American Association for Respiratory Care

Board of Directors Meeting

Anaheim Marriott
Anaheim, CA

November 14-15, 2013

Index

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – November 13, 2013
Board of Directors Meeting – November 14-15, 2013

Wednesday, November 13

4:00-7:00 pm Executive Committee Meeting (Committee Members only) *[Los Angeles/La Jolla]*

7:00-8:00 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) *[Orange County Ballroom 1-2]*

Thursday, November 14

8:00 am-5:00 pm **Board of Directors Meeting** *[Orange County Ballroom 1-2]*

8:00 am Call to Order
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10:00 am BREAK

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12:00 pm Lunch Break

1:30 pm Reconvene – JOINT SESSION

3:30 pm Break

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5:00 pm RECESS

Friday, November 15

8:00 am-5:00 pm **Board of Directors Meeting** *[Orange County Ballroom 1-2]*

8:00 am Call to Order

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- American Heart Association pg. 122 (R)
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- Extracorporeal Life Support Organization (ELSO) pg. 129
- International Council for Respiratory Care (ICRC) pg. 130
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- National Asthma Education & Prevention Program pg. 138
- National Coalition for Health Professional Ed. In Genetics pg. 139
- National Sleep Awareness Roundtable pg. 140
- Neonatal Resuscitation Program pg. 141

10:00 am BREAK

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10:45 am Ad Hoc Committee Reports pg. 156
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 157
- Ad Hoc Committee on Officer Status/US Uniformed Services pg. 160
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12:00 pm Lunch Break (Daedalus Board Meeting)

1:30 pm Reconvene

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3:30pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(as of October 30, 2013)

AARC Board of Directors Meeting

November 14-15, 2013 • Anaheim, CA

Bylaws

Recommendation 13-3-9.1 "That the AARC Board of Directors accept and approve the Texas Society Bylaws."

Recommendation 13-3-9.2 "That the AARC Board of Directors accept and approve the California Society Bylaws."

Continuing Care Rehabilitation

Recommendation 13-3-51.1 "To update the Pulmonary Rehabilitation Facility/Program Locator on the AARC website."

Recommendation 13-3-51.2 "Have a link for Pulmonary Rehabilitation Program Locator on the front page of the AARC Website – to click and go directly to the site."

Recommendation 13-3-51.3 "That a task force be immediately organized for a Grant Submission for a National Pulmonary Rehabilitation Disease Management/Maintenance Exercise Program."

Diagnostics Section

Recommendation 13-3-52.1 "Provide complimentary AARC Congress registration for each recipient of section Specialty Practitioners of the Year."

Management Section

Recommendation 13-3-55.1 "With the assistance of AARC Board staff, create and conduct a survey to the Section Membership to investigate the drop of membership."

Position Statement Committee

Recommendation 13-3-26.1 "That the AARC Board of Directors approve and publish the revised White Paper 'Guidance Document on Scope of Practice'."

Recommendation 13-3-26.1 "That the AARC Board of Directors approve and publish the revised 'AARC White Paper on RRT credential'."

Social Media Committee

Recommendation 13-3-19.1 "That the AARC BOD accepts the changes made to the current AARC Connect Code of Conduct."

American Heart Association

Recommendation 13-3-64.1 "That the Executive Office reach out to the leadership of AHA to determine if an AARC representative is needed."

Comm on Accreditation of Medical Transport Systems (CAMTS)

Recommendation 13-3-66.1 "To increase travel support stipend from the current level of $2,000 a year for the three yearly meeting to $2,500 which would match the stipend level supported by CAMTS."

Military

Recommendation 13-3-45.1 "That the AARC BOD encourage the AARC state delegates and officials of other state level respiratory care societies to follow the lead from the Texas Society of Respiratory Care (TSRC) and offer similar memberships and registrations to conferences, convention and other meetings at a reduced rate or complimentary to members of the armed forces."

Tobacco Free Lifestyle

Recommendation 13-3-41.1 "that AARC urge membership to take a leadership role in their respective workplaces to update work environment safety policies to address e-cigarettes."

Ad Hoc Committee on 2015 & Beyond

Recommendation 13-3-32.1 "That the AARC BOD approve the combining of the two committees: *Ad-Hoc Committee on 2015 and Beyond* and *Ad-Hoc Workgroup on Strategies for 2015* into one committee to be named Ad-Hoc Committee on 2015 and Beyond."

Recommendation 13-3-32.2 "The AARC BOD approve the revised charges for the Ad-Hoc Committee on 2015 and Beyond."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

July 18, 2013 • Orlando, FL

Minutes

Attendance

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

Consultants

John Hiser, MEd, RRT, FAARC, Past Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
Karen Schell, RRT-NPS, RPFT, RPSGT, Past Speaker

Guests

Lorraine Bertuola, RRT, Long-Term Care Section Chair

Absent (Excused)

Lori Conklin, MD, BOMA Chair
Mike Runge, BS, RRT, FAARC, Parliamentarian
Karen Stewart, MSc, RRT, FAARC, Past-President

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director
Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Director of Regulatory Affairs
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
President George Gaebler called the meeting of the AARC Board of Directors to order at 8:03am EDT, Thursday, July 18, 2013. Secretary/Treasurer Frank Salvatore called the roll and declared a quorum.

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

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

Greg Spratt – employed by Covidien
Cyndi White – consultant for Aerogen and Philips Respironics

APPROVAL OF MINUTES
Bill Cohagen moved "To approve the minutes of the April 12, 2013 meeting of the AARC Board of Directors."
Motion carried

Doug McIntyre moved "To approve the minutes of the April 13, 2013 meeting of the AARC Board of Directors with one amendment. Bill Cohagen nominated Kathy Blackmon for Honorary Membership, not Doug MacIntyre."
Motion carried

E-MOTION RATIFICATION
There have been no E-Motions since the April 2013 Board meeting.

GENERAL REPORTS

President
President Gaebler gave highlights of his written report.

EXECUTIVE SESSION
Colleen Schabacker moved to go into Executive Session at 8:23am EDT, Thursday, July 18, 2013.
Motion carried

Bill Cohagen moved to come out of Executive Session at 8:41am, Thursday, July 18, 2013.
Motion carried

CoARC
Kathy Rye, CoARC President-elect, asked the Board to consider the following recommendations:

Bill Cohagen moved to accept Recommendation 13-2-80.1 "That the CoARC request the AARC endorse, in principle, the development and implementation of standards for the accreditation of educational programs to train advanced practice respiratory care practitioners (APRTs) as defined in the draft APRT standards."
Motion carried

Bill Cohagen moved to accept Recommendation 13-2-80.2 "That the CoARC request that AARC and NBRC appoint representatives to a work group made up of representatives of the three organizations to review the APRT concept and make recommendations for further development and implementation."

Bill Cohagen moved to refer to the President for implementation.
Motion to refer carried

President Gaebler continued with highlights of his written report and presented new charges for the Ad Hoc Committee for 2015 & Beyond:

New Charges for 2015 and Beyond Ad Hoc Committee for 2013-2014

1. Competency Level Focus –The 2015 ad hoc committee study mechanisms for 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.

2 .Explore models that could be used by clinical department's educators, and state affiliates as continuing education venues for the use of clinical simulation as a major tactic for increasing competency levels for the current workforce.

3. That the Committee in cooperation with the CoARC, consider development models 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.
A. Models should include the methods to overcome barriers for different state models that govern colleges articulation agreements and bridge agreements
B Develop models of long distance learning that can be used with smart classroom education and clinical in different areas away from the distance classroom sites.

4. CoARC completed a recent survey of the accredited associate degree granting programs which identified those without existing bridges to baccalaureate programs. It was found that funding was not a major barrier. Use this report to create models and make recommendations on methods to overcome the newly identified barriers. Since November the programs with agreements has increased for 47 to 56%.

5. The committee should assess whether the development and promotion of career ladder education options for the members of the existing workforce can be used for advanced competencies and the advancement to baccalaureate degree.

FM 13-2-4.1 Joe Sorbello moved to approve the new charges for 2015 & Beyond.
Motion carried

FM 13-3-4.2 Denise Johnson moved to approve the appointments of Dan Van Hise to the International Committee and Ray Pisani to the Membership Committee.
Motion carried

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

Doug Laher, Associate Executive Director Meetings/Convention, informed the Board of some of the changes that will take place at Congress 2013 in Anaheim. The meeting will now be three and a half days as opposed to four and there will be a closing ceremony.

Shawna Strickland, Associate Executive Director Education, gave the Board updates of the Leadership Institute and Clinical Practice Guidelines.

Steve Nelson, Associate Executive Director IT, informed the Board of the progress of being PCI-compliant (credit card processing) by August 31st.

Tim Myers, Associate Executive Director Brands Management, informed the Board that the third edition of the Guide to Aerosol Delivery Devices for the Respiratory Therapists was recently released. "Bringing Breath to Life" is the theme for Respiratory Care Week and will be launched to the membership shortly after Summer Forum. Digital ads are now on our webpages and we have contracted with Multiview. Multiview will also be hosting a new platform called "AARC Respiratory Care Marketplace" (formerly "The Buyers Guide"). A third party has been secured to build the new aarc.org website with a target date of September 2013 to launch.

Jason Moury, Drive4COPD Coordinator, gave the Board an update of the Drive. So far over 6,100 screeners have been completed since December 2012. He has been contacting Educators and Managers to participate.

Colleen Schabacker moved to accept Recommendation 13-2-1.1 "That an Ad Hoc Committee be appointed to recommend the content to be included in exhibits for the proposed virtual museum." Refer to President to appoint members of this Ad Hoc Committee
Motion carried

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

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 10:10am EDT Thursday, July 18, 2013.

RECONVENE
George Gaebler reconvened the meeting of the AARC Board of Directors 10:22am EDT Thursday, July 18, 2013.

President Gaebler informed the Board that at future meetings only reports that have recommendations will be reviewed at the Board meeting so that the Board may strategize more.

STATE GOVERNMENT AFFAIRS
Cheryl West provided the Board with an update of the current developments in state RT laws, in particular Michigan de-licensing efforts.

FEDERAL & REGULATORY AFFAIRS
Anne Marie Hummel gave the Board an update of CMS regulatory affairs. Cheryl and Anne Marie updated HR-2619 RT Access Act.

HOUSE OF DELEGATES
Past-Speaker, Karen Schell, informed the Board that the House has been diligently working to update the HOD policy manual.

PRESIDENT'S COUNCIL
Dianne Lewis reported that the President's Council is waiting on Life and Honorary nominees from the House of Delegates before voting can begin.

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

STANDING COMMITTEES REPORTS

Bylaws Committee
Brian Walsh moved to accept Recommendation 13-2-9.1 "That the AARC BOD accepts and approves the Georgia Society for Respiratory Care Bylaws"
Motion carried
Lynda Goodfellow abstained (from Georgia).

Brian Walsh moved to accept Recommendation 13-2-9.2 "That the AARC BOD accepts and approves the North Dakota Society for Respiratory Care Bylaws"
Motion carried

Brian Walsh moved to accept Recommendation 13-2-9.3 "That the AARC BOD accepts and approves the New York State Society for Respiratory Care Bylaws"
Motion carried
Joe Sorbello and Sheri Tooley abstained (from New York).

Elections Committee
Brian Walsh moved to accept Recommendation 13-2-10.1 "Amend the Election Committee Policy by adding the following to item 5: 'The Committee will develop a question for the Section Chair nominees that would be specific to the role, with input from the AARC President, focusing on the charges set forth for the particular section. The question will be generic for all Section Chair nominees.'"
Colleen Schabacker moved to make a friendly amendment to change "the role" to "their role" and delete the last sentence.
Motion carried

Brian Walsh moved to accept Recommendation 13-2-10.2 "Amend the Election Committee Policy by adding the following: '18. The Executive Office will provide updated section membership numbers and election grid to the Elections Committee, reflecting December 31st membership.'"
Colleen Schabacker moved to refer to Executive Office for implementation.
Motion carried

FINANCE COMMITTEE
Brian Walsh moved to accept Recommendation 13-2-1.3 "That the BOD approve the purchase of a new phone system to replace the current one that is over six years old."
Motion carried

Brian Walsh moved to accept Recommendation 13-2-1.4 "That the AARC BOD approve the addition of Merrill Lynch as an investment advisor."
Motion carried

Bill Cohagen moved to accept Recommendation 13-2-1.5 "That the AARC BOD approve opening a brokerage account with the Bank of Texas."
Motion carried

Bill Cohagen moved to accept Recommendation 13-2-42.1 "That the AARC reconsider stance on AARC presenter registration to include full complimentary registration."
Motion defeated

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

SPECIALTY SECTION REPORTS

Adult Acute Care Section
Brian Walsh moved to accept Recommendation 13-2-50.1 "That the AARC BOD consider creating an 'Acute/Critical Care Workshop' to be presented at Summer Forum." Colleen Schabacker moved to refer to the Program Committee for feasibility.
Motion carried

Brian Walsh moved to accept Recommendation 13-2-50.2 "That the AARC BOD look into the feasibility of creating a 'back to basics' education curriculum much like the ACCS Prep Course." Chair of Adult Acute Care Section, Keith Lamb, withdrew this recommendation.

Brian Walsh moved to accept Recommendation 13-2-50.3 "That the AARC BOD appoint members to look into the best approach to organize the AARConnect archives into easily accessible and partitioned areas to include, but not limited to, protocols, policies, and clinically relevant articles."
Chair of Adult Acute Care Section, Keith Lamb, withdrew this recommendation.

RECESS
George Gaebler recessed the meeting of the AARC Board of Directors at 11:55am EDT Thursday, July 18, 2013.

JOINT SESSION
Joint Session was called to order at 1:35pm EDT on Thursday, July 18, 2013. Secretary/Treasurer, Frank Salvatore, called roll and declared a quorum.

Frank Salvatore moved to go into Executive Session at 1:40pm EDT. Executive Session ended at 1:50pm EDT.

Gary Wickman gave highlights of the written Membership report.

John Hiser presented the International Committee report and informed the audience that six International Fellows had been selected for the 2013 International Fellowship Program:

Ana Cristina Okada (Brazil) Philadelphia, PA Cincinnati, OH Lysbeth Roldan (Colombia) Baltimore, MD Rochester, MN
Jithin Kalathikudiyil Sreedharan (India) Charlottesville, VA Winston-Salem, NC Daisuke Tsukahara (Japan) Kailua, HI Boise, ID
Mohamad El-Khatib (Lebanon) Salt Lake City, UT Portland, OR
Mohammed Herrag (Morocco) Emporia, KS Minneapolis, MN

Alternates-
Gashaw Takele (Ethiopia) Chulee
Jones (Thailand) Marshfield, WI

Terry Gilmore presented the Bylaws Committee report.

Ross Havens presented the slate of candidates for the 2013 election:

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

Cheryl West and Anne Marie Hummel gave highlights of the written State and Federal Regulatory Affairs report.

President Gaebler adjourned the Joint Session at 3:35pm EDT, Thursday, July 18, 2013.

RECONVENE

George Gaebler reconvened the meeting of the AARC Board of Directors 3:45pm EDT Thursday, July 18, 2013.

Brian Walsh moved to accept Recommendation 13-2-50.4 "That the AARC BOD, in conjunction with possibly the Research Roundtable, develop a way that budding researchers can tap into the

vast knowledge and resources available to the AARC to assist them with their research design, data analysis, and presentation."
Colleen Schabacker moved to accept for information only.
Motion carried

Brian Walsh moved to accept Recommendation 13-2-50.5 "That the AARC BOD look into the possibility of developing a committee or such group that would look into ways of ensuring that non-traditional clinical responsibilities and opportunities are being fully supported."
Brian Walsh moved to refer to Executive Office.
Motion carried

Doug McIntyre moved to accept the Specialty Section reports as presented.
Motion carried

House Resolutions
Past Speaker, Karen Schell, presented the House Resolutions.

Frank Salvatore moved to accept Resolution 62-13-02: Be it resolved that the AARC allocate sufficient funds to the Delegate Assistance committee to allow Affiliates approved for assistance to receive an additional day of lodging and per-diem at the winter meeting.
Motion carried

SPECIAL COMMITTEE REPORTS

Position Statement Committee
Colleen Schabacker moved to accept Recommendation 13-2-26.1 "Approve and publish the position statement on 'Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care' with no revisions."
Motion carried

Colleen Schabacker moved to accept Recommendation 13-2-26.2 "Approve and publish the revised position statement on 'Home Respiratory Care Services'."
Motion carried

Colleen Schabacker moved to accept Recommendation 13-2-26.3 "Approve and publish the position statement on 'Respiratory Care Scope of Practice'."
Motion carried

Colleen Schabacker moved to accept Recommendation 13-2-26.4 "Approve and publish the position statement 'Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists' with no revisions."
Motion carried

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

Social Media Committee
Brian Walsh moved to accept Recommendation 13-2-19.1 "That the AARC BOD approve the

Mission Statement & Guidelines documents as listed below in the 'Other' section."
Colleen Schabacker moved to refer back to Committee with explanations from Tim Myers and Brian Walsh for a future E-Vote.
Motion carried

Brian Walsh moved to accept Recommendation 13-2-19.2 "That the AARC BOD approve the structural approach described below in the 'Report' section, providing any suggestions at this point."
Brian Walsh moved to refer back to Committee to include in document.
Motion carried

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

RECESS
President Gaebler called a recess of the AARC Board of Directors meeting at 5:00pm EDT on Thursday, July 18, 2013.

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

_____ _____
Frank Salvatore Date
AARC Secretary/Treasurer

Attachment “A”

Position Statements:
Home Respiratory Care Services
Respiratory Care Scope of Practice

American Association for Respiratory Care

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

Position Statement

Home Respiratory Care Services

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

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

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

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

- develop an individualized plan of care designed to minimize symptoms and limitations, achieve a maximum level of patient function;
- educate patients and their caregivers to maximize participation in self-care and enhance compliance with prescribed care;
- inform the health care team on the patient's condition and response to care plan;
- administer diagnostic and therapeutic modalities and services as prescribed;
- conduct disease state management; and
- promote health, minimizing the need for hospitalization and other higher levels of care.

It is the position of the American Association for Respiratory Care (AARC) that the respiratory therapist—by virtue of education, training, and competency testing—is the most competent health care professional to provide prescribed home respiratory care. The

complexities of the provision of home respiratory care are such that the public is placed at a significant risk of injury when respiratory care services are provided by unqualified persons, either licensed or unlicensed, rather than by persons with appropriate education, training, credentials, and competency documentation.

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

Effective 12/14/00
Revised 12/07
Revised 07/10
Revised 07/13

American Association for Respiratory Care

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

Position Statement

Respiratory Care Scope of Practice

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

These responsibilities are supported by education, research and administration. Diagnostic activities include but are not limited to:

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

Therapy includes, but is not limited to:

1. The application and monitoring of medical gases and environmental control systems
2. Mechanical ventilator management
3. Insertion and care of artificial airways
4. Bronchopulmonary hygiene
5. Administration of Pharmacological agents
6. Cardiopulmonary rehabilitation
7. Hemodynamic cardiovascular support
8. Sleep support

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

Effective 8/87
Revised 12/07
Revised 12/10
Revised 07/13

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

July 19, 2013- Orlando, FL

Minutes

Attendance

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

Consultants

John Hiser, MEd, RRT, FAARC, Past Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
Karen Schell, RRT-NPS, RPFT, RPSGT, Past Speaker

Absent (Excused)

Lori Conklin, MD, BOMA Chair
Mike Runge, BS, RRT, FAARC, Parliamentarian
Karen Stewart, MSc, RRT, FAARC, Past-President

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director
Cheryl West, MHA, Director of Government Affairs
Anne Marie Hummel, Director of Regulatory Affairs
Tony Lovio, CPA, Controller
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President George Gaebler called the meeting of the AARC Board of Directors to order at 8:30am EDT, Friday, July 19, 2013. Secretary-Treasurer Frank Salvatore called the roll and declared a quorum.

SPECIAL REPRESENTATIVES REPORTS

American Society for Testing and Materials (ASTM)

Colleen Schabacker moved to accept Recommendation 13-2-65.1 "That the AARC BOD direct the Executive Office to investigate the potential of hosting F29 should AAMI be voted down on July 1, and report back to the BOD their recommendations."
Frank Salvatore moved to refer to Executive Office.
Motion carried

Joe Sorbello moved to accept the Special Representatives reports as presented.
Motion carried

ROUNDTABLE REPORTS

Asthma Disease Management Roundtable

Brian Walsh moved to accept Recommendation 13-2-42.2 "If not already available, consider developing formal AARC sponsored smoking cessation counselor training for RTs. If already available, consider a media blitz to raise awareness so interested RTs can enroll."
Brian Walsh moved to refer to Executive Office for feasibility.
Motion carried

Brian Walsh moved to accept Recommendation 13-2-42.3 "Develop tools that will help RTs gain the support of local Executive Leadership (e.g. CEOs, CMOs)."
Colleen Schabacker moved to accept for information only.
Motion carried

Brian Walsh moved to accept Recommendation 13-2-42.4 "Provide an educational session (Webcast?) on motivational interviewing /behavioral change strategies."
Frank Salvatore moved to accept for information only.
Motion carried

Doug McIntyre moved to accept the Roundtable reports as presented.
Motion carried

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on Cultural Diversity

Brian Walsh moved to accept Recommendation 13-2-29.1 "That the AARC promote the Cultural Diversity in Care Management Committee Mentoring Program in the AARC News."
Frank Salvatore moved to refer to the Executive Office.
Motion carried

Doug McIntyre moved to accept the Ad Hoc Committee reports as presented.
Motion carried

OTHER REPORTS (ARCF, CoARC, NBRC)

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

RECESS
George Gaebler called a recess of the AARC Board of Directors at 9:45am EDT, Friday, July 19, 2013.

RECONVENE
President Gaebler reconvened the meeting of the AARC Board of Directors 10:05am EDT Friday, July 19, 2013.

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS

POLICY REVIEW
Policy No. BOD.025 **–** *Conventions and Meetings*
FM 13-2-84.1 Bill Cohagen moved to accept as amended.
Motion carried

Policy No. CT.007 – *Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges*
FM 13-2-84.2 Doug McIntyre moved to refer to the Chair of the Judicial Committee to work with Executive Office to make any changes and report back at the November 2013 meeting.
Motion carried

Policy No. FM.017 – *Fiscal Management – Presidential Stipend*
FM 13-2-84.3 Frank Salvatore moved to refer to Executive Office for review of Presidential employer stipend amount and payment options related to the President's employment status and report back at November 2013 meeting.
Motion carried

Policy No. FM.019 – *Fiscal Management – Fiscal Policies – Investments*
FM 13-2-84.4 Frank Salvatore moved to accept as amended.
Motion carried

(See Attachment "A" for all amended policies above.)

Referrals from last Board meeting
Doug Laher began a discussion about Internet in hotel rooms/meeting rooms. President Gaebler says it is necessary to have it for Board of Directors and House of Delegates to be able to fulfill duties and responsibilities from their employers. Doug Laher will negotiate all future hotel contracts to have complimentary sleeping room Internet access.

Brian Walsh will contact Joe Huff regarding his Ad Hoc Committee on Cultural Diversity referral/recommendation from the April 2013 meeting to get more clarification

Treasurers Motion
Frank Salvatore moved “That expenses incurred at this meeting be reimbursed according to AARC policy.”
Motion carried

MOTION TO ADJOURN
George Gaebler moved “To adjourn the meeting of the AARC Board of Directors.”
Motion carried

ADJOURNMENT
President George Gaebler adjourned the meeting of the AARC Board of Directors at 10:00am EDT, Friday, July 19, 2013.

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

_____ _____

Frank Salvatore Date
AARC Secretary/Treasurer

Attachment “A”

Policies: BOD.25 – Meetings and Conventions
FM.019 – Fiscal Policies - Investments

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Meetings & Conventions**

EFFECTIVE DATE:

DATE REVIEWED: September 2005

DATE REVISED: July 2013

REFERENCES: CM.000, CM.003 - 1997

EXHIBITORS

1. The AARC reserves the right to reject exhibit applications for any reason.

2. Prizes, awards, drawings, raffles, lotteries, or contests conducted by exhibitors are expressly prohibited to take place in or around the exhibit hall, meeting room space and any public area of the convention center.

3. Exhibitors are only permitted to sell equipment, product or merchandise specific to their industry profile in or around the exhibit hall. Trinkets, souvenirs, T-shirts, gadgets etc. are not permitted for resale.

4. Priority Points will determine booth location. AARC reserves the right to alter booth location based on Association needs.

5. Exhibitors will be provided with 6 complimentary registrations for company employees for every 100 sq. ft. of exhibit space that they purchase. Registered exhibitors who are also respiratory therapists are eligible to earn CRCE at no cost as part of their booth registration.

6. Hospitality Suites/Meeting Rooms: Authorization and assignment of suites and meeting room space shall be handled on a first come, first served basis on the following criteria:

A. Availability of space
B. Area is not being used to host/entertain conference attendees during normally scheduled convention events (including AARC social functions). This includes, but is not limited to the following:
i. Welcome party, Sputum Bowl Finals etc.
C. Only companies with confirmed booth space in the exhibit hall are eligible for hospitality suites, meeting rooms etc.
D. Exhibitors must not allow attendees in hospitality areas who are under the legal drinking age if alcohol is served.

American Association for Respiratory Care
Policy Statement

E. The AARC reserves the right to refuse hospitality space to any exhibitor for any reason.
F. Those in violation of these stipulations are subject to immediate loss of booth space in current and/or future years.

ATTENDANCE & REGISTRATION

7. All persons attending AARC Congress must register and pay applicable registrations fees.

8. There will be a separate and more expensive registration tier for non-AARC members

9. Only members who have paid their current annual dues or whose applications are in progress will be admitted at the member rate. All others will pay the non-member rate.

10. Refunds will not be given to any individuals for fees paid by employer check. Refunds will be made directly to the employer, provided a request for a refund is made prior to the meeting within established guidelines.

11. All cancellations are subject to applicable cancellation fees. The AARC reserves the right to waive these cancellation fees in lieu of extenuating circumstances.

12. AARC reserves the right to provide complimentary registration to appropriate VIPs, dignitaries or others whose complimentary registration would otherwise be of benefit to the business practices of the Association.

13. Smoking is prohibited in all indoor/outdoor-sanctioned events of the AARC Congress.

14. Admission to social functions at AARC Congress is complimentary to all registered attendees.

15. Members of the President's Council and their spouses may register for AARC Congress at no cost.

16. Spousal registration is permitted for AARC Congress. Registration includes access to all AARC sanctioned events, but is not eligible for CRCE.

American Association for Respiratory Care
Policy Statement

EMPLOYEES, APPOINTED & ELECTED OFFICIALS

17. BOMA members will be granted free registration to AARC Congress

18. AARC will provide complimentary, full meeting registration for members of the Board of Directors and officers of the House of Delegates.

19. AARC employees and/or political representatives are prohibited from smoking on any property affiliated with AARC Congress (i.e. convention center, HQ hotel).

SPUTUM BOWL

20. Individuals may compete in the Sputum Bowl competition and attend all Sputum Bowl functions without having to pay Congress registration; however they are not permitted to attend any other AARC sanctioned event, nor are they eligible to earn CRCE.

CHARTERED AFFILIATES

21. Chartered affiliates exhibits at the annual meeting:

A. Upon written request, each AARC chartered affiliate may be granted, free of charge, one (1) 10x10 booth space in the exhibit hall at the annual meeting… space pending.
B. Affiliates requiring additional space may do so by applying and paying the commercial exhibit fees.
C. Location of the chartered affiliate booth to be determined by AARC. Chartered Affiliates serving as host state to the meeting will be permitted to secure a booth location outside of the Exhibit Hall (location at the discretion of the AARC… space pending).
D. Personnel manning the chartered affiliate booth must register for AARC Congress and pay all applicable registration fees.

