American Association for Respiratory Care

Board of Directors Meeting

Marco Island Marriott Beach Resort
Marco Island, FL

July 18-19, 2014

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – July 17, 2014
Board of Directors Meeting – July 18-19, 2014

Thursday, 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) – *Caxambas Room*

Friday, July 18

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

8:00 am Call to Order
Announcements/Introductions
Disclosures/Conflict of Interest Statements
Approval of Minutes pg. 8
E-motion Acceptance pg. 38

General Reports pg. 39
- President pg. 40
- Past President pg. 41
- Executive Director Report pg. 42 (R)
- Government & Regulatory Affairs pg. 52
- House of Delegates pg. 64
- Board of Medical Advisors pg. 66
- Presidents Council pg. 70

10:00 am BREAK

10:15 am Standing Committee Reports pg. 71
- Audit Subcommittee pg. 72
- Bylaws Committee pg. 73 (R)
- Elections Committee pg. 101
- Executive Committee pg. 102
- Finance Committee pg. 103
- Judicial Committee pg. 104
- Program Committee pg. 105
- Strategic Planning Committee pg. 108 (A)

12:00 pm Lunch Break (Daedalus Board Meeting via conference line)

1:30 pm Reconvene – JOINT SESSION

3:30 pm Break

3:45 pm Specialty Section Reports pg. 113
- Adult Acute Care pg. 114 (R)
- Continuing Care-Rehabilitation pg. 115
- Diagnostics pg. 116
- Education pg. 117
- Home Care pg. 118
- Long Term Care pg. 119

Management pg. 120
Neonatal-Pediatrics pg. 121 (R)
Sleep pg. 122
Surface to Air Transport pg. 123

4:15 pm Special Committee Reports pg. 124

Benchmarking Committee pg. 125
Billing Code Committee pg. 126
Federal Govt Affairs pg. 127
Fellowship Committee pg. 128
International Committee pg. 129
Membership Committee pg. 130
Position Statement Committee pg. 132 (R)
Social Media Committee pg. 138
State Govt Affairs pg. 139

5:00 pm RECESS

Saturday, July 19

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

8:00 am Call to Order

Special Representatives pg. 141
- AMA CPT Health Care Professional Advisory Committee pg. 142
- American Association of Cardiovascular & Pulmonary Rehab pg. 143
- American Heart Association pg. 144
- American Society for Testing and Materials (ASTM) pg. 145
- Chartered Affiliate Consultant pg. 146
- Comm. on Accreditation of Medical Transport Systems pg. 147
- Extracorporeal Life Support Organization (ELSO) pg. 157
- International Council for Respiratory Care (ICRC) pg. 158
- The Joint Commission (TJC) pg. 161
- National Asthma Education & Prevention Program pg. 164
- National Coalition for Health Professional Ed. In Genetics pg. 165
- National Sleep Awareness Roundtable pg. 166
- Neonatal Resuscitation Program pg. 167

10:00 am BREAK

10:15 am Roundtable Reports pg. 168
- Asthma Disease pg. 169
- Consumer (see Executive Director report pg. 42) pg. 170
- Disaster Response pg. 171
- Geriatrics pg. 172
- Hyperbaric pg. 173
- Informatics pg. 174
- International Medical Mission pg. 175
- Military pg. 176
- Neurorespiratory pg. 177
- Palliative Care pg. 178
- Patient Safety pg. 179
- Research pg. 180
- Simulation pg. 181
- Tobacco Free Lifestyle pg. 182

10:45 am Ad Hoc Committee Reports pg. 183
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 184
- Ad Hoc Committee on Officer Status/US Uniformed Services pg. 185
- Ad Hoc Committee on 2015 & Beyond pg. 186
- Ad Hoc Committee to Reduce Hospital Readmissions pg. 194
- Ad Hoc Committee on Virtual Museum Development pg. 195 (R)

12:00 pm Lunch Break

1:30 pm Reconvene

1:30 pm Other Reports pg. 197

American Respiratory Care Foundation (ARCF) pg. 198
Commission on Accreditation for Respiratory Care (CoARC) pg. 200 (A)
National Board for Respiratory Care (NBRC) pg. 201

2:00 pm **UNFINISHED BUSINESS pg. 205**

NEW BUSINESS pg. 206

Policy Review

- BOD.024 – BOD – AARC Disaster Relief Fund pg. 207
- BOD.027 – BOD – Policy for Surveys Conducted by the Association pg. 209 (A)
- CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges (A)
- FM.002 – Fiscal Management – Annual Independent Audit pg. 213
- FM.005 – Fiscal Management – Independent Auditors and Audit Subcommittee pg. 214
- FM.018 – Fiscal Management – Audit and Oversight Standards pg. 215
- RT.001 – Roundtables – Roundtables pg. 217 (A)

HOD Resolutions pg. 220

3:30pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of July 3, 2014)

AARC Board of Directors Meeting

July 18-19, 2014 • Marco Island, FL

Executive Office

Recommendation 14-2-1.1 "That the AARC Board of Directors officially endorse 'Care of the Critically Ill and Injured During Disasters and Pandemics: A CHEST Consensus Statement'."

Bylaws

Recommendation 14-2-9.1 "That the AARC Board of Directors find that the Louisiana Society for Respiratory Care Bylaws are not in conflict with AARC Bylaws."

Recommendation 14-2-9.2 "That the AARC Board of Directors find that the South Dakota Society for Respiratory Care Bylaws are not in conflict with AARC Bylaws."

Adult Acute Care

Recommendation 14-2-50.1 "That a group be appointed to put together a 'consensus' statement or statements addressing the following topics: the use of non-invasive capnography during conscious sedation, patient specific strategies for invasive mechanical ventilation, the use of invasive ventilation outside of the Critical Care Areas, the use of NIPPV outside of the Critical Care Areas, establish recommended competency standards for working in Critical Care."

Neonatal-Pediatrics

Recommendation 14-2-56.1 "That the NBRC update the NPS examination to be a true specialty examination in line with the level and quality of the ACCS.
Specifically the NBRC consider:

1. RRT with 12 month experience in pediatrics/neonatal care as minimum qualifications
2. The survey for standard practice to guide test questions only be sent to CHA and NACHRI participating hospitals.
3. Request an official statement from the NBRC in response to this request that can be shared with the section membership and preferable representation at the NeoPeds section meeting in Las Vegas to be available for questions."

Position Statement Committee

Recommendation 14-2-26.1 "Approve and publish the revised Position Statement 'Pre-Hospital Mechanical Ventilator Competency'."

Recommendation 14-2-26.2 "Approve and publish the Position Statement 'Competency Requirements for the Provision of Respiratory Services'."

Recommendation 14-2-26.3 "Approve and published the Position Statement 'Verbal / Telephone Orders'."

Recommendation 14-2-26.4 "Approve and publish the newly developed Position Statement 'Interstate Transport License Exemption'."

Ad Hoc Committee on Virtual Museum Development

Recommendation 14-2-28.1 "That the BOD approve the proposal to establish the *Legends of Respiratory Care* program**."**

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 11, 2014 • Grapevine, TX

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Frank Salvatore, MBA, RRT, FAARC, President-elect
Karen Stewart, MSc, RRT, FAARC, Past-President
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Brian Walsh, MBA, RRT-NPS, RPFT, FAARC, VP Internal Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, MBA, RRT, RCP, FAARC
Lynda Goodfellow, EdD, RRT, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS
Joe Sorbello, MEd, RRT
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC
Cynthia White, MSc, RRT-NPS, FAARC
Gary Wickman, BA, RRT, FAARC
Kim Wiles, BS, RRT, CPFT

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
John Steinmetz, MBA, RRT, Past Speaker

Excused

Peter Papadakos, MD, BOMA Chair
John Wilgis, MBA, RRT, HOD Speaker-elect
Kari Woodruff, BS, RRT-NPS, HOD Secretary

Guests

Kathy Rye, EdD, RRT, FAARC, CoARC President
Tom Smalling, PhD, RRT-NPS, FAARC, CoARC Executive Director
Carl Haas, MS, RRT, FAARC, NBRC President
Gary Smith, FAARC, NBRC Executive Director
Deb Skees, MBA, RRT, CPFT, HOD Speaker
Keith Siegel, RRT, CPFT, HOD Treasurer

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director

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

CALL TO ORDER

President George Gaebler called the meeting of the AARC Board of Directors to order at 8:00am CDT, Friday, April 11, 2014. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

DISCLOSURE

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

WELCOME AND INTRODUCTIONS

Members introduced themselves and stated their disclosures as follows:

Linda Van Scoder – CoBGRTE member, Life member
Karen Schell – Consumer member FDA Board Pulmonary and Allergy Committee
Natalie Napolitano – Consultant for Draeger and AANMA, research relationship with Aerogen
Lynda Goodfellow – NAECB Board member, CoBGRTE member and employer is an institutional member of CoBGRTE
Bill Lamb – National clinical manager, Ohio Medical
Kim Wiles – Advisory Board member IUP/West Penn School of RT
Cynthia White – Researcher with Philips Respironics, Advisory Board for Aerogen and Vapotherm
Dianne Lewis - Life member
Brian Walsh – Research relationship with Vapotherm, Draeger, Maquet, Teleflex, Massachusetts State Society and CoBGRTE member
Karen Stewart – Life member
Frank Salvatore – Advisory Board member of SUNY
Doug McIntyre, MS, RRT, FAARC – Life member

APPROVAL OF MINUTES

Lynda Goodfellow moved to approve the minutes of the November 14, 2013 meeting of the AARC Board of Directors.
Motion carried

Lynda Goodfellow moved to approve the minutes of the November 15, 2013 meeting of the AARC Board of Directors.
Motion carried

Lynda Goodfellow moved to approve the minutes of the December 7, 2013 meeting of the AARC Board of Directors.
Motion carried

GENERAL REPORTS

President

President Gaebler gave highlights of his written report. He has appointed Chuck Menders as Chair of the Benchmarking Committee and Rick Ford as a member.

He also informed the Board that there would be significant changes to this Board meeting including only reviewing reports with recommendations and including a strategic planning session.

President Gaebler moved to accept **FM 14-1.84.1** "That the AARC Board of Directors strongly recommends that the NBRC and CoARC work with the AARC to come to a solution that is workable for all parties (NBRC, CoARC, AARC and the respiratory therapy education programs) regarding Policy 13. A committee should be appointed with a solution presented to the AARC by July 1, 2014."

Bill Lamb moved to call the question.
Motion carried

President Gaebler called for an immediate vote on the main motion **FM 14-1-84.1**.
Motion carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 8:55am CDT Friday, April 11, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 9:00am CDT Friday, April 11, 2014.

AUDITORS REPORT
Bill Sims, of Salmon, Sims, & Thomas updated the Board on the audited financial statements and answered questions from Board members.

LEGAL COUNSEL
Larry Wolfish gave an overview of Board member fiduciary responsibility and answered questions from Board members.

INVESTMENT REPORT

John Barrett of Merrill Lynch, via phone, gave an overview of the current investments of the Association.

RECESS

George Gaebler recessed the meeting of the AARC Board of Directors at 10:00am CDT Friday, April 11, 2014.

RECONVENE

George Gaebler reconvened the meeting of the AARC Board of Directors at 10:15am CDT Friday, April 11, 2014.

COMMISSION ON ACCREDITATION OF RESPIRATORY CARE (CoARC)

Kathy Rye, President of CoARC, and Tom Smalling, Executive Director of CoARC gave highlights of their written report.

NATIONAL BOARD FOR RESPIRATORY CARE (NBRC)

Carl Haas, President of NBRC and Gary Smith, Executive Director of NBRC, gave highlights of their written report.

A discussion regarding Policy 13 ensued between the Board of Directors, CoARC, and NBRC. NBRC stated that concessions will be made regarding the students who are caught in the middle during the change to Policy 13. Tom Smalling gave a brief history of Policy 13.

RECESS

George Gaebler recessed the meeting of the AARC Board of Directors at 12:25pm CDT Friday, April 11, 2014.

RECONVENE

George Gaebler reconvened the meeting of the AARC Board of Directors at 1:45pm CDT Friday, April 11, 2014.

GENERAL REPORTS

Executive Director/Office

Executive Director Tom Kallstrom gave an overview of the written Executive Office report. He stated that Dr. Stephen Jencks and Becky Anderson would be in town next week to record a one hour program geared towards respiratory therapists about being proactive in their hospitals (sponsored by Boehringer-Ingelheim, Monaghan, and Sunovian). Tom has also been in contact with Vernon Pertelle regarding his seminar about reducing hospital readmissions and disease management in the home. Joe Morrison (NHRA driver) has approached the AARC to partner up with NHRA, National Hot Rod Association; Mr. Morrison's father has COPD. Edison Medical has offered entrepreneurial RTs the opportunity to patent a product and sell it to a potential buyer. This opportunity would only be offered to AARC members.

Tom attended the NAMDRC meeting with Anne Marie Hummel which focused on RTs. Brian Carlin and Tom have been asked to present at AACVPR. Tom is a Board member with AANMA and has been working with Masimo on the National Patient Safety Movement. He and Tim Myers will be participating in the Sleep and Wellness Conference next month in Phoenix by displaying a booth and expanding the AARC's exposure to the sleep community.
The Executive Office continues to be budget conscious and staff members have proposed ideas on saving money.

The Associate Executive Directors gave updates of their respective departments.

Executive Office referrals from the November 2013 Board meeting were reviewed.
Brian Walsh moved to accept Recommendation 13-3-52.1 "Provide complimentary AARC Congress registration for each recipient of section Specialty Practitioners of the Year."
Motion carried

Sheri Tooley moved to accept Recommendation 14-1-1.1 "To form a roundtable on Patient Safety."
Motion carried

Linda Van Scoder moved to accept Recommendation 14-1-1.2 "That the Board approve expenses in the amount of $85,000 to upgrade the AARC Membership Management database system from iMIS 15 to iMIS 20."
Motion carried

State Government and Regulatory Affairs
Cheryl West provided an update on federal legislative issues, including recapping the success of the April 1 PACT Hill Lobby Day and the status of HR 2619. An update on state legislative legislation was also provided.

Anne Marie Hummel detailed the impact of the most recent CMS policies and rule changes and noted the AARC's public comments and input to CMS.

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 3:35pm CDT Friday, April 11, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 3:47pm CDT Friday, April 11, 2014.

House of Delegates
Deb Skees updated the Board on the recent activities of the House of Delegates.

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

Brian Walsh moved to refer to the President to work with the HOD Speaker. A group will be formed by president Gaebler.
Motion carried
President's Council
Colleen Schabacker moved to accept Recommendation 14-1-8.1 "That complimentary registration for the AARC educational meetings be offered to AARC Life Members."
Motion carried
Current Life Members - Linda Van Scoder, Karen Stewart, Doug McInytre – abstained.

Brian Walsh moved to accept the General Reports as presented.
Motion carried

STANDING COMMITTEES REPORTS

Audit Subcommittee
Brian Walsh moved to accept Recommendation 14-1-13.1 "That the Board of Directors accept the auditor's report as presented."
Motion carried

Bylaws Committee
Policies CA.001 (Chartered Affiliate Bylaws) and CA.007 (Chartered Affiliate Bylaws in Conflict with AARC Bylaws) were revised to read as follows:

> (CA.001) "The committee will recommend that the AARC Board of Directors find that the Affiliate's bylaws are not in conflict with AARC Bylaws."
>
> (CA.007) "The Bylaws Committee may make recommendations regarding grammar, spelling, or internal inconsistencies but will not delay recommendation to the AARC Board of Directors."

(See Attachment "A" for revision.)

Brian Walsh moved to accept Recommendation 14-1-9.1 "That the AARC Board of Directors find that the Texas Society Bylaws are not in conflict with AARC Bylaws."
Motion carried

Brian Walsh moved to accept Recommendation 14-1-9.2 "That the AARC Board of Directors find that the Massachusetts Society Bylaws are not in conflict with AARC Bylaws."
Motion carried

Brian Walsh moved to accept Recommendation 14-1-9.3 "That the AARC Board of Directors a find that the Arizona Society Bylaws are not in conflict with AARC Bylaws."
Motion carried

Brian Walsh moved to accept Recommendation 14-1-9.4 "That the AARC Board of Directors find that the Wisconsin Society Bylaws are not in conflict with AARC Bylaws."
Motion carried

Program Committee

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

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

Colleen Schabacker moved to refer to Program Committee for clarification.
Motion carried

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

SPECIALTY SECTION REPORTS

Home Care Section

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

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

Surface to Air Transport Section

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

Brian Walsh moved to make a friendly amendment to “draft”, not “consider drafting”.
Motion carried

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

RECESS
President Gaebler called a recess of the AARC Board of Directors meeting at 5:20pm CDT on Friday, April 11, 2014.

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

_____ _____
Linda Van Scoder Date
AARC Secretary/Treasurer

Attachment “A”

Policy CA.001 – Chartered Affiliate – Chartered Affiliate Bylaws
Policy CA.007 – Chartered Affiliates – Chartered Affiliate Bylaws in Conflict with AARC Bylaws

American Association for Respiratory Care
Policy Statement

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliate Bylaws**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 11, 2014

DATE REVISED: April 11, 2014

REFERENCES: Bylaws

Policy Statement:
All Chartered Affiliates shall submit all proposed Chartered Affiliate Bylaws changes to the AARC Bylaws Committee for review. The purpose of the review is to determine if there is conflict with the AARC Bylaws in reference to two questions:
1) Are active members of the Society also active members of the AARC? (YES)
2. Does the Society allow non-AARC members to vote and/or hold a voting position on the Society's Board of Directors? (NO)

~~If no conflicts are found,~~ ~~t~~The committee will recommend that the AARC Board of Directors find that the Affiliate bylaws are not in conflict with AARC bylaws. ~~the Chartered Affiliate's bylaws for approval and ratification by the AARC Board of Directors.~~

Policy Amplification:

1. A cover letter outlining each proposed bylaws amendment with a short explanation or justification for the change must be submitted by the Chartered Affiliate.

    A. All proposed Chartered Affiliate Bylaws amendments shall be submitted through the AARC Executive Office.

2. All proposed Bylaws amendments must be submitted in a contiguous single document that shows current and proposed language.

    A. Old language must be submitted in "*strike through*" format; new language must be submitted in underline format.

B. Incomplete or separate copies of “old” and “new” proposed Bylaws shall not be accepted.

American Association for Respiratory Care
Policy Statement

C. Proposed Bylaws amendments not presented in the correct format shall be returned to the Chartered Affiliate for conversion to the correct format.

3. Projected timelines for bylaws submission and action are as follows:

   A. Bylaws amendments must be submitted to the Executive Office, in the correct format, at least 120 days prior to the AARC Board Meeting at which they will be considered.
   B. The chair of the Bylaws Committee or designee will provide feedback to the Affiliate Representative no later than 30 days after the Executive Office has sent the Affiliate Bylaws to the members of the Bylaws Committee.
   C. Recommendations regarding conformance with AARC Bylaws made by the Bylaws Chair to the affiliate will be acknowledged by the affiliate representative within 30 days of the date feedback is provided.
   D. All issues regarding conformance with AARC Bylaws must be resolved between the Bylaws Committee and the Affiliate at least 45 days prior to the next scheduled AARC BOD meeting in order to be considered at that meeting.
   E. In some instances, affiliate bylaws may be submitted to the Board for electronic review in advance of a scheduled meeting.
   F. If more than three AARC BOD meetings have passed between the initial request for review and resolution of outstanding issues without ongoing dialogue with the affiliate representative, the Bylaws review process will be terminated.
   G. Upon termination the affiliate representative and the current chartered affiliate president shall be notified of the termination by the Bylaws chair.
   H. If the affiliate wishes to proceed with the revisions/amendments at this point, the process must be initiated again at the first step.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CA.007

SECTION: Chartered Affiliates

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

EFFECTIVE DATE: November 3, 2011

DATE REVIEWED: April 11, 2014

DATE REVISED: April 11, 2014

REFERENCES:

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

Policy Amplification:

~~1.~~ Affiliate bylaws will only be reviewed for compliance with AARC Bylaws. Errors in grammar, spelling or internal inconsistencies will be the responsibility of the Chartered Affiliate. The Bylaws Committee may make recommendations regarding grammar, spelling, or internal inconsistencies but will not delay the ~~approval process over such issues~~. recommendation to the Board of Directors.

a. All Affiliate Bylaws shall be submitted to the AARC Bylaws Committee every 5 years for review and approval. The AARC Bylaws Committee will request in writing that the Chartered Affiliate submit the affiliate bylaws so that they can be reviewed.
b. The Affiliates have six months to respond to the Bylaws Committee request for review.
c. If an Affiliate does not respond with submission of the bylaws, the Bylaws Committee will notify the Chartered Affiliate in writing that they are in conflict with the Chartered Affiliates Policy.
d. Failure to submit Bylaws or respond with a plan for submission within 45 days shall start the process in section 5 below.

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

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

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

5. The Bylaws Committee will recommend to the AARC Board of Directors that their Affiliate Charter be suspended until the Chartered Affiliate makes changes to their bylaws to bring them into compliance with AARC Bylaws.

    a. The charter affiliate shall lose their voting powers in the House of Delegates until the Bylaws are revised and accepted by the AARC Board of Directors.
    b. If after a period of one year the Affiliates Bylaws are still not in compliance, the AARC Board will take action by withholding Affiliate revenue sharing starting at one quarter of revenue sharing every six months.
    c. This would be a three year process whereby revenue would dwindle to zero after three years of non-compliance.
    d. The AARC Board of Directors would then revoke the charter of the affiliate.

DEFINITIONS:
ATTACHMENTS: AARC Bylaws

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 12, 2014- Grapevine, TX

Minutes

Attendance

George Gaebler, MSEd, RRT, FAARC, President
Frank Salvatore, MBA, RRT, FAARC, President-elect
Karen Stewart, MSc, RRT, FAARC, Past-President
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Brian Walsh, MBA, RRT-NPS, RPFT, FAARC, VP Internal Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, RRT, MHSCA, FAARC
Bill Lamb, BS, RRT, CPFT, FAARC
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS
Joe Sorbello, MEd, RRT
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC
Cynthia White, MSc, RRT-NPS, FAARC
Gary Wickman, BA, RRT, FAARC
Kim Wiles, BS, RRT, CPFT

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
John Steinmetz, MBA, RRT, Past Speaker

Excused

Lynda Goodfellow, EdD, RRT, FAARC
Peter Papadakos, MD, BOMA Chair
John Wilgis, MBA, RRT, HOD Speaker-elect
Kari Woodruff, BS, RRT-NPS, HOD Secretary

Guests

Deb Skees, MBA, RRT, CPFT, HOD Speaker
Keith Siegel, RRT, CPFT, HOD Treasurer

Staff

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

Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
President George Gaebler called the meeting of the AARC Board of Directors to order at 8:34am CDT, Saturday, April 12, 2014. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

Sherry Milligan gave a preview of the Virtual Museum and new AARC website.

SPECIAL COMMITTEE REPORTS

Membership Committee
Brian Walsh moved to accept Recommendation 14-1-24.1 "That the AARC Board of Directors approve our AARC Membership campaign incentive program."
Motion carried

Position Statement Committee
Colleen Schabacker moved to accept Recommendation 14-1-26.1 "Approve and publish the revised Position Statement 'Definition of Respiratory Care'."
Motion carried

Colleen Schabacker moved to accept Recommendation 14-1-26.2 "Approve and publish the revised Position Statement 'Health Promotion and Disease Prevention'."
Motion carried

Colleen Schabacker moved to accept Recommendation 14-1-26.3 "Approve and publish the revised Position Statement 'Tobacco and Health'."
Motion carried

Colleen Schabacker moved to accept Recommendation 14-1-26.4 "Approve and publish the revised Position Statement 'Pulmonary Rehabilitation'."

Natalie Napolitano moved to change wording to "encourage appropriate utilization of healthcare services".
Motion carried

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

Colleen Schabacker moved to include in NewsNow that the position statement was replaced with a CMS document http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
Motion carried

Colleen Schabacker moved to accept Recommendation 14-1-26.6 "Approve and publish the new Position Statement 'Electronic Cigarette'."

Dianne Lewis made a friendly amendment to review at December 2014 meeting.
Motion carried

(See Attachment "A" for all revised position statements.)

FM 14-1-22.7 Colleen Schabacker moved that newly adopted position statements and white paper be published in AARC Times. If major revisions are made to existing position statements and/or white papers, the Board should consider publishing these as well.

Brian Walsh moved to refer to Executive Office for implementation.
Motion carried

State Government Affairs Committee
Brian Walsh moved to accept Recommendation 14-1-22.1 "That the AARC Board of Directors approve the Michigan State Society for Respiratory Care's application for the $10,000 grant/loan."
Motion carried

George Gaebler moved to accept the Special Committee reports as presented.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

American Society for Testing and Materials (ASTM)
Colleen Schabacker moved to accept Recommendation 14-1-65.1 "That the Executive Director investigate the possibility of appointing a member of the Executive Office to attend and participate in the appropriate standards organizations to further the development and improvement in standards that impact the respiratory profession."

Colleen Schabacker moved to refer to Executive Office.
Motion carried

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

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

ROUNDTABLE REPORTS

International Medical Mission
Brian Walsh moved to accept Recommendation 14-1-44.1 "That the ICRC consider adding the IMMR Chairperson as a council member in order to support collaboration between both international groups."

President Gaebler ruled out of order, ICRC is a separate organization and we cannot appoint members to other organizations.

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

Karen Stewart moved to refer to Executive Office to consider.
Motion carried

Colleen Schabacker moved to accept Recommendation 14-1-44.3 "That the AARC allow the IMMR one page in the AARC International Congress Program to increase awareness of the IMMR and encourage involvement."

Karen Stewart moved to refer to Executive Office for consideration.
Motion carried

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

George Gaebler moved to refer to Executive Office to discuss options.
Motion carried

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

Gary Wickman moved to refer to Program Committee to consider.
Motion carried

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

Colleen Schabacker moved to refer to the Executive Office to communicate to Neurosrespiratory Roundtable.
Motion carried

George Gaebler moved to accept the Roundtable reports as presented.
Motion Carried

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 10:06am CDT Saturday, April 12, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 10:23pmCDT Saturday, April 12, 2014.

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on Leadership Institute
Brian Walsh moved to accept Recommendation 14-1-35.1 "That the AARC BOD terminate the Ad-Hoc Committee: AARC Leadership Institute."

Karen Stewart moved to refer to President to terminate.
Motion carried

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

Colleen Schabacker moved to refer to Executive Office to get cost estimate and report back by June 1, 2014 and then an e-vote can take place.
Motion carried

Brian Walsh moved to accept Recommendation 14-1-28.2 "That the Executive Office be charged with developing a plan to digitize past serial publications."

Accepted for information only – already being done.

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

NEW BUSINESS

$1,000,000 Research Fund

Shawna Strickland asked to confirm with the Board that the intent of the fund is still the same as listed at http://www.aarc.org/resources/grant_fund/.

Appointments

President Gaebler replaced Karen Stewart and Doug McIntyre with John Hiser and Mike Runge on the Elections Committee.
President Gaebler also informed the Board that Karla Smith will replace Russell Rozensky as Sleep Section Chair.

Karen Stewart moved to ratify the appointments.
Motion carried

RECESS

George Gaebler recessed the meeting of the AARC Board of Directors at 11:40am CDT Saturday, April 12, 2014.

RECONVENE

George Gaebler reconvened the meeting of the AARC Board of Directors at 1:37pm CDT Saturday, April 12, 2014.

Life Membership Nominee

Colleen Schabacker moved to nominate Debbie Fox – nominated by Karen Schell
Motion carried

Honorary Member Nominee

George Gaebler moved to nominate Edna Fiore – nominated by Doug McIntyre
Motion carried

ARCF AWARD NOMINEES

The Board brought forth the following nominees for the ARCF Awards in 2014:

Charles H. Hudson Award for Cardiopulmonary Public Health

Karen Schell moved to nominate Dave Burnett – nominated by Karen Schell
Motion carried

Forrest M Bird Lifetime Scientific Achievement Award

Linda Van Scoder moved to nominate Dick Sheldon – nominated by George Gaebler

Motion carried

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care
Bill Cohagen moved to nominate Angela King – nominated by Kim Wiles
Motion carried

Mike West, MBA, RRT Patient Education Award
Colleen Schabacker moved to nominate Sharon Williams – nominated by Karen Schell
Motion carried

All ballots were destroyed.

STRATEGIC PLANNING
President Gaebler divided the Board members into three Focus Groups. One group discussed research and the $1,000,000 research fund. The other two groups brainstormed on the following topics: RRT entry, CoARC/NBRC moratorium on new AS degree programs, move to BS degree, roundtables, readmission prevention, and other strategic issues.

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 3:15pm CDT Saturday, April 12, 2014.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors at 3:25pm CDT Saturday, April 12, 2014.

A representative from each Focus Group presented the ideas from their respective groups. The ideas will be put into a document and distributed to the Board of Directors.

Policy review was tabled until the Summer 2014 meeting.

Shawna Strickland updated the Board of Directors on the new Learning Management System (LMS) to help users take on-line educational courses, more user-friendly.

Bill Cohagen moved to ratify the capital purchase of LMS software program (PEACH) for educational programs in the amount of $25,700.
Motion carried

Treasurers Motion

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

MOTION TO ADJOURN
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 4:06pm CDT, Saturday, April 12, 2014.

