RTs in the news
- leaders and legends in the profession
- special exhibits during world or national months for asthma, COPD, etc…

Plans to promote the proposed museum at the 2013 International Congress were also discussed.

During the visit to the Executive Office, I also reviewed and selected an initial batch of prints as well as approximately 40 tapes (VHS and audiotapes) of presidential interviews conducted by Robert Weilacher to be converted into the appropriate digital formats.

We could capture a number of the interviews during the International Congresses and would require a dedicated room with table and chairs, a digital camcorder, tripod, and supplemental batteries and memory cards.

For those leaders or legends unable to participate in an interview at the Congresses, an "interview in a box" kit could be provided. The interview questions, detailed set- up instructions for the camcorder and tripod, and the required equipment could be sent to a local trusted therapist who could conduct the interview or the package could be sent directly to the interviewee via package tracking.

I apologize for not recommending a specific dollar amount with this recommendation but it would be dependent upon when such interviews could begin and what resources might currently available be available. Costs for this project would include the room rental at the International Congress, equipment purchases, and shipping fees. A complete digital camcorder bundle package with case, tripod, battery charger and memory card can be purchased from a big box store for under $500.

Summary

I am happy to expound on the information provided in this report in Orlando. We look forward to a productive meeting.

Executive Office
Referrals and Recommendations
July 2013

Referrals (from April 2013 BOD meeting)**:**

Recommendation 13-1-1.2 "That the AARC Board of Directors endorse the attached document Clinical Practice Guidelines for Quality Palliative Care" (see attachment "NCP Guidelines"). **Motion carried pending adding "respiratory therapist" in the Foreword**

Tom Kallstrom contacted NCP and the document had already been produced and, therefore, no changes could be made to the Foreword. The term "respiratory therapist" is, however, mentioned throughout.

FM 13-1-29.1 "That the AARC Executive Office develop a method to collect diversity information of its members."

We collect a variety of demographic information at the time an individual joins the AARC. We could add diversity-related questions on the membership application (both the online and paper versions) and the online profile of the member (that is available for correction and updating by the member at any time). This would require some simple modifications to our member database.

We also suggest that the purpose and future use of this information be identified by the committee at the beginning of the project, so that the data can be collected, programmed, and output from our system in a way that meets our needs as an organization.

FM 13-1-1.3 "That the AARC ensure the members of the Executive Committee, Board of Directors, and House of Delegates have access to the Internet while at meetings."

In conjunction with the Meetings & Conventions department, AARC Information Technology department, and AARC hotel partners, an evaluation of internet access costs was conducted. Depending on connection preference and number of concurrent users, pricing fluctuates considerably; however pricing does not significantly fluctuate from property to property.A cost analysis was performed and the following was identified:

- Option #1: 1 hard wired connection for BOD, 1 hard-wired connection for HOD, + "AARC wireless router" per room connecting to AARC server = $500/day per room ($1,000 per day for both BOD/HOD)
    - Pros: Most economical
    - Cons: Slow connection speeds
- Option #2: Wireless internet access for every BOD/HOD member = $3,500 - $5,000 in total for both BOD/HOD meetings (x 2 days)
    - Pros: Faster connection speeds. More band width
    - Cons: Very expensive

Policy No. BOD.025 – *Conventions and Meetings*
Karen Stewart moved to refer to Executive Office for review.

Will be addressed during Policy and Procedure review

Recommendations:

Recommendation 13-2-1.1 "That an Ad Hoc committee be appointed to recommend the content to be included in exhibits for the proposed virtual museum."

Justification: The proposed virtual museum will focus on the evolution of the respiratory care profession and the AARC. In addition to AARC representatives, input from the NBRC, CoARC, manufacturers, physicians, and topic experts will be required to ensure thorough, quality content for the museum exhibits.

Recommendation 13-2-1.2 "That resources be allocated to conduct and record interviews with Past Presidents, key physicians, and other leaders in the profession."

Justification: We need to capture interviews with approximately 20 of the more recent Past Presidents. We also need interviews with Jimmy Young Medalists as well as other therapists, physicians, and key Executive Office staff.

Recommendation 13-2-1.3 "That the BOD approve the purchase of a new phone system to replace the current one that is over six years old."

Justification: We wish to request authorization to replace the current phone system to mitigate the risk of having an unsupported system. The phone system that we have installed in the office is over 6 years old. Unfortunately, it was discontinued by the manufacturer a couple of years ago. Parts and services are now only available on an "as available" basis. We are concerned that unless we make this change we could be at risk in our communications.

Making this move with the current phone system now will present us with an unamortized balance of about $13,000 which would be expensed (original cost: $38,051). We have looked at replacing the system and have two options. The cost estimates for replacing the phones system and updating internal network where needed and training will cost $25,000 which would be amortized over five years

Recommendation 13-2-1.4 "That the AARC BOD approve the addition of Merrill Lynch as an investment advisor."

Recommendation 13-2-1.5 "That the AARC BOD approve opening a brokerage account with the Bank of Texas."

State Government Affairs
Activity Report – July 2013

BOD/HOD July 2013
Cheryl A. West, MHA
Director Government Affairs

Introduction

The majority of state legislatures have recessed for the year. Budgetary issues were still the focus of the legislatures. As a sub-category to addressing fiscal concerns, a number of legislatures believe that de-regulating or repealing "burdensome" rules and regulations is one way to not only to decrease the costs of a state government but will engender a more "entrepreneurial" climate to simulate job growth and business expansion.

Most state legislatures and Administrations also addressed two looming issues resulting from the provisions of the Affordable Care Act (ACA) aka Obama Care. One provision, the Medicaid expansion is an option for the states, the other, the implementation of health insurance mandates on individuals and small employers is not.

The first is whether or not a state choses to participate in the expansion of Medicaid outlined in the ACA. The ACA expands Medicaid to nearly all low-income individuals under age 65 with incomes up to 138% federal poverty level (FLP) ($15,856 for an individual or $26,951 for a family of three in 2013). If all states implement the expansion, an estimated 21.3 million additional people could be covered by Medicaid and the Children's Health Insurance Program (CHIP) by 2022.

As of June 1, 30 states have agreed to expand their Medicaid Program, 15 states will not participate and 6 states are weighing their options. For a list of the states go here: http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

The other key ACA issue on the agenda of state governments is the level of participation each state will have in developing and administering Health Exchanges i.e. a menu of health insurance packages or "marketplaces" where individuals and small businesses will be able to shop for coverage when the health insurance mandate is implemented on January 1, 2014.

The exchanges must be up and running by October 1, 2013 in order to be "ready" by the January start date. State governments can choose to develop their own Exchange network, develop an Exchange in partnership with the Federal government or opt to let the Federal government create in its entirety an Exchange for their state.

Again as this Report is written, 17 states and DC intend to establish a state-based marketplace; 7 states are planning to pursue a state-federal partnership marketplace, and to date 27 states have indicated they will not create a state-based marketplace and will likely default to a federally-facilitated marketplace.

Why are the above 2 issues important to respiratory therapists and the profession of respiratory care?

Clearly regardless how smoothly or how widespread the implementation of both provisions will be, there is going to be a significant increase in the number of individuals who will now have access to Medicaid services or actual private insurance coverage (i.e. not using the ED as the doctor's office, and (potentially) not ignoring an illness or condition until it is acute). With more people having access to "reimbursable" services previously unavailable or inaccessible to them this will logically increase the demand for RT services. With COPD the third leading cause of death and asthma prevalent for all age groups just to highlight two diagnoses, the numbers simply add up to a greater need for respiratory therapists.

Respiratory Therapy Licensure

The 2012 effort by the **Indiana** Government to repeal licensure for RTs was defeated through the focused efforts of the leadership of the Indiana State Society and Indiana RTs. The effort in 2012 to de-license **Michigan** RTs while at first appearing to be derailed was, as we have found out, merely postponed until this year.

The efforts to legislatively repeal or replace state licensure for numerous **Michigan** regulated professions is moving relentlessly forward. Most surprising factor in this de-licensing effort is that it is being spearheaded by the Michigan Department of Licensing and Regulatory Affairs (LARA). This Licensing Agency claims that it doesn't have enough staff and money to oversee so many licensed professions; that most professional licensure laws do not really protect the public and licensure inhibits job growth. LARA's anti licensure stance has strong support among de-regulatory minded legislators who evidently make up a majority of Michigan legislative members.

As they did in 2012 the Michigan Society is once again fighting the battle. AARC is in continuous contact with past MSRC Past President Steve Hamrick who has been assigned by the MSRC as AARC's liaison on this critical issue. As we did last year in Michigan (and Indiana) the AARC is offering to assist however we can on this assault on the profession.

As it stands now the MSRC is working with their lobbyist to push legislators to take RT off the de-license agenda. However, with the majority of legislators in support of de-licensing, a bill to repeal RT licensure is expected to be introduced and will be debated (as will the legislation to de-license 17 other professions including occupational therapists, and dieticians). Supportive legislators for RT licensure are urging the MSRC to come up with a Plan B in case the worse scenario unfolds and this juggernaut to de-regulate cannot be stopped.

It has been recommended that RTs (and again the other professions on the chopping block) come up with a substitute proposal that would turn over the review of licensure applications, fee collection, and renewals to an outside private entity, leaving investigations, sanctions and the actual issuing of the "paper" license to LARA (in theory making the MI license reciprocal to other states). This proposed structure, i.e. a private entity doing the administrative work of licensing is similar to how attorneys are "regulated" in the US. Lawyers are not licensed by state agencies, but are admitted the state Bar Association, after going through an application process. They can also be dis-barred and banned from practicing.

Legislation

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

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

Specific RT Licensure Legislation and Legislation that Includes RTs

Arkansas enacted a law that will permit the Medical Board (under which RTs are licensed) to share information with credentialing organizations **Arkansas** also passed a law that creates a Healthcare Quality and Payment Policy Advisory Committee, which will collect health quality data from providers and many professions including RT

California has a bill that will clarify the exemption to the law that RT services may be provided in case of an emergency or by self-care. Another provision of this bill is specifically targeted to provide a RT licensure law exemption for individuals performing PFTs in Los Angeles area hospitals as long as these individuals have been performing PFTs for at least 15 years

Delaware legislation that would provide a transport exemption for out of state licensed RTs coming into the state

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

Iowa (enacted) a new provision that specifically inserted "surgeon" in RT Licensure law as a designated type of physician who may write RT orders

Maryland (enacted) to assure that fees RTs pay for their license will also be able to cover the cost of rehabilitation programs for RTs, (presumably for those requiring "intervention and assistance")

Nevada has a bill that would require, to the extent feasible, certain professional licensing boards (RT included) to communicate or cooperate with or provide documents or other information to another licensing board or agency, or state law enforcement agencies
North Dakota (enacted) a law that will eliminate the provision that permits temporary RT license (temp licenses have not been issued for many years) and raise licensure fees. The law would also permit NPs and PAs to write RT orders, which is in line with the 2010 revised Medicare Hospital Conditions of Participation (HCOPs)

North Carolina a bill that beginning on January 2015 will create 2 levels of RT licensing. RTs with an associate degree in RT and either the CRT or RRT credential will be licensed as *respiratory therapists*. Those RTs with a 4 year baccalaureate degree and the RRT will be licensed as *respiratory care practitioners*

Ohio has a bill that would provide for an exemption under the RT licensure law for certified hyperbaric technologists**. Ohio** also has a bill that would require licensed health professionals to wear a badge with name and picture on it when providing care to patients. The bill also prohibits licensed professionals form making false claims or advertising in the solicitations of clients

Oklahoma enacted technical revisions to the RT Practice act which will now reference CoARC (not JERCRTE) and the correct terms for the NBRC credentials (remove CRTT)

Oregon enacted a bill requiring licensees to document participation in continuing education opportunities relating to cultural competency approved by Oregon Health Authority. **Oregon** has another bill that would tighten the rules regarding the disclosure of licensee personal information

Texas has passed law that would expands the TX Medicaid Home and Community Based Waiver program to require increased services, including RT

Expansion of Other Disciplines and Professions

It is very clear from the type of legislation introduced this year, some enacted, some not that the trend to expand the scope of practice, site of care for both non-regulated disciplines and licensed professions is increasing.

Perhaps this is a reflection of a state's determination to pay less costly personnel to provide services (i.e. budgetary issues mentioned in the Introduction) or in anticipation of the influx of new patients into the system (the ACA) combined with an impending shortage of licensed health professionals- physicians in particular.

One trend has been very clear this year- legislation to expand the scope, type of services sites of care for advanced practice nurses and physician assistants. Particularly noteworthy are the provisions that de-link or loosen NPs and PAs from the legal oversight by physicians.

Florida, Georgia, Illinois, Missouri, New Mexico, Rhode Island, Texas, West Virginia all have legislation that in some fashion expands the scope and authority of NPs and PAs.

West Virginia legislation was introduced that permitted unlicensed (specifically noted as unlicensed) personnel, reimbursed by the state to provide a list of "health maintenance tasks" to patients in their home or other personal care facilities (ex. assisted living entities). Originally the bill included among those "tasks" that unlicensed personal could provide were oxygen therapy and performing vent and trach tube respiratory care and suctioning. Through the focused efforts of the WV Society they were successful in removing the references to the "RT tasks". The final version of the legislation which was enacted, requires the WVSRC and the state nurses association to participate in further regulatory discussions regarding what are appropriate services to be deemed" health tasks".

District of Columbia a bill that would create a new discipline called the licensed Trauma Technologists. Included in the scope of practice is: "Identify respiratory emergencies and perform critical interventions with oxygen therapy equipment including bag valve masks.". This bill has not been passed.

Georgia a bill that would require the state to begin a pilot program creating a new discipline termed "Protocol Technician" to be utilized in underserved areas of the state that have a limited number of hospitals. Hospitals would train these protocol techs to provide a number of services including, noted in the bill, providing "respiratory rates". This bill has not moved forward.

California has a bill that would remove the restrictions on the sites of care where a medical assistant (still under the supervision of physician or nurse) may provide services.

Iowa, Maryland (enacted), Montana, North Carolina (enacted), Oregon (enacted) will permit pharmacists to administer vaccinations

Indiana a bill to license polysomnographic personnel was again introduced. Similar to the 2012 bill, this legislation did not contain an explicit exemption for respiratory therapists. Again the Indiana Society entered into negotiations with the state Sleep Society, seeking a RT exemption, again the request was denied. The ISRC launched a coordinated opposition effort and was successful in defeating the passage of the legislation. The legislature referred the bill to "Summer Study" where the merits of the legislation will be reviewed and considered after the legislature has adjourned for the year

Iowa as with Indiana, Iowa also saw a repeat of the 2012 polysom licensure bill. And as with Indiana this polysom licensure legislation again did not include a RT exemption. The Iowa Society RT leadership met several times with the Iowa Sleep Society to try to work out issues. Again, the Sleep Society declined to amend their bill to include a RT exemption. In the end the legislature declined to move the bill forward

Other Legislation of Interest to the RT Profession

Tobacco

Illinois has a Resolution (not a bill) that would urge all drivers who transport minors in their vehicles to refrain from all types of smoking if any minors are under the age of 13. **Utah** enacted restrictions for smoking in vehicles with minors. **Maine** has a similar bill, while not prohibiting the action, would levy a heavy fine for smoking in the care with minors. **Illinois** also passed a law that would prohibit smoking on state colleges and universities. **New Mexico and North Carolina** have similar bills regarding college campuses but not enacted. **Massachusetts** has a bill that would prohibit smoking in a multi-unit residence where an inhabitant uses oxygen

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

Missouri has a bill that would require home care providers (HMEs) to notify the local fire department when oxygen equipment is both installed and removed in a person's home. **New Jersey** enacted a nearly identical bill. Another **New Jersey** bill would require each pharmacy or other provider of oxygen or an oxygen delivery system that is delivered to a patient to prepare and adopt an emergency action plan

Texas had an unusual number of "interesting" bills introduced. These included: a bill to establish a state plan for bacterial pneumonia education and prevention; another (enacted) to set up a reuse program for durable medical equipment provided to recipients under the Medicaid program; another requiring certain health care providers (HMEs included) to give patients a good faith estimate of the expected payment for health care services and goods before the services or goods are provided

New York again has an abundance of legislation focused on asthma, asthma management and asthma tracking. These bills appear to be the same or similar to bills introduced, but not passed in previous legislative sessions. It should be noted, that several other states, including **Minnesota** also have legislation that requires the state to develop asthma care plans and/or track asthma data

Illinois (adopted), Michigan (adopted), New Jersey, North Dakota (adopted), Oregon (adopted), South Dakota (adopted), Texas (adopted) have legislation (House/Senate

Resolutions) that would adopt a COPD Awareness Week or Month. **Pennsylvania** also adopted a Pulmonary Rehabilitation Week.

DC, Illinois (adopted), Pennsylvania (adopted) have legislation proclaiming Asthma Awareness Month or Week, or World Asthma Day

Respiratory Related Rules/Regulations

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

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

Maryland adopts sanctioning guidelines which will be used by the Board of Physicians in sanctioning licensed respiratory care practitioners

New Hampshire has made significant clarifications to the licensure application process, including rules for documenting continuing education, renewals and procedures for licensees who do not wish to renew their license

Ohio the OH Respiratory Care Licensure Board has finalized new rules that will, beginning in January 1, 2015, require any new RT license applicants to hold the RRT credential in order to be licensed. The current CRT only RTs will be grandfathered in until that date.

North Carolina clarifies the tasks an unlicensed support tech may perform under the oversight of a licensed RT

I will provide verbal updates at the July Meeting.

Federal Government Affairs
Activity Report – July 2013

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

NOTE: The Board might recognize that some of the discussion below repeats what was in your April Board Report, especially the discussion of our Medicare Part B Initiative. This was purposefully done so that the House of Delegates, who were not privy to the April Report, would have the same information as you have received. CW

The Congress

Over the past 7 months, continued partisan rancor among members of Congress has had the expected result: little legislation has moved forward nor been enacted. Looming fiscal issues still need to be addressed but deep political and philosophical divisions exist between Democrats and Republicans and factions within their own parties do not bode well for future action or even compromise. According to data from the government tracking website, **only 11% of House bills made it past committee and only 3% were enacted in 2011–2013.**

With no agreement reached on budget issues, the provisions of the Sequester were implemented on March 1, triggering automatic spending cuts to nearly every federal program. The Sequester law was enacted 18 months ago and was intended to be a "poison pill"; that is, cuts would be so onerous that Congress would have to act to address budget and deficit issues to avoid the Sequester from being implemented. As we all know, that didn't happen and federal programs were cut. Medicare itself was "spared" if that is the correct term by only receiving an across the board cut of 2%; many other programs were cut a full 8% as required by the Sequester. The remainder of the year has further budget and deficit deadlines on the agenda and how other important issues will be addressed remains unknown. The federal government is operating on a continuing resolution (CR) that runs through the end of the fiscal year which is September 30, 2013. The consequences of a CR are that agencies operate without a budget and appropriation on the assumed amount of the previous year – freezing spending in many areas.

Legislation

The Medicare Respiratory Therapist Access Act

By now you are aware that we revised the provisions of our previous Medicare Part B legislation. The rationale for the revisions was straightforward: to gain a favorable cost analysis from the Congressional Budget Office (CBO) and open the door for respiratory therapy to be recognized by Medicare B. If legislation is to be seriously considered it is sent to CBO for a cost estimate to determine if the legislation will cost or save the federal government. Simply put, if the CBO determines that the legislation has a high cost, chances of the bill being enacted vanishes.

After extensive discussions with AARC leadership our approach was changed to do the following:

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

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

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

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

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

AARC has commissioned Dobson/DaVanzo, a well-respected DC-based firm we've previously used, to do an analysis of the Medicare Part B files for an outside cost estimate on the newly redrafted initiative. In April we requested that the firm do an additional cost analysis that we believe will be useful in our lobbying efforts with members of Congress. The analysis will be completed by the time of the summer meeting and we will give a verbal update at that time.

Miriam O'Day has continued to meet with members and staff to urge introduction of the legislation. In addition she has met with government relations staff of some of the companies that AARC does business with including BI, Hill Rom, and Philips to garner their support. The lead sponsor, Congressman Lewis from Georgia has submitted our language to legislative counsel on Capitol Hill and received a bill draft that is being circulated to previous sponsors in the House of Representatives and staff on the Committees of jurisdiction. We hope to have a bill number for our constituency to support very soon.

AARC Capitol Hill Lobby Day

The AARC in partnership with our state societies held its 13th Capitol Hill Lobby Day in Washington, D.C. Forty four states and the District of Columbia sent at least one if not multiple PACT representatives to DC. All told there were 119 respiratory therapists, 30 RT students from regional RT education programs, and 15 patients from our patient partners sponsored by the COPD Foundation. PACT reps scheduled 322 meetings with members of Congress or their staff, which is an all-time record. We simply could not organize a successful Hill Lobby Day without the dedicated RT volunteers and the unfailing support of the state societies. Thank you.

Virtual Lobby Week

As is our custom now, prior to the Hill Lobby Day we launch, with much fanfare, our Virtual Lobby Week. Using the AARC's Capitol Connection site, we asked that emails be sent to members of Congress urging support for our Medicare Part B Initiative. Frank Salvatore, Board Member and Chair of the Federal Government Affairs Committee led the effort by encouraging

the leaders of our state societies to push the effort with RTs in their states. As this Report is written we have had over 21,000 email messages sent to the Hill. Again, another record for us!

As soon as we have our legislation introduced we will be revising the current wording of the template emails on Cap Connection to request *co-sponsorship* by Members of Congress. This update will change the currently written Action Alert as requesting *support for* and we will again launch another push for members and supporters of the RT profession to write to the Hill.

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

As many of you know, the home medical equipment industry has tried for some time to repeal competitive bidding and replace it with an alternative that provides for smaller bid areas and more transparency in the bidding and financial process. To that end, on April 24, Representatives Tom Price (R-GA) and John Larson (D-CT) introduced HR 1717, a bill to establish a Market Pricing Program that would cover items and supplies currently part of competitive bid program. The MPP is consistent with Congress' original intent to offer competition, maintain beneficiary access to quality items and services and ensure Medicare savings.

The bill would terminate the current Round 1 competitive bidding program as of December 31, 2013 and restrict the Secretary from taking action to implement Round 2 or future rounds. Depending on the date of enactment, the bill would provide for transitional payments after termination of the current competitive bidding program.
The bill has 122 co-sponsors as of mid-June (97R/25D) and has been "Referred to Committee" for action. According to the government tracking website, this bill has a 49% chance of getting past Committee and only a 12% chance of enactment.

The AARC sent letters in support of HR 1717 to Capitol Hill. A copy of our letter to Congressman Price and Congressman Larson is attached as **Appendix 4**. If there is further action on the bill before July 1, 2013, when Round 2 is expected to begin, we will provide an update at the Summer Meeting.

S 382 - Technical Change to Medicare Outpatient Pulmonary Rehabilitation Benefit

Legislation was introduced that would provide a no-cost technical amendment permitting physician assistants, nurse practitioners, and clinical nurse specialists to supervise pulmonary and cardiac rehabilitation programs. This change would make the pulmonary rehab benefit consistent with the supervisory requirements for other Medicare outpatient programs. Currently, there are only 12 co-sponsors of the bill and according to NAMDRC there is not much interest in moving it forward.

HR 460 – Patients' Access to Treatments Act

Legislation was introduced by Congressman David McKinley (R-WV) and Congresswoman Lois Capp (D-CA) to address commercial health insurers who have charged fixed co-pays for different tiers of medications: generics (Tier I), name brands (Tier II), and off formulary brand medications (Tier III). For many high cost pulmonary diseases such as Alpha-1 the augmentation therapy is sometimes placed on a fourth tier; which can mean that cost sharing for the individual makes treatment inaccessible.

Some commercial health insurance policies are now moving vital medications mostly biologics into "specialty tiers" that utilize high patient cost-sharing methods. This "fourth tier (IV)" is now commonly requiring patients to pay a percentage of the actual cost of these drugs – from 25% to 33% or more, often costing hundreds of dollars, even thousands of dollars, per month for a single

medication – rather than a fixed, flat dollar co-payment. These practices are placing medically necessary treatments out of reach of average Americans.

The AARC decided to support the bipartisan Patients' Access to Treatments Act (H.R. 460), which limits cost-sharing requirements applicable to medications in a specialty drug tier (typically Tier IV or higher) to the dollar amount applicable to drugs in a non-preferred brand drug tier (typically Tier III). It will enable patient access to treatments, reduce disability and constrain health care costs.

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. As noted in previous Reports over the past three years our coalition partners regardless of the specific issue have backed away from requesting Congress increase the funding for their particular programs, and have directed their requests to simply maintain current funding.

The AARC signed onto a joint letter to Congress asking that current funding be maintained for the CDC's **National Asthma Control Program** and that any effort to combine this important program with other programs within the CDC not occur.

Tobacco Partners

The AARC continues its long-time relationship with the many organizations that participate in the Tobacco Partners Coalition (a Coalition organized and supported by the American Heart Association, the American Lung Association, and the American Cancer Society). Recently we have been involved in activities regarding regulation of cigars.