American Association for Respiratory Care
Policy Statement

SPEAKERS & HONORARIUM

22. Speaker honorarium and reimbursable travel expenses:

The American Association for Respiratory Care has an obligation to its membership to produce a superior program for AARC Congress and one that is inclusive of high quality presenters. In addition, it is also incumbent of the Association to be fiscally responsible with financial resources. As such, the following parameters should be used when determining honorarium and reimbursed travel expenses for AARC Congress presenters:

A. The Association will commit appropriate financial resources necessary to secure presenters as requested by the Program Committee (commensurate with established budget).

B. If the presenter is available, able and willing to present at AARC Congress with no required honorarium or reimbursed travel expense, the Association should pursue such an arrangement.

C. For presenters requiring airfare, the AARC is authorized to extend national/international round-trip, coach airfare when purchased no less than 3 weeks prior to the meeting.

D. For presenters requiring mileage/railway reimbursement, the AARC is authorized to extend mileage/lump sum reimbursement at the prevailing federal rate, up to, but not exceeding the amount of the lowest available round-trip, coach airfare ticket.

E. For presenters requiring lodging, the AARC is authorized to extend reimbursement up to, but not to exceed lodging costs of the highest priced authorized convention hotel.

F. Should negotiated reimbursement include per diem, per diem compensation shall be determined based on AARC policy.

G. All presenters will receive (at minimum) complimentary one-day registration for the day in which they are scheduled to present, up to and including full 4- day meeting registration.

H. Bundled “lump sum” compensation for honorarium, travel and lodging may be offered in lieu of reimbursement for itemized expensed.

I. Honoraria and expenses will not be paid to AARC officials presenting programs dealing with their area of involvement

J. Honoraria shall not be paid to AARC employees.

American Association for Respiratory Care
Policy Statement

SECTION: Fiscal Management

SUBJECT: **Fiscal Policies – Investments**

EFFECTIVE DATE: July 2005

DATE REVIEWED: July 2013

DATE REVISED: July 2013

REFERENCES: FI.0786

Policy Statement:

The AARC shall continue to take a conservative approach to future investment policy based on current and projected economic trends.

Policy Amplification:

1. ~~As of July 2005, t~~ The investment policy for the AARC is ~~changed from an~~ ~~investment policy asset allocation of 60/40~~ a 40-60% asset allocation range to debt instruments and a 40-70% asset allocation range to equities with no investment related to the tobacco industry being allowed. A Return on Investment (ROI) of 2% over the Consumer Price Index (CPI) shall be the long-term goal. ~~between~~ debt instruments and equities ~~to a 50/50 asset allocation between debt instruments and equities with no less than 25% of the~~ equities being ~~invested in stocks which yield dividends.~~

DEFINITIONS:

ATTACHMENTS:

AARC
INVESTMENT POLICY AND PROCEDURES (Revised *JULY2013*)

The Executive Director has been delegated by the Board of Directors the authority for management of the AARC's cash funds. Such investments must be carried within the guidelines provided herein which have been reviewed and approved by the Board of Directors.

Policy Statement

Maximum utilization of Association assets is a primary objective of the Board of Directors. Cash balances represent an available asset that, when effectively managed can contribute to the overall goal of providing services at reasonable costs. Although the investment of cash on either a short or intermediate term basis is not AARC's principal activity, it is the nature of business operations that there will be excess funds available. The objective of the investment guidelines contained herein is to allow the AARC to maximize its return on cash balances while operating within established limitations that will minimize the risk of financial loss.

A matter of primary importance in determining the application of excess cash is ensuring that funds will be available to meet upcoming cash requirements. This can be achieved through the anticipation of cash needs by preparing projections of cash flow. The Executive Office is responsible for the preparation of such projections. However, their accuracy depends on the cooperation and awareness of all directors, officers, committee chairs, etc. All departments should, on a timely basis, provide the Executive Director with any information regarding contractual obligations or other types of arrangements that will significantly affect cash flow.

An additional consideration in the management of cash balances is alternative uses of cash, such as early debt retirement and early payment on accounts in order to receive cash discounts. It is the AARC's position that decisions involving alternative uses of funds will be based on an evaluation and comparison of economic benefits to the Association. After an evaluation, it may dictate that these alternative uses may be more attractive investment alternatives. Generally, in such cases, these alternatives should be pursued. However, should early debt retirement become economically attractive, implementation would require the prior approval of the Board of Directors.

Investment Guidelines

In order to minimize the risk of loss to cash balances, it is necessary to determine levels of risk that are compatible with overall management philosophy. Based on this determination, guidelines can be established for use in the investment of funds. The guidelines set out below establish not only the types of investments that are acceptable, but also limitations on the amount of any one of those investments that may be held at any point in time.
All investments of Association cash shall fall within the following guidelines:

- Fixed income-type investments
  - **R** 40-60% of entire portfolio; Optimum allocation: 45%
- In addition, within the fixed income range above, the following investment sub-categories will be consider acceptable:
  - Corporate Fixed Income Securities

- Government Fixed Income Securities
- Foreign Fixed Income Securities
- Short term
- Intermediate
- Long term

Acceptable investments (in no order of importance / use):

- Bank CD's (FDIC insured ONLY), maximum in any one institution: $100,000
- Repurchase agreements collateralized by government securities
- Bankers Acceptances
- Federal government or government agency securities
- Corporate commercial paper with an S & P rating of A-1 or Moody's rating of P-1
- Money market accounts trading at $1.00 / unit and comprised of the above type securities
- Corporate bonds with a rating of no lower that "BBB" by S&P or "Baa" by Moody's.
  - Bond maturities may be staggered over a 10 year period with the average maturity not to exceed 5 years.
  - No one bond may comprise more than 7% of the total fixed income portfolio
- Bond mutual funds
  - Must be primarily comprised of the above type of investments

and

  - Must be judged to be of high quality by considering:
    - S&P or Moody's ratings
    - Past earnings records
- May include so-called high yield or "junk bonds" (rated below "BBB" by S&P or "Baa " by Moody') but they may not comprise more than 7% of the total BOND PORTFOLIO.

  - Equity investments

Range** : 40-[redacted]ntire portfolio; Optimum allocation: 55%

In addition, within the Equity range above, the following investment sub- categories will be consider acceptable:

- Small Cap--growth
- Small Cap--value
- **Mid Cap—growth**
- **Mid Cap--value**
- **Large Cap--growth**
- **Large Cap--value**
- **Foreign (ALL)**

Single issues---Any stock EXCEPT those that are:

- A Penny Stock (i.e. trading for less than $1 via OTC (pink sheets))
- Highly speculative, for example:
  - Be trading with unusually high P/E ratios…50-75++ or
  - Have little or no history of any earnings

Stock Mutual funds must be:

- Primarily comprised of the stock issues allowed for above and
- Judged to be of high quality by considering:

- S&P or Moody's ratings
- Past earnings records / future growth
- Fund manager experience and track record

**** - From time-to-time, due to market conditions, operating cash needs or other circumstances, cash may be held in the investment portfolio that is not invested in securities. Compliance with the Fixed Income or Equity Investment percentages above is to be calculated WITHOUT considering such cash held in money market or other similar very short-term accounts.**

- No investment in any security that is related to the tobacco industry is permitted.

  However, it is acknowledged that mutual funds, by their very nature, may have amounts invested in tobacco-related securities that may be very difficult or virtually impossible to easily determine. Nonetheless, such funds will still be reviewed periodically (1-2 times a year) and if it is seen that they have invested in tobacco-related securities, they will be divested.

- No one equity security issue shall comprise more than 5% of the total equity portfolio and no one sector shall comprise more than 15% of the total equity portfolio.
- Alternative investments
  - No more than 5% of portfolio
    - Options, derivatives, future contracts, REITs
- Range: no more than 2.5% of entire portfolio
- Each trade must be approved by AARC CEO
    - Real Estate
- Range: no more than 2.5% of entire portfolio
- Each purchase must be approved by AARC CEO

Implementation.

In implementing the cash management program, the following minimum objective must be retained:

1. Achieve maximum yields on invested funds while insuring reasonable protection of principal.
2. A return on investment / benchmark goal of 2% over the annual Consumer Price Index shall be the long-term (3-5 years) goal

The employment of outside investment counsel may be considered when implementing a part or all of this cash management program. Such professional service must be bound by these same guidelines while undertaking their investment management role
Adequate accounting procedures must be developed, implemented and continually exercised. These procedures will insure adequate forward cash planning, proper controls over transfers of cash, establishment of maturity dates, recording and receipt of interest income and maintenance of individual accounting records for each investment.

All Association held negotiable instruments must be controlled using external safekeeping facilities. Access will be limited and must require a minimum of two appropriately designated representatives.

A Quarterly Investment report will be sent to the AARC's Executive Committee and show:

- **Investment balances at cost and market**
- **Investments at market segmented by investment type (stocks, bonds, etc.)**
- **Investment performance (ROI, dividends, gains and losses)**
- **Compliance with Range percentage guidelines, above**

Any material deviation from these guidelines and their implementation procedures must be submitted to and approved by the Board's Finance Committee.

E-Motions

(Since Last Board Meeting in July 2013)

13-3-9.1 "That the AARC BOD approve the Bylaws amendments as revised by the Ad Hoc Committee to Recommend Bylaws Changes and approved by the AARC Bylaws Committee."

Results – September 24, 2013
Yes – 9
No – 8
Abstain –
Did Not Vote –

General Reports

President Report

Submitted by George Gaebler – Congress 2013

Correspondence and activities since April BOD Meeting:

- I have worked with Tom Kallstrom and Cheryl West gets ramped up for the push for 2619 using Physician members of the Senate and Congress to support and push our bill forward.
- We have readdressed the AHA related to the Patient Care Team of Future and new language should be forthcoming shortly.
- The have been multiple Licensure issues in Montana, North Carolina and Michigan since the summer meeting. All are proceeding in good ways so far. Montana had their licensure law continued for another 5 years before sunset is considered again.

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

Committee Additions/Changes
Lot of changes but they will get added via the ratification for the committee members and charges at the Tuesday BOD meeting.

Membership is staying relatively steady from last year within about 180 members at 51,300. We will talk extensively about the Membership charges and plans at the meeting.

Bylaws: We have had extensive discussions about Bylaws before during and after the voting by the BOD. There will be more extensive discussion regarding them at the meeting. Suffice it to say that using an E-vote should not be done for these in the future.
We will talk about next moves on the proposed Bylaws Changes.

Progress and Transition for the BOD. I will be seeking to have an Ad Hoc Committee to create a document that could be used to give an easy to research historical perspectives about what past issues have been decided and why. There will be extensive discussion about this at the meeting.

2015 and Beyond; Toni Rodriguez and Linda Goodfellow have gotten the ball moving quickly with their new charges so much more will be discussed by the time the meeting occurs.

Tom Kallstrom and I have covered many of the items that have been happening related to the Affordability Care Act (ACT) in talks to different states. More to come at the meeting.

Co ARC and NBRC: Some of you may have heard that Co ARC has been considering the removal of policy 13.0 that essentially gives the Associate equivalency that many Respiratory programs use. Roughly half of the BS/Masters programs use it. We will spend some time talking about the history of this and what we are doing about it.

We will do a Tribute for Trish Blakely who passed away shortly after I spoke at the SC meeting. She was to receive the Invacare Award at the International Congress. Her husband Blake is coming to receive the award.

Travel:

July 2013
Orlando for Summer Forum and BOD/HOD meetings

September 2013
South Carolina for State meeting
Pennsylvania for State Meeting

October 2013
New York State Meeting

April 2014 Connecticut State Meeting
Spring BOD Meeting

May 2014
Colorado Society for Respiratory Care:

June 2014 New York and New Jersey Spring Conference

July 2014
TriState Meeting Louisiana, Mississippi and Alabama

September 2014
South Carolina Society for Respiratory Care Speaker
Pennsylvania Society for Respiratory Care Speaker

October 2014
New York Society for Respiratory Care: Speaker

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

Past President Report

Submitted by Karen Stewart – Congress 2013

Nothing to report.

Executive Office

Submitted by Tom Kallstrom, Executive Director – Congress 2013

Membership:

As of October 24, 2013 our membership numbers were 51,300. We will have a more current number to report at the board meeting in November.

Advocacy and Public Awareness:

Alpha One study

Last year, with support from the Alpha One Foundation, the AARC developed an online course about Alpha One 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. The data has been collected and written into a scientific paper, which was accepted by Respiratory Care Journal for publication in 2014. To see an prepublication version go to http://rc.rcjournal.com/content/early/2013/10/08/respcare.02817.abstract?sid=717c6fc7-8652-42fb-a180-f796a92efbd2

Drive4COPD

The 2013 Adopt-A-Company initiative for the DRIVE4COPD is almost at a close. This initiative included the recruitment and support of the Crew Chiefs and members of the AARC with shipping, receiving, and processing of the DRIVE4COPD material so that they could partner with businesses in their local community. So far over 130 members signed up for participating in a DRIVE4COPD event for either RC Week or COPD Awareness Month. We are working with COPD Foundation to determine 2014 strategy and subsequent opportunities for AARC members to participate.

AACVPR

As directed by the Board, I attended a face-to-face leadership meeting with the AACVPR in early October. I will provide a verbal update of this meeting in Anaheim. There are many opportunities for ongoing partnership with AACVPR and that would benefit our members who have an interest in Pulmonary Rehabilitation.

Advertising and Marketing

Advertising continues to be in a state of flux with many changes in the industry and with our advertising base. At the time of this report, advertising is behind target for both RESPIRATORY CARE Journal and behind target for *AARCTimes* on the print side. This comes despite efforts to create a flexible portfolio of opportunities. We are seeing a slight increase in advertisements on our e-newsletter products.

We continue to develop and grow our platforms in the digital advertising environments. Our agreements with a digital advertising firm, Multiview Inc (Las Colinas, TX), to procure digital advertising for our various digital and online platforms, has provided a new royalty stream that is well ahead of 2012 and will be more fully realized in 2014. We are developing new opportunities for advertisement banners and towers. We will also, in the near future, begin selling advertising in a digital format on other platforms.

We also successfully launched our new "Online Buyer's Guide" right after Summer Forum. The new platform and product is hosted by Multiview Inc. as is "AARC Respiratory Care Marketplace" and can be found on both www.aarc.org and www.YourLungHealth.org. This platform was

highlighted in this month's *AARCTimes* with its new options and opportunities.

We have also finalized the Multimedia Rates for Advertising in 2014 with some variations in rates for print (decreased), recruitment (increased), digital (proposed increased) and packaging of bundles.

Corporate Partners
We had a very successful year of revenue and sponsorships from our 2013 Corporate Partners. We will see two Corporate Partners lose their status in 2014 and the addition of two new Partners.

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

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

Website Project
We have been working diligently with our website designer, AXZM, on modernizing and streamlining our web presence for AARC in the coming months. We have finalized branding concepts and are currently in the process of developing the layout of the site. An aggressive timeline has been established to develop and implement the new websites before 2014.

Marketing
Upon Susan Gill's retirement in early August, we hired Jeanette Chawdhury as our Manager of Marketing and Productions. Jeanette has a Graphic Design undergrad degree and recently received her MBA with a Marketing focus. Many of the in-house ads that you have seen on AARC newsletters and the website have come from Jeanette. She is a wonderful addition to the team and we look forward to working with her on a 2014 Marketing campaigns.

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

Products
Benchmarking has seen a slight decline in membership in the second half of 2013 as the economic reigns are tightening for hospitals with approximately 110-120 hospitals (-18%) around the US and in Middle East (3). The Benchmark Committee is currently conducting an assessment of the program, possible upgrades and a potential new product line to ensure it is a current and valued tool to its participants. We are also reviewing the pricing structure for 2014 to ensure that has a good ROI for both the AARC and its participants.

As you are aware, in 2012 we outsourced our Respiratory Care Week products to a third party supplier, Jim Coleman Ltd that handle all products and the necessary shipping. This is our second year outsourcing RC Week products to Coleman and, at the time of this report, sales are significantly ahead in 2013 compared to 2014. As we still have 2 weeks left in October, final sales royalties are not as yet complete.

We continue to work to acquire sponsorships for our various educational products to offset production expenses as we head into 2014. In 2013, we acquired 5 sponsors for Professors Rounds. Webcast sponsorship acquisition was not as successful in 2013 and we will restructure our

sponsorship rates and deliverables for 2014. We have also introduced a new product in this area with Webcast-specific for Editor's Choice publications in RESPIRATORY CARE, which have been met with great satisfaction and participation. We have also received approval on our US Trademark for this series for 2014….AARC RESPIRATORY CARE *JournalCast*.

As we continue to review our product offerings, we have engaged in the review, revision and update on our patient, disease and professional brochures that we have sold for many years with great success for health fairs, RC Week and other community events. The current items have been used for approximately 6 years and are in need of a good refresh. These new brochures and IQ cards were released in October just in time for RC Week events.

We are also currently conducting an overall review of our educational products both online and in print for their clinical relevance and pricing, as well as potential for new product development. As part of this review, we are also exploring the opportunities for packaging of products and licensing agreements to increase our flexibility to offer these products to a wider audience in an affordable manner. You will see some new pricing for Archived Webcast in 2014 and we have recently released some Education Resource Bundles of older Professors Rounds (2009-11, 6 per set) for $99 as just two examples.

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

COPD Best Practices: A dedicated user community has been established on AARConnect with 180 members currently subscribed. This user community was established as a mechanism for members to share best practices in COPD disease management, readmission reduction programs, and other programs to improve outcomes in the COPD population. A COPD Best Practice webcast was also delivered on August 29, 2013. 447 members were granted CRCE credit for this course. The webcast has been archived and the slide decks from the webcast have been added to the COPD Best Practice Library on AARConnect. In addition, there are no less than 10 sessions/symposia dedicated to this topic at AARC Congress 2013 as well as our Keynote address of which this will be the focus.

COPD Toolkit: The beta-test for the COPD Toolkit is complete. Seven hospitals participated in the beta-test and collected data on 188 patients. Due to incomplete documentation on data collection forms, we were unable to make statistically significant claims regarding the impact of the toolkit; however, a cursory review of the data did suggest that there was benefit provided to the patients. Boehringer Ingelheim provided an unrestricted grant for the Toolkit.

Hospital to Home: Acting upon the charges of the BOD, providing education to hospital-based members regarding the transition of patients from hospital to home continues to be a major point of emphasis for the Executive Office. These charges were communicated to the Program Committee, and as such, no less than 8 sessions/symposia will be delivered on this topic at AARC Congress 2013.

Nutrition Guide: At the time of this Board report, the Nutrition Guide titled "A Guide to the Nutritional Assessment and Treatment of the Critically Ill Patient" is in production by the AARC publications/graphic arts department. The Guide has been written, reviewed, and copy-edited and is scheduled for hard copy distribution at AARC Congress 2013. The Guide was funded through an unrestricted educational grant from GE, and will be distributed from their booth at Congress. Online access and accompanying CRCE will be made available through the AARC website

starting Tuesday, November 19, 2013.

Meetings & Conventions:

The 2013 Summer Forum in Orlando, FL was a very successful meeting for the AARC. As is customary with Orlando destinations, they are well attended, and attendance for Summer Forum exceeded budget. Despite poor weather for the duration of the meeting which kept people confined indoors for the majority of the meeting, survey feedback was very favorable and has already been forwarded to the 2014 Program Committee. The new venue (Orlando Renaissance at Sea World), welcome reception, new speakers, and a pre-course that drew over 200 people left people very satisfied in their meeting experience. Areas of opportunity have already been identified and will be addressed during the planning for the 2014 Summer Forum in Marco Island, FL.

AARC Congress 2013: Below are highlights for this year's meeting and notable changes geared towards an improved attendee/exhibitor experience:

- Stephen Jencks (noted expert in hospital readmissions) will deliver the keynote address
- Bob Eubanks; award winning television host of "The Newlywed Game" will deliver the first ever closing ceremony. He will deliver a motivational presentation on how to interact, communicate, and connect with patients… all skills the RT will need to become better patient educators and provide added value to their organizations in improving HCAHPS scored. He will also host an RT-themed game show titled "Workmates" that is a takeoff of the Newlywed Game. And finally, in the closing moments, one lucky attendee will be asked to come up on stage to compete in "America's Greatest Game show" challenge with a chance to win $100,000.
- 4 Pre-courses: SNS course (morning/afternoon), Patient Safety, Tobacco Cessation, and Trauma
- 19 Open Forums
- 30 minute lectures, all with the same start/stop time so that attendees can maximize CRCE
- ~ 225 presentations, accounting for more than 18 CRCE
- 133 speakers with 46 first time presenters
- 3 scheduled breakfast symposia
- New exhibit hall hours to better meet the needs of exhibitors (11:00 - 4:00 Sat., 9:30 - 3:00 Sun., and 9:30 - 2:00 Mon.)
- Thomas L. Petty Memorial Lecture added as a new plenary session (David Pierson MD to present)
- 1/2 day Tuesday lectures to provide more flexibility in attendee's travel plans and allow dedicated "free" time for attendees to enjoy the host city

Co-Marketing Opportunities with our Chartered Affiliates

As of today there are 8 co-marketing opportunities for the states who sign the revenue sharing and co-marketing agreements. Since the beginning of the year 40 of the chartered affiliates have signed the agreements. 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 states that signed the revenue sharing agreement for 2013) to each affiliate for each 4-day, full registration paid for by members of their state (AARC Congress 2013).

2015 & Beyond

As per the recommendation of the AARC Board of Directors, we are working on completing the 2015 & Beyond FAQ webpage. Anticipated launch of completed webpage: November 11, 2013.

This will be another addition to our website that is dedicated to updating the membership about the 2015 initiative.

Education

Adult Critical Care Specialist (ACCS) examination prep course

Our first live event was held in September 18 and 19, 2013, in Las Vegas, NV. Faculty (Gerald Fulda MD; Carl Hinkson MS RRT-ACCS; Keith Lamb RRT-ACCS; Tom Lamphere BS RRT-ACCS; Kathy Moss MEd RRT-ACCS; Brady Scott MS RRT-ACCS) was well received and delivered excellent content both for the ACCS examination and general adult critical care knowledge. Contemplating next steps (studio vs. live event).

Asthma Educator course

CNE approval for this course was received in March 2013. In September 2013, the Ohio Nurses Association sent us audit notification. Materials were submitted to ONA on September 26, 2013. We are currently waiting for communication from ONA regarding the status of that audit. This course has prepared respiratory therapists and nurses to sit for the NAECB Asthma-Certification exam. Of note is that the NAECB this summer has revised their criteria for renewing credentials and thus has offered a year for all who had let their credential lapse to be recertified once they provide proof of pertinent continuing education credits.

Asthma Self-Management Education Program (ASME)

In 2013, we had one initial certification application and one renewal application. Both were accepted and granted ASME status. One previously accredited program has been terminated and, therefore, we now have 3 ASME accredited programs.

California ethics course

A new version of the course has been developed and has passed through the rough draft review from RCBC. AMS and AARC IT are making minor edits to the course. Full content (PDF copy of the content) is due to RCBC by October 28, 2013. The official launch date is January 1, 2014.

Continuing Respiratory Care Education

Electronic processes are functioning smoothly, for the most part. Minor issues occur from time to time but course sponsors seem to be pleased with the system. Applications are reviewed in a very reasonable time frame. Fees will increase in 2014 for applications.

COPD Educator course

CNE approval for this course was received in March 2013. In September 2013, the Ohio Nurses Association sent us audit notification. Materials were submitted to ONA on September 26, 2013. We are currently waiting for communication from ONA regarding the status of that audit.

CPG Development

The new webpage with retired CPGs was met with mixed reviews. Many respiratory therapists use older CPGs as policy and procedure templates. This highlights the need for a more robust policy and procedure campaign as well as updated guidelines. The non-pharmacologic airway clearance therapies CPG has been accepted for publication by RESPIRATORY CARE and will be published in the December 2013 issue. Early release (papers in press online) in November.
We have submitted a proposal from Vanderbilt EPC for pharmacologic interventions in airway clearance CPG project to President Gaebler for Board consideration. It is anticipated that work will begin on that CPG in January 2014 with publication by December 2014.

Human Resources Survey

Project details discussed with Rob Shaw (AMP) in Spring 2013. Process will start (for November

2014 release) in January 2014.

Leadership Institute
Leadership Institute content is complete and the project is in the last phase of development. The AARC IT/publications staff (Steve Bowden and Kelly Piotrowski) is incorporating content into final formatting. The project chairperson is Toni Rodriguez; the research track chair is Rob Chatburn; the education track chair is Linda Van Scoder; and the management track chair is Rick Ford. Content contributors are: Garry Kauffman, Cheryl Hoerr, John Sabo, John Salyer, Toni Rodriguez, Diane Oldfather, Sarah Varekojis, Christine Hamilton, Rob Chatburn, and Shawna Strickland.

Learning Management System
We have been investigating Learning Management Systems (LMS) for the delivery of educational content. The cost of product is far less than the cost of AARC IT department cost in labor and/or AMS production cost in off-site production for our courses. There are two major companies at this time: Peach New Media and Verified Learning. Both have provided hands-on training for me. We are in the process of scheduling group demonstrations and anticipate making a recommendation on which product to use by the end of November. We would like to see the product installed and transition of courses to begin by March 2014.

Palliative Care Roundtable Liaison
This new roundtable started in 2013 currently has 110 members. Chair: Helen Sorenson. Moderately active AARConnect group. A roundtable meeting is planned for the AARC Congress. Terminal weaning webcast in July was well attended.

Preceptor Training course
The Clinical PEP: Practices of Effective Precepting was released in August 2013. So far the course has been well received. Content developers: Crystal Dunlevy, Georgiana Sergakis, Sarah Varekojis (OSU).

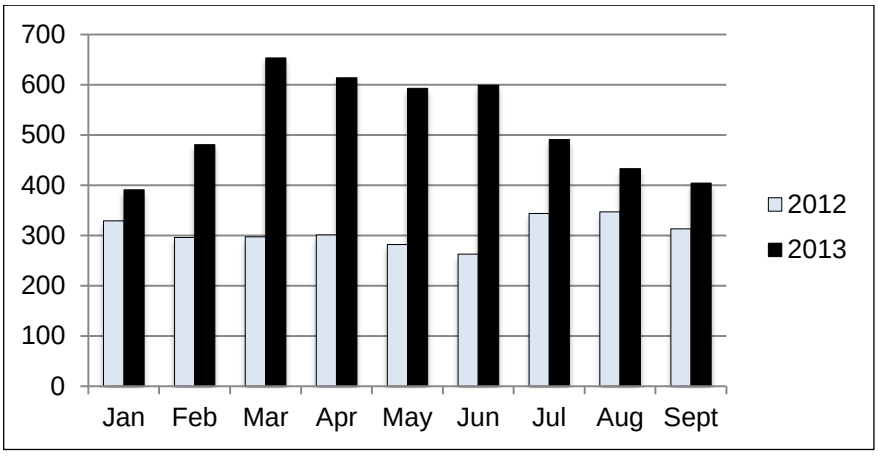
Respiratory Care Education Annual
The Respiratory Care Education Annual was released on September 2, 2013, in an electronic format only: PDF and ePub. Nine manuscripts were published. Editorial board consists of Dennis Wissing (editor), Helen Sorenson (associate editor), Will Beachy, David Chang, Arthur Jones, and Linda Van Scoder. Paul Matthews and Lynda Goodfellow resigned in early 2013. Doug Gardenhire was appointed in the Spring. We are currently recruiting for one more editorial board member before the next deadline (February 2014).

Webcasts
There are 11 webcasts planned for 2014. To ensure that we do not saturate the webcast environment, there will be no more than two (2) scheduled webcasts/Journal webcasts planned per month (not to exceed 24/year of BOTH types of webcasts). Currently, the annual total of webcasts for 2014 is anticipated at 21.

