American Association for Respiratory Care

Board of Directors Meeting

JW Marriott Phoenix Desert Ridge Resort & Spa
Phoenix, AZ

July 16-17, 2015

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – July 15, 2015
Board of Directors Meeting – July 16-17, 2015

Wednesday, July 15

2:00-4:00 pm Executive Committee Meeting (Committee Members only) – *Desert Conference Suite I; Level 2 Lobby Level*

4:30-5:30 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) – *Desert Conference Suites III, V; Level 2 Lobby Level*

Thursday, July 16

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. 7
E-motion Acceptance pg. 36

General Reports pg. 37
- President pg. 38
- Past President pg. 39
- Executive Director Report pg. 40 (R)
- Government & Regulatory Affairs pg. 55
- House of Delegates pg. 66
- Board of Medical Advisors pg. 68
- Presidents Council pg. 69

10:00 am BREAK

10:15 am Standing Committee Reports pg. 70
- Audit Subcommittee pg. 71
- Bylaws Committee pg. 72 (R) (A)
- Elections Committee pg. 73
- Executive Committee pg. 74
- Finance Committee pg. 75
- Judicial Committee pg. 76
- Program Committee pg. 77 (R)
- Strategic Planning Committee pg. 80

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. 81
- Adult Acute Care pg. 82
- Continuing Care-Rehabilitation pg. 83
- Diagnostics pg. 84

Education pg. 87
Home Care pg. 89
Long-Term Care pg. 90
Management pg. 91
Neonatal-Pediatrics pg. 93
Sleep pg. 94
Surface to Air Transport pg. 95

4:15 pm Special Committee Reports pg. 96

Benchmarking Committee pg. 97 (R)
Billing Code Committee pg. 98
Federal Gov't Affairs pg. 99
Fellowship Committee pg. 100
International Committee pg. 101
Membership Committee pg. 103
Position Statement Committee pg. 105 (R)
State Gov't Affairs pg. 114
Virtual Museum pg. 115

5:00 pm RECESS

Friday, July 17

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

8:00 am Call to Order

Special Representatives pg. 117
- AMA CPT Health Care Professional Advisory Committee pg. 118
- American Association of Cardiovascular & Pulmonary Rehab pg. 120
- American Heart Association pg. 121
- American Society for Testing and Materials (ASTM) pg. 122
- Chartered Affiliate Consultant pg. 123
- Comm. on Accreditation of Medical Transport Systems pg. 124
- Extracorporeal Life Support Organization (ELSO) pg. 125
- International Council for Respiratory Care (ICRC) pg. 126
- The Joint Commission (TJC) pg. 128
- National Asthma Education & Prevention Program pg. 131
- Neonatal Resuscitation Program pg. 132

10:00 am BREAK

10:15 am Roundtable Reports pg. 133

10:45 am Ad Hoc Committee Reports pg. 135
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 136
- Ad Hoc Committee on RTs and Disease Management pg. 138
- Ad Hoc Committee on Revisions to AARC Bylaws pg. 139
- Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education pg. 140

12:00 pm Lunch Break

1:30 pm Reconvene

1:30 pm Other Reports pg. 142

American Respiratory Care Foundation (ARCF) pg. 143 (A)
Commission on Accreditation for Respiratory Care (CoARC) pg. 146 (A)
National Board for Respiratory Care (NBRC) pg. 147

2:00 pm **UNFINISHED BUSINESS pg. 150**

- Workgroup Updates
- Policy Updates (from April 2015 meeting) (A)

NEW BUSINESS pg. 157

3:30pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of July 2, 2015)

AARC Board of Directors Meeting

July 16-17, 2015 • Phoenix, AZ

Executive Office

Recommendation 15-2-1.1 "That the AARC Board of Directors approve the further amended 401(k) restatement."

Recommendation 15-2-1.2 "That the AARC Board of Directors approve up to $40,000 for foundation repairs on the northeast side of the building."

Bylaws Committee

Recommendation 15-2-9.1 "That the AARC Board of Directors find that the West Virginia Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Program Committee

Recommendation 15-2-15.1 "That the AARC Board of Directors approve Jacksonville, FL (JW Marriott Sawgrass Resort) as the destination for the 2016 AARC Summer Forum."

Recommendation 15-2-15.2 "That the AARC Board of Directors accept for **information only and refer to the Executive Office** that site procurement for future AARC Congress locations *should* be selected at least 4-5 years in advance."

Benchmarking Committee

Recommendation 15-2-17.1 "That the AARC Executive Office explore database revisions with the vendor who manages the benchmarking database as recommended by the Committee and explore the cost for enhancements and revisions."

Position Statement Committee

Recommendation 15-2-26.1 "That the AARC Board of Directors approve and publish the revised Position Statement 'Definition of Respiratory Care'."

Recommendation 15-2-26.2 "That the AARC Board of Directors approve and publish the Position Statement 'Respiratory Therapist Education' with revisions."

Recommendation 15-2-26.3 "That the AARC Board of Directors approve to retire the position statement 'Development of Baccalaureate and Graduate Education Degrees'."

Recommendation 15-2-26.4 "That the AARC Board of Directors approve and publish the position statement 'Best Practices in Respiratory Care Productivity and Staffing' as revised."

Recommendation 15-2-26.5 "That the AARC Board of Directors approve and publish the newly developed Position Statement 'Insertion and Maintenance of Vascular Catheters by Respiratory Therapists'."

Recommendation 15-2-26.6 "That the AARC Board of Directors approve and publish the newly developed position statement 'Insertion and Maintenance of Arterial Lines by Respiratory Therapists'."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 24, 2015 • Grapevine, TX

Minutes

Attendance

Frank Salvatore, RRT, MBA, FAARC, President
George Gaebler, MSEd, RRT, FAARC, Past President
Cynthia White, MSc, RRT-NPS, AE-C, CPFT, FAARC, VP External Affairs
Lynda Goodfellow, EdD, RRT, FAARC, VP Internal Affairs
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS, Secretary/Treasurer
Timothy Op't Holt, EdD, RRT, AE-C
Lisa Trujillo, DHSc, RRT
Bill Lamb, BS, RRT, CPFT, FAARC
Doug McIntyre, MS, RRT, FAARC
Sheri Tooley, BSRT, RRT-NPS, CPFT, CPFT, AE-C, FAARC
Gary Wickman, BA, RRT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Keith Lamb, RRT
Natalie Napolitano, MPH, RRT-NPS, FAARC
Ellen Becker, PhD, RRT-NPS, FAARC
Kimberly Wiles, BS, RRT, CPFT

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
John Wilgis, MBA, RRT, HOD Speaker
Jakki Grimball, RRT, AE-C, PAHM, HOD Speaker-elect
Curt Merriman, BA, RRT, CPFT, HOD Treasurer
Deb Skees, MBA, RRT, CPFT, Past Speaker
Steve Boas, MD, BOMA Chair
Teri Miller, MEd, RRT, CPFT, HOD Secretary

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
Tony Lovio, Controller
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:00am CDT, Friday, April 24, 2015. Secretary/Treasurer Karen Schell called the roll and declared a quorum.

DISCLOSURE

President Salvatore 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:

Karen Schell – FDA Pulmonary Asthma/Allergy Advisory Committee, Washburn University Advisory Board Respiratory Care Program
Lisa Trujillo – CoBGRTE Committee member of International Outreach
Lynda Goodfellow – NAECB Board member, CoBGRTE member
Ellen Becker – CoBGRTE member, Chicago Asthma Institute Consortium Board of Directors, Chicago Area Patient-Centered Outcomes Research Network Steering Committee
Tim Op't Holt – CoBGRTE member, NAECB member
Curt Merriman – Project Manager LAS-MD-45, AARC Grant Project
John Wilgis – National Healthcare Preparedness Program – Grant Program for Hospital of Public Health Emergency Preparedness
Jakki Grimball – ALA Southwest Board of Directors
Teri Miller – Chair of Dept of Respiratory Therapy Middle George State University, Advisory Council for School of Health Sciences and RT Dept, CoBGRTE member
Natalie Napolitano – Research relationships with Aerogen, Nihon-Kohden, Draeger, CVS Health, CoBGRTE member, Allergy & Asthma Network Board member
Gary Wickman – CoBGRTE member
Bill Lamb – Ohio Medical, University of Missouri, St. Louis Community College, Southwest Illinois College
John Lindsey – Director Respiratory Care Chicago St. Vincent Hot Springs, Advisory Committee member National Park Community College Hot Springs, AR, Seark College Pine Bluff, AR
Keith Lamb – GE, Masimo, Sunovian
Cheryl Hoerr – Southmedic, Cardinal, Advisory Boards for Rolla Technical Center, St. Louis College of Health Careers, Missouri State University – West Mains
Cyndi White – Philips, Aerogen, Vapotherm, Discovery Labs, PhD student at Rush Univ., Advisory Board for Masters in Respiratory Leadership Program at Northwestern Univ.
Frank Salvatore – SUNY – Sullivan Community College Advisory Board

APPROVAL OF MINUTES

Karen Schell moved to approve the minutes of the December 7, 2014 meeting of the AARC Board of Directors.

Motion carried

Karen Schell moved to approve the minutes of the December 8, 2014 meeting of the AARC Board of Directors.
Motion carried

Bill Lamb moved to approve the minutes of the December 12, 2014 meeting of the AARC Board of Directors.
Motion carried

E-MOTION ACCEPTANCE
Karen Schell moved to ratify the E-motions.
Motion carried

GENERAL REPORTS

President
Karen Schell moved to accept Recommendation 15-1-4.1 "That the AARC Board of Directors approves the creation of the Joint Taskforce on a White Paper Regarding – Safe Initiation and Management of Mechanical Ventilation." (See Attachment "A")
Motion carried

Karen Schell moved to accept Recommendation 15-1-4.2 "That the AARC Board of Directors approves the objectives and membership of the Ad Hoc Committee on Advanced RT Practices, Credentialing and Education." (See Attachment "B")
Motion carried
Ellen Becker abstained since she is a committee member.

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

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

FM 15-1-42.1 Natalie Napolitano moved to change the name of the "Asthma Disease Management Roundtable" to the "Pulmonary Disease Management Roundtable".
Motion carried

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

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 8:58am CDT Friday, April 24, 2015.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 9:15am CDT Friday, April 24, 2015.

INVESTMENT REPORT
John Barrett and Nancy Bello of Merrill Lynch gave an overview of the current investments of the Association and answered questions from Board members.

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

FM 15-1-14.1 Natalie Napolitano moved that the Executive Office, along with the Judicial Committee, create a guidance document for the Board of Directors on Conflicts of Interest.
Motion carried

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 10:50am CDT Friday, April 24, 2015.

RECONVENE
Frank Salvatore reconvened the meeting of the AARC Board of Directors at 11:05am CDT Friday, April 24, 2015.

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.

INSTALLATION BOARD MEMBERS
Doug McIntyre, John Lindsey, and Dianne Lewis were sworn in as members of the Board of Directors by Immediate Past President George Gaebler.

Executive Director
Tom Kallstrom gave highlights of his written report. The Associate Executive Directors gave updates of their respective departments.

Natalie Napolitano moved to accept Recommendation 15-1-1.2 "That the AARC Board of Directors authorize $6,000 for development of the Fundamental of Respiratory Care Support Course (FRCSC)."
Motion carried

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

Executive Office referrals from the December 2014 Board meeting were reviewed.

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 12:05pm CDT Friday, April 24, 2015.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 1:50pm CDT Friday, April 24, 2015.

INSTALLATION BOARD MEMBERS
Immediate Past President George Gaebler swore in Dr. Steven Boas to the Board of Directors.

GENERAL REPORTS CONT'D

House of Delegates
House Speaker John Wilgis gave highlights of the written report he submitted.

Board of Medical Advisors (BOMA)
BOMA Chair Dr. Steven Boas gave highlights of his written report.

President's Council
Dianne Lewis gave highlights of her written report.

STANDING COMMITTEES REPORTS

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

Sheri Tooley moved to accept Recommendation 15-1-13.2 "That the Board of Directors accept the auditor's report as presented."
Motion carried

Bylaws Committee
Lynda Goodfellow moved to accept Recommendation 15-1-9.1 "That the AARC Board of Directors find that the Indiana Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Motion carried

Lynda Goodfellow moved to accept Recommendation 15-1-9.2 "That the AARC Board of Directors find that the Pennsylvania Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."
Motion carried

FM 15-1-9.0 Bill Lamb moved to postpone votes on the Bylaws recommendations until the July meeting during Joint Session.
Motion carried

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

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

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

> **Article III, Section 7(a).**
> a. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. A seat on the Board of Directors, up to a maximum of six seats, were granted to those Specialty Sections ~~consisting of at least~~ with a minimum of 1000 active members as defined in the policies and procedures of the Association ~~to be considered for a seat on the Board~~."

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

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

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

> **Article IV, Section 4(c and d).**
> c. Vice President for Internal Affairs - The Vice President for Internal Affairs shall serve as a liaison to the ~~Chartered Affiliates, Specialty Sections, and~~ committees and

groups of the Association as designated by the President and perform such other duties as shall be assigned by the President or the Board of Directors. The Vice President for Internal Affairs shall assume the duties of the President-elect in the event of the President-elect's absence, resignation, or disability, but will also carry out the duties of the office of the Vice President for Internal Affairs.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The committee shall be composed of five (5) Active Members; three (3) elected by the House of Delegates and ~~two~~ one (1) elected by the Board of Directors and the seated Past President. The Chair shall be selected by the House of Delegates. The term of office for each member except the seated Past President shall be three (3) years. The election of the members shall be staggered, so that no more than 50% of the membership changes each year."

Executive Committee
Bill Lamb moved that the AARC Board of Directors ratifies the Executive Committee vote consenting to the CoARC Accreditation Standards for Advanced Practice Programs in Respiratory Care.
Motion carried

Program Committee
Karen Schell moved to accept **FM 15-1-15.1** "That the AARC Board of Directors approve Las Vegas, NV and the Mandalay Bay Convention Center and Hotel as the host city and headquarter hotel for AARC Congress 2018."
Motion carried

Lynda Goodfellow moved to accept the Standing Committee reports as presented.
Motion carried

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 2:50pm CDT Friday, April 24, 2015.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 3:10pm CDT Friday, April 24, 2015.

SPECIALTY SECTION REPORTS

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

Lynda Goodfellow moved to refer to Executive Office to form a committee and report back by November 2015 Board meeting.
Motion carried

Lynda Goodfellow moved to accept the Specialty Section reports as presented.
Motion carried

SPECIAL COMMITTEE REPORTS

Position Statement Committee
Lynda Goodfellow moved to accept Recommendation 15-1-26.1 "Approve and publish the revised Position Statement 'Ethics and Professional Conduct'."
Motion carried

Lynda Goodfellow moved to accept Recommendation 15-1-26.2 "Approve and publish the Position Statement 'Licensure of Respiratory Care Personnel' with no revisions."
Motion carried

Lynda Goodfellow moved to accept Recommendation 15-1-26.3 "Approve and publish the Position Statement 'AARC Statement of Continuing Education' with no revisions."
Motion carried

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

Lynda Goodfellow moved to accept Recommendation 15-1-26.4 "Be it resolved the AARC develop and publish a new Position Statement regarding respiratory therapists inserting and maintaining arterial lines."
Motion carried

Lynda Goodfellow moved to accept Recommendation 15-1-26.5 "Be it resolved the AARC develop and publish a new Position Statement regarding respiratory therapists inserting and maintaining vascular lines."
Motion carried

Lynda Goodfellow moved to accept the Special Committee reports as presented.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

American Heart Association
Cyndi White moved to accept Recommendation 15-1-64.1 "That Keith Lamb replace Brian Walsh as AARC Liaison to the AHA."
Motion carried
Keith Lamb abstained.

Cyndi White moved to accept the Special Representatives reports as presented.
Motion carried

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on Cultural Diversity in Patient Care
Cyndi White moved to accept Recommendation 15-1-29.1 "That the AARC continue with the program of Developing and Mentoring AARC members with the purpose of increasing the Diversity of the BOD and HOD."
Motion carried

Cyndi White moved to accept the Ad Hoc Committee reports as presented.
Motion carried

ROUNDTABLE REPORTS

Board liaisons gave updates on their respective Roundtables and their activity.

Lynda Goodfellow moved to accept the verbal Roundtable reports.
Motion carried

POLICY REVIEW
Policy No. MP.002 – Membership – Membership Challenge Policy
Lynda Goodfellow moved to refer to the Judicial Committee to review and provide changes in time for the July 2015 Board meeting.
Motion carried

RECESS
President Salvatore called a recess of the AARC Board of Directors meeting at 4:45pm CDT on Friday, April 24, 2015.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

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

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

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

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

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

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

Committee Members:

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

AARC Executive Office Liaison: Shawna Strickland

Attachment “B”

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

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

Objectives:

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

Committee:

AARC Representatives:

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

CoARC Representatives:

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

NBRC Representatives:

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

Attachment “C”

AARC Statement of Ethics and Professional Conduct
Licensure of Respiratory Care Personnel
AARC Statement of Continuing Education

AARC Statement of Ethics and Professional Conduct

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

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

☐Promote and practice evidence-based medicine.

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

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

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

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

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

☐Promote disease prevention and wellness.

☐Refuse to participate in illegal or unethical acts.

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

☐Follow sound scientific procedures and ethical principles in research.

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

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

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

☐Encourage and promote appropriate stewardship of resources.

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

Effective 12/94
Revised 12/07
Revised 07/09
Revised 07/12
Revised 04/15

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

Position Statement

Licensure of Respiratory Care Personnel

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

Effective 03/90
Revised 03/00
Revised 12/06
Revised 07/09
Revised 04/12
Reviewed 04/15

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

Position Statement

AARC Statement of Continuing Education

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

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

Effective 1990
Revised: 2000
Revised: 2005
Revised: 2012
Reviewed: 2015

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

April 25, 2015- Grapevine, TX

Minutes

Attendance

Frank Salvatore, RRT, MBA, FAARC, President
George Gaebler, MSEd, RRT, FAARC, Past President
Cynthia White, MSc, RRT-NPS, AE-C, VP External Affairs
Lynda Goodfellow, EdD, RRT, FAARC, VP Internal Affairs
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS, Secretary/Treasurer
Timothy Op't Holt, EdD, RRT, AE-C
Lisa Trujillo, DHSc, RRT
Bill Lamb, BS, RRT, CPFT, FAARC
Doug McIntyre, MS, RRT, FAARC
Gary Wickman, BA, RRT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Keith Lamb, RRT
Natalie Napolitano, MPH, RRT-NPS, FAARC
Ellen Becker, PhD, RRT-NPS, FAARC
Kimberly Wiles, BS, RRT, CPFT

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
John Wilgis, MBA, RRT, HOD Speaker
Jakki Grimball, HOD Speaker-elect
Curt Merriman, HOD Treasurer
Deb Skees, Past Speaker
Steve Boas, MD, BOMA Chair

Excused

Teri Miller, MEd, RRT, CPFT, HOD Secretary
Sheri Tooley, BSRT, RRT-NPS, CPFT, CPFT, AE-C, FAARC

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 Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:00am CDT, Saturday, April 25, 2015. Secretary-Treasurer Karen Schell called the roll and declared a quorum.