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

_____ _____

Linda Van Scoder Date
AARC Secretary/Treasurer

Attachment “A”

Position Statements:
Definition of Respiratory Care
Health Promotion and Disease Prevention
Tobacco and Health
Pulmonary Rehabilitation
Inhaled Medication Administration Schedules
Electronic Cigarette

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

Position Statement

Definition of Respiratory Care

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

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

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

Effective 12/99
Revised 12/06
Revised 07/09
Revised 7/12
Revised 04/14

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

Position Statement

Health Promotion and Disease Prevention

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

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

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

The AARC recognizes the need to:

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

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

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

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

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

6. Monitor all such activities for appropriateness and effectiveness

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

Effective 1985
Revised 2000
Revised 2005
Revised 2011
Revised 04/2014

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

Position Statement

Tobacco and Health

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

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

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

Effective: 1991
Revised: 07/11
Revised 04/2014

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

Position Statement

Pulmonary Rehabilitation

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

Effective 1973
Revised 12/08
Reviewed 11/2011
Revised 04/2014

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

Position Statement

Inhaled Medication Administration Schedules

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

Effective 8/08
Revised 7/2011
Retired 04/2014

This position statement is being retired because the issue of administering drugs within 30 minutes before or after the scheduled time for administration has been resolved by CMS. CMS has revised its Hospital Interpretative Guidelines at Section 482.23(c), Preparation and Administration of Drugs, to conform to guidelines issued by the Institute for Safe Medication Practices. The revised CMS guidelines can be found on pages 203-212 of the PDF file at the link below:

http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

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

Position Statement

Electronic Cigarette

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

Effective 04/2014

E-Motions

(Since Last Board Meeting in April 2014)

E14-1-15.1 "That the AARC Board of Directors ratify the chair and members of the 2014 Sputum Bowl Committee as noted:

2014 Sputum Bowl Committee
Chair: Sherry Whiteman (MO)
Committee Members: Tom Lamphere (PA), Diane Oldfather (MO), David Panzlau (MI), Rick Zahodnic (MI) and Jim Ciolek (TX)."

Results – May 9, 2014
Yes – 15
No – 0
Abstain – 0
Did Not Vote – 3

General Reports

President Report

Submitted by George Gaebler – Summer 2014

Past President Report

Submitted by Karen Stewart – Summer 2014

Nothing to report.

Executive Office

Submitted by Tom Kallstrom – Summer 2014

We look forward to another productive board meeting in Marco Island. In preparation for the meeting, below are some of the highlights from the Executive Office since the spring meeting in Dallas in April.

Membership

As of the end of June, membership was 48,324 (June 2013 it was 50,310). While we always experience a dip in student members during the summer, we do see a 1,270 decrease in actual members compared to June 2013. The membership committee will report on their activities at the Board and House meetings. One thing that we have identified is that on the average 100-120 retirement age members are not renewing. This could be part of the reason we are seeing a drop in membership.

Co-Marketing Opportunities with our State Affiliates

To date there are 41state affiliates who have signed revenue sharing agreements and 41 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

Recruiting for the Profession

There were two major events for recruiting this year: HOSA, an annual event in which the AARC participates, and the USA Science & Engineering Festival. USA SEF was held in Washington, DC in April. Carolyn Williams, RRT, coordinated volunteers for that event. The sponsor recap report noted that more than 325,000 people attended over 4 days and many exhibitors estimated that 10,000 visitors stopped by their booths. Attendees represented all 50 states and 20 different countries and rated the event at 9.2/10. Demographics identified that the gender representation was 50/50. Ethnicity breakdown showed 32% of participants were Caucasian, 20% were African-American, 18% were Asian-American, 5% were Native American, 3% were Pacific Islander and 12% were "other." 20% of attendees were 10 years of age or younger; 25% were middle school or junior high age; 15% were high school age; and 40% were over the age of 18 years. The HOSA event was held in Orlando, Florida, in June. Jamy Chulak, RRT, coordinated volunteers for that event.

Association for the Advancement of Medical Instrumentation (AAMI):

The AARC participated in a coalition meeting hosted by AAMI in April of this year. The purpose of the meeting was to bring industry experts, manufacturers, engineers, hospitals/clinicians, medical associations and regulatory agencies together with the intent to identify safety issues surrounding medical alarms, gaps in understanding and opportunities for improvement. It is the goal of AAMI and of the coalition to develop a best practices white paper or compendium to provide clinicians with information and guidance on how to address the National Patient Safety Goal on Alarm Fatigue by The Joint Commission. It is also the hope that manufacturers will incorporate recommendations by the group in new products/technology. Future webcasts and live meetings have been scheduled to keep the coalition on point towards accomplishing these goals.

AAMI has invited AARC to participate in another summit put on by them and US Food and Drug Administration (FDA) on September 16-17, 2014. This will be the sixth technology-focused

summit that they convened together. The topic will be mechanical ventilation technology. Following the same format as other successful summits recently convened by AAMI and the FDA, this event will bring together leaders from the medical device industry and regulatory bodies, clinicians from healthcare institutions, researchers, and others to identify, discuss, and formulate strategic initiatives and priorities focused on ensuring the safety and effectiveness of critical care ventilators. We have asked Dario Rodriquez, RRT and Rich Branson, RRT to represent the AARC.

Drive4COPD

April:

In April the DRIVE4COPD participated in one event in Albuquerque, NM. The event was focused on Native Americans and was called the Gathering of Nations. Over 100,000 Native Americans from around the USA were in attendance and the DRIVE4COPD along with two local community colleges (Santa Fe Community College & Central New Mexico Community College) screened 298 attendees and 19.5% were high risk.

May:

In May, the DRIVE4COPD attended two events, both in Boston and one was geared towards providers and the other towards the public. The public show was the spring AARP Life@50+ event. In total we screened 649 people with 11% at high risk. Foot traffic was much lower than previous years, but the DRIVE4COPD is exploring the option to attend the fall show in San Diego, which is expected to have a higher turnout rate. The provider show was for physician assistants and no one was screened at this event. Information about the DRIVE4COPD was handed out to PA's, with additional time being spent with PA's with a specialty of pulmonary medicine.

Other efforts in this month were devoted to the 2014 DRIVE4COPD campaign for the members. This year's competition will be geared towards the RTs screening through the online website with their own custom URL link. This is scheduled to be kicked off at Summer Forum and will conclude at the end of November. The winner will be announced at the conference in December, possibly at the AARC booth.

June:

In June, the DRIVE4COPD is scheduled to attend one health fair. The health fair is the Boston Health and Fitness Expo (June 14-15).

CPG Development

The airway clearance CPG was published in RESPIRATORY CARE in December 2013. Work began on the follow-up of that guideline, Pharmacologic Interventions for Airway Clearance in Hospitalized Patients, in January 2014. Submission for publication of the second CPG is expected by December 2014. The group is exploring funding opportunities and areas of interest for future CPGs.

Leadership Institute

The Leadership Institute was launched in early 2014. Consisting of 3 tracks (management, research, and education), the Leadership Institute was designed to provide real-world education for respiratory therapists who wish to expand their breadth and depth of knowledge beyond the clinical realm. In February 2014, Dräger sponsored a scholarship competition to support the tuition for 9 RTs.

AARC University

In early 2014, the AARC signed with Peach New Media for the Freestone LMS product. This

platform will consolidate all educational items available from the AARC into one platform. It allows the consumer to search, purchase, watch, read, test, and earn credit in one location. The AARC University launched in May 2014 and early feedback is positive.

Clinical PEP: Practices of Effective Preceptors
The Clinical PEP: Practices of Effective Preceptors was released in August 2013. So, far the course has been well received. At this time, the AARC has sold 103 units (roughly 23% of accredited programs have purchased). The plan for 2014 is to update some of the videos so that the content remains dynamic and relevant to educators and preceptors.

Respiratory Care Education Annual (RCEA)
The 2014 RCEA review process is in the second stage. The review board has selected 8 papers for the 2014 fall edition. Currently in the process of edits and final reviews.

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

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

Educational Product Sales/Attendance Trends at a glance

	2014 through 5/27	2013 through 5/31	2012 through 5/31	Comments
Webcasts and JournalCasts	4185 +123% since 2013 +137% since 2012	3408	3061	JournalCasts now regular feature
Asthma Educator Prep Course	151 +168% since 2013 +140% since 2012	90	108	Offered bonus with EPA courses
COPD Educator Course	340 +131% since 2013 +167% since 2012	259	203	Positive trends
Ethics	555 -52% since 2013 -60% since 2012	1154	1365	Trending lower; slightly below budgeted volumes
RT as the VAP Expert	80 +186% since 2013 -62% since 2012	43	208	Offered “winter special” in Q1 2014
Alpha-1	93 +182% since 2013 -62% since 2012	51	248	Offered “winter special” in Q1 2014
Exam Prep	31 +194% since 2013	16		Launched in May 2013
Leadership Institute	56			Launched in January 2014

AARC Congress 2014

Logistical planning for AARC Congress 2014 is progressing as scheduled. Details of the meeting are as follows:

- As in 2013, AARC Congress 2014 will be hosted over 3 ½ days
- 8 hours of unopposed exhibit hall hours
- More than 140 presenters
    - 32 first time presenters
    - 6 of which were invited as a result of the AARC Speaker Academy hosted last year in Anaheim.
- ~ 240 unique presentations representing all specialty sections and roundtables.
- 16 Open Forums in 3 unique formats
    - **Traditional Format**: Poster discussion + 5-minute summary/Q&A from podium.
    - **Poster Discussion Only**: To be presented in designated space and at designated times in the exhibit hall. No summary, Q&A or podium presentation.
    - **Editor's Choice**: Best of the Best.
    - Best 6 submitted abstracts. Showcased as a stand-alone, high profile Open Forum presentation. Poster discussion + 10-minute slide presentation/summary + 10-minute Q&A.
- Plenary Session Schedule:
    - Keynote (Dec. 9): To Be Determined
    - Thomas L. Petty Memorial Lecture (Dec. 10): Management of the 2015 Asthmatic: Phenotyping and Managing Refractory Asthma (James Good MD)
    - Donald F. Egan Scientific Memorial Lecture Dec. 11): What Have We Learned about Noninvasive Ventilation in the Past 20 Years? (Laurent Brochard MD)
    - Phil Kittredge Memorial Lecture (Dec. 12): Positioning the Respiratory Therapist as a Disease Manager: Now is the Time (Thomas J Kallstrom MBA, RRT, FAARC)
    - Closing Ceremony (Dec. 12): To Be Determined
- 30-minute presentations + required 5-minute commitment for Q&A
- Each presentation will be designated by Content Category
- 5 pre-courses:
    - Preparing for a Pandemic: The Strategic National Stockpile – Mechanical Ventilation Workshop
    - Current Practice of Mechanical Ventilation: A Case-Based Audience Interactive Session
    - Pulmonary Function Testing
    - ECMO: A Comprehensive Approach for Pediatric and Adult Practitioners
    - Sleep & Wellness 2014

Project Updates

COPD Flip Chart:
The COPD Flip Chart is the premier component of the AARC COPD Tool Kit Project completed in 2013. Based on strong feedback and multiple inquiries to make the flip chart commercially available (Christ Hospital in Cincinnati has requested 200 copies), the AARC is working actively with the project sponsor (Boerhinger Ingelheim) to ensure commercial sale of the flip chart

maintains compliance with the project agreement originally signed with BI.

Target Decision Date: By Summer Board Meeting

ACCS Critical Care Course:
An ACCS critical care course will be held in Marco Island, FL, July 13-14, just prior to the AARC Summer Forum. At the time of this report, pre-registered attendance is 80 attendees. An update on final attendance and feedback regarding the course will be provided at the Board Meeting. Based on feedback, demand and funding, AARC may consider moving this course to an on-line, on-demand product.

Target Decision Date: By Winter Board Meeting

Stephen Jencks COPD Readmission Video:
Dr. Stephen Jencks, national readmission expert, healthcare safety consultant and keynote presenter at AARC Congress 2013, was the lead presenter on a COPD readmission video to educate respiratory therapists and department managers on step-by-step strategies to reduce unplanned COPD readmissions. The project was partially funded in part through unrestricted educational grants from Boerhinger Ingelheim, Sunovion Pharmaceuticals, and Monaghan Medical Corp. Funding also includes dedicated advertising with hospital administrator, CEO and President organizations (i.e. American Hospital Association, American College of Healthcare Executives).

Timeline: Completed. Video currently released to AARC membership. Advertising with AHA newsletter in progress.

Edison:
The AARC has partnered with an innovation company by the name of Edison. Edison is a gateway company that brings innovative ideas to market. AARC members will be encouraged to submit ideas through the Edison portal. In conjunction with the AARC and other industry experts, Edison will patent ideas they feel have potential to take to market. Once patents have been secured, Edison will attempt to find a manufacturer interested in producing the idea. The submitter of the idea will receive a 50% royalty on all sales. In addition, the AARC will also receive a small royalty of which all will be routed to the ARCF. The partnership with Edison is a member-only benefit.

Launch Date: September 2014

Target Date: Ongoing

Advertising and Marketing

Advertising
Advertising continues to decrease and miss budget targets with many changes in the industry and with our advertising base. At the time of this report, with almost 6 months of sales date, advertising is lagging behind target for both Resp Care Journal and *AARCTimes*. This comes despite efforts to create a flexible portfolio of opportunities. We are seeing a slight increase in Digital Advertisements on our e-newsletter products and our Recruitment Advertisements in 2014. We will look to shake things up in the second half of 2014 and as we begin work on our 2015 campaigns and budgets.

We continue to develop and grow our platforms in the digital advertising environments. We are developing new opportunities for advertisement banners and towers with them as they have done a nice job selling out our space on AARC.org. We will also, in the near future, begin selling advertising in a digital format on other platforms through Multiview.

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

Corporate Partners
We had a very successful meeting with the Corporate Partners on Monday evening and all day Tuesday at the conclusion of our BOD meetings in Dallas this spring. We have also had several face-to-face meetings with partner leadership in the spring with more scheduled in the fall.

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

There are 2-3 other companies looking to step up to the program in 2015 possibly.

Website Project
We have been working diligently with our website designer, AXZM, on modernizing and streamlining our web presence for AARC in the coming months. We have finalized branding concepts and are currently in the process of developing the layout of the site. An aggressive timeline has been established to develop and implement the new websites in 2014. The aarc.org website design is about 85% completed as we meet. We expect a soft launch in August / September.

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

We have seen growing interest in our Educational product lines due to the implementation of AARC U, creative pricing and marketing and bundling of some other product lines.

Products
Benchmarking has seen a moderate decline in membership in 2014 as the economic reigns are tightening for hospitals with approximately 82 hospitals (-8%) around the US and in Middle East (3). The Benchmark Committee is currently conducting an assessment of the program, possible upgrades and a potential new product line to insure it is a current and valued tool to its participants. We are also considering a 2nd revision in the pricing structure for 2015 to insure that has a good ROI for both the AARC and its participants that has led to an uptick in renewals and a few new clients.

As you are aware, in 2012 we outsourced our Respiratory Care Week products to a third-party supplier, Jim Coleman Ltd that handles all products and the necessary shipping. 2013 was our second year outsourcing RC Week products to Coleman. We came in right about our budget target

in 2013 and realized a higher royalty than in year one. We have already begun work on the 2014 campaign and expect it to launch shortly after Summer Forum giving us our earliest start in a few years.

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

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 is an example and other products will include a line of products that are published in an ePub format for digital readers.

IT Update

Email upgrade

All accounts were moved to the Exchange 2010 server. We will complete the upgrade to Exchange 2013 in the next month. There will be no user impact, it will just allow better integration with Mac and PC platforms.

PCI

We have completed installation of the wifi system. This will allow us to shortly isolate all wifi traffic off the internal network. Version 3 of the PCI specification is out. We need to recertify our PCI compliance prior to it taking effect this fall, but we will start reviewing the changes so that we are ready.

VPN

This is part of the PCI compliance. We have tested a method for accessing servers from outside for designated staff. It is awaiting approval for purchase. The funds were approved in the PCI capital budget by the board.

Phone upgrade

The new phone system was installed with nothing more than a couple minor issues. The new system provides much more information about people's status and integrates with the calendar system in Exchange.

IMIS upgrade

We are on schedule to move to the new version of IMIS late July/early Aug. It will allow us to gradually migrate away from several third party apps as the integrated pieces are implemented. As an example, the current store will be changed to use the new built-in store. This will positively impact the bottom line.

Mobile App

The mobile app for Summer Forum and Congress is up and running. This app provides direct integration with IMIS, reducing some duplicate work that was required with previous apps.

RESPIRATORY CARE Journal

At the beginning of 2014 we closed the Seattle office and assigned some of the work previously performed there by 2 employees (manuscripts management and copy editing) to a long-time editorial assistant promoted to the position of assistant editor. The bulk of the work was then outsourced to Cenveo, the long-time printer of the Journal. It has been six months now and we are happy to report that all changes have been implemented without any problems and everything is functioning as anticipated. Most important, we are certain that by the end of 2014 we will experience considerable financial savings, strengthen our small staff operation, assure continuity when employees leave, and improve the overall quality of our offerings.

Effective June 1 open access to the online Journal ended and we now require everyone wishing to read it must either be an AARC member or subscriber with an active online subscription. As of the writing of this report more than 7,800 members and about 200 subscribers have activated their online subscriptions. We would like to thank the AARC Member Service department for their intense work in getting everyone to activate their online subscription and for assisting those with problems.

We continue to receive record numbers of manuscript submissions, proving that our Journal is indeed recognized as a significant player among pulmonary publications. Every submission is thoroughly analyzed and if accepted, goes through an intense review process and copy editing before publication. The final result is an article without errors and helpful to the reader. We are particularly proud of the June 2014 issue with the proceedings from the 52nd Journal Conference on Artificial Airways and Airway Adjuncts. Articles in this issue present the most updated information available in this important task performed by respiratory therapists, and enhanced by figures, tables, and charts never published before. Special thanks to the ARCF for their support enabling the presentation and publication of the Journal Conferences. In June of this year the Journal and the ARCF held the latest Journal Conference on Aerosol Delivery in Respiratory Care; publication of the proceedings will occur in 2015.

We are now heavily involved with the review and selection process of abstracts to be presented at the Open Forum during the AARC Congress in Las Vegas. In 2014 accepted abstracts may be presented in the traditional format of poster discussions, or as a poster display only, or as an editors' choice presentation. We are excited about these additions and we hope they will result in more future submissions and more publications by respiratory therapists.

Executive Office Referrals

(from April 2014 BOD meeting)

- ***Recommendation 14-1-54.1 (from Homecare Section)*** *"That the AARC Board of Directors investigate the feasibility of a post-acute care certification program for RTs."*

Referred to Executive Office to explore and report back at July 2014 meeting.

Result: Shawna Strickland has been in communication with Home Care Section Chair Kim Wiles to address these needs. During a conference call with Tom Kallstrom and Drs. Christopher and Carlin, Kim and Shawna have developed short-term and long-term educational plans. Short term plans include scheduling an annual webcast to address an urgent post-acute care topic and updating the 2009 Hospital to Home survey. Long-term plans include performing a needs assessment to develop competencies as well as for educational activities addressing preparing the RT to work in the home and preparing the acute care RT to transition the patient for home.

- ***Recommendation 14-1-65.3 (from ASTM)*** *"That the Executive Director investigate the possibility of appointing a member of the Executive Office to attend and participate in the appropriate standards organizations to further the development and improvement in standards that impact the respiratory profession."*

Referred to Executive Office.

Result: Tom Kallstrom and Shawna Strickland have spoken with Bob McCoy, who is resigning, and the Executive Office will accept the responsibility of interacting with ASTM with regards to furthering the development and improvement in standards that impact the respiratory care profession.

- ***Recommendation 14-1-44.2 (International Medical Mission Roudtable)*** *"That the AARC provide a table for the IMMR in the vendor area or outside the main hall at the AARC International Congress for the purpose of sharing mission opportunities and to increase IMMR membership and awareness."*

Referred to Executive Office to consider.

Result: A small area, similar to the PAC booth, will be available for all Roundtables who reserve in advance and commit to scheduled times.

- ***Recommendation 14-1.44.3(International Medical Mission Roundtable)*** *"That the AARC allow the IMMR one page in the AARC International Congress Program to increase awareness of the IMMR and encourage involvement."*

Referred to Executive Office.

Result: A ¼ page house ad for all Roundtables will be included in the Congress Program.

- ***Recommendation 14-1-44.4 (International Medical Mission Roundtable)*** *"That the AARC add an open forum section to the AARC International Congress that focuses on international mission work, volunteerism and global research."*

Referred to Executive Office.

Result: A poster will be allowed at the International Reception.

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

Referred to Executive Office to get cost estimate.

Result: $10,000 plus cost of travel

State Government Affairs
Activity Report
BOD/HOD July 2014

Cheryl A. West, MHA
Director Government Affairs

Introduction

This year is an election year, where most if not all state legislators' seats will be up for election or reelection. The rule of thumb will be for most legislatures to recess earlier in the fall than in non-election years in order for candidates to campaign full time.

Respiratory Therapy Licensure

Michigan RT License Repeal Efforts

The Michigan Society has for the past two plus years been able to prevent any further effort by the MI state legislature to de-license MI RTs. This has taken time, effort and financial resources on the part of the MSRC leadership and many MI RTs in order to hold the line against proactive efforts to legislate the rescinding of RT licensure.

Interestingly, one of the most vocal proponents of de-licensing the RTs (and the 17 other professions on the Governor's "Rescind List"), comes from the state government agency that actually licenses the professions i.e. the MI Department of Licensing and Regulatory Affairs known as LARA. Normally employees of state agencies must remain neutral or mute on any legislative issue that affects their agency, especially if the proposed actions are perceived as making a structural change to the agency itself. Evidently LARA staff does not adhere to this standard practice as the key staffs of LARA are quite vocal in supporting de-licensing of the noted 18 professions. This adds to the advocacy burden of the MSRC as the Society must counter the de-licensing arguments LARA makes to the legislators.

At this time the de-licensing effort is on hold. With elections coming in November one can presume/hope that the legislators do not want to take on such a controversial issue. De-licensing up to 18 professions who do not wish to be de-licensed represents thousands of individuals who also happen to be MI voters. However while confidence is high that the moving de-licensing forward can be prevented at least for this year, until the effort is totally and completely "dead" the MSRC remains hyper vigilant.

Texas RT License Repeal

Texas Government operates under a fairly strict Sunset Review Process where programs and laws and in this case agencies are scrutinized and critiqued to determine if the programs and agencies should be restructured. The TX State Sunset Advisory Commission made up of state House and Senate Legislators received a Sunset Commission Staff Report that made extensive recommendations on a variety of programs under the TX Department of State Health Services (DSHS). Key among the numerous recommendations in the Sunset Staff Report was one that would "discontinue" licensure for 19 professions and disciplines, including respiratory care practitioners (RCPs). The AARC has worked closely with the Texas Society for Respiratory Care

(TSRC) to refute the contention that RCP licensure is no longer justified in the state. The TSRC has provided numerous pathways for RTs, supportive physicians and pulmonary patients to let both the Sunset Commissioners and state legislators know that de-licensing RTs is unacceptable. After submitting extensive written comments stating that RCP licensure must continue and that state licensure of RTs be "relocated" to another state agency- the Department of Licensing and Regulation, both the TSRC and AARC representatives attended a late June public hearing in Austin, TX. A final vote on the recommendations of the Commission will take place in August.

If the vote of the Sunset Commission were to still recommend the de-licensing of RTs, the next step in the process would require the Texas state legislature to actually pass a bill (pre-filed in November, session to begin in January 2015) to de-license RTs. The legislature created RT licensure and the legislature will have to pass a law to de-license RTs.

However, it is the TSRC's and AARC's goal not to have to get to the legislative stage. The strategy is to provide enough documentation and community support that when the August vote takes place the Commissioners will remove RT from the list of recommended de-licensing professions and transfer RT licensure to the TX State Licensing and Regulation Agency. If this does not happen we will move the focus of our efforts to the state legislature.

We also extend our thanks to the NBRC, the Alpha One Foundation and the COPD Foundation who at our request immediately wrote and submitted letters in support of the continuation of Texas RCP Licensure.

I will provide a verbal update at the July meeting.

Iowa a polysomnography licensure bill was introduced in early spring. The original legislation did include a RT exemption which would have protected the licensed IA RT from potentially having to obtain an additional polysom license. A subsequent version of the bill, advanced by the sleep interests, deleted this RT exemption. The Iowa Society vigorously objected to this revision and engaged in intense lobbying efforts. As part of their lobbying effort, the Society reached out the Iowa Hospital Association and after educating the IHA and the IHA lobbyists on the negative impact this legislation would have on hospital staffing, the IHA weighed in with its' opposition. The combined efforts of the IHA position and the all-out effort undertaken by the ISRC and the IA RTs, the bill was not advanced in the legislature.

California Bill Requiring the RRT Credential for a RT License

While reported to the AARC Board of Directors at the April meeting, it bears repeating in this report. Legislation was introduced earlier this year that beginning January 1, 2015 "new" RTs applying for a CA respiratory care license will have to hold the RRT credential in order to qualify for a CA RCP license. Those holding only the CRT credential prior to that date would be grandfathered in and not be affected by this change. This legislation mirrors the revisions made in Ohio regarding new license credential requirements, also due to be implemented January 1, 2015. While indeed the Ohio change is poised to be implemented, thus far the CA bill has not moved forward in the CA legislature.

Legislation

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

Legislation that Includes RTs

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

Louisiana (enacted) creates the Louisiana State Health Care Profession Institute. The membership of this Institute would be made up of representatives from various licensure Boards, including RT.

Oregon (enacted) a new law to allow returning military personnel to substitute their comparable education gained through the military for certain licensure requirements of certain professions, RTs are among the listed professions. **Oklahoma and Ohio** have enacted similar bills addressing military training and state licensing. **Vermont** has enacted the same type of law and specifically includes the RT profession.

It should be noted that over the past several years' states have continued to pass laws for many licensed professions (not all the same professions) that will recognize military training, education or acquired skills as comparable to a particular professions licensure requirements In addition there are some new laws that expedite the licensing applications of spouses of military personnel.

Other Legislation of Interest

There is an uptick in legislation that promotes the coverage of telehealth services. **Louisiana** enacted a bill that expands state coverage of telehealth services. The bill lists those professions that will be able to provide telehealth covered services, with RTs specifically listed. **NY** has a telehealth bill specifically mentioning the monitoring of continuous oxygen and ventilators. **MS** has enacted a more general bill for remote patient monitoring services aka telemedicine. **VT** passed legislation that would increase Medicaid coverage of telehealth services for qualifying patients including who have COPD, asthma and pneumonia. **CT** has a bill that provides telehealth coverage for Medicaid patients with chronic diseases

Colorado has enacted a bill that would require Durable Medical Equipment suppliers to be licensed in the state.

State Resolutions COPD/Asthma/Others

The usual number of state Resolutions (a "sense" of the legislature, but not an actual change in the law) have been introduced and/or passed that recognize in various fashion the importance/ health threat of studying/preventing COPD: **IN** (adopted) **IA** (adopted), **KS** (adopted), **SD** (adopted).

NJ has a bill that would establish a Task Force on Chronic Obstructive Pulmonary Disease in the Department of Health. Task force members would include "one member who is a respiratory therapist with experience in treating persons with chronic obstructive pulmonary disease".

KS early this spring introduced a House Resolution that would create a Kansas plan for comprehensive treatment of COPD. Karen Schell from the KSRC leadership testified before the legislature, and the Resolution was passed out of committee, albeit without funding but clearly a step in the right direction.

A number of states have introduced or passed Resolutions that "recognize" COPD either through Day or Month proclamations:
AR (adopted) **CA, IL,** (adopted), **SD** (adopted)**, TN** (adopted), and **WI** (adopted).

DE (adopted), **RI** (adopted) and **PA** (adopted) have Resolutions that call for a week in May to be Women's Lung Health Week. **PA** has also adopted a Resolution that designated a week in March as Pulmonary Rehabilitation Week and another for The Great American Smokeout Day. **MI** adopted an Alpha-1 Awareness Month**. OH** has both an Asthma Awareness Day, and a separate Day recognizing Childhood Asthma Awareness Day. **IL** has enacted a Resolution that recognizes World Pulmonary Hypertension Day. **MO** has introduced a Missouri No Smoking/Tobacco Day Resolution. **DE** has proclaimed May as Cystic Fibrosis Month.

Tobacco Legislation

Many states introduce legislation to raise taxes on tobacco products or to prohibit smoking in a variety of places. These bills are too numerous to mention.

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

Expansion of Scope of Practice Other Professions

As noted in previous Reports over the last 2 years there has been a noticeable increase in legislation that expand the scope of practice for a variety of licensed or regulated professions or disciplines. Also noted, this increase may be due in part in anticipation of the increased demand (most likely triggered by the ACA and/or Medicaid expansion) for the clinical services of health care professionals that states or insurance providers may not be able to meet. Permitting less costly personnel to provide clinical services previously only provided by more 'expensive' clinicians may meet the increased demand at a lower cost to the state. This "expansion" trend is particularly noticeable for nurse practitioners (NPs) and physician assistants (PAs) and to some extent pharmacists. For the PAs and especially NPs the focus is to increase the autonomy from physician oversight.

The following states have NP/PA legislation

CT, KS (enacted) **& OH,** have bills that would provide more autonomy for PAs. Bills in **KS, FL** & **ID** (enacted) expand the authority of NPs. And **OR** (enacted)**,** & **WV** have legislation that addresses expansion for both PAs and NPs. **WV** has a slightly different expansion bill that expands the prescriptive authority of NPs and eliminates their formal "collaborative" agreement with physicians. **CO** has passed a Resolution (not a bill which would change the actual law) that requests the federal government to permit NPs, PAs, nurse mid-wives to make and change home health care plans. **FL** passed a bill that allows the physician to supervise a greater number of PAs then currently permitted.

RI has a bill that would permit CRNAs to order medications to be administered by other health care professionals. **VT** has a more specific RT related bill that among other areas of expansion would permit CRNAs to supervise RTs (VT already allows NPS to supervise RTs).

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

There are a number of bills that expand the scope of practice for pharmacists. **GA & OH** (has

passed the House) would permit pharmacists to administer immunizations. **MN** has a bill that would permit dentists to administer flu vaccinations.

GA has introduced a bill that is very similar to one from 2013 that would establish a pilot project to assess the need for and effectiveness of using protocol technicians in areas of GA which do not have access to a hospital …the scope of these protocol technicians would include doing undefined "respiratory rates".

