American Association for Respiratory Care

Board of Directors Meeting

JW Marriott
614 Canal St
New Orleans, LA

November 8-9, 2012

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AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – November 7, 2012
Board of Directors Meeting – November 8-9, 2012

Wednesday, November 7

3:30-7:00 pm Executive Committee Meeting (Committee Members only)
St. Jerome – JW Marriott

7:00-8:00 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) **Conde/Frontenac – JW Marriott**

Thursday, November 8

8:00 am-5:00 pm **AARC Board of Directors Meeting – Conde/Frontenac – JW Marriott**

8:00 am Call to Order
Announcements/Introductions
Disclosures/Conflict of Interest Statements
Approval of Minutes pg. 9
E-motion Acceptance pg. 37

General Reports pg. 39
- President pg. 40
- Executive Director Report pg. 42 (R) (A)
- Government & Regulatory Affairs pg. 57
- House of Delegates pg. 69
- Board of Medical Advisors pg. 72
- Presidents Council pg. 77

10:00 am BREAK

10:15 am Standing Committee Reports pg. 78
- Audit Subcommittee pg. 79
- Bylaws Committee pg. 80 (R) (A)
- Elections Committee (in Joint Session) pg. 82 (R)
- Executive Committee pg. 86
- Finance Committee pg. 87
- Judicial Committee pg. 88
- Program Committee pg. 89
- Strategic Planning Committee pg. 90

12:00-1:30 pm Lunch Break

1:30 pm Reconvene – JOINT SESSION (agenda pg.91)

3:30 pm BREAK

3:45 pm Specialty Section Reports pg. 92

- Adult Acute Care pg. 93 (R)
- Continuing Care-Rehabilitation pg. 96 (R)
- Diagnostics pg. 97
- Education pg. 99 (R) (A)
- Home Care pg. 101
- Long Term Care pg. 102
- Management pg. 103
- Neonatal-Pediatrics pg. 104
- Sleep pg. 105
- Surface and Air Transport pg. 106

4:15 pm Special Committee Reports pg. 107

- Benchmarking Committee pg. 108
- Billing Code Committee pg. 110
- Federal Govt Affairs pg. 111
- Fellowship Committee pg. 112
- International Committee pg. 113
- Membership Committee pg. 119
- Position Statement Committee pg.121
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- State Govt Affairs pg. 124

5:00 pm RECESS

Friday, November 9

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

8:00 am Call to Order

Special Representatives pg. 125
- AMA CPT Health Care Professional Advisory Committee pg. 126
- American Association of Cardiovascular & Pulmonary Rehab pg. 127
- American Heart Association pg. 133 (R)
- American Society for Testing and Materials (ASTM) pg. 134
- Chartered Affiliate Consultant pg. 135
- Comm. on Accreditation of Medical Transport Systems pg. 136
- Extracorporeal Life Support Organization (ELSO) pg. 137
- International Council for Respiratory Care (ICRC) pg. 138
- The Joint Commission (TJC) pg. 140
- National Asthma Education & Prevention Program pg. 143
- National Coalition for Health Professional Ed. In Genetics pg. 144
- National Sleep Awareness Roundtable pg. 145
- Neonatal Resuscitation Program pg. 146

10:00 am BREAK

10:15 am Roundtable Reports pg. 147
- Asthma Disease pg. 148
- Disaster Response pg. 149
- Geriatrics pg. 150
- Hyperbaric pg. 151
- Informatics pg. 152
- International Medical Mission pg. 153
- Military pg. 154
- Neurorespiratory pg. 155
- Research pg. 156
- Simulation pg. 157
- Tobacco Free Lifestyle pg. 158

10:45 am Ad Hoc Committee Reports pg.159
- Ad Hoc Committee on Cultural Diversity pg. 160
- Ad Hoc Committee on Officer Status/US Uniformed Services pg. 166
- Ad Hoc Committee on Leadership Institutes pg. 167
- Ad Hoc Committee on 2015 & Beyond pg. 177
- Ad Hoc Committee to Recommend Bylaws Changes pg. 183
- Ad Hoc Committee to Reduce Hospital Readmissions pg. 201
- Ad Hoc Committee for Continued Development of Educ Competition pg. 202

12:00 – 1:30 pm LUNCH BREAK (Daedalus Board Meeting)

1:30 pm Other Reports pg. 203

American Respiratory Care Foundation (ARCF) pg. 204
Commission on Accrediation for Respiratory Care (CoARC) pg. 207 (A)
National Board for Respiratory Care (NBRC) pg. 208

2:00 pm **UNFINISHED BUSINESS pg. 211**

2:30pm **NEW BUSINESS pg. 212**
HOD Resolutions pg. 235
MISCELLANEOUS pg. 241

4:30 pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment/s

Recommendations

(as of October 24, 2012)

AARC Board of Directors Meeting

November 8-9, 2012 • New Orleans, LA

Executive Office

Recommendation 12-3-1.1 "That the AARC Board of Directors officially endorse the Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit as requested by the Society of Critical Care Medicine."

Bylaws Committee

Recommendation 12-3-9.1 "That the AARC BOD accept and approve the Bylaws of the Alabama Society for Respiratory Care."

Recommendation 12-3-9.2 "That the AARC BOD accept and approve the Bylaws of the Iowa Society for Respiratory Care."

Recommendation 12-3-9.3 "That the AARC BOD accept and approve the Bylaws of the Maine Society for Respiratory Care."

Recommendation 12-3-9.4 "That the AARC BOD accept and approve the Bylaws of the Mississippi Society for Respiratory Care."

Recommendation 12-3-9.5 "That the AARC BOD accept and approve the Bylaws of the Nebraska Society for Respiratory Care."

Recommendation 12-3-9.6 "That the AARC BOD accept and approve the Bylaws of the Puerto Rico Society for Respiratory Care."

Recommendation 12-3-9.7 "That the AARC BOD accept and approve the Bylaws of the Rhode Island Society for Respiratory Care."

Recommendation 12-3-9.8 "That the AARC BOD accept and approve the Bylaws of the South Carolina Society for Respiratory Care."

Recommendation 12-3-9.9 "That the AARC BOD accept and approve the Bylaws of the Tennessee Society for Respiratory Care."

Recommendation 12-3-9.10 "That the AARC BOD accept and approve the Bylaws of the Utah Society for Respiratory Care."

Recommendation 12-3-9.11 "That the AARC BOD accept and approve the Bylaws of the Wyoming Society for Respiratory Care."

Recommendation 12-3-9.12 "That the AARC BOD find the Texas Society for Respiratory Care in violation of Chartered Affiliate Policy CA.007."

Recommendation 12-3-9.13 "That the AARC BOD appoint an ad hoc committee to address the current imbalance in the 5-yr review cycle."

Elections Committee

Recommendation 12-3-10-1 "That the following statement be added to Policy CT.003 (Elections Committee – Nomination Process) 'The Committee's goal will be to have a minimum of two qualified members for each elected position'."

Adult Acute Care Section

Recommendation 12-3-50.1 "That the BOD evaluate the feasibility of creating a Critical Care Clinic Fellowship syllabus and in conjunction with large academic centers, implement such a fellowship."

Recommendation 12-3-50.2 "That the BOD evaluate the feasibility of creating and supporting a monthly critical care teleconference and potentially offering continuing education credits for participants."

Continuing Care Rehab Section

Recommendation 12-3-51.1 "That the AARC pursue a more formal partnership with the AACVPR which has been recommended in the AACVPR report."

Education Section

Recommendation 12-3-53.1 "That the Preceptor Training Program as developed by the Preceptor Training Subcommittee of the Education Section be accepted, at least in concept, as the AARC's Preceptor Training Program."

American Heart Association

Recommendation 12-3-64.1 "That the AARC Executive Office pursue the AHA's intent to limit the ability to issue cards for respiratory therapists who are seeking advance life support provider or instructor status enforced by some regional offices."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

July 16, 2012 • Santa Fe, NM

Minutes

Attendance

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

Absent

Toni Rodriguez, EdD, RRT, FAARC, Past President
Lori Conklin MD, BOMA Chair

Consultants

Margaret Traband, MEd, RRT, FAARC, President's Council President
Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Bill Lamb, BS, RRT, CPFT, FAARC, Past Speaker

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Sam Giordano, MBA, RRT, FAARC, Consultant
Doug Laher, RRT, MBA, Associate Executive Director
Tim Myers, MBA, RRT-NPS, Associate Exec Director/Brands Management
Steve Nelson, RRT, FAARC, Associate Executive Director
Cheryl West, Government Affairs Directors
Anne Marie Hummel, Regulatory Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Assistant

CALL TO ORDER
President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:03am MDT, Monday, July 16, 2012. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

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

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

Cynthia White – Aerogen, Speaker
Fred Hill – Alabama Board, Chair
Greg Spratt – Oridion/Covidien, Director of Clinical Marketing
Bill Lamb – Ohio Medical Corp, National Clinical Manager
Denise Johnson – Bylaws Committee Minnesota Society, Chair
Lynda Goodfellow – Teleflex Medical

APPROVAL OF MINUTES
Bill Cohagen moved to approve the minutes of the April 20, 2012 meeting of the AARC Board of Directors.
Motion Carried

Bill Cohagen moved to approve the minutes of the April 21, 2012 meeting of the AARC Board of Directors.
Motion Carried

E-MOTION RATIFICATION
Bill Cohagen moved to ratify the E-Motions discussed over the Board AARConnect since April 2012 as follows:

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

GENERAL REPORTS

President
President Stewart gave highlights of her written report.

President Stewart began a discussion regarding Policy No. CA.007 "Chartered Affiliate Bylaws in Conflict with AARC Bylaws". The wording on items #5 and 6 will be amended.

Colleen Schabacker moved to accept the motion to amend CA.007 as stated.
Motion carried

Colleen Schabacker moved to make a friendly amendment to remove item #6 from CA.007.
Motion carried

President Stewart will communicate this policy with the Chartered Affiliates. (See Attachment "A")

President Stewart informed the Board of Directors that there are two sections (Homecare and Sleep) that are close to losing their seat on the Board. Homecare will need 1,000 members by December 31, 2012 to keep their Board seat. After the Business Meeting in November 2012, Sleep Section will not have a seat on the Board.

President Stewart announced to the Board of Directors that the Louisiana Society for Respiratory Care will be holding a reception at AARC Congress 2012 and are asking for a $20 donation to offset the costs.

Executive Director/Office
Tom Kallstrom gave highlights of the Executive Office written report. New membership rates will be offered beginning in July 2012.

Government & Regulatory Affairs
State Government Affairs
Director of Government Affairs, Cheryl West, provided an update on state legislative and regulatory issues.

Federal Government Affairs
Cheryl West provided an update on our legislative issues pending before Congress.

Regulatory Director Anne Marie Hummel also provided an update on pulmonary rehab.

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

Linda Van Scoder moved to refer to the President-elect for development of an Ad Hoc Committee to address the BOMA request.
Motion carried

STANDING COMMITTEES REPORTS

Bylaws Committee
Susan Rinaldo Gallo moved to accept Recommendation 12-2-9.1 "That the AARC BOD accept and approve the Respiratory Care Society of Washington bylaws."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-2-9.2 "That the AARC BOD accept and approve the Nevada Society for Respiratory Care bylaws."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-2-9.3 "That the AARC BOD accept and approve the Minnesota Society for Respiratory Care bylaws."
Motion carried
Denise Johnson abstained from voting.

Susan Rinaldo Gallo moved to accept Recommendation 12-2-9.4 "That the AARC BOD accept and approve the Virginia Society for Respiratory Care bylaws."
Motion carried

Bill Cohagen moved to table until further review from Bylaws Chair, Rick Weaver.
Motion to table carried

Bill Cohagen moved to withdraw his motion to table.
Motion to withdraw carried
Original motion to accept and approve was carried.

Elections Committee
Susan Rinaldo Gallo moved to accept Recommendation 12-2-10.1 "That the AARC Board provide guidance in the form of a policy statement on the number of candidates that can be placed on the ballot for each position."

Colleen Schabacker moved to refer back to the Elections Committee to develop a policy.
Motion carried

Finance Committee
Approval of Capital purchase April-May 2012
A printer for customer service was purchased for $6,068.89 and a new air conditioning unit for the Executive Office was purchased for $7,941.29.

Linda Van Scoder moved to accept the approval for the capital purchases.
Motion carried

Linda Van Scoder moved "To approve $832.24 for AMA CPT meeting expense." This additional meeting was to propose CPT code revision and Susan Rinaldo Gallo attended.
Motion carried

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

The Executive Committee changed the wording to read "That the AARC Board of Directors authorize an additional amount up to $10,340 to be spent for travel-related expenses for the 2012 Sputum Bowl Committee to work on Sputum Bowl activities in New Orleans."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-2-15.2 "That the AARC Board of Directors approve Marco Island, FL as the destination for AARC Summer Forum 2014."
Motion carried

Susan Rinaldo Gallo moved to accept Recommendation 12-2-15.3 "That the AARC Board of Directors approve Phoenix, AZ as the destination for AARC Summer Forum 2015."
Motion carried

RECESS
President Stewart recessed the meeting of the AARC Board of Directors at 10:18am MDT Monday, July 16, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 10:32am MDT Monday, July 16, 2012.

Susan Rinaldo Gallo moved to accept the Standing Committee Reports as submitted.
Motion carried

House of Delegates
Karen Schell gave highlights of her written report.

Bill Cohagen moved to accept the General Reports as presented.
Motion Carried

SPECIALTY SECTION REPORTS

Education Section
Colleen Schabacker moved to un-table the recommendation from the April 2012 Board of Directors meeting.
Motion carried

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

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

Fred Hill moved to refer to the Executive Office to execute in line with the web site redevelopment.
Motion carried

Sleep Section
Mike Runge gave highlights of his written report. A discussion ensued regarding the BSRT credential.

Susan Rinaldo Gallo moved to accept the Specialty Section Reports as presented.
Motion carried

SPECIAL COMMITTEE REPORTS

Membership Committee
Frank Salvatore commented on his written report. President Stewart suggested LinkedIn as a means of a membership drive.

Position Statement
Susan Rinaldo Gallo moved to accept Recommendation 12-2-26.1 "Approve and publish the revised position statement on 'AARC Statement of Ethics and Professional Conduct'. This statement is submitted for your review as Attachment #1. Text to be deleted appears with strikethrough and text to be added appears with underline."
Motion carried
(See Attachment "B")

RECESS
Karen Stewart called a recess of the AARC Board of Directors at 11:40am MDT, Monday, July 16, 2012.

JOINT SESSION

President Stewart convened Joint Session at 1:35pm MDT, Monday, July 16, 2012. Secretary/Treasurer Linda Van Scoder called the roll and declared a quorum.

President Stewart informed the House of Delegates that only the Board of Directors can suspend a Chartered Affiliate's status and that the policy is being revised to more clearly reflect that.

American Respiratory Care Foundation (ARCF)
Michael Amato gave an update on the Foundation.

International Committee Report
John Hiser gave highlights of his written report.

The AARC is now funding the International Fellows. This year there were 23 International Fellowship applications from 18 different countries and 7 new countries and 20 City Hosts applied. There were 7 International Fellows selected and 2 alternates:

China – Ling Liu – Honolulu, HI and Oakland, CA (Kaiser)
China – Manling Liu – Portland, OR and Oakland, CA (Katy)
Ecuador – Raul Castro Garcia – Charleston, SC and Winston-Salem, NC
Ghana – Audrey Forson – Emporia, KS and Salt Lake City, UT

Haiti – Job Joseph – Charlottesville, VA and Washington, DC
India – Anitha Nileshwar – Brooklyn, NY and Baltimore, MD
Turkey – Sanihe Ugurlu – Cincinnati, OH and Baltimore, MD

Alternates:
Argentina – Marina Busico
Columbia – Lsybeth Yamylle Roldan Valencia

Elections Committee Report
Jim Lanoha, Elections Committee Chair, advised of the following slate of candidates:

Vice President of Internal Affairs
1. Bill Lamb
2. Brian Walsh

Vice President of External Affairs
1. Patricia Blakely
2. Colleen Schabacker

Secretary/Treasurer
1. Frank Salvatore
2. James Taylor

Director at Large
1. Curt Merriman
2. Sheri Tooley
3. Gary Wickman

Homecare Section Chair
1. Kimberly Wiles

Sleep Section Chair
1. Craig Johnson
2. Russell Rozensky

Neonatal/Pediatrics Section Chair
1. Kathleen Deakins
2. Natalie Napolitano

Government Affairs
Cheryl West and Anne Marie Hummel presented highlights of Government and Regulatory Affairs.

EXECUTIVE SESSION
Colleen Schabacker moved to convene Executive Session at 3:00pm MDT, Monday, July 16, 2012.
Motion carried

Linda Van Scoder moved to adjourn Executive Session at 3:25pm MDT, Monday, July 16, 2012.
Motion carried

President Stewart adjourned the joint session at 3:26pm MDT, Monday, July 16, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 3:33pm MDT, Monday, July 16, 2012.

Position Statement Committee
FM 12-2-26.1 Colleen Schabacker moved to accept the amended position statement "Best Practices in Respiratory Care Productivity and Staffing".
Motion carried
(See Attachment "B")

FM 12-2-26.2 Colleen Schabacker moved to charge the Position Statement Committee to develop a white paper on "Best Practices in Respiratory Care Productivity and Staffing".
Motion carried

Colleen Schabacker would like to thank Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Bill Dubbs and Linda Van Scoder for their hard work on position statements.

Bill Cohagen moved to accept the Special Committee Reports as submitted.
Motion carried

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

Linda Van Scoder moved to amend the recommendation to read "That the AARC BOD accept the competencies needed by future graduate respiratory therapists and workforce as recommended in the publication 'Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond' by Thomas A Barnes EdD RRT FAARC, David D. Gale PhD, Robert M Kacmarek PhD RRT FAARC, and Woody V Kageler MD MBA; Published -Respir Care 2010;55(5):601–616. © 2009 Daedalus Enterprises."
Amended motion carried

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

Linda Van Scoder moved to refer to the President-elect to develop a work group for 2013.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

Committee on Accreditation of Air Medical Transport Systems (CAMTS)
Colleen Schabacker moved to accept Recommendation 12-2-66.1 "That the travel funding allowance for the AARC representative to the Commission on Accreditation of Medical Transport Services (CAMTS) be increased from the current level of $2,000 a year to $2,500 a year."

Linda Van Scoder moved to refer to the President-elect for consideration in 2013 budget.
Motion carried

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

Linda Van Scoder moved to accept for information only. This recommendation was approved in April 2012.
Motion carried

Colleen Schabacker moved to accept the Special Representatives Reports as submitted.
Motion Carried

ROUNDTABLE REPORTS
George Gaebler moved to eliminate the Consumer Roundtable since the report is part of the Executive Director report.
Motion carried

George Gaebler withdrew his motion.
Motion to withdraw carried

Geriatrics
Susan Rinaldo Gallo moved to accept Recommendation 12-2-48.1 "That the Geriatrics Roundtable be expanded to include Palliative Care."

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

Susan Rinaldo Gallo moved to accept the Roundtable Reports as submitted.
Motion carried

AD HOC COMMITTEE REPORTS
Linda Van Scoder moved to dissolve the Ad Hoc Committee on Home Oxygen since their work is complete.
Motion carried

President Stewart appointed Denise Johnson to Chair the Ad Hoc Committee to Recommend Bylaws Changes, with Susan Rinaldo Gallo, Colleen Schabacker and Linda Van Scoder to complete the charges of the Ad Hoc Committee by Congress meeting in 2012.

Frank Salvatore moved to ratify Denise Johnson as Chair, in place of George Gaebler, of the Ad Hoc Committee to Recommend Bylaws Changes and to assign Tim Myers as staff liaison.
Motion carried

Linda Van Scoder moved to dissolve the Ad Hoc Committee on Section Membership because charges have been completed.
Motion carried

Susan Rinaldo Gallo moved to accept the Ad Hoc Committee Reports as submitted.
Motion carried

RECESS
President Karen Stewart recessed the meeting of the AARC Board of Directors at 4:45pm MDT, Monday, July 16, 2012.

Attachment “A”

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

American Association for Respiratory Care
Policy Statement

SECTION: Chartered Affiliates

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

EFFECTIVE DATE: November 3, 2011

DATE REVIEWED: ~~April 2012~~ July 2012

DATE REVISED: ~~April 2012~~ July 2012

REFERENCES:

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

Policy Amplification:

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

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

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

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

5. The Bylaws Committee will recommend to the AARC Board of Directors that their Affiliate Charter be suspended until the Chartered Affiliate makes changes to their bylaws to bring them into compliance with AARC Bylaws.
    a. The charter affiliate shall lose their voting powers in the House of Delegates until the Bylaws are revised and accepted by the AARC Board of Directors.
    b. If after a period of one year the Affiliates Bylaws are still not in compliance, the AARC

Board will take action by withholding Affiliate revenue sharing starting at one quarter of revenue sharing every six months.

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

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

DEFINITIONS:
ATTACHMENTS: AARC Bylaws

Attachment “B”

Position Statements:

AARC Statement of Ethics and Professional Conduct
Best Practices in Respiratory Care Productivity and Staffing

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

Effective: 12/94
Revised: 12/07, 07/09, 07/12

American Association for Respiratory Care

Position Statement

Best Practices in Respiratory Care Productivity and Staffing

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

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

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.

Effective: July 2012

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

Santa Fe, NM • July 17, 2012

Minutes

Attendance

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

Absent

Toni Rodriguez, EdD, RRT, FAARC, Past President
Lori Conklin MD, BOMA Chair

Consultants

Margaret Traband, President's Council President
Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Bill Lamb, BS, RRT, CPFT, FAARC, Past Speaker

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Sam Giordano, MBA, RRT, FAARC, Consultant
Doug Laher, RRT, MBA, Associate Executive Director
Tim Myers, MBA, RRT-NPS, Associate Exec Director/Brands Management
Steve Nelson, RRT, FAARC, Associate Executive Director
Ray Masferrer, RRT, FAARC, Managing Editor, RESPIRATORY CARE
Cheryl West, State Government Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Assistant

CALL TO ORDER
President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:34am MDT, Tuesday, July 17, 2012. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

OTHER REPORTS
ARCF, CoARC, and NBRC reports were reviewed.

George Gaebler moved to accept the agency updates as submitted.
Motion carried

Unfinished Business
There was no unfinished business.

New Business
White Paper Review

Susan Rinaldo Gallo moved to retire the white paper entitled, "Respiratory Care Practitioner 2001" and place in the archives.
Motion carried

Frank Salvatore moved to retire the white paper entitled, "Evolution and Utilization of Respiratory Services" and place in the archives.
Motion carried

POLICY REVIEW

Policy No. BOD.004 – Board of Directors – Continuous Quality Improvement Plan
Linda Van Scoder moved to accept with new reviewed date.
Motion carried

Policy No. BOD.005 – Board of Directors – Oversight of Executive Director
Linda Van Scoder moved to change the wording of this policy.
Motion carried

Policy No. BOD.011- Board of Directors - Parliamentarian
Frank Salvatore moved to accept new reviewed and revised date.
Motion carried

Mike Runge moved to change the wording of policy BOD.011 to include removal of attachments.
Motion carried

Policy No. BOD.012 – Board of Directors – Approval of Presidential Appointments, Goals, Charges
Colleen Schabacker moved to accept new reviewed date.
Motion carried

Policy No. BOD.013 – Board of Directors – Professional Attire
Susan Rinaldo Gallo moved to approve changes.
Motion carried

See Attachment “A” for all revised polices listed above.

HOUSE RESOLUTIONS
There were no House Resolutions.

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

MOTION TO ADJOURN
Bill Cohagen moved to adjourn the meeting of the AARC Board of Directors.
Motion Carried

ADJOURNMENT
President Karen Stewart adjourned the meeting of the AARC Board of Directors at 10:00am MDT, Tuesday, July 17, 2012.

Attachment “A”

Policy No.BOD.004 – Continuous Quality Improvement Plan
Policy No. BOD.005 – Oversight of Executive Director
Policy No. BOD.011 – Parliamentarian
Policy No. BOD.012 – Approval of Presidential Appointments, Goals, Charges
Policy No. BOD.013 – Professional Attire

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Continuous Quality Improvement Plan**

EFFECTIVE DATE: December 1999

DATE REVIEWED: December 2009

DATE REVISED: ~~December 2009~~ July 2012

REFERENCES:

Policy Statement:
The Board of Directors shall continually evaluate its effectiveness as the governing entity of the Association.

Policy Amplification:

1. As part of this process, the Board of Directors shall review planning, operation and service delivery to assure quality performance of the Association based upon key quality precepts.

Quality Performance

The Board of Directors is responsible for the efficient use of available resources to operationalize the mission statement and attain the strategic objectives of the AARC. Quality performance occurs through the continuous improvement of key processes and activities that contribute to the advancement of the art and science of respiratory care irrespective of venue.

Quality Precepts

- Continuous improvement of every process of planning operation and service delivery.
- Elimination of barriers which have the effect of adding costs through waste reduction and simplification.

- Alignment with outside organizations as partners.
- Management practices that focus on improvement of the systems in which members work.
- Emphasis on continuous process improvement rather than periodic inspection
- Continuous evaluation and improvement of working relationships with related organizations.
- Promotion of member understanding of their jobs and individual roles in providing quality services.
- Creation of a caring organizational environment that is characterized by trust and integrity and strives to drive out fear and frustration for optimal performance; encourages suggestions for improvement and innovation; and promotes sharing of ideas.
- Communication about organizational goals and progress as essential for enlisting effective participation.
- Creation of budgets and performance management each year for monitoring progress internally.
- Improvement in statistical processes and planning, and application of quantitative methods for continued improvement.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Oversight of Executive Director**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~March 2008~~ July 2012

DATE REVISED: ~~December, 2007~~ July 2012

REFERENCES:

Policy Statement:
The day-to-day functioning and business aspects of the Executive Office shall be the responsibility of the Executive Director.

Policy Amplification:

1. These duties and responsibilities shall not be altered, except by the full Board of Directors.

2. Individual officers or directors shall neither cause nor direct a change in Executive Office operations.

3. ~~The President and Executive Committee will review and approve the employment contract of the Executive Director.~~ Although the Bylaws of the Association give the Board of Directors the authority to employ and govern the activities of the Executive Director, members of the Executive Committee shall review and approve the details of the Executive Director contract, including salary.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Parliamentarian**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~July 2007~~ July 2012

DATE REVISED: July 2012

REFERENCES:

Policy Statement:
~~Consultants appointed by the President may include a Parliamentarian.~~ The Parliamentarian is appointed by the President.

Policy Amplification:

1. The Parliamentarian shall

   - sign and submit Conflict of Interest and Tobacco Free Pledge to the President
   - attend regularly scheduled meetings of the Executive and Finance Committees
   - attend Awards Ceremony at the Annual International Respiratory Congress and Annual Business Meeting
   - extend appreciation to key sponsors and exhibitors at the Annual International Respiratory Congress and Annual Business Meeting
   - attend receptions when invited
   - perform other duties as directed by the President

2. Additionally, the Parliamentarian shall:

   - assist the President by ensuring adherence to Robert's Rules of Order during official meetings of the Association
   - coordinate schedules for joint sessions with the House of Delegates' Parliamentarian
   - assist the President and President-elect in coordination of schedules for meetings
   - coordinate, in cooperation with Executive Office staff, on-site support

- provides logistical support for meeting
- assists with Presidential transitions
- assists with orientation of new Board Members

DEFINITIONS:

ATTACHMENTS: ~~AARC Conflict of Interest Statement (See Appendix)~~
~~AARC Tobacco Free Pledge (See Appendix)~~

American Association for Respiratory Care
Policy Statement

Policy No.: BOD.012

SECTION: Board of Directors

SUBJECT: Approval **of Presidential Appointments, Goals, Charges**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~March 2008~~ July 2012

DATE REVISED: December 2007

REFERENCES:

Policy Statement:
All goals, charges, and appointments made by the President shall be approved by the Board of Directors before being considered official.

Policy Amplification:

1. At the Board of Directors meeting following the Annual Meeting of the Association, the President shall submit:

    A. Appointments of individuals to serve on Special Committees, Task Forces, Focus Groups, and Panels, and as representatives to other organizations, as applicable

    B. Goals for the succeeding year

    C. Charges to Special Committees, Task Forces, Focus Groups, Panels, Specialty Sections and representatives, as applicable

2. Any other appointments made by the President during his/her term shall also be submitted to the Board of Directors for approval prior to being considered official.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Professional Attire**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2012

DATE REVISED: ~~March 2009~~ July 2012

REFERENCES:

Policy Statement:
All Officers, Directors, and guests shall adhere to appropriate attire requirements when attending business meetings and social gatherings.

Policy Amplification:

1. ~~Unless otherwise determined by the President, business attire shall be required for all meetings of the Board, Finance Committee and Executive Committee meetings.~~ Unless otherwise determined by the President, the following dress is required at meetings:

    a. Business casual dress at the Finance and Executive Committee meetings at the Summer Board of Directors meeting and the second day of the Spring Board of Directors meeting.
    b. Business attire shall be worn at the Winter Board of Directors meeting and social gatherings sponsored by other organizations and the first day of the Spring Board of Directors meeting.

This requirement shall also apply to invited guests.

2. Attire worn to receptions and other social gatherings sponsored by other professional organizations (i.e. NBRC) shall be identified by the sponsoring group, unless otherwise defined by the President.

DEFINITIONS:

ATTACHMENTS:

E-Motions

Since Last Board Meeting in July 2012

E12-3-81.1 Colleen Schabacker moved **"**to ratify the appointment of Robert Joyner to the NBRC Board of Trustees".

Results – August 2, 2012
Yes – 14
No – 0
Abstain - 0
Did not vote – 4

The motion carried

E12-3-15a.1 Susan Rinaldo Gallo moved "to ratify the appointment of Richard Zahodnic to the Sputum Bowl Committee".

Results – August 13, 2012
Yes – 10
No – 0
Abstain – 1 (Frank Salvatore)
Did not vote – 6

The motion carried

E12-3-9.1 Susan Rinaldo Gallo moved "that the AARC BOD approve the amended bylaws of the Pennsylvania Society for Respiratory Care".

Results – August 31, 2012
Yes – 14
No – 0
Did not vote – 3

The motion carried

E12-3-1.1 Susan Rinaldo Gallo moved "to ratify the appointment of Dr. Toni Rodriguez to the Elections, Finance, Judicial, Program, Strategic Planning and Membership Committees, and as the BOD Liaison to the International Medical Mission Roundtable".

Results – September 10, 2012
Yes – 15
No – 0
Abstain – 1 (Rodriguez)
Did not vote – 1

The motion carried

E12-3-40.1 Susan Rinaldo Gallo moved "to ratify the appointment of Lois Rowland, MS, RRT-NPS, FAARC as Chair of the Neurorespiratory Roundtable."

Results – October 10, 2012
Yes – 16
No – 0
Did not vote – 1

The motion carried

General Reports

President Report

Karen Stewart
October 2012

As I finish the final days of my term as President of the AARC, I wanted to take the time to say thank you. It has been a wonderful opportunity and an honor to serve you and the AARC.

The AARC remains a strong organization with membership at 52,000 members, despite the sluggish economy; we continue to remain a great professional organization with great members.

AARC continues with activity in Washington DC to make sure patients have access to respiratory therapists. The plan is in place for renewed activity starting with the new legislative session in January 2013.

The following is a high level summary the accomplishments in relation to my goals over the last 2 years.

1. Continue to promote the patient and their family's needs by being the advocate for those patients with respiratory disorders.
    - AARC has continued to support patient advocacy groups and continues to support the web site Your Lung Health. The booklet entitled A Patient's Guide to Aerosol Drug Delivery Continues to be available patient's use.
    - Under way is the Home Oxygen Users Survey. This survey will help the AARC understand the needs of patients regarding their home oxygen education and other needs related to receiving service in the home.

2. Continue to develop and execute strategies that will increase membership and participation in the AARC both nationally and internationally.
    - Membership remains strong but we cannot stop our efforts to grow our membership. The membership committee has been very active looking at ways to continue our growth. Activity on the international level is growing as more areas around the world look to the USA model of Respiratory Therapy Education.

3. Promote patient access to respiratory therapists as medically necessary in all care settings through appropriate vehicles at local, regional, and national venues.
    - The AARC activity to bring the respiratory therapist to more venues with continued efforts in Washington. There will new and continued efforts as the new legislative session begins in January 2013.

4. Continue to advance our international respiratory community presence through activities designed to address issues affecting educational, medical and professional trends in the global respiratory care community and continue to advance advocacy for the patient.
    - International activity continues to grow. During this past 2 years several opportunities to provide education was achieved and plans continue to assist those with requests.

5. Evaluate transitional needs to meet the competencies necessary to develop the "Respiratory Therapist for 2015 and beyond" based on the expected needs of respiratory care patients, the profession, and the evolving health care system.
    - The past two years has been filled with activity regarding Respiratory Therapist for 2015 and beyond. Data has been gathered from a number of organizations, information has

been shared at a great number of meetings around the country. Decisions have been made to accept the first and second publications and final decisions will be made in November 2012 to set the direction for implementation of the final decisions. An Implementation committee will be formed and appointed by the incoming president George Gaebler.

6. Promote the access of high-quality continuing education to develop and enhance the skill base of current respiratory therapists to meet the future needs of our profession.
    - AARC continues to be the leader in education for the respiratory therapist through publications, conferences and webinars.

7. Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.
    - AARC continues to develop relationships with other organizations and advocacy groups with goals similar to those of the AARC.

8. Expand efforts to obtain research funding.
    - AARC continues to work on efforts to obtain and increase research funding.

9. Increase and enhance activities to increase public awareness of respiratory therapists and their role in the treatment of respiratory disorders.
    - AARC remains involved with activity to increase the awareness of respiratory therapists. One great example that is the work that has been done in Drive for COPD. Therapists throughout the USA participated in screening for COPD.