UNFINISHED BUSINESS
2015 & Beyond Recommendations from December 2014 meeting:

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

Cyndi White moved to accept Recommendation 14-3-32.1 "That the AARC BOD review and discuss the Issue Brief on Clinical Simulation as prepared by sub-committee #2, found under Appendix A of the final AARC 2015 report."
Motion carried

FM 15-1-80.1 George Gaebler moved to consent to the CoARC Accreditation Standards for Degree Advancement Programs in Respiratory Care.
Motion carried

NEW BUSINESS
Policy Review
Policy No. FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities
Karen Schell moved to accept the recommended changes but requested a report back at the July 2015 meeting about the funding levels.
Motion carried
(See Attachment "A")

Frank Salvatore appointed a committee to revise policy SS.002 (Formation, Dissolution, and Conversion of Specialty Sections) – Deb Skees, Chair; Doug McIntyre, Karen Schell, members; and Tim Myers Staff Liaison and report back at the July 2015 meeting.

EXECUTIVE SESSION
Bill Lamb moved to go into Executive Session at 9:17am on Saturday, April 25, 2015.
Motion carried

Karen Schell moved to come out of Executive Session at 9:42am on Saturday, April 25, 2015.
Motion carried

FM 15-1-24.1 Cyndi White moved that the AARC BOD approves a dues increase and directs the Executive Office to put together a marketing plan to present to the Board of Directors and House of Delegates in July.
Motion carried

RECESS
Frank Salvatore recessed the meeting of the AARC Board of Directors at 9:45am CDT Saturday, April 25, 2015.

RECONVENE
Frank Salvatore reconvened the meeting of the AARC Board of Directors at 9:55am CDT Saturday, April 25, 2015.

FM 15-1-15.2 Natalie Napolitano moved that the Program Committee explore all venues for the International Congress and not automatically consider Las Vegas every 3-4 years.

Justification: All cities that have gone smoke-free have excused casinos from the laws.
Motion carried
Karen Schell abstained as she is on the Program Committee.

ARCF REPORT
Tom Kallstrom gave highlights of the recent activities of the ARCF.

EXECUTIVE SESSION
Natalie Napolitano moved to go into Executive Session at 10:08am on Saturday, April 25, 2015.
Motion carried

Karen Schell moved to come out of Executive Session at 11:04am on Saturday, April 25, 2015.
Motion carried

RECESS
Frank Salvatore recessed the meeting of the AARC Board of Directors at 11:05am CDT Saturday, April 25, 2015.

RECONVENE
Frank Salvatore reconvened the meeting of the AARC Board of Directors at 11:10pm CDT Saturday, April 25, 2015.

Life Membership Nominee
Bill Lamb moved to nominate Fred Hill– nominated by Doug McIntyre.
Motion carried

Honorary Member Nominee
Karen Schell moved to nominate Grace Anne Doorley Koppel – nominated by Frank Salvatore.
Motion carried

Legends of Respiratory Care Nominee
Gary Wickman moved to nominate Robert Lawrence - nominated by Doug McIntyre.
Motion carried

Karen Schell moved to nominate Dave Pierson - nominated by Gary Wickman.
Motion carried

Natalie Napolitano moved to nominate Jim Whitacre - nominated by Dianne Lewis.
Motion carried

Bill Lamb moved to nominate Jimmy Young - nominated by Doug McIntyre.
Motion carried

Doug McIntyre moved to nominate Kent Christopher - nominated by Karen Schell.
Motion carried

ARCF AWARD NOMINEES
The Board brought forth the following nominees for the ARCF Awards in 2015:

Charles H. Hudson Award for Cardiopulmonary Public Health
Natalie Napolitano moved to nominate Brooke Yeager – nominated by Karen Schell.

Motion carried

Forrest M Bird Lifetime Scientific Achievement Award
Cyndi White moved to nominate Tim Myers – nominated by Dianne Lewis
Motion carried

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care
Lynda Goodfellow moved to nominate Kent Christopher – nominated by Kim Wiles.
Motion carried

Mike West, MBA, RRT Patient Education Award
Bill Lamb moved to nominate Trina Linberg – nominated by Kim Wiles.
Motion carried

All ballots were destroyed.

GENERAL REPORTS CONT'D

State Government Affairs
Cheryl West provided an update to the written report noting that CO, IL, and NM successfully passed extensions of the RT licensure laws. The issues with TX licensure still remain in question.

Federal Government Affairs
Cheryl West also provided an update on the successful PACT Hill Advocacy Day. Anne Marie Hummel then provided a detailed update on the status of the Medicare Telehealth Parity Act and FDA tobacco updates.

Karen Schell moved to accept the General Reports as presented.
Motion Carried

STRATEGIC PLANNING
President Salvatore asked Board members to work on the Strategic Plan and created 5 workgroups to report back at the July 2015 meeting.

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

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

ADJOURNMENT
President Salvatore adjourned the meeting of the AARC Board of Directors at 12:30pm CDT, Saturday, April 25, 2015.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

Policy No. FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Guidelines for the Funding of State Legislative & Regulatory Activities**

EFFECTIVE DATE:

DATE REVIEWED: ~~September 2005~~ April 2015

DATE REVISED: ~~September 2005~~ April 2015

REFERENCES: FA0486

Policy Statement:

State Societies may request funding to supplement efforts undertaken by the society to support or oppose legislation, regulations or state policy that can adversely impact or enhance the profession of respiratory therapy. Occasionally these efforts require the expertise of contracted lobbyists or assist in covering the costs that state society leadership assumes in mounting a response. These costs can become excessively burdensome on the budget of the state society, thus triggering the request for the AARC grant/loan.

The state society requesting funds must provide the Government Affairs Committee, State Co-Chair (GAC) with the following documentation.

Policy Amplification:

1. Requirements of State Societies:

A. The state society requesting funds must provide the State Co-Chair of the AARC Government Affairs Committee (GAC) the following:

1) A letter signed by the state society president stating the reason for the request. Requests for funding may be made before the legislative/regulatory/policy process is initiated, while the legislative/regulatory process is taking place or after enactment or implementation of the legislative/regulatory/policy initiative. Passage or implementation of the initiative, however, will not assure AARC funding.

2) A complete financial statement shall be submitted and shall include the state society's total current assets and liabilities. The current year's budget as approved by the state society's Board of Directors shall also be submitted for review. A financial plan for the requested funds shall also be submitted.

3). A most current draft of the legislation or proposed regulation or policy.

4) A written response to include supporting documentary to each statement found in the "Criteria for State Society's Seeking Funding from the AARC for Legislative Initiatives" be submitted under the signatures of the state society's president.

2. Responsibilities of the AARC Government Affairs Committee (GAC)

A. Upon receipt of the state society's request for funding the State GAC Co-Chair shall:

1) Distribute the state society's letter of request and supportive information to the members of the State GAC who shall:

2). Review the legislation/regulation/policy utilizing the AARC Evaluation Form.

B. Review and evaluate the supportive documentation provided by the state society utilizing the: AARC Funding Recommendation Report".

C. If necessary conduct conference calls with the GAC State committee members to discuss the evaluations and generate a consensus option.

D. Request additional information from the state society where it is required.

E. The State GAC Co-Chair will tabulate the votes from the committee members, for or against approval. A simple majority carries the vote.

F. Formulate a recommendation for funding and submit the recommendation to the AARC President and Board of Directors.

G. The AARC Board of Directors will have final approval of the grant/loan application and will have the right to determine the final dollar amount to be disbursed.

3. Methodology for Disbursement of Funds:

A. The State GAC Co-Chair funding recommendation presented to the AARC President and Board shall take into consideration the state society's

1) Total current assets and current liabilities.
2) Expected revenues and disbursements per the state society's budget.
3) The amount of money the state society has spent to date on its legislative/regulatory/policy effort.
4) Consistency of the state society's position with AARC policy, position and standards. The AARC President, AARC Executive Committee, in consultation with the Executive Office, will determine if the legislative/regulatory/policy content merits financial support.
5) State Society preparation to mount a response to the legislative/regulatory/policy initiative.

B. The State GAC Co-Chair recommendation shall be based, whenever possible, on the concept that AARC funding shall match the funds the state society has allocated and/or spent on its legislative effort.

C. Affiliates requesting funding shall only specify the amount required. Funds will be allocated on a 60% grant and a 40% no interest loan basis (e.g., $2,000 requested = $1,200 grant and $800 loan). The maximum request may not exceed $10,000 (per BOD recommendation, this figure is to be reviewed by EO and reported back at the July 2015 meeting)

D. The disbursement of funds shall:
1) Generally the full amount of the allocation be disbursed to the state society as soon as is practically possible AFTER AARC Board approval and implementation of the contract described in b) below
2) Be contingent upon issuance and acceptance by both parties of a contract, memorandum, or agreement stating terms and conditions relating to the allocation of funds. Terms shall include:
   i. Repayment of the loan portion of the allocated funds will commence within six months following the initial disbursement of the funds to the society by AARC.

ii. Presentation of invoices by the society to the AARC Executive Office (Controller) supporting the Society's expenditures within six months of the AARC's funds disbursement. If invoices are not presented within such six months after AARC disbursement, any "Excess Disbursement" (Defined as monies received by the State Society from AARC which are not supported by invoices presented) must be immediately returned to the AARC and the loan repayment terms will be adjusted accordingly. Extension of this six month period for extenuating circumstances may be granted by the Executive Office.

iii. Provision for loan repayment via Society Revenue Sharing withholding on any loan payment that is delinquent for more than 60 days.

iv. Depending on the circumstances other terms of repayment may be established by the AARC Executive Office and the AARC Controller as well.

.

E. It is expected that the aforementioned shall serve as guidelines which will be applied consistently. However, unusual circumstances may require waiver of some elements. When an element is waived, the State GAC Co-Chair shall provide reasonable cause for such exception.

DEFINITIONS:

ATTACHMENTS:

E-Motions

(Since Last Board Meeting in April 2015)

There have been no E-votes since the last Board of Directors meeting.

General Reports

President Report

Submitted by Frank Salvatore– Summer 2015

Presidential Committee and Goals Additions/Changes Needing Board Approval:

1. None.

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

1. May 6, 2015 – Spoke at CTSRC Conference in Southington, CT
2. May 27, 2015 – Spoke at ILSRC Conference in Oakbrook Terrace, IL.
3. June 5-6, 2015 – Attended the COPD9usa Conference in Chicago, IL.
4. June 12, 2015 – Spoke at the Long Island Jewish/Northshore University Hospital Conference in New Hyde Park, NY.
5. July 9-10, 2015 – Spoke at the TXSRC Conference in Houston TX.
6. July 13-15, 2015 – Spoke and Participated in the AARC Summer Forum in Phoenix, AZ.

The following are the items that were given to me at the April 2015 board meeting:

1. None

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

1. Letter written to Representative J.D. Sheffield in the Texas House of Representatives endorsing and urging support for HB 2752 related to the creation of a strategic plan to significantly reduce morbidity and mortality from chronic respiratory disease. (April 2015)
2. Letter of support for application to PCORI by Rebecca Bascom MD MPH entitled "Comparitave effectiveness research to develop and maintain functional capacity in patients with idiopathic pulmonary fibrosis (IPF). (April 2015)
3. Joint Tripartite letter to the President of the American Society of Anesthesiologists (ASA) regarding concerns for endorsing CoARC Accreditation Standards for Advanced Practice Programs in Respiratory Care. (May 2015)
4. Comments to CMS regarding the elimination of the Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Forms (DIF) as a way to reduce burden on providers. (June 2015)
5. Letter of support to U.S. Congressman Mike Thompson for the reintroduction of the Medicare Telehealth Parity Act in the 114th Congress. (June 2015)
6. Comments to Senate Finance Committee from AARC and AAN regarding recommendations related to Telehealth and Patient Self-Management (June 2015)

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

Past President Report

Submitted by George Gaebler – Summer 2015

Nothing to report.

Executive Office

Submitted by Tom Kallstrom – Summer 2015

Recommendations

That the AARC Board of Directors approve the further amended 401(k) restatement.

Justification: At the December 2014 AARC board meeting, a multi-year restatement of the Employee 401K plan was approved by the board. This restatement was essentially a housekeeping process codifying several years of law changes and is a normal government process done about every 4-5 years. It did not materially change any of the basic features of the plan. Unfortunately, the government has since comeback and told our bank trustee that further refinements, apparently not known previously, were still needed. There was no substantive change in the plan and was additional housekeeping. The Board's approval here gives the AARC Executive director the authority to approve such further restatement.

That the AARC Board of Directors approve up to $40,000 for foundation repairs on the northeast side of the building.

Justification: This amount will cover the 21 piers that our engineer has recommended along the south and northeast side of the building along with a urethane injection that will lift the interior.

Report

Welcome to Phoenix!! We look forward to a most productive meeting. Below is up-to-date information that I hope you find useful.

AARC 2015 International Congress

Logistical planning for AARC Congress 2015 is progressing as scheduled. Details of the meeting are as follows:

- AARC Congress 2015 will be hosted over 3 ½ days
- 8 hours of unopposed exhibit hall hours
- 148 presenters
    - 37 first time presenters (32 in 2014)
    - AARC Speaker Academy will return in 2015
- 256 unique presentations representing all specialty sections and roundtables.
- CRCE by Content Category
    - Adult Acute Care: 22.62
    - Management: 16.24
    - Neo/Peds: 21.46
    - Sleep: 13.34
    - Education: 8.7
    - Clinical Practice: 43.0
    - Pulmonary Function: 9.86

    - Patient Safety: 4.06
    - BioTerrorism/Emergency Preparedness: 1.74
    - Ethics: 2.9
- 12-16 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 Abstracts. Showcased as a stand-alone, high profile Open Forum presentation. Poster discussion + 5-minute slide presentation/summary + 5-minute Q&A.
- Plenary Session Schedule:
    - Keynote (Nov. 7): Tobacco Wars - The Battle for a Smokefree Society (Patrick Reynolds)
    - Thomas L. Petty Memorial Lecture (Nov. 8): Surviving the ICU: Taking a Step Back into the Future (Dale Needham MD)
    - Donald F. Egan Scientific Memorial Lecture (Nov. 9): Monitors: Improving Safety or Increasing Risk? (Charles Durbin MD)
    - Phil Kittredge Memorial Lecture (Nov. 10): To Be Determined
    - Closing Ceremony (Nov. 10):
- 30-minute presentations + required 5-minute commitment for Q&A
- Each presentation will be designated by Content Category
- 3 pre-courses:
    - Managing Chronic Hypoxemia: RTs Integrating Other Care Settings with the Home
    - Adult and Pediatric Mechanical Ventilation
    - Vascular Access Workshop

AARC Congress 2018
A contract has been signed with the Mandalay Bay Hotel & Convention Center to host AARC Congress 2018. Dates for the meeting are scheduled for Dec. 4 – 7, 2018

Project Updates

F&P Humidification Project:
A 5-module education course on humidification has been added to AARC University funded through an educational grant from Fischer & Paykel. The course IS NOT eligible for CRCE as it was developed for 2nd year respiratory students and would only serve as a refresher for the licensed respiratory practitioner.

An incentive in the form of complimentary access to the AARC Exam Prep course to the first 150 respiratory students with a 2015 graduation date is part of the grant. As of June 1, 2015, 129 students have taken advantage of the offer. F&P has expressed interest in establishing a long-term commitment in funding this course.

Target Decision Date: Completed - ongoing

Association for the Advancement of Medical Instrumentation (AAMI):
The AARC has been collaborating with AAMI on several projects for the last year. The AAMI is advancing the ventilator alarm safety initiative with three webinars in 2015: one aimed at the

bedside nurse and two aimed at the respiratory therapist. Shawna Strickland and AARC member Jenifer Burke (nurse practitioner at Rush University) presented the "Nurses and Respiratory Therapists-Working Together for Safe Alarm Systems Management" webinar in May. The other two webinars are in development and will be partnered with the AARC for CRCEs for participants: Understanding the Physiology of Ventilator Alarms and Ventilators in a Non-Clinical Setting.

The AARC participated in a coalition meeting hosted by AAMI in April of last 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.

Currently, the coalition is making progress in the following areas:

- Alarm Taxonomy: Developing a universally agreed taxonomy for alarm monitoring
- SpO2 toolkit: Best practice sharing
- Gap Analysis: Understanding inherent risks in alarm monitoring/management. Identify existing tools to support alarm management and potential alarm changes.
- Focus Groups: Interview hospitals regarding what they would like to see included in future monitor alarm reports from manufacturers.

Target Date: Ongoing

RESPIRATORY CARE Journal

We are happy to report the Journal continues to receive submissions at record pace. That is the good news; the bad news is that it is not economically feasible for us to publish all the articles worthy of publication by our editors. To partly overcome this quandary, early this year we ceased accepting submissions of case reports and teaching cases (scarcely accessed by our readers) in order to publish more original research articles.

As previously reported, access to the online edition of the Journal is limited to AARC members and subscribers with both groups required to activate their subscriptions. In spite of numerous attempts for over a year now by the AARC to encourage members to do so, as of the writing of this report only 10369 members have activated their subscriptions and of those, 1998 let their subscriptions expire.

The just published June issue of the Journal contains the proceedings from last year's Journal Conference on *Aerosol Drug Delivery in Respiratory Care.* The Conference was presented under the auspices of the American Respiratory Care Foundation and the articles provide evidence-based information about the many aerosol medications now in use and under development with an emphasis on novel medications and the role of the Respiratory Therapist in drug delivery and assessment. The papers also review the many aerosol devices in clinical use today, provide insight into new devices being developed and discuss how these can be evaluated, including the best evidence for the effectiveness of patient and provider education, and improving adherence. Last month the Journal held this year's Conference on *Controversies in Respiratory Care* ranging from topics like using or not using ventilator associated events as quality indicators to when to use sedation to achieve patient ventilator synchrony, and much more. Thanks again to the ARCF for enabling the presentation and publication of the Conference proceedings.