UT has legislation that creates a dispensing medical practitioner license and a license classification for a dispensing medical practitioner

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

Respiratory Related Rules/Regulations

A change in the rules and regulations for respiratory therapy may have just as much impact on how respiratory therapists are permitted to practice as does amending the licensure laws for RT. For the most part in this first half of 2014 there have been limited number of administrative changes in RT related rules and regs.

Specific RT related Rule/Reg Changes

OH has issued a number of changes including rules for continuing ed requirements (including for those in the military) and ethical and professional conduct revisions and personal information. **TN** has also made a number of changes to the RT licensure requirements and procedures.

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

AR and **WY** revise various RT licensure fees.

FL has deleted the previously required two hour continuing education course for emergency preparedness.

NH has clarified its rules to describe the assembly, delivery, maintenance, repair, and testing of respiratory care equipment and supplies. **NH** also adopted rules to clarify the approved duties of polysomnographic personnel.

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

I will provide a verbal update at the July BOD/HOD Meeting.

Federal Government Affairs
Activity Report – July 2014

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

The Congress

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

Legislation

HR 2619 - The Medicare Respiratory Therapist Access Act

As you know, our legislation is designed to provide coverage of pulmonary self-management education and training services when furnished in a physician practice by qualified respiratory therapists to Medicare beneficiaries who have been diagnosed with specific chronic lung diseases. As of mid-June we had 30 co-sponsors for our bill. The efforts of our PACT representatives and the meetings we held in April have yielded new House co-sponsors to the bill and educated Senators of the importance of physician office- based pulmonary self-management as provided by qualified RTs.

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

Of further note, Tom Kallstrom and Sam Giordano have engaged in a series of teleconferences with Congressional staff to promote the bill. Tom attended the AANMA legislative day and asked Miriam to follow-up with all of the co-sponsors of the resolution designating May as National Asthma and Allergy Awareness Month. Sam Giordano attended the annual face-to-face meeting of the US COPD Coalition and promoted our patient partnership and legislative agenda. Finally, the COPD Foundation and Alpha-1 Foundation had a joint lobby day where the focus was access to care and HR 2619 was included as a discussion item.

We continue to use AARC PAC funds to influence the process and have attended fundraisers for Congressman Pitts, Lewis and Senators Udall and Wyden. Because these funds are limited AARC

is very selective about their use generally choosing to attend fundraisers that are small and with key members.

AARC Capitol Hill Lobby Day

The AARC held its 16th annual Capitol Hill Lobby Day (April 1) in Washington, D.C. 132 respiratory therapists from 43 states and DC attended. These dedicated RTs scheduled nearly 350 firm Congressional appointments, the greatest number of meetings to date. It should be noted that every year it becomes harder to set these meetings due to the need to meet on one specific day as well as the competition for meeting time from other organizations and special interests. We continue to be very proud and thankful that so many RTs with support from their state societies continue to be dedicated to advancing the respiratory therapy legislative agenda.

As a further note to the Hill Lobby Day, over 25 RT students from regional RT education programs came to the pre-Hill Day briefing and went on Hill visits. We also extended an invitation to other DC-based pulmonary patient advocacy associations and representatives from the Asthma and Allergy Network Mothers of Asthmatics (AANMA), the Pulmonary Hypertension Association, and the COPD Foundation participated in our meetings. We were very fortunate to have several pulmonary patients who attended and went to Hill meetings to attest to the importance to their own health of having access to the expertise of respiratory therapists.

Finally, this year we received a small grant from Glaxo Smith Kline (GSK) to help underwrite the expenses of the meeting. We are most grateful for GSK's support.

Virtual Lobby Week

As you know, Virtual Lobby Week is a critical part of our run-up to Hill Lobby Day and is designed to send as many e-mails as possible to the Hill to support our PACT representatives' efforts and to generate traction for HR 2619l. This year we had over 22,000 emails from supporters prior to our April 1 Hill Lobby Day!

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

An alternative to the current competitive bidding program is still active in this session of Congress. You will recall that this legislation sets up an auction style program that is designed to be more transparent and offer bids in smaller areas. As of June 2014, it had 178 sponsors. AARC supports the legislation as noted previously.

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

These companion bills led by Senator Wyden [D-OR] and introduced in mid-January 2014 represent a bi-partisan approach to improving care coordination. The legislation would establish Better Care Programs (BCPs) along the lines of Accountable Care Organizations (ACOs); however, unlike ACOs, the BCPs would focus specifically on targeting chronically ill beneficiaries, allowing physician groups to be more involved in the care assessment and treatment of those with multiple chronic conditions.

The programs are supposed to fill the gap in areas where there are no ACOs and improve access in rural areas. While there is no specific mandate as to the conditions to be covered, Senator Wyden's website provides data on heart disease, diabetes and COPD.

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

The Sustainable Growth Rate (SGR) formula determines the annual payment update to physicians based on Medicare fee schedule amounts. Legislation to reduce these payments was enacted many years ago but has never been implemented and continues to be postponed. Without taking action, the rates were expected to drop by about 24 percent in April 2014. Prior to the deadline, Congressional lawmakers came to bi-partisan agreement to permanently fix the SGR based on new payment systems over the next several years but in the end could not agree on how to pay for the bill estimated to cost $138 billion over the period 2014-2024.

This inaction left us in what is now the usual and customary practice of passing short term "patches" which are less expensive. The last expiration and extension left members of Congress with three choices: agree in a bi-partisan fashion on how to pay for a permanent fix; put a temporary fix on the legislation that would expire after the recess but before the election cycle forcing hard decisions or the easy way out; a temporary fix that expires during the "lame-duck" session. Congress took the easy way out and passed an extension that will need repair during the lame duck.

HR 4673 – Bundling and Coordinating Post-Acute Care Act of 2014

This bill was introduced by Rep. David McKinley [R-WV] on behalf of himself and Rep. Tom Price [R-GA] on May 24, 2014. The bill would establish a new post-acute care bundled payment system for services otherwise paid for by both Medicare Parts A and B, beginning in 2016. The bundled payment would cover post-acute services (e.g., extended care services, home health, inpatient rehab, DME, drugs, and SNFs] within 90 days of hospital discharge. Physician services, outpatient hospital services, hospice, ambulance services, and PT, OT and speech therapy services are excluded from bundling. RTs would not be impacted directly by this rule since it does not change any of the services they currently provide; it only impacts how payment is made. However, it could offer new opportunities for RTs as care coordination takes center stage towards providing better care at lower costs and Medicare moves away from a fee-for-service program.

Regulations and Other Issues of Interest

Updates to the Hospital Inpatient Prospective Payment System for Fiscal Year 2015

CMS has issued proposed updates to the hospital inpatient PPS regulations for FY 2015 that include increasing the percent reductions for hospital value-based purchasing and hospital readmissions in accordance with the Affordable Care Act requirements.
In previous regulations CMS finalized the addition of COPD to the Hospital Readmissions Reduction Program effective October 1, 2014 (FY 2015). The latest proposed rule would make changes to the calculation of the aggregate payments for excess readmissions to include COPD and refine the planned readmissions algorithm for all covered conditions based on the number of discharges between 2009 and 2012. The current readmission rate for COPD is 21.1%.

There are no planned additions to the readmission program for FY 2016; however, in FY 2017 CMS is proposing to add as a condition patients readmitted following Coronary Artery Bypass Graft (CABG) surgery

FDA Proposes to Regulate E-Cigarettes and Other Tobacco Products

On April 24, 2014, AARC participated in a conference call in which FDA announced its proposal to "deem" all categories of products that meet the statutory definition of "tobacco product" to be subject to FDA's regulatory authority under the Family Smoking Prevention and Tobacco Control

Act. This action has been long-awaited among tobacco advocacy groups and other public health organizations.

The "deeming" authority proposes to add e-cigarettes, pipes, cigars, nicotine gels, dissolvable products and waterpipe smoking (also known as hookah, shisha and narghile) to the list of products subject to FDA's regulatory authority. Currently FDA regulates cigarettes, cigarette tobacco, roll-your-own tobacco, and smokeless tobacco. Accessories and other items that are not used to consume a deemed tobacco product would not be subject to the proposed rule. Of particular concern are flavored products that entice youth to use the products and marketing of such products.

FDA will allow a 75-day comment period and is seeking specific input on several proposed options as well as comments on the overall proposal. As part of the Tobacco Partners Coalition, AARC participated in a June 3 conference call to discuss the bill's summary and outline for proposed comments. AARC plans to submit separate comments in addition to signing-on to a joint letter from the Coalition members.

CMS Proposes to Require Prior Authorization of Certain DME Items

On May 28, 2014, CMS announced plans to establish a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supply items that are frequently subject to unnecessary utilization, including items subject to improper payments based on lack of documentation, insufficient documentation, inadequate evidence of medical necessity and incorrect coding as determined by the Comprehensive Error Rate Testing (CERT) program. Respiratory equipment is often subject to frequent claims denials based on pre-payment review as part of the CERT audits.

CMS has proposed a Master List of items that may be subject to prior authorization. Respiratory items include CPAP devices (E0601) and Bi-level RADs (E0470). The public will be notified prior to implementation on any items CMS determines appropriate for prior authorization with a 60-day period to comment. Prior authorization does not create additional documentation requirements or delay medical service. It requires the same information that is currently necessary to support Medicare payment, but earlier in the process.

HHS Reports Improvement in Reductions in Hospital-Acquired Conditions and Readmissions

On May 7, 2014, HHS announced great strides in reducing hospital-acquired conditions and hospital readmissions due to its nationwide efforts to keep patients from being harmed in hospitals and heal without complications under the umbrella of its Partnerships for Patients initiative. This initiative began in April 2011 and includes leaders representing hospitals, employers, health care plans, physicians, other health care professionals, patient advocates and others. AARC was among the organizations to join the initiative.

The Partnership for Patients identified ten core patient safety areas of focus that include nine hospital-acquired conditions. Ventilator-acquired pneumonia is on the list. Based on 2010 baseline data through the 4th quarter of 2013, there has been a 53.2% reduction in reported VAP. According to the data, Medicare fee-for-service all-cause hospital readmissions show an 8 percent

reduction during that timeframe.

Update on Chronic Care Management Services

In the last Board report, we mentioned new care coordination services aimed at physician practices that would allow them to treat patients with multiple chronic conditions (MCC) who meet certain criteria and bill separately for non-face-to-face services outside of the routine evaluation and management codes. In the final rule, CMS changed the billing requirements of one claim that included at least 1 hour of service within a 90-day period to one claim within a 30-day period with a minimum of at least 20 minutes of service.
With the ability of clinical staff employed by the physician to provide a number of the services, it opens to door to new opportunities for RTs in the physician practice setting.

We expect to see proposed rules in the 2015 update to the physician fee schedule that would establish certain standards physician practices would be required to follow in order to bill for the CCM services. This is necessary because not all physicians have the capability to furnish fully the required scope of services within their current infrastructure.

Clarification of National Correct Coding Initiative Edits on Inhalation Treatments

In our last report, we discussed coding edits that were causing concerns as to whether inhalation treatments subsequent to the initial patient encounter could be reported. The codes only impact hospital services covered under Part B. To get further clarification, we went directly to the Medicare contractor responsible for the NCCI edits (e.g., the Medical Director and Coding Specialist at Correct Coding Solutions, LLC). They in turn discussed our comments with CMS which makes all decisions about the NCCI contents.

On May 13, 2014, the contractor clarified that when inhalation therapy involves multiple nebulizer administrations at a single patient encounter, CPT Code 94640 is only reported once; however, if there are multiple separate patient encounters for inhalation therapy on the same date of service, the additional encounters for inhalation therapy may be reported with modifier 76. A patient encounter is a direct personal contact between a patient and a physician, or other person who is authorized by State law to order or furnish hospital services for the diagnosis or treatment of the patient. An article outlining the clarification was also posted on the AARC website and various AARC list serves.

Medicare Dashboard on Chronic Conditions and Utilization/Spending

On June 2, 2014, CMS updated its Multiple Chronic Conditions (MCCs) dashboard to include State and County data. It tracks 17 conditions; COPD and asthma are among them. Data can be derived by gender, age group, and Medicare enrollment. The Data Trends section also tracks the percentage of hospital readmissions and the number of ED visits per 1,000 based on the number of multiple chronic conditions.

The national prevalence of COPD among Medicare beneficiaries is 11.28%; for asthma it is 4.86%. As you know, patients diagnosed with COPD and asthma generally present with other co-morbidities. Sample charts below compare COPD and asthma by individual states versus the national average with respect to the prevalence of MCCs.

COPD Co-Morbidity

Gender: All, Age Group: All, Enrollment: All

Grid

State	Only Condition	1-2 Other Conditions	3-4 Other Conditions	5+ Other Conditions
National	2.94%	17.04%	28.19%	51.84%
California	2.82%	16.88%	27.28%	53.01%
Florida	1.86%	13.14%	26.48%	58.52%
Massachusetts	2.75%	18.11%	28.47%	50.67%
Texas	2.50%	14.23%	25.77%	57.50%

Asthma Co-Morbidity

Gender: All, Age Group: All, Enrollment: All

Grid

State	Only Condition	1-2 Other Conditions	3-4 Other Conditions	5+ Other Conditions
National	3.91%	20.54%	28.74%	46.82%
Indiana	3.84%	19.95%	28.14%	48.08%
New Jersey	3.44%	17.36%	27.93%	51.26%
North Carolina	3.91%	21.52%	30.61%	43.96%
Rhode Island	4.70%	25.32%	31.57%	38.40%

The dashboard also allows access to per capita Medicare spending at the state and county level, but it is only available by number of conditions. It cannot be broken out by COPD and asthma. The data also show ED visitis per 1,000 beneficiaries and the 30-day readmission rate.

4 to 5 Chronic Condition(s)				
State	Prevalence	Per Capita Medicare Spending	ED Visits per 1,000 Beneficiaries	30 Day Readmission Rate
National	**21.06%**	**$11,069**	**794**	**12.63%**
Alabama	22.53%	$11,317	819	12.27%
Alaska	14.30%	$11,020	1,028	13.26%
Arizona	19.49%	$11,675	764	12.13%
Arkansas	20.28%	$11,485	862	13.11%
California	19.92%	$10,814	718	13.09%
Colorado	16.00%	$12,922	954	12.18%
Connecticut	22.01%	$10,817	854	13.54%
Delaware	24.29%	$9,524	624	10.82%
District of Columbia	20.25%	$12,398	1,198	16.39%

County data can also be broken down by the counties with the highest and lowest prevalence of COPD and asthma among Medicare beneficiaries in the state. See the tables below for those with the highest prevalence.

Counties With the Highest Prevalence for Asthma

County	State	Prevalence
Buffalo	South Dakota	23.19%
Jim Wells	Texas	9.58%
Brooks	Texas	9.50%
Hardin	Illinois	9.45%
Mifflin	Pennsylvania	9.37%
Duval	Texas	9.27%
Rutherford	North Carolina	9.07%
Greenup	Kentucky	8.95%
Bronx	New York	8.93%
Harmon	Oklahoma	8.91%

Counties With the Highest Prevalence for COPD

County	State	Prevalence
Pemiscot	Missouri	31.44%
Scott	Tennessee	28.43%
Johnson	Kentucky	27.64%
Fentress	Tennessee	27.60%
Knott	Kentucky	26.49%
Buffalo	South Dakota	26.09%
Breathitt	Kentucky	26.02%
Harlan	Kentucky	25.60%
Wolfe	Kentucky	25.37%
Leslie	Kentucky	25.20%

CMS also provided new Medicare utilization and payment data. It lists individual hospitals within a state and reports total discharges, average covered charges, average total payments, and average Medicare payments by DRG. The DRGs include COPD, simple pneumonia, respiratory infections and inflammation, bronchitis and asthma, and respiratory system diagnoses with ventitlaor support 96+ hours and less than 96 hours.

Links to the main pages for these data statistics are listed below. There are numerous way to break out the data.

Chronic Conditions: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html

Medicare Utilization Data: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html

Conclusion

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

HOD Report

Submitted by Deb Skees – Summer 2014

Recommendations

None

Report

- Facilitated HOD Officer conference calls on 4/24/14 and 6/26/14.
- Participated in 3P/HOD conference call on 6/20/14.
- Appointed a special committee to assist with HOD interest in AARC Bylaw changes.
- HOD Meeting efficiency: With the assistance of the HOD Parliamentarian have identified several opportunities to update processes to be more consistent with current revision of Robert''s Rules of Order. Changes communicated to Delegates. Delegate education updated.
- Developed meeting agenda in conjunction with the HOD Officers for Summer HOD meeting in Marco Island.
- Developed action plan to address referral recommendation from BOD: Recommendation 13-3-45.1 "That the AARC BOD encourage the AARC state delegates and officials of other state level respiratory care societies to follow the lead from the Texas Society of Respiratory Care (TSRC) and offer similar memberships and registrations to conferences, convention and other meetings at a reduced rate or complimentary to members of the armed forces. "Brian Walsh moved to amend the motion to read "That the AARC BOD encourage the AARC state affiliates to offer reduce rate or complimentary registrations to conferences for active members of the armed forces." Karen Stewart moved to refer to speaker-elect of House of Delegates.

  Delegates from TX to present at summer HOD in Marco Island

- The HOD Connections on Professional Volunteerism will be collaborating with the International Mission Roundtable to spotlight their work at the summer HOD meeting.
- A brief memorial presentation will be conducted at the Summer HOD meeting to honor Jerry Bridgers, past Delegate from Mississippi. In honor of his numerous contributions to the HOD and the AARC, the HOD will hold a moment of silence and collect donations to purchase bricks in the AARC Virtual Museum as a memorial.

Other

2014 Speaker Goals:

1. Improve tools that facilitate hand-off and transitions for officers and committee chairs/co-chairs. *Ongoing*
2. Continue the refining and review progress on the HOD policy and procedure manual. *Ongoing. Recommendation to the HOD to eliminate the language of delegation approval for Committee appointments.*
3. Investigate, develop and implement an archival system to record rationale for creation, revision and discontinuation of HOD policies and procedures. *Complete. Policy Committee changed template to document background info for changes or creation.*
4. Continue to promote student involvement to cultivate future professional participation and evaluate outcomes of student strategies. *Ongoing. 20 students have applied and are planning on participating in the HOD meeting. A focus group activity is planned to solicit feedback on professional involvement with the AARC.*
5. Increase efficiency and productivity at HOD meetings. *Ongoing. Updating meeting workflows to be consistent with Robert's rules.*
6. Investigate and execute a guidance document for the HOD role in AARC bylaw amendments to more effectively collaborate with the BOD for desired changes. *Pending BOD action on HOD Recommendation.*
7. Clarify the expectations and establish the infrastructure to support chartered affiliates in meeting AARC documentation requirements. *Completed through Credentialing Committee*
8. Work with the Executive Office to create a process for updating delegate information to provide a reliable directory for the HOD. *Ongoing*
9. Continue to identify opportunities to strengthen HOD communication and contributions with the BOD to advance the interests of the chartered affiliates and profession. *Ongoing.*

Thanks to Asha Desai and Sherry Milligan for their assistance and support of the important work of the HOD. Their guidance is invaluable. I would like to also acknowledge the teamwork of my Officer team: Keith Siegel, Kari Woodruff, John Wilgis, John Steinmetz and Parliamentarian extraordinaire, Rick Weaver. I continue to be impressed by the energy, enthusiasm by the delegates to advance the profession on behalf of student RTs, affiliates, members and the patients we care for.

Board of Medical Advisors Report

Submitted by Dr. Peter Papadakos – Summer 2014

Below are the minutes from the Board of Medical Advisors virtual meeting that was held on May 31st.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Medical Advisors Meeting

May 31, 2014 – Conference Call

Minutes

Attendance

Peter Papadakos, MD, FCCM, FAARC (SCCM), Chair
Steven Boas, MD, Chair-elect (AAP)
Russell Acevedo, MD, FCCP (ACCP)
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Kent Christopher, MD, RRT, FCCP (NAMDRC)
Harold Manning, MD, FCCP (ACCP)
Col. Michael Morris, MD, FACP, FCCP, USA RET
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)
Ravi Tripathi, MD (ASA)

Excused

Terence Carey, MD (ACAAI)
Lori Conklin, MD (ASA), Past Chair
Thomas Fuhrman, MD (ASA)
David Kelley, MD, RRT-NPS, CRT (ASA)
Barrett Kitch, MD (ATS)
Neil MacIntyre, MD (ATS)
Kevin Murphy, MD (ACAAI)
Woody Kageler, MD, MBA, FACP, FCCP (ACCP)
Karen Stewart, MSc, RRT, AARC Past President, BOMA Liaison

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
Cheryl West, MPH, Director of Government Affairs
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

Chairman Papadakos called the meeting of the AARC Board of Medical Advisors to order at 12:04pm CDT, Saturday, May, 31, 2014.

INTRODUCTIONS

Chairman Papadakos asked members to disclose any conflicts of interest.

Papadakos – Member, Board of Professions, State of New York

CHAIRMAN'S REPORT

Dr. Papadakos thanked Drs. Fuhrman and Aranson who contributed articles to CHEST in support of HR619. The articles were accepted and will be published in the August 2014 issue. Tom Kallstrom informed the Board that he and AARC president, George Gaebler, also contributed articles that will be published as well. Dr. Christopher suggested publishing in AARC Times or on the AARC website so the membership can see how BOMA is supporting HR2619.

Dr. Papadakos also discussed CoARC Policy 13 and an email that was sent out by Tom Barnes. Tom Kallstrom explained that Tom Barnes is not a part of AARC or CoARC but that he was president of CoBGRTE which is a group that is very vocal about the removal of Policy 13. The email was forwarded to all BOMA members who did not originally receive it. Shawna Strickland gave a brief explanation of Policy 13. CoARC Policy 13 allows students enrolled in baccalaureate (4 year) respiratory therapy programs to challenge the NBRC examinations before graduation but after a pre-approved milestone in the respiratory therapy curriculum is successfully achieved. The original intent of this policy was to provide baccalaureate respiratory therapy students with an opportunity to begin practicing prior to graduation as they would have achieved the same level of knowledge as associate (2 year) respiratory therapy graduates. The NBRC and CoARC announced a compromise in May 2014 so that currently matriculating students could complete their programs of study without incident. A discussion among BOMA ensued.

Chair Papadakos suggested BOMA members work with their sponsoring organizations to fulfill new appointments and well as welcome new appointees and inform them of their expectations as members of BOMA. Dr. Christopher volunteered to contact new appointee Dr. Kevin Murphy.

It was suggested that the BOMA organizational document be reviewed and possibly revised before the Fall meeting. Representation from certain organizations may no longer be necessary but increased participation may be necessary from some current organizations.

Dr. Selecky moved that the AARC leadership and BOMA Chair review the BOMA organizational document and make recommendations for change, including representation from other organizations.

Motion carried

Dr. Papadakos encouraged BOMA members to speak at Congress. Dr. Cheifetz, current Program Committee Chair, explained that the agenda for the upcoming Congress in Las Vegas has already been set but that BOMA will be sent notifications for future meetings. Dr. Fuhrman is speaking at Congress presenting work from the VA regarding Credentialing RT's as the PREFERRRED Airway Management providers when Anesthesia is not available.

During the Fall BOMA meeting a short brainstorming session will take place to discuss topics

and speakers for the Congress in 2015.

APPROVAL OF MINUTES

Dr. Christopher moved to accept the minutes of the November 17, 2013 meeting of the AARC Board of Medical Advisors.

Motion carried

CoARC (Commission on Accreditation for Respiratory Care) Report

The written report was reviewed.

NATIONAL BOARD FOR RESPIRATORY CARE

The written report was reviewed. Shawna Strickland briefly discussed NBRC pass rates. Pass rate as of December 2013 is 14.6% for repeat candidates for the CRT exam. The AARC offers Exam Prep to better prepare them for the exam. Dr. Papadakos suggested that NBRC be present at the BOMA meeting in December.

PRESIDENT AND EXECUTIVE DIRECTOR REPORT

Tom Kallstrom gave highlights of his written report. A new roundtable has been recently formed, Patient Safety, with Steve Sittig and Kevin McQueen as co-Chairs. The AARC has been working with the Patient Safety Movement group as well.

Dr. Bruce Rubin published an article in RESPIRATORY CARE JOURNAL regarding the ineffectiveness of Mucinex to clear airways and some media outlets contacted him for interviews.

AARC was recently invited to be participants at American Sleep and Breathing Academy Conference in Phoenix. Tom Kallstrom, Tim Myers, and Shawna Strickland attended.

Many have asked when another COPD Educator Course will be held. The AARC is looking to create a "chronic pulmonary disease educator" certificate which would ultimately turn into a credential, a process that takes 3 years. Tom Kallstrom asked for volunteers to help with the formation of this course. Drs. Christopher, Papadakos, Acevedo, and Morris volunteered to assist.

LEGISLATIVE AFFAIRS REPORT

Cheryl West, Director of Government Affairs, provided updates to both the State and Federal Government Affairs Reports. She discussed AARC's long standing participation in the Washington, DC-based Tobacco Coalition and the AARC's upcoming comments on new FDA tobacco regulations for e-cigarettes. Ms. West also provided an update on the emerging issue, and the AARC response to the issue, of a Texas government proposal to de-license Texas RTs.

MEDICAL ADVISOR REPORTS

NAMDRC - Dr. Kent Christopher informed the Board that the pulmonary summit report has been finalized. The report will be sent to the respective organizations that attended the Pulmonary Summit in 2013. CMS is seeking public comments on the next phase of competitive bidding.

SPECIALTY SECTION REPORTS

The Specialty Section Reports were reviewed. Karla Smith is the new Sleep Section Chair.

OTHER REPORTS

American Respiratory Care Foundation (ARCF) - There will be a fundraising event at the

Mandalay Bay in Las Vegas at Congress in December, a Night at the Vineyard. BOMA members will be sent more information about purchasing tickets in the coming months. Tom Kallstrom gave an update on the Virtual Museum as well.

The International Committee report was reviewed. ARCF now administers the International Fellowship Program. The deadline for International Fellows applications is June 1st.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Due to the upcoming annual meeting in Las Vegas, BOMA members discussed hosting AARC meetings at smoke-free properties. BOMA passed a motion in November 2011- "that the AARC Board of Directors consider smoke-free properties/venue for future annual meetings." Tom Kallstrom explained that our meetings are usually booked 5-6 years in advance and Doug Laher explained that there are only 3 properties in Las Vegas that can accommodate our meeting. At Mandalay Bay you are only allowed to smoke in the casino and designated smoking rooms. The AARC Board of Directors passed a motion over ten years ago to host the annual meeting in Las Vegas every 3-4 years. It is estimated that there is an approximate 20% increase in attendance when the meeting is held in Las Vegas. Dr. Papadakos may make a recommendation to the AARC Board of Directors to amend the motion that was passed over ten years ago after the meeting this year.

MOTION TO ADJOURN

Dr. Aranson moved to adjourn the meeting of the AARC Board of Medical Advisors.
Motion Carried

ADJOURNMENT

Dr. Papadakos adjourned the meeting of the AARC Board of Medical Advisors at 2:32pm CDT, Saturday, May 31, 2014.

President`s Council

Submitted by Dianne Lewis – Summer 2014

Recommendations

None

Report

Nothing to report.

Standing Committee Reports

Audit Sub-Committee

Submitted by John Wilgis – Summer 2014

Recommendations

None

Report

The Audit Sub-Committee report presented at the April Board of Directors meeting was accepted. The Audit Sub-Committee continues to review monthly financial statements provided by the AARC.

I want to thank the committee for their participation and Tony Lovio as our liaison to the AARC.

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

Liaison: Tony Lovio (TX).

Bylaws Committee

Submitted by Tom Cahill – Summer 2014

Recommendations

- That the AARC Board of Directors find that the Louisiana Society for Respiratory Care Bylaws are not in conflict with AARC Bylaws.
- That the AARC Board of Directors find that the South Dakota Society for Respiratory Care Bylaws are not in conflict with AARC Bylaws.

(See cover letters and Bylaws below)

Report

- The Bylaws Committee has met its charges so far this year. At this time there are no pending resolutions or bylaws changes for review.
- The Bylaws Committee has review the above 2 sets of bylaws and recommends the AARC Board of Directors accept and approve those states bylaws listed above.
- We have not received bylaws from Connecticut.
- There is a large bottle neck of bylaws due for review in 2016 and 2017; as time permits I will be contacting states from that list to see if they may be ready to submit their reviews early to help ease the bottle neck in those years.

Other

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

Tom,

Attached you will find the LSRC amended bylaws dated 3-8-2014 for submission to the AARC for approval.

You will find that we have covered the criteria below regarding membership and voting privileges.

Also we have cleaned up the language in (1) preamble, (2) terms of office for President Elect, President and Immediate Past President, and (3) process of membership vote if needed before next scheduled annual meeting.

We have changed some committees: (1) Combined Nominations and Elections and (2) Re-established the Judiciary Committee; (The advisory committee will be addressed in policy and procedure manual.) Committee specific duties are listed and discussed in policy and procedure manual.

The new additions to the bylaws include: (1) statement to address dissolution of society, (2) ethics section for member misconduct, (3) statement to address BOC meetings by electronic means: teleconference, etc. (4) Establishment of President's Council.

If you have any further questions or concerns, please let me know.

Diana Merendino, DPT, RRT-NPS, PT
LSRC Bylaws, Chair

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APPENDIX F

Louisiana Society of the American Association for Respiratory Care
Bylaws

Approved: July 27, 1974---------Effective January 1, 1975

Amended: April 19, 1985

Amended: February 1, 1991

Amended: November 15, 1994------Effective January 1, 1995

Amended : Sept. 26 1998-------Effective January 1, 2000

Amended: August 28, 2000-------Effective January 26, 2001

Amended: November 19, 2008------Effective January 1, 2009

Amended: March 8, 2014--------Effective: _____/_____/_____

ARTICLE I
~~NAME~~ PREAMBLE

~~This organization shall be known as the Louisiana Society of the American Association 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. The Louisiana Society is incorporated under the General Not-For-Profit Corporation Act of the State of Louisiana.~~

~~The short name of this organization shall be the Louisiana Society for Respiratory Care "LSRC", and shall hereinafter in these Bylaws be referred to as the "Society".~~

This organization shall be known as the Louisiana Society for Respiratory Care, incorporated under the General Not-For-Profit Corporation Act of the State of Louisiana, hereinafter referred to as the "Society" or "LSRC". Articles of Incorporation are on file with the Secretary of State of Louisiana.