Conclusion: I would like to thank the AARC membership, the House of Delegates, the executive office and the state societies for making this one of the more delightful times in my life. I have had fun being able to serve you and a profession that is near and dear to my heart. I look forward to continuing to serve the AARC and look forward to working with your next President, George Gaebler.

Executive Office Report

AARC 2012 Fall Meeting Executive Office Report

Tom Kallstrom, MBA, RRT, FAARC
Executive Director

Membership:

As of October 1, 2012 our member numbers were 52,267. This is slightly above the number of members on the same date in 2011. I will have a more current number to report at the board meeting in November.

At this meeting the membership committee will be introducing a new campaign that will launch in New Orleans.

Advocacy and Public Awareness:

CMS Tracers

We in August and September we were made aware from members of CMS tracers that were occurring this summer in which respiratory care departments were being identified as being out of alignment with their in-hospital nebulizer handling between patient use. The critical component that was identified as a problem was a recommendation that isopropyl alcohol be used to rinse out nebulizers between treatments. This practice is one that we postulated was an unnecessary step and one that could in fact cause the exacerbated patient with reactive airways disease more difficulty.

We asked for and were granted a conference call with CMS and CDC in an effort to let them know of our extreme concerns. We also wanted to ask CDC to update their standards as per our recommendations. We were successful on both fronts and both have agreed to change the tracer recommendation as well as the CDC's. Once the standards are published we will share with the membership.

Alpha One study

In January we started to offer the Alpha One Course as a response to a needs assessment done to our membership. RTs who signed up for the course were encouraged to be part of a larger multicenter study that is trying to determine the effectiveness of the respiratory therapist in patient education and diagnosis of Alpha One. Preliminary data is showing a positive correlation. We urge all respiratory therapist members to take the course and sign on as a study site.

Drive4COPD.

The Drive4COPD was transferred to the COPD Foundation earlier this year. Since that time there has been transition within the COPD Foundation and the AARC as our partnership effort becomes more solidified. The AARC has received funding for a COPD Coordinator who will oversee the ongoing efforts in 2013.

The AARC working with the Louisiana Society of Respiratory Care will again be hosting a public pulmonary health event. This public education, COPD screening, and Spirometry will take place on November 9th. This happens to be the day before the Congress starts. We invite you to join us from 1:00 to 4:00 p.m. at the St Thomas Community Wellness Center, located at 2010 Magazine St, New Orleans.

AARP
The AARC again was represented by a team of Respiratory Therapists at the AARP Conference in New Orleans in September. As part of this annual event the AARC had an exhibit in partnership with the COPD Foundation where we provided lung health education, screening, and spirometry to attendees. The attendance at this years meeting was notable as there were more in attendance (compared to last year in Los Angeles) and there was a broader representation of the over 55 years of age demographic.

Peak Performance USA (PPUSA)
Peak Performance USA is an outreach program developed by the AARC that is designed to position the respiratory therapist as liaison between hospital and elementary schools. Its purpose is to teach students, teachers, administration, and parents about asthma, the signs and management. PPUSA has reached an estimated 47,000 children with asthma. It has been implemented in 900 schools in 34 states.

NIOSH
In 2011 the AARC Executive Office was approached by the National Institute for Occupational Safety and Health (NISOH) with an invitation to be a part of a national survey, which would specifically look at health and safety practices of respiratory therapists in the hospital environment. We were among 20 other professional healthcare organizations asked to be part of the survey. The survey sought to uncover types of exposures with chemicals as well as other relevant health care and safety issues such as but not limited to work schedules, exposure to chemical agents, exposure to aerosolized medications, exposure to infectious diseases, physical demands, workplace violence, stress, vaccinations and safety and health perception. The survey is titled *NIOSH Health and Safety Practices Survey of Healthcare Workers: A Report of Survey Participants from the American Association for Respiratory Care (AARC)* and is attached to this report. While we cannot generalize from this survey it does allow us to identify areas of potential concern and/or opportunity. Much of this information is not available elsewhere and should be useful in guiding health and safety promotion and future research. This information will also be appropriate for benchmarking and identifying areas that may need guideline development. The AARC thanks our members who took part in this survey. The entire survey will be posted on our website (aarc.org) for access for members only in the coming weeks. (See "NIOSH AARC report" attached)

Pulmonary Medicine Health Policy Summit
On April 8–9, 2013, the American Association for Respiratory Care along with other key pulmonary related societies and others interested in health policy will convene for the Pulmonary Medicine Health Policy Summit in Washington, DC. The goal of the Summit is to address a limited number of specific issues facing the pulmonary medicine community that lend themselves to regulatory and/or legislative solutions.

At the two-day summit's conclusion, a detailed strategic roadmap will be developed and widely distributed across the pulmonary medicine community. The conference findings will also be distributed from the participating societies to inform their respective constituencies. The issues that will be address have been vetted by the respective societies and will involve several hours of discussion from experts, including members of Congress and their staffs, representatives of regulatory agencies and nationally recognized experts and include:

- Performance measures for pulmonary medicine and their impact on health policy/readmission rates pay for performance, etc.
- NHLBI funding of COPD; COPD as public health issue
- Telemedicine for pulmonary related diseases—the technology, access, barriers, etc.
- Documentation/HER
- Oxygen payment reform

Other professional associations scheduled to participate include: the National Association for Medical Direction of Respiratory Care (NAMDRC), the American College of Chest Physicians (ACCP), the American Thoracic Society (ATS), the National Home Oxygen Patients Association, and the COPD Foundation.

Joint Commission
The AARC continues to participate in the Joint Commission Standards Field Review process. We do this by coordinating a response specifically reaching out to appropriate membership sections. Since the summer board meeting we have responded to these 2 additional reviews relevant to respiratory therapy:

- Primary Care Medical Home for Hospitals and Critical Access Hospitals (7-10-12)
- Advanced Disease Specific Care Certification for Primary Stroke Center (8-16-12)

Uniform Reporting Manual (URM)
As a reminder, this enhanced URM will contain data from hospitals (data from LTACH, short stay acute, inpatient rehab and SNF) and diagnostic laboratories (PFT, blood gases, echo/non-invasive cardiology, and sleep) and pulmonary rehabilitation. Development of the contents of the manual is now complete. It will be ready prior to and available for purchase at the Congress.

Benchmarking
As of the end of September, there were 143 facilities participating in the benchmarking service. Our persistent monthly follow-up continues to yield a higher percentage of subscribers with current data. Members of the benchmarking committee continue to personally contact new subscribers within one week after they have gained access to the system and offer personal assistance to facilities that are within 4 months of their expiration date and have not entered at least one quarter of data. The committee is now conducting a brief survey to help evaluate the effectiveness of the monthly webcasts for benchmarking subscribers.

AARC Research Fund
The BOD approved $88,020 to fund a research proposal from Barnes for a respiratory therapist to serve as an advanced patient care coordinator for patients discharged from the hospital with COPD/asthma. Their role would be to oversee the discharge of the patient to insure that respiratory treatments and medications are appropriately prescribed for outpatient therapy, that adequate follow-up occurs post discharge in a medical clinic, that outpatient access to medications is available, and that other social services are involved as needed. They will also monitor study patients to assure adherence to COPD/asthma management guidelines during their inpatient stay. The desired outcome would be to reduce readmissions to the hospital and visits to the emergency department. We await our first report from Barnes.

Advertising and Marketing

Corporate Partners
Since the Summer Forum, we have visited two Corporate Partners at their facilities to provide an AARC update and to discuss synergistic opportunities. We are currently tracking our Corporate Partners status and working with our 2012 partners to insure their continuance into 2013.

2012 Partners: Carefusion, Masimo, Covidien, Monaghan, Philips/Respironics, Drager, GE Healthcare, Maquet, Kimberly Clark, Tri-Anum and Teleflex.

We are currently tracking towards at least 12 Corporate Partners for 2013. An update of the companies will be announced at the board meeting. The Executive Office is currently reviewing the Corporate Partner program and its mutual benefits for AARC and its partners that would take effect in the first quarter of 2013 for Partner status in 2014.

Focus Groups

Website Project

We conducted a focus group at Summer Forum with 20 respiratory therapists to get feedback and input on our websites as we prepare to install a new IT platform for our websites (AARC, ARCF and YourLungHealth.org) in the first quarter of 2013. We received valuable feedback and our current product, what works and what doesn't, as well as some valuable feedback on a new, sleeker layout and design for the new platform.

Sleep Focus Group

We have seen our advertising with companies in the Sleep Service lines not be as strong as we would like it in the past few years. The feedback we have received is the misperception that the respiratory care profession is not heavily invested or active in sleep medicine as they were several years ago. We have organized a Focus Group to take place this year at AARC Congress where 8-12 respiratory therapist participants will demonstrate and discuss their role that respiratory care plays in adults, pediatrics and a growing area of sleep screenings and mask fittings in hospitalized patients (Adults and Peds). Not only will we invite companies with heavy products in Sleep to be observers to this Question and Answer Focus Group, but we intend to publish its proceedings in *AARCTimes* sometime in 2013.

Marketing and Products

As you are aware, we outsource our Respiratory Care Week products to a third-party supplier (Jim Coleman Ltd). As this is the first year we have done such and Respiratory Week concludes to close to Congress, we will review the program's successes and opportunities for 2013 and provide an update at the Spring BOD meeting in Dallas.

In the 4th quarter of 2012, we are conducting a review of our remaining "in-house" products and evaluating their current relevance and assessing the need for updates or revisions. This includes goods, educational products, webcasts and courses for 2013 and discussing future opportunities.

We were excited to be provided the opportunity to receive the publishing rights to Dr. Thomas Petty's final book, Adventures of an Oxyphile2, in an audio format. It is current available at no cost on aarc.org and YourLungHealth.org and we are attempting to make it available through the iTunes store. A special thanks goes out to Patrick Dunne for his hours of narration to assist us with the project.

EDUCATION

Asthma/COPD Course

The Asthma/COPD course continues to attract interest internationally. We were again invited to present the course again the Middle East in twice in the first half of 2012. In September in Dallas we hosted a COPD Educator Program for 20 Egyptian Pulmonologists at the Baylor Heart Hospital. The intent is for the physicians to use the information we provided to teach 1,000 PCPs in Egypt about COPD management in 2013. They specifically sought out the AARC for this course. We will keep in communication with them as we keep a close eye on their efforts and share their successes with our members in 2013.

Respimat Education

The AARC was provided a grant to teach respiratory therapists, nurses, and physicians about the use of the newest device available for aerosol delivery. The Boehringer Ingelheim Respimats' design and application is different and does require a higher level of teaching so that respiratory therapists (the primary educator) can better instruct our patient and their peers on the use of the device. Two live web casts were presented in October and is archived as well. Those who registered were provided a placebo to use while viewing the presentation.

Web Casts

To date we will have conducted 15 webcasts and have 2 more scheduled for 2012 at this time. We continue to

attract a large number of live participants. It is not unusual to have over 400 participants in our live webcasts. Planning for the 2013 webcast series will began in October. We are reaching out to our sections and roundtables regarding new topics to be covered.

Professors Rounds

All productions for 2012 have been completed plus a bonus presentation. In 2013 we will be exploring other local production option to see if we can obtain better value than with our present vendor (AMS).

Next years the professors will be:

Moving Beyond VAP - Ventilator Associated Events

Professor: Dean Hesss RRT, PhD , FAARC

Oxygen Therapy in the Hospital

Professor: Keith Lamb, RRT

Caring for Patients with Chronic Critical Illness

Professor: Shannon Carson, MD

Cystic Fibrosis - A 21st Century Perspective

Professor: Elliot Dasenbrook, MD, MHS

Medicated Aerosol Therapy - New Drugs and Devices

Professor: Douglas S. Gardenhire, EdD RRT-NPS

Airway Clearance

Professor: Timothy R. Myers, MBA RRT-NPS

Humidification During Mechanical Ventilation - A Review of the Literature

Professor: Richard D. Branson, MSc RRT

PROJECTS

Aerosol Guides

All three aerosol guides (RT, Patient, and nurses, physicians, pharmacists, and other health care professionals) are in the final process of editing and update. We expect to release them at the Congress or soon thereafter.

Patient Safety Checklist

Patient safety oxygenation checklists for adults/pediatric patients, neonatal/newborn patients, and adult ventilation checklist are now complete and have been released. We expect to do other checklists in the future. We are pleased that our Keynote Speaker for this years Opening Ceremonies, John Nance will be speaking of the role of the respiratory therapist in the hospital and the importance of checklists in preventing medical errors.

Co-Marketing Opportunities with our Chartered Affiliates

In 2011 we added three new co-marketing opportunities in addition to COPD Educator and Asthma Prep Courses and in 2012 we added the Alpha One and VAP courses. Upon the launch of Exam Prep Course this too will be added to the other co-marketing opportunities for the affiliates. Since the beginning of the year 32 of the chartered affiliates are qualified to sign the agreement Chartered affiliates have signed up for co-marketing. The state leadership has been made aware about this opportunity for the states to bring in 10% of the registration

fees that are collected.

AARC has expanded co-marketing opportunities for state affiliates in 2013 by offering revenue sharing to each affiliate for each 4-day, full registration paid for by members of their state (AARC Congress 2013)

In the coming year we will work with our co-marketing partners to provide other co-marketing opportunities which will bring in more money to the chartered affiliates as well as the AARC.

COPD Toolkit
After a very lengthy review process, the flip chart component of the COPD toolkit has officially received legal approval by our sponsoring organization. The flip chart has been professionally produced and is being send out to the beta test sites. Hospitals/individuals have been identified to serve as beta-testers, and will receive the toolkit and its contents. Data will be collected from patients and RTs to determine whether standardized education with the COPD toolkit was of benefit to patients, their understanding of the disease, and ability to self manage the disease.
Estimated Completion Date for Data Collection: Summer 2013

- **Hospital to Home**
- The Executive Office continues to work with the Home Care and
- Management Specialty Sections in developing educational sessions for
- the hospital-based RT to become more knowledgeable on the equipment,
- care, barriers, and limitations faced by the respiratory patient as they leave
- the hospital and enter the home. Three symposia will be offered on this topic
- at AARC Congress 2012 and a webcast on this topic was delivered on Aug.
- 28, 2012.

Conventions and Meetings
Summer Forum 2012 was a very successful meeting for the AARC. Attendance exceeded the previous year's meeting in Vail. Executive Office employees and Program Committee members also received favorable feedback from attendees regarding the destination and program content. A focus group was held in Santa Fe on how the Summer Forum and Congress could be improved. Results of the focus group will be shared with the 2013 Program Committee. Some of the highlights at the AARC Congress 2012 in New Orleans, LA (Nov. 10-13, 2012) include:

- John Nance; book author, airline pilot and patient safety advocate is scheduled to deliver the keynote address.

- AARC Congress 2012 will have a strong international presence this year with speakers, abstract presenters, and attendees from around the globe. Dr Stefano Nava from Pavia, Italy will present this year's Egan lecture.

Two post-graduate pre-courses have also been scheduled:

- Patient Safety StartsWith You!

- Mechanical Ventilation 2012

Over 275 individual presentations are scheduled with more than 175 speakers from around the world.

A record 20 Open Forum categories are scheduled totaling more than 275 poster presentations.

Pre-registration attendance is on budget and ahead of AARC Congress 2011 in Tampa, FL. We've exceeded our contracted hotel room block and have had to expand to overflow hotels.

5 breakfast symposia have been scheduled.

Dr. Sherry Magill from the CDC will present and discuss the new definition of a Ventilator Associated Event, This culminated as a result of a national VAP workgroup that included the AARC

Public Relations

We track citations in the trade and consumer press on a daily basis. Virtually every day we are able to identify articles that mention respiratory therapists in a variety of contexts. These range from clinical issues to community outreach events. This represents a geometric increase compared to five years ago. Since the Summer Forum there were a total of 307 mentions.

RESPIRATORY CARE Journal

We continue to enjoy a record number of manuscripts received and published. The interest in the articles is apparent in the table below showing the number of online downloads and views. Among more than 10,000 titles hosted by at the online site hosting RESPIRATORY CARE, our Journal rankings and downloads are:

		Full-Text Downloads	Ranking	Abstract Views	Ranking
2011	**January**	15	-	328	-
	February	62	-	747	-
	March	2139	40	5177	161
	April	2366	38	5953	123
	May	3107	22	8310	87
	June	2902	23	8202	89
	July	2977	19	8310	75
	August	2514	21	7127	97
	September	3688	17	10648	59
	October	4789	16	15991	40
	November	4758	20	19659	33
	December	4306	14	15071	43
2012	**January**	5220	10	16970	42
	February	5798	11	16905	33
	March	6495	7	20452	26
	April	6107	9	18553	30

May	6606	7	19858	31
June	5747	7	19600	30
July	5765	6	19073	21
August	6959	3	20937	24

Since our last report…

- The Journal held the 51st Journal Conference on *Adult Mechanical Ventilation in Acute Care: Issues and Controversies*.
- The 52nd Journal Conference on *Artificial Airways and Airway Adjuncts* will be held June 14-15, 2013. As always, the Journal and the AARC are gratefully and indebted to the American Respiratory Care Foundation for their support resulting in the presentation and publication of the conference proceedings.
- We decided that beginning in 2013 we will only present one Journal Conference per year instead of two. The original idea behind the conferences was to generate significant papers for the profession by known authors to fill the pages of the publication. This is no longer the case and we are now confident that original contributions will satisfy the Journal requirements.
- We handled a record number of reviews and selection of abstracts of original research to be presented at the Open Forum of the International Respiratory Congress in New Orleans. We received 421 abstracts, accepted 328 (78%) and rejected 93 (22%). The abstracts and posters will be presented during 20, 2-hour sessions at the Congress.
- In 2011 we began CRCE through the Journal as a monthly feature instead of annually:

  2010 – 1 test annually for 6 credits for the year
  Total CRCE credits granted: 3,276
  Unique users: 546

  2011 – 1 test monthly for 1 credit, up to 12 credits for the year
  Total CRCE credits granted: 3,082
  Unique users: 828

  2012 – 1 test monthly for 1 credit, up to 12 credits for the year
  Total CRCE credits granted thru Sept: 2,432
  Unique users thru Sept: 683

- The biggest Journal project going on is the hosting of the Journal website in the HighWire platform at Stanford University. Implementation is scheduled with the Dec 2012 issue of the Journal. Our online presence in this state-of-the-art platform should result in widen readership and grow usage, and the readers will enjoy hundreds of features, from advance discovery and analysis tools, to different types of alerts. For example, pop-up abstracts can be accessed without leaving the Table of Contents; figure and table thumbnails can be enlarged in place without extra clicks; and multi-media, video and data supplements can be viewed within the article. The new website will be followed soon thereafter by the offerings of apps for mobile devices. This will enable the Journal contents be available to the user anywhere, anytime.

- This December will be five years since Dean Hess became Editor-In-Chief of the Journal. During this time we have witnessed unprecedented growth of the publication. Dean's energy, high standards, and vision for the future have guided the publication on these fast-paced times, to a point where we can now say our publication is on par with all others in pulmonary medicine. We are happy to report that Dean has agreed to continue his editorship position for the next five years.

IT Upgrade
We are progressing as scheduled on our upgrade and installation is ongoing. We have made all server purchases. The Windows hardware is being installed. Next and final steps will be an upgrade exchange program installation, rewire of network and installation of remote routers. ATTACHMENT #2 (see below)

Summary
I would like to thank the board for their support of the past five months as I assumed the responsibilities of Executive Director. We are in a transition period and will see other personnel changes in the coming months. As you know Bill Dubbs announced his retirement, earlier this year, which will occur at the end of 2012. We are excited that Dr. Shawna Strickland will be assuming Bills position. We are thankful for all that Bill has done for the AARC and we will miss him. We also look forward to adding Shawna to the Executive Office. I am certain that her talents and expertise will be of great benefit for our members.

As always please remember that this report is a summary and I would be happy to expand on any areas you wish to know more of at the board meeting.

Recommendation:
That the AARC Board of Directors officially endorse the Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit as requested by the Society of Critical Care Medicine. (See "AARC-PAD Endorsement Letter", "PAD Guideline Figures", "SCCM Pain Agitation Delirium Guideline" attached)

YTD AARConnect

Specialty Sections

Discussion	**New Threads**	**Reply to Discussion**	**Total Messages**
Adult Acute Care **(members 1849)**	0214	0514	0728
Continuing Care/Rehab **(members 475)**	0099	0175	0274
Diagnostics **(members 899)**	0147	0458	0605
Education **(members1212)**	0155	0416	0571
Home-Care **(members 870)**	0042	0057	0099
Long-Term Care **(members 488)**	038	0045	0083
Management **(members 1794)**	0683	1726	2409
Neonatal-Pediatrics **(members 2022)**	0287	0770	1057
Sleep **(members 950)**	0051	0044	0095
Surface & Air Transport **(members 407)**	0108	0390	0498

Roundtables

Discussion	New Threads	Reply to Discussion	Total Messages
Asthma Disease Management **(members 158)**	0005	0007	0012
Disaster Response **(members 56)**	0009	0001	0010
Geriatrics **(members 39)**	0000	0000	0000
Hyperbarics **(members 39)**	0001	0000	0001
Informatics **(members 66)**	0005	0001	0006
International Medical Missions **(members 68)**	0002	0002	0004
Military **(members 36)**	0009	0010	0019
Neurorespiratory **(members 58)**	0016	0015	0031
Research **(members 78)**	0007	0006	0013
Simulation **(members 112)**	0006	0014	0020
Tobacco-Free Lifestyle **(members 80)**	0024	0014	0038

Other Communities

Discussion	New Threads	Reply to Discussion	Total Messages
Leadership Book Club	0051	0071	0122
Bylaws	0052	0179	0231
Coding	0034	0070	0104
Resolutions Committee	0018	0062	0080
Board of Directors	0056	0185	0241
House of Delegates	0073	0020	0093
Help Line	0365	0785	1146

ATTACHMENT #2

Section	Budgeted	Actual	Savings
Section 4: Datacenter Infrastructure	$82,677.00	$67,920.76	$14,756.24
Section 5: Network Infrastructure	$50,000.00		$50,000.00
Section 6: Workstation Hardware and Software	$82,508.00	$71,283.04	$11,224.96
Section 7: Information Security, Firewall and Spam/Virus Protection	$12,995.00		$12,995.00
Section 8: Membership Management System (iMIS)	$14,550.00	$22,839.06	($8,289.06)
Section 9: Accounting Software (Great Plains)	$13,200.00	$22,273.04	($9,073.04)
Section 10: Document Imaging and Paperless Workplace	$80,160.00		$80,160.00
Section 11: Video Production Facility	$35,000.00		$35,000.00
Overall Cost	$371,090.00	$184,315.90	$186,774.10

News Now@AARC
The American Association for Respiratory Care's Electronic Newsletter

October 11, 2012

RC Week: 10 Days and Counting

Here's the final call for RC Week, as we all get ready to celebrate Oct. 21-27. Check our website to help with all the items and ideas you need.

Pre-Courses Boost Congress Value

AARC Congress 2012, this Nov. 10-13 in New Orleans, will feature a wealth of presentations and original research, but you can boost the value of your attendance even further by signing up for one of two great pre-courses offered on the Friday before the official kickoff on Saturday morning. "Patient Safety Starts with You!" and "Mechanical Ventilation 2012" will bring you up-to-date on two important professional topics. Preregistration is required by Mon., Oct. 22. Congress attendees qualify for a 50% reduction in the registration fee. Both courses offer CRCE credits.

Here's another **Congress deadline you don't want to miss**: next Tuesday, Oct. 16, is the last day for making hotel reservations at the discounted AARC rate. Everything you need to get started is on our **Site and Hotel Information** page. (Look for info on the hotel shuttle there too.)

AARC Member Co-Authors New Trach Care Statement

Kathleen Deakins represented the AARC and her fellow RTs well on a consensus panel to review trach care, and now the group is sharing their results in a

Quick Click Resources

International Reception: Buy Tickets Here

Read AARC Times Online

Join the Discussion on AARConnect

consensus statement published in *Otolaryngology – Head and Neck Surgery*.

AARC Election Results Announced
The AARC election has concluded. See who will be serving with incoming president George Gaebler when they are installed at the upcoming Annual Business Meeting.

Legislation to Replace Competitive Bidding Gets AARC Backing
The AARC is on board with legislation pending in Congress to replace DMEPOS Competitive Bidding with a market pricing system. The Association just sent a letter to the bill's sponsor, Congressman Tom Price from Georgia, outlining its belief that a market pricing system would better serve patients who depend on the life extending benefits that come from home respiratory equipment and services.

Bedside Teaching Webcast Scheduled for the 24th
Our next webcast is coming up on Wed., Oct. 24 and will address "The Art of Teaching at the Bedside." Register now to hear Susan Johnson talk about the preceptor approach to bedside teaching and share some strategies for making it a success. Attendees at the live session will earn one free CRCE.

And don't forget to sign up for the **Combivent® Respimat®** on Thurs., Oct. 25 too. The webcast is free to all, so be sure to invite the physicians and nurses you work with to attend as well.

Good Press: AARC Members in the News
This edition features several great stories, including one about the vital role RTs play

in the NICU at the University of Arkansas for Medical Sciences.

Comments or questions? Want to opt out of future emails? **Let us know**.

AARC Member Co-Authors Consensus Statement on Trach Care

October 9, 2012

AARC member Kathleen Deakins, MSHA, RRT-NPS, FAARC, is a co-author of a new clinical consensus statement on tracheostomy care. The paper has been **published** online ahead of print by *Otolaryngology—Head and Neck Surgery* and is expected to help guide tracheostomy care for adults and children.

Deakins got involved in the project a couple of years ago after the AARC was contacted for the name of a respiratory therapist who could serve on the consensus panel. She was recommended due to her long record of active involvement in respiratory care at Rainbow Babies & Children's Hospital in Cleveland, OH, where she currently serves as clinical manager of woman's and children's respiratory care and pediatric pulmonary function and infant monitoring and has spearheaded numerous continuous quality improvement (CQI) efforts over the years.

Those efforts earned her the Sally Ann Shipley Award earlier this year, a newly established award given by her hospital group to honor those who have excelled in the area of CQI.

Deakins says she agreed to serve on the panel because she believed it would be a great opportunity to share the respiratory therapist's expertise in the area of trach care. "Respiratory therapists spend a great deal of time at the bedside caring for these patients and work closely with the otolaryngologists in making recommendations for improvement in selection of trach sizes and emergency management," she says. "They depend on us to help provide excellence in transitioning these patients to long-term care."

According to Deakins, the consensus team was collaborative and open, and spoke very highly of all multidisciplinary roles and their involvement in caring for trach patients. "Respiratory therapists play an

integral role in the day to day management of tracheostomy patients and are respected for their contribution and expertise."

The group reached consensus on 77 statements pertaining to initial tracheostomy tube change, management of emergencies and complications, prerequisites for decannulation, management of tube cuffs and communication devices, and specific patient and caregiver education needs. The panel also highlighted 39 other areas where consensus could not be reached, paving the way for further study in those areas.

Deakins believes the statement will go a long way to improving the consistency of trach care provided in hospitals and urges her fellow RTs to share the document with the physicians they work with. That's something she and her colleagues have already done at Rainbow Babies and Children's.

"In discussing the results of this statement with the pulmonary physician colleagues at our hospital, we determined that the emphasis on pre-surgical education to patients and families is crucial and greater now more than ever," she says.

She also noted that there are minimum expectations for the management of tracheostomy patients that must be met to provide safe and effective care and specifically cited the need to address equipment and emergency care needs, along with the need to take the differences in management of adult and pediatric trach patients into account. The latter, she says, are clearly outlined in the statement.

Deakins says serving on the consensus panel was an interesting experience and she was pleased to be able to bring the respiratory therapist's perspective to the group. "Clarifying care practices is beneficial for streamlining health care," she says. "The role that RTs play in the delivery and integration of health care is valued, and this consensus statement gives us another example of how we can contribute to excellence in providing a continuum of care."

This page is located at: http://www.aarc.org/headlines/12/10/trach_care.cfm

State Government Affairs
Activity Report – November 2012

BOD/HOD/BOMA November 2012
Cheryl A. West, MHA
Director Government Affairs

Introduction

As we are all aware, 2012 is a general election year where voters will decide who will hold office at all levels of government, from local town councils to the President of the United States.

Because this Activity Report is written and finalized prior to the November 6th elections, it is impossible to predict how the results of this election will affect the course of the nation overall, the direction of health policy specifically and thus in a more global sense the impact on the respiratory therapy profession .

The Government Affairs staff will of course provide as much clarity as possible on what the results of the elections might mean during the verbal update at the November meeting.

Overall at the state level 2012 was a continuation of previous years where state government legislative and administrative initiatives had to reconcile the increased needs of their citizens with the reality of budget limitations. This reconciliation often resulted in a decrease in reimbursement for health service providers; limiting coverage for state sponsored health programs; and/or increasing fees on numerous other government services.

Given the fragile economic recovery, I believe 2013 will produce more of the same in terms of cut backs and limitations.

Michigan Government Recommends Repeal of MI RT Licensure

As reported in the July Update, the Michigan Office of Regulatory Reinvention issued a report to Governor Rick Snyder with the recommendation that 18 MI licensed health professions including respiratory therapy be de-licensed (and numerous other
professional licensing boards be reorganized in some fashion). The rationale given to de-license RTs was the NBRC voluntary professional credentials were sufficient to assure practitioners competency and as the report states, "provide employers of the qualifications of the respiratory therapists."

Also noted in the July Update the Michigan Society for Respiratory Care (MSRC), the AARC and most notably the NBRC wrote to the Governor adamantly opposing the de-licensing recommendation. In addition, in late summer the MI Chapter of the American College of Chest Physicians (ACCP), the COPD Coalition and the Alpha One Association all submitted letters to the Governor in opposition to the proposed de-licensing of RTs.

The MSRC continues its well organized and orchestrated strategy to achieve its goal to delete MI RTs from the de-licensing list of professions. It should be noted that Governor Snyder has had the final report on his desk since February 2012 and has yet to move the recommendations forward to the legislature. Regardless of what the Governor does or does not do, it will require the Michigan legislature to initiate the repeal of the licensure law for any profession. State mandated licensure is created through legislation and it must be rescinded through the same process.

Michigan RTs and the supporters of the RT profession, following the strategy developed by the MSRC leadership have been concentrating on communicating with their own state representatives making it abundantly clear that repeal of respiratory therapy licensure is not an option.

Indiana Respiratory Therapy Licensure Review
The Indiana the Regulated Occupations Evaluation Committee (ROEC) was established to assess the efficiency and effectiveness of all professional licenses regulated by the Indiana Professional Licensing Agency (IPLA). In August respiratory therapy licensure came under review to determine if RT licensure should continue. No decision was made during this August meeting, nor the follow up meeting in September. A further meeting of the ROEC to address RT licensure will be held in October. It appears the continued point of discussion, as it is in Michigan, is whether NBRC credentials can substitute for state licensure. The Indiana Society has risen to the challenge this review poses to the profession. Again the Society submitted its own detailed rationale as to why RT licensure must be preserved. The AARC and the NBRC also sent letters strongly supporting the need for licensure continuation.

I will provide any updates on this issue at the November meeting.

Comment on Above
Whether it is this era we are in where state licensure is viewed as an example of government over-regulation or licensure is seen an impediment to individuals entering the job market or administering the licensing process is costly to the state, it appears that some states are seriously assessing the merits of continuing licensure for many professions. While two states do not necessarily make a national trend, it is unsettling to say the least that in one year two state governments are reviewing the necessity of respiratory therapy licensure. Forewarned is forearmed. Therefore, it is critical for RT state societies to make sure that the following are in place:

Good communication with the staff of the RT licensing agency (licensure boards/councils/committees staff are often the first to know if they are under scrutiny)

The Society has a strong and committed group of RTs on the legislative or government affairs committee

The contact information for RTs in the state, members or not, are as thorough and as up to date as possible.

Action by the North Carolina Respiratory Care Licensure Board
This past July, the NC Respiratory Care Licensure Board sent an open to all NC RTs that showed the Boards support for the following: the growth of baccalaureate and master degree RT education programs in the state; amending the current NC RC licensure law to permit offering a provisional license for those holding the CRT credential and "full" license for those with the RRT); and its support for the move towards requiring a bachelor degree in respiratory care as a licensure requirement. Please see the attached for the accurate wording of these positions.

Ohio Respiratory Care Board Proposed Regulation Revisions
The Ohio RC Board has been deliberating for well over a year a proposal to amend its regulations to require the RRT credential for state licensure. The proposal would also provide for a lead in time prior to the RRT requirement and a grandfather provision for those currently holding the CRT credential.

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

The legislation and regulations discussed below reflect what has occurred since the July State Government Activity Update.

Because of the volume of activity from the many states that pass legislation to raise tobacco taxes or restrict smoking in public places I have not included these types of bills in this report.

Mississippi enacted a law that makes certain technical amendments to the RT licensing law. One provision of note tightens the exemption provisions by allowing only those holding credentials to provide RT services without being a RT. The exemption language then goes on to require that those exempted individuals with credentials must also be licensed practitioners in MS.

Massachusetts legislation that requires the state to develop educational publications to address the unique health issues affecting infants born prematurely, the list of clinical issues specifically includes "respiratory problems".

Michigan earlier this year a Resolution (FYI- Resolutions are the "sense" of the legislature and not an actual mandated law) that would remove the current ban (initiated on December 31, 2011) on the over the counter sale of Primatene Mist. While this MI Resolution was of interest, it did not raise too much concern (it is a Resolution, not a possible law). What is more concerning, however is the surprisingly serious effort in Congress to rescind the ban on Primatene Mist (see the Federal Activities Report).