If you use an Apple mobile device you know Apple made major changes to their operating system with iOS7 and continued the shift with iOS8. HighWire, the provider of the Apple app we use, has accommodated all the requirements and our updated app has many improvements. We encourage everyone to check out the updated app and to take advantage on its new offerings.

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 Tampa. The AARC Program Committee early this year accepted the Journal Conference to continue the three formats of presentation of abstracts first adopted last year: abstracts may be presented in the traditional format of poster discussions; or as a poster display only; or as an editors' choice presentation.

Membership Report

Update of AARConnect

We have refreshed the look of AARConnect, creating a responsive web design for that site as well. This allows people looking at the site to use it easily on a phone, tablet, or computer. One of the newest features is the ability to respond right from email, which is something our members have asked for.

Participation in AARConnect Engagement test

The vendor of AARConnect (Higher Logic) has asked us to participate in a test of their automated email engagement system. We will be part of a multi-association project to see if email sent to a segment of members about their participation on AARConnect will ultimately lead to higher retention rates. A subset of members will receive emails reminding them to post, log in, or update their profile on AARConnect and to thank them for initiating posts or responding to posts on the site. At the conclusion of the test in one year, it will be determined whether higher use of a social site leads to higher levels of retention.

Recognition of Long-Time members

Members reaching their 5-year milestone anniversaries with us have received emails, certificates, or personal letters recognizing their achievement. Frank, Gary and Tom wrote personal letters to longer term members who have remained member for over 40 years.

Student Dues Letters

Students continue to receive their invitations to become Active members upon graduation with good results. At this point in time, we have had 515 students take advantage of the early renewal program. It is too early to tell if this is having a measurable impact on the renewal numbers for students, but the buzz and inquiries to our office continue to be there.

Win-Back Campaign

We have instituted a new series of renewal messages, so that members who do not renew during a course of two years receive a progressive series of emails and reminders to rejoin. We are gauging its success at the current time.

Retiring Members

We have about 60 members who have availed themselves of the Senior Member program. An email to all members 65 and older has been sent to notify them of the program and as individuals call or write our office indicating retirement, they are told about this program.

Auto-Draft
We have a final set of questions into our vendor to assure that the auto-draft will appropriately work with our system. Auto-Draft will allow us to offer 1) automatic renewal and 2) installment payments.

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

Recruiting for the Profession
There were two major events for recruiting in the next calendar year. The next USA SEF event will be held in April 2016. Carolyn Williams has agreed to coordinate that event again. The next HOSA event will be held in June 2015 in Anaheim, CA. Dr. Henry Oh is coordinating this event.

Professor's Rounds and Current Topics in Respiratory Care
The 2015 Current Topics in Respiratory Care series has been well received and the 2016 topic selection process is underway. Recording will take place in Tampa, FL, during AARC Congress 2015.

Education

Respiratory Care Education Annual
The RCEA received 11 submissions in 2015 for review and 8 manuscripts have been tentatively accepted for publication. The 2015 issue will be released in September. Dr. Linda Van Scoder has resigned from the editorial board effective after the 2015 publication. Recruitment for a new editorial board member is in progress.

Pulmonary Disease Educator course in Dallas
The Pulmonary Disease Educator course will be held in September in Dallas. Based on course feedback, the course will now include two components: an online pre-course with the asthma, COPD, cystic fibrosis, pulmonary fibrosis, and pulmonary hypertension lectures and a 2-day live course with an expanded curriculum. In addition to adding lung transplantation to the course topics, the tobacco cessation session has been expanded to provide more hands-on practice with motivational interviewing techniques.

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

Pfizer Grant
The AARC received a Pfizer grant for the development of "Clinician Training on Tobacco Dependence for Respiratory Therapists." The project includes development of a training course to

assist respiratory therapists in initiating the smoking cessation conversation and referring patients to formal smoking cessation programs. The project also includes a study to determine the effectiveness of the intervention. Studio and on-location recording takes place in June and the study participants will begin the course in early to mid-July. The course is expected to be open to all RTs by October 2015 and data dissemination from the study is expected in early 2016.

Additions to Education

Several additions to AARC University are in the works for 2015. The Adult Critical Care Specialist course (13.5 CRCE) and the Caring for the Chronically Critically Ill course (3 CRCE) were added in January 2015 and the Spirometry course (2 CRCE) was added in February 2015. In July, we expect to launch two PFT courses: Pulmonary Function Technology: Advanced Concepts (2.5-3 cr) and Pulmonary Function Technology: Pediatrics (3 CRCE). The Congenital Heart Defects course (5 CRCE), collaboration with Duke Pediatrics, and the Clinician Training on Tobacco Dependence for Respiratory Therapists (5 CRCE) are scheduled for October.

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

	2015 to date	2014	2013	2012	Comments
Webcasts and JournalCasts	4,224	8,812	7,511	6,289	Per session attendance in 2014: 383; 2015: 470
Asthma Educator Prep Course	99	268	203	224	Slightly under budget 2014
COPD Educator Course	360	820	570	420	Well over budget 2014
Ethics	746	1,757	2,361	2,711	Slightly over budget 2014
RT as the VAP Expert	26	115	81	275	At budget 2014
Alpha-1	35	125	98	330	At budget 2014
Exam Prep	12	39	40		Under budget 2014
Leadership Institute	27	89			Slightly under budget 2014
Asthma & the RT	189	172			Launched in July 2014
ACCS	46				Launched in January 2015
PFT: Spirometry	34				Launched in January 2015

*2015 through May 31, 2015

Advertising and Marketing

Advertising

Print advertising remains to be a rollercoaster ride from quarter to quarter. Respiratory Care is even with 2015 projections and previous year, while AARCTimes lags behind in both.

Digital advertising on aarc.org continues to remain consistent and strong through our partner, Multiview. In fact, almost all of aarc.org and *AARConnect* advertising positions have been sold out for the remainder of 2015. We are also seeing increase interest and sales through the AARC

Respiratory Care Marketplace site. RESPIRATORY CARE JOURNAL website has been turned over to Multiview for digital advertising sales and we should have a progress report by AARC Congress.

Other advertising channels through eNewsletters, ePubs and recruitment ads are also part of the digital advertising footprint. Recruitment ads continue to be favorable compared to prior years and budget. Changes here can be attributed to a fresh website and the biweekly Career News distribution channel. eNewsletter advertising remains less than stellar despite high readerships on 4 of those products.

Corporate Partners

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

We met with almost all AARC Corporate Partners after the conclusion of our Spring BOD meetings in Dallas. Along with our elected leadership and Executive Office team, we will have presentations by Richard Ford and Garry Kauffman on the ACA's impact on from the C-Suite and Respiratory Care Department perspectives.

The meeting was very productive and allowed us to hold several group and individual conversations with Partner representatives that may blossom into sponsorships or other opportunities that will benefit our patients, families, communities and the profession.

Just prior to Summer Forum, Tom Kallstrom and Tim Myers will be visiting numerous Partners on the West Coast to see if we can develop synergies with those groups as they did on their East Coast and ATS visits.

Marketing

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

We also redesign the AARC Store site to optimize its appearance and utility to those that visit us for our variety of products. We have also been able to develop a dashboard that allows us more real-time feedback on the products we host in the AARC store. We have also open up sections for donations to various AARC/ARCF fundraising activities in the new store as well.

We are also looking at "value added" products through our Membership Affinity program that may my find highly desirable. We have reinvigorated our relationship with Geico Insurance and hope to see a boost in revenues from that program. We also continue our relationship with the malpractice insurance group for our members. Shortly before we have our Summer Board meeting, we will be launching a new membership credit and reloadable debit card program with VISA. Both of these new programs will provide additional revenue streams on customized AARC and ARCF cards that are acquired and used by our membership. We are awaiting final regulatory approval on the VISA credit card site and finishing up the debit card program details with the sponsor. We have also been approach with 3-4 other affinity membership programs on items that people utilized in their

everyday lives that we will investigate further for possible membership enhancements.

Products
Benchmarking continues to see a decline in membership early in 2015 as the economic reigns are tightening for hospitals with approximately 50-55 hospitals (-15-18%) around the US and in Middle East (2). This will be a make or break year for this product. The Benchmark Committee is currently conducting an assessment of the program, possible upgrades and a potential new product line to insure it is a current and valued tool to its participants. We have also installed a new pricing structure in 2015 to insure that has a good ROI for both the AARC and its participants that has led to an uptick in renewals and a few new clients. We are also looking at a "view only" option based on a 2-year analysis of our program.

As you are aware, in 2012 we outsourced our Respiratory Care Week products to a third-party supplier, Jim Coleman Ltd that handle all products and the necessary shipping. 2014 was our third year outsourcing RC Week products to Coleman. We came in right about our budget target in 2014 and realized a similar royalty to last year. And will look to continue and hopefully enhance these sales for RC Week in 2015. We have selected a slogan for 2015 and completed logo design as well. We hope to be able to launch everything shortly after Summer Forum this year.

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

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

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

Information Technology
The IT department has been evaluating the next steps in our technology refresh.

The electrical service continues to be a concern. We experience momentary outages of up to a minute several time a week. We manage these without disruption with our backup power systems. This will cover outages up to about 15 minutes before we need to start shutting down servers. We have been experiencing longer outages requiring shutdowns about once/month.
We have investigated increasing the battery backup capacity and adding an on-site backup generator. Both options are very costly, and have ongoing costs.

A second alternative is to look at cloud services. We have already been using cloud services for about 5 years to deliver online media for several courses. The next step would be to host the

majority of our servers externally. We are currently getting information from several sources. One advantage to this approach is that we could leverage bulk pricing for some of our Microsoft licensing. Currently we get no discount, but using a reseller could reduce costs.

Our website conversion is still a work in progress. The changes to a new platform have increased key measurements for the site by between 200 and 2000%. The number of pages that a visitor goes to during a visit session is up, and the number that landed on our page 'by mistake' (bounce rate) is down.

Our updated security system will be installed by the time of the meeting.

State Initiatives

COPD management in the United States costs over $32 billion annually and is estimated to rise to $49 billion by 2020. Of note is that 25% of these costs are paid by state Medicaid programs. Couple this with the rising number of *baby boomers* with chronic lung disease and we are set up for the perfect storm.

A few months ago President Salvatore assembled a small group of experienced state side respiratory therapists who either work for their state health department or have been successful in implementing respiratory care services through Medicaid. This group includes John Wilgis (Florida Hospital Association), Ken Alexander (Louisiana Hospital Association), Gene Gant, Jan Fields (CDC), with myself, Sam and Cheryl as liaisons. The purpose of this group is to reach out to the local state Medicaid providers with an ask to consider including the services of a respiratory therapist in the provision of disease management.

We are seeking to partner with State Medicaid Program staff in developing delivery models that would increase access to the services and skills of a respiratory therapist. In this ask we have provided some possible pilot projects. We ask our state affiliates to join us as we work towards expanding both nationally (telemedicine) and state-side the role of the respiratory therapist in post discharge management of patients with chronic lung disease. Our first ask to our board and house member is to help us identify specific state health cost of Medicaid COPD patients. This would include metrics that include:

1. number of physician office appointments
2. emergency department visits
3. access and use of outpatient services
4. skilled nursing facility stays
5. home care services
6. long-term care services
7. durable medical equipment usage
8. hospitalizations
9. hospital readmissions

Once this letter is sent out (see below), and upon an interest of the state Medicaid department, we will contact the state president and delegates and will help coordinate ongoing talks and hopefully a pilot project.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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http://www.aarc.org, E-mail: info@aarc.org

TO: State Medicaid Director, State Affiliate President, State Hospital Association President

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

SUBJECT: AARC Collaboration with State Medicaid Programs for COPD Delivery Improvement

DATE: <INSERT DATE>

The American Association for Respiratory Care (AARC) in collaboration with its State Affiliates is seeking to partner with State Medicaid Programs and other state health care entities, as appropriate, to introduce cost efficient delivery models for patients suffering from Chronic Obstructive Pulmonary Disease (COPD) that improve care and increase access to treatment by respiratory therapists.

The cost to the United States for health care services for Americans with COPD is rapidly increasing. According to a 2014 *Chest* research paper,[1] COPD costs in 2010 were estimated at $32.1 billion with projected costs to reach $49 billion by 2020. Approximately 25% of those costs are borne by State Medicaid Programs.

Unless more innovation is introduced within the context of the treatment of patients with COPD, the nation's health care system will see costs continue to rise due to increased consumption of health care resources. This impact is especially profound when looking at the utilization of our most expensive health care setting - hospitals.

As part of this collaborative effort, the AARC offers the following proposed endeavors:

- Identifying specific state health care costs of Medicaid COPD patients using available data sources;
- Developing alternative care delivery models; and,
- Piloting models that will increase access to the services and skill set of licensed respiratory therapists within each State Medicaid Program.

The foregoing represents just some of the initiatives we can develop in collaboration with the State Medicaid Program while controlling the scope and costs of such pilot demonstrations. More detailed information is included in the attached Concept Paper titled, "COPD Delivery Improvement for State Medicaid Programs."

We hope that you are as interested in helping our patients as we are while keeping an eye on the ever-increasing expenditures associated with the care of COPD Medicaid beneficiaries.

Please contact me at 972-243-2272 or kallstrom@aarc.org for questions and information.

Sincerely,

<SIGNATURE>

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

Attachment: Concept Paper

American Association for Respiratory Care – Concept Paper
COPD Delivery Improvement for State Medicaid Programs

The American Association for Respiratory Care (AARC) in collaboration with its State Affiliates is seeking to partner with State Medicaid Programs and other state health care entities, as appropriate, to introduce cost efficient delivery models for patients suffering from Chronic Obstructive Pulmonary Disease (COPD) that improve care and access to treatment by respiratory therapists.

The cost to the United States for health care services for Americans with Chronic Obstructive Pulmonary Disease (COPD) is rapidly increasing. According to a 2014 Chest research paper,[1] COPD costs in 2010 were estimated at $32.1 billion with projected costs to reach $49 billion by 2020. Approximately 25% of those costs are borne by State Medicaid Programs.

Unless more innovation is introduced within the context of the treatment of patients with COPD, the U.S. health care system will see costs continue to rise due to increased consumption of health care resources. This impact is especially profound when looking at the utilization of the most expensive health care setting - hospitals.

According to the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project (HCUP),[2] a 25% hospital readmission rate within a 30-day period for Medicaid recipients is the highest among all insurance groups. It is unsustainable for the current health care system, in particular State Medicaid Programs to continue to provide resources in a scenario where one out of every four Medicaid COPD recipients is readmitted to the most expensive health care setting. It is the objective of the AARC to shift this paradigm! With the support and assistance of State Medicaid Programs, the AARC seeks to collaborate to drive down the Medicaid beneficiary readmission rate and its associated expense, and more importantly, the rate of exacerbations which serve as the underlying cause of the readmission trigger.

Primarily, the AARC seeks to align key members of a State Affiliate's leadership to work with the appropriate State Medicaid Program staff in identifying the specific state health care costs of Medicaid COPD patients. This analysis would include the overall incidence of COPD including the costs to the state for these recipients in terms of direct and indirect medical expenses. Using metrics like: the number of physician office appointments by these recipients; emergency department visits; access and use of outpatient services; skilled nursing facility stays; homecare services; long-term care services; durable medical equipment usage; hospitalizations; and, hospital readmissions will collectively provide the data and objective evidence describing the severity and challenges of providing care for COPD patients using traditional service delivery models.

Second, the AARC would like to collaborate on the development of alternative care delivery models. There is strong evidence suggesting admissions and readmissions for COPD patients may be reduced if patients are permitted access to the skills of a licensed respiratory therapist before

[1] Earl S. Ford, MD, MPH, Louise B. Murphy, PhD, et al. Total and state-specific medical and absenteeism costs of chronic obstructive pulmonary disease among adults aged ≥18 years in the United States for 2010 and projections through 2020, Chest On Line First, July 2014.

[2] Anika L. Hines, Ph.D., M.P.H., et al. Conditions With the Largest Number of Adult Hospital Readmissions by Payer, Statistical Brief #172 AHRQ, April 2014.

and after being admitted and discharged from a hospital.[3] The AARC hypothesizes part of the problem generating a 25% readmission rate is the limited access to skills processed by licensed respiratory therapists.

The AARC is not asking for changes to Medicaid policy. The AARC is looking to partner with State Medicaid Program staff in developing and testing innovative delivery models that will increase access to the services and skill set of licensed respiratory therapists. That these alternative delivery models can take a variety of forms and flexibility is perhaps the greatest asset in this instance. An outline of proposed projects is listed below for consideration:

- **Pilot Project 1**: Target physician practices that have a high percentage of COPD patients to place qualified licensed respiratory therapists in the office specifically directed to render services to defined COPD Medicaid beneficiaries. Participating licensed respiratory therapists will educate, monitor, manage, coach and follow-up with COPD patients to assure physician order compliance, appropriate medication management, and early recognition of the occurrence of disease exacerbation. A limited demonstration should provide outcome metrics in terms of cost offsets, improvement to overall quality of life and a reduction in health care system encounters. These data will be compared to a control group of Medicaid COPD recipients without access to targeted services of the licensed respiratory therapist and using traditional services provided by the State Medicaid Program to demonstrate reductions to program utilization.

- **Pilot Project 2:** Designate and support specific community-based, respiratory therapy outreach programs developed within a hospital respiratory services department. These outreach programs would be directed to specifically manage Medicaid COPD patients' post hospital discharge care and case management. The same data set previously mentioned in Pilot Project 1 would be used to compare the results of the outreach program with those of traditional care for Medicaid COPD patients.

- **Pilot Project 3**: Explore the development of a pilot program involving hospitals and participating or integrated providers or delivery systems (e.g., physician practices under hospital ownership, etc.) that provide services to a large volume of COPD Medicaid recipients. According to a recent American Medical Association Review Document,[4] over the last several years hospitals have been acquiring physician practices. It is has been estimated that as many as 50% of hospitals in the United States have at least some ownership position in physician practices. Given these new structures of integrated care delivery, Pilot Project 3 would explore ways to leverage this structure to utilize licensed respiratory therapists employed by the hospital but practicing under an agreed arrangement to the hospital owned physician practices. As with the previous suggested

[3] Rice KL, et al. Disease management program for chronic obstructive pulmonary disease: a randomized controlled trial. *Am J Respir Crit Care Med* 2010 Oct 1;182(7):890-6. DOI: 10:1164/rccm200910-1579OC. Epub 2010 Jan 14.