The AARC signed on to a joint letter to the Secretary of Housing and Urban development supporting the Department's efforts to encourage broader smoke-free policies in multi- family housing units. We also signed onto a letter to Congress that opposes legislation that would exempt certain small cigars, especially those that are flavored, from FDA regulation under the Family Smoking Prevention and Tobacco Control Act. Recently HR 792 has been introduced to exempt traditional and premium cigars wrapped in 100% leaf tobacco. AARC has added its name along with other organizations opposing this legislation which is a re-introduction of a bill brought forth in the 112th Congress.

The current issue facing FDA is what to do about the rise in e-cigarettes, since the uncertainty of its long-term use has yet to be determined. The Tobacco Coalition will monitor this issue closely as e-cigarettes have the potential to increase smoking among young adults. Many of the e-cigarettes on the market today come in flavors which attract the young. FDA is expected to issue regulations, but it is uncertain how long that may take as the agency grapples with a number of questions on the best approach to regulate e-cigarettes.

Regulations and Other Issues of Interest

It's that time of year when CMS starts its annual process to update various prospective payment system (PPS) programs. To date, proposed rules have been published to update 2014 payment rates for hospital inpatient services and hospital inpatient rehabilitation services. Updates to hospital outpatient PPS and the physician fee schedule for 2014 most likely will occur in early July. We will give a verbal update to the board if those regulations are published by the time of our Board meeting.

2014 Update to Inpatient Hospital PPS

CMS is proposing changes to two of its key programs that are of interest to our membership; namely, Hospital Readmissions Reduction Program and the Value-Based Purchasing (VBP) Program.

Hospital Readmissions Reduction Program

CMS proposes to add COPD to the list of conditions subject to the readmissions payment adjustment effective for FY 2015. This comes as no surprise, especially since the Medicare Payment Advisory Committee (MedPAC) cited COPD as the fourth most costly condition associated with potentially preventable readmissions in a 2007 report to Congress. CMS cites several reasons for the inclusion: 1) variation in readmissions for COPD supports the finding that opportunities exist to improve care; 2) the median, 30-day, risk-standardized readmission rate among Medicare fee-for-service patients aged 65 or older hospitalized for COPD in 2008 was 22 percent, ranging from 18 to 25 percent across 4,546 hospitals; and 3) inclusion aligns with CMS' priority to promote successful transitions of care from the acute care setting to the outpatient setting, which ties in nicely with our Part B legislative initiative.

The proposal goes on to define the data sources, outcome measures, cohort of patients, and inclusion and exclusion criteria for the COPD readmissions measure. If you are interested, details can be found on pages 27597-27599 of the Federal Register proposal at: http://www.gpo.gov/fdsys/pkg/FR-2013-05-10/pdf/2013-10234.pdf.

The pulmonary community had discussed the possibility of a meeting with CMS to ask that the Agency delay inclusion of COPD as part of the readmissions reduction program until additional data can be collected. However, it appears that there is some inconsistency among the medical societies as to the course of action. With the comment period ending June 25, the societies will submit separate comments on the proposed rule, as will AARC.

The COPD Foundation will be convening a Readmissions Summit in the fall in Washington, DC which will include sessions designed by the AARC.

Value-Based Purchasing (VBP) Program

There are 3 new mortality outcome measures that will be added to the VBP program for FY 2014, one of which is 30-day mortality for pneumonia. The reduction in DRG payments to fund the incentive pool will increase from 1% to 1.25 percent. While CMS proposed no changes to VBP in FY 2015, they are proposing to remove three measures and add three new ones for FY 2016. One of the new measures being proposed is Influenza Immunization, which is described as a "prevention measure that addresses acute care hospitalized inpatients age 6 months or older that were screened for seasonal flu immunization status and were vaccinated prior to discharge, if indicated." According to CMS, about 36,000 adults die and over 200,000 are hospitalized annually for flu-related causes. Adults over age 65 account for 90 percent of deaths related to flu.

Competitive Bidding

CMS continues to move forward with the planned July 1 implementation of Round 2, which expands the number of metropolitan areas subject to competitive bidding from 9 to 91 markets. As reported earlier, the second round results in substantial cuts to previous payment amounts. The average reduction amounts to 45% compared to the current fee schedule amounts. Diabetes testing strips takes the biggest hit at a 72% cut. Payment for oxygen equipment and supplies results in a 41% cut, while CPAP devices get hit with a 47% reduction.

Recently there has been a surge in support on the Hill to implore the CMS Administrator to delay implementation of Round 2 and that the competitive bidding program be reviewed in its entirety. Of concern are reports that CMS awarded contracts to firms that do not have proper credentials such as accreditation and state licensure for the specific products they are contracted to provide. As of early June, 220 Congressional leaders had signed on to a letter to CMS urging the Agency delay in the July 1 implementation date.

Trach Replacement Schedule – DME MAC Local Coverage Policy

As reported in an earlier Report, the regional DME MACs last August revised a number of local policies to include what they considered to be a standard replacement schedule for various DME items. For trach tubes, the schedule was one replacement every 90 days.
This schedule is inconsistent with evidence-based studies, Medicare data, FDA standards and manufacturers' package inserts that reflect the appropriate replacement to be at a minimum of once every 30 days. Consequently, NAMDRC, ATS, ACCP and AARC met with CMS in early March after attempts to get the policy revised at the local level failed. As a follow-up to the CMS meeting, we also worked with the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) and other specialty organizations to provide additional data to CMS and to confirm that the AAO-HNS and the others also supported a replacement schedule of at least once every 30 days. Internal meetings in CMS have been held to determine a final course of action.

State Surveyor Worksheets – Cleaning of Nebulizers

AARC continues to get updates from CMS on the status of its revisions to state surveyor worksheets with respect to nebulizer cleaning. As you know, we asked CMS to remove references to "rinsing nebulizers with tap water followed by isopropyl alcohol" as being unsupported by scientific evidence and a risk to patient safety. Current worksheets have a placeholder for this issue noting that it is under revision.

As of mid May, CMS says they are still working with CDC on the final revisions to the pilot infection control surveyor tool and when they have a final draft of the nebulizer issue they will get AARC's input before finalizing. CMS expects the final draft in the next few months.

Conclusion

The AARC will continue to aggressively pursue both our legislative and regulatory agendas. We will continue to take advantage of opportunities and oppose challenges.

Attachments

Attachment #1

Title: To amend title XVIII of the Social Security Act to provide for Medicare coverage of pulmonary self-management education and training services furnished by a qualified respiratory therapist in a physician's office.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Respiratory Therapist Access Act of 2013".

SEC. 2. MEDICARE COVERAGE OF PULMONARY SELF-MANAGEMENT EDUCATION AND TRAINING SERVICES FURNISHED BY A QUALIFIED RESPIRATORY THERAPIST IN A PHYSICIAN'S OFFICE.

(a) In General.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (EE);

(B) by adding "and" at the end of subparagraph (FF); and

(C) by adding at the end the following new subparagraph:
"(GG) pulmonary self-management education and training services (as defined in subsection (iii)(1)) furnished to an eligible individual (as defined in subsection (iii)(2)) by a qualified respiratory therapist (as defined in subsection (iii)(3)) in a physician's office."; and
(2) by adding at the end the following new subsection:

Pulmonary Self-Management Education and Training Services; Eligible Individual; Qualified Respiratory Therapist

"(iii) For purposes of subsection (s)(2)(GG) only:
"(1) The term 'pulmonary self-management education and training services' means patient education and training services furnished to an eligible individual (as described in (iii)(2)) by a qualified respiratory therapist (as described in (iii)(3)) in a physician's office but only if the physician who is managing the individual's chronic lung condition determines that such services are needed under a comprehensive plan of care related to the patient's chronic lung condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to proper inhaler techniques) to participate in the management of the individual's condition.

“(2) The term ‘eligible individual’ means an individual who has been diagnosed with a chronic lung disease that includes one of the following:

“(A) Chronic obstructive pulmonary disease (COPD), including emphysema and bronchitis.

“(B) Asthma.

“(C) Pulmonary hypertension.

“(D) Pulmonary fibrosis.

“(E) Cystic fibrosis.

“(3) The term ‘qualified respiratory therapist’ means an individual who—

“(A) is credentialed by a national credentialing board recognized by the Secretary;

“(B)(i) is licensed to practice respiratory therapy in the State in which the respiratory therapy services are performed; or

“(ii) in the case of an individual in a State which does not provide for such licensure, is legally authorized to perform respiratory therapy services (in the State in which the individual performed such services) under State law (or the State regulatory mechanism provided by State law);

“(C) is a registered respiratory therapist; and

“(D) holds at a minimum either a bachelor’s degree or other advanced degree from an accredited school of higher education in a health science field.”.

Attachment #2

MEDICARE RESPIRATORY THERAPIST (RT) ACCESS ACT – BETTER ACCESS, BETTER CARE, LOWER COSTS

Background

Pulmonary medicine has evolved over the years since the Medicare law was enacted. With a shift to reward hospitals and physicians for quality care rather than volume of services, the time has come for Medicare to recognize the value respiratory therapists bring to treating beneficiaries with chronic lung diseases.

As health care costs continue to soar for these patients and physician shortages become a major concern, the status quo is not an option. This is even more evident with the Centers for Disease Control and Prevention (CDC) now listing chronic lower respiratory diseases as the **3rd leading cause of death** in the country.

Improving Health Outcomes through Better Access to Respiratory Therapists

Today's Medicare goals center on quality care, better value, lower costs, and reducing excess hospital readmissions. For those with chronic lung disease, a key to achieving these goals is to reduce or eliminate exacerbations which can lead to costly emergency room visits and/or hospital admissions or readmissions.

The ***Medicare RT Access Act*** is designed to address these issues and achieve key Medicare priorities.

- It will amend Medicare Part B to provide coverage of pulmonary self-management education and training services furnished by a qualified respiratory therapist in the physician practice setting; the physician will bill Medicare.
- It will provide Medicare beneficiaries suffering from chronic obstructive pulmonary disease (COPD), asthma, pulmonary hypertension, pulmonary fibrosis, and cystic fibrosis greater access to the care they need from RTs.
- It will provide the tools pulmonary patients need to self-manage their disease and improve their outcomes.

Respiratory Therapists are Experts in the Field of Pulmonary Medicine

Respiratory therapists are the only allied health professionals with comprehensive education in all aspects of pulmonary medicine, including management of patients with chronic lung disease.

It is important to recognize the expertise RTs can bring to pulmonary patients in a physician practice by helping to educate them on how to recognize and reduce symptoms and triggers of their disease and to ensure their proper training and adherence with inhaled medications. The ***Medicare RT Access Act*** will achieve these goals.

Respiratory Therapists are Currently Excluded from Recognition by Medicare

A number of non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists and clinical social workers are specifically recognized in Medicare law.

- The ***Medicare RT Access Act*** will give qualified RTs similar recognition.
- The RT must hold at a minimum a bachelor's degree or other advanced degree in a health science field and be credentialed as a "registered" respiratory therapist (RRT).
- The qualification standards are similar to other qualified health professionals recognized by Medicare.
- Employment of RTs who do not meet these qualifications will not be impacted by this initiative.

Better Data Can Lead to Future Cost Savings

Enactment of the ***Medicare RT Access Act*** will also enable Medicare to collect data that can be used to validate the value of pulmonary self-management education and training services provided by RTs. Long-

term savings can be achieved across the entire continuum of care. Beneficiaries, working with respiratory therapists, will have the tools they need to practice wellness and prevention strategies, slow progression of their disease and reduce hospital costs.

Attachment #4

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
9425 North MacArthur Blvd., Suite 100, Irving, TX 75063, (972) 243-2272, Fax (972) 484-2720
http://www.aarc.org, E-mail: info@aarc.org

May 9, 2013

Congressman Tom Price, MD
403 Cannon House Office Building
Washington, DC 20515

Dear Congressman Price:

As an organization whose mission in part is to serve as an advocate for patients with pulmonary disease so that they receive the highest quality of care in a safe and consistent manner, the American Association for Respiratory Care (AARC) offers its support of HR 1717, the Medicare DMEPOS Market Pricing Program Act of 2013.

AARC is a professional organization representing 53,000 respiratory therapists nationwide who treat patients with chronic pulmonary disease. Respiratory therapists provide clinical care and services to pulmonary patients across the continuum of care and have the expertise to assure that Medicare pulmonary patients have access to these critical elements in their homes

The AARC and our members are very much aware of the struggles many of our pulmonary home care patients are having in receiving the full range of Medicare services for which they are eligible and which they desperately need. Medicare beneficiaries with Chronic Obstructive Pulmonary Disease (COPD) including emphysema and chronic bronchitis, as well as those diagnosed with other pulmonary diseases, require a diverse array of respiratory equipment and frequently rely on the uninterrupted use of such equipment in order to live or, at the very least, maintain their expected quality of life.

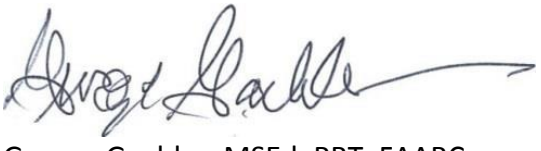
Access to appropriate oxygen systems as well as other equipment related to patients' specific pulmonary conditions is being compromised by the current competitive bidding program. Our patients need access to systems delivering this life sustaining technology. Since these equipment systems support clinical therapy interventions, they must be selected keeping individual patient nuances and requirements in mind. Therefore, they should not be subject to a reimbursement policy that views them as "commodities" or "products" subject to the lowest bid price. Oxygen devices and other respiratory support systems and methods continue to evolve, and respiratory patients need to be assured that they will have continued access to these improved technologies, including liquid oxygen. We believe an alternative system to competitive bidding can be used which will help patients avoid costly exacerbations and improve their respiratory quality of life.

HR 1717 provides an alternative to the current flawed competitive bidding program that is consistent with Congress' original intent to offer competition, maintain beneficiary access to quality items and services and ensure Medicare savings. It can give Medicare beneficiaries who suffer from chronic pulmonary diseases the peace of mind they do not have now. Moreover, it will enable them to have access to high quality medical equipment and services they need to assist them in living independently in their homes.

As advocates for pulmonary patients everywhere, AARC urges Congress to pass this important legislation.

A similar letter has been sent to Congressman John Larson.

Sincerely,



George Gaebler, MSEd, RRT, FAARC
President

HOD Report

Submitted by John Steinmetz – Summer 2013

Recommendations

None at this time

Charges

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

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

Summer meeting: June 14, 2013

Winter meeting: October 11, 2013

Appoint a Parliamentarian: ***Completed***

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

Chairs and standing members appointed.

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

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

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

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

Report

Update on Speaker Goals:

Goal #1 – Committees

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

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

• Policies revisions are being updated to reflect current practices

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

• Continue to work with BOD to facilitate communication – Tom Kallstrom, Speaker and staff hold monthly phone calls, President Gaebler holds routine President's call that includes Speaker, Past Speaker and Speaker-Elect

Goal #2 – Engaging and involving HOD members

• Regular communication through AARConnect with members

• Overseeing communication of committee work through AARConnect

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

Goal # 3 – Volunteering

• Develop and promote activities through the AD HOC Committee

Goal # 4 - Mentoring

• Develop and promote student and professional volunteering through appropriate committees

Goal # 5 – Communication

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

Board of Medical Advisors Report

Submitted by Dr. Lori Conklin – Summer 2013

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Medical Advisors Meeting

April 27, 2013 – Virtual Meeting

Minutes

Attendance

Lori Conklin, MD (ASA), Chair
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
William Bernhard, MD (ASA)
Steven Boas, MD (AAP)
Terence Carey, MD (ACAAI)
Bradley Chipps, MD (ACAAI)
Kent Christopher, MD, RRT, FCCP (ACCP)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
David Kelley, MD, RRT-NPS, CRT (ASA)
Neil MacIntyre, MD (ATS)
Col. Michael Morris, USA, RET
Peter Papadakos, MD, FCCM, (SCCM)
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)

Guests

Tom Smalling, CoARC Executive Director

Excused

Cliff Boehm, MD, RRT (ASA)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Thomas Fuhrman, MD (ASA)
Barrett Kitch, MD (ATS)
Harold Manning, MD, FCCP (ACCP)
Christopher Randolph, MD (AAAAI)
Richard Sheldon, MD, FAARC (ATS)

Consultant

Karen Stewart, Past President, BOMA Liaison

Staff

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

CALL TO ORDER
Chairman Conklin called the meeting of the AARC Board of Medical Advisors to order at 9:12am CDT, Saturday, April 27, 2013.

INTRODUCTIONS
Chairman Conklin asked members to introduce themselves and explained the importance of advising the Board of any conflicts of interest.

Michael Morris – paid speaker for Spiriva
Neil MacIntyre – Consultant for Carefusion and Breathe Technologies

APPROVAL OF MINUTES
Lori Conklin moved to accept the minutes of the November 11, 2012 meeting of the AARC Board of Medical Advisors.
Motion Carried

CHAIRMAN'S REPORT
Dr. Conklin gave highlights of her written report. The issue in Ohio was briefly discussed by Tom Kallstrom. Ohio is changing licensure requirements for respiratory therapists and Tom Kallstrom, George Gaebler, and Tim Myers recently attended a hearing in Ohio regarding this new change.

Dr. Conklin asked members of BOMA to email her with webinar ideas.

CoARC (Commission on Accreditation for Respiratory Care) REPORT
Tom Smalling, Executive Director of CoARC, updated BOMA on CoARC's recent activities and outlined the number of respiratory therapy programs, examination pass rates, and job placement statistics.

NATIONAL BOARD FOR RESPIRATORY CARE
The submitted report was reviewed.

EXECTUIVE DIRECTOR REPORT
Tom Kallstrom gave highlights of his submitted written report. Dr. Shawna Strickland has replaced Bill Dubbs who retired at the end of 2012. Doug Laher gave an overview of Congress 2012 as well as what to expect at Summer Forum and Congress 2013. Steve Nelson notified the Board of new technology available for webcasts and podcasts and Shawna Strickland gave a brief update on 2015.

LEGISLATIVE AFFAIRS REPORT
Cheryl West gave an update of State and Government Affairs. Indiana and Michigan Societies have worked diligently to defeat efforts by their respective states to de-license the RT profession. Indiana issue has been resolved, RT licensure kept, Michigan licensure still in flux.

SPECIALTY SECTION REPORTS
The Specialty Section Reports were reviewed.

OTHER REPORTS

ARCF and International Committee reports were reviewed. Tom Kallstrom spoke about recent and upcoming ARCF activities. The International Fundraiser will now be a stand-alone reception and not part of the International Reception. The International Fellows will be handed back over to ARCF in 2014 for tax benefits.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

AAAAI

Has decided to no longer to discontinue their relationship with BOMA at this time. Dr. Chipps said he would speak with Linda Cox, AAAAI President, to get more details.

Department of Defense Qualification Standards

Michael Morris explained to the group that the old standards did not require minimal qualification. The new standards now require all civilian personnel who are respiratory therapists at the Department of Defense have the minimum of the NBRC credential. Dr. Morris asked that BOMA draft a letter in support of this new change. Cheryl West will draft the letter and send to BOMA for review and approval.

MEDICAL ADVISOR REPORTS

Some BOMA Members gave updates on their sponsoring organizations.

Dr. Aranson informed the Board that ACCP voted to not support HR941.

Dr. Christopher offered comments about NAMDRC.

The next BOMA meeting will take place on November 17th, 2013 in Anaheim, CA with a reception the evening on November 16th.

Tom Kallstrom stated that a survey would be forthcoming so BOMA could express their likes/dislikes of this first virtual meeting.

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 11:40am CDT, Saturday, April 27, 2013.

President`s Council

No report submitted as of July 3, 2013.

Standing Committee Reports

Audit Sub-Committee

Submitted by Debra Skees – Summer 2013

Recommendations

None

Report

No report

Bylaws Committee

Submitted by Terrance Gilmore – Summer 2013

Recommendations

That the BOD approve the following Bylaws as submitted and approved by the Bylaws Committee:

GSRC

NDSRC

NYSSRC (sent to Bylaws Committee and BOD simultaneously)

(All Bylaws are attached to this report)

Report

The Bylaws Committee met via AARC Connect and Approved the Bylaws listed above (NYSSRC Bylaws sent simultaneously to Bylaws Committee and BOD to help facilitate the request of the NYSSRC)

All charges to date have been met

The full Bylaws committee will meet at the Summer HOD meeting to discuss the TSRC Bylaws and review our charges and request the remaining Bylaws to be submitted this year.

Other

The TSRC Bylaws were submitted on time but the committee is not in agreement as to whether they meet the criteria. We will discuss this issue @ the AARC HOD meeting in Orlando. I recused myself from the discussion since I am the TSRC Delegate and assigned Tom Cahill to head up the Bylaws with the TSRC. I might add he did a great job.

I want to thank all of my committee members, Tom Cahill, Chair-Elect Bylaws Committee, Lori Shoman, Karen Stewart, John Jarosz, Timothy Myers, Brian Kendall Walsh,
Sherry Milligan.

GEORGIA SOCIETY FOR RESPIRATORY CARE, INC.

BY-LAWS

ARTICLE I NAME

This organization shall be known as the Georgia Society for Respiratory Care, Inc., incorporated under the General Not For Profit Act of Georgia, referred to here in after as the Society. It is a chartered affiliate of the American Association for Respiratory Care, Inc., referred to here in after as the Association, which is incorporated under the General Not for Profit Corporation Act of the State of Illinois.

ARTICLE II BOUNDARIES

The boundaries of this Society shall be the State of Georgia inclusive.

ARTICLE III OBJECT

SECTION I. PURPOSE

A. To encourage, develop and provide educational programs for those persons interested in the field of respiratory care.

B. To advance the science, technology, ethics and art of respiratory care through institutes, meetings, lectures, publications and other materials.

C. To facilitate cooperation between respiratory care practitioners and the medical profession, hospitals, service companies, industry, governmental organizations and other agencies interested in respiratory care except that this society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of Georgia.

D. To encourage and promote membership in the Association.

E. To provide education of the general public in pulmonary health promotion and disease prevention.

SECTION 2. INTENT

A. No part of the monies of the Society shall inure to the benefit of any private member or individual, nor shall the Society perform particular services for individual members thereof.

B. Distribution of funds, income and property of the Society may be made to charitable, educational, scientific or religious organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes if at the time of distribution the payee or distributes are exempt from income taxation, and if gifts or transfers to the payee or distributes are then exempt from taxation under the provisions of sections 501, 2055 and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.

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

ARTICLE IV MEMBERSHIP

SECTION 1. TYPES

The membership of the Society shall include four (4) types; Active Member, Associate Member, Special Member, and Patron Member.

SECTION 2. ELIGIBILITY

An individual is eligible to be a member of this Society if the individual is a member of the Association as specified in the Association By-Laws and provided the place of employment is within the defined boundaries of this Society. Associate and Special Members of the Society may be accepted who are not in the defined boundaries. An individual may be a Patron member if they pay dues to the society as defined in the GSRC bylaws.

SECTION 3. CLASSIFICATION

A. Active Members - A person is eligible for Active membership in the society if the individual is an Active Member in good standing of the Association. Active Members shall have all the rights and privileges granted them by this Society, such as the right to hold office, the right to vote, submit nominations and hold committee chairs.

B. Associate Members - A person is eligible for Associate membership if the individual is an Associate Member in good standing of the Association. Associate Members shall have all of the rights and privileges of Active Members except that they shall not be entitled to hold office or vote.

C. Special Members - A person who is a special member in the Association shall have the same rights and privileges as Special members as described in the Association bylaws

D. Patron Member - An individual may qualify as a Patron member if they meet the requirement for Active, Associate or Special member as defined by the Association, but are not members of the Association, and pay annual dues as established by the Board of Directors. Patron members will have rights and privileges of membership, but cannot vote, chair committees, or hold office in the GSRC.

Section 4. Regional and District Representatives

A. Regional Representatives are elected Directors at Large. The regions are North Georgia, South Georgia, and the Atlanta region.

B. Districts are geographic areas within the above-defined Regions. District Representatives are appointed by the Regional Representatives, or may be appointed by the President. District Representatives are not members of the Board of Directors but have duties as assigned by the board or the Regional Representatives. District Representatives vote on amendments to the bylaws as described in Article XV.

SECTION 5. RESIGNATIONS

A member may resign from the Society by submitting a letter to the Secretary of the Society.

ARTICLE V. BOARD OF DIRECTORS

SECTION 1. COMPOSITION AND POWERS

A. The government of this Society shall be vested in a Board of eleven (11) Active Members consisting of the President, President-Elect, Immediate Past President, Vice President, Secretary, Treasurer, Delegate, Delegate-elect and three (3) Regional Representatives elected from specific regions as defined by the Board of Directors.

B. The President shall be Chair and presiding officer of the Board of Directors and of the Executive Committee. The President shall invite such individuals to the meetings of the Board as shall be deemed necessary.

C. The President may appoint a member of the Society to serve as Parliamentarian and a member to serve as Protocolarian who shall attend Board Meetings without a vote.

SECTION 2. MEETINGS

A. The Board of Directors shall meet at least two (2) times per year.

B. Additional meetings of the Board of Directors shall be called by the President at such times as the business of the Society may require, or upon written request of the majority of the members of the Board of Directors filed with the President and the Secretary of the Society.