Missouri a bill was introduced that adds eleven new sections relating to reporting of medical harm events, with penalty provisions and includes ventilators in the definition of a "medical harm event". Also another **Missouri** bill, which was enacted which permits school nurses to administer asthma related rescue medications.

New Jersey has an interesting bill that requires oxygen providers to notify the local fire department whenever the HME provider stops supplying or delivering oxygen or an oxygen delivery system to a particular patient. The bill also requires that notification be given if and when the system has been removed from the residence. Another interesting bill in **New Jersey** would require the emergency department of a hospital to have on hand the necessary monitoring devices, supplies and equipment to meet the needs of patients of all ages. The provisions also reference the need to follow Pediatric Equipment Guidelines, then mentions the organizations that endorse these guidelines, including the AARC.

New York- enacted a law to set up a rural telehealth demonstration project. Among the details the new law lists the diagnoses for patients to qualify for this service, including COPD. **New York** also has a bill that would establish a detailed Asthma Prevention Plan. Among the practitioners listed as providers of the education of patients and families are RTs.

COPD Awareness Month/Day
A number of states have introduced or passed Resolutions designating November as COPD Awareness Month or Day: **Alabama (adopted); California (adopted), Florida (adopted);Georgia (adopted), Illinois (adopted), Indiana (adopted), Iowa (adopted), Louisiana (adopted), New Jersey, South Dakota (adopted).** FYI **Florida and North Carolina** have also recognized efforts of their states COPD Coalitions.

Respiratory Related Rules/Regulations
A change in the rules and regulations for respiratory therapy may have just as much impact on how respiratory therapists practice as does amending the licensure laws for RT.

California among other changes, new rules amend addressing disciplinary guidelines, citations, fines and fees.

Florida updates on-line applications and addresses CEs for CRT license

Georgia defines the availability of the medical director in the workplace. Also defines who can set up CPAP, and BiPAP, Bi-Level support or any respiratory assist device with or without oxygen.

Iowa makes changes to the license renewal process

Maryland adopts guidelines which will be used by the Board of Physicians in sanctioning licensed respiratory care practitioners. Also a **Maryland** rule that requires
oxygen providers to be Medicare-accredited providers as a condition of Medicaid enrollment.

Nevada amends rules governing investigations concerning practitioners of respiratory care (and perfusionists) who test positive for exposure to the HIV virus.

New Hampshire revises and clarifies the rules regarding the reinstatement of the RT license that has lapsed for more than 6 years when licensees have been active in the profession in another state. Also another **New Hampshire** rule that specifies the documents which applicants for initial licensure must provide in support of their applications.

Pennsylvania makes technical changes to the RT (and physician assistants) rules regarding licenses, certificates and registrations.

Rhode Island establishes standards for the licensure of respiratory care practitioners.

Concerns or Challenges from Other Occupations

As noted in previous Updates, there is a growing trend in the states to legally expand the clinical services that practitioners of other disciplines may provide. A number of these disciplines are not licensed by the state. This expansion is occurring regardless whether or not these individuals have had formal training or valid competency testing. This trend may result from a combination of factors: a shortage of licensed health professionals; the de-regulation spirit as previously noted; the well-intentioned but perhaps short sighted attempt to create an expanded job market or the desire on the part of state governments to reduce budgets by utilizing less costly personnel.

Whatever the reasons, this trend is growing and needs to be closely monitored by the state societies.

Oregon a bill was enacted earlier this year that expands the scope of services of medical assistants. In spite of concentrated efforts by the RC Society of Washington to remove "respiratory testing" as one of the expanded services, this provision remains in the new law. The state regulatory agency is moving quickly to write implementing regulations. The leadership of the WA Society will be involved in the rule writing process providing input and rationale to limit to the extent possible the RT tests to be included.

Massachusetts legislation permitting home health aides to administer inhaled meds as delegated by RNs was introduced. The legislation requires the aide to have "completed training on medication administration". The bill, however, leaves open, just what type of "training" will be acceptable.

Sleep Disorder or Polysomnography State Legislative Activities

Since the July Update activity from the sleep disorder sector has been relatively quiet. This simply may be due to the fact that most legislatures have recessed for the year.

New York two years after enacting a law that "authorizes" sleep personnel to provide services, final regulations have been issued. While the law does not officially license sleep personnel its authorization requirements include training, testing and payment of fees ($300 for a triennial license) which mirrors the standard license requirements. As we understand the NY polysom law, the scope of practice is a carve out form the RT law. And, again as we interpret the rules, RTs under their own license will be permitted to provide the services

describe as polysom services. The polysoms will be regulated under the RT Licensure Board. We will closely monitor the implementation of this new law.

Minnesota While nothing is official as of yet, the Minnesota Society has received information that the Minnesota Sleep Society is preparing to approach the legislature to enact polysom licensure legislation in the 2013 session. The MN Society is already closely monitoring and preparing to engage in discussions with interested parties should this effort move forward.

I will provide verbal updates at the November Meeting.

NORTH CAROLINA RESPIRATORY CARE BOARD
1100 Navaho Drive, Suite 242
Raleigh, NC 27609

AN OPEN LETTER TO THE NORTH CAROLINA RESPIRATORY CARE COMMUNITY CONCERNING BACCALAUREATE AND GRADUATE RESPIRATORY CARE EDUCATION --

The North Carolina Respiratory Care Board has been charged by the General Assembly with responsibility to ensure the competency of respiratory care in this state and to protect the citizens of North Carolina from the unqualified practice of respiratory care. In keeping with this responsibility, the Board is issuing this letter to address the need for more intensive educational programs for Respiratory Care Practitioners (RCP's). The increasing demands on the practice of Respiratory Care require careful attention to the clinical skills that will be necessary for future practice.

There are over four thousand practitioners in North Carolina who have been nationally credentialed and have become licensed by the Board. Like the 100,000 RCP's across the United States, North Carolina RCP's work with patients of all ages and in many different care settings. RCP's work in hospitals where they perform intensive care procedures in the adult, pediatric and neonatal critical care units, and are typically a vital part of the hospital's lifesaving response team that handles patient emergencies. They also are a vital part of the health care team that provides respiratory care for patients with heart and lung disorders in many non-institutional settings.

Wherever they practice, RCPs are expected to participate in the development, modification and evaluation of care plans, protocol administration, disease management and patient education. The continued growth and advancement of the profession, and the expectations placed on RCP's will require that every RCP demonstrate an advanced level of critical thinking, assessment and problem solving skills. These skills are essential in today's health care environment not only to improve the quality of care, but also to reduce inappropriate care and control costs.

The associate degree programs have been the foundation for the respiratory care profession and do an outstanding job in providing the initial training of many practitioners in the field, but there is an increasing need for RCP's with advanced credentials and education who can take on leadership roles, including research, education, management, as well as advanced clinical diagnostic skills. Therefore, the Board supports the development of baccalaureate and masters level education in respiratory care.

There is currently one baccalaureate level education program in respiratory care at the University of North Carolina at Charlotte. In order to meet the current and future need for RCP's with advanced credentials and education, the Board supports the establishment of at least two more similar programs in the state to accommodate selected graduates of the 14 associate degree programs in the state. The Board also supports the establishment of a Clinical Masters Respiratory Care program in the state
to provide a midlevel Clinical Respiratory Care Practitioner who can function as a clinical assistant to physicians such as Pulmonologists, Anesthesiologists, Hospitalists and Intensivists.

The Board also plans to explore several amendments to the Respiratory Care Practice Act which would:

allow for the associate level respiratory care graduate who has passed the Certified Respiratory Therapist (CRT) exam to practice with a basic / provisional license under the direct supervision of an active / advanced licensed RCP. The provisional licensee would be limited in the procedures that he/she may perform.

require the associate level graduate to successfully pass the Registered Respiratory Therapist (RRT) exam and complete a baccalaureate degree in respiratory care or other health services related degree within a set period of time, such as 5 years.

allow RCP's who have passed the RRT exam and completed a baccalaureate degree in respiratory care or other degree program approved by the Board to practice advanced procedures such as ECMO, moderate sedation, protocol development, respiratory care consult, ventilation management, and advanced medication administration such as moderate sedation, nitric oxide administration, and prostaglandin administration.

grandfather those individuals that are currently licensed as RCP's on the effective date of the statute.

In conclusion, the Board believes that the establishment of baccalaureate level education programs in respiratory care and the requirement of a baccalaureate degree in respiratory care as the minimum entry level for advanced practice is needed to advance the respiratory care profession and improve patient outcomes. The Board also supports the development of masters level respiratory care education programs for clinical practice, education and management.

The Board is issuing this letter to start a dialogue within the respiratory care community about these critical issues for the future of our profession.

On behalf of
The North Carolina Respiratory Care Board:

_____

Floyd E. Boyer, RCP Executive Director

Approved by the NCRCB 7/19/2012

Federal Government Affairs
Activity Report – November 2012

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

The Congress

This Federal Update Report is due prior to the November 6th general elections. The outcome of the elections - in particular which political party will win the Presidency and what will be the Republican/Democratic makeup of the House and Senate - will determine the direction of the nation's health care policy for the next several years.

We will be meeting with you two days after the election and at that time we should be able to provide some general assessments of what might and might not unfold as a result of the election.

Regardless of the January 2013 configuration of the White House and Congress, there remains unfinished business that this current Congress will address during a Lame Duck Session. The question still remains how Congress and President Obama will tackle the extension or elimination of the Bush tax cuts set to expire December 31. Moreover, if Congress does not act (as it has for the past 9 years) physicians accepting Medicare patients will face an over 25% reduction in reimbursement starting January 1, 2013. Then there is the issue of extending or "fixing" the federal debt ceiling which also must be addressed before January 1, 2013. If no action is taken, then an automatic "sequestration", i.e., an across-the-board cut of 8.4% for most federal programs occurs (including the FDA, CDC, NIH, and certain programs of the Department of Defense). State Medicaid payments, State Children's Health Insurance Programs (SHIP) coverage, and Veterans benefits are spared any cuts. However, there would be a 2% reduction in reimbursement for all Medicare services. Clearly Congress will not be finished with its work even after the elections are over.

Legislation

The Medicare Respiratory Therapy Initiative

The AARC's Congressional advocacy efforts remain focused on legislation that will expand patient access to respiratory therapists in the physician's office. The Congressional Budget Office (CBO) scored our last attempt HR 941 very high which makes the bill undesirable for co-sponsorship and un-passable. As you are aware, we have refuted the CBO score and asked for further explanation. This was received by CBO thanks in large part to the bill's sponsors and relationships in Congress developed by our PACT representatives. Accepting that CBO will not change their position on the current legislation has led us to revise the language of the bill to tighten up the provisions, while keeping the intent of HR 941.

Senate Legislative Counsel has drafted a new bill based on specifications provided by AARC which we hope to get introduced in the Senate following the elections. The focus will be on chronic disease management services with particular emphasis on patient self-management education and training. The timing of this new direction is critical given the increased emphasis on hospital readmissions. We believe the revisions made to the RT initiative will be advantageous to RTs as it will place greater emphasis on the importance of the care they provide to pulmonary patients. We are working with those who have supported AARC in the Senate but will need to identify new House leaders to carry the ball for us as Congressman Mike Ross (D-AR) will not be returning.

AARC Capitol Hill Lobby Day

This upcoming March 2013 will mark the 14th consecutive year the AARC, partnering with our state societies and patient organizations, will once again have a Capitol Hill Lobby Day. We are scheduled to be in DC March 11-12th with Tuesday the 12th being Hill Day.

As noted in our July Update we are refiguring and revising the provisions of our Medicare Respiratory Therapy Initiative to focus on a set of chronic disease management services provided in a physician's office/practice by respiratory therapists. As with any new Congress (January is the start of the 113th Congress) and with any new bill, our draft language will need to be introduced and be assigned a bill number. Our revised Respiratory Therapy Initiative will be the main agenda item for our Hill Lobby Day.

Virtual Lobby Week

As part of the lead up to our Hill Lobby Day, the AARC also sets in motion our Virtual Lobby Week just prior to the RTs and our patient partners coming to Washington, D.C. This event is where we generate nationwide support from RTs, patients and caregivers to email their members of Congress in support of our legislative agenda. Of course, we will again be organizing and getting the word out for respiratory therapists, patients and supporters of the profession to do the same in 2013.

Technical Change to Medicare Outpatient Pulmonary Rehabilitation Benefit - Update

As previously reported, Senators Schumer (D-NY) and Crapo (R-ID) earlier this year introduced S 2057, a no-cost technical amendment that would permit physician assistants, nurse practitioners, and clinical nurse specialists to supervise pulmonary and cardiac rehabilitation programs consistent with other Medicare outpatient therapeutic supervisory requirements. The last update was referral to the Committee on Finance. It will most likely have to be re-introduced in the 113th Congress. The legislation is being supported by the pulmonary multi-societies/associations and AARC.

New Alternative to Competitive Bidding Introduced – HR 6490

Recognizing that the Medicare competitive bidding program had little chance of being repealed, the home medical equipment (HME) industry has successfully lobbied the introduction of a new replacement known as the Market Pricing Program (MPP). Called the "Medicare DMEPOS Market Pricing Program Act of 2012", the bipartisan bill was introduced on September 21, 2012 by Rep. Tom Price (R-GA) together with 13 co-sponsors. AARC has sent a letter of support for the new bill to Rep. Price.

One of the biggest flaws in the current competitive bidding program is the fact that the contracts are non-binding and that there are no safeguards to ensure that the winning bidders are qualified to provide the required equipment. The new program aims to fix that by achieving an accurate market price, making the bids binding, requiring cash deposits so only those who are serious about the program actually bid, making the bid areas smaller and limiting only two product categories per bid per geographic area. The same items and services currently subject to competitive bidding remain the same and those areas that are exempt under the current program will also be exempted under MPP.

Coalition Activities

The AARC continues its practice of participating in a number of Coalitions of like-minded associations and organizations to advance particular legislation and/or regulations. In previous years our participation with certain Coalitions was focused on urging greater funding for health and/disease research to promoting issues that will enhance the clinical support of patients with particular illnesses. Over the past two years Coalitions have urged Congress not to cut funding for specific programs during the appropriation process.

This year, because the concerns are mounting over the real possibility of major reductions (8.4%) in funding for key programs, (i.e. the sequestration mandate if debt ceiling is not raised), Coalitions have been organizing

grassroots efforts to send the message to Congress about the dire consequences that sequestration will have on critical research programs.

Coalition for Health Funding

We continue to support the efforts of this broad-based Coalition which is a nonprofit alliance working to preserve and strengthen public health investments. The focus at the moment is on the potential sequestration of the appropriations for the National Center for Health Statistics, research funding at the NIH as well as research done and services such as immunizations performed by the CDC.

Joint Letter Opposing Exemption for Primatene Mist

The AARC joined with many other medical and public health organizations in signing on to a letter to Congress to oppose legislative efforts to lift the ban on the sale of over-the- counter Primatene Mist. After many years of fair warning that this product would be removed from the market last December 31, 2011, significant headway is occurring in Congress to lift the ban and put the medication back on the shelves of retail pharmacies. The AARC joined with the ATS, ALA, COPD Foundation, Alpha-1 Association, Asthma and Allergy Foundation of America and numerous other organizations to oppose this effort. Unfortunately legislation that would allow the stockpile of Primatene mist to be sold has moved through Committee but is unlikely to pass.

Tobacco Partners

The AARC continues its long-time relationship with the many organizations who participate in the Tobacco Partners Coalition (a Coalition organized and supported by the American Heart Association, the American Lung Association and the American Cancer Society). The Coalition's recent activities have been to appeal to Congressional Committee leaders to continue to support FDA funding of the Centers for Tobacco Products at the full authorized level and reject any efforts to weaken its authority and to stop an amendment being considered by the House Appropriations Committee to exempt "premium" cigars from FDA oversight. Cigars which appeal to a younger population that are packaged to attract their attention and use could end up being exempt from regulation if this amendment is passed.

Another concern of the Coalition is the recent decision by the US Court of Appeals for the DC Circuit Court that struck down the graphic cigarette warning labels which were to have been required of all manufacturers this year. Only one other appellate court has considered this issue, and that court upheld the use of graphic warnings, making this issue one that most likely will end up with the US Supreme Court.

National Heart Lung and Blood Institute (NHLBI)

Miriam O'Day represented the AARC at the recent joint NHLBI and NIH Public Interest Organization (PIO) meeting where key policymakers from both agencies hear from a variety of interest groups on the areas where these organizations believe these two key federal research organizations should focus more intense research.

Miriam is also serving on the planning committee for a Congressional Reception to be held mid December for the new Director of the NHLBI, Dr. Gibbons.

Regulations and Other Issues of Interest

Updates to the Medicare physician fee schedule and inpatient and outpatient prospective payment systems, which are the primary vehicles for policies affecting the pulmonary community, are generally proposed in the spring and finalized in early fall. Only the inpatient PPS regulations have been finalized at the time of this report. We expect the physician fee schedule and outpatient PPS regulations will most likely be out by the time of our November meeting and we will give a verbal update if there are any significant changes to those that have been proposed.

FY 2013 Update to Inpatient PPS – Final Rule

The key provisions to the FY 2013 update to the Inpatient PPS regulations that will impact respiratory

therapists involve implementation of the Value-based Purchasing Program and the Hospital Readmission Reduction program, both of which have been discussed in earlier Board reports and are effective for services on or after October 1, 2012. To recap:

Value-Based Purchasing
Value-Based Purchasing tracks a hospital's performance compared to other hospitals across the country as well as improvement within each individual hospital's system. Performance in FY 2013 is based on quality measures for 5 conditions or procedures – heart attack, heart failure, pneumonia, surgical care and healthcare-associated infections (no respiratory HAIs at this time). Patient experience with the care measures is also factored in.

With respect to pneumonia, respiratory therapists will have the chance to play an important role in how well their hospitals perform in terms of receiving incentive payments. This opportunity will increase when a thirty-day mortality measure for pneumonia becomes effective in FY 2014. A similar value-based payment modifier will be used to provide incentive payments for physician groups beginning in FY 2015. A number of respiratory quality measures have been proposed under that program.

On September 19, The Joint Commission released a report on how well hospitals have done in reporting quality measures including pneumonia, and provided a list of 620 hospitals they consider to be "top performers". An article with links to the JC report/list is available on the AARC.org website.

Hospital Readmissions Reduction Program
With regulations now final, CMS will begin reducing payments to hospitals that have excess readmissions within 30 days of discharge for three selected diagnoses: heart attack, heart failure and pneumonia. The maximum penalty in the first year amounts to a 1% reduction of the base operating DRG payment amount (the payment that would have been made for a discharge in the absence of the Program) using data from July 1, 2008 to June 30, 2011. The Kaiser Family Foundation reports that 278 hospitals will face the maximum penalty in the first year of implementation with 1,933 hospitals receiving less than 1%. The reduction is set to increase to 2% in FY 2014 and capped at 3% for FY 2015 and beyond.

The Accountable Care Act (ACA) authorizes expansion of the list in FY 2015 for conditions that represent high costs and high volumes of readmission. Chronic obstructive pulmonary disease is likely to be proposed, but any new additions must first receive approval from a multi-stakeholder group, the Measure Application Partnership, prior to formal rulemaking. If our Part B initiative is enacted, it will place respiratory therapists at a critical juncture in the physician office to provide chronic disease self-management education and training that has the potential to limit the number of hospital readmissions.

Pulmonary Rehabilitation
As reported earlier, CMS has proposed that the new payment rate per session for pulmonary rehabilitation for calendar year 2013 in the hospital outpatient department will be $39.58. AARC and other pulmonary organizations continue to educate hospitals on how to accurately set the charges for the single bundled PR code in an effort to improve over time the overall payment rate. There is a chance that the 2013 proposed rate may be somewhat higher when the final rules come up because CMS will have reviewed additional data which they will take into consideration in setting the final rate.

New DME Face-to-Face Provisions Proposed
As part of the Physician Fee Schedule update for FY 2013, CMS is proposing to implement a face-to-face requirement as a condition of payment for certain high-cost DME covered items as a way to help combat fraud and abuse and reduce improper payments in DME items. It is one of the anti-fraud requirements in the ACA and is consistent with similar face-to-face requirements under the home health and DME benefits.

Specifically, CMS is proposing to require that the physician have a face-to-face encounter no earlier than 90 days prior to each written order for a covered item of DME or within 30 days after the order is written. Options for documentation are also proposed when the face-to-face encounter is conducted by a nurse practitioner, physician assistant or clinical nurse specialist. Oxygen and respiratory equipment are items that are subject to this new requirement.

DME Items Provided on a Recurring Basis and Refill Requirements

In August 2011, CMS set forth certain documentation requirements for DME items needing replacement or refill. CMS received numerous comments given the range of products subject to these requirements and as a result issued clarifications to its policy in June 2012. One such clarification is documentation for non-consumable supplies, such as PAP and RAD supplies that may need periodic replacement. In such cases, the supplier has to document its assessment as to why the supply is no longer functional before a replacement can be requested. This set off a new round of comments since many viewed this explanation to be very subjective based on conversations with the beneficiary rather than visual assessment.

On August 31, 2012, CMS issued a set of questions and answers to address these concerns. To be "non-functional" means that the item is no longer able to be used safely or effectively for the purpose for which it was intended. Examples include breakage, wear, soiling or contamination that is unable to be removed with recommended cleaning. Justification that may not result in replacement includes a CPAP mask leak that is due to ill-fitting or incorrectly worn interface rather than the leak due to a non-functioning mask.

LCD for Oxygen and Oxygen Equipment Revised

DME Medicare Administrative Contractors (DME MACs) announced new revisions to their LCD on oxygen/oxygen equipment effective October 1, 2012. A key revision is to add a section on cluster headaches in conjunction with CMS' national coverage decision. Other changes are to clarify that home sleep testing requirements are limited to stand-alone overnight pulse oximetry and to expand qualification testing for high liter flow to greater than or equal to 4 LPM.

Conclusion

The results of the election may have a profound effect on the future directions of the Medicare and Medicaid programs and national health policy overall. Regardless of elections, the AARC will continue our efforts on Capitol Hill to advance our legislative agenda. We believe our increased efforts to partner with patient organizations and other like-minded associations will provide forward momentum in achieving our goals. We will also maintain our vigilance on the regulatory side responding to both challenges and opportunities.

HOD Report

Reporter: Karen Schell

Last submitted: 2012-10-03 11:48:08.0

Recommendations

No Recommendations at this time

Charges

1. Preside at all meetings of the House: ***Completion November 9, 2012***

    1. Prepare an agenda for each meeting and submit to each delegation - ***Completed***
    2. Appoint Parliamentarian – ***Completed***
    3. Appoint the chairs and members of the House Standing and Special committees – ***Completed***
    4. Remove the chairs and members of the House Standing, special, and elected committees – ***Ongoing as needed***
    5. Invite persons other than delegates to participate in House activities – ***Ongoing***
    6. Be an ex-officio member of all House committees except the Elections Committee - ***Ongoing***
    7. Serve as Chair of the House Executive Committee – ***Ongoing***
    8. Perform other duties as authorized - ***Ongoing***

REPORT

- Speaker of the HOD has worked closely with the AARC office updating the HOD roster with new delegates, calendar of time lines, current photographs, HOD AARConnect, and HOD AARConnect Committees on a timely basis to improve communication and access to information for the HOD members. As the results of each Affiliate elections come in, names are forwarded to the AARC office for quick update. Conference calls occurred with the AARC CEO, Tom Kallstrom, Sherry Milligan, and Tina Sawyer to keep informed and updated on a regular basis.

- House officers worked with assigned committees to keep goals on track and be available for assistance as needed.

- AARConnect continued to be a major communication tool used for committee work and communication.
- Committee work continues with assigned committee goals and work continues on AARConnect for ease of communication and progress of goals.
- Speaker has developed clear instructions and communication between officers, committee chairs and members with posted charges on each committee in AARConnect with follow-up on a regular basis. Working on timely completion of projects and assignments, improving processes and improve communication of information from the BOD.

Update on Speaker Goals and Major achievements for the year:

- Goal #1 – Communication
    - Committee chairs and officers have been working through AARConnect to achieve specific goals. AARConnect has worked well for committees to keep informed and updated.
    - Policies revisions are being updated to reflect current practices and approved by the HOD with ongoing policies to continue to be developed as needed. The committee has done a wonderful job!
    - Big list update continues for delegations to report back to their affiliates and posted to delegates through AARConnect.
    - Continue to work with BOD to facilitate communication – Tom Kallstrom, Speaker and staff hold phone calls, HOD officers attending BOD meetings.
    - Committee chairs were provided opportunity for conference calls by the AARC Executive office when requested to assist in facilitating communication as needed.
    - AARC Executive office assisted Speaker in keeping current lists, calendars, and time lines accurate.
    - Committee chairs have kept speaker informed of progress on specific goals via AARConnect and personal emails.
    - Speaker available for consultation through emails, phone calls, and personal contact.
- Goal #2 – Engaging and involving HOD members
    - Speaker performed regular communication with AARConnect with HOD members.
    - House Officers were on AARConnect with each committee to keep informed and oversee communication of the committees.
- Goal # 3 – Volunteering
    - Develop and promote activities through the AD HOC Committee
    - Work with AdHoc Committee on Connections developing opportunities to volunteer, article pending for the AARC Times
    - Speaker and Delegate from Kansas volunteered for Honor Flight after request from John Hiser at the Summer meeting
    - Committee working on helping performing PFT screening at International Congress.
- Goal # 4 - Mentoring
    - Continue to develop and promote student and professional volunteering through appropriate committees.
    - Students attending HOD meetings in Santa Fe and New Orleans
    - Ongoing communication through email and phone conversation to mentor the development of incoming Speaker Elect and facilitate his transition to Speaker
- Goal # 5 – Informing
    - Promote the HOD work and members through the AARConnect, AARC Times, web page and give opportunity for feedback
    - Article in AARC Times on Best Practices through the HOD
    - Posting Best Practices for all affiliates to access through the AARC Web page
    - Develop and encourage HOD roles with clear directions and understanding of responsibilities

    - Consult with Past Speaker, AARC Executive Office, and BOD members as needed to provide direction clarify any questions I may have regarding policies and procedures
- Goal # 6 – Fund raising
    - Encouraged delegations to consider contributing to the AARC Disaster fund and International Fellows fund through AARConnect due to natural disasters occurring before the summer meeting.
    - Appeal on AARConnect again prior to the Winter meeting.
    - Consider specific fund raising projects to promote the common good among our members.
- Goal #7 – Have Fun doing goals 1-6!

Other

Thank you to HOD Members, BOD, and HOD Officers for making 2012 a successful year. It was a joy working with everyone promoting the profession of Respiratory Care and your support has been greatly appreciated.

Respectfully Submitted, Karen Schell, Speaker HOD 2012

Board of Medical Advisors Report

Board of Medical Advisors (BOMA) Report for the 2012 Board Meeting of the American Association of Respiratory Care (AARC) 10-13 November 2012 at the International Congress in New Orleans, LA.

It was noted that Dr. Cliff Boehm's membership in BOMA will expire at the end of 2012. Dr. David Kelley has been appointed as the new ASA representative. The initial meeting of the committee will occur in conjunction with the International Congress of the AARC in Tampa Florida. Sam Giordano has retired as CEO and Executive Director of the AARC, however, he will remain involved as a consultant. Tom Kallstrom accepted the position as the new CEO and Executive Director. Tim Myers has joined AARC as the Associate Executive Director.

National Board for Respiratory Care President Kerry George highlighted significant changes to the respiratory therapy credentialing system beginning in 2015, including a single multiple choice exam with separate passing points for the CRT credential and eligibility for the Clinical Simulation Examination which will encompass a larger number of shorter simulation problems.

Tom Smalling, Executive Director of CoARC expressed concern regarding the excessive number of respiratory therapy schools, and Dr. Carey recommended the formation of an Ad Hoc Committee to place information on the different schools on their website specifically listing benchmarks such as first time board examination pass rates, job placement, and faculty strengths/weaknesses.

Tom Kallstrom lead a discussion regarding attendance at the BOMA Summer Meeting. It was decided to hold a Fall 2012 Webinar as a possible alternative to a face-to-face summer meeting. Unfortunately, a quorum was never achieved for the Webinar; therefore, the BOMA Summer Meeting will continue.

Respectfully submitted,

Lori D. Conklin, M.D.
Chair of BOMA
ASA Delegate to BOMA

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

Minutes

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

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

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

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

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

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

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

INTRODUCTIONS
Chairman Conklin asked members to introduce themselves.

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

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

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

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

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

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

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

RECONVENE
Chairman Conklin reconvened the meeting of the AARC Board of Medical Advisors at10:32a.m. CDT, Saturday, June 9, 201

EXECUTIVE DIRECTOR REPORT

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

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

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

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

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

Motion Carried

LEGISLATIVE AFFAIRS REPORT

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

RECESS

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

RECONVENE

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

MEDICAL ADVISOR REPORTS

Some BOMA Members gave updates on their sponsoring organizations.

SPECIALTY SECTION REPORTS

The Specialty Section Reports were reviewed.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Patient Safety and Respiratory Care Staffing Standards Position Statement

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

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

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

President`s Council

Submitted by Margaret Traband

Recommendations

No Recommendations

Report

The President’s Council voted to award Life Membership to Richard M. Ford, BS, RRT, FAARC, Administrative Director, Respiratory Services, University of California, San Diego Medical Center. Life Membership will also be awarded to Timothy Myers, MBA, RRT-NPS, Past President of the AARC. Honorary Membership will be awarded to Miriam A. O’Day, Director Legislative Affairs, American Association for Respiratory Care.

Other

The President’s Council will meet on Sunday, November 11, 2012 to discuss topics that are of critical importance to our profession. The Council will also honor individuals who have received the above mentioned awards along with honoring the Jimmy A. Young Medalist.

Standing Committee Reports

Audit Sub-Committee

John Steinmetz

No report

Bylaws Committee Report

Recommendations

Recommend that the AARC BOD accept and approve the Bylaws of the Alabama Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Iowa Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Maine Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Mississippi Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Nebraska Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Puerto Rico Society for Respiratory Care (see attachment)

- If approved, the PRSRC will be assisted in preparing a clean copy for the Executive Office. The Committee asks for your forbearance, as these bylaws have never been reviewed since their initial submission in 1975, because the PRSRC President and Delegate are working with English as a second language, and because the Committee Chair was unsuccessful in reworking the copy submitted to the Committee.

Recommend that the AARC BOD accept and approve the Bylaws of the Rhode Island Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the South Carolina Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Tennessee Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Utah Society for Respiratory Care (see attachment)

Recommend that the AARC BOD accept and approve the Bylaws of the Wyoming Society for Respiratory Care (see attachment)

Recommend that the AARC BOD find the Texas Society for Respiratory Care in violation of Chartered Affiliate Policy CA.007

Justification: The Texas Society for Respiratory Care (TSRC) is in violation of the requirements of CA.007 to:
Submit a plan for bylaws approval within 6 months of initial notification. Said notification occurred in Jan 2012
Submit bylaws every 5 years for review

Recommend that the AARC BOD appoint an ad hoc committee to address the current imbalance in the 5-yr review cycle

Justification: Over several years since the initial determination of the review cycle, a number of affiliates were not reviewed in their scheduled year. This has led to an imbalance in the scheduled dates of review. The attached Bylaws Status Table.xlsx shows what the approval cycle will look like if all submitted bylaws are approved this year. An amendment to CA.007 may be needed to reset the cycle.

Report

The AARC Bylaws Committee reviewed and approved 17 of 18 affiliate bylaws due this year, plus South Carolina.

The Texas SRC is the only affiliate presently out-of-compliance with AARC Policy CA.007.

Other

I would like to commend the members of the Bylaws Committee for outstanding work this year. The committee was faced with the daunting task of ensuring all affiliates had the help they needed and the opportunity to submit their bylaws before the provisions of CA.007 were enacted. They did a great job, especially with the rush of submissions at the end of the year!

I specifically thank Tim Myers for his wisdom, Toni Rodriquez for her blazing fast speed when she took his place late in the year, Doug McIntyre for his prompt reviews all year long, and Susan Rinaldo-Gallo for her calming influence.

To Lori Shoman, Jim Lanoha, and Terry Gilmore, thank you so much for your support and comments and gittin'er done this year. You rock! Good luck next year, Terry!

Elections Committee Report

Recommendations

The Committee recommends the following statement be added to Policy CT.003 (Elections Committee – Nomination Process [see below]), "The Committee's goal will be to have a minimum of two qualified members for each elected position".

Report

The slate of nominees approved by the BOD and HOD was submitted to the general membership for vote. The Ballot count was made and the results were certified on October 4, 2012 by Jim Lanoha, AARC Elections Committee Chair, Karen Stewart, AARC President, and attested by Sherry Milligan, AARC Elections Committee Liaison. The results are as follows:

CERTIFICATE OF BALLOT COUNT

THIS IS TO CERTIFY that a count was made of the 2013 general election ballots for AARC Officers and Directors at Large on October 4, 2012. The following is certified as the official count:

OFFICERS VOTES %		DIRECTORS AT LARGE VOTES %	
Vice President for Internal Affairs		Curt Merriman, BA, RRT, CPFT	921/29%
Bill Lamb, BS,RRT,CPFT,FAARC	895/41%	Sherri Tooley, BSRT, RRT-NPS, CPFT	1213/39%
Brian Walsh, MBA,RRT-NPS, FAARC	1268/59%	Gary Wickman, BA, RRT, FAARC	975/31%
Vice President for External Affairs			
Patricia Blakely, RRT, FAARC	956/45%		
Colleen Schabacker, BA, RRT, FAARC	1179/55%		
Secretary-Treasurer			
Frank Salvatore, MBA, RRT, FAARC	1077/50%		
James William Taylor, PhD, RRT, FAARC	1063/50%		

1. Brian Walsh was elected Vice President for Internal Affairs with 1268 votes for 59% of the votes.
2. Colleen Schabacker was elected Vice President for External Affairs with 1179 votes for 55% of the votes.
3. Frank Salvatore was elected Secretary with 1077 votes for 50.3% of the votes.
4. Sherri Tooley was elected Director at Large with 1213 votes for 39% of the votes.
5. Gary Wickman was elected Director at Large with 975 votes for 31% of the votes.