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

~~ARTICLE II~~
~~BOUNDARIES~~

~~The area included within the boundaries of this Society shall be the boundaries of the State of Louisiana~~.

ARTICLE ~~III~~ *II*
OBJECT

LSRC Vision/Mission Statement:
The LSRC serves as a state and regional professional association for respiratory care. The LSRC will encourage and promote professional excellence, advance the science and practice of respiratory care and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist.

Section 1. Purpose

The LSRC is formed:

a. To encourage and develop ~~on a~~ regional ~~basis~~ 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 regional institutes, meetings, lectures, and the preparation and ~~up keep~~ *maintenance* of *the* website and other materials.

c. Develop and maintain standards for the practice of respiratory care.

~~c.~~*d.* 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; except that 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.

~~d~~. *e.* To provide education of the general public in pulmonary health promotion and disease prevention.

Section 2. Intent

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

b. *The Board of Directors, hereinafter referred to as the "Board", shall provide for the* ~~D~~ *d*istribution of the funds, income, and property of the Society ~~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~~ *provided that* at the time *gifts or transfers to* ~~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 amend or supersede the said sections.

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

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

ARTICLE III.
BOUNDARIES

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

ARTICLE IV
MEMBERSHIP

Section 1. Classes

The membership of this Society shall include three classes: Active Member, Associate Member, and Special Member, *as defined by the AARC Bylaws.*

Section 2. Eligibility and Classification

a. Membership eligibility and classification shall be established in accordance with Article III of the AARC Bylaws.

b. Only members in good standing of the AARC shall be members of this Society with the exception that the AARC Board of Directors may confer Honorary or Life Membership.

Section 3. Annual Registration

Each Society member must annually reassert AARC membership by whatever means the AARC Board of Directors deems appropriate.

Section 4. Privileges

a. Active members and Active Life members in good standing shall be entitled to all the rights and privileges of membership in the Society, including the right to vote, hold office, hold committee chairmanships, committee memberships, and serve as Delegate to the Association.

b. All Associate member classifications and Special member classifications in good standing shall be entitled to all the rights and privileges of membership of the Society except the right to vote, hold office, hold committee chairmanships, and serve as Delegate to the Association.

Section 5. Ethics

If the conduct of any member shall appear to be in violation of the Articles of Incorporation, Bylaws, policies or procedures adopted by the Society, or shall appear to be prejudicial to the Society's interest, such members may be reprimanded, suspended, or expelled in accordance with the procedures as set forth in the LSRC policy and procedures.

ARTICLE V
OFFICERS AND DIRECTORS

Section 1. Officers

The officers of the Society shall consist of: President, President-Elect, Immediate Past President, Vice-President, Secretary, and Treasurer.

Section 2. Directors-at-Large

a. There shall be four (4) Directors-at-Large. Two (2) Directors-at-Large shall be elected every two years and such others as necessary in order to fill existing

vacancies.

b. When multiple vacancies are being filled, the member with the most votes shall fill the longest term, the member with the second highest number of votes shall fill the next longest term, and so on according to the number of votes received.

Section 3. Chapter Representation

Each Chapter shall be represented on the Board of Directors by the Chapter President.

Section 4. Term of Office

a. The term of office for Society Officers shall be for two (2) year term. The term shall begin immediately following the Annual Business Meeting following their election.

b. The President-Elect shall serve one (1) year until the next Annual Business Meeting and then shall accede to the President for a (2) year term.

c. The President shall accede to the Immediate Past President for a one (1) year term.

~~*b.*~~ *d.* The President-Elect *and Immediate Past President* shall not serve more than *a* one (1) *year* ~~consecutive~~ term in the same office.

~~c. The Vice President, and Secretary, and the Treasurer shall not serve more than three (3) consecutive terms in the same office.~~

~~d.~~ *e.* The term of office for Directors-at-Large shall begin immediately following the Annual Business Meeting following their election and shall be for a four year term.~~non-recurring term of office.~~

Section 5. Vacancies in 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 the successive term as President.

b. In the event of a vacancy in the office of President-Elect, *due to resignation or inability to perform duties,* the Vice-President shall assume the duties, but not the office of, President-Elect ~~as well~~ *and shall also continue to serve* as the Vice-~~Presidency~~ *President* until the next meeting of the Board of Directors at which time the Board shall elect a qualified member to fill the vacancy. This individual shall serve the remainder of the term as President-Elect and then accede to President for a regular term as if elected by the membership.

c. In the event of a vacancy in the office of Vice President, Treasurer, or Secretary, the Board of Directors shall elect a qualified member to fill the vacancy until the Annual Business Meeting following the next election.

d. In the event of a vacancy in the office of Immediate Past-President, that office shall remain vacant until filled by the normal process of Presidential succession.

Section 6. Duties of Officers

a. **President**

The President shall be the chief executive officer of the Society. The President shall preside at the Annual Business Meeting and all meetings of the Board of Directors and present an annual report of the Society; prepare an agenda for the Annual Business Meeting and submit it to the membership via the LSRC website not fewer than thirty (30) days prior to such a meeting in accordance with these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board of Directors not fewer than fifteen (15) days prior to such meeting; appoint standing and special committees subject to the approval of the Board of Directors; and present an annual report of the Society's activities to the Board of Directors and the membership.

The President shall automatically become and serve in the office of Immediate Past President following the completion of their two year term and perform such duties as assigned by the President with voting privileges.

b. **President-Elect**

The President-Elect 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, the Board of Directors, or elsewhere by these Bylaws.

The President-Elect shall serve as Chair of the Nominations and Elections Committee.

The President-Elect shall be a one year term.

c. **Vice-President**

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 will also continue to carry out the duties of the Vice-President.

d. **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.

The Treasurer shall see that full and accurate accounts are kept, submit quarterly trial balances to the Executive Committee; make a written financial report to each meeting of the Board of Directors.

At the expense of the Society, the Treasurer and all other signatories of Society (not Chapter/Committee) checks shall be bonded in an amount determined by the Board of Directors.

The outgoing Treasurer shall automatically become Immediate Past Treasurer as a non-voting member of the BOD in order to insure smooth transition of all Society finances. Immediate Past Treasurer may hold another concurrent office. The Treasurer, the President *Immediate Past President,* or the President-Elect shall be included on all Society financial institutes' signature cards.. All debt to accounts will require two signatures.

e. **Secretary**

The Secretary shall have charge of keeping the minutes of the regular meetings of the Board of Directors, the Annual Business Meeting, and meetings of the Executive Committee; executing the general correspondence; ~~affixing the corporate seal on documents so requiring~~; and in general, performing all duties as from time to time shall be assigned by the President or the Board of Directors.

f. **Immediate Past President**

The Immediate Past President shall serve on the Executive Committee with voting privileges and assist in formulation of the LSRC annual budget and also serve on the Legislative Committee.

~~ARTICLE VI~~
~~NOMINATIONS AND ELECTIONS~~

~~**Section 1. Nominations**~~

~~a. Calendar of Nominations Process~~

~~i. Nominations shall open not later than May 15.~~

~~ii. The Nominations Chairperson shall report the slate of nominees to the Board of Directors not later than August 15 for their approval.~~

~~iii. On written petition of ten (10) or more Active members filed at any office of~~

~~the Society, no later than September 1, any other member or members eligible to hold office will be added to the approved slate.~~

~~iv. The Nominations Committee shall present the slate of nominees to the Elections Committee no later than September 15.~~

~~v. Ballots shall be mailed to the membership no later than October 10. The membership shall have no less than twenty-five (25) calendar days to return their ballots.~~

~~vi. Returned ballots must be postmarked not later than November 10.~~

~~b. The Nominations Committee shall determine the eligibility of all nominees. Only Active or Life members may be candidates.~~

~~c. The Nominations Committee shall name at least two (2) nominees for all Offices, Board of Directors positions, and vacancies.~~

~~i. If, despite every reasonable effort, the Nominations Committee is unable to assemble a slate with at least two (2) candidates for each position, the Board of Directors may authorize publication of a ballot with only one (1) candidate for some or all of the positions to be filled.~~

~~ii. If, despite every reasonable effort, the Nominations Committee is unable to solicit any nominee for any position(s), the Board of Directors shall appoint a qualified member to serve the next term.~~

~~**Section 2. Ballot**~~

~~a. The Nominations Committee's slate and biographical sketches shall be mailed to every Active or Life Member in good standing according to the last available membership galley at the time of mailing at their last address on the record of the Society not later than October 10.~~

~~b. The ballot shall be so designed as to be a secret mail ballot with provisions for write-in votes for each office. Ballots, to be acceptable, must be postmarked by the stipulated deadline date, which shall be no later than November 10. The deadline date shall be clearly indicated on the ballot.~~

~~**Section 3. Elections Committee**~~

~~The President shall appoint an impartial Election(s) Committee which shall prepare the ballots, conduct the election, check the eligibility of each returned ballot and tally the votes no later than November 20. The results of the election shall be announced at the last regular Board of Directors meeting of the calendar year.~~

ARTICLE ~~VII~~ *VI*
BOARD OF DIRECTORS

Section 1. Composition and Powers

a. The executive government of this Society shall be invested in a Board of Directors of no fewer than twelve (12) members and no more twenty (20) voting members consisting of the Officers, Delegates, and Directors-at-large (as defined in Article V, Sections 1 & 2) and the President of each chapter (as defined in Article XII. ~~Sections 3 & 5~~).

b. The President shall be Chairperson and presiding officer of the Board of Directors and the Executive Committee. The President shall invite in writing such individuals to the meetings of the Board of Directors as deemed 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) vote, upon refusal or neglect of any member of the Board of Directors 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.

d. The Society's Medical Director and Immediate Past Treasurer shall be non-voting

members of the Board of Directors.

e. No Board of Directors member may hold concurrent Board of Directors-level elective offices. This limitation does not preclude Board of Directors members from holding chapter offices other than Chapter President.

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 remuneration, stipends, the amount of membership dues for the following year, and other related matters, after consideration of the budget.

d. Receive and act upon the reports and recommendations of the special and standing committees.

e. Perform such other duties as may be appropriate for the management of the Society.

Section 3. Vacancies

a. Any vacancy that occurs *for a Board Member At Large* ~~on the Board of Directors, with the exception of the President, Immediate Past President, Immediate Past Treasurer, Delegates and the Chapter Presidents~~, shall be filled by qualified members elected by the Board of Directors. Individuals so elected shall serve until the Annual Business Meeting following the next ~~annual~~ election.

~~b. An elected President shall serve until the Annual Business Meeting following the next annual election and then accede to the Past President.~~

~~c~~. *b.* In the event of a vacancy among the Chapter Presidents, the respective Chapter(s) shall fill the vacancy through their defined ascendancy process. This individual must be eligible to be a member of the Society's Board of Directors. In the event the chapter fails to name a replacement, the Board of Directors shall appoint a qualified member.

Section 4. Meetings

a. The Board of Directors shall meet as part of the Annual Business Meeting of the Society and shall not hold fewer than two (2) regular and separate additional meetings during the calendar year. The planned dates and locations of these additional meetings shall be presented at the Annual Business Meeting. In the event of an emergency or unexpected circumstances, the date and location of these additional meetings may be changed, provided the members of the Board of Directors are given at least fifteen (15) days notice of the new date and location; or the business of the scheduled meeting may be conducted by mail vote in accordance with Section 5 of this Article.

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, or upon written request of three (3) members of the Board of Directors filed with the President and Secretary of the Society.

c. Meetings of the Board of Directors may be in person, by telephone, video-conference or other electronic means as shall be determined by the Board of Directors.

~~c.~~ *d.* A majority of the voting members of the Board of Directors shall constitute a quorum at any meeting.

Section 5. ~~Mail~~ Vote *of Membership*

~~Whenever, in the judgment of the Board of Directors, it is necessary prior to the next regular or Annual Business Meeting, the Board of Directors may, unless otherwise required by these Bylaws, instruct the Elections Committee to conduct a vote of the membership by mail. The question thus presented shall be determined according to a~~

~~majority of the valid votes received by mail 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 the Bylaws shall be binding upon each member of the Society.~~

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

~~Section 6. Executive Committee~~

~~The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Vice-President, Immediate Past-President, Secretary, Treasurer and Immediate Past Treasurer. The Immediate Past Treasurer is a non-voting member. The Executive Committee shall have the power to act for 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~~ *VII*
ANNUAL BUSINESS MEETING

Section 1. Date and Place

a. The Society shall hold an Annual Business Meeting within sixty (60) days following the end of each calendar year.

b. The date and place of the Annual Business Meeting 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 mail~~ provided the material is sent in the same words to the voting membership.

Section 2. Purpose

The Annual Business Meeting shall be for the purpose of installation of the new Board of Directors, receiving reports of officers and committees, and for other business brought by the President.

Section 3. Notification

~~Written notice of the time and place of the Annual Business Meeting shall be sent to all members of the Society, or published in an official Society publication which is mailed to all members, or posted on LSRC website not fewer than ninety (90) days prior to the meeting. An agenda for the Annual Business Meeting shall be likewise distributed to the membership not fewer than thirty (30) days prior to the meeting.~~

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

~~Section 4. Quorum~~

~~A majority of the voting members registered at a duly called Annual Business Meeting shall constitute a quorum~~.

ARTICLE ~~IX~~ *VIII*
SOCIETY DELEGATES TO THE AARC HOUSE OF DELEGATES

Section 1. Election

a. Delegates of this Society to the House of Delegates of the AARC shall be elected as specified in Article VII of the AARC Bylaws.

b. To be nominated for the position of Delegate from this Society the nominee must attend a minimum of 75% of all Society Board of Directors meetings for two years prior to their vying for said position.

c. The Society's delegation will consist of up to three delegates, one of whom may be the President. If the President selects a designee, he or she must be a member elected by the entire membership of the LSRC. For the other members of the delegation, one will be elected every two years for a four year term. The delegates will be limited to five consecutive terms.

Section 2. Duties

The duties of the Delegates shall be as specified in the Bylaws of the AARC *(ARTICLE VII, Section 3c).*

~~The Delegate on their 3rd or 4th year in elected office shall actually prepare all reports for the Society and act as a mentor to other Society delegates and cast the LSRC's vote while the House is in session. In the absence of the delegate in their 3rd or 4th year the delegate in their 1st or 2nd year of elected office will assume the afore mentioned responsibilities. The 1st/2nd year and 3rd/4th year Delegate shall serve as Co-Chair's of the Fundraising Committee for the Society.~~

Section 3. *Voting* Board Member

The Delegates shall be voting members of the Society Board of Directors.

Section 4. Multiple Offices

Elected Delegates may not hold concurrent elective offices.

Section 5. Vacancy

a In the event of a vacancy in the position of Delegate, the Board of Directors may designate a qualified member to fill the role, but not the office of, Delegate until the next election.

b. The President may be designated to attend the House of Delegates in the place of any of the Delegates if they are unable to attend. In the event the President is seated in place of the 3rd or 4th year Delegate the1st or 2nd year delegate shall be the lead member of the delegation.

ARTICLE IX
PRESIDENT'S COUNCIL

a. The President's Council shall be composed of those individuals who served a full term as Past President of the Society.

b. The President's Council shall serve as an advisory body to the Board of Directors and perform other duties as assigned by the Board of Directors.

c. The President's Council shall meet annually and elect a Chair from its membership.

d. The Chair of the President's Council shall preside at meetings of the Council, and shall serve as a non-voting member of the Board of Directors.

e. The President's Council may appoint committees as necessary to complete all its duties.

f. *In the event of a vacancy of the Chair, the vacancy shall be filled according to the procedure defined by the Society.*

ARTICLE X
COMMITTEES

Section 1. Executive Committee

The Executive Committee of the Board of Directors shall consist of the President, President-Elect, Vice-President, Immediate Past-President, Secretary, Treasurer and Immediate Past Treasurer. The Immediate Past Treasurer is a non-voting member. The Executive Committee shall have the power to act for 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.

Section ~~1~~. *2.* 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 term of two (2) years.

a. Membership
b. Budget ~~and~~ / Audit
c. *Nominations /* Elections
d. *Judicial* ~~Respiratory Care Advisory~~ Committee
~~e. Nominations~~
~~f.~~ *e.* Education
    1. Program
    2. Scholarship
    3. Pelican Bowl
    4. ~~Pioneer~~ *Awards*
        (a) *Pioneer Award*
        (b) *Award for Excellence*
        (c) *Other Awards*

~~g.~~ *f.* Bylaws / *Policy & Procedure*
~~h.~~ *g.* Public Relations
    1. ~~Publications~~ *Communication / Relations*
    2. Chapter Affairs
    3. *Hospital of the Year Award*
~~*i.*~~ *h.* Legislative
    1. *PACT*
~~j.~~ *i.* Fundraising

Section ~~2.~~ *3.* Special Committees and Other Appointments

Special committees may be appointed by the President to carry out specific tasks.

Section ~~3.~~ *4.* Committee Chairperson's Duties

a. The chairperson of each committee shall confer promptly with the members of the committee on work assignments. If a committee has written policies or procedures they will *be* reviewed and approved by the BOD annually.
b. The chairperson of each committee may recommend prospective committee members to the President. When possible, the chairperson of the previous year shall serve as a member of the new committee. The chairperson shall submit a written report to the President and Secretary of the Society at each Board of Directors meeting.
c. Nonmembers or physician members may be appointed as consultants to committees.

d. Each committee chairperson requiring operating expenses shall submit a budget for the next fiscal year to the Budget and Audit Committee at least ~~ninety~~ ~~(90)~~ *sixty (60)* days prior to the Annual Business Meeting.

ARTICLE XI
DUTIES OF COMMITTEES

Section 1. Membership Committee

a. This Committee shall consist of one (1) member of the Board of Directors and one (1) member from each chapter.

b. This Committee shall encourage recruitment and retention of applicants for membership in the AARC and report to the Membership Committee of the AARC as required by the AARC Bylaws.

Section 2. Budget and Audit Committee

a. This Committee shall be composed of the Executive Committee and the Medical Advisor(s).

b. The Budget and Audit Committee proposes an annual budget for approval by the Board of Directors. The budget shall then be submitted to the Society website for publication at prior to the Annual Business Meeting.

Section 3. *Nominations /* Elections Committee

a. This Committee shall be chaired by the President and shall consist of at least five (5) voting members of the Society who shall serve for a term of one (1) year.

b. No member of this Committee is eligible to be placed on a Society ballot during their term on the Committee, although they will remain eligible to run for chapter offices, other than Chapter President. Members of the Board of Directors may be on, or chair, the Nominations/Elections Committee provided they are not in the final year of their term or are willing to decline all nominations for the year (s) they serve on this Committee.

c. The duties of the Nominations and Elections Committee are:

1. Solicit nominations from the membership and determine the eligibility for each office.

2. Prepare a slate of qualified nominees and submit to the Board of Directors for their review and approval.

3. Collect the required biographical information from the nominees, which is to be included on the ballot.

4. Prepare and verify ballots and validate election results for all elections held during the calendar year.

5. Notify the various candidates of the results of the election. If the Chair is unable to reach any of the candidates, the President of the Society shall be notified immediately.

6. These obligations shall be accomplished in accordance with the time frames as defined in the Society Policy.

~~a. This Committee shall prepare, receive, verify, and count ballots for all elections held during the calendar year.~~

~~b. This Committee shall consist of at least five (5) voting members of the Society. No member of this Committee is eligible to be placed on a Society ballot during their term on the Committee, although they will remain eligible to run for chapter offices other than Chapter President. Members of the Board of Directors may be on, or Chair, the Elections Committee provided they are not in their final year of their term or are willing to decline all nominations for the year(s) they serve on this Committee. This Committee shall be chaired by the President- Elect.~~

~~c. This Committee will work in conjunction with the Nominations Committee for the timely election of officers. The ballots shall be true secret ballots, with the~~

process completed within the time frames defined in Article VI of these Bylaws.

d. It shall be the duty of the Chair of the Elections Committee to notify the various candidates of the results of the election not later than November 27. If the Chair is unable to reach any of the candidates by this date, the President of the Society shall be notified immediately.

Section 4. *Judicial* /Respiratory Care Advisory Committee

a. This Committee shall consist of six (6) *a total of five (5)* members *and will be chaired by a member of the Executive Committee*. These six members shall be the Respiratory Therapists represented on the Respiratory Care Advisory Committee of the Louisiana State Board of Medical Examiners.

b. This Committee shall:

1. Advise the Board on issues affecting applicants for licensure and regulation of respiratory therapy in the state.
2. Provide advice and recommendations to the Board regarding the modification, amendment, and supplementation of rules, regulations, standards, policies, and procedures for respiratory therapy licensure and practice.
3. Serve as liaison between and among the Board, licensed respiratory therapists, and professional organizations.
4. Review and advise the Board on issues affecting requests for temporary licenses.
5. Conduct audits on applications to ensure satisfactory completion of continuing education and competency as specified by the board's rules.
6. Perform such other functions and provide such additional advice and recommendations as may be requested by the Board.

b. The Judicial Committee shall serve as an impartial body to investigate, deliberate, and render decisions on matters referred to it for consideration and determination.

Section 5. Nominations Committee

a. This Committee shall prepare for approval by the Board of Directors a slate of candidates for officers, delegates, directors-at-large, and chapter presidents for the annual election.

b. The Committee shall be chaired by the President-Elect and consist of at least four (4) Active Members, with a least one (1) Active Member from each Chapter, who shall serve for a term of one (1) year.

c. It shall be the duty of this Committee to solicit nominations from the membership, determine the eligibility to hold office of each submitted nominee, prepare a slate of those nominees who meet the criteria for eligibility to hold office, present the slate to the Board of Directors for review and approval, and collect the information for the biographical sketches to be included with the ballot. These obligations shall be accomplished in accord with the time frames defined in Article VI of these Bylaws.

d. The Nominations Committee shall work closely with the Elections Committee in processing ballot distribution.

Section 6. *5.* Education Committee

a. This Committee shall consist of at least six (6) members and be so constructed as to provide experienced members for program and education planning.

b. The Medical Advisor(s) will be a consultant member of the Committee.

c. The Committee shall encourage and assist chapters in the efforts to conduct educational programs and maintain a list of educational materials for the Society.

d. There will be three (3) subcommittees of the Education Committee. These

committees are: Program, Scholarship, Pioneer and Pelican Bowl.

1. Program Subcommittee shall plan, coordinate, budget, implement and publicize the State Annual Meeting. Members shall be invited to join as need indicates.
2. Scholarship Subcommittee shall advertise, coordinate, and award the Society scholarships.
3. The Pelican Bowl Subcommittee shall plan, coordinate and implement the Pelican Bowl at the Society's Annual Meeting; complete all necessary correspondence with the teams, the Society and/or the AARC.
4. Pioneer Committee shall honor and induct new members.

Section ~~7~~. *6.* Bylaws Committee

a. This Committee shall consist of three (3) members, one (1) of whom shall be a Past-President, with one (1) member being appointed annually for a three (3) year term, except as is necessary to establish and maintain this rotation.

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 ~~8~~. *7.* Public Relations

a. The Committee shall maintain such liaison as has been established by the Board of Directors with other organizations whose activities may be of interest to the members of this Society. This shall include the preparation of exhibits, programs, and other items to bring the message of respiratory care and the AARC to medical, nursing, and hospital groups as well as educational facilities where using such material can be expected to recruit new people to the field of respiratory care. Such material shall be subject to the approval of the Medical Advisor(s).

b. Coordinate state wide observances of the National Respiratory Care Week.

c. Delegate and maintain PR mailing list for State Society.

d. Establish correspondence with programs across the state and serve as a resource to them.

e. There will be two subcommittees of the Public Relations Committee. These committees are Publications and Chapter Affairs. Each subcommittee shall consist of at least three (3) members, one (1) of whom shall be a Past-President, with members being appointed annually by the President for a one (1) year term, subject to reappointment.

1. The Publications Subcommittee shall concern itself with the execution of a Society Website and all other publications of this Society with the public, hospitals, and other organizations through dissemination of information concerning respiratory therapy.
2. The Chapter Affairs Subcommittee shall receive applications for Chapters and review the proposed Policies and Procedures for compliance with the objectives of Section XII of the Bylaws of the Society, and report its findings to the Board of Directors.
    i. Review amendments to existing Chapter Policies and Procedures.
    ii. Review the minutes of all meetings of the Chapter and advise the Chapter President and Secretary of any irregularities or other recommendations.
    iii. Coordinates the Chapter of the Year Program as well as the Affiliate of the Year award program.
    iv. Collect information on respiratory care departments within the state which are undergoing any type of patient care restructuring;

~~monitor statewide supply and demand trends and restructuring, and report this information to the Board of Directors.~~

a. The Public Relations Committee shall concern itself with the activities of the Society in relation to the public, hospitals, and other organizations.

Section ~~9.~~ *8.* Legislative Committee

a. ~~This~~ *The Legislative* Committee shall consist of *at least six (6) members to include:* the President *and/or* Past-President, *or* President- Elect. ~~President of Chapter VI and others as appointed by the chairperson.~~ The chairperson shall be appointed by the President *with other members being appointed as needed.*.

b. This Committee shall inform the Board of Directors of all legislative activity pertinent to the role of the respiratory care practitioners. The Committee shall communicate directly with the lobbyist and network all information to the Board of Directors.

Section ~~10~~. *9.* Fundraising Committee

a. ~~This~~ *The Fundraising* Committee shall be chaired by the 1st/2nd year and 3rd/4th year Delegates. Committee members shall be appointed by the President.

b. The ~~duties~~ *duty* of this Committee is to carry out fundraising activities as directed by the Executive Committee.

ARTICLE XII
CHAPTER ORGANIZATIONS

Section 1. Boundaries

The Society may be divided into a maximum of ten (10) chapters and no fewer than (3) chapters. Boundaries of the chapters will be determined by the ~~association's~~ *Society's* operating ~~rules~~ *policies.*

Section 2. Organization

The ~~rules~~ *policies.* under which the chapter*s* ~~is~~ *are* governed shall not be in conflict with these Bylaws.

Section 3. Officers and Chapter Representation

a. The President of each active chapter shall be a voting member of the Society's Board of Directors.

b. The Active Members of this Society *who are* employed within the chapter boundaries ~~shall~~ *may* elect a President ~~and,~~ Secretary, *and Treasurer* and other officers as circumstances may require. The Secretary ~~shall~~ *may* be the official correspondent for the chapter to the Society.

c. The membership in a Chapter shall be determined by address listed with AARC with stipulations by petition.

~~**Section 4. Activities**~~

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

~~**Section 5. Responsibilities of the Chapter President**~~

~~a. Represent the chapter from which elected.~~

~~b. Submit a written report with three copies at each Board of Directors meeting, relating to the activities in the chapter.~~

~~c. Carry out the duties and responsibilities as detailed in the Chapter Handbook.~~

~~**Section 6. Chapter Admission Requirements**~~

~~a. Ten or more Active Members of the Society meeting the requirements for affiliation may become a Chapter of the Society upon approval of the Chapter~~

Affairs Committee, subject to ratification by the Board of Directors of the Society. Members of Chapters must be members of the State Society.

b. The formal application shall be sent to the Society's office and shall consist of a list of officers, membership, minutes of the organizational meeting, Chapter Bylaws, geographical location (by parishes) and a letter requesting approval of the proposed Medical Advisor.

c. Active Chapters are defined geographically in Article XII, Section 1. In addition, an active chapter must maintain no less than twenty (20) active members and must submit to the Nominations Committee no less than two (2) candidates for Chapter President.

Section 7. Duties

a. Two copies of the minutes of the governing body and business meetings of the Chapter shall be sent to the Society's Board of Directors following the meeting. One copy shall be forwarded to the Society Secretary, the other to the Chairperson of the Chapter Affairs Committee.

b. The names and addresses of Officers and Medical Advisor shall be sent to the Society's office following the meeting.

Section 8. Dissolution of Chapter

a. Any chapter which no longer wants to maintain its separate identity may petition to dissolve by simply failing to place into nomination potential president of that Chapter.

b. The boundaries of that Chapter shall then be incorporated into a neighboring Chapter as determined by the Board of Directors and consent of the neighboring Chapter.

ARTICLE XIII
SOCIETY MEDICAL ADVISOR

The Society shall have at least one (1) Medical Advisor who shall conform to Article X, Section 3 of the AARC Bylaws. Each Chapter shall *may* have at least one (1) Medical Advisor. Together, they shall form a Board of Medical Advisors of which the Society Medical Advisor shall be Chairperson.

ARTICLE XIV
FISCAL YEAR

The fiscal year of this Society shall be from January 1 through December 31.

ARTICLE XV
DUES AND ASSESSMENTS

Section 1. Active, Associate Members Within the Society's Boundaries

Society dues shall be considered paid in full upon payment of AARC dues. Compliance with Article III, Section 7 *8*, paragraph a, of the AARC Bylaws is required for Society membership.

Section 2. Active, Associate Members Not Within the Society's Boundaries

a. This is considered a separate state membership, in which does not qualify these members to vote for the AARC Delegation.

b. Annual Society dues for each category of membership other than Honorary and Life shall be determined for the following year by the Board of Directors after consideration of the budget.

Section 3. Assessments

The Society shall retain the right to assess fees if it is necessary to carry on local activities. The amount of this fee will be set by the Board of Directors yearly as needed.

ARTICLE XVI
ETHICS

If the conduct of any Society member shall appear, by report of the Society 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 as defined in the AARC Code of Ethics, the Board of Directors may, by a two-thirds 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 XVII
PARLIAMENTARY PROCEDURE

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

ARTICLE XVIII
AMENDMENTS

These Bylaws may be amended at any regular or called meeting or by mail vote of the Louisiana Society of the AARC by a two-thirds majority of those voting, provided that the amendment has been presented or posted on website to the membership in writing at least sixty (60) days prior to vote. All amendments must be approved by the AARC Bylaws Committee and shall become effective upon ratification by the AARC Board of Directors.