SECTION 3. DUTIES

A. Supervise all the business and activities of the Society.

B. Provide a review of the budget and financial status of the society annually.

C. Establish the rate of annual dues.

SECTION 4. EXECUTIVE COMMITTEE

The Executive Committee of the Board of Directors shall consist of the President, President Elect, Past-President, Vice-President Secretary and Treasurer. They shall have the power to act for the Board of Directors in the absence of the Board and such action shall be subject to ratification by the full Board at its next meeting.

SECTION 5. REGIONAL REPRESENTATIVES

The President may assign the Regional Representatives duties. The term of office for Regional Representatives shall be two (2) years, with the North and South Regional Representatives election to take place on even years, and the Atlanta Area Regional Representative election to take place on odd years.

ARTICLE VI. OFFICERS

SECTION 1. OFFICERS

The officers of the Society shall be; President, President-Elect, Immediate Past President, Vice President, Secretary, Treasurer, Delegate, Delegate-elect and Regional Representatives. No officer may hold concurrent office.

SECTION 2. TERM OF OFFICE

The term of office for each officer shall ~~coincide with the fiscal year~~ be July 1 through June 30. If an officer is elected by special election to fill a vacancy, the officer elected will take office following certification of the election by the Board of Directors.

SECTION 3. VACANCIES IN OFFICE

A vacancy occurring among officers shall be filled as follows with the approval of the Board of Directors:
A. In the event of a vacancy in the office of the President, the Vice President shall become President to serve the unexpired term. –
B. In the event of a vacancy in the office of President-Elect, the Nominating Committee shall place in nomination the names of two (2) candidates for the vacant office. One shall be chosen for the office, through a special election held within 90 days.
C. If a vacancy occurs in the office of Delegate, the Delegate-elect shall assume the duties of the Delegate as well as complete the term for which he or she was elected to serve.

D. If a vacancy occurs in the office of Delegate-elect, Vice President, Secretary, Treasurer, or Regional Representatives, the President, with the approval of the Board of Directors, shall appoint a person which meets the criteria to hold office as he or she sees fit to fulfill the duties until the next election. At the next election an individual shall be elected to fill the vacancy for the remainder of the term for that office.
E. The board of directors shall have the power to declare an office vacant by a two-thirds (2/3) vote of the entire board, upon refusal or neglect of any member to perform the duties of the office, or for any conduct deemed prejudicial to the Society. Written notice shall be given to the member that the office has been declared vacant.

SECTION 4. DUTIES OF THE OFFICERS

A. President

The President shall be the Chief Executive Officer of the Society. The President shall preside at all regular and special meetings of the Society and all meetings of the Board of Directors and membership; prepare an agenda for each meeting of the Board; appoint Standing Committees and Special Committees, subject to the approval of the Board of Directors; be an ex-officio member of all committees; present to the Association, the Board of Directors of the Society and the membership an annual report of the Society's activities; assign the Treasurer signature responsibility for all checks and/or countersign all checks at the expense of the Society. The President shall notify the Medical Advisors of all such meetings and actions as are deemed pertinent. The President may be seated as a Delegate in the House of Delegates if the need arise.

B. President-Elect

The President-Elect shall serve a one-year term and assume the office of President on the first day of ~~the fiscal year~~ the term of office. The President-Elect shall be responsible for chairing the Bylaws Committee and shall assume all other duties as charged by the President. The President-Elect shall prepare Committee appointments for presentation to the Board at the first meeting following the assumption of the office of President.

C. Immediate Past President

The Immediate Past President shall assume the duties charged by the President and ratified by the Board of Directors to facilitate continuity in the Society operations.

D. Vice President

The Vice President shall assume the duties of the President in the event of the President's absence, resignation or disability. The Vice president shall assume the duties charged by the President.

E. Treasurer

The Treasurer shall account for the monies of the Society, approve payment of bills and disburse funds under the direction of the Board of Directors. The Treasurer shall be responsible for the continuing record of all income and disbursements and prepare and submit in writing an annual report of the finances of the Society for the preceding year to the Board of Directors and the membership. The Treasurer will serve a two (2) year term.

F. Secretary

The Secretary shall keep minutes of the Board of Directors and all regular and special meetings; attest to the signature of the officers of the Society; send to the Executive Office of the Association a copy of the minutes of every Society and Board of Directors meeting within ten (10) days following approval; perform duties as assigned by the President and the Board of Directors of the Society; and submit such reports as required. The Secretary will serve a two (2) year term.

G. Delegate and Delegate-elect

The duties of the Delegate and Delegate-elect in part, shall be all those outlined in the Association By-Laws. The Delegate and Delegate-elect shall represent the members of the Society in the House of Delegates of the Association. To establish a vacancy in the office of Delegate and/or Delegate-elect the Society shall follow the procedure as outlined in the Association's By-Laws. The term of office for each position shall be two (2) years and the Delegate-elect shall automatically succeed the Delegate

H. Regional Representative

The President may assign the Regional Representatives duties. The term of office for Regional Representatives shall be two (2) years, with the North and South Regional Representatives election to take place on even years, and the Atlanta Area Regional Representative election to take place on odd years.

ARTICLE VII. NOMINATIONS AND ELECTIONS

SECTION 1. NOMINATIONS COMMITTEE

The Committee Chair, with approval of the Board of Directors, shall appoint a Nominations Committee each year. The Chair of the committee shall be the Immediate Past President. The committee shall submit a slate of nominees to the Board of Directors no later than the midway point of the ~~fiscal year~~ term of office.

SECTION 2. NOMINATIONS

A. The Nominations Committee shall place in nomination the names of more than one (1) person for the elected offices of the Society.

B. Life and Active members in good standing shall be eligible for nomination. The Nominations Committee shall provide a pertinent biographical sketch which shall be a part of the ballot.

SECTION 3. BALLOT

A. The Nominations Committee's slate and biographical sketches shall be provided to every voting member of the Society.

B. The list of nominees shall be so designed as to be a secret ballot with provisions for write-in votes for each office except in cases of run-off elections. Ballots, to be acceptable, must be received at the designated place and by the designated time. The deadline date and time shall be clearly indicated on the ballot.

C. Officers to be elected must receive a majority of all votes cast for each office with the exception of the three (3) Regional Representatives, where the individual receiving the highest vote total for their respective region, are elected.

D. A run-off election will be conducted for any office in which a candidate did not receive a majority of the votes cast. The run-off Ballot will list the names of the two (2) candidates receiving the highest number of votes cast; no write-in votes will be accepted on this Ballot. In the event of a tie among more than two (2) candidates a decision will be made by the drawing of two (2) of those names by the President.

E. Membership rolls for voting shall be closed at the end of the month preceding the distribution of the Ballot. Run-off Ballots are a continuation of the original election and the same roll for the distribution of the Ballots will be used.

SECTION 4. ELECTION COMMITTEE

The Nominations Committee Chair shall appoint an impartial Election Committee, which shall check the eligibility of each ballot and tally the votes. The results of the ballot shall be announced.

ARTICLE VIII MEDICAL ADVISOR

SECTION 1. NUMBER OF ADVISORS

There shall be at least one (1) Medical Advisor, who shall conform to the association's By-Laws concerning chartered affiliates' Medical Advisors.

SECTION 2. FUNCTION AND POWER

A. The Medical Advisor(s) shall have only such powers as are granted to them by the Board of Directors of the Society.

B. The Board of Directors of the Society should consult with the Medical Advisor(s) regarding matters of medical policy and ethics.

ARTICLE IX. SOCIETY MEETINGS

SECTION 1. BUSINESS MEETINGS AND SEMINARS

A. At least one (1) educational seminar and business meeting of the Society shall be held each year.

B. Additional meetings may be held as deemed necessary by the Board of Directors.

C. A majority of the Active Members of the Society present at a duly called business meeting shall constitute a quorum.

SECTION 2. ANNUAL MEETING

A. The date and place of the Annual meeting and additional meetings shall be decided by the Board of Directors. In the event of an emergency the Board of Directors may cancel the scheduled meeting, set a new date and a place if feasible, or conduct the business of the Society by distribution of materials to the voting membership.

B. The Annual Meeting shall be for the purpose of receiving reports of officers and committees.

C. Not less than 30-days prior to the Society's Annual Meeting, notice of time and place of the Annual Meeting shall be made to all members of the Society.

ARTICLE X. COMMITTEES

SECTION 1. STANDING COMMITTEES

The members of the following Standing Committees shall be appointed by the President and subject to ratification by the Board of Directors. Each committee shall have no fewer than three (3) members.

Membership and Public Relations
Subcommittees: Scholarship and Polysomnography

Financial
Subcommittee: Long Range Planning
Bylaws
Subcommittee: Judicial

Program and Education
Subcommittees: Continuing Education, Specialty Committees, Student Activity Committee
Nominations
Subcommittee: Elections
Publications
Subcommittees: Advertising and Website
Legislative

Committee charges in addition to those specified in the bylaws will be issued annually by the President.

SECTION 2. SPECIAL COMMITTEES AND OTHER APPOINTMENTS

Special committees and other appointments shall be at the discretion of the President.

SECTION 3. DUTIES OF COMMITTEE CHAIRMEN

A. The Chair of each committee shall confer promptly with the members to consider committee charges. When possible, the Chair of the previous year shall serve as a member of the new committee.

B. All committee reports must be made in writing and submitted to the President and Secretary of the Society at least ten (10) days prior to the meeting at which time the report is to be read.

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

D. Each committee Chair requiring operating expenses shall submit a request for funding to the Treasurer.

SECTION 4. VACANCIES

In the event of vacancies occurring of any committee chair, the President shall make appointments to fill such vacancies.

ARTICLE XI. COMMITTEE STRUCTURE

SECTION 1. MEMBERSHIP AND PUBLIC RELATIONS COMMITTEE

A. This Committee shall consist of a Chair, one (1) member of the Board of Directors and additional geographical appointments.
B. This Committee shall utilize public relations and other methods to increase the membership of the Society and the Associations
C. This Committee shall also act to promote, to the general public, awareness of the Respiratory Care Profession in the state. The Committee shall also act to foster a positive image of the GSRC among Respiratory Care Practitioners in the State.

SECTION 2. FINANCIAL COMMITTEE

A. This Committee shall consist of a Chair and at least two (2) members of the Board of Directors, and other members as deemed appropriate. They shall review and audit the financial records of the Society at least annually and report to the membership.

B. Subcommittees ~~under this committee~~ includes ~~Budget and Audit and~~ the Long Range Planning Committee
   1. ~~Budget and Audit Subcommittee, This Committee shall be composed of a Chair, Two (2) members of the Board of Directors, and other members as deemed appropriate. They shall review the financial records of the Society at least annually and report to the membership.~~
   2. Long Range Planning Subcommittee: This Committee shall consist of a Chair who shall be the Society President-Elect, and at least two (2) Active Members. This Committee shall make recommendations for future Society development..

SECTION 3. BY-LAWS COMMITTEE

A. This Committee shall consist of three (3) members appointed by the Chair of the Bylaws Committee. The President-Elect shall serve as Chairperson.
B. This Committee shall receive and prepare all amendments to the By-Laws for submission to the Board of Directors. The Committee may also initiate such amendments for submission to the Board of Directors.
C. The Judicial Committee is subcommittee of the Bylaws committee
   1. The Judicial Committee shall consist of three (3) members appointed by the Chair of the Bylaws Committee.
   2. This Committee shall review formal written complaints against any individual Society member charged with any violation of the Society By-Laws or otherwise with any conduct deemed detrimental to the Society or the Association. Complaints or inquiries may be referred to this Committee by the Judicial Committee of the Association.
   3. If the Committee determines that a complaint justifies an investigation, a written copy of the charges shall be prepared for the Board of Directors.

SECTION 4. PROGRAM AND EDUCATION COMMITTEE

A. This Committee shall consist of a Chair and at least four (4) members. This Committee is to provide planning and/or support for all program and education activities
B. Members of any GSRC Clinical Specialty Committees are to be represented on the Program and Education Committee.

SECTION 5. NOMINATIONS COMMITTEE

A. This Committee shall perform in accordance with article VII, Sections 1 and 2 of these By-Laws.
B. The Subcommittee will be the Elections committee
   1. This Committee shall consist of a Chair, and at least two (2) members.
   2. The Committee shall prepare, distribute, receive, verify, count and certify all ballots.

SECTION 6. PUBLICATIONS COMMITTEE

A. This Committee shall consist of a chair and at least two (2) members.
B. This committee shall edit and publish a periodic newsletter or other medium to inform the members of the Society's activities.
C. Advertising and Website

SECTION 7. LEGISLATIVE COMMITTEE

A. This committee shall Consist of a chair and at least one (1) member
B. This committee shall review and report state and federal activity that may affect respiratory care practitioners or the profession.

ARTICLE XII. FISCAL YEAR

The Fiscal Year of the Society shall be from ~~July 1 through June 30~~ January 1 through December 31.

ARTICLE XIII. DUES

SECTION 1. AMOUNT

Annual Society dues and other fees shall be determined by the Board of Directors.

SECTION 2. PAYMENT

Each member of the Society shall pay dues in such amounts and in such manner as may be established annually by the Board of Directors.

ARTICLE XIV. ETHICS

If the conduct of any Society member shall appear, by report of the Society or Association's Judicial Committee, to be in willful violation of the Bylaws, the standing rules of the Society or the Association, or be prejudicial to the Society's interests as defined in the Society's Code of Ethics, the Board of Directors may, by two-thirds (2/3) vote of its entire membership, suspend or expel such a member. A motion to reconsider the suspension or expulsion of a member may be made at the next regular meeting of the Board of Directors. All such suspension or expulsion actions shall be reported immediately to the Association's Judicial Committee. The Society shall recognize the Code of Ethics of the Association as its own.

ARTICLE XV. AMENDMENTS

These bylaws may be amended by a two-thirds (2/3) majority of the board of directors and a majority of the district representatives, provided that the amendment has been approved by the AARC Board of directors. Once approved by the AARC, the membership is to be notified ~~in writing~~ at least thirty (30) days prior to the vote by the GSRC Board and district representatives. (See article IV, Section 4 for the role of district representatives in the amendment process)

ARTICLE XVI. PARLIAMENTARY PROCEDURE

Questions of Parliamentary procedure shall be settled according to Robert's Rules of Order, Newly Revised, whenever they are not in conflict with bylaws of the Society or of the Association.

ARTICLE XVII. SOCIETY PROPERTY

All documentation, Committee reports, correspondence, historical documents, tape recordings of business meetings and other valuable records used to conduct the Society's business shall be the sole property of this Society.

ARTICLE XVIII. ADOPTION

With the adoption of these bylaws on 07/01/2013, all previous enactment of Constitutions and bylaws of the Society are herein repealed.

Bylaws of the North Dakota Society for Respiratory Care

April 2011

Article I:

Name

The organization shall be known as the North Dakota Society for Respiratory Care, a chartered affiliate of the American Association for Respiratory Care, hereinafter referred to as the AARC, which is incorporated under the General Not-For-Profit Corporation Act of the State of Illinois.

Article II:

Boundaries

The boundary of this Society shall be within the boundary of the State of North Dakota.

Article III:

Object

Section 1. Purpose

a. To encourage and develop educational programs on a regular basis for those persons interested in the practice of Respiratory Care, and to provide education to the general public.

b. To advance the science, technology, ethics and art of Respiratory Care through meetings, lectures, and the preparation and distribution of news and/or other materials as determined by the Board of Directors.

c. To facilitate cooperation between Respiratory Care personnel and the medical profession, hospitals, service companies, industry, and other agencies within the State Interested in Respiratory Care.

Section 2. Intent

a. No part of the net earnings of the Society shall incur to the benefit of any private member or individual, nor shall the corporation perform particular services for individual members thereof.

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

later or other Sections of the Internal Revenue Code which amends or supercedes the said Sections. The Society may also distribute funds in honor of deceased active members in the form of memorials.

c. This Society shall not commit any act, which shall constitute unauthorized practice of medicine under the laws of the State of Illinois in which the parent Association is incorporated, or any other State.

Article IV:

Membership

Section 1. Membership

a. The membership of this Society shall be as defined in the AARC bylaws.

b. An individual is eligible to be a member of this Society if he/she is a member of the AARC as specified in the AARC Bylaws.

Section 2. Application for Membership

a. Application for membership in this Society shall follow the procedure specified in the AARC Bylaws.

Article V:

Officers and Directors

Section 1. Officers

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

Section 2. Term of Office

a. ~~The term of each officer shall be for two (2) years beginning July 1 of the year following the election. The President and President-Elect shall not serve more than one (1) consecutive term in the same office. The Secretary and Treasurer shall not serve more than two (2) consecutive terms in the same office.~~

a. The term of Secretary and Treasurer shall be for two (2) years beginning July 1 of the year following the election.
b. The term of President is a track that includes successive terms of (1) year in the office of President-Elect, a two (2) year term as President and a one (1) year as Past President beginning July 1 of the year following the election.
c. The Presidential Track shall not be served for more than one (1) consecutive term by the same person. The Secretary and Treasurer shall not serve more than two (2) consecutive terms in the same office.

Section 3. Vacancies of Office

a. In the event of a vacancy in the Office of President, ~~the President-Elect shall become acting President to serve the unexpired term and shall serve his/her own successive term as President.~~ during the second year of Presidency, the President-Elect shall become Acting President to serve the unexpired term and shall serve their successive term as President. In the event of a vacancy in the office of the President during the first year of Presidency, the Immediate Past President will assume the duties, but not the office, of the President as well as their own. Following the annual election, the newly elected President-Elect shall become Acting President to serve the unexpired term and shall serve their successive term as President.

b. ~~In the event of a vacancy of any office the Board of Directors shall at the next meeting of the BOD appoint a qualified member to fill the vacancy until the next scheduled general election, at which time the Society membership shall elect a new officer to serve the rest of the vacated term. In the event of the vacancy of the Past President, the Board of Directors at the next meeting shall elect a previous Past President to fill that vacancy.~~ In the event of a vacancy in the office of the President-Elect, The Director at Large with the shortest remaining term shall assume the duties, but not the office, of the President-Elect as well as their own. The Board shall elect a qualified member to fill the vacancy of President-Elect until the next annual election. The annual election ballot will be adjusted to include a position for the remaining unexpired term of a two (2) year Presidency followed by one (1) year as Immediate Past President.

c. In the event of the vacancy of the Past President, the Board of Directors at the next meeting shall elect a previous Past President to fill that vacancy.

d.In the event of a vacancy of any *other* office the Board of Directors shall at the next meeting of the BOD appoint a qualified member to fill the vacancy until the next scheduled general election, at which time the Society membership shall elect a new officer to serve the rest of the vacated term.

Section 4. Duties of Officers

a. President

The President shall be the Chief Executive Officer of the Society. He/she shall preside at the annual business meeting and all meetings of the Board of Directors; prepare an agenda for the annual business meeting and submit it to the membership not fewer than thirty (30) days prior to such a meeting in accordance with Article VIII of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) days prior to such meeting; appoint standing and special committees subject to the approval of the BOD; be an ex-officio member of all committees; present to the BOD and membership an annual report of the

Society activities.

b. President-Elect and Past President

The President-Elect or Past President shall become acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability, and shall perform such other duties as shall be assigned by the President or the BOD. ~~The~~ They ~~President-Elect~~ shall be a member of the Budget/Audit and Bylaws ~~Committee~~ Committees.

c. Treasurer

The Treasurer shall have charge of all funds and securities of the Society, endorsing checks, notes, or other orders for payment of bills, disbursing funds as authorized by the Board of Directors and or in accordance with the adopted budget, depositing funds as the BOD may designate, and preparing of documents for annual audit and tax return. He/she shall see that full and accurate accounts are kept, submit quarterly reports to the BOD and AARC, and make written reports at all BOD and business meetings of the Society. He/she shall prepare, in conjunction with the Budget and Audit Committee, a proposed budget to be presented at the pre-board and annual business meeting preceding the year it will be in effect.

d. Secretary

The Secretary shall have charge of keeping the minutes of BOD, regular business meetings and the annual business meeting; submitting a copy of the minutes of every meeting of the governing body and other business of the Society, to all members of the BOD within thirty (30) days and, if requested, to the AARC Executive Office executing the general correspondence; and in general, performing all duties as from time to time shall be assigned by the President or the BOD. The Secretary shall also be responsible for submitting the list of NDSRC Officers to the AARC following the annual election.

~~e. Past-President~~

~~The Past-President shall be an active member of the Bylaws Committee. The Past-President will be readily available as a resource to the current President and perform all other duties assigned by the President and the BOD.~~

Article VI:

Nominations and Elections

Section 1. Nominations and Elections Committee

a. The President shall appoint a Nominations and Elections Committee. It shall be the responsibility of the Nominations and Elections Committee to assure that the individual verifying the eligibility of each ballot, tallying the votes and reporting the results (in writing) to the BOD is not on the ballot.

Section 2. Nominations

a. The Nominations and Elections Committee shall prepare a slate of one (1) or more candidates for each office for approval by the BOD at least thirty (30) days before the scheduled election.

b. Only active members in good standing shall be eligible for nomination.

c. Active members may have their name placed in nomination upon written petition of at least ten (10) active members of the Society. The petition must be filed with the Secretary of the Society at least thirty (30) days before the scheduled election.

Section 3. Ballot

a. The Nominations and Elections Committee shall be responsible for distributing the biographical sketches and to every active member in good standing and eligible to vote at least fifteen (15) days prior to the scheduled election.

b. The election of officers shall be by mail, electronic or other acceptable form of voting as determined by the Board of Directors with provisions for write-in for each office. Ballots, to be acceptable, must conform to instructions supplied with the ballot. The deadline date shall be clearly indicated on the ballot.

Section 4. Election Date

a. The date of annual election shall be set by the Board of Directors.

Article VII:

Board of Directors

Section 1. Composition and Powers

a. The executive government of this Society shall be vested in a Board of Directors consisting of President, President-Elect, Secretary, Treasurer, Past President, two Delegates and two Directors at large.

b. The President shall be the Chairperson and presiding officer of the Board of Directors and the Executive Committee. He/she shall invite non-members/members to the meetings of the Board of Directors, as he/she deems necessary, with the privilege of voice, but not vote.

c. The Board of Directors shall have the power to declare an office vacant by a two-thirds (2/3) majority vote, upon refusal or neglect of any member of the Board to perform the duties of that office, or for any conduct deemed prejudicial to the Society. Written notice shall be given to the member that the office has been declared vacant by certified mail.

d. Voting members of the Board shall consist of the Officers, Directors at large, and Delegates. The President shall vote only in the presence of a tie vote.

Section 2. Duties

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

Bylaws.

b. Adopt and rescind standing rules of the Society.

c. Determine enumerations, stipends, and other related matters, after consideration of the budget.

Section 3. Meetings

a. The Board of Directors shall meet immediately preceding and immediately following the annual business meeting of the Society and shall not hold less than one other regular and separate meeting during the calendar year.

b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society shall require upon written request of four (4) members of the Board of Directors filed with the President and Secretary of the Society or upon phone request of four (4) members of the Board of Directors via phone conference with the President and Secretary.

c. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

Section 4. Voting

a. Whenever, in the judgment of the Board of Directors, it is necessary to present any business to the membership prior to the next regular or annual business meeting, the Board of Directors may, unless otherwise required by these Bylaws, instruct the Nominations/Elections Committee to conduct a vote of the membership by mail, electronic, or other acceptable form of voting as determined by the Board of Directors. The questions thus presented shall be determined according to a simple majority of the valid votes received post-marked prior to established voting deadline, except in the case of a constitutional amendment change in the Bylaws when a two-thirds (2/3) majority of the valid votes received is required. Any and all action shall be binding upon each member thereof. Any amendment to the Bylaws of this Society shall be presented to the membership at least fifteen (15) days prior to a vote, as provided in Article XVII of these Bylaws concerning amendments.

Section 5. Executive Committee

a. The Executive Committee of the Board of Directors shall consist of the President, President-Elect, immediate Past-President, Secretary and Treasurer. They shall have the power to act for the Board of Directors between meetings of the Board of Directors and such action shall be subject to ratification by the Board at its next meeting.

Section 6. Multiple Offices

a. No two (2) offices may be held simultaneously.

Article VIII:

Annual Business Meeting

Section 1. Date and Place

a. The Society shall hold an annual business meeting. Additional meetings may be held as required to fulfill the objectives of the Society whenever called by the President or petitioned by at least five percent (5%) of the voting members.

b. The date and place of the annual business meeting and additional meetings shall be decided in advance by the Board of Directors. In the event of a major emergency the President may cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by mail, phone, or other means. (According to Article VII, Section 4 of these Bylaws).

Section 2. Purpose

a. The annual business meeting shall be for the purpose of receiving the annual reports of officers and committees and for other business brought by the membership and the Board of Directors.

b. Additional business meetings shall be called as deemed appropriate by the President or voting membership in accordance with Article VIII, Section 1, Part A.

Section 3. Notification

a. Notification of the time and place of the annual business meeting and agenda shall be available to all members of the Society not fewer than thirty (30) days prior to the meeting.

Section 4. Quorum

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

Article IX:

Society Delegates to the American Association for Respiratory Care (AARC) and House of Delegates (HOD)

Section 1. Term of Office

a. Delegates to the AARC shall be elected by the membership for a four (4) year term of office with the exception of Article IX, Section 3. No person may serve more than eight (8) consecutive elected years in the AARC House of Delegates. The Delegates shall be past Board members.