Write-in candidates for Officers received no more than _1_ vote(s) each.
Write-in candidates for Directors received no more than _1_ vote(s) each.

CERTIFICATE OF BALLOT COUNT

THIS IS TO CERTIFY that a count was made of the 2013 sections election ballots for AARC Specialty Sections Chairs-elect on October 4, 2012. The following is certified as the official count:

	VOTES/
Home Care Section	
Kimberly Wiles, BS, RRT, CPFT	*104/99*
Neonatal-Pediatrics Section	
Kathleen Deakins, MHA, RRT-NPS, FAARC	*60/27*
Natalie Napolitano, MPH, RRT-NPS, FAARC	*160/72*
Sleep Section	
Craig Johnston, BBA, RRT, AE-C	*24/23*
Russell Rozensky, BS, RRT-SDS, RPSGT, CPFT	79/75

1. Kimberly Wiles was elected Chair-elect of the Home Care Section with 1047 votes for 99% of the votes.
2. Natalie Napolitano was elected Chair-elect of the Neonatal-Pediatrics Section with 160 votes for 72% of the votes.
3. Russell Rozensky was elected Chair-elect of the Sleep Section with 79 votes for 75% of the votes.

Write-in candidates for Home Care Section received no more than _1_ vote(s) each.
Write-in candidates for Neonatal-Pediatrics Section received no more than _1_ vote(s) each.
Write-in candidates for Sleep Section received no more than _1_ vote(s) each.

I want to thank the committee members Ross Havens, Jacklyn Grimball, Doug McIntyre, Tim Meyers and Toni Rodriguez, as well as, Sherry Milligan and Beth Binkley, committee liaisons from the AARC executive office for their hard work.

American Association for Respiratory Care
Policy Statement

Policy No.: CT.003

SECTION: Committees

SUBJECT: **Elections Committee – Nominations Process**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 22, 2011

DATE REVISED: July 22, 2011

REFERENCES: AARC Bylaws, CT.005, and Delegate Handbook

Policy Statement:

The process used to prepare a slate of candidates for Association offices and to conduct elections shall be in accordance with the following revision from AARC's July 2011 BOD meeting.

Policy Amplification:

1. An official nomination form must be submitted for each nominee.

2. Each nominee shall be notified of the location on-line where they can find the requirements of the Elections Committee in order to continue in the elections process with full instructions and the submission deadline date.

3. All candidates shall submit information (e.g., answers to questions. **Biographical form**) required of all nominees with a defined date of return to the Executive Office for preparation and publication in the appropriate publication to provide the general membership with additional information about the candidates.

4. An AARC Officer or Director shall not hold a paid or voluntary position of authority for or in any AARC Chartered Affiliate during his/her term of office as an AARC Officer or Director. Candidates holding such positions must submit in writing a plan for resolution of any conflict of interest prior to Election Committee consideration of candidates.

5. Questions will be derived from HOD/BOD input, and organized/compiled by the Elections Committee. Nominees will respond via mail, e-mail or fax to the Executive Office according to established timelines.

6. The administrator/supervisor of each nominated individual must submit written certifying support for the candidate's nomination and time commitment for AARC responsibilities.

7. The Elections Committee members, under the guidance of the Committee chair, will review the compiled data, assess qualifications, rank, etc. Once the data is compiled, it will be sent to each committee member, followed by a telephone conference, and the committee will decide upon a slate of candidates.

8. All nominated individuals shall be notified in writing the outcome of their nomination.

9. All deliberations within the Elections Committee for preparation of the slate of candidates shall be performed in Executive Session and may not be discussed beyond the committee. Any committee member breaching confidentiality of the aforementioned deliberations shall be referred to the AARC Judicial Committee for appropriate action.

10. The Elections Committee Chair shall submit the elections slate in writing to the Board of Directors and the House of Delegates no later than June 1. This deadline for submission of nominees may be extended as necessary.

11. Voting will be by an online process with the order of candidate names randomly listed.

12. The Elections Committee Chair shall receive and review the layouts of the general election ballots and the biographical forms.

13. The Elections Committee shall forward a roster of all nominees for the AARC Board of Directors to the President and/or President-elect which would include all personal contact information for these individuals (i.e., e-mail, work address, work phone, etc.) for consideration in the committee appointment process.

14. Past speakers of the House of Delegates are eligible for nomination for Association officer positions to include Secretary-Treasurer, Vice President for Internal Affairs, Vice President for External Affairs and President-elect, provided that they will have completed their full term of office as speaker-elect, speaker and immediate past speaker sometime prior to the year for which they would serve as an Association officer.

15. Write-in candidates for Directors and Officers of the Board of Directors of the AARC must meet the minimum eligibility requirements for the office for which they have received votes.

16. The Elections Committee shall have the ability to extend the established nomination period by 20 days if a full slate of candidates for each position has not been obtained.

DEFINITIONS:
ATTACHMENTS: Biographical Form Guidelines (See Appendix)

Executive Committee

(Karen Stewart)

Finance Committee

(Karen Stewart)

Judicial Committee

Reporter: Patricia Blakely

Last submitted: 2012-09-24 15:21:06.0

Recommendations

There are no recommendations at this time

Report

The committee has not received any inquiries or formal complaints since the last BOD report.

Other

The committee is aware that Dr Toni Rodriguez has been added to the committee membership

Program Committee

Submitted by Cheryl Hoerr
October 2, 2012

AARC Congress 2012; The 58th International Respiratory Convention & Exhibition will take place November 10 – 13 in New Orleans, LA. The Program is currently posted on-line and in hard copy in the Sept. edition of the AARC Times. We will offer more than 275 presentations covering all aspects of Respiratory Care and other healthcare related topics. More than 325 abstracts are scheduled for presentation during 20 Open Forum sessions. Easy Street will open for proposal submission beginning in mid-October 2012. The Program Committee will convene early in 2013 (date still to be determined) to plan the 2013 Summer Forum which will be held in Orlando, FL and AARC Congress 2013 will take place in Anaheim, CA. The Program Committee sincerely thanks the BOD and AARC membership for their continued support and contributions to the program.

The Sputum Bowl is progressing as planned. There will be some new rule changes this year (ala "lifelines" from "Who Wants to be a Millionaire") to create additional drama and excitement for attendees and competitors alike. There will also be audience participation via ARS technology during the halftime event. Select members of the audience will get to compete against each other for bragging rights and small prizes. We encourage all members of the BOD to attend the competition to see the new changes.

Strategic Planning Committee

Reporter: Toni Rodriguez

Last submitted: 2012-10-04 15:26:00.0

Recommendations

[No Recommendations at this time]

In my role as temporary Past President I was not made aware of any pending activity for this committee. I have nothing to report at this time.

Toni L Rodriguez Ed.D, RRT

Past-President AARC

Joint Session
Board of Directors
House of Delegates

Joint Session: AARC BOD & HOD	K. Stewart, AARC President, K. Schell, Speaker
Roll Call	Karen Stewart, AARC President
CoARC	Dr. Kathy Rye, CoARC Chair
AARC ELECTIONS COMMITTEE	Jim Lanoha, Chair
GOVERNMENT AFFAIRS	Cheryl West, Miriam O'Day, Anne Marie Hummel
INTERNATIONAL COMMITTEE	John Hiser, Chair
American Respiratory Care Foundation (ARCF)	Mike Amato, Chair
Special Recognition	Karen Schell, 2012 House Speaker
Executive Session / 2012 Budget	Linda Van Scoder, AARC Treasurer
Consideration of HOD Resolutions Cont'd	Brent Kenney, Chair Resolutions Committee

Specialty Section Reports

Adult Acute Care Section

Reporter: Keith Lamb
Last submitted: 2012-09-14 22:38:03.0

Recommendations

1. That the BOD evaluate the feasibility of creating a Critical Care Clinic Fellowship syllabus and in conjunction with large academic centers, implement such a fellowship.

2. That the BOD evaluate the feasibility of creating and supporting a monthly critical care teleconference and potentially offering continuing education credits for participants.

A. Critical Care Clinical Fellowship

In an environment where it is expected that RCP's will be taking on more responsibility in the future, it is proposed that the AARC develop a comprehensive critical care training course of study that would provide the RCP with the skills needed to practice at a high level in critical care. This course of study would prepare the graduate for practice in large complicated systems, as well as smaller rural centers.

It is anticipated that this would be an effective means to train RCP's that are currently practicing in smaller centers, and allow them to return after completing their fellowship and practice at a higher level than previous, effectively making them physician extenders capable of taking on more responsibility in both their practice and as educators.

1) That the AARC establish a group to develop a post graduate clinical fellowship. This fellowship would be a comprehensive curriculum that would be centered around a strong critical care core. This would include but not be limited to subjects such as:

a) ACLS, PALS, NRP etc.

b) Infectious disease

c) Trauma/Surgical Critical Care

d) Cardiovascular Critical Care

e) Renal

f) Neuro/Neurosurgical Critical Care

g) Critical Care Pharmacology

h) Research

i) Pulmonary Critical Care

j) Airway management

k) Ventilator management

2) This fellowship could be developed to closely follow our Critical Care Specialty Study Guide which is currently under construction.

3) Once the curriculum is developed, large centers around the country (that would be capable of providing the above comprehensive curriculum) could be approached and a list of those centers that are interested in "hosting" a fellowship closely following the AARC's fellowship curriculum could be established.

4) Applicants for the clinical fellowship would have to satisfy some pre-requisites, that need to be determined: ie RRT, etc.

5) Once accepted into the fellowship (the duration of which would need to be determined (1 year – 18 months or so) the "critical care fellow" would travel to the "host center" and complete the fellowship.

6) In terms of financial obligation, it is recommended that guidelines be established similar to the following:

a) The "host center" would pay the "critical care fellow" the pay rate of a new staff therapist at that center.

b) The AARC would provide an educational stipend (amount to be determined) to the "fellow"??

c) Other fees etc could be determined for materials cost, licensing for the curriculum, etc.

B. Monthly Critical Care Teleconference

The Adult Acute Care Section has been hosting a monthly "skype" teleconference that has been developed to discuss both the monthly journal club article, and current case studies/clinical

issues as appropriate. Strong clinical relationships have been developed during these teleconferences, and it is anticipated that stepping this concept up a bit will help develop a network of interactive professionals that teach, learn and continue to consult each other between teleconferences.

Participation thus far has been limited due to; a) limits in available technology, and inability to "market" the concept and make it more appealing for the masses.

1) It is recommended that the AARC look into potential venues that would make this concept available on a larger scale.

2) Look into the possibility of awarding CEU's for participation in a one hour interactive Journal Club discussion and case study presentation/discussion.

3) That the access to the "teleconference" be made available to other sections in order to take advantage of their specific expertise as well, ie management and education sections.

Report

1) The AAC Section continues to hold our monthly journal club on-line as well as via teleconference.

2) The section continues to cooperate with other sections as needed with other projects.

3) The section continues to assist with the preparation of our critical care specialist exam preparation guide.

4) The Section represented the AARC in Shanghai China in August, by providing lectures at a mechanical ventilation conference, and by visiting a local hospital/ICU.

Respectfully Submitted,
Keith D. Lamb
Chair, Adult Acute Care Section

Continuing Care-Rehabilitation Section

Reporter: Debra Koehl

Last submitted: 2012-10-04 19:32:43.0

Recommendations

Recommend that the AARC pursue a more formal partnership with the AACVPR which has been recommended in the AACVPR report.

- A more formal relationship with the AACVPR can strengthen the respiratory therapist's position as the pulmonary rehabilitation professional.
- The AARC and AACVPR partnership would assist/enhance both organizations.

Report

- Continued support of AARC Uniform Reporting Manual development.
- Wrote article for AARCTimes
- Speaking at the MSRC meeting on the Pulmonary Rehabilitation Toolkit and PR Outcomes in October
- Will assist in transition of leadership to Gerilynn Connors
- Attended the AACVPR National meeting
    - Ran the pulmonary liasion meeting
    - engaged in conversation about the AARC and AACVPR professional relationship
- Continued monitoring of AARConnect content

Other

After serving 2 consecutive terms as the continuing care and rehab section chair, I would like to thank the staff of AARC for their support during my tenure. They were always available to answer questions and provide guidance as needed. Thanks also to the member of the BOD directors for their guidance as well.

Diagnostics Section

Reporter: Matthew O'Brien

Last submitted: 2012-10-04 16:46:55.0

Recommendations

None

Report

Charges:

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

•· In addition to the accepted proposals from the Diagnostics Section, this year's congress has a multitude of presentations that overlap well with the needs of diagnostic section members. We included a list of topics and speakers in our quarterly bulletin to help members decide which talks to attend. In all there are 36 presentations and 2 Open Forums that relate to our sections interest.

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

•· Our bulletin editor is Lisa Becker, is doing a great job at helping new contributors and polishing bulletin articles.

•· We are still in the planning stages for a diagnostic specific webinar for 2013.

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

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

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

•· In addition to this year's Specialty Practitioner of the Year, several new individuals have been identified.

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

•· Ongoing

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

•· Ongoing monitoring of site.

Education Section

Submitted by Joe Sorbello

October 2012

Recommendation:
That the Preceptor Training Program as developed by the Preceptor Training Subcommittee of the Education Section be accepted, at least in concept, as the AARC's Preceptor Training Program.

I have not heard any concerns or issues from the membership since the Summer Forum. The Education Section listserv has been relatively quiet and most discussions have included text book selection choices and curriculum content. I am about to propose that the Section be aware of and take action on the fact that the ARCF needs to increase its funding due to several factors, not the least of which is the U.S. economy. I will be proposing that the Education Section take the lead in a fund-raising campaign to boost funding particularly since the ARCF funds student scholarships. Where appropriate in the order of business I would propose that the Preceptor Training Program as proposed by a subcommittee of the Education Section be accepted, at least in concept, as the AARC's Preceptor Training Program.This program is a hybrid of two outstanding Preceptor Training Programs developed by the faculty at the University of Arkansas at Little Rock, AK and the Georgia Health Sciences University in Augusta, GA (formerly the Medical College of Georgia). I have attached a sample Proposed Program (see below) and two Power Point presentations (attached), one each from faculty from each of the aforementioned education programs.

Respectfully Submitted,

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

Proposed Clinical Preceptor Training Program:
"Bringing Excellence to Clinical Respiratory Care Education"

Day One

8:15 - 8:30 am	Introduction
8:30 - 9:20 am	Principles of Adult Learning
9:30 - 10:20 am	Teaching and Learning Styles
10:30 - 11:20 am	The Effective Preceptor: From Good to Great
11:30 am - 12:50 pm	Lunch
1:00 - 1:50 pm	The One-Minute Preceptor
2:00 - 2:50 pm	Using Direct Observational Skills
3:00 - 3:50 pm	Questioning Techniques: Verbal and Non-Verbal
4:00 - 5:30 pm	Interactive Session I: Applying What We've Learned

Day Two

8:15 - 8:30 am	Let's Review: Day One Clinical Preceptor Pearls
8:30 - 9:20 am	Providing Constructive Feedback
9:30 - 10:20 am	Techniques of Evaluation
10:30 - 11:20 am	Teaching at the Bedside
11:30 am - 12:50 pm	Lunch
1:00 - 1:50 pm	The Difficult or Struggling Learner
2:00 - 2:50 pm	Solving Problems in Learner/Preceptor Relationships
3:00 - 4:30 pm	Preceptor Inter-rater Reliability
4:30 – 5:00	Interactive Session II: Putting It All Together Day Two Clinical Preceptor Pearls
5:00 - 6:00 pm	Attendee Preceptor Self-Evaluation Session and Program Evaluation

Home Care Section

Reporter: Greg Spratt
Last submitted: 2012-10-04 22:34:49.0

Recommendations

None

Report:

HC Section Highlights

Since the last meeting we have produced one quarterly newsletter. The September edition was guest edited by Lou Kaufmann.

Membership

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

Patient Survey

I am working with Nicholas Macmillan (a past HC Section Chair) to distribute a survey of home care patients to better understand their perspectives on the care being delivered to them. The BREATHE (Basic Respiratory Evaluation and Assessment at Home) survey has been developed, approved, and passed to the AARC for distribution. The survey will be made available to patients via Home Care Section members and patient advocacy groups (viewable at www.yourlunghealth.com).

Follow Up on Previous Recommendations:

Hospital to Home Project:

At the last BOD meeting, a recommendation was made to "Create pilot studies for RT-led programs for reducing readmissions. This was referred to the Executive Office to help gain assistance from the Research Roundtable to help develop an RFP to be able to present back at the the Summer Forum. Tom Kallstrom and I had a call on May 11th with John Davies to discuss and John was to discuss with the Research Roundtable and return ideas. John's feedback was that he agreed with the guidance of the Hospital to Home Committee. Tom Kallstrom suggested we get additional input from Kent Christopher and possibly other physicians.

Combining Sections Survey

At the last BOD meeting, a recommendation was made to "Survey section members for potentially combining home care and long-term care specialty sections." The survey has been sent to the AARC offices for distribution.

Long Term Care Section Report

Board report October 2012

The Long Term Care Section continues to make major strides. At the 2012 AARC Congress a new accreditation for long term ventilator units will be unveiled. This accreditation is the result of an effort by the section to raise the bar in long term ventilation and to create a mechanism for consumers to have a level of confidence that certain quality measures are being achieved.

Accreditation surveys will be performed by HQAA, a CMS recognized accrediting body currently providing accreditation to DMEs as required by law for Medicare funding. In early conversations with Insurers and several state Medicaid agencies this accreditation is being well received, several have stated plans to require this accreditation in order for a provider to receive funds. The accreditation was developed by using the AARC position statement **Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care** as a foundation. There was input from both the section chair, the chair elect the AARC executive team, and our legislative affairs team. We are very excited to see this come to pass in 2012 and I take great pride in the section for actively pursuing and working to develop this accreditation.

This is my final report to the board as my tenure as chair comes to a close. It has been my pleasure to have served in this capacity for the past several years and I thank the board for its support along the way.

Gene Gantt RRT

Management Section

Reporter: Bill Cohagen

Last submitted: 2012-10-01 12:27:28.0

Recommendations

None

Report

- As of 10/1/2012 the membership is 1793
- Bill Roberts has been named Management Section SPOY
- Nearing completion on the updated TJC guidelines for RT departments
- Leadership Book club participation is growing
- The Management Section is promoting the 2015 plan with its membership
- The newsletter is having an abundance of submissions each quarter
- The Expert group is thriving

Looking at 2013

- An independent query has been done with Management Section members on topics for 2013 conferences and webinars (results will be reviewed with the conference committee)
- Continued work on increasing both AARC membership as well as Management Section membership
- Assist the Leadership Academy for the managers portion
- Encourage active Management Section members to get more active

Respectfully submitted: Bill Cohagen, RCP, RRT, BA, FAARC

Management Section Chair

Neonatal-Pediatrics Section

Reporter: Cynthia White

Last submitted: 2012-10-06 17:41:17.0

Recommendations

[No recommendations]

Report

- Formed committee to review nominations for SPOY
- 2012 Specialty practitioner of year selected
- Continued to publish quarterly section bulletins and review monthly e news
- Worked with program committee to make adjustments for neonatal pediatric lectures and symposia at AARC
- Moderating lectures and 2 neonatal/ pediatric open forums at Congress 2012
- Working with section members to institute and engage members with journal club discussions

Sleep Section

Reporter: Mike Runge
Last submitted: 2012-10-01 10:42:49.0

Report

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

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

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

4. Identify, cultivate, and mentor new section leadership.
Elections underway at the time of this report.

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.
Ongoing.

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

Surface to Air Transport Section

Reporter: Steven Sittig

Last submitted: 2012-10-4 20:26:57.0

The Surface and Air Specialty Section has been active fulfilling all charges set forth by the BOD. The bulletins have been published on time with relevant content. As current chair have been asked to help a large children's hospital as they are starting to develop a neonatal transport team with an RT and RN model.

The section has a great selection of lecture topics that are to be presented at the AARC Congress. During the section meeting there, chair elect Billy Hutchinson will become the new chair. We are planning on formatting the meeting so that those in attendance may be able to view content. We will also be promoting next year's congress encouraging lecture submissions knowing the short turn-around time for next year's program.

In closing this will be my last board report as the Surface and Air Transport section chair. It has been an honor and a privilege to have served the AARC in this capacity. I will continue to be active in this area as well as the neonatal/pediatric section and CAMTS representative.

Special Committee Reports

Benchmarking Committee

Reporter: Richard Ford
Last submitted: 2012-10-02 17:53:05.0

Report

•1. The Benchmarking Committee Team continued the provision of monthly webinars offered to subscribers. These programs have been archived and are available to any client. Topics in the past three months included:

•a. Sharing Benchmarking Data with Staff - Stan Holland

•b. Comparison with Premier - Cheryl Hoerr

•c. Benchmarking Educational Resources - Rick Ford

•2. The AARC Times published "Benchmarking in the Trenches" in the August 2012 issue. The piece was authored by Rick Ford, however included stories about the benefits of AARC Benchmarking by Chuck Menders, Robert Pikarsky, and Ed Burns.

•3. Presentations were made at the Summer Forum by Frank Sandusky and Rick Ford that featured the use and benefits of AARC Benchmarking. While there are 3 formal presentations accepted for the National Congress in New Orleans in which benchmarking is a key topic, we have seen that other managers are now including their own experience in AARC in their presentations of topics related to best practice and staffing.

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

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

•6. Pat Ingle resigned from her position as a member of the committee. We are currently seeking a replacement for Pat.

•7. A committee conference call was held August 27th in which specific operational concerns with the web application were identified and fixed through Devore. The committee also discussed the need to refine the product once the new Uniform Reporting Manual is published.

•8. As of June 1 there are 136 active subscribers.

Billing Codes

Submitted by Susan Rinaldo Gallo

Activities

1. Communication of Code Changes – this is ongoing. The latest codes communicated were:

   99464 – Attendance at Delivery and Initial Newborn Stabilization

   When the physician managing the patient's delivery requests a RT to attend the delivery and the RT provides initial stabilization of the newborn, this may be reported with code 99464.

   99465 - Delivery or Birthing Room Resuscitation

   Resuscitation of a newborn in the delivery or birthing room is reported with code 99465. This code indicates the provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output. Suctioning without intubation is also included in resuscitation services

2. Monitoring the Billing Codes list serve
   I monitor the list serve along with committee member Karen Boyer.

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

4. I have contributed codes for the procedures in the new Uniform Reporting manual.

5. Cheryl, Ann Marie and I have updated the Coding Resources on AARC.org

Federal Government Affairs Committee

Reporter: Frank Salvatore

Last submitted: 2012-10-08 11:48:12.0

Recommendations

NO RECOMMENDATIONS

Objectives:

1. Continue implementation of a 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts. **[Ongoing and we stand at the ready for any late activity in the upcoming lame duck session.]**

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

Ongoing Objectives:

Assist in coordination of consumer supporters **[Ongoing]**

Other

I want to thank the members of the Federal Government Affairs committee for their work this year. I also would like to once again point out that we are served immensely by Cheryl West the Director of Government Affairs, Miriam O'Day and Ann Marie Hummel. We are blessed to have such high-powered and tireless people working for our profession,

Fellowship Committee Report

Reporter: Patrick Dunne

Last submitted: 2012-10-04 11:56:37.0

Recommendations

There are no recommendations at this time

Report

The Committee has completed it charge to review and select the 2012 inductees for AARC Fellow. The Committee reviewed 42 completed nominations received by the established deadline and eventually selected 32 exemplary individuals to receive the FAARC designation. Those selected for induction have been so notified. Similarly, those individuals submitting nominations of individuals not selected were also notified. Selected nominees have been invited to attend the Awards Ceremony to be held on Saturday morning, November 10, the opening day of the 58th AARC International Respiratory Congress in New Orleans, to receive their certificate and pin.

The Chair is pleased to report that, with the diligent and creative efforts of Kris Kuykendall, the entire AARC Fellow review/selection process has been fully converted to an electronic format. Committee members were quite vocal in their appreciation of this time saving enhancement, not to mention the obvious contribution to the AARC's continuing efforts to become even more environmentally friendly.

International Committee

Recommendations

None

Report

1. Administer the International Fellowship Program.

This year we will welcome seven new international fellows. We have invited five physicians, two from China and one each from Ghana, Haiti and India. We also invited one respiratory therapist from Ecuador and on Physiotherapist from Turkey. We are now at 147 fellows from 60 countries over the last 23 years.
I want to thank the AARC Board of Directors and the ARCF Board of Trustees and the ICRC for supporting the international fellowship program and the other international activities of the international committee.
Thank you.

All of the charges to the committee were successfully completed.

2012
22 applicants
17 different countries
9 applicants from countries without past fellows
(Nigeria, Syria, Haiti, Ecuador, Botswana, Morocco, Ghana, Columbia, Belize)

International Fellow Applications by year

- 2002 38
- 2003 40
- 2004 24
- 2005 18
- 2006 17
- 2007 40
- 2008 46
- 2009 44
- 2010 37
- 2011 27
- 2012 22

City Host Applications by year

- 2002 Not available
- 2003 Not available
- 2004 14
- 2005 18
- 2006 13
- 2007 21
- 2008 23
- 2009 13
- 2010 21
- 2011 13
- 2012 20

2012 Program Schedule

Event	Date
Arrive in the First City	Saturday, October 27
First City Rotation	Monday, October 29–Friday, November 2
Arrive in Second City	Saturday, November 3
Second City Rotation	Monday, November 5–Thursday, November 8
Arrive in New Orleans, LA	Friday, November 9
AARC International Congress	Saturday, November 10–Tuesday, November 13
Fellowship Program Ends	Wednesday, November 14

2012 AARC
International Fellows

Liu Ling, MD
Critical Care Medicine Specialist
Dept. of Critical Care Medicine
Nanjing Zhong-Da Hospital & School of Clinical Medicine
Southeast University, Nanjing, China
Supervises & Teaches Residents & Medical Students – Attending Physician

Researcher & Author
“Improve professional practice & enhance awareness of RC”
Hosts
Ron Taylor - Honolulu, HI,
Kathy Jessen - Oakland, CA

Liu Manling, MD
Professor & Chief Pediatrician
Xi’an Medical University
Xi’an, China
Professor - RC Program Xi’an Med University
Editor / Author- Texts & Papers
Sustain & Develop RT major
Support establishment of profession
Hosts
Phil Finch, Portland, OR
Katie Sabato -Oakland, CA

Raul Castro Garcia, RT
Respiratory Therapist
IESS Hospital Dr. Teodora Maldonado Carbo, Guayaquil, Ecuador
Teaches RT - State University of Guayaquil
BOD LABPCRT
Organized RT Chapter of Ecuadorian Intensive Care Society
Orgtanized 1st International RT Congress
Hosts
Jacque Bowman - Charleston, SC
Garry Kauffman- Winston-Salem, NC

Audrey Forson, MD
Director Department of Medicine / Pulmonologist
University of Ghana Medical School, Korle Bu Teaching Hospital, Accra, Ghana
Trains physicians in RT
Researcher & Author
“To see how a RC unit in a well-funded hospital is run- how services are made available…”
Hosts
Karen Schell - Emporia, KS
Lisa Trujillo - Salt Lake City, UT

Job Joseph, MD
Head of Internal Medicine / Internist
Hospital Sacre’-Coeur, Milot, Haiti

Setting up 12 month RT training program
"to see how RC is provided in US & repeat that model in Haiti"
Hosts
Chad Gibbs - Charlottesville, VA
Tabatha Dragonberry–Washington, DC

Anitha Nileshwar, MD
Professor of Anesthesiology & Head of Department of RT
Manipal University, Manipal, India
Vice President – Indian Association of RC
Editor – Indian Journal of RC
Volunteer for Operation Smile
Researcher & Author
"hopes to observe & compare RT especially in areas of home care & develop a world wide networks of RTs"
Hosts
Felix Khusid - Brooklyn, NY
Jeff Ford - Baltimore, MD

Sanihe Ugurlu, Msci, PT
Respiratory Physiotherapist/Educator/Researcher
Istanbul Memorial Hospital
Istanbul, Turkey
Clinical Applications of MV / ICRC/IERS
Pulmonary rehab/critical care/academic training
"interested in promoting RC & the AARC to other PT's in Turkey & establishing the profession"
Hosts
Jerry Edens - Cincinnati, OH
Kris Hammel - Rochester, MN

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

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

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

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

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

The International Fellows List serve continues to show activity and continues to be valued by our past fellows.

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

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

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

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

The international activities of the AARC continue to be of great interest to both the ARCF and to our AARC Corporate Partners.

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

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

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

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

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

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

I want to thank April Lynch and Kris Kuykendall of the Executive Office and the committee members for all of their hard work.

The International Committee:

John D. Hiser, MEd, RRT, CPFT, FAARC
Vice Chairs
Debra Lierl, MEd, RRT, FAARC, Vice Chair for International Fellows
Hassan Alorainy, BSRC, RRT, FAARC, Vice Chair for International Relations
Committee members:
Michael Amato, MBA
Jerome Sullivan, PhD, RRT, FAARC
Arzu Ari, PhD, MS, MPH, RRT
John Davies, MA RRT FAARC
ViJay Desphande, MS, RRT, FAARC
Hector Leon Garza, MD, FAARC
Derek Glinsman, RRT, FAARC
Yvonne Lamme, MEd, RRT
Dan Rowley, BS, RRT-NPS, RPFT
Bruce Rubin, MD, FAARC
Michael Runge, BS, RRT

Membership Committee

Reporter: Frank Salvatore

Last submitted: 2012-10-08 12:03:41.0

Recommendations

NO RECOMMENDATIONS AT THIS TIME

Charges:

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

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

Identify and evaluate methods to recruit respiratory therapy students as ACTIVE members of the AARC.**[I have asked Emily Zyla and Janelle Gardiner to lead a sub-group of the Membership Committee to address not only this charge but strategies to improve the use of their student membership. More information will be shared at the meetings.]**

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

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

Report

Recruitment Campaign #1 for 2012:

The first campaign targeted non-member leaders in hospitals. A specific website and incentives to entice non-member leaders to join were created for this campaign. All non-member leaders identified through work done by the state societies were sent a brochure via U.S. Mail. Last check in July, we garnered about four (4) new members. We discussed this in the House of Delegates meeting during my report and were going to try to make this a local campaign, but have decided to merged it to be included within the new campaign.

Recruitment Campaign #2 for 2012:
We plan to unveil this campaign at the November Board of Directors and House of Delegates meetings. The committee is diligently working with the Executive Office to put the finishing touches on it, but we aren't prepared to announce it at this time..

Other

I want to thank the members of the Membership Committee. They have been pressed into action late in the year here and have done excellent work on coming up with ideas and suggestions. I'd also like to thank Tom Kallstrom, Sherry Milligan, Doug Laher and Tim Myers for all their work and guidance they have given our committee.

Position Statement Committee

Reporter: Colleen Schabacker

Last submitted: 2012-10-03 13:07:01.0

Recommendations

NONE

Report

Charges:

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

•· A draft of the proposed AARC position statement "Respiratory Therapists in the Emergency Department" was approved at the April Board meeting.

•· "Best Practices in Respiratory Care Productivity and Staffing" position statement was approved in July. The members are Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Linda VanScoder and Bill Dubbs from the AARC. The BOD approved a motion to move forward with the development of a White Paper that would better define this position statement. There is a conference call scheduled for Friday, October 5, 2012 to hopefully finalize what the sub-committee has been working on. We are working towards a completed paper by this November meeting.

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

- During 2012, the Committee's goal is to complete the review of the four (4) position statements listed below. Action on each statement to this point is listed following the statement title as is the name of the Committee member spearheading the review.

•1) Respiratory Therapy Education - Deryl Gulliford - presented revisions at April BOD meeting

•2) Licensure of Respiratory Care - Kathy Deakins - presented revisions at April BOD meeting

•3) Continuing Education - Jim Allen - presented revisions at April BOD meeting

•4) Ethics and Professional Conduct - Linda VanScoder - presented revisions at the July BOD meeting

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

Presented at the April BOD

Other

A special thank you to committee members Kathleen Deakins, Deryl Gulliford, Jim Allen and Nick Widder. A special thanks Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Bill Dubbs and Linda VanScoder for their work on the new "Best Practices in Respiratory Care Productivity and Staffing" position statement and for their continued work on the White Paper.

Public Relations Action Team

Reporter: Trudy Watson
Last submitted: 2012-09-30 23:41:32.0

Recommendations

No recommendations.

Report

Although the Public Relations Action Team did not receive any requests for action during this reporting period, I'd like to thank Jerry Edens, Kathy Rye, and Ken Thigpen for being on "stand-by" for assignments.

Charges:

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

   No requests were received to participate in radio interviews.

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

   No requests were received to assist with **Your Lung Health** activities.

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

The Presidents of the Chartered Affiliates were contacted regarding this charge and the results reported in Summer 2011.

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

No requests to update any PR materials were received from the Executive Office.

Respectfully submitted,

Trudy Watson

State Government Affairs Committee Report

Tom McCarthy, RRT; Chair

October 2012

Legislative sessions in most States will be beginning soon for 2013. Polysomnography bills before the State legislatures remain as the single most time and resource consuming item on the State Government Affairs agenda.

Of particular note for this upcoming session is a recommendation forwarded to the Michigan State Legislature that would de-license Respiratory Care Practitioners. We are viewing the recommendation as, among other things, a public safety issue. Updates will be made forwarded to the membership as they become available.