May 12, 2014

To Whom It May Concern:

Enclosed are the bylaws of the South Dakota Society for Respiratory Care. The bylaws committee and Board of Directors have reviewed them and have no recommended changes. We are requesting our review early to help with the bottle neck that will occur in 2016 and 2017.

Thank you for your consideration.

Thomas Cahill, BA, RRT, RPFT
SDSRC Bylaws Chair.

BYLAWS OF THE SOUTH DAKOTA SOCIETY FOR RESPIRATORY CARE
Updated 2011

Article I **NAME**

This organization shall be known as the South Dakota Society for Respiratory Care, 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 boundaries of this society shall be within the boundaries of the State of South Dakota.

Article III **OBJECT**

Section I Purpose

a. To encourage and develop on a regional basis 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 regional institutes, meetings, lectures, and other materials;

c. To facilitate cooperation and understanding between respiratory care personnel and the medical profession, hospitals, service companies, industry, and other agencies within the region interested in respiratory care.

d. Provide education of the general public in pulmonary health promotion and disease prevention.

Section 2 Intent

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

b. 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.

c. Distribution of the funds, income, and property of the Society 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 section 501, 2055, and 2522 of the Internal Revenue Code, or any later or other sections of the Internal Revenue Code which amend or supersede the said sections.

Article IV **MEMBERSHIP**

Section I Classes

The membership of this Society shall include three (3) classes: Active, Associate and Special Members.

Section 2 Eligibility

An individual is eligible to be a member of this Society if that person is a member of the AARC as specified in the AARC Bylaws and meets their requirements for Chartered Affiliate membership in the SDSRC.

Section 3 Classifications
The classifications and limitations of membership shall be as defined in the AARC Bylaws.

Section 4 Application for Membership
Application for membership in this Society shall follow the procedure specified in the AARC Bylaws.

Article V **OFFICERS**

Section 1 Officers
The Officers of the Society shall be: President, President Elect, Immediate Past President, Secretary, and Treasurer.

Section 2 Chapter Representation
Each Chapter shall be represented on the Board of Directors by the Chapter President.

Section 3 Term of Office
The term shall begin Jan. 1 of the year following the election. The term of President, President-elect and Immediate Past President shall be two years each. The term of the Secretary and Treasurer shall be three years each.

Section 4 Vacancies of Office

a. In the event of a vacancy of 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.

b. In the event of a vacancy of any office (except President) the Board of Directors (BOD) shall at the next meeting of the BOD elect a qualified member to fill the vacancy.

Section 5 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 make it available to the membership 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 Board of Directors; be an ex-officio member of all committees.

b. President-Elect – The President –Elect 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 Board of Directors and will also continue to carry out the duties of President-Elect.

c. Immediate Past President – The Immediate Past President shall advise and consult with the President, serve as a member of the Bylaws Committee, serve as Parliamentary Authority, and perform such other duties as shall be assigned by the President or the Board of Directors.

d. 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. He/She shall see that full and accurate accounts are prepared quarterly and made available as requested by the BOD and AARC and make written reports at all Board of Directors and business meetings of the society. He/She shall prepare, in conjunction with the Financial Review Committee, a proposed budget to be presented at the pre-board and annual business meeting proceeding the year it will be in effect. The Treasurer will submit State and Federal Tax Forms as required by law.

e. Secretary – The Secretary shall have charge of keeping the minutes of the Board of Directors, 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 upon request following the meeting; executing the general correspondence; and in general , performing all duties as from time to time shall be assigned by the President or the Board of Directors.

Article VI **NOMINATIONS AND ELECTIONS**

Section 1 Nominations Committee

The President shall appoint a Nominations Committee in accordance with the AARC Bylaws.

Section 2 Nominations

a. The Nominations Committee shall prepare a slate of one (1) or more candidates for each office for approval by the BOD.

b. Only active members in good standing shall be eligible for nomination, and only active AARC members may vote.

Section 3 Ballot

a. The Nominations Committee's slate and biographical sketches shall be made available to every active member in good standing prior to the scheduled election. The President will be responsible for submitting the list of SDSRC officers to the AARC following the annual election.

b. The election of officers shall be performed by mail or electronic vote with provisions for write-in votes for each office. Ballots, to be acceptable, must conform to instructions supplied with the ballot. The deadline date must be clearly indicated on the ballot.

Section 4 Election Committee

The President shall appoint an Election Committee, whose names shall not be on the ballot, to verify the eligibility of each ballot, tally the votes and report the results to the Board of Directors.

Section 5 Election Date

The date of the 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, Immediate Past President, two Delegates, two Directors-at-Large, and the President of each Chapter, who must be in good standing with the AARC during their term of office.

b. The President shall be Chairperson and presiding officer of the Board of Directors. He/She shall invite in writing such individuals to the meetings of the Board of Directors as deemed necessary, with the privilege of voice but no vote.

c. The Board of Directors shall have the power to declare an office vacant by a two-thirds (2/3) 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.

Section 2 Term of Office

a. The term of President, President-Elect, Immediate Past President, Secretary, and Treasurer has been addressed in Article V, Section 3.

b. The term of the Delegates is addressed in Article IX, Section 1.

c. Directors-at-large shall serve two years, with a new Director-at-large elected every year.

d. Chapter Presidents shall serve two years.

e. An elected President-elect shall serve two years and then automatically succeed to the Presidency.

Section 3 Duties

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

b. Adopt and rescind the policy and procedure manual of the Society.

c. Determine remuneration, stipends, the amount of membership dues for the following year, and other related matters, after consideration of the budget.

d. Perform other duties as may be necessary or appropriate for the management of the Society.

Section 4 Vacancies

a. Any vacancy that occurs on the Board of Directors, with the exception of the President, Immediate Past President, and the Chapter Presidents, shall be filled by qualified members elected by the Board of Directors. Individuals so appointed shall serve until the next scheduled election.

b. In case a vacancy occurs in the office of Delegate, the SDSRC Board of Directors may appoint a member to serve. There will be a Delegate election to complete the remainder of the vacant term at the next annual election.

c. In the event that both elected Delegates are unable to attend the House of Delegates Meeting(s) the President or elected Board Member may attend as a voting delegate. This representative shall not assume the office of Delegate

Section 5 Meetings

a. The Board of Directors shall meet preceding and may meet 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, or upon written request of four (4) members of the Board of Directors filed with the President and Secretary of the Society.

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

Section 6 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 Elections Committee to conduct a vote of the membership by mail, electronic mail or other means available.

b. Business to be decided by vote shall be presented to the Membership at least thirty (30) days prior to the vote deadline. The outcome of this vote shall be determined according to the majority of the valid votes received, except in the case of an amendment or a change in the Bylaws when a two-thirds (2/3) majority of the valid votes received is required.

c. Any and all action approved by the members in accordance with the requirements of this Article shall be binding upon each member thereof.

d. It is the responsibility of the voting member to provide a current email address to the Society and the AARC.

Section 7 Multiple Offices
No officer shall hold concurrent elected offices.

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 at least 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 Board of Directors shall cancel the scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by mail, electronic mail or other means available provided the material is sent in the same words to the voting membership.

Section 2 Purpose

a. The annual business meeting shall be for the purpose of receiving the reports and for other business brought by the President.

b. Additional BOD business meetings shall be for the purpose of receiving the reports of officers and committees and for other business brought by the President and may be conducted

Section 3 Notification
Notice of the time and place of the annual business meeting shall be available to all members of the Society. An agenda for the annual business meeting shall be available to all members of the Society prior to the annual business meeting.

Section 4 Quorum
A majority of the voting members registered at a duly called business meeting shall constitute a quorum.

Article IX **SOCIETY DELEGATION TO THE AARC HOD**

Section 1 Term of Office
Delegates to the AARC shall be elected by the active membership for a four-year term of office, with a new delegate elected every two years. The Delegate nominate shall be an active AARC member in good standing and must have held a previous Board of Director position in the Society.

Section 2 Duties

a. The duties of the Delegation shall be specified in the Bylaws of the AARC.

b. The Delegates shall be empowered to vote on behalf of the membership of the Society.

c. 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.

Section 3 Vacancies
Refer to Article VII, Section IV.

Section 4 Representation
There shall be two Society Delegates to the AARC House of Delegates.

Section 5 Multiple Offices
No Delegate shall hold concurrent elected offices.

Article X **COMMITTEES**

Section 1 Standing Committees
The members of the following standing committees shall be appointed by the President, subject to the approval of the Board of Directors.

- Membership
- Financial Review
- Elections
- Nominations
- Program and Education
- Bylaws
- Public Relations, and Chapter Affairs

Section 2 Special Committees and Other Appointments
Special committees may be appointed by the President.

Section 3 Committee Chairperson's Duties

a. The President shall appoint the chairperson of each committee

b. The Chairperson of each committee shall confer promptly with the members of his/her committee on work assignments.

c. The Chairperson of each committee may recommend prospective committee members to the President. When possible, the Chairperson of the previous year shall serve as a member of the new committee.

d. All committee reports shall be submitted to the President and Secretary of the Society.

e. Non-members or physician members may be appointed as consultants to committees. The President shall request recommendations for such appointments from the Medical Advisor(s).

f. Each committee chairperson requiring operating expenses may submit a request for the next fiscal year to the Financial Review Committee.

Article XI **DUTIES OF COMMITTEES**

Section 1 Membership Committee

a. The committee shall consist of two (2) members of the Board of Directors and additional members as needed.

b. The committee shall be responsible for recruiting new members and retaining current members.

Section 2 Financial Review Committee

a. The committee shall be composed of the Board of Directors and additional members as needed.

b. They propose an annual budget for approval by the Board of Directors. The proposed budget shall then be presented and ratified by the membership at the annual business meeting.

Section 3 Elections Committee
The election committee under the direction of the Society President/Board of Directors shall prepare, receive, verify, and count ballots for all elections held during the calendar year.

Section 4 Nominations Committee
a. The committee shall prepare for approval by the Board of Directors a slate of officers for the annual election.

b. 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 5 Program and Education Committee
The purpose of this committee is to plan, organize and conduct educational meeting for the Society in conjunction with the annual business meeting and/or any other meeting as deemed by the Board of Directors.

Section 6 Bylaws Committee
The Committee shall review and update the bylaws of the Society and prepare any amendments to the Bylaws for approval by the Board of Directors, AARC and Society membership.

Section 7 Public Relations and Chapter Affairs Committee
The committee shall concern itself with the preparation and publications of this Society for the public, hospitals, and other organizations through dissemination of information concerning respiratory care.

Article XII **CHAPTER ORGANIZATIONS**

Section 1 Organization
The internal organization, except where in conflict with these Bylaws shall not be the concern of this document.

Section 2 Officers and Chapter Representation
a. The President of the Chapter shall be a member of the Society's Board of Directors.

b. The active members of the Society working in the Chapter shall elect a President and Secretary and other officers as circumstances may require. The Secretary shall be the official correspondent for the Chapter to the Society.

Section 3 Activities
Chapter organization shall be encouraged to expand the membership of the Chapter and to develop educational activities and other such activities as is consistent with the Articles of Incorporation and these Bylaws.

Section 4 Responsibilities of the Chapter President
Represent the Chapter from which he/she is elected.

Section 5 Chapter Admission Requirements
a. Ten or more active members of the Society meeting the requirements for affiliation may become a Chapter of the Society upon approval of the Chapter Affairs Committee, subject to ratification by the Board of Directors of the Society. Members of Chapters must be members of the State Society.

b. The formal application shall be sent to the Society's office and shall consist of a list of officers, membership, minutes of the organizational meeting, Chapter Bylaws, geographical location (by counties) and a letter requesting approval of the proposed Medical Advisor.

Section 6 Duties

a. A copy of the minutes of the governing body and business meetings of the Chapter shall be available to the Society's Board of Directors within thirty (30) days following the meeting. The minutes will be available to the Chairperson, Chartered Affiliates Committee, AARC when requested.

b. The names and addresses of officers and medical advisor shall be available to the Board of Directors within thirty (30) days following the meeting.

Article XIII **SOCIETY MEDICAL ADVISOR**

The Society shall have at least one (1) Medical Advisor who shall conform to the AARC Bylaws. Each Chapter 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 Chairperson.

Article XIV **FISCAL YEAR**

The fiscal year of this Society shall be from January 1 to December 31.

Article XV **ETHICS**

If the conduct of any Society member shall appear, by report of the Society 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 the Society's interests as 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 AUTHORITY**

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

Article XVII **AMENDMENT**

Amendments originated by the Society's Bylaws Committee are submitted to the AARC Bylaws Committee. This Committee will review, and if appropriate, make recommendations to the Society. The Society may either accept and incorporate the Committee's recommendations or leave the document as originally submitted. The Society then corresponds back to the Committee regarding their decision. The AARC Bylaw's Committee makes a final recommendation to the AARC Board of Directors, who makes the final decision regarding acceptance of the revisions. Once approved, the Bylaws are submitted to the Society membership for comments and ratification as defined in Article VII, Section 6.

Enacted:	July 1988	Revised:	May	1992
		AARC Approval	Dec.	1992
		SDSRC Approval	Dec.	1992
		Revised:	Sept.	1996
		AARC Approval	Oct.	1996

SDSRC Approval	Apr.	1997
Revised:	Sept.	1999
AARC Approval	Dec.	1999
SDSRC Approval	Apr.	2000
Revised:	Jan	2005
AARC Approval	Mar	2005
SDSRC Approval	June	2005
Revised:	May	2011
AARC Approval	Aug	2011
SDSRC Approval	Dec	2011

Elections Committee

Submitted by: Jakki Grimball - Summer 2014

Recommendations

None at this time

Report

On behalf of the AARC Elections Committee, I am pleased to present the slate of candidates for the 2014 election.

Director-at-Large:	John Lindsey Timothy Op't Holt Raymond Pisani Lisa Trujillo
VP External:	Doug McIntyre Cynthia White
VP Internal:	Lynda Goodfellow Camden McLaughlin
Secretary/Tresurer:	Colleen Schabacker Karen Schell
Continuing Care Section:	Connie Paladenech Arianna Villa
Transport Section:	Charles Bishop Tabatha Dragonberry
Long Term Care Section:	Gene Gantt Randy Reed

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 Jim Lanoha, Dan Rowley, Tim Myers, John Hiser and Mike Runge. I would like to give special thanks to Sherry Milligan and Beth Binkley at the Executive office for their guidance and assistance

Executive Committee

Finance Committee Report

Judicial Committee

Submitted by Anthony DeWitt – Summer 2014

Recommendations

None

Report

The Judicial Committee has not taken any action over the past four months.

Other

Certain policies and procedures are being reviewed with AARC Staff to bring them into compliance with legal standards. Chair is working with Tom Kallstrom on this.

Program Committee

Submitted by Ira Cheifetz – Summer 2014

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 Marco Island, FL. A Pre-course and a Welcome Reception will take place on Sunday, July 14th. The Welcome Reception will also serve as an opportunity to raise awareness about the ARCF. ARCF trustees will be on hand to answer questions and raffle tickets will be sold to raise money for the Foundation. Several prizes will be raffled off that were donated by local establishments.

Back by popular demand, 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 60th AARC International Respiratory Convention & Exhibition Program is all but finalized. Information on early registration for the Congress was published in the June issue of the AARC Times and the Advance Program was posted to the AARC website June 19… 2 months earlier than normal. The Congress will take place Dec. 9-12, 2014 in Las Vegas, NV at the Mandalay Bay Resort & Convention Center. There will be approximately 250 sessions on current respiratory topics and 16 Open Forum symposia offered in 3 unique formats.

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:

Summer Forum - Destinations have been secured through 2015. The Program Committee, working in conjunction with the Executive Office will explore future destinations starting in Q1 2015.

AARC Congress - Destinations have been secured through 2016. The Executive Office is engaged in conversations with Indianapolis as a future potential destination, however no recommendations are forthcoming at this time. Doug Laher from the Executive Office will have an update to share with the BOD regarding these discussions. It is likely the Program Committee will make a recommendation for our 2017 meeting prior to the Fall BOD meeting in Las Vegas and respectfully ask that an eVote be considered.

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 well-rounded representations of specialty section interests are included in our programs. To better facilitate representation of Roundtables on the Program, the Program Committee added a special liaison specifically for this group (Tom Lamphere).

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:

Summer Forum - 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. Eliminating session overlap to facilitate movement of conference participants between specialty track sessions has also incorporated member feedback.

AARC Congress 2014 - 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. Each session will last 35 minutes in length (a 30-minute presentation and required 5-minute Q&A). In addition, each session will be identified by "Content Category", making it easier for CRCE reporting for membership. 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: **Preparing for a Pandemic, Mechanical Ventilation, Pulmonary Function Testing, ECMO, and Sleep & Wellness.**

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

Attached is a listing of the number of individual sessions based on content category:

- Adult Critical Care: 46
- Clinical Practice: 67
- Education: 12
- Ethics & Law: 5
- Management: 24
- Neo/Pediatrics: 25
- Patient Safety: 6
- Pulmonary Function Testing: 15
- Sleep Medicine: 12

Sputum Bowl Sub-Committee Report:

Status: The updates implemented at the 2013 Sputum Bowl will continue into 2014. 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

"Poll the Audience" – Using audience interactive software via "PollEverywhere", contestants will be able to poll the audience for select questions in which they do not know the answer.

Renegade Teams – In an effort to improve participation in the Sputum Bowl, additional teams (teams who did not win their state competition) will be permitted to play under a new team category call "Renegade" teams. Once an established deadline has come and gone that ensure all state competition winners to participate in the SB, miscellaneous Renegade teams will be permitted to enroll on a 1st come, first served basis. Once the limit for the number of competing teams has been met, no more Renegade teams will be expected. Renegade teams will be charged a fully refundable registration fee of $50 to participate. If the team participates in the competition in Las Vegas, there $50 registration fee will be refunded to them.

New 2014 updates to the competition include:

o New question category called Patient Assessment as well as the renaming of an old category to Acute Care/Critical Care

o Bracket methodology and social media to update the game; conference attendees as well as those at home can follow their teams' progress via Twitter or on the AARC website.

o 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 2014

Recommendations

None

Report

During the Spring 2014 Board meeting a brainstorming session was held to discuss the strategic plan of the AARC. Below is a draft of the new Strategic Plan and notes from the session are attached as "AARC Strategy Session April 2014".

AARC Vision/Mission Statement (draft 2014 update)

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

Strategic Objectives and Strategies for Implementation

Objective 1. Refine and expand the scope of practice for respiratory therapists in all care settings.

Description. Promote advanced practice and practice expansion for respiratory therapists. Assure that the science that demonstrates the value and role of the respiratory therapist is provided to those stakeholders whose decisions and actions need to be guided by that information.

Strategies.

1. Collect and disseminate information that documents the costs in dollars, length of stay, and lives of respiratory care being provided by persons other than respiratory therapists.
2. ~~Assist respiratory therapists to eliminate the provision of inappropriate respiratory care.~~
3. Focus the attention of respiratory therapists on providing respiratory care at the lowest cost.
4. Increase the access of underserved populations to the services of respiratory therapists.

5. Promote positive models of excellence in respiratory care.
6. Develop model position descriptions for respiratory therapists in various roles which emphasize quality, access, and cost control.
7. ~~Encourage protocol-based care and the use of respiratory care plans.~~
8. Develop model, evidence-based protocols and respiratory care plans for clinical practice.
9. Promote the development of specialty tracks and/or specialty programs for respiratory therapists (e.g. polysomnography).
10. ADD—Establish a time frame for Advanced Practice Respiratory Therapist with a Baccalaureate Degree .

Objective 2. Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.

Description. The AARC will promote the continuing development of the respiratory care workforce by promoting formal educational programs and continuing education in order to ensure competent, safe and effective patient care, and provide for the transfer of new knowledge to clinical practice.

Strategies.

1. Support existing educational programs in colleges and universities.
2. Promote the continuing development of baccalaureate and graduate degree education in respiratory care, ADD- with Baccalaureate degree being the entry level by 2030
3. Encourage respiratory therapists to pursue advanced and continuing education.
4. Encourage all respiratory therapists to seek and obtain the registered respiratory therapist (RRT) credential. ADD – Support entry level Registered Respiratory Therapist by 2017.
5. Support the development of new specialty credentials, as appropriate, and encourage current practitioners to seek and obtain credentials for advanced and specialty practice.
6. Assist educational programs in recruitment of quality students by developing materials which will present the profession positively and promote the profession.

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

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

Strategies.

1. Financially support research which seeks to advance the science and practice of respiratory care provided across all care sites.
2. Publish scientific information which advances the science and practice of respiratory care.
3. Work collaboratively with other health professions to conduct research to demonstrate the value of allied health professionals.
4. Demonstrate the effectiveness of the respiratory therapist in health promotion and disease prevention.

Objective 4. Establish professional standards and outcomes that are supported by scientific evidence.

Description. The AARC will continue to develop and disseminate position statements, white papers, consensus conference reports, evidence-based clinical practice guidelines and other professional standards that promote safe and effective care and provide guidance on all aspects of respiratory care.

Strategies.

1. Continue to develop and revise evidence-based Clinical Practice Guidelines to reflect the science of respiratory care and the role of the respiratory therapist.
2. Conduct scientific conferences to advance the science and practice of respiratory care.
3. Develop and publish white papers and position statements related to respiratory care practice, education and management.

Objective 5. Advocate for federal and state health care policies that enhance patient care, patients' access to care and professional practice.

Description. Advocate at the federal and state level for health care policy that promotes access to appropriate, safe and effective respiratory care for patients and the public. Develop and implement promotion/marketing of the respiratory therapist targeted to legislators, policy makers and payers. Messages will emphasize the value of the respiratory therapist in controlling the utilization of services, creating cost savings, improving outcomes and patient safety and increasing access to respiratory care as provided by a respiratory therapist.

Strategies.

1. Legislators: Provide information to assist them to advocate for their constituents with a focus on safety and cost advantages of respiratory care provided by respiratory therapists.
2. Regulators: Emphasize support of legislatures, focus on cost savings, quality of care and improved patient safety from utilizing respiratory therapists.
3. Payers: Emphasize cost effectiveness due to improved outcomes and lower cost than other providers.

4. Decision Makers: Emphasize provision of high quality care by respiratory therapists while controlling costs of that care. Focus on the value of respiratory care and the respiratory therapist as the best practitioner to provide that care, control inappropriate utilization of respiratory care and ensure patient safety.

Objective 6. Partner with governmental agencies, community organizations, third party payers, professional societies and the public to promote healthy behaviors and prevent cardiopulmonary disease.

Description. Promote partnerships with interested stakeholders to improve lung health, prevent cardiopulmonary disease, and identify and maximize the care of patients with chronic disease.

Strategies.

1. Participate in consumer, professional and governmental coalitions to promote lung health.
2. Support efforts to encourage smoking cessation and tobacco control.
3. Partner in public education efforts to advise the public on lung health and
4. cardiorespiratory disease.
5. Participate in efforts to educate patients, their families and the public on the importance of disease management for chronic respiratory disease (e.g. Asthma and COPD).

Objective 7. Broaden consumer and health care providers' knowledge and understanding of the value of respiratory therapists in providing safe, competent and cost effective care.

Description. Develop and implement promotion/marketing of the respiratory therapist targeted to health care providers, patients and the public. Educate respiratory therapists on the importance of health promotion, effective smoking cessation and tobacco control programs, pulmonary health screenings, patient education and disease management.

Strategies.

1. Consumers: Provide information on higher mortality and increased costs when respiratory care is not provided and when it is provided by someone other than a respiratory therapist. Focus on quality, safety, and cost issues.
2. Other Health Professionals: Provide information and assistance to assure that respiratory care is provided by appropriate personnel when such care falls outside of the domain covered by the training and demonstrated competence of those individuals.
3. Current Respiratory Therapists: Provide information to assist them in developing and maintaining their skill as asthma educators, disease management specialists and experts in smoking cessation and chronic disease management.

Objective 8. Assure the Association has the resources to meet the needs of its members.

Description. Assure that the AARC has the financial, volunteer, and staff resources needed

to accomplish the implementation of the strategic plan of the Association. It is necessary to have sufficient income to support the ongoing and new initiatives of the Association if we are to accomplish the goals of the AARC. In addition to financial resources, it is essential that there be active participation of sufficient numbers of effective leaders and an effective and efficient Executive Office to support the efforts to be a leader in health care.

Strategies.

1. Increase the membership of the Association
2. Increase the diversity of the members of the Association by providing information to encourage persons who are members of underrepresented groups to enter the respiratory care profession and actively participate in the AARC.
3. Develop and increase the revenue sources needed to support the activities of the Association
4. Participate collaboratively with strategic partners for mutual benefit
5. Provide mechanisms to assure a continuous supply of interested, qualified leaders
6. Increase the involvement of members in the activities of the Association
7. Reduce costs of delivering services to members by using the technology which is available
8. Improve the responsiveness of the leadership to the rapidly changing environment today and in the future
9. Provide information to non-member respiratory therapists which will reveal why being an AARC member will benefit them in terms of developing and maintaining their skills and convinces them that not supporting the AARC will be a detriment to their career.
10. Provide information to instructors and managers to encourage active participation of students in the AARC and its chartered affiliates and assure they are fully informed of the science of respiratory care.
11. Align incentives with state affiliates.

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Summer 2014

Recommendation

That a group be appointed to put together a "consensus" statement or statements addressing the following topics:

- The use of non-invasive capnography during conscious sedation
- Patient specific strategies for invasive mechanical ventilation
- The use of invasive ventilation outside of the Critical Care Areas
- The use of NIPPV outside of the Critical Care Areas
- Establish recommended competency standards for working in Critical Care

Report

Members of the Adult Acute Care Section continue to remain active and involved in many projects nationally and internationally. Members have traveled to many countries and have been involved in humanitarian and educational efforts both at home and abroad.

The section continues to maintain:

- Busy list serve
- Monthly newsletter
- Quarterly bulletin
- Monthly case report
- Monthly journal club article
- Image of the month
- Dysrhythmia of the month

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Summer 2014

Recommendations

None at this time

Report

1. **Pulmonary Hypertension Association is an affiliated organization to AARC**

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

**responded to questions from PH Ex. Office on PR charge codes and oxygen therapy

B. International Pulmonary Hypertension Conference and Scientific Sessions – Racing Toward a Cure, June 20-22, 2014, Indianapolis, Ind. – attended/presented:

**Power Breakfast – Exercise for PH Patients on Oxygen, Sat. June 21 8:00 – 9:00 am

**Medically Led Session: Cardiac and Pulmonary Rehabilitation in PH, Sat. June 21 9:30 – 10:30 a with Dr. Bull University of Colorado, Dr. Lewis Cedars-Sinai Medical Center, Dr. Maron, Brigham and Women's Hospital

**This was the first time national experts were very clear about the need for Pulm. Rehab. With PH and that exercise should be monitored when PH patient begins an exercise program

**Dr. Bull referred to the recently published WHO PH Treatment Recommendations that listed exercise as a A1 recommendation – over 10 years ago exercise was discouraged in PH patients so this is a really significant evidenced based direction where Pulmonary Rehab plays a vital role

**Debbie Koehl was also a speaker at a Medically Led Session, Sat. June 21 1:30 – 2:30 on Exercise in PH with a PT, RN, MD, she represented the RRT Pulm. Rehab. Profession very well

C. **OPEN** - A 2014/2015 Goal is to develop a guideline on pulmonary rehabilitation for the PH Patient and ask AARC & AACVPR to be a part of the review committee to give support

2. **Section Newsletters – quarterly newsletters, edited by Arianna Nunn, UCSD has done an outstanding job putting the newsletters together**

3. **Phone and e-mail communication with AARC members regarding questions on billing codes, audits and documentation**

4. **Liaison to AACVPR – see submitted report for Liaison**

Diagnostics Section

Submitted by Matthew O'Brien – Summer 2014

Recommendations

None

Report

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

•· Presentations are being developed by Diagnostics Section members and abstract reviews are underway.

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

•. Jeff Haynes, RRT, RPFT is our new bulletin editor and we are releasing our Summer bulletin soon. Jeff is well connected and has proven capable of recruiting authors for interesting and useful articles.

•· We will offer a diagnostic specific webinar in July titled. 1. What is your Cardiopulmonary Exercise Testing IQ? Presenter: John Ortiz PhD, RRT.

BioQC for the Pulmonary Lab is another topic we hope to present in September.

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

•· Ongoing, We are striving to increase our membership by providing high quality bulletin content and webinars.

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

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

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

•· Ongoing

6. Review all materials posted in the AARC Connect library for their continued relevance.

•· Ongoing monitoring and personal responses to members.

Education Section

Submitted by Joe Sorbello – Summer 2014

Recommendations

None

Report

- With the success of the March 2014 online Section meeting, another is being planned for Fall 2014. The AARC's system worked very well for this meeting!
- The call for SPOTY nominations has gone out and I have received 2 nominations as of June 20, 2014.
- Kim Wiles, Home Care Section Chair, will be authoring an article in the Fall 2014 Education Section Bulletin entitled, "Home Respiratory Care: What is missing from current RT education programs?"
- Bob Fluck has submitted his resignation as the Editor of the Education Section Bulletin effective June 16, 2014. I have assumed this role until the end of this calendar year.
- I would like to commend Debbie Bunch for her continued excellence in editing both the Newsletter and Bulletin for the Section.