RESPIRATORY CARE Journal: 2013 Overview

- Record number of manuscripts received and processed
- New Journal website launched in January, followed soon thereafter by the mobile, Apple, and Android apps
- Once they are accepted, manuscripts are now posted online as PDF files within a week of acceptance
- Guidelines for Authors updated (see ww.rcjournal.com)

- More AARC members taking advantage of CRCE Through the Journal:



- Journal Webcasts launched in March. The webcasts are designed for the Editor's Choice paper to be presented, critically evaluated, and discussed by a therapist and AARC member with expertise on the subject matter. This is a member benefit to AARC members and approved for CRCE:
  - *Evaluation of Recruited Lung Volume at Plateau Inspiratory Pressure with Positive End Expiratory Pressure Using Bedside Digital Chest X-ray in Acute Lung Injury/Acute Respiratory Distress Syndrome Patients.* Presenter: Keith D. Lamb RRT-ACCS, Newark DE
  - *Contemporary Ventilator Management in Patients with and at Risk of ALI/ARDS.* Presenter: Carl Hinkson MS RRT-ACCS NPS FAARC, Seattle WA
  - *Effect of Ventilatory Variability on Occurrence of Central Apneas.* Presenter: Paul F Nuccio MS RRT FAARC, Boston MA
  - *Comparison of Two Lung Recruitment Strategies in Children with Acute Lung Injury.* Presenter: Kathleen M Deakins MSHA RRT-NPS FAARC, Cleveland OH
  - *Individualized PEEP Setting in Subjects with ARDS: A Randomized Controlled Pilot Study.* Presenter: Brian K Walsh MBA RRT-NPS RPFT FAARC, Boston MA
- The results of 288 research scientific studies will be presented in 19 OPEN FORUM sessions at AARC Congress 2013
- Portuguese podcast of the Editor's Commentary launched in September
- Assisted the ARCF with selection of research fellowships
- Guided the development of the AARC's evidence-based CPGs project resulting in the first one on non-pharmacologic airway clearance techniques in hospitalized patients to be published in December
- Represented the AARC in the CDC special project to develop a new, national approach to surveillance for ventilator-associated events (executive summary published in November)

Cost savings

We were able to work with Dallas County this year and had our property value reassessed after an original assessment this year that showed an increase in property value from $1,500,000 to $2,424,660 (pre 2008 level). We felt this unreasonable given the age of the building and a somewhat improving economic climate. We protested the valuation and after a board hearing we were able to bring the cost down to $1,575,500. This was a realized savings of $19,000 (.142 cent rate per KWH) in 2013 real estate taxes for the association.

In addition, we reviewed our current electric costs. We had been with TXU for many years. The average cost of electricity being $3,000-$6,000 a month. After consulting with local electrical

broker we were able to find a better cost (0.73 – 0.91 KWH). By years end we expect to have saved over $30,000 in electrical cost savings. We will continue to assess other costs in an effort to see if there may be other cost saving opportunities.

Summary

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. I look forward to seeing you in Anaheim.

Executive Office Referrals

(from Nov 2012 BOD meeting)

HOD Resolution 06-12-03 *"Be it resolved that the AARC investigate starting a public membership for patients and other interested parties."*

Result: YourLungHealth website needs to be redesigned in order to accommodate this request and tangible benefits would need to be identified.

HOD Resolution 13-12-04 *"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."*

Result: Shawna Strickland spoke with John Davies, Chair of Research Roundtable, to inquire what objectives are not provided by the Roundtable and Leadership Institute that the House may be looking for.

(from July 2013 BOD meeting)

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

Result: The item has been added to the policy and Tim Myers will be responsible for providing the election grid to the Elections Committee.

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

Result: There is a smoking cessation pre-course at Congress this year and a webcast planned for 2014. The Executive Office is exploring the fiscal burden of a formal online course.

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

Result: Tom Kallstrom will discuss with Keith Lamb.

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

Result: Tom Kallstrom spoke with Bob McCoy and has never received a formal letter with this request.

Recommendation 13-2-29.1 *"That the AARC promote the Cultural Diversity in Care Management Committee Mentoring Program in the AARC News."* Referred to Executive Office

Result: We contacted Joe Huff to learn more about this request. It is a program to bring members of diversity into the House of Delegates to observe and learn about governance in the AARC. After discussing this with him, he agreed to more fully outline the goals of this program, create the ideas for including individuals in this program, and develop a mechanism for allowing members to apply. We talked about replicating the features of the Student Mentorship Program in the House. Once the program is more fully developed, we can assist in publicizing it.

FM 13-2-84.3 - Policy No. FM.017 Fiscal Management – Presidential Stipend Referred to Executive Office to report back at November 2013 meeting.

Result: According to a September 2013 report completed by the American Association of Medical Society Executives, 71% of national societies do not provide a stipend for their presidents. The average annual stipend was determined to be $11,223 for a national specialty medical society. In our research we anecdotally learned that many societies pay this to the institution of the president, as we do, though some do pay it directly to the person.

State Government Affairs Activity Report

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

Introduction

As this report is written, most state legislatures have adjourned for the year. Some states are now engaged in preparing for the 2014 sessions. The majority of legislatures will come back into session in January.

The overarching umbrella of the fragile economic recovery heavily influenced budget and spending decisions in the states this year. Moreover, states also debated and decided, some more easily than others, whether to participate in two key provisions of the Affordable Care Act (ACA, aka Obama Care).

The first issue was the state option to expand Medicaid for a large group of low income people under the age of 65. The ACA requires the Federal Government to pay for the first 3 years 100% of the costs of the expansion to the states that chose to participate. Thereafter the Feds would pick up 90% of the costs. As of October1, twenty six states have chosen to take this option which will go live on January 1, 2014. Twenty two states are not planning to move forward, and there is ongoing debate in three states. A good site to monitor this issue is the non-partisan Kaiser Family Foundation:
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

The other ACA provision is the requirement that individuals without health insurance chose a health plan no later than March 1, 2014 (those who select earlier will have their coverage begin January 1, 2014). While the one year delay (January 1, 2015) in the implementation of the ACA's mandate for *employers* with over 50 FTEs to offer health insurance this delay did not apply to the individual mandate.

To assist consumers in making the insurance choices, the ACA opened up the Health Care Exchanges or Marketplaces on October 1. The Marketplace gathers health coverage options available in the locality of the individual where comparisons of plans based on price, benefits, quality, and other features can be made.

State governments had to make the decision whether to set up their own Marketplace Network; develop a Marketplace in partnership with the Federal government or opt to let the Federal government create in its entirety the Marketplace for their state. The Federal government's website for the Health Marketplace can be found here:
https://www.healthcare.gov/

As with the Medicaid expansion option, states have made widely divergent decisions on the developing the Marketplace.

As this Report is written, 17 states and DC established a state-based marketplace; 7 states pursued a state-federal partnership marketplace, and 27 states chose not to participate in developing a Marketplace and have turned that task over to the federal government.

As noted in the July Report, the importance to the RT profession of these two ACA provisions is fairly straight forward: there will be a significant increase in the number of individuals who will now have access to either Medicaid services or private insurance coverage. And that will translate into a greater demand for the services of respiratory therapists.

Respiratory Therapy Licensure

The **Michigan** state government has continued to move towards de-licensing the 18 professions (including RT) that a 2012 Michigan Commission Report earmarked for de-regulation. Ultimately, it will be the Michigan legislature that must enact any de-licensing law. The legislature has methodically been introducing individual de-licensing bills for each of the 18 professions. The bill to de-license respiratory therapists, SB 514, was introduced at the end of September.

Since 2012, when Michigan began the de-licensing initiative, the Michigan Society leadership has continued to build up support for RT licensure, by organizing many dedicated respiratory therapist volunteers to execute assignments (lobbying legislators, educating employers, engaging RTs, patients and physicians to voice their opposition, etc.). This is in addition to the direct contact with legislators that MSRC leadership and their contracted lobbyist have undertaken. At the invitation of the MSRC the AARC has participated in the many strategy conference calls the leadership has held and we continue to stand ready to assist the Society in every way possible.

On a similar note, you recall that in 2012 there was an effort by the **Indiana** government to de-license respiratory therapy. This effort was defeated due to the focused actions of the Indiana Society. But of note, a bill was introduced in the 2013 Indiana legislature, termed ERASER that would have given clear cut authority and a much easier "pathway" for the Indiana Administration to move to de-license professions as it would see fit. The preamble of the bill states it this way: "…review and recommend the continuation, elimination or combination of Indiana licensure boards and professions." This bill did not pass, but certainly its very existence should be a warning the de-licensing efforts will continue.

The state of **Montana** has a licensure review committee, the Economic Affairs Interim Committee (EAIC). Comprised of 8 state legislators the Committee systematically reviews the licensure requirements for each regulated profession, determines if licensure has met the mandate to protect the public and makes recommendations to the full legislature whether or not licensure should continue or be repealed. We understand that over the course of the years the EAIC has never once recommended a profession be de-licensed. Licensure for RTs in Montana was up for review this October.

Keeping in mind the de-regulation climate many state governments are embracing these days, and the challenges their RT colleagues in Michigan are facing, the Montana Society has left nothing to chance in presenting a detailed rationale why licensure for RTs must continue. The hearing on the RT profession will occur after submission of this Report. An update will be provided at the meeting.

On the other hand, under the **California** Sunset law that required the Respiratory Care Licensure Board (and therefore RT license) to be reviewed this year, legislators deemed (and enacted) it necessary to continue RT licensure until January 1, 2018 (the next Sunset review).

Legislation

This section provides an update from the information that was reported in the July Report.

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

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

Ohio (enacted) various changes to license renewal and disciplinary provisions. In **Illinois** (enacted) disciplinary charges may now be brought against professionals who are named as perpetrators in Reports issued by the Department on Aging (elder abuse). In **Nevada** (enacted), there is a clarification of the penalties for practicing without a license. **Utah** (enacted) now provides the Licensing Agency with "better access to criminal background information for applicants applying for licensure, licensure renewal, licensure reinstatement, and re-licensure".

Nevada (enacted) a new provision that will authorize licensed health care providers from other states to provide voluntary health care service in Nevada as long as they are associated with a sponsoring organization.

Utah (enacted) a similar bill to Nevada that "authorizes the local health departments to train health care professionals who volunteer as medical reserve corps during public health emergencies and disasters." The new law also provides immunity from liability for those who chose to volunteer.

Other Legislation of Interest
Oregon a bill that would establish a system for repurposing durable medical equipment that is no longer medically appropriate for medical assistance recipients for use by other medical assistance recipients.

New Jersey (enacted) requires when HME companies remove oxygen delivery systems from a patient's home that the company must notify, in a timely manner, the local fire department. Another **NJ** bill (*not enacted but interesting*) requires "certain entities (such as health care facilities, first aid, ambulance, and rescue squad buildings, and firehouses, community centers, senior centers, and other public buildings), if they provide public charging stations for portable electronic devices, be equipped with sufficient outlets for members of the public to charge these devices including…..battery-powered, portable oxygen units…."

Texas a bill with a provision that requires certain health care providers give patients a good faith estimate of the expected payment for health care services and goods before the services or goods are provided; DME providers are included. Another bill in **Texas** (enacted) establishes a reuse program for durable medical equipment provided to recipients under the Medicaid program.

Expansion of Scope of Practice Other Professions
As noted in the July Report there was a significant increase in legislation that expanded the scope of practice or eliminated restrictions on a number of professions, most notably nurse practitioners (NPs) and physician assistants (PAs). Some legislation is aimed at removing the physician supervision requirement; other bills would authorize these practitioners to have prescriptive authority; some provided expanded delegation authority.

State focus on PAs and NPs legislation may be the result of a number of factors, most notably, the anticipation that due to the ACA health insurance mandate, the number of people entering the health care system will substantially increase. This increase in the volume of patients will require more primary care practitioners beyond the current number of physicians who would be able to

serve this increased demand. Another possible reason, also previously noted in the July Report, is that for states and state sponsored health coverage (Medicaid, CHIP, etc.), paying for the services of non-physician practitioners costs less than paying for the services of physicians.

The following states had NP/PA legislation and while this was noted in the July Report it bears repeating: **Florida, Georgia, Illinois, Missouri, Mississippi** (enacted), **New Mexico, Rhode Island** (enacted), **Texas** (enacted), **West Virginia** (NPs and nurse mid-wives).

There have been additional NP/PA bills introduced since the Summer Meeting:

California and **Washington State** have introduced NP and PA "expansion" bills. You'll note that few bills have passed, and one could speculate that this may have much to do with state medical society opposition.

From another angle, a number of states introduced (but thus far have not enacted) legislation, which would establish nurse staffing ratios: **Florida** (for medically fragile children under 21), **Iowa, Minnesota, New Mexico** and **Texas.**

It is also noteworthy that there are a number of bills that expand the scope of practice for pharmacists. In **California** the pharmacist "expansion" bill which was enacted includes explicit provisions that address the "advanced practice pharmacist" one who differs from the "regular" pharmacist by permitting among other responsibilities the advanced practice pharmacist the authority to undertake patient assessments.

Respiratory Related Rules/Regulations

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

Arkansas made revisions to the RT licensing rules.

Iowa further defines the direct supervision requirement for RTs.

Maryland adopts new sanctioning guidelines for RTs and others licensed under the Board of Physicians.

Missouri set requirements for participation in the MO HealthNet Invasive Ventilator Program and the per diem add-on amounts to be applied to nursing facility reimbursement rates.

New Hampshire a rule that describes procedures for licensees who: do not wish to renew their license; the license renewal procedures; the license renewal application form; the multipart application form; documents required for initial licensure and the content of the letter of reference.

North Carolina Clarifies the tasks an unlicensed support tech may perform under the oversight of a licensed practitioner.

Ohio rule revision for license application procedures and renewal of licenses or permits.

Virginia revised rule that now allows an out-of-state applicant to demonstrate competency through documentation of 20 hours of continuing education within the 24-month period preceding application for licensure in lieu of documentation of "active practice.

I will provide a verbal update at the November Meeting.

Federal Government Affairs
Activity Report – November 2013

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

The Congress

As the first session of the 113th Congress comes to a close, the rancor and partisan politics that has plagued this Congress continues. Unfortunately for any organization or coalition of like-minded groups that desires to pass changes in any specific part of a federal law, all roads have to go through what is generally viewed as a dysfunctional Congress. This of course applies to the AARC and our allies in the attempt to enact HR 2619, the Medicare Respiratory Therapist Access Act. Regardless of the difficulties working with this Congress imposes on the respiratory community we will continue to persevere to seek out Hill support for our important legislation.

Legislation

HR 2619 - The Medicare Respiratory Therapist Access Act

Congressman John Lewis (D-GA) introduced our legislative initiative, HR 2619 in early July. As of October 14, HR 2619 had 12 co-sponsors. Our legislation is designed to provide coverage of pulmonary self-management and education services when furnished in a physician practice by qualified respiratory therapists to Medicare beneficiaries who have been diagnosed with certain chronic lung diseases. We will need significantly more co-sponsors to be able to gain serious consideration by Congress – particularly in the current environment.

In order to address the inevitable questions that will be asked from Hill staff regarding the potential cost of the legislation, the AARC commissioned Dobson/DaVanzo, a well-respected DC-based firm, to do an independent cost estimate based on an analysis of Medicare Part B files. The analysis indicated that over the course of ten years there would be a cost increase of between $245 and $500 million depending on the how well Medicare patients complied with self-management skills. Dobson/DaVanzo also provided likely offsets that could result in Medicare savings. For example, it is likely that the additional spending to implement our bill could be totally offset by a decrease in emergency room visits and improved medication adherence, including oxygen, due to a patient's ability to self-manage his or her disease. While it is unlikely that CBO would consider these offsets, it is an important strategy in gaining sponsorship.

Attachment #1 is a revised one page background paper that now includes the Dobson/DaVanzo cost figures in more detail.

Throughout the year Miriam O'Day has continued to meet with Congressional members and staff. In the spring Miriam made follow-up visits to those receptive Capitol Hill offices that had shown some level of support in response to the AARC's Hill Lobby Day. As PACT reps, State Society leadership and individual RTs reached out to their Congressional Representatives during the summer and early fall back in the district, Miriam also secured follow-up meetings with those same Members back in DC.

In September Tom Kallstrom and Sam Giordano traveled to Washington for a series of meetings with members and staff on Committees of jurisdiction for HR 2619. This trip included a breakfast

with Congressman Joe Pitts (R-PA), Chair Energy and Commerce, Health Subcommittee, his Chief of Staff, Health Aide and Committee Staff. Joe Goss, respiratory therapist from the New Jersey joined us for a meeting with Congressman Rob Andrews (D-NJ). Congressman Andrews has stated he will become a co-sponsor of HR 2619 and offered to write a letter to CMS regarding respiratory care. At this writing, Congressman Andrew's plans on stopping by the AARC at our meeting in Anaheim where we will be putting together a small VIP meeting and taking him on a tour of the Exhibit Hall to get a feeling of the scope of the profession.

During the September round of Hill meetings we also met with key Senators to try to secure a companion bill. To date the Senate has not yet introduced a companion.

AARC Capitol Hill Lobby Day

As noted in the July Report, the 13th annual Capitol Hill Lobby Day in Washington, D.C. bought in 119 respiratory therapists from 44 states and DC, 30 RT students from regional RT education programs, and 15 patients from our patient partners sponsored by the COPD Foundation. Dates for the 2014 Hill Lobby Day have been set for March 31-April 2 (Hill Day set for Tuesday April 1). As we note in every Report, the success of this important high profile event would not be possible without the support from our state societies' and dedicated RT volunteers.

Virtual Lobby Week

As you know, just prior to our Capitol Hill Lobby Day, the AARC launches its Virtual Lobby Wee. The goal of VL Week is to have as many emails going to the Hill as possible in support of our PACT reps efforts to generate support for our legislative agenda. Through the efforts of the PACT and the state societies we were able to have over 21,000 emails sent to Capitol Hill.

Since the introduction of our bill HR 2619 on July 8, the AARC, PACT Representatives and the state society leadership have urged our members and supporters through stories on the Website and *AARC News Now* to continue to use Capitol Connection to send additional emails to the Hill. Since that time, an additional 14,100 emails have been sent to the Hill.

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

This bill offers an alternative to competitive bidding by replacing it with an auction-type program that is designed to be more transparent and offer bids in smaller areas. The language in the bill also calls for terminating the current Round 1 competitive bidding program as of December 31, 2013 and restricting the Secretary from taking action to implement Round 2 or future rounds.

Regardless of the efforts to delay Round 2, the program was expanded to 91 areas in July. Round 1 was also re-competed which resulted in a weighted average savings of 40% for respiratory equipment and related supplies and accessories. As of September 20, 2013, the bill had 156 co-sponsors. AARC supports the legislation as noted previously.

Regulations and Other Issues of Interest

Since the last board meeting, CMS has published its annual updates to the hospital outpatient prospective payment rules and the physician fee schedule. These contain issues of interest to the respiratory care community.

Pulmonary Rehabilitation

The update to the Hospital Outpatient Prospective Payment Regulations for 2014 contained changes to the payment group for pulmonary rehabilitation. Pulmonary rehabilitation (G0424) is now in the same payment group as the respiratory therapy codes (G0238-G0239) used for non-COPD patients. Since the inception of the program, pulmonary rehabilitation had been in a

payment group by itself because CMS had determined there were no current payment groups that appropriately reflected the components of the program.

While the change makes no difference in the payment amount, which is proposed at $38.97 for all of the codes, it does raise questions as to how pulmonary rehabilitation (billed per one hour session) can be lumped into a category with codes that pay the same amount per 15 minute increments. The pulmonary community, including AARC, sent comments to CMS on this issue.

Discharge Planning

The interpretive guidelines that state surveyors use when evaluating compliance with the Hospital Conditions of Participation (HCOPS) have been completely revised to address the importance of care transitions and reducing hospital readmissions. The changes also include "advisory boxes" intended to offer successful industry practices that promote better patient outcomes.

While the advisories are for information only, they send a strong message to hospitals that there are practices that can work to their advantage in the long term if they are implemented. For example, in one advisory box it states that a well-designed discharge evaluation process should involve a multidisciplinary team, including RTs. Specific requirements as part of the evaluation process should include an assessment to determine a patient's capacity for self-care and the extent to which the patient may need post-hospital services such as respiratory therapy. These new policies make the case for the respiratory therapist to assume a greater role in his or her facility's discharge planning process.

Care Coordination

With the numerous innovative pilot programs underway to test new payment models, CMS has placed significant emphasis on primary care and "care transitions" as a way for patients to stay healthier, have better outcomes, and most of all, to stay out of the hospital. New care management services also offer additional opportunities for respiratory therapists outside the hospital setting and complement our Part B initiative.

Transitional Care Management Services

January 1, 2013 saw the advent of transitional care management services. These services offer another way to provide seamless care from hospital to home or community for patients with moderate and complex medical needs during a 30-day period post hospital discharge. Services that can be provided by licensed clinical staff, such as respiratory therapists, working under physician supervision include assessment and support of patient adherence to the treatment regimen, oversight of medication management and education to support self-management, independent living and activities of daily living.

Complex Chronic Care Management Services

In the 2014 update to the physician fee schedule, CMS is proposing new complex chronic care management services (CCCM) effective at the beginning of calendar year 2015. These services are intended for patients with 2 or more chronic conditions lasting at least 12 months or until death, or put the patient at risk for acute exacerbation, decomposition or functional decline. The episode of care is for a 90-day period.

A unique feature of the CCCM services is that patients must have access to a health care professional 24 hours a day, 7 days a week. CMS would waive the current "direct" supervision requirements under the "incident to" rules and permit the services to be rendered under the general supervision of the physician; that is, the physician would not have to be physically present with the service is being performed. Second, to ensure continuity of care, patients will be permitted to get successive routine appointments with a designated practitioner or a member of the care team. These

services also offer new opportunities for RTs to work in the physician practice setting.

Nebulizer Cleaning and State Surveyor Worksheets

CMS/CDC contacted AARC recently for final guidance on the nebulizer cleaning issue. The guidance to "rinse nebulizers with tap water followed by isopropyl alcohol" we believe has been resolved and the reference to isopropyl alcohol will be deleted from final language. AARC recommended the guidelines reflect the differences in newer technologies, noting that all nebulizers are not alike. While we have no specific date from CMS/CDC as to when the final worksheets will be sent to surveyors, based on previous information from CMS we would expect them to be out by the end of the year and hopefully sooner.

"Incident to" Rules – Qualifications of Auxiliary Personnel

In the physician fee schedule update for 2014, CMS is proposing to amend the definition of "auxiliary personnel" (e.g., nurses, respiratory therapists, lab techs, etc.) under the "incident to" provisions in the physician office setting. The change, which responds to recommendations in a 2009 OIG report, would require these individuals to meet "any applicable requirement to provide the services, including licensure, imposed by the State in which the services are being furnished." While practitioners who bill for Medicare services have always been required to comply with state law as a condition of getting paid, the requirement has not been mandated for other personnel until now.

AARC supports the change; however, we have raised questions to CMS as to how the revision would impact RTs and other personnel working in a state that has no licensure laws or state standards and asked that they address this issue in the final rule.

OIG Report on Payment for Mechanical Ventilation

The Office of the Inspector General (OIG) published a September 2013 report on overpayments to hospitals for Medicare beneficiaries who had not received 96 or more hours of mechanical ventilation. Of 377 claims filed by 290 hospitals, 363 of them used the incorrect procedure code 96.72 resulting in overpayments of $7,714,825 over a 3-year period (CY 2009-11). The hospitals at fault attributed the errors to incorrectly counting the number of hours that beneficiaries had received mechanical ventilation or clerical errors in selecting the appropriate procedure code. To address the problem, CMS instituted a new length-of-stay edit last year that flags claims for validation and resubmission. The report can be accessed at http://go.usa.gov/Dd6G .

Conclusion

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

Attachment below

HR 2619 – Medicare Respiratory Therapist Access Act of 2013
Better Access, Better Care, Lower Costs

Background

HR 2619, *the Medicare Respiratory Therapist Access Act*, was introduced by Rep. John Lewis [D-GA] on July 8, 2013.

As health care costs continue to soar for patients with multiple chronic conditions and physician shortages become a major concern, the status quo in health care is no longer an option. With the evolution of pulmonary medicine over the years since the Medicare law was enacted, it is time to recognize the expertise respiratory therapists (RTs) can bring to pulmonary patients.

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

Improving Health Outcomes through Better Access to Respiratory Therapists

Reducing excess hospital readmissions, improving care transitions, and lowering costs are key Medicare goals. For those with chronic lung disease, a key to achieving these goals is to reduce or eliminate exacerbations which can lead to costly emergency room (ER) visits and/or hospital admissions or readmissions.

HR 2619, the *Medicare Respiratory Therapist Access Act,* is designed to address these issues and achieve key Medicare priorities.

- It will amend Medicare Part B to provide coverage of pulmonary self-management education and training services furnished by a qualified RT in the physician practice setting; the physician will bill Medicare.
- It will provide Medicare beneficiaries suffering from chronic obstructive pulmonary disease (COPD), asthma, pulmonary hypertension, pulmonary fibrosis, and cystic fibrosis greater access to the care they need from RTs.
- It will provide the tools pulmonary patients need to self-manage their disease and improve their outcomes by educating them on how to recognize and reduce symptoms and triggers of their disease and to ensure proper training and adherence with inhaled medications.

Respiratory Therapists are Currently Excluded from Recognition by Medicare

The Medicare law currently recognizes a number of non-physician practitioners such as physical and occupational therapists, physician assistants, and others, but RTs are not included.

- **HR 2619**, *the Medicare Respiratory Therapist Access Act*, will bring recognition to RTs.
- The RT must hold at a minimum a bachelor's degree or other advanced degree in a health science field and be credentialed as a "registered" respiratory therapist (RRT).
- The qualification standards are similar to other qualified health professionals recognized by Medicare.
- Employment of RTs who do not meet these qualifications will not be impacted by this initiative.

Medicare Costs Are Likely to be Offset by Reduced ER Visits and Better Adherence to Medication Protocols

The American Association for Respiratory Care (AARC) commissioned an independent cost analysis from Dobson/DaVanzo, a well-known health care consulting firm in Washington, DC.

- The analysis indicates that implementation of **HR 2619** would result in an increase of between $245 and $500 million over a 10-year period from 2014 through 2023. The range is based on an assumption of compliance by Medicare beneficiaries who have been taught self-management skills.
- It is reasonable to expect that if one-half of one percent of ER visits for the population served by **HR 2619** were avoided due to self-management skills taught by RTs, the costs could be totally offset.
- If 24 percent of patients who had an ER visit and a claim for oxygen improved their oxygen utilization and adherence to inhaled medications as a result of self-management, it could result in a total offset of the costs associated with implementation of **HR 2619**.