[4] Carol K. Kane, PhD and David W. Emmons, PhD New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment. AMA Research Perspectives, 2013.

pilot projects, an assessment of the costs, quality of life, and number of health care encounters as determinants of success, or lack thereof, would be performed.

- **Pilot Project 4**: Across the U.S. access to and affordability of physician services for Medicaid recipients is a problem. Pilot Project 4 seeks to offer the services of a licensed respiratory therapist as an employee or contractor to physicians who do not currently accept Medicaid recipients allowing increased access to Medicaid COPD patients for patient services. A physician that would appropriately delegate respiratory care services and related scope of practice to a licensed respiratory therapist supports making care affordable to the patient and the State Medicaid Program. For example, a respiratory therapist could provide inhaler or nebulizer education. Medication non-adherence has been estimated to cost the U.S. health care system between $100 billion and $289 billion in direct costs.[5] Patient education and proper device selection for both inhalers and oxygen systems are critical for optimal clinical outcomes and cost effectiveness. Licensed respiratory therapists are experts in this field and the added time they can spend with the patient to assist the physician can be invaluable. Other services provided by the skilled, licensed respiratory therapist could include oxygen titration and selection of appropriate oxygen devices, follow up for medication management, monitoring of compliance with the physician's care plan, and earlier detection of exacerbations before the patient deteriorates to warrant an emergency department visit or hospital admission or readmission.

The foregoing represents just some of the initiatives the AARC can develop collaboratively with the State Medicaid Program while controlling the scope and costs of such pilot demonstrations.

In summary, there are creative solutions to improving the access, cost and quality care to Medicaid COPD recipients. Given the documented impact COPD places on State Medicaid Programs, the AARC and its State Affiliates are seeking a collaborative approach with State Medicaid Programs to develop long range solutions to the challenges of effective disease management of Medicaid COPD recipients. As indicated, the overarching objectives of this proposal focus on improving the quality of care and patient outcomes, expanding access to treatment and respiratory care services, and reducing the cost of care to the patient and the State Medicaid Program. This approach is centered on concerted efforts to develop efficient delivery models aligning the services and expertise of the licensed respiratory therapist with the care and treatment of the Medicaid COPD recipient. While we focus on COPD throughout our proposals; it is important to note that the aforementioned innovative projects do have applicability to virtually all chronic lung diseases, such as asthma, cystic fibrosis, pulmonary fibrosis, and pulmonary hypertension. We selected COPD due to the unusually high hospital readmission rate.

State Medicaid Programs are encouraged to contact the AARC to determine a collaborative process for State Medicaid Program improvement that best serves the Medicaid COPD recipient. We look forward to working with you.

[5] Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment Number 208. 4. Medication Adherence Interventions: Comparative Effectiveness. Closing the Quality Gap: Revisiting the State of the Science. Executive Summary.

Executive Office Referrals

(from April 2015 BOD meeting)

- ***FM 15-1-14.1*** *"That the Executive Office, along with the Judicial Committee, create a guidance document for the Board of Directors on Conflicts of Interest."*

Result: An update will be provided at the meeting.

- ***FM 15-1-24.1*** "That the AARC BOD approves a dues increase and directs the Executive Office to put together a marketing plan to present to the Board of Directors and House of Delegates in July."

Result: More information about the proposed increase and how we will communicate this to members will be presented at the summer meeting.

State Government Affairs
Activity Report
BOD/HOD July 2015

Cheryl A. West, MHA
Director Government Affairs

Introduction

Between January and May nearly every state legislature came back into session and for the most part the majority of them have already recessed for the year. As is the usual case, some bills that the profession supported and/or opposed were passed and some, supported or opposed by the profession were not enacted.

There continues to be a heightened scrutiny from state legislatures and state governments to assess relevance of state mandated licensure for a variety of professions, be they health related or not. For this reason this Report will devote more attention to what seems to be a steadily growing area of concern for the licensure of respiratory therapists.

The concern comes in four areas:

First, the embedded Sunset provisions or "expiration dates" on licensure laws for regulated professions.

Second legislation that without any particular trigger (i.e. Sunset date) concludes that many licensure laws simply should be repealed.

Third, the legislative move towards consolidating (or eliminating) stand-alone licensure boards into an umbrella state licensing agency.

Fourth, authorizing private outside entities to assume the regulatory tasks of a state licensure board or regulatory agency.

SUNSET

As noted in previous communications to the BOD and HOD Sunset provisions included in the original RT licensure laws were a standard provision and one that up until the last 5 years was a pro forma non-controversial process. In the past, a licensure law would come up for Sunset, the legislature would quickly determine that the law was fulfilling its purpose and simply pass an extension of the licensure law for another 5 to 9 years depending on the state.

That simple process clearly no longer applies and RT Societies must and certainly are focusing major efforts and resources to assure that when their state RT licensure law is up for Sunset that the legislature (the ultimate decider) will vote to continue RT licensure.

Colorado RT Licensure Sunset

The Colorado State Society has been preparing for their licensure Sunset process for over a year. CSRC leadership first worked closely with the Government Agency that was tasked to review and report on the relevance of the RT licensure law. The Final State Review Report with a

few suggested operational changes to the law fully supported the continuation of RT licensure in the state. The CO legislature then stepped in and with the close monitoring by the CSRC the legislation was passed to continue RT licensure for another 9 years.

New Mexico RT Licensure Sunset
Respiratory Therapy licensure in New Mexico also was up for Sunset this year. Similar to CO, an extensive review of the profession was delivered to the state legislators in a written report clearly justifying the continuation of RT licensure. The NM Society also monitored and provided input to the legislature and the bill was enacted that extends RT licensure until 2022.

Illinois RT Licensure Sunset
2015 was also the year that the Illinois Respiratory Care Licensure law was due for Sunset review. With a great deal of focus and effort, the IL Society was successful in having the legislature enact continuation of RT licensure until 2026. Moreover, in addition to licensure continuation provisions the Illinois Society took the opportunity to include a number of important revisions to their licensure law including: inserting a RT transport exemption; revising the RT scope of practice to include cardio pulmonary disease management; permitting CRNAs to issue RT orders, and providing a more explicit and detailed DME exemption that clarifies what unlicensed personal may and may not do. These additions clearly strengthen the RT practice act and make it more relevant to how 21st century RT is provided. At this writing, the bill now awaits the Governor's signature.

Hawaii RT Licensure Sunset
The licensure law in HI will be up for its first Sunset review in 2016. In preparing for this review the HI Society has been providing detailed responses to questions posed by the Hawaii's Professional and Vocational Licensing Division (PVLD). Again this is to establish that RT licensure is fulfilling its mandate to protect the health and safety of the public. The AARC was also contacted by the HI Government Agency to fill out a detailed questionnaire on AARC's "opinion" of RT licensure in general and Hawaii's RT licensure specifically.

LEGISLATION TO REPEAL

Texas Licensure Repeal Efforts
The Texas RT Licensure situation continued to evolve over the spring. As you recall, in the summer of 2014 a Preliminary Sunset Review Report was issued recommending that RT along with over a dozen other professions be de-licensed. With the hard work of the TX Society and engaged TX RTs the Final Sunset Report (2014) revised the earlier recommendation and endorsed continued RT licensure and recommended regulatory authority be moved from the current Licensing Agency and placed under the TX Medical Board. To implement this recommendation the TX legislature was required to amend the RT licensure law. Two bills were introduced in January that would pave the way for RTs to move to the Medical Board and continue licensure. The bills were proceeding through the legislative process with seemingly no opposition.

However, in late April another TX legislator amended one of the RT bills and inserted controversial "social" amendments. Over the course of a month the fate of the RT licensure bill ran hot and cold, appearing at one point that the sponsor of the original legislation would pull the bill entirely after the "unfriendly" social amendments had been added onto the bill. However, in late May the path was cleared and at this writing the bill sits on the Governor's desk waiting his signature. It must be noted that the TX RTs, under the leadership of TSRC President Russ Graham,

RRT did a terrific job of face to face lobbying, and multiple times rallying the RTs and RT supporters to contact their members, efforts which clearly appear to have paid off.

Michigan RT License Repeal Efforts
The Michigan Society continues to hold the efforts (now in its 3rd year) to de-license the profession at bay. No legislation has been introduced thus far in 2015, but MI is one of a handful of states that stay in session all year long, so continued vigilance is required. The MSRC maintains close monitoring and has a dedicated group of RTs along with an outside lobby firm to make sure that the current status quo, i.e. MI RT licensure continues.

LICENSURE BOARD CONSOLIDATION
This concerning development has appeared sporadically over the past 2 years but became more noticeable in the first half of 2015. This new pathway is one where stand-alone licensure boards are disbanded by the legislature and the regulation of certain professions (not just limited to health professions) are brought under an umbrella of a state licensing agency. More often than not the rationale given to support repealing stand-alone Boards is one of more efficient government, the popular trend of state de-regulation, and better cost effectiveness (fewer state staff, aka employees needed).

FYI about 1/3 of the RT Licensure Boards/Committees/Councils in the country are stand alone licensure boards, another third of the RT Boards are under the umbrella of the Medical or Physician Licensure Board. The last third of the RT Boards come under a state licensing agency.

While there are certainly RT licensing "boards" that under the auspices of a state licensing agency and that are proactive, the rule of thumb is that often times they are not. Umbrella licensing agencies rarely issue rulings or public interpretations and rarely have Board/Council meetings, and a few do not actually have a Board or Council or Committee, members thereby for the RT profession there is no formal RT input indecisions. Again not all state umbrella licensing agencies are like this but there are some that are.

Another very concerning development that may add momentum to licensure board consolidation is a 2015 US Supreme Court ruling that could have a significant and nationwide impact on independent stand-alone licensing boards.

The case, North Carolina Board of Dental Examiners v. Federal Trade Commission, concerned the independent NC Dental Board issuing a cease and desist order for non licensed teeth whitening technicians. Basically the Dental Board, the majority of whom were licensed dentists, stated these technicians were practicing dentistry without a license and must stop doing so. The case worked its way to the US Supreme Court where it ruled in favor of the teeth whitening techs. The Supreme Court stated "*The Board's principal duty is to create, administer, and enforce a licensing system for dentists. …To perform that function it has broad authority over licensees. ….. The Board's authority with respect to unlicensed persons, however, is more restricted: like "any resident citizen," the Board may file suit to "perpetually enjoin any person from . . . unlawfully practicing dentistry (emphasis added).*

In essence this ruling means that a professional licensure board can regulate its own practitioners, but it cannot regulate a non licensee from providing aspects of its scope of practice. A Board can indeed file a lawsuit against that person or request that the State Attorney General do so, but that is an expensive and very long complicated process. It is clear from the Court's ruling that this Board

cannot on its own issue a cease and desist order for non licensees practicing in this case what the Board has determined is a component of dentistry.

Because this is ruling from the US Supreme Court the implications will be nationwide and certainly not limited to dentistry. There are ripple effects already being seen.

North Carolina Not surprisingly, since the Court case was from NC, a bill was introduced that would in effect disband many licensure Boards including the RT Board and shift them to a newly created State Occupational Licensing Agency.

Rhode Island a bill has been introduced that would disband a number of licensure boards, most notably the RT Board (which of course would include eliminating Board members) and place regulatory authority over the RT profession into a newly created state Division of Health Regulation. The RI Society is mounting opposition to this effort.

West Virginia in the beginning of the year a bill was introduced that would have disbanded nearly all health licensing boards and created one state Board of Health Professions. In addition to eliminating the stand alone RT Board the language of the bill also eliminated both the Physician and Nursing board, not the wisest inclusion. Needless to say opposition from all quarters was intense. The bill was subsequently amended to a more benign version that would provide licensing boards the *option* to coordinate their just their administrative operations (such as the IT department) to gain better efficiencies.

AUTHORIZE PRIVATE ENTIES TO PROVIDE REGULATION

This is a forth way one state, Indiana, has tried two variations of the same idea. In 2012 a State Report was issued by the Administration that recommended that state RT licensure was not needed and that RTs holding the NBRC's credentials would be sufficient to assure the public of the competency of Indiana RTs. The Indiana Society was quick to respond (as well as the AARC and especially the NBRC) to quash this notion that credentials could be substituted for state licensure and regulatory oversight.

This year Indiana tried again. This time the legislature took the lead. Initially a bill with strong support was introduced that would permit outside organizations to petition the Licensure Agency of Indiana to be designated, as a private regulating entity for individuals within its discipline. This private organization would be required to show proof to the IN Agency that it had the ability to provide testing, and continuing education, a scope of practice (which the entity alone could determine what the scope was) all leading to individuals receiving certification to practice from the private entity. If the criteria were met Indiana would "accredit" the outside private entity as offering state approved certification of those practitioners. Individuals within a discipline or occupation would go through the "accredited" private entity (not the state), be issued a certification that would now be accepted by IN in order to provide services as set forth in the scope of practice again as determined by the "accredited entity. Most stakeholders in IN saw this as a clear relinquishing of IN's role in regulating professions and ultimately protecting the public.

The bill would have impacted licensed as well as non licensed professions and disciplines and the opposition was fierce especially from health professions. In late spring the bill was revised to make it a pilot program, not a sweeping statewide change and secondly to exclude all health professions whether licensed or not from being subject to this new type of regulation.

Summary

Undermining the stability and/or existence of state RT licensure laws can come in many forms. Vigilance by the State Societies is key, so too is a vigorous response. Partnering with other affected professions into a coalition can help take the burden and workload of the State Societies and increase the "voice" of opposition.

RT Legislation

A number of these legislative developments were included in the April Board of Directors Report. However I believe they are of sufficient interest to the HOD that some bear repeating.

California supported/drafted by the CA RC Society a bill that among other provisions would expand the RTs scope of practice by permitting RTs to provide conscious sedation with training and under direct supervision. Moreover this bill would expand the CA RTs scope of practice to include providing care to patients with "deficiencies and abnormalities affecting the heart and cardiovascular system". Note the standard state licensure RT scope of practice says "*cardiorespiratory*" but not *heart and cardiovascular*. Finally the bill would clarify that the RT scope of practice would include '*education, and care of patients with sleep and wake disorders "*. Another **CA** bill would amend the RT Licensure law to include among those causes for discipline the commission of an act of neglect, endangerment, or abuse involving a person under 18 years of age, a person 65 years of age or older, or a dependent adult.

North Carolina With support from the NC Society a bill was introduced that would require the RRT as the only credential accepted for licensure application. The bill also provides that the provisional i.e. the temporary license can be issued for those with the CRT credential (good for 1 year and can be renewed with specific Bd. approval up to a maximum of 5 years). There is a grandfather clause for those with the CRT only. The grandfather clause expires October 1, 2016.

New Jersey a bill with the backing of the NJ Society that would revise the NJ RT Licensure law by adding disease management to the scope of practice, specifically permit RTs to provide protocols, allow NPs and PAs to give RT orders and deletes temporary RT licenses.

Arizona legislation has been enacted that repeals the issuing of temporary RT licenses.

Ohio a bill that requires all health care professionals, including RTs to wear identification when providing care or treatment in the presence of a patient.

Massachusetts Respiratory Care License Board and CPAP

The MA RC Licensure regulations are very clear in the requirement that if CPAP/BiPAP devices are delivered to the home and fitted/adjusted to a patient that this must be done by a licensed respiratory therapist. Earlier this year, home care companies in the state formerly requested that the current rules be revised and be made less stringent by permitting non licensed, but trained personnel to provide the delivery and set up of PAP devices. The MA RC Licensure Board sent out a survey questionnaire to nationwide stakeholders requesting input on this requested change to the current requirements. AARC was specifically asked to answer the survey which was done in great detail.

As an update to this issue, the MA RC Licensure Board has yet to issue any final ruling. However, presumably as a backup to a possible rejection by the Board to revise the current CPAP/BiPAP regulation legislation has been introduced that would indeed allow non-licensed personnel to

provide CPAP/BiPAP. However, there is a provision included in the bill requiring 500 hours of training of the non–licensed person by a licensed MA RT in order to qualify to do CPAP set-ups in the home.

Other Legislation of Interest

Delaware enacted a telemedicine bill for DE health insurance providers as well as state health programs. Adds telemedicine as a covered service as a general new coverage and also adds the following to the RT scope of practice *"The use of telemedicine as defined in this Chapter and, as, further described in regulation, the use of and participation in telehealth."*

New York to amend the social services law, in relation to establishing topical oxygen wound therapy as a Medicaid benefit. **NY** also has a bill that would specifically add RTs as providers of out of hospital services in order to transition patients from the hospital to home or nursing home.

Maine a bill that would expand housing opportunities for patients with complex medical conditions specifically includes vent dependent patients.

Asthma and COPD related Legislation

Minnesota a bill that would establish an enhanced asthma care services benefit for medical assistance.

New York a very extensive smoking/tobacco related bill that also includes a provision requiring all teachers to be trained in identifying and responding to asthma emergencies. **NY** also has another bill focused on childhood obesity that also includes a provision that would require the state to make recommendations on how to reduce the incidence of asthma, chronic bronchitis and other chronic respiratory diseases.

Massachusetts a bill that would establish a state plan to reduce the incidence of chronic disease, including, including chronic lung disease, & COPD.

New Jersey legislation establishing the Task Force on Chronic Obstructive Pulmonary Disease in the Department of Health.

Texas a chronic respiratory disease state strategic plan would be developed by the Department of State Health Services.

Tobacco Related Legislation

States continue to introduce and pass legislation to raise tobacco taxes and/or prohibit smoking in a variety of public areas. Of particular note is the volume of legislation this session that addresses electronic cigarettes and/or vapor devices or the catchall phrase "nicotine delivery devices".

There has been an alarming increase in the use of these devices particularly among teenagers. States are passing legislation to limit where these devices can be used and in some cases to put an age limit on the purchasing of these devices. Also know that since the devices do not use *tobacco leaves* in the manufacture of these products these devices circumvent tobacco taxes therefore revenue to the state is lost. States are rectifying this omission.