Home Care Section

Submitted by Kim Wiles – Summer 2014

Recommendations

None

Report

- Two section bulletins produced since last meeting, with two new authors
- Cover article in July AARC times regarding home care RT and future role
- Phone conference regarding Home care competencies/certification with Shawna, Tom, Dr. Christopher and Dr. Carlin
- Action items for immediate dissemination of education-webinar on oxygen therapy scheduled for August 2014, webinar for 2015 to be discussed for topic
- Complete a needs assessment and review the "hospital to home" survey and potentially re-distribute
- Short term vision-Online course (2-3 hours)-Shawna and Kim will work on topics, speakers, timeline
    - long term vision-certification program through NBRC

Long Term Care

Submitted by: Lorraine Bertuola– Summer 2014

Recommendations

None

Report

Nothing to report

Management Section

Submitted by: Bill Cohagen – Summer 2014

Recommendations

None

Report

1. MGT SPOY search underway.

2. Leadership Journal Club going strong.

3. Preparing for the International Congress.

4. Completing transition for incoming Chair.

Neonatal-Pediatrics Section

Submitted by Natalie Napolitano – Summer 2014

Recommendations

The AARC BOD recommends that the NBRC update the NPS examination to be a true specialty examination in line with the level and quality of the ACCS.
Specifically the NBRC consider:

1. RRT with 12 month experience in pediatrics/neonatal care as minimum qualifications
2. The survey for standard practice to guide test questions only be sent to CHA and NACHRI participating hospitals.
3. Request an official statement from the NBRC in response to this request that can be shared with the section membership and preferable representation at the NeoPeds section meeting in Las Vegas to be available for questions.

Justification: Individuals obtaining the NPS credential appear to be no more clinically competent than those who do not. When explored, much of the knowledge demonstrated is no longer relevant to clinical practice and is not equally distributed in acute and critical care. Much of the clinically relevant practice appears to be limited in testing. This maybe an influence from the practice survey in which full-time neonatal and pediatric specialist credentialed therapists are not the sole source of data for analysis and the majority of centers responding predominantly practice in acute vs critical care in this population. Therefore, we recommend updating the exam to the level and quality of the ACCS by exclusively seeking high volume centers of neonatal and pediatric care such as CHA or NACHRI associated hospitals. The Neonatal/Pediatric Section is happy to partner with the NBRC on this endeavor to assist with response rates to the job survey and to recruit physician representation as well as writers for test questions.

Report

Continue to have high amount of activity on the listserve and continued to monitored appropriate use of listserves in discreet ways.

The section membership is very concerned and unhappy with the direction the NBRC NPS credential has been maintained and do not feel it currently represents a specialty as the new ACCS credential does. There are many people with the NPS credential that have never worked in pediatrics and yet with this project themselves as a specialist in this area. This goes to show the level of the exam that any individual can take the course and pass. We are submitting the following resolution for recommendation to update this exam and volunteer to assist the NBRC in this task as they deem necessary and appropriate.

Sleep Section

Summer 2014

No report submitted as of July 3, 2014.

Surface to Air Transport Section

Summer 2014

No report submitted as of July 3, 2014.

Special Committee Reports

Benchmarking

Submitted by Chuck Menders – Summer 2014

Recommendations

None

Report

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

2. The regional client support has continued by all members of the team to assist new clients and follow up with subscribers.

3. In April, there was a transition of the Chair of the AARC Benchmarking Committee was from Rick Ford to Chuck Menders. Rick continues his service as a valuable member of the committee.

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

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

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

6. Membership in AARC Benchmarking has declined from 124 in September 2013 to approximately 80 as of June 1, 2014. The AARC Executive Office approved a new pricing structure to make the program more affordable for both current and new subscribers. This was put in place in the spring of 2014. Increased marketing efforts and additional price reductions are also being considered.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Summer 2014

Recommendations

None

Report

Some concerns remain about the NCCI edit from CMS, related to 94640. You may remember that the change was in outpatient billing. The change which occurred on January 1st stated that no more than one treatment (94640) could be billed for each patient encounter or visit. Ann Marie wrote a web article on this topic to help explain the change.

In the News - Respiratory Therapists Have Concerns about Changes ...

... a change in Medicare billing practices as it relates to the National Correct Coding

Initiative (NCCI) Edits for certain nebulizer treatments (94640, 94060, and ...

www.aarc.org/headlines/14/02/coding.cfm

The impact is lee than originally anticipated. RT departments can continue to bill for outpatient treatments given to the same patient at different encounters. *A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.* Therefore, a modifier can still be used and the treatments billed. The treatments that cannot be billed are those that are given at the same "visit".

Federal Government Affairs Committee

Submitted by John Lindsey – Summer 2014

Recommendations

None

Report

There is really nothing going on with the AARC Federal Government Affairs Committee. Things will, most likely, stay quiet for a while and ramp up with a summer "TO DO" which typically has us finding opportunities to meet with the member in the district over the summer recess. The goal of the meeting is to try and to meet face-to-face with the congressional member and if they are not a co-sponsor (house members), ask them to become one.

I will point out that there has already been a shake-up in the primary elections. Congressman Eric Cantor of Virginia was defeated by David Brat. In Arkansas, Incumbent Senator Mark Pryor is being challenged by Congressman Tom Cotton, should be very interesting race.

The goals of the AARC Federal Government Affairs Committee are on-going. We certainly hope to get everyone stirring during the congressional summer recess.

Fellowship Committee

Submitted by: Patrick Dunne – Summer 2014

Recommendations

None

Report

The work of the Fellowship Selection Committee will begin in earnest during the first week of September, 2014. Please note that the deadline for receipt of online nominations for 2014 Fellow is Friday, August 29. In September the Selection Committee will then commence review of all nominations received by the established deadline. The selection process will be completed by the end of September with notification letters being sent shortly thereafter.

International Committee Report

Submitted by John Hiser – Summer 2014

Recommendations

None

Report

1. Administer the International Fellowship Program.

   As of today June 3, 2014 we have 16 applicants for International Fellows and 17 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 20st. The committee will meet on Thursday, 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.

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.

Membership Committee

Submitted by Gary Wickman – Summer 2014

Recommendations

None at this time

Objectives

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

Report

We launched this year's membership campaign at the President's Workshop in Dallas after the April ARC Board meeting. I went over the details of the campaign and Sherry went over the tools we have set up for the Affiliates to use in their campaigns. The attendees were very engaged and asked a lot of questions. We then held our first webinar with the State Affiliate Membership Chairs on April 28th. Again we had good participation and engagement in the discussion, over 60 people took part in the webinar. At that meeting we gave them an assignment to make at least three of their 5 required visits to either a hospital or educational program by July 1st. We also set up our Membership AARConnect Community where all of the Affiliate Membership Chairs can communicate with each other on things that come up.

The AARC Membership Committee has also reached out to support the Affiliate Chairs. We have had several meetings of just the committee and will have another on July 1st. I will include an update from this meeting at the July Board meeting.

We have scheduled another Student webinar for April 30th. We hope to get a good turnout especially from this year's new graduates. I will be able to update the Board on how this webinar went at the July Board meeting.

We will be awarding the general membership prizes for the second quarter in July; I can update the Board at the July meeting on this as well. As of today, we have 40,230 active members. We are still down about 1,000 active members from the end of 2013. Our goal is to increase this to 46,000 active members. The "Visit Project" is a large part of this year''s campaign. We will evaluate how this is going in July. I do not expect to see any large increases until after that. Our first priority is to engage with the students who are transitioning from students to professionals to get them to understand why it is so important to support the profession by becoming members in the AARC. The next priority is to engage with those who have lapsed memberships to try to get them

to come back. Lastly, we will work to engage those who are not members through our visits to hospitals to try to engage them. It will take all of us, the AARC Membership Committee, the State Affiliates, the AARC Board and the Executive Office to help to engage people through communicating what we are doing for the profession, listening to the input we receive and do what we can to eliminate the barriers that are identified by this process. One of the asks that keeps coming up is to make the annual renewal automatic like other subscriptions. That way, once you become a member, you will be automatically renewed unless you take an active step to stop. Sherry is looking into this option again and I hope to be able to update you at the July Board meeting.

Other

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

Position Statement Committee

Submitted by Colleen Schabacker – Summer 2014

Recommendations

Recommendation #1: Approve and publish the revised Position Statement "Pre-Hospital Mechanical Ventilator Competency". This paper is submitted for your review as attachment #1. Text to be added appears with underline.

Justification: There are just a few changes in grammar, none in content.

Recommendation #2: Approve and publish the Position Statement "Competency Requirements for the Provision of Respiratory Services". This paper is submitted for your review as attachment #2.

Justification: The committee members felt this statement was still current and needed no changes.

Recommendation #3: Approve and published the Position Statement "Verbal / Telephone Orders". This paper is submitted for your review as attachment #3.

Justification: The committee members felt this statement was still current and needed no changes.

Recommendation #4: Approve and publish the newly developed Position Statement "Interstate Transport License Exemption". This paper is submitted for your review as attachment #4.

Justification: This position statement was developed by the Surface and Air Transport Section members.

Report

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

    a. We wrote a Position Statement regarding the electronic cigarette, which was approved by this Board in April, 2014.
    b. We were directed by the Board to write a position statement on Interstate Transport License Exemption. This position statement will be presented at this Board meeting.

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

a. During 2014, the Committee's goal is to complete the review/revision of the eight (8) position statements listed below:

i. Competency Requirements for the Provision of Respiratory Therapy Services
ii. Definition of Respiratory Care
iii. Health Promotion and Disease Prevention
iv. Inhaled Medication Administration Schedule
v. Pre-Hospital Mechanical Ventilator Competency
vi. Pulmonary Rehabilitation
vii. Tobacco and Health
viii. Verbal Orders

b. As of this Board meeting, all Position Statements listed above will have been reviewed/revised.

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

a. This schedule has been updated and presented and approved by this Board in April.

Other

As always, I would like to thank my committee members Kathleen Deakins, Deryl Gulliford, Linda VanScoder, Jim Allen and Tony Ruppert for their continued input and feedback.

Attachment #1

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

Position Statement

Pre-Hospital Ventilator Management Competency

It is the position of the American Association for Respiratory Care (AARC) that all persons involved in the setup, initiation, application, and maintenance of mechanical ventilators in the pre-hospital setting be formally trained in both the clinical and disease-specific applications of mechanical ventilation. To meet the goals of mechanical ventilation and promote positive outcomes, pre-hospital care givers must be trained to understand ~~the~~ age-specific ~~the~~ applications of positive airway pressure ~~has on~~ and its effect on the cardio-pulmonary system, as well as the mechanisms available for the monitoring of these interactions. The pre-hospital provider must also be familiar with proper assessment of the airway and the indications for changes in the settings on a mechanical ventilator.

The ~~American Association for Respiratory Care~~ AARC promotes the use of standardized terminology to promote understanding of the applications and pre-hospital management of mechanical ventilators. Furthermore, the AARC recommends that all pre-hospital providers of mechanical ventilation be required to demonstrate competence, at regular intervals, in the use and manipulation of all mechanical ventilators used during the transport of sick and injured patients.

Effective 12/07
Revised 9/2011

Attachment #2

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

Position Statement

Competency Requirements for the Provision of Respiratory Care Services

The complexities of respiratory care are such that the public is at risk of injury, and health care institutions
are at risk of liability when respiratory care is provided by inadequately educated and unqualified health care providers rather than by practitioners appropriately educated in the specialty of Respiratory care.

All health care practitioners providing respiratory care services to patients, regardless of the care setting and patient demographics, shall successfully complete training and demonstrate initial competence prior to assuming those duties. This training and demonstration of competence shall be required of any health care provider regardless of credential, degree, or license.

Formal education is defined as a systematic educational activity in the affective, psychomotor and cognitive domains. It is intended to develop new proficiencies with an application in mind, and is presented with attention to needs, objectives, activities and a defined method of evaluation.

The education shall be approved by a national accrediting entity. In the allied health fields, this training
includes supervised pre-clinical (didactic and laboratory) and clinical activities, as well as documentation of competence accredited by an independent accrediting entity to be valid and reliable. The qualifications of the faculty providing this training shall be documented and also meet accreditation standards.

AARC, therefore, supports recognition of individuals with competencies from the aforementioned accredited formal education programs for the purpose of providing care which includes a subsection of the respiratory care scope of practice with the caveat that such provision be limited to the elements contained within each credentialing examination's matrix respectively.

Effective 11/98
Revised 12/08, 11/11

Attachment #3

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

Position Statement

Verbal/Telephone Orders

Registered and Certified Respiratory Therapists, subject to local health care institution policy and state licensure acts, may record the verbal/telephone orders of Licensed Independent Practitioners (LIP) for drugs, devices, and treatments directly related to the provision of a patient's care.

Effective 3/90
Revised 07/11

Attachment #4

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

Position Statement

Interstate Transport License Exemption

The American Association for Respiratory Care (AARC) recommends temporary licensure exemption for respiratory therapists who are licensed or certified to practice respiratory care in another state or ~~foreign~~ country.

These Respiratory Therapists must meet the following criteria:

- Must practice within the scope of their licensing medical board
- Must function under the direction of their transport agency's Operational Medical Director
- Must follow their transport agency's patient care protocols or their receiving physician's online medical control.

This position of the AARC seeks to ensure that patients needing specialty care or critical care transport have access to Respiratory Therapists' knowledge, skills and the abilities they bring to the transport team.

Effective 07/2014

Social Media Committee

Submitted by: Brian Cayko - Summer 2014

Recommendations

None

Report

Nothing to report

State Government Affairs Committee

Submitted by: John W. Lindsey - Summer 2014

Recommendations

None

Report

Election 2014

2014 is an election year and most legislative seats and numerous governorships will be up for election or re-election. There has been one big upset already: Republican US House Majority Leader Eric Cantor of Virginia was defeated in a primary by first time candidate David Brat. The very unexpected outcome of the Cantor loss has upset the power structure in the Republican held US House of Representatives. This once again proves that all politics are local and that engaging in political activities on the local level can impact not just state election outcomes but federal as well. In my state, Arkansas, former US Congressman Mike Ross who sponsored AARC's previous Hill legislation is running for Governor. If elected we, Arkansas RTS, hope we will have a "Friend" in the Governor's Office.

Sleep Licensure

In Iowa, the legislative bill to pass Polysomnography Licensure did not pass. The original bill had included a RT exemption but a subsequent version did not. This engaged the Iowa RT Society in opposition. The ISRC also altered the Iowa Hospital Association, which when learning of the restrictive bill would impact hospital personnel also weighed into the legislature in opposition.

Kentucky RT Layoffs

The AARC has responded to the Kentucky situation whereby a number of RTs were being laid off by of Kentucky One Health by sending a letter to the CEO of Kentucky One Health. This raised the interest of on Kentucky Television Station and they actually interviewed AARC Executive Director-Tom Kallstrom and AARC Associate Executive Director-Tim Meyers. This was in response to the layoffs of respiratory therapist in Kentucky Free Standing Emergency facilities. Our other state societies are, as expected, very concerned with the Kentucky situation, but thankfully, the AARC has pushed back. Refer to http://www.aarc.org/headlines/14/03/kentucky/ for a more in depth explanation of the issue and our response.

Medicaid Expansion Option

Twenty six states have chosen the option to expand their Medicaid programs under the Affordable Care Act. In a few of the states that have decided not to expand their Medicaid Program pressure is mounting from the state hospital association to accept the expansion.

RT Licensure

Michigan

In Michigan, the ongoing effort by the state of Michigan to de-license RTs (and other professions) is at a standoff. While the push to de-license RTs has not gone away, neither has it gained any momentum due to the continuous and unceasing efforts of the Michigan Society for Respiratory Care. The MSRC has for over two years fought the concerted effort by the State of Michigan

Administration to de-license respiratory therapists. The Society has engaged a well-connected health lobby firm in this effort and the Society has expended many of their financial resources to underwrite this effort including the costs incurred by the RTs in their active engagement at the State Capitol and with legislators.

This 2 year (and ongoing) effort has been very costly for the MSRC and the Society applied for assistance under the AARC's Grant/Loan Program (60% grant 40% no interest loan, repayable over 2 years). This long standing AARC program financially helps state societies in their efforts to gain (in previous years) or maintain (the current iteration) RT licensure. An extensive application process is required by any state applying for consideration of the grant/loan.

One of the assigned tasks of the State Government Affairs Committee is to closely review any Loan/Grant application and vote to support or deny the request. The outcome of this Committee's vote is then passed on the AARC Board of Directors for final consideration.

Earlier this spring our Committee Members reviewed and voted to approve on the MSRC's application and the AARC Board of Directors voted for final approval.

Texas

In Texas, the State Sunset Advisory Committee has recommended de-licensing of RTs. The AARC has already responded to this and the TSRC has called a meeting to discuss steps. If the Sunset Commission were to still recommend de-licensing, it would still require the Texas state legislature to pass a bill to de-license. It is certainly the goal of the TSRC and the AARC to see that it does not reach this stage.

Cheryl West will be giving a much more detailed report to the Board of Directors and House of Delegates at the July meeting. I need to once again, thank Cheryl for the outstanding job that she does.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Summer 2014

Recommendations

None

Report

A meeting was held in February in Rosemount, TX. We are working to achieve a clear definition of use of code 94640.

94640 - Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device).

The indications for the use of 94640 are numerous, as you know. These include pulmonary hypertension, administration of antibiotics, maintenance of airway stability, etc. We are in the process of submitting a new article to the AMA publication; ***Cpt Assistant*** to define the indications.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors – Summer 2014

Recommendations

None

Report

I. Liaison to AACVPR

A. AACVPR Nationals - I will be facilitating a Roundtable discussion, topic/s TBD, with the following choices picked:

- 1st pick: Utilizing the New Pulmonary Rehab Tool Kit
- 2nd Pick: Developing Individualized Treatment Plans in Pulmonary Rehab Programs
- 3rd pick: Tools for Assessment in Pulmonary Rehab Pros and Cons
- 4th pick: Ways to Get Involved in AACVPR State Affiliates; Grassroots and UP!
- 5th pick: Sexual Concerns and Difficult Conversations for Pulmonary Patients

B. Current Past-President of the AACVPR Affiliate, the Virginia Association of Cardiovascular and Pulmonary Rehabilitation

- Continuing to deal with 90-100% denials for G0424 Pulmonary rehab. in MAC11 and have continuing discussions with MAC 11 Senior Medical Director - Dr. Feliciano
- Quarterly BOD meetings
- Dr. Feliciano spoke at the VACVPR state conference April 2014 on "the Pulmonary Rehab. Health Information Supply Chain"

C. AACVPR PR Program Certification Expert Panel committee member, chaired by Trina Limberg

American Heart Association

Submitted by Brian Walsh – Summer 2014

Recommendations

None

Report

Nothing to report.

No report submitted as of July 3, 2014.

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Summer 2014

Recommendations

None

Report

I conducted a strategic and operational planning session with the Georgia Society for Respiratory Care the weekend of May 30-31st in Atlanta Georgia, as approved by President Gaebler. The outcome of the session was to create a new mission statement, core operating values, selection of strategic goals and a template to guide their performance in each of the strategic goals.

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.

I am in discussions with the Michigan Society for Respiratory Care leadership to begin discussions on a strategic and operational planning session. MSRC president, Teena Culhane, is working on scheduling the engagement.

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

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Summer 2014

Recommendations

None

Report

The CAMTS BOD met in Austin TX for its annual spring meeting in March. In addition to program deliberations, additional discussion centered in levels of care and assessment of critical elements in evaluating submitted program protocols such as rapid sequence intubation etc. Our summer meeting will be held in July in San Diego which will be a business only meeting as any program accreditation deliberations are to be completed via web go to meeting format

Below are the minutes of the last Board meeting.

Meeting Minutes of the
COMMISSION ON ACCREDITATION OF MEDICAL TRANSPORT SYSTEMS
Austin, Texas - March 27, 28 and 29 of 2014.

Scheduled for:
Thursday, March 27, 2014 from 8:00am till 5:00pm
Friday, March 28, 2014 from 8:00am till 5:00pm
Saturday, March 29, 2014 from 8:00am till 5:00pm

EXECUTIVE COMMITTEE MEMBERS PRESENT: Mr. Gryniuk, Mr. Sittig, Dr. Orr, Mr. A. Smith, Dr. Rogers

BOARD MEMBERS PRESENT: Mr. Hickman, Dr. Stuhlmiller, Mr. Tangerose, Dr. Brunko, Ms. Palmer, Mr. Brisbois, Ms. Palmer, Dr. Price-Douglas, Dr. Holleran, Dr. Becker, Ms. Montgomery, Dr. Nix, Dr. Alexander, Ms. Rush, Ms. Treadwell, Dr. Wedel (arrived 1129hrs Friday morning), Ms. Holtschneider (by telephone on Friday afternoon), Dr. Conn (by telephone on Saturday morning)

STAFF PRESENT: Ms. Frazer, Mr. D. Smith,

MEMBERS ABSENT: Mr. Brown,

GUESTS:

Call to Order .....……..Dr. Rogers
Meeting called to order at 0810hrs on March, 27th, 2014.

Introductions.....……..The Board

Four new board members were introduced. Ms. Kim Montgomery representing AMOA, Dr. Sam Nix representing NEMSPA, Dr. David Alexander representing AsMA and Ms. Tammy Rush representing NANN. The board provided introductions as to who they represent and their professional backgrounds.

Approval of Minutes: January 2014…….....Dr. Rogers

A motion was made by Dr. Holleran and seconded by Dr. Orr to approve the minutes as distributed. Motion passed unanimously.

Treasurer's Report…….....Mr. A. Smith / Ms. Frazer

The board reviewed a balance sheet and cash basis Profit & Loss Budget versus Actual spreadsheet from January through December 2013. Mr. A. Smith provided an overview of our current financial state. Mr. A. Smith stated that our legal fees were approximately 3 times the budgeted amount. If the legal expenses were removed, the organization was profitable. Ms. Frazer states that we currently have a cash reserve of approximately $250,000 which would cover approximately 6 months of operating expenses.

Executive Director's Report…..……Ms. Frazer / Mr. D. Smith

Ms. Frazer distributed copies of the CAMTS annual report and provided copies of the letters that she sent to the member organizations describing their board member's participation.

Ms. Frazer provided an update on our current legal proceedings. Ms. Frazer states that our current action against NAAMTA is near resolution through a settlement agreement. Dr. Rogers cautioned the board to maintain the confidentiality of these discussions regarding or legal actions.

Ms. Frazer discussed EURAMI's use of the CAMTS standards. The original EURAMI standards were copied directly from CAMTS. EURAMI has restructured and has redistributed a draft copy of their standards which still use some CAMTS standards verbatim. EURAMI was notified by Ms. Frazer of those standards that still are in dispute. EURAMI has expressed an interest in collaborating with CAMTS.

Mr. D. Smith stated that we just exhibited at Heli-Expo in Anaheim, CA. Mr. Smith states that our booth traffic was very busy. Mr. Smith also presented a Just Culture class during the conference which was well attended. Mr. Smith and Ms. Frazer believe it is worthwhile to continue to exhibiting at this event.

Ms. Frazer provided an update on our efforts to complete a fatigue study. There was discussion regarding several different options of other organizations and research groups to partner with in order to assist with the financial aspect.

Ms. Frazer provided an update on our Aviation Advisory Committee. Mr. Brisboi authored a draft document identifying the purpose and expectations of the advisory committee. Dr. Rogers asked all board members to review this document for later discussion.

Ms. Frazer discussed the FAA's HEMS final rule-making. Ms. Frazer has been asked if CAMTS was planning on commenting on the final rule. The board felt that it would not be appropriate for CAMTS to provide official comment.

Mr. D. Smith discussed CMS's conditions of participation (COP). AAMS has created a working group to

review COP for air medical services. Mr. Smith has participated in these committee meetings.

Mr. D. Smith discussed his continued evaluation of achieving the Baldridge award for CAMTS. Mr. Smith states this will be a very long process and may take up to 7 years. In the short-term, Mr. Smith has evaluated the ANSI process for certifying the CAMTS standards making process. Mr. Smith states that CAAS is currently going through this process. Mr. Smith believes that we currently meet the majority of the ANSI standards. The executive committee is in support of seeking this accreditation and Mr. Smith will gather more information at our next board meeting. Dr. Stuhlmiller made a motion seconded by Dr. Holleran to continue pursuit of ANSI certification. Motion passed unanimously.

Mr. D. Smith discussed joining NASEMSO as an affiliate member. CAMTS has attended their meetings in the past. As an affiliate member, we are allowed three members. Ms. Frazer and Mr. Smith are currently listed and we have a vacancy for a third member.

Ms. Frazer discussed CAMTS' upcoming participation at the AirMed 2014 conference in Rome, Italy. Ms. Frazer and Mr. D. Smith will be attending and providing presentations.

Ms. Frazer discussed using our July meeting in San Diego to use as a strategic planning meeting for CAMTS. Ms. Frazer states that we can clear the agenda for that meeting by conducting a web meeting between now and then. Dr. Rogers discussed ideas to streamline our accreditation deliberations. One idea discussed was to do away with areas of excellence or acknowledgement but rather leave them as areas of "strength". There was also discussion about further streamlining the review of the safety culture survey graphs. The board was queried for additional ideas as to how to streamline our deliberations.

Ms. Frazer discussed some questions she has received regarding Assist Company accreditations. CAMTS currently has no standards governing this aspect of the industry. Mr. D. Smith related the details of an inquiry he just received from a private citizen regarding their recent disturbing experience using a fixed wing company for a transport from the Baja peninsula area of Mexico to San Diego, California. The transport was completed only after a cash payment was made of $15,500.00 that was negotiated down from $30,000. Following the transport, the complainant was informed that her insurance carrier would be balance billed for the transport to a total of $300,000. This total charge was only disclosed after the transport was completed. The complainant believed their cash payment of $15,500 was the total charge. Mr. D. Smith referred them to the Attorney General's office of the State of California and the FBI.

Executive Committee Report.....Dr. Rogers

Dr. Rogers provided an overview of the Executive Committee meeting last night. Dr. Rogers stated that 48 progress reports were reviewed, the majority of those being by Ms. Frazer and Mr. D. Smith.

ACCREDITATION DELIBERATIONS.....The Board

The board entered into Executive Session at 1008hrs. Dr. Orr reviewed our Mission Statement, Vision and Values, as well as the rules of conduct for program deliberations.

Program #119621 was presented for consideration of reaccreditation by Dr. Holleran. Ms. Montgomery, Mr. A. Smith, Ms. Treadwell and Mr. Tangerose were excused for a conflict of interest.

Following board review, a motion was made by Dr. Holleran and seconded by Mr. Hickman for probational accreditation. Following discussion of possible preliminary denial, the question was called. Motion passed unanimously.

Program #089207 was presented for consideration of reaccreditation by Dr. Orr. Mr. Hickman, Dr. Brunko, Mr. Tangerose and Mr. Gryniuk were excused for a conflict of interest. Following board review, a motion was made by Dr. Orr and seconded by Dr. Holleran for full accreditation with follow-up to the Executive Committee in 3 months. Motion passed unanimously.

Program #060413 was presented for consideration of reaccreditation by Ms. Treadwell. Mr. Tangerose and Ms. Montgomery were excused for a conflict of interest. Following board review, a motion was made by Ms. Treadwell and seconded by Dr. Holleran for probational. Following extensive discussion, the question was called. Motion failed with no votes in favor. A motion was then made by Dr. Becker and seconded by Dr. Brunko for deferral of accreditation pending a supplemental visit. Motion passed unanimously.

Meeting was placed in recess for lunch at 1150hrs.

Meeting reconvened at 1237hrs.

Program #010403 was presented for consideration of reaccreditation by Mr. Sittig. Mr. Gryniuk was excused for a conflict of interest. Following board review, a motion was made by Mr. Sittig and seconded by Dr. Stuhlmiller for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed unanimously.

Program #060510 was presented for consideration of reaccreditation by Mr. Hickman. Mr. Gryniuk and Mr. Tangerose were excused for a conflict of interest. Following board review, a motion was made by Mr. Hickman and seconded by Dr. Holleran for probational accreditation. Following board discussion, the question was called. Motion passed unanimously.

Program #119107 was presented for consideration of reaccreditation by Dr. Brunko. Ms. Montgomery was excused for a conflict of interest. Following board review, a motion was made by Dr. Brunko and seconded by Dr. Holleran for probational accreditation. Following extensive board discussion, the question was called. Motion passed unanimously.

Program #040610 was presented for consideration of reaccreditation by Dr. Orr. Dr. Rogers was out of the room so Mr. D. Smith facilitated the discussion. Mr. Tangerose, Mr. Hickman, and Dr. Brunko were excused for a conflict of interest. Mr. A. Smith was absent. Dr. Rogers returned during the presentation and resumed the duties of the chairman. Following board review, a motion was made by Dr. Orr and seconded by Dr. Becker for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed with Dr. Rogers abstaining.

Program #110718 was presented for consideration of reaccreditation by Dr. Holleran. Mr. Tangerose was excused for a conflict of interest. Mr. A. Smith was absent. Following board review, a motion was made by Dr. Holleran and seconded by Ms. Treadwell for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed unanimously.

Program #099414 was presented for consideration of reaccreditation by Mr. Sittig. Mr. Tangerose, Mr. Hickman and Dr. Brunko were excused for a conflict of interest. Following board

review, a motion was made by Mr. Sittig and seconded by Dr. Holleran for full accreditation with follow-up to the Executive Committee in 6 months and a requirement to repeat the safety culture survey. Motion passed unanimously.

Program #099616 was presented for consideration of reaccreditation by Dr. Rogers. Mr. Gryniuk, Mr. Hickman, Mr. Tangerose, and Dr. Brunko were excused for a conflict of interest. Following board review, a motion was made by Dr. Rogers and seconded by Mr. Sittig for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed unanimously.

Program #021309 was presented for consideration of board action by Mr. A. Smith. Mr. Gryniuk, Mr. Hickman, Mr. Tangerose, and Dr. Brunko were excused for a conflict of interest. Following board review, a motion was made by Mr. A. Smith and seconded by Dr. Becker to maintain the program on provisional status with a report back to the full board in July and a supplemental visit for the new base. Motion passed with Ms. Treadwell abstaining.

Executive session was placed in recess for the day.

Policy Review.....The Board

Draft policy revisions were reviewed by the board. A motion was made by Dr. Orr and seconded by Mr. A. Smith to accept the policies as amended in discussion.

Meeting was placed in recess for the day at 1630hrs.

Meeting reconvened at 0801hrs on March 28th, 2014.