HOD Report

Submitted by John Steinmetz – Congress 2013

Recommendations

None at this time

Charges

Preside at all meetings of the House: ***Ongoing***
Prepare an agenda for each meeting and submit to each delegation: ***Ongoing***
Summer meeting: June 14, 2013 ***Completed***
Winter meeting: October 11, 2013
Appoint a Parliamentarian: ***Completed***
Appoint the chairs and members of the House standing and special committees: ***Completed***
Chairs and standing members appointed.
Invite persons other than delegates to participate in House activities: ***Ongoing***
Be an ex-officio member of all House committees except the Elections Committee: ***Ongoing***
Serve as Chair of the House Executive Committee: ***Ongoing***
Perform other duties that may authorize: ***Ongoing***

Report

Update on Speaker Goals:
Goal #1 – Committees
Chairs, delegate members, and liaisons (HOD officers) have been assigned.
• Committee chairs and officers have been working through AARConnect to achieve specific goals
• Policies revisions are being updated to reflect current practices
• Big list update continues for delegations to report back to their affiliates
• Continue to work with BOD to facilitate communication – Tom Kallstrom, Speaker and staff routine phone calls, President Gaebler holds routine President's call that includes Speaker, Past Speaker and Speaker-Elect
Goal #2 – Engaging and involving HOD members
• Regular communication through AARConnect with members. All Delegates have been assigned to working committees. The HOD dedicates time for committee work during the summer and fall meeting, developing action plans and assignments. This has led to a more efficient and product process
• Overseeing communication of committee work through AARConnect
• Work with executive office to improve accuracy of AARConnect HOD communities to improve communication
Goal # 3 – Volunteering
• Develop and promote activities through the AD HOC Committee
Goal # 4 - Mentoring
• Develop and promote student and professional volunteering through appropriate committees
Goal # 5 – Communication
• Promote the HOD work and members through the AARConnect, AARC Times, web page and give opportunity for feedback

Board of Medical Advisors Report

Submitted by Dr. Lori Conklin – Congress 2013

The Respiratory Care Committee for the American Society of Anesthesiologists met in San Francisco, CA on October 12, 2013. At the meeting, we discussed appointing anesthesia residents to serve on the NBRC Board as "consultant members." This idea was well received and members were encouraged to have interested residents contact Gary for possible membership. The testing process for RT's was also outlined. Of interest, the entry level exam would function as a combined examination. RT's scoring a "low level" would be given the title CRT, while those scoring in the "high range" would be considered RRT's. CRTs would be required to retake the test and achieve a high score before they would be qualified to take the simulation section of the examination process. Basically, all RRT's will have achieved two bench marks: (1) achieving a "high level" on the written examination; and (2) passing a simulation examination comprised of an information gathering section and a decision-making section. Tom Smalling gave his CoARC report indicating the international RRT program was withdrawn in May 2013. He also discussed establishing RRT's as "mid-level care providers" working under the supervision of a physician. Finally, Robin Elwood, M.D. was introduced as the new Chairman for the Respiratory Care Committee.

At this point, I would like to thank each one of you for your leadership, guidance, and mentorship of me as BOMA Chairman these past 18 months. I have learned an incredible amount and thoroughly enjoyed the experience. I look forward to supporting the next BOMA Chairman, Dr. Peter Papadakos.

Sincerely,

Lori D. Conklin, M.D.

President's Council

Submitted by Dianne Lewis – Congress 2013

Recommendations

None

Report

I am pleased to announce the new AARC Life and Honorary members. Linda Van Scoder, EdD, RRT, FAARC was awarded Life membership and Kathy Blackmon was awarded Honorary Membership.

The President's Council will be meeting Sunday at the International Congress, Kathy, Linda & Kerry George, RRT, MEd, FAARC, Jimmy A Young medalist will join the Council for lunch.

Standing Committee Reports

Audit Sub-Committee

Submitted by Debra Skees – Congress 2013

Recommendations

None

Report

Nothing to report

Bylaws Committee

Submitted by Terrance Gilmore – Congress 2013

Recommendations

That the AARC Board of Directors accept and approve the Texas Society Bylaws. *(see attachment "TSRC Bylaws 2013 Proposed Changes")*

That the AARC Board of Directors accept and approve the California Society Bylaws. *(see attachments "CSRC Shoma letter", "CA SRC Bylaws DR 8-24-13" and "CSRC Bylaws Proposed 2012 Revision Draft 8 062313")*

Report

The Bylaws committee has met all of its charges for the year except for the recommendation from the House to review a Bylaws change to allow for the Immediate Past Speaker to be a voting member of the Board and there is only one Bylaws revision we did not receive when requested and that was Massachusetts.

The Committee reviewed and approved the Bylaws changes submitted by the Board Ad Hoc committee on Bylaws Changes. The House voted on it and the results will be released by the speaker of the House.

The House made a resolution to allow the Past Speaker of the House to be a voting member of the Board last year. The resolution was found not to be the proper way to go about affecting the requested change. The House then sent it on to the House for review and a recommendation. We still have to finish that charge and plan to by the House Meeting this fall.

Other

I would like to thank the members of my committee: John Andrews Jarooz, Lori Shoman, Tom Cahill, Brian Kendall and Karen Stewart. A special thanks to Sherry Milligan and Timothy Myers. Good Luck to Tom Cahill as he takes over as Bylaws Chair.

Elections Committee

Submitted by: Ross Havens – Congress 2013

Recommendations:

None at this time.

Report:

The slate of nominees approved by the BOD and HOD in the summer was submitted to the membership for vote. The ballot count was made, and the results were certified by Ross Havens, AARC Elections Committee Chair, verified by George Gaebler, AARC President, Karen Stewart, AARC Past-President, and attested by Beth Binkley and Sherry Milligan, AARC Elections Liaison.

CERTIFICATION OF BALLOT COUNT

This is to certify that a count was made of the general election ballots for AARC Officers, Directors and section Chairs on October 1, 2013. The following is certified as the official count:

For President-Elect

Frank Salvatore	1,809 votes / 53.57%
Colleen Schabacker	1,544 votes / 45.72%

(Write-in candidates for President-Elect received no more than 1 vote each)

For Director At Large

Bill Lamb	1,768 votes / 52.05%
John Lindsey	1,226 votes / 36.09%
Camden McLaughlin	1,091 votes / 32.12%
Curt Merriman	916 votes / 26.96%
Karen Schell	1,982 votes / 58.35%
Cynthia White	2,169 votes / 63.85%

(Write-in candidates for Director At Large received no more than 2 votes each)

For Adult Acute Care Section Chair-Elect

Keith Lamb	168 votes / 56.57%
Daniel Rowley	129 votes / 43.43%

(Write-in candidates for Adult Acute Care Section Chair-Elect received no more than 0 votes each)

For Diagnostics Section Chair-Elect

Katrina Hynes	109 votes / 58.92%
Kevin McCarthy	73 votes / 39.46%

(Write-in candidates for Diagnostics Section Chair-Elect received no more than 1 vote each)

For Education Section Chair-Elect

Ellen Becker	164 votes / 51.74%
Georgianna Sergakis	152 votes / 47.95%

(Write-in candidates for Education Section Chair-Elect received no more than 1 votes each)

For Management Section Chair-Elect

Bill Cohagen	173 votes / 42.51%
Cheryl Hoerr	232votes / 57.00%

(Write-in candidates for Management Section Chair-Elect received no more than 1 vote each)

- Frank Salvatore was elected President Elect with 1,809 votes (53.57% of votes cast)
- Cynthia White was elected Director at Large with 2,169 votes (63.85% of votes cast)
- Karen Schell was elected Director at Large with 1,982 votes (58.35% of votes cast)
- Bill Lamb was elected Director at Large with 1,768 votes (52.05% of votes cast)
- Keith Lamb was elected Adult Acute Care Section Chair-elect with 168 votes (56.57% of votes cast)
- Katrina Hynes was elected Diagnostics Section Chair-elect with 109 votes (58.92% of votes cast)
- Ellen Becker was elected Education Section Chair-elect with 164 votes (51.74% of votes cast)
- Cheryl Hoerr was elected Management Section Chair-elect with 232 votes (57.00% of votes cast)

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

Executive Committee

Finance Committee Report

Judicial Committee

No report.

Program Committee

Submitted by Cheryl Hoerr – Congress 2013

Recommendations

None

Report

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

2. Recommend sites for future meetings to the Board of Directors for approval.

3. Solicit programmatic input from all Specialty Section and Roundtable chairs. Review with each section all selections pertaining to their specialty before finalization. The Program Committee decisions shall be final.

4. Develop and design the program for the annual congress to address the needs of the membership regardless of area of practice or location. Assure educational opportunities for other health care related practitioners.

Progress:

AARC Congress 2013: The 59th International Respiratory Convention & Exhibition will take place November 16 – 19 in Anaheim, CA.

- The Program is currently posted on-line and in hard copy in the Sept. edition of the AARC Times.
- Dr. Stephen Jencks; expert on hospital readmissions will deliver the keynote address.
- We will offer more than 235 presentations covering all aspects of Respiratory Care and other healthcare related topics.
    - Number of Symposia (by section):
        - Adult Acute Care: 43
        - Management: 27
        - Neo/Ped: 27
        - Diagnostic: 20
        - Education: 22
        - Long-term/Rehab: 18
        - Continuing Care: 18
        - Transport: 3
        - Home Care: 14
        - Sleep: 9

          Note: Symposia are defined as 1 or more presentations (i.e. 3 Transport symposia could equal 9 or more total presentations).

- More than 300 abstracts are scheduled for presentation during 19 Open Forum sessions.
- The traditional format of the program has been modified to offer 30-minute presentations (all starting and stopping at the same time) to maximize attendee CRCE.
- AARC Congress 2013 will conclude with a closing ceremony for the first time in the history of the program (delivered by award-winning TV game show host Bob Eubanks).
- This will also be the inaugural year for the Thomas L. Petty Memorial Lecture, which will become a staple of future Congress programs. Dr. David Pierson will deliver the lecture.
- New Exhibit Hall hours to better meet the needs and demands of exhibitors:
    - Saturday: 11:00 am – 4:00 pm
    - Sunday: 9:30 am – 3:00 pm
    - Monday: 9:30 am – 2:00 pm
- Sputum Bowl: 12 Practitioner Teams and 18 Student Teams will compete.
    - Audience Engagement during Sputum Bowl Finals Competition:
        - An audience response competition will take place throughout the evening during the Finals competition. Prizes will be given out to top finishers.
        - A comedian will entertain attendees during halftime as has customarily been done in the past.

2014 Meetings:

- Easy Street will open for proposal submission beginning in mid-to-late October 2013. All proposals (Open Forum, Summer Forum and AARC Congress 2014 will be submitted through Easy Street.
- Ira Cheifetz, MD will be the new Program Committee Chair. The committee will convene Feb 7-9, 2014 in Dallas, TX.
- The 2014 Summer Forum will be held in Marco Island, FL from July 15 – 17, 2013
- AARC Congress 2014 which will take place in Las Vegas, NV at the Mandalay Bay from Dec. 9 – 12, 2014.

The Program Committee sincerely thanks the BOD and AARC membership for their continued support and contributions to the program.

Strategic Planning Committee

Submitted by Karen Stewart – Congress 2013

Recommendation

None

Report

There has been no work done in strategic planning still awaiting more results regarding 2015.

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Congress 2013

Recommendations

None

Report

The Adult Acute Care Section continues to be busy with projects and section activities:

- Monthly newsletter
- Quarterly bulletin
- Monthly journal club article selection
- Monthly journal club article live on-line discussion
- Monthly interactive clinical scenario discussion
- Image of the month
- Arrhythmia of the month
- Active discussion board on AARConnect
- Members continue to travel and speak at various state and national conferences and meetings
- All faculty members of the first ACCS preparatory course were Section members except Dr. Fulda.

- We chose our SPOTY. Tom Gillin, BS, RRT

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Congress 2013

Recommendations

- **Recommendation #1**: "To update the Pulmonary Rehabilitation Facility/Program Locator on the AARC Website.
  - Justification – Patient and Health Care Professionals looking for a pulmonary rehabilitation program need to find accurate program information. The Pulmonary Rehab. Locator has not been updated in recent years and it's needed.

- **Recommendation #2:** "Have a LINK for Pulmonary Rehabilitation Program Locator on the Front page of the AARC Website – to click and go directly to the site".
  - Justification - The Pulmonary Rehabilitation Program Locator is impossible to find easily for patients and health care professionals
    - The current steps required to find the Pulmonary Rehabilitation Program Locator are: Click-Your Lung Health, Click-Finding Care, Click-Quality Respiratory Care, Click-Pulmonary Rehabilitation Locator
    - The above steps are tedious, a patient would NEVER know to find the Pulmonary Rehab Locator since the patient would have to know to click Health, click Respiratory Care, etc. These steps are also LOST on other health care providers that we want to Liaison with to provide information about programs, from the COPD Foundation, the Pulmonary Hypertension Association, etc.
    - To look at other websites such as AACVPR which has a link right on the front page of website, easy to find/use for patient and Health Care professionals looking to find programs throughout the U.S. to refer patients to

- **Recommendation #3:** "Task Force immediately organized for a Grant Submission for a National Pulmonary Rehabilitation Disease Management/Maintenance Exercise Program. Task Force will write the Grant to submitted to PCORI (Patient Centered Outcomes Research Institute) for post COPD pulmonary rehabilitation program disease management/maintenance exercise program. Task Force to consist of COPD Foundation: TBD such as John Walsh and Dr. Byron Thomashow; AARC: TBD such as Tom Kallstrom, Brian Carlin, myself; AACVPR: TBD such as Trina Limberg and a National Gym/Corporation Representative such as the YMCA
  - Justification - Long Term Adherence following Comprehensive Pulmonary Rehabilitation through Disease Management/Maintenance Exercise is needed. The benefits of pulmonary rehabilitation are LOST if patients do not adhere to the exercise program. Yet, many hospitals cannot provide Maintenance Exercise and public gyms are not welcoming to pulmonary patients. The patient often finds themselves being discriminated against because of oxygen, use of a walker, and just not feeling comfortable exercising in a gym that does not have experience or skill working with respiratory patients
    - Grant Submission dates with PCORI for Early 2014 would be a goal for the Task Force

Report

1. **Web cast on July 24, 2013, titled: Surviving Pulmonary Rehabilitation Medicare Audits: The Essentials of Documentation and Coding.** Concerns on Pulmonary Rehab Medicare G0424 denials occurring in various MAC's around the U.S. Documentation and diagnosis are just a few of the reasons given by Medicare for denials. AARC agreed to offer quickly a Webcast and I presented the Web cast twice, once at 2:00 pm and then again at 7:00 pm. Attendance was very good.

2. **Pulmonary Hypertension Association is an affiliated organization to AARC – active with the PHA nationally**

**I served a 2-year team that just ended as chair of the Practice Committee of the PH Professional Network. I have stayed on as a committee member

**The Practice Committee has worked on Webinars/slides for lecture use and practice guidelines

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

**This year at the AARC nationals a lecture on PH by Dr. Gold will follow a presentation by me on PR Program Modifications for the PH Patient

**Co-Lectured at the PHA -PHPN National Meeting Sept. 27, 2013 on High Flow Oxygen Therapy in the PH Patient: Prepare to be Blown Away

**Important news is the PH Association will be Credentialing PH Centers and the RRT is listed as a discipline and pulmonary rehabilitation is also on the expectations for credentialed centers, on site Reviewers will evaluate sites

3. **Section Newsletters – submitted notes from Chair**

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

Diagnostics Section

Submitted by Matthew O'Brien – Congress 2013

Recommendation

Provide complimentary AARC Congress registration for each recipient of section Specialty Practitioners of the Year.

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.

•· We have a quality group of Diagnostic related presentations for this year's Congress.

•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.

•· Katrina Hynes from Mayo Clinic is the current bulletin editor and has done a great job with the first two bulletins.

•· I was unable to coordinate a section specific webinar for 2013 however will volunteer to provide one during the next quarter for the new section chair.

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

•· We offered the first state level- diagnostic membership meeting at the Washington State RC meeting in April 2013. I donated back my honorarium to the Washington State RC group and they provided diagnostic memberships to over 20 individuals.

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

•· Chair- Elect voting has occurred.

•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

Education Section

Submitted by Joe Sorbello – Congress 2013

Recommendations

None

Report

I was fortunate to be able to speak at the New Jersey Society for Respiratory Care on Thursday October 17, 2013 at the Tropicana Resort and Casino on the topic entitled: "2015: Challenges and Opportunities". President George Gaebler was kind enough to both lend me some Power Point slides and his blessing in letting me go forward to speak on this topic. As agreed, none of the slides from my presentation were available to anyone at the conference. I referred all to the AARC website to read the AARC's official and transparent actions regarding 2015. The presentation was well-received and my sense was that the attendees are at least beginning to understand the implications of the 2015 project particularly in light of todays and the future realities of the health care in the United States.

Other

- I again wish to commend everyone in the AARC Office for their assistance over the past 3 years. We have a highly competent, dedicated and professional staff who are the right people in the right place at the right time. The leadership, headed by Tom Kallstrom, has been truly outstanding and I thank all for helping me in serving the AARC.

Home Care Section

Submitted by Greg Spratt – Congress 2013

Recommendations

None

Report

POC Survey

The survey has been posted on the Your Lung Health website.

Accountable Care Act / Hospital Readmission Reduction Program Best Practices

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

An AARC webcast was held in September with three programs relating their experiences in regard to readmission reduction programs implemented and early outcomes.

Several sessions are planned at the upcoming Congress on this topic.

HC Section Highlights

Since the last meeting we have produced two quarterly newsletters.

Competitive Bidding

A question was posted Home Care Section members via AARC Connect to solicit feedback on impact from Rounds 1 and 2 of competitive bidding on RTs. Several responses were received and will be incorporated into an update presentation at the Congress.

Other: None

Long Term Care

Submitted by: Lorraine Bertuola– Congress 2013

Nothing new to report.

Management Section

Submitted by: Bill Cohagen – Congress 2013

Recommendations

With the assistance of AARC Board staff, create and conduct a survey to the Section Membership to investigate the drop of membership.

Reasons:

- Drop in Section Membership
- Poor response for SPOY nominations
- Drop in attendance at the Summer Forum

Report

At the writing of this report membership is at 1702 members which continues to show a slow decline in section membership.

We continue to meet all charges directed to the Section including:

- 2013 Management SPOY is Dana Evans of Chesterfiled, MO. Congratulations to Dana!
- The Extubation/Re-intubation rate benchmark program continues.
- Work with the Hospital to Home program is awaiting further duties.
- Continued work in aligning with the AARC's 2015 and Beyond Plan.
- Sustained success in our Section Book Club.
- Working and assisting our leaders with the AHCA.
- Establishing stellar conferences and webcasts that meet needs of our members.
- Welcome the Section Chair-Elect.
- Publication of valuable quarterly Bulletins.

Other

Right after this Congress this Section will:

- Start planning the 2014 Summer Forum and Congress lecture agendas.
- Increase membership and activeness of the membership.
- Increase education through webcasts and articles.
- Continue to work with the AARC BOD and Office in any charges needed.

Neonatal-Pediatrics Section

Submitted by Cynthia White – Congress2013

Recommendations

None

Report

- 10 nominees for Neonatal Pediatric Specialty Practitioner of the Year
- Wade Rich, BS, RRT-NPS, CCRC was selected as this year's SPOTY recipient
- 1,826 current section members
- List serve remains active with some increase in activity in pediatric journal club discussions
- High abstract submission activity from neonatal pediatric RT's at the congress this year with 3 Neonatal Pediatric focused open forums

Sleep Section

Submitted by Russell Rozensky – Congress 2013

Nothing to report.

Surface to Air Transport

Submitted by Billy Hutchison – Congress 2013

Recommendations

None

Report

- We had a steady year with great discussions on Connect and great participation in assisting new transport programs.

- Our membership is basically holding steady and we are starting the new year encouraging members to each bring in a new member this year.

- There are two new transport programs with transport therapists and we are helping to set up training and classes to assist them.

- We elected Alex Brendel from Clarion Clinic Children's Hospital. Alex has been a great resource for all and also been very instrumental in obtaining reciprocity across state lines for transport therapists.

- Steve Sittig and Bryan Byrd have done an outstanding job with our newsletter this year. They are both very dedicated and we appreciate all they do to help out.

- My goals this year are of course to build membership and to also raise the awareness for the importance of having Respiratory Therapist on Specialty Transport Teams.

- I would also like to say a special thanks to Debbie Bunch and Sherry Milligan for all of their help this year in assisting and teaching me.

Special Committee Reports

Benchmarking Committee

Submitted by: Richard Ford – Congress 2013

Recommendations

None

Report

1. The Benchmarking Committee Team will re-initiate the provision of 4-6 webinars for 2014.

2. 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.

3. AARC Benchmarking has retained the original data elements and configuration since inception in 2006, although the structure of RC departments has changed significantly and the 5th Edition of the Uniform Reporting Manual was released in 2012. The committee has identified the need review and refine the following:

a. The need to refine AARC benchmarking so time standards and terminology was consistent with the URM 5th edition.

b. The need to insure metrics reported in AARC Benchmarking are consistent with terminology used by other corporate benchmarking firms in order to eliminate confusion.

c. The need to fix the display of graphic information which currently does not autoscale and difficult for user to view if more than 4-5 hospitals are included.

d. The hospital and department profile content needs revision to incorporate changes in department structure that have emerged since the profile was originally created in 2006.

e. The reporting of ventilator days need to better differentiate the type of patient or setting to differentiate chronic vs. acute settings as well as invasive and non-invasive.

f. Investigate the feasibility of adding a Sub-acute care subgroup into the benchmarking software and program.

4. To accommodate resolution of the issues identified in item 3 it is realized that such changes will need to be funded. Such expenditures would need to be accounted for in the AARC budget process for 2014.

5. As of Sept 2013 there were 124 active subscribers.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Congress 2013

Recommendations

None

Report

1. Activity on the list serve has been light. Coding and reimbursement questions are often posted on other lists serves such as Management and the Help Line.

2. Recently, there has been discussion on the code 94640 (Pressurized or non pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device) note: This code can be used for IPV, per CPT assistant, 9/10, 20:9). A health care system in North and South Dakota received an interpretation from their AHA. The AHA indicated that this code should only be paid if the patients have the two indications listed in the description (ACUTE airway obstruction or sputum induction for diagnosis). The description for this code has been in place for a very long time. It truly does not begin to describe the indications for this therapy. These indications continue to expand ie. pulmonary vasodilatation, prevention of airway obstruction, antibiotics, etc.. However, most payers do not have an issue paying this code regardless of the indication.

A group of Respiratory Therapists in the Dakotas have requested that the AARC propose a change in the description of the code. In discussion with our pulmonary physician coding representatives and Ann Marie we have developed an action plan. We have decided to write an explanation of how this code is used in the CPT Assistant publication. Once the article appears in the CPT Assistant this would serve as acceptance by the AMA CPT. This could be used by hospital coders, RC departments and financial representatives. This is a much safer option than opening the code for revision. Once a code opened it is highly scrutinized and very bad things can happen. This code is our most frequently used code and we do not want to jeopardize it. I will explain all this to the Dakota group.

3. Code 94640 is also being scrutinized for use with patients who self administer their treatments when at home. Some payers are refusing to reimburse these treatments when the patient is in the hospital. There are many reasons that these patients might need the assistance of a Respiratory Therapist when they are in the hospital. This is an excellent example of the payers trying to reduce costs.

4. CPT code **94669** Mechanical chest wall oscillation to facilitate lung function, per session, is in the CPT 2014 Professional edition book. Facilities can begin using this as of January 1, 2014.

Federal Government Affairs Committee

Submitted by Frank Salvatore – Congress 2013

Recommendations

None

Report

Objectives:

1. Continue implementation of a 435 plan, which identifies a Respiratory Therapist and consumer/patient contacts team in each of the 435 congressional districts. [Ongoing]
2. Work with PACT coordinators, the HOD and the State Governmental Affairs committee to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care. [Ongoing]

Ongoing Objectives:

1. Assist in coordination of consumer supporters [Ongoing]

Other

I had hoped to have a comprehensive report on the status of the 435 plan and what was done this past year. Unfortunately, due to competing priorities, our committee only heard back from no more than 10 states on the questions posed to them which included:

1. *Do you know if any of the following were contacted to get state based support for HR 2619 (based on Cheryl West's e-mail on 8/9/13 to the pact)? (If yes to any of the following, see if they have a copy to give you electronically and/or if it was sent to Cheryl West).*
    a. *State Society letter of support*
    b. *State Medical Society letter of support*
    c. *State Hospital Association letter of support*
    d. *Consumer advocacy group letter of support*

2. *Did your state highlight the PACT and/or have a PACT booth at the state society's annual convention/symposium/conference?*

3. *How many of your Congressional Districts have at least one RT who you have listed that can be contacted to write a letter to Congress if the AARC 435 Plan is enacted.*

4. *Did your state society place information on your website in a prominent place for the Annual Virtual Lobby day and for the call to action once HR 2619 was enacted?*
5. *Did the PACT or State Society work on getting face time with Representatives during the August Recess?*

Thanks to the 10 states that did get back to us, but I've decided to not publicize the findings and will work with the committee in early 2014 to see if we can get a more comprehensive list going.

I want to thank my committee once again for the work they've done this past year. The Federal Government Affairs committee stands ready to act if the call comes from our Government Affairs Team. Once again, I'd like to give our usual high accolades to Cheryl West, Miriam O'Day and Ann Marie Hummel for their tireless efforts on our behalf.

Fellowship Committee

Submitted by: Patrick Dunne – Congress 2013

Recommendations

None

Report

The Committee is pleased to report that ten (10) distinguished members of the association have been selected for induction in 2013 as a Fellow of the AARC. The individuals selected have been so notified and will be formally inducted during the Award Ceremony, to be held Saturday, November 16, 2013, in conjunction with the 59th AARC International Congress, Anaheim, CA.

Other

There is nothing else to report at this time.

International Committee Report

Submitted by John Hiser – Congress 2013

Recommendations

None

Report

1. Administer the International Fellowship Program.

This year we will welcome six new international fellows. We have invited two physicians, one from Lebanon and one from Morocco. We also invited two respiratory therapists, one from Columbia and one from Ethiopia, one RN from Japan and one Physio-respiratory therapist from Brazil. We are now at 153 fellows from 64 countries over the last 24 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.

2013
32 applicants
23 different countries
7 applicants from 6 countries without past fellows
(Cambodia, Columbia, Ethiopia, Lebanon, Morocco, and Singapore)

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
- 2013 32

City Host Applications by year

- 2004 14
- 2005 18
- 2006 13
- 2007 21
- 2008 23
- 2009 14
- 2010 21
- 2011 13
- 2012 20
- 2013 15

2013 Program Schedule

Event	Date
Arrive in the First City	Saturday, November 2
First City Rotation	Monday, November 4–Friday, November 8
Arrive in Second City	Saturday, November 9
Second City Rotation	Monday, November 11–Thursday, November 14
Arrive in Anaheim, CA	Friday, November 15
AARC Congress 2013	Saturday, November 16–Tuesday, November 19
Fellowship Program Ends	Wednesday, November 20

2013
AARC
International Fellows

- **Ana Cristina Okada, PT**
- Maternal & Child Development Dept.
    - Albert Einstein Hospital
    - Sao Paulo, Brazil
    - Neonatal/Pediatric Specialist – NICU Physio/Respiratory Therapist
    - Masters in Pulmonology
    - Instructor/Researcher/Protocol
- Published-book chapters, abstracts
- Presented at several meetings /awards
- Hosts
    - Philadelphia, PA- Natalie Napolitano
    - Cincinnati, OH- Jerry Edens

- **Lysbeth Roldan, RT**
- Faculty & Neonatal Pediatric Specialist
    - Universidad Autonoma de Americas
    - Medellin, Colombia
- Presented at several meetings
- Helped start a new Neonatal Care Unit in Uraba, Antioquia
- *"To become an Ambassador for the AARC in Colombia"*
- Hosts
    - Baltimore, MD- Jeff Ford
    - Rochester, MN- Kris Hammel

- **Gawsha Takele, MS, BSRT, RRT**

- Respiratory Therapist / Educator
- Woreta, Ethiopia

- Starting New RT Program/School
- *"Fellowship status would provide more recognition by the government of Ethiopia"*
- Hosts
  - Charlottesville, VA- Judith Seal
  - Winston-Salem, NC- Garry Kauffman

- **Daisuke Tsukahara, RN**
- Lecturer of intensive care department for graduate nurses
  - Japanese Nursing Association
  - Tokyo, Japan
  - Emergency & Critical Care Nurse
- *"I hope to contribute to formulation of a systematic education system for Japanese nurses"*
- Hosts
  - Kailua, HI- Ron Sanderson
  - Boise, ID- Conrad Colby

- **Mohamad El-Khatib, MD, PhD, RRT, MBA**
  - Professor of Anesthesiology & Director of Respiratory Therapy
  - American University of Beirut
  - Beirut, Lebanon
- Written numerous Articles/Abstracts
- Well published
- Lecturer/Researcher
- Hosts
  - Ogden, UT- Lisa Trujillo
  - Portland, OR- Brenda Batts

- **Mohammed Herrag, MD, PhD**
- Mohammed VI Teaching Hospital
    - Faculte de Medecine d'Oujda
    - Oujda, Morocco
  - Director of Respiratory Disease Department
  - Professor in Respiratory Diseases
    - Teaching medical students, physiotherapists, and residents
- Well published & researcher
- "To build a relationship & coordination between myself & my hosts"
- Hosts
  - Emporia, KS- Karen Schell
  - Minneapolis, MN- Mary Wightman

Sponsors to Date

AARC
AARC HOD
AMP/NBRC
Aspirant Education
Draeger Medical
Philips/Respironics

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.