No recommendations at this time.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Reporter: Susan Rinaldo Gallo
Last submitted: 2012-09-25 14:48:24.0

As stated in the summer report, we (AARC, ACCP and ATS) were unable to get the code proposal for HFCWO accepted. There are several reasons for this. However, the main reason is that the number of times per day was going to be limited to a maximum of two. Twice a day would be acceptable for clinic or outpatient use but insufficient for inpatient. We did not resubmit this proposal.

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

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

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

There is an AMA CPT meeting being held October 11 -12, 2012. I will provide an update at the BOD meeting.

American Association of Cardiovascular & Pulmonary Rehab

Reporter: Debra Koehl
Last submitted: 2012-10-09 08:15:18.0

Recommendations

See Continuing Care Rehab Section Recommendation

There are 3 attachments outlining a formal proposal to the AARC from the AACVPR to enhance our relationship with the AACVPR. At the most recent AACVPR Professional Liaison Committee meeting it was recommended by AACVPR staff that they "upgrade" their relationship with the AARC. They feel that the AARC has the contacts and connections with respiratory therapists who are leaders in the field of pulmonary rehabilitation. We currently have a good working relationship with the AACVPR when it comes to legislative activities for PR. I think we can strengthen this existing relationship.

My recommendation is that the AARC BOD consider and accept their proposal.

Report:

- I attended the AACVPR National meeting in Orlando in September.
- I was asked to chair the pulmonary section of the Professional Liaison committee.
    - Trina Limberg and Gerilynn Connors are also a part of that committee.
- Both organizations are still working hard to promote the Pulmonary Rehabilitation Reimbursement Toolkit in order to improve PR reimbursement.
- To note, as of recent, the AACVPR's Executive Director Joanna Ray has resigned to take another position closer to her home. The AACVPR is going to actively pursue her replacement.
- Thank you to the BOD for your continued support of the Continuing Care/Rehab Section chair in regards to attendance at the AACVPR meeting. It truly allows us to stay in the loop and make sure our profession is recognized in the field of pulmonary rehabilitation.

Three attachments to this report

1. Letter to Karen Stewart requesting a more formal relationship.
   The letter is under my signature as the new chair of the Pulmonary Liaison Subcommittee (below)
2. Fact Sheet (see attachment "AACVPR Fact Sheet")
3. AACVPR & AARC Reciprocal Activity Options (below)

AACVPR
American Association of Cardiovascular and Pulmonary Rehabilitation
Promoting Health & Preventing Disease

October 4, 2012

Karen Stewart, MS, RRT, FAARC
President, American Association for Respiratory Care (AARC)
9425 N. MacArthur Blvd.
Suite 1000
Irving, TX 75063

Dear Karen,

I appreciate your help with the liaison relationship between the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) and AARC over the past several years. This letter is to update you about key AACVPR strategic goals and initiatives. Feel free to forward this letter and the attachments to other leadership and staff in AARC as appropriate.

Founded in 1985, the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) is dedicated to our mission of reducing morbidity, mortality and disability from cardiovascular and pulmonary diseases through education, prevention, rehabilitation, research and aggressive disease management. Central to the core of our mission is improvement in quality of life for patients and their families.

AACVPR membership is comprised of approximately 3,000 multi-disciplinary professionals including cardiovascular and pulmonary physicians and nurses, exercise physiologists, physical therapists, behavioral scientists, respiratory therapists, nutritionists and other professionals working in cardiovascular and pulmonary rehabilitation. AACVPR has 42 regional affiliate societies representing approximately 9,000 cardiovascular and pulmonary professionals.

Two years ago, AACVPR leadership formulated three key Strategic Goals for the organization that guide both yearly operations and long term planning. All AACVPR committees have been tasked with making the majority of their efforts tied to these Goals.

The Goals are:

1. Improve Use and Viability of Cardiac and Pulmonary Rehabilitation and Prevention Services
2. Enhance and Support the Quality of Cardiac and Pulmonary Rehabilitation and Prevention Services
3. Grow and Retain Membership, thus Driving Viability and Quality Through Increased Resources

To accomplish these goals, AACVPR volunteers and staff are currently devoting much time and effort to three large Strategic Initiatives:

1. Program Certification
2. National Cardiac and Pulmonary Rehabilitation Data Registries
3. Cardiac and Pulmonary Rehabilitation Performance Measures

Program Certification

Great strides have been made in the logistics of filings applications, with the process moving from paper and pencil to an online application. The scoring mechanisms for committee members have been streamlined, and now the Certification and Re-certification applications are identical.

However, goals for the next year center on the question of whether Certification actually defines quality programs, and how to ensure that measures for Certification agree with those used in the Registries and for Performance Measures.

To determine if Certification actually defines quality programs, a solid evidence base from the peer reviewed literature will be incorporated in the next Certification cycle. Additionally, over the next several years, data from the Registries will help to define quality.

National Cardiac (CR) and Pulmonary Rehabilitation (PR) Data Registries

These will be the first comprehensive, national outcomes registries devoted to cardiac and pulmonary rehabilitation. They will include demographic, enrollment, completion and outcome data, as well as benchmarking and reporting mechanisms. Data from these Registries will be used to identify best practices, track composite patient outcomes, and provide programs with data to use for performance improvement.

The CR Registry launched in June 2012 and has nearly 500 programs involved from all over the country. The PR Registry development is underway and will launch in spring 2013. Currently in discussion is the potential integration of our registry data with data from the American College of Cardiology (ACC) Pinnacle Registry, thus allowing for tracking of cardiac rehab data across the continuum from referral through program completion. This is an exceptional example of how the relationship between AACVPR and a liaison organization has evolved and may ultimately greatly influence patient outcomes.

AACVPR believes that AARC members will greatly benefit from the PR Registry and would like to explore ways we might partner in promoting Registry participation through AARC's channels.

Pulmonary Rehabilitation Performance Measures

The Pulmonary Rehabilitation Performance Measurers were developed and submitted to NQF. These performance measures defined outcomes for determining functional capacity and health-related quality of life for patients in pulmonary rehabilitation programs, and have also received a time limited endorsement from NQF. Data to extend this measure beyond the time limit is now being collected and analyzed by an AACVPR taskforce.

We cannot achieve such initiatives that will move the field forward without support from organizations like AARC that share in this passion.

AACVPR is proud to partner with a wide variety of professional organizations such as AARC that share our Mission and Vision. The goal of this collaboration is mutual benefit to our members, improvement in program services and ultimately enhanced patient outcomes.

I would like to discuss with you in further details of ways AACVPR and AARC might partner in the coming year. I have enclosed for your reference the guidelines for reciprocal activities developed by AACVPR.

These are certainly flexible and we are open to discussion of ways we might partner that are not included here. I also enclosed a Fact Sheet which includes further information about AACVPR.

Once you have had a chance to review the enclosed, please contact me to discuss these areas for collaboration in further detail. Please also feel free to visit www.aacvpr.org to learn more about AACVPR activities. You may also contact Jessica Eustice, AACVPR Development Manager, by calling 312/673-5929 or via email to jeustice@aacvpr.org for further information.

I look forward to hearing from you and to developing a mutually beneficial partnership between AACVPR and AARC.

Best Regards,

Debbie Koehl, MS, RRT, AE-C

AACVPR
American Association of Cardiovascular and Pulmonary Rehabilitation
Promoting Health & Preventing Disease

AACVPR Proposed Reciprocal Arrangement Options with AARC

Website Enhancements

AACVPR has ample professional and patient resources available on www.aacvpr.org. Many of the professional resources are available exclusively to AACVPR members, while patient resources are publicly available. We strive to promote credible resources that benefit pulmonary rehabilitation patients and caregivers.

We would be interested in exploring opportunities such as:

- Posting links to specific sections of AARC website in the AACVPR Resources for Professionals and Resources for Patients sections
- Posting links to sections of the AACVPR web site on AARC web site, such as the Program Directory, About PR or About AACVPR
- Providing content for AARC website about PR and/or AACVPR

Articles in Association Publications and Electronic Communications

AACVPR publishes a number of key documents dedicated to advancing the quality of cardiovascular and pulmonary rehabilitation, which allows for ample opportunities to promote our liaison organization relationships.

We are interested in exploring opportunities such as:

- "Spotlight on Liaison Activity" is the quarterly article in *News & Views* that can be used to highlight liaison activities or opportunities for members from liaison associations; *News & Views* also offers advertising opportunities
- Breaking news about CR, PR, or AACVPR activities can be released to AARC for your print or electronic newsletters
- Web advertising monthly placement exchanges are available

Co-Promotion or Co-Production of Educational Opportunities

AACVPR strives to provide our members the highest quality education. By partnering with liaison organizations such as AARC we are able to expand our reach in this area.

Partnership opportunities vary greatly and include:

- Annual Meeting – reciprocal promotion of calls for abstracts, speakers, or meeting registration
- Webcasts and Annual Meeting Sessions can either be co-promoted or co-produced, with the latter requiring more effort and cooperation

Activities at Annual Meetings

AACVPR conducts an Annual Meeting each fall. The 2013 meeting will be held October 5-7, 2013 at the Gaylord Opryland Hotel in Nashville, TN. The Annual Meeting provides a terrific venue to highlight our partnerships such as that with AARC.

Opportunities in conjunction with the Annual Meeting include:

- Booth exchange
- Presence of one another's Board member or leader as a speaker, acknowledged as such (i.e. recognized AACVPR speaker at AARC meeting and recognized AARC speaker at AACVPR)
- Meetings with leadership or staff to promote projects and interaction
- Meetings with industry representatives to promote funding and strategic partnerships

Membership Mailing Lists

AACVPR is pleased to partners with organizations such as AARC to get pertinent educational information in the hands of our members.

Therefore, we are interested in exploring opportunities such as:

- AACVPR's membership mailing list may be shared with AARC for the distribution of patient and/or professional education materials to AACVPR members
- AACVPR can use membership lists from AARC to promote the Annual Meeting, webcasts and other educational forums

American Heart Association

Reporter: Brian Walsh
Last submitted: 2012-10-09 12:57:53.0

Recommendations

That the AARC Executive Office pursue the AHA's intent to limit the ability to issue cards for respiratory therapist who are seeking advance life support provider or instructor status enforced by some regional offices.

Report

The below is reported to have occurred within the state of MT.

"The guidelines state that to be eligible to receive a card in an ACLS/PALS course, the student must be able – legally – to function in the role of the team leader and, as such, be able – legally – to perform all the functions/skills of a team leader. Those functions/skills include having the training, knowledge base and scope of practice encompassing the foundations of ACLS knowledge and skills. That means the student must be licensed/certified to start IVs, administer a wide range of medications, provide assessment of the total patient systems and possess the knowledge base to be able to recognize changes in the patient status and accurately identify care protocols and interventions that will benefit the patient. Every state defines and regulates each discipline's scope of practice, in other words, what each discipline is legally allowed to do as they provide patient care. Heart identifies three groups of healthcare providers, based on education and licensure, as those who would typically be issued an ACLS/PALS provider card: physicians, nurses and paramedics. All others who respond to codes or emergencies are strongly encouraged to attend ACLS/PALS to learn the information and will be issued a certificate"

I have corresponded with Bill Dubbs, Monica Kleinmen (Chair of the AHA scientific committee), and Tim Myers on the subject. Dr. Kleinmen has promised a statement will be drafted a sent out. However, there has been such negative press surrounding this topic on several networking sites and because the AHA is in the Dallas area, I feel that this could be quickly resolved if each of the Executive Offices (AHA and AARC) communicated directly.

If you have additional questions or need additional supporting evidence for the above topic, I would be happy to forward.

Amer Soc for Testing and Materials

Reporter: Robert McCoy

Last submitted: Last submitted: 2012-10-01 14:18:39.0

Recommendations

Nothing to report

R McCoy

Chartered Affiliate Consultant

Reporter: Garry Kauffman
Last submitted: 2012-09-14 09:54:44.0

Recommendations: None

Report:

I facilitated a strategic and operational planning session with the Virginia Society for Respiratory Care June 22nd and 23rd in Richmond, VA. The leadership of this chartered affiliate was well represented and actively engaged throughout the 1 ½ day session. The result of the session was the creation of a new mission, operational values, and an operational plan to guide the chartered affiliate in the next year to achieve increased performance in the core strategic areas of advocacy, education, and engagement.

On August 4th and 5th, I facilitated a strategic and operational planning session with the Indiana Society for Respiratory Care in Indianapolis, IA. Chartered affiliate leadership demonstrated commitment throughout the 1 ½ day session, culminating in the creation of a new and focused mission statement, core values to aid in their decision making and operations, and an operational plan to enhance their operations from that of a successful organization to that of a high performing organization.

I have been in contact with several other chartered affiliate leaders to assist them in these efforts and will request permission from the AARC president as these requests arise. I appreciate the support of the AARC leadership, AARC Executive Office, and the Chartered affiliate leadership- all of whom demonstrate the commitment, dedication, and passion to make these efforts both rewarding and successful.

Respectfully submitted,

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

Committee on Accreditation of Air Medical Transport System

The CAMTS BOD has met for a total of 4 times this calendar year of 2012. Most recently we met in Seattle Washington October 18- 2oth. Also this year we have released the 9th edition of the CAMTS standards which I am proud to say has RT's more incorporated into the standards of critical care transport. We now include the NBRC Adult Critical Care Specialist (ACCS) credential as an advanced transport credential for RT's transporting adults. These new guidelines are available online on the CAMTS web site and will be available at the AAMS Air Medical Transport Conference which follows our board meeting in Seattle. During this meeting I will be conducting my last meeting with the transport RT's who attend this conference. I have been conducting these meetings for about 10 years in order to have them hopefully see benefits of section and AARC membership. This is also a great opportunity to find speakers for future AARC Congresses.

The CAMTS BOD continues to strive to improve the safety of patient transport not only for the patient but for medical crew involved in this profession.

Extracorporeal Life Support Organization

Reporter: Donna Taylor

Last submitted: 2012-10-04 14:34:52.0

Report

I very much appreciated being able to attend this recent joint meeting of the Extracorporeal Life Support Organization (ELSO) and American Society of Extracorporeal Support (AmSect) meeting in Seattle last month due to the financial support of the AARC. Over 450 ELSO and AmSect members attended with a wide range of presentations and a special pre conference workshop focused on simulation training. Both organizations remain committed to establishing a certification and standardized training and competency assessment for ECMO. At the ELSO Steering committee meeting, I was able to meet and talk with Dr. Dan Brody, one of the first pulmonologist to my knowledge elected to the Steering Committee who is working on revising the ELSO guidelines. He will be soliciting information from the Steering Committee regarding these guidelines. By giving input into the ventilation guidelines and staffing model guidelines, I will utilize this opportunity to promote Respiratory Therapists further in the care of these complex patients.

ELSO has established a European organization and is currently working on Asia. As our program has worked with two programs in Columbia in establishing their ECMO program and recently trained a physician from Italy and Spain, we continue to pursue efforts with other countries and are especially interested in assisting with an ELSO organization made of Latin American members. Our Medical Director has proposed taking two bilingual members of our ECMO team both an RN and an RRT to Columbia to further train their RNs and RRTs. I am also working with our previous ECMO director to integrate RRTs in her new facility into the ECMO program, which has previously only used RNs to manage the ECMO systems.

I wish to thank the board for their making my attendance at this conference possible.

Respectfully,

Donna M. Taylor, RRT-NPS

International Council for Respiratory Care Report

Reporter: Jerome Sullivan
Last submitted: 2012-09-27 14:32:46.0

Recommendations

No recommendation at this time

Report

I. The 4th International Respiratory Care Symposium: This meeting was held in Xi'an, China June 14-16, 2012. President Li and his team at The Affiliated Hospital of Xi'an Medical University provided leadership in presenting the "4th International Respiratory Care Symposium".The meeting was excellent and provided the AARC/ICRC the opportunity to work together on current concepts in Respiratory Care. Below find a summary of our discussions during a Business Meeting held during the evening of June 15th.

Respiratory Care Business Meeting
"4th International Respiratory Care Symposium"
Xi'an, China
June 15, 2012

Cooperation: Participants in the group included representatives from China, Mexico, Taiwan, South Korea, and the United States. Those in the Working Group agreed that more progress in the development of Respiratory Care (RC) in China could be realized if we worked together to determine the unmet needs of patients and the appropriate level and model for RC education to meet those needs. There was also discussion of a Regional approach which could include the experiences and expert knowledge on the development of RC witnessed in South Korea and Taiwan. In addition, the experiences with the development of the Mexican RC Association and the Latin American Board for Respiratory Therapy Certification could lend further valuable lessons for recognition of the profession by government entities, and the future development of educational programs and RC practitioner credentials. Some of the trial and error experiences of the RC profession in the United States spanning some 60 years could be consulted for guidance. Finally, whatever the outcome if RC is to succeed in China it must undoubtedly be a system which is acceptable to a broad spectrum of medical and allied health professionals. Those in attendance agreed to participate in a Working Group to consider these suggestions and to work together to explore opportunities for the development of RC.

Physician and RC Practitioner Support: It was recognized that in order for RC to succeed as a profession it will require close cooperation between physician advocates and recognized RC practitioners in the region. Physician leaders such as President Li, Dr. Zhang, Dr.Wang and

others are recognized as strong supporters of RC and their continued support will be necessary for RC to succeed. Ultimately physician advocacy coupled with competent, safe RC practitioners completing quality training programs will determine the future of the profession.

II. New Governor At Large: The Council unanimously elected the following individual as a Governor At Large: Dr. Li is a recognized physician, author, teacher and administrator in Xi''an China. He is a noted supporter of the recognition of the profession of Respiratory Care in China and has a well-organized and staffed RC Department in his teaching hospital.

Ya -Jun Li, MD, PhD
President, The Affiliated Hospital of Xi'an Medical College
Director, Neurological Department
Xi'an, China

III. Endorsement of the Revision of the AARC International Mission Statement: The ICRC Executive Committee has been asked to serve as one of several constituent groups to make recommendations for revision of the AARC International Mission Statement. There has been a comprehensive review of the entire AARC International Mission Statement and the current draft submitted separately to the AARC BOD has been endorsed by the ICRC Executive Committee.

IV. "V National Congress for Respiratory Care", October 4 - 6, 2012, Royal Park Metroltel Convention Center, Bogota, Columbia. This is a major meeting being sponsored by Foundation Universitaria Del Area Andina, an influential university offering a degree granting Respiratory Care Program. Other sponsors of the Congress include **Aire Libre, the national research organization and ACOLFATER which is the association representing all respiratory care faculty in Columbia. Three members of the ICRC Executive Committee and a representative of the NBRC will participate as faculty in the meeting.**

V. International Education Recognition System (IERS): Approval of International Respiratory Care Educational programs and seminars continues to be in high demand. IERS approval has been awarded this year in Mexico, Japan, Columbia, South Korea, United Arab Emirates, Saudi Arabia and Shanghai & Xi'an China.

VI. 2012 ICRC Business Meeting will be held in conjunction with the AARC 58th International Congress in New Orleans, Louisiana. The meeting is scheduled as follows:

ICRC Business Meeting
DATE: Monday, November 12, 2012
TIME: 7:30 a.m. – 4:00 p.m.
LOCATION: New Orleans Marriott, LaGaleries 1 – 3

Joint Commission - Ambulatory PTAC

Reporter: Suzanne Bollig
Last submitted: 2012-09-27 21:46:17.0

Recommendations

None at this time

Report

The Ambulatory Care Professional and Technical Advisory Committee (PTAC) held a conference call on August 15, 2012 in place of the cancelled July 12th conference call. The PTAC was asked to review and discuss issues associated with a targeted set of requirements in the ambulatory care accreditation manual.

Key Points

1. Staff initiated a targeted standards review project to develop strategies to improve compliance with ambulatory accreditation requirements. Focus group discussions with accredited organizations were held in July 2012.
2. Several standards and elements of performance (EP''s) regarding the method of verifying training, clinical knowledge, and skill set of licensed independent practitioners were discussed and updated to reflect the use of electronic methods of communication.
3. There was significant discussion on a number of ambulatory accreditation standards and EP''s that included the term "discharge". Based on feedback received at the focus group sessions in July, the staff had recommended that the term "discharge" be removed from the standards. It was thought that the term "discharge" might not be applicable to a patient dismissed from an ambulatory care setting. Most of the comments from Committee members questioned this conclusion.

The next conference call is scheduled for October 10, 2012.

Respectfully submitted,

Suzanne Bollig

Joint Commission - Home Care PTAC

Reporter: Joseph Lewarski

Last submitted: 2012-10-01 08:14:29.0

Recommendations

No recommendations

Report

There is a PTAC conference call scheduled for October 2, 2012 to review some standards that may have applicability to HMEs. I will be traveling and unable to attend the call, however Kim Wiles, PTAC alternate will be attending as the AARC representative. We will report any relevant findings to the board.

Joint Commission - Lab PTAC

Reporter: Franklyn Sandusky
Last submitted: 2012-10-02 07:11:10.0

Recommendations

NONE

The LABPTAC phone conference meeting was held Thursday, August 9, 2012.

The follow was discussed:

- There was a face-to-face Laboratory PTAC meeting on Wednesday, September 19th. This was held in conjunction with the Joint Commission annual meeting.

  At the meeting there will be a demo of a new product the Joint Commission is rolling out called Lab Central. It is a portal to provide information to the Joint Commission prior to inspections to make the inspection process easier, hence making the application process easier. There is a lot of functionality within the program. It is the intent to replace some of the application information with the information that is in the portal so that it will make that process go much faster. Lab-specific information would be entered by laboratorians in the lab portal, improving the quality. It will assist customers in centralizing their information related to survey process and other compliance activities.

- Field review of proposed new and revised 2013 lab standards which opened on June 29th and is scheduled to close on August 10th. The review lasted 6 weeks.

  The new standards and EPs were developed to address existing and emerging issues (e.g. telepathology services, urine reducing substances, and synoptic reporting).

  Comments from the field review were discussed. The standards were passed on to the standards committee.

- There will be an optional LABPTAC meeting on October 25, 2012. This is a follow-up meeting to the Face to Face meeting held in September. Klaus Nether and Colleen Smith will talk about the Center for Transforming Healthcare regarding the Safety Culture.

  The Last LabPTAC meeting scheduled for 2012 will be on December 13.

- Report respectively submitted.

  Frank Sandusaky, RRT, MBA

National Asthma Education & Prevention Program

Reporter: Natalie Napolitano

Last submitted: 2012-10-02 08:10:53.0

Recommendations

No Report - the NAEPP has not had its fall meeting and at this point it is still not scheduled. There are some organizational changes occurring within the NAEPP and they may be waiting until these changes occur (the election is final) to make decisions and schedule the next meeting.

Natl Coalition/Hlth Pro Edu - Genetics

Reporter: Linda Van Scoder

Last submitted: 2012-10-01 09:54:37.0

Recommendations

No recommendations

Report

Nothing new to report. Will continue to monitor Genetic Alliance newsletters.

National Sleep Awareness Roundtable

Reporter: Mike Runge
Last submitted: 2012-10-01 16:04:48.0

Report

The National Sleep Awareness Roundtable (NSART) met on September 12, 2012 in Crystal City, VA. Anne Marie Hummel is AARC''s representative and participates on the Membership Committee. The organization is currently funded by the National Sleep Foundation through a grant from the CDC which expires next year. Its primary goal is to promote sleep as a healthy behavior and to raise awareness of the importance of sleep. During the meeting, members were asked to come up with catchy slogans that could be used to get the public to think about sleep. Two rounds of voting took place in which three finalists were chosen. They are:

- Who Needs Sleep? You Do!
- Sleep, the natural energy drink!
- Good Sleep = Good Health

The slogans are currently being reviewed for inclusion on the NSART website.

A representative from the Department of Health and Human Services gave an update on Healthy People 2020, since Sleep Health is now one of the topic areas. Of interest to RTs is the objective to increase the proportion of persons with symptoms of COPD who seek medical evaluation.

One NSART activity is to explore partnership opportunities with the Health Occupations Students of America to promote awareness among future healthcare professional about sleep disorders and sleep as a healthy behavior. HOSA is a national career and technical student organization endorsed by the US Department of Education and the Association for Career and Technical Education. It is the largest student organization that prepares students to enter the health care field. Apparently organizations, such as AARC, are welcome to interact with them in making a pitch for a particular professional field, such as respiratory therapy. As more details become known, they will be passed on to the Board Members.

Neonatal Resuscitation Program

Reporter: John Gallagher

Last submitted: 2012-10-05 08:59:38.0

Recommendations

No Recommendations at this time.

Liaison Report for NRP Steering Committee

The last 6 months of activity have been largely focused on instructor development. I have been active in a subcommittee that is charged with transitioning the high performing hospital based instructor to a more regional instructor. This has involved identifying the desired skills, functions, and collaborative roles that would be necessary for a successful transition. We have established timelines and milestones for progression and speak regularly via conference calls.

The next face-to-face meeting will take place in October in New Orleans, LA at the site of the AAP national meeting. We will be continuing our work on instructor development and evaluating proposals for research funding. In addition, the AARC liaison will be an active contributor to the annual NRP Seminar which takes place at the beginning of the AAP meeting.

Roundtable Reports

Asthma Disease Mgmt Roundtable

Eileen Censullo

No report

Disaster Response Roundtable

Reporter: Steve Sittig

10/3/12

Nothing new to report

Geriatrics Roundtable

Mary Hart

There hasn't been much activity with our group but we are planning to meet in New Orleans and refocus on our goals. The group will continue to write articles for the Coming of Age section of the AARCTimes as well as offer suggestions and develop new educational material for both patients and clinicians.

The last board report recommended that the palliative care roundtable join the geriatrics roundtable and it was noted. We believe RTs should work with Geriatric patients/families, take on a more active role in providing them with information about palliative care/hospice care earlier as part of the treatment for chronic disease/end of life needs. I do realize that not all patients requiring palliative care are geriatric patients, however a large number are.

Hyperbaric Roundtable

Reporter: Clifford Boehm

Last submitted: 2012-10-01 19:15:01.0

Report

Nothing to Report

Informatics Roundtable

Jim Fielder

No report

International Medical Mission Roundtable

Reporter: Lisa Trujillo
Last submitted: 2012-10-08 11:47:31.0

Recommendations

- No Recommendations at this time

Report

Our roundtable membership has increased to 69 to date. As the fall season draws near, I have requested that roundtable members share the successes and challenges they faced throughout their medical missions over the past 6 months. It is also anticipated that this roundtable will meet as a group at the AARC Conference in New Orleans, pending room space.

Other

Military Roundtable

Reporter: Harry Román

Last submitted: 2012-10-02 14:56:23.0

Recommendations

- No recommendations at this time.

Report

- Several e-mails have been posted on AARC Connect with job opportunities information for veterans.
- Promoting the ARRC to the members of the military via the Army/Navy RT schoolhouse Facebook page.

Neurorespiratory Roundtable

Reporter: Lee Guion
Last submitted: 2012-09-28 16:40:09.0

Recommendations

Report

The Neurorespiratory Roundtable continues its primary role as support, education, and information for AARC members working with patients with motor neuron and neuromuscular diseases. A primary goal of the past year was to connect with members of other roundtables and sections through joint memberships, in hopes of fostering more cross talk and improving continuum of care for patients and families. This is on-going and we will continue to improve our presence on line and at conferences. We see ourselves as an important component the hospital-to-home initiative, even though the focus is on COPD. Our patients, too, are at risk of hospital readmissions if discharge planning is not well coordinated and RCPs not actively involved.

Our members will meet at the AARC Congress in New Orleans following the Manager''s Section meeting.

Other

I have asked Lois Rowland, RRT, FAARC to chair the Neurorespiratory Roundtable in 2013. If approved by the AARC President, I will formally pass the position on to her at our meeting in November.

It has been an honor to serve as chair of this roundtable as we moved from an e-mail group to AARC Connect. I will continue to work with Lois and all members to grow the roundtable, foster communication with members of other roundtables and sections with whom we share common purpose, submit abstracts for conference presentations and Open Forum, share independent research, and develop best practice in the respiratory management of neuromuscular diseases.

Research Roundtable

Reporter: John Davies

Last submitted: 2012-10-02 09:04:35.0

Report

- Membership is up to 78
- Discussion in the roundtable remains slow
- There is a research symposium at the International Congress which should stimulated some roundtable interest

Simulation Roundtable

Submitted by Julianne Perretta

10/10/12

Recommendations

None

Report

Nothing to report

Tobacco Free Lifestyle Roundtable

Reporter: Jonathan Waugh

Last submitted: 2012-10-08 15:44:13.0

Report

- Update on the "Clinician Guide for Tobacco Cessation," a joint effort between the TFL Roundtable in and the AARC executive office. Co-chairs are Georgianna Sergakis and Rita Mangold are hoping to meet with members of the working committee at the AARC Congress in November. I am trying to arrange a meeting of the TFL members attending the Congress as well.
- The "Patient Guide for Tobacco Cessation" is in its 2nd printing thanks to the efforts of Steve Nelson and his staff. The 200,000 copies have been received and will be distributed through the "new" AARC online store (scheduled to open sometime mid-November). The mechanism to make free copies available to AARC members is still be worked out.
- Intermittent requests for information on tobacco prevention/treatment have been fielded, several from RTs who are not AARC members and thus could not access the TFL roundtable. It would be great to have access to the TFL and its resources mentioned in the daily AARC Congress Gazette/Newsletter as one of the "benefits" of AARC membership.
- Recent conference call with AARC executive office discussed tobacco-related grant application and possible Congress programming proposals for the future.
- The TFL stands ready to assist with educational programs and curricula for tobacco-related training for national, regional, and state meetings/events.

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity

Fall 2012

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

Recommendation: None

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

Status: **Salvador Santana,** Santa Monica College Respiratory Therapy Program, in Santa Monica, California, Will be participating in the Cultural Diversity Mentoring Program this Fall. Salvador's Resume to follow. (see below)

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

Status: **Ongoing**

Salvador Santana
1220 s Lake Street, Los Angeles, CA 90006
Main. 213.908.5914 Cell. 213.924.9996
Santana_salvador@smc.edu

Profile	**Highly qualified respiratory care practitioner, respiratory therapy program coordinator for Santa Monica College, in partnership with East Los Angeles College a top ranked respiratory care program. Responsible for organization, administration, continuous review, planning, development and general effectiveness of clinical experience for students in the respiratory care program. Manages day to day operations of the respiratory therapy programs in all aspects, including the clinical setting. Supervises didactic and clinical faculty, coordinates clinical rotations, performs student's evaluations, develops student educational plans and ensures that clinical documentation and competencies between students and clinical sites are complete. Skilled in developing and implementing standardized policies and procedures. Promotes team work and imparts discipline as necessary. Consistently exceeds expectations in patient care goals and patient/customer service expectations. Actively involved with south coast region, California Society for Respiratory Care (CSRC), co-chair of CSRC, neonatal pediatric + *plus* conference, 2011. Motivated, hard working, eager to learn, excellent communication skills, the tools necessary for a job well done.**	
Education		*June 2006*
	B.S. Molecular Cell and Developmental Biology **U.C.L.A**	*December 1999*
	Registered Respiratory Therapist, RRT **NBRC**	*August 1999*
	Respiratory Care Practitioner **RCB**	
	Associate Science Degree, Certificate in Respiratory Therapy, RCP **E.L.A.C**	*June 1999*
Certificates/ Associations		*June 2011*
	• On-course student success workshop (Palo Alto, CA)	*January 2012-May 2012*
	• Faculty Learning Academic for student success (Los Angeles, CA)	
	• NRP Instructor	*2009- to Present*
	• BLS Instructor	*2009 to Present*
	• AARC	*2007 to Present*
	• CSRC	*1998 to Present*
	• NRBC	*1999 to Present*

Career History	**Santa Monica College** **Respiratory Therapy Program, Coordinator** • **Tenured track faculty** • **Exceeds on yearly evaluation** • **Teach introduction to respiratory care, cardiopulmonary anatomy and physiology, pathophysiology, advanced cardiac life support and monitoring** • **Student advisor** • **Coordinates students with clinical sites** • **Coordinates consortia contracts** • **Completes student competencies** • **Represents respiratory therapy in CTE and Health sciences committees** **Los Angeles Valley College** **Adjunct Faculty** **Teach cardiopulmonary anatomy and physiology** **Los Angeles Valley College** **Director of Clinical Education** • **Tenured track faculty** • **Exceeds on yearly evaluation** • **Teach cardiopulmonary anatomy and physiology** • **Coordinates students with clinical sites** • **Coordinates clinical affiliates contracts** • **Completes student competencies** • **Member of career technology education committee** **UCLA Medical Center** • Supervisor • Managed day to day operations of respiratory care department • Trainer Cardiothoracic ICU • Trainer Neuro-Trauma ICU • Exceeded on yearly evaluation for patient care services • Educates new hires in CTICU and Neuro Trauma ICU • Consistently earn highest rating in patient service by peers • Solid communication skills with supervisors and superiors • Exceeds in competencies completed	*August 2011 to Present* *August 2011 to Present* *July 2008 to August 2011* *February 2000 to August 2008*

Teaching Experience	**Santa Monica College/Los Angeles Valley College** **Classroom Teaching Experience** **Classes Taught** • Introduction to Respiratory Therapy RT 01 • Fundamentals of Respiratory Therapy RT 02 • Cardiopulmonary Anatomy and Physiology RT 06/60 • Applied Medicine and pathophysiology RT 07/70 • Advanced cardiac life support and monitoring RT 30 **Co-Taught** • Introduction to clinical experience RT 15 • Applications of Respiratory Therapy and • Clinical Experience I RT 03 • Applications of Respiratory Therapy and • Clinical Experience II RT 04 • Applications of Respiratory Therapy and • Clinical Experience III RT 05 • Applications of Respiratory Therapy and • Clinical Experience IV RT 11 **UCLA Medical Center** ***Clinical Instruction Experience*** **Clinical Instructor/preceptor for ELAC/SMC students** • Functioned as clinical instructor for ELAC/SMC students while at UCLA Medical Center. • Educated and mentored students throughout entire rotation. • Lectured and demonstrated floor care to students, performing Hand Held Nebulizers, IPPB, and MDIs. Also instructed students on mechanical ventilation, various modes of ventilation and non-invasive ventilations. • Provided environment that promoted intellectual growth and stimulated critical thinking. **Clinical Instructor for UCLA new hire** • Functioned as clinical instructor for new UCLA staff employees. • Under my supervision, new hire employees performed,	

	discussed or observed all aspects of respiratory therapy related to floor and critical care therapy. • Floor Therapy involved the following: Oxygen therapy, Cool Aerosol, Heated Aerosol, HHN, MDI, IPPB, IPPV, CPAP, Heliox and HiFLO Nasal cannula. • Critical Care therapy involved: Modes of mechanical ventilation (PRVC, PCV, CMV, VC, PSV, CPAP, VS, SIMV/PC/PS, SIMV/VC/PS, and ARDSNet protocol), Ventilators (Servo-I, Servo 300, Avea, and SMITH (ventipac)), Nitric Oxide via INO, and non invasive ventilation (BiPAP). **Cardiothoracic ICU mentor** • Educated respiratory therapists about cardiac anomalies/conditions affected by the use of mechanical ventilation and acid-base balance maintenance. • Topics discussed included: hypoplastic left ventricle, Norwood, Glenn Shunt, Fontan, AV Canal, TOF, Unifocalization, TGA, etc. **NeuroTrauma ICU mentor** • Educated respiratory therapists on the use of hyperventilation to prevent increase of intracranial pressures, Xenon, Technetium 99 and PETSCAN. Lectures Presented • Oxygen Therapy • Basic CXR reading • Pediatric airway management • Modes of Mechanical Ventilation	

Reference:

1. Mr. Melvin Welch, MA, RRT, RCP

   Santa Monica College
   Bundy 31-N
   Santa Monica, CA 90405
   Telephone: (310) 434-3463

2. Mrs. Bernadette Dizon BS, RRT, RCP

UCLA Medical Center
Respiratory Therapy
BOX 951658, A6-215 CHS
Los Angeles, CA 90095
Telephone: (310) 206-2855

3. Mr. Gregory Morrison

   Los Angeles Valley College
   Director, Respiratory Therapy Program
   5800 Fulton Avenue
   Valley Glen, CA 91401
   Telephone: (310) 206-4786

Ad Hoc Comm on Officer Status in the US Uniformed Services

Scott Woodcox

No report

Ad Hoc Committee on Leadership Institute

Reporter: Toni Rodriguez
Last submitted: 2012-10-04 15:15:19.0

Report

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

Vision Statement

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

Mission Statement

The mission of the Learning Institute is:

To foster leadership talent

To teach the skills of academic leadership

To advance the science of respiratory care

Summary of Activities Spring 2012

Discussion over the current lack of progress.