Section 2. Duties

a. The Delegates are empowered by the Society membership to vote on its behalf on resolutions and other issues brought to the floor of the AARC House of Delegates. The Delegates are bound to vote as directed by the Society membership through the Society's Board of Directors. If no direction is given to the Delegates in this regard, the Delegates are free to vote as they deem to be in the best interest of the Society membership. The

Delegates shall, at the expense of the Society, and with the authority of the Board of Directors, attend all House of Delegates meetings of the AARC. The Delegates will be voting members of the Society Board of Directors.

Section 3. Vacancies

a. If the office of one Delegate becomes vacant, the Society's Board of Directors shall appoint a substitute Delegate to serve until the next scheduled general election, at which time the Society membership shall elect a new Delegate to serve the remainder of the vacated term. If the offices of both Delegates are vacated, a special general election shall be held to fill the remainders of both vacated terms.

Section 4. Representation

a. There shall be two Society Delegates to the AARC House of Delegates.

Section 5. Multiple Offices

a. Delegates may not hold concurrent elective offices.

Article X:
Committee Structure

Section 1. Standing Committees

a. The Chairperson of the following Standing Committees and Ad Hoc shall be appointed by the President, subject to approval of the Board of Directors

Standing Committees

1. Nominations/Elections
2. Program and Education
3. Bylaws
4. Publications
5. Membership
6. Budget/Audit
7. Scholarship

Ad Hoc Committees

1. Public Relations
2. Legislation
3. Sputum Bowl

Section 2. Special Committees and Other Appointments

a. Special committees may be appointed by the President.

Section 3. Committee Chairperson's Duties

a. The Chairpersons of each committee shall be responsible for appointing his/her committee members and assure their participation in committee activities.

b. All committee reports shall be made in writing and submitted to the President and

Secretary prior to the meeting at which the report is to be read.
c. Physician non-members may be appointed as consultants to committees with recommendations for appointment coming from Society medical advisor(s).

d. Each committee Chairperson requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee.

e. Professional non-members may be appointed as consultants to committees pending approval by the Board of Directors.

Article XI:

Standing Committees

Section 1. Membership Committee

a. This Committee shall be responsible for the recruitment of new members and the retainment of current members. The membership Committee shall also act as a resource:

- to the Board of Directors for active members wishing to participate in Society activities.
- to the general membership of the Society as to how they may be involved in Society activities.

Section 2. Budget/Audit Committee

a. The Treasurer and President-Elect shall be members of this Committee, with the Treasurer being the Chairperson of the Committee.

b. The Committee will propose an annual budget for approval by the Board of Directors. Proposed budget shall then be submitted to the membership thirty (30) days prior to the annual business meeting. The budget shall then be voted on by the membership at the annual business meeting.

Section 3. Nominations/Elections Committee

a. This Committee shall prepare, for approval by the Board of Directors, a slate of nominees for the annual election. This Committee shall also receive, verify, and count the ballots for all elections held during the calendar year.

b. This Committee shall make the final critical appraisal of the candidates to see that the nominations are in the best interests of the AARC and the Society through a consideration of personal qualifications.

c. This Committee shall prepare for approval by the Board of Directors a slate of officers for the annual election.

d. It shall be the duty of this Committee to make the final critical appraisal of candidates, to see that the nominations are in the best interests of the AARC and the Society through a consideration of personal qualifications and geographical representations as applicable.

Section 4. Programs and Education Committee

a. The Committee shall be constructed as to provide experienced leadership and serve as a resource for those persons organizing education programs for the Society.

b. The Medical advisor(s) or his designate will be a consultant member of this Committee.

Section 5. Bylaws Committee

a. This Committee shall include a Past Board of Directors member and the President Elect.

b. The Committee shall receive and prepare all amendments to the Bylaws for submission to the Board of Directors. The Committee may also initiate such amendments for submission to the Board of Directors.

Section 6. Publications Committee

a. The Chair of this Committee shall be the Editor of the Society's website and/or other publications.

b. The membership of this Committee shall be appointed as deemed necessary by the Chair.

c. This Committee shall concern itself with the distribution of information to the Society’s membership.

Section 7. Public Relations Committee

a. This Committee shall concern itself with the relations of the Society with the public, hospitals, health care institutions and associations, regulatory agencies, and other organizations through the dissemination of information concerning Respiratory Care.

Section 8. Legislation Committee

a. This Committee shall concern itself with the business of the North Dakota Legislative assembly and its impact on health care in general and Respiratory Care, specifically.

b. The Society's lobbyist shall be a consultant to this Committee.

Section 9. Scholarship Committee

a. This Committee shall concern itself with the distribution of scholarship monies, and the selection of the recipient(s) of those monies.

Section 10. Sputum Bowl Committee

a. This Committee shall concern itself with the organization and administration of the annual Sputum Bowl, assuring adherence to the NDSRC Sputum Bowl Organization Guidelines.

Article XII:

Directors at Large

Section 1. Directors

a. Two (2) Directors at large shall be elected in alternating years for a two (2) year term. The Directors at large shall not serve more than two (2) consecutive terms in office.

b. Directors at large shall be voting members of the Board of Directors.

Section 2. Duties

a. Directors at large shall attend all Board of Directors meetings and perform duties as assigned by the President or the Board of Directors.

Section 3. Vacancies

a. A vacancy of the office of Director at large shall be filled in accordance with Article V, Section 3 of these Bylaws.

Article XIII:
Society Medical Advisor

Section 1. Medical Advisor

a. The Society shall have at least one (1) Medical Advisor appointed by current President.

Article XIV:

Fiscal Year

Section1. Fiscal Year

a. The fiscal year of this Society shall be from July 1 through June 30.

Article XV:

Ethics

Section 1. Ethics

a. If the conduct of any Society member shall appear, by report or the AARC Judicial Committee, to be in willful violation of the Bylaws or standing rules of this Society or the AARC, or prejudicial to this Society's interests defined in the AARC Code of Ethics, the Board of Directors may, by a two-thirds (2/3) vote of its entire membership, suspend or expel such a member. A motion to reconsider the suspension or expulsion of a member may be made at the next regular meeting of the Board of Directors. All such suspension or expulsion actions shall be reported immediately to the AARC Judicial Committee.

Article XVI:

Parliamentary Procedure

Section 1. Parliamentary Procedure

a. The rules contained in Roberts Rules of Order Revised shall govern whenever they are not in conflict with the Bylaws of the Society or the AARC.

Article XVII:

Amendments

Section 1. Amendments

a. These Bylaws may be amended at any regular or called meeting or by mail vote of the North Dakota Society for Respiratory Care by a two-thirds (2/3) majority of those voting, provided that the amendment has been presented to the membership in writing at least fifteen (15) days prior to the vote. All amendments must be approved by the AARC Bylaws Committee prior to presentation and vote by the membership. The amendments shall become effective upon ratification by the AARC Board of Directors and the Membership.

BYLAWS OF THE NEW YORK STATE SOCIETY FOR RESPIRATORY CARE, INC.

CHARTERED AFFILIATE OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE, INC.

Amended, June, 2004

Amended, August, 2009

Proposed Amendment 2013

Article I. Name

This organization shall be known as the New York State Society for Respiratory Care, Inc., hereinafter referred to as the Society, a chartered affiliate of the American Association for Respiratory Care, hereinafter referred to as the AARC, which is incorporated under the general not-for-profit Corporation Act of the State of Illinois.

Article II. Boundaries

The area included within boundaries of this Society shall be the boundaries of the State of New York.

Article III. Objectives

Section A. Purpose

1. To encourage and develop educational programs for those interested in the field of respiratory care.
2. To advance the science, technology, ethics and art of respiratory care through institutes, meetings, lectures, and the preparation and distribution of a newsletter and other materials.
3. To facilitate cooperation between respiratory care personnel and the medical professions, hospitals, service companies, industry, governmental organizations and other agencies interested in respiratory care.
4. To provide education to the general public in pulmonary health promotion and disease prevention.

Section B. Intent

1. No part of the net earnings of the Society shall inure to the benefit of any private member or individual nor shall the corporation perform particular services for individual members thereof.
2. Distribution of the funds, income and property of the Society shall be determined by the Board of Directors, and may be made to charitable, educational, scientific or religious corporations, organizations, community chests, foundations or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payees or distributees are exempt from income taxation under the provisions of Sections 501, 2055 and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections. The distribution of funds, income and property of the Society upon dissolution may be made available to any similar charitable, educational, scientific or religious corporation, organizations, community chests, foundations or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of the distribution the payee or distributees are then exempt from taxation under the provisions of Sections 501, 2055 and 2522 of the Internal Revenue Code or changes which amend or supersede the same sections.
3. The Society shall not commit any act which shall constitute unauthorized practice of medicine under the laws of the State of New York, or any other state.

Article IV. Membership

Section A. Classifications

The membership of this Society shall include three (3) classifications: active member, associate member, ~~and~~ special member, and life member.

Section B. Qualifications

An individual is qualified for membership in this Society if (S)he is a member of the AARC as specified in the AARC Bylaws, Article III-Membership, Section 1-5

Article V. Officers and Directors

Section A. Officers

The officers of the Society shall be the: President, President-Elect (who automatically succeeds to the presidency when the President's term expires), Past President, Vice-President, Secretary and Treasurer. The officers shall be elected by popular vote.

Section B. Directors

There shall be not more than fourteen (14) Directors comprised of regional directors and two delegates~~.~~

Section C. Term of Office

The terms of office for Society officers shall be for two (2) years. The term shall begin immediately following the annual business meeting. The President and President-Elect shall not serve more than one (1) consecutive term in the same office. The Vice-President, Secretary, and Treasurer shall not serve more than two (2) consecutive terms in the same office.

Section D. Vacancies in Office

1. Any vacancy that occurs on the ~~Executive Committee~~, **Board of Directors** with the exception of the President, immediate Past-President and Delegate**s** shall be filled by qualified members elected by the Board of Directors. Individuals so elected shall serve until the next election.
2. In the event of a vacancy in the office of President, the President-Elect shall become acting President to serve the unexpired term and shall serve his/her own, the successive term, as President.
3. In the event of a vacancy in the office of President-Elect, the Vice-President shall assume the duties, but not the office, of President-Elect as well as his/her own until a special election is held to fill the vacancy.
4. An elected President-Elect shall serve until the next election and then automatically accede to the presidency.
5. If there is a vacancy in the delegation, an election will be held within ninety (90) days.
6. If there is a vacancy in the office of Past-President, the most recent Past-President will assume the office.

Section E. Duties of Officers

1. President: The President shall be the chief executive officer of the Society. (S)he ~~He~~ shall preside at the annual business meeting and all meetings of the Board of Directors, prepare an agenda for the annual business meeting and submit it to the membership not fewer than thirty (30) days prior to such a meeting in accordance with Article 8 of these bylaws, prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) days prior to such meeting, appoint standing and special committees subject to the approval of the Board of Directors, be an Ex-Officio Member of all committees except the nominations and elections committees, present to the Board of Directors and membership an annual report of the Society's activities, and inform the President-Elect and Vice President of all the Society's activities. (S)he ~~He~~ may be the third member of the Delegation to the AARC House of Delegates. (S)he ~~He~~ shall, with the Treasurer, be responsible for disbursement of all Society funds.
2. President-Elect: The President-elect shall chair the Nominations and Elections Committee. (S)he ~~He~~ shall also become acting President and shall assume the duties of the President in the event of the President's absence, resignation, or disability, and shall perform such other duties as shall be assigned by the President or Board of Directors.
3. Vice-President: The Vice-President shall be a member of the Bylaws, Publications, and Public Relations and Society Affairs Committees. The Vice-President shall assume the duties but not the office of the President-Elect in the event of the President-Elect's absence, resignation, or disability, and shall perform such other duties as assigned by the President or Board of Directors.
4. Treasurer: The Treasurer shall have charge of all funds and securities of the Society, endorsing checks, notes, or other orders for payment of bills, disbursing funds as authorized by the Board of Directors and/or in accordance with the adopted budget, depositing funds as the Board of Directors may designate. (S)he ~~He~~ shall see that full and accurate accounts are kept and make a written financial report at every regularly scheduled meeting of the Board of Directors. At the expense of the Society, (s)he ~~he~~ shall be bonded in an amount determined by the Board of Directors. (S)he ~~He~~ shall, with the President, be responsible for disbursement of all Society funds.
5. Secretary: The Secretary shall have charge of keeping the minutes of the Board of Directors meetings, regular business meetings, and the annual business meeting, submitting a copy of the minutes of every meeting of the governing body and other business of the Society to the executive office of the AARC within ten (10) days following the meeting at which they are approved, executing the general correspondence, ~~affixing the corporate seal on documents so requiring and in general performing~~ all duties as assigned by the President or the Board of Directors.
6. Past-President: The Past President will maintain and update the strategic plan. (S)he ~~He~~ shall perform such other duties as assigned by the President or the Board of Directors.

Section F. Voting

Each position will have one (1) vote (except the President, who votes only in case of a tie. Proxies will be accepted on specific issues when submitted to the Secretary at the beginning of the meeting and approved by the Board.

Article VI. Nominations and Elections

Section A. Nominations and Elections Committee

The Nominations and Elections Committee will consist of one of the directors of each region (or their designee) and will present a slate of nominees to the Board of Directors for approval at least ninety (90) days prior to the annual meeting. It shall be chaired by the President-elect.

Section B. Nominations

1. The Committee shall place in nomination, for each of the officers to be elected, the names of one (1) or more active or life members.
2. Only active and life members of the AARC in good standing shall be eligible for nomination.
3. The Nominations Committee shall provide a pertinent biographical sketch of each nominee's professional activities and services to the organization, all of which shall be part of the ballot.
~~4. On written petition of at least twenty-five (25) active voting members, not less than ninety (90) days prior to the annual business meeting, any other member or members may be nominated; if a nominating petition is so filed, such further nominations shall be placed on the ballot.~~

Section C. Ballot

1. The Committee's slate and biographical sketches shall be distributed to every active and life member in good standing and eligible to vote at least forty-five (45) days prior to the annual business meeting.
2. The Society's vote may be by mail or electronic means and the list of nominees shall be designed with provisions for write-in votes. If the vote is by mail, the list of nominees shall be so designed as to be a secret mail ballot with provisions for write-in votes. Ballots, to be acceptable, must be returned or completed electronically at least ten (10) days before the annual meeting. The deadline date shall be clearly indicated on the ballot.
3. The ballots shall be proxies which will authorize the secretary to vote at the annual meeting in accordance with the directions of the member.
4. The Board of Directors shall declare a date of record for members who will be eligible to cast a ballot in each election.
5. The committee will select an accountant who will verify and tabulate ballots and report the results in writing to the elections chair.
6. Elections shall be decided by a plurality of votes cas~~e~~t. The minimum number of votes cast for a valid election shall be one-tenth of the active and life members of the Society or 100; whichever is less.
A tie shall be decided by lot.

Article VII. Board of Directors

Section A. Composition and Powers

1. The government of this Society shall be vested in a board of not more than twenty (20) members consisting of fourteen (14) Directors and the President, President-Elect, Past President, Vice-President, Secretary, and Treasurer.

2. The President shall be chairman and presiding officer of the Board of Directors and the Executive Committee. (S)he ~~He~~ shall invite in writing such individuals to the meetings of the Board as (s)he ~~he~~ shall deem necessary, with the privilege of voice but not vote.
3. The Board of Directors shall have the power to declare an office vacant by a two-thirds (2/3) vote of those present upon refusal or neglect of any member of the Board to perform the duties of that office, or for any conduct deemed prejudicial to the Society. Written notice shall be given to the member that the office has been declared vacant. Such action shall not take place until a letter of intent is submitted to the member by certified mail.

Section B. Duties

1. Supervise all business and activities of the Society within the limitations of these bylaws.
2. Adopt and rescind standing rules of the Society.
3. Determine remuneration and stipends, and other related matters, after consideration of the budget.

Section C. Meetings

1. The Board of Directors shall not hold fewer than one (1) meeting every four (4) months during the calendar year.
2. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Society shall require, or upon written request of five (5) members of the Board of Directors filed with the President and Secretary of the Society.
3. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

Section D. Vote

Whenever, in the judgment of the Board of Directors, it is necessary to present any business to the membership prior to the next regular or annual meeting, the Board of Directors may, unless otherwise required by these bylaws, instruct the Nominations and Elections Committee to conduct a vote of the membership by mail or electronic means. The question thus presented shall be determined according to a majority of the valid votes received or completed electronically within thirty (30) days after date of such submission, except in the case of a change in the bylaws when a two-thirds (2/3) majority of the valid votes received is required. Any and all action approved by the members in accordance with the requirements of this article shall be binding upon each member hereof. Any amendment to the bylaws of this Society shall be presented to the membership at least sixty (60) days prior to a vote, as provided in Article XVII of these bylaws concerning amendments.

Section E. Executive Committee

The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Vice-President, immediate Past-President, Secretary, Treasurer, both Delegates and the Executive Director (Ex Officio). They shall have the power to act for the Board of Directors between meetings of the Board of Directors and such action shall be subject to ratification by the Board at its next meeting. The Executive Committee shall also function as the Budget and Audit Committee.

Article VIII. Annual Meeting

Section A. Date and Place

1. The Board of Directors shall hold an annual meeting in each calendar year.
2. The date and place of the annual meeting and additional meetings shall be decided in advance by the Board of Directors. In the event of a major emergency, the Board of Directors shall cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by electronic means.

Section B. Purpose

The annual meeting shall be for the purpose of receiving reports of officers and committees, receiving the results of the election (every other year as appropriate), and for other business brought by the President.

Section C. Notification

Notice of the time and place of the annual meeting shall appear on ~~in the Society Newsletter and~~ the Society web site.

Article IX. Society Delegates to the AARC House of Delegates

Section A. Election

Delegates of this Society to the House of Delegates of the AARC shall be elected as specified in the AARC bylaws.

Section B. Duties

The duties of the Delegates shall be as specified in the bylaws of the AARC.

Section C. Multiple Offices

Except for the offices of President and Past-President, the members of the delegation may not hold concurrent office on the Executive Committee.

Section D. Composition

The delegation may be comprised of up to three members, including two at-large delegates and the Society's President. ~~The Delegate in his second term will be referred to as the senior delegate~~.

Section E. Succession

No person may serve more than four (4) consecutive years in the House of Delegates. Approval for the senior Delegate to appear on the slate must be by two-thirds (2/3) vote of those Board members present. The Delegates shall be elected to a term of four (4) years; one Delegate shall be elected every two years.

Article X. Committees

Section A. Standing committees

The members of the following standing committees shall be appointed by the President, subject to the approval of the Board of Directors, to serve for a period of two (2) years.

1. Awards
2. Budget and Audit
3. Bylaws
4. Disaster Response
5. Education and Research
6. Governmental Affairs
7. Judicial
8. Membership Services
9. Nominations and Elections
10. Program
11. Publications
12. Public Relations and Society Affairs
13. Sputum Bowl

Section B. Special Committees and Other Appointments

Special committees may be appointed by the President.

Section C. Committee Chairman's Duties

1. Committee chairs should be members of the Board of Directors. If a non-Board member is appointed as a committee chair. a liaison from the Board of Directors to this committee shall be appointed.
2. The President shall appoint the Chairman of each committee.
3. The Chairman of each committee shall confer promptly with the members of his/her committee on work assignments.
4. The Chairman of each committee may recommend prospective committee members to the President. When possible, the Chairman of the previous year shall serve as a member of the new committee.
5. All committee's reports shall be submitted to the Secretary of the Society at least ten (10) days prior to the meeting ~~at which the report is to be read~~.
6. Non-members or physician members may be appointed as consultants to committees. The President may request recommendations for such appointment from the medical advisor(s).
7. Each committee chairman requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee.
8. All committee appointments will be for two years to coincide with the term of the members of the Board of Directors.

Article XI. Duties of Committees

Section A. Awards Committee

This committee shall consist of at least one (1) member from each region. Members shall recommend recipients of all Society awards ~~and~~ and scholarships. The committee shall also be responsible for obtaining awards.

Section B. Budget and Audit Committee

This committee shall be composed of the Executive Committee who shall assist the Treasurer in preparation of the annual budget and shall oversee disbursement of Society funds

Section C. Bylaws Committee

1. This committee shall consist of at least ~~six (6)~~ **seven (7)** members, one (1) from each region, one (1) of whom shall be the Vice-President of the Society, ~~with two (2) members appointed annually for a two (2) year term, except as is necessary to establish and maintain this rotation~~.
2. The committee shall receive and prepare all amendments to the bylaws for submission to the Board of Directors.

Section D. Disaster Response Committee

1. This committee will be composed of a chair appointed by the President and a representative for each region.
2. The members of the committee will partner with outside organizations ~~as possible~~ to prepare for a disaster scenario.
3. The committee members will coordinate disaster response in the state among the regions.

Section E. Education and Research Committee

1. This committee shall consist of at least five (5) educators and be constructed and rotated so as to guarantee a core of experienced members.
2. This committee shall concern itself with issues related to the establishment, development, and evaluations of academic respiratory care programs sponsored by both public and private institutions.
3. The committee shall encourage research throughout the State of New York by developing awards or displays at meetings.

Section F. Governmental Affairs Committee

1. The members of this committee shall be selected from the Executive Committee.
2. This committee shall propose an annual legislative agenda to the Board of Directors.
3. This committee will work with our legislative advisor to advance pertinent bills in the legislature and monitor other legislation which may have an impact on the practice of respiratory care in New York State.
4. A representative from this committee shall attend ~~all~~ meetings of the New York State Board for Respiratory Therapy and other meetings as invited by the Office of the Professions in the New York State Education Department.
5. This committee shall provide representatives to the AARC Political Advocacy Contact Team (PACT).

Section G. Judicial Committee

1. This committee shall consist of at least six (6) members. One (1) shall be a member of the Society's Board of Directors ~~and at least one (1) member shall be appointed each year for a two year term of office, except as is necessary to establish and maintain this rotation~~.
2. This committee shall review formal written complaints against any individual Society member charged with any violation of the Society Bylaws or otherwise with any conduct deemed detrimental to the Society or the AARC. Complaints or inquiries may be referred to this committee by the Judicial Committee of the AARC.

Section H. Membership Services Committee

This committee shall consist of at least one member from each region. Members shall investigate ways in which the Society can serve its members.

Section I. Nominations and Elections Committee

1. This committee is chaired by the President-elect.
2. This committee shall prepare for approval by the Board of Directors a slate of candidates for Directors-at-large and a delegate.
3. The committee shall consist of six (6) members with at least one member from each region who shall serve for a term of two (2) years.
4. It shall be the duty of this committee to make the final critical appraisal of candidates to see that the nominations are in the best interests of the AARC and the Society through consideration of personal qualifications and geographical representation as applicable.
5. This committee shall receive ballots for all elections held during the calendar year

Section J. Program Committee

1. This committee shall consist of at least three (3) members and be so constructed as to provide experienced members for program and educational planning.
2. The medical advisor or his/her designee will be a consultant member of this committee.
3. ~~This committee shall plan and execute the State symposia~~.
4. This committee will also coordinate symposia within the State.
5. This committee shall maintain ~~and distribute the~~ a calendar of the NYSSRC.

Section K. Publications Committee

1. This committee shall consist of at least three (3) members, one (1) of whom shall be the Vice-President, ~~with members being appointed annually for a two (2) year term, subject to reappointment~~.
2. The committee shall be responsible for such publications (newsletters, journals) ~~as meet the communications needs of the Society~~.

Section L Public Relations and Society Affairs Committee

1. This committee shall consist of at least three (3) members, one (1) of whom shall be the Vice-President. ~~with members being appointed for two (2) year terms, subject to reappointment~~.
2. The committee shall concern itself with the relations of the Society to the public, hospitals, and other organizations through the dissemination of information concerning respiratory care.
3. This committee will maintain records of Board of Directors personnel and orientation of new members of the Board of Directors.

Section M. Sputum Bowl Committee

1. This committee will be composed of at least 4 members.
2. The committee will choose representatives for therapist and student teams if they are sent to the AARC International Congress.
3. The committee will complete the required documentation for the team(s) which go to the International Congress.

Article XII. Regions

Section A. Boundaries of Regions
The New York Regions shall be comprised of the following counties:

Central Region**:** Broome, Cayuga, Chenango, Cortland, Franklin, Herkimer, Jefferson, Lewis, Madison, Oneida. Onondaga, Oswego, St. Lawrence, Seneca, Tioga, Tompkins.

Long Island Region**:** Nassau, Suffolk,

New York City Region**:** the Boroughs of Bronx, Brooklyn, Manhattan, Queens, Richmond (Staten Island), and A.P.O.

Northeastern Region**:** Albany, Clinton, Columbia, Essex, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington

Hudson Valley Region**:** Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

Western Region**:** Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Steuben, Yates, Wayne, Wyoming

Section B. Organization

The internal organization, except where in conflict with these bylaws, shall not be the concern of this document.

Section C. Regional Representation

1. The directors of each region shall be members of the Society's Board of Directors.
2. Each region will elect a regional director every two years for a 4-year term so that each region will have two directors at any time.
3. Membership in the Region shall be determined by place of employment or as specified by the member.