Success in 2013

Success has a lot of definitions. To some it is defined as the gaining of fame or prosperity or achieving a certain level of social status. To others it is the achievement of something desired, planned, or attempted, in other words the achievement of a goal.

Over last quarter of a decade AARCTimes has published hundreds of articles about success in achieving the goals related to our international mission. In this issue I wanted to present examples of some of our most recent successes and highlight how our past AARC International Fellows (IF) are having an impact on the profession in their countries.

Enhance the awareness and understanding of the profession of respiratory care and its vital role on the health care team.

Argentina

Past Fellow Gustavo Olguin, PT, BS, CRT, MHA (IF - 2001) working with other members of the newly formed Argentine Society in Cardio Respiratory Kinesiology (SAKICARE) successfully lobbied the Argentine Ministry of Health to adopt rules that mandate a minimum number of Physiotherapist specialized in Critical Respiratory Care be present in all intensive care units in Argentina.

Saudi Arabia

Mohammed Al-Ahmari, BSRC, MSc, RRT (IF - 2005) reported on two major developments in Saudi Arabia which will greatly improve awareness of the profession in that country. After 10 years of lobbying efforts the Ministry of Civil Service has approved a Respiratory Therapist position providing more recognition for the profession as well as producing more jobs and opportunities for respiratory therapists at a national level. Secondly a Fellowship of Respiratory Care in Critical Care (FSRC) under the national accrediting body for all health Specialties (Saudi Commission for Health Specialties) was recently created.

This 2 years fellowship is equivalent to a master degree.

Provide encouragement and assistance to those countries seeking to gain legal recognition of the profession of respiratory care.

United Arab Emirates (UAE)/Philippines

After 25 years of intense lobbying efforts, Noel Tiburcio, PhD; RRT-NPS; RTRP (IF – 2009) along with several other UAE and Filipino respiratory therapists celebrated this last July when the Philippine Respiratory Therapy Act of 2009 was fully implemented. The first Professional Regulatory Board of Respiratory Therapy (PRBRT) was created by the Professional Regulation Commission (PRC) to regulate the practice of the RT profession in the Philippines thru licensure examination. The first Oath-taking Ceremony for the first group of Registered Respiratory Therapist was held in Manila. Several newly credentialed respiratory therapists from the UAE, Saudi Arabia, Qatar and Singapore came home to attend this memorable event.

Newly licensed RTs celebrate the implementation of licensure at the historic Manila Hotel.

Provide encouragement and assistance to those countries seeking to establish the profession of respiratory care as an independent profession.

China

Pei-Feng Xu of Sir Run Run Shaw Hospital in Hangzhou, China along with Yue-hua Yuan (IF – 2009) and Hui-qin Ge (IF – 2008) have successfully trained 204 RT students from 14 provinces this year. The program is an AARC International Education Recognition System (IERS) Level II Program designed to help establish the profession in China.

Provide encouragement and assistance to those seeking to provide and establish seminars, programs, and schools in their home country.

Ghana

Following her fellowship last year Audrey Forson, MD ChB, FWACP, MSc (IF – 2012) returned to Ghana and with the help of AARC members Paul Eberle, Ph.D, RRT and Lisa Trujillo, DHSc, RRT, of Weber State University and Karen Schell, RRT-NPS, RPFT,RPSGT were able to convince the Provost of the University of Ghana that the college needed to start a new school for the training of respiratory therapists. The curriculum is being finalized and the program may begin as early as 2014.

Encourage and promote the exchange of qualified speakers between the AARC and other professional associations around the world.

China

This last July Manling Liu (IF – 2012) hosted AARC International Committee member Natalia Napolitano, MPH, RRT-NPS, AE-C, FAARC at Shaanxi Provincial People's Hospital in Xi'an, China. During Nathalie's time in Xian, she visited the NICU providing insight into the treatment of neonates as well as presented lectures on the treatment and prevention of bronchopulmonary dysplasia. The lecture was attended by pediatricians and nurses from many hospitals across Shaanxi Province.

Natalie Napolitano, second from the right and Manling Liu, furthest to the left discuss the treatment of a premature infant at Xi'an Medical University Hospital.

Manling Lui (IF – 2012) as well as Shengyu Wang (IF - 2011) are both instructors in the newly created respiratory care program at Xi'an Medical University which graduated their first class in 2012. Seven of those graduates are now employed at Xi'an Medical University Hospital.

Recent graduate from the RT program at Xi'an Medical University Hospital in Xi'an, China.

Norway

Past fellows Heidi Markussen, RN, MHSc (IF - 2008) and Siguard Aarrestad, MD (IF - 2008) of Bergen, Norway will be speaking at the AARC Congress this year. Their topics are NIV Competencies: The Norwegian Model and Monitoring of Non-invasive Ventilation

Provide encouragement and assistance to those countries seeking to establish professional associations for respiratory therapists.

Latin America

Past Fellows Gustavo Olguin, PT, BS, CRT, MHA (IF 2001 – Argentina), Jose Landeros, PT, CRT (IF 2007 – Chile) and Daniel Arellano, PT, CRT (IF 2005 – Chile) along with AARC member Ruben Restrepo, MD, RRT, FAARC were instrumental in starting the Latin American Society for Respiratory Care. Their first Congress was held this year in Santiago, Chile.

Encourage and assist our international colleagues in publishing articles, case studies, or abstracts in RESPIRATORY CARE, *AARCTimes*, or other professional journals from their country.

China

Recently an original research article by Ms. Jie Li, MSc RRT-NPS (IF - 2005) entitled Respiratory Care Practices and Requirements for Respiratory Therapists in Beijing Intensive Care Units was published in *Respiratory Care*.

Ge Hui Qing (IF – 2008) will also be presenting at this year's Open Forum.

United Arab Emirates

Noel Tiburcio's, PhD; RRT-NPS; RTRP (IF – 2009) abstract titled " The PDCA Cycle: A Powerful Quality Improvement Tool in Respiratory Care - the UAE Experience" has been accepted for this year's AARC 59th International Respiratory Convention & Exhibition - Open Forum / Management Section.

Egypt/India/Lithuania/Peru/Saudi Arabia

In our last International issue past Fellows Malak Shaheen, MD (IF – 2011), Devasahayam Christopher, MD (IF – 20015), Valdone Miseviciene, MD, PhD (IF – 2007), Guillermo C.C, Nogales, MD (IF – 2010), and Adil Al Otaibi, MSrc, RRT (IF – 2010) all had articles published in AARC Times about drug resistant tuberculosis in their countries.

India/Saudi Arabia/UAE

We also had articles from Arvind Bhome, MD (IF – 2002), Mohammed Al Ahmari, PhD, RRT (IF – 2005) and Noel Tiburcio, PhD,RRT-NPS about obstructive sleep apnea.

Encourage respiratory care professionals to participate in medical mission projects.

Ghana/Haiti/Dominican Republic
AARC members continue to take medical mission trips around the world. This year trips were taken to Ghana, Haiti, and the Dominican Republic. Those activities are highlighted in this issue.

Encourage and assist our international colleagues in providing translations of AARC publications.

Saudi Arabia
Muhammed Al-Ahmari, BSRC, MSc., RRT (IF – 2005) has requested and received permission to translate the 3rd Edition of the Guide to Aerosol Delivery Devices for Respiratory Therapists into Arabic.

Encourage professional and educational organizations to gain recognition of seminars, programs, and schools through the ICRC International Education Recognition System (IERS).

In the last 12 months IERS has approved 5 Level I Seminars and 9 Level II Programs in 6 different countries.

Encourage student and faculty exchange programs between respiratory care programs around the world.

For the fourth year in a row students from China Medical University's respiratory care program in Taichung, Taiwan visited the program at Tarrant County College in Fort Worth, Texas for three weeks of classroom, laboratory and clinical education. Chia-Chen Chu (IF – 2001) is the Technical Director for the program in Taiwan.

Encourage the sharing of AARC publications with related foreign publications around the world.

Italy

Selezione ARIR da Respiratory Care e AARC Times the official publication of the Associazione Riabilitatori Dell'Insufficienza Respiratoria (the Italian Association for Rehabilitation of Respiratory Insufficiency) continues to take advantage of a long term agreement with the AARC and publishes two articles selected from *Respiratory Care* or *AARCTimes* in each of their issues. Past Fellow Pamela Frigerio, PT (IF – 2000) was instrumental in helping to establish the original agreement.

Encourage international membership in the AARC.

The AARC now has over 650 international members in over 60 countries around the world.

Provide encouragement and assistance to those seeking to establish Governors representing their country to the ICRC.

China

At the most recent meeting of the International Council for Respiratory Care two new Governors for China were approved. They are Xiangyu Zhang, MD, FCCP, FACCM (IF – 1998) from Shanghai and Yuan Ye-hua, RN, RT (IF – 2009) from Hangzhou.

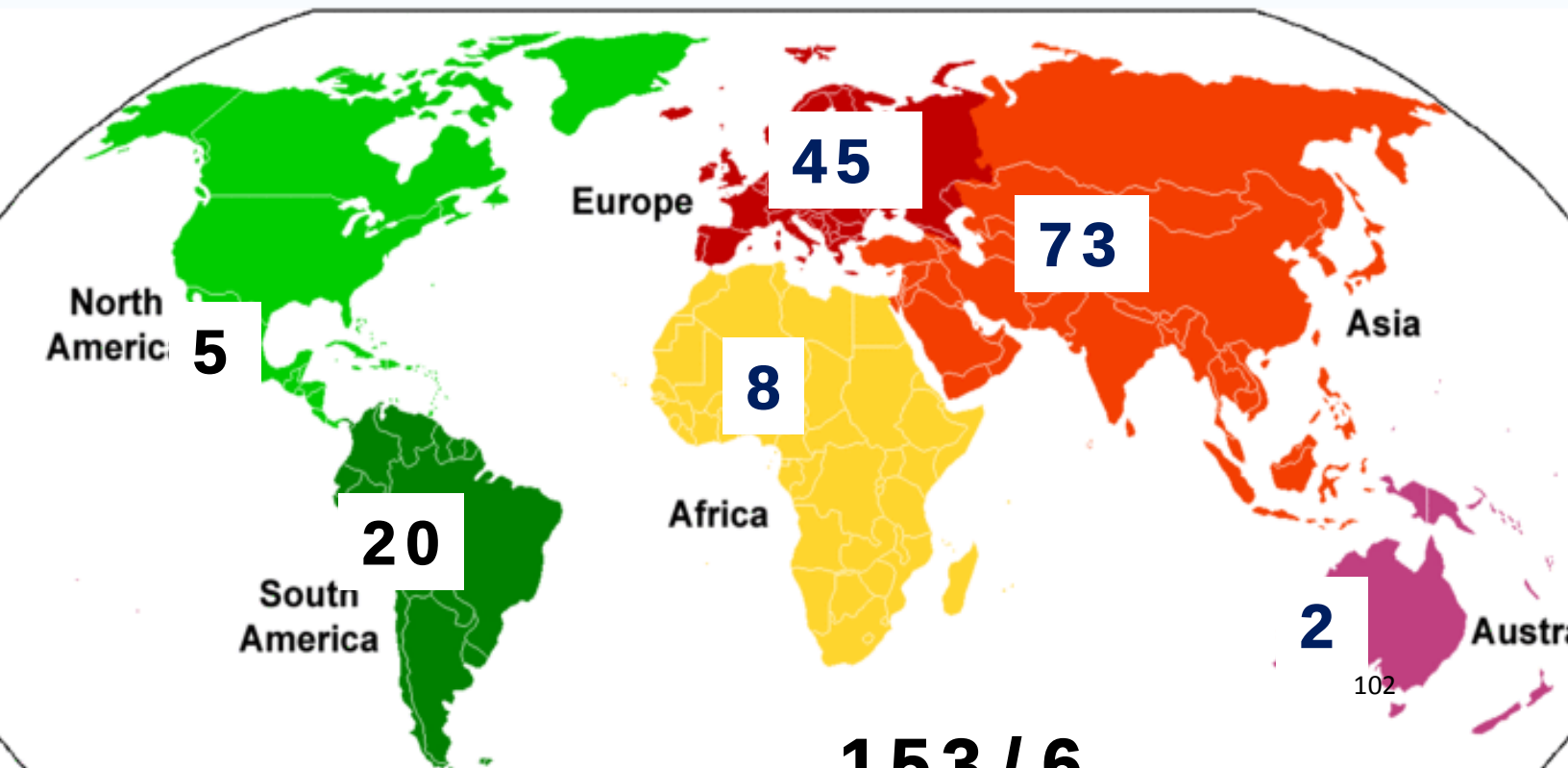
Promote the exchange, development, and coordination of the art, science, and application of respiratory care.

Allow meaningful interaction and cooperation among multi-national colleagues in an apolitical, humanitarian context.

I am proud to announce that with the one exception of adding a new AARC International Affiliate, this year we have achieved at several examples of all of the international goals of the AARC. I want to congratulate all of our AARC International Fellows for their achievements and thank all of our members who are helping to globalize respiratory care.

Take care,

John



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:

Chair
John D. Hiser, MEd, RRT, FAARC

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

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

Membership Committee

Submitted by Frank Salvatore and Gary Wickman – Congress 2013

Recommendations

None

Charges:

Review, as necessary, all current AARC membership recruitment documents and toolkits for revision, addition and/or elimination based on committee evaluation.

In conjunction with the Executive office, develop a membership recruitment campaign based on survey results for implementation.

Identify and evaluate methods to recruit respiratory therapy students as ACTIVE members of the AARC.

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

Develop strategy to entice more member use of AARConnect.

Report

The 2013 AARC Membership Campaign will end at the end of October. While this campaign is coming to a close, membership campaigns will not end. By the time we meet in Anaheim, we will have the final results for the Affiliate competition and will have rewarded two more members with an IPad or Kindle Fire. The committee and the Executive staff continue to work and react to the campaign. Specifics related to our charges are listed below.

1) We finished the 2013 membership campaign with incentives for both the members and the Affiliates. The Website continues to be up and running. The site has current data for the Affiliates to review their progress and to help us all strategize on how to move forward. The website includes resources for the Affiliates to use in their recruitment strategies. A recap of the year's activities; we started the year with a kick off webinar for the Presidents in January. Sherry and Gary presented to the Presidents at the President's workshop in Dallas. Each President was given the opportunity to record a video on membership they could post as a You Tube video for their Affiliates. Frank and Gary recorded videos as well that were posted on the AARC website. We also held a Student webinar to promote students converting to active members.
2) Two more were awarded for the 3rd quarter. Polly Ann Scott won the IPad for renewing her membership. Greg McGuire won the Kindle Fire for new membership. We will share the 4th quarter winners at the meeting in Anaheim.
3) Frank and I communicated to the Affiliate President's with a monthly update on how the campaign is going, some tips on recruitment and the data.
4) The Membership Committee has been engaged in supporting their assigned Affiliates and shared what they learned with the committee.
5) The **Student Membership Retention Sub-Committee:** The committee consists of Co-Chairs Janelle Gardiner (UT) and Emily Zyla (MI). The rest of the committee includes Melanie McDonough (FL), Fred Goglia (WA), Kerry McNiven (CN) and Aaron Light (MO). Their report is as follows:
    i. Tim and I met with some of the team after the July session to brainstorm ideas for going forward.

ii. They finalized a survey to be sent to the Faculty to try to better understand what is working well and what the barriers to success are for Student Retention.
iii. Next steps include a survey that will be directed to the students.
iv. They will then come back with a recommendation on how best to move forward in promoting students converting to active members.

6) Sherry sent out a survey to exiting members to see if we can better understand why they did not renew. She will also survey members after 6 months and 16 months to see what is working well and what things could be better. We will use that data to better design membership benefits to fit current needs.
7) We will share the campaign data at the November board meeting reviewing the highs and lows of the campaign. We will also announce the Affiliates won the Affiliate Awards at that time.
8) Next steps include meeting with the House of Delegates to brainstorm ideas for a 2014 campaign. Frank and Gary met with the Executive Office staff and President Gaebler to review the results of the current campaign and to begin the discussion of what to do for 2014. President Gaebler felt that we do need a 2014 campaign. It will look different from the 2013 campaign. The committee will work with President Gaebler, the Board and the House in Anaheim and we will come back with a recommendation for the 2014 campaign after that work.
9) Things to consider and discuss in November:
    a. How can we better engage all of the Affiliates in membership?
        i. Do we need incentives?
        ii. Can the Affiliates have "Skin in the Game" to get them more engaged?
    b. What will help students convert to active membership?
    c. What are the barriers to success?

Other

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

Position Statement Committee

Submitted by Colleen Schabacker – Congress 2013

Recommendations

Recommendation # 1:
Approve and publish the revised White Paper "Guidance Document on Scope of Practice". This paper is submitted for your review as Attachment #1. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: This White Paper needed very little revision. Replaced program matrixes with web sites for the NBRC and BRPT.

Recommendation # 2:
Approve and publish the revised "AARC White Paper on RRT credential. This paper is submitted for your review as Attachment #2. Text to be deleted appears with strikethrough and text to be added appears with underline.

Justification: No major changes, just changing "therapy" to "care" in a few places and removing the dollar amount in the difference in pay between a CRT and a RRT. Referred to the AARC Human Resource Study.

Report

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

•· A draft of the proposed AARC position statement "Development of Baccalaureate and Graduate Education Degrees" is being presented at the April Board meeting. A special thanks to Linda VanScoder and Deryl Gulliford for their very timely and excellent submission.

•· A draft of the proposed AARC position statement "Concurrent Therapy" is being presented at the April Board meeting. A special thanks Rick Ford, Dan Grady, Garry Dukes, Rob Chatburn, Bill Dubbs, Shawna Strickland, Anne Marie Hummel, Susan Rinaldo-Gallo and Linda VanScoder for their work on "revamping" the "Concurrent Therapy" position statement.

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

- During 2013, the Committee's goal is to complete the review of the eight (8) position statements listed below. Action on each statement to this point is listed following the statement title as is the name of the Committee member spearheading the review.

•§ Administration of Sedatives and Analgesic Medication by Respiratory Therapists - on hold

•§ Cultural Diversity - Kathleen Deakins - was presented in April

•§ Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care - to be presented in July

•§ Home Respiratory Care Services - Jim Allen - was presented in April

•§ Respiratory Care Scope of Practice - to be presented in July

•§ Respiratory Therapy as Extracorporeal Membrane Oxygenation (ECMO) Specialists - to be presented in July

•§ Respiratory Therapy Protocols - Tony Ruppert - was presented in April

•§ Telehealth - Kathy Deakins - was presented in April

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

The committee was given the task of reviewing two (2) White Papers: "The AARC White Paper on RRT Credential" and "Guidance Document on Scope of Practice". These revisions will be presented at the November meeting.

Other

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

Attachment #1

Guidance Document on Scope of Practice

The American Association for Respiratory Care (AARC) is aware that a credentialing examination is required by law in ~~the vast majority of states in order to provide respiratory services described in their respective~~ states that have a respiratory care practice act~~s~~.

The American Association for Respiratory Care (AARC) has received several inquiries regarding its opinion of competency documentation for persons who possess credentials other than Certified Respiratory Therapists (CRT) and Registered Respiratory Therapists (RRT) for the purpose of permitting these individuals to provide part of the scope of practice for respiratory therapists as described in respiratory care practice acts throughout the United States.

The AARC believes that to ensure safe and effective care for all consumers requiring respiratory therapy, documentation of the provider's competency to do so must possess the same rigor and validity as the examination processes that CRTs and RRTs must undergo in order to achieve their respective credentials.

The credentialing examinations for CRT and RRT are accredited by the National Organization for Competency Assurance's (NOCA) accrediting arm, the National Commission for Certifying Agencies (NCCA). The AARC recognizes that the credentialing examinations for Certified Pulmonary Function Technologist (CPFT), Registered Pulmonary Function Technologist (RPFT), and the Registered Polysomnographic Technologist (RPSGT) have also been accredited by the National Commission for Certifying Agencies (NCCA), assuring that these examinations are valid and reliable measures of competence within the limits of their respective examination matrices. The AARC, therefore, supports recognition of individuals with the aforementioned credentials for the purposes of providing care which includes a subsection of the respiratory therapy scope of practice with the caveat that such provision be limited to the elements contained within each credentialing examination's matrix respectively.

5/2003

~~**CRT Examination Matrix**~~

~~**RRT Examination Matrix**~~

~~**CPFT Examination Matrix**~~

~~**RPFT Examination Matrix**~~

~~RPSGT Examination Matrix~~

www.nbrc.org
www.brpt.gov

Attachment #2

AARC White Paper
On RRT Credential

With several developments over the history of the respiratory therapy profession, the education and credentialing processes have evolved to having two basic credentials for respiratory therapists. The Certified Respiratory Therapist (Entry Level) credential (CRT) has been adopted by most states as the minimum level of competency a therapist must demonstrate to obtain recognition by the government of that state as a licensed (certified or registered) respiratory care practitioner. The Registered Respiratory Therapist (Advanced) credential (RRT) has become the credential for advanced-level respiratory therapists. The selection of the CRT as the demonstrated competence needed for state recognition, coupled with a common lack of differential in responsibility and pay between therapists holding the CRT and RRT credentials, has led to decreased numbers of respiratory therapists obtaining the RRT credential. This paper presents the reasons respiratory therapists should obtain the Registered Respiratory Therapist credential.

Respiratory therapists who complete advanced-level respiratory therapy programs have completed education and training that provides them with knowledge and clinical expertise at a level above those needed by the Entry Level Practitioner. The written and clinical simulation components of the RRT exam are the only examination system that documents attainment of the additional knowledge. A graduate of an advanced-level program who does not complete the examinations to earn the RRT credential has not documented that he or she had actually acquired the knowledge and skills necessary to practice as an advanced-level respiratory therapist. This situation is similar to a physician who completes a residency program in a medical specialty and lists his/her credentials as Board Eligible in Internal Medicine rather than completing certification and listing him/herself as Board Certified, one would correctly question the professional commitment of both the Board Eligible physician and Registry Eligible respiratory therapist. Confusion for consumers and regulators arises when a person completes the training and education but does not complete the credentialing process to demonstrate achievement of the competency.

Possessing the RRT credential exemplifies the dedication of a respiratory therapist to professional excellence. A therapist who achieves the RRT credential has demonstrated a commitment to providing care at the highest possible level. Respiratory therapists are more readily able to achieve autonomy in their practice of respiratory care when they have achieved the RRT credential. Medical Directors of respiratory ~~therapy~~ care departments and other medical staff recognize the higher level of knowledge and clinical expertise of the RRT compared to the CRT. Accordingly, they will be more receptive to therapists utilizing protocols in the care of patients if there is an assurance of the level of knowledge and skill conveyed by possession of the RRT credential. A respiratory therapist with education at the advanced-level

who has not achieved the RRT credential has not demonstrated he or she has the patient assessment and evaluation skills necessary for determining the needs of the patient or the knowledge to follow the protocol to determine the appropriate intensity of care needed by the patient. A respiratory ~~therapy~~ care department director will more easily make the case that therapists are able to implement care using respiratory therapy protocols if the therapists are credentialed at the highest level available.

The RRT credential is the credential that demonstrates respiratory therapists have parity with other credentialed health care professionals. The Registered Respiratory Therapist will have more credibility with the Registered Nurse, the Registered Dietician, the Registered Physical Therapist and the Registered Occupational Therapist. Each of these professions has a practitioner level below that of the Registered individual. In each case, this lower level practitioner is prohibited from performing evaluations for the purpose of defining the care plan, or altering the plan as a result of evaluating the appropriateness of the current care. The scope of practice for the lower level practitioner may be seen as more analogous to that of the Certified Respiratory Therapist. Respiratory therapists wanting other health care professionals, administrators and governmental regulators to respect their knowledge and skills must document possession of that knowledge and those skills through attainment of the RRT credential.

Possession of the RRT credential will assist respiratory therapists who wish to expand their scope of practice. As respiratory therapists seek to become involved in intubation, ~~conscious~~ moderate sedation, invasive line insertion and monitoring they must be able to demonstrate they possess the knowledge and skills necessary to be able to perform these functions safely and effectively. A respiratory ~~therapy~~ care director can build a much stronger case for expansion of the scope of practice to assist an institution to respond to shortages of health professionals when the staff possesses the RRT credential.

Appropriate recognition of the respiratory therapy profession will be more easily accomplished at the federal and state levels when the majority of respiratory therapists have achieved the RRT credential. Third party payers will recognize the higher-level credential (RRT) in contrast to the entry-level therapist (CRT).

Advancement to positions in management, education and supervision are generally limited to those persons holding the RRT credential. For a person to be considered for these types of positions, attainment of the advanced-level credential is considered the minimum necessary demonstration of knowledge and competence.

According to the AARC's latest Human Resources Survey, ~~T~~ there is a significant financial incentive to earn the RRT credential. Respiratory therapists who have achieved the RRT credential are often paid at a higher rate than those with the CRT credential. ~~As little as $0.20 / hour amounts to a difference $11,929.42 in additional earnings over a 20 year career. At a difference of $1.00 / hour, this difference over 20 years amounts to $59,647.00 in additional earnings.~~

Conclusions:

- All respiratory therapists are encouraged to obtain the Registered Respiratory Therapist (RRT) credential. The RRT credential is the standard by which a respiratory therapist

demonstrates the achievement of excellence. Evidence-based research documents the value of critical thinking, problem solving and advanced patient assessment skills. Only those respiratory therapists who possess the RRT credential have documented they possess these skills and abilities.

- All respiratory therapists involved in the performance of assessment-based care; problem solving and critical thinking; protocol application; diagnostic critical thinking; respiratory care plan development, implementation and analysis; disease management; mechanical ventilator support; critical care; and critical care monitoring should possess the Registered Respiratory Therapist credential.
- Employers of respiratory therapists should develop policies and implement methods to recognize and compensate employees who hold the RRT credential. Such methods should include requirements for RRT credential for protocol implementation and assessment, increased pay, additional opportunities for cross training and expanded scope of practice for those with the RRT credential.

July 10, 2003

Social Media Committee

Submitted by: Brian Cayko - Congress 2013

Recommendation

- That the AARC BOD accepts the changes made to the current AARC Connect Code of Conduct.

Report

- These changes will allow the policy to guide the administration and moderation of AARC Social Media Accounts including but not limited to Connect, Facebook, Twitter & LinkedIn.
- The SM committee members continue to post to the AARC and non-AARC SM sites encouraging positive interactions and highlighting value of AARC membership.

Other

- See attached documents to support recommendation.
- Original Code of Conduct http://connect.aarc.org/AARC/CodeofConduct
- Microsoft Word document using "Track Changes" to show revisions (See Attachment "AARC Connect Code of Conduct Revision October 2013")

State Government Affairs Committee

Submitted by: John W. Lindsey - Congress 2013

John W. Lindsey, Jr., M.Ed., RRT-NPS – Chair
Natalie Golden – Member-at-Large
Jeffrey Gonzalez – Member-at-Large
Joseph Goss, MSJ, RRT-NPS, AE-C – Member-at-Large
Pat Munzer – Member-at-Large
Daniel Perrine – Member-at-Large

North Carolina had a bill (HB0285) that would have, as of January 1, 2015, created a two-tiered system of RT licensing. The licensed RCP would hold the baccalaureate degree and the RRT credential. The licensed RT will hold the associate degree and either the CRT or RRT credential. This legislation is supported by the state society and the RC licensing board. However, bill was not enacted, but plans are to re-introduce it again in the January, 2014.