•o Problem of recruiting authors for Core Curriculum Modules was attributed to: 1) Content areas are not in line with our membership's areas of expertise and 2) the money offered to complete a module was too low.

•o Possible suggestions to overcome current stumbling blocks and move forward:

•§ Have participants provide proof of attainment of Core Course objectives from another appropriate venue. We would then only provide the specialty tracks. It was agreed that this would not be the best option given the extra time and cost to program participants.

•§ Subsume the core competencies in a more generalist form into each specialty track. Specialty content experts authoring a module would be better able to speak to core concepts in context. It was agreed that this would be the best solution and the committee chair was charged with presenting a model for accomplishing this. See Appendix A. Each committee member volunteered to rewrite the original track competencies to incorporate the newly developed general core competencies.

•o The committee agreed that we should proceed with development of a model script for the purpose of answering some of the questions raised at the end of the final 2011 committee report. Rob Chatburn volunteered to work out the Research Track. A meeting between Rob, Toni and Tom identified the following points:

Conclusions used for developing the original RFP:

•o 5 modules in the Core Track/ 34 competencies to be covered

•o Total of 45 contact hours for the entire core

•o 9 hours of instruction per module

•o 9:1 ratio for instructional development of a module = 81 hours of development time per module or 405 hours of instructional development for the entire track.

•o 81 hours X $30.00 per hour = $2430.00 per module

•o RFP amount $2500.00 to be paid per module

New consideration used in developing a new proposal for development:

•1) Based upon anecdotal data reported in the December 2011 committee report $65 - $150.00 per hour, based upon developer background and experience, was the standard range for content development. In addition consultation fees can be as much as $200.00 per hour. Given this data and even factoring in the desire to contribute as a volunteer, $30.00 per hour was an unrealistic amount to pay for the development of instructional content.

•2) Content authors would not be working on the project full time since they will most likely have a full time job. Rob indicated that upon his current commitments the most time he would be able to expend on the project is 10 hours per week. Using this time frame as an example, 432 hours of instructional content would require 43 weeks to complete or approximately 9 months.

Based upon this information the following conclusions were arrived at:

The original concept behind the institute was to provide continuing education for our members to prepare them for career advancement and/or make them more value as employees. The core was generalist skills and the three tracks were chosen because they are pillars of the profession essential to its continued growth. The time span of 45 hours was chosen based upon a desire to eventually have the courses accepted for credit by a traditional education program (i.e.: 2 or 4 year institution). 45 hours correlates with 3 credit hours in a traditional education environment (15 hrs = 1 credit). The three tracks plus the core would equal 12 credits in a traditional education environment.

Currently the project is at a standstill. We could not entice our own membership to author the Core modules at $30.00 per hour and an outside company intimated that it would cost "mid six figures" to produce the five modules. In addition, if membership could be recruited to produce course content it would be on a part time basis. Given Rob''s guesstimate of 10 hr per week to work on the project, it would take almost a year to get the instructional material for a track completed.

Given this information we may need to rethink our approach. Going back to our original premise, the concept was to provide continuing education. Continuing education is by definition training received post formal education to maintain or improve job skills. Continuing education is usually awarded CEU''s over credits. According to Wikipedia one CEU is generally 10 hours

of participation. Even considering the reference source we have greatly exceed traditional CEU standards with our desire to one day to align with a traditional education institution. It may be advisable to reduce the number of hours in each track in line with providing general knowledge instead of producing and expert.. The goal would be for enlightenment that could peak someone''s interest in pursuing more in depth education in a subject area. For the sake of discussion we considered the following based upon a rate of pay for development at $100.00/ hr which is the minimum amount Rob would consider to author the Research Track.

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

•o 6 modules in research track/ 30 competencies

•o Total of 45 - 50 contact hours for the entire track

•o 8 hours (round up from 7.5 hrs) of instruction per module.

•o 9:1 ratio for instructional development of a module = 72 hours of development per module or 432 hours of instructional development for the entire track.

•o 432 hours X $100.00/hr =$43,200.00 cost for development of the Research track.

•o 432 hours/10 hr per week = 43 weeks or 10 months to complete.

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

•o 6 modules in research track/30 competencies

•o Total of 15 contact hours for the entire track

•o 2.5 hours of instruction per module

•o 9:1 ratio for instructional development of a module = 22.5 hours of development per module or 135 hours of instructional development for the entire track.

•o 135 hours X $100.00/hr = $13,500.00 cost for development of the Research Track

•o 135 hours/10 hr per week = 13.5 weeks or 3.5 months to complete.

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

Summary of Activities Summer 2012

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

Summary of Activities Fall 2012

Committee activities are now focused on the creative process. Rob Chatburn continues the work on the Research Track and Toni Rodriguez has been contracted to complete the Education Track. Work on the Management Track will begin this quarter with Karen Stewart and Rick Ford taking on the challenge. The Research and Education Tracks are scheduled for competition early 2013. It has taken us a while to arrive at this point in the process and without a doubt we still have challenges related to the translation the developed curriculum and instruction to a web based format. But this ground work will prove to be invaluable in the completion of future endeavors related to the development and implementation of online learning modules.

Committee Members:

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

Staff Liaisons: Tom Kallstrom, RRT FAARC,

Appendix A:

CCC 101 Introduction to Human Communication:

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

Competencies:

1. Describe the process of interpersonal communication in terms of models and principles.

2. Describe the nature and function of communication on all levels within organizations.

3. Identify the components of listening and common barriers to the process.

4. Identify and explain the elements of nonverbal communication.

5. Identify strategies for conflict resolution within small groups.

6. Explain the impact of cultural and gender variables on interpersonal communication.

7. Prepare and demonstrate the effective delivery of a verbal presentation to a small group.

Suggested General Communication Competency:

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

CCC102 Health Information Management and Informatics:

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

Competencies - Basic Computer and Health Information Literacy Skills

Pre-Requsites

*Demonstrate proficiency in the Windows operating environment.

*Resolve minor technical problems associated with use of computers.

*Demonstrate use of email, addressing, forwarding, attachments, and netiquette.

*Create and name or rename subdirectories and folders.

*Demonstrate how to save work to a computer file, and printing and copy a file.

*Create and edit a formatted document using tables and graphs

*Demonstrate use of the essential aspects of file organization, information storage (such as disk or flash drive), protection from data loss, and basic computer skills.

Competencies:

1. Demonstrate Internet/intranet communication and topic search skills

2. Use basic word processing, spreadsheet, database, and desktop presentation applications as applicable to your work.

3. Use statistical analysis packages.

3. Differentiate between the types and content of patient health records (such as paper- based, electronic health records, and personal health records).

4. Know the architecture and data standards of health information systems.

5. Demonstrate an understanding of the relationship of telemedicine and its application to all care settings.

6. Identify legal and regulatory requirements related to the use of personal health information and apply policies and procedures for access and disclosure.

Suggested General Health Information Competency:

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

CCC 103 Financial Planning and Budgeting Principles:

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

Competencies:

1. Demonstrate generally accepted accounting principles (GAAP).

2. Explains income statement, balance sheet and cash flow

3. Prepare a simplified balance sheet and income statement.

4. Demonstrate knowledge of ratio analysis, cost-benefit analysis and cost-effectiveness analysis

5. Demonstrate knowledge of strategic planning, strategic financial planning, operational planning and capital budgeting.

Suggested General Financial Management Competency:

Organize, direct and control the financial activities related to project design and implementation

CCC 104 Small Group Problem Solving and Decision Making

Course Description: An organized approach to problem solving, decision making and small group management to include: group facilitation, conducting meetings, team building, intervention strategies and monitoring group progress.

Competencies:

1. Define the role of the facilitator, team leader and team members.

2. Discuss the impact of group dynamics in facilitating small group communication.

3. Explain how listening and speaking skills facilitate communication. Identify methods for identifying and defining problems

4. Select a problem and develop a solution based upon established problem solving protocol to include: study design, data analysis, selection of best solution, action plan analysis , implementation and follow up.

5. Define the steps in effective team building

6. Identify effective conflict management and intervention techniques.

7. Discuss strategies to be used in conducting effective meetings.

8. Identify ways to monitor group progress.

Suggested General Small Group Problem Solving Competency:

Demonstrate the ability to effectively manage and guide group efforts by providing appropriate feedback and prevent, manage, and/or resolve conflict.

CCC 105 Basic Management Skills

Course Description: The functions of management, specific roles and responsibilities of the supervisor and the application of leadership principles in addressing on-the-job situations and handling work related conflicts.

Competencies:

•1. Demonstrate an understanding of what it is to manage and to lead in the role of a

successful department manager.

•2. Describe the roles, functions of management and the responsibilities of supervisors and how they impact effective relationships in the workplace.

•3. Examine different leadership styles, explaining the advantages and disadvantages of each.

•4. Explain how to be successful in communicating with others based on their leadership style.

•5. Demonstrate an understanding of the characteristics of effective leaders, how to identify mentors, and gain from the example of others.

•6. Evaluate how to motivate others and coach them to improved performance

•7. Demonstrate an appreciation for teams, the importance of prioritizing conflicting demands, achieving desired outcomes and accountability for the achievement of outcomes.

Suggested General Management Competency:

Demonstrate the ability to support, promote, and ensure alignment with an organization''s vision and values while ensure the effective, efficient, and sustainable use of resources and assets.

Ad Hoc Committee on 2015 & Beyond

October 2012

Co-Chairs: Lynda Goodfellow, EdD, RRT, FAARC & John D. Hiser, MEd, RRT, FAARC

Staff Liaisons: Tom Kallstrom/Bill Dubbs/Tim Myers

Preface:

The 2015 ad hoc committee accepts the basic transitioning framework for the respiratory therapy workforce as presented by the publication *Transitioning the Respiratory Therapy Workforce for 2015 and Beyond* by Thomas A Barnes EdD RRT FAARC, Robert M Kacmarek PhD RRT FAARC, Woody V Kageler MD MBA, Michael J. Morris MD, and Charles G Durbin MD FAARC Published -Respir Care 2011; 56(5):681– 690.

To move forward, the transition plan attributes approved by the BOD in November 2010 are provided to insure that the recommendations submitted as part of this BOD report, if accepted, are not in violation of any previous BOD action. This report also includes the recommendations from the publication above (AKA "the third conference"), with a review of any action taken or planned since the gap analysis was completed. To this end, we cannot support any recommendations within the third conference which violates any transition plan attributes approved by the BOD in November 2010.

Final Transition Plan Attributes

The transition plan must:

1. Maintain an adequate respiratory therapist workforce throughout the transition.
2. Address unintended consequences such as respiratory therapist shortages.
3. Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc.)
4. Require competency documentation options for new graduates.
5. Support a process of competency documentation for the existing workforce.
6. Assure that credentialing and licensure recommendations evolve with changes in practice.
7. Address implications of changes in licensing, credentialing and accreditation.
8. Establish practical timelines for recommended actions.
9. Reflect the outcomes of the previous two 2015 and Beyond conferences
10. Identify the agencies most appropriate to implement identified elements.

Recommendations of the third conference publication:

1. That the AARC request CoARC to change by 7/1/12 accreditation standard 1.01 to read as follows:

    - 1.01 the sponsoring institution must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education (USDE) and must be authorized under applicable law or other acceptable authority to award graduates =of the program a baccalaureate or graduate degree at the completion of the program.

      Programs accredited prior to 2013 that do not currently offer a baccalaureate or graduate degree must transition to conferring a baccalaureate or graduate degree, which should be awarded by the sponsoring institution, upon all RT students who matriculate into the program after 2020.

    Action: do not adopt due to violation of attributes 1, 2, 3
    Not supported by AARC research, CoARC, and NBRC because of the potential negative impact on the availability of future entry level respiratory therapists.

2. That the AARC recommends to the NBRC on July 1, 2011, that the CRT examination be retired after 2014; And, that the AARC recommends to the NBRC on July 1, 2011 that the multiple choice examination components (CRT and RRT written) for the RRT should be combined after 2014.

    Action: do not adopt due to violation of attributes 1, 2
    NBRC is implementing a change in their credentialing system that will achieve a similar end.

3. That the AARC establish on July 1, 2011, a commission to assist state regulatory boards transition to a RRT requirement for licensure as a respiratory therapist.

    Action: defer at this time
    Various state boards are considering changing licensure requirements but no evidence presently exists for this need.

4. That the AARC Executive Office request that the AARC Board of Directors ask the appropriate existing sections to develop standards to assess competency of RTs in the workforce relative to job assignments of the RT.

    a. Standards should address the variety of work sites that employ RTs.

b. Standards should address RT knowledge, skills and attributes relative to the tasks being evaluated.

Action: see 2015 & Beyond recommendations below

5. That AARC encourage clinical department's educators, and state affiliates continuing education venues to use clinical simulation as a major tactic for increasing competency levels for the current workforce.

Action: see 2015 & Beyond recommendations below

6. That the AARC, in cooperation with the CoARC, consider development of consortia and cooperative models for associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.

Action: see 2015 & Beyond recommendations below

7. That the AARC provide budgetary resources to assist associate degree programs with the transition to baccalaureate level respiratory therapist education.

Action: defer at this time
No evidence presently exists for this need.

8. That the AARC BOD explores development and promotion of career ladder education options for the member of the existing workforce to obtain advances competencies and the baccalaureate degree.

Action: see 2015 & Beyond recommendations below

Recommendations of the 2015 & Beyond Ad Hoc Committee

Recommendation 1

Education by Degree Focus - The 2015 ad hoc committee recommends increased access to baccalaureate degrees (either Bachelors Science Respiratory Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the

workforce, be readily available to access by established articulation or transfer agreements by 2015.

Justification: The AARC clearly supports all associate-degree programs that are accredited by the CoARC. However, in order to maintain an adequate therapist workforce and avoid unintended consequences of a shortage of respiratory therapists, multiple options and flexibility are required. Working with CoARC, model affiliation agreements between AS programs and BS programs are needed with mentoring assistance provided in the articulation process. Lastly, distance learning opportunities that provide flexibility for working therapists and the acceptance of experiential work experience should be thoroughly explored. This recommendation addresses recommendations 6 & 8 of the third conference.

Recommendation 2

Competency Level Focus –The 2015 ad hoc committee recommends the acquisition of the competencies approved at the July 2012 BOD meeting by segregating those required at entry level and those that can be acquired after entering practice by 2015.

Justification: If the competencies required at entry- level are identified, then the CoARC can incorporate them into their future standards which will assure that they are included into the curriculum of accredited programs. As these skills find their way into the workplace, the NBRC will eventually detect this through their job analysis and incorporate them into their credentialing examinations. This can be accomplished by the development of standardized curricula that incorporates the teaching of knowledge, skills and attributes (KSA's) necessary to acquire the competencies that can be acquired after entering practice. The content can be delivered through continuing education programs developed by the AARC; CoARC accredited respiratory therapy education programs, and other institutions that deliver education. In traditional courses, participants can gain the needed KSAs and competency documentation. Nontraditional programs can be used to deliver the educational content while the skill development and competency documentation can be conducted in laboratories of accredited respiratory programs or skills labs located in the facilities, or systems (high-fidelity), where therapists are employed. This recommendation addresses recommendations 4, 5 & 8 of the third conference.

Recommendation 3

Project Leadership Focus - The 2015 ad hoc committee recommends that the AARC BOD recruit stakeholders who understand the issues, recognize the barriers, and are motivated to make the 2015 and Beyond efforts successful.

Justification: Representation from CoARC accredited associate degree programs that have and don't have an articulation agreements as well as representatives from baccalaureate and masters (BSRT and MSRT) degree programs are urged to participate in order to successfully overcome barriers to higher education. Other professionals needed to guide the process are a distance

learning specialist, representatives from CoARC and the NBRC, respiratory therapy employers from both the hospital and home care settings. As specific tasks are defined, additional volunteers will likely be required. This recommendation addresses recommendations 4,5,6 & 8 of the third conference.

Conclusion: It is essential that the AARC plan for the future and take steps to assure that we are prepared to assume the duties and responsibilities that may be required of the respiratory therapist in the years to come. By accepting these recommendations, the BOD is sending the message that you agree with the findings of the third conference supporting the need for more bachelor degree level therapists and the requirement that the transition plan conforms to the transition plan attributes.

Committee Objectives:

1. Review the attributes and compare to the recommendations for areas that required additional definition.
   Complete - The committee reviewed and compared the attributes to the recommendations from the third conference and completed a Gap Analysis which is included with this report.

2. Identify gaps and identify other information that will be necessary to act on the recommendations.
   Complete - Gaps were identified and are included in the Gap Analysis.

3. Identify groups of organizations and interested parties that would be necessary to obtain feedback regarding the recommendations and the attributes.
   Complete - Feedback from numerous sources has been received.

4. Identify a mechanism to obtain additional feedback from members and mangers of respiratory care.
   Complete - Surveys were performed a second time in June 2012.

5. Develop a time line of activity the needs to occur and a time line for BOD action.
   Complete

   November BOD Meeting
   a. Present final 2015 and Beyond recommendations to the BOD
   b. Send an update of progress to AARC members following the BOD meeting

The co-chairs would like to thank President Stewart for her leadership in this effort and also thank her for the trust she has placed in us to carry on this initiative. Also thanks to the members and a big thank you to Bill Dubbs for all of his work.

Members:
Patricia Doorley
George Gaebler
Denise Johnson
Woody Kageler (BOMA)
Dianne Lewis
Toni Rodriguez
Karen Schell
Richard Sheldon (BOMA)
Margaret Traband

Ad Hoc Committee to Recommend Bylaws Changes

Chair, Denise Johnson
November 2012, BOD Meeting

Recommendation: Review and accept proposed changes to AARC Bylaws as written below.

1. ARTICLE II – OBJECT
   SECTION 1. PURPOSE

AARC Vision/Mission Statement

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.

2. SECTION 7. SPECIALTY SECTIONS

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 will be granted to those Specialty Sections consisting ~~of at least~~ with a minimum of 1000 active members to be considered for a seat on the Board.
b. The active members of each Specialty Section shall elect a Chair-elect every third year. Elections shall be staggered such that a maximum of one third (1/3) of section chairs-elect shall be elected each year.

3. ARTICLE IV - OFFICERS

SECTION 1. OFFICERS

a. The Officers of the Association shall consist of the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, Secretary-Treasurer, and in alternate years President-Elect, and shall be elected in accordance with the provisions of Article XII, Section 2 (b).
b. Officers of the Association shall not concurrently be members of national respiratory care credentialing or accreditation bodies or chartered affiliate or voting members of their Board of Directors.

4. SECTION 4. DUTIES OF OFFICERS

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.

5. ARTICLE V - BOARD OF DIRECTORS

SECTION 1. COMPOSITION AND POWERS

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 Section ~~of at least~~ with a minimum of 1000 active members of the Association to be considered for a seat on the Board of Directors. So 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 Section Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of ~~seventeen~~ twelve (~~17~~ 12) ~~members~~ director seats on ~~of~~ the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the Presidents 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 or voting members of their Board of Directors.

c. The President shall be the Chair and Presiding Officer of the Board of Directors and the Executive Committee. The President shall invite such individuals to the meetings of the Board as deemed necessary, who shall have the privilege of voice but not vote.

6. SECTION 2. COMPOSITION AND DUTIES OF COMMITTEES

1. The committee shall be composed of ~~five~~ six (~~5~~ 6) Active Members; three (3) elected by the House of Delegates and two elected by the Board of Directors and the Immediate Past President. The Chair shall be selected by the House of Delegates.

2. The term of office for each member except the Immediate 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.

7. ARTICLE VIII – BOARD OF MEDICAL ADVISORS

SECTION 3. DUTIES

b. The Board of Directors of the Association and all of 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.

Unfinished Business:

- Do we need policy to deal with more than six eligible sections?

- Physician membership definition (see below)

SECTION 3. ASSOCIATE MEMBER

d. Physician Member – Individuals will be classified as Physician Members if they meet all the requirements for Associate membership and are duly licensed as doctors of medicine or osteopathy.

- Board of Medical Advisors Composition and Term of Office (see below)

ARTICLE VIII - BOARD OF MEDICAL ADVISORS
SECTION 1. COMPOSITION

The Board of Medical Advisors of the Association shall consist of no less than twelve (12) individual members. Representation shall be maintained from each member organization, as defined by the Association Board of Directors policy. Members of the Board of Medical Advisors shall not concurrently be members of national respiratory care credentialing or accreditation bodies. Appointees to the Board of Medical Advisors must be physicians who have an identifiable role in clinical, organizational, educational or investigative respiratory care. Members of the Board of Medical Advisors must be members of the Association during their term.

SECTION 2. TERM OF OFFICE

Each member shall be appointed by the sponsoring member organization in such a manner that no more than one-fourth of the members of the Board of Medical Advisors shall be replaced in any year. Any vacancy that occurs on the Board of Medical Advisors should be filled by an appointment from the member organization. Terms shall commence immediately following the Annual Business Meeting.

Committee members:
Susan Rinaldo-Gallo, Linda Van Scoder, and Colleen Schabacker Staff: Timothy Myers

AARC Bylaws

ARTICLE I - NAME

This organization shall be known as the American Association for Respiratory Care, incorporated under the General Not-For-Profit Corporation Act of the State of Illinois, hereinafter referred to as the Association.

ARTICLE II - OBJECT

SECTION 1. PURPOSE

AARC Vision/Mission Statement

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.

The Association is formed to:

a. Encourage, develop, and provide educational programs for those persons interested in respiratory therapy and diagnostics, hereinafter referred to as Respiratory Care.
b. Advance the science, technology, ethics, and art of respiratory care through institutes, meetings, lectures, publications, and other materials.
c. Facilitate cooperation and understanding among respiratory care personnel and the medical profession, allied health professions, hospitals, service companies, industry, governmental organizations, and other agencies interested in respiratory care.
d. Provide education of the general public in pulmonary health promotion and disease prevention.

SECTION 2. INTENT

a. No part of the monies of the Association shall inure to the benefit of any private member or individual, nor shall the Association perform particular services for individual members thereof.
b. The Board of Directors shall provide for the distribution of the funds, income, and property of the Association to charitable, educational, scientific, or religious corporations, organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payee or distributees are exempt from income taxation, and if gifts or transfers to the payee or distributees are then exempt from taxation under the provisions of Sections 501, 2055, and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.
c. In the event of the dissolution of this Association, whether voluntary or involuntary, all of its remaining assets shall be distributed in such a manner as the Board of Directors of this Association shall by majority vote determine to be best calculated to carry out the objectives and purposes for which the Association is formed. The distribution of the funds, income, and property of this Association upon the dissolution may be made available to any charitable, educational, scientific, or religious corporations, organizations, community chests, foundations, or other kindred institutions maintained and created for one or more of the foregoing purposes, if at the time of distribution the payee or distributees are then exempt from income

taxation, and if gifts or transfers to the payee or distributee are then exempt from taxation under the provisions of Sections 501, 2055 and 2522 of the Internal Revenue Code or changes which amend or supersede the said sections.
d. The Association shall not commit any act which shall constitute the unauthorized practice of medicine under the laws of the State of Illinois or any other state.

ARTICLE III - MEMBERSHIP

SECTION 1. CLASSES

The membership of the Association shall include three classes: Active Member, Associate Member, and Special Member.

SECTION 2. ACTIVE MEMBER

An individual is eligible for Active Membership if he/she lives in the United States or its territories or was an Active Member prior to moving outside its borders or territories, and meets ONE of the following criteria: (1) is legally credentialed as a respiratory care professional if he/she is employed in a state or territory that maintains a legal credential for respiratory care professionals OR (2) is a graduate of an educational program in respiratory care accredited by an AARC- recognized agency, OR (3) holds a credential issued by an AARC-recognized agency. An individual who was an AARC Active Member in good standing on December 8, 1994, will continue as such, providing his/her membership remains in good standing. Active Members in good standing shall be entitled to all the rights and privileges of membership of the Association including: the right to hold office, hold committee chairs, and vote.

SECTION 3. ASSOCIATE MEMBER

Individuals will be classified as Associate Members if they hold a position related to respiratory care but do not meet the requirements to become Active Members. Associate Members shall have all the rights and privileges of membership except that they shall not be entitled to hold office, vote, or serve as a director, chair of any standing committee or specialty section of the Association. There shall be the following subclasses of Associate Membership:
a. Foreign Member – Individuals will be classified as foreign members if they meet all the requirements for Associate Membership and they are citizens of or reside in any country other than the United States of America.
b. Student Member – Individuals will be classified as Student Members if they meet all the requirements for Associate Membership and are enrolled in an educational program in respiratory care accredited by, or in the process of seeking accreditation from, an AARC-recognized agency.
c. Foreign Student Member – Individuals will be classified as Foreign Student Members if they meet all the requirements for a Foreign Member and are enrolled in an educational program in respiratory care which is accredited or is seeking accreditation by an appropriate governmental or professional accrediting agency.
d. Physician Member – Individuals will be classified as Physician Members if they meet all the requirements for Associate membership and are duly licensed as doctors of medicine or osteopathy.
e. Industrial Member – Individuals will be classified as Industrial Members if they meet all the

requirements for Associate Membership and their primary occupation or business or a majority of their business time is directly or indirectly devoted to the manufacture, sale, or distribution of equipment or products which are directly or indirectly used in the area of respiratory care.

SECTION 4. SPECIAL MEMBER
a. Life Member – Life Members shall be members who have rendered outstanding service to the Association as Active Members. Life Members shall have all the rights and privileges of active membership of the Association. Life Members shall be exempt from the payment of dues. Hereinafter all references to Active Members shall refer to both Active and Life Members of the Association.
b. Honorary Members – Honorary Members shall be persons who have rendered distinguished service to the field of respiratory care. Honorary Members shall have all the rights and privileges of Associate Membership of the Association. Honorary Members shall be exempt from the payment of dues.
c. General Member – General Members shall be individuals who have an interest in respiratory care and who do not qualify for other membership classifications. General Members shall have all the rights and privileges of Associate Membership in the Association.

SECTION 5. PREREQUISITES
FOR MEMBERSHIP

Applicants for membership shall meet all the qualifications of the class of membership for which they apply. As a condition of membership, all Members shall be bound by the Articles of Incorporation, Bylaws, standing rules, code of ethics, and other rules, regulations, policies, and procedures adopted from time to time by the Association.

SECTION 6. APPLICATION
FOR MEMBERSHIP

a. Applicants for membership shall submit their completed official application to the Executive Office of the Association.
b. The names and addresses of applicants accepted by The Executive Office shall be submitted for publication.
c. Any member or members may object to approval of an applicant for membership by filing written objection with the Executive Office within (30) calendar days after publication of the applicant's name. If an objection is received, the Executive Office shall promptly notify the President, Judicial Committee Chair, the applicant, and the Chartered Affiliates-President. Whenever there is an objection, the Judicial Committee shall reevaluate the application and make a decision regarding admission.

SECTION 7. SPECIALTY SECTIONS

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 will be granted to those Specialty Sections consisting ~~of at least~~ with a minimum of 1000 active members to be considered for a seat on the Board.
b. The active members of each Specialty Section shall elect a Chair-elect every third year. Elections shall

be staggered such that a maximum of one third (1/3) of section chairs-elect shall be elected each year.

SECTION 8. PAYMENT OF DUES

Each member of the Association, except Life Members and Honorary Members, shall pay dues in such amounts and in such manner as may be established annually by the Board of Directors.

SECTION 9. ETHICS

If the conduct of any member shall appear to be in violation of the Articles of Incorporation, Bylaws, standing rules, code of ethics, or other regulations, policies, or procedures adopted by the Association, or shall appear to be prejudicial to the Association's interests, such members may be reprimanded, suspended, expelled, or have their membership status reclassified in accordance with the procedures set forth in the Association's policies and procedures.

ARTICLE IV - OFFICERS

SECTION 1. OFFICERS

a. The Officers of the Association shall consist of the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, Secretary-Treasurer, and in alternate years President-Elect, and shall be elected in accordance with the provisions of Article XII, Section 2 (b).
b. Officers of the Association shall not concurrently be members of national respiratory care credentialing or accreditation bodies or chartered affiliate or voting members of their Board of Directors.

SECTION 2. TERM OF OFFICE

a. The term of office for the President-elect shall be one (1) year. The term of office for the President, Immediate Past President, Vice President for Internal Affairs, Vice President for External Affairs, and Secretary-Treasurer shall be two (2) years. The term shall begin immediately following the Annual Business Meeting.
b. The President-elect shall complete immediate successive full terms for the offices of President-elect, President, and Immediate Past President before being eligible to serve a successive term in any elected office.

SECTION 3. VACANCIES IN OFFICE

a. In the event of a vacancy in the office of President, the Immediate Past President shall resume the duties but not the office of President until a special election can be held to fill the office.
b. In the event of a vacancy in the office of President-elect due to resignition or inability to perform duties, the Vice President for Internal Affairs shall assume the duties, but not the office, of the President-elect and shall also continue to serve as Vice President for Internal Affairs until a special election is held to fill the office of President-elect.
c. Any vacancy in the office of either Vice President or the Secretary-Treasurer shall be filled by the appointment of a qualified individual by the Board of Directors. Individuals so appointed shall serve until

the next scheduled election for that office.
d. In the event of a vacancy in the office of immediate Past President, the most recent Past President will assume the office of Immediate Past President. If that person is unable or unwilling to serve, the office shall be filled by the appointment of a qualifed individual by the Board of Directors. Individuals so appointed shall serve the remainder of the term.

SECTION 4. DUTIES OF OFFICERS

a. President – The President shall be the Chief Executive Officer of the Association. The President shall preside at the Annual Business Meeting and all meetings of the Board of Directors; prepare an agenda for the Annual Business meeting and submit it to the membership not fewer than thirty (30) calendar days prior to such a meeting in accordance with Article VI of these Bylaws; prepare an agenda for each meeting of the Board of Directors and submit it to the members of the Board not fewer than fifteen (15) calendar days prior to such meeting; appoint standing and special committees subject to approval of the Board of Directors; be an ex-officio member of all committees except the Elections Committee; and present to the Board of Directors and membership an annual report of the Association.
b. President-elect – The President-elect, if sitting, shall perform duties as assigned by the President or Board of Directors.
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.
e. Secretary-Treasurer – The Secretary Treasurer shall see that full and accurate accounts are kept; see that the Executive Office submits monthly financial statements to the Board of Directors, House of Delegates Officers, and the Finance Committee within a reasonable period of time after the monthly closing of the books, make a complete written yearly report at the Annual Business Meeting; keep complete and accurate minutes of meetings of the Board of Directors, Executive Committee, Finance Committee, the Annual Business Meeting, and any other meeting as directed by the President; and perform such other duties as shall be assigned by the President or the Board of Directors. At the expense of the Association, the Secretary-Treasurer shall be bonded in an amount determined by the Board of Directors.
f. Immediate Past President – The Immediate Past President, shall advise and consult with the President, serve as a member of the Bylaws Committee, serve as a liaison to the Board of Medical Advisors and perform such other duties as shall be assigned by the President or the Board of Directors. If the office of President becomes vacant, the Immediate Past President will resume the duties of President until a special election can be held.