~~4. For the purposes of transition, at the time these bylaws take effect, the current president of each chapter will become a regional director for a two-year term and the president elect will become a regional director for a four-year term~~.
5. ~~In the event that there is a vacancy in a position of regional director, the region will hold a special election to replace that director.~~

Section D. Activities

Each region shall be encouraged to expand the membership of the Society and to develop educational activities and such other activities as is consistent with ~~the Articles of Incorporation of~~ these Bylaws.

Section E. Responsibilities of the Regional Directors

A. Represent the region from which they are elected.
B. Submit a written report at least ten (10) days prior to each Board of Directors meeting, relating the activities in the region.

Section F. Duties

1. A copy of the minutes of the governing body and business meetings of the Region shall be sent to the secretary within thirty (30) days following the meeting.
2. The names and addresses of directors and medical advisor(s) shall be sent to the Society's office within thirty (30) days following the Region's annual meeting.

Article XIII Society Medical Advisor

The Society shall have at least one (1) medical advisor who shall conform to Article VIII, Section 1 of the AARC Bylaws. Each Region shall have at least one (1) medical advisor. Together, they shall form a Board of Medical Advisors, of which the Society Medical Advisor shall be chairman.

Article XIV Executive Director

The Society shall employ an Executive Director to manage the daily affairs of the Society and assist the Board of Directors as they may direct. (S)he ~~He~~ shall report directly to the Presi~~d~~ent. ~~He shall be part-time with compensation negotiated at the time of his hi~~ring.

Article XV Fiscal Policies

Section A. The fiscal year of this Society shall be from January 1 through December 31.
Section B. All funds of this Society will be contained in a central treasury overseen by the Society treasurer.
Section C. The treasurer shall arrange for an external audit at least on an annual basis of the Society's~~'s~~ finances.

Article XVI Parliamentary Procedure

The rules contained in the latest edition of Robert's Rules of Order Revised shall govern whenever they are not in conflict with the Bylaws of the Society or the AARC.

Article XVII Amendments

These bylaws may be amended by vote of the New York State Society for Respiratory Care of the AARC by two-thirds (2/3) of those voting, provided that the amendment has been presented to the membership in writing at least sixty (60) days prior to the vote. All amendments must be approved by the AARC Bylaws Committee and ratified by the AARC Board of Directors prior to being voted on by the membership of the Society.

Joe to speak with attorney

Elections Committee

Submitted by: Ross Havens - Summer 2013

Recommendation 1: Amend the Election Committee Policy by adding the following to item 5.

The Committee will develop a question for Section Chair nominees that would be specific to the role, with input from the AARC President, focusing on the charges set forth for the particular section. The question will be generic for all Section Chair nominees.

Justification: A position specific question will give section members better insight into The goals of the nominees for Section Chair.

Recommendation 2: Amend the Election Committee Policy by adding the following:

18. The Executive Office will provide updated section membership numbers and election grid to the Elections Committee, reflecting December 31st membership.

Justification: This will assure that the Elections Committee have accurate information and that the election grid will be current.

Report

On behalf of the AARC Elections Committee, I am pleased to present the slate of candidates for the 2013 election:

President-Elect:	Frank Salvatore
	Colleen Schabacker
Director at Large:	Bill Lamb
	John Lindsey
	Camden McLaughlin
	Curt Merriman
	Karen Schell
	Cynthia White
Adult Acute Care Section Chair-Elect:	Keith Lamb
	Daniel Rowley
Diagnostics Section Chair-Elect:	Katrina Hynes
	Kevin McCarthy
Education Section Chair-Elect:	Ellen Becker
	Georgianna Sergakis
Management Section Chair-Elect:	Bill Cohagen
	Cheryl Hoerr

I would like to thank the members of the Committee for their hard work and diligence in considering this year's nominees. Committee members include Jakki Grimball, Jim Lanoha, Doug McIntyre and Karen Stewart. I would also like to give special thanks to Tim Myers, Sherry Milligan and Beth Binkley at the Executive office for their assistance and guidance.

Executive Committee

Finance Committee Report

Judicial Committee

Submitted by Patricia Blakely – Summer 2013

Recommendations

There are no Committee recommendations at this time.

Report

The Chair has not received any formal or incomplete complaints since the last reporting period.

Other

No actions to report.

Program Committee

Submitted by Cheryl Hoerr - Summer 2013

Recommendations

None

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 15 - 17 in Orlando, FL. Pre-Sessions and a Welcome Reception will take place on Sunday, July 14th. Based on focus group feedback the educational sessions will start and end earlier each day to allow participants additional unscheduled time to enjoy the venue. Optional boxed lunches are being offered to facilitate the working lunch sessions.

The 59th AARC International Respiratory Convention & Exhibition Program is being finalized. Information on early registration for the Congress was published in the June issue of the Times and has also been posted online. The Congress will take place November 16 - 19 in Anaheim, CA. 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 Summer Forum and Congress destinations have been secured through 2015.

3. Solicit programmatic input from all Specialty Sections and Roundtable chairs.

Status: Proposals for the Summer Forum and the Congress were received from all Specialty Sections and Roundtables. Program Committee liaisons worked closely with Section Chairs to ensure a well-rounded representation of specialty section interests are included in our programs.

4. Develop and design the program for the annual 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 starting the program earlier in the day and ending earlier in the afternoon. The lunch break will be shortened and boxed lunches are being offered to facilitate working lunch sessions. Member feedback has also been incorporated by eliminating session overlap to facilitate movement of conference participants between specialty track sessions.

Once again the Program Committee incorporated member feedback into the Congress 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 extended, unopposed exhibit hall hours and an official closing ceremony. Pre-Congress sessions will be offered to meet broadening specialty education needs of therapists to include: trauma, tobacco intervention & cessation, and patient safety.

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: The updates implemented at the 2012 Sputum Bowl will continue into 2013. The updates proved to be very popular with participants and include:

- **Risk/Reward** - present throughout the entire game, and if a team buzzes in before the end of a question and answers incorrectly, they lose a point
- **Ask The Expert** - during preliminary games, each team may utilize this lifeline; during finals night, this lifeline becomes Ask the Posse
- **"Are You Smarter than a Sputum Bowler"** - audience participation game occurring at half-time on finals night; utilizes an audience response system and gives audience members a chance to test their knowledge and compete for great prizes

New 2014 updates to the competition include:

- New question category called Patient Assessment as well as the renaming of an old category to Acute Care/Critical Care
- Bracket methodology and social media to update the game; conference attendees as well as those at home can follow their team''s progress via Twitter
- Bonus Phase - teams buzzing in early and answering correctly can earn 2 points instead of the traditional 1 point

Strategic Planning Committee

Submitted by Karen Stewart – Summer 2013

Nothing to report

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Summer 2013

Recommendations

1) The section leadership recommends that the AARC BOD consider creating an "Acute/Critical Care workshop to be presented at summer forum. This would allow department leadership and educators to take the latest evidence back to their respective centers/schools. This could be a very concentrated "symposia" covering any new data/patient management strategies that have emerged since the previous congress.

2) The section leadership recommends that the AARC BOD look into the feasibility of creating a "back to basics" education curriculum much like the ACCS Prep course. This course would cover a basic overview of the standard practice strategies for acute care outside of the critical care arena.

3) The section leadership recommends that the AARC BOD appoint members to look into the best approach to organize the AARConnect archives into easily accessible and partitioned areas to include but not limited to Protocols, policies, and clinically relevant articles. The section has identified members that are willing to serve in this capacity.

4) The section leadership recommends that the AARC BOD in conjunction with possibly the research roundtable develop a way that budding researchers can tap into the vast knowledge and resources available to the AARC to assist them with their research design, data analysis and presentation. This "brain trust" could include many of the professional researchers that are members of this association, board and section membership.

5) The section leadership recommends that the AARC BOD look into the possibility of developing a committee or such group that would look into ways of ensuring that non-traditional clinical responsibilities and opportunities are being fully supported. This would include but are not limited to IABP management, ECMO, central line placement etc. This group would focus on supporting these sub-specialties etc. and ensure that the appropriate resources are being used to make sure that RRT's succeed in these endeavors. This may also include working with state societies and practice boards to help with scope of practice language etc.

The section continues to provide monthly interactive educational activities:

- Case studies

- Image of the month

- Arrhythmia of the month

- Journal club and conference call

The section continues to participate in association wide activities as well:

- ACCS Prep Course

- Professors Rounds

Continuing Care-Rehabilitation Section

No report submitted as of July 3, 2013.

Diagnostics Section

No report submitted as of July 3, 2013.

Education Section

Submitted by Joe Sorbello – Summer 2013

Report:

•Activity in the Section has been relatively quiet on the listserv. However, electronic books has been discussed at some length on the listserv and I anticipate we will be seeing a progressive transition from conventional text to e-books. In discussion with some publishers, the trend is towards e-books and away from physical texts.

•Support, innovation and service from the AARC for our all members must be noted, especially those within the section and their stakeholders, in the form of three major preparation courses:

1) AARC Exam Prep Course (now available for purchase online)
2) ACCS Exam Prep Course (September 18-19, 2013 in Las Vegas)
3) Preceptor Training Course (By students and faculty at THE Ohio State University, at Summer Forum 2013)

I want to thank all those who have developed these programs since this especially useful for not only the membership but also to educators in all venues of the profession.

•We are also looking forward to seeing and learning about the NBRC's new multiple choice exam that will be discussed at the Summer Forum.

•I would like to commend Dr. Shawna Strickland for all of her hard work and also say that it has been a pleasure to work with her in her new role.

Home Care Section

Submitted by Greg Spratt – Summer 2013

Recommendations:

None

Report:

POC Survey

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

CMS Recommends Adding COPD to Hospital Readmission Reduction Program

COPD will be among those diagnoses monitored under the Hospital Readmissions Reduction Program beginning October 1, 2014. CMS invited public comments on this proposal and President George Gabler responded on behalf of the AARC with comments regarding how Respiratory Therapists are well positioned to be a key resource in this regard and current efforts by the AARC to gather best practices. CMS' reasons stated for the inclusion of COPD include:

- COPD is a leading cause of readmissions to hospitals.
- In 2007, the MedPAC published a report to Congress in which it identified the seven conditions associated with the most costly potentially preventable readmissions. Among these seven conditions, COPD ranked fourth.
- Evidence also shows variation in readmissions for patients with COPD, supporting the finding that opportunities exist for improving care. The median, 30-day, risk-standardized readmission rate among Medicare fee for- service patients aged 65 or older hospitalized for COPD in 2008 was 22.0 percent, and ranged from 18.33 percent to 25.03 percent across 4,546 hospitals.
- Clinical trials and observational studies suggest that several aspects of care provided to patients hospitalized for exacerbations of COPD can have significant effects on readmission.
- In addition, inclusion of this measure in the Hospital Readmissions Reduction Program aligns with CMS' priority objectives to promote successful transitions of care for patients from the acute care setting to the outpatient setting, and reduces short-term readmission rates.

Accountable Care Act / Hospital Readmission Reduction Program Best Practices

The AARC has solicited its membership to submit best practices in regard to preventing unnecessary readmissions. The intent is to gather best practices including related outcome data when available so that it can be made available to all members. Responses have been received and information is currently being gathered. A discussion is planned for the AARC Congress.

HC Section Highlights
Since the last meeting we have produced two quarterly newsletters.

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

Other: None

Long Term Care

Submitted by: Lorraine Bertuola– Summer 2013

Nothing new to report.

Management Section

Submitted by: Bill Cohagen – Summer 2013

Recommendations

None

Report

The Management Section is growing in information. The following are some of the projects:

Published updated TJC RT Department requirements.
Final prep work for the Summer Forum
Election process for Chair
SPOY search started
Starting the prep for the International Congress
Data collection for Extubation/Reintubation Benchrmark program
Continued success for the Management Book Club
Continued success for the quarterly bulletins
Monitoring of the AARConnect messages have;

1. Creating a FAQ section
2. Better monitoring of the section library
3. Improvement for the mentor list.

Other

Future projects;

Increasing membership
2014 SF and Congress program
Creation of a toolkit for the AHCA

Neonatal-Pediatrics Section

Submitted by Cynthia White – Summer 2013

Recommendations

No new Recommendations

Report

- Membership at 1,923 Active members
- Summer Section Bulletin now published online with some great contributions from new authors
- Recruiting authors for fall section bulletin
- Actively seeking candidates for Specialty Practitioner of the Year
- List serve has remained active with lots of discussion
- Involving new Chair elect in processes to take over in November
- Working on quarterly summer updates screen cast to Neo-Peds Section Members
- Serving as reviewer for AARC Open forum abstracts

Sleep Section

No report submitted as of July 3, 2013.

Surface to Air Transport Section

No report submitted as of July 3, 2013.

Special Committee Reports

Benchmarking Committee

Submitted by: Richard Ford – Summer 2013

Recommendations

No Recommendations

Report

1. Members of the committee continue to personally welcome new clients, insure they are aware of educational materials, and make themselves available to assist with the use of AARC Benchmarking.

2. As of Jun 1 there were 139 clients

3. There is the need to update the program procedure definitions and time standards to comply with the new 5th Edition Uniform Reporting Manual. There is also the need to update the department profile which has not been refined since inception of the program in 2005. Lastly it is the intent to refine the on-line reports so they can better be compared with "standard" metric formats reported in corporate systems commonly used, as well as fix issues with the trend plots that become unusable if there are more than 5-6 in the compare group. A change request will be provided to Devore and a cost estimate obtained for consideration in the AARC 2014 budget.

4. Rick Ford has served as the committee chairperson since the inception of this program. After 9 years Rick is looking to step down as chair, but desires to remain a member of the committee and support the product. Rick recently took on significant additional responsibilities at UC San Diego and he has not had the prior level of time to commit to the program.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Summer 2013

Report

We continue to receive calls and e mails with questions about coding. The most recent discussions concern coverage of Asthma Education programs.

We have updated the Coding FAQ s site on AARC.org

The list serve has been under-utilized.

Federal Government Affairs Committee

Submitted by Frank Salvatore – Summer 2013

Recommendations

No Recommendations

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

It has been a quiet time since our March Hill Day. The Federal Government Affairs committee stands ready to act if the call comes from our Government Affairs Team. Once again, I thank those who are serving on this committee and give our usual high accolades to Cheryl West, Miriam O'Day and Ann Marie Hummel for their tireless efforts on our behalf.

Fellowship Committee

Submitted by: Patrick Dunne – Summer 2013

Recommendations

There are no recommendations at this time.

Report

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

In prior years, nominees receiving support from four of the five Committee members were selected for induction. Effective this year, in an attempt to make the FAARC designation more distinctive, only those nominees receiving unanimous support from all five Committee members will be selected for induction.

Other

There is nothing else to report at this time.

International Committee Report

Submitted by John Hiser – Summer 2013

Recommendations

None

Report

Report

1. Administer the International Fellowship Program.

   As of today June 13, 2013 we have 30 applicants for International Fellows and 15 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 17th during the Summer Forum. I'll be sharing the final selection of fellows and hosts with BOD and HOD at your July meetings.
   We surveyed the Fellows and Hosts again this year. All of the comments were positive. The results of the surveys are being used to further improve the operations of the committee.

   32 applicants
   23 different countries
   7 applicants from countries without past fellows
   (Cambodia, Columbia, Ethiopia, Lebanon, Morocco, Singapore)
   11 MD
   15 RT
   3 PT/RT
   2 Nurses
   1 Other

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.

   Work by past fellows continues on translations for different AARC publications continues. 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.

Respectfully submitted,

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

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

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

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

Membership Committee

Submitted by Frank Salvatore – Summer 2013

Recommendations

NONE

Charges:

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

Report

The 2013 AARC Membership Campaign continues. We are now through our 7th month of the campaign and will be through the 8th month at the time of the July meeting. We continue to work and tweak the campaign in response to the data. Specifics related to our charges are listed below.

1) We continue the 2013 membership campaign with incentives for both the members and the Affiliates. The Website is up and running. This site has current data for the Affiliates to review their progress. The website includes resources for the Affiliates to use in their recruitment strategies. Sherry and Gary presented to the Presidents at the President's workshop in Dallas. They reviewed strategies about how better to recruit members. Each president was also given the opportunity to record a You Tube video that they can use for recruitment on their own websites. Gary also recorded a video to promote the benefits of membership and incentives that was placed on the AARC website in April.
2) Frank and Gary with Sherry's help put on a webcast that was focused on recruiting students to convert to active membership in May. The webcast was offered live on four different times on two different days. It was well attended with good interaction and questions.
3) Two more were awarded for the 2nd quarter. Jana Carlton won the IPad for renewing her membership. Dang Quach won the Kindle Fire for new membership.
4) Frank and I are communicating to the Affiliate President's with a monthly update on how the campaign is going, some tips on recruitment and the data.
5) The Membership Committee has been assigned Affiliates so they can work with the Membership Chairs from each Affiliate. They are actively engaging these folks with support for their Affiliate campaigns.
6) The **Student Membership Retention Sub-Committee** was formed and started their work in the last quarter. The committee consists of Co-Chairs Janelle Gardiner (UT) and Emily Zyla (MI). The rest of the committee includes Melanie McDonough (FL), Fred Goglia (WA), Kerry McNiven (CN) and Aaron Light (MO). Their report is as follows:

a. We had a conference call with the committee in January. Since that time we have begun work on survey to send to faculty. We are also planning to put together a survey to send to students. Neither has been sent out yet. We planned to gather information to meet the above objectives through the use of the faculty and student surveys. As I mentioned, the faculty survey has been started and can be finalized, but we ran out of time before the educators left for the summer. Some of the logistics, who to send it to exactly, and when, etc., still need to be worked out. The student survey has not been initiated. Although initial work has begun, no findings or preliminary outcomes are being presented at this time. The goals of our committee:
    i. Address the needs to enhance and add value to the student membership of the AARC.
    ii. Address strategies and methods to increase student members to continue their membership as "active" members of the AARC after graduation.
    iii. Present findings and preliminary outcomes of the above objectives.

7) Frank and I are working with the committee to work through the member survey approval process. We have also asked them to look into the issue of free Student memberships if the Faculty are members. We will work with them and come back with a recommendation on this issue for the fall board meeting.
8) We will share up to date data at the July board meeting and let you know which Affiliates are leading for the Affiliate Awards.
9) Next steps include Affiliates sharing Best Practices from the own membership committees at the HOD meeting. We will continue to reach out and support the Affiliates from our committee. We will work with the Student retention Sub-Committee to fulfill their goals. Continue to work to engage the Affiliates in this campaign to fulfill our goal to increase membership.

Other

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

Position Statement Committee

Submitted by Colleen Schabacker – Summer 2013

Recommendations

Recommendation # 1:
Approve and publish the position statement on "Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care" with no revisions. This statement is submitted for your review as Attachment #1.

Justification: This position statement was reviewed by the Long Term Care Section and they found no revisions necessary.

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

Justification: Suggest to eliminate reference to the "skilled nursing facilities" as it is a separate area of care. Home care accreditation by Joint Commission standards require "individualized plan of care" as stated in the edited document. Additional statements regarding "work together with the health care team" is essential and required as part of the "healthcare team." Addition of "maximize participation in **self-care**...." (an essential goal in home care!!!) With the new healthcare guidelines it is important to add the statement "minimize the need for hospitalization and other high levels of healthcare."

Recommendation # 3:
Approve and publish the position statement on "Respiratory Care Scope of Practice". This statement is submitted for your review as Attachment #3. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: This position statement was provided to all Section chairs for their input. Patient assessment and disease management were added under responsibilities. The word "activities" was replaced by the work "responsibilities" to better capture the depth of what therapists do. "Administration" of pharmacological agents was added to help open up areas where therapists work; cath labs for example. Therapy was further expanded to include intubation and sleep support.

Recommendation # 4:
Approve and publish the position statement "Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists" with no revisions.

Justification: The position statement was submitted to the chair of the Neonatal - Pediatric section for revisions, of which they had none.

Report

Charges:

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

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

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

- During 2013, the Committee''s goal is to complete the review of the eight (8) position statements listed below. Action on each statement to this point is listed following the statement title as is the name of the Committee member spearheading the review.
- Administration of Sedatives and Analgesic Medication by Respiratory Therapists - on hold
- Cutural Diversity - Kathleen Deakins - was presented in April
- Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care - to be presented in July
- Home Respiratory Care Services - Jim Allen - was presented in April
- Respiratory Care Scope of Practice - to be presented in July
- Respiratory Therapy as Extracorporeal Membrane Oxygenation (ECMO) Specialists - to be presented in July
- Respiratory Therapy Protocols - Tony Ruppert - was presented in April
- Telehealth - Kathy Deakins - was presented in April

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

Other

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

Attachment #1

American Association for Respiratory Care

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

Position Statement

Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care

Skilled nursing facilities are increasingly becoming the venue for the management of patients who require the full array of respiratory therapy services, from oxygen therapy and inhalation medication management to pulmonary rehabilitation and ventilator management. Skilled nursing facilities should recognize the clinical value to the patient of utilizing a respiratory therapist to provide the complete spectrum of services that respiratory therapists are both educated and competency tested to provide.

The American Association for Respiratory Care recommends that the basic standard of care for skilled nursing facilities be to employ Respiratory Therapists to render care to patients. Additionally, the following basic standards are recommended to ensure the safe and efficient delivery of respiratory therapy services in skilled nursing facilities delivering ventilator and/or high acuity respiratory care:

1. A Certified, or Registered, Respiratory Therapist—licensed by the state in which he/she is practicing if applicable—will be on site at all times to provide ventilator care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing.
2. A Pulmonologist, or licensed physician experienced in the management of patients requiring respiratory care services (specifically ventilator care), will direct the plan of care for patients requiring respiratory therapy services.

3. The facility will establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.
4. Facilities will be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.
5. Clinical assessment of oxygenation and ventilation—arterial blood gases or other methods of monitoring carbon dioxide and oxygenation—will be available on site for the management of patients receiving respiratory therapy services at the facility.
6. Emergency and life support equipment, including mechanical ventilators, will be connected to electrical outlets with backup generator power in the event of power failure.
7. Ventilators will be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.
8. An audible, redundant ventilator alarm system will be located outside the room of a patient requiring mechanical ventilation to alert caregivers of a ventilator malfunction/failure or a patient disconnect.
9. A backup ventilator will be available at all times that mechanical ventilation is being provided to a patient.

Developed: 10/2009
Revised: 04/2010

Attachment #2

American Association for Respiratory Care

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

Position Statement

Home Respiratory Care Services

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

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

These services are provided on a physician's written, verbal or telecommunicated order (as required) and practiced under appropriate law, regulation, and qualified medical direction or physician supervision. A patient's place of residence may include, but is not limited to: single-family homes, multi-family dwellings, assisted living facilities, and retirement communities~~., and skilled nursing facilities~~. (I would pull this out as it is currently a separate AoC).

The goals of home respiratory care are to work together with the health care team to:

- develop an individualized plan of care designed to minimize symptoms and limitations, achievinge ~~the~~ a ~~optimum~~ maximum level of patient function; ~~through goal setting~~
- educate patients and their caregivers to maximize participation in self-care and enhance compliance with prescribed care;
- inform the health care team on the patient's condition and response to care plan;
- administer diagnostic and therapeutic modalities and services as prescribed;
- conduct disease state management; and

- promote health, minimizing the need for hospitalization and other higher levels of care.

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

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

Effective 12/14/00
Revised 12/07
Revised 07/10

Attachment #3

American Association for Respiratory Care

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

Position Statement

Respiratory Care Scope of Practice

Respiratory Therapists are health care professionals whose responsibilities include ~~the~~ patient assessment, disease management, diagnostic evaluation, management, education, rehabilitation and care of patients with deficiencies and abnormalities of the cardiopulmonary system. The scope of practice includes the application of technology and the use of ~~treatment~~ protocols across all care sites including, but not limited to, the hospital, clinic, physician's office, rehabilitation facility, skilled nursing facility and the patient's home.

~~The practice of respiratory care encompasses activities in diagnostic evaluation, therapy, and education of the patient, family and public.~~ These ~~activities~~ responsibilities are supported by education, research and administration. Diagnostic activities include but are not limited to:

1. Obtaining and analyzing physiological specimens
2. Interpreting physiological data
3. Performing tests and studies of the cardiopulmonary system
4. Performing neurophysiological studies
5. Performing sleep disorder studies

Therapy includes but is not limited to the application and monitoring of:

1. Medical gases and environmental control systems
2. Mechanical ventilator ~~support~~ management
3. Insertion and care ~~A~~ of artificial airways ~~care~~
4. Bronchopulmonary hygiene
5. Administration of Pharmacological agents ~~related to respiratory care procedures~~
6. Cardiopulmonary rehabilitation
7. Hemodynamic cardiovascular support

8. Sleep support

The focus of patient and family education activities is to promote knowledge and understanding of the disease process, medical therapy and self help. Public education activities focus on the promotion of cardiopulmonary wellness.

Effective 8/87
Revised 12/07
Revised 12/10

Attachment #4

American Association for Respiratory Care

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

Position Statement

Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists

The American Association for Respiratory Care endorses the use of qualified and appropriately educated Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists.

ECMO is a modified cardiopulmonary bypass technique used for the treatment of life threatening cardiac or respiratory failure. An ECMO Specialist is the technical specialist educated to manage the ECMO system including blood pump, tubing, artificial oxygenator, and related equipment. The ECMO Specialist, under qualified medical direction and supervision, is also educated to be responsible for the clinical needs of the patient on ECMO which can include: (1) maintenance of normal acid-base balance, oxygenation, and ventilation, (2) administration of blood and blood by-products, (3) medication delivery, and (4) maintenance of appropriate anticoagulation.