The AARC State Government Affairs Committee continues to be updated on the issue of respiratory therapy de-licensure, particularly in Michigan. Our members are standing ready to assist the MSRC if called upon.

There is a rising concern with states scrutinizing respiratory care and other profession's laws to determine if license needs to continue as we are seeing with Michigan. Also the more intense sunset reviews by Indiana in 2012 and Montana and California earlier in the year. Please be forewarned that if a state's RT license is up for sunset review that state should be extra vigilant in their stance.

Ms. Cheryl West will be able to fill in any blanks. Also, I would like to take this opportunity to thank Ms. West for the incredible job that she is doing and how much this committee appreciates all the work she does for the AARC.

I would also like to thank the committee members that served with me on this committee in 2013 and to AARC President George Gaebler for allowing me to chair this committee. It has been an honor.

Respectfully submitted:

John W. Lindsey, Jr., M.Ed., RRT-NPS, FAARC
Chair, AARC State Government Affairs Committee

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Congress 2013

Recommendations

None

Report

Ann Marie and I attended the AMA CPT meeting along with the annual HCPAC meeting, October 10-12, 2013.

There were some consistent themes expressed in discussions/presentations held during the meetings. These were intergraded health care, transactional care management, complex chronic care coordination and patient centered medical home. The AMA has approved codes that would cover physicians for follow up care of patients post hospital discharged. These codes are 99495 and 99496- Transactional Care Management and 99487-99489 – Complex Chronic Care Coordination. These codes cover care for 30 days post discharge. The services specified are non face to face contact with the patient within 48 hours of discharge, on face to face visit within 7- 14 days and some additional non face to face communication. At day 30 post discharge the physician will be reimbursed. There is no specification on who can provide the non face to face contacts; this is left up to the physician. This may be an opportunity for Respiratory Therapists.

The Health Care Professionals Advisory Committee (HCPAC) organization documents were updated and approved at this meeting. The term qualified non physician health care professional was changed to qualified health care provider. This is in keeping with the renewed emphasis for integration of patient care.

As a reminder, the membership composition of the CPT HCPAC includes:

Am Nurses Association

Am Academy of Audiology

Am PT Association

Am Speech-Language-Hearing Association

National Association of Social Workers

Am OT Association

Am Psychological Association

Am Optomometric Association

Am Chiropractic Association

Am Podiatric Medical Association

Am Dietetic Association

Am Association of Pas

Am Association of Naturopathic Physicians

Am Association for RC

Am Massage Therapy Association

National Athletic Trainers' Association

National Society of Genetic Counselors

Pharmacist Services Technical Advisory Coalition

Lastly, our new CPT code **94669** Mechanical chest wall oscillation to facilitate lung function, per session, is in the CPT 2014 Professional edition book. Facilities can begin using this as of January 1, 2014. We do not know the value of this code at this time.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors – Congress 2013

Recommendations

None

Report

- 1. **Liaison to AACVPR**

**Attended the AACVPR & AARC Face-to-Face Partnership Discussion on Thurs. Oct. 3, 2013 2:45 – 3:45 pm. During the National AACVPR conf. in Nashville. Mr. Tom Kallstrom was also in attendance. Good meeting, great dialogue with many Action items. See attached minutes of the meeting, drafted by me

**I am also the current President of the AACVPR Affiliate the Virginia Association of Cardiovascular and Pulmonary Rehabilitation – working to educate PR programs on coding and documentation, publicized the AARC Web cast between MAC 11 states, VA/WV/NC/SC

**AACVPR MAC 11 Reimb. Committee member, planning to have Ed Haver Mac 11 Chair, myself and my medical director – Dr. Lamberti have a conf. call with the MAC 11 Medical Director to address denials in MAC 11 for COPD Gold II – IV qualifications

**AACVPR PR Program Certification Expert Panel committee member, chaired by Trina Limberg working on ITP's and staff competencies

** Leadership Board Development Committee member – voted on BOD presented to AACVPR membership

**Master Fellows Committee member – Dr. John Hodgkin and Trina Limberg received Master Fellowship from AACVPR this year in Nashville

Other

Minutes of Liaison meeting 10-3-13 with action Items below

AACVPR & AARC Face-to-Face Partnership Discussion

Date: Thursday, Oct 3rd, 2013
Time 2:45 – 3:45 pm CT
Location: Gaylord Opryland Hotel in Nashville, TN, in Ryman Studio K
Attendees Present: Gerilynn Connors, Tom Kallstrom, Trina Limberg, Margie King, Tom Draper, Chris Garvey, Brian Carlin, John Pellicone, Abigail Lynn and Megan Cohen was able to join the meeting toward the end of the hour discussion
Not Present: Debbie Koehl

I. Introductions – all members present introduced themselves and their role in AACVPR or AARC and discipline

GOAL of the Partnership Discussion: spreading news between AACVPR & AARC members, share links to websites, webinars and other actions items shared between organizations

II. AACVPR's Strategic priorities: Update from 2010-2013 and plans for 2013 – 2016

- **Preventative Care Model** with usual multidisciplinary functions which RRT is part of
- **Professional Certification Cardiac Rehabilitation Exam** with a Sept. 2014 projected date for any Cardiac Rehab professional (RN, RRT, Exercise Physiologist, etc.) to sit for exam
- **Program Certification** Process for Cardiac and Pulmonary Rehabilitation Programs
- **Pulmonary Rehabilitation Registry** current 77 PR Programs – platform to describe outcomes in PR on a large scale and RRT's largest clinical provider of pulmonary rehabilitation

III. AARC Strategic priorities for 2013-2014

A. AARC Initiatives:

1. AARC'S Medicare Respiratory Therapist Access Act HR 2619

- Bill introduced by Rep. John Lewis [D-GA] on July 8, 2013 and to date have 25 co-sponsors
- RRT Incident to MD in physician office
- Dz Management: CF, COPD, Asthma IPF, PH
- Evaluation and Management Code – non-physician provider would be billed at 85%
- Respiratory Therapist qualifications would be a minimum Bachelor's degree or other advanced degree in a health science field and be credentialed as a "registered" respiratory therapist (RRT)
- AARC commissioned an independent health care firm, Dobson and Associates to develop a cost estimate of bill. The results was an increase to Medicare between $245 and $500 million over a 10-year period

For more details on this legislation go to AARC website at: https://www.aarc.org/headlines/13/09/hr2619/
"Legislation would amend Medicare Part B to add coverage of pulmonary self-management education and training services when furnished by qualified respiratory therapists in the physician practice setting to Medicare patients who have been diagnosed with COPD, asthma, pulmonary hypertension, pulmonary fibrosis and cystic fibrosis. If enacted, this new benefit will not only enhance patient access to respiratory therapists, it will also provide Medicare pulmonary patients with the tools they need to lead healthier lives through self-management of their disease."

Action Item: Can AACVPR'S Day on Hill include AARC'S Medicare Respiratory Therapist Access Act HR 2619
Plan:
1. Topic to be brought to AACVPR's BOD for discussion
2. AACVPR's Legislative Advocate, Mr. Phil Porte will be asked for comment on this request

3. BOD response will be reported back to AARC

2. Rehab/Continuing Care Section Newsletter – in latest issue Chris Carvey submitted article on AACVPR Program Certification information for section members to be informed
Action Item: completed

3. AARC Nationals Nov 2013, Rehab/Continuing Care Section Meeting:

Action Items: Gerilynn Connors will include in the Rehab/Cont. Care Section Meeting Agenda Monday Nov. 18th, 12:50-1:20 pm at the AARC Congress, AACVPR Activities such as:

a. PR Program Certification – updates and news of program requirement expectations
b. PR Program Registry
c. Professional Cardiac Rehabilitation Certification Process and pulmonary will follow – stay tuned
d. AACVPR/AARC Partnership Discussion summary

e. AACVPR agreed to provide a Tool Kit Handout for this section meeting, AACVPR office will send Trina the handout and she will bring to the AARC section meeting, Monday Nov. 18th 12:50 – 1:20 pm

4. AARC Times is a publication that is not peer reviewed and has a section of NEWS NOW AARC. Tom suggested AACVPR submit an article on an AACVPR Initiative.

Action Item: Chris Garvey suggested that an article on the AACVPR Registry be written for submission and Chris volunteered to write this article with a submission by the 3rd week of November for publication in the AARC Times.

5. National Meeting Speaker Swaps is an opportunity for AARC and AACVPR to support speakers at each other's National Conferences. AACVPR is Sept. 3-5, 2014 and AARC will be in Las Vegas, Dec. 9-12, 2014.

Action Item: AACVPR to submit proposals for speakers/topics by November 2013 on the AARC website for AARC Congress 2014

6. Educational Web cast are offered twice a month for AARC members.

Action Item: During an earlier conf. call in Sept. outcomes was a topic discussed. Chris Garvey volunteered to contact Dr. Shawna Strickland AARC Director of Management and Education to discuss topic/time/date of such a presentation with Jessica Eustice

7. COPD Foundation & AARC are hosting a COPD Re-admission Summit Oct. 11, 2013 in Washington DC – if anyone is interested to attend
a. Best Practices AARC call to members to share their best practice on 30 day Re-admission, webinar COPD readmission hosting with COPD Foundation and at the AARC Nationals, Dr. Jenks is the keynote address former CMS Director who is speaking on COPD 30 day re-admissions
b. *AARC wants to embrace COPD Readmission*
c. 30 day transitions with CMS payment impact – create a Team to address this
***a lot of discussion centered around 30 day COPD Re-admission: acute RRT what pathway to refer inpatients to PR and is PR on protocol, Hospital to home program**
***ACC patient seen at 7 days by MD or CR**
***Cardiac Rehab. Performance Measures – one page AACVPR developed – an example as a template**
***Trina's upcoming AARC presentation on COPD Re-admission program**
***Brian's discussion on Home RT's role – Home Pulmonary Rehab and the need to get payers involved with BC/BS 50% paid out of hospital, nurses/pharmacist, and early detection RRT's have expertise on**

IV. Areas for synergy and continued partnership

1. What is the number of RRT members in AACVPR?

Action Item: AACVPR - Jessica will get the number of RRT's who are members of AACVPR and sent this information to this AARC - Tom.

2. What can AARC/AACVPR do together? Is Rehab 101 needed? Pre-conference 2014 to consider in the future. Present to AARC Program Committee by January this idea

Action Item: Brian/Tom/Trina/Gerilynn – pre AARC congress course to discuss PR 101 or what is needed. Jessica (AACVPR) could send out a doodle to set up a conf. call to discuss.

3. **New Respiratory Therapy Medical Devices and home vendors support education and is a Round Table idea for meetings**

Action Item: Consider item #3 above for annual meetings

4. Discussion of Post Hospital Discharge Summary Check off Sheets

Action Item: AARC/AACVPR to Develop a checklist of hospital post discharge instructions, is an Ad Hoc Committee needed to work on this topic?

American Heart Association

Submitted by Brian Walsh – Congress 2013

Recommendations

That the Executive Office reach out to the Leadership of AHA to determine if an AARC Representative is needed.

Report

There have been no meetings. AHA is going through a huge reorganization and may no longer require an AARC Representative.

Other

No AHA meeting scheduled for the fall that I am aware of.

American Society for Testing and Materials

Submitted by Robert McCoy – Congress 2013

No report submitted as of October 30, 2013.

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Congress 2013

Recommendations

None

Report

I have remained in contact with those chartered affiliates with whom I have worked over the past 5 years to provide ongoing assistance to their business planning and operations.

The Georgia Society for Respiratory Care President sent a request for me to facilitate their operational planning session, which was approved by President George Gaebler and scheduled for January 2014.

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 Systems

Submitted by Steve Sittig – Congress 2013

Recommendations

To increase travel support stipend from the current level of $2000 a year for the three yearly meeting to $2500 which would match the stipend level supported by CAMTS. It has been about 5 years since this has been increased.

Report

The CAMTS Board of Directors met in Zurich Switzerland at Rega Headquarters July 29-31, 2013. In addition to scheduled deliberation of accreditations, work continued on the development of levels of care establishing a new process of accreditation. We are scheduled to meet Oct 17th - 19th for the final meeting of the year in Virginia Beach VA prior to the Air Medical Conference. Below is the executive summary of the July meeting.

camts
Commission on Accreditation of Medical Transport Systems

Executive Summary – Board of Directors Meeting – July 29-31, 2013

The Board of Directors met in Zurich Switzerland at Rega Headquarters July 29-31, 2013. Board members present included: Mr. Hickman, Dr. Conn, Dr. Stuhlmiller, Mr. Tangerose, Dr. Wedel, Dr. Brunko, Dr. Holleran, Ms. Treadwell, Dr. Graf, Mr. Becker, Mr. Gryniuk, Mr. Sittig, Mr. A. Smith, Dr. Orr, Mr. Brisbois, Mr. Ragsdale

Staff present: Ms. Frazer and Mr. D. Smith

Dr. Orr presided and thanked Mr. Stefan Becker for hosting the meeting at Rega headquarters and for the opportunity to tour the facility, aircraft and communications center.

Executive Directors' Report

Ms Frazer provided a report and discussion followed on each topic below:

Ms Frazer along with Mr. Becker spoke at the 1st Civilian Air Medical Transport conference in Bangkok prior to this meeting. Ms Frazer presented topics on CAMTS and Just Culture and also provided a 4 hour workshop on Just Culture.
The Bangkok Hospital's transport service is preparing for CAMTS accreditation. They are currently accredited by EURAMI. There were several Asian air medical services attending who expressed interest in CAMTS accreditation.

Two items to be considered for capital budget 2014 were introduced – a fatigue study with Alertness Solutions and a Database overhaul with the goal to receive future applications and PIFs on-line through a secure system. More details to follow at the October meeting.

Mr. D. Smith summarized the Baldridge seminar he attended. The board agreed that we should pursue achieving the prestigious Malcom Baldridge Award.

Mr. Ragsdale informed the board that this would be his last meeting representing AMOA. He will introduce the new AMOA representative at the October meeting. Discussion followed regarding AMOA's concerns that they would like to be more involved in the standards setting process. Ms Frazer discussed the Aviation Advisory Committee that had been part of our activities years ago but was dropped because of poor participation. Mr. Ragsdale volunteered to chair that committee and be responsible for inviting attendees to an October 2013 meeting during AMTC.

Policy Changes:

Ms Frazer discussed the need to change our term "On Hold" in Policy 04.01.00 meaning a program is under review due to major changes or a fatal accident to "Under Review". The connotation of "On Hold" was leading the press to assume it meant accreditation was suspended during the last flurry of helicopter accidents. The board voted unanimously to change the term in our policy and on the website.

Dr. Wedel discussed her idea to review the same 5 medical protocols from each PIF and develop critical elements for each protocol that the pre-reviewers would verify when reviewing that

attachment from a PIF prior to a site visit. Several board members volunteered to help develop critical elements.

The travel policy for site surveyors was discussed and it was suggested that we require business class for site surveyors for any flight longer than 6 hours.
A recent flight to South Africa was in excess of 15 hours and site surveyors needed more than a day to recover after traveling in Coach.

Education and Marketing Committees

Dr. Holleran discussed the poor quality of some recent videos she reviewed for simulation approval . The board discussed that we need specific criteria for instructors and scenarios – Education Committee will have a conference call before the next board meeting.

The Marketing Committee, headed by Ms Palmer, will start tweeting the workshops for October. We placed a 2 month ad on News and Views and have updated our website with access to registration forms. Mr. Smith will conduct a new workshop entitled "Quality and Utilization Management: Doing Things Right and Doing the Right Things". We will also present Intro to Just Culture, Advanced Just Culture and Preparing for Accreditation – all in 4 hour blocks on Sunday, October 20, prior to AMTC. CEs are approved and will be provided for the Just Culture workshops and we are applying for CEs for the other 2 workshops. Details and registration forms can be accessed through the CAMTS website.

Executive Session - there were 24 accreditation decisions: 20 Full accreditations, 2 Probational accreditations, 1 Deferred, and 1 Preliminary Denial.

Congratulations to the following services who achieved accreditation for the first time!

Aviation One Medical Transport Services (ME) Apopka, FL

Meducare Air (RW) Charleston, SC

St. Vincent Newborn & Pediatric Transport – (G) Indianapolis, IN

UVA Medical Transport Network (RW/G) Charlottesville, VA

Congratulations to the following services that were reaccredited!

AeroMed Spectrum Health (RW) Grand Rapids, MI

AeroCare Medical Transport (FW/ME) Tulsa, OK

AirLink Critical Care Transport (RW/FW/GCC) Bend, OR

AirLink at Regional West (RW) Scottsbluff, NE

AirMed International (FW/ME) Birmingham, AL

AirRescue Africa (FW) Gauteng, South Africa

Air St Luke's (RW/FW/GCC and GALS/BLS) Boise, ID

Arizona LifeLine (RW) Tucson, AZ

Boston Medflight (RW/FW/CCG) Boston, MA

Cox Air Care (RW) Springfield, MO

East Texas Medical Center Air One (RW) Tyler, TX

MSVMC Life Flight (RW/GCC) Toledo, OH

Nightingale Regional Air Ambulance (RW) Norfolk, VA

Phoenix Air Group Inc.(FW) Cartersville, GA

Rico Aviation, LLC (FW) Amarillo, TX

St Mary's CareFlight (RW/FW/GCC) Grand Junction, CO

Tulsa Life Flight (RW) Tulsa, OK

West Michigan Air Care (RW) Kalamazoo, MI

The next Board meeting will be in Virginia Beach on October 17-19, 2013.

Extracorporeal Life Support Organization

Submitted by Donna Taylor – Congress 2013

Recommendations

No recommendations at this time

Report

In August, ECMO centers were notified that shipments of the only oxygenator option for US customers were being held. The FDA requested that information be formally submitted from actions the Maquet company took in response to a previous adverse event report involving the oxygenator. This interruption in supply of an integral part of the ECMO system for the United States ECMO centers could have greatly impacted patient care and safety. The oxygenator ship hold was resolved however last month when most hospitals signed a certificate of medical necessity. Fortunately, our program was not impacted due to our available stock and we did not need to revert to sub optimal oxygenators used in the operating room that required frequent replacement, interrupting flow and putting the patient at increased risk.

As a result of a letter signed by the steering committee and many discussions with the FDA, the Maquet company and Dr. Bill Lynch, the steering committee chair, the hold was lifted. FDA panel recently recommended that extracorporeal membrane oxygenation therapy be reclassified from the highest risk associated category, Class III to a lower risk Class II device with special controls. Hopefully, if approved, this would open up doors to the United States ECMO community for ECMO products that are in use in the rest of the world. I plan to attend the ECMO conference in Keystone in February and attend the Steering Committee meeting for further information about this recommendation.

Respectfully submitted,

Donna Taylor, RRT-NPS

International Council for Respiratory Care

Submitted by Jerome Sullivan – Congress 2013

Report

1) **The Inaugural Issue of the ICRC *e-Newsletter*:** The 1st Issue of the ICRC Newsletter was released earlier this quarter. The electronic mailing was distributed to over 1,500 members of the international Respiratory Care community. The e-publication included coverage of information, announcements and hyperlinks to topics of interest to the international Respiratory Care community and carried a strong connection to the AARC/ICRC/IERS brand. It was well received and many positive comments were received from the international RC community.
2) **International Council Facebook Page:** Also earlier in the quarter a new International Council Facebook page for viewing and sharing among our international friends. The page received over 300 "Likes" in the first week of release. Further data on page responses and use is being compiled.
3) **The Council Governors Currently Developing the ICRC Annual Business Meeting Agenda:** A draft copy of same is listed below.

INTERNATIONAL COUNCIL FOR RESPIRATORY CARE

Business Meeting – Anaheim Marriott – Marquis Room
Monday, November 18, 2013 - 7:30 a.m. – 4:30 p.m.

DRAFT AGENDA

I. **8:00 a.m. -** Welcome, **Jerome M. Sullivan, PhD, RRT, FAARC**, President, ICRC
Recognition of Award Winners – **Hector Leon Garza, M.D., International Achievement Award & Toshihiko Koga, M.D. International Medal**

II. **8:10 a.m. -**Introduction of All Participants and Guests

III. Report AARC International Committee – **John D. Hiser, M.Ed., RRT, FAARC, Chairman & Vice Chairs, Daniel Rowley, MSc., RRT, FAARC & Hassan Alorainy, BsRC, RRT, FAARC**

IV. Reports of International Fellows: **Brazil, Colombia, Ethiopia, Japan, Lebanon & Morocco**

V. **9:10 a.m. – Sigurd Aarrestad, MD & Heidi Markussen, RN, Oslo & Bergen, Norway**
"Home Mechanical Ventilation - The Norway Experience "

VI. 9:40 a.m. – David J. Pierson, MD, FAARC, Prof. Emeritus, Div. of Pulmonary & Critical Care Medicine, Univ. of Washington, "Globalization of RC: 30 Years of Personal Experience"

BREAK – 10:00 A.M.

VII. **10:10 a.m.** – International Education Recognition Sys (IERS). - **Louis Sinopoli, EdD, RRT, FAARC**

VIII. **10:30 a.m.** – **Dean Hess, PhD, RRT, FAARC,** Editor in Chief, ***Respiratory Care Journal***
"Update on New Developments in the Journal"

IX. 10:50 a.m. – Welcome from AARC **– George Gaebler, MSed, RRT, FAARC, President**

X. 10:55 a.m – AARC Executive Director – **Thomas Kallstrom, MBA, RRT, FAARC**

XI. **11:00 a.m**. **–** National Board for Respiratory Care (NBRC)
Kerry George, MS, RRT, FAARC, President, Gary Smith, BS, FAARC, Executive Director & Homer Rodriguez, RRT, FAARC, Director, International Affairs

XII. **11:10 a.m.** – Report from Mexico & Latin American Certification Board, **Hector Leon Garza, MD, Governor for Mexico**

XIII. **11:30 a.m.** – Report from Japan, **Kazunao Watanabe, MD, Governor for Japan & Keiko Hasegawa, MD, Kameda Medical Center, Chiba, Japan** "Enhanced Quality Respiratory Patient Care Following Hands-On Respiratory Management Workshop for Physicians in Japan". **Tetsuo Miyagawa, PhD, RRT, Governor for Japan,** "National Survey of Respiratory Care Team in Japan"

XIV. **11:55 a.m**. - Report from *Colombia*, **Marcela Spraul, RRT, BSA, Rubin Restrepo, MD, RRT, FAARC, Governors for Colombia, & Martha Milena Diaz Cedeno, Clinical Instructor, Simone Bolivar Hospital Bogota, Colombia**

LUNCH BREAK – 12:15 P.M.

XV. **1:00 p.m. -** Report from Canada**, Christiane Menard, CSRT Exec. Dir. & Angela Coxe, MBA, RRT, CSRT President, Governors for Canada**

XVI. **1:15 p.m.** – Report from Saudi Arabia, **Hassan Alorainy, BsRC, RRT, FAARC & Mohammed AlAhmari, MSc, PhD, RRT, Governors for Saudi Arabia**

XVII. **1:30 p.m.** - Report from Italy, **Sergio Zuffo, PT**, **Governor for Italy,** representing **Associazione Riabilitatori dell' Insufficienza Respiratoria (ARIR), Simone Gambazza, PT, ARIR Board Member, & Marta Lazzeri, PT, President, ARIR**

XVIII. **1:45 p.m. -** Report from China, **Yuan Yue-hua, RN, RT, & Xiangyu Zhang, MD, FCCP, Governors for China,** "New Developments & Status of RC in China "

XIX. **2:00 p.m. –** Report from South Korea, **Kook-Hyun Lee**, **MD**, **Governor for South Korea**

XX. **2:15 p.m.** - Report from The Philippines, **Noel Tiburcio, PhD, RRT-NPS, Governor for The Philippines** – Update on Status of RT in the United Arab Emirates

XXI. **2:30 p.m. -** Report from Taiwan, **Chia-Chen Chu, MS, SRRT, FAARC, Governor for Taiwan**

XXII. **2:45 p.m. - Ya-Jun Li, MD, PhD, President, The Affiliated Hospital Of Xi'an Medical College, Governor At Large**

XXIII. 3:00 p.m. - Report from Turkey, **Arzu Ari, PhD, RRT, Governor for Turkey**

XXIV. 3:15 p.m. – Report from India, **Arvind Bhome, MD, Governor for India**

XXV. **3:30 p.m. -** Report from Argentina, **Gustavo Olguin, PT, RTC, MHCA**, **Governor for Argentina**

XXVI. **3: 45 p.m.** - Ratification of Governors and Officers

For further information in Anaheim, please contact:
Jerome M. Sullivan Anaheim Marriott, Anaheim Phone: 714-750-8000
Email: Jerome.Sullivan@utoledo.edu, Mobile: 419-276-5583

Joint Commission - Ambulatory PTAC

Submitted by Suzanne Bollig – Congress 2013

Recommendations

No recommendations at this time.

Report

The Ambulatory Care Professional and Technical Advisory Committee (PTAC) held two conference calls since the last reporting period. The first call took place on June 20, 2013 and the second on September 9, 2013. The next PTAC conference call will take place the afternoon of October 16, 2013.

Conference Call June 20, 2013

The Ambulatory Care PTAC reviewed and discussed, prior to field review, proposed standards changes for accredited ambulatory health care organizations that provide diagnostic imaging services.

Key Points

1. In 2011, The Joint Commission's Ionizing Radiation and Magnetic Resonance (MR) Safety Steering Team was formed with staff across The Joint Commission. The major focus of the team has been to develop a comprehensive and cohesive approach to evaluating and educating health care organizations on the safe delivery of ionizing radiation and MR services.

2. Over the past year, Steering Team staff conducted research and literature reviews and monitored media reports regarding several significant patient safety incidents related to radiation therapy and the provision of diagnostic imaging services, including computerized tomography (CT), nuclear medicine, positron emission tomography (PET), and magnetic resonance imaging (MRI). The first phase of the Steering Team's work will address diagnostic imaging services.

3. Through the above activities, staff have learned the following:

• Several significant quality- and safety-related issues exist around radiation and MR safety that are not currently addressed by Joint Commission requirements.

• State and federal governments, along with other key stakeholders, have growing expectations for The Joint Commission to respond to the recent and on-going radiation and MR safety issues.

• Current requirements do not adequately address changes in the field (e.g., state legislative changes requiring increased oversight of CT services, initiatives from imaging equipment manufacturers, and radiology stakeholders).

• The Joint Commission has lost opportunities as private payors look to competitors rather than The Joint Commission for advanced diagnostic imaging (ADI) accreditation.

• A proactive approach is needed in anticipation of The Centers for Medicare & Medicaid Services'' expansion of requirements for the ADI program, and in response to the recent U.S. Government Accountability Office (GAO) report, *Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services.* Included in this report were criticisms of The Joint Commission's ADI program.

4. In October 2012, The Joint Commission convened a group of imaging experts to provide recommendations regarding processes that must be evaluated to ensure the safe delivery of diagnostic imaging services.

5. Staff analyzed the feedback provided by the imaging experts and conducted a gap analysis to compare their recommendations to The Joint Commission's current requirements and survey process related to diagnostic imaging services.

6. The gap analysis identified the need to add more specificity to current standards in order to allow a more focused and effective evaluation of risks in the provision of diagnostic imaging services.

7. Staff developed standards changes that would add specific language focused on processes for diagnostic imaging. The proposed changes would apply to all ambulatory organizations providing these services, including those organizations that have achieved ADI certification, since this optional certification requires ambulatory accreditation.