ARTICLE V - BOARD OF DIRECTORS

SECTION 1. COMPOSITION

AND POWERS

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 Section ~~of at least~~ with a minimum of 1000 active members of the Association to be considered for a seat on the Board of Directors. So 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 Section Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of ~~seventeen~~ twelve (~~17~~ 12) ~~members~~ director seats on ~~of~~ the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the Presidents 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 or voting members of their Board of Directors.
c. The President shall be the Chair and Presiding Officer of the Board of Directors and the Executive Committee. The President shall invite such individuals to the meetings of the Board as deemed necessary, who shall have the privilege of voice but not vote.

SECTION 2. TERM OF OFFICE

Up to one-third (1/3) of the at-Large Directors shall be elected each year, and the term of office for all Directors shall begin following the Annual Business Meeting and shall be three (3) years.

SECTION 3. DUTIES

The Board of Directors shall:
a. Supervise all the business and activities of the Association within the limitation of these Bylaws.
b. Employ a business counsel to be identified as the Executive Director, who shall manage the Executive Office from which the business of the Association is conducted.
c. Govern the activities of the Executive Director.
d. Grant charters to affiliates which meet the requirements for affiliation upon recommendation of the Chartered Affiliates Committee; and have the power to revoke charters.
e. Adopt and rescind standing rules, regulations, policies, and procedures of the Association.
f. After consideration of the budget, determine for the following year the amount of membership dues, remunerations, stipends, and other related matters.
g. Furnish the elections committee with the names of qualified candidates for AARC Officers.
h. Perform such other duties as may be appropriate for the management of the Association.

SECTION 4. VACANCIES

a. Any vacancy that occurs in the office of an at-Large Director shall be filled by appointment by the Board of Directors.
b. An appointed at-Large Director shall serve until the next scheduled election, or until a successor is

elected.
c. Any vacancy that occurs in the office of Section Chair serving as a Director shall be filled by the Chair-elect of that Specialty Section, if one is serving at that time. The ascending Chair-elect shall serve the unexpired term of the Chair and his or her own three (3) year term. If there is no Chair-elect, that Specialty Section will hold a special election of a Chair, who will serve the unexpired term and his or her own three (3) year tem.
d. If no Chair-elect is serving at the time of vacancy, the vacancy shall be filled by appointment, of a member of that Specialty Section, by the Board of Directors. An appointed Section Director shall serve until the next scheduled election, or until a successor is elected.
e. The Board of Directors shall have the power to declare an office or seat on the Board of Directors vacant by a two-thirds (2/3) vote upon refusal, neglect or inability of any officer or director to perform their duties, or for any conduct deemed prejudicial to the Association. Written notice shall be given to the member that the office has been declared vacant.

SECTION 5. MEETINGS

a. The Board of Directors shall meet immediately preceding and immediately following the annual Business Meeting of the Association and shall hold not fewer than two (2) regular and separate meetings during the course of the year.
b. Special meetings of the Board of Directors shall be called by the President at such times as the business of the Association shall require, or upon written request by the majority of the Board of Directors filed with the President and the Executive Director of the Association.
c. Meetings of the Board of Directors may be in person, by telephone or video conferencing or other electronic means as shall be determined by the Board of Directors.
d. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board.

SECTION 6. VOTE OF MEMBERSHIP

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

ARTICLE VI - ANNUAL BUSINESS MEETING

SECTION 1. DATE AND PLACE

a. The Association shall hold an Annual Business Meeting each calendar year. Additional meetings may be held as required to fulfill the objectives of the Association.
b. The date and place of the Annual Business Meeting and additional meetings shall be decided in advance by the Board of Directors. In the event of a major emergency, the Board of Directors may cancel the

scheduled meeting, set a new date and place if feasible, or conduct the business of the meeting by alternate means provided the material is distributed in the same words to the membership.

SECTION 2. PURPOSE

a. The Annual Business Meeting shall be for the purpose of receiving reports of officers and committees, the results of the election, and for other business brought by the President.
b. Additional business meetings shall be for the purpose of receiving reports and for other business brought by the President.

SECTION 3. NOTIFICATION

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

ARTICLE VII - HOUSE OF DELEGATES

SECTION 1. COMPOSITION

a The House of Delegates shall be composed of from one (1) to three (3) delegates from each Chartered Affiliate of the Association They shall be hereinafter referred to as the Delegation.
b. A Speaker shall be elected by and from the House to chair House meetings. The House shall elect such other officers and be responsible for such organizational practices as it may otherwise require.

SECTION 2. PURPOSE

The House of Delegates shall serve as a representative body of the general membership and the representative body of the Chartered Affiliates of the Association. It shall participate in the establishment of the goals and objectives for the Association and participate in the governance of the Association.

SECTION 3. DUTIES

a. The House of Delegates shall adopt such rules, regulations, policies, and procedures with respect to the House as it may deem necessary or appropriate, and all Delegates shall be bound thereby.
b. The House Speaker may appoint members to the House Committees, subject to the approval of the House of Delegates. In the event of vacancies occurring in any House Committee, the Speaker may appoint members to fill such vacancies, subject to the approval of the House of Delegates.
c. Each Delegate shall:
1. Attend all meetings of the House of Delegates and report the activities to the respective Chartered Affiliate.
2. Attend the Annual Business Meeting of the Association as the representative of the Active Members of the Association within their respective Chartered Affiliate.
3. Furnish the Elections Committee with the names of qualified members for nomination as Director-at-

Large.
4. At the direction of their respective Chartered Affiliate, present proposed amendments to the Bylaws Committee.
5. Perform such other duties of office as may be necessary or required.

SECTION 4. MEETING

The House of Delegates shall meet preceding the Annual Business Meeting of the Association and at such other times as called by its Speaker or by the majority vote of the House of Delegates.

SECTION 5. ELECTION OF DELEGATES

a. The Delegation shall be elected by the Active Members of the Association within their respective Chartered Affiliates.
b. Only Active Members in good standing of the Association who are not on the Board of Directors of the Association shall be eligible to be members of a delegation.
c. The Chartered Affiliate shall have the power to declare any position of the Delegation vacant upon refusal, neglect or inability of the Delegate to perform the duties of office, or for any other conduct deemed prejudicial to the Chartered Affiliate of the Association. Written notice shall be given to that Delegate and the Speaker of the House of Delegates that the office has been declared vacant.

SECTION 6. VOTING

a. Each delegation shall have one (1) vote for each Active Member within their Chartered Affiliate as submitted by the Executive Office and certified by the House of Delegates Credentials Committee.
b. The House Speaker shall appoint the members of the House Credentials Committee from the House. This Committee shall certify the Delegation and number of votes each Delegation may cast.

SECTION 7. QUORUM

A majority of the credentialed Delegations shall constitute a quorum at any meeting of the House of Delegates.

ARTICLE VIII - BOARD OF MEDICAL ADVISORS

SECTION 1. COMPOSITION

The Board of Medical Advisors of the Association shall consist of no less than twelve (12) individual members. Representation shall be maintained from each member organization, as defined by the Association Board of Directors policy. Members of the Board of Medical Advisors shall not concurrently be members of national respiratory care credentialing or accreditation bodies. Appointees to the Board of Medical Advisors must be physicians who have an identifiable role in clinical, organizational, educational

or investigative respiratory care. Members of the Board of Medical Advisors must be members of the Association during their term.

SECTION 2. TERM OF OFFICE

Each member shall be appointed by the sponsoring member organization in such a manner that no more than one-fourth of the members of the Board of Medical Advisors shall be replaced in any year. Any vacancy that occurs on the Board of Medical Advisors should be filled by an appointment from the member organization. Terms shall commence immediately following the Annual Business Meeting.

SECTION 3. DUTIES

a. The Board of Medical Advisors shall elect their own officers and be responsible for such organizational policies and procedures as they may require.
b. The Board of Directors of the Association and all of 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.
c. The Chair of the Board of Medical Advisors shall be a non-voting member of the Board of Directors.

SECTION 4. MEETINGS

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.

ARTICLE IX - PRESIDENTS COUNCIL

a. The Presidents Council shall be composed of Past Presidents of the Association who have been elected to membership by the Council.
b. The Presidents Council shall serve as an advisory body to the Board of Directors and perform other duties assigned by the Board of Directors.
c. The Presidents Council shall elect a Chair from its membership to serve a one-year term beginning immediately following the Annual Business Meeting.
d. The Chair of the Presidents Council shall serve as a non-voting member of the Board of Directors and preside at meetings of the Presidents Council.
e. The Presidents Council shall meet annually following the Annual Business meeting of the Association.
f. The Presidents Council may appoint committees as necessary to complete its duties.
g. In the event of a vacancy in the Chair, the vacancy shall be filled according to the procedure defined by the Association.

ARTICLE X - CHARTERED
AFFILIATES

SECTION 1. REQUIREMENTS

Twenty (20) or more Active members in good standing of the Association meeting the requirements for affiliation may become a Chartered Affiliate of the Association upon the affirmative recommendation of the Chartered Affiliates Committee and approval by the Board of Directors of the Association. Active Members of Chartered Affiliates must be Active Members of the Association. The minimum geographical boundaries of an applicant for a Chartered Affiliate of the Association shall encompass one or more entire states, territories, possessions, or protectorates of the United States. The District of Columbia shall be considered an entire state for this section.

SECTION 2. ADMISSION PROCEDURE

The formal application for a charter shall be sent to the Executive Office of the Association and shall consist of a list of officers, membership, minutes of the organizational meeting, the Bylaws, and a letter requesting approval of the proposed medical advisor or advisors.

SECTION 3. MEDICAL ADVISOR

Each Chartered Affiliate shall have one (1) or more medical advisors whose name(s) shall be submitted to the Board of Medical Advisors.

SECTION 4. DUTIES

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

SECTION 5. SUSPENSION OR
REVOCATION OF A CHARTER

a. The Board of Directors of the Association may suspend or revoke the charter of any affiliate with due and sufficient cause or upon the failure of an affiliate to maintain a membership of at least twenty (20) Active Members in good standing of the Association.
b. Action for the suspension or revocation of the charter of any affiliate shall follow approved Association policy and procedure.

ARTICLE XI - INTERNATIONAL
AFFILIATES

SECTION 1. REQUIREMENTS

Twenty (20) or more Foreign Members in good standing of the Association meeting the requirements for affiliation may become an International Affiliate of the Association upon the affirmative recommendation of the Chartered Affiliates Committee, and approval by the Board of Directors of the Association.

SECTION 2. INTERNATIONAL
AFFILIATE ADMISSION PROCEDURE

The formal application for International Affiliate status shall be sent to the Executive Office of the Association and shall consist of a list of officers, membership, minutes of the organizational meeting, the Bylaws, and a letter requesting approval of the proposed medical advisor or advisors.

SECTION 3. INTERNATIONAL
AFFILIATE MEDICAL ADVISOR

Each International Affiliate shall have one (1) or more medical advisors whose name(s) shall be submitted to the Board of Medical Advisors.

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 meeting.

SECTION 5. SUSPENSION OR
REVOCATION OF INTERNATIONAL AFFILIATE STATUS

a. The Board of Directors of the Association may suspend or revoke the International Affiliate status with due and sufficient cause or upon the failure of an affiliate to maintain a membership of at least twenty (20) Foreign Members.
b. Action for the suspension or revocation of International Affiliate status shall follow approved Association policy and procedure.

ARTICLE XII - COMMITTEES

SECTION 1. STANDING COMMITTEES

a The standing committees of the Association shall be: Bylaws, Elections, Executive, Finance, Judicial, Program and Strategic Planning. The Chair and members of standing committees, not otherwise designated in these Bylaws or Association Policy and Procedure, shall be appointed by the President, subject to the approval of the Board of Directors. With the exception of the Elections and Bylaws Committees, committee terms shall be for two (2) years. The Chartered Affiliates Committee, as referred to in these Bylaws, shall be a standing committee of the House of Delegates.
b. Decisions of standing committees, except as specified in Article XII, Section 2 (a) (3), may be appealed to the Board of Directors. A two-thirds (2/3) vote of the Board of Directors shall be required to sustain an appeal.

SECTION 2. COMPOSITION AND DUTIES OF COMMITTEES

a. Bylaws Committee

1. The committee shall be composed of the Immediate Past President and four (4) additional Active Members of the Association elected by the House of Delegates. The House elect members shall serve two year terms. These terms shall be staggered, with two (2) members being elected each year. The Chair shall be the senior House elect member, who, between the two senior members, received the greatest number of votes cast by the House.

2. Proposed amendments to the Bylaws may be originated by the Bylaws Committee or submitted to the Bylaws Committee only by the Board of Directors, House of Delegates, or Chartered Affiliates. The committee shall review the amendments proposed by any of the foregoing bodies and shall submit its recommendations to the proponent. Upon receipt of such recommendations, the proponent may, but shall not be obliged to, withdraw the proposed amendments from further consideration. Any proposed amendments that are not withdrawn by the proponent and any proposed amendments which are originated by the Bylaws Committee shall be delivered to the House of Delegates and the Board of Directors, with the committee's recommendations for same, at least sixty (60) calendar days prior to the date on which voting begins.

3. In the event of a problem with the interpretation of the Bylaws, the question shall be referred to the Bylaws Committee. Either the Board of Directors or the House of Delegates may refer a Bylaws interpretation matter to the committee by a two-thirds (2/3) affirmative vote. The decision of the committee shall be final.

b. Elections Committee

1. The committee shall be composed of ~~five~~ six (~~5~~ 6) Active Members; three (3) elected by the House of Delegates and two elected by the Board of Directors and the Immediate Past President. The Chair shall be selected by the House of Delegates.

2. The term of office for each member except the Immediate 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.

3. The committee shall screen candidates nominated for Director, Officer, and Specialty Section Chair-Elect positions. Nominations for at-Large Directors shall be submitted to the committee only by the House of Delegates. Nominations for Section Chair-elect shall be submitted to the committee only by members of that Specialty Section. Nominations for Officers shall be submitted to the committee only by the Board of Directors.

4. The Chair of the committee shall report the slate of nominees to the Board of Directors and House of Delegates no later than June 1. The final slate of candidates shall be submitted to the Board of Directors and the House of Delegates before submission to the general membership.

5. The committee shall be responsible for preparing, distributing, receiving, and verifing all ballots. At least sixty (60) days prior to the Annual Business Meeting, ballots setting forth the slate of candidates shall be made available to Active Members of the Association in good standing. Only Active Members of a Specialty Section may vote for the Chair-elect of the Specialty Section. Provisions shall be made on the ballot for write-in votes for each office to be filled. Voting will close no less than thirty (30) calendar days prior to the Annual Business Meeting. Ballots shall be counted no less than twenty-one (21) calendar days prior to the Annual Business Meeting. The deadline date and time shall be clearly indicated on the ballot.

6. Association elections shall be determined by a plurality of the votes cast. A tie vote shall be decided by

lot.
c. Executive Committee
1. The Executive Committee of the Board of Directors shall be composed of the President, Immediate Past President, Vice President for Internal Affairs, Vice
President for External Affairs, Secretary-
Treasurer, and in alternate years, the
President-Elect.
2. The Executive Committee shall have the power to act for the Board of Directors between meetings of the Board and such action shall be subject to ratification by the Board at its next meeting.
d. Finance Committee
1. The Finance Committee is composed of the Executive Committee of the Board of Directors and the House of Delegates Treasurer and Speaker-elect. The committee shall be chaired by the President. The committee shall submit for approval the annual budget to the House of Delegates and the Board of Directors.
2. The Audit Subcommittee shall consist of the Speaker-elect, who shall be the chair, the House of Delegates Treasurer, and one member of the Executive Committee appointed by the President. The Secretary-Treasurer shall be a non-voting member. The subcommittee is responsible for monitoring the financial affairs of the Association in cooperation with external independent auditors.
e. Judicial Committee
1. The committee shall consist of not fewer than four (4) Active Members.
2. The committee shall review membership challenges, or complaints against any member charged with any violation of the Association's Articles of Incorporation, Bylaws, standing rules, code of ethics, or other rules, regulations, policies, or procedures adopted, or for any conduct deemed detrimental to the Association. Such complaints must be filed with the Chair of the Judicial Committee. The committee shall conduct a review in accordance with established policies and procedures. Such policies and procedures shall be available to any member upon request.
3. If the committee determines in its sole discretion that the complaint warrants further action, a written statement of the charges shall be prepared with benefit of legal counsel if deemed advisable, and the matter shall be resolved according to established policies and procedures.
4. The member shall have the right to appeal the decision of the committee to the Board of Directors There shall be no appeal from the decision of the Board of Directors.
f. Program Committee
1. The committee shall consist of not fewer than four (4) Active Members.
2. The committee shall prepare the program for the Annual Business meeting and all other programs, as directed by the President.
g. Strategic Planning Committee
1. The committee shall consist of not fewer than five (5) members. The chair shall be the Immediate Past President.
2. The committee shall make recommendations to the Board of Directors about the direction of the Association and the profession of Respiratory Care.

SECTION 3. COMMITTEE CHAIR'S
DUTIES

a. The Chair shall perform those duties as specified by the President and the Board of Directors to carry out the objectives of the Association.
b. The Chair of each committee shall confer promptly with the members of that committee on work assignments.
c. Members of any membership class, as well as non-members, may be appointed as consultants to committees. The President shall request recommendations regarding physician consultants from the Chair of the Board of Medical Advisors.

SECTION 4. SPECIAL COMMITTEES
AND OTHER APPOINTMENTS

a. Special committees may be appointed by the President, subject to the approval of the Board of Directors.
b. Representatives of the Association to such external organizations as may be required shall be appointed by the President, with the approval of the Board of Directors.

SECTION 5. VACANCIES ON
COMMITTEES

In the event of vacancies occurring in any committee, the President may appoint members to fill such vacancies, subject to the approval of the Board of Directors.

ARTICLE XIII - FISCAL
YEAR AND BUDGET

a. The fiscal year of the Association shall begin on January 1 and end on December 31.
b. The annual budget proposed by the Finance Committee, shall be approved by the House of Delegates and Board of Directors before implementation.

ARTICLE XIV - PARLIAMENTARY AUTHORITY

The rules contained in the most current edition of Robert's Rules of Order shall govern whenever they are not in conflict with the Articles of Incorporation, Bylaws, standing rules, or other rules of the Association.

ARTICLE XV - AMENDMENT

These Bylaws may be amended in accordance with Article XII, Section 2 (a) 2, if an amendment receives an affirmative majority vote of the Board of Directors and also receives an affirmative majority vote of the House of Delegates. The amendment must then be submitted to the membership for comments and input within forty-five (45) days of the first affirmative vote. After which the Board of Directors and the House of Delegates will have a second reading and vote. If the amendment receives an affirmative vote of two-thirds (2/3) of the Board of Directors and also receives an affirmative vote of two-thirds (2/3) of the House of Delegates, then it shall be adopted.

Ad Hoc Committee to Reduce Hospital Readmissions

Reporter: Greg Spratt

Last submitted: 2012-10-04 22:36:07.0

Recommendations

None

Hospital to Home Project:

At the last BOD meeting, a recommendation was made to "Create pilot studies for RT-led programs for reducing readmissions. This was referred to the Executive Office to help gain assistance from the Research Roundtable to help develop an RFP to be able to present back at the the Summer Forum. Tom Kallstrom and I had a call on May 11th with John Davies to discuss and John was to discuss with the Research Roundtable and return ideas. John''s feedback was that he agreed with the guidance of the Hospital to Home Committee. Tom Kallstrom suggested we get additional input from Kent Christopher and possibly other physicians.

Ad Hoc Committee for Continued Development of Education Competition

Reporter: Bill Cohagen

Last submitted: 2012-10-03 17:54:40.0

Recommendations

None

Report

As of 10/1/2012

- The committee has been reduced in size for improved efficiency.
- We will have representation in New Orleans throughout the competition, including the finals to witness and evaluate the changes to this year's Competition Bowl to see how well the changes are doing.
- A detailed synopsis will be made at the 2013 AARC Spring Board Meeting.

Respectfully submitted; Bill Cohagen, RCP, RRT, BA, FAARC

Ad Hoc Committee Chair.

ARCF
CoARC
NBRC

ARCF Report

To: AARC Board of Directors and House of Delegates
From: Michael Amato, Chairman, ARCF
Date: October 2012
RE: ARCF Report

The American Respiratory Care Foundation has been busy since I last submitted a progress report to you. The following are highlights of activities currently under taken by ARCF which are all in addition to administering the extensive array of education recognition awards, fellowships, and grants.

As previously reported, the ARCF's strategic plan is complete, and contains the following strategic objectives:

1. Set a goal to increase research/education endowment to $3M over next two years and to $5M over next five years. Coupling this with the consolidation of endowments described above should allow funding of two important programs:
    a) At least two $7500-$10,000 advanced degree scholarships/year. These degrees could include MS, PhD, EdD etc. which have a commitment to respiratory care. A particularly attractive degree to specifically address ICU staffing shortfalls and address RT career ladders would be the MS-PA degree followed by a critical care residency.
    b) This amount of endowment should also allow the yearly funding of a meaningful $25,000-$35,000 research award. The ARCF should take an active role in helping formulate the research plans to meet goals important to respiratory care: patient outcomes, cost-effectiveness, and the clinical scientific evidence base. To this, end partnering with AARC on their funding program for outcomes research would seem logical.

2. Develop fund raising strategies to meet Objective 1: i.e.:
    - Aggressive member solicitation
        – Dues check boxes and marketing to the profession.
        - The Foundation should also raise awareness of ARCF on a day-by-day basis rather than annually or periodically.
    - Develop videos, brochures to focus on the profession's future and the ARCF role
    - Continue to explore fund alternative fund raising events the night before the AARC Congress begins
    - Explore funding from other foundations/government

3. Maintain current award structure, with periodic reviews.
    – Encourage more nominees from members and sponsors
    - Maintain high visibility at the AARC International Congress' opening ceremonies, and use of video.
4. Maintain support for at least one Respiratory Care Journal Conference annually.
    - Keep affiliation with RC's editorial staff planning group
    - Keep relationship strong with RC's publishing company, Daedalus Enterprises Inc.

5. Explore opportunities with the International Committee to enhance respiratory care around the world

- Consider "special fellow" funding for international dignitaries

We are again hosting a fundraising reception on November 12 at the AARC 2012 International Congress in New Orleans. I want to take this opportunity to thank those of you who donated to the fundraiser last year and this year. I hope many of you are able to attend the reception. This reception is the only face to face fundraising event undertaken by ARCF each year. We will once again honor International Fellows, City Hosts, ICRC, and AARC's International Committee. The ARCF provides financial support for their participation in the event. It is still not too late to attend. The Trustees have set the minimum donation at $100 per person. For those of you who may not have attended in the past, I encourage you to take advantage of this event. It's a tremendous opportunity to get to know our colleagues from all over the world as well as enjoy some excellent food and beverages. This is a great way to show your support for the profession's philanthropic arm. We will gladly accept your donation at the door if you'd like to support the event and attend.

This past September, ARCF funded a Conference focusing on the "Adult Mechanical Ventilation in Acute Care: Issues and Controversies". The preceedings from that special Conference will be published in the June 2013 issue of the RESPIRATORY CARE. As you may recall, this past spring the Foundation funded a Conference focusing on all aspects of oxygen delivery.

General ARCF fund raising remains a challenge. This year we developed, and published, another article for AARC Times October issue, describing the work and value of the Foundation, and asked for tax deductible contributions from the membership. The past year averages are approximately $7,000 from our over 50,000 members. This is about 12 cents per member!

Our major contributors remain corporate entities. While we welcome their support for endowed awards; ARCF wants to do more, and requires additional contributions that are not restricted to a specific award or program.

ARCF Awards 2012

Achievement Awards

Forrest M. Bird Lifetime Scientific Achievement Award	Patrick Dunne, MEd, RRT, FAARC
Hector Leon Garza, MD Achievement Award for Excellence in International Respiratory Care	Saverio P. Giordano, MBA, RRT, FAARC
Dr. Charles H. Hudson Award for Cardiopulmonary Public Health	Melaine Giordano, MSc, RN, CPFT
Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care	Linda A. Smith, BS, RRT, FAARC
Mike West, MBA, RRT Patient Education Achievement Award	Mike West, MBA, RRT

Fellowships

Monaghan/Trudell Fellowship for Aerosol Technique Development	Jinxiang Xi, PhD
Philips Respironics Fellowship in Mechanical Ventilation	Anna C. Braga, MSc, PT
Philips Respironics Fellowship in Non-Invasive Respiratory Care	Patricia A. Achuff, MBA, RRT-NPS
Charles W. Serby COPD Research Fellowship	Alexandros G. Mathioudakis MD
CareFusion Healthcare Fellowship for Neonatal and Pediatric Therapists	Christine N. Kearney, BS, RRT
NBRC/AMP H. Frederick Helmholz, Jr., MD, Educational Research Grant	Not Awarded

Education Recognition Awards

William F. Miller, MD Postgraduate Education Recognition Award	Bryan A. Wattier, BA, RRT
Morton B. Duggan, Jr., Memorial Education Recognition Award	Claudia Ramos
Jimmy A. Young Memorial Education Recognition Award	Janet. J. Vadakkan
NBRC/AMP William W Burgin, Jr., MD Education Recognition Award	Adriana Cheteles
NBRC/AMP Gareth B. Gish, MS, RRT Memorial Education Recognition Award	Matthew Trojanowski, BA, RRT
NBRC/AMP Robert M. Lawrence, MD Education Recognition Award	Not Awarded

Literary Awards

Allen DeVilbiss Best Paper Award	Jeffrey M. Haynes, RRT, RPFT
IKARIA Best Paper Award by Best First Author	Robert F. Wolken, RRT Russell J. Woodruff, RRT Jan Smith, RN Richard K. Albert, MD Ivor S. Douglas, MD

Summary

I want to thank all of you that gave to the Foundation. I want to urge all of you who haven't to join them in providing your support for the Foundation. Please consider making a tax deductible donation to ARCF. Your support is indispensable to our success. I look forward to presenting this report to you and entertaining any questions you may have.

Thank you.

CoARC Report

The CoARC report is availble as an attachment to this book.
“CoARC Update to AARC BOD 11.8.12 handouts”

NBRC Report

MEMORANDUM

Date: October 9, 2012

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

From: Kerry E. George, RRT, MEd, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you an update on the activities of the NBRC. Since the last report, the Executive Committee along with the Clinical Simulation Examination Committee met in Kansas City in September to discuss business related items pertinent to the credentialing system and to conduct examination development activities. Additionally, the NBRC along with the AARC hosted the 21st Annual State Licensure Liaison Group Meeting. The following details the current status of examinations and significant activities in which the Board and staff are currently involved.

Adult Critical Care Specialty Examination

The much awaited Adult Critical Care Specialty Examination made its debut on July 17, 2012. To date, 135 individuals have attempted this new specialty examination. The committee met and finalized the examination cut-score and score reports have now been mailed to all candidates who have attempted the test. Candidates who take an exam on or after October 10, 2012 will receive their score report immediately after testing at the assessment center.

Credentialing System Evolves

Details regarding the significant changes that will soon be occurring in the credentialing system were announced during the Jimmy Young Memorial Lecture at the AARC Summer Forum in Santa Fe, New Mexico on July 15, 2012. Changes will include a single multiple choice examination with separate passing points for the CRT credential

and eligibility for the Clinical Simulation Examination which will include a larger number of shorter simulation problems.

NCCA Accreditation

The NBRC recently submitted its renewal application for accreditation of all of its examination programs (except the Adult Critical Care Examination) by the National Commission for Certifying Agencies. This once every five year process requires extensive documentation of the processes and procedures employed by the NBRC to ensure a fair, valid and reliable examination system. The NBRC will apply for accreditation of the new Adult Critical Care Specialty Examination in July 2013.

Examination Statistics – January 1 – September 30, 2012

The NBRC administered over 32,600 examinations for the period January 1 – September 30, 2012. Pass/fail statistics for the respective examinations follow:

Examination	***Pass Rate***	
CRT Examination – 11,040 examinations		
	Entry Level	Advanced
First-time Candidates	67.1%	82.3%
Repeat Candidates	15.7%	27.8%
Therapist Written Examination – 10,980 examinations		
First-time Candidates	67.9%	
Repeat Candidates	33.3%	
Clinical Simulation Examination – 9,515 examinations		
First-time Candidates	64.5%	
Repeat Candidates	52.4%	
Neonatal/Pediatric Examination – 694 examinations		
First-time Candidates	67.6%	
Repeat Candidates	43.5%	
Sleep Disorders Specialty Examination – 43 examinations		
First-time Candidates	87.2%	
Repeat Candidates	25%	

Adult Critical Care Specialty Examination – 129 examinations

First-time candidates	85.3%
Repeat candidates	N/A

CPFT Examination – 238 examinations

First-time Candidates	74.3%
Repeat Candidates	32.3%

RPFT Examination – 59 examinations

First-time Candidates	86.5%
Repeat Candidates	33.3%

Your Questions Invited

I look forward to continuing to work with you during my term as President. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and all of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the integrity of the credentialing process.

Unfinished Business

New Business

White Paper Review

- "Development of Baccalaureate and Graduate Education Degrees" pg. 213
- "Guidance Document on SARS" pg. 223

Policy Review

- BOD.015 – AARC Stationery, Business Cards pg. 231
- BOD.016 – Board of Directors Votes on HOD Recommendations pg. 232
- CT.004 – Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations pg. 233

Development of Baccalaureate and Graduate Degrees in Respiratory Care

A White Paper From the AARC Steering Committee of the Coalition For Baccalaureate and Graduate Respiratory Therapy Education

Background

Introduction

Being a respiratory therapist in the 21 st century has become a highly complex occupation. The results of twenty years of expanded clinical research have empowered respiratory therapists with additional therapeutic techniques, medications, and medical devices used to evaluate and treat patients with increasingly complex cardiopulmonary disorders. Educators have been challenged to expand their curricula to prepare students for these new responsibilities. 1-9 Progressively more respiratory therapists are expected to assess and quantify their patient's cardiopulmonary status, to provide appropriate respiratory care by applying patient care protocols, and to evaluate the medical and cost effectiveness of their care. 10-12 Critical thinking, decision-making, and competence to perform these responsibilities have become expected of most therapists, and many roles of the advanced therapist have become expected at entry-level. 13-15

Respiratory therapists have often promoted the expansion of services in their communities, such as diagnosis and treatment of sleep disorders, health promotion and disease prevention patient education, pulmonary rehabilitation, disease specific case management, and life support outside of the intensive care unit. Changes in health care policy, regulation, and reimbursements have required therapists to adopt these expanded roles, work more independently in settings across the continuum of care, and collaborate as partners on the health care delivery team. Although experienced therapists have adapted well to the changing and increasing demands, problems have emerged:

- Producing new therapists with the knowledge and skills expected of a modern respiratory therapist has become increasingly difficult within the confinement of 2 years of post-secondary education. 16,17
- With less than a baccalaureate degree, respiratory therapists are often not recognized as professionals by government agencies, third party payers, the uniformed services, labor unions, and others.
- Recruitment of students has declined in recent years, creating severe shortages of therapists. 18-20

- Severe budget deficits have required some state governments to limit associate degree curricula in community colleges to 60 semester hours limiting what can be taught.

Historical Development

During the latter half of the 20 th century, the respiratory care profession evolved from an on-the-job trained workforce to a college educated and licensed profession. Consistent with this evolution, education and training of therapists began as apprenticeships, and hospital-based programs became organized and awarded certificates of study. The first on-the-job hospital-based inhalation therapy schools were unable to provide adequate numbers of graduates. By the mid-1960's new programs began in vocational-technical schools and the community colleges which mushroomed across the United States. Growth of educational programs in community and technical colleges helped fill the demand for therapists during years of unprecedented growth into the 1980's. Innovative educators with new teaching strategies were able to maximize the compact 2-year time-frame. As the educational needs of new therapists increased, the need for expanded curriculum shifted the responsibility for professional preparation of therapists to colleges and universities that awarded academic credit and degrees. Throughout this period, the demand for therapists exceeded the supply, and the pressure to meet workforce needs may have contributed to an artificially short course of study with artificially low academic awards as compared to other health professions.

Recognizing the need to plan for future change, during the 1990s the American Association for Respiratory Care organized educational consensus conferences and supported research on the future scope of practice and education of therapists. 21-23 These efforts contributed to the growing recognition of the need for an associate degree minimum academic preparation for entry-level therapists for 2002. As expectations accelerate for therapists to analyze and evaluate patient needs, to plan and provide care, to participate effectively on professional interdisciplinary teams, and to provide patient and caregiver education, the need to expand opportunities for baccalaureate and graduate education has become evident. 24 In recent years, respiratory care educational programs at the baccalaureate level have increased by 75% with 57 such programs identified in 2002.

Rationale

Profound and extensive changes have occurred regarding medicine's delivery systems, economic and governmental constraints, and societal expectations. Over time, the profession of respiratory care has adapted quickly to new technologies and practices which the founding fathers had never considered. 25,26 There has been the birth of critical care medicine, pulmonary rehabilitation, and neonatology, as well as advances in cardiovascular diagnostics, sleep-disorders, and emergency transport. The advent of therapist-driven protocols, emphasis on patient outcomes and evidence-based medicine reflect this continuing transformation into the 21 st century. 27,28 Consequently, respiratory care departments and educational programs have been required to constantly upgrade in order to keep pace with escalating demands on new graduates. Preparation

of educated and skilled practitioners in adequate numbers has been a concern over most of the profession's first fifty years.

There has always been a core of baccalaureate degree programs, primarily at academic medical centers. In 1970 there were seven of these programs, and currently there are about sixty. The need for a greater number of baccalaureate and graduate respiratory care programs appears to be based on multiple evolutionary factors.