The Respiratory Therapist's education provides extensive training in maintenance of normal acid-base balance; oxygenation and oxygen delivery; ventilation; and cardiorespiratory anatomy, physiology, and pathophysiology. These fundamentals of Respiratory Care education make the Respiratory Therapist uniquely qualified to undertake further education as an ECMO Specialist. Additionally the Respiratory Therapist's ability to function in multiple clinical settings among all age groups enhances his/her value as an ECMO Specialist, allowing for care of all patient populations in a variety of critical care environments.

The requisite qualifications for educating a Respiratory Therapist to be an ECMO Specialist should include: (1) the successful completion of an accredited respiratory care educational program, (2) an earned Registered Respiratory Therapist (RRT) credential from the National Board for Respiratory Care (NBRC), (3) a state license (where required), and (4) clinical experience in critical care. Education as an ECMO Specialist should be in accordance with

the Extracorporeal Life Support Organization's (ELSO) document entitled "Guidelines for Training and Continuing Education of ECMO Specialists."

Effective 8/3/98
Revised 07/07

Social Media Committee

Submitted by: Brian Cayko - Summer 2013

Recommendations

The Social Media Committee recommends the AARC approve the Mission Statement & Guidelines documents as listed below in the "Other" section.

The Social Media Committee recommends the AARC approve the structural approach described below in the "Report" section, providing any suggestions at this point.

Report

The SMC has been busy working on providing a Mission statement regarding the use of Social Media as it relates to the AARC and its chartered affiliates. This statement will provide the fundamental basis for how to use the platforms available and the respective metric data that can be obtained by these platforms to guide future use of social media to achieve the goals of supporting the profession of Respiratory Therapy and driving membership for the AARC.

We have formulated a structural plan moving forward to provide the attached statements provided below in "Other". This structure consists of the Mission statement previously mentioned, and a set of general "guidelines" for the chartered affiliates.

As a committee we will then begin to focus on a "best practices" type of document for each social media platform deemed to be addressed. This will allow living documents to change as does the technology and platforms changes. Upon completion of these initial documents we will consider the need to provide support to the affiliates regarding their society's websites.

I am pleased that this committee has shown strong collaboration and communication since the last report and is working together nicely.

Other

AARC Social Media Mission & Vision Statement

The AARC and associated chartered affiliates shall utilize social media to support AARC members, and all others supportive of Respiratory Care, emphasizing AARC resources and benefits.

Guidelines for Affiliates

The AARC and all chartered affiliates are encouraged to participate, positively support, and encourage thoughtful exchange of ideas and information across the respiratory care community through social media, not limited to Respiratory Therapists or AARC members but to all who positively support the profession. Chartered affiliates are encouraged to promote their social media on their state society website and in communications to their membership. All social media accounts should inform and direct; presenting and distributing appropriate respiratory care information including but not limited to patient wellness, research, therapist education, advocacy, friendship and to overall better the advancement of the Respiratory Care profession and the AARC membership. Support for the AARC as well as affiliates (including international) is highly encouraged.

State Government Affairs Committee

Submitted by: John W. Lindsey - Summer 2013

Ohio has moved ahead with final regulations that will require that on January 1, 2015, all new licenses be issued at the RRT level. There is a grandfather clause that will permit current CRT only RTs to keep their license and that will be in effect until December 31, 2014. The same will apply for out of state licensed RT coming into the state with a CRT credential. They will be good until the December 31, 2014 date, but the regulations are now final and unless there is a legislative change that reverses the rules, these will move forward.

North Carolina has a bill (HB0285) that will as of January 1, 2015, create a two-tiered system of RT licensing. The licensed RCP will hold the baccalaureate degree and the RRT credential. The licensed RT will hold the associate degree and either the CRT or RRT credential. This legislation is supported by the state society and the RC licensing board. Both entities have kept the AARC apprised of their intent to move forward over the past 18 months.

We hear that California is considering moving to the RRT as well, but no details are available at this time.

We also hear that the New Jersey Society has approved moving forward with practice act changes in the following areas:

1. Disease prevention
2. Accepting orders from licensed physicians, license physician assistants, or license advanced practice nurses
3. Protocols
4. Respiratory education program defined
5. Continuing education defines and continuing education credits clarification
6. Title protection
7. Removal of temporary license
8. Removal of the grandfather clause.

Ms Cheryl West has not heard anything about the Seattle (ECMO) issue, but will continue to check on and report to the AARC Board of Directors.

As for duel licensed states: Maine, New York, Florida, North Dakota, West Virginia and Tennessee. Tennessee actually had 3 licensed levels, including a RT assistant. Tennessee has not issued a new RT-Assistant license in 10 years and they will not, but they have to keep renewing old ones, which amount to about 30 individuals.

The AARC State Government Affairs Committee continues to be updated on the issue of respiratory therapy de-licensure, particularly in Michigan. Our members are standing ready to assist the MSRC if called upon.

Ms. Cheryl West will be able to fill in any blanks. Also, I would like to take this opportunity to applaud Ms. West – she is doing just an incredible job!!!!!!!!!!!!!

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Summer 2013

Report

A regular scheduled AMA/CPT meeting was held in May. We did not attend. However, I have reviewed the minutes. There is nothing specific to Respiratory Care to report.

The recently approved CPT code for HFCWO will be published in the 2014 CPT book. This book is generally available in November. We can publically announce the code at that time. This code was repeatedly requested by our members so the response should be positive.

I thank the AARC for reappointing me to another three year term as their representative. It is my pleasure to serve in this capacity.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

No report submitted as of July 3, 2013.

American Heart Association

Submitted by Brian Walsh – Summer 2013

Recommendations

None

Report

The AHA continues to slowly transition into their new format. This is set to be complete the first of 2014. No meeting this quarter, therefore nothing to report.

American Society for Testing and Materials

Submitted by Robert McCoy – Summer 2013

Recommendations:

The AARC BOD direct the Executive Office to investigate the potential of hosting F29 should AAMI be voted down on July 1, and report back to the BOD their recommendations.

Report

ASTM has decided to not host the F29 anesthesia and respiratory section in the future. F29 serves as the Technical Advisory Group (TAG 21) to the International Standards Organization (ISO). ASTM is looking for a group to host the F29 to allow for a smooth transition of this standards section. American Society of Anesthesia (ASA) and the Association for the Advancement of Medical Instrumentation (AAMI) are both interested in hosting F29, yet several members F29 feel the AARC might be a better option.

These members are asking if there is a possibility of the AARC considering becoming the administrator of the equipment standards

If the AARC is concerned that this equipment standards effort may bring them too close to manufacturers, there was a suggestion of the possibility of setting up at arm's length a new respiratory standards foundation. Here unrestricted grants can be provided to support the standards development effort.

There currently is a vote of the F29 members to choose AAMI as the administrator of F29. If this is voted on down July 1, the AARC may be a better option for hosting F29.

Equipment variability and confusion related to consistent development, labeling and utilization of respiratory equipment has been an issue for all respiratory therapists. Having the AARC host F29 and recruit more respiratory therapist to participate in the standards process could improve the quality and safety of respiratory equipment used in all locations from hospitals to the home.

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Summer 2013

Recommendations

None at this time

Report

I have remained in contact with those chartered affiliates with whom I have worked over the past 5 years to provide ongoing assistance to their business planning and operations.

The Georgia Society for Respiratory Care President notified me officially that they want to utilize my services by working with their board to develop an operating plan to guide their affiliate. We are coordinating schedules to fit this schedule into a late summer or early fall timetable.

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

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Summer 2013

Recommendations

None at this time

Report

The CAMTS BOD met this past April 4- 6th in Austin Texas for the annual spring meeting prior to the Critical Care Medical Transport Conference. (CCTMC). Approximately 24 programs were reviewed for accreditation as well as additional business items. Greg Brown was introduced as the new representative for the National Association of State EMS Officials (NASEMSO).

Due increasing requests from European medical transport programs for CAMTS accreditation, discussion on the potential logistics of holding a board meeting in Zurich the end of July were held. Stephan Becker, the representative from European HEMS and Air Ambulance Committee (EHAC) who is based in Zurich will be checking on options for such a meeting for the CAMTS summer meeting.

Extracorporeal Life Support Organization

Submitted by Donna Taylor – Summer 2013

Recommendations

No recommendations at this time

Report

All members of the Extracorporeal Life Support Organziation steering committee were asked by the Chairman of the Steering Committee, Dr. William Lynch, to list influencial organizations in our respected professional communities. Of course, I listed the AARC and the ICRC. The ELSO Steering Committee is looking to target professional organizations and societies for publication and to advertise ELSO offerings. ELSO has been invited to a number of professional societies'' meetings to speak and or have a booth for information representing ELSO

Dr. Lynch has also reached out to the Joint Commission to discuss things that would designate ELSO as an expert in the use of this technology so therefore be able to assist with developing standards.

Collaborative efforts are under way with the American Society of ExtraCorporeal Technology (AmSect) to provide access to the Journal for ELSO members. The ECLS content is growing in the Journal as ECMO is becoming more widely performed and instituted throughout the world. As a member of AmSect via the Blood Management section as an autotransfusion operator, I have seen the number of ECMO related articles increase in the journal exponentially in the last few years.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Summer 2013

Report

1) ICRC participation in 7th Annual Congress Chinese Society for Critical Care Medicine: The Council President represented the ICRC at the CSCCM held in Xiamen, China May 23 – 27, 2013. This was a noteworthy occasion as this was the 1st time that the CSCCM had included a Respiratory Care Section in their Annual Congress. Of particular note it was very positive to see faculty that provide respiratory care services in China who presented at the Congress referencing the *Respiratory Care Journal* and the *AARC Clinical Practice Guidelines.* The Journal was well known in China and a number of questions were asked regarding AARC Membership and subscription to the *RC Journal.*

2) International Education Recognition System (IERS): Demand continues to be high for recognition and approval of international respiratory care related programs, ranging from 2-3 day Seminars, 3-4 week Programs and degree granting Programs. In the 1st half of 2013 there have been 8 international programs approved. The following applications are currently under review:

Shanghai, China - Level I July 2013
Hangzhou, China – Level II July-August 2013
Cairo, Egypt – Level II July-August 2013
Tokyo, Japan – Level II June 2013

3) 2013 International Awards of the AARC: The Council Nomination Committees are currently considering candidates for the Hector Leon Garza International Achievement Award and for the Toshihiko Koga, MD International Medal. Recommendations will be made to the Council and the ARCF for the AARC 2013 International Congress in Anaheim in November.

Joint Commission - Ambulatory PTAC

Submitted by Suzanne Bollig – Summer 2013

Recommendations

None at this time.

Report

The Ambulatory Care Professional and Technical Advisory Committee (PTAC) held a conference call on March 15, 2013 to review and discuss the proposed revisions to the Medication Management standards regarding sample medications for the Ambulatory Care and Office-Based Surgery accreditation programs.

Key Points

1. At this time in the AHC accreditation program, the Medication Management chapter has 20 standards and 113 elements of performance (EPs). Of the 113 EPs, all but one applies to sample medications. For the Office-Based Surgery (OBS) accreditation program, the medication management chapter has 16 standards and 56 elements of performance. Of the 56 EPs, all apply to sample medications.

2. In 2012, The Joint Commission's Standards Interpretation Group (SIG) reported that there were an increasing number of questions regarding the Medication Management standards and their applicability to the use of sample medications. The Joint Commission decided to conduct an in-depth review regarding the applicability of the Medication Management standards to sample medications.

3. The Joint Commission formed an interdivisional, multidisciplinary team, including a physician, nurses, and pharmacists, to conduct the review with the specific charges of:

a. Determining the definition of sample medications from the recent scientific literature.

b. Reviewing the Medication Management standards and EPs for relevance to sample medications for all applicable accreditation programs.

c. Conducting a review of the literature regarding sample medications to determine if there are any critical safety issues associated with sample medications that are not addressed by the Medication Management standards.

d. Providing recommendations regarding the applicability of the Medication Management standards to sample medications and any other needed revisions.

The next conference call is scheduled for June 20, 2013.

Joint Commission - Home Care PTAC

Submitted by Joe Lewarski – Summer 2013

Recommendations

None

Other

A Home Care PTAC conference call was held this Spring but there is nothing significant to report.

Joint Commission - Lab PTAC

Submitted by Franklyn Sandusky – Summer 2013

Report

The next Lab PTAC meeting is June 20, 2013.

There is nothing to report at this time.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Summer 2013

Nothing to report

Natl Coalition/Health Professional Education In Genetics

Submitted by Linda Van Scoder – Summer 2013

Recommendations

None

Report

I submitted info to Tom Kallstrom on the new Genetic Alliance disease information web site (www.DiseaseInfoSearch.org). Tom passed it on to Marsha Cathcart for placement on the AARC website and distribution to selected member groups. I will continue to monitor Genetic Alliance communications for opportunities to support our patient's needs.

National Sleep Awareness Roundtable

Submitted by Anne Marie Hummel – Summer 2013

No recommendations

Report

At its last meeting, the National Sleep Awareness Roundtable (NSART) presented findings from the National Sleep Foundation's (NSF) 2013 *Sleep in America*® poll. Noteworthy highlights follow:

- Exercisers say they sleep better
- Those who exercise vigorously are almost twice as likely as non-exercisers to get a good night's sleep and the least likely to report sleep problems
- Non-exercisers are the sleepiest and have the highest risk of sleep apnea
- Less time sitting is associated with better sleep
- Exercise at any time of day appears to be good for sleep

The full report and press release are available at www.sleepfoundation.org/2013poll

The American Sleep Apnea Association, a member of NSART, announced a CPAP assistance program to provide gently used CPAP devices for those who are in need of the therapy and cannot afford it or whose insurance does not cover it. Anyone wishing to donate a device can do so at http://www.sleepapnea.org/resources/cpap-assistance-program.html . If RTs have patients who may need a device, the patient can also apply for one on the website. Monetary donations to support the program are also welcome.

"The Sleep Disorders" guide is available as a free resource on the NSF's web site. It was first published by Peter Hauri, PhD, in 1997 as a guide for non-sleep physicians, technicians and allied sleep professionals. It covers topics such as normal sleep, insomnia, sleep related breathing disorders, hypersomnias, circadian rhythm sleep disorders, parasomnias, sleep related movement disorders and variants (long sleepers). It can be accessed at: http://sleepdisorders.sleepfoundation.org/

Funding for NSART ends August 31, 2013. Bids for new sponsors are expected to go out this summer.

Neonatal Resuscitation Program

Submitted by John Gallagher – Summer 2013

Recommendations

No recommendations at this time.

Report

Meetings:

The NRP Steering Committee Meeting held its strategic planning meeting on March 4-5, 2013 in Elk Grove Village, Illinois. The focus of the meeting was to further define to aim and scope of the Neonatal Resuscitation Program.

The NRP exam format was discussed and a review of specific questions that have received unfavorable response rates was conducted. In addition, the committee discussed current hurdles that are being experienced by the new online format of the exam.

Considerations for the 7th edition of the NRP textbook were also a major topic of the meeting. The debate as to which clinicians should complete all 9 lessons and which clinicians should only be required to complete 1-4 and 9 was conducted but remains unresolved. As AARC liaison, I strongly advocated that RTs should complete all 9 lessons.

The NRPSC plans to meet again on-site of the AAP National Conference in Orlando, Florida on October 23-25, 2013.

Projects:

The most recent NRP Instructor Update included an article highlighting the important role that RTs play in neonatal resuscitation. It was written by the liaison and edited by a small working group of the committee. For reference, it is included in this report (pp. 8 & 9 of attached newsletter).

Roundtable Reports

Asthma Disease Management

Submitted by: Michael Shoemaker – Summer 2013

Recommendations

1. Reconsider stance on AARC Congress presenter registration to include full complimentary registration.

Rationale:

•· Will encourage front-line RTs and other healthcare professionals to be more involved.

•· Will offset travel costs as few healthcare systems are allowing budgeted funds for employee travel that is not directly tied to increased revenue generation.

2. If not already available, consider developing formal AARC sponsored smoking cessation counselor training for RTs. If already available, consider a media blitz to raise awareness so interested RTs can enroll.

Rationale: Members have noted the availability of smoking cessation resources (brochures, etc.) but feel ill-equipped to coach smokers through behavioral changes, etc. There is a need for more front-line RTs who are empowered to address smoking cessation effectively. If this kind of training is readily available to RTs - many are unaware of how to access and enroll.

3. Develop tools that will help RTs gain the support of local Executive Leadership (e.g. CEOs, CMOs).

Rationale: Many programs struggle and fail secondary to a lack of organizational support.

4. Provide an educational session (Webcast?) on motivational interviewing / behavioral change strategies.

Rationale: Members feel this would be invaluable to help RTs better navigate an ever-changing healthcare environment.

Report

•· The Roundtable has ~180 members.

•· 22 Roundtable members participated in an IRB approved, multi-center study: *A Survey of Asthma Knowledge Across Multiple Disciplines*. Data collection phase is complete and analysis is underway.

Consumer

See Executive Director Report

Disaster Response

Submitted by Charles Friderici – Summer 2013

Membership is stable, no other report at this time.

Geriatrics

Submitted by Mary Hart – Summer 2013

Recommendations:

None at the time

Report:

- Geriatric Committee members contacted to submit suggestions for the Coming of Age section in the AARC Times.
- Geriatric Committee members contacted to submit / volunteer to author articles for the AARC Times.
- Review of Current Geriatric publications/research/assessment literature to begin Aug. 2013. Results to be reported and possibly used for future patient/family education/RT education/ other clinician education (timeline: 4 months)
- Email sent to fellow RTs to join the Geriatric Roundtable and Palliative Care Roundtable

No other business

Hyperbaric

Submitted by Cliff Boehm – Summer 2013

No report submitted as of July 3, 2013.

Informatics

No report submitted as of July 3, 2013.

International Medical Mission

Submitted by Lisa Trujillo – Summer 2013

Recommendations

No new recommendations at this time.

Report

Membership has increased to 80. As indicated in the March report, folders will be created for sharing of donation information, mission opportunities, educational presentations and resources, etc. These folders have been updated in the last few months to include information available to roundtable members related to community health education that can be and has been used in developing nations. Mission trip opportunities have also been posted to this site.

Other

Side note: National involvement in mission trips seems to be growing through exposure to this roundtable, AARC Times articles and AARC Congress presentations on International Missions. As membership grows, it is anticipated that further networking and collaboration across state borders will continue to grow. Speaking from personal experience, I was fortunate to have RTs from 5 states join me in Ghana over the past 2 months. Through AARC exposure, I currently have 4 more from additional states that are interested in joining our future missions. I expect that other mission opportunities are experiencing similar networking benefits.

Military

Submitted by Harry Roman – Summer 2013

Recommendations

None at this time

Report

There is nothing to report at this time.

Neurorespiratory

Submitted by: Lois Rowland - Summer 2013

Recommendations

No recommendations at this time.

Report

The Neurorespiratory Roundtable currently has 112 members, reflecting a 10% decrease since March 2013, but still 87% higher than in October 2012.

Palliative Care

No report submitted as of July 3, 2013.

Research

Submitted by John Davies – Summer 2013

Report

Not much discussion taking place. Attempted to stir up discussion by posting a few controversial papers. The discussion level still remained low with few responses.

Simulation

No report submitted as of July 3, 2013.

Tobacco Free Lifestyle

Submitted by Jonathan Waugh – Summer 2013

Recommendations

None at this time.

Report

•· Work continues on "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). Video will be included since the guide will be an electronic publication.

•· The one-day pre-Congress workshop on tobacco intervention and treatment was approved. Dr. Stephen Schroeder, the nationally-known physician director of the Smoking Cessation Leadership Center at UCSF will be part of the faculty. Please help promote this workshop among your colleagues. Susan Gallo and I are meeting regularly by phone to work on the details of the approved curriculum. If the workshop is well-received, it would be possible to repeat it at future regional meetings to make it easier for RTs to attend.

•· The TFL stands ready to assist with educational programs and curricula for tobacco-related training for national, regional, and state meetings/events.

Other

I commend the Congress planning committee for supporting the one-day tobacco treatment pre-Congress workshop. Given the competing high-quality presentations throughout the Congress, we need more tobacco treatment presentation choices during the Congress so that if attendees miss a presentation on one-day due to a conflict they will be able to attend on a subsequent day. I will be glad to communicate preferred sub-topics for proposal submissions to TFL members.

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Summer 2013

Recommendation: That the AARC promote the Cultural Diversity in Care Management Committee Mentoring Program in the AARC News.

Justification: The committee would like to utilize the AARC News to promote the committee's Mentoring Program. By increasing the awareness of the Mentoring Program to the membership, we can increase the number of candidates who would like to attend the HOD Meeting.

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

Status: **Kelley Jenkins, President Florida Society for Respiratory Care will attend the HOD Meeting to participate in the Cultural Diversity Mentoring Program.**

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

Status: **Ongoing**

Ad Hoc Committee on Officer Status/US Uniformed Services

No report submitted as of July 3, 2013.

Ad Hoc Committee on Leadership Institutes

Submitted by Toni Rodriguez – Summer 2013

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

Report: Summer 2013

Thanks to the guiding hand of Shawna Strickland Associate Executive Director of Education, AARC the project is back on target. Dr. Strickland has contracted with several high caliber Respiratory Care Managers to complete the 8 Management Modules. The work is being completed on time. We would like to thank Garry Kauffman, Cheryl Hoerr and John Sabo in addition to Dr. Strickland for answering the call. The Research Modules being written by Rob Chatburn are also nearing completion. There has been a set back with the Education Section as I have been unable to concentrate on the project. Dr. Strickland has graciously agreed to find authors for four of the modules and I will complete the first module only. It is a relief as well as exciting to see the project finally coming together. The AARC projects a November 2013 launch for the three tracks. I would like to thank my committee, all the AARC members the AARC Executive Office staff and Dr. Strickland for believing in and committing time and resources to the project.

Respectfully Submitted

Toni L Rodriguez Ed.D, RRT, FAARC
Committee Chair

Committee Members:

Chair: Rodriguez, Toni Ed.D, RRT; Members: Chatburn, Robert MHHS, RRT-NPS, FAARC; Ford, Richard RRT, FAARC; Van Scoder, Linda EdD, RRT, FAARC,
Staff Liaisons: Shawna Strickland, Ph.D, RRT-NPS, AE-C, FAARC , Shawna Strickland Associate Executive Director of Education, AARC

Ad Hoc Committee on 2015 & Beyond

Submitted by Toni Rodriguez – Summer 2013

Nothing to report.

Ad Hoc Committee to Recommend Bylaws Changes

Submitted by Denise Johnson – Summer 2013

Recommendations

No recommendations

Report

The Ad Hoc Committee on Recommended Bylaws Changes submitted the proposed changes to the BOD at April 2013 meeting (see attachment "Proposed Changes by the Ad Hoc Committee to Recommend Bylaws Changes"). These changes were approved by the BOD and sent to the Bylaws Committee.

All Charges of this ad hoc committee have been completed.

Members of the committee include Denise Johnson, Chair, Linda Van Scoder, Colleen Schabacker and Susan Rinaldo Gallo.

Timothy Myers, AARC Staff liaison

Ad Hoc Committee to Reduce Hospital Readmissions

Submitted by Greg Spratt – Summer 2013

Recommendations

None

Report

CMS Recommends Adding COPD to Hospital Readmission Reduction Program

COPD will be among those diagnoses monitored under the Hospital Readmissions Reduction Program beginning October 1, 2014. CMS invited public comments on this proposal and President George Gaebler responded on behalf of the AARC with comments regarding how Respiratory Therapists are well positioned to be a key resource in this regard and current efforts by the AARC to gather best practices. CMS'' reasons stated for the inclusion of COPD include:

- COPD is a leading cause of readmissions to hospitals.

- In 2007, the MedPAC published a report to Congress in which it identified the seven conditions associated with the most costly potentially preventable readmissions. Among these seven conditions, COPD ranked fourth.

- Evidence also shows variation in readmissions for patients with COPD, supporting the finding that opportunities exist for improving care. The median, 30-day, risk-standardized readmission rate among Medicare fee for- service patients aged 65 or older hospitalized for COPD in 2008 was 22.0 percent, and ranged from 18.33 percent to 25.03 percent across 4,546 hospitals.

- Clinical trials and observational studies suggest that several aspects of care provided to patients hospitalized for exacerbations of COPD can have significant effects on readmission.

- In addition, inclusion of this measure in the Hospital Readmissions Reduction Program aligns with CMS'' priority objectives to promote successful transitions of care for patients from the acute care setting to the outpatient setting, and reduces short-term readmission rates.

Accountable Care Act / Hospital Readmission Reduction Program Best Practices

The AARC has solicited its membership to submit best practices in regard to preventing unnecessary readmissions. The intent is to gather best practices including related outcome data when available so that it can be made available to all members. Responses have been received and information is currently being gathered. A discussion is planned for the AARC Congress.

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Summer 2013

The ARCF Board of Trustees has been active in a number of areas as we move into 2013. In addition to meeting in Dallas in the Spring, we now have a quarterly Board of Trustees call, of which the latest occurred on May 15, 2013.