8. The standards changes proposed in response to the gap analysis address the following areas:

• Activities to prevent unnecessary radiation exposures
• Activities to prevent MR safety incidents
• Qualifications for radiologists and radiology staff
• Imaging equipment maintenance and oversight
• The application of the imaging-specific requirements developed for the ambulatory ADI certification program to all accredited ambulatory organizations
• The application of the imaging-specific requirements developed for accredited ambulatory organizations and hospitals performing CT exams in the State of California to all accredited ambulatory organizations

<u>PTAC Conference Call September 9, 2013</u>
The Ambulatory PTAC reviewed and discussed the proposed revisions to the Medication Management standards regarding sample medications for the Ambulatory Care (AHC) and Office-Based Surgery (OBS) accreditation programs.

<u>Key Points</u>
1. At this time in the Ambulatory Care accreditation program (AHC), the Medication Management chapter has 20 standards and 113 elements of performance. Of the 13 EPs, all but one applies to sample medications. For the Office Based Surgery (OBS)accreditation program, the medication management chapter has 16 standards and 57 elements of performance. Of the 57 EPs, all but one applies to sample medications.

2. In 2012, The Joint Commission's Standards Interpretation Group (SIG) reported that there were an increasing number of questions regarding the Medication Management (MM) standards and

their applicability to the use of sample medications. The Joint Commission decided to conduct an in-depth review regarding the applicability of the MM standards to sample medications.

3. For the AHC accreditation program, the sample medication team reviewed all 113 EPs in the MM standards and determined that only 34 of the EPs actually applied to sample medications. For the OBS accreditation program, the sample medication team reviewed all 57 EPs in the MM standards and determined that only 21 of the EPs actually applied to sample medications.

4. On March 15, 2013 staff presented the sample medication recommendations and revisions to the PTAC for field review consideration: The recommendations included the following:

• A reduction in the number of MM standards that are applicable to sample medications:
•For the AHC accreditation program, out of 113 MM EPs, 34 EPs should apply to sample medications.
•For the OBS accreditation program out of 57 MM EPs, 21 EPs should apply to sample medications.
• The proposed Standard MM.09.01.01 should be field reviewed with the AHC and OBS accreditation programs. This proposed MM standard specifically addresses sample medications along with the critical safety issues identified from the review of literature.

5. On May 23, 2013 the Standards and Survey Procedures (SSP) Committee approved a field review on sample medications for the AHC and OBS accreditation programs.

PTAC Conference Call September 9, 2013
The Ambulatory PTAC reviewed and discussed, prior to field review, the proposed new National Patient Safety Goals (NPSG) for the Ambulatory Health Care (AHC) and Office-Based Surgery (OBS) accreditation programs addressing patient care transitions.

Key Points
1. Because of the significant risks to patient safety and quality of care, in 2012, The Joint Commission began a three-year, enterprise-wide initiative to improve transitions of care across the continuum of health care. The initiative included an evaluation of The Joint Commission''s standards, NPSGs, survey methods, and other accreditation requirements to determine whether they were relevant, contemporary, and comprehensive in addressing the challenges associated with transitions of care. An extensive literature review, a series of learning visits (including visits to settings from each accreditation program and providers in various parts of the country), calls with several experts in transitions of care, and program-specific focus group calls provided the staff of the Division of Healthcare Quality Evaluation (DHQE) with a great deal of helpful information that has been used to guide them in their work.

2. DHQE staff concluded that in their current configuration, Joint Commission standards and NPSGs related to transitions of care are relatively few in number, are not comprehensive, and do not specifically acknowledge care across the continuum of health care.

3. DHQE staff worked then closely with staff across the enterprise and determined that a multi-pronged approach would be the most effective way to improve patient care transitions. Tools and publications developed to date include the following:
• A surveyor education module on current standards that relate to discharge planning and transfer of patients
• A Transitions of Care portal on The Joint Commission website (updates made 2-3 times per year)
• Two "Hot Topics in Health Care: Transitions of Care" publications

• Two *Perspectives* articles introducing the project and new portal
• A surveyor resource tool on the concepts involved with care transitions

In terms of Joint Commission accreditation requirements, staff believe the best approach is to focus on an NPSG addressing patient care transitions from one health care setting to another. The NPSG language is specific to each accreditation program where necessary, and the standards applicability grid will be utilized to demonstrate which standards and EPs in the NPSG will apply to each ambulatory setting.

4. The proposed NPSGs (see Attachment A) are based on seven key concepts resulting from extensive research, as explained in Key Point 1. It also includes information identified in the work done by The Center for Transforming Healthcare's Hand-off Communication project and Targeted Solutions Tool (TST). These key concepts are as follows:

• Leadership support
• Early identification of patients at risk
• Thorough psychosocial assessment
• Interdisciplinary team involvement
• Patient and family/caregiver engagement
• Medication management
• Transfer of information

These key concepts are directly related to the concepts mentioned in the AMA care transitions report for ambulatory settings (see number 3 under Background on page 1).

5. The request for field review approval will be presented to the Standards and Survey Procedures Committee at its November 2013 meeting. The field reviews for the various accreditation programs are planned for late November through early January 2014.

Results of the field reviews and any proposed revisions to the NPSGs will be presented to the PTACs in spring 2014.

Joint Commission - Home Care PTAC

Submitted by Joe Lewarski – Congress 2013

Recommendations

None

Report

The Joint Commission PTAC conference call was held in September and was attended by Kim Wiles the alternate, as I was out of the country. There is nothing of concern to discuss.

Joint Commission - Lab PTAC

Submitted by Franklyn Sandusky – Congress 2013

Recommendations

None

Report

The Next LAB PTAC meeting is December 2, 2013. I have no other information to report.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Congress 2013

Nothing to report

Natl Coalition/Health Professional Education In Genetics

Submitted by Linda Van Scoder – Congress 2013

Recommendations

None

Report

The Genetic Alliance sent out a request for its member groups to sign on to a letter urging the federal government to resolve its issues and end the government shutdown (AKA the "slimdown"). I passed the request on to the Executive Office but the issue was deemed too politically charged for the AARC to participate. I will continue to monitor Genetic Alliance communications for opportunities to support our patient's needs.

National Sleep Awareness Roundtable

Submitted by Anne Marie Hummel – Congress 2013

Recommendations

None

Report

The commentary, "Raising Awareness of Sleep as a Healthy Behavior," has been published in the CDC journal *Preventing Chronic Disease*. This article is a product of NSART and meets its goal to raise awareness of the importance of sleep. A copy was sent to the Sleep Section.
NSART has not met since the previous Board meeting.

Neonatal Resuscitation Program

Submitted by John Gallagher – Congress 2013

Recommendations

None

Report

The NRP Steering Committee will meet on October 23 and 24, 2013 at the AAP national convention in Orlando, Florida. Following the meeting, the committee and its liaisons will host a NRP Current Issues Seminar for NRP providers and instructors on October 25th. As AARC liaison, I will conduct a break-out learning session at the seminar on the management of airway anomalies during neonatal resuscitation.

The scheduled meeting in October will include a review of research grant proposals aiming to receive grants from the NRP Young Investigators program. I am assigned to review multiple proposals that relate to respiratory equipment and ventilatory support of the newborn.

Additional liaison activity over the past 6 months has included the investigation into several pointed questions related to respiratory care and the content of the textbook. With literature reviews and impromptu bench testing, we have successfully answered requests from the field of NRP providers.

No further updates.

Roundtable Reports

Asthma Disease Management

Submitted by: Michael Shoemaker – Congress 2013

Recommendations

None

Report

The Asthma Mgmt Roundtable currently has 191 members. It is Co-chaired by Mike Shoemaker and Eileen Censullo.

For professional and personal reasons, Mike Shoemaker will not be able to serve as a chair for 2014. Eileen Censullo is willing to continue serving and has requested that the Board nominate a co-chair to help her.

Consumer

See Executive Director Report

Disaster Response

Submitted by Charles Friderici – Congress 2013

Recommendations

None at this time.

Report

We have had a modest increase in membership since the last update.

Geriatrics

Submitted by Mary Hart – Congress 2013

Nothing to report.

Hyperbaric

Submitted by Cliff Boehm – Congress 2013

No report submitted as of October 30, 2013.

Informatics

Submitted by James Fielder – Congress 2013

No report submitted as of October 30, 2013.

International Medical Mission

Submitted by Lisa Trujillo – Congress 2013

Recommendations

No new recommendations at this time.

Report

Membership has increased to 82. As indicated in the June report, folders are available for members to post information related to sharing of donations, mission opportunities, educational presentations and resources, etc. The IMMR will meet in Anaheim during the AARC Conference. These annual meetings provide an opportunity for RCPs who are seasoned in international mission an opportunity to share experiences and advice regarding mission work. It also provides RCPs who are new to international mission work, or who are interested in getting involved, an opportunity to network and make personal connections with those who have similar interests. As 2014 draws closer, it is anticipated that upcoming mission trip opportunities will be posted on AARConnect via the IMMR site.

Military

Submitted by Harry Roman – Congress 2013

Recommendations

I would like to encourage the AARC state delegates and officials of other state level respiratory care societies to follow the lead from the Texas Society of Respiratory Care (TSRC) and offer similar memberships and registrations to conferences, convention and other meetings at a reduced rate or complimentary to members of the armed forces. Many of these individuals will one day become permanent residents of your state and will already be members of your state RT society.

Report

1. Active duty military respiratory therapist are now eligible to receive a complimentary membership to the Texas Society of Respiratory Care (TSRC). The TSRC in their August 2013 meeting approved to present complimentary membership to active duty military respiratory therapists.

2. Active duty military respiratory therapists can register to attend the 19th Annual Alamo District Seminar, TSRC, October 18-19, 2013 at the Norris Conference Center, 4522 Fredericksburg Rd, San Antonio, TX 78201 at a reduced rate for active duty military respiratory therapist of $20.00 to cover meal expenses.

Other

The Fort Sam Houston "News Leader" weekly periodical just published an article in the center spread of 13 September issue describing the very successful and challenging Army/Navy RT Program taught at the Medical Education Training Campus. Follow the link below and go to pages 12-13

http://www.samhouston.army.mil/pao/NewsLeader.aspx

Neurorespiratory

Submitted by: Lois Rowland – Congress 2013

Recommendations

No recommendations at this time.

Report

The Neurorespiratory Roundtable had 118 members in October 2013, reflecting a 5% increase since June 2013. In October 2012 there were 60 members.

Palliative Care

Submitted by: Helen Sorenson - Congress 2013

The Palliative Care Roundtable went live in May 2013. In 4 months we have had 110 therapists/physicians become members and the discussions have been very interesting. Paul Selecky and I are going to have a brief roundtable meeting after our Palliative Care Symposium on Tuesday the 19th, at 11:20 AM. We will discuss future directions for the Roundtable.

Research

Submitted by John Davies – Congress 2013

Report

I have been contacted by Shawna Strickland about how the Research Roundtable can play a role in the development of a research mentorship program. We plan to meet and discuss in more detail at the International Congress.

Simulation

Submitted by Julie Perretta – Congress 2013

Recommendation

None

Report

This year's AARC International Congress features a presentation by Joel M. Brown II on simulation: Get Real! How Good is Today's Simulation Technology? (Saturday, 430-530). We are also pleased that the Open Forums feature 10 simulation-based abstracts, as listed below. These will be featured on the Simulation Roundtable's AARConnect:

1. The Use of the ASL 5000 to Validate Pediatric and Neonatal Normal and Disease State Lung Models—Amanda Dexter MS, Chicago IL
2. Effects of an Interprofessional Simulation Activity to Improve Students' Perceptions of Other Healthcare Professions—Chase Poulsen PhD RRT-NPS, Roanoke VA
3. High-Fidelity and Low-Fidelity Simulation: Does Fidelity Effect the Self-Efficacy and Learning Outcomes of Associate Degree-Seeking Respiratory Care and Nursing Students?—Luster Fowler PhD RRT MBA, Indianapolis IN
4. An Interprofessional Simulation Activity to Provide Early Mobilization of the Ventilated Patient in an ICU Setting—Jose D Rojas PhD RRT, Galveston TX
5. "I Can Do It!" Improving Staff Confidence Through Simulated Learning—Ben Downs RRT-NPS, Little Rock AR
6. Use of Human Patient Simulation to Improve Critical Thinking and Performance on the CSE—Tammy Babcock MHA RRT-NPS, Galveston TX
7. Evaluation of Interprofessional Learning Through a Ventilator Bundle Patient Case Simulation—Tonya Cook MEd RRT, Little Rock AR
8. Inter-Professional Multi-Patient Clinical Simulation by Health Sciences Students—Georgianna Sergakis PhD, Columbus OH
9. In-Vitro Evaluation of the Pressure Volume Characteristics of a High Fidelity Simulation Manikin for Neonatal Resuscitation Training—Joseph Ciarlo RRT-NPS, Newark DE
10. Use of a Lung Simulator to Evaluate the Performance Characteristics of Oscillatory Positive Pressure Devices—Diane K Dunn RRT, Akron OH

Tobacco Free Lifestyle

Submitted by Jonathan Waugh – Congress 2013

Recommendations

Recommend that AARC urge membership to take a leadership role in their respective workplaces to update work environment safety policies to address e-cigarettes (see comment below in "Other").

Report

We are pleased to announce that a one-day pre-Congress workshop on tobacco treatment for the respiratory therapist is scheduled for Nov. 14, 2013. Three of the four faculty are members of the TFL roundtable and the fourth is the well-known physician tobacco education specialist Steven Schroeder, MD. Doug Laher has been very helpful in working out the logistical details for this event.

- Article on hookah (water pipe) and impact on lung health submitted for upcoming issue of Allergy & Asthma Health.
- Georgianna Sergakis and Rita Mangold continue work on the clinician guide to tobacco treatment intended as a companion to the patient guide.

Other

*Note on recommendation: While the use of e-cigarettes is still being debated in the literature, it is clear that e-cigarettes emit a vapor that contains chemicals including the addictive drug nicotine. While this may/may not be as dangerous as tobacco smoke, it cannot be deemed "safe" for bystanders in an enclosed work setting nor children in any enclosed setting.

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff – Congress 2013

Recommendation:

None

Report:

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

Status: **Arianna Villa, University of California San Diego, will attend the HOD Meeting to participate in the Cultural Diversity Mentoring Program. See CV below.**

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

Status: **Ongoing**

Arianna Villa

UNIVERSITY OF CALIFORNIA, SAN DIEGO, UCSD MEDICAL CENTER, 200 W. ARBOR DR #8377
SAN DIEGO, CA 92103 | 619-543-7542 | a1nunn@ucsd.edu

EDUCATION

PIMA MEDICAL INSTITUTE

A.S. IN RESPIRATORY THERAPY- 2005

UNIVERSITY OF CALIFORNIA, DAVIS

B.S. BIOPSYCHOLOGY – 2003

PROFESSIONAL PRACTICE

University of California, San Diego Medical Center
Pulmonary Rehabilitation Department

Registered Respiratory Therapist Case Coordinator **March 2007 – Present**
· Responsible for teaching classes on respiratory care over an 8 week period to patients with chronic lung disease
· Responsible for exercise training and fitness instruction over an 8 week period in patients with chronic lung disease
· Responsible for communicating oxygen prescription and medication recommendations to pulmonologists on behalf of managed patients

Study Coordinator, LOTT (Long term oxygen treatment trial)-UCSD Satellite Site **December 2011-Present**
· Study coordinator for CMS/NIH funded national research trial: LOTT (Long term oxygen therapy trial)
· Responsible for recruitment, randomization, data collection, and data entry for all patients enrolled at site

Concorde College, San Diego

Respiratory Therapy Instructor, Part Time **April 2007 - February 2010**
· Didactic instructor for 18month respiratory therapy (A.S.) program

Paradise Valley Hospital, National City

Senior Respiratory Therapist **November 2005-March 2007**
· Managed departmental staff of up to 25 respiratory therapists on daily basis
· Wrote/created departmental policy and procedure
· Performed patient care including ICU, NICU, intubation, arterial line insertion, and all other respiratory therapy procedures/functions

Kindred Hospital, San Diego

Registered Respiratory Therapist, Per Diem **August - November 2005**
· Responsible for patient care including treatment administration, ventilator management, patient monitoring and assessment
· Experience in weaning and ventilator management for patients considered "unweanable" at acute care hospitals

Kaiser Permanente, San Diego

Registered Respiratory Therapist **March - November 2005**

- Responsible for patient care including treatment administration, ventilator management, patient monitoring and assessment
- Clinical training in many different patient care areas including ICU, NICU, pediatric and adult care

PROFESSIONAL LICENSURE AND CERTIFICATIONS

Registered Respiratory Therapist, National Board of Respiratory Care **March 2005-present**
State of California, License #24311

AARC COPD Educator Certification **September 2013**

Current CPR certification (UCSD Basic Resuscitation Training Program)

AWARDS

American Association of Respiratory Care **AARC Congress 2012**
Specialty Practitioner of the Year, Continuing Care/Rehabilitation

PUBLICATIONS

“Pulmonary Rehabilitation Corrects Oxygen Prescriptions in Chronic Lung Disease Patients” **AARC Open Forum 2011**
Published in Respiratory Care
Presented at the AARC Annual Congress

American Association for Respiratory Care **2012-present**
Continuing Care/Rehab Section Bulletin Editor

Educational Presentations

"Oxygen and You" **April 2013**
Presented to the American Lung Association Better Breather's Club
San Diego

"Exercise Basics" **May 2013**
Presented to the American Lung Association Better Breather's Club
San Diego

Upcoming:

"Living Well with COPD" **November 2013**
To be presented at the American Lung Association Respiratory Rally

"Migrating from Acute Care to Pulmonary Rehabilitation Case Manager: What does it take? **AARC Congress 2013**
To be presented at AARC Congress

Professional Affiliations

Member of the American Association for Respiratory Care **2007-present**

Member of the AARC Continuing Care/Rehab Section **2007- present**
Section Bulletin Editor, 2012-present

Member of the California Society for Respiratory Care **2007 - present**

Ad Hoc Committee on Officer Status/US Uniformed Services

Submitted by Scott Woodcox – Congress 2013

No report submitted as of October 30, 2013.

Ad Hoc Committee on Leadership Institutes

Submitted by Toni Rodriguez – Congress 2013

Recommendations

None

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

Report: Summer 2013
Thanks to the guiding hand of Shawna Strickland Associate Executive Director of Education, AARC the project is back on target. Dr. Strickland has contracted with several high caliber Respiratory Care Managers to complete the 8 Management Modules. The work is being completed on time. We would like to thank Garry Kauffman, Cheryl Hoerr and John Sabo in addition to Dr. Strickland for answering the call. The Research Modules being written by Rob Chatburn are also nearing completion. There has been a set back with the Education Section as I have been unable to concentrate on the project. Dr. Strickland has graciously agreed to find authors for four of the modules and I will complete the first module only. It is a relief as well as exciting to see the project finally coming together. The AARC projects a November 2013 launch for the three tracks. I would like to thank my committee, all the AARC members the AARC Executive Office staff and Dr. Strickland for believing in and committing time and resources to the project.

Report: Fall 2013
We are currently on schedule with this project and I would like to thank Shawna Strickland, her staff at the AARC and all the members of the association for putting it all together.

Activities since the last report:

1. Special thanks goes out to Marsha Cathcart and the editorial staff at the AARC as they have proofed all of the institute modules (all 20!) to make sure we all sound our best! The AARC IT department will be initiating programming within the next few weeks.

2. Track chairs Linda, Rob, and Rick, will video a short (3-4) welcome message for their track participants. In addition each module author will record a 1-2 minute intro to their module ("Hi, my name is… This module is important because… The key point of this module is..." etc.). A videographer at this year's AARC International Congress (November 16-19) will record these for us.

3. An AARC Connect community will be developed for each of the three institute tracks. The point is to give participants a discussion board of sorts for various questions/topics. Module contributors have agreed to serve as mentors in this community, checking in from time to time to answer questions.

4. Launch is set for January 2014. A feature story on the Leadership Institute will appear in the January AARC Times to coincide with the launch.

Leadership Institute Faculty

Toni L. Rodriguez, EdD, RRT, FAARC
Leadership Institute Chairperson
Program Director, Respiratory Care Program
Gateway Community College
Phoenix AZ

Linda I. Van Scoder, EdD, RRT, FAARC
Leadership Institute Education Track Chairperson
Program Director, Respiratory Care Program
Indiana Respiratory Therapy Education Consortium
Indianapolis, IN

Richard M. Ford, BS, RRT, FAARC
Leadership Institute Management Track Chairperson
Director, Respiratory Services
UC San Diego Health System
San Diego CA

Robert L. Chatburn, MHHS, RRT-NPS, FAARC
Leadership Institute Research Track Chairperson
Research Manager, Adjunct Professor of Medicine
Cleveland Clinic
Cleveland OH

Education Track Faculty

- Christine A. Hamilton, DHSc, RRT, AE-C
  Director of Clinical Education, Assistant Professor
  Tennessee State University
  Nashville TN
- Diane R. Oldfather, MHEd, RRT, RCP
  Program Director
  Rolla Technical Center
  Rolla MO
- Toni L. Rodriguez, EdD, RRT, FAARC
  Program Director, Respiratory Care Program
  Gateway Community College
  Phoenix AZ
- Shawna L. Strickland, PhD, RRT-NPS, AE-C, FAARC
  Associate Executive Director
  American Association for Respiratory Care
  Irving TX
- Sarah M. Varekojis, PhD, RRT
  Director of Clinical Education, Assistant Professor
  The Ohio State University
  Columbus OH

Management Track Faculty

- Cheryl A. Hoerr, MBA, RRT, CPFT, FAARC
  Director, Respiratory Therapy
  Phelps County Regional Medical Center
  Rolla MO
- Garry Kauffman, MPA, FACHE, RRT, FAARC
  Director, Respiratory Care Services
  Wake Forest Baptist Medical Center
  Winston-Salem NC
- John Sabo, MS, RRT, RN, FAARC
  Administrative Director, Respiratory Care/Sleep
  St. Luke's Episcopal Hospital
  Houston TX
- John Salyer, MBA, RRT-NPS, FAARC
  Director, Respiratory Therapy
  Seattle Children's Hospital and Research Institute
  Seattle WA
- Shawna L. Strickland, PhD, RRT-NPS, AE-C, FAARC
  Associate Executive Director
  American Association for Respiratory Care
  Irving TX

Research Track Faculty

- Robert L. Chatburn, MHHS, RRT-NPS, FAARC
  Research Manager, Adjunct Professor of Medicine
  Cleveland Clinic
  Cleveland OH

Respectfully Submitted

Toni L Rodriguez Ed.D, RRT, FAARC
Committee Chair

Committee Members:

Chair: Rodriguez, Toni Ed.D, RRT; Members: Chatburn, Robert MHHS, RRT-NPS, FAARC; Ford, Richard RRT, FAARC; Van Scoder, Linda EdD, RRT, FAARC,

Staff Liaisons: Shawna Strickland, Ph.D, RRT-NPS, AE-C, FAARC, Shawna Strickland Associate Executive Director of Education, AARC

Ad Hoc Committee on 2015 & Beyond

Submitted by Toni Rodriguez –Congress 2013

Recommendations

Recommendation: That the AARC BOD approve the combining of the two committees: *Ad-Hoc Committee on 2015 and Beyond* and *Ad-Hoc Workgroup on Strategies for 2015* into one committee to be named Ad-Hoc Committee on 2015 and Beyond.

Rationale: Upon communication with President Gabler it was determined that he intended only one committee exist to work on the assigned committee charges co-chaired by Lynda Goodfellow and Toni Rodriguez. The formation and posting of two separate committees was in error.

Recommendation: The AARC BOD approved the revised charges for the Ad-Hoc Committee on 2015 and Beyond.

Rationale: The original charges approved for the committee required clarification and in some instances more specific outcomes. Original charges 3 and 4 were combined into one charge due to their content similarities. No change was made that altered the original purpose of the charge. Changes were reviewed by President Gaebler and committee chairs were directed to move forward with the revised charges.

Original and Revised Charges:

1. Competency Level Focus –The 2015 ad hoc committee study mechanisms for 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.

Revised

1. Competency Level Focus –The 2015 ad hoc committee based upon conference document II: "Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond " as approved by the AARC BOD in July 2012, will identify competencies for entry level practice and those that should be acquired after entering practice with suggested mechanisms for competency acquisition.

2. Explore models that could be used by clinical department's educators, and state affiliatesas continuing education venues for the use of clinical simulation as a major tactic for increasing competency levels for the current workforce.

Revised

2. Explore models that validate the use of clinical simulation as a major tactic for increasing or upgrading the competency level of students and the current workforce for the purpose of 1)

establishing the relevance of clinical simulation in the college/university settings as a substitute for actual clinical practice as required by accreditation agencies 2) developing a "Standards of Quality Clinical Simulation" check list to guide clinical departments, educators and state affiliates in the development and effective use of clinical simulation projects.

3. That the Committee in cooperation with the CoARC, consider development models 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.

A. Models should include the methods to overcome barriers for different state models that govern colleges articulation agreements and bridge agreements

B. Develop models of long distance learning that can be used with smart classroom education and clinical in different areas away from the distance classroom sites.

4. CoARC completed a recent survey of the accredited associate degree granting programs which identified those without existing bridges to baccalaureate programs. It was found that funding was not a major barrier. Use this report to create models and make recommendations on methods to overcome the newly identified

Revised

3. That the Committee in cooperation with the CoARC, develop models of consortia and cooperative agreements to assist associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.

A. Models should include the methods to overcome barriers to articulation and bridge agreements that arise from different state guidelines that govern college articulation and bridge agreements.

B. Models should include long distance learning that can be used with smart technology and have the ability to fulfill clinical requirements in unique ways that align with clinical education away from the distance classroom.

C. Recommend strategies for implementing parts A & B.

5. The committee should assess whether the development and promotion of career ladder education options for the members of the existing workforce can be used for advanced competencies and the advancement to baccalaureate degree.

Revised

4. The committee should assess the validity of career ladders as an education option for upgrading and maintaining the skill set of the existing workforce. The assessment should explore the need for career ladders to facilitate acquisition of advanced competencies and advancement to baccalaureate degree as well as identify how career ladders could be implemented.

Report

Fall Report

After clarification of committee members and charges work began in earnest for the committee in late August. All committee members were contacted and asked if they still had an interest in serving on the committee and what charge they desired to work on. Once sub committees were organized, each sub-committee participated in a separate conference call to identify a plan of action for completion of the assigned charge with time lines. Conference calls were conducted the weeks of September 8th and 15th . A synopsis of sub-committee activities with time lines follows:

CHARGE #1

1. Competency Level Focus –The 2015 ad hoc committee based upon conference document II: "Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond " as approved by the AARC BOD in July 2012, will identify competencies for entry level practice and those that should be acquired after entering practice with suggested mechanisms for competency acquisition.

Conference Call: 9/12/2013

Call Participants: Claire Aloan, Bill Dubbs, Tim Myers, John Hiser, Woody Kageler

Summary of final conclusions:

1. Dr. Rodriguez will prepare a compiled list of all the competencies by category as identified in the AARC document: Competencies Needed by the Graduate Respiratory Therapists in 2015 and Beyond. (Due Date 9/20/2013) **DONE**

2. List of competencies will be sent out to the committee members who will review the list for inclusion and completeness.(Return by 11/1/2013) **DONE**

3. Tim Myers will arrange for the AARC Executive office to produce a survey of the competencies to be sent out to the membership for the purpose of determining what competencies are entry level (entry level as defined as should be possessed by a respiratory care student graduating in 2015).(Deadline line: November 31, 2013)

4. Committee will review the results of the survey and determine a final listing of entry level and advanced competencies. (Mid -January 2015)

CHARGE #2:

Explore models that validate the use of clinical simulations as a major tactic for increasing or upgrading the competency level of students and the current workforce for the purpose of 1) establishing the relevance of clinical simulation in the college/university setting as a substitute for actual clinical practice as requires by accreditation agencies 2) developing a "Standards of

Quality Clinical Simulation" check list to guide hospital departments, educators and state affiliates in the development and effective use of clinical simulation projects.