<u>ACCREDITATION DELIBERATIONS</u>.....The Board

The board entered into Executive Session at0802hrs. Dr. Orr reviewed our Mission Statement, Vision and Values, as well as the rules of conduct for program deliberations.

Program #020504 was presented for consideration of reaccreditation by Mr. Gryniuk. Ms. Montgomery, Dr. Stuhlmiller and Dr. Price-Douglas were excused for a conflict of interest. Following board review, a motion was made by Mr. Gryniuk and seconded by Mr. Sittig for probational accreditation Following extensive discussion including whether or not a supplemental visit was required, the question was called. Motion passed with three against the motion.

Program #051316 was presented for consideration of reaccreditation by Mr. Hickman. No one was excused for a conflict of interest. Following board review, a motion was made by Mr. Hickman and seconded by Dr. Holleran for full accreditation with follow-up to the Executive Committee in 3 months. Motion passed unanimously.

Program #040611 was presented for consideration of board action by Dr. Stuhlmiller. Mr. Gryniuk was excused for a conflict of interest. Following board review, a motion was made by Dr. Stuhlmiller and seconded by Mr. A. Smith for continued probation. Motion passed unanimously.

Program #040408 was presented for consideration of board action by Dr. Stuhlmiller. Mr. Gryniuk was excused for a conflict of interest. Following board review, a motion was made by Dr. Stuhlmiller and seconded by Dr. Holleran for full accreditation with follow-up to the

Executive Committee in 6 months. Motion passed unanimously.

Program #120030 was presented for consideration of reaccreditation by Mr. Tangerose. No one was excused for a conflict of interest. Following board review, a motion was made by Mr. Tangerose and seconded by Dr. Holleran for probational accreditation. Following extensive discussion, Dr. Holleran proposed a friendly amendment to the current motion to include a supplemental visit to be completed in 6 months. The amendment was accepted by Mr. Tangerose. Motion passed with three against the motion.

Program #051318 was presented for consideration of accreditation by Ms. Palmer and Dr. Brunko. Mr. Tangerose and Mr. Gryniuk were excused for a conflict of interest. Following board review, a motion was made by Ms. Palmer and seconded by Dr. Holleran for full accreditation with follow-up to the Executive Committee in 6 months. Following discussion of possible provisional action, the question was called. Motion passed unanimously.

Program #011302 was presented for consideration of accreditation by Mr. Gryniuk and Mr. A. Smith. No one was excused for a conflict of interest. Following board review, a motion was made by Mr. Gryniuk and seconded by Mr. Sittig for provisional action. Following extensive discussion, the question was called. Motion passed unanimously.

Dr. Wedel arrived to the meeting at 1129hrs.

Program #099614 was presented for consideration of reaccreditation by Dr. Price-Douglas. Mr. Tangerose and Ms. Treadwell were excused for a conflict of interest. Following board review, a motion was made by Dr. Price-Douglas and seconded by Mr. Sittig for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed unanimously.

Meeting recessed for lunch at 1140hrs.

During lunch, Dr. Price-Douglas was recognized and thanked for her years of service to the board as this is her last board meeting. Dr. Price-Douglas will continue her service to CAMTS as a site surveyor.

Meeting reconvened at 1239hrs.

Dr. Price-Douglas and Ms. Rush left the meeting.

Program #061319 was presented for consideration of accreditation by Mr. Tangerose and Mr. A. Smith. Dr. Stuhlmiller was excused for a conflict of interest. Following board review, a motion was made by Mr. Tangerose and seconded by Mr. A. Smith for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed with Dr. Becker abstaining.

Program #091324 was presented for consideration of accreditation by Mr. Gryniuk and Mr. Brisboi. No one was excused for a conflict of interest. Following board review, a motion was made by Mr. Gryniuk and seconded by Mr. Sittig for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed unanimously.

Executive session was placed in recess at 1326hrs.

Standards Committee…….....Mr. D. Smith

Mr. D. Smith reviewed the proposed timeline for implementation of the new Levels of Care revision:

July board meeting will be for strategic planning and focus on Levels of Care.
September AMTC rollout of first draft of new standards.
October-January 2015 public review and comment of new standards.
March 2015 second draft of new standards.
June 1, 2015 final comments on second draft are due.
July 2015 board meeting for completion of the final draft.
Release of new standards at AMTC 2015.

Aviation Advisory Committee…….....Mr. Brisboi / Mr. A. Smith

Mr. A. Smith discussed the need to bring our current aviation standards through our fledgling aviation advisory committee. Mr. Brisboi presented his paper describing the purpose and composition of the committee which he has recommended rebranding as the Aviation and Safety Advisory Committee. Following review, Mr. Brisboi, Ms. Frazer, Mr. A. Smith, Ms. Palmer, Dr. Becker and Mr. Nix volunteered to work on a revision of the document based upon the feedback received from the board.

Ms. Frazer reviewed a letter she just received from the EURAMI board to the CAMTS board. EURAMI states they have been made aware of the duplication of some CAMTS standards within their standards and they are working to correct those areas. EURAMI also has asked for CAMTS to consider increased collaboration with them. The board discussed the letter and the possibility of collaboration. Ms. Frazer, Mr. D. Smith, and Dr. Becker will be available to meet with EURAMI representatives at AIRMED 2014 in Rome.

The board discussed the need to examine bringing additional European representation onto the CAMTS board. a few potential organizations/individuals were discussed as possible options.

Dr. Alexander discussed an opportunity for CAMTS to enter into accreditation standards for low earth orbit and space medical care. Dr. Alexander has noted that this need is arising due to the emergence of commercial space travel and requirements that NASA has for care capabilities during recovery operations. The board agreed that this opportunity is worth additional investigation.

Quality Management Committee…….....Ms. Treadwell

Ms. Treadwell stated that the committee is still gathering and evaluating our past QM activities and forms before making additional recommendations.

Ms. Frazer raised her concerns regarding the difficulty in locating the critical elements in the clinical standards during program reviews. Often, these critical elements might be scattered through many different clinical standards. Dr. Wedel suggested that we require the programs to submit these items as a separate attachment. The board revisited what goals we were attempting to accomplish by evaluating these critical elements. There was discussion that if we draw attention to these specific protocols, the program may focus only on updating those standards. The goal was to better assess the program's overall compliance with maintaining the currency of their medical protocols. Ms. Frazer will now place program medical standards into a DropBox folder for review by our physician board members. The physicians will then discuss the challenges in evaluating these standards and will report back to the board. Dr. Stuhlmiller, Dr. Rogers, Dr. Wedel, Dr. Brunko and Dr. Orr will conduct these reviews.

Executive session was reconvened at 1520hrs. Ms. Holtschneider was called for teleconference with the board.

Program #079609 was presented for consideration of reaccreditation by Ms. Holtschneider. No one was excused for a conflict of interest. Following board review, a motion was made by Ms. Holtschneider and seconded by Dr. Holleran for full accreditation with follow-up to the Executive Committee in 6 months. Following extensive discussion, the question was called. Motion failed to pass with no support. A motion was made by Mr. Brisboi that was seconded by Mr. Gryniuk for probational accreditation. Following extensive discussion, the question was called. Motion failed with only one vote in favor. A motion was made by Dr. Wedel and seconded by Dr. Becker for preliminary denial of accreditation. Motion passed unanimously.

Ms. Holtschneider ended her call and executive session was placed in recess.

Dr. Rogers invited our new board members to comment on their first impressions of our process. Ms. Montgomery, Dr. Nix, Dr. Alexander and Ms. Rush shared there perspectives.

The meeting was placed in recess for the day at 1621hrs.

The meeting was reconvened at 0806hrs on Saturday, March 29th.

Meeting was placed into executive session.

Program #010402 was presented for consideration of board action by Mr. Sittig. Mr. Hickman was excused for a conflict of interest. Following board review, a motion was made by Mr. Sittig and seconded by Dr. Holleran for continued full accreditation with follow-up to be conducted by the site surveyors during their upcoming survey. Following extensive discussion. Motion failed with Ms. Montgomery abstaining. A motion was made by Mr. A. Smith and seconded by Dr. Becker to defer action until the full site visit is conducted this May. Motion passed with one vote in opposition and Ms. Montgomery abstaining.

Dr. Conn was called for teleconference with the board.

Program #061320 was presented for consideration of accreditation by Dr. Conn. Mr. Gryniuk and Mr. Tangerose were excused for a conflict of interest. Following board review, a motion was made by Dr. Conn and seconded by Mr. Brisboi for full accreditation with follow-up to the Executive Committee in 6 months. Motion passed unanimously.

Dr. Conn ended his call.

Program #050707 was presented for consideration of reaccreditation by Ms. Rush and Dr. Price-Douglas. Mr. Sittig was excused for a conflict of interest. Following board review, a motion was made by Ms. Rush and seconded by Dr. Holleran for full accreditation with follow-up to the Executive Committee in 6 months. After extensive discussion. Motion passed with two votes against the motion and Dr. Wedel abstaining.

Executive session was placed in recess.

Levels of Care Discussion…….....The Board

The board entered into review of the current Levels of Care project. Ms. Frazer and Mr. D. Smith

collected detailed notes regarding the elements discussed by the board as each level was reviewed. Mr. D. Smith will confer with Mr. Brown regarding the minimum requirements and allowed variability for BLS and ALS services. Dr. Stuhlmiller will review the AMPA guidelines and pull out the metrics that are pertinent to ALS. Levels V through III were reviewed.

Ms. Rush and Dr. Price-Douglas departed the meeting.

The board recessed for lunch at 1200hrs.

The board reconvened at 1236hrs.

Levels of Care Discussion…….....The Board

The board continued their discussion on the Levels of Care. Levels II through I were reviewed and discussed. The board discussed the minimum numbers of mission types that are required for competency and will need to further consider this topic as the process progresses. Mr. D. Smith advised that we should release information regarding our expectations of where we expect most programs to fall which would likely be a Level III. In doing this, we might lessen the impact on programs that expect a higher level of accreditation. There was also discussion that we will make the determination as to the level of care they provide, they will not apply for a specific level. Mr. D. Smith raised the question as to whether or not we should rename this process from "Levels of Care" and reconsider the numeric designation in order to make this system more palatable to our constituency. The decision was made to change the name to "Types of Care" and reverse the numeric identifiers so that the previous "Level I" is now a "Type V". Ms. Frazer will query several of our programs to determine what volume of transports they are conducting in these specialty area in order to help assist in identify minimum competency volume levels. Ms. Frazer also asked the board members to seek out this information through their community contacts. The suggestion was then made to request this informational from all of our accredited programs which may help prepare them for the potential changes.

Ms. Palmer, Mr. A. Smith, Dr. Rogers and Dr. Wedel departed the meeting at 1352hrs. Dr. Orr assumed the duties of the chairman.

Dr. Holleran departed the meeting at 1410hrs.

Aviation Advisory Committee…….....Ms. Frazer

Ms. Frazer discussed the need for a board member to serve as chairperson of this committee. Fred Brisboi accepted the nomination to perform this duty. Fred will reach out to several parties that have expressed an interest in participating.

Ms. Frazer stated that the next CAMTS meeting is July 10-12 in San Diego at the US Grant hotel. She will be sending out the hotel information. Ms. Frazer anticipates the need for a board web meeting to be held the end of June and the end of July. Ms. Frazer will send out some prospective dates for these meetings. Board members should plan on committing 4 hours for each meeting. Our September meeting will be the 18th-20th in Nashville, TN in conjunction with AMTC. Board members were invited to attend any of the CAMTS workshops at AMTC. Ms. Frazer discussed options for our Spring 2015 meeting. Following discussion, the board felt it was worthwhile to continue to partner with CCTMC which will be held in Charlotte, NC next year. The dates for that meeting are

April 16-18, 2015. The need for a January in person meeting was discussed. Options of partnering with the NAEMSP conference or Heli-Expo were discussed as well as just conducting a meeting independent of any other conference. Dr. David Alexander offered the possibility of hosting the board at NASA in Houston, TX for next summer and provide a tour of the center. Ms. Palmer would look into some short sea cruise options following the meeting.

Ms. Frazer stated that board officers will need to be elected at the July meeting in San Diego. Any board member expressing an interest in one of the officer positions should make their interest known.

Airway Committee…….....Dr. Stuhlmiller

Dr. Stuhlmiller stated that no further work has been conducted by the workgroup as so much of the content will be incorporated into the Type of Care process.

Ms. Frazer stated that she has been contacted by former board member Howard Ragsdale who is completing a cross country drive as part of an air medical safety initiative called the Great American Safety Drive. Mr. Ragsdale requested permission to use the CAMTS logo on the vehicle. The board was in favor of supporting this request.

There being no further business, a motion was made by Dr. Brunko and seconded by Ms. Montgomery to adjourn. Motion passed unanimously. Meeting adjourned at 1448hrs.

Respectfully Submitted,

Jonathan Gryniuk
Recording Secretary – CAMTS

Extracorporeal Life Support Organization

Summer 2014

No report submitted as of July 3, 2014.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Summer 2014

Recommendations

None

Report

1. **Canadian Society of Respiratory Therapists Celebrates 50th Anniversary:** Both the AARC and the ICRC sent representatives to the CSRT Annual Meeting held in Montreal May 22 – 24, 2014. George Gabler, AARC President and Tom Kallstrom, AARC Executive Director as well as Jerome Sullivan, ICRC President and Hassan Alorainy, ICRC Executive Committee were on hand to make presentations and to recognize the CSRT's 50th Anniversary. (Read more on ICRC Facebook page.) On behalf of the ICRC Jerome Sullivan presented the membership of the CSRT with a plaque inscribed as follows:

50th Anniversary Recognition Award
Fifty Years of Service & Excellence
Presented to
The Canadian Society of Respiratory Therapists
On Occasion of
50th Annual CSRT Education Conference
May 22 – 24, 2014
Queen Elizabeth Fairmont Hotel
Montreal, Quebec, Canada

2. **The International Education Recognition System (IERS):** Nine (9) recent IERS Program Approvals include

Level II - College of Medicine, Zhejiang University
"Ventilator Management/Monitoring for Acute Respiratory Failure"
Sir Run Run Shaw Hospital, Respiratory Care Department
Hangzhou, Zhejiang, China
March 20 - 21, 2014

Level III - China Medical University
Respiratory Therapy Bachelor Degree Program
March 7, 2014 - March 7, 2015
Tiachung, Taiwan

Level I - Guang An' men Hospital
"2nd Annual GAM Respiratory Therapy Symposium"
Beijing, China
April 21 - 25, 2014

Level II - The Japan Association for Respiratory Care
"The Physicians' Ventilation Workshop Program"
Paramount Bed Co. Training Center Tokyo, Japan
May 31 - June 1, 2014

Level I - Tongji University School of Medicine
"2014 Tongji Mechanical Ventilation Forum"
Shanghai Tenth People's Hospital
Shanghai, China
June 6 - 8, 2014

Level II - College of Medicine, Zhejiang University
"Respiratory Care Practice in The ICU"
The 8th Intercoastal China Combined Meeting
Sir Run Run Shaw Hospital, Respiratory Care Department
Hangzhou, Zhejiang, China
July 5 – 7, 2014

Level I - Shonan Kamakura Hospital
& Japanese Association for Respiratory Care
"Respiratory Care Seminar in Shonan 2014"
Shonan, Japan
July 19 - 20, 2014

Level II - The Japan Association for Respiratory Care
"The Physicians' Ventilation Workshop Program"
Paramount Bed Co. Training Center Tokyo, Japan
August 2 - 3, 2014

Level I - The XII International Congress in Respiratory Care
The Mexican Association for Respiratory Therapy (AMTR)
Paraíso Radisson Perisur Hotel
Mexico City, Mexico
August 6 - 9, 2014

3. **4th Annual Tongji Mechanical Ventilation Forum:** The ICRC was represented by Jerome Sullivan at this important meeting I early June 2014. The Forum registered 220 physicians, respiratory therapists, and nurses for the IERS Approved, "Tongji Mechanical Ventilation Forum" at the 2,000 bed Shanghai 10th People's Hospital of the Tongji University School of Medicine, June 6 -9, 2014, Shanghai, China. (Read more on ICRC Facebook page.)

4. **COPD Foundation Establishes Fundación EPOC:** The ICRC has collaborated with the COPD Foundation to promote awareness of their plans to incorporate as a nonprofit organization Fundación EPOC, in Spain. Fundación EPOC will facilitate collaborative efforts by convening a series of global patient summits with the goal of addressing COPD worldwide. Fundación EPOC will also be critical in the COPD Biomarkers Qualification Consortium’s efforts to submit biomarker qualification packages to the European Medicines Agency.

5. **British Columbia, Canada RT's Teach in Peru:** Thompson Rivers University (TRU) Respiratory Therapy Program faculty and students have recently completed their third annual visit to Peru where they have been educating and learning from healthcare professionals across the country. This unique program not only provides quality RT education training programs for the Peruvians, but also is designed for Canadian RT student volunteers participating in the program to earn credit hours toward completion of their RT degree at TRU.

Joint Commission - Ambulatory PTAC

Summer 2014

No report submitted as of July 3, 2014.

Joint Commission - Home Care PTAC

Submitted by Kimberly Wiles – Summer 2014

Recommendations

None

Report

Nothing to report, quarterly meeting scheduled for 6/24/2014 which is after BOD report due.

Joint Commission - Lab PTAC

Summer 2014

No report submitted as of July 3, 2014.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Summer 2014

Recommendations

None

Report

Attended "School Asthma Education Subcommittee" conference call on May 28th. The following are the highlights of the call:

- **NAEPP update form Ms. Tracy**: needs assessment for need to update NIH asthma guidelines has been completed and the recommendations will go to the NIH administrative council in June. Once we hear the decision made by the council than we will know the next steps for this update. NACHI activities are wrapping up and they will be submitting the results of their programs for publication. There is a plan for a coordinating committee webinar in July when we have the decision from the administrative council. Planning a potential in person meeting for the fall.
- **New educational materials from NHLBI are available online and in print**. They will put together a announcement flyer for us to be able to advertise these materials with our organizations – I will send this over to the executive office and Asthma Disease Roundtable when I get it.
- **Possible Asthma Action Plan in schools activity next year**: Dr. Lemanske will be the new president of AAAAI next year and his president's initiative will be asthma action plans in school. His goal is for every child with asthma to have an action plan in the school. He would like to partner with NAEPP School committee and the partnering organizations. I will be in contact with Dr. Lemanske to assist and bring information to the BOD and recommendations where the AARC can partner as the planning commences.

Natl Coalition/Health Professional Education In Genetics

Submitted by Linda Van Scoder – Summer 2014

Recommendations

None

Report

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

National Sleep Awareness Roundtable

Submitted by Anne Marie Hummel – Summer 2014

Recommendations

None

Report

The National Sleep Foundation's 5-year contract to run NSART ended August 2013. The last meeting was February 2013. The contract was re-bid and, as reported at the Spring Board meeting, we understand the American Academy of Sleep Medicine (AASM) won the new contract. To date, there has been no information as to whether NSART will continue or if the AASM plans to hold meetings with the organizations that comprise the Roundtable.

Neonatal Resuscitation Program

Submitted by John Gallagher – Summer 2014

Recommendations

No recommendations at this time.

Report

The NRP Steering Committee (NRPSC) has not met since the last liaison report was submitted in March of 2014. However, the 7th edition of the NRP textbook continues to be the topic of focus for the committee. Final edits will be made in the months to come as the scientific findings from the International Liaison Committee on Resuscitation (ILCOR) become available in the very near future.

The next planned event is a NRPSC meeting in San Diego, CA in October of 2014 to complete all outstanding edits to the 7th edition textbook and evaluate grant proposals for research funding. In addition, the NRP Current Issues Seminar will take place following the meeting and the AARC liaison will be involved as a coordinator of a hands-on break out session during that seminar.

Roundtable Reports

Asthma Disease Management

Submitted by: Natalie Napolitano – Summer 2014

Recommendations

None at the time

Report

Solicited ideas from roundtable for AARCTimes articles for next year – forwarded ideas to Marsha and Doug

Consumer

See Executive Director Report pg. 42

Disaster Response

Submitted by Charles Friderici – Summer 2014

Recommendations

None

Report

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

Geriatrics

Submitted by Mary Hart – Summer 2014

Recommendations

None at the time

Report

Topics / authors for aarc times articles being discussed.

Will have meeting of members at congress in Las Vegas.

No Chair, no report

Informatics

Summer 2014

No report submitted as of July 3, 2014.

International Medical Mission

Submitted by Lisa Trujillo – Summer 2014

Recommendations

None

Report

Membership is currently at 79.

Meeting during AARC Summer Forum

The IMMR will meet to discuss follow up on previous identified goals established during the IMMR meeting held at the AARC 2013 Congress.

Meeting goals include:

- Discuss progress on previously established goals (an agenda will be made prior to the meeting and it is anticipated that phone in capability will be available for IMMR members who are unable to attend the meeting in person.
- Discuss additional goals and possible options to aid in increasing IMMR membership

Update since previous board report:

Arrangements are being made to share posters of mission work with the AARC House of Delegates at the Summer Forum and the AARC International Congress in the fall. Currently, IMMR members are preparing posters to share at the Summer Forum HOD meetings.

A shipment of respiratory therapy and general medical supplies (40’ container) was successfully delivered to Korle Bu Teaching Hospital in Accra, Ghana. In addition to this donation, the University of Ghana School of Allied Health Sciences has formally approved a baccalaureate degree program for respiratory therapy to begin August 2015.

Additional mission work continues throughout the world and we anticipate being able to share spotlights of these efforts on storyboards (posters) that will be displayed at the Summer Forum.

Military

Summer 2014

No report submitted as of July 3, 2014.

Neurorespiratory

Submitted by: Lois Rowland - Summer 2014

Recommendations

None

Report

Nothing to report.

Palliative Care

No report submitted as of July 3, 2014.

Patient Safety

No report submitted as of July 3, 2014.

Research

Submitted by John Davies – Summer 2014

Recommendations

None

Report

Discussion level still remains low. I am waiting to hear more details about the research mentorship program to hopefully get feedback from the group.

Simulation

Submitted by Julianne Perretta – Summer 2014

Recommendations

None

Report

AARC International Congress: Friday am, December 12, will be a set of 4 presentations (1 lecture and a 3 part workshop) regarding simulation curriculum design and best practices.

Tobacco Free Lifestyle

Submitted by Jonathan Waugh – Summer 2014

Recommendations

None

Report

A one-day, pre-Congress workshop on tobacco treatment techniques was conducted by three respiratory therapists and a physician tobacco specialist. The faculty commends Doug Laher for his efforts to make this workshop a success. It would be great if this type of training could be repeated at regional meetings so that RTs who are unable to attend the Congress can still access the training. News on activities of TFL members:

- TFL members Jay Taylor, Georgianna Sergakis, Karen Schell and Jonathan Waugh were interviewed for an AARC article on smoke-free hospital campuses and the role the respiratory therapist can and should play in developing and maintaining these policies.
- AARC Clinician Guide for Tobacco Cessation (companion to AARC Patient Guide on same topic). Work group co-chair Georgianna Sergakis reports that the writing for the guide is complete and a proof copy is being generated for final review. The plan is to print this guide as an ePublication to make it easily available to as many clinicians as possible.
- The MSQuit randomized control trial conducted by U Mass Med School and Harvard U School of Public Health is drawing to a close and will soon start publishing results of a multi-modal educational method to improve tobacco dependence treatment skills (i.e. 5As) among medical students (design paper Contemporary Clinical Trials 2014;37(2):284-93.). The results will likely apply to other health professions including respiratory therapy. TFL member Jonathan Waugh is a co-investigator at one of the ten universities that participated in the study and will post relevant findings to the Tobacco Free Lifestyle discussion board as they are released.

Other

- TFL members have submitted proposals for tobacco treatment and education for the next AARC Congress and await notification.
- Invitation to present at Smoking Science Summit (May 2015) in London (https://www.regonline.co.uk/builder/site/Default.aspx?EventID=1568483). TFL roundtable member Mary Martinasek, PhD, RRT, is willing to prepare several presentations for the summit if she can obtain sponsorship for $1800 for her travel expenses (registration and food are covered). This is an excellent opportunity to showcase the respiratory care profession at an international smoking science summit. We respectfully request support from the AARC for this activity.

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Summer 2014

Recommendations

None

Report

Charge:	Develop a mentoring program for AARC members with the purpose of increasing the Diversity of the BOD and HOD.
Status:	LT Joseph Buhain, EdD, MBA, RRT, FAARC from Minnesota Golda Crowder from California will attend in the Fall. Also communicating with other interested members.
Charge:	The Committee and the AARC will continue to monitor and develop the web page and other assignments as they arise.
Status:	Ongoing

Ad Hoc Committee on Officer Status/US Uniformed Services

Summer 2014

No report submitted as of July 3, 2014.

Ad Hoc Committee on 2015 & Beyond

Submitted by Toni Rodriguez – Summer 2014

Recommendations

None

Report

CHARGE #1

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

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

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

Summer Report:

In analysis of the survey results the committee:

1. Focused only on the competencies that the sample identified as being acquired after graduation.
2. Determined the standard error for the results based upon the data (8,400 members asked to complete the survey, 948 members responded for an 11% response rate) .
3. Multiplied the standard error times a 95% confidence intervals factor to arrive at how much we should subtract from each response percentage to create our lower confidence interval boundary.

4. Compared the standard error corrected percentage against our selected threshold of 60%.

After statistical manipulations the following competencies were identified from the study as acquired after entering practice:

Competency	Corrected Response %
2. Compare and evaluate indications and contraindications for advanced pulmonary function tests (plethysmography, diffusion capacity, esophageal pressure, metabolic testing, and diaphragm stimulation) and be able to recognize normal/abnormal results.	78.6
6. Describe the bronchoscopy procedure and describe the respiratory therapists role in assisting the physician.	60.3
26. p. Ensure financial/economic support of plan/program and related documentation	74.5
28. Review and critique published research.	68.4
29. Explain the meaning of general statistical tests.	59.8
31. Explain the use of evidence-based medicine in the development and application of hospital-based respiratory care protocols.	60.8
47. Team Leader Understand the role of team leader: specifically, how to lead groups in care planning, bedside decision making, and collaboration with other healthcare professionals.	68.9
50. Perform endotracheal intubation.	66
98. Hyperbaric oxygen systems	69
99. Sub-ambient oxygen delivery systems (neonatal only)	73.5
110. Nitric oxide therapy	64.4
154. Assist physician in placing surgical or percutaneous tracheostomy tube.	69.5
167. Recommend cardiovascular drugs based on knowledge and understanding of pharmacologic action.	64.1 *
195. Negotiate with veracity for emergency situations worked outside of medical orders.	60.8 *
208. Develop a broader context of healthcare: costs, services, reform, restructuring. • Indicates that more that 20% of the survey takers skipped the question. It was noted that the percentage of skipped questions progressively increased due to the length of the survey.	65.1 *

The identified competencies could be grouped into the following categories:

I. Advanced Assessment of Pulmonary Function (2)
II. Assisting Physicians and/or Performing Diagnostic Procedures (6, 50, 154)
III. Review and Implement Published Research (28, 29, 31)
IV. Respiratory Care Department Stewardship and Management (26p, 47, 195, 208)
V. Specialty Gas Administration (98, 99, 110)
VI. Advanced Cardiopulmonary Pharmacology (167)

Committee comments related to suggested mechanisms for competency acquisition included:

1. Identifying current AARC educational resources that cover these competencies.

2. Make State Societies aware of the competencies so that they may be included in their continuing education offerings.
3. AARC create on line learning modules or web-casts to cover the competencies.
4. As advanced education models for Respiratory Care develop encourage the inclusion of these competencies at the advanced course levels.

CHARGE #2:

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

Committee Members:

Lisa Shultis
Joseph Goss
Denise Johnson
Lynda Goodfellow
Toni Rodriguez

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

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

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

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

Discussion:
Committee requested that committee chairs contact Shawna Strickland and Pat Doorley on advice related to the production of an official AARC white paper. Toni volunteered to follow up on this. **Done**
Response: Based upon information received from several knowledgeable sources, committee chairs Goodfellow and Rodriguez recommend that the committee produce an" Issue Paper" on

the topic of Simulation for the AARC BOD. The Issue Paper would provide essential information and recommendations on the topic without the need for official BOD approval. The BOD could then decide on what to do with the information.

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

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

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

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

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

Summer Report

Committee members completed their research assignments and data was shared with the entire committee. A conference call was conducted on June 12th to discuss next steps. It was decided that the researched information would be formulated into an Issue Brief to be presented to the AARC BOD. Toni Rodriguez will compose the Issue Brief with the goal of presentation at the July BOD Meeting.

CHARGE #3:

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

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

Committee Members:

Pat Doorley	Toni Rodriquez	Karen Stewart
Brad Leidich	Lynda Goodfellow	Helen Sorenson

A conference call was conducted on March 6.