One of the projects that are underway is the ARCF awareness video. This is similar to last year's video, which included notable contributors to our profession. We have identified additional people who we will be video taping at the Summer Forum for this year's promotion. We expect this presentation will draw attention to the members of the AARC who need to know more about their Foundation. This is an ongoing effort that was started by the ARCF Board of Trustees last year.

The ARCF will host their Fundraiser at the Congress this year on the evening preceding the start of the Congress. The theme will be "A Night at the Museum". This event will highlight the construction of the AARC Virtual Museum. Currently we have identified antiquated recorded media that will be transferred into digital media. We will also be reaching out to companies so that we can have on display some of our equipment used in that past that our members would find of interest. They would then be put on display at the Fundraiser and later in the AARC Booth at the Congress this year. We will be selling bricks to members at the Fundraiser to help us raise the needed funding for the museum. Our Fundraising Committee is currently negotiating with the hotel in Anaheim for best rates for our event this year. They are also planning to make this an event that will draw large numbers of donors.

The ARCF has agreed to accept sponsorship of the AARC International Fellow program. This had been given to the AARC for the past two years but because by doing so we realized a decrease in donations primarily due to the loss of a tax write off when a donation is given directly to the AARC. The ARCF will take this responsibility over in 2014.

These are just a few of the most recent activities from the ARCF Board and I will be able to expand more on these in Orlando. We look forward to seeing you this year at the Summer Forum and AARC Board/House meetings and as always I will be happy to answer any questions that you may have at the Agency Briefing in Orlando.

Michael Amato
ARCF President

CoARC Report

Submitted by Tom Smalling – Summer 2013

See Attachment:

"CoARC Update to AARC BOD 7 2013"

MEMORANDUM

Date: June 12, 2013

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

From: Kerry E. George, RRT, MEd, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you an update on the activities of the NBRC. Since the last report the NBRC Board and committees met in April of 2013 in Atlantic Beach, Florida and continued the work of approving test items and developing examination forms for the computerized testing system. Since that meeting, the examination committees have been very busy with the ongoing activities involved in the development of examination forms and working on many of the changes that will be made to the the examination systems in the coming years. For the fourteenth year (since the implementation of computer based testing) the NBRC has been able to continue to provide very high quality credentialing programs to the respiratory therapy profession with no increase in the testing fees for candidates.

Therapist Multiple-choice Examination

Members of the committee have been very involved in the activities that need to be completed prior to the implementation of the new examination in 2015. The job analysis has been completed, the Detailed Content Outline has been developed and is being released in July. All the procedures and materials for the validation study are being finalized. The NBRC will be inviting therapists to complete a three part process to participate in this important step in the development of the new exam. The NBRC Board has approved a small financial incentive to those individuals who participate in the validation study as thanks for their participation. The committee also continues the ongoing work of developing and approving examination forms for the testing network.

Adult Critical Care and Sleep Disorders Specialty Examinations

The much requested Adult Critical Care Specialty Examination made its debut in July 2012. As of May 28, 2013, 296 individuals have earned the RRT-ACCS credential. Since the inception of the Sleep Disorders Specialist Examination in December 2008, 245 individuals have earned the SDS credential.

The NBRC appreciates the ongoing assistance of the AARC in making respiratory therapists aware of the value of these specialty credentials.

Clinical Simulation Examination

The Clinical Simulation Examination Committee has been working very hard to meet the deadline of January 2015 for the implementation of the changes to this examination program. They have been working very hard to develop the newer, shorter examination problems and have them pretested in the examination system and develop the needed changes to the scoring of the examination. The committee has also developed more specific test specifications of the types of problems that will be represented on each form of the examination.

NCCA Accreditation

All NBRC examination programs (except the new Adult Critical Care Specialist Examination) continue to be accredited by the National Commission for Certifying Agencies. The NBRC will apply for accreditation of the new Adult Critical Care Specialty Examination in 2013.

Summer Forum

Dr. Rob Shaw, PhD, RRT is presenting an Item Writer Workshop on Sunday, July 14, 2013. This is a great opportunity for anyone interested to learn how to develop better examination items either for use in their own educational programs or to become item writers for the NBRC. Thank you for restoring the time, nature and length of the Jimmy Albert Young Memorial Lecture which will deal with the changes to the examinations for the CRT and RRT credentials that will occur in 2015.

Public Relations / External Relationships

The staff and leadership of the NBRC continue to be very involved in working with our sponsoring organizations and presenting information with meetings of respiratory therapy societies and organizations. Gary Smith attended the meeting of the National Association for Medical Direction of Respiratory Care meeting. Chelsea Earhart spoke to the Georgia State Respiratory Therapy Student conference. Kerry George presented NBRC updates at meetings of the Illinois Society for Respiratory Care and the National Network for Associate Degree Respiratory Care. Kerry, Gary, Lori Tinkler and Ted Oslick attended the annual meeting of the American Thoracic Society.

Continuing Competency Program

Now entering its 6th year, credentialed therapists seem to function better with the Continuing Competency Program. The first persons who renewed the credentials starting in July of 2007 have now renewed credentials for a second time. This program which seeks information to assure the public that persons who have earned the NBRC credentials have been working to maintain current knowledge and ability as respiratory therapists.

Examination Statistics

The NBRC administered nearly 40,000 examinations in 2012. Through June 15, 2013, the NBRC has administered 18,132 credentialing examinations across all programs.

Pass/fail statistics for the respective examinations for the period January 1 – June 15, 2013 follow:

Examination	***Pass Rate***	
CRT Examination – 6,328 examinations		
	Entry Level	Advanced
First-time Candidates	70.0%	82.6%
Repeat Candidates	14.7%	25.2%
Therapist Written Examination – 5,838 examinations		
First-time Candidates	69.6%	
Repeat Candidates	33.2%	
Clinical Simulation Examination – 5,173 examinations		
First-time Candidates	65.0%	
Repeat Candidates	49.2%	
Neonatal/Pediatric Examination – 408 examinations		
First-time Candidates	72.5%	
Repeat Candidates	45.7%	
Sleep Disorders Specialty Examination – 26 examinations		
First-time Candidates	85.0%	
Repeat Candidates	60.0%	
Adult Critical Care Specialty Examination – 148 examinations		
First-time candidates	86.5%	
Repeat candidates	46.7%	
CPFT Examination – 169 examinations		
First-time Candidates	70.5%	
Repeat Candidates	62.2%	
RPFT Examination – 42 examinations		
First-time Candidates	48.1%	
Repeat Candidates	53.3%	

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

Policy Review

- BOD.025 – BOD - Conventions and Meetings
- CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges
- FM.017 – Fiscal Management – Presidential Stipend
- FM.019 – Fiscal Management – Fiscal Policies – Investments

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Conventions and Meetings**

EFFECTIVE DATE:

DATE REVIEWED: September 2005

DATE REVISED: September 2005

REFERENCES: CM.000, CM.003 - 1997

Policy Statement:

Policy Amplification:

1. Products not related to respiratory care will not be permitted in the exhibit hall at the annual convention. The determination of non-related products shall be made at the discretion of the Convention Manager.

2. Prizes, awards, drawings, raffles, lotteries, or contests of any kind are expressly prohibited at the AARC convention.

3. Merchandise sale will not be allowed in the registration area. A special association booth will be located in the exhibit hall for sales. A current membership card is required in order to purchase AARC merchandise.

4. Point system for the sale of exhibit space:

    A. A priority closing date will be established approximately two weeks after the mailing of the initial notice of the convention.

    B. Exhibit applications received prior to this closing date will be assigned booth numbers by the point system.

C. Points to be awarded at the rate of one point per single booth for each of the last five years for which records have been kept.

D. Applications received after the closing date will be assigned space on a first-come, first-serve basis.

5. Hospitality Suite Policy: Assignment of suites shall be handled by the Convention Manager subject to the rules and regulations governing same.

A. Suites or other hospitality areas will not be open to the membership whenever any technical or educational session is underway, nor will they be open during exhibit hours.

B. Hospitality areas will only be open from 6:00 p.m. to 11:00 p.m., and if members do not cooperate, exhibitors will be asked to notify the Convention Manager and/or the Executive Director. Spot checks of hospitality areas will be made to insure that members are not present after 11:00 p.m.

C. Only firms or companies which have booth space at the exhibit hall will be allowed to maintain a hospitality suite.

D. Exhibitors must not allow members in hospitality areas who are under the legal drinking age. Exhibitors must enforce this policy, and members will be asked for identification if there is doubt that they are of drinking age.

E. Violators of this policy may, at the discretion of the Board of Directors or its designee, be subject to the loss of booth space privileges for two consecutive years.

F. A letter shall be sent to all exhibiting companies outlining the hospitality suite policy.

6. All persons attending the annual convention must register. No fees will be charged for attendance at constitutionally required sessions, i.e., meetings of the Board of Directors, House of Delegates, or Board of Medical Advisors. Fees will be charged for all other activities, i.e., lectures, general sessions and exhibits.

7. Registration fees are listed in the schedule of fees. Only members who have paid their current annual dues or whose applications are in progress will be admitted at the member rate. All others will pay the non-member rate.

8. Members registering at the meeting who have not registered in advance will be required to present their current membership card in order to register at the member fee. Any person who does not present a current membership card will be required to register at the non-member fee.

9. Refunds will not be given to an individual for fees paid by employer check. Refunds will be made directly to the employer following the meeting, provided a request for a refund is made prior to the meeting.

10 All advance registrations must be prepaid. No invoice will be issued for advance registration. Advance registration will be acknowledged.

11. No checks will be cashed in the registration area.

12. Tickets for meal functions at the convention will not be included in registration fees. Purchase of meal tickets shall be optional.

13. The American Association for Respiratory Care, by action of its House of Delegates and its Board of Directors goes on record as opposing the practice of smoking, and in an effort to discourage smoking in all meetings of its annual convention, shall make this fact known through frequent and appropriate announcements during the course of the various meetings, and through the establishment of no smoking policies in all meeting room.

14. All committees desiring activities during the convention program shall be required to inform the Program Committee prior to starting work on such programs.

15. Tickets for social functions at the annual convention shall be provided at no charge to those persons whose attendance at such functions is mandatory.

16. All students shall be required to pay a registration fee, either at the student membership rate or the non-member rate. A student member is defined as one who is a member of the AARC and presents a current validated membership card attesting to that effect.

17. The purpose of the annual convention shall be identified in the following order of importance: a) to further the education of the members, b) to increase opportunities for fellowship among members, c) to transact the association business, and d) to serve as a source of revenue.

18. Members of the President's Council and their spouses will be registered for the annual convention at no charge; function tickets are included in such registrations.

19. A spouse registration fee shall be set annually and shall require positive identification.

20. Bus service for the annual convention shall be included in the convention budget as a membership service at no charge to the registrants.

21. The Board of Directors shall establish a flat fee for the annual convention registration.

22. Each 10 X 10 exhibit boot shall be allowed six (6) exhibitors to register free of additional charge, and the Executive Director shall be given the discretion of allowing visitors.

23. All physicians, including affiliate medical advisors and registry examiners, but excluding Board of Medical Advisors, will be required to pay fees, either at the member rate or non-member rate. (NOTE: BOMA members will be granted free registration at the annual meeting.

24 Pre-registration of spouses for AARC conventions and meetings is abolished.

25. Chartered affiliates planning to hold meetings within the geographic boundaries of another chartered affiliate should inform the other chartered affiliate during the planning stage as to their attention and should seek their written concurrence. In the event the affiliates cannot agree, the Speaker of the House of Delegates and Chair of the Chartered Affiliates Committee should be contacted for assistance in resolving the conflict.

26. The Chair of the Program Committee will notify the President of the Chartered Affiliates, in writing, of the plans to hold an AARC sponsored seminar, and that this notification be given as far in advance as possible.

27. Deadlines for pre-registrations and cancellations for all AARC meetings will be determined by the Director of Conventions. The deadlines will be announced in the programs for such meetings. A cancellation fee, also to be determined by the Director of Conventions, will be deducted from all cancellations; the fee amount will be announced in the program.

28. Non-member registration fees for all meetings shall be higher than member fees and large enough to encourage non-members to join the association.

29. Participants in the Sputum Bowl shall register for the annual meeting, but shall not be required to pay the registration fee for the meeting unless they wish to attend the convention.

30. Chartered affiliates exhibits at the annual meeting:

    A. Upon written request, each AARC chartered affiliate may be granted, free of charge, one (1) booth space in the exhibit hall at the annual meeting, if space is available.

    B. Affiliates requiring additional space may do so by applying and paying the commercial exhibit fees.

    C. The location of the free booth space will be determined by the Convention Manager in consultation with the Executive Director.

    D. Personnel manning the chartered affiliate exhibits must register for the meeting by paying the appropriate registration fee.

    E. No chartered affiliate may conduct sales, raffles, solicit donations, etc. as part of their exhibit.

    F. The association discourages exhibits outside the exhibit hall. The Executive Director may consider granting such requests if circumstances, as determined by the Executive Director, indicate their appropriateness.

31. Smoking is discouraged at social events held during AARC meetings. Proper announcements should be made prior to and during the event itself. If the event is being presented and/or sponsored by an outside group/company, it will be the responsibility of the group/company, to make sure that this policy is observed at all times.

32. Beginning in 1989, the AARC Executive Office shall plan and conduct a leadership workshop for leaders and potential leaders on the day before each annual convention.

33. Policy to establish guidelines for expenses to be paid to speakers participating in AARC seminars and educational meetings:

A. *Scope:* This policy includes compensation to persons requested to participate in a program. This is to apply as follows:

1) Out of Town Speakers

a) Transportation – Coach airfare, round trip
b) Lodging – Single room rate for each day required to be at the convention site.
c) Per diem - $30 for each day required to be at the convention site, plus one per diem for travel.
d) Registration – No charge. Function tickets not included.
e) Honorarium - $250 for each lecture at the annual meeting and summer forum.

2) Out of Country Speakers

a) Same as #1 above will apply, plus one additional lodging day and one additional per diem.
b) All out of country speakers must be approved, in advance, by the Program Committee before an invitation is issued.

3) *Local Speakers*

a) Same as #1 above with the following exceptions:
i) No transportation will be paid
ii) No lodging will be paid
iii) No per diem for travel will be paid

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4) *Special Lectures*

a) Egan Lecture: Up to $500 honorarium plus travel expenses will be paid according to current travel policies.
b) Keynote Address: #'s 1, 2 and 3 above will apply; however, an honorarium will be determined by the Program Committee on an annual and individual basis subject to budget allocation.

5) *Panel Discussions*

a) Speakers will receive a $125 honorarium and complimentary registration only.

6) *OPEN FORUM Speakers*

a) Student members presenting papers will receive complimentary registration. This will be limited to the student presenting the paper (in cases where there is more than one student author.)
b) All other authors presenting papers must pay the appropriate registration fee if they wish to attend the convention.
c) All individuals presenting at the OPEN FORUM who arrive at the meeting with a manuscript ready to submit to RESPIRATORY CARE for consideration would have their registration at the Annual Meeting refunded, up to $2,000, excluding Editorial Board members.

7) *Workshops*

Each instructor will receive a $125 per hour honorarium not to exceed $400 per day and complimentary registration. If per diem and travel expenses are to be reimbursed, they will be reimbursed in accordance with existing policy.

8). Contingencies

a) Honorarium and expenses will not be paid to AARC officials presenting programs dealing with their area of involvement.
b) Honorarium shall not be paid to AARC employees.
c) Special circumstances not covered in these guidelines shall be referred to the Chair of the Program Committee for their consideration and action.

34. Requests for co-sponsorship of international meetings related to respiratory care shall be submitted to the International Council for Respiratory Care to review and recommendation to the Board of Directors.

35. Candidates for officers and directors will be provided lodging and per diem for the meeting at which they take office.

36. AARC will provide complimentary registration for members of the Board of Directors and officers of the House of Delegates under the following conditions:

A. The director or officer is unable to obtain registration for payment from his or her employer.
B. A request is made to the AARC for complimentary registration or reimbursement to the director or officer after he or she has rendered payment for registration to the association.

37. **CRITERIA FOR CO-SPONSORSHIP OF MEETINGS**

A. Co-sponsorship is defined as the AARC actively participating in the preparation, presentation, funding or otherwise accepting responsibility for programs involving other organizations or groups.

C. Co-sponsorship shall not be construed to include anything other than the scientific portion of the program.

C. To be considered for co-sponsorship, the requesting organization should write a letter to the AARC President outlining the nature of the request. The President should solicit the advice of the Program Committee in making the decision whether to recommend or reject co-sponsorship. The following criteria should be considered in making the decision:

1) The AARC should only consider co-sponsorship with organizations sharing the same philosophies of patient care.

2) The written request must be received at least 12 months in advance and prior to the fall or spring meetings of the program Committee. The terms and expectations from AARC shall be outlined.

3) Our section of the program should be developed by the AARC Program Committee in concert with the Program Committee of the requesting organization.

4) The AARC must be apprised of any and all other co-sponsoring organizations.

5) The co-sponsored program must not conflict (by calendar, time or geographic location) with any other official AARC program.

6) Co-sponsorship of a meeting includes content of scientific sessions only and does not imply any staff time or resources.

7) Unless authorized by the Board of Directors, no expense is to be incurred by the AARC.

8) Registration fees, if any, for AARC members should be the same as the other association members and not gust admission fees.

9) If there is net income from the meeting, the AARC should receive an amount proportional to the AARC's input and participation.

10) All organizations applying for co-sponsorship should be considered equally and expected to meet the same criteria.

11) Approval of co-sponsorship should be for a one time only, with reapplication necessary for each successive program.

12) Each program will be evaluated while in progress and in retrospect. This may require funding from the AARC.

13) Evaluation criteria should be the same for co-sponsoring meetings as for all formal AARC meetings.

14) In general, the AARC does not subscribe to outside organizations co-sponsoring sections of our annual convention. The AARC does reserve to contact outside organizations as consultants.

15) Any and all exceptions to this policy shall be at the discretion of the AARC President and the Program Committee.

DEFINITIONS:

ATTACHMENTS

PROPOSED – JULY 2013

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **MEETINGS & CONVENTIONS**

EFFECTIVE DATE: July 2013

DATE REVIEWED: September 2005

DATE REVISED: July 2013

REFERENCES: CM.000, CM.003 - 1997

EXHIBITORS

1. The AARC reserves the right to reject exhibit applications for any reason.

2. Prizes, awards, drawings, raffles, lotteries, or contests conducted by exhibitors are expressly prohibited to take place in or around the exhibit hall, meeting room space and any public area of the convention center.

3. Exhibitors are only permitted to sell equipment, product or merchandise specific to their industry profile in or around the exhibit hall. Trinkets, souvenirs, T-shirts, gadgets etc. are not permitted for resale.

4. Priority Points will determine booth location. AARC reserves the right to alter booth location based on Association needs.

5. Exhibitors will be provided with 6 complimentary registrations for company employees for every 100 sq. ft. of exhibit space that they purchase. Registered exhibitors who are also respiratory therapists are eligible to earn CRCE at no cost as part of their booth registration.

6. Hospitality Suites/Meeting Rooms: Authorization and assignment of suites and meeting room space shall be handled on a first come, first served basis on the following criteria:

    A. Availability of space.

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B. Area is not being used to host/entertain conference attendees during normally scheduled convention events (including AARC social functions). This includes, but is not limited to the following:
    i. Welcome party, Sputum Bowl Finals etc.
C. Only companies with confirmed booth space in the exhibit hall are eligible for hospitality suites, meeting rooms etc.
D. Exhibitors must not allow attendees in hospitality areas who are under the legal drinking age if alcohol is served.
E. The AARC reserves the right to refuse hospitality space to any exhibitor for any reason.
F. Those in violation of these stipulations are subject to immediate loss of booth space in current and/or future years.

ATTENDANCE & REGISTRATION

7. All persons attending AARC Congress must register and pay applicable registrations fees.

8. There will be a separate and more expensive registration tier for non-AARC members

9. Only members who have paid their current annual dues or whose applications are in progress will be admitted at the member rate. All others will pay the non-member rate.

10. Refunds will not be given to any individuals for fees paid by employer check. Refunds will be made directly to the employer, provided a request for a refund is made prior to the meeting within established guidelines.

11. All cancellations are subject to applicable cancellation fees. The AARC reserves the right to waive these cancellation fees in lieu of extenuating circumstances.

12. AARC reserves the right to provide complimentary registration to appropriate VIPs, dignitaries or others whose complimentary registration would otherwise be of benefit to the business practices of the Association.

13. Smoking is prohibited in all indoor/outdoor-sanctioned events of the AARC Congress.

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14. Admission to social functions at AARC Congress is complimentary to all registered attendees.

15. Members of the President's Council and their spouses may register for AARC Congress at no cost.

16. Spousal registration is permitted for AARC Congress. Registration includes access to all AARC sanctioned events, but is not eligible for CRCE.

EMPLOYEES, APPOINTED & ELECTED OFFICIALS

17. BOMA members will be granted free registration to AARC Congress

18. AARC will provide complimentary, full meeting registration for members of the Board of Directors and officers of the House of Delegates.

19. AARC employees and/or political representatives are prohibited from smoking on any property affiliated with AARC Congress (i.e. convention center, HQ hotel).

SPUTUM BOWL

20. Individuals may compete in the Sputum Bowl competition and attend all Sputum Bowl functions without having to pay Congress registration; however they are not permitted to attend any other AARC sanctioned event, nor are they eligible to earn CRCE.

CHARTERED AFFILIATES

21. Chartered affiliates exhibits at the annual meeting:

    A. Upon written request, each AARC chartered affiliate may be granted, free of charge, one (1) 10x10 booth space in the exhibit hall at the annual meeting… space pending.

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B. Affiliates requiring additional space may do so by applying and paying the commercial exhibit fees.
C. Location of the chartered affiliate booth to be determined by AARC. Chartered Affiliates serving as host state to the meeting will be permitted to secure a booth location outside of the Exhibit Hall (location at the discretion of the AARC… space pending).
D. Personnel manning the chartered affiliate booth must register for AARC Congress and pay all applicable registration fees.

SPEAKERS & HONORARIUM

22. Speaker honorarium and reimbursable travel expenses:

The American Association for Respiratory Care has an obligation to its membership to produce a superior program for AARC Congress and one that is inclusive of high quality presenters. In addition, it is also incumbent of the Association to be fiscally responsible with financial resources. As such, the following parameters should be used when determining honorarium and reimbursed travel expenses for AARC Congress presenters:

A. The Association will commit appropriate financial resources necessary to secure presenters as requested by the Program Committee (commensurate with established budget).
B. If the presenter is available, able and willing to present at AARC Congress with no required honorarium or reimbursed travel expense, the Association should pursue such an arrangement.
C. For presenters requiring airfare, the AARC is authorized to extend national/international round-trip, coach airfare when purchased no less than 3 weeks prior to the meeting.
D. For presenters requiring mileage/railway reimbursement, the AARC is authorized to extend mileage/lump sum reimbursement at the prevailing federal rate, up to, but not exceeding the amount of the lowest available round-trip, coach airfare ticket.
E. For presenters requiring lodging, the AARC is authorized to extend reimbursement up to, but not to exceed lodging costs of the highest priced authorized convention hotel.

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F. Should negotiated reimbursement include per diem, per diem compensation shall be determined based on AARC policy.
G. All presenters will receive (at minimum) complimentary one-day registration for the day in which they are scheduled to present, up to and including full 4-day meeting registration.
H. Bundled "lump sum" compensation for honorarium, travel and lodging may be offered in lieu of reimbursement for itemized expensed.
I. Honoraria and expenses will not be paid to AARC officials presenting programs dealing with their area of involvement
J. Honoraria shall not be paid to AARC employees.

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Judicial Committee Procedures for Processing Complaints and Formal Charges**

EFFECTIVE DATE: December 1980
DATE REVIEWED: May 2004
DATE REVISED: May 2004

REFERENCES:

Policy Statement: The following will define the procedures followed by the Judicial Committee in processing complaints and formal charges against a member or members of the Association who have allegedly violated the AARC Bylaws and/or Code of Ethics.

Policy Amplification:

Definitions:
Association: American Association for Respiratory Care (AARC)

Formal Complaint: A complaint submitted to the Judicial Chairperson which details the specifics of a complaint, and which has been signed and duly notarized. Specifics of the complaint must include: (1) a detailed description of the violation; (2) when, how, and where the violation occurred; (3) the name of the organization or person affected by the violation; (4) the name, address, and telephone number against whom the complaint is being filed; and (5) the name, address, and telephone number of the person making the complaint. The complaint may include more than one individual, organization, and/or violation, if applicable. The complaint and its specifics must be legible.

Valid Complaint: A Formal Complaint judged by the Committee as having substance. Formal Complaint processed into a Formal Charge.

Complaint Without Substance: A Formal Complaint judged by the Committee to be lacking substance. Formal Complaint is dropped from record.

Formal Charge: A Formal Complaint judged valid by the Committee and issued to the charged member as a "Resolution Preferring Charges Against a Member.

Formal Hearing: A Telephone hearing with the Committee, requested by the charged member.

Executive Session: A Committee meeting following a Formal Hearing to determine Committee action.