Below is a brief list of the states that are addressing just vapor devices or electronic cigarettes, and this is just legislation for 2015:

AK permits regulation of devices
HI (enacted) permits state regulation, imposes taxes
IN taxes electronic devices
IL includes electronic devices as “tobacco” and prohibits locations for use
KY sets out where one can use
LA taxes electronic and vapor devices
NM includes devices under “tobacco”, allows taxation, and requires labeling, another bill prohibits sales to minors, another bill requires child resistant packaging
OR allows regulation of devices
NY limits where devices can be used
NC impose taxes
ND prohibits sales to minors
PA locations where one can use tobacco and nicotine devices, raises age to 21 to purchase
RI includes nicotine devices in definition of “tobacco” and can be taxed, also requires warning labels
TX prohibits sales to minors, another bill limits advertising both bills have been enacted
UT will regulate devices and tobacco shops
WA limits sales to minors

I will provide a verbal update at the July Summer Meeting.

Federal Government Affairs Activity Report
Board of Directors/House of Delegates - July 2015

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

The Congress

Congress continues to deal with big ticket items such as the trade agreement and reached somewhat of a major milestone by enacting legislation to fix the Sustainable Growth Rate which has plagued physicians year after year. With the national Presidential elections kicking into high gear, we will have to "wait and see" whether any other high level initiatives such as tax reform, immigration or possible changes to entitlement programs get off the ground. Nevertheless, Congress continues to be acutely aware that the voters regardless of Party affiliation are highly dissatisfied with their past productivity. Showing the voters that compromise can be reached and legislation benefiting the American people can be passed may result in more bills being enacted than what "Hill Watchers" are predicting.

Legislation

AARC Legislative Initiative – Medicare Telehealth Parity Act

As noted previously, AARC leadership decided to support the Medicare Telehealth Parity Act (Parity Act) this year. Numerous studies recognize telehealth or telemedicine as having the potential to provide cost effective care or management in an alternative manner as well as reduce hospital admissions and readmissions, thus having appeal for both Democrats and Republicans.

To recap, the bill, which was introduced by Reps. Mike Thompson [D-CA] and Gregg Harper [R-MS] in the last Congress, expands Medicare coverage of originating sites (i.e., where the beneficiary is located) beyond the current rural professional shortage areas and includes home as a telehealth site. It adds respiratory therapists as covered telehealth practitioners in addition to others and includes coverage of respiratory services. The bill also includes COPD as one of the chronic conditions covered under remote patient management services that involve consultations, patient monitoring, patient training, clinical observation, assessment and treatment. Reintroduction has been held up due to other priority items of the Congressional committees and legislative counsel; however, the latest information is that the bill will be reintroduced by the end of June.

AARC and Asthma & Allergy Network leaders met with Congressman Harper and his legislative aide Jordon See on June 3 to discuss the Parity Act and other legislation sponsored by the Congressman and the Energy and Commerce Committee that include telehealth and could benefit respiratory therapists. Further details of the meeting will be presented in Phoenix.

Other Legislative Initiatives

The Medicare Access and CHIP Reauthorization Act of 2015: HR 2

This bill, often referred to as the "doc fix", was signed into law by President Obama on April 16, 2015. Among other things it repeals the Medicare sustainable growth rate and strengthens

Medicare access by improving physician payments and making other improvements.

Family Asthma Act

The Asthma & Allergy Network asked AARC to support this legislation during our March Hill Advocacy Day**.** It was introduced in the last Congress by Senators Kristen Gillibrand [D-NY] and Cory Booker [D-NJ]; AARC sent support letters at that time. Among other things, the bill directs the Centers for Disease Control and Prevention (CDC) to expand their collection of information on asthma prevalence and costs, including the number of school and work days missed by patients and parents due to asthma, physician and emergency room visits, and hospitalizations. We do not have word yet as to when or if this bill will be reintroduced.

Ensuring Assess to Clinical Trials of 2015: HR 209 and S 139

The Cystic Fibrosis Foundation asked that we support this bill which was reintroduced in the 114th Congress during our March Hill Day meetings. AARC also signed-on to a group letter of support. The bill allows patients with cystic fibrosis and other rare diseases to participate in and benefit from clinical trials without fear of losing vital benefits. Patients would be able to receive up to $2000 in compensation without it counting towards their income eligibility limits for Supplemental Security Income (SSI) and Medicaid. It would make permanent a law enacted in 2010 and scheduled to sunset in October this year.

21st Century Cures Act: HR 6

This bill, recently passed by the House Energy and Commerce Committee, is spearheaded by Chair Fred Upton (R-MI) and Rep. Diana DeGette (D-CO) and has been receiving a lot of publicity because of its bipartisan support. Other committees of jurisdiction have to consider the bill before the full House can vote; however, the Senate has yet to come up with a companion piece.

The bill would accelerate the discovery, development and delivery of promising new cures for patients. It includes expedited review of breakthrough drugs and devices and enhancement of innovative and biomedical research. There is a telehealth section in the bill but it does not address the needs of pulmonary patients as advocated by AARC. Rather, it requests CMS and the Medicare Payment Advisory Commission provide certain information to Congress that will help determine what populations of Medicare beneficiaries might benefit from telehealth.

Medicare Telehealth Enhancement Act: HR 2066

This bill, sponsored by Rep. Gregg Harper (R-MS) was reintroduced in the 114th Congress on April 28, 2015. It contains the same provisions as last year's bill which includes coverage of telehealth and remote patient monitoring services as part of a national pilot program for bundled payments and as supplemental health benefits in Accountable Care Organizations. It does not contain language that would include respiratory therapists and other health care professionals to be qualified telehealth practitioners.

Medicare DMEPOS Competitive Bidding Improvement Act of 2015: HR 284 and S 148

The bill was passed as part of the legislation to fix the sustainable growth rate. AARC sent letters of support when it was first introduced in the 113th Congress. It bans non-binding bids within the competitive bidding program and requires providers to prove licensure and obtain a bid bond before they submit bids. Bonds could be forfeited if the contract is declined at or above the bid price.

In other actions, the House Ways and Means Committee held a hearing on May 19 titled "Improving Competition in Medicare: Removing Moratoria and Expanding Access" at which time the AAHomecare Board Chairman testified about the problems with the current competitive bidding system and recommended the Market Pricing Program as a sound alternative. This bill was introduced in the last Congress and supported by AARC.

Regulations and Other Issues of Interest

Regulatory Overview

Physician Fee Schedule and Hospital Outpatient Policies

Because the proposed annual updates to both the physician fee schedule and hospital outpatient prospective payment regulations don't take place until July each year, there are no updates to these issues at this time. In looking forward, however, it is doubtful we will see any further revisions to the care management services policies that would impact respiratory therapists. However, we do anticipate further increases in payment for pulmonary rehabilitation programs in the hospital outpatient setting as hospitals refine their claims reporting.

Hospital Inpatient Prospective Payment System (IPPS) and Hospital Readmissions

The proposed 2016 update to IPPS was published in May. CMS is proposing to expand the principal discharge diagnosis for pneumonia to include aspiration pneumonia and a principal diagnosis of either sepsis or respiratory failure with a secondary diagnosis of pneumonia present on admission. Evidence shows an increase in the use of these diagnoses which is supported by a new study. It also enables CMS to better capture the complete patient population receiving clinical management/treatment for pneumonia. It also adds the COPD mortality measure to the value-based purchasing clinical domain for FY 2021.

FDA's Proposal to Regulate E-Cigarettes and Other Tobacco Products

As reported last year, FDA finally published its proposed rule to "deem" all categories of products that meet the statutory definition of "tobacco product" subject to FDA's regulatory authority, including e-cigarettes and cigars. In submitting comments to FDA, AARC and numerous other organizations that are part of the Tobacco Partners Coalition urged FDA to publish final rules no later than April 25, 2015, which is one year from the date of the proposed rule. Rumor has it that FDA will not likely publish the final rules until sometime this summer. AARC, together with numerous other organizations, sent a letter to the President on April 28 urging him to have the rules published as quickly as possible.

Ventilators

As reported at the April Board meeting, CMS had planned to add noninvasive pressure support ventilators (E0464) to the list of products subject to the 2017 Round 1 competitive bidding cycle. However, they have since rescinded that requirement due to significant changes being made to the current HCPCS codes for ventilators. CMS has proposed to create two new codes effective January 1, 2016 for home ventilators -- one used with an invasive interface (e.g., tracheostomy tube) and the other used with a non-invasive interface (e.g., mask, chest shell). Five current ventilator codes (E0450, E0451, E0461, EO463 and E0464) would be eliminated. According to Medicare, the change is needed to address national coverage and payment rules and to prevent abuse.

On a related issue, AARC has been working with other pulmonary organizations to require the Durable Medical Equipment Medicare Administrator Contractors (DME MACs) to revise the

current local coverage determination for respiratory assist devices. The current LCD is out of date and does not reflect changes in technologies that have taken place over the past decade. In essence, physicians are forced to prescribe a more expensive ventilator (E0464) for a certain subset of patients with COPD when a lower priced respiratory assist device could be used without harm to the patient. The contractors believe they have no discretion to make changes; thus, a meeting has been scheduled with CMS Central Office on July 21 to discuss the possibility of a national coverage determination. An in-depth review of the new coding changes is also necessary to determine the impact on this and future actions by AARC and others.

Possible Elimination of the Certificate of Medical Necessity Form

CMS held a conference call on May 27 with interested stakeholders to gather information as to whether current Certificate of Medical Necessity (CMN) and DME Information (DIF) forms should be eliminated as part of the agency's efforts to reduce provider burden. This would include the CMN for oxygen and oxygen equipment. While the CMNs were initially developed to provide evidence of medical necessity, CMS and suppliers have found during audits that the CMN information often conflicts with the medical record and is not used in the deliberative process.

Suppliers would still be required to obtain the necessary information prior to delivery and the local coverage policies would still mandate the requirements as they do now. CMS is considering developing an electronic clinical template that may replace the CMN for oxygen. AARC would not object to eliminating the form if other requirements were in place and submitted comments to CMS on June 8.

Major Reforms to Medicaid Managed Care

CMS published a proposed rule on June 1 that is designed to modernize the Medicaid managed care program to reflect changes in the usage of managed care delivery systems. It includes beneficiary protections with respect to enrollment and disenrollment and continuity of benefits. Proposed revisions would align the Medicaid Managed Care framework with other public and private programs to improve coordination and continuity of care and ensure utilization management strategies that adequately support individuals with ongoing or chronic conditions or who require long-term services and support. AARC plans to submit comments to CMS to emphasize the expertise of respiratory therapists in treating patients with chronic pulmonary disease and the benefit of increasing their utilization in the managed care arena.

Accountable Care Organizations (ACOs)

Earlier this year AARC submitted comments to CMS on proposed changes to ACOs that would strengthen care coordination activities, permit ACOs to furnish telehealth and remote patient monitoring services and enhance opportunities for respiratory therapists. On June 9, CMS published final rules that will require ACO applicants to define the process they will use to encourage and promote use of technologies that include telehealth and remote patient monitoring, promote patient management (which could include self-management education and training by RTs), and coordinate care among primary care physicians, specialists, and acute and post-acute providers and suppliers.

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 July meeting in Phoenix.

HOD Report

Submitted by John Wilgis – Summer 2015

Recommendations

None

Report

- Continued monthly conference calls with House Officers to share information and in support of House objectives, goals, strategies and charges.
- Held quarterly conference calls with House Committee Co-Chairs to share information and in support of House objectives, goals, strategies and charges.
- Participated in quarterly conference calls with President Salvatore, Past-President Gaebler, AARC leadership and liaisons to share information and collaborate House activity with AARC and AARC Board actions and plans.
- House Speaker appointed by President Salvatore to serve on the Ad Hoc Committee on Advanced RT Practices, Credentialing and Education. Elected by the committee to serve as Co-Chair of the committee.
- Collaborated House activities with AARC BOD Executive Committee at Spring BOD meeting.
- Worked with President Salvatore, the Executive Office, House Officers and the Delegate Assistance Committee to prepare information to share with the House related to affiliate information sharing requirements, affiliate responsibilities as a non-profit organization and create a mechanism of assistance and resource information for affiliate use.
- Worked with the Executive Office, House Officers and the Student Mentoring Committee to define ways to improve the student mentoring program in a responsible, efficient and effective manner.
- Worked with President Salvatore, the Executive Office, House Officers and the AARC Bylaws Committee Co-Chairs to identify ways information from the AARC Bylaws Committee can be shared in a timely and effective manner as related to affiliate bylaws review and approval and AARC Bylaws amendment process.
- Advised and assisted the House Bylaws Committee on implementing proposed changes approved by the House to the AARC Bylaws.
- Identified challenges and areas of concern related to House activities as they relate to BOD actions and determined mitigation strategies and response steps to be taken to address the issue(s).

- Created the Ad Hoc Committee for House Collaboration and Assistance in Implementing the AARC Strategic Plan. The committee will focus on House Objectives 1, 2 and 5 and begin working in July 2015.
- Serving as a work group member with AARC Board Members to review AARC Strategic Goals 1, 2, 3, 5 and 8.
- Advised and assisted House Committees as requested.
- Provided quarterly progress reports to the House.

I would like to that the Executive Office, Board of Directors and House leaders who have assisted me over the past several months. Their contributions continue to assist the House in its activities.

Board of Medical Advisors Report

Submitted by Dr. Steven Boas – Summer 2015

A verbal report will be provided by Dr. Boas.

President`s Council

Submitted by Dianne Lewis – Summer 2015

Recommendations

None

Report

We are waiting for the HOD nominees for Life and Honorary membership for the Council to complete its process; otherwise, nothing to report.

Standing Committee Reports

Audit Sub-Committee

Submitted by Jacklyn Grimball – Summer 2015

Recommendations

None

Report

The Audit Sub-Committee is prepared to participate in the Finance Committee meeting at the AARC Winter Congress November 4, 2015 being held in Tampa, Florida.

The Audit Sub-Committee continues to review and monitor the monthly financial statements provided.

Bylaws Committee

Submitted by Troy Whittaker – Summer 2015

Recommendations

That the AARC Board of Directors find that the West Virginia Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment "WVSRC Bylaws)

Report

Throughout the review process, the AARC Bylaws Committee considered the implications of all recommended bylaws changes to both the respective affiliates and the AARC and has determined that these changes are appropriate and are not in conflict. Potential conflicts with affiliates Bylaws changes were considered and were determined to be consistent with the AARC Bylaws and established requirements. The AARC Bylaws Committee has approved and submitted the West Virginia Society for Respiratory Care amended bylaws to the BOD for consideration.

There are three state affiliates that are due for bylaws review this year that have yet to submit their bylaws to the Bylaws Committee. Those remaining affiliates that are due this year are the following: Idaho, Maryland-DC and Oregon. The Bylaws Committee will be reaching out to those states in the very near future to inform them and work with them to get their bylaws submitted for review this year. As for next year (2016), there are several states – fifteen - that are due for bylaws review and the Bylaws Committee will be contacting those states as well to give them early notice with a suggestion to consider submitting their bylaws as early as possible (i.e. this year). This strategy should help to avoid a significant burden on the 2016 Bylaws Committee, BOD & HOD with an onslaught of submissions in the coming year all at once.

The AARC Bylaws Committee has also received recommendations submitted from the HOD Bylaws Committee / House Leadership for changes to the AARC Bylaws. AARC Bylaws Committee members have individually reviewed these changes and we are currently in the process of scheduling a conference call to deliberate over these recommended changes as a committee. The AARC Bylaws Committee will be meeting in the next few weeks to discuss and consider these recommended changes with due diligence as the AARC Bylaws require.

Other

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

Elections Committee

Submitted by: Jim Lanoha- Summer 2015

Recommendations

None at this time

Report

Nothing new to report at this time.

Executive Committee

Verbal report

Finance Committee Report

Verbal report

Judicial Committee

Submitted by Anthony DeWitt – Summer 2015

No report submitted as of July 2, 2015.

Program Committee

Submitted by Ira Cheifetz – Summer 2015

Recommendations

That the AARC Board of Directors approve Jacksonville, FL (JW Marriott Sawgrass Resort) as the destination for the 2016 AARC Summer Forum.

Justification Since 2000, attendance for Summer Forum has been on average 20% higher when the meeting is held in the state of Florida and/or tropical destinations as compared to all other destinations (mountains, desert). The JW Marriott Sawgrass Resort offers amenities customary with the JW brand including access to the Marriott Cabana Beach Club and a world-class golf course. The AARC executive office has negotiated a room rate of $145 per night + a $1 per night resort fee (that includes FREE parking and complimentary in-room Wi-Fi internet).

The AARC Program Committee has also made efforts to rotate Summer Forum destinations between east and west coast destinations so as to not disenfranchise a particular segment of AARC membership. The 2015 AARC Summer Forum was held in Phoenix, AZ. As such, an easterly destination would normally be scheduled as part of said rotation.

That the AARC Board of Directors accept for **information only and refer to the Executive Office** that site procurement for future AARC Congress locations *should* be selected at least 4-5 years in advance.

Justification In lieu of the hotel and hospitality industry's rebound from the recession, we are finding it more difficult to find qualified cities to host our convention when looking to book the meeting 3 years out. Space is simply very difficult to come by when planning on such a short time frame. Booking meetings at least 4- 5 years out allow us the opportunity to find the best possible city to host our convention (and one that meets the needs of our membership).

Report

1. Prepare the Annual Meeting Program, Summer Forum, and other approved seminars and conferences.

Status: The Summer Forum program has been published both in print and online. The Summer Form will take place July 13-15, 2015 in Phoenix, AZ. A Pre-course and a Welcome Reception will take place on Sunday, July 14. 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.

The 61st AARC International Respiratory Convention & Exhibition Program is all but finalized. Information on early registration for the Congress will be published in the July issue of the AARC Times and the Advance Program (while not posted at the time of this report) will be posted to the AARC website by the time of the Summer Forum. AARC Congress 2015 will take place Nov. 7-10, 2015, 2014 in Tampa, FL. There will be approximately 250 sessions on current respiratory

topics and 12 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 – See recommendations

AARC Congress - Destinations have been secured through 2018. See recommendation above.

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 representation of specialty section interests is included in our programs. For further information on specialty section and roundtable representation, see "AARC Congress 2015" below under bullet point #4.