The clinical work has become more technically complex:

Respiratory care has evolved from conducting limited, task-based technical functions, to performing an array of services requiring more complex cognitive abilities and patient management skills. Consequently the body and complexity of knowledge and skills needed for clinical practice continues to increase and shows no sign of abating. The National Board for Respiratory Care (NBRC) examinations have reflected this theme, and questions now emphasize higher levels of cognition beyond recall and application. Earlier versions of the examinations did not include technical advances such as pulse oximetry, noninvasive ventilation, and computer-interfaced medical hardware that are now considered to be routine.

There is a greater demand for respiratory care at alternate sites

There is an increasing level of non-technical professional abilities that reflect greater levels of responsibility, accountability and authority. 29 Respiratory care continues to incorporate more specialized and diverse services beyond the traditional bedside caregiver role and has moved to alternative care sites. Therapists are becoming more involved in public health, outpatient care, private office practice, end-of-life and palliative care, smoking cessation, home care and as case managers for asthma, COPD and cystic fibrosis clinics. Therapists are, and will continue to be, more involved in providing patient education, and coordinating care in cost-effective approaches and multiple settings. To meet these future needs, educational programs will need to move beyond traditional teaching in hospital wards and ICUs.

There is increased need for non-technical skills

Professional competence goes beyond developing skills to perform technical tasks. Patient care is interactive, humanistic, and impinges on affective and moral dimensions. Practice is now participatory and involves interpretation and deductive reasoning. 28 There is need to develop these additional skills. 29,30 Educational programs that incorporate the liberal arts allow students to face future medical delivery changes, wavering economies and an unsure job market. Meeting such challenges is more certain for practitioners with the ability to write well, speak clearly and think more critically. Some Department managers now look to employees that are caregivers, but also have skills to assist in management tasks, patient and staff development education, and research. The current and future health care environment is creating demand for coordinators and planners instead of only bedside caregivers. Therapists participating in formal teaching or staff development are required to achieve baccalaureate or graduate degrees.

There is a growing educational gap between respiratory care and other health professions

In a delivery system that is based on interdisciplinary teamwork, educational differences are important. Physical therapy, pharmacy, audiology and other professions have raised educational standards to baccalaureate or higher since the mid-1960's. For example, pharmacy has moved from the BPharm to the PharmD as the entry level within the past 10 years. Physical therapy has moved from the BS to the MS within about the same time frame, and will require the doctoral degree within a few years. Physician assistant studies have mandated a master's degree entry level, and occupational and physical therapy currently require a master's degree as entry level. The perception of respiratory care as a potential career choice by both young people and adults may be influenced by its minimum educational standards for entering clinical practice. 31 Failure to provide an adequate education level can negatively impact that perception, suggesting a more technical and less professional career. Governmental agencies, legislators, third-party payers, and the military services all use the baccalaureate degree as a method of professional recognition.

The AARC advocated an increase in the minimum education requirements a decade ago, 22,23 and the 1995 PEW Commission Report, Critical Challenges: Revitalizing the Health Professions for the 21 st Century, reiterated much of AARC report's findings. 32 The Commission spoke to innovation, restructuring and flexibility in both practice and professional medical education. It also urged multi-skilling and streamlining of service delivery instead of continued specialization.

Most notable in this discussion was the PEW Commission's recommendations for nursing, which has maintained two levels of education (AS & BS) for one entry-to-practice credential as a registered nurse (RN). This has been reflected in respiratory cares' two levels of education, (AS & BS) for the registered respiratory therapist (RRT) credential. Among the recommendations for nursing are:

- Recognize the value of the multiple entry points to professional practice available to nurses through preparation in associate, baccalaureate and masters programs; each is different, and each has important contributions to make in the changing health care system.
- Consolidate the professional nomenclature so that there is a single title for each level of nursing preparation and service.
- Distinguish between the practice responsibilities of these different levels of nursing, focusing associate preparation on the entry level hospital setting and nursing home practice, baccalaureate on the hospital-based care management and community-based practice, and masters degree for specialty practice in the hospital and independent practice as a primary care provider. Strengthen existing career ladder programs in order to make movement through these levels of nursing as easy as possible.
- Encourage the expansion of the number of masters level nurse practitioner training programs by increasing the level of federal support for students.

For 30 years various groups within the nursing profession have repeatedly recommended the baccalaureate degree as the minimum registered nurse educational entry-level. The American

Nursing Association has maintained this position since 1965. In 1996 24% of nurses held a diploma, 34% held an associate degree and 31% a BSN. Presently about 40% hold a baccalaureate or higher nursing degree. However, opposition from state nursing associations, physicians and hospital administrators has been blamed for the failure to adopt the recommendation. 33

Setting education levels for practice entry has been an economically, politically and emotionally charged issue for many medical professions. Future challenges will more likely be met by leveraging greater support for baccalaureate and graduate respiratory care education.

How Do We Move Ahead?

On January 10, 2003 the AARC issued a Landmark Statement on Education and Credentialing. To support a stronger profession, the AARC, CoARC, and NBRC have all approved a statement to encourage advanced education and credentialing for respiratory therapists. While reiterating their support for associate degree programs, the groups want to ensure the profession of respiratory care is positioned for the future by encouraging pursuit of advanced training, education and credentials by the individuals in this country practicing respiratory care." 36

Respiratory Care: Advancement of the Profession Tripartite Statements of Support

The continuing evolution of the Respiratory Care Profession requires that every respiratory therapist demonstrate an advanced level of critical thinking, assessment and problem solving skills. These facilities are essential in today's health care environment not only to improve the quality of care but also to reduce inappropriate care and thereby reduce costs. Respiratory therapists are expected to participate in the development, modification and evaluation of care plans, protocol administration, disease management and patient education. Accordingly, the agencies representing the profession (American Association for Respiratory Care), program accreditation (Committee on Accreditation for Respiratory Care), and professional credentialing (National Board for Respiratory Care) together support the following as essential for the continued growth and advancement of the profession.

- The RRT credential is the standard of excellence for respiratory therapists. Evidence-based research documents the value of critical thinking, problem solving and advanced patient assessment skills. Therefore we encourage all respiratory therapists to pursue and obtain the Registered Respiratory Therapist (RRT) credential. • We support the development of baccalaureate and graduate education in respiratory care and encourage respiratory therapists to pursue advanced levels of education.
- We have complete confidence in the professional credentialing system. The three agencies will cooperate in evaluating the results of national job analysis research to insure that the credentialing system remains current and appropriate as the profession evolves. We recognize the NBRC's obligation to administer job related, validated credentialing examinations based on the results of national job analysis research as mandated by the "Standards for Educational and

Psychological Testing" (1999) published by the American Educational Research Association, American Psychological Association, and the National Council on Measurement in Education. Job analysis research is also guided by Section 1607.14 of the Technical Standards for Validity Studies from the Federal Government's Uniform Guidelines on Employee Selection Procedures. These guidelines are found within Title 29 – Labor within the Code of Federal Regulations (29CFR1607.14). In addition, the NBRC must maintain its compliance with the standards for accreditation of certification programs developed by the National Commission for Certifying Agencies (NCCA).

- The three agencies recognize the importance of effective recruitment and retention strategies to recruit and retain respiratory therapists for the health care workforce, and qualified respiratory therapy students. We encourage the use of existing resources available from the three agencies.
- The three organizations will cooperate in evaluating examination pass rates for entry level and advanced practice programs and for associate and baccalaureate degree programs to assure that the educational requirements for admission both to the educational programs and to the examination system are appropriate.
- We encourage the development of appropriate career ladders and pay differentials based on the advanced practice credential (RRT) and education beyond the Associate Degree.
- We strongly support faculty development activities specific to educational methodology. 37

As evidenced by this Tripartite statement it is clear that community colleges are, and will continue to be, important partners in providing respiratory care education. A plan that does not use the resources they can provide will be unnecessarily limited in scope. The AARC must facilitate the development of workable articulation and bridge agreements between community colleges and 4-year colleges. These articulations may take the form of moving students from an associate degree in respiratory therapy to a BSRT, or they may use a model where students receive two years of preparatory course work at a community college before transferring to a 4-year college to complete their bachelor's degree. Community colleges could also partner with 4-year colleges and graduate schools to provide sites for distance education. Other options for expanding baccalaureate and graduate education certainly exist and should be explored.

Currently respiratory care programs tend to have small class sizes but high fixed costs. Of the 12,183 students who graduated from advanced practitioner respiratory care programs during the years 1998 through 2000, 1773 (14.6%) were at the baccalaureate level. 34 If we are to make it attractive for educational institutions to establish new baccalaureate and graduate programs, we must rethink this model. Models that can accommodate larger classes of baccalaureate level students without a substantial increase in program costs should be explored. Because laboratory and clinical courses are usually the limiting factor for enrollment, they should be the initial targets for remodeling. We must look to other therapy-based allied health professions that successfully accommodate large enrollments in their educational programs and examine how their approach might be adapted for respiratory therapy.

If the respiratory care profession is to move ahead we must make a concerted effort to increase the number of graduate programs. The demand for such programs will increase as we increase the number of baccalaureate program graduates. However, at present, the vast majority of respiratory therapists who seek graduate degrees must do so in another field such as education or physiology. We must develop more graduate degrees that are specific to respiratory care if we are to meet the need for clinical specialists, researchers, faculty, and professional leaders.

The need for graduate education in respiratory care

Currently, there are only a handful of graduate degree programs with majors in respiratory care in the U.S. Because of this, leadership training in clinical specialty areas, research, management, and education has been provided at the baccalaureate level or not at all. This has resulted in a dearth of qualified individuals able to fulfill the need for trained practitioners to teach, perform management and supervision, assist with research, and fulfill other professional leadership roles. Respiratory therapists with graduate education and training are needed to fill the demand for future educators, managers, researchers, and clinical specialists. A tremendous demand for respiratory care services is projected over the next fifteen years. This projected shortage is due to the aging of the population, increases in respiratory diseases (including asthma and COPD), increases in the general population, and advances in technology and treatment. Coupled with an increase in demand for services and personnel, the current generation of educators and leaders in respiratory care will be retiring. There is a major need for the respiratory profession to prepare advanced level respiratory therapists who have a foundation for leadership in the areas of education, management and supervision, and clinical practice. There are over 300 college or university-based respiratory care educational programs in the U.S. and approximately 2,700 respiratory therapists are employed as educators by colleges, universities, and health care agencies. Nationally, the vacancy rate for instructors/educators was 9.8% in year 2000, and graduates of the existing Master's degree programs in respiratory care are sought after by colleges and universities to fill faculty vacancies. In addition, about 11% of the respiratory care workforce is employed in management and supervision (11,685 FTEs in year 2000) and the anticipated demand for managers and supervisors is also expected to increase. 35

Graduate education in respiratory care is needed to advance the science and practice of respiratory care by providing a link between the sciences, clinical research and practice; increase knowledge within the discipline; provide for interdisciplinary collaboration and research; and train future faculty for the profession. The goals of graduate respiratory care educational programs may include:

- To prepare advanced level respiratory therapists for clinical practice.
- Provide leadership training in the areas of management, supervision, education and research.
- Develop clinical specialists in the areas of adult critical care, pediatric critical care, neonatal critical care, pulmonary function technology and cardiopulmonary diagnostics, polysomnography, and other clinical areas, as needed.
- Prepare future faculty for college and university based respiratory care educational programs.

- Develop individuals who can formulate appropriate questions, organize and test hypotheses, and apply research results to the practice of respiratory care.
- Prepare clinical practitioners with advanced knowledge and skills in basic and clinical sciences.
- Prepare leaders, who are able to plan, develop, and deliver high quality, cost-effective health care services.

Conclusion

There is a need to increase the number of respiratory therapists with advanced levels of training and education to meet the demands of providing services requiring complex cognitive abilities and patient management skills. Therefore the AARC strongly encourages the continuing development of baccalaureate and graduate education in respiratory care, to include:

- Traditional BS degree programs
- Associate degree to baccalaureate degree articulation and bridge agreements with area community colleges
- Distance education for BS degree programs offered at the community college level
- Promotion of Master of Science in Respiratory Care degree programs for the development of leadership in the areas of management, education, research, and clinical specialization.

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AARC SARS Guidance Document

Statement of Intent: The purpose of this document is to provide guidance to respiratory care staff and managers involved in addressing SARS issues at their facilities and in their practice. The content of this document is based on information found on the web site of the Centers For Disease Control and Prevention (CDC). Because new information about SARS is being published constantly, using the website links in this document will provide the reader access to the latest available information.

Basic Information About SARS

Source: http://www.cdc.gov/ncidod/sars/factsheet.htm

In addition to the following basic information about SARS, frequently asked questions about SARS are found on the CDC website at http://www.cdc.gov/ncidod/sars/faq.htm

A new disease called SARS

Severe acute respiratory syndrome (SARS) is a respiratory illness that has recently been reported in Asia, North America, and Europe. This fact sheet provides basic information about the disease and what is being done to combat its spread. To find out more about SARS, go to www.cdc.gov/ncidod/sars/ and www.who.int/csr/sars/en/ .

Symptoms of SARS

In general, SARS begins with a fever greater than 100.4°F [>38.0°C]. Other symptoms may include headache, an overall feeling of discomfort, and body aches. Some people also experience mild respiratory symptoms. After 2 to 7 days, SARS patients may develop a dry cough and have trouble breathing.

How SARS spreads

The primary way that SARS appears to spread is by close person-to-person contact. Most cases of SARS have involved people who cared for or lived with someone with SARS, or had direct contact with infectious material (for example, respiratory secretions) from a person who has SARS. Potential ways in which SARS can be spread include touching the skin of other people or objects that are contaminated with infectious droplets and then touching your eye(s), nose, or mouth. This can happen when someone who is sick with SARS coughs or sneezes droplets onto themselves, other people, or nearby surfaces. It also is possible that SARS can be spread more broadly through the air or by other ways that are currently not known.

Who is at risk for SARS

Most of the U.S. cases of SARS have occurred among travelers returning to the United States from other parts of the world with SARS. There have been very few cases as a result of spread to close contacts such as family members and health care workers. Currently, there is no evidence that SARS is spreading more widely in the community in the United States.

Possible cause of SARS

Scientists at the CDC and other laboratories have detected a previously unrecognized coronavirus in patients with SARS. The new coronavirus is the leading hypothesis for the cause of SARS.

CDC RECOMMENDATIONS FOR HEALTH CARE WORKERS:

Transmission of SARS to health-care workers appears to have occurred after close contact with sick people before recommended infection control precautions were put into use.

Updated Interim Domestic Infection Control Guidance in the Health-Care and Community Setting for Patients with Suspected SARS

May 1, 2003
Source: http://www.cdc.gov/ncidod/sars/infectioncontrol.htm

The CDC is issuing revised interim guidance concerning infection control precautions in the health-care and community settings. To minimize the potential for transmission, these precautions are recommended as feasible given available resources, until the epidemiology of disease transmission is better understood.

For all contact with suspect SARS patients, careful hand hygiene is urged, including hand washing with soap and water; if hands are not visibly soiled, alcohol-based handrubs may be used as an alternative to hand washing.

Access www.cdc.gov/handhygiene for detailed information on hand hygiene.

For the ***inpatient*** setting:

If a suspected SARS patient is admitted to the hospital, infection control personnel should be

notified immediately. Infection control measures for inpatients (www.cdc.gov/ncidod/hip/isolat/isolat.htm) should include:
Standard precautions (e.g., hand hygiene); in addition to routine standard precautions, health-care personnel should wear eye protection for all patient contact.
Contact precautions (e.g., use of gown and gloves for contact with the patient or their environment)
Airborne precautions (e.g., an isolation room with negative pressure relative to the surrounding area and use of an N-95 filtering disposable respirator for persons entering the room)
If airborne precautions cannot be fully implemented, patients should be placed in a private room, and all persons entering the room should wear N-95 respirators. Where possible, a qualitative fit test should be conducted for N-95 respirators; detailed information on fit testing can be accessed at http://www.osha.gov/SLTC/etools/respiratory/oshafiles/fittesting1.html. (Summarized in Appendix C) If N-95 respirators are not available for health-care personnel, then surgical masks should be worn. Regardless of the availability of facilities for airborne precautions, standard and contact precautions should be implemented for all suspected SARS patients.

For the ***outpatient*** setting:

Persons seeking medical care for an acute respiratory infection should be asked about possible exposure to someone with SARS or recent travel to a area with SARS. If SARS is suspected, provide and place a surgical mask over the patient's nose and mouth. If masking the patient is not feasible, the patient should be asked to cover his/her mouth with a disposable tissue when coughing, talking or sneezing. Separate the patient from others in the reception area as soon as possible, preferably in a private room with negative pressure relative to the surrounding area. All health-care personnel should wear N-95 respirators while taking care of patients with suspected SARS. In addition, health care personnel should follow standard precautions (e.g., hand hygiene), contact precautions (e.g., use of gown and gloves for contact with the patient or their environment) and wear eye protection for all patient contact.
For more information, see the triage guidelines in Appendix A.

For ***home*** or ***residential*** setting:

Placing a surgical mask on suspected SARS patients during contact with others at home is recommended. If the patient is unable to wear a surgical mask, it may be prudent for household members to wear surgical masks when in close contact with the patient. Household members in contact with the patient should be reminded of the need for careful hand hygiene including hand washing with soap and water; if hands are not visibly soiled, alcohol-based handrubs may be used as an alternative to hand washing. For more information, see the household guidelines in Appendix B.

Interim Domestic Guidance for Management of Exposures to Severe Acute Respiratory Syndrome (SARS) for Health-Care Settings

May 20, 2003

Source: http://www.cdc.gov/ncidod/sars/exposureguidance.htm

Given the currently available information on the epidemiology of SARS, the following outlines interim guidance for the management of exposures to SARS in a health-care facility.

Surveillance of Health-Care Personnel

Surveillance of health-care personnel is necessary to ensure that workers who are ill receive appropriate care and are isolated to prevent transmission. Health-care facilities that care for SARS patients should implement surveillance of health-care workers who have any contact with SARS patients or their environment of care. Recommendations for surveillance include:

- Develop and maintain a listing of all personnel who enter the rooms of SARS patients, or who are involved in the patient's care in other parts of the hospital.
- Instruct personnel who have contact with SARS patients, or their environment of care, to notify occupational health, infection control or their designee if they have unprotected exposure to a SARS patient or if they develop fever or respiratory symptoms.
- Monitor employee absenteeism for increases that may suggest emerging respiratory illness in the workforce. Notify local and state health authorities of clusters or unusual increases in respiratory illness, including atypical pneumonia.

Management of Asymptomatic, Exposed Health-Care Workers

1. To date, there is no evidence to suggest that SARS is transmitted from asymptomatic individuals. However, according to recent reports, health-care workers who developed SARS may have been a source of transmission within health-care facilities during the early phases of illness when symptoms were mild and not recognized as SARS. To minimize the risk of transmission from unrecognized SARS infections among health-care workers, health-care workers who have **unprotected high-risk exposures** to SARS should be excluded from duty (e.g. administrative leave) for 10 days following the exposure. Unprotected high-risk exposure is defined as presence in the same room as a probable SARS patient during a high-risk aerosol-generating procedure or event and where recommended infection control precautions are either absent or breached. Aerosol-generating procedures or events include aerosolized medication treatments, diagnostic sputum induction, bronchoscopy, endotracheal intubation, airway suctioning, positive pressure ventilation via facemask (e.g.,BiPAP,CPAP), during which air may be forced out around the facemask , high frequency oscillatory ventilation (HFOV), and close facial contact during a coughing paroxysm. Health-care workers who are excluded from duty should limit interactions outside the home, and should not go to work, school, church, or other public areas.
2. Health-care workers who have other unprotected exposures to patients with SARS need not be excluded from duty, but should undergo active surveillance for symptoms, including measurement of body temperature at least twice daily for 10 days following the exposure. Prior to reporting for duty each day, the health-care worker should be interviewed regarding respiratory symptoms and have their temperature measured by employee health or other designee.
3. Health-care workers who have cared for, or otherwise been exposed to SARS patients while adhering to recommended infection control precautions, should be

instructed to be vigilant for fever and respiratory symptoms, including measurement of body temperature at least twice daily for 10 days following the last exposure to a SARS patient. These health-care workers should be contacted by occupational health, infection control or their designee regularly over the 10 day period following exposure to inquire about fever or respiratory symptoms.

Management of Symptomatic, Exposed Health-Care Workers

1. Any health-care worker who has cared for or been exposed to a SARS patient who develops fever or respiratory symptoms within 10 days following exposure should not report for duty, but should stay home and report symptoms to the appropriate facility point of contact immediately. If the symptoms begin while at work, the health-care worker should be instructed to immediately apply a surgical mask and leave the patient care area. Symptomatic health-care workers should use infection control precautions (see Appendix B) to minimize the potential for transmission and should seek health-care evaluation. **In advance of clinical evaluation, health-care providers should be informed that the individual may have been exposed to SARS so arrangements can be made, as necessary, to prevent transmission to others in the health-care setting.**
2. If symptoms improve or resolve within 72 hours after first symptom onset, the person may be allowed, after consultation with infection control and local public health authorities, to return to duty and infection control precautions can be discontinued.
3. For persons who meet, or progress to meet the case definition for SARS (e.g., develop fever and respiratory symptoms), infection control precautions should be continued until 10 days after the resolution of fever, provided respiratory symptoms are absent or improving.
4. If the illness does not progress to meet the case definition, but the individual has persistent fever or unresolving respiratory symptoms, infection control precautions should be continued for an additional 72 hours, at the end of which time a clinical evaluation should be performed. If the illness progresses to meet the case definition, infection control precautions should be continued as described above. If case definition criteria are not met, infection control precautions can be discontinued after consultation with local public health authorities and the evaluating clinician. Factors that might be considered include the nature of the potential exposure to SARS, the nature of contact with others in the residential or work setting, and evidence for an alternative diagnosis.
5. Persons who meet, or progress to meet the case definition for suspected SARS (e.g., develop fever and respiratory symptoms), or whose illness does not meet the case definition, but who have persistent fever or unresolving respiratory symptoms over the 72 hours following onset of symptoms, should be tested for SARS coronavirus infection. Collection of appropriate specimens for laboratory testing (See Appendix

H for collection of respiratory specimens) should be coordinated with and guided by local/state public health authorities and consultation with the CDC .

Prevention of Unprotected Exposures

Prevention of unprotected exposures will limit the need for exclusion from duty. Health-care facilities should address the following:

- Review current procedures for early detection and isolation of suspected SARS patients
- Educate all health-care personnel on the signs and symptoms of SARS and recommended infection control practices
- Review use of personal protective equipment with health-care personnel, including physicians, who may care for SARS patients
- Follow current CDC recommendation for aerosol-generating procedures in suspected or probable SARS patients

Management of Symptomatic, Exposed Visitors

Close contacts (e.g., family members) of SARS patients are at risk for infection. Close contacts with either fever or respiratory symptoms should not be allowed to enter the health-care facility as visitors and should be educated about this policy. A system for screening SARS close contacts who are visitors to the facility for fever or respiratory symptoms should be in place. Health-care facilities should educate all visitors about use of infection control precautions when visiting SARS patients and their responsibility for adherence to them. Patient education information is available at: http://www.cdc.gov/ncidod/sars/factsheetcc.htm and are abridged in Appendix I

Regarding the Appendices of This Document

The appendices in this document (many of which have not been referenced to this point) are from the CDC website and provide detailed information about minimizing risks for caregivers of SARS patients. Each contains critical information for respiratory therapists and should be carefully reviewed.

Appendix A - Updated Interim Domestic Guidelines for Triage and Disposition of Patients Who

May Have Severe Acute Respiratory Syndrome (SARS)

Appendix B - Interim Guidance on Infection Control Precautions for Patients with Suspected Severe Acute Respiratory Syndrome (SARS) and Close Contacts in Households

Appendix C - Fit Testing

Appendix D - Case Definition for suspected Severe Acute Respiratory Syndrome (SARS)

Appendix E - Interim Domestic Infection Control Precautions for Aerosol-Generating Procedures on Patients with Severe Acute Respiratory Syndrome (SARS)

Appendix F-Interim Recommendations for Cleaning and Disinfection of the SARS Patient Environment

Appendix G - Interim Domestic Guidance on the Use of Respirators to Prevent Transmission of SARS

Appendix H - Guidelines for Collection of Specimens from Potential Cases of SARS

Appendix I - Information For Close Contacts Of SARS Patients

Appendix J -Isolation and Quarantine

Appendix K - Updated Interim Guidance: Pre-Hospital Emergency Medical Care and Ground Transport of Suspected Severe Acute Respiratory Syndrome Patients

Appendix L - Interim Guidance: Air Medical Transport for Severe Acute Respiratory Syndrome (SARS) Patients

Appendix M - Treatment

Appendix N - SARS Training and Reference Materials

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **AARC Stationery, Business Cards**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2008

DATE REVISED:

REFERENCES: AARC Bylaws

Policy Statement:
Only authorized personnel shall use Association stationery and receive Association business cards.

Policy Amplification:

1. Officers and directors may be supplied with business cards indicating their position with the AARC, and their business title and contact information subject to approval of the President.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Board of Directors Votes on House of Delegates Recommendations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2008

DATE REVISED: July 2008

REFERENCES:

Policy Statement:
Resolutions brought by the House of Delegates to the Board of Directors shall be submitted, considered, and voted upon in an appropriate and timely manner.

Policy Amplification:

1. All resolutions from the House of Delegates shall be presented to the Board of Directors by the Immediate Past Speaker and/or a designee identified by the Speaker of the House of Delegates and approved by the President.

2. For a HOD resolution to be acted upon by the Board during the same meeting at which it is considered by the House, it shall be submitted in written form including the House-assigned resolution number by 12:00 noon on the final day of the Board of Directors' Meeting.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2005

DATE REVISED: July 2005

REFERENCES: AARC Bylaws, CT.001, CT.002, CT.003 and CT.004

Policy Statement:
Special Committees or Representatives to External Organizations may be appointed by the President to carry out specific activities, subject to ratification by the Board of Directors.

Policy Amplification:

1. The President may appoint a Special Committee, Task Force, Focus Group or Panel to complete specific charges related to the needs of the Association or the profession.

2. The Executive Director, Board of Directors, Board of Medical Advisors, House of Delegates, Chartered Affiliates, Specialty Sections or member may request that the President appoint a Special Committee, Task Force, Focus Group or Panel to perform specific charges.

3. In the event of vacancies occurring in Special Committees, Task Forces, Focus Groups or Panels, the President may appoint members to fill such vacancies, subject to ratification by the Board of Directors.

4. Representatives of the Association to such external organizations as may be required shall be appointed by the President, subject to ratification by the Board of Directors.

5. In the event of vacancies occurring in any representative position to external organizations, the President may appoint members to fill such vacancies, subject to ratification by the Board of Directors.

6. Trustees of the CoARC, ARCF and NBRC :

A. Shall not serve as voting members of more than one of the above identified organizations during any single term of appointment.

B. Presents and communicates the positions, policies and concerns of the AARC.

C. Desired qualifications include:

1) AARC Member for five (5) years.
2) Knowledge of AARC bylaws, positions, policies and philosophies.
3) One year previous experience at the AARC level, e.g., Board of Directors, House of delegates, special representative, committee chair or member.
4) Ability to communicate effectively.
5) For CoARC: Previous management/supervisory experience as faculty of a CoARC accredited respiratory care program.

DEFINITIONS:

ATTACHMENTS:

HOD Resolutions

HOD Resolution 06-12-03

Resolution Author: Joseph Huff
E-mail: jgh578@aol.com
Phone Number: 216 287-2191
Author's State: Ohio
Co-Sponsors and Their States: N/A

Be it resolved that the AARC investigate starting a public membership for patients and other interested parties.

Rationale:
The AARC has been a longtime advocate for Respiratory Patients. I believe by creating a membership for patients and other interested parties, we can expand on those efforts. With this new Membership, it will give patients an avenue to get clear and precise information about their disease.

1. Develop a safe web for patients-A place where they can ask questions and get correct answers.
2. Provide an internet site where patients can come and order replacement items for their equipment-Products can be offered at reduced rates though a partnership with equipment companies.
3. Membership cost between $10-$20 each year.
4. Reach out to physician to offer their time and knowledge to give the right advice to patients.

I believe this resolution could give the AARC the positive image it needs to move our profession successfully into the next decade. With more input from the Board and Executive Office, this resolution can be moved forward for the good of both the profession and patients.

Impact of Resolution:
General Membership, AARC Bylaws, Affiliates, AARC Officers & BOD, Executive Office, State/Federal Legislation

Implementation Cost:
0.00

Ongoing Cost:
0.00

Relationship to AARC Strategic Plan:
Develop human resources, Increase membership, and Increase financial resources

HOD Resolution 13-12-04

Resolution Author: Joseph Huff
E-mail: jgh578@aol.com
Phone Number: 216 287-2191
Author's State: Ohio
Co-Sponsors and Their States: N/A

That the AARC investigate the formation of an apprenticeship Program in partnership with the ARCF, for Respiratory Therapists who would like to learn from established researchers.

Rationale:

1. Having the opportunity to work with a seasoned researcher and learn the proper way to do research is priceless to a Respiratory Therapist who has the desire to learn the proper techniques to perform research. The candidate would apply for a grant through the ARCF. The grant would cover financial needs of the candidate for a set period of time to work with the researcher.
2. This process would increase the number of Therapists who could work as a researcher and one day help train other therapists. Further details can be worked out by the AARC.

Impact of Resolution:
General Membership, HOD, Affiliates, AARC Officers & BOD, Executive Office, NBRC, CoARC

Implementation Cost:
0.00

Ongoing Cost:
0.00

Relationship to AARC Strategic Plan:
Develop art and science of RC, Develop human resources, Increase membership, Increase organizational effectiveness

HOD Resolution 16-12-01

Author: John Wilgis
E-mail: john@fha.org
Phone Number: 407-841-6230
Author's State: FL

Co-Sponsors and Their States: TBD
"Resolve that any credentialed Registered Respiratory Therapist (RRT) actively enrolled in an AARC recognized and/or accredited advanced level educational program (e.g., Bachelors in Respiratory Therapy) holding Associate Member (Student Member) status be eligible to participate in Continuing Respiratory Care Education programs as a Student Member."
Rationale:

1. Currently, Student Members do not receive Continuing Respiratory Care Education (CRCE) transcripts.
2. Therapists who have entered or are entering advanced level programs (i.e., Bachelors Level programs) with NBRC RRT certification may be required to participate in the NBRC Continuing Competency Program which requires CRCE transcripts to maintain NBRC certification.
3. Therapists who have entered or are entering advanced level programs (i.e., Bachelors Level programs) with NBRC RRT certification are required to meet specific state licensure CRCE requirements.

Impact of Resolution:
Active and Associate membership, Student membership, approved / accredited educational programs and affiliates
Implementation Cost:
$0
Ongoing Cost:
$Unknown
Relationship to AARC Strategic Plan:
Supports the following Strategies under Objective 8: "Assure the Association has the resources to meet the needs of its members."

- Increase the membership of the Association.
- Increase the diversity of the members of the Association by providing information to encourage persons who are members of underrepresented groups to enter the respiratory care profession and actively participate in the AARC.
- Improve the responsiveness of the leadership to the rapidly changing environment today and in the future.
- Provide information to non-member respiratory therapists which will reveal why being an AARC member will benefit them in terms of developing and maintaining their skills and convinces them that not supporting the AARC will be a detriment to their career.

- Provide information to instructors and managers to encourage active participation of students in the AARC and its chartered affiliates and assure they are fully informed of the science of respiratory care.

Supports the following Strategies under Objective 2: "Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives."

- Promote the continuing development of baccalaureate and graduate degree education in respiratory care.
- Encourage respiratory therapists to pursue advanced and continuing education.
- Encourage all respiratory therapists to seek and obtain the registered respiratory therapist (RRT) credential.

HOD Resolution 16-12-02

Author: John Wilgis
E-mail: john@fha.org
Phone Number: 407-841-6230
Author's State: FL
Co-Sponsors and Their States: TBD
"Resolve that any credentialed Registered Respiratory Therapist (RRT) actively enrolled in an AARC recognized and/or accredited advanced level educational program (e.g., Bachelors in Respiratory Therapy) is eligible to change their membership status to Associate Member (Student Member) with all rights and benefits provided to that level of membership."

Rationale:

1. Current AARC Bylaws do not permit member status change based on Active Membership criteria stating, " An individual who was an AARC Active Member in good standing on December 8, 1994, will continue as such, providing his/her membership remains in good standing." Membership status should be a individual choice that may alter over time given life circumstances.
2. Currently, many therapists with NBRC RRT certification and licensure are entering advanced level programs.
3. Many graduates at the associate level programs are entering advanced level programs without a break from their education even though they have obtained NBRC RRT certification and meet the current criteria for Active Membership.

Impact of Resolution:
Active and Associate membership, Student membership, approved / accredited educational programs and affiliates
Implementation Cost:
$0
Ongoing Cost:
$0
Relationship to AARC Strategic Plan:
Supports the following Strategies under Objective 8: "Assure the Association has the resources to meet the needs of its members."

- Increase the membership of the Association.
- Increase the diversity of the members of the Association by providing information to encourage persons who are members of underrepresented groups to enter the respiratory care profession and actively participate in the AARC.
- Improve the responsiveness of the leadership to the rapidly changing environment today and in the future.
- Provide information to non-member respiratory therapists which will reveal why being an AARC member will benefit them in terms of developing and

maintaining their skills and convinces them that not supporting the AARC will be a detriment to their career.

- Provide information to instructors and managers to encourage active participation of students in the AARC and its chartered affiliates and assure they are fully informed of the science of respiratory care.

Miscellaneous