Procedure:

1. All improperly completed written complaints received by the Committee Chair shall be responded to within ten (10) working days by certified mail, return receipt requested. Instructions for proper completion of the complaint and time limitations shall be included with the Chairperson's response.
2. Failure of a complainant to return the information needed to complete the specifics of a formal complaint within thirty (30) days of the date of the signed return receipt shall be sufficient reason for abandoning the complaint.
3. The identity of any complainant shall be held confidential and provided to the accused member(s) only if the Committee determines the complaint(s) valid and a formal charge(s) is processed.
4. Upon receipt of a properly completed Formal Complaint, the Chair shall notify the accused member of the specifics of the Formal Complaint within ten (10) working days, by certified mail, return receipt requested.
5. The Chair shall conduct a complete preliminary investigation, as expeditiously as practical, involving only the complainant and the accused member to collect supportive documentation from both parties. The complainant, accused member, AARC President, and Judicial Committee members shall be notified of any serious delays in the investigation. Other individuals or institutions may be asked to submit written statements only with the written permission of the accused member. Such written statements must be acknowledged and sworn to before notaries, before they will be relied upon by the Committee.
6. Following the preliminary investigation, the Formal Complaint and all notarized documentation will be sent to Judicial Committee members for review.
7. The Chair shall schedule a telephonic meeting of the Judicial Committee to analyze the merits of the Formal Complaint and determine by majority vote, whether the Formal Complaint is Valid or Without Substance. This meeting requires a two-thirds presence of the Judicial Committee members, in addition to the Chair. The Chair votes only to bring majority. The AARC legal counsel shall be present to assist the Committee with any legal questions which may arise. Should the Committee determine the Formal Complaint is without substance, the complainant and accused member shall be so notified, within ten (10) working

days, by certified mail, return receipt requested.

8. Should the Committee determine the Formal Complaint is valid, a Formal Charge shall be issued to the accused member. A current "Resolution Preferring Charges Against a Member" shall be prepared, with the benefit of legal counsel, and forwarded to the charged member within fifteen (15) working days by certified mail, return receipt requested.
9. The charged member shall be requested to reply to the specified charges within fifteen (15) working days from the date of receipt of the "Resolution Preferring Charges Against a Member."
10. Notification of Formal Charge shall include a clear statement of the options available to the charged member:
    a. the right not to reply to the Committee's request for response;
    b. the right to provide a detailed response in rebuttal, denial, justification, explanation, or admission of the Formal Charge; and/or
    c. the right to request a Formal Hearing in order to present a direct personal defense to refute the Formal Charge.
11. This notification shall also include a copy of "Judicial Committee Guidelines for Processing Complaints and Formal Charges."
12. If the charged member fails to respond in writing within the time specified for reply, the Committee, by majority vote, may take action it deems appropriate.
13. If the charged member's response is sufficient for Committee action, and no Formal Hearing is requested, the Committee, by majority vote, shall take whatever action it deems appropriate.
14. The Committee Chair may grant a reasonable extension on charged member response deadlines upon receipt of a written, notarized request for an extension, which details the circumstances warranting the requested extension.
15. Should the written response, by the charged member, prove to be inadequate by the Committee to refute, explain, justify or admit to the specifics of the charge, the Chair shall:
    a. Request a final, more detailed statement or clarification from the charged member. No further written replies shall be requested.
    b. Re-extend the opportunity for a Formal Hearing, which will serve in lieu of a final written response.

    This request shall be forwarded to the charged member within ten (10) working days of the Committee's determination of inadequate response by certified mail, return receipt requested. The charged member shall be requested to reply within ten (10) working days of his/her receipt of the committee's second request.

16. Without any request for a Formal Hearing, the Committee shall, by majority vote, take action in the case of each charged member within fifteen (15) working days of the receipt of a charged member's final written response. The charged member shall be notified within ten (10) working days of Committee action by certified mail, return receipt requested.

    a. If a Formal Hearing is requested, the AARC President shall be notified so that all necessary funds may be appropriated. The Judicial Committee Chair, with the assistance of the AARC executive office, shall schedule a telephonic Formal Hearing to be held within sixty (60) days from the date of receiving the charged member's request for Formal Hearing.
    b. The charged member requesting a Formal Hearing shall be notified by certified mail return receipt requested of the date and time of the Formal Hearing and shall be issued the Formal Hearing guidelines no less than thirty (30) days prior to the date of the Formal Hearing.
    c. The Judicial Committee Chair reserves the right to include or exclude presence of non-delineated individuals at the Formal Hearing.
    d. The AARC legal counsel will be present at all Formal Hearings and will assist the Committee with any legal questions.
    e. At no time shall the Chair or any Committee member attempt to bias any Committee member prior to a Formal Hearing.
    f. A Formal Hearing requires two-thirds (2/3) presence of the Judicial Committee members in addition to the Chair. The Chair votes only to bring majority vote.
    g. Letters or written statements introduced before the Committee must be duly notarized.
    h. Should the charged member no be present at the Formal Hearing, the Judicial Committee shall proceed with the Formal Hearing and make a decision by majority vote based on available information. A transcript of all oral testimony shall be taken.
    i. The Judicial Committee Chair shall preside over all Formal Hearings. All individuals present including the Judicial Committee members shall be identified for the record.
    j. The Chair will identify the method of recording the Formal Hearing by the Judicial Committee and by the charged member.
    k. The Chair shall read the procedures to be followed in conducting the Formal Hearing and inquire of those present if there are any questions concerning those procedures.
    l. The Chair shall then read the specifics of the "Resolution Preferring Charges Against a Member."
    m. The Chair will then review all documentation concerning the aforementioned "Resolution Preferring Charges Against a Member."

17. The charged member and/or his/her legal counsel shall then have the opportunity to rebut.
18. The charged member(s) involved shall then present witnesses and/or other admissible documents in defense of their position.
19. The Judicial Committee shall have the option of asking relevant questions about each document and/or from each witness presented by the charged member.
20. At the completion of the charged member's presentation, the Committee shall ask if the charged member has any further information. If none, the charged member presentation is closed, subject to rebuttal by the Committee.
21. The Judicial Committee may consult legal counsel prior to closing the Formal Hearing and going into Executive Session.
22. The Chair shall then close the Formal Hearing. The charged member shall be informed that he/she will be notified by the Judicial Committee Chair, within ten (10) working days of the Judicial Committee decision by certified mail return receipt requested.
23. The Chair shall reconvene the Committee and declare Executive Session to review the testimony and to vote on action to be taken.
24. In those cases where disciplinary action is taken against a charged member, notification of Committee action shall inform the charged member of his/her right to appeal the Committee action directly to the Board of Directors of the Association as defined in Article XI Section 2f of the Association Bylaws.
25. Should a charged member against whom disciplinary action has been taken, fail to appeal Committee action to the Board of Directors of the Association, within the time specified, the Chair shall notify the charged member by certified mail return receipt requested that his/her rights as defined by these policies and AARC Bylaws have been exhausted and that the case is no longer appealable and that the Committee action is now binding.
26. Upon advise of Legal Counsel, notification of Association member suspension or termination shall be given to:
    a. National Board for Respiratory Care (NBRC)
    b. State affiliate of member
    c. Local Chapter of member
    d. AARC member via *AARC Times* (only action taken, not names, shall be reported)
    e. Employer of member (upon written request of employer)

Procedure For Appeals to the Board of Directors
(EP.1280)

Policy:

All members against whom disciplinary action has been imposed shall be granted the opportunity to appeal such action(s) to the Board of Directors of the Association. The objective of this appeal mechanism is to provide an impartial forum responsible for the review of adjudged evidence. Judicial Committee procedures and the severity of the penalties assessed against members. Under no circumstances shall the right to appeal be denied any member.

Outline of Preliminary Procedures:

All appeals must be received in writing within thirty (30) days of the member's receipt of notification of disciplinary action, and must be forwarded directly to the AARC President.

Appeals received beyond the thirty (30) day deadline shall be returned to the appellant, by certified mail within five (5) working days of its receipt by the AARC President with notification of its invalidity.

Any and all appeals must detail, in explicit terms the basis for the appeal and justifications which might warrant the reversal or modification of Judicial Committee actions.

Any appeal based upon the submission of new evidence or the reversal of testimony shall be forwarded to the Judicial Committee for preliminary review and recommendations.

Upon receipt of a valid appeal the AARC President shall request the original case file and hearing transcript, if any, from the Judicial Committee Chair.

The AARC President shall forward all case materials to the officers and directors of the Association within twenty (20) days of the receipt of the member's appeal. Within thirty (30) days of the President's receipt of the member's appeal, the Board of Directors, by majority mail or conference call vote shall:

Determine if the appeal is or is without merit.

1. Determine if all formal Judicial Committee procedures were followed appropriately.
2. Determine if Judicial Committee actions were appropriate for member responsibility.
3. Determine whether or not the strength of the appeal warrants reversal or modification of committee action.
4. Determine whether or not the appellant should be granted a formal hearing before the Board to present his/her case.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Presidential Stipend**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 28, 2008

DATE REVISED: March 28, 2008

REFERENCES:

Policy Statement:
The Association shall, in accordance with the following policy amplification, grant the sum of $25,000 to the Association President's employer for each year in office.

Policy Amplification:

1. The intent of this stipend shall be:

    A. As partial reimbursement for the loss incurred by the President's employer as a result of the President's commitments to the Association

    B. To reduce the financial obstacles relevant to the President's employer during the President's term of office

    C. To recognize the President's employer for supporting the President's commitment to the Association

2. This stipend shall be:

    A. Included as a line item in the President's section of the Annual Budget

    B. Paid on a quarterly basis

PROPOSED CHANGES JULY 2013

American Association for Respiratory Care
Policy Statement

Policy No.: FM.019

SECTION: Fiscal Management

SUBJECT: **Fiscal Policies – Investments**

EFFECTIVE DATE: July 2005

DATE REVIEWED: ~~December 2007~~ July 2013

DATE REVISED: ~~December 2007~~ July 2013

REFERENCES: FI.0786

Policy Statement:

The AARC shall continue to take a conservative approach to future investment policy based on current and projected economic trends.

Policy Amplification:

1. ~~As of July 2005,~~ ~~t~~ The investment policy for the AARC is ~~changed from an investment policy asset allocation of 60/40~~ a 40-60% asset allocation ~~between~~ range to debt instruments and a 40-70% asset allocation range to equities with no investment related to the tobacco industry being allowed. An ROI of 2% over the CPI shall be the long-term goal. ~~to a 50/50 asset allocation between debt instruments and equities with no less than 25% of the equities being invested in stocks which yield dividends.~~

DEFINITIONS:

ATTACHMENTS:

AARC
INVESTMENT POLICY AND PROCEDURES
(Revised ***December 2007***)

The Executive Director has been delegated by the Board of Directors the authority for management of the AARC's cash funds. Such investments must be carried within the guidelines provided herein which have been reviewed and approved by the Board of Directors.

Policy Statement

Maximum utilization of Association assets is a primary objective of the Board of Directors. Cash balances represent an available asset that, when effectively managed can contribute to the overall goal of providing services at reasonable costs. Although the investment of cash on either a short or intermediate term basis is not AARC's principal activity, it is the nature of business operations that there will be excess funds available. The objective of the investment guidelines contained herein is to allow the AARC to maximize its return on cash balances while operating within established limitations that will minimize the risk of financial loss.

A matter of primary importance in determining the application of excess cash is ensuring that funds will be available to meet upcoming cash requirements. This can be achieved through the anticipation of cash needs by preparing projections of cash flow. The Executive Office is responsible for the preparation of such projections. However, their accuracy depends on the cooperation and awareness of all directors, officers, committee chairs, etc. All departments should, on a timely basis, provide the Executive Director with any information regarding contractual obligations or other types of arrangements that will significantly affect cash flow.

An additional consideration in the management of cash balances is alternative uses of cash, such as early debt retirement and early payment on accounts in order to receive cash discounts. It is the AARC's position that decisions involving alternative uses of funds will be based on an evaluation and comparison of economic benefits to the Association. After an evaluation, it may dictate that these alternative uses may be more attractive investment alternatives. Generally, in such cases, these alternatives should be pursued. However, should early debt retirement become economically attractive, implementation would require the prior approval of the Board of Directors.

Investment Guidelines

In order to minimize the risk of loss to cash balances, it is necessary to determine levels of risk that are compatible with overall management philosophy. Based on this determination, guidelines can be established for use in the investment of funds. The guidelines set out below establish not only the types of investments that are acceptable, but also limitations on the amount of any one of those investments that may be held at any point in time.

All investments of Association cash shall fall within the following guidelines:

- Fixed income-type investments
  - Range: 40-60% of entire portfolio; Optimum allocation: 45%
  - Acceptable investments (in no order of importance / use):
    - Bank CD's (FDIC insured ONLY), maximum in any one institution: $100,000
    - Repurchase agreements collateralized by government securities
    - Bankers Acceptances
    - Federal government or government agency securities
    - Corporate commercial paper with an S & P rating of A-1 or Moody's rating of P-1
    - Money market accounts trading at $1.00 / unit and comprised of the above type securities
    - Corporate bonds with a rating of no lower that "BBB" by S&P or "BAA" by Moody's.
      - Bond maturities may be staggered over a 10 year period with the average maturity not to exceed 5 years.
      - No one bond may comprise more than 7% of the total fixed income portfolio
    - Bond mutual funds
      - Must be primarily comprised of the above type of investments and
      - Must be judged to be of high quality by considering:
        - S&P or Moody's ratings
        - Past earnings records
    - May include so-called high yield or "junk bonds" (rated below "BBB" by S&P or "Baa " by Moody') but they may not comprise more than 7% of the total BOND PORTFOLIO.

- Equity investments
  - Range: 40-70% of entire portfolio; Optimum allocation: 55%
  - Single issues---Any stock EXCEPT those that are:
    - A Penny Stock (i.e. trading for less than $1 via OTC (pink sheets))
    - Highly speculative, for example:
      - Be trading with unusually high P/E ratios…50-75++ or
      - Have little or no history of any earnings
  - Stock Mutual funds must be:
    - Primarily comprised of the stock issues allowed for above and
    - Judged to be of high quality by considering:
      - S&P or Moody's ratings
      - Past earnings records / future growth
      - Fund manager experience and track record

- No investment in any security that is related to the tobacco industry is permitted
- No one equity security issue shall comprise more than 5% of the total equity portfolio and no one sector shall comprise more than 15% of the total equity portfolio.
- Alternative investments
    - No more than 5% of portfolio
        - Options, derivatives, future contracts, REITs
            - Range: no more than 2.5% of entire portfolio
            - Each trade must be approved by AARC CEO
        - Real Estate
            - Range: no more than 2.5% of entire portfolio
            - Each purchase must be approved by AARC CEO

Implementation

In implementing the cash management program, the following minimum objective must be retained:

1. Achieve maximum yields on invested funds while insuring reasonable protection of principal.
2. A return on investment / benchmark goal of 2% over the annual Consumer Price Index shall be the long-term (3-5 years) goal

The employment of outside investment counsel may be considered when implementing a part or all of this cash management program. Such professional service must be bound by these same guidelines while undertaking their investment management role
Adequate accounting procedures must be developed, implemented and continually exercised. These procedures will insure adequate forward cash planning, proper controls over transfers of cash, establishment of maturity dates, recording and receipt of interest income and maintenance of individual accounting records for each investment.

All Association held negotiable instruments must be controlled using external safekeeping facilities. Access will be limited and must require a minimum of two appropriately designated representatives.

Any material deviation from these guidelines and their implementation procedures must be submitted to and approved by the Board's Finance Committee.

AARC
INVESTMENT POLICY AND PROCEDURES
(Revised *JULY 2013*)

The Executive Director has been delegated by the Board of Directors the authority for management of the AARC's cash funds. Such investments must be carried within the guidelines provided herein which have been reviewed and approved by the Board of Directors.

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Maximum utilization of Association assets is a primary objective of the Board of Directors. Cash balances represent an available asset that, when effectively managed can contribute to the overall goal of providing services at reasonable costs. Although the investment of cash on either a short or intermediate term basis is not AARC's principal activity, it is the nature of business operations that there will be excess funds available. The objective of the investment guidelines contained herein is to allow the AARC to maximize its return on cash balances while operating within established limitations that will minimize the risk of financial loss.

A matter of primary importance in determining the application of excess cash is ensuring that funds will be available to meet upcoming cash requirements. This can be achieved through the anticipation of cash needs by preparing projections of cash flow. The Executive Office is responsible for the preparation of such projections. However, their accuracy depends on the cooperation and awareness of all directors, officers, committee chairs, etc. All departments should, on a timely basis, provide the Executive Director with any information regarding contractual obligations or other types of arrangements that will significantly affect cash flow.

An additional consideration in the management of cash balances is alternative uses of cash, such as early debt retirement and early payment on accounts in order to receive cash discounts. It is the AARC's position that decisions involving alternative uses of funds will be based on an evaluation and comparison of economic benefits to the Association. After an evaluation, it may dictate that these alternative uses may be more attractive investment alternatives. Generally, in such cases, these alternatives should be pursued. However, should early debt retirement become economically attractive, implementation would require the prior approval of the Board of Directors.

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In order to minimize the risk of loss to cash balances, it is necessary to determine levels of risk that are compatible with overall management philosophy. Based on this determination, guidelines can be established for use in the investment of funds. The guidelines set out below establish not only the types of investments that are acceptable, but also limitations on the amount of any one of those investments that may be held at any point in time.

All investments of Association cash shall fall within the following guidelines:

- Fixed income-type investments
  - **Range **** : 40-60% of entire portfolio; Optimum allocation: 45%
  - In addition, within the fixed income range above, the following investment sub-categories will be consider acceptable:
    - Corporate Fixed Income Securities
    - Government Fixed Income Securities
    - Foreign Fixed Income Securities
    - Short term
    - Intermediate
    - Long term
  - Acceptable investments (in no order of importance / use):
    - Bank CD's (FDIC insured ONLY), maximum in any one institution: $100,000
    - Repurchase agreements collateralized by government securities
    - Bankers Acceptances
    - Federal government or government agency securities
    - Corporate commercial paper with an S & P rating of A-1 or Moody's rating of P-1
    - Money market accounts trading at $1.00 / unit and comprised of the above type securities
    - Corporate bonds with a rating of no lower that "BBB" by S&P or "Baa " by Moody's.
      - Bond maturities may be staggered over a 10 year period with the average maturity not to exceed 5 years.
      - No one bond may comprise more than 7% of the total fixed income portfolio
    - Bond mutual funds
      - Must be primarily comprised of the above type of investments and
      - Must be judged to be of high quality by considering:
        - S&P or Moody's ratings
        - Past earnings records
    - May include so-called high yield or "junk bonds" (rated below "BBB" by S&P or "Baa " by Moody') but they may not comprise more than 7% of the total BOND PORTFOLIO.

- Equity investments
  - **Range**** : 40-70% of entire portfolio; Optimum allocation: 55%
  - In addition, within the Equity range above, the following investment sub-categories will be consider acceptable:
    - Small Cap--growth

        - Small Cap--value
        - **Mid Cap—growth**
        - **Mid Cap--value**
        - **Large Cap--growth**
        - **Large Cap--value**
        - **Foreign (ALL)**
    - Single issues---Any stock EXCEPT those that are:
        - A Penny Stock (i.e. trading for less than $1 via OTC (pink sheets))
        - Highly speculative, for example:
            - Be trading with unusually high P/E ratios…50-75++ or
            - Have little or no history of any earnings
    - Stock Mutual funds must be:
        - Primarily comprised of the stock issues allowed for above and
        - Judged to be of high quality by considering:
            - S&P or Moody's ratings
            - Past earnings records / future growth
            - Fund manager experience and track record

**** - From time-to-time, due to market conditions, operating cash needs or other circumstances, cash may be held in the investment portfolio that is not invested in securities. Compliance with the Fixed Income or Equity Investment percentages above is to be calculated WITHOUT considering such cash held in money market or other similar very short-term accounts.**

- No investment in any security that is related to the tobacco industry is permitted. **However, it is acknowledged that mutual funds, by their very nature, may have amounts invested in tobacco-related securities that may be very difficult or virtually impossible to easily determine. Nonetheless, such funds will still be reviewed periodically (1-2 times a year) and if it is seen that they have invested in tobacco-related securities, they will be divested.**

- No one equity security issue shall comprise more than 5% of the total equity portfolio and no one sector shall comprise more than 15% of the total equity portfolio.
- Alternative investments
    - No more than 5% of portfolio
        - Options, derivatives, future contracts, REITs
            - Range: no more than 2.5% of entire portfolio
            - Each trade must be approved by AARC CEO
        - Real Estate
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Implementation.

In implementing the cash management program, the following minimum objective must be retained:

3. Achieve maximum yields on invested funds while insuring reasonable protection of principal.
4. A return on investment / benchmark goal of 2% over the annual Consumer Price Index shall be the long-term (3-5 years) goal

The employment of outside investment counsel may be considered when implementing a part or all of this cash management program. Such professional service must be bound by these same guidelines while undertaking their investment management role
Adequate accounting procedures must be developed, implemented and continually exercised. These procedures will insure adequate forward cash planning, proper controls over transfers of cash, establishment of maturity dates, recording and receipt of interest income and maintenance of individual accounting records for each investment.

All Association held negotiable instruments must be controlled using external safekeeping facilities. Access will be limited and must require a minimum of two appropriately designated representatives.

A Quarterly Investment report will be sent to the AARC's Executive Committee and show:

- **Investment balances at cost and market**
- **Investments at market segmented by investment type (stocks, bonds, etc.)**
- **Investment performance (ROI, dividends, gains and losses)**
- **Compliance with Range percentage guidelines, above**

Any material deviation from these guidelines and their implementation procedures must be submitted to and approved by the Board's Finance Committee.

HOD Resolutions

#29-13-01
Resolution Author: Ann Wilson

E-mail: awilson@wellspan.org

Phone Number: 717-497-1645

Author's State: Pennsylvania

Co-Sponsors and Their States: None at this time

Resolution: "Resolve that the AARC contact the NBRC and request a change to the NBRC's "Continuing Competency Program" to allow a therapist whose credential has expired to regain active status without re-examination by providing proof of completion of the 30 hour continuing education requirement during the five year active credential period regardless of how long the credential has been expired."

Rationale: The PSRC has received numerous complaints from therapists who have completed their continuing education requirements but did not receive notice of their reporting obligation to the NBRC for any one of several reasons. The most frequent reason is that the therapist changed their address and forgot to notify the NBRC. Six months prior to the credential's expiration date, the NBRC sends out a reminder to the address on file which obviously doesn't make it to the therapist. Subsequent reminder notices are also completely useless.

Once the expiration passes, the NBRC deactivates their active credential status but will allow the RT to reactivate their credential for up to 6 months from their credential expiration date upon submission of proof of completion of the continuing education hours and paying a fee of $150. The 6 month time period is of little use since the therapist is unaware that their expiration date has passed. After six months has lapsed from the date of expiration, the RT must retake and pass the credentialing exam and must pay both the normal examination fee(s) AND a $250 "reactivation" fee to re-instate active status.

The PSRC does not object to these requirements for therapists who do not meet the continuing competency requirement during their active credential period. However, these penalties apply even if the therapist is able to provide documentation (such as their AARC continuing education transcript) that they had indeed met the continuing education requirements during the 5 year active credentialing period. The PSRC believes that requiring these therapists to re-take what may amount to THREE examinations (for an RRT credential therapist) AND pay a $250 reactivation fee is too steep a price to pay for simply forgetting to update their

mailing address with the NBRC. In some cases,
a therapist may have taken their examinations 10 or more years ago and many must then purchase exam prep materials (i.e. Kettering's course) to prepare for the exam(s) which adds additional costs. The total cost for an RRT that loses their credential and who purchases Kettering's prep course materials would be:

Kettering Course: $360 + CRT Exam: $190 + RRT Exams: $390 + NBRC Reactivation Fee: $250 = $1,190 Total cost

Impact of Resolution: General Membership, NBRC

Implementation Cost: 0

Ongoing Cost: 0

Relationship to AARC Strategic Plan: Increase organizational effectiveness

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House of Delegates Resolution

62-13-02

Resolution Author: Rick Weaver

E-mail: rtpftguy@msn.com

Phone Number: 719313-7746

Author's State: CO

Co-Sponsors and Their States: WY

Resolution: Be it resolved that the AARC allocate sufficient funds to the Delegate Assistance committee to allow Affiliates approved for assistance to receive an additional day of lodging and per-diem at the Winter meeting.

Rationale: The AARC bylaws, Article VII, Section 3c2, state that it is a Delegate's duty to attend the Annual Business meeting. This traditionally happens 2 days after the HOD and BOD meetings conclude during the Winter meeting.

Currently, Affiliates requesting Delegate assistance, if approved, receive partial funding for lodging for 3 nights. This does not cover the 4th night of lodging required to attend the Annual Business meeting. CO is aware of Delegates who have had to leave because they could not afford to pay for a night's lodging.

In contrast, HOD Officers and others required to attend this meeting are funded for at least four full nights, 3 days' full per diem, and 2 days' partial per diem.

We believe that extending coverage for Affiliates requesting assistance is fair and equitable.

Impact of Resolution: HOD, Affiliates, Executive Office

Implementation Cost: $1,000

Ongoing Cost: $1,000

Relationship to AARC Strategic Plan: Increase organizational effectiveness