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 – After two years of experimenting with an early start/end time for the Summer Forum agenda, we are reverting back to a more traditional start/end time to meet the education needs of attendees as well as provide them adequate exposure to exhibits and a longer lunch break. These changes came as a result of feedback provided by 2014 Summer Forum attendees. We've also minimized 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: **Adult and Neo/Ped Mechanical Ventilation, Managing the Chronic Oxygen Dependent Patient Across the Continuum, and a Vascular Access Workshop (funded in part through an unrestricted educational grant from Teleflex).**

Attached is a listing of the number of CRCE offered by content category:

- Adult Acute Care: 22.62
- Management: 16.24
- Neo/Peds: 21.46

- Sleep: 13.34
- Education: 8.7
- Clinical Practice: 43.0
- Pulmonary Function: 9.86
- Patient Safety: 4.06
- BioTerrorism/Emergency Preparedness: 1.74
- Ethics: 2.9

Sputum Bowl Sub-Committee Report:

No report at this time

Strategic Planning Committee

Submitted by George Gaebler – Summer 2015

Recommendations

None

Report

· I have worked with the team on the Strategic Plan Group number 2 that has reported its activities for this AARC BOD Meeting.

· All of the different groups should have reported their progress on the area they are committed to for this meeting

· I will report on the BOMA conference call meeting on June 27, 2015 and in person at the AARC BOD Meeting.

· I have worked on specific issues related to Bylaws and strategic activities for communications with the Strategic Plan as requested by President Salvatore

Other

Will give up to date report on other activities verbally at the meeting

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Summer 2015

Recommendation

None

Report

- Section has begun organizing discussion regarding Strategic Plan Group 3 as it pertains to limitations to RTs performing quality research. Will report on these discussions separately from this report.
- Awaiting executive office recommendations on how to approach other research barriers and potentially supporting initiatives like CARTER

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Summer 2015

No report submitted as of July 2, 2015.

Diagnostics Section

Submitted by Katrina Hynes – Summer 2015

Recommendations

None

Report

2015 Diagnostic Section Charges

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the deadline in Jan 2015.
    a. *Multiple proposals were accepted and speakers notified out of the 47 lecture proposals submitted by the Diagnostic Specialty Section membership for this year's conference. The official count has not been released to the Chair by Ms. Annissa Buchana.*

2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings. Documentation of such a meeting shall be reported in the April 2015 Board Report.
    a. *Section Bulletin – the 2015 Summer Bulletin has been completed and is awaiting publication. Quarterly Bulletin deadlines: Winter Issue: December 1; Spring Issue: March 1; Summer Issue: June 1; Fall Issue: September 1.*
    b. *Section Specific web cast/chat – continued efforts are being made by the Section Chair to identify a topic and lecturer for 2015. Webcast topics and proposed lecturers for 2016 have been communicated with Ms. Shawna Strickland, Associate Executive Director – Education.*
    c. *1-2 web-based Section meetings – communication has been made by the Chair with Ms. Shawna Strickland, Associate Executive Director – Education regarding the logistics of setting up a web-based meeting. An official web-based meeting agenda and date has not been determined. Any progress or outcomes will be reported to the Board of Directors in the third quarter report.*

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

interactions.

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

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

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2015 Board Report and updated for each Board report.
    a. *Pages 1-5 of materials posted in the AARC Connect library and swap shops have been reviewed. The recommendations to remove several old posts have been communicated to Mr. Steve Nelson, Diagnostic Section Liaison. Pages 6-8 will be reviewed in the third quarter and reported in the third quarter Board of Directors Report.*

7. Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendations as to what should be done with that section.
    a. *Ongoing communication occurs between the Section Chair and Ms. Shawna Strickland, Associate Executive Director-Education, to identify and address educational needs of the Diagnostic Section.*

Other

Action Item:

1. Upon review of the resources and links provided on the Diagnostic Section webpage, major errors/updates were identified. The following webpage deficiencies have been brought to the attention of Mr. Steve Nelson, Diagnostic Section Liaison.

a. *A biography was provided about the new Section Chair to be uploaded to the "About the Chair" link. Currently, the link is inaccessible.*
b. *Updates to the "Diagnostic Section Resource List" are in progress. A message to the section membership via AARConnect will be posted in the third quarter, requesting volunteers to be listed as contact experts and resources. All updated information will be communicated to the appropriate personnel to be uploaded to the site.*
c. *The following links are inaccessible under the Respiratory Diagnostics Online Resources/Professional Links: Pulmonary Diagnostics Page, Respiratory Therapy Encyclopedia, Social Security Disability Determinations, Virtual Hospital University of Iowa (Interpretation of PFTs), Virtual Hospital University of Iowa (pulmonary information), and Virtual Hospital University of Iowa (PFTs).*
d. *The last Section Newsletter, found under the Respiratory Diagnostics Section Newsletter, is June 2014.*

Diagnostic Professional Representation:

1. Mr. Carl Mottram RRT RPFT FAARC and Mr. Greg Ruppel RRT RPFT FAARC have been requested to serve on the newly formed ATS – PF Laboratory Accreditation Committee.
2. The NBRC PFT Examination Committee, including AARC members: Susan Blonshine, Carl Mottram, Greg Ruppel; standing consultants to the committee: Jeffrey Haynes and Ralph Stumbo; and invited Ad Hoc members: Katrina Hynes, Renee Kiourkas, Andrea Stiller, Jennifer Weltz Horpedahl, met in Hilton Head, South Carolina to define the cut-scores for the PFT Single Examination that will take effect July 1, 2015.
3. Mr. Carl Mottram RRT FAARC, Director of the Pulmonary Function Laboratories and Associate Professor of Medicine at the Mayo Clinic was elected as Treasurer and Executive Committee Member of the Board for the Clinical and Laboratory Standards Institute.
4. Mr. Jack Wanger MS RRT, Independent Consult continues to serve on the ATS Pulmonary Function Standards Committee and is currently working on their updated guideline on Bronchoprovocation Testing.

Education Section

Submitted by Ellen Becker – Summer 2015

Recommendations

None

Report

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the deadline in Jan 2015.

   Status: Completed.

2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings. Documentation of such a meeting shall be reported in the April 2015 Board Report

   Status: As reported in April, the Education Section did not produce a bulletin due to the low readership based upon Google analytics over the past year. Rather an Education Book Club was initiated. A survey about the utility of the book club is pending. A section webcast was held in March 2015 and a webcast is planned for September 1, to be delivered by Ms. Roberta Hales, which will address assessing competency and fostering education for hospital-based educators.

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

   Status: Feedback on the content for the upcoming Summer Forum was shared with the marketing department to highlight value to educators.

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

   Status: No work on this goal was initiated. Emerging leaders will be approached at the Summer Forum and International Congress to encourage interest.

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

   Status: Requests from members who had difficulty logging on to AARC Connect were promptly addressed. Also, I participated in developing a survey to evaluate the issues surrounding the academic credentials required for respiratory therapists to evaluate arterial blood gas analysis competencies. Results are not yet analyzed, but a report to the section membership will be sent.

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April

2015 Board Report and updated for each Board report.

Status: Dr. Shawna Strickland contacted the current members of the Education Section Resource Directory to see if they were still active and wanted to continue as a resource person. A message was sent to the Education Section membership to determine whether the current resource categories were appropriate and solicit additional volunteers. Volunteers to evaluate the swap shop and AARC Connect libraries will also be solicited through the AARC Connect listserve and at the Summer Forum in July.

7. Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendation as to what should be done with that section.

Status: The current Education Section membership is 1,076. The plan is to utilize a portion of the Summer Forum meeting to identify what current educators value from the section resource and use these finding to aid in a marketing plan. A section volunteer willing to serve on a membership subcommittee will also be sought.

8. Work to develop more programming directed at hospital educators and all therapists whose position requires some sort type of education process.

Status: Numerous presentations for both the Summer Forum and International Congress were selected based upon the need to serve this important education constituency. Further, the section-specific thematic webcast (see #2 above) is directed towards hospital-based educators.

Home Care Section

Submitted by Kim Wiles – Summer 2015

Recommendations

None

Report

1. Several homecare topics and a pre-Congress session on the management of chronic hypoxemia across the continuum of care were submitted and accepted.

2. Three home care section bulletins were completed and submitted timely with the recruitment of 2 new authors

3. Second AARC Times article completion

4. Working with section members on lobbying efforts related to non-invasive ventilation

5. Continued work with Shawna on homecare competencies, condensed competency survey results to be released and discussions of next steps will continue.

Long Term Care

Submitted by: Lorraine Bertuola– Summer 2015

No report submitted as of July 2, 2015.

Management Section

Submitted by: Cheryl Hoerr – Summer 2015

Recommendations

None

Report

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

   Status: As noted in the Spring 2015 report to the Board; no new information.

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

   Status: The winter and spring bulletins were published as scheduled. Our bulletin editor, Roger Berg, has contacted 12 members of the Management Section for an article for the summer Bulletin and has not received any responses back one way or another. The spring Management Section Meeting was held via a webcast on May 14th with 34 members logged in to participate in the meeting.

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

   Status: The management section web meeting format was well received by those in attendance. The agenda centered on a discussion of the AARC Strategic Goals and the financial challenges facing healthcare. The critical importance of AARC membership as well as Management Section membership was also a topic of discussion. Our Program Committee liaison, Garry Kauffman, worked diligently to develop a Summer Forum program for our management membership that was both timely and relevant to their practice. AARC efforts on boosting management attendance included postings on AARConnect, Facebook and Twitter in an attempt to reach a wider audience.

4. Identify, cultivate, and mentor new section leadership

   Status: Met with all RT leaders in the SSM system on May 4th. RT leaders from a 3 state area were in attendance. Discussed the AARC Strategic Goals, the Board's vision for the future of respiratory care, the critical importance of membership, and the AARC Benchmarking program. Their 10 hospitals committed to enrolling in Benchmarking but emphasized that their continuing participation would be contingent upon the updating of the program with additional quality measures. Two leaders were convinced to attend the Summer Forum for the first time this year; Jeff Ball spoke at the summit and I suggested to him that he would be a great speaker for future AARC programs, and Teresa Power who is a newer manager and expressed interest in becoming more involved.

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

   Status: Daily review of management section list serve postings and reply as necessary. 56 threads were started in April, 35 in May, and 65 in June yielding an average of 52 threads per month. Hot topics included:

   - A discussion of whether advanced certifications for therapists should be mandatory or recommended
   - A discussion about productivity and therapists performing EKGs
   - Confusion over The Joint Commission's interpretation of CLIA regulations for ABG competency validation
   - Two requests for information: (1) who is responsible for movement of oxygen cylinders within your facility? (2) do you track ventilator days or hours
   - A request for samples of clinical ladders

6. Review all materials posted in the AARC Connect library for their continued relevance. Provide a calendar of when the reviews will occur and updated for each Board Report.

   Status: There are currently 685 documents in the Management Specialty Library. No reviews were able to be accomplished prior to this meeting. A review of 1/3 of these documents will be attempted by the BOD meeting in November.

7. Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendation as to what should be done with that section.

   Status: There are currently 1,598 total management specialty section members. This is a 3% decrease in membership numbers reported at the April BOD meeting. No action is currently necessary for the management specialty section as of this posting.

Neonatal-Pediatrics Section

Submitted by Natalie Napolitano – Summer 2015

Recommendations

None

Report

Continued with quarterly Newsletters

Reminding section to nominate colleagues for SPOY

Participated in Allergy and Asthma Network 30 Year Celebration including congressional meetings on Capitol Hill and spirometry screening at National's baseball game.

Worked with program committee to rate Neo/Peds Proposals for conference.

Spoke at 3 conference in 3 cities related to neonatal pediatric respiratory care including challenges of neonatal mechanical ventilation and health effects of environmental tobacco smoke on pediatric patients.

Worked with Respiratory Care Journal on rating and selection of Abstracts for 2015 conference.

Continued working with government affairs and research sub groups for strategic plan that will be updated at this meeting.

Work with international committee to choose international fellows and host cities for 2015.

Sleep Section

Peter Allen - Summer 2015

Recommendations

None

Report

New Interim Sleep Section Chair Peter Allen was introduced to the Sleep Section and the membership as a whole via AARConnect and other means as determined by AARC support staff.

Projects now under way:

- Section Survey polling sleep section members regarding demographics and to also gain insight into their needs and concerns.
- Practitioner of the Year Award being promoted with section members, deadline upcoming.
- Promotion of the AARC World Congress
- Members being contacted for articles.
- Sleep Survey being prepared for approval to approach membership at large regarding the many cross-over points between other sections.
- Initial goal is to increase sleep section membership by responding to survey, touching membership at large, and continuing to build section offerings.
- Peter will be contacting AARC leadership across the country to increase both value and awareness of sleep section support for their regional efforts.

Sleep Section membership is currently between 900 and 1000 members.

AARC staff has been very helpful and supportive with New Chair orientation.

Increasing section membership by reaching out to current members and AARC membership at large is my main goal at this time.

Surface to Air Transport Section

Billy Hutchison - Summer 2015

Recommendations

None

Report

This has been an exciting year as the number of transport therapists around the country is improving and the role of the therapists in education for transport teams is increasing.

The membership is not where we would like and many section members have been reaching out and assisting with sharing the value of the section.

I fill we need a more active forum. With this I would propose we develop a weekly question to provoke thought and participation.

I am excited about the election of Tabatha Dragonberry to the next chair as she brings great enthusiasm and knowledge to the section.

Special Committee Reports

Benchmarking

Submitted by Chuck Menders – Summer 2015

Recommendations

That the AARC Executive Office explore database revisions with the vendor who manages the benchmarking database as recommended by the Committee and explore the cost for enhancements and revisions.

Report

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

2. Tim Myers presented a webcast in April that focused on productivity and benchmarking and highlighted the AARC benchmarking system.

3. Discussed how to best utilize the Benchmarking dashboard. Many non-subscribers had the benefit of using the data but would not subscribe. However, the dashboard has the potential to be used to entice new customers. With lower subscriber volume, metrics often do not have enough power to populate the report data, so use of this dashboard will be evaluated again in the future.

4. A survey is being finalized and will soon be sent out to members of the management section to assess the types of quality indicators that should be added to benchmarking, as well as barriers for becoming a benchmarking subscriber.

5. Created rough draft of revised department profile to allow for quicker data entry. Currently assessing what is necessary for comparison and creating compare groups.

6. Rick Ford is looking at the matrix and formulas to determine if removing various items will have a negative impact on performance or calculations.

7. Other various elements of AARC Benchmarking software have been identified as needing updating including alignment with time standards and definitions included in the 5th Edition URM and refinement of metric terminology and measures to be consistent with terms considered universal in reporting performance

8. Membership in AARC Benchmarking has increased from 50 on March 30, 2015 to 52 as of May 2015. A new pricing structure is in place to make the program more affordable for both current and new subscribers.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Summer 2015

Recommendations

None

Report

The list serve continues with minimal but important discussions.

Federal Government Affairs Committee

Submitted by John Lindsey – Summer 2015

Recommendations

None

Report

As Co-Chair of the AARC Federal Government Affairs Committee, I am also a member of AARC President Frank Salvatore's Strategic Initiative Group and with input from committee members. We are devising recommendations and responses to the noted strategic sections, several of which AARC has or is currently addressing.

This Committee awaits definitive movement from Congress as to which telehealth legislation will become the one with the most possibilities to move forward. Unlike previous legislation AARC has supported where we dealt with just one bill there are 3 House telehealth bills and a potential Senate bill in play. Once we know which bill will become the lead bill we will issue a call to action for RTs to use Capitol Connection to send in emails of support as well as encourage PACT reps to set up District meetings with their legislators.

The Committee continues to be kept informed of state legislative developments of interest to the RT profession, especially those that impact RT state licensure.

Fellowship Committee

Submitted by: Patrick Dunne – Summer 2015

Recommendations

None

Report

The work of the Fellowship Selection Committee will begin in earnest during the first week of September 2015. Please note that the deadline for receipt of online nominations for 2015 Fellow is Monday, August 31. 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 2015

Recommendations

None

Report

1. Administer the International Fellowship Program.

   As of today June 3, 2015 we have 13 applicants for International Fellows and 9 applicants for City Hosts. The deadline for applications to be received was June 1st. We have extended the application deadline by 1 week and after that will be 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 Wednesday, July 15th 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 with minor exceptions, 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.

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

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

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

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

Respectfully submitted,

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

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

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

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

Membership Committee

Submitted by Gary Wickman – Summer 2015

Recommendations

None

Objectives

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

Report

New Projects

The following activities were done by the Membership Committee with the help of the Executive Office:

1. Educational Program Survey
    a. We conducted a survey of the educational programs to identify Best Practices for how the engage their students with the AARC
    b. We are compiling the data and will share with the Educational Programs, possibly by webinar.
    c. The idea is to help Educational Programs engage students so they understand what the AARC offers to support them as students and then what is available once they transition to Active Members.

2. Committee member's communication to their Affiliates and the Affiliates that they support.
    a. Many of the committee members made visits to educational programs to market the new active membership options for students to transition to Active Membership.
    b. I spoke on this subject at the RCSW and the Colorado State conferences.
        i. We did see that many graduating students have taken advantage of the new membership options and there was much enthusiasm around this.
    c. Many of the Membership Committee members also spoke at their local and regional conferences on this topic.
    d. We will have a mid-year communication, possibly webinar, with the Affiliate Membership Chairs.

3. Sent written letters to renewing members that were 45 year members
    a. This was a way to say thanks to these members.

b. Adding this to the 45 year members is new. We currently thank renewing members by email at 5, 10 and 20 years of membership. We send a certificate at 25, 30 and 35 years. Tom sends a letter thanking those at 40 years. The Membership Committee is now sending a signed personal letter for 45 years. Frank sends a personal letter to 50 and 55 year members.

4. Win Back Program
    a. We continue to work on this program which has been very successful in "winning back" lapsed members. Sherry continues to have pretty good success with this program

Data Review

We continue to evaluate the data. We still hover between 38,000 and 39,000 active members.

Next Steps

The Membership committee has not had a formal meeting since the last board meeting. We are continuing to gather more data around total number of educational programs, the number of those programs that are utilizing the free student member benefit. We also are reviewing the conversion rate of those free student members versus those student members who paid for their membership. We are still planning to hold a teleconference for the Charted Affiliate Membership Chairs to review the new programs and to also go over Best Practices from affiliates who have been successful. We will focus on educational programs and students while continuing to meet with RCPs in a hospital setting. We still believe that a grass roots effort is needed for this campaign. There was a lot of discussion and ideas to renew and re-energize this campaign. The Membership Committee will meet in July to rekindle the energy and momentum going forward. Other ideas include presenting the new programs and Best Practices at our local conferences and at the larger meetings like the Summer Forum and the International Congress. The Chair will also meet individually with all of the members of the committee to ensure that they still will be engaged in this program.