Conference Call: September 17th from 4:30 - 5:15 pm by phone.

Participants: Joseph Goss, Wes Granger, Lisa Shultis, Lynda Goodfellow, Toni Rodriguez

Absent: Denise Johnson

Committee Actions with Time Lines:

1. Committee will check with CoARC regarding their formal policy and/or philosophy regarding the use of clinical simulation time in lieu of actual clinical rotation time.

Time Line: Lisa Shultis will contact CoARC and report back by September 2oth. **DONE**

2. Committee will conduct a literature search on the validity of substituting time engaged in clinical simulation for actual clinical time for the purpose of producing a reference document or White Paper.

Time Line: Lisa Shultis will send out a list of references for the committee to review by September 27th.

Committee members will review the documents and meet during the week of October 21 to discuss findings and determine a outline for the final document.

In regard to developing Standards of Quality Clinical Simulation check list: The committee identified several elements that should be investigated prior to tackling this component of the charge. Committee members volunteered to research a specific element and report back to the group by the first of next year.

* When is it best to use simulated clinical experiences and when is it best to use real clinical practice in facilitating practitioner learning? (Lisa Shultis)

* What are the various type of simulation that can be used in practitioner education and when should each be employed to achieve the best results. (Toni Rodriguez)

* Best Practices to employ in the planning and implementation of simulation education.

(Joseph Goss)

*The use of clinical simulations in interdisciplinary education. (Wes Granger)

Time Line: Committee members to report back to the committee by mid-January. A meeting will be scheduled.

CHARGE #3:

3. That the Committee in cooperation with the CoARC, develop models of consortia and cooperative agreements to assist associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.

A. Models should include the methods to overcome barriers to articulation and bridge agreements that arise from different state guidelines that govern college articulation and bridge agreements.

B. Models should include long distance learning that can be used with smart technology and have the ability to fulfill clinical requirements in unique ways that align with clinical education away from the distance classroom.

C. Recommend strategies for implementing parts A & B.

Conference Call: Sept. 20th

Participants: Pat Doorley, Toni Rodriquez, Brad Leidich, Lynda Goodfellow
Excused: Karen Stewart, Helen Soreson

1. Discussion of past experience with AS to BS bridge programs. The costs involved, affordability, on-line rate structures (flat rates), and in-state v. out-of state tuition was reviewed. Many examples were reviewed such as the "open-university" a concept being developed in Virginia. We questioned if the RRT can count towards degree credit as experiential credit.

2. Articulation agreements and how AS degree credits are transferred/accepted were considered. Some agreements are known to accept all AS credit towards the BS degree while others accept specific number with the remaining number of credits taken as on-line classes. Some articulation agreements are completely on-line with some accepting the on-line credit at in-state tuition rates. Payment structure and credits accepted depend on the agreement and program. Biggest problem seems to be that practicing RRTs with AS degrees do not take advantage of these opportunities.

3. Magnate Status- As with many hospitals seeking Magnate Status as a marker of quality, standards of educational level for RNs is to have all RNs to have their BSN within 3-years of employment. The sub-committee discussed having the management section assist with encouraging technical directors to ask their hospitals to participate in this program with their RT staff.

4. Barriers for most RRTs appear to be 1. Cost; 2. Access; and 3. compensation/recognition.

5. Virginia asked recently if the RT managers in the state were willing to do what was necessary to bridge their AS staff to BSRT. They are interested but need incentives to offer RRTs.

6. The Advanced Practitioner Degree being considered by CoARC with standards under development is not applicable to Bridge/Consortia degree granting institutions. At this point, there are no known standards for bridge programs since students upgrading their degree from AS to BS have already been accounted for under their AS program of study.

7. Should clinical practice be required when upgrading your education? We discussed several known options, such as accepting/validating the CRT for 2 semesters of clinical practice and requiring more clinical hours if the AS therapist has not passed the RRT. If the AS graduate has passed the RRT, then no further clinical hours are required.

8. The call closed with Lynda Goodfellow agreeing to investigate and provide a list of bridge programs to the group. **IN PROGRESS**

CHARGE # 4 :

4. The committee should assess the validity of career ladders as an education option for upgrading and maintaining the skill set of the existing workforce. The assessment should explore the need for career ladders to facilitate acquisition of advanced competencies and advancement to baccalaureate degree as well as identify how career ladders could be implemented.

Conference Call –SEPT 12, 2013

Present on Call: Lynda Goodfellow, Dianne Lewis, Karen Schell, Shantelle Graves

Summary of discussion:

A review of charge 4 and its components:

a. Determine the validity of career ladders
b. Determine the need for career ladders for skill acquisition
c. Determine the need for career ladders to encourage B.S. degrees
d. Determine the best practices for career ladder implementation

Discussed various levels of ladders used in the past with a summary of successes/failures of a ladders/levels program. Next, a discussion of what a career ladders program should entail in order to prepare new graduates and practicing therapists in a hospital setting to become a "Critical Care Specialist" for 2015 and Beyond.

Action Items and Timeline:

1. Lynda will begin a literature search for current career ladder programs in nursing and other disciplines. Purpose of lit review is to assess the validity of career ladder programs. Timeline: Due November 1, 2013
2. An inquiry will be posted to the Management section on AARC Connect to ask how many managers are offering career ladders in their facility and if they are hiring CRTs (CRTs who due to terminal degree/diploma are only eligible for the CRT credential or as new graduates

who are registry-eligible with a timeline to become registered). Timeline: Due October 15, 2013

3. An inquiry will be posted to the Management section on AARC Connect to ask for examples of current career ladder programs either in use or in a proposal format. Timeline: Due October 15, 2013
4. From action item #3, begin to look for best practices and list criteria that should be included in various levels of a career ladder Timeline: Due October 31, 2013
5. Next Conference call to be scheduled the week of October 28 to review material gathered thus far and possibly plan a face-to-face meeting in November at the AARC Congress.

Respectfully Submitted: Lynda Goodfellow Ed.D, RRT FAARC

Toni Rodriguez Ed.D, RRT, FAARC

Ad Hoc Committee to Reduce Hospital Readmissions

Submitted by Greg Spratt – Congress 2013

Recommendations:

None

Report:

Accountable Care Act / Hospital Readmission Reduction Program Best Practices

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

An AARC webcast was held in September with three programs relating their experiences in regard to readmission reduction programs implemented and early outcomes.

Several sessions are planned at the upcoming Congress on this topic.

Other: None

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Congress 2013

The American Respiratory Care Foundation (ARCF) has been very active since I last submitted a progress report to you this past summer. 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 you are aware the ARCF earlier this year decided to no longer host the International Reception but rather host an ARCF Fundraiser separate from this event. This year our ARCF Fundraiser will be held on Friday November 15, 2013 at the Anaheim Marriott. The theme will be *"A Night at the Museum"*. A portion of the proceeds will be used to pay for the development and upkeep of a virtual museum that is dedicated to the history of the profession. The evening will feature some older versions of mechanical ventilators, nebulizers, oxygen devices, and a variety of devices that are part of the rich history of respiratory care. We hope that holding this on the evening before the Congress Opening will allow more opportunity for others who may be able to participate. I hope that you will be able to join us this year.

This past June, ARCF funded its 52nd Journal Conference focusing on the "Adult Artificial Airways and Airway Adjuncts". The preceedings from that Conference will be published in a 2014 issue of RESPIRATORY CARE. Moving forward, the Foundation has decided that it will host a minimum of one Journal Conference a year starting in 2013. Plans are underway and solicitation has begun for the next Journal Conference to be held June 6 – 7. The title will be "Aerosol Drug Delivery in Respiratory Care".

General ARCF fundraising continues to remain a challenge. This year we developed, and published, another article for AARC Times describing the work and value of the Foundation, and asked for tax-deductible contributions from the membership. So far in 2013 approximately $3,520 has been donated from our over 50,000 members. In an effort to make our members better understand the Foundation we again have produced a digital recording. This recording will be used to promote and educate attendees at the Congress and later placed on the AARC and ARCF web sites.

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 2013

Forrest M. Bird Lifetime Scientific Achievement Award
Michael T. Newhouse, MD, MSc, FRCP(C), FACP

Hector Leon Garza, MD Achievement Award for Excellence in International Respiratory Care
David J. Pierson, MD, FAARC

Dr. Charles H. Hudson Award for Cardiopulmonary Public Health
COPD Foundation

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care
Patricia Blakely, RRT, FAARC

Mike West, MBA, RRT Patient Education Achievement Award
William F. Galvin, MSEd, RRT, CPFT, AE-C, FAARC

Fellowships

Monaghan/Trudell Fellowship for Aerosol Technique Development
John W. Newhart, RRT, RCP

Philips Respironics Fellowship in Mechanical Ventilation
Gerald Moody, RRT-NPS, AE-C

Philips Respironics Fellowship in Non-Invasive Respiratory Care
Miri Suh, MD

Charles W. Serby COPD Research Fellowship
Krystal Craddock, RRT-NPS

C**areFusion Healthcare Fellowship for Neonatal and Pediatric Therapists**
Robert Gillete, MD

Education Recognition Awards
William F. Miller, MD Postgraduate Education Recognition Award
Jared B. Rice, BSRT, RRT-NPS, RPFT, AE-C

Morton B. Duggan, Jr., Memorial Education Recognition Award
Stewart W. Morrison

Jimmy A. Young Memorial Education Recognition Award
Kanokon Raksriaksorn

NBRC/AMP William W Burgin, Jr., MD Education Recognition Award
Tracy Bedar

NBRC/AMP Gareth B. Gish, MS, RRT Memorial Education Recognition Award
Charity Clark, BS, RRT

NBRC/AMP Robert M. Lawrence, MD Education Recognition Award
Katherine Meza

Literary Awards

Allen DeVilbiss Best Paper Award
Mark S Siobal, BS, RRT, FAARC

IKARIA Best Paper Award by Best First Author
Cynthia C White, MSc, RRT-NPS, FAARC

Summary

The ARCF Trustees have been in frequent communication this year through a minimum of quarterly phone conferences as well as two face to face meetings (Spring meeting in Dallas and one at the International Congress). I want to thank all of you that gave to the Foundation in 2013 and urge all of you who haven't yet provided your support for the Foundation to consider making a tax-deductible donation. Your support is indispensable to our success. I look forward to presenting this report to you and entertaining any questions you may have while at the Board Meeting.

Thank you.

CoARC Report

Submitted by Tom Smalling – Congress 2013

See Attachment:

“CoARC Update AARC HODBOD 11 13”

MEMORANDUM

Date: October 16, 2013

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

From: Kerry E. George, RRT, MEd, FAARC, President

Subject: NBRC Report

I appreciate the opportunity to provide you my final update as President of the NBRC. Since the last report, the NBRC Executive Committee and Clinical Simulation Examination Committee met in September in Kansas City. Additionally, the NBRC along with the AARC hosted the 22nd Annual State Licensure Liaison Group Meeting. The Board of Trustees and committees will meet in December to conduct examination development activities and discuss business related items pertinent to the credentialing system. For the fourteenth year (since the implementation of computer based testing) the NBRC has been able to continue to provide very high quality credentialing programs to the respiratory therapy profession with no increase in the testing fees for candidates.

Therapist Multiple-choice Examination

Members of this committee have been very involved in the activities that need to be completed prior to the implementation of the new examination in 2015. The job analysis has been completed and the Detailed Content Outline was developed and released in July. The validation study for the new Therapist Multiple Choice as well as the Clinical Simulations Examinaton is well underway and will be completed in December.

Clinical Simulation Examination

The Clinical Simulation Examination Committee has been working very hard to meet the deadline of January 2015 for the implementation of the changes to this examination program. Their efforts require the development of the newer, shorter examination problems and to pretest them in the examination system and develop the needed changes to the scoring of the examination. The committee has also developed more specific test specifications of the types of problems that will be represented on each form of the examination.

NCCA Accreditation

The NBRC recently applied for accreditation of the new Adult Critical Care Specialty Examination. We expect to hear the outcome of our application by the end of the year.

Examination Statistics

Through September 30, 2013, the NBRC has administered 32,000 credentialing examinations across all programs. Pass/fail statistics for the respective examinations for the period January 1 – September 30, 2013 follow:

Examination	***Pass Rate***	
CRT Examination – 10,561 examinations		
	Entry Level	Advanced
First-time Candidates	67.7%	82.5%
Repeat Candidates	16.3%	27.0%
Therapist Written Examination – 10,475 examinations		
First-time Candidates	70.0%	
Repeat Candidates	34.3%	
Clinical Simulation Examination – 9,612 examinations		
First-time Candidates	64.0%	
Repeat Candidates	50.6%	
Neonatal/Pediatric Examination – 718 examinations		
First-time Candidates	72.7%	
Repeat Candidates	48.6%	
Sleep Disorders Specialty Examination – 42 examinations		
First-time Candidates	87.9%	
Repeat Candidates	75.0%	
Adult Critical Care Specialty Examination – 237 examinations		
First-time candidates	88.1%	
Repeat candidates	51.9%	
CPFT Examination – 287 examinations		
First-time Candidates	68.8%	
Repeat Candidates	57.1%	
RPFT Examination – 68 examinations		
First-time Candidates	54.5%	
Repeat Candidates	50.0%	

Your Questions Invited

It has been my honor to serve as President of the NBRC for the past two years. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and all of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the integrity of the credentialing process.

Unfinished Business

New Business

Policy Review

- BA.001 – BOMA – Medical Advisors
- BA.003 – BOMA – Policies and Procedures
- CT.002 – Committees – Medical Advisors

American Association for Respiratory Care
Policy Statement

Policy No.: BA.001

SECTION: Board of Medical Advisors

SUBJECT: **Medical Advisors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December, 2007

DATE REVISED:

REFERENCES:

Policy Statement:
Upon the President's request, the Chairperson of the Board of Medical Advisors (BOMA) shall identify Medical Advisors for Committees, Specialty Sections, and other appropriate Association Groups.

Policy Amplification:

1. Medical Advisors shall be limited to:

    A. Members of the Board of Medical Advisors
    B. Physicians approved by the Board of Medical Advisors

2. Medical Advisors so identified shall be appointed by the President, subject to ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: BA.003

SECTION: Board of Medical Advisors

SUBJECT: **Policies and Procedures**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December, 2007

DATE REVISED:

REFERENCES:

Policy Statement:
Policies and procedures adopted by the Board of Medical Advisors shall not be in conflict with Association policies and procedures.

Policy Amplification:

1. The Chairperson of the Board of Medical Advisors shall present policies and procedures being considered by the Board of Medical Advisors to the President.

2. The President shall, in collaboration with the Chairperson of the Board of Medical Advisors, present such policies and procedures to the Board of Directors as appropriate.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CT.002

SECTION: Committees

SUBJECT: **Medical Advisors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: December 2009

DATE REVISED: March, 2009

REFERENCES:

Policy Statement:
Committees shall have Medical Advisors as requested by the President, identified by the Chair of the Board of Medical Advisors (BOMA) and appointed by the President.

Policy Amplification:

1. Special Committees and other groups shall have Medical Advisors as determined by the President.

   A. BOMA shall submit names for Committee Medical Advisors to the President for appointment and ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS:

HOD Resolutions

House of Delegates Resolution 77-13-14

Resolution Authors: Carl Hinkson, Angela Gasparri

E-mail: gooddog@uw.edu

Phone Number: 206-744-3046

Author's State: Washington, Rhode Island

Co-Sponsors and Their States: Keith Hirst-IL, Sheila Guidry-LA, Laurie Tomaszewski-MN, Nancy DiAmbrosio-NJ, Virgina Foster-MD, Brent Kenney-MO

Resolution:
Resolved that the AARC Board of Directors approve an annual recognition award to be entitled, The Bill Lamb Volunteer Award, presented at the national congress which recognizes a respiratory therapist who has demonstrated exemplary service as a volunteer.

Rationale:
Professional activities such as volunteering at an asthma camp, traveling with a medical mission team, or volunteering for their state affiliate requires a respiratory care practitioner to spend time away from family and work. Often practitioners are required to utilize vacation time or other work benefit to make this possible. These volunteer activities also require respiratory therapists to cover their own expenses.

Establishing a national award to recognize respiratory care practitioners that have dedicated themselves to volunteerism serves several functions. First, the establishment of such an award validates the activity as one worth pursuing, second, encourages others to engage in volunteer activities, and lastly recognizes a deserving individual

AARC
The Volunteer Award

Purpose
The Volunteer Award exists to recognize those who exemplify the best efforts of volunteering and mentoring by going above and beyond while consistently demonstrating the AARC values.

- Promotes professional excellence
- Serves as an advocate for the profession and for the patients
- Educates and mentors others
- Participates in Community

Who can be nominated?

Any respiratory therapist that is an AARC member in good standing.

When should I nominate someone?

This is intended to award respiratory therapists for exceptional volunteer performance. The

following criteria should be considered when nominating a respiratory therapist.

- Promoting professional excellence: Displays and promotes professional excellence at all times.
- Serve as an advocate: Encourages and demonstrates advocacy towards making a difference for patients, their families, and the public, the profession and the respiratory therapist.
- Educates and mentors others: Promotes and educate others towards advancing the science and practice of respiratory care.
- Community and outreach: Promotes and participates in public awareness and community outreach on a local, state, national, and/or international level.

How to Nominate a Respiratory Therapist

The state society who wishes to nominate an individual should provide a written narrative focusing on how that individual has gone above and beyond demonstrating the AARC Values of Promoting Professional Excellence, Advocacy, Education/Mentoring and Community and International Outreach. Specific examples include time frames should be included for each value. A CV and or Resume along with a letter of reference(s) from an individual associated with that organization should be accompanied with the application.
All applications/Nominations need to have the State Society approval. States can nominate no more than 1 individual per year and nominations have to be submitted by the State Delegates prior to the Summer Meeting.

Selection Process

The selection process will consist of the members from the HOD/ Mentoring and Volunteering Committee. All applications will be reviewed at the Summer Meeting

Recognition and Award Ceremony
Once the selection is made the individual is notified and recognized at the AARC Awards Ceremony during the annual International Congress. The AARC Times will feature the individual with their story of recognition. (Pending for approval)

Impact of Resolution:
Affiliates, Executive Office

Implementation Cost:
50.00

Ongoing Cost:
50.00

Relationship to AARC Strategic Plan:
Develop human resources, Increase organizational effectiveness

House of Delegates Resolution 36-13-15

Resolution Author: Thomas Cahill

E-mail: tcahill2001@sio.midco.net

Phone Number: 605-359-0361

Author's State: South Dakota

Co-Sponsors and Their States: none

Resolution:
Be it resolved that the AARC Board of Directors collaborate with the CoARC, CoBGRTE and the NBRC to develop a strategic plan, complete with timetable, to develop Graduate Level Educational Programs equivalent to PA's CNP's, CRNA's and Anesthesia Assistants and develop a strategic plan to help the State Affiliates obtain the appropriate licensure for these Advanced Practice Respiratory Therapists in each of the States and Territories within the United States of America.

Rationale:
1. Developing additional Graduate Level tracts for Respiratory Therapists who wish to advance their skills without having to leave the profession and retaking or obtaining additional licensure such as an RN before moving on to an Advanced Level Practitioner program will make it more rewarding for those entering the profession and is consistent with the AARC's stance on current issues such as Sleep Testing.

2. In its 2013 Position Statement on the development of baccalaureate and graduate level education the AARC states (in part): "The continually expanding knowledge base of today's respiratory care field requires a more highly educated professional than ever before. The realities of healthcare reform under the Patient Protection and Affordable Care Act place additional importance on higher education as the foundation for professional roles and reimbursement for professional services. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate respiratory therapists achieve formal academic preparation commensurate with an advanced practice role. It is the position of the American Association for Respiratory Care that practicing respiratory therapists and respiratory therapy students currently in training should be strongly encouraged to seek higher education beyond the associate degree entry-level to the bachelors' level, thereby preparing themselves for greater responsibility and greater independence of function over the decades ahead. Academic institutions which conduct respiratory therapy education should develop bachelors', masters' and doctoral programs at this time to support the need for such higher education within the field of respiratory care."

Impact of Resolution:
General Membership, Affiliates, AARC Officers & BOD, Executive Office, State/Federal Legislation, NBRC

Implementation Cost:
Unknown

Ongoing Cost:

Unknown

Relationship to AARC Strategic Plan:
Develop art and science of RC, Develop human resources, Increase membership

House of Delegates Resolution 19-13-16

Resolution Author: Will Beachey

E-mail: wbeachey@primecare.org

Phone Number: 701-530-7757

Author's State: North Dakota

Co-Sponsors and Their States: None at this time

Resolution:
Be it resolved that the AARC communicate with the CoARC and request that the new accreditation Standards require all new programs seeking initial accreditation to grant, at minimum, the baccalaureate degree to its graduates, with the proviso that existing fully accredited associate degree programs may continue to function as long as they meet CoARC accreditation Standards and actively develop articulation mechanisms whereby graduates can pursue baccalaureate degrees relevant to the respiratory care profession.

Rationale:
This resolution is consistent with (1) the requirements of HB2619, which requires respiratory therapists to possess the minimum of a baccalaureate degree to qualify for Medicare reimbursement, and (2) white papers and position statements published by the AARC: (a) in 2003, Development of Graduate and Baccalaureate Degrees in Respiratory Care and Respiratory Care: "Advancement of the Profession Tripartite Statements of Support, and (b) Development of Baccalaureate Degrees 2013. Excerpts from the 2013 AARC position statement include the following: The continually expanding knowledge base of today's respiratory care field requires a more highly educated professional than ever before. The realities of healthcare reform under the Patient Protection and Affordable Care Act place additional importance on higher education as the foundation for professional roles and reimbursement for professional services. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate respiratory therapists achieve formal academic preparation commensurate with an advanced practice role...It is the position of the American Association for Respiratory Care that practicing respiratory therapists and respiratory therapy students currently in training should be strongly encouraged to seek higher education beyond the associate degree entry-level to the bachelors' level, thereby preparing themselves for greater responsibility and greater independence of function over the decades ahead...Academic institutions which conduct respiratory therapy education should develop bachelors', masters' and doctoral programs at this time to support the need for such higher education within the field of respiratory care."

Impact of Resolution:
AARC Officers & BOD, Executive Office, NBRC, CoARC

Implementation Cost:
0

Ongoing Cost:
0

Relationship to AARC Strategic Plan:
Develop art and science of RC, Develop human resources

House of Delegates Resolution 35-13-17

Resolution Author: Will Beachey

E-mail: wbeachey@primecare.org

Phone Number: 701-530-7757

Author's State: North Dakota

Co-Sponsors and Their States: None at this time

Resolution:
Be it resolved that the AARC Board of Directors collaborate with the CoARC, the CoBGRTE and the NBRC to develop a strategic transitional plan, complete with timetable, to require the minimum entry-level educational preparation of respiratory therapy program graduates to be the baccalaureate degree level. The strategic plan is to include model curricula to assist existing associate degree programs in formulating articulation strategies with baccalaureate degree granting institutions.

Rationale:
1. HB 2619, introduced in the US House of Representatives, requires respiratory therapists to possess the minimum of a baccalaureate degree to qualify for Medicare reimbursement. Since almost 90% of respiratory therapy educational programs are at the associate degree level, the credibility of the profession's quest for Medicare recognition is at stake and hinges on the perception that Congressional lawmakers have of the AARC's efforts to move to the baccalaureate entry level. The AARC can (a) overtly express intentions to move educational preparation to the baccalaureate entry level, or (b) adopt a passive stance and wait to see if HB 2619 passes. These two options send distinctly different messages; congressional members considering the bill will see either a progressive profession actively engaged in effecting change, or a reactionary passive profession that hopes HB 2619 will do the difficult work.

2. In its position statement, Development of Baccalaureate Degrees 2013 the AARC states (in part): "The continually expanding knowledge base of today's respiratory care field requires a more highly educated professional than ever before. The realities of healthcare reform under the Patient Protection and Affordable Care Act place additional importance on higher education as the foundation for professional roles and reimbursement for professional services. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate respiratory therapists achieve formal academic preparation commensurate with an advanced practice role". It is the position of the American Association for Respiratory Care that practicing respiratory therapists and respiratory therapy students currently in training should be strongly encouraged to seek higher education beyond the associate degree entry-level to the bachelors' level, thereby preparing themselves for greater responsibility and greater independence of function over the decades ahead. Academic institutions which conduct respiratory therapy education should develop bachelors', masters' and doctoral programs at this time to support the need for such higher education within the field of respiratory care."

3. Predating this position statement, in 2003 the tripartite organizations (AARC, CoARC, NBRC) published two white papers promoting the development of baccalaureate and graduate educational programs, noting that the knowledge and skills required of respiratory therapists in the 21st century are difficult to teach within the confines of a two year program (Development of Graduate and Baccalaureate

Degrees in Respiratory Care and Respiratory Care: Advancement of the Profession Tripartite Statements of Support).

4. To address concerns that enactment of this resolution would bring about workforce shortages or disenfranchise existing therapists: basic components of a responsible strategic plan for this kind of transition include "grandfathering" mechanisms and generous timetables for the negotiation of articulation strategies and agreements.

Impact of Resolution:
General Membership, AARC Officers & BOD, Executive Office, NBRC, CoARC

Implementation Cost:
0

Ongoing Cost:
0

Relationship to AARC Strategic Plan:
Develop art and science of RC, Develop human resources

House of Delegates Resolution 32-13-18

Resolution Author: Joe Dwan

E-mail: joe.g.dwan@bctonline.com

Phone Number: 503-313-7336

Author's State: Oregon

Co-Sponsors and Their States: None at this time

Resolution:
Resolved that the AARC Board of Directors and Executive Office collaborate with the State Affiliate Charters and the NBRC to develop a strategic transitional plan, complete with timetable, to require minimum entry-level for respiratory therapist licensure to be the RRT credential.

Rationale:
The profession must evolve from our past in order to meet the challenges of healthcare reform. HB 2619, introduced in the US House of Representatives this year, requires respiratory therapists to possess the minimum of a baccalaureate degree to qualify for Medicare reimbursement. The NBRC will eliminate the CRT exam in 2015 and have one exam with a CRT pass rate and RRT pass rate. The NBRC has publicly stated that they will evaluate the possibility to end the CRT credential after the new Therapist Multiple Choice (TMC) exam begins in 2015. The NBRC recognizes that the skill set of CRT and RRT is so similar that one test can be used. A new grad can take the new TMC exam and Clinical Simulation within a week of graduation and become an entry-level employee. The advance credentials are now the NPS, RPFT, SDS and ACCS and the RRT should be the entry-level credential.

The AARC developed "2015 and Beyond" to begin this evolution. Developing a strategic plan around the RRT as minimum for licensure is a necessary step prior to a bachelor's degree as minimum entry level in the future. The transition plan has been described in the "2015 and Beyond" documentation available on the AARC website.
The transition plan remains incomplete. In particular, assuring that credentialing and licensure recommendations evolve and addressing implications of changes in licensure, credentialing and accreditation are incomplete and must include transitioning licensure requirements from CRT to RRT as minimum entry level as a licensed respiratory therapist. As leaders in the profession, the HOD should direct the AARC Executive office and Board to develop a strategic transitional plan for RRT as minimum for state licensure.

This resolution fits well with the AARC Strategic Objectives which included: Refine and expand the scope of practice, ensure competent care, establish professional standards, advocate for federal and state healthcare policies that enhance patient care, access and professional practice. The time for action is now. As leaders, we see our profession falling further behind other professions in licensure and education minimums and are concerned about the unintended consequences of not taking action.

Impact of Resolution:
General Membership, HOD, Affiliates, AARC Officers & BOD, Executive Office, State/Federal Legislation, NBRC, CoARC

Implementation Cost:
0

Ongoing Cost:
0

Relationship to AARC Strategic Plan:
Develop human resources, Increase membership, Increase organizational effectiveness