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

Member assignments to prepare for next meeting:

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

Summer Report

Conference call conducted June 4th, 2014

Discussion and Action Items (Underlined):

1. Create a generic "Bridge" model for state societies to provide as a template for an AS to BS bridge program. An explanation of how Virginia is developing such a model was shared. With the Kacmarek, et al publication (Resp Care 2012; 57(5); 710-720) as the theoretical framework, an 18-questionnaire was sent to VA society members with specific questions to the value of the RRT as entry-level credential and the value of BS-entry education. Results from the VA survey found that 1). Employers in most markets are mandating the RRT upon employment or within 6-months; 2). Few BS programs are available and there is concern that existing programs may not be able to handle potential demand; 3). More on-line options are needed and 4). Local membership opinions are important. VA has offered to share survey questions with other societies. A complete list of known existing completion and on-line Bridge programs by July HOD meeting & provide list of states which allow community colleges to offer BS degrees
2. What degree is best when partnerships are being negotiated? To have a BS in Respiratory therapy or BS in Health Sciences is questioned most often but will other degrees be recognized for mobility? There is a need for current information to be made available on bridge programs for articulation agreements to be successful. Investigate/explore reference for optimal degree name(s). Create list of known articulation agreements currently in use and use information to create an articulation model matrix of degree program options to include degree name, institution, accreditation status and accrediting agency, transfer credit accepted, cost per credit hour, Financial Aid information and web link
3. Advanced Practice in 2+2 programs. An advanced practice component should be an option as not all future Bridge students will want a management or education focus. The aim would be a RT who is prepared for the Adult Critical Care, Pediatric/Neonatal or other specialty practice exam. Need to know if this is already in practice.
4. HOD talking points to include:
    - Background as to why it was important to survey (see Kacmarek, et al. article)
    - Differences in BS degrees; value of BS in Respiratory Therapy vs. other BS degree options
    - List of current AS to BS completion and on-line programs available
    - Model "state" articulation agreement for bridging AS to BS degrees
    - Provide VA survey summary results

CHARGE # 4 :

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

Committee Members:

Lynda Goodfellow
Dianne Lewis
Karen Schell
Shantelle Graves
Toni Rodriguez

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

Summer Report

Conference call conducted June 9th, 2014

Discussion and Action Items (Underlined):

1. The committee members believe that there is enough information to demonstrate the value and validity of career ladders; which also includes skill acquisition. Career ladders should include the advancement to B.S. and M.S. degrees as part of any program.
2. Committee members believe that a marketing campaign from the AARC is needed with involvement from new graduates, current practitioners and retirees. This AARC campaign can add credence to hospitals who are struggling to receive approval to begin a ladders program. This possibly being a project within the leadership institute with a focus on branding or marketing career ladders.
3. Committee members noted that facilities in larger cities are mostly hiring RRTs and now with the RRT being the credential of choice for employment, rural facilitates are able to recruit RTS as there more opportunities available today in rural areas than in the past.
4. The committee members believe that a culture that values and appreciates the practitioner who wants upward mobility – not just a job, but a career is needed. This includes professional pride, an internal desire to not only do the work but make sure that the work is performed at the highest level. This culture adaption will allow all of us to see ourselves as a profession with a professional identity. Respect must be earned and career ladders is believed to be an avenue to impact this desired culture change.
5. The literature is non-conclusive on the value of career ladders for upward mobility. An "issues" paper will be drafted to outline the pros and cons of career ladders.

6. Comments from AARC Connect indicate that career ladders assist with retention of RTS. It is noted that pay increases are one of the biggest barrier for administrative approval. However, a stronger argument for implementation approval may be an emphasis on personnel investment to improve retention over time of the more talented RTs is more suitable.

Respectfully Submitted: Lynda Goodfellow Ed.D, RRT FAARC

Toni Rodriguez Ed.D, RRT, FAARC

Ad Hoc Committee to Reduce Hospital Readmissions

Summer 2014

No report submitted as of July 3, 2014.

Ad Hoc Committee on Virtual Museum Development

Submitted by Trudy Watson – Summer 2014

Recommendations

That the BOD approve the proposal to establish the *Legends of Respiratory Care* program**.**

Justification: We are proposing the establishment of a prestigious new recognition program to honor individuals who have made significant historic contributions to the respiratory care profession or to the science of respiratory care.

The Legends of Respiratory Care Recognition Program

The Legends of Respiratory Care recognition program is established to honor individuals who have made significant historic contributions to the respiratory care profession or to the science of respiratory care.

Nomination Process

- Nominations will be solicited from the Board of Directors of the AARC, the Board of Trustees of the NBRC and ARCF, and the Board of Commissioners of CoARC.
- The nomination criteria may include, but shall not be limited to:
    - Recognized professional achievements related to the clinical practice, education, or the science of respiratory care, publication of scientific articles or other activities bringing significant, sustained career recognition.
    - Sustained personal service, representation, or advocacy on behalf of the respiratory care profession, and/or individual's creativity or ideas that resulted in historic advancement of the profession or its professional societies.
    - Scientific achievements and/or inventions of historical significance that revolutionized, or remarkably enhanced delivery of respiratory care.
    - Singularly distinctive individual actions during historic professional events, above and beyond reasonable expectations, that resulted in advancement of respiratory care and/or resolution of a significant crisis or issue facing the profession.
    - Other sustained historic achievements as determined by the Boards of the AARC, ARCF, CoARC, and NBRC.
- Nominations require approval of a two-thirds (2/3) majority vote of the Board submitting the nominations.
- A list of nominees and a summary of qualifications limited to two (2) pages for each nominee must be received at the AARC Executive Office by the established deadline.
- Individuals are ineligible for nomination while seated on the Board of the AARC, NBRC, ARCF, or CoARC.

Legends Selection Committee

- A selection committee, consisting of the Executive Directors of the AARC, NBRC, CoARC and the Chair of the ARCF, or their designees, will serve as the selection committee.

- The selection committee will review the nominations and select up to the designated number of Legends each year.
- In 2014:
    - Up to ten (10) nominations each may be submitted by the Board of Directors of the AARC, the Board of Trustees of the ARCF and the NBRC, and the Board of Commissioners of CoARC to the AARC Executive Office within 45 days following the AARC Summer Forum. A summary of qualifications, limited to two pages for each nominee, must be received at the AARC Executive Office by the stated deadline.
    - The selection committee will review the nominations and select up to ten (10) Legends in 2014.
- Beyond 2014:
    - The Board of Directors of the AARC, the Board of Trustees of the ARCF and the NBRC, and the Board of Commissioners of CoARC may each submit up to five (5) nominees by May 1 to the AARC Executive Office. A summary of qualifications, limited to two pages for each nominee, must be received at the AARC Executive Office by the stated deadline.
    - The selection committee will review the nominations and select up to five (5) Legends each year.

Announcements of the Legends of Respiratory Care

- The Legends will be announced at the AARC International Congress and will be featured in the *Legends of Respiratory Care* gallery of the AARC's Virtual Museum.

Over recent months, representatives from the AARC, NBRC, CoARC, and ARCF have held multiple conference calls to discuss the *Leaders and Legends* gallery for the AARC's Virtual Museum and to develop the nominations process and selection criteria for the *Legends of Respiratory Care* recognition program. Tom Kallstrom, Gary Smith, Tom Smalling, Sam Giordano, Robert Weilacher, Sherry Milligan and I have participated on the "Leaders and Legends" team. With the exception of Bob Weilacher, all of the team members participated in a conference call on June 27, 2014. The proposal was unanimously approved by the team members on the call, subject to review by the respective Boards.

Fiscal impact for the program would be minimal. The individuals designated as *Legends* would be showcased and honored in a special gallery in the AARC's Virtual Museum. A plaque or certificate could be presented to living Legends to commemorate their designation as *Legends*.

Report

Programming revisions are on-going to ensure that all features of the template for our virtual museum galleries will operate as expected across multiple platforms. Until the programming revisions are completed, we have slowed down our efforts to enter content into new galleries. Meanwhile the teams have continued to collect and research material for their assigned exhibits.

The committee is grateful for the generosity of our Association members who have embraced the virtual museum concept and contributed vintage photos from their archives and personal collections. Some members have shared a single photo while others have shared dozens. Every photo contribution has truly been appreciated.

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Summer 2014

The American Respiratory Care Foundation (ARCF) continues to stay active in promoting and increasing awareness of our mission and purpose. The ARCF continues to hold quarterly calls, and will have its 2014 face-to-face meeting at Marco Island preceding Summer Forum. The following are highlights of recent board actions as well as activities currently under taken by ARCF, which are all in addition to administering the extensive array of education recognition awards, fellowships, and grants.

During the Trustee conference call held in April, it was decided that the Foundation will no longer promote the Vent 5K and the community grants provided by this event. It was found that as the event had not been trademarked, many other organizations were using this event to support their own purposes under the same name.

In accordance with the ARCF's plan to increase awareness to the members, its first quarterly newsletter was emailed to AARC members this past May. The newsletter highlighted the educational and achievement awards, the International Fellowship program, the Journal Conference, as well as the abstract submissions deadline for the literary and fellowship awards. The next quarterly newsletter will be sent in August. In addition, the June 2014 issue of AARCTimes included a column dedicated to the ARCF.

This June 6-7, ARCF presented the 53rd Journal Conference focusing on the "Aerosol Drug Delivery in Respiratory Care". The proceedings from this Conference will be published in a 2015 issue of RESPIRATORY CARE. Sponsors of the Journal Conference included Monaghan, Aerogen, and InspiRx at the Sponsor level, and Teleflex at the Donor level. In all, $66,000 was raised to support the Conference. Solicitations for sponsorship of the 54th Journal Conference will begin in the fall.

As of June, the 2014 International Fellowship Program had sponsorship from Draeger Medical, Philips Respironics, Pima Medical Institute, Aspirant Education, the NBRC/AMP, the AARC, and the AARC House of Delegates. There were 17 fellow applications and 17 city host applications. The International Committee will be meeting during Summer Forum to discuss and select the 2014 International Fellows and City Hosts.

This year the ARCF educational awards received over 30 applications, and11 individuals were nominated for the achievement awards. The applications and nominees for all ARCF awards are currently in the process of being reviewed and voted on by the Trustees. Winners will be notified beginning the end of July.

The ARCF will be hosting an awareness event and fundraiser raffle during the welcome reception at Summer Forum in Marco Island, Florida. We were able to obtain several gift cards and other donations from organizations for the fundraising raffle to be held during the welcome reception. The Trustees will be in attendance at the event in order to help promote awareness of the Foundation to the members.

Planning is still underway for the 2014 ARCF Fundraiser Reception "A Night in the Vineyards" to be held December 8 in Las Vegas. More details will follow in the upcoming weeks. I hope that you will make it a point to attend this year's event, as we need the support of our peers to encourage the support of our members.

Summary

The ARCF Trustees continues to have frequent communication through quarterly phone conferences and face-to-face meetings. The ARCF will continue in its quest to increase awareness of our Foundation in order to be successful at our mission of promoting respiratory health through the support of research, education, and patient-focused philanthropic activities in respiratory care. On behalf of the Trustees, I greatly encourage you to attend our awareness event during the Welcome Reception and to support our Foundation with your purchase of raffle tickets or any monetary tax-deductible donations. We urgently need you to join us in support of our Foundation.

I look forward to presenting this report to you and entertaining any questions you may have while at the Board Meeting.

CoARC Report

Submitted by Tom Smalling – Summer 2014

See Attachment:

"CoARC Update to AARC 7 14"

Date: June 19, 2014

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

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

Subject: NBRC Report

I appreciate the opportunity to provide you this update on activities of the NBRC. Since the last report, the Board of Trustees and its committees met in late April/early May 2014. The Executive Committee will meet in September and the full Board of Trustees will hold its fall meeting November 18-23 in Phoenix to conduct examination development activities and discuss business related items pertinent to the credentialing system. The following information summarizes the current status of significant changes to several examinations and major activities in which the Board and staff are currently involved.

Credentialing System Evolves

Therapist Multiple-Choice Examination

We are in the final stages of development of the new Therapist Multiple-Choice (TMC) Examination. In late April, examination committee members and invited outside representatives conducted the passing point study to determine the low and high cut-scores for this new examination, which allow one exam to be used to establish competence at the CRT level and eligibility to sit for the Clinical Simulation Examination, respectively. The new examination will be implemented in January 2015. The first form of the TMC SAE has been released and is available for purchase through the NBRC's online store. A second TMC SAE will be available in October. Details regarding admissions policies, how/when to apply, etc. can be found on the NBRC's website.

Clinical Simulation Examination

The committee is finalizing the test forms which will be introduced in January 2015. The new format will contain twice as many (20) shorter

questions and allow the committee advantages such as more efficient problem updates. Dr. Robert Shaw, NBRC's psychometrician and Assistant Executive Director will present more details about the new simulation examination and the value of the Clinical Simulation Examination to the RRT credential at the Summer Forum in Marco Island.

Specialty Examination for Sleep Disorders Testing and Therapeutic Intervention

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

Extension of Special Certificate of CRT/RRT Eligibility

In January 2014, CoARC and the NBRC issued a joint announcement to discontinue CoARC Policy 13 and related admissions policies effective January 1, 2015. Subsequent to this announcement, CoARC and NBRC received a number of letters of concern about this decision and its potential effect on students who currently matriculated in a program that is authorized to issue a Special Certificate.

Therefore, in an effort not to penalize these students, the NBRC Board of Trustees voted to authorize the Special Certificate as a route for admission to the new Therapist Multiple-Choice (TMC) and Clinical Simulation Examinations for individuals who are issued such a certificate by a program authorized to do so by CoARC until December 31, 2015. Candidates utilizing this exception to the admissions policy must apply and test by December 31, 2015. After this date, all candidates must meet the admission requirements for the TMC and Clinical Simulation Examinations previously approved by the NBRC which require graduation from an institution supporting a COARC accredited respiratory therapy education program.

Clinical Experience Requirements Change

At its May 2014 meeting, the Board of Trustees approved changes related to admissions policies that include clinical experience requirements (CRT-to-Registry and several specialty examinations). Rather than requiring a certain number of years of experience to be deemed eligible, individuals will now have to hold their base credential (CRT or RRT) for a certain number of years to be eligible for those examinations which have a clinical experience requirement.

Support for Texas Licensure

At the request of the AARC, the NBRC moved quickly to submit a letter to the Texas Sunset Commission opposing its recommendation to deregulate the practice of respiratory care in that state. Specifically, the NBRC encouraged the Sunset Advisory Commission to reconsider its position concerning the deregulation of respiratory care practitioners and pointed out the differences between voluntary NBRC credentialing versus state licensure. Removal of the licensure process for respiratory care practitioners in Texas would most certainly endanger the health, safety and welfare of the citizens of that state. Deregulation of these health professionals would be a step backwards for any jurisdiction that has properly installed mechanisms to license and regulate respiratory care practitioners.

2014 Examination and Annual Renewal Participation

Through June 15, 2014, we have received nearly 20,000 applications across all examination programs, comparable to 2013 numbers. To date, 48,366 credentialed practitioners have paid their active status fee for 2014; this exceeds the number of active status renewals compared to this time in 2013.

Examination Statistics – January 1 – June 15, 2014

The NBRC has administered just shy of 18,000 examinations thus far in 2014. Pass rate statistics for the respective examinations follow:

Examination	***Pass Rate***
CRT Examination – 6,118 examinations	
• First-time Candidates	84.3%
• Repeat Candidates	27.3%
Therapist Written Examination – 5,553 examinations	
• First-time Candidates	71.1%
• Repeat Candidates	34.0%
Clinical Simulation Examination – 5,149 examinations	
• First-time Candidates	63.6%
• Repeat Candidates	48.0%
Adult Critical Care Examination – 307 candidates	
• First-time Candidates	85.7%
• Repeat Candidates	55.9%
Neonatal/Pediatric Examination – 544 examinations	
• First-time Candidates	69.6%

- Repeat Candidates 42.4%

Sleep Disorders Specialty Examination – 39 examinations
- First-time Candidates 94.3%
- Repeat Candidates 75.0%

CPFT Examination – 163 examinations
- First-time Candidates 81.1%
- Repeat Candidates 41.5%

RPFT Examination – 42 examinations
- First-time Candidates 60.7%
- Repeat Candidates 50.0%

Your Questions Invited

I look forward to working with you during my term as President. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and each of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the integrity of the credentialing process.

Unfinished Business

New Business

Policy Review

- BOD.024 – BOD – AARC Disaster Relief Fund
- BOD.027 – BOD – Policy for Surveys Conducted by the Association (see attachment “Policy BOD 27 BW Recommendations”)
- CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges (see attachment “CT 007 Judicial Cmte w Dewitt edits”)
- FM.002 – Fiscal Management – Annual Independent Audit
- FM.005 – Fiscal Management – Independent Auditors and Audit Subcommittee
- FM.018 – Fiscal Management – Audit and Oversight Standards
- RT.001 – Roundtables – Roundtables (see attachment “Policy RT 001 BW Recommendations”)

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **AARC Disaster Relief Fund**

EFFECTIVE DATE:

DATE REVIEWED: July 22, 2011

DATE REVISED: July 2011

REFERENCES:

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

Policy Amplification:

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

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

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

    a. Funding will also include payment of membership dues.

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

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

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

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Policy for Surveys Conducted by the Association**

EFFECTIVE DATE: March 2001

DATE REVIEWED: July 2010

DATE REVISED: July 2010

REFERENCES: CT.0688b Revised

Policy Statement:

1. All surveys of the AARC membership must be reviewed and approved by the Executive Committee before permission will be granted for conducting them.

Policy Amplification:

Definition of Surveys: For the purposes of this policy a survey is a document requesting data answers which may be used to comprehensively consider an area of subject matter for the purposes of gathering data where the analysis could be considered for publishing or corporate use.

Definition of Listserve Questionnaires: Any question or questions posed that would be considered personal information gathering for one's own use in their area of interest or practice.

1. Information requests occurring within AARC Section mail lists (Listservs) do not require board review provided that they adhere to the rules governing them. ***See attachment A below***

Survey Procedure

1. The requester must submit a copy of the survey plus communication stating the intent of the survey to the AARC President c/o the Executive Office, no less than30 days prior to the requested distribution date. The President will distribute the material directly to the Executive Committee.

2. Prior to Executive Committee the Executive Director or designate will evaluate the survey based upon the following criteria:

A. Overall appearance (e.g. clarity of layout, correction of typographical and other areas, etc.
B. Have similar surveys have been done within the last 24 months?
C. Clarity of questions and appropriateness of format.
D. No redundancy of questions.
E. Has the appropriate demographic information is requested.

F. Has a survey been sent to the same population of AARC members during the last six months?

3. After Executive Committee review, the requester will be informed by the Executive Office of the Committee's decision. If revisions are needed, the requester shall submit the revisions to the AARC Secretary who will be authorized to approve or reject these revisions on behalf of the Executive Committee.

4. ***Approved Surveys will be done using web based survey systems or be forwarded only directly to requestor/author of survey and not using the AARC Listserve system.***

Attachment A

AARC Listserv Rules

General

1. Message content must be relevant to the intent of the electronic mail list.
2. The following are not permitted to be posted:
    - Advertisements or motions for products, services, job
    - Meetings and events not sponsored by AARC
    - Poems, jokes and other forms of personal expression, chain mail, virus warnings, etc.
    - Copyrighted material from a source other than the AARC
    - Inquiries and promotions related to products/services by consultants, manufacturers, marketing firms and other similar entities outside of the AARC.
    - Discussions relating to pricing or cost of goods as this may be considered price fixing and is a federal offense.

3. The AARC reserves the right to remove anyone for any reason from the AARC electronic mailing list.

A. This includes the archival entries on the Listserve that pertain to a subject considered inappropriate or in violation of the Listserve guidelines.

The Exchange of Information:

1. AARC members may use the Listserv to exchange information between other Listserv subscribers.

2. Information shared on Listservs may be distributed and used in other AARC sponsored forums, but may not be utilized for commercial purposes outside the AARC.

3. When you post a question, or series of questions, be sure that you title it with a good, concise, explanatory title in the subject line to clearly differentiate the message from others being posted or responded to.

4. Regarding information requests posted by Listserv clients, the Section and Roundtable Chairs determine if the Listserv posting represents a survey that requires Executive Committee approval. The following guidelines can be utilized to differentiate Listserv information requests from query requests.

    4.1 Surveys often include the capturing of user specific information and hospital/department demographics for comparison reporting.
    4.2 The creator of a survey may embed a separate link to ask specific questions so participants do not have the option to view other responses. If the creator of this type of inquiry tool has not expressively indicated results will be shared and accessible to all

Listserv participants, the Section Chair will refer the individual to the Executive Office as per Policy BOD 027.

5. The sender of the information request may instruct section participants to reply to the Listserv or reply directly to their personal email.

5.1 In the event responses are sent directly to the personal email of the individual who posted the information request, a summary of those responses should be posted so all Listserv participants may share the information.

5.2 If your reply is simply a request to receive a copy of what someone has offered to share, or simply to agree with someone (such as: “Me too”), please do not reply to the entire group. Instead, send your response directly to the email address of the person who posted the message by clicking on your “Forward To” button, and typing in or cutting and pasting in the email address of the individual to whom you are responding.

American Association for Respiratory Care
Policy Statement

Policy No.: FM.002

SECTION: Fiscal Management

SUBJECT: **Annual Independent Audit**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December 2006

DATE REVISED: December 2006

REFERENCES:

Policy Statement:

The Association shall require an annual independent audit of its fiscal operations.

Policy Amplification:

1. The Board of Directors shall, with the advice of its business counsel, be responsible for selecting a qualified auditing firm.

2. The independent auditor's report shall be made available to the membership in a manner deemed appropriate by the Board of Directors.

3. Rotate the managing partner every three to four years, and share all policies with the Audit Committee that pertain to the Audit Committee.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: FM.005

SECTION: Fiscal Management

SUBJECT: **Independent Auditors and Audit Subcommittee**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December 2006

DATE REVISED: December 2006

REFERENCES:

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

Policy Amplification:

1. The independent auditor shall:

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

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

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

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Audit and Oversight Standards**

EFFECTIVE DATE: April 1, 2004

DATE REVIEWED: April 23, 2010

DATE REVISED: April 23, 2010

REFERENCES:

Policy Statement:

1. The Board of Directors and the Audit Subcommittee will review financial transactions and auditing procedures of the AARC.
2. The Audit Subcommittee is composed of members from the Executive Committee and officers of the House of Delegates (HOD). AARC staff and management ~~do~~ cannot serve as members.
3. The Board of Directors and HOD officers are not part of management of the AARC nor do they receive any compensation from the AARC.
4. A full independent audit will be conducted annually by an outside auditor.
5. The Audit Subcommittee shall meet with the outside auditors, review the audit and recommend its approval.
6. The Audit Subcommittee should consider retaining the current partner or request obtaining another audit partner to be considered for rotation every five years.
7. The Board of Directors and HOD officers must have a conflict of interest policy with disclosure.
8. The AARC will not provide personal loans for its directors or executives.
9. The AARC must develop and adopt a formal process to deal with complaints from employees and prevent retaliation.
10. The AARC will have a written, mandatory document retention and periodic destruction policy.

American Association for Respiratory Care
Policy Statement

Policy Amplification:

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

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

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

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

   b. A member of the Board of Directors can report fiscal inappropriateness to the Executive Director.

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

3. Forms 990 or 990-PF should be filed electronically to the IRS, in a timely and accurate manner.

Reference: The Sarbanes-Oxley Act and Implications for Nonprofit Organizations, 2003BroadSource and Independent Sector, www. broadsource.org

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Roundtables

SUBJECT: **Roundtables**

EFFECTIVE DATE: August 22, 2001

DATE REVIEWED: December 2009

DATE REVISED: December 2009

REFERENCES:

Policy Statement:

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

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

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

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

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

5a If the Listserv has three consecutive months with no posts the Roundtable Chair and AARC Board liaison will be notified of the lack of communication.

5b The Roundtable Chair will post a query to see if the Roundtable needs to continue or has served its useful life and should be dissolved to its Listserv members.

5c If the Listserv replies indicate a desire to continue, then the 3-month probationary sequence will commence.

5d If the Listserv has no posts during the three-month probationary period, the roundtable shall be dissolved.

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

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

American Association for Respiratory Care

Roundtable Proposal Form

Please read the *AARC Roundtable Policy* before completing this form.

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

Your Name _____

AARC Member # _____ E-Mail _____

Employer _____

City _____ State _____

Suggested name for proposed Roundtable _____

List reasons you and others feel justify the establishment of the Roundtable:

_____
_____
_____
_____
_____
_____

Before your proposal is submitted, at least 9 other AARC members must concur with you. E-mails to you will be accepted in lieu of their signatures; in such case, attach the e-mails to this form.

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Your Signature _____ Date _____

Please Send via US Mail to: **President, American Association for Respiratory Care**
9425 N. MacArthur Blvd #100
Irving, TX 75063

HOD Resolutions

House of Delegates Resolution
Resolution # 57 - 14 - 1

Resolved that the AARC create a financial assistance budget of $1000 per year to support Respiratory Care Students attending the House of Delegates meeting

EXECUTIVE SUMMARY
Student attendance at the AARC House of Delegates meeting promotes understanding and awareness of the inner workings of the AARC. This activity supports initiatives to increase student membership and retention of their membership post-graduation. This also serves as a method of developing new leaders for the state affiliates and the AARC.

Historically, students attending the AARC HOD meeting are those sponsored by their state affiliate or those that live near the meeting location. Student attendance is often limited due to the financial burden of travel and time away from home imposed upon the student while attending the meeting. This is particularly true for those students who attend without the benefit of state affiliate funding/sponsorship.

The Student Mentorship Committee recommends the development of a small budget (up to $1000/year) to assist students who wish to attend a meeting of the House of Delegates. This budget is intended to offset parking fees, meals and other minor fees the student will incur in order to attend.

The current student application for attendance at the House of Delegates would be modified to include the option to request funding. Students in attendance would receive a $25 per diem for each day at the HOD ($50 maximum if they attend both days). Proposed funds will be on a first come, first serve basis with each student limited to the set per diem. Cost per year not to exceed $1000 total per calendar year for all student funding.

Funding will be restricted to students who do not already receive reimbursement/funding from the state affiliate (as in the case with some student leadership initiatives at the state affiliate level).

OUTCOME:
Direct/short term outcome: Increased student attendance at the AARC House of Delegates meetings. Long term outcome: increased member retention post-graduation, increased involvement in the AARC and with State affiliates.

Strengths:
Strengths include increased student attendance at the AARC House of Delegates meetings

Weaknesses:
Weaknesses include no guarantees that students who attend the HOD meeting will remain AARC members or become (and remain) active within their state affiliate.

Opportunities:
Opportunities include improved relationship with Respiratory Care students, increased member retention of newly graduated respiratory therapists and development of future leaders for both the AARC and state affiliates.

Action:
HOD Date_____ BOD
_____ Amended _____
_____ Passed _____
_____ Defeated _____
_____ Tabled _____
_____ Referred to _____
_____ Report back due_____
_____ Postphoned until_____

Resolution Author:
Dana Evans

E-mail:
DanaEvansRRT@gmail.com

Phone Number:
314-610-0124

Author's State:
Missouri

Co-Sponsors and Their States:
Kerry McNiven, Connecticut

Date Submitted:
5/16/2014

Date Received:
5/16/2014

Potential Barriers:
Potential Barriers include that the dollar amount may not be sufficient to entice additional student attendance at the HOD.

Financial Impact:
Implementation Cost Estimate: $1000

Ongoing Costs:

Resources required: continued student mentorship at the AARC HOD with volunteers from HOD serving as mentors during the meeting to students in attendance.

AARC Resources in time, dollars: Time spent coordinating reimbursement of the per diem to each student

Volunteer Resources in time: mentorship to students during the AARC HOD meetings, Student Mentorship Committee to review request for funding.

Impact of Resolution:
This resolution will impact the General Membership, HOD, Affiliates

Relationship to AARC Strategic Plan:
Develop human resources, Increase membership

House of Delegates Resolution

Resolution # 94 – 14 - 2

Resolved that The AARC establish a committee to review and update the Code of Ethics and Professional behavior statement, to include specific language addressing unacceptable conduct related to intimidating and disruptive behaviors

EXECUTIVE SUMMARY

The presence of horizontal violence/ bullying is well documented in the literature. …horizontal violence, and horizontal hostility are terms used to describe the physical, verbal and emotional abuse of an employee. It is overt and covert non-physical hostility, such as criticism, sabotage, undermining, scapegoating, infighting and bickering occurring over time (Jackson, Clare & Mannix, 2002) It is an "offensive, abusive, intimidating, malicious or insulting behavior, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset, threatened, humiliated or vulnerable." It undermines self-confidence and cause stress. It is a behavior which is generally persistent, systematic and ongoing (Task Force on the Prevention of Workplace Bullying, 2001, p.10)

The current literature reflects its presence throughout the health care setting, specifically in disciplines of nursing (**Lateral Hostility Between Critical Care Nurses: A Survey Report** Crit Care Nurse April 2008 28:13-19) and and also in physicians. Students at the Ohio State University recently surveyed respiratory staff in the state of Ohio and found the same statistics are reflected in our own profession. The AARC has in place a Statement of Ethics and Professional Behavior, with this statement our organization has already outlined behaviors that are expected of respiratory therapists. With this document, we have the opportunity to take a stand against the proliferation of horizontal violence among respiratory therapists by including specific language addressing appropriate behaviors of health care professionals on this issue.

This resolution fits well with the AARC Strategic Objectives which included "…ensure competent care…establish professional standards….and that enhance patient care, access and professional practice". Improving the professionalism of the RT workforce will increase AARC membership and finances.

OUTCOME:

The AARC will foster an awareness of horizontal hostility and the behaviors negative impact in healthcare and specifically within Respiratory Care. There will be a reduction of intimidating and disruptive behaviors in the workforce by the AARC recognizing this practice is unprofessional and unacceptable for respiratory therapists.

Strengths:

Endorsing the standard of the highest level of professional behavior in the workforce that is reflected in the literature and a Joint Commission Standard. Other professional organizations have adopted similar language.

Weaknesses:

None

Resolution Author:
Jerry Edens
jerry.edens@cchmc.org
513-636-7461

Author's State:
Ohio

Co-Sponsors and Their States:
Michael Jackson, Massachusetts; Alicia Wafer, Michigan; Virginia Forster, Maryland; Heather Neal-Rice, Arkansas; Kevin Taylor, Alabama

Date Submitted:
5/16/2014

Date Received:
5/16/2014

ACTION
HOD Date_____ BOD
_____ Amended _____
_____ Passed _____
_____ Defeated _____
_____ Tabled _____
_____ Referred to _____
_____ Report back due_____
_____ Postphoned until_____

Opportunities:
To update and set the standard for professional behavior in the workplace through our Statement of Ethics and Professional behavior. It has not been reviewed since 2012. Align ourselves with Joint Commission Standards

Potential Barriers:
None

Financial Impact:

Implementation Cost Estimate: $0

Ongoing Costs:

AARC Resources in time, dollars:

Volunteer Resources in time:
24 hours total

Impact of Resolution:
This resolution will impact the General Membership, HOD, AARC Officers & BOD

Relationship to AARC Strategic Plan:
Develop art and science of RC, Develop human resources