Other

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

Position Statement Committee

Submitted by Colleen Schabacker – Summer 2015

Recommendations

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

Justification: There are only a few minor additions to make the statement flow better.

Recommendation #2
Approve and publish the Position Statement "Respiratory Therapist Education" with revisions. This paper is submitted for your review as attachment #2.

Justification: The committee looked at the old position statement and decided it would be wise to combine the "Respiratory Therapist Education" with the position statement "Development of Baccalaureate and Graduate Education Degrees".

Recommendation: #3
Approve to retire the Position Statement "Development of Baccalaureate and Graduate Education Degrees. This paper is submitted for your review as attachment #3.

Justification: Listed above in justification #2.

Recommendation #4
Approve and publish the Position Statement "Best Practices in Respiratory Care Productivity and Staffing" as revised. Additions are in blue. This paper is submitted for your review as attachment #4

Justification: Both Karen Stewart and Rick Ford reviewed this position statement. It was felt to be important to adapt to some of the new metrics of value associated with the Affordable Care Act. Several departments have justified positions and used value metrics to determine productivity…The AARC does need to recognize that approach in this statement.

Recommendation #5
Approve and publish the newly developed Position Statement "Insertion and Maintenance of Vascular Catheters by Respiratory Therapists". This paper is submitted for your review as attachment #5.

Justification: The Board of Directors approved for this Position Statement to be developed at the April Board meeting.

Recommendation #6
Approve and publish the newly developed Position Statement "Insertion and Maintenance of Arterial Lines by Respiratory Therapists". This paper is submitted for your review as attachment #6.

Justification: The Board of Directors approved for this Position Statement to be developed at the April Board Meeting.

Report

Objectives

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

Ongoing

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

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

Ongoing

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

This schedule was approved at the April Board meeting.

Other

A sincere thank you to the members of this committee for their input: Kathleen Deakins, Deryl Gulliford Linda Van Scoder, Tony Ruppert and Karen Stewart. I would also like to thank Rick Ford for his input into the "Best Practices in Respiratory Care Productivity and Staffing" position statement.

Attachment #1

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

Position Statement

Definition of Respiratory Care

Respiratory Care is the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness. 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 application of technology, enable**s** respiratory therapists to provide patient care services efficiently. 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~~ settings serve as the practice site**s** 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 4/14
Revised 6/15

Attachment #2

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

Position Statement

~~Development of Baccalaureate and Graduate Education Degrees~~

Respiratory Therapist Education

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

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

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

It is the position of the American Association for Respiratory Care (AARC) that practicing respiratory therapists, and respiratory therapy students currently in training, should be strongly encouraged to seek higher education beyond the associate degree entry-level to the bachelor~~s~~ or master level, thereby preparing themselves for greater responsibility and greater independence of function over the decades ahead. To this end, the AARC supports existing and future articulation agreements between associate and baccalaureate respiratory therapy programs. In addition, the AARC will dedicate resources to expedite the continuing development of baccalaureate and graduate degree education in respiratory therapy with the goal of the baccalaureate degree as entry level.

It is the position of the American Association for Respiratory Care that respiratory therapists seeking to practice in advanced clinical settings, in leadership roles, and in professional

educator roles be strongly encouraged to seek higher education at the masters or doctoral levels, demonstrating the value of advanced learning in their own organizations.

Programs for the education of respiratory therapists, managers, researchers, faculty, and professional leaders should be accredited by a body recognized by the Council for Higher Education Accreditation, and through a rigorous and ongoing process which assures quality outcomes. Respiratory Therapists completing such training should be eligible for credentialing to reflect their didactic preparation and clinical skills. Credentialing in areas of specialization is encouraged.

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

Effective 1998
Revised 03/2009
Revised 04/2012
Revised 07/2015

Attachment #3

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

Position Statement

Development of Baccalaureate and Graduate Education Degrees

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

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

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

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

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

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

Effective: 04/2013

Attachment #4

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

Position Statement

Best Practices in Respiratory Care Productivity and Staffing

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

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

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

Use of unweighted metrics of workload may lead to the determination of inaccurate staffing requirements. An exclusive focus on CPT coded procedures to determine staffing levels or other standards based exclusively on billable activities can lead to the omission of a significant number of non-billed activities from the estimated respiratory care workload and result in underestimating the number of staff needed. Appropriate staffing levels help assure that a consistent standard of Respiratory Care is provided throughout the facility. Adequate staffing levels decrease the potential for error and harm by providing respiratory therapists adequate time to perform required functions and can contribute to greater levels of patient satisfaction.

Additionally it is recognized that health care reforms and programs may provide new opportunities in which value metrics can be applied. In such cases respiratory care resources can be justified and productivity assessed through value outcomes, inclusive of indicators of quality, cost reductions, customer satisfaction, penalty reduction, decrease readmissions, and other metrics that can be linked directly to the activities of Respiratory Therapist.

Understaffing Respiratory Care services places patients at risk for unsafe incidents, missed treatments, and delays in medication delivery, as well as increases the liability of risk for the facilities. Patient harm directly related to inadequate staffing must be reported to the appropriate state and federal regulatory agencies.

Attachment #5

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

Position Statement

Insertion and Maintenance of Vascular Catheters by Respiratory Therapists

The American Association for Respiratory Care (AARC) endorses the use of qualified and appropriately educated Respiratory Therapists to insert and perform maintenance of vascular catheters.

Vascular access catheters (VAC) are important instruments in the care of acute and critically ill, and those with chronic illnesses.

Increasing needs for more timely VAC insertion as well as the need to manage adverse events of mal-positioned catheters, pneumothorax, pulsatile blood flow, and daily site maintenance provides impetus for respiratory therapists to perform these tasks. Because respiratory therapists are available around the clock seven (7) days a week they are excellent resources for inserting and maintaining vascular access devices.

The respiratory therapist's education provides extensive training in cardiorespiratory anatomy, physiology and pathophysiology. These fundamentals of Respiratory Care education make the respiratory therapist uniquely qualified to undertake further education to be competent in this procedure.

The requisite education for a respiratory therapist to be qualified to insert and maintain VACs should include specific training, proof of competence and continuing education as outlined by those institutions that use respiratory therapists to perform this procedure.

Effective 07/2015

Attachment #6

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

Position Statement

Insertion and Maintenance of Arterial Lines by Respiratory Therapists

The American Association for Respiratory Care (AARC) endorses the use of qualified and appropriately educated Respiratory Therapists to insert and perform maintenance of arterial lines.

Because respiratory therapists are familiar with arterial punctures and are available around the clock seven (7) days a week they are excellent resources for inserting and maintaining arterial lines.

The respiratory therapist's education provides extensive training in maintenance of normal acid-base balance, oxygenation and oxygen delivery, ventilation, and interpretation and management of arterial blood gases. These fundamentals of Respiratory Care education make the respiratory therapist uniquely qualified to undertake further education to be competent in this procedure.

The requisite education for a respiratory therapist to be qualified to insert and maintain arterial lines should include specific training, proof of competence and continuing education as outlined by those institutions that use respiratory therapists to perform this procedure.

Effective 07/2015

State Government Affairs Committee

Submitted by: Raymond Pisani - Summer 2015

Recommendations

None

Report

The State Government Affairs Committee will work closely with the Federal Government Committee on leading the charge in generating for RT support as soon as the Medicare Telehealth Parity Act is re-introduced in House. We anticipate the bill will be re-introduced prior to the Summer meeting and our Committee will be assisting the in re-boot of this summer's version of Virtual Lobby week.

State Government Affairs Committee has been kept up to date on state legislation and regulations impacting the RT profession.

Of key focus this session in the states are the several RT Licensure laws (CO, NM and IL) that have been going through the licensure Sunset process. We are pleased to say that all 3 states through the dedication of the State societies and involvement of RTs have successfully had their licensure laws continued. It must be noted that the TX RT licensure law was not up for Sunset this time, but faced an equally threatening and ongoing situation: that of an outright legislative effort to repeal the TX RT license. The Texas Society and Texas RTs would not allow that to happen, and it was only through their constant efforts has RT licensure not only been preserved but strengthened in Texas.

The Hawaii RT license will face its first Sunset review in 2016 and the again it's clear that the RTs are ready as they have been in every state to meet the challenges.

Virtual Museum

Submitted by: Trudy Watson - Summer 2015

Recommendations

None

Report

2015 Legends of Respiratory Care

The selection of the 2015 Legends of Respiratory Care is underway and will be completed by the end of June. Although fourteen names were originally submitted, only eleven completed the nominations process by the June 1, 2015 deadline. In addition to the nominees submitted by the AARC, the Boards of NBRC, ARCF, and CoARC also submitted nominations. Three individuals were nominated by more than one agency. Five individuals will be selected as the 2015 Legends. The Legends will be announced at the AARC Congress and their names and photos added to the "Legends of Respiratory Care" gallery in the Virtual Museum.

Virtual Museum Galleries

The committee currently has six galleries under construction:

- Aerosol Delivery Devices
- Early ICU Vents
- Asthma Management
- Humidifiers
- Resuscitation Equipment
- Diagnostics

In mid-June, I was given remote access to the staging museum so I now can directly enter images and text and edit the galleries under construction. Asha Desai deserves kudos for coordinating the museum project since it began… and most especially for her patience with me over the past 18 months! Crystal Maldonado is now coordinating the museum activities for us. By the summer meeting, several of the galleries listed above will be launched. If you have images we could add to the new galleries (or any of the existing galleries), please forward the images to me. Not only do we want the museum to show the evolution of equipment through the years, we'd especially welcome more images of our members through the decades at conferences, participating in health fairs and community education programs, and in the lab and clinical settings.

I'd appreciate your support in soliciting images from your contacts. Here are just a few suggestions:

- Respiratory Care Departments
- Respiratory Care Program Faculty (past and present)
- Home care companies
- Individuals planning medical missions (Donated equipment and supplies are often "vintage")

- Retired or senior therapists and physicians
- Members of your state society
- Representatives from medical product companies
- Your institution's archives (great source for newspaper clippings featuring staff at screening programs, career days, new equipment donations, etc.)

Future Plans

Several conference calls were held in recent weeks to discuss requirements for adding video and audio clips to the museum. A number of vintage audiotapes and VHS tapes have recently been digitized but still require review, identification of key clips, and editing.

On June 16th Tom Kallstrom and I discussed strategies to solicit images for the museum's current and future galleries.

Other Info:

On behalf of the committee, I'd like to thank the BOD and the Executive Office staff for the continued support of this project.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Summer 2015

Recommendations

None

Report

AMA/CPT Editorial Panel Meeting May 14 – 16, 2015

This meeting was well attended. In addition to the medical specialty organizations, a many industry representatives were present. Industry has become more involved in the CPT coding process in the recent past. There were 42 codes proposals. Any code which is approved at this meeting will not be activated until January 2017.

As a reminder, according to the Guidance for CPT/HCPAC Advisors document, information on the new codes should not be disclosed to the general membership of the society until August 31 of the publication year of the new codes.

The final results of proposals will be sent with the meeting minutes (Panel Action Memo), mid to late June 2015.

Below are some of the issues discussed at this meeting.

1. Revision in the quality measurement code 6030F; Prevention of Catheter Related Bloodstream Infections. This was proposed by the ASA. Changes proposed for CVC *insertion* are the definition of **Maximal Sterile Barrier Techniques**; which includes use of a cap, mask, sterile gown, sterile gloves and full body drape. Also added was Sterile Ultrasound Techniques; which require sterile gel and sterile probe covers. Since this is a category II code, there is no billing associate with this, as stated previously it is a quality measure.
2. Revision in the language for the Inpatient Neonatal and Pediatric Critical Care Evaluation and Management (E & M) code. These are the daily codes which providers use. **Codes 99468 (day of admission to critical care), and 99469 (all subsequent** days) are used to report the services for directing the inpatient care of a critically ill neonate or infant 28 days of age or younger. Revisions were necessary to ensure that definitions for critical care services are similar in the adult, child and neonate.
3. Also noted, the initial day neonatal critical care code (99468) can be used in addition to 99464 or 99465 as appropriate, when the physician or other qualified health care professional is present for the delivery (99464) or resuscitation (99465) is required. Other procedures performed as a necessary part of the resuscitation (eg, endotracheal intubation [31500]) can also be reported separately when performed as part of the pre-admission delivery room care. If the providers do not submit codes 99464, 99465 or 31500 when these services are performed by an RCP, the RCP can submit these, if they performed the service. RCP's services are incident to the providers (as we all know).
4. **Codes 99471-99476** are the E & M codes used to report the services of the inpatient care of a critically ill infant or young child from 29 days of postnatal age through 5 years of age. They represent care starting with the date of admission (99471, 99475) to pediatric critical care services and all subsequent day(s) (99472, 99476) that the infant or child remains condition.

5. Please note that E & M codes are paid to the providers in addition to the amount billed from a DRG or other insurance payments

6. Revisions to the Code Change application process was discussed at this meeting. Going forward individuals or organizations can request a review of proposals that might affect them, ***prior*** to the meeting. The originator (individual or organization) of the code change application will be notified if a review is requested. This change is in an effort to make the proposal process more visible to those outside of the AMA CPT.

7. Telehealth was also discussed. The utilization of Telehealth services has grown substantially and is expected to expand even further as non-face-to-face services and patient health monitoring become more important. As the technology and utilization of telehealth services advance, the AMA and the CPT Editorial Panel are looking to leaders in telehealth technology to provide guidance in maintaining and advancing the future needs for expected coding and reporting services. A June 22nd webinar is being held at the Hyatt Regency, Washington, DC. Information on the results of this meeting will hopefully be presented at the October 2015 AMA/CPT panel meeting. Ann Marie and I attended a pre-conference web ex. The purpose of the pre-conference was to give background information on the telehealth codes that currently exist.

As an FYI, the AMA has posted ICD-10 information on its web site http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.page? Interesting to note, that in response to the compliance date (October 1, 2015), AMA President-elect Steven J. Stack stated, "While the AMA appreciates that physicians have additional time to comply with ICD-10, we continue to have fundamental concerns about ICD-10 and its implementation, which will not be resolved by the extra time. The AMA has long considered ICD-10 to be a massive unfunded mandate that comes at a time when physicians are trying to meet several other federal technology requirements and risk penalties if they fail to do so."

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors – Summer 2015

No report submitted as of July 2, 2015.

American Heart Association

Submitted by Keith Lamb – Summer 2015

Recommendations

None

Report

Nothing to report at this time.

Verbal report

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Summer 2015

Recommendations

None

Report

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

I was requested to provide these services for the Utah Society, and completed a strategic and operational planning session with their leadership team. I was extremely impressed with the seasoned leadership as well as their ability to develop their team by inviting two newer careerists.

I am engaged with the Idaho Society for Respiratory Care to facilitate a strategic and operational planning session and will be spending the weekend of June 19-21, 2015 with them. I'll report on this engagement in the next report.

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

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Summer 2015

Recommendations

None

Report

The CAMTS Board met in April for its spring meeting in Charlotte NC. In addition to 25 accreditation decisions, we discussed the evolving 10th edition standards as well as levels of care discussion. This year marks 25 year anniversary of CAMTS and celebration is planned after the fall meeting in Long Beach the evening prior to the start of the Air Medical Transport Conference. An invitation is to be sent to the three previous AARC representatives to the board to recognize their contribution to the organization. At this time the summer meeting is taking place the weekend of July 23rd to 25th.

Extracorporeal Life Support Organization

Donna Taylor - Summer 2015

Recommendations

None

Report

I continue in my charge to promote the training and use of Respiratory Therapists as ECMO specialists. This quarter, I was contacted by the Perfusion Director for Baylor Health Care Systems regarding strategies to bring respiratory therapists on board in their system to manage ECMO equipment and patients. The growing use of ECMO for adults and the staffing issues this presents makes this an excellent time for RRTs to maximize their unique cardiopulmonary training in this field. We discussed the concerns he had heard from the nursing administration regarding blood administration, medicine and licensure. I was able to answer those concerns as well as send him a recent ELSO survey from 2014 detailing the discipline composition of the respondents' teams. This survey demonstrated that of the 87 respondents to the survey, 58 of those had RRTs integrated into their team composition. In our discussion I also pointed out that there are several notable institutions that have since inception of ECMO used respiratory therapists exclusively to manage their ECMO patients --- such as Boston Children's and Johns Hopkins.

ELSO has just received official word from the IRS that ELSO (Inc.) has been granted its official nonprofit status. The organization is now fully a nonprofit tax-exempt corporation. The new organization continues a liaison relationship with U of M for certain contracts and housing the ELSO registry, but this gives much more flexibility and freedom to grow and respond quickly to needs.

The next ELSO conference is in September in Atlanta where my ECMO center will be organizing the first annual 'Cannulation Cup" modeled after the Sputum Bowl. We look to introducing ELSO to this AARC tradition.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Summer 2015

Recommendations

None

Report

I. **Fundamental Respiratory Care Support Course (FRCSC):** Following support from the ICRC, AARC BOD and the ARCF the Steering Committee with international representation has been identified and all members have enthusiastically agreed to serve. Currently draft materials on the Lesson Plans for lecture/demonstrations and Skill Stations are being prepared for distribution to the Committee for review and refinement. Initial reactions as well as additions and revisions will be submitted and agreed upon. A Progress Report will be submitted to the AARC BOD and other parties of interest in time for the AARC Annual Meeting in Tampa.

II. **Philippine Respiratory Care Professionals Center Established in Marikina City Has Connection to ICRC:** A teaching/learning center for Respiratory Therapy has been established in the Philippines to enhance the clinical exposure of RT students and interns in a controlled simulation environment. Philippine Respiratory Care Professionals, Inc. (PRCPI) is located in Marikina City and is designed to provide training, continuing professional education and life support services to the respiratory community. The future goal of PRCPI is to develop the first Clinical Simulation Training Center in the Philippines exclusive for Respiratory Therapy. Noel Tiburcio, PhD, RRT is founder and President and hopes that "the Center will provide a central, comprehensive focal point for collaboration with RT professionals and related government health officials in the Philippines". The Philippines is a member of the International Council for Respiratory Care (ICRC) and Dr. Tiburcio is the Governor for the Philippines to the ICRC.

III. **Italian Association for the Rehabilitation of Respiratory Care Marks 26th Year of Improving Patient Care: ARIR**, Associazione Italiana Riabilitatori dell'Insufficienza Respiratoria (Italian Association for the Rehabilitation of Respiratory Care) was born in 1989 from an idea of a few physiotherapists (PT), who felt the need to extend the practice of physiotherapy beyond the treatment of orthopedic and neurologic disorders. This desire paved the way for some Italian physiotherapists to broaden their practice to include respiratory care and pulmonary rehabilitation. A number of chest physiotherapists followed a model imported in the 1970's from the Brompton Hospital, and began to differentiate their professional practice to include the treatment of subjects suffering from cystic fibrosis and from complications of thoracic surgery.

Due to the lack of a formal educational program in pulmonary rehabilitation and the less than adequate role attributed to the physiotherapist by the National Health Care System, ARIR faced a tremendous challenge to gain recognition for the establishment of the respiratory physiotherapist professional. In 1994, after a five year effort by the Association, the Ministry of Health ratified the professional role and profile of

Physiotherapists, giving them the chance to access post-graduate respiratory care courses following their 3-year PT degree. Thirteen years later, ARIR sealed an alliance with the University of Milan, officially recognizing the professional of physiotherapist in the respiratory field, which provided post-graduate academic training in respiratory physiotherapy and pulmonary rehabilitation. In the same year of 2007, the program at the University of Milan became the first post-graduate program in Respiratory Care recognized by the **International Education Recognition System (IERS)** and maintains its Level III approval status to this date.

ARIR is a founding member of the 29-country **International Council for Respiratory Care (ICRC)** representing Italy on this body since 1989. From the onset of its creation, ARIR has been dedicated to covering scientific updates, publishing and disseminating information about respiratory physiotherapy all over the country. The 3rd International ARIR Conference on Respiratory Physiotherapy embodies their educational mission and is entitled "*Physiotherapy, Rehabilitation and the Burden of Respiratory Diseases*". All are invited to participate in this international conference which will gather March 10-12, 2016 in Rimini, Italy. Sergio Zuffo, PT and Simone Gambazza, PT serve as the two Governors for Italy to the ICRC.

IV. Prince Sultan Military College of Health Science Celebrates 27 Years of Respiratory Care Education: Celebrations were held the last week of April 2015 commemorating the 27th Anniversary of the Respiratory Care (RC) Program at Prince Sultan Military College of Health Sciences in AlKobar, Saudi Arabia. Formal celebration events concluded with the *2nd Annual Respiratory Care Student Symposium* on April 30th. The Respiratory Care Program began in 1988 and through 2007 only granted diplomas to its graduates. Since that time the program has been upgraded to a baccalaureate program and is one of only three RC BS Programs outside of the United States that holds International Education Recognition System (IERS) Level III Approval.

Taking a step forward to advance the level of respiratory education and ultimately patient care the Prince Sultan Respiratory Care Program offered the first "Bridging" Program in Saudi Arabia for former graduates to complete the bachelor program. The College opened its doors for former students to return and seek their bachelor degree in its newly initiated "Bridging Program". In February 2015, the College was able to proudly celebrate the graduation of the first cohort of bridging students who successfully earned their Bachelor Degree in Respiratory Care.

In addition to the scientific sessions, some of the activities presented in the *2nd Annual Respiratory Care Student Symposium* included an RC competition between participating universities, as well as a "The Best Video contest". Department Heads representing various Hospitals served as Judges on the Executive Committee to determine the winners of the competitions. Because of the overwhelming popularity of the event among the RC students, Dr. AlAhmari, Vice Dean for Postgraduate Studies & Research, and Head of the Respiratory Care Program announced that the symposium will continue as a respiratory care student conference in 2016. Dr. AlAhmari PhD, RRT is one of the two Governors to the ICRC for Saudi Arabia.

Joint Commission - Ambulatory PTAC

David Bunting - Summer 2015

Recommendations

None

Report

The meeting of the Joint Commission PTAC - Ambulatory Care scheduled for May 28, 2015 was cancelled due to a lack of agenda items ready for discussion.

Other

The next meeting of the Joint Commission PTAC - Ambulatory Care is scheduled for Monday September 14th, 2015.

Joint Commission - Home Care PTAC

Submitted by Kimberly Wiles – Summer 2015

Recommendations

None

Report

Nothing to report at this time.

Joint Commission - Lab PTAC

Darnetta Clinkscale - Summer 2015

Recommendations

None

Report

LAB PTAC met for the first time this year on June 23, 2015. The main concerns for the AARC are the New and Revised Standards for the Individualized Quality Control Plans (IQCP). The Centers for Medicare and Medicaid Services (CMS) introduced a new voluntary quality control option for clinical laboratories on January 1, 2014. The IQCP will replace existing Equivalent Quality Control (EQC) procedures after an education-an-transition period ending January 1, 2016.

Under the IQCP, which applies to all specialties and subspecialties except pathology, organizations that meet manufacturers' recommendations for quality control do not have to fully meet Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) regulatory requirements. Because EQC will no longer be an acceptable option for CLIA '88 quality control compliance in two years, organizations must decide whether they will follow the CLIA regulatory requirements as written or implement the IQCP by January 1, 2016.

Other

For additional information, please see follow this link to the:

Quality Control Option Changing for Clinical Laboratories:

- http://www.jointcommission.org/assets/1/6/JCP0314_QC_Clin_Labs.pdf

New and Revised Standards for Individualized Quality Control Plans (IQCP New and R

- http://www.jointcommission.org/prepublication_standards_–_new_and_revised_laboratory_standards_for_individualized_quality_control_plans_iqcp_/

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Summer 2015

Recommendations

None

Report

Next teleconference Wednesday, June 24th. Can give a verbal report at the meeting if there is anything imperative to relay at that time.

Neonatal Resuscitation Program

Submitted by John Gallagher – Summer 2015

Recommendations

None

Report

The Neonatal Resuscitation Program's Steering Committee (NRPSC) has had only limited activity since the previously submitted activity report dated March 30, 2015.

The Spring/Summer 2015 update for NRP Instructors, which is issued by the AAP/AHA, highlighted the change in practice regarding Regional Trainers for NRP. The role of the regional trainer will be retired on January 1, 2017. In exchange, NRP will provide a standardized, online instructor course. The new process will also incorporate a mentorship component where experienced instructors will serve as resources for newer instructors. This change in format will not impact the provider role.

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

Roundtable Reports

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

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Summer 2015

Recommendations

None

Report

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

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

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

The Committee will work with the Executive Office to complete the Charges

In process: Survey questions are complete and distributed to each of the groups to be surveyed.

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

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

In process

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

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

In process:

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

Status: **Ongoing**

Ad Hoc Committee on RTs and Disease Management

Submitted by Becky Anderson/Claire Aloan – Summer 2015

Recommendations

None

Report

Preliminary plan:

1. Create a list of diseases that RT's may be involved in managing

2. Ask committee members to:
    a. Identify their areas of interest in disease management
    b. Solicit and present any evidence-based information available on best practices for management of the selected disease process or other aspect of disease management (e.g., reimbursement)

3. Solicit information on what role RT's are currently playing in management of identified disease processes. Information to be solicited by:
    a. Existing publications on the RT role
    b. Review of existing materials on roundtables, e.g, asthma and COPD and in section libraries and discussions
    c. Contact with RT's known to be involved in disease management programs to solicit their input
    d. Solicitation of information from section and roundtable members, e.g, through survey
    e. Ask state societies for assistance in identifying RT disease management experts and/or programs

4. Gather information on training and certification for disease management
    a. Patient education e.g., asthma, smoking cessation, pulmonary disease
    b. Case manager certification process

5. Review documents from *2015 and Beyond* project
    a. What is expected role in disease management?
    b. How will this guide the work of the committee?

Ad Hoc Committee on Revisions to AARC Bylaws

Submitted by Mike Runge – Summer 2015

Recommendations

None

Report

Charges for this Adhoc Committee are complete and final Bylaw recommendations will be reviewed for first reading by the BOD and the HOD in Joint Session during the Summer Meeting!

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

Submitted by John Wilgis – Summer 2015

Recommendations

None

Report

Committee Objectives:

1. General – Identify an institution (or institutions) to be pilot programs and provide funding through ARCF or other source.
2. General (Licensure) – identify states where passage of APRT licensure would have the greatest chance of success.
3. CoARC – Develop application and accreditation documents for APRT Standards.
    a. Validate if a needs assessment was done to create the CoARC standards (if it was done, share it with the group) and if not, do a survey of the current needs assessment.
4. AARC (Reimbursement) –
    a. The APRT workgroup supported an 'incident to' approach versus an 'independent practice' approach.
    b. Direct billing versus salary from physician/facility.
        i. One suggestion - 75% of physician fee schedule should be competitive with AA/CRNA, ANP, CNM, and PA;
        ii. Level of supervision (general/direct/indirect).
5. NBRC – Develop the credential for the APRT.

Report:

- Held conference calls on May 11 and June 18 to discuss the scope of work based on the committee's objectives and to engage committee members in defining an approach to achieve objectives.
- Established committee leadership.
- Worked with the AARC Executive Office and committee members to establish a series of meeting dates for 2015.
- Reviewed CoARC's Accreditation Standards for Advanced Practice Programs in Respiratory Care.

- The committee continues to work on developing specific deliverables related to APRT practice, credentialing and education.

The co-chairs would like to thank the committee members from the AARC, CoARC and NBRC for their active involvement in this committee.

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Summer 2015

The ARCF has been busy over the past several months. Below are updates of these activities.

International Fellow and City Host Applications

- 13 Fellow applications received
- 10 City Host applications received
- Information has been sent to the International Committee and placed in the International Committee community on AARConnect.
- The International Committee will decide on winners during the SF2015 Int. Comm. Meeting, held July 15, 2015 from 1:00 pm – 5:00 pm in Phoenix, AZ

Summer Forum 2015 Fundraiser

- ARCF / AARC Welcome Reception
  Sunday, July 12, 2015
  5:30 pm – 7:30 pm
  JW Marriott Desert Ridge Resort and Spa
  Phoenix, AZ

At the reception we will be selling raffle tickets from individual donations from all members of the ARCF Fundraiser subcommittee as well as others collected from the Marriott, AARC, NBRC, and local establishments. All ARCF trustees will be at the reception. This allows for the rank and file to learn more about the ARCF and what it does to give back to the profession.

Congress 2015 ARCF Fundraiser

- Vapotherm sponsorship in the amount of $30,000 was received on June 1, 2015
- Yacht ticket sale site is open
- Grand Prize donated by Mark Valentine ARCF board member – Caribbean cruise for 2 (including domestic airfare)
- Ticket prices:
  - $150 if purchased by October 25 (includes access to boat, meal and one entry for grand prize)
  - $175 if purchased between October 26 and day before cruise (includes access to boat, meal and one entry for grand prize)
  - Additional tickets for grand prize: 1 for $25 or 5 for $100
  - NO SELLING TICKETS AT THE DOOR

List of Awards for this year (Winners are TBD)

- Forrest M Bird Lifetime Scientific Achievement Award
- Hector Leon Garza, MD Achievement Award for Excellence in International Respiratory Care

- Dr. Charles H Hudson Award for Cardiopulmonary Public Health
- Thomas L Petty, MD Invacare Award for Excellence in Home Respiratory Care
- Mike West, MBA, RRT Patient Education Achievement Award
- Monaghan /Trudell Fellowship for Aerosol Technique Development
- Philips Respironics Fellowship in Mechanical Ventilation
- Philips Respironics Fellowship in Non-Invasive Respiratory Care
- Charles W Serby COPD Research Fellowship
- CareFusion Healthcare Fellowship for Neonatal and Pediatric Therapists
- Jeri Eiserman, RRT Professional Education Research Fellowship
- Allen & Hanburys / GlaxoSmithKline Fellowship for Asthma Care Management Education
- NBRC/AMP H. Frederick Helmholz Jr. MD, Educational Research Grant
- William F Miller, MD Postgraduate Education Recognition Award
- Morton B Duggan., Jr Memorial Education Recognition Award
- Jimmy A Young Memorial Education Recognition Award
- NBRC/AMP Gareth B Gish, MS, RRT Memorial Education Recognition Award
- NBRC/AMP William W Burgin, Jr., MD and Robert M Lawrence MD Education Recognition Award
- International Fellows

Respiratory Care Journal

The just published June issue of the Journal contains the proceedings from last year's Journal Conference on *Aerosol Drug Delivery in Respiratory Care.* The Conference was presented under the auspices of the American Respiratory Care Foundation and the articles provide evidence-based information about the many aerosol medications now in use and under development with an emphasis on novel medications and the role of the Respiratory Therapist in drug delivery and assessment. The papers also review the many aerosol devices in clinical use today, provide insight into new devices being developed, and discuss how these can be evaluated, including the best evidence for the effectiveness of patient and provider education and improving adherence. Last month the Journal held this year's Conference on *Controversies in Respiratory Care* ranging from topics like using or not using ventilator associated events as quality indicator to when to use sedation to achieve patient ventilator synchrony, and much more.

AARC Times

In the July issue of the AARC Times there were two featured articles about the strong relationship of the ARCF and AARC as told through an interview with President Frank Salvatore. The other article featured past respiratory therapists award winners. (Please see attachments "ARCF article AT July 2015" and "ARCF faces article AT July 2015".)

Summary

The ARCF Trustees continue 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 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 2015

See Attachment:

"CoARC Update to AARC 7.15"

Date: June 19, 2015

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

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

Subject: NBRC Report

I appreciate the opportunity to provide you this update on activities of the NBRC. Since the last meeting, the Board of Trustees and its committees met in April/May 2015 to conduct examination development activities and discuss business related items pertinent to the credentialing system. The following information summarizes the current status of significant changes to several examinations and major activities in which the Board and staff are currently involved.

Credentialing System Evolves

On January 15, 2015, the new Therapist Multiple-Choice and Clinical Simulation Examinations were launched in the computer-based testing network. To date, we have administered 3,979 Clinical Simulation Examinations and 5,738 Therapist Multiple-Choice tests. Pass rate information can be found below.

Pulmonary Function Technology Examination Committee

The committee conducted a cut-score study at its April 2015 meeting and the new Pulmonary Function Technology Examination was introduced on June 15, 2015, using two cut scores. The lower score is used to identify those attaining the CPFT credential and the higher the RPFT credential.

Collaboration with AARC

The NBRC Board authorized the staff to engage in further discussions with AARC staff to determine whether AARC CRCE data could be transmitted directly into the NBRC's online recertification database for AARC members who choose to participate. Staff of both organizations have been working together on the logistics of this plan and we anticipate a roll-out in mid-late 2015.

Continuing Competency Program

In 2015, the NBRC will reconvene a Recertification Commission to take an in-depth look at the NBRC's current Continuing Competency Program (CCP). Much is changing in the world of continuing competence, and to ensure that our program meets the intent of our accreditation

with the National Commission for Certifying Agencies (NCCA), we feel it is time to review our program that has now been in place for 13 years. Stakeholders from related organizations will be invited to participate when the Recertification Commission convenes later this year in September.

Advanced Practice Respiratory Therapist/Competency Ad Hoc Committees

In concert with the AARC and CoARC, the NBRC has appointed four representatives to serve on an Ad Hoc Committee on the Advanced Practice RT to work on issues related to the education, credentialing, and practice of these therapists. In anticipation of an eventual credentialing examination for these therapists, the NBRC is working with trademark counsel to protect, through intent to use, the terms APRT and RRT-AP. Four representatives of the NBRC are also participating in the Competency Ad Hoc Committee along with the CoARC and AARC to develop competencies for entry into practice.

International Activities

The NBRC continues its efforts in Latin America by supporting the Latin American Board for Professional Certification in Respiratory Therapy (LABPCRT) which now has 12 countries actively participating in its credentialing program.

Most recently, the NBRC entered into an agreement with the Saudi Society for Respiratory Care to use the NBRC's Therapist Multiple-Choice and Clinical Simulation Examinations for credentialing purposes in that country. Individuals who successfully complete the examinations under this agreement are not eligible for the NBRC's CRT or RRT credentials.

2015 Examination and Annual Renewal Participation

Through May 31, 2015, the NBRC has administered 10,815 tests across all examination programs. Active status renewals continues to increase and 2015 is no exception. To date, 48,739 credentialed practitioners have renewed their active status with the NBRC for 2015; this is up over 1,000 compared to this time last year.

Examination Statistics – January 1 –May 31, 2015

Examination	***Pass Rate***
Therapist Multiple-Choice Examination – 5,738 examinations	
• First-time Candidates 80.7%	Exceed High Cut-Score – Exceed Low Cut-Score – 88.3%
• Repeat Candidates 36.6%	Exceed High Cut-Score – Exceed Low Cut-Score – 56.4%
Clinical Simulation Examination – 3,979 examinations	

- First-time Candidates 58.5%
- Repeat Candidates 39.5%

Adult Critical Care Examination – 327 candidates
- First-time Candidates 82.4%
- Repeat Candidates 47.3%

Neonatal/Pediatric Examination – 414 examinations
- First-time Candidates 77.0%
- Repeat Candidates 51.8%

Sleep Disorders Specialty Examination – 26 examinations
- First-time Candidates 86.4%
- Repeat Candidates 100%

CPFT Examination – 139 examinations
- First-time Candidates 66.7%
- Repeat Candidates 35.0%

RPFT Examination – 57 examinations
- First-time Candidates 78.9%
- Repeat Candidates 47.4%

Your Questions Invited

I look forward to continuing to work with you during my final 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

- **Workgroup Updates**

- **Policy Updates**

  - ✓ Policy MP.002 – Membership- Membership Challenge Policy

    "Referred to Judicial Committee to review and provide changes in time for the July 2015 Board meeting."
    - An update will be provided at the meeting.

  - ✓ Policy FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities (see pg. 34)

    "Recommended changes accepted but a report back at the July 2015 meeting was requested regarding funding levels."
    - $10,000 has been the loan amount and remains reasonable.

  - ✓ Policy SS.002 – Specialty Sections – Formation, Dissolution, and Conversion of Specialty Sections

    "Frank Salvatore appointed a committee to revise policy SS.002 (Formation, Dissolution, and Conversion of Specialty Sections) – Deb Skees, Chair; Doug McIntyre, Karen Schell, members; and Tim Myers Staff Liaison and report back at the July 2015 meeting."
    - See attached documents "Policy SS 002revisions – committee and Presidents changes- 6-29-15" and "Policy SS 002revisions – committee and Presidents changes – clean copy – 6-29-15"

New Business